GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	15 August 2024
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risks Assigned to the Quality, Safety and Experience Committee (QSEC)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer Jill Paterson, Director of Primary Care, Community & Long Term Care Dr Ardiana Gjini, Director of Public Health Mr Mark Henwood, Interim Executive Medical Director Sharon Daniel, Interim Director Nursing, Quality & Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Director of Corporate Governance Charlotte Wilmshurst, Assistant Director of Assurance and Risk

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

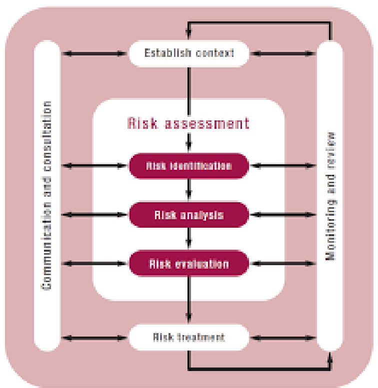
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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



(Risk Management Process, ISO 31000)

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

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

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

- Associated with the delivery of our annual plan; or
- Significant corporate risks escalated that are of significant concern and require corporate oversight and management.

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

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

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

Asesiad / Assessment

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

The Terms of Reference state that:

3.2 Seek assurance on the management of risks within the Corporate Risk Register (CRR) and Directorate level risks allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g., where risk tolerance is exceeded, lack of timely action.

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

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

There are 10 risks currently aligned to QSEC (out of the 22 that are currently on the CRR) as the potential impacts of the risks relate to the safety of patients, quality of services and patient outcomes.

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

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

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

Total Number of Open Risks	10	
New Risks Being Reported	1	*See note 1*
De-escalated/Closed Risks	2	*See note 2*
Increase in Risk Score ↑	1	*See note 3*
Decrease in Risk Score ↓	2	*See note 4*
No Change in Risk Score →	6	*See note 5*

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

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5			1531 (↑)	1859 (NEW)	
MAJOR 4			1812 (↓)	684(→) 1708 (→)	797 (→) 1027(→) 1032 (→) 1664 (→)
MODERATE 3					1810(↓)
MINOR 2					
NEGLIGIBLE 1					

Note 1- New risks being reported:
Since the previous report, 1 new risk has been added to the Corporate Risk Register:

Risk Reference & Title	Date risk identified	Lead Director	Current risk score	Update	Target Risk Score
1859 - Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration **NEW**	01/05/24	Interim Director of Nursing, Quality & Patient Experience	**4x5=20** (Reviewed 18/07/24)	There are specific concerns relating to Glangwili General Hospital (GGH) and Withybush General Hospital (WGH) in relation to cardiac arrests and unplanned admissions. There has been an increase in cardiac arrest rates at GGH in the period January - April 2024 (15), compared to the period January - April 2023 (8). Of the 15 arrests noted for 2024, 4 of these were a result of failure to recognise/respond. There has been a significant increase in unplanned admissions at WGH, with 28 noted in the period January - March 2024 at WGH (15 for the equivalent period of January - March 2023). 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. Work is underway investigating the opportunity to benchmark the position of Hywel Dda on an All-Wales basis. Prior to Covid-19, the National Acute Deterioration Group for Wales (RRAILS) was in place, which gave direction on key initiatives such as Sepsis and NEWS, however this group is no longer supported, which poses the risk on a national level regarding a disjointed approach across Wales. As of June 2024, compliance rates for Level 2 and Level 3 Resuscitation Training are at	**2x3=6**

				40%. While there is no set compliance target, compliance has never been greater than 60%.	

Note 2 – De-escalated/Closed Risks:
1 risk has been de-escalated to Directorate Level since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Reason for de-escalation
1699 - Risk of loss of service capacity at Withybush General Hospital due to surveys and remedial work relating to reinforced autoclaved aerated concrete (RAAC)	13/06/23	Chief Operating Officer	The Executive Team confirmed the de-escalation of this risk at its meeting held on 5 June 2024 to Directorate level, recognising the progress made to manage the risk, the reduction in current risk score, and ongoing project plans. However, it is accepted that a number of services are still displaced.
1548 - Risk to the Health Board maintaining service provision due to industrial action	09/11/22	Director of Public Health	The risk was approved for closure via Chair's Action from Executive Team on 26 July 2024 as there are no longer active disputes with Trade Unions.

Note 3 –Increase in risk score:
There has been an increase in current risk score of the following risk since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Previous Risk Score	Current Risk Score	Update	Target Risk Score
1531 - Risk of being unable to safely support the Consultant on-call rota at Withybush General Hospital (WGH) and Glangwili General Hospital (GGH) due	10/11/22	Chief Operating Officer	**3x5=15**	**4x5=20** (Reviewed 02/07/24)	The risk score was increased in April 2024. In addition to the risk at WGH, the GGH surgical consultant on call rota is also in a fragile position. The GGH rota is currently running as a 1:5.5 which is not sustainable. There is also currently unplanned sickness in the team at GGH, causing further pressure on remaining consultants and has	**1x5=5**

to workforce pressures					impacted elective activity. The fragilities at WGH remain the same, with high cost Medacs locums supporting the consultant and SAS level on call rotas. There are only 2 substantive consultants on the 1:4 consultant on call rota. Work is currently being undertaken as part of the Health Board's Clinical Services Plan to address rota fragilities across both sites.	

Note 4 – Decrease in risk score:
There have been decreases in current risk scores of the following risks since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Previous Risk Score	Current Risk Score	Update	Target Risk Score
1810 - Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS).	01/02/24	Director of Primary Care, Community & Long Term Care	**4×5=20**	**3x5=15** (Reviewed 10/07/24)	The facilities of WGH Aseptic unit are currently non-compliant with regulatory standards. The unit is subject to external audit by the National Pharmacy Quality Assurance Lead and the facilities were identified as being a high risk to patient safety in 2019. An audit performed in February 2023 confirmed the facilities were a high risk, and the unit at risk of forced closure. A pharmacy aseptic unit based at GGH was forced to close in December 2018 as the facilities were deemed a risk to patient safety. WGH Aseptic unit is the only functional unit that can manufacture cancer	**1x5=5**

						treatments remaining in the Health Board. Short term control measures have been implemented to reduce the risk of immediate forced closure, and are currently successfully minimising the amount of microbial contamination present within the unit. This is demonstrated by ongoing environmental monitoring results undertaken by the aseptic unit staff (combination of daily/weekly/monthly 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. This is because continued manufacture of cancer treatments within non-compliant facilities with unacceptable levels of microbial contamination would be a high risk to patient safety. Due to the age of the equipment and facilities, and the fact that the facilities were not designed against current regulatory standards, it is not possible to predict if or when the current controls will fail.	

					If the unit was forced to close, the Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. Some cancer treatments cannot be outsourced due to their short shelf life. There were 345 reported service and quality-related incidents (e.g. delayed or failed deliveries) linked to outsourcing from commercial suppliers between September 2022 and August 2023 at Hywel Dda (an average of 29 incidents each month). The number of service and quality-related incidents between September 2023 and February 2024 remained high at an average of 25 incidents each month. Without a functioning Aseptic unit, the Health Board could not offer over 500 cancer treatments each year, and further treatments would be delayed/cancelled due to supplier service failures. Demand for aseptically prepared cancer therapy increased by an average of 14% each year between 2021 and 2023. Therefore, the negative impact of not having a functioning aseptic unit is likely to grow each year. The most recent audit, conducted on the 20 and 23 February 2024, confirmed that the control measures employed are mitigating the risk and that all	

						reasonable controls have been implemented, with the current risk score subsequently reduced from 20 to 15 reflecting the reduced likelihood of the risk of forced closure materialising (provided that these control measures remain effective). A business case for the demountable unit at WGH was submitted to WG in February 2023, and also requested funding to convert the current Aseptic unit into drug storage facilities. Based on budget cost estimates of £2.89m, the submission was for review and scrutiny by WG to provide assurance to the Health Board before resourcing, and underwriting the financial risk, of progressing a detailed design for tendering. In September 2023, WG requested submission of a fully tendered business justification case, which is currently being worked up. 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, originally estimated to open during 2028. 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 Wales 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.	
1812 - Risk of non-compliance with Medical Examiners (Wales) Regulations due to the failure to fully resource internal processes	16/11/21	Interim Executive Medical Director	**4x4=16**	**4x3=12** (Reviewed 30/07/24)	New processes are in place for mortality review, in line with the All Wales Learning from Mortality Framework, supported by the Clinical Lead for Mortality and Mortality Review and Improvement Facilitator. As at July 2024, 2 wards remain outstanding at GGH who require training, with this envisaged to be completed by mid-August 2024, therefore increasing scanning capacity. As of July 2024, the risk score has been reviewed and revised to 12, with the likelihood score reduced reflecting the increased capacity to scan, along with a review of existing processes and procedures to ensure compliance with Medical Examiner requirements. The capacity for clinical scanning remains below the required level, however it has increased recently due to the appointment of a Clinical Effectiveness Co-ordinator, and the Directorate will continue	**2x2=4**

					to review ongoing capacity requirements. GGH scanning staff are currently scanning some of Prince Philip Hospital (PPH) casenotes and all GGH wards. In line with the above screening resources, the Directorate will monitor the current backlog and develop contingency plans where required.	

Note 4 - No change in risk score:
There have been no changes to the risk score of the risks included in the table below since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Current Risk Score	Update	Target Risk Score
1027 - Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	19/11/20	Chief Operating Officer	**4x5=20** (Reviewed 21/06/24)	Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. This is driven by post pandemic demand and the broader impacts of COVID-19. 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 significantly worrying trends. The indirect legacy of the pandemic has resulted in increasing levels of frailty in the community and consequent demand on the 'front door'. The situation remains at high levels of risk escalation across the acute sites on a daily basis. Notwithstanding continuing progress in delivering the Health Boards Transforming Urgent and Emergency Care	**3x4=12**

				(TUEC) objectives, there has been a notable increase in the volume of patients with lengths of stay in excess of 21 days across all hospital locations during this period. With specific reference to WGH, UEC performance has been significantly impacted since the Summer of 2023 due to the extent to which the RAAC infrastructure improvement project has reduced capacity. The completion of improvement works in closed wards areas has enabled the return of previously closed capacity at the hospital and it is anticipated this will support performance, quality and patient experience improvements from April 2024. Whilst recent experience suggests early signs of improvement against key UEC metrics, these remain outside target requirements and therefore the risk score remains unchanged, pending further review. *Discussions are underway to undertake a complete refresh of this risk assessment.*	
1032 - Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	02/11/20	Chief Operating Officer	**5x4=20** (Reviewed 25/06/24)	The service is experiencing significant waiting times as a result of increasing demand levels which are exceeding pre-pandemic levels, compounding the backlog due to COVID-19 restrictions. Due to increasing Did Not Attend (DNA) rates, ongoing recruitment challenges and increasing demand there is an impact on the service's ability to see the same volume of service users as they were previously able to. Some posts continue to be funded	**3x4=12**

				on fixed term basis which can make staff retention challenging along with having to train new incoming staff. As of June 2024, there are 3,460 on the waiting lists. Recommendations received from NHS Executive in relation to Children's Neuro-Developmental (ND) services are in the process of being implemented. The Directorate is working with the Women and Children's Directorate to implement these. For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit to establish trajectories, along with the commissioned service, which were agreed in March 2023. The Delivery Unit were unable to provide trajectories, therefore the Health Board has agreed to a 1% monthly improvement trajectory. For psychological services a trajectory is now in place for 1% per month.	
797 - Risk to the ability to deliver ultrasound services due to workforce pressures	07/11/19	Chief Operating Officer	**5x4=20** (Reviewed 10/07/24)	Despite best efforts, the service remains fragile. There are still vacancies which remain unfilled, but there has been an improvement in recruitment due to the financial picture across Wales and the cessation of use of agency staff above A4C pay rates. Even if all vacancies were recruited to, the Health Board would still not have the capacity to meet current demand (as at end June 2024 there were 608 patients waiting 8 weeks plus for non-obstetric ultrasound (December 2023:1547), with the reduction as a result of the use of insourcing and a small amount of overtime by	**3x4=12**

				substantive staff (utilising recovery monies). Long term vacancies exist in WGH, and potential retirements at PPH in the near future, and a number in BGH which constitute a significant percentage of the workforce. However, staff are due to return at PPH in Summer 2024 after a period of maternity leave. There will be an inability to secure agency staff due to the current financial climate of the Health Board. Modality leads have been recruited at WGH in 2023 and BGH in 2024 which is positive and will ensure that governance and audit requirements are undertaken. Three Radiographer Sonographers and two Midwife Sonographers commenced training in January 2024, however training takes two years to complete for Radiographer Sonographers and one year for Midwife Sonographers (obstetric only). 3 of the 4 vacancies as advertised in July 2023 were successfully appointed to (with agency staff), though this has not resulted in additional capacity to the service as roles have been given to previous locum staff.	
1664 - Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	23/05/23	Chief Operating Officer	**4x5=20** (Reviewed 15/07/24)	Increased demand and reduced capacity continue to be a challenge. Balancing Eye Care Measures for patients most at risk with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional Age-related Macular Degeneration	**2x5=10**

				(AMD) sessions on weekends, however these additional sessions have not been enough to meet the demand across all counties in the Health Board. Patient delays continue across the Health Board. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. Additional staffing for Wet AMD was incorporated into IMTP but no funding was allocated. The service as at February 2024 has 6,383 patients (Nov 23: 5,713) that have been 100% delayed for their follow up appointment. The total new patient referrals is at 7,088 (Nov 23: 5492) of which 713 (Nov 23: 403) are breaching 52 weeks (the longest wait from this cohort is 84 weeks (Nov 23: 67 weeks)). 4,040 patients are awaiting an Ophthalmic operation (Nov 23: 3,785) of which 46 (Nov 23: 24) are breaching 104 weeks (the longest wait from this cohort is 130 weeks). The current impact has been scored a 5 as patients suffering irreversible sight loss or damage is a reality and the current likelihood has been scored 4 as Ophthalmology is a fragile service. It is unlikely that we will be able to achieve the Board tolerance score of 6 without a regionally agreed solution.	
1708 - Risk of increasing fragility in	07/07/23	Director of Primary Care,	**4x4=16** (Reviewed 10/07/24)	Eight dental contracts have been returned to the Health Board in the last twelve	**2x4=8**

primary care contractor services due to recruitment challenges		Community & Long Term Care		months, of which four contracts (totalling £958,500) confirmed as being awarded by NWSSP Procurement Services in May 2024. In addition, a further eight dental practices have not signed up to the contract reform, 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 do not fall into this category but require a level of dental care are detrimentally impacted, and that any further contracts returned will exacerbate this situation. The capacity of the Health Board in terms of staffing to absorb further contract reform will impact on the ability to effectively deliver services, and a detrimental impact on staff welfare. There has been increased demand in urgent dental appointments resulting in appointments for the week being booked up early within the same week. The Dental Access Portal (DAP) is due to be piloted in Powys in June 2024, with national roll out due after this date. Two General Medical Service (GMS) contracts have been returned to the Health Board in the last twelve months. However, from previous contract terminations, two out of the three 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 April 2024 after a successful procurement process. The contract which was returned in April 2024 is currently being taken through the vacant practice process, with a recommendation due to Board in July 2024. 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, HQC and Medical Retina) as part of the new Optometry contract implementation which commenced in April 2024.	
684 – Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	04/01/19	Chief Operating Officer	**4x4=16** (Reviewed 10/07/24)	The Health Board's stock of 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. Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scanners have been replaced and has reduced the frequency of machine downtime compared to previous experience. The risk score is assessed as 16, reflecting that some equipment has been installed and is operational, however further investment is required given recent breakdowns of	**2x4=8**

				key imaging equipment. A costed plan along with a rolling programme for the installation of additional equipment is in place. The next batch of equipment for replacement has been prioritised and identified. For 2023/24, funding was obtained to replace one X-ray room and due to the Radiology Information Systems Procurement (RISP) risks of non-Digital Radiography (DR) compliant equipment, it was decided to replace the x-ray equipment at Tenby Cottage Hospital. The gamma camera at WGH is the only scanner of its nature in the Health Board and experienced a breakdown in August 2023 due to intermittent failures which resulted in several Healthcare Inspectorate Wales (HIW) reportable Ionising Radiation Medical Exposure Regulations (IRMER) incidents. This item of equipment is on the current priority list of items to replace. While a new CT scanner has been obtained and installed at GGH, the original CT scanner has had a number of breakdowns due to its age. 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.	

Argymhelliad / Recommendation

The Committee is requested to seek assurance that:

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

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

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

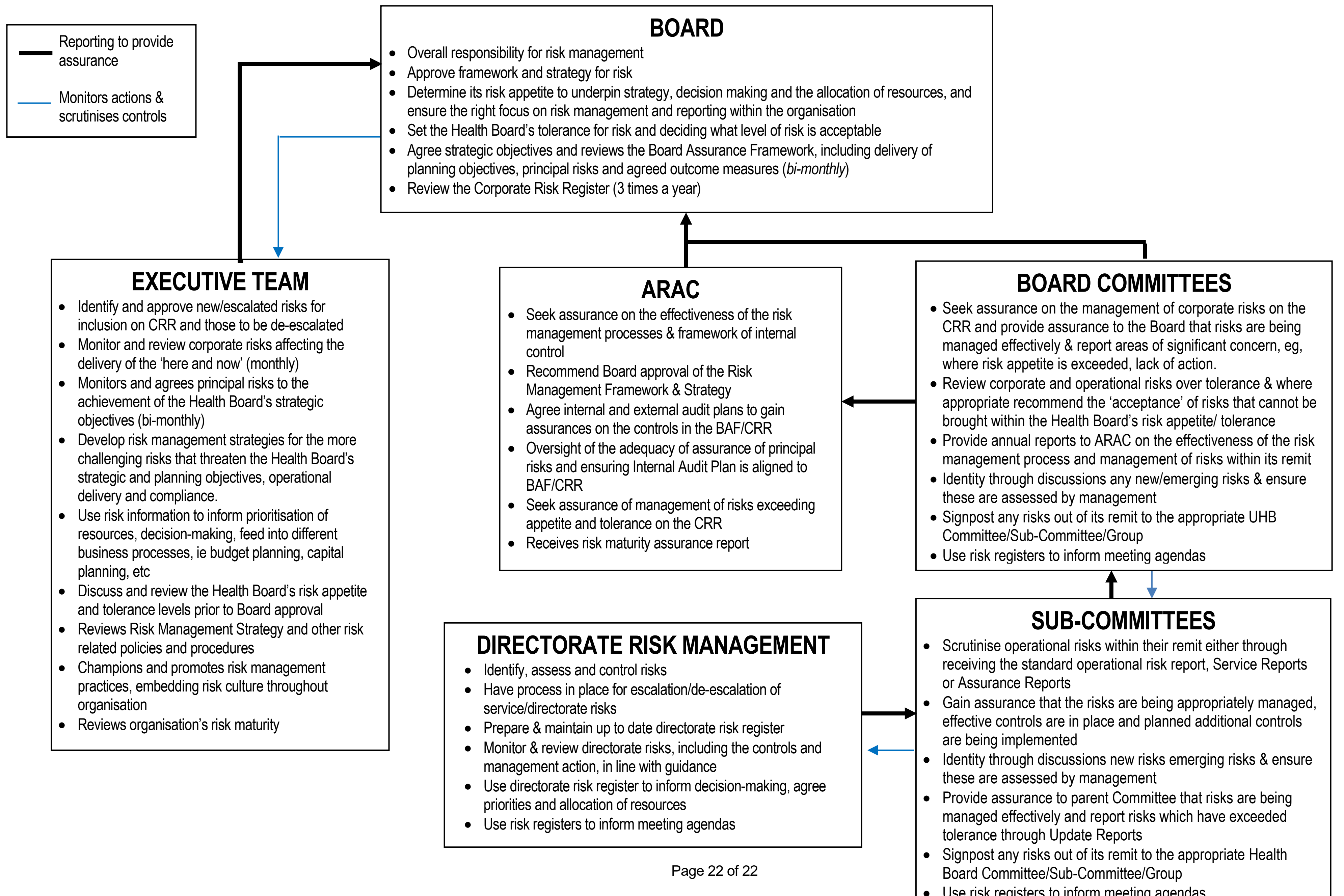
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	Not Applicable Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable Choose an item. Choose an item. Choose an item.

