Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	10 June 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risks Assigned to the Quality, Safety and Experience Committee (QSEC)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer Jill Paterson, Director of Primary Care, Community & Long Term Care Mark Henwood Medical Director Sharon Daniel, Director of Nursing, Quality & Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Director of Corporate Governance Charlotte Wilmshurst, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

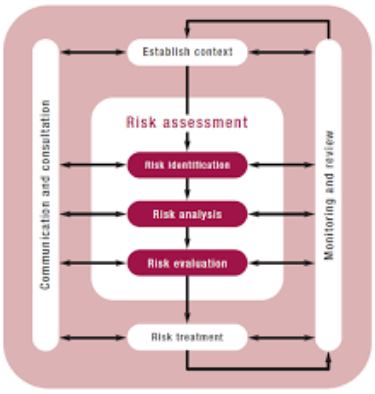
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Quality, Safety and Experience Committee (QSEC) is asked to request assurance from Executive Directors that the corporate risks in the attached report are being 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)

The Board's Committees are responsible for the monitoring and scrutiny of risks within their remit. They are responsible for:

- Seeking assurance on the management of risks on the Corporate Risk Register (CRR) and providing assurance to the Board that risks are being managed effectively and report areas of significant concern, for example, where risk appetite is exceeded, lack of action, etc.
- Reviewing corporate risks over tolerance and, where appropriate, recommend the 'acceptance' of risks that cannot be brought within Hywel Dda University Health Board's (HDdUHB) risk appetite/tolerance to the Board.
- Identify through discussions any new/emerging risks and ensure these are assessed by management.
- Signposting any risks outside of its remit to the appropriate HDdUHB Committee.
- Using risk registers to inform meeting agendas.

The Board has delegated a proportion of its role of scrutiny of assurances to its Committees to make the most appropriate and efficient use of expertise. Therefore, Committees should also ensure that assurance reports relevant to the principal risks are received and scrutinised, and an assessment made as to the level of assurance it provides, taking into consideration the validity and reliability i.e., source, timeliness, methodology behind its generation and its compatibility with other assurances. This will enable the Board to place greater reliance on assurances, if they are confident that they have been robustly scrutinised by one of its' Committees; and provide them with greater confidence regarding the likely achievement of strategic objectives, as well as providing a sound basis for decision-making. It is the role of Committees to challenge where assurances in respect of any component are missing or inadequate. Any gaps should be escalated to the Board.

A revised approach to risk tolerance was agreed by the Board at its meeting in March 2025 to reflect the organisation's readiness to bear the risk after risk treatment, in order to achieve its objectives. This supersedes the previous approach agreed in September 2018 which set the tolerance levels for risk aligned to risk impact domains.

The revised approach utilises the target risk score (TRS) of risks in order to demonstrate the lowest level of risk exposure that the Health Board is willing to tolerate, following the completion of all planned actions aligned to each risk. The TRS represents the ultimate level of risk achievable given the available means and resource. Once the TRS is achieved, if the risk continues to exist, it should then be tolerated / accepted unless further actions are identified or made possible (e.g., additional resources). If achieving the TRS is deemed unacceptable (i.e., the TRS is too high), further discussion or escalation is required. The TRS should be quantified, and where possible aligned to performance targets (including quality metrics), with a set timescale for achieving the reduction of the Current Risk Score to the TRS.

Risks will be 'treated' until a discussion to 'tolerate' a risk is triggered – this would be when the Executive Risk Owner for corporate risks does not support the TRS. The Board will be asked to accept any risks where the Health Board is unable to treat within its available means.

These risks have been identified by individual Directors via a top down and bottom-up approach and are either:

- Associated with the delivery of the Health Board objectives; or
- Significant operational risks escalated that are of significant concern and require corporate oversight and management.

Each risk on the CRR has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account the gaps, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

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The process for risk reporting and monitoring within the UHB is outlined at Appendix 1.

Asesiad / Assessment

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

The Terms of Reference state that:

3.2 Seek assurance on the management of risks within the Corporate Risk Register (CRR) and Directorate level risks 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.

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

3.4 Receive assurance through Sub-Committee Update Reports that risks relating to their areas are being effectively managed across the whole of the UHB's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

There are 9 risks currently aligned to QSEC (out of the 21 that are currently on the CRR) as the potential impacts of the risks relate to the safety of patients, quality of services and patient outcomes.

Each of these risks have been entered onto a 'risk on a page' template, which includes information relating to the strategic objective, controls, assurances, performance indicators and action plans to address any gaps in controls and assurances. These can be found at Appendix 2.

Changes since the previous report to QSEC (December 2024):
The Committee is requested to seek assurance from risk owners (Executive Directors) that each risk is being managed effectively and will be brought within the UHB tolerance.

Below is a summary of changes since the previous report to QSEC:

Total Number of Open Risks	**9**	
New Risks Being Reported	0	
De-escalated/Closed Risks	1	*See note 1*
Increase in Risk Score ↑	0	
Decrease in Risk Score ↓	3	*See note 2*
No Change in Risk Score →	6	*See note 3*

The 'heat map' below includes the risks currently aligned to QSEC:

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	**RARE 1**	**UNLIKELY 2**	**POSSIBLE 3**	**LIKELY 4**	**ALMOST CERTAIN 5**
CATASTROPHIC 5			1531 (↓) 1859 (↓)	1027 (→)	
MAJOR 4				684(→) 1708 (→) 1664 (↓)	797 (→) 1032 (→)
MODERATE 3					1810 (→)
MINOR 2					
NEGLIGIBLE 1					

Note 1 – Risk de-escalated/closed:
The following risk has been de-escalated to Operational Level since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Update
1812 - Risk of non-compliance with Medical Examiners (Wales) Regulations due to the failure to fully resource internal processes	16/11/21	Executive Medical Director	Risk de-escalated to operational level for ongoing monitoring and review at Formal Executive Team meeting held 8 January 2025, as mitigating actions in place to manage compliance, with no specific concerns raised by the Medical Examiners Service to date.

Note 2 – Decrease in risk score:
The following risk has decreased in score since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Previous Risk Score	Current Risk Score	Update	Target Risk Score
1664 - Risk to ophthalmology service delivery due	23/05/23	Chief Operating Officer	**4x5=20**	**4x4=16** (Reviewed 25/04/25)	Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1	**5x2=10**

to a national shortage Consultant Ophthalmolo-gists and the inability to recruit					patients (high risk) with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional Age-Related Macular Degeneration (AMD) sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the Health Board. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. Recently the service has transferred Glaucoma funding to the Intra Vitreal Injection Therapy (IVT) service to create a new Band 7 post for IVT. The additional staffing needed for Wet AMD have been identified in the Eye Care Measures SBAR, which identifies the R1 delivery at 35%. The Welsh Government (WG) target for R1 delivery is 95%. The service as at April 2025 are expected to reach waiting times of stage 1 52 weeks and all stages 104 weeks with a robust plan in place to	

					reach this by the end of quarter one. 7612 patients have been 100% delayed for their follow up appointment. The current risk score has been noted as 16 as ophthalmology is a fragile service. It is unlikely that this risk will be able to be significantly reduced without considerable investment or a regionally agreed solution. The workforce challenges have led to an impact on the Health Board's ability to deliver services within the ophthalmology referral to treatment (RTT) plan, which has been sustained through non recurrent funding secured for the out-sourcing of cataract procedures and IVT patients. Waiting list initiatives have been utilised for additional out-patient appointments. This is in direct conflict with the Health Board's ability to comply with WG Eye Care Measures (ECMs) which is the delivery of timely care for the high risk (R1) category of patients. There are delays to the delivery of R1 appointments for both Glaucoma and the delivery of Intravitreal injections for the Wet AMD pathway, which affects the National Institute for Health and Care Excellence (NICE) 14-day pathway for AMD	

					appointments, impacting on the ability to provide timely diagnosis and treatment and directly impacting on patient safety, with the potential for sight loss and long-term lifestyle impacts. Recruitment difficulties have led to the Consultant on-call rota being covered by 4 substantive Consultants with a gap of 2. This gap is filled by the substantive consultants working additional duty hours to ensure the delivery of the ophthalmology on call service. This is an on-call structure which is impacted by sickness and annual leave. However it is now more stable than previously reported. The service has been able to reduce the impact score of this risk as whilst the consequences to the patient remains high, an SBAR for the recovery of the R1 Eye Care Measures target has been produced which demonstrates a trajectory for recovery if the required investment is secured. This would allow the service to recover to a 65% R1 delivery target allowing the likelihood score to be reduced to a 3 which would reduce the overall score to 15. If the investment was secured in April 2025 the service could recover to 65% by September 2026. Further	

					development would be required to reach a 95% R1 delivery score, which would reduce the likelihood to a 2. With the required investment in Glaucoma and IVT with the additional workforce and focused management of the waiting lists, the HB will potentially reduce the likelihood score on this risk to a 2. The service also will meet their ministerial measures targets by the end of quarter 1.	
1859 - Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	01/05/24	Director of Nursing, Quality & Patient Experience	**4x5=20**	**3x5=15** (Reviewed 25/04/24)	There are specific concerns relating to Glangwili General Hospital (GGH) and Withybush General Hospital (WGH) in relation to cardiac arrests and unplanned admissions. There was an increase in cardiac arrest rates in GGH in the period January - December 2024 (35) compared to the same period January - October 2023 (15). GGH senior management team have agreed to Datix all cardiac arrests and establish bi-monthly meetings to review cases and identify themes and learning opportunities. There has been an increase (22%) in unplanned admissions at WGH, with 92 noted in 2024 (71 noted for 2023). Following the recent WGH Recognition of Acute Deterioration and Resuscitation (RADAR) meeting it was	

					agreed that the Treatment Escalation Plan (TEPs) task & finish group in WGH would be re-established. There are also concerns across the Health Board relating to the National Early Warning Scores (NEWS), and appropriate escalation where required as part of observation processes. Currently working with Clinical Audit to develop an audit tool on the Audit Management and Tracking (AMaT) system to audit on a monthly basis NEWS charts on wards and identify good practice and areas for improvement. A National Safe Care Collaborative meeting held in Cardiff in October 2024 began exploring the possibility of establishing a National Acute Deterioration Clinical Reference Group which will provide an opportunity to benchmark the position of Hywel Dda on an all Wales basis. As of January 2025, compliance rates for Level 2 and Level 3 Resuscitation Training are at 49% and 46% respectively, an increase on the previous figure noted of 40% at November 2024. While there is no set compliance target, compliance has never been greater than 60%. Staff availability to attend resuscitation training is problematic due to	

					operational pressures and demand, therefore, need to identify the most appropriate training level and method to deliver to meet mandatory requirements. As at February 2025, all actions are being processed within set dates / timeframes although many remain long term. Current controls are managing the risk and the increasing awareness of gaps in assurance and local actions to mitigate and manage the risk have been established. The full implementation of the actions noted in the risk action plan will support the reduction in the likelihood and impact score of this risk to a target risk of 10. With recruitment into the Resuscitation Team and the establishment of a supported cascade training process the aim will be to see an increase in training compliance in both level 2 & level 3 training by October 25 to >60%. This will enable the risk to be reduced to the Target Risk Score of 10, >85% would enable the risk score to be reduced further to 5. We will aim to see a reduction in cardiac arrest rates across all 4 sites and unplanned admissions into Intensive Therapy Unit (ITU) from ward areas by October 2025.	

1531 - Risk of being unable to safely support the Consultant on-call rota at Withybush General Hospital (WGH) and Glangwili General Hospital (GGH) due to workforce pressures	10/11/22	Chief Operating Officer	**4x5=20**	**3x5=15** (Reviewed 24/04/25)	Whilst this risk is relating to workforce issues, the domain for the risk is patient safety. The reason for this decision is that, although the rota in WGH has been stabilised, gaps in the service remain e.g. Upper Gastrointestinal (GI). The risk to emergency Upper GI patients at WGH is due to no Upper GI specialists on site and no Endoscopic Retrograde Cholangiopancreatography (ERCP) service on the site. An SBAR has been populated, highlighting the risk to emergency Upper GI patients in WGH. The recommendation from the senior clinical team is for these patients to be admitted directly to GGH. This SBAR was presented at Acute Leadership Group (ALG) on 25/09/2024, at the Quality, Safety and Experience Committee (QSEC) on 08/10/2024 and at the Scheduled Care Quality, Safety and Experience (QSE) meeting on 29/01/2025. The concern is that the GGH clinical team have absorbed the patients that cannot be treated at WGH, without additional resource and this is currently exacerbated by the rota gaps on the GGH consultant on-call rota. As this situation has not changed, the current	**1x5=5**

					risk score remains the same. The consultant on-call rota at WGH remains a 1:4 with 2 substantive consultants and 2 NHS locum consultants on the rota, 1 of which is an internal associate specialist upgraded to a locum consultant. At GGH, the consultant on-call rota is a 1:8 with one gap and one consultant only participating in 50% of the rota. The 1 full gap is currently being covered by a Medacs agency locum consultant and interviews are taking place for an NHS locum colorectal consultant to fill this gap. The 50% gap is being covered by an internal locum at the health board card rate. There are 3 NHS locum consultants participating in this rota. An options appraisal was presented to board in November 2024 and there was an urgent meeting between the Clinical Care Group and Executives in early 2025. The outcome of this was the approval to advertise the posts to fill the gaps. This supersedes the content of a previous SBAR presented at various Executive committees as the plan is no longer to amalgamate rotas, at least in the short term. Following the Scheduled Care Escalation Meeting	

					in March 2025, where the immediate risk of the GGH rota collapsing was highlighted, due to the internal consultants withdrawing from covering the 1 gap on the rota, an urgent executive meeting was arranged for 12 March 2025. The outcome of the meeting was to appoint a substantive colorectal consultant to the GGH rota and for 2 substantive Upper GI consultants in a dual location role across WGH and GGH. It was recognised that this would take some time, there was an agreement that the service would recruit a Medacs locum consultant immediately, to cover the upcoming gap in April and in parallel, advertise an NHS locum colorectal consultant to GGH. On the appointment of the locum consultant, the agency locum will be terminated. On the appointment of the substantive consultant, the NHS locum will be terminated. An NHS locum colorectal consultant was successfully appointed on 30 April 2025, to commence in post in August 2025. The job descriptions and adverts for the 3 substantive consultant posts have been approved by the Medical Director and are now with the Royal College. The aim is that they will be ready to go	

					out to advert by 23 May 2025.	

