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**Assurance on Governance Arrangements
Quality, Safety and Experience Committee August 2025**

Situation



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This report provides the Quality, Safety & Experience Committee (QSEC) with the current status of the Corporate risks and Ministerial Directions (MDs) within its remit. The Committee is asked to seek assurance from the Lead Executive Directors that risks are being managed effectively, and that we are compliant with MDs issued to the Health Board. At the time of reporting, there are no Ministerial Directions aligned to QSEC.

Corporate Risks:

9

Ministerial Directions

0

Risk Management - Overview



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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.

The Health Board’s risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either Principal, Corporate or Operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval processes and governance arrangements.

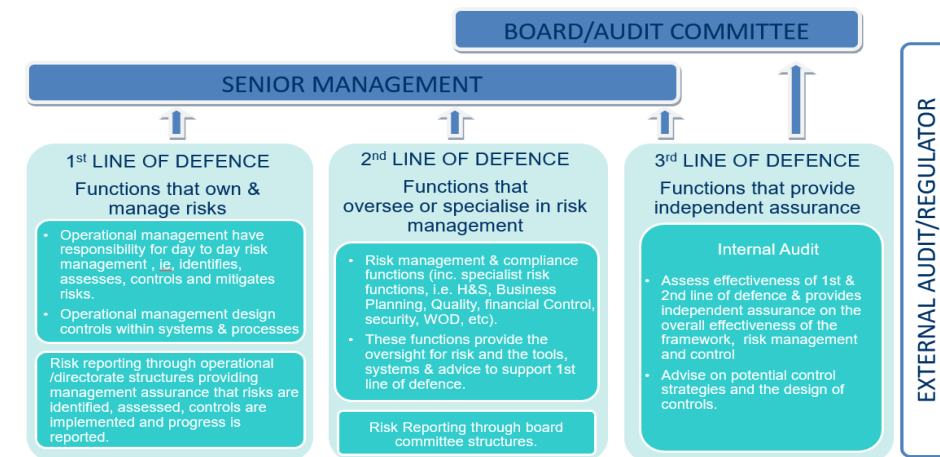
The Health Board operates within the widely accepted “Three Lines of Defence” model to ensure the appropriate responsibility is allocated for the management, reporting and escalation of risk.

Risks are aligned to an appropriate Clinical Care Group or Executive Function (hereto referred to as “Functions”), and each has a designated risk lead responsible for reviewing in a timely and comprehensive manner.

The Board’s Committees are responsible for the monitoring and scrutiny of corporate and operational risks within their remit and providing assurance to the Board that risks are being managed effectively and report areas of significant concern (eg where the risk appetite is exceeded, or there is a lack of action).

Committees are also responsible for reviewing risks over tolerance and where appropriate, recommend the ‘acceptance’ of risks that cannot be brought within risk appetite.

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. Risk leads are required to provide a rationale for the target risk score (TRS), and an expected date when the TRS will be achieved. These are mandatory fields on Datix as of 1 July 2025, and therefore where risks do not currently have this detail, risk leads will be asked to provide by the next report to QSEC.



Corporate Risks Assigned to QSEC



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

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

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 escalated operational risks that are of significant concern and require corporate oversight and management.

There are 9 risks currently aligned to QSEC (out of the 21 that are on the CRR as of 21 July 2025).

The following slide provides a summary of the reportable corporate risks aligned to QSEC. The Corporate Risk Register attached at **Appendix 1**, provides full detail of the risk, including control measures in place, a risk action plan to further manage and mitigate the risk, and sources of assurance.

Corporate Risks assigned to QSEC



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Risk Reference & Title	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS
1027 – Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Chief Operating Officer	20 →	8	31/03/2026
797 - Risk to the ability to deliver ultrasound services due to workforce pressures	Chief Operating Officer	20 →	12	30/07/2026
1032 - Risk of timely diagnosis and treatment of Mental Health and Learning Disabilities clients due to demand and capacity	Chief Operating Officer	20 →	20	TRS met as at July 2025
684 - Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Chief Operating Officer	16 →	8	Not known
1664 - Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Chief Operating Officer	16 →	10	31/03/2027
1708 - Risk of increasing fragility in primary care contractor services due to external factors	Chief Operating Officer	16 →	12	TBC
1531 - Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Chief Operating Officer	15 →	5	TBC
1810 - Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with Quality Assurance of Aseptic Preparation Services Standards	Chief Operating Officer	15 →	5	30/09/2026
1859 - Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Executive Director of Nursing, Quality & Patient	15 →	10	31/12/2025

Corporate Risks assigned to QSEC



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Risk 1027 - Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity

Rationale for Current Risk Score (20)	Rationale for Target Risk Score (8)
Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. The situation remains at high levels of risk escalation across our acute sites on a daily basis. Early signs of improvement against key UEC metrics but still outside target requirements. Recent external reviews (NHS Executive Same Day Emergency Care (SDEC) Review, NHS Executive Emergency Department (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.	An expected date of March 2026 has been noted to achieve the target risk score of 8 to allow transformation changes to embed.

797 - Risk to the ability to deliver ultrasound services due to workforce pressures

Rationale for Current Risk Score (20)	Rationale for Target Risk Score (12)
Service remains fragile. Long term vacancies and maternity leave further impacting fragility. 2 potential retirements 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. vacancies have been advertised and appointed as training posts under Annex 21 posts, with trainees expected to qualify in September 2026. May 2025 position has improved slightly for Urgent Suspected Cancer (USC) due to funding received.	The annual plan describing Radiology's demand and capacity work was approved at the March 2025 Board meeting and Radiology are working with executives as of April 2025 to answer queries in relation to the agreed investment. Improvement was seen during Q4 of 2024 and Q1 2025 due to insourcing at additional cost.

1032 - Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity

Rationale for Current Risk Score (20)	Rationale for Target Risk Score (20)
The service is experiencing significant waiting times because of increasing demand levels which are exceeding pre-pandemic levels, compounded by the longer-term impacts of Covid. Demand exceeds capacity. Recommendations received from NHS Executive in relation to Children's Neurodevelopmental (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.	A reduction in the CRS is dependant on securing a regional, strategic approach to creating whole system, needs-led integrated services, in addition to an uplift in recurring funding for Children's ND service, a date for which cannot be provided at this time. Without a credible and deliverable plan, a TRS cannot be provided as at July 2025.

Corporate Risks assigned to QSEC



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684 - Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	
Rationale for Current Risk Score (16)	Rationale for Target Risk Score (8)
Aged imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites with a significant impact on the Health Board's ability to meet its Referral to Treatment (RTT) target and causing delays in diagnosis and treatment for patients. 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.	Once the Nuclear Medicine Single Photon Emission Computed Tomography (SPECT) scanner, the 2nd CT scanner at GGH, and Dual-Energy X-Ray Absorptiometry (DEXA) scanner at BGH have been replaced, the risk score will decrease. This is dependent on WG funding being agreed and the required additional infrastructure in place for machinery to be operational. Without a credible and deliverable plan, a TRS cannot be provided as at July 2025.
1664 - Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	
Rationale for Current Risk Score (16)	Rationale for Target Risk Score (10)
Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1 (high risk) patients with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The current non-medical workforce establishment is not aligned to service needs and workforce challenges have led to an impact on the Health Board's ability to deliver services within the Ophthalmology Referral to Treatment (RTT) plan. Recruitment difficulties have led to the Consultant on-call rota being covered by four substantive Consultants with a gap of two.	A trajectory for the recovery of the R1 Eye Care Measures target has been outlined and the required investment was secured in May 2025 which will allow the service to recover to 65% by March 2026 if all posts are recruited into and all estates needs are met.
1708 - Risk of increasing fragility in primary care contractor services due to external factors	
Rationale for Current Risk Score (16)	Rationale for Target Risk Score (12)
The number of complaints received has increased due to returned dental contracts, and while the Health Board is currently containing the demand for urgent dental care, other patients are detrimentally impacted. Any further contracts returned will exacerbate this situation. The capacity of the Health Board to absorb further contract reform will impact on the ability to effectively deliver services and could have a detrimental impact on staff welfare.	A high dependency on external factors makes reduction of the risk score challenging. It is unlikely to be achieved without the approval of the Primary Care Strategy and successful conclusion of contract negotiations with professional contractor groups.