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

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

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

Appendix 1 – Committee Reporting Structure



Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Jul-24	Trend	Target Risk Score	Risk on page no…
797	Risk to the ability to deliver ultrasound services due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12	3
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×5=20	→	3×4=12	7
1032	Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12	12
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×5=20	→	2×5=10	18
1859	Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Daniel, Sharon	Safety - Patient, Staff or Public	6	N/A	4×5=20	New risk	2×3=6	25
1531	Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	3×5=15	4×5=20	↑	1×5=5	28
1708	Risk of increasing fragility in primary care contractor services due to recruitment challenges	Paterson, Jill	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	2×4=8	32
684	Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Carruthers, Andrew	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	2×4=8	36
1810	Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Paterson, Jill	Service/Business interruption/disruption	6	4×5=20	3×5=15	↓	1×5=5	41
1812	Risk of non-compliance with Medical Examiners (Wales) regulations due to the failure to fully resource internal processes	Henwood, Mr Mark	Quality/Complaints/Audit	8	4×4=16	4×3=12	↓	2×2=4	45

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

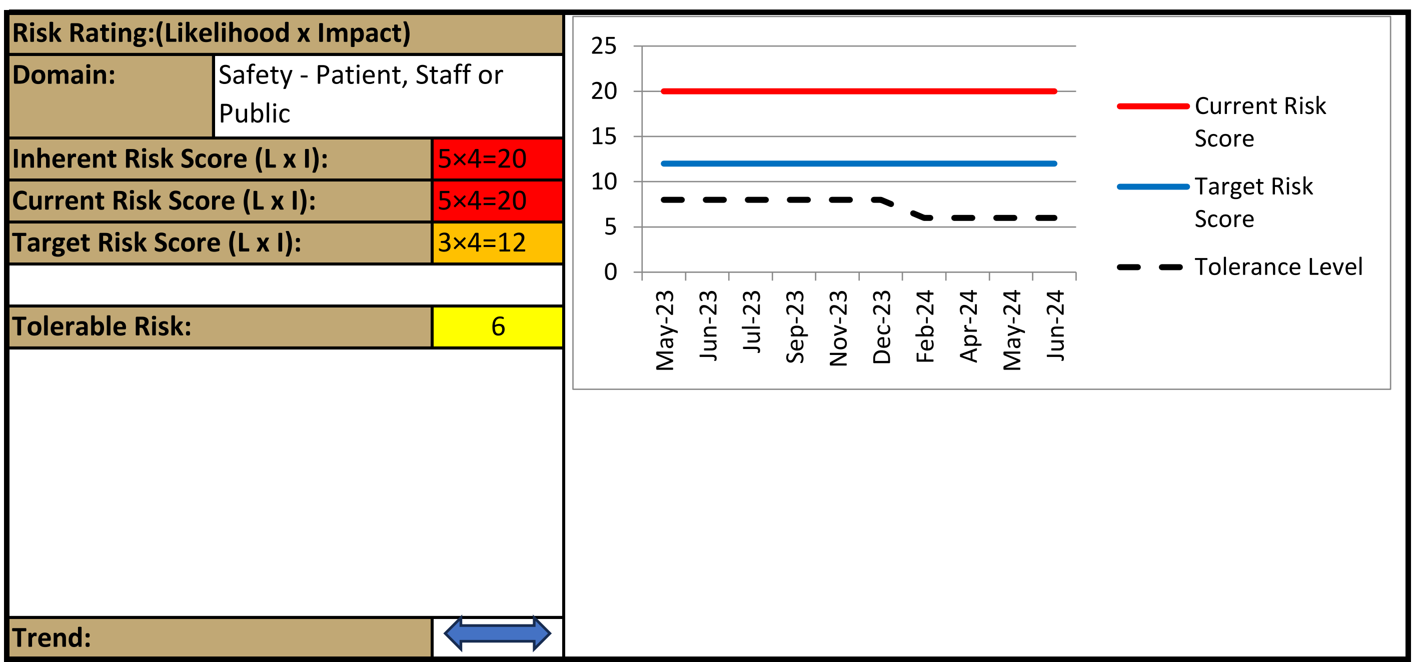
Key - Assurance Required		*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*
(blue)	Detailed review of relevant information	
(pink)	Medium level review	
(purple)	Cursory or narrow scope of review	

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

Date Risk Identified:	Nov-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jul-24
Strategic Objective:		**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Aug-24

Risk ID:	**797**	**Principal Risk Description:**	There is a risk of being unable to provide a full range of ultrasound services including antenatal across the Health Board. This is caused by 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 current service demands. This could lead to an impact/affect on 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. In addition, there is 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 repetitive strain injuries (RSI), along with increased incidents of staff stress and burnout. This could ultimately lead to increased errors when performing the dynamic diagnostic test.
Does this risk link to any Directorate (operational) risks?			1557, 1349, 1658

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



Rationale for CURRENT Risk Score:

Despite best efforts, the service remains fragile. There are still vacancies which remain unfilled, but there has been an improvement in recruitment due to the financial picture across Wales and the cessation of use of agency staff above AFC pay rates. Even if all vacancies were recruited to, the Health Board would still not have the capacity to meet current demand (as at end June 2024 there were 608 patients waiting 8 weeks plus for non-obstetric ultrasound (Dec 2023:1547, February 2024:1288, March 2024:917, April 2024:962,May 2024:731), with the reduction a result from the use of insourcing and a small amount of overtime by substantive staff (utilising recovery monies).

Long term vacancies exist in Withybush. There are 2 potential retirements at PPH in the near future and a number in BGH, which constitute a significant percentage of the workforce, though there are maternity returns due back at PPH by summer 2024. There will be an inability to secure agency staff due to the current financial climate of the Health Board.

Modality leads have been recruited at Withybush (2023) and Bronglais (2024) which is positive and will ensure that undertake governance and audit requirements.

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).

3 of the 4 vacancies as advertised in July 2023 were successfully appointed to (with agency staff), though this has not resulted in additional capacity to the service as roles have been given to previous locum staff.

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 and is due to be complete by the end of July 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.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Process in place for the movement of staff across the Health Board to maintain capacity where possible. Ultrasound Control Group reconvened in Jan 2024 after having not met since July 2023 due to operational pressures. Meetings take place on a bi-monthly basis. The PPH modality lead vacancy was filled (Feb 2024) Utilising insourced ultrasound service to reduce backlogs of patients waiting >8weeks subject to the availability of recovery funding.	Inability to release existing staff to train and develop to undertake sonography and growth scans. Inability to recruit and retain staff. 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.	Develop a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Jones, Keith	~~31/12/2022~~ ~~31/10/2023~~ ~~31/01/2024~~ ~~30/06/2024~~ 31/01/2025	Discussions have taken place with Head of Maternity Services. Protocols and training being developed. Implementation date to be agreed. A meeting was scheduled for 20th June 2023 with CVUHB in order to assist with the development of a training plan but there was no midwifery representation available on the day. Midwifery services approached Powys for assistance with training midwives sonographers, and appointed 2 midwives to join the ultrasound course for January intake 2024. This training will be brought back to Hywel Dda once the newly appointed Clinical Educator commences post in July 2024.
		Train members of staff to become sonographers, the number of which dependant on capacity to take training.	Roberts-Davies, Gail	31/03/2020 ~~31/12/2022~~ ~~01/02/2023~~ ~~30/09/2024~~ 31/01/2026	As at November 2023, we are currently training 3 members of staff (2 at GGH and 1 at PPH) along with 2 Midwife Sonographers who are currently undertaking clinical training in Powys.

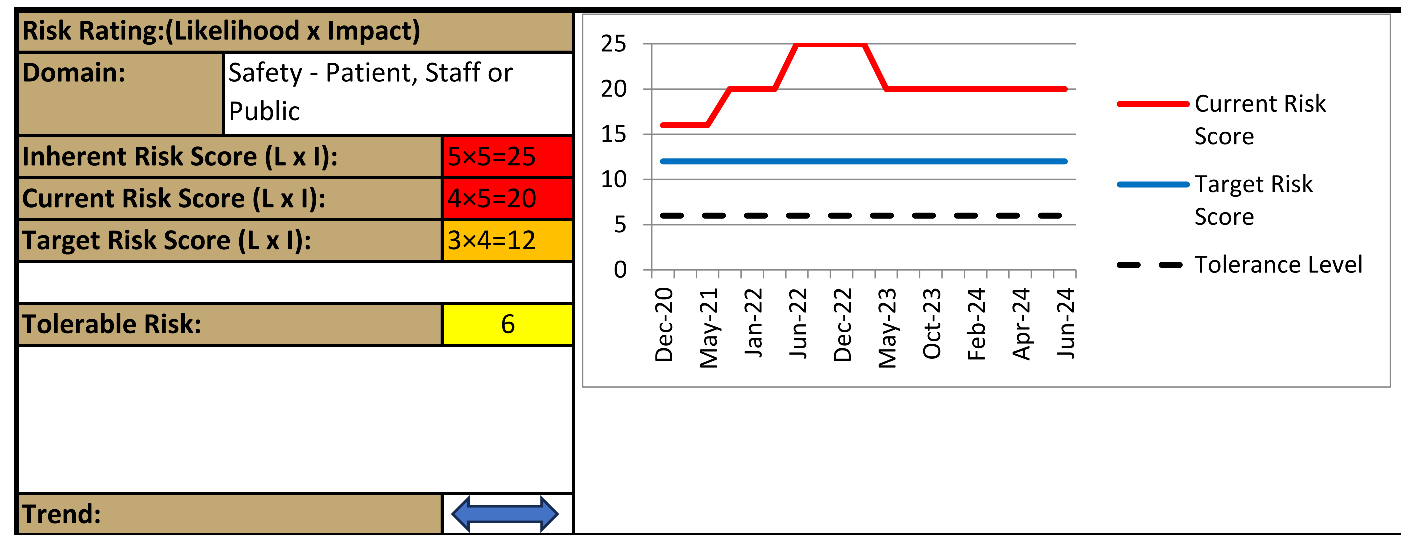
		Work with the workforce planning team to build a sustainable workforce plan for ultrasound services.	Roberts-Davies, Gail	~~31/10/2023~~ ~~31/03/2024~~ 31/07/2024	Fortnightly workforce planning meetings in place with colleagues from Radiology and Workforce in attendance. Stakeholder mapping exercise being undertaken as at December 2023. Work is ongoing in this area and is currently concerned with the Clinical Services Plan issues paper along with the Radiology Annual plan (Jan/Feb 2024) and the Ultrasound needs assessment. A draft operational workforce plan has been developed as of June 2024.
		Seek support to undertake a demand and capacity (D&C) review and detailed establishment review of the radiology service.	Jones, Keith	~~30/06/2022~~ ~~30/11/2022~~ ~~31/03/2023~~ ~~30/08/2023~~ ~~31/01/2024~~ ~~31/05/2024~~ 31/07/2024	Initial contact made with workforce planning team re: establishment review work. This has been discussed in the Radiology Use of Resources Meeting. A Radiology dashboard is in place which provides activity and demand. A new dashboard was published in Jan 2024 which is aligned to ARCH development. As of November 2023 there have been some significant staff changes on various sites with the loss and gain of sonographer hours. D&C needs further review and is being linked into Workforce planning. Workforce planning work is taking place and as of Jan 2024 and concerned with the operational workforce plan and annual plans. An ultrasound needs assessment is currently being undertaken via the Ultrasound Control Group and is due to be completed by the end of July 2024.

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 38 weeks as at end June 2024 Radiology Dashboard IPAR Reports WG Cancer PTL, reported monthly	Management review of sonography and SCP diagnostic waiting times	1st			Sonography Report to Acute Bronze and Operation Planning and Delivery Programme meeting					
	Monthly review of USC performance undertaken monthly (18% of USC carried out in 7 days, 46% carried out in 14 days at May. 2024), included in the IPAR & reported to WG	1st								
	Performance monitored at Directorate Improving Together Sessions	2nd								
	Performance monitored via IPAR, overseen SDODC & Board	2nd								

Date Risk Identified:	Nov-20	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jun-24
Strategic Objective:	5. Safe and sustainable and accessible and kind care	Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Jul-24

Risk ID:	1027	Principal 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 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,

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⬌



Rationale for CURRENT Risk Score:

Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. This is driven by post pandemic demand and the broader impacts of COVID-19. 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 significantly worrying trends. The indirect legacy of the pandemic has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains at high levels of risk escalation across our acute sites on a daily basis.

Notwithstanding these challenges, whilst positive progress has been achieved during 2023 in reducing peak levels of pressure with notable improvements achieved in key urgent and emergency care (UEC) pathway metrics relating to ambulance handover and emergency departments (ED) waiting times; this has not been sustained through the winter 2023/24 period, with a significant re-emergence of system-wide capacity pressures. Notwithstanding continuing progress in delivering the Health Boards TUEC objectives, there has been a notable increase in the volume of patients with lengths of stay (LOS) in excess of 21 days across all hospital locations during this period.

With specific reference to Withybush Hospital, UEC performance has been significantly impacted since the Summer of 2023 due to the extent to which the RAAC infrastructure improvement project has reduced capacity. The completion of improvement works in closed wards areas has enabled the return of previously closed capacity at the hospital and it is anticipated this will support performance, quality and patient experience improvements from April 2024.

Whilst recent experience suggests early signs of improvement against key UEC metrics, these remain outside target requirements and therefore the risk score remains unchanged as at June 2024, pending further review.

Rationale for TARGET Risk Score:

There is a significant challenge across the Urgent and Emergency Care system. The combined impact of the multi-faceted pressures which underpin this risk have led to an incremental increase in the overall level of pressure as reflected in deteriorating delays for ambulance handover, access to urgent and emergency care and delayed discharges. The extent to which these combined pressures impact upon the timeliness and quality of care provided is related to the overall availability of staffing resources on a daily / weekly basis, which in turn is influenced by increasing levels of staff sickness/absence.

Plans for improvement during 2024/25 are reflected in the HB's Annual Plan, approved by the Board in March 2024.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage unscheduled care risks on daily basis including multiple daily multi-site calls in times of escalation which include efficient handover from WAST into ED. # Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. # Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds. # Discharge lounge takes patients who are being discharged. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites. # Regular advice on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, Social services and the Long Term Care Team support. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Winter Plans developed to manage whole system pressures. # Joint workplan with Welsh Ambulance Services NHS Trust. # 111 implemented across Hywel Dda. # Transformation fund bids in relation to crisis response being implemented across the Health Board. # Ability to deploy Health Board staff where workforce compromise is immediately threatening to continuation of care for residents. # Care Home Risk & Escalation Policy to be applied to support failing care homes as required. # Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across Health Board # Integrated whole system, urgent and emergency care plan agreed. # Establishment of a Discharge to Assess (D2A) Group which reports to the Unscheduled Care group. # Establishment of a D2A Escalation Transfer panel which provides senior oversight of delays, assesses risk of the delay to the patient and organisation in terms of flow compromise # To optimise step down bed capacity in the community across care homes and community hospitals # SRO in place to lead agreed Urgent and Emergency Care (UEC) programme	# Fragility of Care Home Sector exacerbated by COVID related issues such as financial viability, staffing deficits, recruitment and retention of workforce. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff # Nurse staffing availability to ensure safe levels of care as a consequence vacancies. # Inability to offload ambulances to release them back for use within community. # Increased pressures at ED as a result of WAST ambulance response policy resulting in very poorly patients self-presenting. # Better understanding of ED presentations to ensure development of alternative pathways in primary care / community to prevent ED attendance # Effective and timely communication to the public at times of pressure but also of safe alternatives to hospital admission / ED presentation that will contribute to changing public mind set / expectation and culture in terms of use of NHS resource and 'Home First' # Education and training for best practice in frailty management mandated to effect culture of 'unsafe to admit' for our very / severely frail # Supporting staff to be able to better manage family dispute relating to expectation eg home of choice, transfer pathways to short term placement in care home pending home care availability # Development of a 'tool' that supports	Develop plans to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	~~31/03/2024~~ 30/06/2024	Please refer to risk 1649 on the corporate risk register which provides detail on actions to address insufficient workforce to support delivery of essential services.
		Incorporate and deliver actions that will address control gaps into the Health Board's UEC Plan.	Carruthers, Andrew	31/03/2025	The Annual Recovery Plan for 2023/24 outlines the UEC improvement actions being progressed during the current financial year in support of this longer-term objective. These are overseen and monitored by the TUEC steering group, chaired by the Director of Operations, with progress reported regularly to Board Committees.

# Supernumery HCSWs aligned to the acute response teams to support failing community care capacity # Support for complex discharge caseload management tool (SharePoint) appointed # SDEC models continuously reviewed and refined to maximise impact on admission avoidance. # Alternative models of medical oversight i.e service level agreement with local GPs and HB salaried community GPs. # Service provision in the community for people pending ambulance conveyance, and where conveyance is not possible to manage ambulance handover delays. # Increased bedding capacity in community hospitals. # UEC live performance dashboard in place. # Local streaming hub. # Direct referral into SDEC in WGH, GGH and PPH. # Operational joint meeting with WAST to identify and taking forward key action to help address conveyance. # Clinical Streaming Hub includes APP Navigator working with Physicians to triage and stream patients pending conveyance to more appropriate pathway in the community (In Hours).	staff to assess risk across the whole system to support decision making when discharge appears to be 'risky' to the individual patient. This includes decision making for 'further rehabilitation required in the acute environment' (why not at home?), further blood analysis to confirm medically fit to discharge, home care not available but family happy to take in the interim. # For all patients with LOS > 21 days the need for escalation and 'senior think tank' # If there is a paucity of home care to the extent that we are unable to provide > 28 hours per week (calls four times per day) - why are we advocating this level of commissioning? # Clarity regarding roles and responsibilities for discharge planning and coordination # The availability of live data at Cluster, County and Site level with sufficient analytical support # the ability to risk stratify for people at moderate to high risk of admission in	To develop a plan with Local Authority partners that sets out a model for integrated community health and care provision for older adults and adults living with frailty	Paterson, Jill	30/11/2023	Work is underway across the three counties.

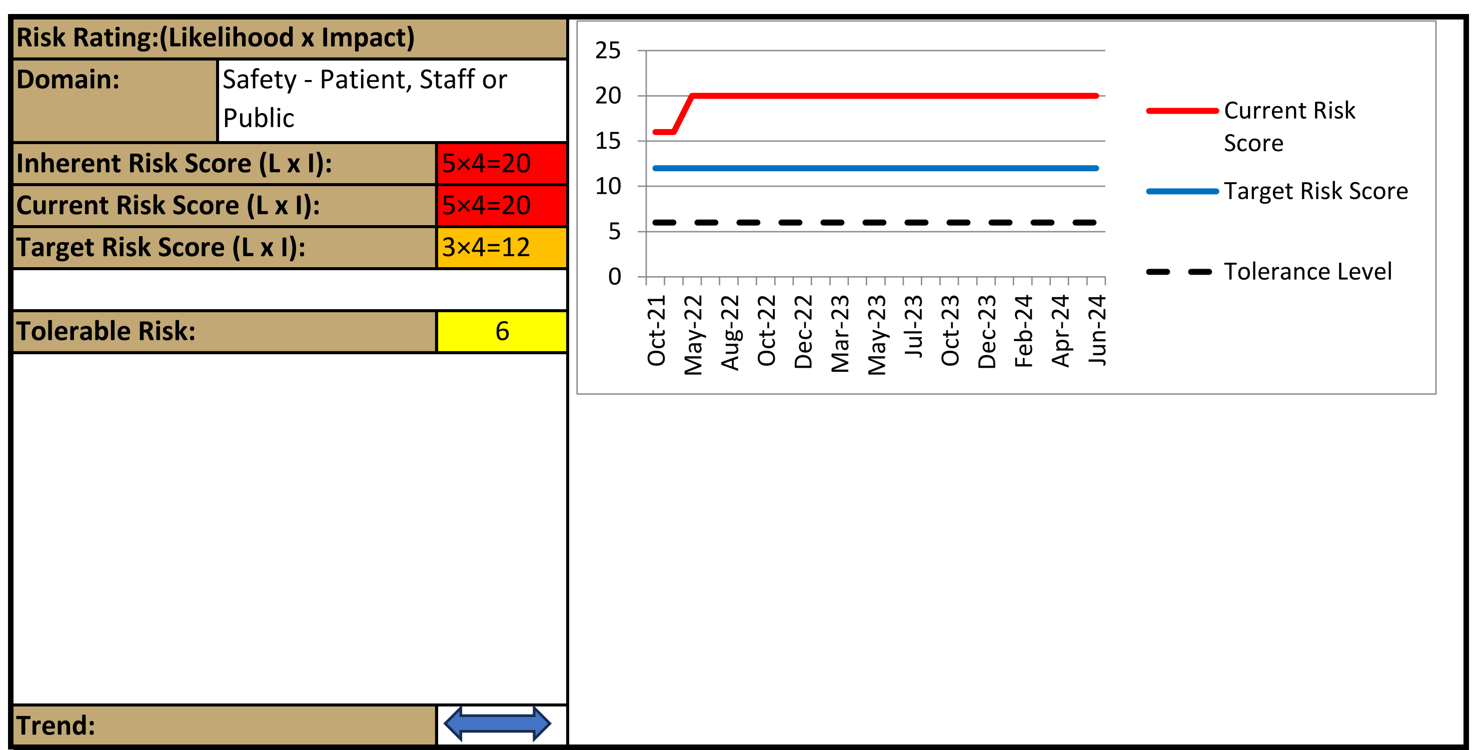
	the community to implement proactive anticipatory care plans to support avoidance of exacerbation / decompensation and hence increased risk of hospital admission # Optimising our bedded facilities in the community i.e we should aim for 'step up' from community and from 'front door' hospitals (within 72 hours) rather than as a 'step down' from acute hospitals after long length of stay. LOS should be no more than 10 days # Bespoke recruitment targeted at critical posts that will deliver improvements in UEC eg ANPs, APPs, PAs etc. and accept risk to permanently fund such posts i.e should not be temporarily funded. # Frailty screening by staff in ED and reporting into WPAS to support risk stratification of patient cohorts who should spend no more than 10 days in hospital. Majority should be turned around in 12 hours and < 72 hours. # Frailty screening and reporting into WPAS of inpatients who either have formal care in place on admission or whose level of frailty on admission suggests a need for care and support on discharge. This will support risk stratification to support discharge planning and coordination. # Consideration of workforce development for existing staff but also bespoke opportunities for non clinical roles that releases clinical time for 'clinicians to only do what they can do' # Reduce service duplication across sites # Inconsistent clinical provision for the Out of Hours (OOH) Service # Development of 24/7 urgent primary care service that integrates urgent primary care service in the day and GP OOH and provides timely information, advice and assistance to patients and clinicians to provide safe alternatives to hospital admissions.				