Note 3 - No change in risk score:
There have been no changes to the risk scores of the risks included in the table below since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Current risk score	Update	Target Risk Score
797 - Risk to the ability to deliver ultrasound services due to workforce pressures	07/11/19	Chief Operating Officer	**5x4=20** (Reviewed 30/04/25)	Despite best efforts, the service remains fragile. As of January 2025, remaining vacancies have been advertised and appointed as training posts under Annex 21 posts, with trainees expected to qualify in September 2026. If all vacancies were recruited to, the Health Board would still not have the capacity to meet current demand (as at end March 2025) there were 1,110 patients waiting 8 weeks plus for non-obstetric ultrasound (February 2024:1288, March 2024:917, April 2024:962, May 2024:731, June 2024 608, July 2024 555, December 2024: 1,960, Jan 2025: 2,301). Reduction in 2025 due to insourcing ultrasound services Long term vacancies exist in WGH with maternity leave which started in summer of 2024 impacting the fragility further. There are 2 potential retirements at Prince Philip Hospital (PPH) in the near future and a number expected in Bronglais General Hospital (BGH), which constitute a significant percentage of the workforce. There will be an inability to secure high-cost agency staff due to the current financial climate of the Health Board. However, in the event of recovery monies being made available we will be able	**3x4=12**

				to re-initiate the current ultrasound insourcing contract 3 Radiographer sonographers and 2 Midwife sonographers commenced training in January 2024, however training takes 2 years to complete for Radiographer Sonographers and 1 year for midwife sonographers (obstetric only). Only 13.82% of Urgent Suspected Cancer (USC) ultrasounds carried out and reported in 7 days, 37.53% carried out and reported in 14 days at end March 2025.	
1027 - Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	19/11/20	Chief Operating Officer	**4x5=20** (Reviewed 21/05/25)	Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. Workforce deficits, handover delays, 4- and 12-hour performance, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating lack of sustainable improvement. The situation remains at high levels of risk escalation across our acute sites on a daily basis. Whilst some positive progress has been achieved in reducing ambulance handover delays and pathways of care delays, Glangwili Hospital (GGH), Bronglais (BGH) and Withybush (WGH) remain a major pressure in the Unscheduled Emergency Care (UEC) system. Whilst recent experience suggests early signs of improvement against key UEC metrics, these remain outside target requirements. Data for April 2025 highlighted that the number of ambulance	**2x4=8**

				handovers taking over one hour was 866, although this is an improvement in comparison to April 2024 (1103) it is not meeting the Targeted Intervention (TI) target of 605 which needs to be maintained for 3 months. Breaches were also noted with the number of patients spending 12 hours of more in Accident & Emergency (A&E) / Minor Injuries Unit (MIU), with actual figure of 1,372 (9%) in April 2025 (compared to 1,543 in November 2024) exceeding the target of 1,137 (7%) TI target. The median time to assessment by a clinical decision maker in April 2025 was 79 minutes (November 2024 87minutes), exceeding the national target of 60 minutes. The Health Board were also over target in April 2025 in relation to Pathway of Care Delays, with actual figure of 223 (November 2024, 204) exceeding the target of 165. As such, the current risk score remains unchanged as at May 2025, pending further review. Recent external reviews (NHS Executive Same Day Emergency Care (SDEC) Review, NHS Executive Emergency Department (ED) Review and Getting It Right First Time (GIRFT) Review on ED) continue to identify concerns with patient flow and quality of service, with a Ministerial Advisory Group (MAG) review received in March 2025.	
1032 - Risk of timely diagnosis and treatment of MH&LD clients	02/11/20	Chief Operating Officer	**5x4=20** (Reviewed 21/05/25)	The service is experiencing significant waiting times as a result of increasing demand levels which are exceeding pre-pandemic levels, compounded by the longer	**5x4=20**

due to demand and capacity				term impacts of COVID-19. Due to increasing demand, there is an impact on the services' ability to see the same volume of service users as they were previously able to. Some posts continue to be funded on a fixed term basis which can make staff retention challenging along with having to train new incoming staff. Recommendations received from NHS Executive in relation to Children's Neurodevelopmental services are in the process of being implemented. The Clinical Care Group is working with the Children, Women and Family Clinical Service Group to implement these. For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit (DU) to establish trajectories, along with the commissioned service which since have been agreed in March 2023. The DU were unable to provide trajectories, therefore the Health Board has agreed to a 1% monthly improvement trajectory.	
1708 - Risk of increasing fragility in primary care contractor services due to external factors	07/07/23	Director of Primary Care, Community & Long Term Care	**4x4=16** (Reviewed 30/04/25)	8 dental contracts have been returned to the Health Board in the last 12 months, of which 4 contracts (totalling £958,500) confirmed as being awarded by NHS Wales Shared Services Partnership (NWSSP) Procurement Services in May 2024. In addition, a further 8 dental practices have not signed up to the contract reform and are signalling that they will return contracts once reform negotiations have concluded. The number of complaints received from the public has increased due to returned	**2x4=8**

				contracts, and while the Health Board is currently containing the demand for urgent dental care, it is recognised that patients who do not fall into this category but require a level of dental care are detrimentally impacted, and that any further contracts returned will exacerbate this situation. The capacity of the Health Board in terms of staffing to absorb further contract reform will impact on the ability to effectively deliver services, and a detrimental impact on staff welfare. There has been increased demand in urgent dental appointments resulting in appointments for the week being booked up early within the same week. The Dental Access Portal (DAP) was successfully rolled out in Hywel Dda in November 2024. 2 General Medical Service (GMS) contracts have been returned to the Health Board in the last 12 months. However, from previous contract terminations, 2 of the 3 GMS contracts have become Health Board managed practices, resulting in additional financial pressures as the workforce is salaried. The third practice has been awarded as of 1 April 2024 after a successful procurement process. The outcome of the contract which was returned in April 2024 was presented and agreed by Board in July 2024, with decision made to manage list dispersal. It is recognised that any further managed practices would likely have a negative impact on the GMS budget.	

				Implementation plans are in place with Ophthalmology to support the transition of patients into Welsh General Optometric Service (WGOS4) (clinical pathways for Glaucoma, Hydroxychloroquine Retinopathy (HCQ) and Medical Retina) as part of the new Optometry contract implementation which commenced in September 2024.	
684 – Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	04/01/19	Chief Operating Officer	**4x4=16** (Reviewed 08/04/25)	The Health Board's stock of aged imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites, which has a significant impact on the Health Board's ability to meet its Referral to Treatment (RTT) target and the impact to patients can include delays in diagnosis and treatment. Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scanners have been replaced and has reduced the frequency of machine downtime compared to previous experience. The risk score is assessed as 16, reflecting that some equipment has been installed and is operational, however further investment is required given recent breakdowns of key imaging equipment. A costed plan along with a rolling programme for the installation of additional equipment is in place. There is a continuous process locally by which equipment is prioritised for replacement. The gamma camera at WGH is the only scanner of its nature in the Health Board and	**2x4=8**

				experienced a series of breakdowns in 2023 and 2024 due to intermittent failures which resulted in several Healthcare Inspectorate Wales (HIW) reportable Ionising Radiation Medical Exposure Regulations (IRMER) incidents. This item of equipment is on the current priority list of items to replace and business continuity plans are being explored. While a new CT scanner has been obtained and installed at GGH, the original CT scanner has had a number of breakdowns. The technology on this scanner is also now out of date and impacts directly on the resilience of the service at our major trauma site in the Health Board. Like-for-like replacement of existing equipment is not necessarily a cost-effective method of maintaining services and in certain circumstances does not meet updated regulatory compliance or meet the requirements of maintenance warranty agreements. This means there will need to be upgraded infrastructure such as air handling units, water chiller systems and the size/accommodation for modalities at an initial increased cost but representing long term savings and service resilience overall. The Dual-energy X-ray Absorptiometry (DEXA) unit at BGH is aged and with the advent of trabeculae bone scoring, any new scanner will have a larger footprint compared with the current scanner and along with necessary shielding required,	

				this may mean that the current DEXA room will be unsuitable to accommodate any new scanner. The technology gap has widened between the services provided at Swansea University Health Board (SBUHB) with concerns raised by referring clinicians. The Health Board's only Nuclear Medicine Single-photon Emission Computed Tomography (SPECT) scanner is overdue for replacement and remains a significant risk to continuity of service provision. The equipment replacement task & finish team are currently looking into options and specifications in readiness for potential funding which was discussed at the National Imaging Equipment and Capital Priorities (NIECP) Group review panel on 2 April 2025.	
1810 - Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS).	01/02/24	Director of Primary Care, Community & Long Term Care	**3x5=15** (Reviewed 22/04/24)	Withybush Aseptic unit is the only functional unit that can manufacture cancer treatments remaining in the Health Board. The facilities of Withybush Aseptic unit are currently non-compliant with regulatory standards. An audit by the National Pharmacy Quality Assurance Lead was performed in February 2024 which confirmed the facilities were a high risk to patient safety, and the unit is at risk of forced closure. Short term control measures have been implemented by the Health Board's aseptic team to reduce the risk of immediate forced closure (see control measures). The controls are currently successfully minimising the amount of microbial	**1x5=5**

				contamination present within the unit, demonstrated by ongoing daily/weekly/monthly environmental monitoring. However, as the unit and equipment are beyond their useful expected life, there will come a time where the control measures will no longer be sufficient to allow the safe running of the unit. If the stringent controls fail at limiting the amount of microbial contamination, the unit may be forced to close. As part of the Transforming Access to Medicines (TrAMS) project programme, a regional manufacturing hub will be built in South West Wales that will prepare cancer therapy for Hywel Dda patients. The hub was originally estimated to open during 2028, however there have been delays to the project plan and the opening date is currently unknown. There is therefore a high risk that the current Aseptic unit at Withybush will be forced to close before the South West TrAMS manufacturing hub is operational. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality	

Argymhelliad / Recommendation

The Committee is requested to seek assurance that:

- All identified controls are in place and working effectively.
- All planned actions will be implemented within stated timescales and will reduce the risk further and/or mitigate the impact, if the risk materialises.
- Challenge where assurances are inadequate.

This in turn will enable the Committee to provide the necessary assurance to the Board, through its Committee Update Report, that the UHB is managing these risks effectively.

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

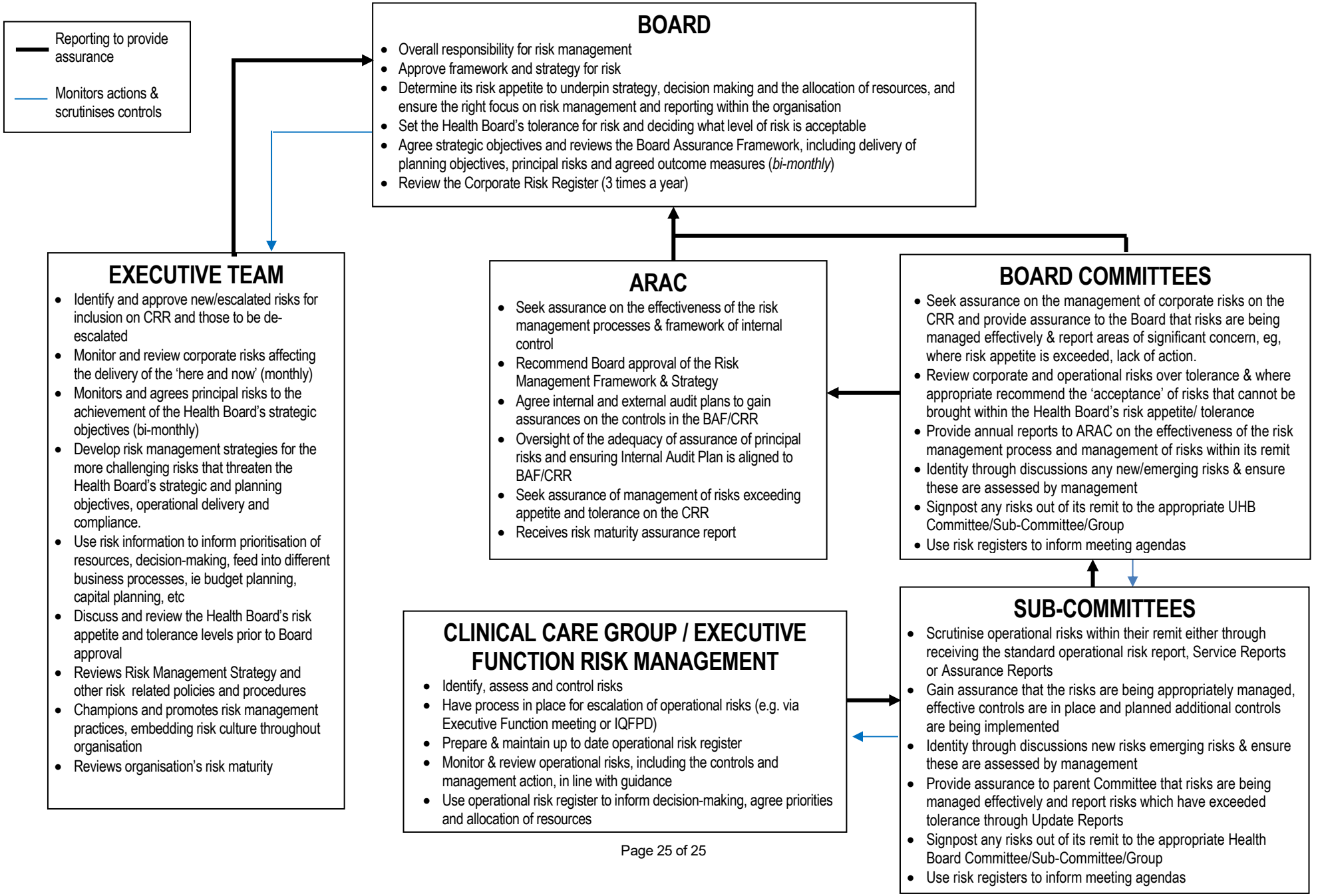
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.2 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g., where risk tolerance is exceeded, lack of timely action. 3.3 Recommend acceptance of risks that cannot be brought within the UHBs risk appetite/tolerance to the Board through the Committee Update Report. 3.4 Receive assurance through Sub-Committee Update Reports that risks relating to their areas are being effectively managed across the whole of the UHB's activities (including for hosted services and through partnerships and Joint Committees as appropriate).
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained within the body of the report
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across the UHB's services reviewed by risk leads/owners
Rhestr Termau: Glossary of Terms:	Current Risk Score - Existing level of risk taking into account controls in place. Target Risk Score - The ultimate level of risk that is desired by the organisation when planned controls (or actions) have been implemented.