Corporate Risks assigned to QSEC



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1531 - Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	
Rationale for Current Risk Score (16)	Rationale for Target Risk Score (5)
Although the rota in WGH has been stabilised, gaps in the service remain. An NHS locum colorectal consultant was appointed in April 2025, to commence in post in August 2025. The Upper GI substantive consultant posts have been advertised and are currently being shortlisted. Interviews and stakeholder panel are due to take place in August 2025. The substantive colorectal consultant post will be advertised in readiness for the end date of the appointed NHS locum. The service has submitted a request for the Medacs locum at GGH to be extended until the end of August and the NHS locum at WGH to be extended for 6 months, to maintain the service while we recruit substantively.	TRS based on Clinical Services Plan work to identify and approve a sustainable solution and reduce likelihood of rota collapse and of not being able to provide a safe and sustainable emergency general surgery service to patients. The risk score will reduce on the appointment of substantive consultants.
1810 - Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	
Rationale for Current Risk Score (15)	Rationale for Target Risk Score (8)
Withybush Aseptic unit is the only remaining functional unit that can manufacture cancer treatments in the Health Board, with facilities that 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. The most recent audit performed during February 2025 highlighted that there is also insufficient resource available to maintain the Quality System against the standards due to staffing fragilities within the service.	Based on funding for new aseptic unit by WG (for HB to comply with regulatory standards and prepare cancer therapy until the Transforming Access to Medicines (TrAMS) South West manufacturing hub is operational), approval of Business Justification Case, unit being operational (Feb 2026), and workforce fragilities addressed (Sept 2026).
1859 - Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	
Rationale for Current Risk Score (15)	Rationale for Target Risk Score (10)
Whilst concerns relating to cardiac arrests and unplanned admissions are decreasing, an Acute Physical Deterioration Implementation Network being established (supported by a Clinical Reference Group), and an audit tool developed to monitor National Early Warning Scores (NEWS), compliance rates for Level 3 Resuscitation Training has never been greater than 60%. Staff availability to attend resuscitation training is problematic due to operational pressures and demand. There is therefore a need to identify the most appropriate training level, method of delivery and meeting mandatory requirements.	Recruitment into Resuscitation Team and establishment of a supported cascade training process will increase training compliance by October 2025 to >60%. >85% would enable the risk score to be reduced further to 5. Aim is to reduce cardiac arrest rates across all sites and unplanned admissions into ITU from ward areas by October 2025.

Recommendations



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The Committee is requested, in relation to the areas presented in this paper, to:

- **RECEIVE ASSURANCE** that identified controls are in place and working effectively;
- **RECEIVE ASSURANCE** that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise; and



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND



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CORPORATE RISK REGISTER SUMMARY JULY 2025

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Jul-25	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	4×5=20	4×5=20	→	2×4=8	31/03/2026
797	Risk to the ability to deliver ultrasound services due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	5×4=20	5×4=20	→	3×4=12	30/07/2026
1032	Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	5×4=20	5×4=20	→	5×4=20	TRS met as at July 2025
684	Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Carruthers, Andrew	Service/Business interruption/disruption	4×4=16	4×4=16	→	2×4=8	Not known
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	4×4=16	4×4=16	→	2×5=10	31/03/2027
1708	Risk of increasing fragility in primary care contractor services due to external factors	Carruthers, Andrew	Service/Business interruption/disruption	4×4=16	4×4=16	→	3×4=12	TBC
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	3×5=15	3×5=15	→	1×5=5	TBC
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	3×5=15	3×5=15	→	1×5=5	30/09/2026
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	3×5=15	3×5=15	→	2×5=10	31/12/2025

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		<i>NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you</i>
	Detailed review of relevant information	
	Medium level review	
	Cursory or narrow scope of review	

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

CORPORATE RISK REGISTER SUMMARY JULY 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:	Jun-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Jul-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):	5x5=25
Current Risk Score (L x I):	4x5=20
Target Risk Score (L x I):	2x4=8
Expected Date To Achieve TRS:	31/03/2026
Trend:	

Date	Current Risk Score	Target Risk Score	Tolerance Level
Jul-23	20	12	6
Jan-24	20	12	6
Mar-24	20	12	6
May-24	20	12	6
Jul-24	20	12	6
Oct-24	20	12	6
Jan-25	20	8	6
Apr-25	20	8	6
Jun-25	20	8	6

Rationale for CURRENT 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 May 2025 highlighted that the number of ambulance handovers taking over one hour was 1059, which is significantly over the TI target of 680.

Additionally May's data highlighted a breach in the percentage of patients spending 12 hours or more in A&E / MIU, with the actual figure of 8% noted against the TI target of 7%. The median time to assessment by a clinical decision maker was 70mins (April 79mins), exceeding the TI target of 60 minutes. The Health Board was also over target in relation to Pathway of Care Delays, with actual figure of 234 exceeding the target of 174. As such, the current risk score remains unchanged as at June 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.

Rationale for TARGET Risk Score:

The Target Risk Score of 8 reflects the confidence in the delivery of 6 Goals Programme and the Accelerated Transformation 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.

CORPORATE RISK REGISTER SUMMARY JULY 2025

<p># Criteria-led discharge guidance and principles piloted across HB (Sep24).</p> <p># Integrated Regional Winter Plans developed to manage whole system pressures over the winter period and communicated.</p> <p># An operationally focussed 6 Goals Urgent and Emergency Care (UEC) programme with governance structure agreed where all UEC improvement is coordinated.</p>	<p>responsibilities for discharge planning and coordination.</p> <p># 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.</p>	<p>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.</p>	<p>Skitt, Peter</p>	<p>31/10/2025</p>	<p>Initial planning and audit of capacity has been completed. Length of stay data being gathered by County Leads.</p>
<p># Welsh Ambulance Services NHS Trust involved in all 6 Goals UEC workstreams.</p> <p># 111 and 111 press 2 (MH) implemented across Hywel Dda.</p> <p># Regional Integration Fund projects in place across Regional Partnership Board (RPB) footprint, along with Further Faster projects to ensure alignment with Ministerial objectives.</p> <p># Whole system approach to deploy HB staff to ensure continuity of patient care.</p>	<p># Optimising our bedded facilities in the community.</p> <p># Need to develop 24/7 integrated urgent primary care service aligned to Home First hubs.</p> <p># Insufficient IPC single rooms across community and acute sites, negatively impacting on patient flow.</p>	<p>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</p>	<p>Skitt, Peter</p>	<p>31/10/2025</p>	<p>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.</p>
<p># Care Home Risk & Escalation Policy to support failing care homes to be applied as required.</p> <p># Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across the RPB region.</p> <p># 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.</p>	<p># Lack of level 1 / 2 falls response service during out of hours across the Health Board.</p> <p># Fragility of senior medical cover at EDs across the acute sites.</p> <p># Need to create a Health Board wide Frailty approach and appoint a Clinical Lead for Frailty.</p>	<p>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.</p>	<p>Skitt, Peter</p>	<p>31/12/2025</p>	<p>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).</p>
<p># 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</p> <p># SRO in place to lead agreed 6 Goals for UEC programme.</p>	<p># Need to create a Health Board wide Frailty approach and appoint a Clinical Lead for Frailty.</p> <p># 7 day services within the Community are required, particularly around Clinical Streaming Hubs and level 1 / 2 Falls.</p>	<p>Development and implementation of HDUHB optimal SDEC model following on from lessons learnt from peer review and alignment with CSH and local resource hubs.</p>	<p>Skitt, Peter</p>	<p>31/10/2025</p>	<p>An SBAR has been developed to standardise the approach across the Health Board, which is to be discussed at the CCG July 2025 meeting.</p>
<p># 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.</p> <p># Local streaming (Home First) hubs developed with a HB wide approach agreed with clinical triage and screening systems in place, including APP</p>		<p>Continued implementation of Optimal Flow Framework including Community sites supported by Frontier digital platform.</p>	<p>Skitt, Peter</p>	<p>31/10/2025</p>	<p>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.</p>