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
Performance indicators. A suite of unscheduled care metrics have been developed to measure the system performance.	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st				None identified.				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Unscheduled Care Improvement Programme	2nd								
	Bi-annual reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	WAST IA Report Handover of Care	3rd								
	11 x Delivery Unit Reviews into Unscheduled Care	3rd								
	Delivery Unit Report on Complex Discharge	3rd								

Date Risk Identified:	Nov-20	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jun-24
Strategic Objective:	5. Safe and sustainable and accessible and kind care	Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Jul-24

Risk ID:	1032	Principal Risk Description:	There is a risk to the delivery of timely diagnosis to those on the ASD waiting lists, and the commencement of interventions for Psychological Therapies (Integrated Psychology Therapies - Adult and Learning Disability) within required timescales. This is caused by an increase in referrals, as well as recruitment challenges and lack of appropriate estates. This could lead to an impact/affect on those currently awaiting diagnosis and intervention, resulting in delays in care and appropriate treatments 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 commencement of interventions for Psychological Therapies within 26 weeks) 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,

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



Rationale for CURRENT Risk Score:

The service is experiencing significant waiting times as a result of increasing demand levels which are exceeding pre-pandemic levels, compounding the backlog due to Covid restrictions. Due to increasing Did Not Attend (DNA) rates, ongoing recruitment challenges and increasing demand there is an impact on the services' ability to see the same volume of service users as they were previously able to. Some posts continue to be funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff.

As of June 2024, there are 3,460 on the waiting lists. Recommendations received from NHS Executive in relation to Children's ND services are in the process of being implemented. The Directorate is working with Women and Children's Directorate to implement these.

For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit to establish trajectories, along with the commissioned service which since have been agreed in March 2023. The DU were unable to provide trajectories, therefore Health Board has agreed to a 1% monthly improvement trajectory. For psychological services a trajectory is now in place for 1% per month.

Rationale for TARGET Risk Score:

The Directorate is prioritising implementation of WPAS in key areas within MHLD and this will enable improved reporting and waiting list management and enable forward trajectories of improvement in waiting times to be determined.

The target risk score will be dependent on securing recurring funding for the IAS and Children's ND service as well as having access to appropriate clinical venues and other agencies being able to undertake their associated assessments.

While trajectory plans are in place as of March 2024, there is recognition that the Health Board will not achieve WG targets.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS** **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Use of IT/virtual platforms such as Attend Anywhere when appropriate. Clinical prioritisation regarding assessment and treatment of service users by engaging in a dynamic process of reviewing waiting lists in line with any other referrals that may be received in respect of that service user. Additional WG funding received in 2022/23/24/25 for ND services Services are in contact with individuals to provide information regarding mainstream/Tier 0 support, wellbeing at home and guidance should their situation deteriorate. Process in place to ensure individuals on waiting lists are being contacted periodically through the wait for assessment/treatment to monitor any alteration in presentation. Autism Advice Hubs and pre-assessment workshops in place for Childrens Neurodevelopmental Service Monthly meetings with Women and Children's Service to strengthen interdepartmental working. ND Service Delivery Manager appointed and in place.	Although dedicated premises have been sourced for ASD services, there is limited clinical space and Estate issues remain a challenge as identified in the risk narrative. Information not currently included on Health Board website and QR codes due to IT difficulties Additional funding received in 2022/23 for ND service on fixed term annual basis until 2025 Current resource does not provide sufficient capacity to meet demand Unable to recruit in to Clinical psychology in adult ASD service	Keeping in touch processes to be in place (Adult Inpatient and Learning Disabilities Services).	Bassett-Gravelle, Ms Lisa	Completed	Psychology In May 2023, 52 (40.00%) patients out of 130 were waiting less than 26 weeks to start psychological therapy in the Learning Disabilities Psychology Service. 78 (60%) were waiting more than 26 weeks. This is a month on month improvement since January 2023 and the position is likely to further improve due to Psychologists returning from maternity leave and recruitment. All new referrals are screened by the Community Teams and priority given where possible. Waiting lists review has been undertaken and keeping in touch letters in easy read have been sent out to all on the waiting list. We have recruited 8b psychologist who commences in August 2023. OT Urgent referrals taking priority. • Continue to prioritise referrals and support workforce modelling as part of service improvement work underway.

ND Service Delivery Manager appointed and in place. Continual review of vacancies via MHLD QSE meetings resulting in the consideration of alternative staffing models when recruitment drives do not materialise. Workforce Management Group has been established which meets monthly. Trajectories have been identified for IPTS and Children's ND and there are systems in place to monitor waiting lists at service level, through performance-management meetings, IPAR and Directorate and service level review meetings. Monthly meetings with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint. Work underway across all services who have waiting times, be they intervention or assessment. Use of HB Third Party Contractor has begun and keeping in touch letters sent to those waiting appointments with the Integrated Autism Service and Children's ND service. ND specific HB internet and intranet pages in development to give guidance and support whilst neuro-divergent individuals and parent carers are waiting. Keeping in touch letters developed and sent to those on ASD waiting lists on a 3-4 monthly basis and monitored by individual service leads. Service Leads secured opportunities for outsourcing for ASD services and Psychological Therapies. Commissioned external provider for ASD services across all ages, similar contract out to tender for Psychological Therapies. 'Grow your own' scheme is coming into place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme						improvement work underway. • Additional up-skilling B4 techs • Reviewing universal offers of support/workshops for families and carers particularly around sensory processing referrals. • Reviewing use of caseload weighting tools and enhanced professional lead oversight of caseloads • Limited clinical support from AMH B7 in Pembs CTLD. • Additional 1.0WTE B6 OT post to cover Carmarthenshire, and 1.0WTE OT B6 post within WEIT being proposed as part of SIP. Physio LD Service Manager EOC will attend peer meetings in the absence of a professional lead. EOC has advised the Physiotherapist that she will be validating and monitoring the waiting list reporting to the Information Dept on a monthly basis until they have a Prof Lead in place. Services developing a professional lead physio for LD JD. All LD Therapies Service Manager EOC has advised the to adopt Psychology's approach of formally writing to each individual on the WL over 6/12 as part of the regular Waiting list review cycles.

[illegible] (3 year programme). Quarterly meetings with the NHS Executive, Welsh Government and Service Leads at the Health Board SMS functionality in place for ND and IPTS to improve attendance and decrease instances of DNA All posts recruited in to Children's ASD service		Identify alternative venues/space to hold clinics(CAMHS & Psychological therapies).	Lodwick, Angela	Completed	Challenges continue in access to Estates to undertake assessments across the three counties. Remains ongoing working with Estates and submitting capital bids to WG for monies to fund works within allocated buildings to make them fit for purpose. SBAR being developed to repurpose the use of Tudor House. RAAC issue is extenuating the estates position with some areas within Pembrokeshire/Ceredigion not being available to undertake assessments/interventions. Ongoing estates issues, movement of Directorate Management team from Ty Gwili to provide additional clinical space. Neuro / IAS moving to Ty Gwili for clinical space by March 2024. Other moves taking place throughout the service and additional funding and areas being explored. Moves have been completed from Ty Gwili to Tudor House to identify clinical space for Neuro in Ty Gwili. Continuing to pay for space within Nurture Centre for DBT and PMH/SiR teams for additional family sessions. Remain looking into additional funding and exploring areas.
		Identify alternative venues/space to hold clinics (Integrated Psychological Services).	Homfray, Andrew	~~31/07/2023~~ 31/11/2023 31/08/2024	As many groups as possible are being set up to utilise online facilities and third sector venues to support any face to face meetings, ensuring that costs are managed appropriately. Phase 1 of groups completed in February 2024, targeting waiting lists. Phase 2 of group implementation to implement a tiered approach to intervention commenced 27th May 2024 following further staff training, with full implementation expected by August 2024.
		Directorate to transfer all service data collection processes to WPAS.	Amner, Karen	Completed	Delays to the Dementia Wellbeing Service, Integrated Autism Service, Perinatal, Memory Assessment Service migration delayed due to capacity within the Digital team to test and develop system at required pace. As at October 2023, all data for the relevant services noted on the risk have been transferred, therefore to close action.

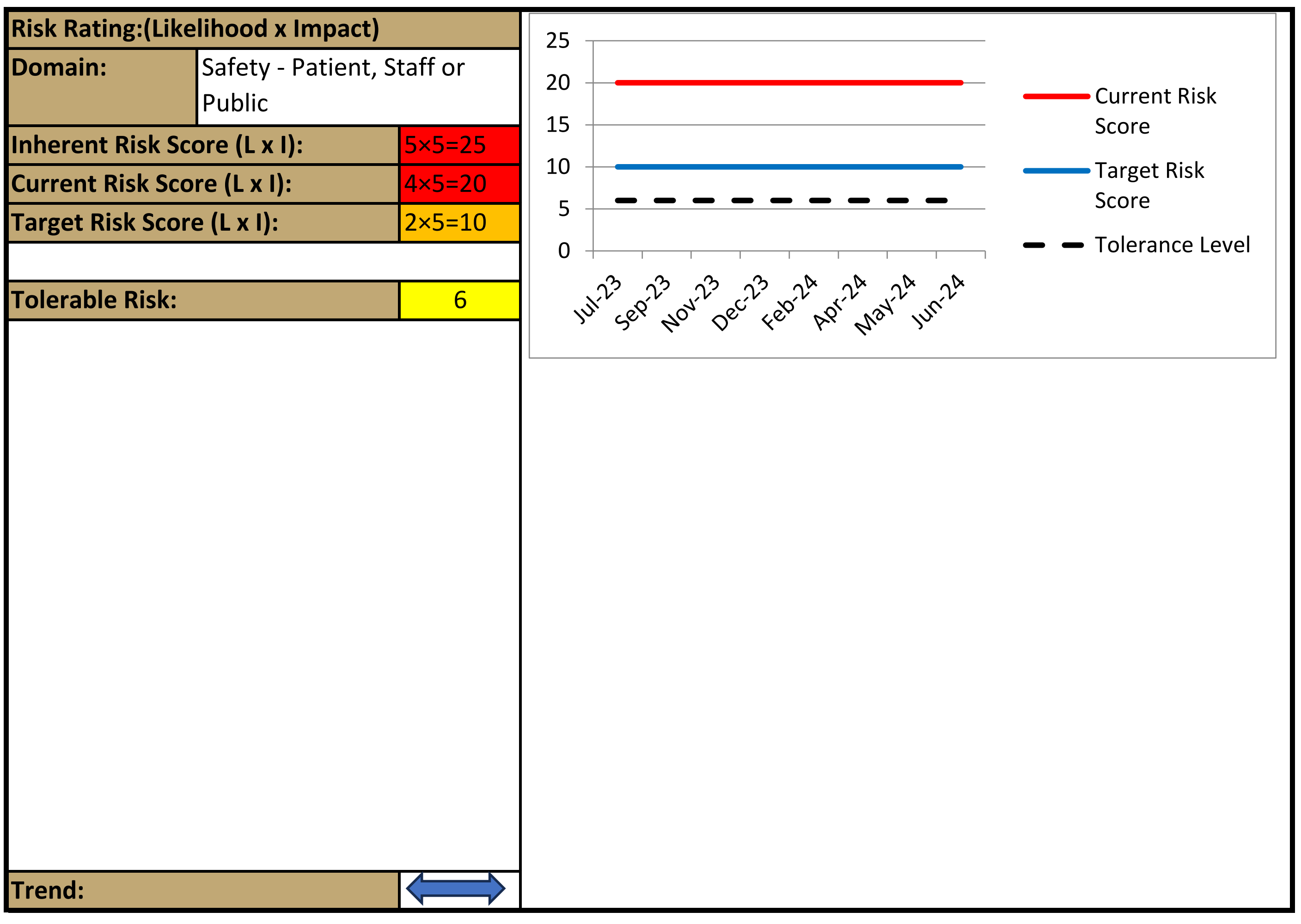
		Review workforce skill mix in light of any potential new funding received from WG for Neurodevelopmental services.	vaughan, Catherine	Completed	Workforce reviewed and skill mix within team expanded to ensure a multidisciplinary approach in order to deliver an integrated multi disciplinary service in respect of the fixed term funding for 2023/24 received on behalf of the Regional Partnership board(RPB). Skill mix introduced but unable to recruit in to some posts due to delay in funding received via RPB and fixed term nature
		Monitor the use of SIFT monies for service development. The Director of Finance has given an undertaking that this will be funded as discussed and agreed at a Directorate Improving Together Session in April.	Carroll, Mrs Liz	Completed	During the budget setting process in Month 7, the £575k for procurement for EMDR and ASD was not factored into the Directorate position despite this having been agreed following agreement at Public Board in September 2022. This was raised by the Finance Business Partner during the budget setting process with Finance colleagues. This leaves a deficit in this years budget. To be reviewed in the DITS meeting on the 27th October 2023. This outsourcing has been absorbed by the Directorate.
		Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Temple-Purcell, Rebecca	~~30/11/2023~~ 31/12/2024	In progress, working with Workforce to develop a training needs and analysis tool. MH&LD to act as a pilot for this pending further roll out across the HB. Ongoing

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Welsh Government performance indicators along with internal monitoring arrangements will be used to ensure the actions are having the desires effect or whether there is more that needs to be done.	Management monitoring of referrals	1st			Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC (Oct21) MHLD progress update on Planning Objective 5G - Board (Mar22) Papers have been presented at the Quality Safety and Experience Assurance Committee with a further update paper provided for the December 2021 meeting outlining control measures to manage the waiting times that the Directorate have at present. A paper was presented at Board Seminar in June 2022 to provide assurance on current waiting times and control measures.	System to improve analysis of patient experience	Outcome measures to be in place to measure effectiveness/quality of services provided (CAMHS & Psychological therapies).	Lodwick, Angela	Completed	S-CAMHS is implementing nationally agreed Welsh Government Outcome Measures - staff have received training as part of the Welsh Government Initiative. Gold Based Outcomes, SDQ and YP Core. Katie O'Shea has implemented this and all staff have received training and aware of expectations.
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd					Outcome measures to be in place to measure effectiveness/quality of services provided(Adult Inpatient and Learning Disabilities Services).	Bassett-Gravelle, Ms Lisa	Completed	Due to staffing issues it has been difficult for the Business Manager to take further with the SALT team due to pressures within services. Business Manager is liaising with Sarah Mackintosh from Carmarthenshire People First with questions to go onto an easy read format. Meeting with Carmarthenshire People first on 17th April 2023 to go through the questions for the easy read format. Once easy read format has been completed Business Manager will take to Q&S Team to add a QR Code to give the service user the choice of both options. 15/06/2023 both easy read and electronic forms completed, meeting with CTLD managers taking place to roll out the new forms.
	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.									

Date Risk Identified:	May-23	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jul-24
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Aug-24

Risk ID:	**1664**	**Principal Risk Description:**	There is a risk to service sustainability in Ophthalmology across the Health Board, and the inability to provide timely care to patients with Glaucoma, wet Age Related Macular Degeneration (wAMD), and Cataracts. 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 three substantive Consultants and a high cost Locum Consultant (Medacs) to ensure the delivery of the Ophthalmology service. This is a fragile on call structure which is impacted by sickness and annual leave. This could lead to an impact/affect on the Health Board's ability to deliver services within the Ophthalmology Referral to Treatment (RTT) plan, and delays in the NICE guidance 14-day pathway for AMD appointments, impacting on the ability to provide timely diagnosis and treatment and directly impacting on patient safety with the potential for sight loss and long-term lifestyle impacts. This will also affect the Health Board's ability to comply with Welsh Government Eye Care Measures (ECMs), and service pressures are impeding on the Health Board's ability to progress with the implementation of recommendations raised by various regulators and inspectorates. This in turn could lead to adverse publicity and reduction in stakeholder confidence, with increased scrutiny/escalation from Welsh Government. Workforce pressures could also impact staff well-being and morale.
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):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:

Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for patients most at 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. Additional staffing for Wet AMD was incorporated into IMTP but no funding was allocated.

The service as at February 2024 has 6,383 patients (Nov 23: 5,713) that have been 100% delayed for their follow up appointment. The total new patient referrals is at 7,088 (Nov 23: 5492) of which 713 (Nov 23: 403) are breaching 52 weeks (the longest wait from this cohort is 84 weeks (Nov 23: 67 weeks)). 4,040 patients are awaiting an Ophthalmic operation (Nov 23: 3,785) of which 46 (Nov 23: 24) are breaching 104 weeks (the longest wait from this cohort is 130 weeks).

The current impact has been scored as 5 because patients suffering irreversible sight loss or damage is a reality and the current Likelihood has been scored 4 as Ophthalmology is a fragile service. It is unlikely that we will be able to achieve the Board tolerance score of 6 without a regionally agreed solution.

Rationale for TARGET Risk Score:

It is unlikely that the service will be able to reduce the impact score of this risk as the consequences to the patient remains high, however due to recent re-structuring of the management team within Ophthalmology it is hoped that this will provide opportunities to review and improve service delivery with an initial focus on meeting eye care measure targets for the most high risk cohort of patients. The recent addition of a substantive WTE Consultant will help to address the longest waits. A Regional Consultant post has been recruited in Swansea Bay to provide an additional 10 sessions a week in HDUHB, however noting that 7 of these sessions relate to clinical delivery.

With the above additional workforce and focused management of the waiting lists, HDUHB will potentially help to reduce the likelihood score on this risk.

Key CONTROLS Currently in Place:
(The existing controls and processes in place to manage the risk)

Active recruitment to vacancies, x1 substantive Consultant has recently been appointed. X1 WTE post secured with Swansea Bay and x1 substantive Consultant post to go out to advert.

Regional Business Case for a South West Wales Glaucoma Service.

Regional discussions regarding a South West Wales Consultant On-call provision.

Additional weekend working to provide Wet Age related Macular Degeneration (AMD) capacity. Currently funded for x2 all day lists per month. Lists cancelled due to AL are offered out to backfill.

Review of service rota undertaken by Clinical lead to ensure stability to existing team and robust cover of emergency work.

Identification of patients suitable to undergo Community Glaucoma data capture and virtual review by Consultant Ophthalmologists.

Gaps in CONTROLS

Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed Further action necessary to address the controls gaps	By Who	By When	Progress
Whilst recurring money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, VR, plastics) that require investment. ARCH programme to be closed, with a regional conversation around a regional clinical workshop to consider opportunities for a long-term regional model. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. Recovery funding was in place until March 2023. Actions have assisted the backlog number of patients waiting to be	Regional discussions to be arranged as a priority around Ophthalmology services to support a long-term sustainability plan for eye care services.	Coppack, Victoria	~~30/09/2023~~ 31/12/2023 31/03/2024 30/06/2024	Regional glaucoma pathway has been established. Outline discussion around regional support for a workforce development plan for HDUHB multi-disciplinary team development. Regional working for Open eyes digitalisation.
	Root and branch review of operational, workforce and sustainability models.	Coppack, Victoria	~~30/06/2021~~ 31/03/2022 31/10/2022 31/12/2023 31/03/2024 30/06/2024	Root and branch review to be undertaken through ARCH group. Regular meetings need to be undertaken for Glaucoma and Workforce plan. As at December 2023, there was the potential for this group to be replaced by an alternative regional group. Outcomes of discussions relating to this proposal are awaited.

Full Business Case for OpenEyes software (National Electronic Patient Record for Ophthalmology) approved and funding for this project has been secured for 1.0 WTE Band 7 project manager and a 0.5 WTE band 5 application support manager. This project is being aligned with SBUHB. Validation taking place through scheduled care validation team. Clinical validation of all HCQ patients being undertaken by nurses (documentation has been approved for a pilot which started in November 2023). Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. ECM Coordinators in place. Review of data quality inclusive of HRF code and clinical codes ongoing to improve data quality. 7 prescribing hubs have now been set up across the Health Board, with the aim to reduce the number of patients requiring Secondary Care Eye Services, ensuring those with the need for secondary care intervention are referred. Highly trained Optometrists working collaboratively with the Secondary Care Eye Service to reduce referrals to secondary care. Ongoing training of Optometrists within secondary care to continue to develop this service. ARCH workstreams in place - looking at Glaucoma and funding has been secured to support this development. ARCH support around Diabetic retinopathy and cataracts has been completed and pathways are in place. Ongoing arrangement of Optometrists enrolling in prescribing training. Weekly monitoring of each sites AMD demand and capacity to allow for recovery planning of breaching patient waiting times. Funding obtained in November 2023 to outsource 330 cataracts patients	number of patients waiting to be managed in subspecialties such a Diabetic Retinopathy however other high volume areas such as AMD and Cataracts continue to see growth in waiting times. There are concerns in data quality due to referral processes and system use. The Ophthalmology service has continued to recruit over budget to sustain current services.	Roll out and implementation of National Electronic Patient Record for Ophthalmology.	Barreiro, Marta	~~30/07/2021~~ 31/03/2022 31/05/2022 30/09/2022 31/10/2023 31/12/2023 31/03/2024 15/07/2024	Issues identified in the planning phase around data governance. DHCW are working to resolve issues. Update provided by the DHCW in January 2024 outlining options available. Regional planning scoped and aligned programme now established with Swansea Bay UHB. Timeline to be established when options appraisal completed. July 2024 - issues with software solution, DHCW trying to source a resolution. Not likely to be implemented before 2027.
		Refurbish and establish a nursing team in the Outpatient Department in Amman Valley Hospital to provide intravitreal treatment for the patients currently attending the day theatre area for their treatment. This will ensure continuity of care for those patients when cataract surgery activity is returned to day theatre.	Coppack, Victoria	~~31/01/2022~~ 30/09/2022 31/10/2023 31/01/2024 31/03/2024 15/07/2024	Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) has been completed since March 2022. Recruitment into nurses posts to support out-patient activity has been successful and recruits are onboarding. This is currently on hold due to the space being utilised for WGH Ophthalmology patients (RAAC). However an alternate site has now been identified in Pembrokeshire, with a date for completion of works in January 2024. Move to be completed March 2024. July 2024 - no further updates. Financial constraints limiting ability to expand workforce. Recurrent sickness and other absence levels affecting the wider team and further impacting on the ability to use AVH OPD for IVT.

from the longest waits (104+) until March 2024. Transformational funding from Welsh Government is in place until March 2024.		Plan for Glaucoma pathways to be implemented through ARCH.	Barreiro, Marta	~~30/06/2022~~ 31/10/2023 30/11/2023 30/04/2024 15/07/2024	Business case has been approved and pathway has been implemented with support from Swansea Bay Consultant. ODCT pathway x2 has been developed, Optometrists virtual pathway for Glaucoma A patients starting in November 2023. Swansea Bay Glaucoma consultants started in HDUHB in November 2023, and further modelling work is required to recover waiting times. Action to be considered for closure once improvements in waiting times observed. July - SB consultants started around December 2023. All planned work currently ongoing but no improvements to waiting lists noticed yet.
		Recruitment of approx. 7 nursing staff and 2 technicians.	Barreiro, Marta	~~30/06/2022~~ 31/10/2023 31/12/2023 31/03/2024 30/06/2024	2.0 WTE Technicians secured 0.8 WTE Glaucoma practitioner secured. 3.3 WTE Nurses secured Outstanding 1.9 WTE Glaucoma practitioner and 1.0 WTE Nurse which have not been recruited into, and still outstanding as at February 2024. The Health Board are looking in to developing training programme prior to advertising in conjunction with Swansea Bay.

		Remodelling the capacity and demand associated with Wet AMD and Amman Valley	Coppack, Victoria	~~31/03/2023~~ 31/10/2023 30/11/2023 31/03/2024 15/07/2024	Ongoing costs associated with additional activity. Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) has been completed since March 2022. Recruitment into nurses posts to support out-patient activity has been successful and recruits are onboarding. This is currently on hold due to the space being utilised for WGH Ophthalmology patients (RAAC). However an alternate site has now been identified in Pembrokeshire, with a date for completion of works in January 2024. Completion of move by March 2024. July 2024 - IVT activity from Pembrokeshire back to base in WGH, although with current staffing pressures there isn't enough staff to cover additional activity in AVH OPD.
		Recruitment of theatre staff and admin support to enable the optimisation of AVH theatres for cataracts.	Barreiro, Marta	~~31/03/2022~~ 31/10/2023 30/11/2023 31/01/2024 31/03/2024 15/07/2024	When IVT service relocates from AVH Theatre to AVH Outpatients Department, the ability to undertake further cataract surgery in AVH Theatre will be increased. July 2024 - SAS doctors onboarding which should support this

		Plan for Cataracts pathway to be implemented through ARCH.	Barreiro, Marta	~~30/06/2022~~ 30/09/2023 30/11/2023 31/03/2024 30/06/2024	Locum Consultant secured to assist with delivery of Cataracts surgery/Substantive Consultant with specialism in plastics secured who can also undertake cataract surgery. Review of Demand and Capacity now undertaken to inform service recovery. The ARCH pathway as of December 2023 has ceased, with plans devised and approved. GIRFT review for cataracts is ongoing, with recommendations raised noted on the Audit and Inspection tracker and progress updates obtained. Action is linked to the ability to restructure service between AVH and Pembrokeshire, which is currently impacted by RAAC.
		Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.	Coppack, Victoria	~~30/09/2022~~ 31/10/2023 30/11/2023 31/03/2024 30/06/2024	Validation of HCQ patient commenced in November 2023. Longest wait HCQ patients have been identified for tech review. Virtual review process to be discussed with Clinical lead. Clinic spaces to be secured for patient review. This is an interim measure whilst community hub is being developed.
		Clinical validation rota to be established within the service to ensure validation of high risk patients and longest waits is undertaken to prioritise patient reviews and safety net patients	Coppack, Victoria	~~30/09/2023~~ 31/12/2023 30/04/2023 15/07/2024	Validation ongoing and R1/longest wait patients booked in terms of their priority for next quarter. Co-ordinator in place, and triage and validation ongoing, however the list has not been reviewed in full as at December 2023, therefore revised action date of April 2024. July 2024 - Due to clinician unavailability, unable to complete action.

ASSURANCE MAP					Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level	Control RAG Rating (what the assurance is telling you about your controls)		Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed. Further action necessary to address the gaps	By Who	By When	Progress
Eye care measures monthly report. GIRFT review Cataracts. GIRFT review Glaucoma. Watchtower review of ministerial measures	WPAS	1st			Ophthalmology 'Deep Dive' paper to ARAC (Dec 2023)					
	GIRFT action plan cataracts	1st								
	GIRFT action plan Glaucoma	1st								
	WPAS, scheduled care performance indicators	1st								

Date Risk Identified:	May-24	Executive Director Owner:	Daniel, Sharon	Date of Review:	Jul-24
Strategic Objective:		Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Aug-24

Risk ID:	1859	Principal 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):	4×5=20
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	6
Trend:	*New risk*

Rationale for CURRENT Risk Score:

There are specific concerns relating to Glangwili General Hospital (GGH) and Withybush General Hospital (WGH) in relation to cardiac arrests and unplanned admissions. There has been an increase in Cardiac Arrest rates at GGH in the period January - April 2024 (15), compared to the period January - April 2023 (8). Of the 15 arrests noted for 2024, 4 of these were a result of failure to recognise / respond.There has been a significant increase in unplanned admissions at WGH, with 28 noted in the period Jan - March 2024 at WGH (15 for the equivalent period of Jan-March 23). 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.

Work is underway investigating the opportunity to benchmark the position of Hywel Dda on an All Wales basis. Prior to Covid-19, the National Acute Deterioration Group for Wales (RRAILS) was in place, which gave direction on key initiatives such as Sepsis and NEWS, however this group is no longer supported which poses the risk on a national level regarding a disjointed approach across Wales.

As of June 2024, compliance rates for Level 2 and Level 3 Resuscitation Training are at 40%. While there is no set compliance target, compliance has never been greater than 60%.

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 6.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
Governance structures in place eg RADAR Group Recognition of Acute Deterioration and Resuscitation, T&F Group chaired by HB RADAR Lead with focus on Sepsis, DNA/CPR group chaired by Deputy Medical Director. RADAR directly reports to Operational QSE. Health Board Resus policy in place (currently out of date requiring updating - however waiting on national guidance) All Wales DNA/CPR policy in place, which is due for update in 2024 Lead for Acute Deterioration Dedicated Resusciation Team in place, consisting of 5 full time and 2 part time employees Networks in place across the wider HB, including support from QIST Organisational training plan in place, including mandatory training Critical Outreach Services in GGH and WGH (not in place at PPH / BGH), managed by Planned Care Directorate (i.e not fully linked to Acute Deterioration resource) New Acute Kidney Injury (AKI) Lead appointed for GGH (12 months) Dedicated resource in Quality Improvement Team monitoring AKI alerts for the HB

Gaps in CONTROLS				
Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
No treatment escalation plans in place No call for concern in place Training demand outstrips capacity to deliver, with time limited in training sessions Inconsistent application of policies and processes eg DNA/CPR, new escalation policy, sepsis assessment tool, National Early Warning Score (NEWS). Reliance on manual / paper based documentation to record patient deterioration and subsequent escalation Critical Outreach Services not in place at PPH / BGH Inability to release staff to complete L2 and L3 training	RADAR to develop a workplan to address gaps in control to improve the recognition and management of acute deterioration across the Health Board.	Davies, Mandy	30/09/2024	Quarterly meetings in place, and sub-groups being established to report to RADAR on sepsis, NEWS, treatment escalation plans, call for concern (Martha's Law) DNA/CPR, acute kidney injury (AKI).
	Develop an organisation-wide training needs analysis to appropriately identify staff across all staff groups complete the most appropriate level of training to improve recognition and management of acute deterioration.	Wastell, David	30/09/2024	The directorate is working with ESR to ensure that staff training attendance is accurately recorded. Work is ongoing with individual line managers to identify the training needs of all their staff groups across all four sites and community. Meetings commenced with all senior nurse managers to discuss current training uptake and training needs to identify the most appropriate training for each staff group across acute and community. Meetings are to be arranged with Heads of Service for other clinical services. As at June 2024, it has been identified that 84 ILS sessions are required in order to ensure compliance with targets for GGH alone. Heads of Nursing requested to discuss training attendance with all ward sisters, and to appropriately prioritise. Monthly analysis of training available, and attendance to be shared with Heads of Service and Senior Nurse Managers. The provision of training continues at current levels, given current resource availability.

	To implement an electronic observations systems across the Health Board to capture real-time bedsite capture of patient assessments and monitoring, in line with the Health Board's Digital Plan	Williams, Caroline	30/09/2025	Tender process currently ongoing. Business case to be 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.
	Develop a dashboard and supporting metric in order to support the recognition and proactive management of acute deteriation	Wastell, David	30/05/2025	Meeting has been scheduled for 25 July 2024

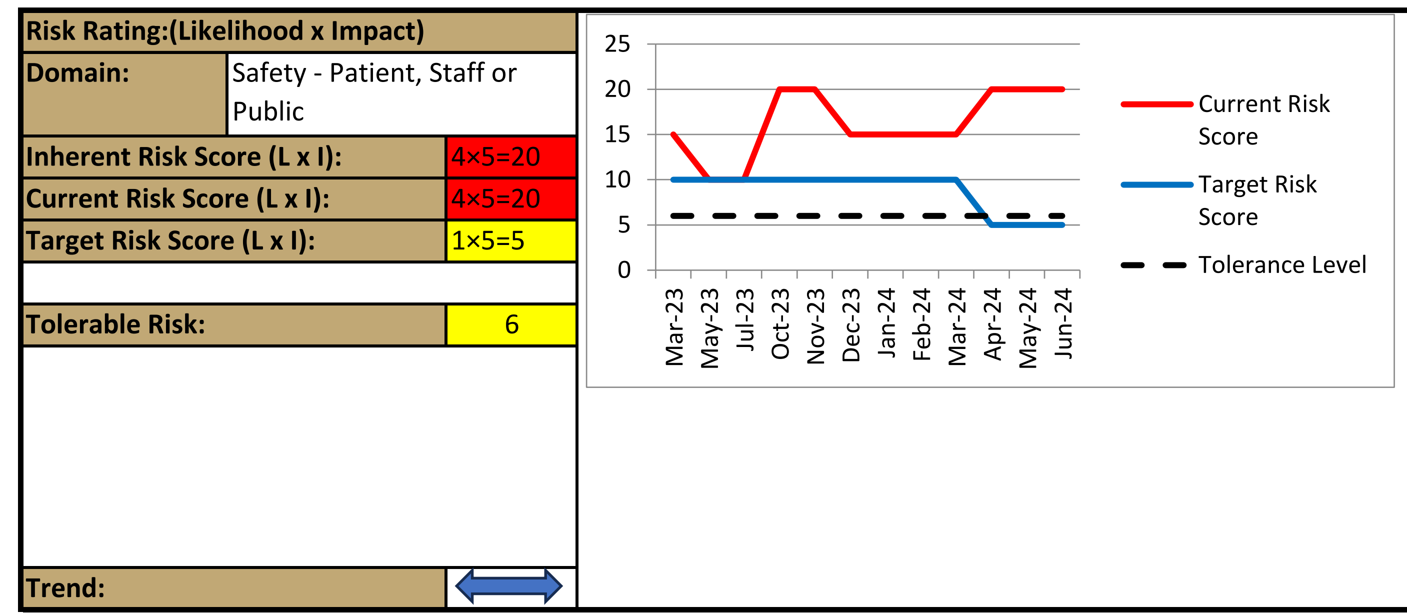
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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 OQSEC, Feb-24	Unreliable RRAILS audit in place	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	Meeting has been scheduled for 25 July 2024
	Review of DATIX incidents, complaints, cardiac arrest reports and Medical Examiners reports relating to acute deterioration	1st								
	Outreach review all unplanned admissions to Intensive Care	1st								
	RADAR Group	2nd								
	T&F Group chaired by HB RADAR Lead with focus on Sepsis	2nd								
	DR/CPR group chaired by Deputy Medical Director	2nd								

Date Risk Identified:	Nov-22
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jul-24
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Aug-24

Risk ID:	1531	Principal 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 One vacancy and one substantive consultant who is no longer taking part in the on call rota, due to health issues, on the General Surgery Consultant rota at WGH (1:5). This is now running as a 1:4 rota with one Medacs and one NHS Locum filling the gaps. One vacancy, one retire and return consultant and one consultant who has reduced their on calls on the General Surgery Consultant rota at GGH (1:8). GGH is now running as a 1:5.5 which is not sustainable. This could lead to an impact/affect 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.
Does this risk link to any Directorate (operational) risks?			

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



Rationale for CURRENT Risk Score:

The risk score was increased in April 2024. In addition to the risk at WGH, the GGH surgical consultant on call rota is also in a fragile position. Since July 2023, due to a retire and return, without on call commitments in their job plan, the 1:8 rota became 1:7 with agreed internal cover for the 1 gap. Since February 2024, the rota has become a 1:6 due to a further vacancy, following a promotion within the team. This is a fixed term arrangement for 12 months and a locum upper GI consultant post to cover this vacancy is currently being reviewed and will be advertised in April 2024. There is a further gap on the rota which affects 1:8 weekends only, this is due to medical reasons. The GGH rota is currently running as a 1:5.5 which is not sustainable. There is also currently unplanned sickness in the team at GGH, causing further pressure on remaining consultants and has impacted elective activity.

The fragilities at WGH remain the same, with high cost Medacs locums supporting the consultant and SAS level on call rotas. There are only 2 substantive consultants on the 1:4 consultant on call rota.

Work is currently being undertaken as part of the Health Board's Clinical Services Plan to address rota fragilities across both sites.

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.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS** **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
The WGH General Surgery consultant on call rota currently runs as a 1:4. There are currently 4 consultants on the rota, 2 substantive, 1 NHS locum and 1 Medacs locum who joined the team on 06/11/2023. An NHS locum consultant post was advertised and appointed to on the 20/11/2023 as an exit strategy for the Medacs locum. The successful candidate withdrew on 29/11/2023. A job description for an emergency general surgeon is currently being developed. The 2.5 gaps on the 1:8 General Surgery consultant on call rota at GGH is currently being covered by internal staff on a locum basis. A job description for a consultant Upper GI surgeon, to join the GGH rota is being updated and the job will be advertised before the end of April. Current staff from WGH and GGH continue to provide backfill to maintain the rota. Continuously liaising with the rota coordinator at WGH for potential gaps on the rota. Proactive sickness management Escalation to clinical leads Medacs locum has been briefed on clinical pathways and procedures within Hywel Dda Health Board and expectations have been made clear by the surgical team. Engagement with WGH Medical Staff Committee and public on changes to services An interim 1:3 model with day consultant cover being provided by WGH consultants and night consultant cover being provided by BGH or GGH on a rota, came to an end on 03/11/2023. Board approval was received for a 1:4 24/7 surgical consultant on call rota to commence from 03/11/2023. The rota consists of 2 substantive consultants, 1 NHS locum, 1 Medacs locum. In response to the fragility of the rotas and the recruitment difficulties that have been faced. A plan for relocating emergency surgical on call from WGH has been submitted as part of the directorates annual plan.	The 1:4 model at WGH, which commenced on 03/11/2023 continues to be fragile, with only 2 substantive consultants on the rota. The 4th slot on the WGH rota is being filled by a Medacs locum which incurs additional costs. There are also risks of the locum leaving at short notice, causing the rota to collapse. An NHS locum consultant post was advertised and appointed to on the 20/11/2023 as an exit strategy for the Medacs locum. The successful candidate withdrew on 29/11/2023. To maintain the current rota model, we will now be reliant on the Medacs locum for a longer period. The locum consultant who started on 04/09/2023 was an associate specialist and part of the SAS level rota at WGH. This has now left a gap on the SAS level rota. This is currently being covered by a Medacs locum. We advertised and appointed a specialty doctor but the successful candidate withdrew on 13/11/2023. The post went back out to advert and we appointed on 01/12/2023. This person withdrew on 07/02/2024. The post is going back to advert in April 2024. Previous difficulties in recruitment into the consultant and specialty doctor post. A job description for a consultant emergency general surgeon is currently being developed with the hope of going out to advert. An increase in consultants at GGH,	Recruitment of 1 Consultant upper GI surgeon for GGH. Agreement to recruit 1 consultant emergency general surgeon for WGH or 1 consultant general surgeon for GGH.	Lewis, Caroline	~~06/06/2023~~ 31/07/2024	One NHS locum has been recruited to WGH and has been in post since 04/09/2023. Following previous withdrawals and a further vacancy in GGH. The plan for recruitment has changed with a consultant upper GI surgeon post to be advertised for GGH in April 2024. A job description for a consultant emergency general surgeon is being devised for WGH, if rotas are amalgamated, a consultant general or upper GI surgeon could be appointed to the new rota. July 2024- post advertised and is being shortlisted.
		To introduce a contingency model of day time consultant on-call rota in WGH with support from GGH and BGH consultant cover out of hours.	Lewis, Caroline	Completed	Report discussed at Acute Leadership Group, Executive Team and Operational Planning and Delivery Programme (OPDP) meetings. A 1:3 rota was agreed and will commence from 01May23.
		Review the longer term sustainability of general surgery on-call rotas across Hywel dda (recommendation from Getting it Right First Time (GIRFT) review in Jan23)	Lewis, Caroline	Completed	The senior consultant leads for general surgery have suggested that the WGH and GGH on call rotas are amalgamated to one site. This would provide an increase of consultants on the rota to either a 1:10 (the 3 WGH consultants and the 7 GGH consultants) or a 1:12 (the 3 WGH consultants, 7 GGH consultants and 2 newly recruited posts). This recommendation is in line with the GIRFT report. An SBAR has been devised by the service to be presented at CDG in April 2024.

In April 2024, an updated SBAR was populated to go to board with the recommendation of amalgamating the two on call rotas to 1 site to either a 1:12 or a 1:10. There is a belief that these changes provide a more sustainable service and would make recruitment more attractive, when comparing to other health boards across Wales who provide emergency general surgery cover in this way.	working additional on call locum weeks is resulting in a reduction in elective activity in OPD, endoscopy and theatre. This will have a negative impact on RTT and SCP targets. The fragility of the GGH rota and it's impact on elective activity has become evident this month with further short notice sickness in the team, causing a further reduction in activity. Concerns raised about a transfer, which is being managed by an IMG process. Vacancies remain due to inability to appoint permanent Consultants to	Robust plans to be developed for transfer and repatriation of patients	Lewis, Caroline	Completed	SOP has been developed and discussed with clinicians.

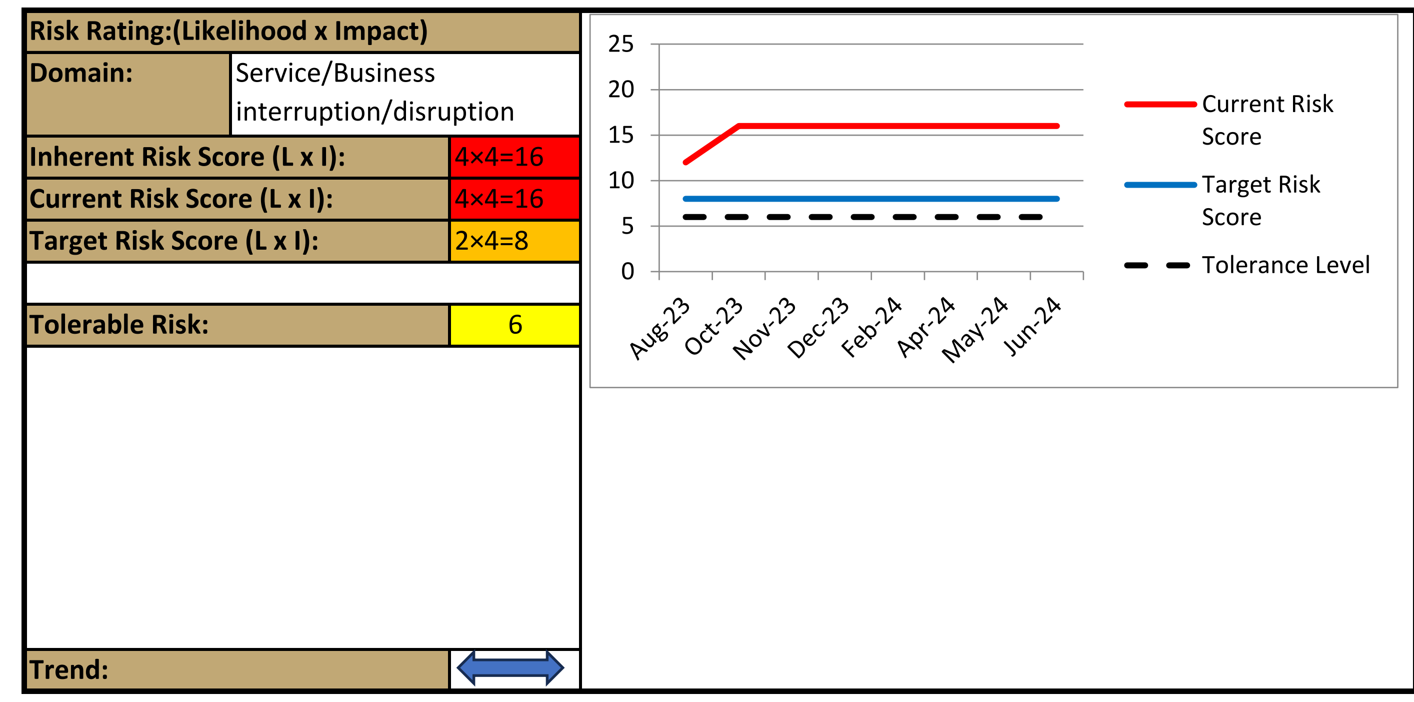
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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) SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23) General Surgery Report to Board (Mar23) Management team to present updated SBAR to Acute Leadership Group (Oct23)	Assurance to Board on communication and repatriation arrangements	Produce update report to Board in May23 to include details on communications with clinicians and the public, details of repatriation arrangements and accommodation and support for families, the patient experience and the governance arrangements for onward scrutiny	Lewis, Caroline	Completed	on 10/05/2023, an update was provided to Ben Rogers of the clinical services programme for the draft SBAR clinical services update which is what was taken to board.
	Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd								
	Reported to bi-monthly Scheduled Care Quality, Safety and Experience Group through exception reporting	2nd								

	Assurance to be reported to the Board following introduction of temporary rota	2nd			Management team to present updated SBAR to Acute Leadership Group (Nov23)						
	GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited(3rd,				Management team to present updated SBAR to Corporate Directorate Group (Apr24)						

Date Risk Identified:	Jul-23	Executive Director Owner:	Paterson, Jill	Date of Review:	Jul-24
Strategic Objective:		Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Aug-24

Risk ID:	1708	Principal Risk Description:	There is a risk of increasing fragility in Primary Care Contractor services. This is caused by challenges in recruiting new clinicians into salaried or partnership roles 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. 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

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



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 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) is due to be piloted in Powys in June 2024, with national roll out due after this date.

2 GMS contracts has been returned to the Health Board in the last 12 months. However from previous contract terminations, 2 out 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 contract which was returned in April 2024 is currently being taken through the vacant practice process, with a recommendation due to Board in July 2024. 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 WGOS4 (clinical pathways for Glaucoma, HQC and Medical Retina) as part of the new Optometry contract implementation which commenced on 1st April 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.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS** **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Primary Care Academy in place, which looks at workforce planning, training and development needs and opportunities 5 Facet Survey completed in 2022 to establish a baseline for the GMS estate GMS and Dental Practices undertake annual reporting which includes reviews of statutory compliance requirements 0.25 FTE Primary Care Development Manager for estates in post but with a focus on GMS Escalation tool for GMS and Community Pharmacy (SITREP) Continue effective engagement with struggling practices to support with their issues through close working relationships developed with practices. Programme of practice visits to review Estates provision, and if remedial action is required Requests sent to contractors to assess potential risk of RAAC, with outcomes reported to WG Nationally agreed Breach Management process in place for Community Pharmacies. Requests for contract variation (termination, merger, branch surgery closure etc) are considered in line with national guidance, with panels convened as stipulated. Recommendations are taken through the Primary Care Contract Review Group with papers to Board when required.	A series of patient facing videos have been developed with Pocket Medic to support patient education in accessing Primary Care Services, and due to launch during Q1 2024/25. Requests for support on addressing the GMS sustainability agenda are with the Strategic Programme for Primary Care as a result of a review paper across all Health Boards on their sustainability pressures. National work on the development of the escalation tool for Dental and Optometry is ongoing but not live. Five Facet Survey and annual reporting of practices has highlighted non-compliance with statutory requirements such as Health and Safety, Fire and IP&C which have now all been addressed. 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 as at June 2023).	Establish workforce plan and recruitment strategy in line with the development of the national Primary Care Workforce Strategy and as a component of the Primary Care Strategy.	Hughes, Samantha	~~31/03/2024~~ 31/03/2025	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.
		To develop the Primary Care Strategy in consultation with statutory stakeholders and consultees, to cover areas including: •Workforce •Sustainable provision of Primary Care services •Estates •Managing contractual change •Developing pathways and new services •Improving access to services across all contractor professions	Bond, Rhian	~~30/09/2024~~ 31/03/2025	Paper submitted to Board in September 2023 setting out the scope of the Primary Care Strategy, with a further paper presented at Board in January 2024. The issues paper was presented at Board in March 2024, with feedback being addressed, with a further paper to be presented to Board in May 2024.
		Consider the potential to deliver a wider range of salaried NHS Dental Services through the Community Dental Service.	Owens, Mary	~~30/04/2024~~ 30/06/2024	Modelling is ongoing, however awaiting further contract guidance which is due by June 2024.

Strategic Programme for Primary Care (SPCC) bids approved for 2024/25 and 2025/26 to support workforce initiatives	Insufficient resources to support the estates development across all Primary Care services, particularly with independent contractors. Due to national review of Premises Directions, there is no improvement grant funding for 2024/25. Whilst Community Pharmacy Breach Management process in place, 2 notices are currently under the appeals process - the Health Board is awaiting confirmation on the outcomes of these by Welsh Government, which to date has taken over a year. Outcomes of these appeals will directly influence the approach taken going forward, and may result in the nationally agreed process unable to be fully implemented. Whilst RAAC declarations were requested, these were not mandatory for contractors to respond.	Implement the Managed Practice Strategy plan will give greater system resilience.	Swinfield, Anna	~~30/04/2024~~ 30/10/2024	The tender process for Neyland and Johnston concluded without a contract award, however taking lessons learnt there is a plan to re-procure for the contract with an estimated contract award date in October 2024.

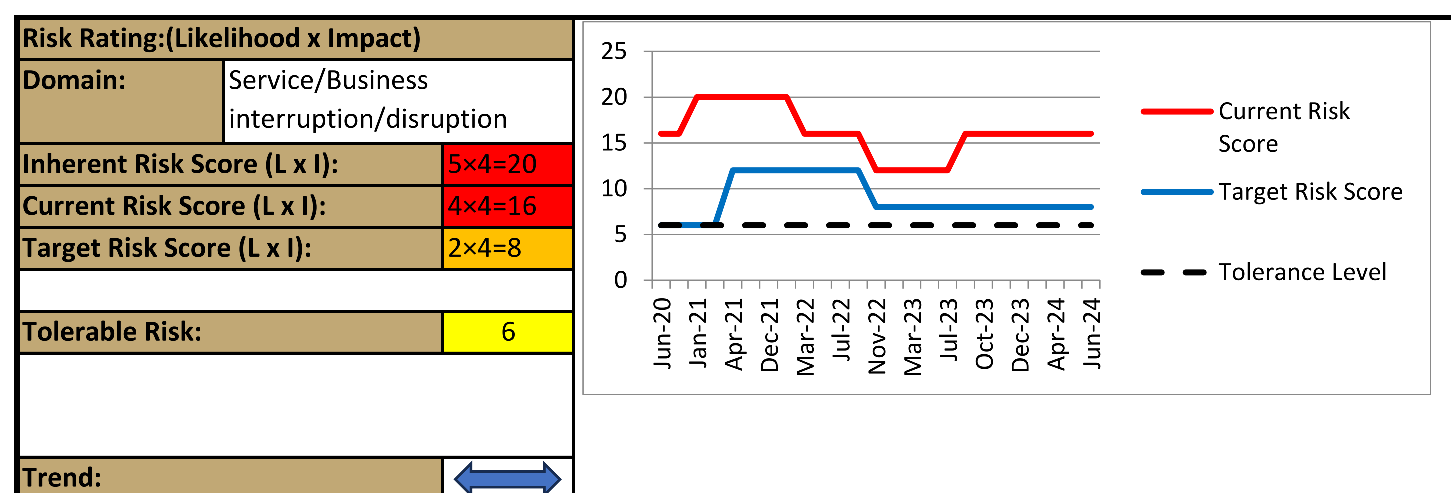
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

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

Date Risk Identified:	Jan-19	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jul-24
Strategic Objective:	N/A - Operational Risk	Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Aug-24

Risk ID:	684	Principal Risk Description:	There is a risk to the radiology service provision from breakdown of key radiology imaging equipment and associated infrastructure to enable equipment to function. This is caused by equipment not being replaced in line with RCR (Royal College of Radiologists) and other guidelines. This could lead to an impact/affect on patient flows resulting from delays in diagnosis and treatments, delays in discharges, increased waiting times on cancer pathways, increased staffing costs to minimise the impact on patients when breakdowns occur and increased number of breaches over 8 weeks due to increased downtime.
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
Tolerable Risk:	6
Trend:	⟺



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 given recent breakdowns of key imaging equipment. A costed plan along with a rolling programme for the installation of additional equipment is in place. There is a continuous process locally by which equipment is prioritised for replacement.

For 23/24 funding was obtained to replace two X-ray rooms and due to the RISP risks of non-DR compliant equipment, it was decided to replace the x-ray equipment at Tenby Cottage Hospital and the A&E x-ray room at Bronglais.

Gamma camera at Withybush General Hospital is the only scanner of its nature in the Health Board, and has experienced a breakdown in August 2023 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 July 2024.

While a new CT scanner has been obtained and installed at Glangwili, the original CT scanner has had a number of breakdowns due to its age. 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.

Rationale for TARGET Risk Score:

While equipment has been installed as part of the current WG funding allocations, and confirmation of funding received for the 24-25 financial year, there is uncertainty as at July 2024 with regards to continued equipment replacements beyond the 2024/25 financial year due to the discontinuation of a dedicated imaging equipment replacement allocation. New All Wales PACS procurement requires all equipment to be DR for compatibility. This has meant that replacement priorities have changed, and that some of the older DR compliant equipment are now overdue for replacement, and at risk of being de-prioritised.

As of July 2024, the x-ray unit at Tenby has been replaced and work underway planning the replacement of equipment in A&E Bronglais which is due to commence in August 2024. 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.

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.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports. # Escalation process in place for service disruptions/breakdowns. # Newly created 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.	Limitation of spare parts for some older equipment leading to extended outages. This issue may be compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment. Competing demands for replacement equipment due to RISP, and the requirement to replace two pieces of equipment which will be non-compliant after August 2025. No dedicated diagnostic equipment replacement funding has meant that DCP bids are having to be developed for all equipment replacement. National Imaging and Capital Priorities Group held its first meeting in September 2023 and has met three times. There is further work required to ensure a fair and robust process is undertaken to appropriately assess all imaging modalities and which understands individual HB risks to equipment replacement.	To confirm the capital funding to replace existing aged equipment for FY 2023/24	Roberts-Davies, Gail	Completed	A prioritisation list of aged equipment to be replaced has been devised, however confirmation needed on funding in order to undertake the required work. Funding has been given to replace Tenby DR equipment by the end of financial year 2023/24, and a task and finish group set up to monitor. Additional EOY funding has been secured to replace US units across the HB and 2 image intensifiers (BGH & WGH). Tenby equipment has been replaced and work is underway to replace an x-ray set at BGH. US and Image intensifiers recieved.
		To confirm funding arrangements for the remaining equipment that needs to be replaced, supported by individual DCP bids or dedicated replacement funds for 2024/25.	Roberts-Davies, Gail	Completed	Directorate has compiled a list of equipment requirements, which have been prioritised dependant on finance availability and functionality of the existing equipment and presented at Capital Sub-Committee in September 2023. Priority list has also been submitted to the National Imaging Equipment Capital Priorities group (NHS Executive Group) via assessment process, with outcomes provided in late May 2024. It is noted that funding has been given to replace Tenby DR equipment by the end of financial year 2023/24, and a task and finish group set up to monitor. NIECP meeting was held in April 2024 where the prioritised list of equipment replacements was be presented for consideration along with those of all HB's. Priorities were reiterated and a list ranked for WG. The outcome of this for Hywel Dda is that the final CR piece of equipment at a main site (WGH) will be replaced with DR equipment, along with the fluoroscopy room at WGH and an upgrade of the aged MRI scanner at PPH will also be undertaken.

Installation of replacement Gamma Camera, WGH	Roberts-Davies, Gail	~~31/07/2024~~ 30/06/2025	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. This will not be replaced in the 24/25 financial year. A specific T&F group has been set up as of June 24 to plan the necessary accommodation improvements required, and meets weekly.
Replacement of CT Scanner at GGH	Procter, Sarah	~~31/03/2024~~ ~~31/07/2024~~ 30/06/2025	CT scanner is 11 years old, with increased failures noted and that new technologies are now available. Colleagues in Estates are currently looking at options and prices, and as at December 2023 no capital bid yet provided as awaiting works costs. Will not be replaced in the 24/25 financial year
Replacement of digital x-ray rooms at Tenby Cottage Hospital and South Pembrokeshire Hospital	Roberts-Davies, Gail	Completed	Funding has been given to replace Tenby DR equipment by the end of financial year 2023/24, and a task and finish group set up to monitor. Tenby equipment has been replaced. SPH will not be replaced in the 23/24 financial year.
Replacement of ultrasound systems at BGH & GGH, image intensifier units at BGH & WGH, and Vacuum Assisted Biopsy (VAB) unit for PPH Breast Clinic	Osell, Fiona	Completed	Ageing equipment with replacements required for obstetric scanning, and resilience of services provided to Theatres. BGH and GGH Image intensifiers replaced. VAB equipment not to be replaced at this time. DCP bids have been collated for BGH ultrasound and WGH image intensifier, and exploring opportunities for charitable funding to support VAB unit for PPH Breast Clinic. Outcomes are still pending as at December 2023.

Replacement of Fluoroscopy room, WGH	Whitecross, Faith	~~31/03/2024~~ 31/07/2024 31/03/2025	Equipment is 17 years old with significant downtime experienced. Routine testing by Medical Physics department in January 2024 has found that image quality has deteriorated and the equipment is delivering increased doses to account for this. 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.
Replacement of CR A&E DR room and OPT (Dental) units, BGH	Edwards, David	Completed	Ageing equipment, with the dental unit 26 years old. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. Equipment in process of being replaced as at April 2024.
Replacement of CR X-ray Room 1, WGH	Roberts-Davies, Gail	~~31/03/2024~~ ~~31/07/2024~~ 31/03/2025	Ageing equipment. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. 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.
Replacement of CR X-Ray room, Llandovery Hospital	Osell, Fiona	~~31/03/2024~~ ~~31/07/2024~~ 30/06/2025	Equipment on site is incompatible with the incoming PACS system, and interim solution required. 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 2024/2025 financial year
Replacement of Mammography Units, BGH and WGH	Roberts-Davies, Gail	~~31/03/2024~~ ~~31/07/2024~~ 30/06/2025	Ageing equipment, exacerbated by the failure of Securview. These will not be replaced in the 2024/2025 financial year

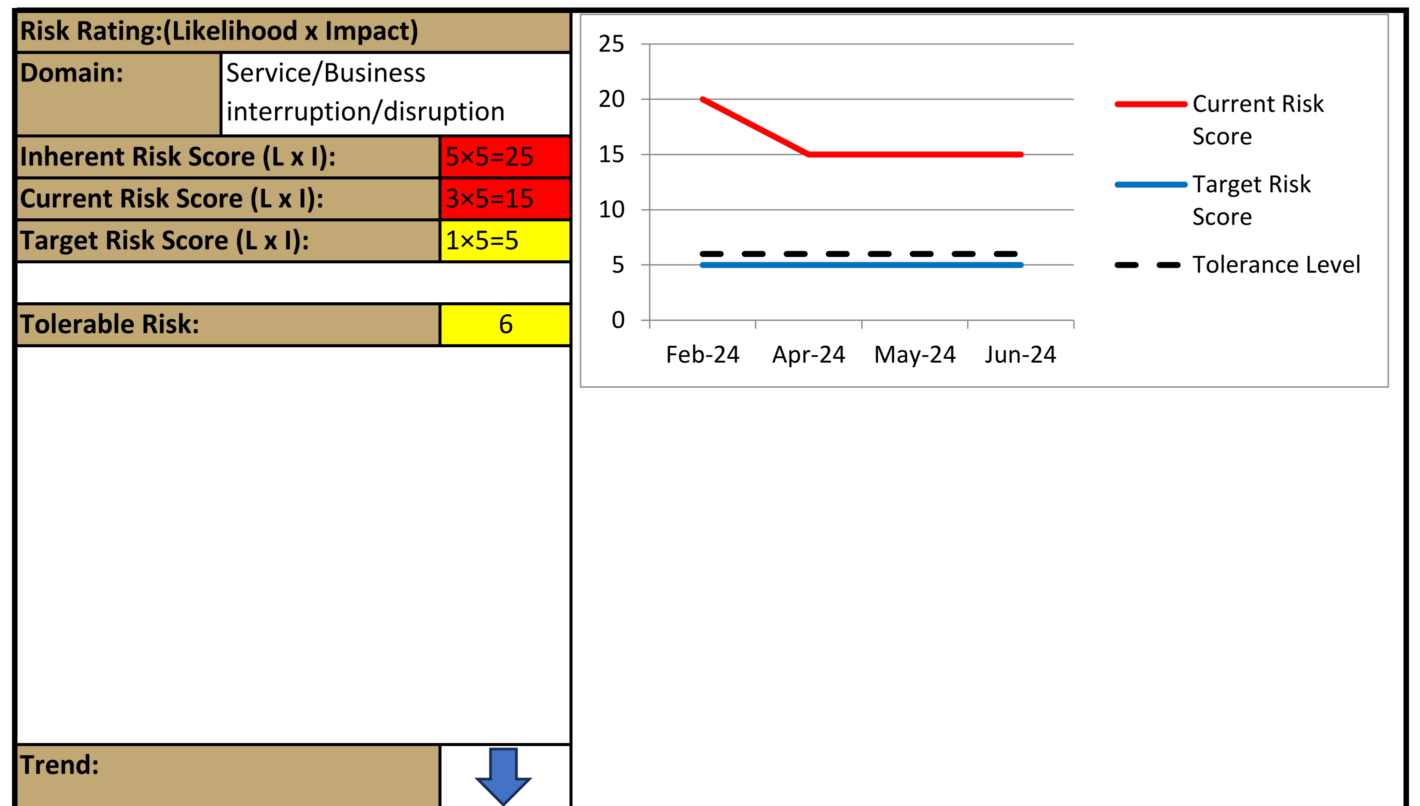
		Upgrade or replacement of MRI scanner, PPH	Osell, Fiona	~~31/03/2024~~ ~~31/07/2024~~ 31/03/2025	Ageing equipment with increasing failures, with new technologies now available. Confirmation that this piece of equipment will be upgraded in the 24/25 financial year was received late May '24- action will be closed when this new piece of equipment is operational.
		Upgrade or replacement of MRI scanner, GGH	Procter, Sarah	~~31/03/2024~~ 30/06/2025	Ageing equipment with increasing failures, with new technologies now available. This will not be replaced in the 24/25 financial year.
		Replacement of Room 3 (Digital x-ray room), BGH	Edwards, David	~~31/03/2024~~ 31/10/2024 30/06/2025	Mobile unit currently being used. This will not be replaced in the 24/25 financial year
		To consider alternative funding options for the DEXA unit, BGH	Edwards, David	~~31/03/2024~~ 30/09/2024	Unit is 17 years old, and previously funded via charitable funds To write business case for charitable funding

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 .	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 July 2022 & July 2023	Lack of process of formal post breakdown review.				
	IPAR report overseen by PPPAC and Board bi-monthly	2nd								
	Internal Review of Radiology Service Report (Reasonable Rating	3rd								
	WAO Review of Radiology - Apr17	3rd								
	External Review of Radiology - Jul18	3rd								

Date Risk Identified:	Feb-24	Executive Director Owner:	Paterson, Jill	Date of Review:	Jul-24
Strategic Objective:		Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Aug-24

Risk ID:	1810	Principal Risk Description:	There is a risk that the Health Board will be unable to continue manufacturing cancer treatments for our patients. This is caused by the facilities of the Pharmacy Aseptic Unit being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS) standards 5th edition (published 2016) and therefore at risk of closure. This could lead to an impact/affect on the Health Board's ability to provide all the cancer treatments currently offered. The Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. A fully outsourced service would cost an additional £1.3m each year. Some therapies cannot be outsourced, meaning Hywel Dda could not offer over 500 cancer treatments each year. This would have a significant negative impact on patient care as patients would either be required to travel further from home to neighbouring Health Boards to receive their treatment (dependant on their capacity to absorb the additional demand) or would be offered less clinically appropriate treatments at Hywel Dda, negatively affecting clinical outcomes. The closure of the Aseptic unit would directly impact the ability of the Health Board to achieve ministerial priorities and targets such as the Single Cancer Pathway, A Healthier Wales, etc.
Does this risk link to any Directorate (operational) risks?	374, 1350, 716		

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



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
The facilities of Withybush Aseptic unit are currently non-compliant with regulatory standards. The unit is subject to external audit by the National Pharmacy Quality Assurance Lead and the facilities were identified as being a high risk to patient safety in 2019. An audit performed in February 2023 confirmed the facilities were a high risk, and the unit at risk of forced closure. A pharmacy Aseptic unit based at Glangwili General Hospital was forced to close in December 2018 as the facilities were deemed a risk to patient safety. Withybush Aseptic unit is the only functional unit that can manufcature cancer treatments remaining in the Health Board. Short term control measures have been implemented by the Health Board 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. This is demonstrated by ongoing environmental monitoring results undertaken by the aseptic unit staff (combination of daily/weekly/monthly 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. This is because continued manufacture of cancer treatments within non-compliant facilities with unacceptable levels of microbial contamination would be a high risk to patient safety. Due to the age of the equipment and facilities, and the fact that the facilities were not designed against current regulatory standards, it is not possible to predict if or when the current controls will fail. If the unit was forced to close, the Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. Some cancer treatments cannot be outsourced due to their short shelf life. There were 345 reported service and quality-related incidents (e.g. delayed or failed deliveries) linked to outsourcing from commercial suppliers between September 2022 and August 2023 at Hywel Dda (an average of 29 incidents each month). The number of service and quality-related incidents between September 2023 and February 2024 remained high at an average of 25 incidents each month. Without a functioning Aseptic unit, the Health Board could not offer over 500 cancer treatments each year, and further treatments would be delayed/cancelled due to supplier service failures. Demand for aseptically prepared cancer therapy increased by an average of 14% each year between 2021 and 2023 (12,718 cancer treatments requiring aseptic preparation in 2021 compared with 16,648 treatments requiring aseptic preparation in 2023). Therefore the negative impact of not having a functioning aseptic unit is likely to grow each year. The most recent audit, conducted on the 20th and 23rd February 2024 with the final report received on 7th March, confirmed that the control measures employed are mitigating the risk and that all reasonable controls have been implemented. Therefore the current risk score has been adjusted from 20 to 15 to reflect the reduction in the likelihood of the risk of forced closure materialising, provided that these control measures remain effective. A business case for the demountable unit at Withybush General Hospital was submitted to Welsh Government in February 2023. The business case also requested funding to convert the current Aseptic unit into drug storage facilities. Based on budget cost estimates of £2.89m the submission was for review and scrutiny by Welsh Government to provide assurance to the Health Board before resourcing, and underwriting the financial risk, of progressing a detailed design for tendering. In September 2023, Welsh Government requested submission of a fully tendered business justification case, which is currently being worked up by the Health Board. As part of the Transforming Access to Medicines (TrAMS) project programme, a regional manufacturing hub will be built in South West Wales that will prepare cancer therapy for Hywel Dda patients. The hub was originally estimated to open during 2028, however there have been delays to the project plan and the opening date is currently unknown. There is therefore a high risk that the current Aseptic unit at Withybush will be forced to close before the South West TrAMS manufacturing hub is operational. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality.	The target risk score is based on the premise that funding for a new aseptic unit is approved by Welsh Government. The unit would be compliant with regulatory standards and once operational, it would be extremely unlikely for the unit to be forced to close. A new unit would allow the Health Board to continue to safely prepare cancer therapy until the TrAMS South West manufacturing hub is operational.

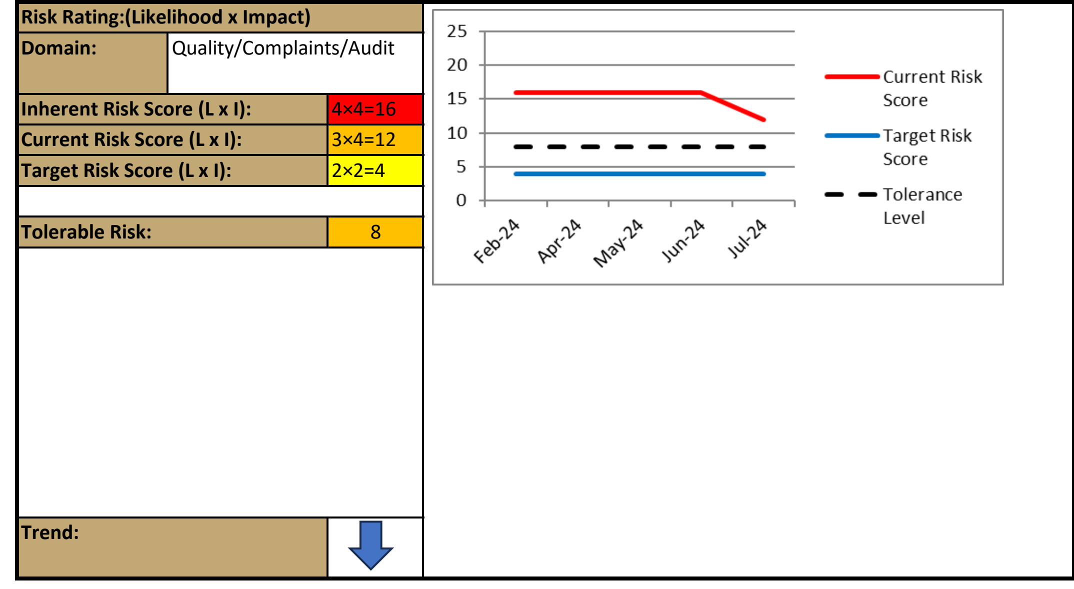
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Transfer of the radiopharmacy service to Singleton Hospital in October 2022; this means less overall activity through the Withybush Aseptic unit reducing the risk of contamination and errors. More time and resource provided to the Quality System (i.e. internal audits, investigation of near misses and microbial growths, maintaining SOPs). Increased training of aseptic staff to develop their skills and knowledge. Increase outsourcing from commercial suppliers; this limits the volume of products prepared within the unit, allowing products that must be made in-house to be prepared safely. New pharmaceutical isolators have been procured to replace the existing isolators that are beyond their working life of 10 years. The new isolators will be stored with the intention of installing into the demountable unit (if funding is secured) or will be installed into the existing unit if the current isolators fail mitigating the risk of equipment failure causing prolonged service disruption. Removal of outsourced dispensing from the Aseptic unit; this minimises the risk of contamination and potential for error. Preparation of products near to the time of use; this limits the pre-administration storage time. More stringent gowning process; this minimises contamination risk. More stringent cleaning and monitoring programmes; this minimises contamination risk and allows early detection of microbial growth. Oversight and steer from Capital Sub-Committee.	Controls are reliant on a key group of skilled staff (i.e to maintain Quality System, to follow cleaning and monitoring procedures) therefore subject to key person dependencies. Limited accommodation to employ additional staff to expand workforce within the existing unit at WGH. Limited accommodation to store starting materials and finished products or to perform the associated tasks that are required to safely supply cancer treatments. Between 2021 and 2023, the number of cancer treatments requiring aseptic preparation at Hywel Dda increased from 12,718 to 16,648 (average of 14% increase each year). There is limited space within the Pharmacy at WGH to manage this increase in demand. Lack of funding to build a new unit at WGH.	To commence tender process for building a demountable aseptic unit on site at Withybush General Hospital.	Morgan, Cerith	Completed	The Mechanical and Electrical Engineering Professional Services evaluation was undertaken on 28.02.2024. A preferred provider was selected. The project timelines are currently running to schedule. Based on current schedule, the demountable aseptic unit will be operational by November 2025 if business case approved by WG.
		To submit revised business case for demountable unit to Welsh Government (estimated £2.89m).	Morgan, Cerith	31/01/2025	The project timelines are currently running to schedule. Based on current schedule, the revised business case will be submitted to WG during January 2025.
		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	30/09/2024	Capital bids proforma submitted to Health Board capital planning team 11 June 2024

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.		To partake in annual audit (WHC 2024-004) by the Lead Quality Assurance Pharmacist.	Morgan, Cerith	Completed	Audit by Lead Quality Assurance Pharmacist was undertaken during February 2024. The audit confirmed that the facilities remain a high risk to patient safety but the control measures in place are appropriate.
							To commence "self-inspection" process where the Health Board pharmacy aseptics team will internally assess compliance of the service against QAAPS standards. Results of self-inspection to be discussed with Lead Quality Assurance Pharmacist or deputy to provide ongoing assurance that the aseptic unit complies with all other standards despite the facilities not meeting the standards.	Morgan, Cerith	~~31/07/2024~~ 31/10/2024	Initial meeting held between Cerith Morgan and Lead Quality Assurance Pharmacist. "Self-inspection" will commence July 2024 and results reviewed with Lead Quality Assurance Pharmacist or deputy during October 2024.

Date Risk Identified:	Nov-21	Executive Director Owner:	Henwood, Mr Mark	Date of Review:	Jul-24
Strategic Objective:	4. The best health and wellbeing for our individuals and families and our communities	Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-24

Risk ID:	1812	Principal Risk Description:	There is a risk of the Health Board failing to comply with Medical Examiners (Wales) regulations and Death Certification Reforms coming into force on 9th September 2024. This is caused by the failure to fully resource internal processes that enable the Medical Examiner Service to scrutinise all deaths from all acute sites. This includes in particular the provision of human and hardware resource to enable the scanning of notes on Glangwili and Prince Philip Hospital sites. This could lead to an impact/affect on the experience of the bereaved following the death of a patient and the inability to register a death in a timely manner and within required timescales. This is likely to increase the number of complaints received from bereaved families. There is also a potential impact on the Health Board's reputation through non-compliance with statutory regulations and legislation. There are missed opportunities to reduce avoidable deaths and improve clinical outcomes through the learning gleaned from Mortality Review, and a failure to consistently reviewing mortality across the Health Board in alignment with the All Wales Learning from Mortality Review Framework.
Does this risk link to any Directorate (operational) risks?			1152, 1335, 1672

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×2=4
Tolerable Risk:	8
Trend:	↓



Rationale for CURRENT Risk Score:

New processes are in place for mortality review, in line with the All Wales Learning from Mortality Framework, supported by the Clinical Lead for Mortality and Mortality Review and Improvement Facilitator. As at July 2024, 2 wards remain outstanding at GGH who require training, with this envisaged to be completed by mid-August 2024, therefore increasing scanning capacity.

As of July 2024, the risk score has been reviewed and revised to 12, with the likelihood score reduced reflecting the increased capacity to scan, along with a review of existing processes and procedures to ensure compliance with Medical Examiner requirements. The capacity for clinical scanning remains below the required level, however it has increased recently due to the appointment of a Clinical Effectiveness Co-ordinator, and the Directorate will continue to review ongoing capacity requirements.

GGH scanning staff are currently scanning some of Prince Philip Hospital (PPH) casenotes and all GGH wards.

In line with the above screening resources, the Directorate will monitor the current backlog and develop contingency plans where required.

Rationale for TARGET Risk Score:

The ability to scan and send notes to the Medical Examiner Service across all sites will enable the Health Board to meet the statutory responsibilities, by providing the information required by the Medical Examiner Service in a timely manner. Full roll-out of this service across all Health Board sites will allow for global communications to be issued, with information about the processes and responsibilities of Doctors. This will also allow for reminders to be sent when there are issues with the process, e.g. support for timely completion of the Medical Certificate of Cause of Death. The Internal Scanning Bureau being developed may provide a potential sustainable, long-term solution however won't be operational prior to 9th September 2024. As an interim measure the Health Board are looking to recruit scanning personnel on a fixed term basis, but this depends on the successful recruitment of staff in to those positions.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Processes have been developed and implemented in line with the All Wales Learning from Mortality Review Framework to manage cases received from the Medical Examiner Service, covering Bronglais, Prince Philip, Withybush and parts of Glangwili Hospitals. The Medical Examiner Service has delivered some sessions at Grand Rounds previously and there are further sessions planned (to outline the basic principles of the Medical Examiner Service and how to complete a Medical Certificate of Cause of Death), through 2024 to introduce the legislative changes once the system becomes statutory on 9th September 2024. Fortnightly Multidisciplinary Review Panel in place, which is Chaired by the Clinical Lead for Mortality and has membership including Deputy Associate Medical Director - Primary Care; Hospital Director; Head of Quality and Governance; Head of Nursing; Assistant Director of Nursing and Quality Improvement; Head of Legal Services; Clinical Pharmacy Lead for Patient Services; Clinical Effectiveness Co-ordinator; Senior Nurse Infection Prevention and Patient Safety Officer. The Mortality Review and Improvement Facilitator is responsible for co-ordinating the Panel. Datix module now being used to record all cases received from the Medical Examiner Service. Community Hospital Roll-out complete and primary care roll-out ongoing	Different processes are in place across acute sites currently to enable the scanning of casenotes to the Medical Examiner Service, with fragility remaining across sites and Glangwili Hospital being only partially rolled out. An interim solution to transfer casenotes from Prince Philip to Glangwili Hospital to be scanned also needs to be addressed. An SBAR has been developed with resource requirements to resolve this and enable the processes to be fully rolled out. The SBAR has been shared at Executive level. The potential solution of the Internal Scanning Bureau will be explored as a long term, sustainable solution, however this may not be operational by 9th September 2024. Full roll-out in Glangwili still to be achieved due to scanning resources. This is having an impact on global communications and training programmes as there is an inability to inform all staff of the new processes	Acceleration of local plans to support the full implementation in Glangwili General Hospital, and provide a sustainable solution for Prince Philip Hospital (as outlined in the SBAR).	Perry, Sarah	~~30/04/2024~~ 30/09/2024	National date amended to 9th September 2024. Local plans being accelerated to support implementation in GGH. Medical Examiner Service is almost fully operational in Hywel Dda UHB for acute and community hospital sites. Bronglais, Prince Philip and Withybush all fully operational, however there are delays being experienced with implementation in Glangwili Hospital, due to scanning capacity. Interim arrangements to scan Prince Philip case notes in Glangwili need to be addressed - the SBAR includes this. There is also some service fragility in Withybush. Detailed conversations are ongoing with regards to clinical engagement, scanning capacity and mortuary provision. Community Hospitals are fully operational. Discussions with Primary Care ongoing. As at July 2024, implementation plan has been agreed for the outstanding areas in GGH (noting no issues at PPH), anticipated to be completed by 15th August 2024.

(which is required to be in place by 9 September 2024), managed by the Medical Examiner Service, with the Health Board assisting with supporting communications. A Care After Death Steering Group has been established and is scheduled to meet bi-monthly. The Group is Chaired by the Assistant Director of Nursing, Legal Services and Patient Experience and is attended by: Head of Bereavement Services, Senior Care After Death Project Manager, Clinical Lead for Mortality, Assistant Director of Nursing and Quality Improvement, Head of Effective Clinical Practice and Quality Improvement, Assistant Director, Medical Directorate, County Director representative, General Manager (Community & Primary Care (Ceredigion), Head of Pathology, Lead Biomedical Scientist for Histology and Mortuary Services, Cellular Pathology Services Manager, Regional Mortuary Manager, Regional Mortuary Manager, Assistant Director Acute Services Nurse Representative, Head of Patient Experience, Clinical Nurse representative Women and Children, Clinical Nurse representative Mental Health and Learning Disabilities, Clinical Nurse representative Primary, Community and Intermediate Care, Specialist Bereavement Counselling Service, Chaplaincy Representative, Transplant Co-Ordinator representative, Learning and Development representative, General Practitioner representative, Psychological Services representative.	whilst there are different processes in operation in Glangwili. Processes for primary and community deaths in progress. This is being led by the Medical Examiner Service. While a Care After Death Steering Group has been established, due to operational pressures, meetings have been postponed. However, there are plans to re-establish the meeting in July 2024.	Ensure engagement on and communication of new processes to all Doctors across sites, using information, training sessions (e.g. Grand Rounds) and promotion of SharePoint information.	Hill, Carly	~~31/03/2024~~ 30/06/2024 30/08/2024	Engagement and communication is ongoing. Discussions with Hospital and Directorate Triumvirates and other Quality and Governance groups. Regular global communications have commenced, and will continue until September 2024. SharePoint pages developed not live until processes are fully in place by 15 August 2024. Training plan developed, with training remaining to be given for the two remaining wards. Wider communications need to be issued when process is fully operational. Discussion has taken place with Medical Education on programme of training for completion of MCCD. Grand Rounds session undertaken in February 2023. Communication to all Doctors has taken place in relation to responsibilities for completion of MCCD.
		Identify additional clinical staff across disciplines to screen letters received from the Medical Examiner Service.	Hill, Carly	Completed	Inclusion of request within the Autumn 2023 and Spring 2024 Medical Directorate newsletter for anyone interested in screening cases to come forward. Attempt to secure an additional Medical screener has failed over negotiations around service release. Clinical Effectiveness Coordinator has commenced in post, who is a registrant and has increased screening resources screening. Quality Improvement team are also supporting the screening effort when possible. Medical Directorate will continue to request additional screening support from operational teams.

				Explore the solution of the Internal Scanning Bureau, once operational.	Hill, Carly	30/09/2024	The tender for the scanners is due out by week ending 19/01/2024 and there is a lead in time of around 8 weeks, once a contract is awarded. Estimated time for service to be fully operational not anticipated until Summer 2024. As at July 2024, contract has been awarded for a 5 year period. 3 scanners to be installed in Dafen. Assistant Director of Medical Directorate to liaise with Head of Health Records to discuss further progress and ownership of this action.

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
Number of deaths not scrutinised. Number of Delayed MCCD's completed. Number of deaths not registered due to lack of Medical Examiner involvement.	Number of deaths and number of case notes shared with Medical Examiner Service	1st			Effective Clinical Practice Advisory Panel (05/12/2023) Effective Clinical Practice Advisory Panel (19/03/2024) Quality, Safety and Experience Committee (13/02/2024) Operational Quality, Safety and Experience Sub-Committee (14/05/2024)	The process from death to registration is not captured on one system therefore gaps in completion and delays are dependent on information sharing across organisations including Health Board, Medical Examiner Service and Registrar Offices in Carmarthenshire, Ceredigion and Pembrokeshire.	Discuss with stakeholders improved information sharing arrangements.	Hill, Carly	Completed	Continued discussions with Health Records service to identify one system, however, scanning bureau not yet operational to support this function. Once a central scanning team has been established this will support the assurance on this risk. As at July 2024, systems are in place across the four sites bespoke to their arrangements that are appropriate for the current situation, whilst awaiting the implementation of a centralised scanning bureau. No concerns have been raised by the Medical Examiners Service.
	Mortality Scrutiny Group Medical Examiner Service	1st								
	Monitored by Medical Examiner Service	1st								

WHC No	Year	Name of WHC	Link to WHC	Date Issued	Status	Category	Overarching Actions Required	Lead Director	Lead Officer	Date of Expiry / Review	Action required from	Action required by	Status RAG / R - behind schedule / A - on schedule / G - Completed	Assurance reporting	Progress update	Lead Service / Directorate	UHB implementation date	Datix risk reference and title	Additional resources required	Capital required?	Will the WHC be taken forward as part of the 2024/25 annual plan? (If this WHC will NOT be taken forward as part of the 2024/25 annual plan, the quality impacts needs to be understood, and the associated risks assessed or re-assessed)	Quality Impact Assessment (QIA) to be undertaken	Date QIA undertaken
006-18	2018	Framework of Action for Wales, 2017-2020	Not available online	01/02/2018	Action	Policy	Integrated framework of care and support for people who are deaf or living with hearing loss.	Director of Operations	Caroline Lewis	2020	Not provided	Ongoing	Red	QSEC	22/04/2024 - An Ear Wax management service has been successfully implemented across the health board, led by the Director of Primary Care, Community and Long Term Care. This addresses the first part of this WHC. The risk of non-compliance with the 2nd part of this Welsh Health Circular is monitored via Risk 1457 on the Scheduled Care risk register - 'Risk of patients not having access to Ear Wax Management pathways due to lack of Advanced Practitioner Audiologist -WHC/2018/006' (Current risk score 12). An implementation date for completing this WHC cannot be provided until funding is confirmed. This WHC has not been included in the Directorate's annual plan and a QIA is being undertaken, as requested by the Quality Safety and Experience Committee (QSEC). There has been little progress with the 2nd part of the WHC, which requires the provision of First-Point-of-Contact Audiologists in community settings. This part of the WHC is aligned to Audiology in Scheduled Care, (under the Director of Operations). If patients were able to access Audiology services directly in community locations, this would free up GP slots, meaning that some patients can be discharged after one appointment but that those who do need hearing aid / tinnitus / balance advice can be triaged appropriately. The Head of Audiology has advised that this change cannot be met as it is an additional service with a cost to providing this in the Community, rather than it being a remodelling of the existing service which Audiology provides in secondary care. The funding required has been outlined as thus: 1) First Point of Contact Audiology - Initial startup cost £206,715 in year one and £180,552 in year 2. 2) School entry hearing screening – The details of this are addressed in WHC 009-21. 3) Co-working with the Memory Assessment service - this is an ongoing project with Audiology and the memory Assessment Service. There is an Audiology 'Cognition working group' for staff with an interest in dementia care. There is an all-Wales dementia pathway being developed. This action has not been costed but it would need to be run by a Band 6 Audiology Practitioner (£35,922 - £45,257). This action has not yet been escalated and is still at the scoping stage for service delivery.	Scheduled Care	Not provided	1457 - Risk of patients not having access to Ear Wax Management pathways due to lack of Advanced Practitioner Audiologist -WHC/2018/006 (Current risk score 12)	Funding	Yes	No	Yes	In progress
026-18	2018	Phase 2 – primary care quality and delivery measures	https://gov.wales/primary-care-quality-and-delivery-measures-whc2018026	16/07/2018	Action/Information	Performance/Delivery	From this financial year (2018-19), health boards, through their clusters, should use their performance against these measures to inform all plans to adopt and adapt the transformational model for primary and community care and monitor the impact of these plans on the cluster population's health and wellbeing.	Director of Primary Care, Community and Long Term Care	Rhian Bond	Ongoing	Not provided	Ongoing	External	QSEC	Assistant Director of Primary Care (ADPC) has suggested to the Assistant Director of Nursing Assurance & Safeguarding that the primary care quality and delivery measures should be used as part of the quality indicators within the new dashboard currently being established. Heads of Primary Care (HOPC) have collated and supplied the information back on phase 1 measures to the Directors of Primary and Community Care (DPCC). Phase 2a is reported on. Awaiting national update on Phase 2b from HOPC. National work was suspended due to COVID-19. ADPC confirmed the position remains unchanged in that there has been no progress nationally on the implementation of the Phase 2 measures. ADPC also confirmed there is no risk associated with this WHC. WHC changed from 'red' to 'external' RAG status as it is reliant on national work and cannot be progressed without national developments.	Primary Care, Community and Long Term Care	N/K- reliant on progress of national work	No risk associated with this WHC	No	No	No		
033-18	2018	Airborne Isolation Room Requirements	Airborne Isolation Room Requirements	25/07/2018	Compliance	Quality and Safety	Working group's recommendations for airborne isolation, and organisations are expected to develop risk based plans to meet these requirements. In some areas this will require further investment and this now needs to be quantified and will need to be included in future IMTPs.	Director of Nursing, Quality and Patient Experience	Sharon Daniel	Jul-19	Not provided	Not provided	Red	QSEC	This WHC requires that Negative Pressure Ventilation (NPV) suites should be sited on each hospital with a 24 hours Emergency Department (ED). There are two existing negative pressure suites within the UHB that have been upgraded to conform to NPV recommendations on Bronglais (CDU) and Glangwili (ITU) estates, however it is expected that the NPV suites should be cited within admission units. The proposal for compliance is for an agreed respiratory pathway for the UHB to be sited in CDU GGH with full NPV suite, this needs to be accepted by WG as it does not fully align to the WHC requirements. Once accepted, the capital investment is to be explored. In September 2023 QSEC received an update on the Welsh Health Circular: Airborne Isolation Facilities Update who noted that despite the requirements of the WHC that was received in 2019 requiring significant capital investment from Welsh Government, creating a Negative Pressure Suite (NPS) pathway within GGH and BGH has been identified as a priority. A potential location has been identified in GGH within the Clinical Decisions Unit (CDU) and agreed in principle by senior clinicians, the Infection Prevention Control team and the Estates Department. The Committee noted that that the Ventilation Safety Group (VSG) will consider the proposal at their meeting in more detail and discuss how to progress to a feasibility survey and business case. In January 2024, WG advised that a re-audit will be undertaken by NWSSP-SES and that next steps will follow. In March 2024, the Assurance & Risk Team were advised that a request was submitted to the Health Board's Discretionary Capital Team for approval for a feasibility study for the first facility to be undertaken as soon as possible, and this has been agreed and signed off by the Glangwili General Hospital triumvirate team (as per Health Board policy). The annual all Wales survey of Health Board facilities and compliance with the Welsh Health Circular has recently been undertaken by NWSSP – Specialist Engineering Services and their feedback/report is awaited. Head of Capital Planning has the request for the first facility to be developed in Glangwili General Hospital and it features within the top 20 priorities, however, an accurate estimation of cost cannot be determined until the feasibility study has been completed. The Consultant Practitioner Infection Prevention has advised (April 2024) of the following developments regarding the first negative pressure isolation suite, to be sited at GGH, CDU: • The Health Board's Architectural Projects Team are now engaged and have done an initial site survey. • Two options have been discussed to develop room 5, CDU and now need to be subject to a more detailed design process to highlight any potential derogations from extant guidelines. • No indication of timescale or cost yet, but will be included in the detailed feasibility report. • Now need to identify another potential option at Bronglais General Hospital, as initial option rejected by Clinicians.	Nursing	Not provided	1640-Risk of harm to patients due to a lack of recommended Airborne Isolation Suites at GGH and WGH - Current Score 15	Capital Investment to be explored following proposal accepted by Welsh Government.	Yes	No - funding requested via DCP	Not at present - dependant on outcome of feasibility study yet to be undertaken.	
017-19	2019	Living with persistent pain in Wales guidance	welsh-health-circular-living-with-persistent-pain-in-wales-guidance.pdf (gov.wales)	07/05/2019	Information/Action	Health Professional Letter	Guidance for NHS staff relating to persistent pain.	Director of Operations	Lydia Davies	Apr-22	Not provided	Not provided	Amber	QSEC	27/11/2023 - A service review day was held in June 2023. Some workstreams were identified to continue to work towards meeting the WHC requirements and national guidelines in the medical pathway with initial work now underway. Implementation is likely to be staggered as each workstream comes to fruition e.g referral criteria, adherence to clinical guidelines, New and Follow Up pathway validation in line with new evidence and guidelines etc. Welsh Government (WG) relaunched these guidelines in September 2023 and the Health Board's clinical lead attended and presented at this event. The presentation on the developed ePMP (self-directed Pain Management Programme developed by Health Board leads in conjunction with OSP Healthcare digital health) was well received and much interest expressed to be able to utilise this digital programme as part of a national digital health plan. The Health Board's Director of Research, Innovation and Value and Deputy Head of Innovation & TriTech are involved in looking at the options available to utilise this programme clinically within the Health Board and wider afield. This aligns well with the Living with Persistent Pain Document (LWPP), advocating earlier and more accessible support for people living with persistent pain. The WG National Pain Leads have also set up an Operational Pain Service group, with Health Board leads attending. This group will be looking at increasing equity and consistency of Pain Service delivery across Wales, starting with the referral criteria. Part of this work is being looked at in detail via the EQIiP project to improve quality of referrals into the service and encourage more effective Pain Management work in Primary and Community Care. The British Pain Scoeity (BPS) service have two commissioned services in Primary Care clusters (North Ceredigion and Amman Gwendraeth) until 31 March 2025. Again, this is fully in line with the LWPP guidance and is evidencing the need to have pain clinicians based in Primary Care.	Scheduled Care	Jan-25	No Risk	Not known	No	TBC	TBC	

WHC No	Year	Name of WHC	Link to WHC	Date Issued	Status	Category	Overarching Actions Required	Lead Director	Lead Officer	Date of Expiry / Review	Action required from	Action required by	Status RAG / R - behind schedule / A - on schedule / G - Completed	Assurance reporting	Progress update	Lead Service / Directorate	UHB implementation date	Datix risk reference and title	Additional resources required	Capital required?	Will the WHC be taken forward as part of the 2024/25 annual plan? (If this WHC will NOT be taken forward as part of the 2024/25 annual plan, the quality impacts needs to be understood, and the associated risks assessed or re-assessed)	Quality Impact Assessment (QIA) to be undertaken	Date QIA undertaken
009-21	2021	School Entry Hearing Screening pathway	https://gov.wales/sites/default/files/publications/2021-04/school-entry-hearing-screening-pathway_0.pdf	25/03/2021	Action	Policy	Health Boards should begin implementation of the new pathway as soon as possible and seek full implementation by April 2022. Welsh Government wish for health boards to follow the recommendations below and be able to provide updates at three monthly intervals from April 2021.	Director of Operations	Jane Deans	Sep-22	Health Boards	Immediately	Red	QSEC	19/04/2024 - The shift of school hearing examinations from the School Nursing service to Audiology would ensure a higher standard of hearing assessment. The capital required to make this move (and comply with the WHC) was outlined in an SBAR presented by the Head of Audiology at Operational Quality and Safety Experience Sub Committee in March 2023. The initial start-up = £88,606.75 and thereafter a recurrent cost of £83,958.50. The risk of non-compliance with this Welsh Health Circular is monitored via Risk 1456 on Datix - Risk of sub-standard/inconsistent School Entry Hearing Screening due to lack of staff, training and equipment -WHC/2021/009 (Current risk score 8). The risk score of 8 is based on the relatively low impact on patient health as they are still receiving hearing examinations, albeit via an alternative route, and school nurses are now being provided with annual training by Audiology. The Head of Audiology has confirmed that the current system is working well and that Powys and Cwm Taf Health Boards both use a similar system, with the service provided by School Nursing rather than Audiology. The Director of Secondary Care advised in April 2023 that unless funding is being transferred from School Nursing, no funding will be available in the immediate future to move school hearing examinations from the School Nursing service to Audiology. The Directorate have therefore decided not to include this WHC in their annual plan for 2024/25 and a Quality Impact Assessment is to be completed as requested by the Quality Safety & Experience Committee (QSEC). An implementation date cannot be provided for this WHC as it is unlikely to progress. The Audiology service have proposed that the risk decision for Risk 1456 be changed to 'Tolerate'.	Scheduled Care	~~Dec-22~~ N/K	1456 - Risk of sub-standard/inconsistent School Entry Hearing Screening due to lack of staff, training and equipment -WHC/2021/009 (Current risk score 8)	Funding	Yes	No	Yes	In progress
004-22	2022	Guidance for the provision of continence containment products for children and young people: a consensus document	guidance-for-the-care-of-children-and-young-people-with-continence-problems.pdf (gov.wales)	21/10/2022	Action	Quality and Safety	Consensus guidance document regarding the provision of continence containment products to children and young people, to ensure all children and young people who have not toilet trained, or have urinary or faecal incontinence, undergo a comprehensive assessment and have access to an equitable service	Director of Operations	Tracey Humble	Aug-25	LHB Directors of Nursing	31/10/2022	Red	QSEC	18/07/2024 - Risk 1615 (Risk of CYP with continence problems not receiving containment products or service required due to lack of cohesive service) reflects current progress within the service, with a Patient Safety Domain assigned to reflect potential long-term affects on patients. The Lead Nurse for Community Paediatrics has undertaken a scoping exercise with School Nursing, Health Visiting and Paediatricians to collate current provision of the service and identify where there are gaps that are preventing closure of this WHC. A further Action Plan based on the outcomes of this exercise is to be developed going forward. There is no current budget/establishment for Paediatric incontinence in Hywel Dda. This is part of a wider service review of Hywel Dda childrens disability services as there are currently no childrens disability provision in Pembrokeshire. The service with be completing a Quality Impact Assessment for this WHC as per the request from QSEC. An options appraisal paper is being prepared for presentation at the August 2024 Women & Childrens Directorate Quality Safety and Experience meeting to consider other potential sources of funding to progress this WHC.	Women and Children's Services	~~Jul-23~~ ~~Aug-23~~ ~~Apr-24~~ ~~May-24~~ ~~July-24~~ N/K (Awaiting outcome of Options paper)	1615 - Risk of CYP with continence problems not receiving containment products or service required due to lack of cohesive service (Current score 12)	Finance	Yes	No	Yes	
017-22	2022	Wales rare diseases action plan 2022 to 2026	https://gov.wales/sites/default/files/publications/2022-06/wales-rare-diseases-action-plan-2022%E2%80%932026-whc-2022-017_3.pdf	16/06/2022	Action/Information	Policy	To work with Welsh Health Specialised Services Committee (WHSSC), Rare Disease Implementation Group (RDIG), third sector and other relevant organisations to facilitate and implement the priorities and actions outlined in the Wales Rare Disease Action Plan.	Medical Director	Debora Harry	Dec-26	All Health Boards, HEIW, WHSSC	Ongoing	Amber	QSEC	07/03/2024 - The Lead Nurse Professional Standards & Assurance was appointed as the new Clinical representative at the Rare Diseases Implementation Group in June 2023 following the departure of the original clinicain who was leading this WHC. The Rare Diseases Implementation Team have advised that the Health Board assign a Strategic representative; this post is currently held by the Head of Effective Clinical Practice and Quality Improvement. These two individuals currently represent the Health Board at the Rare Diseases Implementation Group which meets quarterly, with the last meeting taking place on 21st February 2024, and ensure that any actions required are considered locally. A revised version of the Wales Rare Diseases Action Plan 2022 – 2026 was shared at the October 2023 meeting. Recent activity has included proactively sharing information from the Rare Diseases Implemetation Group within the Health Board, such as including information about Rare Diseases Day on the Health Board's Global Email. There are currently no assigned actions for the Health Board to implement. Work around this WHC will remain ogoing until the noted completion date of 2026 or until superseded by new guidance.	Medical	31/12/2026	N/A	No	No	No	N/A	
019-22	2022	Non Specialised Paediatric Orthopaedic Services	https://gov.wales/sites/default/files/publications/2022-07/non-specialised-paediatric-orthopaedic-services.pdf	21/06/2022	Action	Quality and Safety / Information Governance / Performance / Delivery / Public Health / Policy	To ensure that this service specification is used to inform the delivery and commissioning of Non Specialised Paediatric Orthopaedic Services for children (aged up to 16 years) resident in Wales.	Director of Operations	Lydia Davies	01/04/25	All health boards	01/04/2025	Amber	QSEC	13/05/2024 - The service are awaiting further feedback and information from JCC (Joint Commissioning Committee). The Scheduled Care aspect of this WHC has been addressed. There are some actions remaining for Primary Care.	Scheduled Care	Apr-25	No Risk	Not known	No	TBC	TBC	
021-22	2022	National Optimal Pathways for Cancer (2022 update)	https://gov.wales/sites/default/files/publications/2022-07/national-optimal-pathways-for-cancer-2022-update.pdf	28/07/2022	Action	Quality and Safety	Setting out what should happen according to professional guidance and standards for any patient in Wales presenting with a certain type of cancer.	Director of Operations	Debra Benett	N/A	Local Health Boards NHS Trusts All Health Boards	30/09/2022	Red	QSEC	09/07/2024 - 11 of the 18 National Optimal Pathways (NOPs) have now been completed, with work progressing to map over and implement changes in the 7 remaining. Reviews are undertaken by the Macmillan Cancer Quality Improvement Manager (Wales Cancer Network Senior Project Manager and Senior Project Support Officer posts have now ceased). To achieve compliance with this WHC, a standardised approach to NOP reviews is needed via the production of a best practice guide which ensures engagement of key clinicians/officers and consideration of patient experience (in line with the direction of the Cancer Improvement Plan), the production of service improvement plans as a result of the NOP reviews, and the provision of a clear reporting mechanism to the Cancer Improvement Board in the future. A review of the diagnostic requirement to meet the 7-day turnaround target in NOPs has been undertaken. The review initially considered the total funding requirement to enable the diagnostic turnaround 100% (£6.45m) and then progressed to consider "deliverability" with an annual cost requirement of £2.85m. This document is currently being reviewed by the Health Board's Improving Quality Together mechanism. The risk of non-compliance with this WHC is monitored via Risk 1685 on Datix, "Risk of non-compliance with WHC 021-22 National Optimal Pathways for Cancer (2022 update) due to time taken to rollout NOPs". The risk was updated in July 2024 and the remaining 7 NOPs are outlined in the action plan section with completion dates to reflect the scale of each pathway. Urology Improvement Group and GI Improvement Group met in June 2024 and mapping of Urology and GI pathways have now commenced.	Cancer Services	~~31/08/2023~~ ~~28/02/2024~~ ~~Jun-24~~ Jul-25	1685 - Risk of non-compliance with WHC 021-22 National Optimal Pathways for Cancer (2022 update) due to time taken to rollout NOPs. Current risk score 12	Mapping of pathways is not dependent on funding however implementation in the future may require potential funding.	No	Yes - For specific pathways	No	

WHC No	Year	Name of WHC	Link to WHC	Date Issued	Status	Category	Overarching Actions Required	Lead Director	Lead Officer	Date of Expiry / Review	Action required from	Action required by	Status RAG / R - behind schedule / A - on schedule / G - Completed	Assurance reporting	Progress update	Lead Service / Directorate	UHB implementation date	Datix risk reference and title	Additional resources required	Capital required?	Will the WHC be taken forward as part of the 2024/25 annual plan? (If this WHC will NOT be taken forward as part of the 2024/25 annual plan, the quality impacts needs to be understood, and the associated risks assessed or re-assessed)	Quality Impact Assessment (QIA) to be undertaken	Date QIA undertaken
032-22	2022	Further extending the use of Blueteq in secondary care	https://www.gov.wales/sites/default/files/publications/2023-03/further-extending-the-use-of-blueteq-in-secondary-care.pdf	21/03/2023	Action	Health Professional Letter	Guidance regarding the Implementation of the high-cost drugs reporting system.	Director of Primary Care, Community and Long Term Care	Chris Brown	Apr-24	Medical Directors, Finance Directors, Chief Pharmacists, Local Health Boards and NHS Trusts	01/04/2023	External	QSEC	10/05/2024 - Implementation will be staged and in accordance with priorities set out by the national steering group. The national roll out of Blueteq, a high-cost drugs reporting system, will be managed by the All Wales Blueteq Steering Group, with management support from All Wales Therapeutics & Toxicology Centre on behalf of WG. The Health Board has representation on the Blueteq Steering Group with national drug approval templates being developed on a Once for Wales approach. As at March 2024 the Lead Clinical Development Pharmacist confirmed that there is a delay in implementation due to Information Governance issues with Cardiff and Vale University Health Board affecting work nationally taking place. Discussions continuing nationally to resolve and progress with implementation.	Medicines Manager	~~Apr-24~~ N/K	N/A	No - Blueteq is procured by Welsh Health Specialised Services Committee (WHSSC)	No	No	No	
030-23	2023	New 2023 National Safety Standards for Invasive Procedures (NatSSIPS2) by the Centre for Perioperative Care (CPOC) and Patient Safety Notice PSN 034	https://www.gov.wales/sites/default/files/publications/2023-08/new-2023-national-safety-standards-for-invasive-procedures-natssips2-by-the-centre-for-perioperative-care-cpoc-and-patient-safety-notice-psn.pdf	11/08/2023	Action	Quality & Safety	Organisations are expected to act on NatSSIPs2 and ensure that the actions specified in PSN034 are applied accordingly.	Medical Director	Lisa Davies	N/A	Local health boards and NHS trusts, primary care providers.	Immediate	Red	QSEC	11/07/2024 - The Medical Directorate are developing an action plan in response to National Safety Standards for Invasive Procedures (NatSSIPs 2). An initial Steering Group meeting took place on 31 January 2024, with an agreement reached to capture the NatSSIP's recommendation on the Audit Management and Tracking (AMaT) system and to develop 'Must Do/Should Do' actions which will then be assigned to the relevant teams. It has been recognised that Supporting professional activities (SPA) time and administrative support will be necessary, as well as appropriate funding. Further funding may also be required to enable subsequent implementation of the recommendations. Oversight of the implementation of recommendations will be managed through a series of sub-groups which will report into the Steering Group. The Steering Group will therefore remain small and focused, with a limited number of members but which will include the Chairs of the sub-groups representing and reporting in. It was proposed that the Steering Group reports through the Effective Clinical Practice Advisory Panel. An audit/scoping exercise of current practice across the site will be carried out, reviewing major and minor procedures. An interprofessional awareness raising exercise will also be undertaken In April 2024, the Head of Effective Clinical Practice & Quality Improvement confirmed that in the absence of a Clinical Director for Clinical Effectiveness, Dr Subhamay Ghosh, Associate Medical Director has been nominated as the Health Boards organisational representative for NHS Executive to liaise with, regarding NatSSIPS and next steps. Discussions at the most recent steering group meeting explored how progress may be continued. A meeting also took place with Scheduled care, specifically Theatres, who have given some assurance that they have done a reasonable amount of work already, with an aim to map out remaining areas affected. In June 2024 the plans were presented to the Operational Planning and Delivery Group (OPDG) for organisational oversight and input on how to progress with relevant services outside of the Theatre setting.	Medical	N/K (No date identified as reliant on further scoping and input of key services)	N/A	08/04/2024 - further scoping is required to see if funding is needed	No	No	No	
031-23	2023	AMR & HCAI IMPROVEMENT GOALS FOR 2023-24	https://www.gov.wales/sites/default/files/publications/2023-08/amr-hcai-improvement-goals-for-2023-24.pdf	22/08/2023	Action/Information	Quality and Safety	What we expect health boards and trusts to do to reduce healthcare associated infections and antimicrobial resistance.	Director of Nursing, Quality and Patient Experience	Fances Howells	Mar-24	Health Boards/Trusts: Chief Executives Medical Directors Nurse Executive Directors Infection Control Doctors & Nurses	Immediately	Red	QSEC	The WHC goals for Healthcare Associated Infection (HCAI) are unchanged from last year and whilst the Health Board remains non-compliant for HCAI's, the Health Board is showing signs of improvement for both C.difficile infections and Staph aureus bacteraemias. Improvements have also been noted in Antibiotic stewardship in both Primary and Secondary Care. The Directorate are also working on an 'All Wales' basis with Public Health to identify potential geographical areas and at-risk groups to target a joint health promotion campaign aimed at prevention. It is noted however that Gram negative bacteraemias remain a concerning picture and experienced across Wales. The Health Board is currently working towards the goals of the current 5 year National Plan. A HCAI Action Plan is in place and regularly reviewed, with work ongoing. The next review of the action plan is due in March 2024, after which a revised implementation date will be sought. The risk of non-compliance with this WHC is monitored via Risk 1734 - Risk of patient harm due to increase of nosocomial transmission of HCAI due to reduced bed spacing. Current control measures noted to manage and mitigate this risk include the provision of Infection Prevention & Control (IP&C) policies, and face to face Mandatory training, to all staff groups to inform of standards and policies (including personal protective equipment and transmission-based precautions). The Infection Prevention & Control E-Learning modules are regularly reviewed to track compliance. Antibacterial hand gel is now available within the patient bed areas and at point of care. Risk assessments of patients that are in closer proximity, and in corridors, are being undertaken to ensure that non-infectious patients only are assessed in these areas. New battery-operated agile cleaning machines have been purchased to enable easier access in confined spaces. Head of Infection Prevention and Consultant Practitioner Infection Prevention to liaise with other Health Board's to determine how other Health Board's are recording on their tracker. The Isolation Facilities will be in the capital programme. Discussions to be held with Head of Capital Planning to determine the likelihood of funding into 2024/25 as this is the area where the QIA may be considered.	Nursing	N/K	1490 (Increased risk of patient harm due to escalating rates of Clostridioides difficile Infection (CDI)). (service level, current risk score 12)	No	No	No - not reliant on funding it is more related to practice – any funding for this would sit within the facilities space aligned to cleaning.	Yes	Awaiting update from Simon Chiffi to advise
040-23	2023	The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC)	https://www.gov.wales/newborn-and-infant-physical-examination-cymru-whc2023040-html	09/11/2023	Action	Workforce/Quality & Safety	The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC) have published new set of guidelines and standards for the Newborn and Infant Physical examinations for implementation by health boards in Wales.	Director of Operations	TBC	Nov-23	Local health boards Maternity and neonatal services	Nov-23	External	QSEC	18/07/2024 - A meeting with medical leads in January 2024 confirmed the Health Board is compliant with the practical and training elements of this WHC, including education, ESR model and clinical aspect of the newborn physical examination. There is no national or local system currently available to comply with data capture requirements, therefore the status of this WHC has been changed to 'external' (i.e. outside the gift of the Health Board to comply with at this time). This barrier will remain until an all-Wales data system becomes available. The Head of Midwifery confirmed at the Women & Childrens QSE meeting on 27 June 2024 that there has been no further update on this. New Lead Officer to be confirmed.	Women and Children's Services	N/K	No	Digital solution at an all--Wales level	No	No	No	
005-24	2024	Private obesity surgery and the Welsh NHS	https://www.gov.wales/private-obesity-surgery-and-welsh-nhs-whc2024005	01/02/2024	Compliance	Governance	In recent years, people are increasingly looking to the private sector for management of obesity including bariatric surgery. Successful private sector marketing, particularly from cheaper international providers, strongly appeals to the public. However, there are clear pressures impacting on NHS services due to complications (including death), litigation arising from complications and long term follow up requirements	Director of Therapies and Health Science	Head of Nutrition and Dietetics Service (Zoe Paul-Gough)	N/A	Local health boards Primary Care services NHS Executive	Immediate	Amber	QSEC	18/04/2024 - Head of Nutrition & Dietetics confirmed the Therapies & Health Sciences Directorate are happy to co-ordinate the response to the WHC as the actions cut across several Directorates (Therapies/Primary Care/Women & Children). A scoping exercise is currently underway with additional information awaited from an All-Wales group as well as the Health Board's tertiary provider. 19/04/2024 - Update received from Head of Nutrition & Dietetics, advising that discussions are being held with the Welsh Institute of Metabolic and Obesity Surgery (WIMOS), via the National Level 4 Obesity Group, to identify, if they are unable to provide post operative follow up, the expectation for others for training needs/ risks etc. Information developed for pregnant bariatric women already and a presentation developed/ pathway under development currently (as was flagged as highest risk). Further update to follow.	Therapies	Oct-24		TBC	TBC	TBC- Awaiting response from Service to email sent on 12/03/24)	TBC	

WHC No	Year	Name of WHC	Link to WHC	Date Issued	Status	Category	Overarching Actions Required	Lead Director	Lead Officer	Date of Expiry / Review	Action required from	Action required by	Status RAG / R - behind schedule / A - on schedule / G - Completed	Assurance reporting	Progress update	Lead Service / Directorate	UHB implementation date	Datix risk reference and title	Additional resources required	Capital required?	Will the WHC be taken forward as part of the 2024/25 annual plan? (If this WHC will NOT be taken forward as part of the 2024/25 annual plan, the quality impacts needs to be understood, and the associated risks assessed or re-assessed)	Quality Impact Assessment (QIA) to be undertaken	Date QIA undertaken
002-24	2024	Standards for Competency Assurance of Non-Medical Prescribers in Wales	https://www.gov.wales/standards-competency-assurance-non-medical-prescribers-wales-whc202402	04/03/2024	Action	Health Professional Letter	All health boards, Velindre NHS Trust, the Welsh Ambulance Services NHS Trust, and Public Health Wales NHS Trust are required to implement the standards for competency assurance of non-medical prescribers within their organisation by 31 March 2026 at the latest. To support implementation, these organisations are required to develop an implementation plan with the support of HEIW by 30 September 2024. All health boards, Velindre NHS Trust, the Welsh Ambulance Services NHS Trust, and Public Health Wales NHS Trust should identify an appropriate senior manager within their organisation to be responsible for developing the implementation plan and whose details should be shared with HEIW by emailing Karen.Brambles@wales.nhs.uk by 28 March 2024.	Director of Primary Care, Community and Long Term Care	Chris Brown	Apr-26	Chief Executives, Nurse Directors, Directors of Therapies and Healthcare Science and Chief Pharmacists. Local Health Boards, Velindre University NHS Trust, Welsh Ambulance Services	31/03/2026	Amber	QSEC	09/04/2024 - Part 1 of the WHC required a nominated lead to be submitted to Health Education and Improvement Wales (HEIW) by 28/03/24 and this was submitted on 26/03/24. Part 2 of the WHC is to develop an implementation plan with the support of HEIW by 30/09/24. This is being led by the Assistant Director of Nursing (Corporate Nursing Directorate). Part 3 of the WHC sets out a requirement for all health boards, Velindre NHS Trust, the Welsh Ambulance Services NHS Trust, and Public Health Wales NHS Trust to ensure arrangements for employing, supervising and reviewing the practice of non-medical prescribers comply with the standards in Wales no later than 31/03/26. In April 2024, the Assistant Director of Nursing advised that she is meeting with key stakeholders to agree on plans for implementation.	Medicines Management	Mar-26	N/A	N/A	N/A	N/A	N/A	N/A
011-24	2024	Changes to dietary advice on feeding young children aged 1-5 years	https://www.gov.wales/changes-welsh-government-dietary-advice-young-children-whc2024011	06/03/2024	Action	Workforce	Changes to Welsh Government dietary advice for young children aged 1 to 5 years following acceptance of recommendations made by the Scientific Advisory Committee on Nutrition (SACN) in its report on 'Feeding young children aged 1 to 5 years' The role of SACN is to provide independent scientific advice on, and risk assessment of, nutrition and related health to the 4 UK Governments	Director of Therapies and Health Science	Karen Thomas	Apr-27	Local Health Boards	Immediate	Amber	QSEC	20/03/2024 - Joint Head of Dietetics will lead on the Health Board response. This will require input from a range of services/areas including Paediatrics, Health Visiting, School Nursing, Public Health, Flying Start as well as others. A meeting is to be organised to scope out what needs to change. 08/04/2024 - The Joint Head of Dietetics has emailed leads in the following services: Health Visiting, Public Health, Acute Paediatrics, Community Paediatrics, School Nursing & Childhood Immunization, Lead Pharmacist requesting confirmation that the WHC has been cascaded / communicated to their respective teams, and that any changes required to information / resources / training & education have been identified within their service area and the actions needed have been taken to update these in line with the WHC.	Therapies	Sep-24	N/A	TBC	TBC	TBC - awaiting response from Service (email sent 08/03/24).	TBC	TBC
012-24	2024	Nursing Preceptorship & Restorative Clinical Supervision - A National Position Statement	https://www.gov.wales/nursing-preceptorship-and-restorative-clinical-supervision-position-statement-whc2024012	19/03/2024	Compliance/Action	Workforce/Health Professional Letter	The recent years of unprecedented pressure and strain on the NHS workforce have outlined the need for nationally consistent direction around career spanning support for staff to be factored into our long-term workforce policy. From a preceptorship programme for newly registered nurses to a framework of restorative clinical supervision to continue supporting them throughout their careers. To that end I commissioned a project to be undertaken in my office scoping current practice in Wales and reviewing best practice from around the world to inform a recommended policy direction.	Director of Nursing, Quality and Patient Experience	Janice Cole-Williams	Oct-25	Chief Executives, Executive Directors of Nursing, Directors of Workforce & OD	01/07/2024	Amber	QSEC	24/03/24: Director of NQPE has confirmed that this WHC will sit within the NQPE portfolio. Assistant Director of Nursing to lead.	Nursing	Jul-24			TBC	TBC	TBC	
006-24	2024	National Clinical Guideline for Stroke, for the UK and Ireland	https://www.gov.wales/national-clinical-guideline-stroke-whc2024006	21/03/2024	Action	Quality and Safety/Delivery	This Welsh Health Circular provides a National Clinical Guideline for Stroke for the UK and Ireland. The National Clinical guideline for Stroke provides authoritative, evidence-based practice guidance to improve the quality of care delivered to every adult who has a stroke in the United Kingdom and Ireland, regardless of age, gender, type of stroke, location, or any other feature.	Director of Operations	Bethan Andrews	N/A	All NHS Trusts, Health Boards	Immediate	Red	QSEC	The WHC cannot be implemented until the Clinical Services Plan has been completed (Stroke Services are part of this wider plan as there is a current lack of resource, including staffing, equipment and environment).	Unscheduled Care (WGH)	N/K - until completion of the wider Clinical Service Plan.	233 - Risk of poor patient outcome due to insufficient stroke therapy staff & lack of 7 day Consultant affecting the Health Board (Current Risk Score 12).		Yes	No - Stroke Services are part of the wider Clinical Service Plan	To be undertaken in June 2024	To be undertaken in June 2024
016-24	2024	Healthy Child Wales Programme: for school aged children	https://www.gov.wales/healthy-child-wales-programme-school-aged-children-whc2024016	11/04/2024	Action/Information	Quality & Safety	The Healthy Child Wales Programme for school aged children is a new unified operating model for School Nursing Services which provides a programme of planned universal health contacts for all compulsory school aged children (aged 5 - 16 years) in Wales, regardless of setting.	Director of Operations	Barbara Morgan	Apr-26	Chief Executives NHS Wales Executive Directors of Nursing Directors of Nursing	Immediate	Amber	QSEC	20/06/2024 - Healthy Child Wales Programme (HCWP) 2 was launched by Welsh Government on 30 April 2024. All Health Boards have 2 years to implement the programme. There has not yet been any confirmation of what data the WG will want to monitor. A risk around compliance with this WHC may be considered at a later date once more information is known about what is required. The service have begun collection of data in readiness, with some assumptions made about what data will need to be reported.	Women and Children's Services	Apr-26	No	Information from WG regarding data required.	No	No	No	

WHC No	Year	Name of WHC	Link to WHC	Date Issued	Status	Category	Overarching Actions Required	Lead Director	Lead Officer	Date of Expiry / Review	Action required from	Action required by
024-24	2024	Implementation the agreed approach to preventing Violence and Aggression towards NHS staff in Wales.	https://www.gov.wales/anti-violence-collaborative-obligatory-responses-document-whc2024024-html	17/05/2024	Action	Workforce	To inform organisations of the refreshed Obligatory Responses to Violence in Healthcare Document including the requirements to implement and report upon violent incidents as set out in document	Director of Workforce & OD	Lisa Gostling	N/A	Chief Executives, NHS Wales Health Boards/Trusts/Special Health Authorities Directors of Workforce, Health Boards/Trusts/Special Health	Immediately
025-24	2024	NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2024/25	https://www.gov.wales/nhs-wales-national-clinical-audit-and-outcome-review-plan-2024-2025-whc02524	04/06/2024	Information/Action	Health Professional Letter	The annual National Clinical Audit and Outcomes Review Plan confirms the list of National Clinical Audits and Outcome Reviews all health boards and trusts are expected to participate in 2024-25 (where they provide the service). The plan confirms how the findings from audits and reviews will be used to measure and drive forward improvements in the quality and safety of healthcare services in Wales.	Director of Nursing, Quality and Patient Experience	Ian Bebb	Apr-25	Health Boards and NHS Trusts National Clinical Leads	N/A
027-24	2024	All Wales Critical Care Escalation Guidance for the Management of All Large Unplanned Increases in Demand	https://www.gov.wales/critical-care-escalation-guidance-whc2024027	19/06/2024	Information	Policy	Publication of revised All Wales Critical Care Escalation Guidance. These guidelines replace all previous versions of escalation and emergency planning guidance for critical care services issued by the Welsh Government.	Director of Operations	Keith Jones	Until replaced	Health Boards and NHS Trust in Wales	Immediate

WHC No	Status RAG / R - behind schedule / A - on schedule / G - Completed	Assurance reporting	Progress update	Lead Service / Directorate	UHB implementation date	Datix risk reference and title	Additional resources required	Capital required?	Will the WHC be taken forward as part of the 2024/25 annual plan? (If this WHC will NOT be taken forward as part of the 2024/25 annual plan, the quality impacts needs to be understood, and the associated risks assessed or re-assessed)	Quality Impact Assessment (QIA) to be undertaken	Date QIA undertaken
024-24	Red	QSEC		Workforce & OD	TBC	N/A	TBC	TBC	TBC	TBC	TBC
025-24	Amber	QSEC	The Clinical Audit team are supporting the Clinical Audit Project Programme and have met with the Clinical Audit Department to review participation. Out of the 38 (approximate) clinical audits applicable to the Health Board, the Health Board are expecting to participate to a high level (92%). Services are continuing to contribute to the vast majority of projects and are expected to provide an improvement plan and risk assessment for areas of poor or no participation, and include risks on the Service risk registers, if appropriate. Concerns with participation have been identified in 3 (8%) of the projects and are being discussed directly with auditing teams, before being escalated as appropriate. In addition, the Clinical Audit Scrutiny Panel review all instances of low or no participation and schedule meetings with audit/service leads to discuss. Various reports are provided to CASP, QSEC and Operational Groups.	Nursing	Mar-25	N/A	TBC on a case by case basis	TBC	TBC	TBC	TBC
027-24	Amber	QSEC	28/06/2024 - Director of Secondary Care confirmed this WHC sits with Acute Services but spans two separate operational directorates: Scheduled Care (adult critical care) and Women & Childrens (Paediatric and Neonatal transfers). Whilst this WHC is for information, evidence of compliance with Actions 5, 6 & 7 has been requested from the Directorate Leads for Scheduled Care and the Women & Childrens Directorates to be presented and reviewed at ALG in August 2024.	Acute Services	Aug-24			No	No	No	