	Tolerable risk – this is the level of risk that the Board agreed for each domain in September 2018 – Risk Appetite Statement
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience 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

Appendix 1 – Committee Reporting Structure



Appendix 2

CORPORATE RISK REGISTER SUMMARY MAY 2025

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Tolerance Level	Previous Risk Score	Risk Score May-25	Trend	Target Risk Score	Expected Date of achieving Target Risk Score	Risk on page no...
1032	Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	5×4=20		3
797	Risk to the ability to deliver ultrasound services due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12		8
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×5=20	→	2×4=8	31/03/2026	12
1708	Risk of increasing fragility in primary care contractor services due external factors	Carruthers, Andrew	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	3×4=12		18
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×4=16	↓	2×5=10		24
684	Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Carruthers, Andrew	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	2×4=8		29
1859	Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Daniel, Sharon	Safety - Patient, Staff or Public	6	4×5=20	3×5=15	↓	2×5=10	13/12/2025	36
1810	Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Carruthers, Andrew	Service/Business interruption/disruption	6	3×5=15	3×5=15	→	1×5=5		46
1531	Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	3×5=15	↓	1×5=5		50

CORPORATE RISK REGISTER SUMMARY MAY 2025

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required	
	Detailed review of relevant information
	Medium level review
	Cursory or narrow scope of review

NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

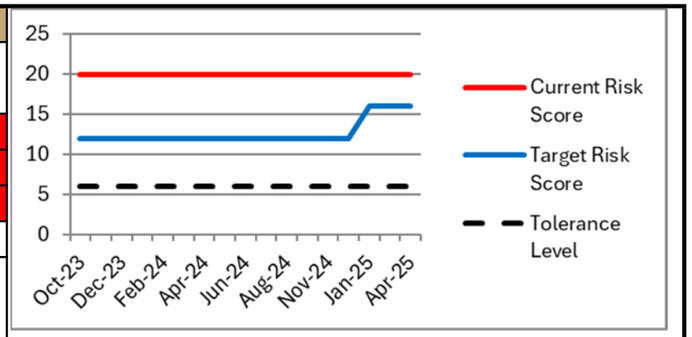
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

Date Risk Identified:	Nov-20		
Strategic Objective:	5. Safe and sustainable and accessible and kind care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-25
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jun-25

Risk ID:	**1032**	**Corporate Risk Description:**	There is a risk to the delivery of timely diagnosis to those on the ASD waiting lists within required timescales - Welsh Government performance standard of 26 weeks. This is caused by an increase in referrals, with demand outstripping capacity and lack of sustainable external funding. This could lead to an impact/affect on those currently awaiting diagnosis and intervention, resulting in delays in care and appropriate support and signposting in a timely manner which may lead to poorer patient outcomes, and delayed adjustments to educational needs. There will also be an impact on the ability of the Health Board to meet Welsh Government targets (diagnosis of ASD within 26 weeks) and the ability to meet the Health Board agreed trajectory of 1% improvement per month which could lead to increased scrutiny from regulators, and escalation from Welsh Government. This in turn could result in adverse publicity and a reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?		138, 1249, 1286, 1287, 1392, 1455, 1422, 1524, 1290, 1260, 1699, 1745, 1414	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	5×4=20
Target Risk Score (L x I):	5×4=20
Expected Date To Achieve TRS:	
Trend:	⟷



Rationale for CURRENT Risk Score:
The service is experiencing significant waiting times as a result of increasing demand levels which are exceeding pre-pandemic levels, compounded by the longer term impacts of Covid. Due to increasing demand there is an impact on the services' ability to see the same volume of service users as they were previously able to. Some posts continue to be funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff. Recommendations received from NHS Executive in relation to Children's ND services are in the process of being implemented. The Clinical Care Group is working with the Children, Women and Family Clinical Service Group to implement these. For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit to establish trajectories, along with the commissioned service which since have been agreed in March 2023. The DU were unable to provide trajectories, therefore Health Board has agreed to a 1% monthly improvement trajectory.

Rationale for TARGET Risk Score:
The Directorate is prioritising implementation of WPAS in key areas within MHLD and this will enable improved reporting and waiting list management and enable forward trajectories of improvement in waiting times to be determined. The target risk score will be dependent on securing recurring funding for Children's ND service as well as having access to appropriate clinical venues and other agencies being able to undertake their associated assessments, digital solutions and review of clinical pathways. While trajectory plans are in place as of March 2025, there is recognition that the Health Board will not achieve WG targets. The end of procurement contracts with external providers will further negatively impact trajectories. Unable to provide a target risk date. The target risk score has been increased.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Use of IT/virtual platforms such as Attend Anywhere when appropriate. Clinical prioritisation regarding assessment and treatment of service users by engaging in a dynamic process of reviewing waiting lists in line with any other referrals that may be received in respect of that service user. Additional WG funding received in 2022/23/24/25 for ND services - currently awaiting confirmation for the next three year cycle. Services are in contact with individuals to provide information regarding mainstream/Tier 0 support, wellbeing at home and guidance should their situation deteriorate. Process in place to ensure individuals on waiting lists are being contacted periodically through the wait for assessment/treatment to monitor any alteration in presentation. Autism Advice Hubs and pre-assessment workshops in place for Children Neurodevelopmental Service. Rolling programme of workshops offering advice and support around neuro-divergence for parents of children aged 2-11 years and 12 years and over awaiting diagnostic assessment. Monthly meetings to meet recommendations of NHS Executive's Action Plan in respect of CYP ND services in place. ND Service Delivery Manager appointed and in place. All posts recruited in to Children's ASD service. With the exception of clinical psychology in adult autism services, all clinical substantive posts recruited in to, with no retention issues. Workforce Management Group has been established which meets monthly.	Although dedicated premises have been sourced for ASD services, there is limited clinical space and Estate issues remain a challenge as identified in the risk narrative. Information not currently included on Health Board website or QR codes due to IT difficulties. Additional funding received in 2022/23 for ND service on fixed term annual basis until 2025. Current resource does not provide sufficient capacity to meet demand. Current procurement exercise to outsource portion of diagnostic assessments to external provider for children and adult services ends March 2025 and will further negatively impact trajectory. Rapid Design Event to achieve critical, systemic and needs led transformation of children's ND services held on 27th and 28th of November 2024. Awaiting outcome report from Welsh Government. Keeping in Touch letters not being sent as of May 2025 - there is a contract monitoring meeting taking place as	Identify alternative venues/space/ virtual to hold clinics (Integrated Psychological Services).	Homfray, Andrew	Completed	Integrated Psychological Therapies Service de-escalated by NHS Executive from Targeted Intervention.
		Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic Training Needs Analysis that can be reviewed at regular intervals and monitored for compliance.	Temple-Purcell, Rebecca	~~30/11/2023~~ ~~31/12/2024~~ 31/03/2025	In progress, working with Workforce to develop a training needs and analysis tool. MH&LD to act as a pilot for this pending further roll out across the HB. Ongoing.

Trajectories have been agreed for Children's ND by NHS Executive and there are systems in place to monitor waiting lists at service level performance-management meetings, IPAR and Directorate service review meetings. Monthly meetings with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint. Use of HB Third Party Contractor to send out Keeping in touch letters and sent to those on ASD waiting lists on a 3-4 monthly basis confirming place on waiting list and signposting to sources of support including access to ND services while waiting. Service Leads secured outsourcing for ASD services up to 2025. Commissioned external provider for ASD services across all ages. Additional NDIP funding secured to outsource a further portion of diagnostic assessments for Children and Young People for previous financial year. Quarterly meetings with the NHS Executive, Welsh Government and Service Leads at the Health Board. SMS functionality in place for ND to improve attendance and decrease instances of non attendance. Support workers recruited in to Children's ND service. Current staff received relevant training, and processes in place to assess training needs on induction for any new starters.	they haven't been meeting the standards set. Dedicated website being launched imminently but the availability of resources for parent/carers are limited due to digital accessibility laws.	ND specific HB internet and intranet pages in development to give guidance and support whilst neuro-divergent individuals and parent carers are waiting.	vaughan, Catherine	~~31/10/2024~~ ~~31/12/2024~~ ~~31/03/2025~~ 30/09/2025	Series of meetings held with Communications team and ND services prioritised to include children's ADHD, Adult ADHD, Integrated Autism Service and Children's ASD service Website remains in development, although all material ready. Adult IAS and Childrens ND content now ready. Awaiting final go live. Children's ADHD and Adult ADHD website has been launched. Digital accessibility issues are being worked through. Due to go live September 2025.

needs on induction for any new starters. "Rapid Access" developed to diagnosis (service improvement initiative) currently being piloted in Children's ND. Started in April 2025. Developed an Early Years pathways for Health Visitors. Social Care and Education Interface Meeting with Carmarthenshire Local Authority to stem the flow (promoting a needs led approach). Fixed term contracts have been agreed for staff until the end of March 2026. Additional resource for admin cover to ND services for a 12 month period.		Grow your own' scheme is coming into place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme (3 year programme).	Carroll, Mrs Liz	~~31/12/2024~~ 31/12/2027	Three year training programme with graduates during 2027.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Welsh Government performance indicators along with internal monitoring arrangements will be used to ensure the actions are having the desires effect or whether there is more that needs to be done.	Management monitoring of referrals	1st			Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC (Oct21) MHLD progress update on Planning Objective 5G - Board (Mar22) Papers have been presented at the Quality	System to improve analysis of patient experience				
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd								

	MH&LD QSE Group overseeing patient outcomes	2nd			at the Quality Safety and Experience Assurance Committee with a further update paper provided for the December 2021 meeting outlining control measures to manage the waiting times that the Directorate have at present. A paper was presented at Board Seminar in June 2022 to provide assurance on current waiting times and control measures.					
	Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd								
	W-PAS Internal Audit (reasonable assurance(	3rd								
	An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.									
	An updated paper was submitted to the December 2024 meeting of the Integrated Quality Finance Performance Delivery Group.									
	Rapid Access Pilot Steering Group (add as action - look at other pathway options/digital)									

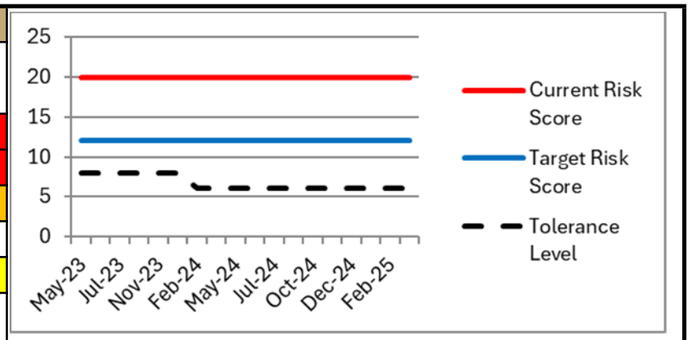
Date Risk Identified:	Nov-19		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Apr-25
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	May-25

Risk ID:	**797**	**Corporate Risk Description:**	There is a risk of being unable to provide a full range of ultrasound services including obstetric and non-obstetric ultrasound across the Health Board. This is caused by workforce pipeline and retention: the retirement and resignation of current sonography staff, low availability of sonographers UK wide, and the inability to recruit to due national shortages of qualified staff, and the inability release existing workforce to train and develop to meet both current and future service demands. Current pressures are also leading to existing staff harm due to repetitive strain injuries (RSI). demand and capacity: there is a gap between funded establishment and demand for ultrasound services This could lead to an impact/affect on patient safety: delays in diagnosis which could result in detrimental outcomes for patients, inability to meet diagnostic targets and cancer pathway targets, and an inability to hold clinics to meet demand in ante natal screening services within required timescales and to implement national scanning guidance. workforce: An impact on staff health and wellbeing in terms of the volume of patients examined within a shift/overtime, which could lead to increased incidents of staff stress and burnout. This could ultimately lead to increased errors when performing the dynamic diagnostic test. This could also lead to increased RIDDOR reporting due to the harm being caused to staff. compliance and litigation: increased instances of RIDDOR and health and safety reporting could trigger monitoring actions by relevant regulator. In the case of obstetric ultrasound, this could lead to failure to detect in utero anomalies, life long, limiting or changing duration which places the Health Board at significant risk of litigation

Does this risk link to any Directorate (operational) risks?	1557, 1349, 1658, 1936

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	5×4=20
Target Risk Score (L x I):	3×4=12
Expected Date To Achieve TRS:	
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Despite best efforts, the service remains fragile. As of January 2025, remaining vacancies have been advertised and appointed as training posts under Annex 21 posts, with trainees expected to qualify in September 2026 If all vacancies were recruited to, the Health Board would still not have the capacity to meet current demand (as at end March 2025) there were 1,110 patients waiting 8 weeks plus for non-obstetric ultrasound (February 2024:1288, March 2024:917, April 2024:962,May 2024:731,June 2024 608, July 2024 555, December 2024: 1,960, Jan 2025: 2,301). Reduction in 2025 due to insourcing ultrasound services Long term vacancies exist in Withybush with maternity leave which started in summer of 2024 impacting the fragility further. There are 2 potential retirements at PPH in the near future and a number in BGH, which constitute a significant percentage of the workforce. There will be an inability to secure high cost agency staff due to the current financial climate of the Health Board. However, in the event of recovery monies being made available we will be able to re-initiate the current ultrasound insourcing contract Three Radiographer sonographers and two Midwife sonographers commenced training in January 2024, however training takes two years to complete for Radiographer Sonographers and 1 year for midwife sonographers (obstetric only). Only 13.82% of ultrasound USC's carried out and reported in 7 days, 37.53% carried out and reported in 14 days at end March 2025.	The actions below will not in themselves reduce this risk significantly. Demand and capacity and the current establishment review is being undertaken by the Ultrasound control group via a needs assessment which was due to be completed by the end of Autumn 2024. It is likely that these reviews will lead to a need for further investment and additional funding to establish a sustainable service model to include a robust perpetual training programme, that will enable the Health Board to met expected diagnostic waiting times targets. Radiology wide demand and capacity work has been undertaken by the Radiology Department which has included the non-obstetric element and has been described in the 2025-2026 annual plan and as of 24/01/2025 an accompanying paper for Board consideration requesting workforce investment in Radiology was submitted on 11/02/2025 and describes the plan for recruitment and expansion of training in all areas of Radiology, including Ultrasound. The annual plan was approved at the March Board meeting and Radiology are working with executives as of April 2025 to answer queries in relation to the agreed investment. Improvement has been seen during Q4 of 2024 and Q1 2025 due to the insourcing at additional cost.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Process in place for the movement of staff across the Health Board to maintain capacity where possible. Conversion of room to increase capacity @ GGH Employment of Physiotherapists and Midwives to undertake scanning within scope of expertise Utilising insourced ultrasound service to reduce backlogs of patients waiting >8weeks (recovery funded). Rolling bank adverts for sonographers. Clinical Educator in post, facilitating the expansion of training across site. Monitoring of cancer patient pathways with ultrasound requirements via weekly Cancer Watchtower, and monthly Cancer and Radiology escalation meetings. Meetings chaired by General Manager of Planned Care and Cancer Services. Continuous recruitment and training of sonographers within current establishment Annex 21 process in place, commencing in January of each year, to train over a period of 2 years sonographers	Inability to recruit and retain sufficient numbers of trained staff. Whilst staff are on the Annex 21 programme, they are not fully qualified until completion of 2 years training and preceptorship (these gaps are covered by insourcing during this period of time) While process in place regarding the movement in staff, due to current staffing levels and pressures, this is not being implemented, however the teams across sites are collaborating and look at all possibilities when gaps in rota arise and are foreseen. Whilst an Ultrasound Control Group is in place, meetings are infrequent due to availability of attendees.	Develop and implement a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Llewellyn, Cerian	~~31/12/2022~~ ~~31/10/2023~~ ~~31/01/2024~~ ~~30/06/2024~~ ~~31/01/2025~~ 31/01/2026	The date of completion of this action has been changed to 31/01/2026 as the midwife identified for training did not start until Jan 2025 due to lack of process to support the clinical aspects and a change in maternity management. Maternity and child health are required to advise of the plan to utilise the skills of the trainee midwife sonographer and also any plans to train more staff.
		Train members of staff to become sonographers, the number of which dependant on capacity to take training.	Roberts-Davies, Gail	~~31/03/2020~~ ~~31/12/2022~~ ~~01/02/2023~~ ~~30/09/2024~~ 31/01/2026	08/04 update. Approval of annual plan, however additional recovery funding has not yet been sourced. Current phasing when signed off will allow the recruitment of 1 additional Sonographer due to the need to fund recovery from recurrent monies.
		Await outcome of Radiology Annual Plan and request for additional workforce investment to enact next phase of recruitment to train.	Roberts-Davies, Gail	Completed	08/04 update. Approval of annual plan, however additional recovery funding has not yet been sourced. Current phasing when signed off will allow the recruitment of 1 additional Sonographer due to the need to fund recovery from recurrent monies.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Non-Obs ultrasound - longest wait 53 weeks as at end March 2025 with 1,110 patients waiting over 8 weeks. Radiology Dashboard IPAR Reports WG Cancer PTL, reported monthly	Management review of sonography and SCP diagnostic waiting times	1st			Sonography Report to Acute Leadership Group (ALG) and Operation Planning and Delivery Programme meeting					
	Monthly review of USC performance undertaken monthly (13.82% of ultrasound USC's carried out and reported in 7 days, 37.53% carried out and reported in 14 days at end March 2025), included in the IPAR & reported to WG	1st								
	Performance monitored at Executive Improving Together Sessions	2nd								
	Performance monitored via IPAR, overseen SDODC & Board	2nd								
	Ultrasound Services Internal Audit, July 2024 reasonable assurance provided	3rd								

CORPORATE RISK REGISTER SUMMARY MAY 2025

Date Risk Identified:	Nov-20		
Strategic Objective:	5. Safe and sustainable and accessible and kind care		

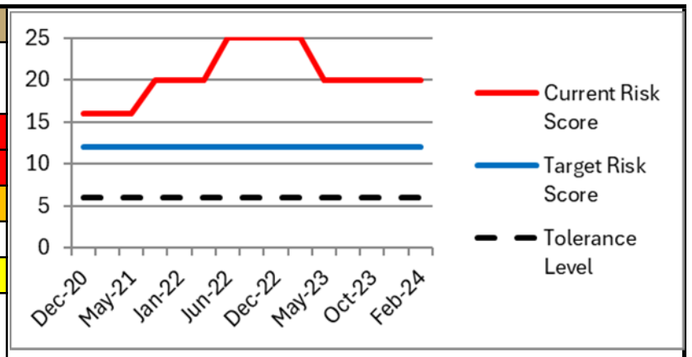
Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-25
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jun-25

Risk ID:	**1027**	**Corporate Risk Description:**	There is a risk to the consistent delivery of timely and high quality urgent and emergency care. This is caused by significant fragility across the urgent and emergency care (UEC) system (acute, primary care (including out of hours), community and social care services), related to workforce compromise and increasing levels of demand and acuity. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays and overcrowding at Emergency Departments (ED) and delayed ambulance response to community emergency calls, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.