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.

Regional Discharge Strategy Group established, providing oversight of all current work streams, and ongoing work on national and local policies

Regional POCD group established January 2025 with a focus on reviewing trends and themes to inform regional and local action plans

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.
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.

ASSURANCE MAP			
Performance Indicators	Sources of ASSURANCE	Type of Assurance	Required Assurance
		(1st, 2nd, 3rd)	Current Level
Ambulance handovers within 15 minutes	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st	
Ambulance handovers over 1 hour	Daily performance data overseen by service management	1st	
Ambulance handovers over 4 hours	Workstream Delivery Plans overseen by 6 Goals Programme	2nd	

Control RAG Rating (what the assurance is telling you about your controls)

Red

Latest Papers (Committee & date)

None

Gaps in ASSURANCES				
Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed	By Who	By When	Progress
Further action necessary to address the gaps				
None identified.				

Date Risk Identified:	Nov-19
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jul-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Aug-25

Risk ID:	797	Corporate Risk Description:	<p>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).</p> <p>demand and capacity: there is a gap between funded establishment and demand for ultrasound services</p> <p>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.</p> <p>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.</p> <p>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</p>
Does this risk link to any Directorate (operational) risks?		1557, 1349, 1658, 1936, 2068	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5x4=20
Current Risk Score (L x I):	5x4=20
Target Risk Score (L x I):	3x4=12
Expected Date To Achieve TRS:	30/07/2026

Trend:	↔
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Rationale for CURRENT 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).

Since receiving funding in April 2025, the May 2025 position has improved slightly for USC: 33% of ultrasound USC's carried out and reported in 7 days (March 2025: 13%), 48.77% carried out and reported in 14 days at end May 2025 (March: 37.53%).

Rationale for TARGET Risk Score:

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.

CORPORATE RISK REGISTER SUMMARY JULY 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	By Who	By When	Progress
<p>Process in place for the movement of staff across the Health Board to maintain capacity where possible.</p> <p>Conversion of room to increase capacity @ GGH</p> <p>Employment of Physiotherapists and Midwives to undertake scanning within scope of expertise</p> <p>Utilising insourced ultrasound service to reduce backlogs of patients waiting >8weeks (recovery funded).</p> <p>Rolling bank adverts for sonographers.</p> <p>Clinical Educator in post, facilitating the expansion of training across site.</p> <p>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.</p> <p>Continuous recruitment and training of sonographers within current establishment</p> <p>Annex 21 process in place, commencing in January of each year, to train over a period of 2 years sonographers</p> <p>Funding to improve USC times was received in April 2025, both insourcing and 1 WTE sonographer. Locum sonographers have also been utilised.</p>	<p>Inability to recruit and retain sufficient numbers of trained staff.</p> <p>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)</p> <p>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.</p> <p>Whilst an Ultrasound Control Group is in place, meetings are infrequent due to availability of attendees.</p>	<p>Develop and implement a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.</p>	<p>Llewellyn, Cerian</p>	<p>31/12/2022 31/10/2023 31/01/2024 30/06/2024 31/01/2025 31/01/2026</p>	<p>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.</p> <p>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.</p> <p>June 2025: Midwife sonographer is now undertaking required training and expected to qualify in January 2026.</p>
		<p>Train members of staff to become sonographers, the number of which dependant on capacity to take training.</p>	<p>Roberts-Davies, Gail</p>	<p>31/03/2020 31/12/2022 01/02/2023 30/09/2024 31/01/2026</p>	<p>April 2025: Approval of annual plan in April , 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.</p> <p>June 2025: Plans to train more staff in 2025-27 via Annex 21 (at least 2 more training posts)</p>


		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.
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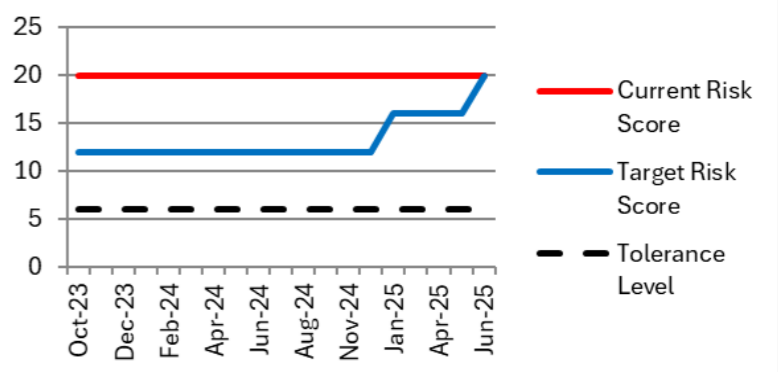
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance Current Level			Identified Gaps in Assurance:	How are the 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								

Date Risk Identified:	Nov-20
Strategic Objective:	4. The best health and wellbeing for our individuals and families and our communities and 5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jun-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Jul-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):	5x4=20
Current Risk Score (L x I):	5x4=20
Target Risk Score (L x I):	5x4=20
Expected Date To Achieve TRS:	TRS met as at July 2025
Trend:	



Month	Current Risk Score	Target Risk Score	Tolerance Level
Oct-23	20	12	5
Dec-23	20	12	5
Feb-24	20	12	5
Apr-24	20	12	5
Jun-24	20	12	5
Aug-24	20	12	5
Oct-24	20	12	5
Nov-24	20	12	5
Jan-25	20	16	5
Apr-25	20	16	5
Jun-25	20	20	5

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. Demand exceeds capacity. 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 NHS Executive to establish trajectories, along with the commissioned service which since have been agreed in March 2023. The NHS Executive were unable to provide trajectories, therefore Health Board has agreed to a 1% monthly improvement trajectory.

In order to move to whole-system, needs-led approaches, this requires regional collaboration and commitment to prioritise innovative, integrated ways of working, focusing on social models of health. Until this is in place, ND will remain a 'health' problem and exponential demand likely to continue.