Does this risk link to any Directorate (operational) risks?	1649, 1406, 1548, 1210, 750, 205, 86, 820, 232, 1298, 1281, 906, 1380, 1116, 878, 839, 1167, 1223, 111, 114, 199, 523, 136, 200, 1115, 1078, 572, 1295, 1231, 966, 967, 565, 852, 1295, 1435, 1377, 1083, 180, 1424, 1417, 1309, 291, 118, 925, 119, 1245, 695

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	31/03/2026
Tolerable Risk:	6

Trend:



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. Workforce deficits, handover delays, 4- and 12-hour performance, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating lack of sustainable improvement. The situation remains at high levels of risk escalation across our acute sites on a daily basis. Whilst some positive progress has been achieved in reducing ambulance handover delays and pathways of care delays, Glangwili Hospital (GGH), Bronglais (BGH) and Withybush (WGH) remain a major pressure in the UEC system. Whilst recent experience suggests early signs of improvement against key UEC metrics, these remain outside target requirements. Data for April 2025 highlighted that the number of ambulance handovers taking over one hour was 866, although this is an improvement in comparison to April 2024 (1103) it is not meeting the TI target of 605 which needs to be maintained for 3 months. Breaches were also noted with the number of patients spending 12 hours of more in A&E / MIU, with actual figure of 1,372 (9%) in April 2025 (compared to 1,543 in November 2024) exceeding the target of 1,137 (7%) TI target. The median time to assessment by a clinical decision maker in April 2025 was 79mins (November 2024 87mins), exceeding the national target of 60 minutes. The Health Board were also over target in April 2025 in relation to Pathway of Care Delays, with actual figure of 223 (November 2024, 204) exceeding the target of 165. As such, the current risk score remains unchanged as at May 2025, pending further review. Recent external reviews (NHS Executive Same Day Emergency Care (SDEC) Review, NHS Executive ED Review and GIRFT Review on ED) continue to identify concerns with patient flow and quality of service, with a Ministerial Advisory Group (MAG) review received in March 2025.	The Target Risk Score of 8 reflects the confidence in the delivery of 6 Goals Programme to address the significant issues across the health and care system. Plans for improvement during 2025/26 are reflected in the HB's Annual Plan, approved by the Board in March 2025, and are informing next year's Annual Plan. The 6 goals plan has been approved by WG in March 2025. TI measures such as ambulance handovers and 12 hour delays in ED will need to improve in order to reduce the current risk score, for a consecutive period of three months. UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly into Formal Executive Team. An expected date of March 2026 has been noted to achieve the target risk score of 8, to allow the transformation change to embed.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Live Operational Dashboard in place and twice HB wide escalation meeting. # Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. Surge and boarding recorded on the twice a day escalation report. # Frontier system in place for recording DPOC and red days flagging required assessments to support discharge. # Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites with associated actions in collaboration with social care partners. # Regular advice on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, social services and the Long Term Care Team support. # Discharge arrangements are in place on all sites with a strategic review underway. # Standardised board rounds processes in place on all sites and D2RA processes are embedded with a 77% D2RA rate (Sep24). # Criteria-led discharge guidance and principles piloted across HB (Sep24). # Integrated Regional Winter Plans developed to manage whole system pressures over the winter period. # An operationally focussed 6 Goals Urgent and Emergency Care (UEC) programme with governance structure agreed where all UEC improvement is coordinated. # Welsh Ambulance Services NHS Trust involved in all 6 Goals UEC workstreams. # 111 and 111 press 2 (MH) implemented across Hywel Dda. # Regional Integration Fund projects in place across Regional Partnership Board (RPB) footprint, along with Further Faster projects to ensure alignment with	# Fragility of Care Home Sector such as financial viability, staffing deficits, recruitment and retention of workforce. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff. # Inability to handover ambulances to release them back for use within community due to lack of flow in acute sites. # Need to have better understanding of ED presentations to ensure development of alternative pathways in primary care / community to prevent ED attendance. # Ability to influence public mind set / expectation and culture in terms of use of NHS resource and ‘Home First’ Ability. # Gap in communication between secondary and primary care that could lead to poor discharge outcomes. # Clarity regarding roles and responsibilities for discharge planning and coordination. # The inability to risk stratify for people at moderate to high risk of admission in the community to implement proactive anticipatory care plans to support avoidance of exacerbation / decompensation and hence increased risk of hospital admission.	Delivery of 6 Goals Programme and Plan via the workstreams and closer working with WAST and primary care 1. Development of Regional Clinical Streaming Hub (CSH) for Health Professionals & Care Homes delivering 24/7 urgent care advice & support and onward referral to local deliver/resource hubs where appropriate	Skitt, Peter	31/10/2025	Piloting a 7 day model on the CSH across the Health Board as part of winter planning (utilising overtime and additional shifts) with an evaluation being finalised by end of May 2025. The plan to produce a business case for substantive arrangements is including in the Accelerated UEC Transformation work to be delivered by October 2025.
		Develop a consultant led ED medical provision that is fit for purpose and meets the D&C requirements utilising all professions.	Skitt, Peter	~~31/03/2025~~ 30/09/2025	Discussions have started, with a lead for the discussion appointed. Lead ED Consultant had gone out to advert as of May 2025 (closing June 2025) following previous advertisement unsuccessful. advised appointment date of September 2025.
		Winter Communication Plan for UEC to include advising the public on community pharmacy provision and avoiding falls	Skitt, Peter	Completed	Communications engagement leads contacted, with a plan in place and social media communications active.
		Utilise the risk stratification data set across the system proactively with the population	Skitt, Peter	~~30/04/2025~~ 31/10/2025	Part of First Home Hub plan and work is underway. Data is being used in primary care multi-disciplinary team meetings across the Health Board and WGH, and requires further embedding to ensure the impact within acute sector is realised.
		Review of Community bed based hospital capacity, with a view to ensuring proactive case load management and estate as part of the Alternative Care Model work. Develop & implement strategy for Alternative Care Community (ACP) Provision across the West Wales region.	Skitt, Peter	31/10/2025	Initial planning and audit of capacity has been completed. Length of stay data being gathered by County Leads.

(RPB) footprint, along with Further Faster projects to ensure alignment with Ministerial objectives. # Whole system approach to deploy HB staff to ensure continuity of patient care. # Care Home Risk & Escalation Policy to support failing care homes to be applied as required. # Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across the RPB region. # Establishment of a Discharge to Recover and Assess (D2RA) Group which reports to the the 6 Goals Programme with a detailed D2RA improvement plan in place. # Establishment of a D2RA Escalation Transfer panel which provides senior oversight of delays at county level, assesses risk of the delay to the patient and organisation in terms of flow compromise # SRO in place to lead agreed 6 Goals for UEC programme. # Agreed SDEC model in place to maximise impact on admission avoidance. NHS Executive review with associate actions are part of the 6 goals UEC programme. # Local streaming (Home First) hubs developed with a HB wide approach agreed with clinical triage and screening systems in place, including APP Navigator in place. # Direct referral into SDEC in place. # OOH Pilot clinical streaming via GP route ongoing as of January 2025 with a view to full completion at the end of the month # Clinical Care Group structure in place where this risk is discussed at the quality meeting. #UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly into Formal Executive Team.	# Optimising our bedded facilities in the community. # Need to develop 24/7 integrated urgent primary care service aligned to Home First hubs. # Insufficient IPC single rooms across community and acute sites, negatively impacting on patient flow. # Lack of level 1 / 2 falls response service during out of hours across the Health Board. # Fragility of senior medical cover at EDs across the acute sites. # Need to create a Health Board wide Frailty approach and appoint a Clinical Lead for Frailty. # 7 day services within the Community are required, particularly around Clinical Streaming Hubs and level 1 /2 Falls.	Enhancements to local delivery / resource hubs to support the CSH providing access to enhanced community care services, third sector services and other pathways to provide safe alternatives to admission. Integration with GP OOHs and APP resources	Skitt, Peter	31/10/2025	Discussions ongoing on providing a single clinical streaming hub across the Health Board footprint, with response resources locally based at cluster level as a phased approach to introducing the care at home blueprint, as described during the 6 Goals review meetings. This will feature strongly in the Accelerated USC Transformation work.
		Development & implementation of consistent approach to Front Door Streaming / Assessment Units focused on our Frail Elderly cohort based on good practice and lessons learnt from Withybush Puffin / South Pembrokeshire model.	Skitt, Peter	31/12/2025	SDEC services available on all sites for medical patients. Surgical SDECs piloted in Glangwili and Bronglais (with further expansion during the next 6 months). Ongoing discussion with Glangwili relating to frailty provision, and further work required in Bronglais (nurse-led frailty team at the front door).
		Development and implementation of HDUHB optimal SDEC model following on from lessons learnt from peer review and alignment with CSH and local resource hubs.	Skitt, Peter	31/10/2025	An SBAR has been developed to standardise the approach across the Health Board, which is to be discussed at the CCG July 2025 meeting.
		Continued implementation of Optimal Flow Framework including Community sites supported by Frontier digital platform.	Skitt, Peter	31/10/2025	On track with roll out plan, and ensuring that all sites are using the framework is ongoing. This work will also feed in to the E-Obs and patient flow project going forward.
		Continuing education at ward level to ensure consistent approach to Board Rounds and Safety Patient Huddles utilising Frontier platform to capture and report information.	Skitt, Peter	Completed	This action links with the management actions as noted in the Discharge Management internal audit issued. This is now complete and evidence to be uploaded to AMaT.
		Implementation of 7 focused areas within ED Quality statement.	Skitt, Peter	31/03/2026	Clinical lead for ED post currently out to advert. ED Quality Statement Action group in place, who report 6 weekly to Welsh Government. Action plan developed and in place, forming the basis of updates to WG, based around the national toolkit.

Develop West Wales Hospital @ Home model to ensure consistent approach and delivery.	Skitt, Peter	30/09/2025	Phased approach to the delivery of the model, with strategic document currently being developed, to be agreed by clinical leads and 6 Goals advisory group.
Establishment of a regional Discharge Strategy Group to provide oversight of all current work streams and actions being undertaken around discharge as well as work around national and local policies - Discharge and Transfer of Care Policy, Reluctant Discharge Policy, Care Home of Choice policy.	Skitt, Peter	Completed	POCD group and Trusted Assessor group in place, and Discharge Strategy group to provide oversight and actions, chaired Assistant Director of Nursing. This work will align with the delivery of the management actions of the internal audit on Discharge Management, which is being monitored by the Health Board via AMAT. Action complete and toolkits available.
Establish regional POCD group to focus on reviewing of trends and themes to develop robust regional or local action plans to deliver improvement.	Skitt, Peter	Completed	In place as at January 2025, and regular monthly meetings with Welsh Government, and onward submission of data. Monitored via the 50 Day Challenge Care Action Committee (CAC) group.
Develop robust regional Trusted Assessor (TA) Model to ensuring consistent approach to assessment across the region - residents can be an inpatient at any of the 4 x general hospital sites.	Skitt, Peter	31/10/2025	Trusted Assessor regional group in place focussing on the model and reporting required to Welsh Government, aligned to further faster monies. A National Audit is to take place in Summer 2025 on Trusted Assessors across the West Wales region.

CORPORATE RISK REGISTER SUMMARY MAY 2025

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Ambulance handovers within 15 minutes Ambulance handovers over 1 hour Ambulance handovers over 4 hours 4 & 12 hour waits in A&E Time to triage in A&E Time to see a Doctor in A&E Pathway of care delays	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st				None identified.				
	Daily performance data overseen by service management	1st								
	Workstream Delivery Plans overseen by 6 Goals Programme	2nd								
	6 Goals Programme / UEC IQFPD 3As report into IQFPD	2nd								
	Bi-annual reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	IA review on Transforming Urgent and Emergency Care	3rd								
	NHS Executive Same Day Emergency Care (SDEC) Review	3rd								
	NHS Executive ED Review	3rd								
	GIRFT Review on ED	3rd								
	MAG review	3rd								

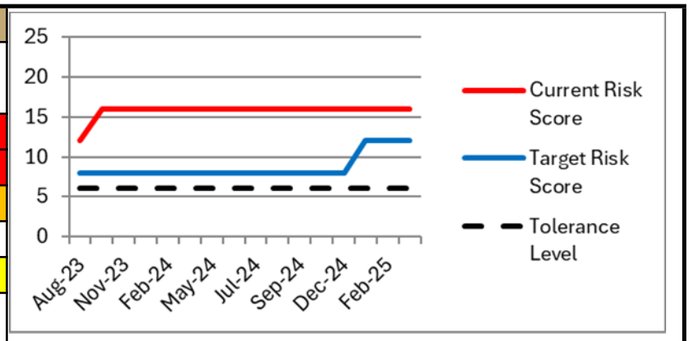
Date Risk Identified:	Jul-23		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Apr-25
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	May-25

Risk ID:	**1708**	**Corporate Risk Description:**	There is a risk of increasing fragility in Primary Care Contractor services. This is caused by several factors including pay-affecting Government decisions, which impacts on succession planning for contractor professions. There are further challenges in relation to premises not being fit for purpose, and not having the capacity to flex to a more modern approach to service delivery e.g. MDT working. In addition, contract reform against the background of significant pressures on the wider system, and exacerbated by financial pressures for the independent contractor business model. This could lead to an impact/affect on undermining the independent contractor model, and therefore the ability for patients to access timely and local primary care services, with potential for demand exceeding capacity. If service users are unable to access these services, this may lead to additional pressures on other primary care services, and wider Health Board services such as Out of Hours and Urgent and Emergency Care. As a result of contract terminations, there will be a detrimental impact on the financial position of the directorate relating to dental contracts.

Does this risk link to any Directorate (operational) risks?	1688, 1451, 1403, 1164, 1660, 933, 800. 912, 1823, 1869, 1109, 1851, 1823, 1993

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×4=12
Expected Date To Achieve TRS:	
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
8 dental contracts have been returned to the Health Board in the last 12 months, of which four contracts (totalling £958,500) confirmed as being awarded by NWSSP Procurement Services in May 2024. In addition, a further 8 dental practices have not signed up to the contract reform, and signalling that they will return contracts once reform negotiations have concluded. The number of complaints received from the public has increased due to returned contracts, and while the Health Board is currently containing the demand for urgent dental care, it is recognised that patients who don't fall in to this category but require a level of dental care are detrimentally impacted, and that any further contracts returned will exacerbate this situation. The capacity of the Health Board in terms of staffing to absorb further contract reform will impact on the ability to effectively deliver services, and a detrimental impact on staff welfare. There has been increased demand in urgent dental appointments resulting in appointments for the week being booked up early within the same week. The Dental Access Portal (DAP) pilot commenced in Powys in June 2024, with roll out at Hywel Dda commencing in November 2024. 2 GMS contracts have been returned to the Health Board in the last 12 months. However from previous contract terminations, 2 of the 3 GMS contracts have become Health Board managed practices, resulting in additional financial pressures as the workforce is salaried. The third practice has been awarded as of 1st April 2024 after a successful procurement process. The outcome of the contract which was returned in April 2024 was presented and agreed by Board in July 2024, with decision made to manage list dispersal. It is recognised that any further managed practices would likely have a negative impact on the GMS budget. Implementation plans are in place with Ophthalmology to support the transition of patients into Welsh General Optometric Service (WGOS4) (clinical pathways for Glaucoma, HCQ and Medical Retina) as part of the new Optometry contract implementation which commenced in September 2024.	Achievement of the target score is subject to the development and agreement of a Primary Care Strategy at Board alongside successful national contract negotiations and subsequent implementation across the Primary Care contractor professional groups. There is a high dependency on external factors which make the reduction of the risk score challenging. It is unlikely that the risk score will reduce to the target risk score within 12 months without the approval of the Primary Care Strategy. Successful conclusion of contract negotiations with professional contractor groups also required.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Primary Care Academy in place, which looks at workforce planning, training and development needs and opportunities 5 Facet Survey completed in 2022 to establish a baseline for the GMS estate GMS and Dental Practices undertake annual reporting which includes reviews of statutory compliance requirements 0.25 FTE Primary Care Development Manager for estates in post but with a focus on GMS Escalation tool for GMS and Community Pharmacy (SITREP) Continue effective engagement with struggling practices to support with their issues through close working relationships developed with practices. Programme of practice visits to review Estates provision, and if remedial action is required Requests sent to contractors to assess potential risk of RAAC, with outcomes reported to WG Nationally agreed Breach Management process in place for Community Pharmacies. Requests for contract variation (termination, merger, branch surgery closure etc) are considered in line with national guidance, with panels convened as stipulated. Recommendations are taken through the Primary Care Contract Review Group with papers to Board when required. Strategic Programme for Primary Care (SPCC) bids approved for 2024/25 and 2025/26 to support workforce initiatives A series of patient facing videos have been developed with Pocket Medic to support patient education in accessing Primary Care Services Whilst Community Pharmacy Breach Management process in place, which has been reviewed in light of appeals process. GMS contract management review process in place, reviewing escalation status, sustainability assurance framework and business continuity plans. Data is reviewed and challenged where necessary by Primary Care Service Managers.	Requests for support on addressing the GMS sustainability agenda are with the Strategic Programme for Primary Care as a result of a review paper across all Health Boards on their sustainability pressures. National work on the development of the escalation tool for Dental and Optometry is ongoing but not live. Five Facet Survey and annual reporting of practices has highlighted non-compliance with statutory requirements such as Health and Safety, Fire and IP&C which have now all been completed, however this is a statutory requirement for the practices to complete. Limited requirements for practices to disclose information to the Health Board about their sustainability pressures, and rare for practices to disclose financial details (reliant on engagement and good will as this is not a contractual requirement). Insufficient resources to support the estates development across all Primary Care services, particularly with independent contractors. Due to national review of Premises Directions, there is no improvement grant funding for 2024/25. Whilst Community Pharmacy Breach Management process in place, which has been reviewed in light of appeals process. Whilst RAAC declarations were requested, these were not mandatory	Establish workforce plan and recruitment strategy in line with the development of the national Primary Care Workforce Strategy and as a component of the Primary Care Strategy.	Hughes, Samantha	~~31/03/2024~~ ~~31/03/2025~~ 30/09/2025	Workforce planning continues. GP Practice workforce plans using data from Welsh National Workforce Reporting System (WNWRS) have been pulled together at Cluster level for Collaborative consideration. This information now needs to inform and align to the Primary Care Workforce Strategy. Support is being provided to the Directorate with this work from colleagues in Workforce, and is also discussed via the Primary Care Academy. Through Strategic Programme for Primary Care (SPPC) fund, a Primary Care Workforce Planner has been appointed on a fixed term basis until March 2026, who will commence work on the workforce plan. Whilst contact has been made with GP Practices to start this work the initial uptake of the offer of support has been low, however that could be attributed to the end of year contractual submissions taking priority.
		To develop the Primary Care Strategy in consultation with statutory stakeholders and consultees, to cover areas including: •Workforce •Sustainable provision of Primary Care services •Estates •Managing contractual change •Developing pathways and new services •Improving access to services across all contractor professions	Bond, Rhian	~~30/09/2024~~ ~~31/03/2025~~ 30/09/2025	Paper submitted to Board in September 2023 setting out the scope of the Primary Care Strategy, with papers presented to Board at regular intervals. A further paper was presented to SDODC in October 2024. Work is ongoing to establish a mechanism to develop a Clinical Reference Group to secure views from across the contractor professions as well as community service staff.

	requested, these were not mandatory for contractors to respond, and therefore effectiveness of responding to outcomes. Whilst challenge is provided via GMS contract reviews, feedback not consistently addressed by practices.	Consider the potential to deliver a wider range of salaried NHS Dental Services through the Community Dental Service.	Owens, Mary	~~30/04/2024~~ ~~30/06/2024~~ ~~31/10/2024~~ ~~31/03/2025~~ 30/09/2025	As of April 2025 Welsh Government have issued a public consultation document on the future of NHS dental services provision. The Health Board will be seeking to provide a robust response. To enact the proposed changes of an integrated dental service there is the potential to need to consider an OCP in the current CDS service to ensure that the delivery model can be flexible to the demands of the service.
		Implement the Managed Practice Strategy plan will give greater system resilience.	Swinfield, Anna	~~30/04/2024~~ ~~30/10/2024~~ ~~31/01/2025~~ ~~31/03/2025~~ 30/09/2025	The tender process for Neyland and Johnston concluded without a contract award. Re-procurement exercise completed in September 2024 with no success. Review of Managed Practice Strategy to be undertaken in line with the development of the Primary and Community Services Strategic Plan. The introduction of a locum rate card in Autumn 2024 has seen an increase in salaried GP posts with two of the six managed practices operating with minimal locum reliance.

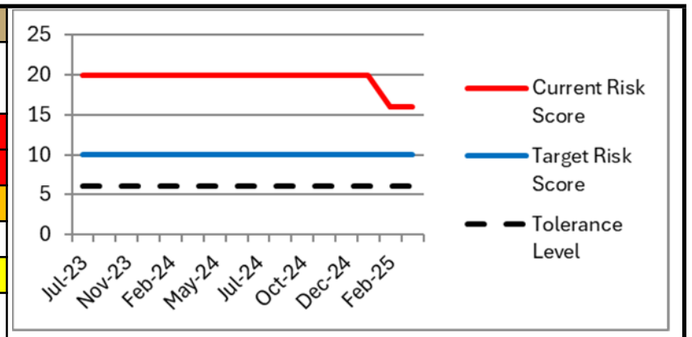
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Sustainability Matrix Contract performance to monitor volume metrics (identifies if dental practices have issues in service delivery), with Primary Care Service Managers reviewing the escalation statuses of practices which is a contractual requirement. Those practices escalated to Level 4 are contacted requesting assurance around their reported level, to identify the potential for any support and where appropriate to challenge the reported level of escalation. Monthly assurance reports and Dental Assurance	GMS practices are asked to complete a WG sustainability matrix every 6 months to track the main risk areas and this contributes to a heatmap. Practices are also asked to report regularly on operational pressures	1st			OQSEC Primary Care Exception Report	Varying levels of engagement from practices in the regular reporting of operational pressures.				
	Dental Management Team undertake annual reviews	1st								
	GMS Practices are part of a rolling visiting programme, based on their annual return which is risk assessed against a framework of any other issues or concerns identified	1st								

Framework - Business Service Authority dashboards, to identify outliers	PCSMs tasked with regular discussions with Practices that report L4 to understand the issues	1st									

Date Risk Identified:	May-23	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Apr-25
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	May-25

Risk ID:	**1664**	**Corporate Risk Description:**	There is a risk to service sustainability in Ophthalmology across the Health Board, and the inability to provide timely care to patients with Glaucoma, wet Age Related Macular Degeneration (wAMD), Vitreoretinal and Cataracts. This is ongoing 25/04/2025 This is caused by a national shortage of Consultant Ophthalmologists and the inability to recruit to vacancies. The workforce position is exacerbated by nursing and medical staffing constraints and a reduction in service capacity due to lack of physical space, and long-term funding. Recruitment difficulties are leading to the Consultant on-call rota being covered by four substantive Consultants with 2 gaps in the rota. To ensure the delivery of the Ophthalmology service the Consultants undertake additional duty hours. This is a fragile on call structure which is impacted by sickness and annual leave. This could lead to an impact/affect on ability to deliver services within the Ophthalmology Referral to Treatment (RTT) plan, and the ability of the Health Board to comply with Welsh Government Eye Care Measures (ECMs). This impacts the ability to provide timely diagnosis and treatment, directly impacting on patient safety, with the potential for sight loss and long-term lifestyle impacts. The Health Board's ability to progress with the implementation of recommendations raised by various regulators and inspectorates is affected by the recruitment and estates issues, which in turn could lead to adverse publicity and reduction in stakeholder confidence, with increased scrutiny/escalation from Welsh Government. The service have undertaken successful recruitment of one consultant and specialty Drs which has improved capability and capacity in part. Regional conversation has been commenced reagrding 2 Regional substantive Consultant posts.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×5=10
Expected Date To Achieve TRS:	
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1 patients (high risk) with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional Age-Related Macular Degeneration (AMD) sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the Health Board. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. Recently the service has transferred Glaucoma funding to the Intra Vitreal Injection Therapy (IVT) service to create a new Band 7 post for IVT. The additional staffing needed for Wet AMD have been identified in the Eye Care Measures SBAR, which identifies the R1 delivery at 35%. The Welsh Government (WG) target for R1 delivery is 95%. The service as at April 2025 are expected to reach waiting times of stage 1 52 weeks and all stages 104 weeks with a robust plan in place to reach this by the end of quarter one. 7612 patients have been 100% delayed for their follow up appointment. The current risk score has been noted as 16 as ophthalmology is a fragile service. It is unlikely that this risk will be able to be significantly reduced without considerable investment or a regionally agreed solution. The workforce challenges have led to an impact on the Health Board's ability to deliver services within the ophthalmology referral to treatment (RTT) plan, which has been sustained through non recurrent funding secured for the out-sourcing of cataract procedures and IVT patients. Waiting list initiatives have been utilised for additional out-patient appointments. This is in direct conflict with the Health Board's ability to comply with WG Eye Care Measures (ECMs) which is the delivery of timely care for the high risk (R1) category of patients. There are delays to the delivery of R1 appointments for both Glaucoma and the delivery of Intravitreal injections for the Wet AMD pathway, which affects the National Institute for Health and Care Excellence (NICE) 14-day pathway for AMD appointments, impacting on the ability to provide timely diagnosis and treatment and directly impacting on patient safety, with the potential for sight loss and long-term lifestyle impacts. Recruitment difficulties have led to the Consultant on-call rota being covered by 4 substantive Consultants with a gap of 2. This gap is filled by the substantive consultants working additional duty hours to ensure the delivery of the ophthalmology on call service. This is an on-call structure which is impacted by sickness and annual leave. However it is now more stable than previously reported. The service has been able to reduce the impact score of this risk as whilst the consequences to the patient remains high, an SBAR for the recovery of the R1 Eye Care Measures target has been produced which demonstrates a trajectory for recovery if the required investment is secured. This would allow the service to recover to a 65% R1 delivery target allowing the likelihood score to be reduced to a 3 which would reduce the overall score to 15. If the investment was secured in April 2025 the service could recover to 65% by September 2026. Further development would be required to reach a 95% R1 delivery score, which would reduce the likelihood to a 2. With the required investment in Glaucoma and IVT with the additional workforce and focused management of the waiting lists, the HB will potentially reduce the likelihood score on this risk to a 2. The service also will meet their ministerial	the service has been able to reduce the impact score of this risk as whilst the consequences to the patient remains high, however an SBAR for the recovery of the R1 Eye Care Measures target has been produced which demonstrates a trajectory for recovery if the required investment is secured. This would allow the service to recover to a 65% R1 delivery target allowing the likelihood score to be reduced to a 3 which would reduce the overall score to 15. If the investment was secured in April 2025 the service could recover to 65% by September 2026. Further development would be required to reach a 95% R1 delivery score, which would reduce the likelihood to a 2. With the required investment in Glaucoma and IVT with the additional workforce and focused management of the waiting lists, the HB will potentially reduce the likelihood score on this risk to a 2. The service also will meet their ministerial measures targets by the end of quarter 1.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
The service is included within the Health Board's Clinical Service Plan (CSP). This will produce efficiency gains but will not secure additional resources. Active recruitment to vacancies, grow your own initiatives to secure Substantive Consultants and develop Consultants for the future. Regional discussion around 2 Regional Substantive posts. Collaborative working with Swansea Bay to deliver a Regional solution to address the workforce and estates constraints. Sub groups to be formulated to address, Glaucoma, AMD, Vitreoretinal and cataract pathways. Additional capacity has been funded for the delivery of Wet Age related Macular Degeneration (AMD). and has reduced the breach from 10 weeks to 8 weeks by March 2025. IVT outsourcing commenced in February 2025 and continues. Eye Care Measures SBAR submitted to board for approval to further develop IVT service delivery. Additional capacity has been funded for the delivery of Cataract surgery to maintain the 104 week wait for 2025/2026. Continued Identification of patients suitable to undergo transfer out to the community to Wales General Ophthalmic Services (WGOS) for Glaucoma and Medical Retina. Continued Validation of waiting lists to remove any patients who no longer require treatment through the scheduled Care validation team. Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. Eye Care Measures co-ordinator in place to oversee and manage the management of all R1 referrals. Review of data quality inclusive of Health Risk Factor (HRF) code and clinical codes ongoing to improve data quality.	Whilst recurring money has been invested into glaucoma and cataract services previously, there still remains areas of the service (e.g. Glaucoma, AMD, Cataract, Paediatrics, Corneal and VR) that require investment. The ARCH programme closed, with a regional conversation around a regional clinical workshop to consider opportunities for a long-term regional model. Central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. Long-term funding required in order to continue with current delivery of IVT, included within the Directorate's annual plans for 2025/26. Recovery funding is non-recurring and reviewed annually, this restricts delivery planning. There are concerns in data quality due to referral processes and system use.	Roll out and implementation of National Electronic Patient Record for Ophthalmology.	Barreiro, Marta	~~30/07/2021~~ ~~31/03/2022~~ ~~31/05/2022~~ ~~30/09/2022~~ ~~31/10/2023~~ ~~31/12/2023~~ ~~31/03/2024~~ ~~15/07/2024~~ 31/03/2027	Issues identified in the planning phase around data governance. DHCW are working to resolve issues. Update provided by the DHCW in September 2024 outlining options available and potential funding required to deliver. Regional planning scoped and aligned programme now proposed with Swansea Bay UHB, but is unlikely to be implemented before 2027. Further funding may be required from each HB to implement this model.
		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.	Coppack, Victoria	Completed	Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) was completed in March 2022. IVT recovery SBAR presented to the Board with associated workforce and drug costs identified. Long term funding is being considered as part of the annual plan.
		Remodelling the capacity and demand associated with Wet AMD and Amman Valley	Coppack, Victoria	Completed	Remodelling exercise complete. Ongoing costs associated with additional activity. SBAR to outline recovery of IVT service has been presented to Board with short term funding secured, with findings being incorporated in to annual planning process for 2025/26.