Rationale for TARGET Risk Score:

The Clinical Care Group has prioritised implementation of WPAS in Children's ASD service which has enabled improved reporting and waiting list management and to determine trajectories of improvement in waiting times. However, the target risk score has increased.

In July 2024, WG announced that ND services across Wales were unable to meet waiting time targets for CYP ND unless rapid, transformational whole-system change was implemented. While trajectory plans are in place, the Health Board has recognised WG targets will not be achieved by the service in its current format, with a further deteriorating position in performance anticipated, compounded by the end of procurement contracts with external providers in March 2025.

The target risk score will be dependent on securing a regional, strategic approach to creating whole system, needs-led integrated services, in addition to an uplift in recurring funding for Children's ND service to develop alternative clinical and support pathways; permission to explore and implement use of artificial intelligence and other digital innovations well as having access to appropriate clinical venues.

A target risk date cannot be provided at this time

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	By Who	By When	Progress
<p>Use of IT/virtual platforms such as Attend Anywhere when appropriate to encourage blended approach to working.</p> <p>Additional WG funding received in 2022/23/24/25 for ND services - currently awaiting confirmation for the next three year cycle.</p> <p>Weekly Autism Advice Hubs in place for parent carers and CYP</p> <p>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.</p> <p>Monthly meetings to meet recommendations of NHS Executive's Action Plan in respect of CYP ND services in place.</p> <p>ND Service Delivery Manager appointed and in place to help improve performance and drive innovative practice in line with WG policy and legislation.</p> <p>Workforce stabilised with no retention issues.</p> <p>Workforce Management Group established and workforce plans in place.</p>	<p>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.</p> <p>Additional funding received in 2022/23 for ND service on fixed term annual basis until 2025. Awaiting ministerial directive on allocation of additional monies 2025/2026</p> <p>Current resource does not provide sufficient capacity to meet demand.</p> <p>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.</p>	<p>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.</p>	<p>Temple-Purcell, Rebecca</p>	<p>Completed</p>	<p>New Action</p>

CORPORATE RISK REGISTER SUMMARY JULY 2025

<p>Trajectories have been agreed for Children's ND by NHS Executive and systems in place to monitor waiting lists at service level performance-management meetings, IPAR and Clinical Care Group BPPP meetings.</p> <p>Use of HB Third Party Contractor to send out Keeping in touch letters 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 and other services while waiting.</p> <p>Use of Covid recovery monies to outsource portion of diagnostic assessments over a 3 year period 2022-2025 for all ages</p> <p>Additional NDIP, WG & Health Board slippage funding secured to outsource a further portion of diagnostic assessments for all-age ADHD and ASD assessments in 2025.</p> <p>Quarterly meetings with the NHS Executive, Welsh Government and Service Leads at the Health Board.</p> <p>SMS text functionality in place for ND to improve attendance and decrease instances of non attendance.</p> <p>Support workers recruited in to Children's ND service.</p> <p>"Rapid Access to Diagnosis " (service improvement initiative) currently being piloted in Children's ND. Started in April 2025.</p>	<p>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.</p> <p>Keeping in Touch letters not being sent as of May 2025 - there is a contract monitoring meeting taking place as they haven't been meeting the standards set.</p>	<p>ND specific HB internet and intranet pages in development to give guidance and support whilst neuro-divergent individuals and parent carers are waiting.</p>	<p>vaughan, Catherine</p>	<p>31/10/2024 31/12/2024 31/03/2025 30/09/2025</p>	<p>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</p> <p>Website remains in development, although all material ready. Adult IAS and Childrens ND content now ready. Awaiting final go live.</p> <p>Children's ADHD and Adult ADHD website has been launched. Digital accessibility issues are being worked through. Due to go live September 2025.</p>
<p>Developed an Early Years pathways for Health Visitors.</p> <p>Social Care and Education Interface Meeting with Carmarthenshire Local Authority to stem the flow (promoting a needs-led approach).</p> <p>Fixed term contracts have been agreed for staff until the end of March 2026.</p> <p>Additional resource for admin cover to ND services for a 12 month period.</p> <p>Website developed for all-age ND services</p>		<p>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).</p>	<p>Carroll, Mrs Liz</p>	<p>31/12/2024 31/12/2027</p>	<p>Three year training programme with graduates during 2027.</p>

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 desired 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 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	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								
	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.									

CORPORATE RISK REGISTER SUMMARY JULY 2025

An updated paper was submitted to the March 2025 Board meeting.				paper was presented at Board Seminar in March 2025 to provide assurance on current waiting times and control measures.					
Rapid Access Pilot Steering Group (add as action - look at other pathway options/digital) - renamed ASD Task and Finish group and run weekly, sponsored by Executives									

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

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jul-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Aug-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, and also lack of suitable physical space and electrical infrastructure. 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:	Not Known
Trend:	↔

Date	Current Risk Score	Target Risk Score	Tolerance Level
Sep-22	16	12	6
Jan-23	12	8	6
Jun-23	12	8	6
Sep-23	16	8	6
Nov-23	16	8	6
Feb-24	16	8	6
May-24	16	8	6
Jul-24	16	8	6
Oct-24	16	8	6
Dec-24	16	8	6
Feb-25	16	8	6
May-25	16	8	6

Rationale for CURRENT 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

Rationale for TARGET Risk Score:

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.

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 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 02/04/2025. Correspondence was received from WG in May 2025 that Nuclear Medicine would be a priority for this year following provision of costing.

June 2025

Due to limitations caused by lack of appropriate physical space and insufficient electrical infrastructure, the costing for replacing the Gamma Camera at WGH has exceeded the expected amount available from WG (£8.6m) within current 2025/25 financial year and therefore the window for funding has been closed.

This delay in replacement scheme is further impacting our ability to comply with NRW specification for Nuclear Medicine Department (NRW report 2023/24).

Future plans will need to be coordinated with Estates to provide more electrical supply and equipment to ensure site meets current and future specifications of Radiology's Nuclear Medicine plans.

CORPORATE RISK REGISTER SUMMARY JULY 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	By Who	By When	Progress
<p># Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained.</p> <p># The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service.</p> <p># Regular quality assurance checks (eg daily checks).</p> <p># Use of other equipment/transfer of patients across UHB during times of breakdown.</p> <p># Ability to change working arrangements following breakdowns to minimise impact to patients.</p> <p># Site business continuity plans in place.</p> <p># Disaster recovery plan in place.</p> <p># Replacement programme has been re-profiled by risk, usage and is influenced by service reports.</p> <p># Escalation process in place for service disruptions/breakdowns.</p> <p># 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.</p> <p># All equipment at main sites are now DR and so will be compliant with the RISP project</p> <p># 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.</p>	<p>Limitation of spare parts for some older equipment leading to extended outages. This issue has been compounded by Brexit.</p> <p>Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites.</p> <p>Reliance on AWCP for replacement of equipment.</p> <p>Inability to undertake specific replacements at this time due to the additional infrastructure required</p> <p>National Imaging and Capital Priorities Group outcomes do not always align with the Health Board priorities, and is subject to negotiations within the group.</p>	<p>Installation of replacement Gamma Camera, WGH</p> <p>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.</p>	<p>Roberts-Davies, Gail</p>	<p>31/07/2024 30/06/2025 31/03/2026 31/03/2027</p>	<p>No funding allocated as of 09/02/2024</p> <p>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.</p> <p>July 2024 the T&F group has been set up and meets weekly</p> <p>Feb 2025 there is a draft plan for replacement. Business continuity plans being explored. The plan has been rejected by WAG for 25/26 due to cost and the electrical instruction T&F looking to alternative sites and will resubmit for funding in 26/27.</p>
		<p>Replacement of aged CT Scanner at GGH</p>	<p>Procter, Sarah</p>	<p>31/03/2024 31/07/2024 30/06/2025 31/07/2026</p>	<p>Awaiting confirmation of funding as at December 2023.</p> <p>No funding allocated as of 09/02/2024</p> <p>This will not be replaced in the 24/25 financial year.</p> <p>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.</p>

CORPORATE RISK REGISTER SUMMARY JULY 2025


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	Completed	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. Update 04/07/2025 confirmation from Site Lead Faith Whitecross that the acceptance testing was completed 02.04.2025. SQ

CORPORATE RISK REGISTER SUMMARY JULY 2025

<p>Replacement of CR X-Ray room, Llandoverly Hospital</p>	<p>Osell, Fiona</p>	<p>31/03/2024 31/07/2024 30/06/2025 01/12/2025 31/03/2026</p>	<p>Equipment on site is incompatible with the incoming PACS system</p> <p>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.</p> <p>In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract.</p> <p>This will not be replaced in the 2025/2026 financial year. Progression of this project reliant upon the outcome of the clinical services plan which is out to consultation</p>
<p>Replacement of Mammography Units, BGH and WGH</p>	<p>Roberts-Davies, Gail</p>	<p>31/03/2024 31/07/2024 30/06/2025 31/03/2027</p>	<p>Ageing equipment, exacerbated by the failure of Securview.</p> <p>These will not be replaced in the 23/24 financial year</p> <p>These will not be replaced in the 2024/2025 financial year</p> <p>These will not be replaced in the 2025/2026 financial year</p>

<p>Upgrade or replacement of MRI scanner, GGH</p>	<p>Procter, Sarah</p>	<p>31/03/2024 30/06/2025 31/03/2026</p>	<p>Ageing equipment with increasing failures, with new technologies now available.</p> <p>Awaiting confirmation of funding as at April 2024. This will not be replaced in the 24/25 financial year.</p> <p>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.</p>
<p>To replace the DEXA scanner at BGH and ensuring suitable accommodation is found to meet regulatory compliance for a larger more modern scanner.</p>	<p>Edwards, David</p>	<p>31/03/2024 30/09/2024 30/09/2025 31/03/2026</p>	<p>Unit is 17 years old, and previously funded via charitable funds</p> <p>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.</p> <p>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.</p>

				Collaboration with Estates to ensure requirements for Radiology at all sites are considered and are integral to future decision-making for site allocation	Procter, Sarah	30/09/2025	This action has been added following a request from QSEC in June 2025 to consider how we include the nature of our Estate within this risk. Initial communication to be established in June 2025 to agree on timelines for future workplan. Estates are currently part of Task & Finish Group, however Head of Engineering to be invited. Further actions to be added based on outcomes.
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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								

Date Risk Identified:	May-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care

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

Risk ID:	1664	Corporate Risk Description:	<p>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.</p> <p>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 regarding 2 Regional substantive Consultant posts.</p>
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):	4x4=16
Current Risk Score (L x I):	4x4=16
Target Risk Score (L x I):	2x5=10
Expected Date To Achieve TRS:	31/03/2027

Current Risk Score	Red line
Target Risk Score	Blue line
Tolerance Level	Black dashed line

Trend: ↔

Rationale for CURRENT 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 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 HB. 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. The current R1 delivery at 35%. The WG target for R1 delivery is 95%.

The service as at July 2025 is expected to reach 0 patients waiting at stage 1 52 weeks, however there has been a breach of 35 patients. The stage 4 104 weeks, is breach of 8. There is a plan in place for quarter 2 with a current threat of 25 patients at 104 weeks due to theatre cancellations and single handed surgeons managing sub-specialties. 7523 patients have been 100% delayed for their follow up appointment.

The current impact has been scored as 4 because patients are experiencing harm and the current likelihood has been scored 4 as ophthalmology is a fragile service. It is unlikely that this risk will be able to be significantly reduced without considerable investment.

Rationale for TARGET Risk Score:

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 and the required investment has been secured. Once implemented this will 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. The investment has been secured in May 2025 which will allow the service to recover to 65% by March 2026 if all posts are recruited into and all estates needs are met. 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.

CORPORATE RISK REGISTER SUMMARY JULY 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	By Who	By When	Progress
<p>The service is included within the Health Board's Clinical Service Plan (CSP). This will produce efficiency gains but will not secure additional resources.</p> <p>Active recruitment to vacancies, grow your own initiatives to secure Substantive Consultants and develop Consultants for the future.</p> <p>Regional discussion around 2 Regional Substantive posts, with SBAR being produced.</p> <p>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, paediatric and cataract pathways.</p> <p>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 approved by board to further develop IVT service delivery.</p> <p>Additional capacity has been funded for the delivery of Cataract surgery to maintain the 104 week wait for 2025/2026.</p> <p>Continued Identification of patients suitable to undergo transfer out to the community to Wales General Ophthalmic Services (WGOS) for Glaucoma and Medical Retina.</p> <p>Continued Validation of waiting lists to remove any patients who no longer require treatment through the scheduled Care validation team.</p> <p>Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards.</p> <p>Eye Care Measures co-ordinator in place to oversee and manage the</p>	<p>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.</p> <p>Recovery funding is non-recurring and reviewed annually, this restricts delivery planning.</p> <p>There are concerns in data quality due to referral processes and system use.</p>	<p>Roll out and implementation of National Electronic Patient Record for Ophthalmology.</p> <p>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.</p> <p>Remodelling the capacity and demand associated with Wet AMD and Amman Valley</p>	<p>Barreiro, Marta</p> <p>Coppack, Victoria</p> <p>Coppack, Victoria</p>	<p>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</p> <p>Completed</p> <p>Completed</p>	<p>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.</p> <p>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.</p> <p>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.</p>

CORPORATE RISK REGISTER SUMMARY JULY 2025

<p>management of all R1 referrals.</p> <p>Review of data quality inclusive of Health Risk Factor (HRF) code and clinical codes ongoing to improve data quality.</p> <p>Highly trained Optometrists working collaboratively with the Secondary Care Eye Service to reduce referrals to secondary care.</p> <p>Ongoing training of Optometrists within secondary care to continue to develop this service for continued delivery of WGOS.</p> <p>Ongoing arrangement of Optometrists enrolling in prescribing training to develop further Independent prescribers in the community.☒</p> <p>GIRFT review undertaken on the Ophthalmology service with progress made against recommendations raised monitored and updated via AMAT.</p> <p>Performance dashboards in place to monitor performance daily.</p> <p>The service albeit still requires investment and continued work with Swansea Bay ref Regional working which is in its infancy in development</p>	<p>Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.</p>	<p>Coppack, Victoria</p>	<p>30/09/2022 31/10/2023 30/11/2023 31/03/2024 30/06/2024 30/09/2024 31/03/2026</p>	<p>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.</p>
	<p>Alignment in the Delivery of Eye Care Measures and Ministerial Measures and effective management of Ophthalmology waiting lists.</p>	<p>Coppack, Victoria</p>	<p>31/03/2027</p>	<p>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.</p>
	<p>Long-term investment required for IVT and Glaucoma Delivery to recover R1 position</p>	<p>Jones, Keith -</p>	<p>31/01/2026</p>	<p>New action - progress update to be provided at next risk review.</p>
	<p>Regional solutions to workforce gaps and estates to be explored through Regional programme</p>	<p>Coppack, Victoria</p>	<p>31/03/2027</p>	<p>2nd Regional meeting booked February 2025 Update 18/02/2025 - meeting rescheduled to 14/03/2025</p>
	<p>Orthoptist posts to be recruited into</p>	<p>Coppack, Victoria</p>	<p>30/09/2025</p>	<p>Band 6 Orthoptist is now onboarding after successful interview. Band 8A JD is being review prior to submitting to Agenda For Change (A4C) panel.</p>

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.	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 review Cataracts.	GIRFT action plan cataracts	1st								
GIRFT review Glaucoma.	GIRFT action plan Glaucoma	1st								
Weekly RTT Optimisation to review Ministerial Measures.	WPAS, scheduled care performance indicators	1st								

Date Risk Identified:	Jul-23
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jun-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Jul-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):	4x4=16
Current Risk Score (L x I):	4x4=16
Target Risk Score (L x I):	3x4=12
Expected Date To Achieve TRS:	TBC
Trend:	↔

Date	Current Risk Score	Target Risk Score	Tolerance Level
Aug-23	16	8	6
Nov-23	15	8	6
Feb-24	15	8	6
May-24	15	8	6
Jul-24	15	8	6
Sep-24	15	8	6
Dec-24	15	8	6
Feb-25	15	12	6
May-25	15	12	6

Rationale for CURRENT 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 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 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) was successfully rolled out in Hywel Dda UHB 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 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.

Rationale for TARGET Risk Score:

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.

CORPORATE RISK REGISTER SUMMARY JULY 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	By Who	By When	Progress
<p>Primary Care Academy in place, which looks at workforce planning, training and development needs and opportunities</p> <p>5 Facet Survey completed in 2022 to establish a baseline for the GMS estate</p> <p>GMS and Dental Practices undertake annual reporting which includes reviews of statutory compliance requirements</p> <p>0.25 FTE Primary Care Development Manager for estates in post but with a focus on GMS</p> <p>Escalation tool for GMS and Community Pharmacy (SITREP)</p> <p>Continue effective engagement with struggling practices to support with their issues through close working relationships developed with practices.</p> <p>Programme of practice visits to review Estates provision, and if remedial action is required</p> <p>Requests sent to contractors to assess potential risk of RAAC, with outcomes reported to WG</p> <p>Nationally agreed Breach Management process in place for Community Pharmacies.</p> <p>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.</p>	<p>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.</p> <p>National work on the development of the escalation tool for Dental and Optometry is ongoing but not live.</p> <p>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.</p> <p>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).</p> <p>Insufficient resources to support the estates development across all Primary</p>	<p>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.</p>	<p>Hughes, Samantha</p>	<p>31/03/2024 31/03/2025 30/09/2025</p>	<p>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.</p>

CORPORATE RISK REGISTER SUMMARY JULY 2025

<p>Strategic Programme for Primary Care (SPCC) bids approved for 2024/25 and 2025/26 to support workforce initiatives</p> <p>A series of patient facing videos have been developed with Pocket Medic to support patient education in accessing Primary Care Services</p> <p>Whilst Community Pharmacy Breach Management process in place, which has been reviewed in light of appeals process.</p> <p>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.</p>	<p>Care services, particularly with independent contractors. Due to national review of Premises Directions, there is no improvement grant funding for 2024/25.</p> <p>Whilst Community Pharmacy Breach Management process in place, which has been reviewed in light of appeals process.</p> <p>Whilst RAAC declarations were requested, these were not mandatory for contractors to respond, and therefore effectiveness of responding to outcomes.</p> <p>Whilst challenge is provided via GMS contract reviews, feedback not consistently addressed by practices.</p>	<p>To develop the Primary Care Strategy in consultation with statutory stakeholders and consultees, to cover areas including:</p> <ul style="list-style-type: none"> •Workforce •Sustainable provision of Primary Care services •Estates •Managing contractual change •Developing pathways and new services •Improving access to services across all contractor professions <p>Consider the potential to deliver a wider range of salaried NHS Dental Services through the Community Dental Service.</p>	<p>Bond, Rhian</p> <p>Owens, Mary</p>	<p>30/09/2024 31/03/2025 30/09/2025</p> <p>30/04/2024 30/06/2024 31/10/2024 31/03/2025 30/09/2025</p>	<p>Paper submitted to Board in September 2023 setting out the scope of the Primary Care Strategy, with papers presented to Board at regular intervals.</p> <p>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.</p> <p>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.</p>
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CORPORATE RISK REGISTER SUMMARY JULY 2025

		<p>Implement the Managed Practice Strategy plan will give greater system resilience.</p>	<p>Swinfield, Anna</p>	<p>30/04/2024 30/10/2024 31/01/2025 31/03/2025 30/09/2025</p>	<p>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.</p> <p>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.</p>
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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	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								

CORPORATE RISK REGISTER SUMMARY JULY 2025

reports and Dental Assurance Framework - Business Service Authority dashboards, to identify outliers	PCSMs tasked with regular discussions with Practices that report L4 to understand the issues	1st									
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CORPORATE RISK REGISTER SUMMARY JULY 2025

Date Risk Identified:	Nov-22
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jun-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Jul-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):	4x5=20
Current Risk Score (L x I):	3x5=15
Target Risk Score (L x I):	1x5=5
Expected Date To Achieve TRS:	TBC
Trend:	↔

Date	Current Risk Score	Target Risk Score	Tolerance Level
Oct-23	20	10	5
Dec-23	15	10	5
Feb-24	20	10	5
Apr-24	20	5	5
Jun-24	20	5	5
Aug-24	20	5	5
Oct-24	20	5	5
Dec-24	15	5	5
Feb-25	15	5	5
May-25	15	5	5

Rationale for CURRENT Risk Score:

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. This is also on the risk register, Risk 2067.

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, an NHS locum colorectal consultant has been appointed to fill this gap, with the hope of a start date in August 2025. 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

Rationale for TARGET Risk Score:

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 substantive 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.

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.

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 March 2025 Escalation Meeting, 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 at GGH, the agency locum will be terminated. On the appointment of the substantive consultants at WGH, the NHS locums will be terminated.

An NHS locum colorectal consultant was appointed on 30 April 2025, to commence in post in August 2025. The Upper GI substantive consultant posts have been advertised and are currently being shortlisted. Interviews and stakeholder panel are due to take place on the 14th and 15th of August 2025. The substantive colorectal consultant post will be advertised in readiness for the end date of the NHS locum that has been appointed. With this in mind, the service has submitted a request for the Medacs locum at GGH to be extended until the end of August and the NHS locum at WGH to be extended for 6 months, to maintain the service while we recruit substantively.

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	By Who	By When	Progress
<p>Rotas monitored daily by the service delivery team</p> <p>When there is sickness or unexpected leave, due to emergency circumstances, the management team work to cover as follows:</p> <ol style="list-style-type: none"> 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. <p>Proactive sickness management</p> <p>Escalation to clinical leads</p>	<p>Potential inability to recruit to all 3 substantive consultant posts scheduled for April 2025.</p> <p>The Consultants at GGH also provide the support to the junior and SAS level doctors at PPH for the elective pathway.</p> <p>The NHS locum in place at WGH is only on a 6 month fixed term contract.</p> <p>No rota co-ordinator in place at GGH to support rota management, and currently undertaken by Service Manager</p>	<p>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)</p>	<p>Lewis, Caroline</p>	<p>Completed</p>	<p>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 been drafted by the service to describe the fragility of the rotas.</p>

CORPORATE RISK REGISTER SUMMARY JULY 2025

<p>On appointment, new consultants undertake an induction with Hospital Director at WGH and Clinical Director for Scheduled Care.</p> <p>SOP in place for the transfer and repatriation of patients</p> <p>Engagement with WGH Medical Staff Committee and public on changes to services</p>	<p>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.</p>	<p>To develop an options appraisal paper with all relevant stakeholders, including WAST, Primary Care, and site teams</p>	<p>Hire, Stephanie</p>	<p>Completed</p>	<p>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.</p> <p>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.</p> <p>We are awaiting confirmation as to when or if the stakeholder discussion will take place.</p> <p>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 recruit suitable candidates.</p>
		<p>To hold interviews to appoint NHS locum consultant</p>	<p>Lewis, David</p>	<p>Completed</p>	<p>Job descriptions have been sent for Royal College approval in April 2025.</p>
		<p>To agree job descriptions and advertise for three substantive consultant posts</p>	<p>Lewis, David</p>	<p>Completed</p>	<p>The two substantive upper GI consultant posts have been advertised and shortlisting is currently being undertaken. If there are suitable candidates, interviews will take place on 14th and 15th August.</p> <p>The substantive lower GI consultant post will be advertised in Spring 2026, in readiness for the end date of the NHS locum that has been appointed.</p>

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
	WGH Medical Staff Committee established to develop models of sustainability	1st			Management team have presented an SBAR to Acute Leadership Group (Feb23)	Assurance to Board on communication and repatriation arrangements				
	Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd			SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23)					
	Reported to bi-monthly Scheduled Care Quality, Safety and Experience Group through exception reporting	2nd			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 service SBAR presented at ALG (Sep24)					
					Upper GI service SBAR					

CORPORATE RISK REGISTER SUMMARY JULY 2025

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

Date Risk Identified:	Feb-24
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jul-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Aug-25

Risk ID:	1810	Principal Risk Description:	<p>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, exacerbated by a fragile workforce within the service.</p> <p>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.</p>
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):	5x5=25
Current Risk Score (L x I):	3x5=15
Target Risk Score (L x I):	1x5=5
Expected Date To Achieve TRS:	30/09/2026
Trend:	↔

Date	Current Risk Score	Target Risk Score	Tolerance Level
Feb-24	25	5	5
May-24	15	5	5
Jul-24	15	5	5
Sep-24	15	5	5
Oct-24	15	5	5
Dec-24	15	5	5
Feb-25	15	5	5
May-25	15	5	5

Rationale for CURRENT 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. The most recent audit performed during February 2025 highlighted that there is also insufficient resource available to maintain the Quality System against the standards due to staffing fragilities within the service.

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.



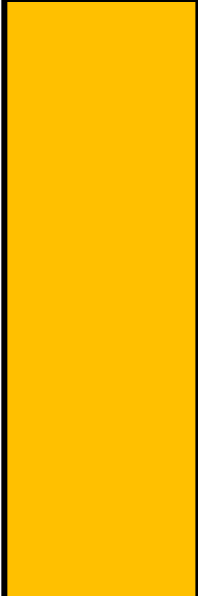


Rationale for TARGET Risk Score:

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 current risk score could be reduced to 10 once the unit is operational, expected to be February 2026. Achievement of the Target Risk Score of 5 is expected once workforce fragilities have been addressed, anticipated to September 2026.

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	By Who	By When	Progress
<p>Transfer of the radiopharmacy service to Singleton Hospital in October 2022; this means less overall activity through the Wthybush Aseptic unit reducing the risk of contamination and errors.</p> <p>More time and resource provided to the Quality System (i.e. internal audits, investigation of near misses and microbial growths, maintaining SOPs).</p> <p>Increased training of aseptic staff to develop their skills and knowledge.</p> <p>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.</p> <p>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.</p> <p>Removal of outsourced dispensing from the Aseptic unit; this minimises the risk of contamination and potential for error.</p> <p>Preparation of products near to the time of use; this limits the pre-administration storage time.</p> <p>More stringent gowning process; this minimises contamination risk.</p> <p>More stringent cleaning and monitoring programmes; this minimises contamination risk and allows early detection of microbial growth.</p>	<p>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. Findings from the audit undertaken in February 2025 highlighted the fragility of the workforce due to key person dependencies which could detrimentally impact on the service.</p> <p>Limited accommodation to employ additional staff to expand workforce within the existing unit at WGH.</p> <p>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.</p> <p>Lack of funding to build a new unit at WGH.</p>	<p>To submit revised business case for demountable unit to Welsh Government (estimated £2.89m).</p>	<p>Morgan, Cerith</p>	<p>Completed</p>	<p>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.</p>

Oversight and steer from Capital Sub-Committee.	Progress dependent on feedback received from Welsh Government	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.
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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 JULY 2025

Date Risk Identified:	May-24
Strategic Objective:	

Executive Director Owner:	Daniel, Sharon	Date of Review:	Jun-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Jul-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
Trend:	↔

25
20
15
10
5
0

Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Apr-25 May-25 Jun-25

— Current Risk Score
— Target Risk Score
- - - Tolerance Level

Rationale for CURRENT Risk Score:

There were 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). In the first 6 months of 2025 (Jan - June) there has been a significant decrease in the Cardiac Arrest rates in GGH compared to the same period 2024. In 2025 = 9, in 2024 = 19.

There had been an increase (22%) in unplanned admissions at WGH, with 92 noted in 2024 (71 noted for 2023). In the first 6 months of 2025 (Jan - June) there has been a reduction in the number of unplanned admissions into WGH ITU compared to the same period in 2024. In 2025 = 39, in 2024 = 52. A Task & Finish group in WGH has been put in place to implement Treatment Escalation Plans (TEPs) and GGH are exploring how to run a similar project.

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. An audit tool on AMAT has been developed to review on a monthly basis NEWS charts on wards and identify good practice and areas for improvement.

An Acute Physical Deterioration Implementation Network has been established and a Clinical Reference Group (CRG) will support the Network with expertise and evidence based decision making to develop national documentation measure and approaches to change and improve training. The CRG will inform direction, sense check thinking and provide a consensus view on acute deterioration across all age groups in Wales. With the support of the CRG the Health Board is on track to implement early warning scores as directed by the Welsh Health Circular by September 2025.

As of 1st June 2025, compliance rates for Level 3 Resuscitation Training Adults is 54% (unchanged since April 2025), Paediatrics 38% (32% April 2025), and Level 2 Training is at 50% (51% April 2025). 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.

All planned actions to mitigate the risk 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.

Rationale for TARGET Risk Score:

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 2025 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.

CORPORATE RISK REGISTER SUMMARY JULY 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	By Who	By When	Progress
<p>Governance structures in place eg RADAR Group (Recognition of Acute Deterioration and Resuscitation).</p> <p>Increased awareness of gaps in assurance and local actions in place to manage and mitigate the risk.</p> <p>T&F Group chaired by HB RADAR Lead with focus on Sepsis, DNA/CPR group chaired by Deputy Medical Director.</p> <p>RADAR directly reports to Operational QSE.</p> <p>Local RADAR groups (across all sites, counties, MHL and Paediatrics) which report to HB wide RADAR group - chaired by a commission.</p> <p>Mechanisms in place across all sites to monitor cardiac arrest rates.</p> <p>Health Board Resus policy in place (currently under review and updated to reflect National Guidance)</p> <p>All Wales DNA/CPR policy in place and has been uploaded onto the Health Board intranet.</p> <p>Clinical Lead Nurse for Acute Deterioration 1WTE</p> <p>Dedicated Resuscitation Team in place, consisting of 5.2WTE across the Health Board (acute, community, mental health and primary care) and one 1WTE admin support</p> <p>Networks in place across the wider HB, including support from QIST (Quality Improvement Service Transformation) and practice development.</p> <p>Organisational training plan in place, including mandatory training</p> <p>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)</p> <p>New Acute Kidney Injury (AKI) Lead appointed for GGH (12 months)</p>	<p>No treatment escalation plans in place</p> <p>Call for Concern is being piloted but only for inpatient adult patients only and at the moment is only across 2 sites.</p> <p>Training demand outstrips capacity to deliver the mandatory level of training recommended by the Resus Council</p> <p>Inconsistent application of policies and processes eg DNA/CPR, sepsis assessment tool, National Early Warning Score (NEWS).</p> <p>Reliance on manual / paper based documentation to record patient deterioration and subsequent escalation</p> <p>Critical Outreach Services not in place at PPH / BGH</p> <p>Inability to release staff to complete L2 and L3 training</p> <p>High number of newly qualified new nurses to the HB including overseas requiring support to develop their expertise in recognising acute deterioration.</p>	<p>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.</p>	<p>Davies, Mandy</p>	<p>30/09/2024 30/11/2024 30/04/2025 30/09/2025</p>	<p>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.</p> <p>Plan is to confirm RADAR Action Plan at next meeting 20Mar25, with risk actions to be updated accordingly.</p> <p>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.</p> <p>Health Board RADAR group met on 19th June - arrangements for leadership of this group have been confirmed and the Medical Director will now lead this group from the next meeting with additional support from the Medical Lead for Sepsis and Acute Deterioration, Dr Vicky Hughes. Workplan will be presented and confirmed at the next meeting.</p>

<p>Dedicated resource in Quality Improvement Team monitoring AKI alerts for the Health Board</p> <p>Bi-monthly scrutiny meetings have been set up in GGH, BGH and WGH to review Cardiac arrests.</p> <p>Cardiac arrest reviews presented at Medical Education sessions</p> <p>Review of feedback from any Medical Examiner reviews, highlighting issues relating to resuscitation/cardiac arrests and lessons learned.</p> <p>Call for Concern are being piloted in GGH and WGH for inpatient adult patients. Process for implementation in Paediatrics, Mental Health and remaining sites under review.</p>	<p>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.</p>	<p>Wastell, David</p>	<p>Completed</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>TNA taken to QSESC advising in January 2025, with further discussion at SNMT and QSESC on cascading this.</p>
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CORPORATE RISK REGISTER SUMMARY JULY 2025

<p>To implement an electronic observations systems across the Health Board to capture real-time bedside capture of patient assessments and monitoring, in line with the Health Board's Digital Plan</p>	<p>Williams, Carolyn</p>	<p>30/09/2025</p>	<p>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.</p>
<p>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).</p>	<p>Wastell, David</p>	<p>30/05/2025 30/09/2025</p>	<p>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.</p> <p>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. As of 16th May, work remains ongoing.</p>

CORPORATE RISK REGISTER SUMMARY JULY 2025

<p>Put in place process for Health Board compliance with Martha's Rule by establishing a Task and Finish Group to implement Call for Concern</p>	<p>Wastell, David</p>	<p>31/03/2025 31/12/2025</p>	<p>Task and Finish Group is in place, chaired by Anna Chiffi.</p> <p>SOP Patient leaflet is being developed and a pilot was due to commence in GGH in Feb25.</p> <p>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.</p>
<p>Put in place All Wales Policy for treatment escalation plans to enable safe and effective care management when patient deteriorating.</p>	<p>Wastell, David</p>	<p>31/12/2024 30/06/2025 30/09/2025</p>	<p>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.</p> <p>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.</p>

CORPORATE RISK REGISTER SUMMARY JULY 2025

<p>Implement a model for CASCADE training for basic life support and monitor impact on basic life support training compliance rates.</p>	<p>Wastell, David</p>	<p>Completed</p>	<p>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.</p>
<p>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.</p>	<p>Wastell, David</p>	<p>30/09/2024 30/03/2025 30/09/2025</p>	<p>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. Health Board Task & Finish Group, chaired by Mandy Davies, established to address WHC in relation to implementation of EWS across the Health Board by September 2025. Membership of this group includes</p>

CORPORATE RISK REGISTER SUMMARY JULY 2025








			<p>Medical and Nursing and Therapy Leadership. Executive Lead and Sponsor is Mark Henwood and implementation lead is David Wastell.</p> <p>A plan is in place and actions being taken to implement changeover as of 16th July across the Health Board.</p>
Work to improve compliance with Sepsis Bundles at the front door.	Wastell, David	31/12/2025	<p>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.</p>

CORPORATE RISK REGISTER SUMMARY JULY 2025

<p>Improve compliance with DNACPR National Guidance</p>	<p>Steele, Cathie</p>	<p>30/10/2024 31/05/2025 30/09/2025</p>	<p>DNACPR Review Group formed and actions identified including development of a SharePoint page (which is now complete) and undertaken an improvement project through EQiIP (complete). Annual audits undertaken by junior doctors, and reviews of medical examiner reports and cardiac arrest to identify learnings. More robust communication between mortality review group and RADAR being established. 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)</p>
<p>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.</p>	<p>Wastell, David</p>	<p>31/05/2025 31/08/2025</p>	<p>Senior nurse for acute deterioration is working with Interim ADN for Quality and Safety to develop SharePoint page. As of 16th May, work is ongoing with the development of the Sharepoint page.</p>
<p>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.</p>	<p>Wastell, David</p>	<p>Completed</p>	<p>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.</p>

CORPORATE RISK REGISTER SUMMARY JULY 2025

<p>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.</p>	<p>Wastell, David</p>	<p>31/01/2025 30/06/2025 30/09/2025</p>	<p>Currently awaiting national updates in order to progress with this action. Links to the modules have still not been established (as of June 2025) because the guidance around NEWS2 and Sepsis is still under development.</p>
<p>Review efficacy of local RADAR groups, and frequency of meetings being held</p>	<p>Davies, Mandy</p>	<p>30/06/2025 30/09/2025</p>	<p>Support being given to Chair of RADAR to liaise with Chairs of local RADAR groups delays due to limited availability and operational pressures. As of June 2025, Mark Henwood is the Executive Sponsor and will be working with Mandy Davies and Vicky Hughes to undertake this review. Ongoing.📧</p>
<p>Develop standardised template to report into Health Board RADAR group</p>	<p>Wastell, David</p>	<p>Completed</p>	<p>Template developed following meetings with Chairs of local RADAR.</p>
<p>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)</p>	<p>Davies, Mandy</p>	<p>30/06/2025 30/09/2025</p>	<p>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.📧</p>

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, May 2025.	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/Oversight Group chaired by Assistant Director of Nursing and Quality Improvement with focus on Early Warning Scores and Sepsis	2nd									
	DNAR/CPR group chaired by Deputy Medical Director - group needs to be re-established (as of June 2025).	2nd	