Highly trained Optometrists working collaboratively with the Secondary Care Eye Service to reduce referrals to secondary care. Ongoing training of Optometrists within secondary care to continue to develop this service for continued delivery of WGOS. Ongoing arrangement of Optometrists enrolling in prescribing training to develop further Independent prescribers in the community. GIRFT review undertaken on the Ophthalmology service with progress made against recommendations raised monitored and updated via AMAT. Performance dashboards in place to monitor performance daily. The service albeit still requires investment and continued work with Swansea Bay ref Regional working which is in its infancy in development	Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.	Coppack, Victoria	~~30/09/2022~~ ~~31/10/2023~~ ~~30/11/2023~~ ~~31/03/2024~~ ~~30/06/2024~~ ~~30/09/2024~~ 31/03/2026	Validation of HCQ patient commenced in November 2023. Longest wait HCQ patients have been identified for tech review, however workforce pressures are negatively impacting on service delivery. Clinic spaces to be secured for patient review. This is an interim measure until WGOS 4 for HCQ can be rolled out. This will follow the roll out of Glaucoma and Medical Retina. HCQ qualified Optometrists will need to be in place in the community to proceed.
	Alignment in the Delivery of Eye Care Measures and Ministerial Measures and effective management of Ophthalmology waiting lists.	Coppack, Victoria	31/03/2027	A Regional Programme Board has now been established. Ophthalmology has commenced a Regional Eye Care Programme. The Regional Eye Care Programme will meet bi-monthly to monitor and progress a Regional solution to the challenges faced in HDUHB and SBUHB, this will be fed to the Regional Programme Board. Identified first steps are to form sub-groups for the review of Paediatric Ophthalmology, Glaucoma, AMD and on call out of hours delivery.
	Long-term investment required for IVT and Glaucoma Delivery to recover R1 position	Jones, Keith -	31/01/2026	New action - progress update to be provided at next risk review.
	Regional solutions to workforce gaps and estates to be explored through Regional programme	Coppack, Victoria	31/03/2027	2nd Regional meeting booked February 2025 Update 18/02/2025 - meeting rescheduled to 14/03/2025
	Orthoptist posts to be recruited into	Coppack, Victoria	30/04/2025	Band 6 Orthoptist is now onboarding after successful interview. Band 8A JD is being review prior to submitting to Agenda For Change (A4C) panel.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Eye care measures monthly report. GIRFT review Cataracts. GIRFT review Glaucoma. Weekly RTT Optimisation to review Ministerial Measures.	WPAS	1st			SBAR for IVT Service Delivery & SBAR for recovery of R1 position (October 2024) Revised RISK SBAR to condense risks submitted to Board for decision.					
	GIRFT action plan cataracts	1st								
	GIRFT action plan Glaucoma	1st								
	WPAS, scheduled care performance indicators	1st								

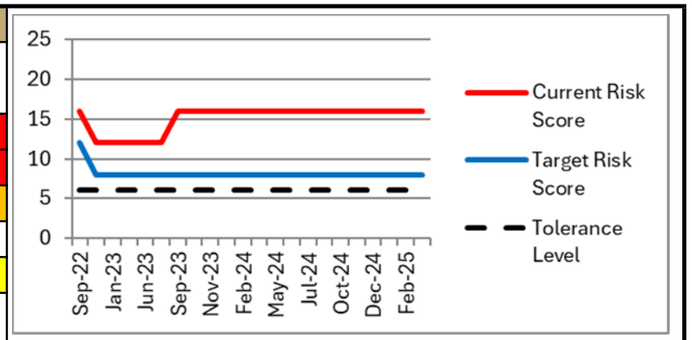
CORPORATE RISK REGISTER SUMMARY MAY 2025

Date Risk Identified:	Jan-19		
Strategic Objective:	N/A - Operational Risk		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Apr-25
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	May-25

Risk ID:	**684**	**Corporate Risk Description:**	There is a risk to the radiology service provision from breakdown of key radiology imaging equipment and associated infrastructure to enable equipment to function. This is caused by equipment not being replaced in line with RCR (Royal College of Radiologists) and other guidelines. This could lead to an impact/affect on patient flows resulting from delays in diagnosis and treatments, delays in discharges, increased waiting times on cancer pathways, increased staffing costs to minimise the impact on patients when breakdowns occur and increased number of SCP breaches and breaches over 8 weeks due to increased downtime. Increased risk of IR(ME)R notifiable radiation incidents due to increased breakdowns as a result of malfunctions during exposures.
Does this risk link to any Directorate (operational) risks?		925, 114, 1668, 1785	

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
The Health Board's stock of aged imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the Health Board's ability to meet its Referral to Treatment (RTT) target and impact to patients can include delays in diagnosis and treatment. CT and MR scanners have been replaced and has reduced the frequency of machine downtime compared to previous experience. The risk score is noted as 16 reflecting that some equipment has been installed and is operational, however further investment is required due to recurrent breakdowns of aged key imaging equipment. A plan and rolling programme for the installation of additional equipment is in place. There is a continuous process locally by which equipment is prioritised for replacement. Gamma camera at Withybush General Hospital is the only scanner of its nature in the Health Board, and has experienced a series of breakdowns in 2023 and 2024 due to intermittent failures which resulted in several HIW reportable IRMER incidents. This item of equipment is on the current priority list of items to replace as at February 2025. While a new CT scanner has been obtained and installed at Glangwili, the original CT scanner is having regular breakdowns. The technology on this scanner is also now out of date and impacts directly on the resilience of the service at our major trauma site in the Health Board. Like-for-like replacement of existing equipment is not necessarily a cost effective method of maintaining services and in certain circumstances does not meet updated regulatory compliance or meet the requirements of maintenance warranty agreements. This means there will need to be upgraded infrastructure such as air handling units, water chiller systems and the size/accommodation for modalities at an initial increased cost but representing long term savings and service resilience overall. April 2025 The DEXA unit at BGH is aged and with the advent of trabeculae bone scoring, any new scanner will have a larger footprint compared with the current scanner and along with necessary shielding required, this may mean that the current DEXA room will be unsuitable to accommodate any new scanner. The technology gap has widened between the services provided at Swansea with concerns raised by referring clinicians. The only HB Nuclear Medicine SPECT scanner is overdue for replacement and remains a significant risk to continuity of service provision. The equipment replacement T&F team are currently looking into options and specifications in readiness for potential funding which was discussed at the NIECP review panel on 02/04/2025.	WG funding has been secured to replace a fluoroscopy unit and a CR x-ray unit at WGH along with a much needed MRI upgrade at PPH during the 24-25 financial year. With more modern equipment, breakdowns will be less likely and less significant in terms of downtime together with a reduced impact on the diagnostic services at the remaining hospital sites. Improved business continuity plans will also help reduce the impact of equipment breakdown across the UHB. Due to the nature of the release of funding which is usually in Q3/Q4 of the financial year it is difficult to plan large installations due to the speed at which the replacement need to be completed. This means that sometimes equipment of lesser priority is replaced before the bigger installations which have a greater need. The number 1 replacement priority in the Health Board is to replace the Nuclear Medicine SPECT scanner. This is a service risk as it is the only scanner in the HB (Risk 1706, score 20) and has suffered frequent breakdowns since June 2023. A specific task and finish group has been convened to forward plan the replacement in anticipation of WG funding. The second CT scanner at GGH is a second priority as this is relied upon to undertake outpatient work and as a back up scanner. This is aged and is having increasing breakdown outages with long lead time to source parts. In addition to this the variation between the DEXA services provided via the SBUHB SLA and at BGH has been made worse by the fact that the Swansea scanner now undertakes Trabecular Bone Scoring (TBS) which is a new and very important way of assessing bone structure. The BGH scanner is unable to do this and there have been a few recent cases of patients who have recently had a DXA in BGH who are now having another DXA in the SBUHB mobile unit because we need obtain the TBS results. The version of windows which this scanner runs on is no longer supported and so is a further risk to the Health Board. Once the Nuclear Med SPECT-CT scanner, the 2nd CT scanner at GGH and the DEXA scanner at BGH have been replaced we would look to seek permission to reduce this risk score and to move the risk directorate level. This is dependent on WG funding, and may not be complete until the end of the 26-27 financial year due to the additional infrastructure required.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports. # Escalation process in place for service disruptions/breakdowns. # National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales. # All equipment at main sites are now DR and so will be compliant with the RISP project # Additional WGH EOY funding was secured (23-24 financial year) and replaced aged US units and upgraded the software on MRI scanners at BGH and WGH providing latest technology.	Limitation of spare parts for some older equipment leading to extended outages. This issue has been compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment. Inability to undertake specific replacements at this time due to the additional infrastructure required National Imaging and Capital Priorities Group outcomes do not always align with the Health Board priorities, and is subject to negotiations within the group.	Installation of replacement Gamma Camera, WGH	Roberts-Davies, Gail	~~31/07/2024~~ ~~30/06/2025~~ 31/03/2026	Gamma camera is 9 years old and the only scanner in the Health Board providing a regional service. Recurrent breakdowns are resulting in HIW reportable incidents. Awaiting confirmation of funding as at December 2023. No funding allocated as of 09/02/2024 This will not be replaced in the 24/25 financial year. A specific T&F group is due to be set up as of June 24 to plan the necessary accommodation improvements required. July 2024 update- the T&F group has been set up and meets weekly Feb 2025 update - there is a draft plan for replacement. Business continuity plans being explored Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The CT replacement of the aged at GGH has been recommended, however funding has not yet been formally agreed.

Replacement of aged CT Scanner at GGH	Procter, Sarah	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ 31/07/2026	Awaiting confirmation of funding as at December 2023. No funding allocated as of 09/02/2024 This will not be replaced in the 24/25 financial year. Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The CT replacement of the aged at GGH has been recommended, however funding has not yet been formally agreed.
Replacement of Fluoroscopy room, WGH	Whitecross, Faith	~~31/03/2024~~ ~~31/07/2024~~ ~~31/03/2025~~ 31/08/2025	Additional infrastructure required to replace this piece of equipment and so will not be completed until the 2025-2026 financial year. Update feb 25: funding approved for installation of fluoroscopy equipment 25/26 financial year.
Replacement of CR X-ray Room 1, WGH	Roberts-Davies, Gail	~~31/03/2024~~ ~~31/07/2024~~ ~~31/03/2025~~ 30/04/2025	Ageing equipment. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. This will not be replaced in the 2023/24 financial year Confirmation that this piece of equipment will be replaced in the 24/25 financial year was received late May '24- action will be closed when this piece of equipment is operational. Equipment replacement complete as of 08/04/2025- awaiting acceptance testing.

Replacement of CR X-Ray room, Llandovery Hospital	Osell, Fiona	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ 01/12/2025	Equipment on site is incompatible with the incoming PACS system, and interim solution required. X Ray room continues to be in use one day per week (Tuesdays) staffed by 1 Radiographer (B5 or B6). Regular maintenance of equipment continues and required QA testing. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. Awaiting confirmation of funding as at April 2024. This will not be replaced in the 2024/2025 financial year. Progression of this project reliant upon the outcome of the clinical services plan which may see the closure of this x-ray department which is expected in November 2025.
Replacement of Mammography Units, BGH and WGH	Roberts-Davies, Gail	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ 31/03/2027	Ageing equipment, exacerbated by the failure of Securview. These will not be replaced in the 23/24 financial year These will not be replaced in the 2024/2025 financial year These will not be replaced in the 2025/2026 financial year

	Upgrade or replacement of MRI scanner, GGH	Procter, Sarah	~~31/03/2024~~ ~~30/06/2025~~ 31/03/2026	Ageing equipment with increasing failures, with new technologies now available. Awaiting confirmation of funding as at April 2024. This will not be replaced in the 24/25 financial year. Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The MRI upgrade of the aged scanner at GGH has been recommended, however funding has not yet been formally agreed.
	To replace the DEXA scanner at BGH and ensuring suitable accommodation is found to meet regulatory compliance for a larger more modern scanner.	Edwards, David	~~31/03/2024~~ ~~30/09/2024~~ ~~30/09/2025~~ 31/03/2026	Unit is 17 years old, and previously funded via charitable funds This has been added to the imaging priorities list and end of year additional funding projects as relative replacement costs are not high, however the infrastructure enablement costs are additional and a suitable location to accommodate a larger scanner needs to be found. Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The replacement of the aged DEXA scanner at BGH has been recommended, however funding has not yet been formally agreed.

CORPORATE RISK REGISTER SUMMARY MAY 2025

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Reduction of waiting times to under 8 weeks. No SCP diagnostic breaches.	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team Mar19 Further updates CEIMT Feb20 Further updates CEIMT Sep20 Radiology Diagnostic Imaging update to Capital Sub-Committee presented September 2024	Lack of process of formal post breakdown review.				
	IPAR report	2nd								

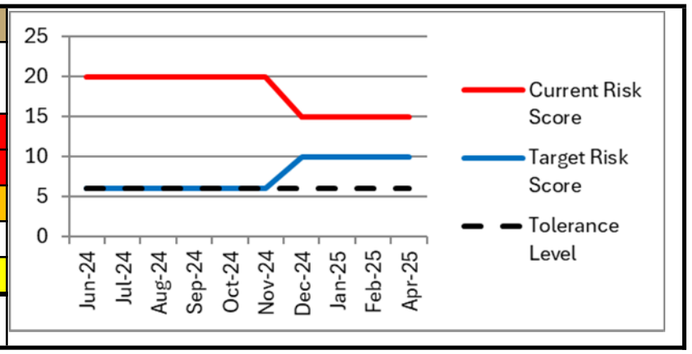
CORPORATE RISK REGISTER SUMMARY MAY 2025

Date Risk Identified:	May-24		
Strategic Objective:			

Executive Director Owner:	Daniel, Sharon	**Date of Review:**	Apr-25
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	May-25

Risk ID:	**1859**	**Corporate Risk Description:**	There is a risk that patients are at increased risk of poor outcomes, and a poor patient experience. This is caused by the Health Board's inability to effectively recognise and manage acute deterioration. This could lead to an impact/affect on increased length of stays, increased admissions to Critical Care, increased risk of cardiac arrests for patients, and poorer patient outcomes who may experience permanent injuries or irreversible health effects.
Does this risk link to any Directorate (operational) risks?		1758	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	2×5=10
Expected Date To Achieve TRS:	31/12/2025
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
There are specific concerns relating to Glangwili General Hospital (GGH) and Withybush General Hospital (WGH) in relation to Cardiac Arrests and unplanned admissions. There was an increase in Cardiac Arrest rates in GGH in the period Jan - Dec 2024 (35) compared to the same period Jan - Oct 2023 (15). GGH senior management team have agreed to Datix all cardiac arrests and establish bi-monthly meetings to review cases and identify themes and learning opportunities. There has been an increase (22%) in unplanned admissions at WGH, with 92 noted in 2024 (71 noted for 2023). Following the recent WGH Recognition of Acute Deterioration and Resuscitation (RADAR) meeting is was agreed that the Treatment Escalation Plan (TEPs) task & finish group in WGH would be re-established. There are also concerns across the Health Board as a whole relating to the National Early Warning Scores (NEWS), and appropriate escalation where required as part of observation processes. Currently working with Clinical Audit to develop an audit tool on AMAT to audit on a monthly basis NEWS charts on wards and identify good practice and areas for improvement. A National Safe Care Collaborative meeting held in Cardiff in October 2024 began exploring the possibility of establishing a National Acute Deterioration Clinical Reference Group which will provide an opportunity to benchmark the position of Hywel Dda on an All Wales basis. First meeting scheduled on 24Mar25 focussing on NEWS, PEWS and MEWS and NEWTS). As of January 2025, compliance rates for Level 2 and Level 3 Resuscitation Training are at 49% and 46% respectively, an increase on the previous figure noted of 40% at November 2024. While there is no set compliance target, compliance has never been greater than 60%. Staff availability to attend resuscitation training is problematic due to operational pressures and demand, therefore, need to identify the most appropriate training level and method to deliver to meet mandatory requirements. As at February 2025, all actions are being processed within set dates / timeframes although many remain long term. Current controls are managing the risk and the increasing awareness of gaps in assurance and local actions to mitigate and manage the risk have been established.	The full implementation of the actions noted in the risk action plan will support the reduction in the likelihood and impact score of this risk to a target risk of 10. With recruitment into the Resus Team and the establishment of a supported Cascade Training process the aim will be to see an increase in training compliance in both Level 2 & Level 3 training by October 25 to >60%. This will enable the risk to be reduced to the Target Risk Score of 10, >85% would enable the risk score to be reduced further to 5. We will aim to see a reduction in Cardiac Arrest rates across all 4 sites and unplanned admissions into ITU from ward areas by October 2025.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Governance structures in place eg RADAR Group (Recognition of Acute Deterioration and Resuscitation). Increased awareness of gaps in assurance and local actions in place to manage and mitigate the risk. T&F Group chaired by HB RADAR Lead with focus on Sepsis, DNA/CPR group chaired by Deputy Medical Director. RADAR directly reports to Operational QSE. Local RADAR groups (across all sites, counties, MHLD and Paediatrics) which report to HB wide RADAR group - chaired by a commission. Mechanisms in place across all sites to monitor cardiac arrest rates. Health Board Resus policy in place (currently out of date requiring updating - however waiting on national guidance) All Wales DNA/CPR policy in place Lead for Acute Deterioration Dedicated Resuscitation Team in place, consisting of 6.2WTE across the Health Board (acute, community, mental health and primary care) plus 1WTE admin support	No treatment escalation plans in place No call for concern in place Training demand outstrips capacity to deliver the mandatory level of training recommended by the Resus Council Inconsistent application of policies and processes eg DNA/CPR, , sepsis assessment tool, National Early Warning Score (NEWS). Reliance on manual / paper based documentation to record patient deterioration and subsequent escalation Critical Outreach Services not in place at PPH / BGH Inability to release staff to complete L2 and L3 training High number of newly qualified new nurses to the HB including overseas requiring support to develop their	Health Board Recognition of Acute Deterioration and Resuscitation (RADAR) group to develop a workplan to address gaps in control to improve the recognition and management of acute deterioration across the Health Board.	Davies, Mandy -	~~30/09/2024~~ ~~30/11/2024~~ ~~30/04/2025~~ 30/09/2025	Quarterly meetings in place, and sub-groups being established to report to Recognition of Acute Deterioration and Resuscitation (RADAR) group on sepsis, NEWS, treatment escalation plans, call for concern (Martha's Law) DNA/CPR, acute kidney injury (AKI). Agenda at August meeting didn't allow for discussion on the development of a workplan. Plan is to confirm RADAR Action Plan at next meeting 20Mar25, with risk actions to be updated accordingly. Update as of April 2025: Health Board RADAR Lead has stepped down and awaiting a replacement to be identified. No scheduled meetings planned at the current time in respect of an overarching Health Board group as awaiting new Lead.

Networks in place across the wider HB, including support from QIST Organisational training plan in place, including mandatory training Critical Outreach Services in GGH and WGH (not in place at PPH / BGH), managed by Planned Care Directorate (i.e not fully linked to Acute Deterioration resource) New Acute Kidney Injury (AKI) Lead appointed for GGH (12 months) Dedicated resource in Quality Improvement Team monitoring AKI alerts for the Health Board Bi-monthly scrutiny meetings have been set up in GGH to review Cardiac arrests. Cardiac arrest reviews presented at Medical Education sessions Review of feedback from any Medical Examiner reviews, highlighting issues relating to resuscitation/cardiac arrests and lessons learned.	expertise in recognising acute deterioration	Develop an organisation-wide training needs analysis to appropriately identify staff across all staff groups complete the most appropriate level of training to improve recognition and management of acute deterioration.	Wastell, David	Completed	The directorate is working with ESR to ensure that staff training attendance is accurately recorded. Work is ongoing with individual line managers to identify the training needs of all their staff groups across all four sites and community. Meetings commenced with all senior nurse managers to discuss current training uptake and training needs to identify the most appropriate training for each staff group across acute and community. Meetings are to be arranged with Heads of Service for other clinical services. As at June 2024, it has been identified that 84 ILS sessions are required in order to ensure compliance with targets for GGH alone. Heads of Nursing requested to discuss training attendance with all ward sisters, and to appropriately prioritise. Monthly analysis of training available, and attendance to be shared with Heads of Service and Senior Nurse Managers. The provision of training continues at current levels, given current resource availability. TNA taken to QSESC advising in January 2025, with further discussion at SNMT and QSESC on cascading this.

To implement an electronic observations systems across the Health Board to capture real-time bedsite capture of patient assessments and monitoring, in line with the Health Board's Digital Plan	Williams, Carolyn	30/09/2025	Tender process completed. Business case presented to Board in July 2024, with a view to implement on a site by site basis over in 18 months, in line with the current Digital Plan. Board approved the business case in Sept 24 however funding has not yet been identified to enable the project to proceed.
As part of the Quality Dashboard, agree the matrix needed for patient deterioration. Include these matrix in the Health Board Quality Dashboard to inform escalation and create a specific dashboard for RADAR (Recognition of Acute Deterioration and Resuscitation).	Wastell, David	30/05/2025	Meeting of 25th July 2024 has identified the following supporting metrics for the dashboard: sepsis, AKI, NEWS audits, cardiac arrests, number of MET calls, treatment escalation plans are in place, call for concern rates and training compliance for ILS and BLS for each Directorate. Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system.
Put in place process for Health Board compliance with Martha's Rule by establishing a Task and Finish Group to implement Call for Concern	Wastell, David	~~31/03/2025~~ 31/12/2025	Task and Finish Group is in place, chaired by Ceri Griffiths. SOP Patient leaflet is being developed and a pilot was due to commence in GGH in Feb25. This pilot will test the process to roll out across the organisation for Adult Inpatients. Pilot scheme at GGH is aiming to be completed by March 2025, with a view to rolling out to other three acute sites by December 2025.

Put in place All Wales Policy for treatment escalation plans to enable safe and effective care management when patient deteriorating.	Wastell, David	~~31/12/2024~~ ~~30/06/2025~~ 30/09/2025	Discussed at Health Board Recognition of Acute Deterioration and Resuscitation (RADAR) group Group (March 2024) - no agreement to move forward with proposed pilot in Withybush. Discussed at Withybush RADAR meeting in July 2024 where agreement reached for pilot. Task and Finish group being established by Lead for Critical Care Outreach in Withybush to devise an implementation plan. RADAR to review following evaluation and consider roll out across other sites. As of January 2025, the situation remains unchanged. TEPS sub group meetings have been held at WGH but there is no set plan at the moment to implement or trial.
Implement a model for CASCADE training for basic life support and monitor impact on basic life support training compliance rates.	Wastell, David	Completed	Model devised by Resuscitation Team - first training session held. 6 Cascade Trainers from across the Health Board Community Teams, trained in July 2024. Training will continue. Training session for Midwife Cascade Trainers in development, with plans for health visitors and school nurses for February 2025.

Following assessment and interpretation of the All Wales Direction, the Health Board is engaging in National work, namely roll out of NEWS2 and Call 4 Concern and contribute to the National Improvement for Acute Deterioration being led through the Safe Care Partnership.	Wastell, David	~~30/09/2024~~ ~~30/03/2025~~ 30/09/2025	Launch of this initiative on 17th September 2024 (World Patient Safety Day). WHCs have been received in relation to NEWS2 and Call 4 Concern. A group led by the Assistant Director of Nursing for Acute Inpatient Services is designing a first phase approach to pilot Call 4 Concern from November 2024. All Wales Safe Care Partnership meeting held on 22 October 2024 to design a national improvement programme for acute deterioration, which the Health Board are engaged in and are contributing towards. National group not yet established as of November 2024. Advised at national level NEWS2 will be launched September 2025.
Work to improve compliance with Sepsis Bundles at the front door.	Wastell, David	31/12/2025	Ongoing quality improvement in place. Has demonstrated improvements in Glangwili and Prince Phillip and now being used in Withybush. Reviewing process for assessing impact on patient outcomes as a result of the response and management of sepsis.

Improve compliance with DNACPR National Guidance	Steele, Cathie	~~30/10/2024~~ 31/05/2025	DNACPR Review Group formed and actions identified including development of a SharePoint page (which is now complete) and undertaken an improvement project through EQIiP (underway). Annual audits undertaken by junior doctors, and reviews of medical examiner reports and cardiac arrest to identify learnings. Training needs have been identified in relation to DNACPR and patients who are considered having learning disabilities, or diagnosed with dementia. Work is commencing with the MHLD directorate to progress this. A full action plan as been agreed in response to the HIW National Report on DNACPR (see AMAT)
Development of an Acute Deterioration Sharepoint page for all advice, guidance, updates, for staff on issues relating to resuscitation, DNACPR, sepsis, call for concern, MET calls, training, etc.	Wastell, David	31/05/2025	Senior nurse for acute deterioration is working with Interim ADN for Quality and Safety to develop SharePoint page.
Trial starting in October 2024 for 3 months re NEWS Audit, NEWS Charts - 5 charts every ward, every month on every site utilising the AMaT system. To review compliance and whether escalation processes are being followed with outcomes being fed back to wards.	Wastell, David	~~31/01/2025~~ ~~31/03/2025~~ 30/09/2025	Training plan developed and was rolled out in March 2025 with 1st audits completed in March and April. The full audit will now start in May on all wards on all four acute sites. Meeting with Clinical Audit on 30th April 2025 to look at developing action plans on AMaT.
Acute Deterioration E-learning modules - topics include NEWS, sepsis, DNACPR and A-E assessment being developed by the Lead Nurse for Acute Deterioration in conjunction with NHS Executive and other leads. Work to develop a process for using these modules with clinical areas in response to issues of concern.	Wastell, David	~~31/01/2025~~ 30/06/2025	Currently awaiting national updates in order to progress with this action.

	Review efficacy of local RADAR groups, and frequency of meetings being held	Davies, Mandy -	30/06/2025	Support being given to Chair of RADAR to liaise with Chairs of local RADAR groups delays due to limited availability and operational pressures.
	Develop standardised template to report into Health Board RADAR group	Wastell, David	Completed	Template developed following meetings with Chairs of local RADAR.
	To develop mechanisms to review and monitor the Acute Deterioration position via Escalation Framework via the Quality domain (including the implementation of the Safety Dashboard)	Davies, Mandy -	30/06/2025	Meeting of 25th July 2024 has identified the following supporting metrics for the dashboard: sepsis, AKI, NEWS audits, cardiac arrests, number of MET calls, treatment escalation plans are in place, call for concern rates and training compliance for ILS and BLS for each Directorate. Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system.

CORPORATE RISK REGISTER SUMMARY MAY 2025

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Training compliance via ESR Cardiac Arrest Audits	RRAILS Audits undertaken by ward staff monthly, and inform the Nursing dashboards	1st			RADAR Group Update to QSESC, Feb-24 and Jan-25	Ward based NEWS audits in place but may be unreliable as self assessed.	Once dashboards in place, to develop a monthly audit process to address key hotspots / areas of concern relating to RAILS	Wastell, David	30/09/2025	Next RADAR meeting scheduled for 20 March 2025.
	Review of DATIX incidents, complaints, cardiac arrest reports and Medical Examiners reports relating to acute deterioration	1st								
	Outreach review all unplanned admissions to Intensive Care	1st								
	RADAR Group	2nd								
	T&F Group chaired by HB RADAR Lead with focus on Sepsis	2nd								
	DR/CPR group chaired by Deputy Medical Director	2nd								

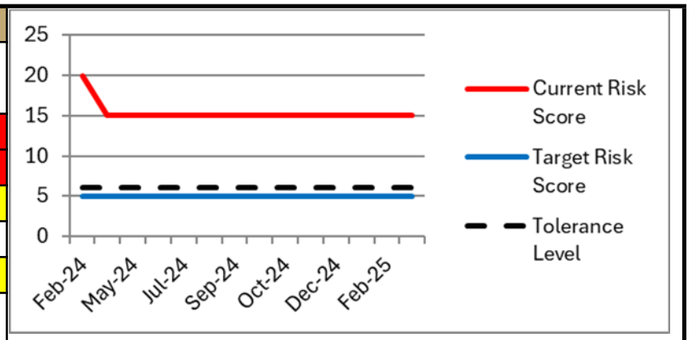
Date Risk Identified:	Feb-24		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Apr-25
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	May-25

Risk ID:	**1810**	**Corporate Risk Description:**	There is a risk that the Health Board will be unable to continue manufacturing cancer treatments for our patients. This is caused by the facilities of the Pharmacy Aseptic Unit being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS) standards 5th edition (published 2016) and therefore at risk of closure. This could lead to an impact/affect on the Health Board's ability to provide all the cancer treatments currently offered. The Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. A fully outsourced service would cost an additional c£1 each year. Some therapies cannot be outsourced, meaning Hywel Dda could not offer over 500 cancer treatments each year. This would have a significant negative impact on patient care as patients would either be required to travel further from home to neighbouring Health Boards to receive their treatment (dependant on their capacity to absorb the additional demand) or would be offered less clinically appropriate treatments at Hywel Dda, negatively affecting clinical outcomes. The closure of the Aseptic unit would directly impact the ability of the Health Board to achieve ministerial priorities and targets such as the Single Cancer Pathway, A Healthier Wales, etc.

Does this risk link to any Directorate (operational) risks?	2004, 374, 1350, 716

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Expected Date To Achieve TRS:	
Tolerable Risk:	6
Trend:	⟺



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Withybush Aseptic unit is the only functional unit that can manufacture cancer treatments remaining in the Health Board. The facilities of Withybush Aseptic unit are currently non-compliant with regulatory standards. An audit by the National Pharmacy Quality Assurance Lead was performed in February 2024 confirmed the facilities were a high risk to patient safety, and the unit is at risk of forced closure. Short term control measures have been implemented by the Health Board's aseptic team to reduce the risk of immediate forced closure (see control measures). The controls are currently successfully minimising the amount of microbial contamination present within the unit, demonstrated by ongoing daily/weekly/monthly environmental monitoring. However, as the unit and equipment are beyond their useful expected life, there will come a time where the control measures will no longer be sufficient to allow the safe running of the unit. If the stringent controls fail at limiting the amount of microbial contamination, the unit may be forced to close. As part of the Transforming Access to Medicines (TrAMS) project programme, a regional manufacturing hub will be built in South West Wales that will prepare cancer therapy for Hywel Dda patients. The hub was originally estimated to open during 2028, however there have been delays to the project plan and the opening date is currently unknown. There is therefore a high risk that the current Aseptic unit at Withybush will be forced to close before the South West TrAMS manufacturing hub is operational. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality	The target risk score is based on the premise that funding for a new aseptic unit is approved by Welsh Government. The unit would be compliant with regulatory standards and once operational, it would be extremely unlikely for the unit to be forced to close. A new unit would allow the Health Board to continue to safely prepare cancer therapy until the TrAMS South West manufacturing hub is operational. On approval of the Business Justification Case, it is anticipated that the target risk score of 5 would be achieved within 18 months.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Transfer of the radiopharmacy service to Singleton Hospital in October 2022; this means less overall activity through the Withybush Aseptic unit reducing the risk of contamination and errors. More time and resource provided to the Quality System (i.e. internal audits, investigation of near misses and microbial growths, maintaining SOPs). Increased training of aseptic staff to develop their skills and knowledge. Increase outsourcing from commercial suppliers; this limits the volume of products prepared within the unit, allowing products that must be made in-house to be prepared safely. New pharmaceutical isolators have been procured to replace the existing isolators that are beyond their working life of 10 years. The new isolators will be stored with the intention of installing into the demountable unit (if funding is secured) or will be installed into the existing unit if the current isolators fail mitigating the risk of equipment failure causing prolonged service disruption. Removal of outsourced dispensing from the Aseptic unit; this minimises the risk of contamination and potential for error. Preparation of products near to the time of use; this limits the pre-administration storage time. More stringent gowning process; this minimises contamination risk. More stringent cleaning and monitoring programmes; this minimises contamination risk and allows early detection of microbial growth. Oversight and steer from Capital Sub-Committee.	Controls are reliant on a key group of skilled staff (i.e to maintain Quality System, to follow cleaning and monitoring procedures) therefore subject to key person dependencies. Limited accommodation to employ additional staff to expand workforce within the existing unit at WGH. Limited accommodation to store starting materials and finished products or to perform the associated tasks that are required to safely supply cancer treatments. Between 2021 and 2023, the number of cancer treatments requiring aseptic preparation at Hywel Dda increased from 12,718 to 16,648 (average of 14% increase each year). There is limited space within the Pharmacy at WGH to manage this increase in demand. Lack of funding to build a new unit at WGH. Progress dependent on feedback received from Welsh Government	To submit revised business case for demountable unit to Welsh Government (estimated £2.89m).	Morgan, Cerith	Completed	As part of the tendering process, no suppliers had submitted a bid for the contract for the demountable aseptic unit as of 03/09/2024. The tender was repackaged to the principal contractor of the project (Lewis Construction) noting the following specialist cleanroom subcontractors; Angstrom, Enbloc, Scitech, T-squared, Cleanroom projects. The quality of the submissions was scored by members of the project team and representatives from NWSSP on 20.11.2024. As no suppliers submitted a bid during the original tender return, this may have an impact on the project timelines. The BJC was presented at Public Board 30th January and approved for submission to WG for scrutiny. WG provided BJC scrutiny comments to the HB on 20th March 2025 with the HB responding on 15th April. Awaiting WG response to HB's scrutiny return.
		To work with estates and capital planning team to source temporary accommodation at Withybush to increase the storage capacity for outsourced cancer therapy. This will help the aseptics service to meet the increasing demand for cancer therapy and will allow cost efficiencies related to outsourcing to be achieved whilst the business case for a demountable aseptic unit is being developed.	Morgan, Cerith	Completed	Capital bids proforma submitted to Health Board capital planning team 11/06/2024. Ratification paper signed off and contract awarded to Portakabin on 02/08/2024. 05.09.2024, awaiting for contract to be signed by the Head of Service - Procurement before order can be placed. Portacabin has now been installed and now awaiting fittings to be installed by the company before unit is operational.

CORPORATE RISK REGISTER SUMMARY MAY 2025

CORPORATE RISK REGISTER SUMMARY MAY 2025

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Audit Reports from annual audits detailing areas of non-compliance KPI Dashboard in place to provide continuous oversight of unit performance, updated monthly.	Annual Audits by Lead Quality Assurance Pharmacist (NWSSP) .	3rd			Capital Sub Committee (22nd January 2024). MMOG report to QSEC for Feb 2024. BJC Board January 2025.					
	Quarterly self-assessments undertaken by Lead Aseptic Pharmacist, with outcomes fed back to Lead Quality Assurance Pharmacist at NWSSP	1st								
	Bi-monthly Senior Pharmacist Leads Business Meeting .	2nd								

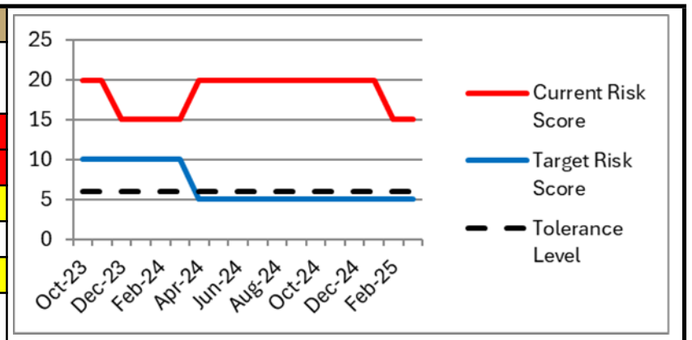
CORPORATE RISK REGISTER SUMMARY MAY 2025

Date Risk Identified:	Nov-22		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Apr-25
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	May-25

Risk ID:	**1531**	**Corporate Risk Description:**	There is a risk of being unable to provide a safe and sustainable general surgery consultant on-call rota at WGH and GGH. This is caused by Unsustainable and fragile rotas, with a difficulty to recruit into substantive posts. This could lead to an impact/affect on on the ability to provide an emergency general surgery service at WGH and GGH affecting patient experience, causing clinical delays and poor outcomes for patients. The wellbeing of remaining consultants who are already working to full capacity is also affected and there is an increased expenditure on agency locum consultants and internal locum rates above the HB card rate. Consultants working additional on call locum weeks is resulting in a reduction in elective activity in OPD, endoscopy and theatre. This could have a negative impact on RTT and SCP targets.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Expected Date To Achieve TRS:	
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
1531 - Risk of being unable to safely support the Consultant on-call rota at Withybush General Hospital (WGH) and Glangwili General Hospital (GGH) due to workforce pressures10/11/22Chief Operating Officer4x5=20 3x5=15 (Reviewed 24/04/25)Whilst this risk is relating to workforce issues, the domain for the risk is patient safety. The reason for this decision is that, although the rota in WGH has been stabilised, gaps in the service remain e.g. Upper Gastrointestinal (GI). The risk to emergency Upper GI patients at WGH is due to no Upper GI specialists on site and no Endoscopic Retrograde Cholangiopancreatography (ERCP) service on the site. An SBAR has been populated, highlighting the risk to emergency Upper GI patients in WGH. The recommendation from the senior clinical team is for these patients to be admitted directly to GGH. This SBAR was presented at Acute Leadership Group (ALG) on 25/09/2024, at the Quality, Safety and Experience Committee (QSEC) on 08/10/2024 and at the Scheduled Care Quality, Safety and Experience (QSE) meeting on 29/01/2025. The concern is that the GGH clinical team have absorbed the patients that cannot be treated at WGH, without additional resource and this is currently exacerbated by the rota gaps on the GGH consultant on-call rota. As this situation has not changed, the current risk score remains the same. The consultant on-call rota at WGH remains a 1:4 with 2 substantive consultants and 2 NHS locum consultants on the rota, 1 of which is an internal associate specialist upgraded to a locum consultant. At GGH, the consultant on-call rota is a 1:8 with one gap and one consultant only participating in 50% of the rota. The 1 full gap is currently being covered by a Medacs agency locum consultant and interviews are taking place for an NHS locum colorectal consultant to fill this gap. The 50% gap is being covered by an internal locum at the health board card rate. There are 3 NHS locum consultants participating in this rota. An options appraisal was presented to board in November 2024 and there was an urgent meeting between the Clinical Care Group and Executives in early 2025. The outcome of this was the approval to advertise the posts to fill the gaps. This	The target risk score is based on the work currently being undertaken as part of the Clinical Services Plan to identify and approve a more sustainable solution in order to reduce the likelihood of rota collapse and reduce the risk of not being able to provide a safe and sustainable emergency general surgery service to patients in the south of the Health Board. The effectiveness of revised rota arrangements will depend on several factors including availability of a labour market. The risk score will reduce on the appointment of consultants. Achievement of the target risk score is dependant on the outcomes of the Clinical Services Plan which will inform future plans or the successful appointment of substantive upper GI consultants to the current model at WGH.

supersedes the content of a previous SBAR presented at various Executive committees as the plan is no longer to amalgamate rotas, at least in the short term. Proposals relating to service changes and the amalgamation of the rotas were presented to ALG in October 2024, with the requirement to engage with relevant stakeholders noted as an action. An options appraisal paper was presented to Board in November 2024 via the Clinical Service Plan (CSP). Following the Scheduled Care Escalation Meeting in March 2025, where the immediate risk of the GGH rota collapsing was highlighted, due to the internal consultants withdrawing from covering the 1 gap on the rota, an urgent executive meeting was arranged for 12 March 2025. The outcome of the meeting was to appoint a substantive colorectal consultant to the GGH rota and for 2 substantive Upper GI consultants in a dual location role across WGH and GGH. It was recognised that this would take some time, there was an agreement that the service would recruit a Medacs locum consultant immediately, to cover the upcoming gap in April and in parallel, advertise an NHS locum colorectal consultant to GGH. On the appointment of the locum consultant, the agency locum will be terminated. On the appointment of the substantive consultant, the NHS locum will be terminated. An NHS locum colorectal consultant was successfully appointed on 30 April 2025, to commence in post in August 2025. The job descriptions and adverts for the 3 substantive consultant posts have been approved by the Interim Medical Director and are now with the Royal College. The aim is that they will be ready to go out to advert by 23 May 2025.	

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Rotas monitored daily by the service delivery team When there is sickness or unexpected leave, due to emergency circumstances, the management team work to cover as follows: 1. Internal Additional Hours (ADH) on the site with the gap. 2. Internal ADH from the other sites across the health board. 3. In the event of steps 1 & 2 being unsuccessful, the service would escalate for agreement on transferring the surgical out of hours on call take to another site. (WGH to GGH) 4. Ensuring that all stakeholders are aware, including site teams, medical teams, WAST, any supporting services as appropriate. Proactive sickness management Escalation to clinical leads On appointment, new consultants undertake an induction with Hospital Director at WGH and Clinical Director for Scheduled Care. SOP in place for the transfer and repatriation of patients Engagement with WGH Medical Staff Committee and public on changes to services	Potential inability to recruit to all 3 substantive consultant posts scheduled for April 2025. The Consultants at GGH also provide the support to the junior and SAS level doctors at PPH for the elective pathway. The NHS locum in place at WGH is only on a 6 month fixed term contract. No rota co-ordinator in place at GGH to support rota management, and currently undertaken by Service Manager There is a risk of consultants requesting rates that are higher than the HB card rate, going forward as they have been covering multiple gaps on the rota for a prolonged time.	Review the longer term sustainability of general surgery on-call rotas across Hywel dda (recommendation from Getting it Right First Time (GIRFT) review in Jan23)	Lewis, Caroline	Completed	The senior consultant leads for general surgery have suggested that the WGH and GGH on call rotas are amalgamated to one site. This would provide an increase of consultants on the rota to either a 1:10 (the 3 WGH consultants and the 7 GGH consultants) or a 1:12 (the 3 WGH consultants, 7 GGH consultants and 2 newly recruited posts). This recommendation is in line with the GIRFT report. SBAR's have bee drafted by the service to describe the fragility of the rotas.
		To develop an options appraisal paper with all relevant stakeholders, including WAST, Primary Care, and site teams	Hire, Stephanie	Completed	A discussion was due to be held live at the health board planning session on 09/1/25, this did not take place due to the clinical lead and clinical director not being able to attend. The EGS situation is regularly reviewed and appropriate action is taken by the service as and when required. It also forms part of the fragile services, which is discussed at escalation. We are awaiting confirmation as to when or if the stakeholder discussion will take place. Following the executive meeting on 12/03/2025 and the agreement to recruit substantive consultants into the gaps on the rotas, this options appraisal paper is no longer required. This will need to be reviewed, if the service is unable to recuit suitable candidates.

	To hold interviews to appoint NHS locum consultant	Lewis, David	30/05/2025	Interviews have been scheduled for 30/04/2025.
	To agree job descriptions and advertise for three substantive consultant posts	Lewis, David	30/06/2025	Job descriptions have been sent for Royal College approval in April 2025.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
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	WGH Medical Staff Committee established to develop models of sustainability	1st			Management team have presented an SBAR to Acute Leadership Group (Feb23) SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23) General Surgery Report to Board (Mar23) Management team to present updated SBAR to Acute Leadership Group (Oct23 & Nov23) Management team to present updated SBAR to Corporate Directorate Group (Apr24) Upper GI	Assurance to Board on communication and repatriation arrangements				
	Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd								

	Reported to bi-monthly Scheduled Care Quality, Safety and Experience Group through exception reporting	2nd			service SBAR presented at ALG (Sep24) Upper GI service SBAR presented at Quality, Safety and Experience committee Meeting (Oct24) Updated SBAR to Executive Team (Nov24)						
	Assurance to be reported to the Board following introduction of temporary rota	2nd			Upper GI service SBAR presented at scheduled care directorate QSEAC (Jan25)						
	GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited										