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

Assurance and Risk Report

Quality, Safety & Experience Committee – 4 December 2025

Situation

This report provides the Quality, Safety & Experience Committee (QSEC) with the status of the Corporate risks, Welsh Health Circulars, and Ministerial Directions within its remit.

The Committee is asked to seek assurance from the Lead Executive Directors that risks are being managed effectively, and that recommendations from Audits and Inspections are being implemented by the Health Board.

Principal risks, Operational Risks, and Audit and Inspections recommendations are reported at alternate meetings, and due to be presented to QSEC at its next meeting in February 2026.

Corporate Risks: 10

Welsh Health Circulars 23

Ministerial Directions 5

Risk Management - Overview

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

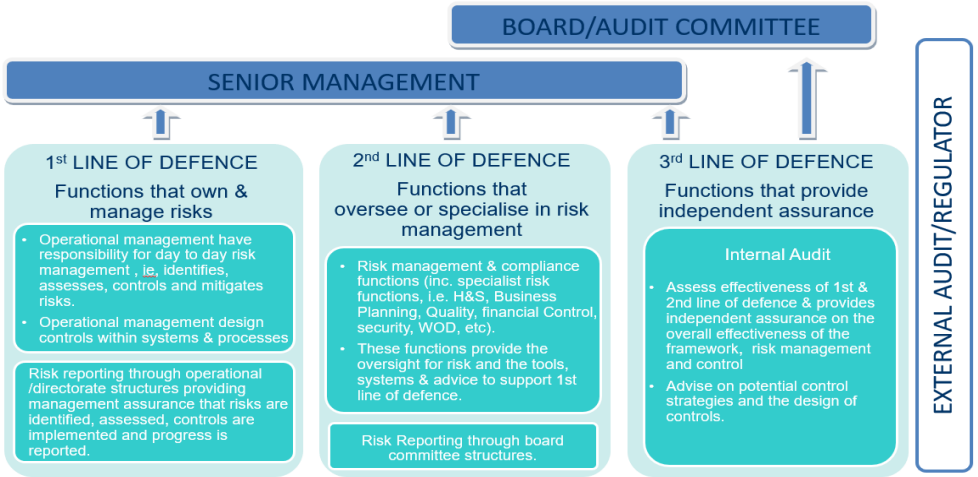
The Health Board's risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either Principal, Corporate or Operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval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

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

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

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

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



Corporate Risks Assigned to QSEC

Hywel Dda Risk Heat Map					
	LIKELIHOOD →				
IMPACT ↓	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5			1531 (→) 1810 (→) 1859 (→)	1027 (→)	797 (↑)
Major 4				684 (→) 1664 (→) 2190 (NEW)	1032 (→) 1552 (NEW)
Moderate 3					
Minor 2					
Negligible 1					

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

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

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

There are 10 risks currently aligned to QSEC of the 23 that are on the CRR as of 24 November 2025.

The following slides provides a summary of the changes to the risks aligned to QSEC since the report submitted previously to in August 2025, and detail on the reportable corporate risks.

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

Corporate Risks Assigned to QSEC – changes since previous meeting

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Risk	Clinical Care Group / Lead Executive	Nature of Change	Reason for change
1708 - Risk of increasing fragility in primary care contractor services due to external factors	Primary, Community Strategy and Long-Term Care: Primary Care *Chief Operating Officer*	**De-escalated** to operational risk register (August 2025)	As agreed at Formal Executive Team, risk de-escalated as whilst there will always be a risk of contract terminations across the Primary Care contractor professions, the Health Board have a statutory duty to deliver services in line with Regulations and Directions, and issues are managed when they arise.
1552 - Risk of insufficient mortuary capacity due to current and anticipated future demand	Operational Allied Health Professions and Health Sciences: Pathology *Chief Operating Officer*	**New risk** (November 2025)	Full risk is included in Appendix 1 to this paper, and summarised here
2190 - Risk of delay in CHC direct payments due to short timescale, limited resources & lack of WG policy guidance	Primary, Community Strategy and Long-Term Care: Long Term Care *Chief Operating Officer*	**New risk** (November 2025)	Full risk is included in Appendix 1 to this paper, and summarised here
797 - Risk to the ability to deliver ultrasound services due to workforce pressures	Operational Allied Health Professions and Health Sciences: Radiology *Chief Operating Officer*	**Increase in current risk score** from 20 to 25 (October 2025)	Full risk is included in Appendix 1 to this paper, and summarised here

Corporate Risks assigned to QSEC (1 of 10)

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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1552 – Risk of inadequate body storage capacity across Health Board mortuaries due to current and anticipated future demand	**Chief Operating Officer**	**20 (NEW) (Reviewed 19/11/25)**	**8**	**31/08/2026**

Rationale for Current Risk Score

The Health Board is exposed to significant risks resulting from insufficient mortuary capacity across its estate. The ongoing dependence on temporary body storage, particularly during periods of excess deaths, presents challenges in maintaining regulatory compliance, protecting staff wellbeing, ensuring safe manual handling practices and upholding the dignity of the deceased. The current infrastructure risks non-compliance with Human Tissue Authority (HTA) standards. According to Office of National Statistics (ONS) projections, the death rate is expected to rise, peaking in 2044, further intensifying these pressures.

Suboptimal facilities may lead to compromised presentation of the deceased, increased emotional distress for families, and safety concerns for mortuary staff, especially manual handling. While control measures are in place, they are not sufficient to manage the current volume of deaths within the mortuary service, particularly during periods of heightened demand. These control measures should serve only as temporary contingencies, in line with the HTA licence however, there is a growing need for enhanced storage capacity throughout the year, not solely during seasonal peaks.

Current body storage provisions do not meet operational requirements, and there is limited flexibility to respond to unplanned disruptions, such as those involving Medical Examiners Service, His Majesty's Coroner Service, or Post-Mortem Service interruptions. Furthermore, the extremely constrained footprint of the mortuary estate significantly restricts opportunities for external expansion or enhancement.

Rationale for Target Risk Score (TRS)

Target score is based on successful outcome from Body Storage Capacity paper being escalated via CCG to IQFPD in June 2025. Funding stream discussed with Executive Director of Finance in July 2025 along with further meetings and support from the Health Board's finance and planning team to ensure a long-term sustainable solution is implemented as soon as reasonably possible. Assurance has been provided by the Executive Director of Finance that financial support will be received to enact the short-term measures to ensure appropriate capacity is available for the approaching winter pressure period. Further discussions will be held with finance and planning colleagues to discuss medium- and long-term mitigating plans.

Long term solution need to be sustainable and future proof to ensure the target risk score is achieved and maintained.

TRS and expected date to achieve have been agreed by Formal Executive Team in November 2025

Corporate Risks assigned to QSEC (2 of 10)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2190 – Risk of delay in CHC direct payments due to short timescale, limited resources & lack of WG policy guidance	**Chief Operating Officer**	**16 NEW (Reviewed 20/11/25)**	**12**	**31/03/2026**

Rationale for Current Risk Score

There is a lack of clarity and national guidance regarding the proposed model for the delivery of Direct Payments, and the time available for implementation which has reduced significantly with proposed date of implementation brought forward from December 2026 to 1 April 2026. There are serious concerns that governance and safety requirements will not be adequately established to meet the revised implementation date, which may increase the risk of inconsistent approaches across Health Boards. The Health Board does not currently have a system in place to manage or deliver Direct Payments in order to comply with the requirements of the forthcoming policy. Robust governance systems have yet to be developed, and there is a notable absence of dedicated resource, and specialist expertise. Delivery within such tight time scales will require additional resources, with a small core of dedicated staff based within a national Hub supported by professional and financial expertise. Each Health Board will also be expected to put in local arrangements to support delivery at a local level. Without additional resources, staff may be unable to allocate sufficient time to support implementation alongside existing duties.

Rationale for Target Risk Score (TRS)

A dedicated local resource is needed to meet legislative requirements by 1 April 2026. Clarity is needed from Welsh Government over guidance and implementation plans to enable robust governance and safety requirements. All Health Boards in Wales require a consistent approach to direct payments. Whilst the implementation date is end of March 2026, there is no certainty that this can be achieved without the additional governance and resources.

Corporate Risks assigned to QSEC (3 of 10)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
797 – Risk to the ability to deliver ultrasound services due to workforce pressures	**Chief Operating Officer**	**25 (↑) (Reviewed 26/11/25)**	**12**	~~**31/07/2027**~~ **30/03/2030**

Rationale for Current Risk Score

This risk was escalated from 20 to 25 in October 2025 due to increased fragility in available workforce (2.0WTE retirement notice given Jan 2026). In November 2025 a full risk review of all elements took place with Radiology and CCG leadership.

Patient outcomes = delays to scans resulting in delays to treatment or death (cancer and maternity pathways)
Workforce outcomes = staff harm from RSI resulting in long term injury from too much scanning of similar types (unable to job plan appropriately due to demand and vacancies).
Quality, complaints and audit - (5)
Totally unacceptable level or quality of treatment/service.
*due to waiting times (see below) patients on maternity and cancer pathways are waiting too long for scans required for intervention
Gross failure of patient safety if findings not acted on.
*concerns regarding non compliance with Welsh Maternity screening targets
Gross failure to meet national standards / performance requirements. As at 25 November 2025:
*Waiting times non-interventional ultrasound are up to 23 weeks
*Interventional ultrasound 52 weeks
*Vascular ultrasound is not available 7 days a week

Probability = >95%. If insourcing capacity cannot be secured from the 1st January 2026 the service will no longer be able to sustain a safe baseline capacity to provide routine and urgent non-obstetric imaging alongside obstetric scanning Monday to Friday, 09:00–17:00 on the WGH site.

Rationale for Target Risk Score (TRS)

Impact of service failure remains the probability of service failure is the aim of mitigating actions.

Probability target of 25-75%.

In November 2025, the target date was reviewed and extended. Justification for this change is the timeline for Radiology Leadership OCP and recruitment to bring in the leadership required to mitigate the gaps in controls thus requires extended timelines due to pathways changes and training timelines.

Corporate Risks assigned to QSEC (4 of 10)

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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1027 – Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	**Chief Operating Officer**	**20 → (Reviewed 12/11/25)**	**8**	~~**31/03/2026**~~ **31/10/2026**

Rationale for Current Risk Score

Levels of urgent and emergency care (UEC) pathway capacity pressures continue at significantly escalated levels. Workforce deficits, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating lack of sustainable improvement. The situation remains at high levels of risk escalation across our acute sites daily. The Front Door Reset week in September 2025 has shown improvements in Ambulance handover delays but this will be challenging to sustain in the longer-term.

Whilst some positive progress has been achieved in reducing ambulance handover delays and getting the scores for this domain below Targeted Intervention (TI) expectations in the last couple of months, the other key metrics remain outside TI requirements. Despite a trend line indicative of slight improvement over the year, October 2025 has 8.5% of people waiting > 12 hours in an ED. This is above the TI target of 6% and up from 8% in September 2025. For Emergency Department (ED) assessment waits, October's average is 78 mins which is above the TI target of 60 and an increase on September's average. Over the year the trend has been fairly static for this metric and has not met TI targets. Finally, Pathway of Care Delays (PoCD) in October were 258, above the TI target of 174. PoCD has shown an increasing trend over the last year and remains the most challenging TI metric for the Health Board currently. Work is ongoing with Local Authorities to try and improve the position, as well as internal actions such as ongoing front door reset actions and the making everyday count reset week. Notable actions from these include a focus on redirection policy, community staff integration into sites, optimisation of discharge lounge and more senior leadership presence in board rounds.

Rationale for Target Risk Score (TRS)

The target risk score of 8 reflects the confidence in the delivery of 6 Goals Programme and the Accelerated Transformation Programme to address the significant issues across the health and care system.

Plans for improvement during 2025/26 are reflected in the HB's Annual Plan, approved by the Board in March 2025, and are informing next year's Annual Plan. The 6 goals plan was approved by WG in March 2025. TI measures such as ambulance handovers and 12 hour delays in ED will need to improve in order to reduce the current risk score, for a consecutive period of three months. UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly into Formal Executive Team.

An expected date of March 2026 had been noted to achieve the target risk score of 8, to allow the transformation change to embed. The embedding of 7-day Clinical Streaming and SDEC services will be thought to significantly impact on patient flow and a business case for this is planned to go to Public Board in January 2026 for discussion. If approved time will be needed for recruitment and embedding of services, as such it is expected that there will may be a delay in hitting the March 2026 target score of 8. The expected date to achieve TRS amended to 31 October 2026 on risk review in November 2025.

Corporate Risks assigned to QSEC (5 of 10)

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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1032 – Risk of timely ASD diagnostic assessment for children and young people due to increasing demand	**Chief Operating Officer**	**20 → (Reviewed 11/11/25)**	**16**	**Not known**

Rationale for Current Risk Score

Significant waiting times have developed as a result of exponential demand. Demand outstrips capacity, with year-on-year increase in referral rates. Current team capacity can only accommodate 11% of total demand, compounded by current funding arrangements which are non-recurring, making recruitment and service delivery challenging.

Rationale for Target Risk Score (TRS)

The Clinical Care Group has prioritised implementation of Patient Administration System for Wales (WPAS) in Children's Autism Spectrum Disorder (ASD) service which has enabled improved reporting and waiting list management and to determine trajectories of improvement in waiting times. While trajectory plans are in place, the Health Board has recognised Welsh Government (WG) targets will not be achieved by the service in its current format, with a further deteriorating position in performance anticipated, compounded by the end of procurement contracts with external providers in March 2025.

The achievement of the target risk score is dependent on WG ring-fenced funding being made available on a recurrent basis, being exempt from cost savings initiatives 2025-2026 to maximise opportunities to outsource diagnostic assessments this financial year, service re-design and waiting list initiatives are completed and implemented. Furthermore, the development of a regional, collaborative strategic approach with key stakeholders is imperative to creating whole system, needs-led integrated services. Digital enablers such as artificial intelligence and licenses for digital platforms essential along with access to appropriate clinical venues essential to help reduce the current risk score to the target risk score.

Corporate Risks assigned to QSEC (6 of 10)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
684 - Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	**Chief Operating Officer**	**16 → (Reviewed 18/11/25)**	**8**	**Not Known**

Rationale for Current Risk Score

The Health Board's aged imaging equipment continues to break down, disrupting diagnostic services and affecting Referral to Treatment (RTT) targets, with delays in diagnosis and treatment for patients. Replacement of CT and MRI scanners has reduced downtime, but recurrent failures of other key equipment highlight the need for further investment. A rolling programme and prioritisation process are in place to manage installations.

The Gamma camera at Withybush General Hospital (WGH), the only unit of its kind in the Health Board, has suffered repeated breakdowns, leading to HIW-reportable IRMER incidents. It remains a priority for replacement as of February 2025. At Glangwili, a new CT scanner has been installed, but the original unit continues to fail due to outdated technology, undermining resilience at the major trauma site. Like-for-like replacement is not always cost-effective or compliant with regulatory and warranty requirements, and infrastructure upgrades—such as air handling, water chillers, and accommodation adjustments—are needed to ensure long-term resilience.

Replacement of the Gamma camera at WGH has been delayed due to insufficient physical space and electrical infrastructure, with costs exceeding Welsh Government allocations for 2025/26. The funding window has closed, further impacting compliance with Natural Resources Wales (NRW) specifications for Nuclear Medicine. Future plans must be coordinated with Estates to expand electrical capacity and ensure facilities meet current and future Nuclear Medicine requirements.

Rationale for Target Risk Score (TRS)

Modern equipment will reduce the likelihood of breakdowns, minimize downtime, and lessen the impact on diagnostic services across other hospital sites. Strengthened business continuity planning will further mitigate risks associated with equipment failure. However, funding is typically released in Q3/Q4 of the financial year, constraining the scheduling of large installations. The urgency of replacements often forces rapid decisions, resulting in lower-priority equipment being replaced ahead of higher-need installations.

The Health Board's top replacement priority is the Nuclear Medicine SPECT scanner, the only unit available which has suffered frequent breakdowns since June 2023. A task and finish group has been convened to plan its replacement in anticipation of Welsh Government funding. The second CT scanner at GGH is the next priority, as it supports outpatient work and serves as a backup; it is increasingly unreliable, with long lead times for parts. Additionally, service variation in DEXA provision has worsened, as the Swansea scanner now performs Trabecular Bone Scoring (TBS), while the BGH scanner cannot. Patients have required repeat scans to obtain TBS results, and the BGH unit also runs on an unsupported Windows version, posing further risk.

Replacement of the Nuclear Medicine SPECT-CT, the second CT scanner at GGH, and the DEXA scanner at BGH would allow risks to be de-escalated to the operational risk register. Completion is dependent on WG funding and may extend to the end of the 2026–27 financial year due to infrastructure requirements.

Corporate Risks assigned to QSEC (7 of 10)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1664 – Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	**Chief Operating Officer**	**16 → (Reviewed 20/11/25)**	**8**	**31/03/2027**

Rationale for Current Risk Score

Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1 patients (high risk) with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity.

The service has provided additional age-related macular degeneration (AMD) sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board. 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. The current R1 delivery at 34%. The WG target for R1 delivery is 95%.

The current waiting list for new patients is 15,074. The service is expected to reach 0 patients waiting at stage 1 over 52 weeks by March 2026. The stage 4 104 weeks, is breach of 8. 7,518 patients have been 100% delayed for their follow up appointment.

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

Rationale for Target Risk Score (TRS)

The service has been able to reduce the impact score of this risk as whilst the consequences to the patient remains high, recurrent funding has been invested into the service for the delivery of an R1 Eye Care Measures target of 65%. The Ministerial Measures target will need to be 0 for 3 consecutive months, and the Follow up delayed will need to be reduced by 12%. Once these targets are reached, the likelihood score can be reduced to a 3 which would reduce the overall score to 12. The 65% R1 delivery by September 2026 is dependent on all posts being recruited into and all estates needs being met. Further development would be required to reach a 95% R1 delivery score, which would reduce the likelihood to a 2.

With the required investment in Glaucoma and IVT and the additional workforce and estates and continued management of the waiting lists, the HB will potentially be able to reduce the likelihood score on this risk to a 2.

Corporate Risks assigned to QSEC (8 of 10)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1810 - Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	**Chief Operating Officer**	**16 → (Reviewed 03/11/25)**	**10**	**~~30/09/2026~~ 31/12/2026**

Rationale for Current Risk Score

Withybush Aseptic Unit is the only remaining aseptic unit in the Health Board capable of producing cancer treatments. However, it is currently non-compliant with regulatory standards. A 2024 audit deemed it a high risk to patient safety, and a 2025 follow-up confirmed ongoing staffing issues and insufficient resources to maintain quality standards, putting the unit at risk of forced closure.

Temporary control measures have been implemented to reduce microbial contamination and delay closure (see control measures), but the aging infrastructure means these measures may soon become ineffective. If contamination increases, the unit may be forced to close. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality.

Rationale for Target Risk Score (TRS)

The target risk score is based on the premise that a new demountable aseptic unit will be built at Withybush in 2026. 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.

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

Corporate Risks assigned to QSEC (9 of 10)

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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1531 - Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Chief Operating Officer	15 → (Reviewed 28/10/25)	5	27/02/2026

Rationale for Current Risk Score

Whilst surgical consultant on-call rotas at GGH and WGH are covered, the service is still reliant on NHS locums and agency locum consultants. This situation will remain the same until substantive upper GI consultants are recruited to address the emergency on-call rota risk and the Upper GI service risk at WGH. Recruitment has been successful to the substantive post at GGH with the candidate commenced in post. One post has been successfully recruited to at WGH with the applicant onboarding, and the second post re-advertised as of November 2025. It is anticipated that both will have fully onboarded by February 2026.

Rationale for Target Risk Score (TRS)

The target risk score is based on the work currently being undertaken as part of the Clinical Services Plan to identify and approve a more sustainable solution in order to reduce the likelihood of rota collapse and reduce the risk of not being able to provide a safe and sustainable emergency general surgery service to patients in the south of the Health Board. The effectiveness of revised rota arrangements will depend on several factors including availability of a labour market.

Achievement of the target risk score is dependant on the outcomes of the Clinical Services Plan which will inform future plans or the successful appointment of substantive upper GI consultants to the current model at WGH.

The risk score will reduce on the appointment of substantive consultants. Should the service be able to recruit suitable candidates to the three upper GI substantive posts, it is anticipated that they rotas at GGH and WGH will be fully functioning by February 2026.

Corporate Risks assigned to QSEC (10 of 10)

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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1859 - Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	**Chief Operating Officer**	**15 → (Reviewed 04/11/25)**	**10**	**31/12/2025**

Rationale for Current Risk Score

There were specific concerns relating to Glangwili and Withybush General Hospitals regarding cardiac arrests and unplanned admissions. There was an increase in cardiac arrest rates in GGH in the period Jan-Dec 2024 (35) compared to the same period Jan – Dec 2023 (20). The first 10 months of 2025 noted a decrease in the Cardiac Arrest rates in GGH compared to the same period 2024, with 20 noted (2024:30).

There had been a 22% increase in unplanned admissions at WGH in 2024. In the first 8 months of 2025 there has been a reduction in the number of unplanned admissions into WGH ITU compared to the same period in 2024 (Jan–August 2025:50 (2024:67)).

As of 8th August 2025, compliance rates for Level 3 Resuscitation Training Adults is 64%, Paediatrics 45%, and Level 2 Training (BLS) is at 51% for adults, and 48% for Paediatrics, an improved position since June 2025. All planned actions to mitigate the risk are being processed within set dates/timeframes although many remain long term.

Current controls are managing the risk and the increasing awareness of gaps in assurance and local actions to mitigate and manage the risk have been established.

Rationale for Target Risk Score (TRS)

The full implementation of the actions noted in the risk action plan will support the reduction in the likelihood and impact score of this risk to a target risk of 10. With recruitment into the Resus Team and the establishment of a supported Cascade Training process the aim will be to see an increase in training compliance in both Level 2 & Level 3 training by October 2025 to >60%. This will enable the risk to be reduced to the Target Risk Score of 10, >85% would enable the risk score to be reduced further to 5. We will aim to see a reduction in Cardiac Arrest rates across all 4 sites and unplanned admissions into ITU from ward areas by October 2025.

Implementation of Welsh Health Circulars (WHCs)

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There are 23 open WHCs aligned to QSEC as at November 2025. 3 new WHCs have been issued since the previous report to Committee.

All WHCs are managed via the Audit Management and Tracking system (AMaT), which gives leads direct access to update and upload relevant evidence to demonstrate compliance with their requirements. Each Welsh Health Circular (WHC) is assigned a status category. The table below outlines the definition of each category, the number of WHCs assigned to each as of November 2025, and the number completed since the previous report. To provide a more accurate reflection of WHC progress, three new status categories have been introduced since the last Committee report. Definitions for these new categories are included in the table below.

Status Category	Definition	Number of WHCs
Overdue	The WHC is behind schedule to the timescale provided by the Lead officer or as stipulated in the WHC, or a plan (with date for implementation) is not yet in place.	3
Unable to Complete (NEW)	The WHC cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	1
Pending Decision (NEW)	The WHC is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the WHC is overdue or not whilst decision pending.	3
In Progress	The WHC is currently in progress, and within the agreed original timeframe for implementation.	9
Reliant on External Factors	The WHC is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	2
Complete Pending Formal Approval (NEW)	The Service / Function have completed the WHC and are currently awaiting formal approval to close.	4
Complete	The WHC has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	1

Oversight of the delivery of WHCs has been included in new Clinical Care Group (CCG) Terms of Reference, with the requirement to escalate appropriately instances of non-compliance.

The timely implementation of WHCs is included within the Governance domain of the Health Board's internal escalation framework, with services escalated in instances of non-compliance.

WHCs - Overdue

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Name of WHC	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Red Status	Impact of non-compliance according to risk assessment	Next Steps
004-22: Guidance for the provision of continence containment products for children and young people: a consensus document **Issued October 2022**	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Original implementation date not met **Original Completion Date:** 31/07/2023 **Revised Completion Date:** 31/01/2026	**Risk Ref:** 1615 **Current Risk Score:** 12 **Impacts:** Right to independence for children and young people; Access to the same services as their peers	A Specialist Nursing post that will enable the Clinical Service Group to demonstrate compliance with the requirements of this WHC has been approved by Financial Control Group. Interviews for the position took place in October and an offer of employment has been made. The timeline for implementation has been set as January 2026 to account for the Specialist Nurse to commence in the role.
019-22: Non Specialised Paediatric Orthopaedic Services **Issued June 2022**	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Original implementation date not met **Original Completion Date:** 30/04/2025 **Revised Completion Date:** Not Known	No risk noted on Datix.	The Trauma and Orthopaedics Service Leads are in the process of drafting a Maturity Matrix to address the requirements of this WHC. The Maturity Matrix will need to be dealt with by multiple CCGs due to the requirements set out in the Service Specification relating to this WHC. Once the Trauma and Orthopaedics Service Leads have completed their elements of the WHC, the WHC can then be re-assigned to Primary Care as per the action of January 2025 Escalation meeting.
006-24: National Clinical Guideline for Stroke, for the UK and Ireland **Issued March 2024**	Community & Integrated Medicine	Chief Operating Officer / CCG Director for Community and Integrated Medicine	Original implementation date not met **Original Completion Date:** 30/04/2025 **Revised Completion Date:** Not Known	**Risk Ref:** 233 **Current Risk Score:** 12 **Impacts:** Delayed assessment and treatment of patients; Increased length of stays	QIA was presented to the panel in September 2025, however was not accepted by the panel, with further work required from the CCG. The panel agreed that future QIAs should be signed off by the Stroke Strategy Group or CCG, and that the process should ensure proposals are clear and supported by appropriate oversight. Service unable to provide an implementation date pending progression of the wider Clinical Service Plan.

WHCs – Unable to Complete

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Unable to Complete Status	Impact of non-compliance according to risk assessment	Next Steps
026-18: Phase 2 – primary care quality and delivery measures – **issued July 2018**	Primary Care, Community Strategy and Long Term Care	Chief Operating Officer / Director of Primary Care, Community and Long Term Care	National work around this transformational model was suspended due to the COVID-19 pandemic and has never progressed further. Currently the Primary Care quality and delivery measures within the new dashboards are being used as equivalent quality indicators. As such, the implementation date for this WHC is currently noted as not known. **Original Completion Date**: 16/07/2018 **Revised Completion Date**: Not Known	No risk noted on Datix.	WHC will be escalated through operational governance structures to obtain relevant approval to close this WHC as the service is unable to implement.

WHCs – Pending Decision

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Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Pending Decision Status	Impact of non-compliance according to risk assessment	Next Steps
006-18: Framework of Action for Wales, 2017-2020 (Not Available Online) – **issued Feb 2018**	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Service unable implement due to funding requirements. WHC requirements and supporting systems have been incorporated into the Annual Planning work stream for 2025/26. **Original Completion Date**: 30/04/2022 **Revised Completion Date**: Not Known - **Overdue**	**Risk Ref :**1457 **Current Risk Score:** 12 **Impacts:** Patients unable to access specialist care in a timely manner, closer to home; Additional pressures on GP capacity	Await the outcome of whether the Service has been granted the relevant funding as part of the Annual Planning 2025/26 to inform next steps required.
017-19: Living with persistent pain in Wales guidance – **issued May 2019**	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Service unable implement due to funding requirements. WHC requirements and supporting systems have been incorporated into the Annual Planning work stream for 2025/26. **Original Completion Date:** 31/01/2025 **Revised Completion Date:** 31/01/2026 - **Overdue**	**Risk Ref:** 2120 **Current Risk Score:** 12 **Impacts: :** Patients unable to access specialist care in a timely manner, breaches in achieving RTT	Await the outcome of whether the Service has been granted the relevant funding as part of the Annual Planning 2025/26 to inform next steps required.
009-21: School Entry Hearing Screening pathway - **issued March 2021**	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Service unable implement due to funding requirements. WHC requirements and supporting systems have been incorporated into the Annual Planning work stream for 2025/26. **Original Completion Date**: 31/01/2023 **Revised Completion Date**: Not Known - **Overdue**	**Risk Ref:** 1456 **Current Risk Score:** 8 **Impacts:** Detrimental impact on quality, accuracy and consistency of screening services provided	Await the outcome of whether the Service has been granted the relevant funding as part of the Annual Planning 2025/26 to inform next steps required.

WHCs - In Progress

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Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
037-25: Infected Blood Inquiry: Implementation of Recommendation 7e: Implementing SHOT reports - **issued September 2025**	Operational Allied Health Professions and Health Sciences	Chief Operating Officer / CCG Director for Operational Allied Health Professions and Health Sciences	Nov-25
041-24: Ambulance patient handover guidance – **issued October 2024**	Community and Integrated Medicine	Chief Operating Officer / CCG Director for Community and Integrated Medicine	Dec-25
017-25: Tranexamic Acid use: Recommendation 7a of the Infected Blood Inquiry (IBI) - **issued May 2025**	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Jan-26
002-24: Standards for Competency Assurance of Non-Medical Prescribers in Wales – **issued March 2024**	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Mar-26
004-25: NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2025/26 - **issued April 2025**	Medical Director	Medical Director	Mar-26
006-25: Recording of Mental Health Outcome Measures - **issued May 2025**	Mental Health and Learning Disabilities	Chief Operating Officer / CCG Director for Mental Health and Learning Disabilities	Apr-26
030-23: New 2023 National Safety Standards for Invasive Procedures (NatSSIPS2) by the Centre for Perioperative Care (CPOC) and Patient Safety Notice PSN 034 – **issued August 2023**	Medical Director	Medical Director	Sep-26
016-24: Healthy Child Wales Programme: for school aged children – **issued April 2024**	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Sep-26
039-25: AMR and HCAI Improvement Goals for 2025 – 2027 - **issued October 2025**	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Mar-27

WHCs – Reliant on External Factors

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for External Status	Impact of non-compliance according to risk assessment	UHB Implementa-tion Date
040-23: The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC) – **issued November 2023**	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	The service is currently compliant with all aspects of this WHC apart from the data capture requirements, for which no national system is currently available. An all-Wales data system is awaited. As such, the implementation date for this WHC is currently noted as not known.	**Risk Ref:** 2109 **Current Risk Score:** 20 **Impacts:** Decrease in staff morale and a negative impact on service leads.	N/K
033-18: Airborne Isolation Room Requirements **– issued July 2018**	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	The Health Board's Architectural Projects Team undertook a Project Feasibility Report in July 2024 and provided a provisional estimate of out-turn costs of £1,419,946.25 (including a contingency fund of £109,416), with a project time of around 48 weeks from project brief development to completion of works to install a negative pressure isolation suite in the Clinical Decisions Unit (CDU), Glangwili General Hospital. To date, funding has not been allocated for this major capital project and whilst the issue has been raised at the 'All Wales High Consequence Infectious Disease Group' hosted by Public Health Wales (as a result of the threat of MPOX in the UK) and the NHS Executive, there has been no indication of any central funding being considered by Welsh Government to support improvement and to move this work forward. In the meantime, out turn costs continue to escalate and it is recognised that the estimated costs of 2024 may well have increased. Discussions were held at the Infection Prevention Strategic Steering Group (IPSSG) in March 2025, when it was agreed that steer is required from the Executive Director given the investment required and the stagnation of progress. As of November 2025, Head of Infection Prevention is currently exploring how other Health Boards are managing this WHC (action agreed at IPSSG) with QIA to be completed by 31 December 2025 by IPC and Planned Care CCG to inform the Board of current circumstances and any changes. Noted as 'unable to complete' until funding is secured.	**Risk Ref:** 1640 **Current Risk Score:** 12 **Impacts:** Increased risk of transmitting infectious disease	N/K

WHCs – Complete Pending Formal Approval For Closure / Complete by Lead Executive

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Complete Pending Formal Approval For Closure

Welsh Health Circular	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Clinical Care Group/Executive Function	UHB Implementation Date
018-25: Tirzepatide (Mounjaro®) for the management of obesity and overweight – **issued May 2025**	Operational Allied Health Professions and Health Sciences	Chief Operating Officer / Director of Operational Allied Health Professions and Health Sciences	Jul-25
027-25: Changes to supply of Gluten Free Foods in Wales; All-Wales Gluten Free Subsidy Card Scheme - **issued July 2025**	Primary Care, Community Strategy & Long Term Care	Director of Primary Care, Community Strategy and Long Term Care	Aug -25
035-24: Standardising the management of acute deterioration – **issued September 2024**	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Sep-25
031-25: 3Ps Waiting Well single point of contact (SPOC) activity and outcomes data reporting. **– issued September 2025**	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Oct-25

Complete

Welsh Health Circular	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Clinical Care Group/Executive Function	UHB Implementation Date
040-24: Adopting a patient and family-initiated escalation approach – **issued October 2024**	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Sep-25

Implementation of Ministerial Directions (MDs)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Ministerial Directives (MDs) are legislative in character as they alter legal rights and duties. MDs are issued by Welsh Ministers and include codes of practice and guidance. In complying with the requirements of various governance codes and the Annual Governance Statement requirements, HDdUHB has a duty to provide assurance of compliance with the MDs. As MDs potentially form part of the process of how the Health Board delivers its services, the Quality, Safety & Experience Committee (QSEC) will receive a regular assurance report on compliance

There are 5 MDs aligned to QSEC as at November 2025, all of which have been noted as complete.

Each MD is assigned a status category. The table below outlines the definition of each category, the number of MDs assigned to each as of November 2025. To provide a more accurate reflection of MD's progress, three new status categories have been introduced since the last Committee report. Definitions for these new categories are also included in the table.

Status Category	Definition	Number of MDs
In Progress	The MD is currently in progress, and within the agreed original timeframe for implementation.	0
Overdue	The MD is behind schedule to the timescale provided by the Lead officer or as stipulated in the MD, or a plan (with date for implementation) is not yet in place.	0
Reliant on External Factors	The MD is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	0
Pending Decision (NEW)	The MD is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests. Committee updates will detail whether the MD is overdue or not whilst decision pending.	0
Unable to Complete (NEW)	The MD cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	0
Complete Pending Formal Approval (NEW)	The Service / Function have completed the MD and are currently awaiting formal approval to close.	1
Complete	The MD has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	4

Oversight of the delivery of MDs has been included in new Clinical Care Group (CCG) Terms of Reference, with the requirement to escalate appropriately instances of non-compliance.

The timely implementation of MDs is included within the Governance domain of the Health Board's internal escalation framework, with services escalated in instances of non-compliance.

MDs – Complete Pending Formal Approval and Complete

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Complete Pending Formal Approval For Closure

Ministerial Direction	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Clinical Care Group/Executive Function	UHB Completion Date
WG25-72: The Primary Care (Contracted Services: Outpatients Waiting Lists First Appointment Scheme) Directions 2025 **– Issued October 2025**	Primary Care, Community Strategy & Long Term Care	Director of Primary Care, Community Strategy and Long Term Care	Oct-25

Complete

Ministerial Direction	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Clinical Care Group/Executive Function	UHB Completion Date
WG25-40: The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults) (Directed Supplementary Service) (Wales) (Amendment) Directions 2025 **– Issued August 2025**	Primary Care, Community Strategy & Long Term Care	Director of Primary Care, Community Strategy and Long Term Care	Sep-25
WG25- 40: The Primary Medical Services (People Living with Severe Frailty in their own Homes) (Directed Supplementary Service) (Wales) Directions 2025 **– Issued September 2025**	Primary Care, Community Strategy & Long Term Care	Director of Primary Care, Community Strategy and Long Term Care	Sep-25
WG25-44: The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No.4) Directions 2025 **– Issued September 2025**	Primary Care, Community Strategy & Long Term Care	Director of Primary Care, Community Strategy and Long Term Care	Oct-25
WG25-45: The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No.4) Directions 2025 **– Issued September 2025**	Primary Care, Community Strategy & Long Term Care	Director of Primary Care, Community Strategy and Long Term Care	Oct-25

Recommendations

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

Risk Management

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

Welsh Health Circulars

- **RECEIVE ASSURANCE**, or otherwise, from the lead Executive Director or Supporting Officer on the management of WHCs within their area of responsibility, particularly in respect of understanding when the WHC will be delivered, any barriers to delivery, impacts of non/late delivery and assurance that the risks associated with these are being managed effectively.

Ministerial Directions

- **RECEIVE ASSURANCE** that the Health Board is compliant with the Ministerial Directions issued by Welsh Government.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

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Hywel Dda
University Health Board

CORPORATE RISK REGISTER SUMMARY NOVEMBER 2025

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Nov-25	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score
797	Risk of adverse patient and workforce outcomes if health board wide ultrasound services are unsustainable	Carruthers, Andrew	Quality/Complaints/Audit	5×5=25	5×5=25	→	3×5=15	~~31/07/2027~~ 31/03/2030
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	4×5=20	4×5=20	→	2×4=8	~~31/03/2026~~ 31/10/2026
1552	Risk of insufficient mortuary capacity due to current and anticipated future demand	Carruthers, Andrew	Safety - Patient, Staff or Public	NA	4×5=20	New risk	2×4=8	31/08/2026
1032	Risk of timely ASD diagnostic assessment for CYP due to increasing demand	Carruthers, Andrew	Safety - Patient, Staff or Public	5×4=20	5×4=20	→	4×4=16	Not known
684	Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Carruthers, Andrew	Service/Business interruption/disruption	4×4=16	4×4=16	→	2×4=8	Not known
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Carruthers, Andrew	Safety - Patient, Staff or Public	4×4=16	4×4=16	→	2×4=8	31/03/2027
2190	Risk of delay in CHC direct payments due to short timescale, limited resources & lack of WG policy guidance	Carruthers, Andrew	Quality/Complaints/Audit	NA	4×4=16	New risk	3×4=12	31/03/2026
1531	Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	3×5=15	3×5=15	→	1×5=5	27/02/2026
1810	Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Carruthers, Andrew	Service/Business interruption/disruption	3×5=15	3×5=15	→	1×5=5	31/12/2026
1859	Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Daniel, Sharon	Safety - Patient, Staff or Public	3×5=15	3×5=15	→	2×5=10	31/12/2025

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
Likelihood	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	**This will probably never happen/recur (except in very exceptional circumstances).**	**Do not expect it to happen/recur but it is possible that it may do so.**	**It might happen or recur occasionally.**	**It might happen or recur occasionally.**	**It will undoubtedly happen/recur, possibly frequently.**
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	**(0-5%*)**	**(5-25%*)**	**(25-75%*)**	**(75-95%*)**	**(>95%*)**
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				
Risk Impact Domains	**Negligible - 1**	**Minor - 2**	**Moderate - 3**	**Major - 4**	**Catastrophic - 5**
Safety of Patients, Staff or Public	**Minimal injury requiring no/minimal intervention or treatment.**	**Minor injury or illness, requiring minor intervention.**	**Moderate injury requiring professional intervention.**	**Major injury leading to long-term incapacity/disability.**	**Incident leading to death.**
	No time off work.	**Requiring time off work for >3 days**	**Requiring time off work for 4-14 days.**	**Requiring time off work for >14 days.**	**Multiple permanent injuries or irreversible health effects.**
		Increase in length of hospital stay by 1-3 days.	**Increase in length of hospital stay by 4-15 days.**	**Increase in length of hospital stay by >15 days.**	**An event which impacts on a large number of patients.**
			Agency reportable incident.	**Mismanagement of patient care with long-term effects.**	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	**Peripheral element of treatment or service suboptimal.**	**Overall treatment or service suboptimal.**	**Treatment or service has significantly reduced effectiveness.**	**Non-compliance with national standards with significant risk to patients if unresolved.**	**Totally unacceptable level or quality of treatment/service.**
	Informal complaint/inquiry.	**Formal complaint.**	**Formal complaint -**	**Multiple complaints/ independent review.**	**Gross failure of patient safety if findings not acted on.**
		Local resolution.	**Escalation.**	**Low achievement of performance/delivery requirements.**	**Inquest/ombudsman inquiry.**
		Single failure to meet internal standards.	**Repeated failure to meet internal standards.**	**Critical report.**	**Gross failure to meet national standards/performance requirements.**
		Minor implications for patient safety if unresolved.	**Major patient safety implications if findings are not acted on.**		
		Reduced performance if unresolved.			

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage
					Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

RISK MATRIX

IMPACT ↓	LIKELIHOOD →				
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

Assurance Key:

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

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

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

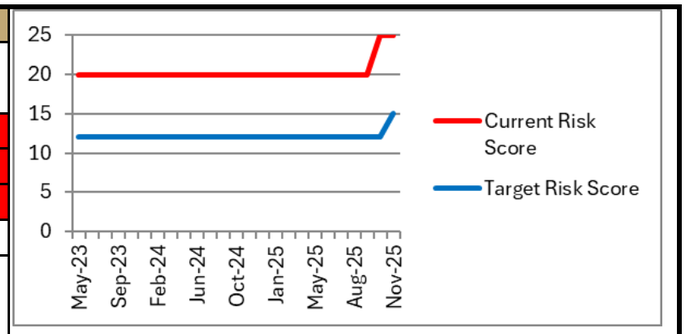
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective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

Date Risk Identified:	Nov-19		
Strategic Objective:	1. Thriving Teams and 2. Healthier Communities and 3. Great Care and 4. Positive Futures		

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

Risk ID:	**797**	**Corporate Risk Description:**	There is a risk that health board wide ultrasound services are unsustainable. This is caused by -Demand increase across NOUS and Maternity Ultrasound pathways requires 34 148 additional scanning hours. -Workforce establishment does not match demand. -Workforce vacancies long standing (national shortage, training pipeline 3 years with large supervision requirement). -Unable to move staff between sites to cover as all sites unable to meet minimum standards required. -Occupational Health impact from workloads reducing workforce available (RSI). This could lead to an impact/affect on -Patient outcomes = delays to scans resulting in delays to treatment or death (cancer and maternity pathways) -Workforce outcomes = staff harm from RSI resulting in long term injury from too much scanning of similar types (unable to job plan appropriately due to demand and vacancies).
Does this risk link to any Directorate (operational) risks?		1349 (WGH), 1658 (RSI), 1547 (maternity)	

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	5×5=25
Target Risk Score (L x I):	3×5=15
Expected Date To Achieve TRS:	31/03/2030
Trend:	↑



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
This risk was escalated from 20 to 25 in October 2025 due to increased fragility in available workforce (2.0WTE retirement notice given Jan 2026). In Nov 2025 a full risk review of all elements took place with Radiology and CCG leadership. Patients outcomes = delays to scans resulting in delays to treatment or death (cancer and maternity pathways) Workforce outcomes = staff harm from RSI resulting in long term injury from too much scanning of similar types (unable to job plan appropriately due to demand and vacancies). Quality, complaints and audit - (5) Totally unacceptable level or quality of treatment/service. * due to waiting times (see below) patients on maternity and cancer pathways are waiting too long for scans required for intervention Gross failure of patient safety if findings not acted on. * concerns regarding non compliance with Welsh Maternity screening targets Gross failure to meet national standards / performance requirements. * Waiting times non-interventional ultrasound are up to 23 weeks (25/11/25) * Interventional ultrasound 52 weeks (25/11/2025) * Vascular ultrasound is not available 7 days a week (25/11/2025) Probability = >95% If insourcing capacity cannot be secured from the 1st January 2026 the service will no longer be able to sustain a safe baseline capacity to provide routine and urgent non-obstetric imaging alongside obstetric scanning Monday to Friday, 09:00-17:00 on the WGH site.	Impact of service failure remains the probability of service failure is the aim of mitigating actions. Probability target of 25-75%. In Nov 2025 target date was reviewed and extended. Justification for this change is the timeline for Radiology Leadership OCP and recruitment to bring in the leadership required to mitigate the gaps in controls thus requires extended timelines due to pathways changes and training timelines.

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**
Insourcing NOUS (planned 125 examinations per week, actual performance 90-120 actual) - monthly data submission to Welsh Government + monthly performance reporting on 8 week and USC pathways (25/11/2025) Locum/Agency capacity - 1.0WTE secured (25/11/2025), 2.0WTE Agency being sought (25/11/2025) Prioritisation of maternity workload by referring clinician - urgency allocated on referral form by referring clinicians Training pipeline (supported practice educator) - 5.0WTE in post (end of training Jan 2027), 2.0WTE qualified 2025, 1.0WTE Midwife sonographer (end of training Jan 2026). Next intake Jan 2027. MSK and Vascular pathways via AHP extended practice roles (some Physiotherapy and Podiatry pathways in place to support ultrasound workload)	Health board wide governance of ultrasound pathways Pathway workforce diversification Workforce pipeline does not meet demand Training capacity (trainees available but inadequate internal capacity to train) Insourcing/outsourcing/Agency/Locum capacity Limited ability to move staff across sites due to extremely low staffing levels	Develop and implement a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Llewellyn, Cerian	~~31/12/2022~~ ~~31/10/2023~~ ~~31/01/2024~~ ~~30/06/2024~~ ~~31/01/2025~~ 31/01/2026	The date of completion of this action has been changed to 31/01/2026 as the midwife identified for training did not start until Jan 2025 due to lack of process to support the clinical aspects and a change in maternity management. Maternity and child health are required to advise of the plan to utilise the skills of the trainee midwife sonographer and also any plans to train more staff. June 2025: Midwife sonographer is now undertaking required training and expected to qualify in January 2026.
		Radiology management restructuring as part of stabilisation plan. new posts needed to provide a longer term solution to issue. Not possible with current management structure and stability risk	Procter, Sarah	31/05/2026	OCP being presented to board 3.9.25 once approved the process will start the following week 8.9.25. Delayed to 1.10.25
		SBAR being written due to increase in risk to 25 - due to inability to meet maternity policy and impact on NOUS. fragility at WGH is extreme due to imminent retirements and inability to fill vacancies with substantive staff or locum due to national shortage.	Procter, Sarah	Completed	Paper submitted to CCG and raised at IQPFD
		Obstetric ultrasound capacity being added to current insourcing contract which starts on 1 November 2025.	Procter, Sarah	Completed	Added to contract
		Training pipeline - 5.0WTE Trainee sonographers scheduled to complete training.	Procter, Sarah	31/01/2027	25/11/2025 - New action.

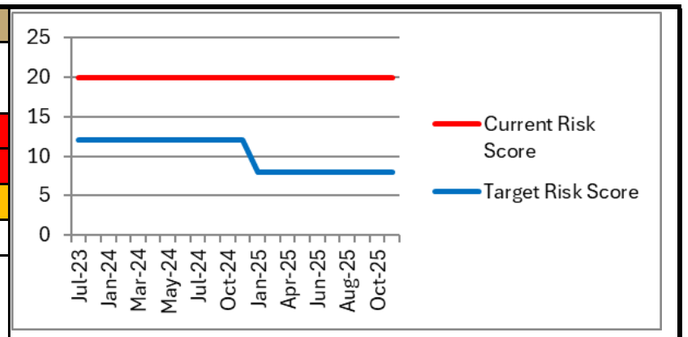
Training pipeline - 1.0WTE midwife sonographer completed training.	Procter, Sarah	31/01/2026	25/11/2025 - New action
Insourcing/Outsourcing - procurement conversation with current provider of ultrasound capacity relating to adding more scanning capacity for obstetric ultrasound capacity (2000 scans) on top of current contract	Procter, Sarah	19/12/2025	25/11/2025 - new action
Agency capacity - 2.0WTE out for advert with agency (AG1 (HR form for agency approval) valid until 2027)	Procter, Sarah	31/01/2027	25/11/2025 - AG1 approved for 2.0WTE until Jan 2027, out with Agencies during 2025/26. No interest this year as yet.

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
8 week USC Ante-natal screening Wales	Waiting list monitoring - Live dashboard review by Radiology Leadership (daily) and monthly formal submission of performance * week data to Welsh government (see iPAR).	2nd			IQFPDG 26/11/2025 - SBAR - Ultrasound Fragility - Corporate risk 797					
	Performance monitored at Executive Improving Together Sessions	2nd								

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Nov-25
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Dec-25

Risk ID:	**1027**	**Corporate Risk Description:**	There is a risk to the consistent delivery of timely and high quality urgent and emergency care. This is caused by significant fragility across the urgent and emergency care (UEC) system (acute, primary care (including out of hours), community and social care services), related to workforce compromise and increasing levels of demand and acuity. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays and overcrowding at Emergency Departments (ED) and delayed ambulance response to community emergency calls, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?		1649, 1406, 1548, 1210, 750, 205, 86, 820, 232, 1298, 1281, 906, 1380, 1116, 878, 839, 1167, 1223, 111, 114, 199, 523, 136, 200, 1115, 1078, 572, 1295, 1231, 966, 967, 565, 852, 1295, 1435, 1377, 1083, 180, 1424, 1417, 1309, 291, 118, 925, 119, 1245, 695	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	31/10/2026
Trend:	⟷



Rationale for CURRENT Risk Score:

Levels of UEC pathway capacity pressures continue at significantly escalated levels. Workforce deficits, bed occupancy rates and significant pressures on wider community and social care capacity demonstrate lack of sustainable improvement. The situation remains at high levels of risk escalation across our acute sites daily. The Front Door Reset week in September has shown improvements in Ambulance handover delays but challenging to sustain in the longer-term. Whilst some positive progress has been achieved in reducing ambulance handover delays, the other key metrics remain outside TI requirements. Despite trend line indicative of slight improvement over the year, October has 8.5% of people waiting>12 hours in an ED. This is above the TI target of 6% and up from 8% in September. For ED assessment waits October's average is 78 mins, above the TI target of 60 and an increase on September's average. Over the year the trend has been fairly static for this metric and has not met TI targets. PoCDs in October were 258 which was above the TI target of 174. PoCD shows an increasing trend and remains the most challenging TI metric for the UHB. Work ongoing with Local Authorities to improve position, and internal actions such as front door reset actions and making everyday count reset week. Notable actions include a focus on redirection policy, community staff integration into sites, optimisation of discharge lounge and more senior leadership presence in board rounds.

Rationale for TARGET Risk Score:

The target risk score of 8 reflects the confidence in the delivery of 6 Goals Programme and the Accelerated Transformation Programme to address the significant issues across the health and care system.

Plans for improvement during 2025/26 are reflected in the HB's Annual Plan, approved by the Board in March 2025, and are informing next year's Annual Plan. The 6 goals plan has been approved by WG in March 2025. TI measures such as ambulance handovers and 12 hour delays in ED will need to improve in order to reduce the current risk score, for a consecutive period of three months. UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly into Formal Executive Team.

An expected date of March 2026 had been noted to achieve the target risk score of 8, to allow the transformation change to embed. The embedding of 7-day Clinical Streaming and SDEC services will be thought to significantly impact on patient flow and a business case for this is planned to go to Public Board in January 2026 for agreement. If approved time will be needed for recruitment and embedding of services, as such it is expected that there will may be a delay in hitting the March 2026 target score of 8 and it is recommended this is put forward to October 2026.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Live Operational Dashboard in place and twice HB wide escalation meeting. # Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. Surge and boarding recorded on the twice a day escalation report. # Frontier system in place for recording DPOC and red days flagging required assessments to support discharge, within continued education at ward level ensuring consistent approach to Board Rounds and Patient Safety Huddles. # Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites with associated actions in collaboration with social care partners. # Regular advice on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, social services and the Long Term Care Team support. # Discharge arrangements are in place on all sites with a strategic review underway. # Standardised board rounds processes in place on all sites and D2RA processes are embedded with a 77% D2RA rate (Sep24). # Criteria-led discharge guidance and principles piloted across HB (Sep24). # Integrated Regional Winter Plans developed to manage whole system	# Fragility of Care Home Sector such as financial viability, staffing deficits, recruitment and retention of workforce. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff. # Inability to handover ambulances to release them back for use within community due to lack of flow in acute sites. # Need to have better understanding of ED presentations to ensure development of alternative pathways in primary care / community to prevent ED attendance. # Ability to influence public mind set / expectation and culture in terms of use of NHS resource and ‘Home First’ Ability. # Gap in communication between secondary and primary care that could lead to poor discharge outcomes. # Clarity regarding roles and responsibilities for discharge planning and coordination.	Delivery of 6 Goals Programme and Plan via the workstreams and closer working with WAST and primary care 1. Development of Regional Clinical Streaming Hub (CSH) for Health Professionals & Care Homes delivering 24/7 urgent care advice & support and onward referral to local deliver/resource hubs where appropriate	Skitt, Peter	31/10/2025	Piloting a 7 day model on the CSH across the Health Board as part of winter planning (utilising overtime and additional shifts) with an evaluation finalised in May 2025. The plan to produce a business case for substantive arrangements is including in the Accelerated UEC Transformation work to be delivered by October 2025.
		Develop a consultant led ED medical provision that is fit for purpose and meets the D&C requirements utilising all professions.	Skitt, Peter	Completed	Lead ED consultant appointed, action complete /
		Utilise the risk stratification data set across the system proactively with the population	Skitt, Peter	~~30/04/2025~~ 31/10/2025	Part of First Home Hub plan and work is underway. Data is being used in primary care multi-disciplinary team meetings across the Health Board and WGH, and requires further embedding to ensure the impact within acute sector is realised.
		Review of Community bed based hospital capacity, with a view to ensuring proactive case load management and estate as part of the Alternative Care Model work. Develop & implement strategy for Alternative Care Community (ACP) Provision across the West Wales region.	Skitt, Peter	31/10/2025	Initial planning and audit of capacity has been completed. Length of stay data being gathered by County Leads.

pressures over the winter period and communicated. # An operationally focussed 6 Goals Urgent and Emergency Care (UEC) programme with governance structure agreed where all UEC improvement is coordinated. # Welsh Ambulance Services NHS Trust involved in all 6 Goals UEC workstreams. # 111 and 111 press 2 (MH) implemented across Hywel Dda. # Regional Integration Fund projects in place across Regional Partnership Board (RPB) footprint, along with Further Faster projects to ensure alignment with Ministerial objectives. # Whole system approach to deploy HB staff to ensure continuity of patient care. # Care Home Risk & Escalation Policy to support failing care homes to be applied as required. # Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across the RPB region. # Establishment of a Discharge to Recover and Assess (D2RA) Group which reports to the the 6 Goals Programme with a detailed D2RA improvement plan in place. # Establishment of a D2RA Escalation Transfer panel which provides senior oversight of delays at county level, assesses risk of the delay to the patient and organisation in terms of flow compromise # SRO in place to lead agreed 6 Goals for UEC programme. # Agreed SDEC model in place to maximise impact on admission avoidance. NHS Executive review with associate actions are part of the 6 goals UEC programme. # Local streaming (Home First) hubs developed with a HB wide approach agreed with clinical triage and screening systems in place, including APP Navigator in place. # Direct referral into SDEC in place.	# The inability to risk stratify for people at moderate to high risk of admission in the community to implement proactive anticipatory care plans to support avoidance of exacerbation / decompensation and hence increased risk of hospital admission. # Optimising our bedded facilities in the community. # Need to develop 24/7 integrated urgent primary care service aligned to Home First hubs. # Insufficient IPC single rooms across community and acute sites, negatively impacting on patient flow. # Lack of level 1 / 2 falls response service during out of hours across the Health Board. # Fragility of senior medical cover at EDs across the acute sites. # Need to create a Health Board wide Frailty approach and appoint a Clinical Lead for Frailty. # 7 day services within the Community are required, particularly around Clinical Streaming Hubs and level 1 /2 Falls.	Enhancements to local delivery / resource hubs to support the CSH providing access to enhanced community care services, third sector services and other pathways to provide safe alternatives to admission. Integration with GP OOHs and APP resources	Skitt, Peter	31/10/2025	Discussions ongoing on providing a single clinical streaming hub across the Health Board footprint, with response resources locally based at cluster level as a phased approach to introducing the care at home blueprint, as described during the 6 Goals review meetings. This will feature strongly in the Accelerated USC Transformation work.
		Development & implementation of consistent approach to Front Door Streaming / Assessment Units focused on our Frail Elderly cohort based on good practice and lessons learnt from Withybush Puffin / South Pembrokeshire model.	Skitt, Peter	31/12/2025	SDEC services available on all sites for medical patients. Surgical SDECs piloted in Glangwili since December 2024. Ongoing discussion with Glangwili relating to frailty provision.
		Development and implementation of HDUHB optimal SDEC model following on from lessons learnt from peer review and alignment with CSH and local resource hubs.	Skitt, Peter	31/10/2025	An SBAR was developed to standardise the approach across the Health Board, which has been incorporated into the Optimal 7 days streaming SDEC Business Care going to Public Board September 2025.
		Continued implementation of Optimal Flow Framework including Community sites supported by Frontier digital platform.	Skitt, Peter	31/10/2025	On track with roll out plan, and ensuring that all sites are using the framework is ongoing. This work will also feed in to the E-Obs and patient flow project going forward.
		Implementation of 7 focused areas within ED Quality statement.	Skitt, Peter	31/03/2026	Clinical lead for ED post currently out to advert. ED Quality Statement Action group in place, who report 6 weekly to Welsh Government. Action plan developed and in place, forming the basis of updates to WG, based around the national toolkit.

# OOH Pilot clinical streaming via GP route ongoing as of January 2025 with a view to full completion at the end of the month # Clinical Care Group structure in place where this risk is discussed at the quality meeting. #UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly into Formal Executive Team. # Regional Discharge Strategy Group established, providing oversight of all current work streams, and ongoing work on national and local policies # Regional POCD group established January 2025 with a focus on reviewing trends and themes to inform regional and local action plans		Develop West Wales Hospital @ Home model to ensure consistent approach and delivery.	Skitt, Peter	30/09/2025	The Health Board Hospital at Home SOP has been drafted and approved by the Community & Integrated Medicine Clinical Care Group Integrated Governance Group (focus on Quality, Health & Safety). Certain elements in the SOP remain outstanding and must be completed prior to initiating the Health Board's internal approval policy process.
		Develop robust regional Trusted Assessor (TA) Model to ensuring consistent approach to assessment across the region - residents can be an inpatient at any of the 4 x general hospital sites.	Skitt, Peter	31/10/2025	Trusted Assessor regional group in place focussing on the model and reporting required to Welsh Government, aligned to further faster monies. A National Audit took place in Summer 2025 on Trusted Assessors across the West Wales region, awaiting outcomes.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Ambulance handovers within 15 minutes	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st				None identified.				
Ambulance handovers over 1 hour	Daily performance data overseen by service management	1st								
Ambulance handovers over 4 hours	Workstream Delivery Plans overseen by 6 Goals Programme	2nd								
4 & 12 hour waits in A&E	6 Goals Programme / UEC IQFPD 3As report into IQFPD	2nd								

Time to triage in A&E Time to see a Doctor in A&E Pathway of care delays	Bi-annual reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	IA review on Transforming Urgent and Emergency Care	3rd								
	NHS Executive Same Day Emergency Care (SDEC) Review	3rd								
	NHS Executive ED Review	3rd								
	GIRFT Review on ED	3rd								
	MAG review	3rd								

Date Risk Identified:	Feb-22		
Strategic Objective:			

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

Risk ID:	**1552**	**Corporate Risk Description:**	There is a risk of insufficient mortuary capacity (Fridge & Freezer capacity) Health Board wide to meet the current and future growing demand and provide adequate and appropriate sized storage for ward and community deaths. This is caused by the severe lack of storage capacity across all mortuaries within the Health Board, compounded by the fact that some of the refrigeration spaces are not big enough to accommodate the increasingly larger bodies that are being admitted into our mortuary facilities, and the inability for staff to safely access refrigeration spaces at WGH and BGH. In addition, the increase in economic, social, demographic, regulatory and legislative (Medical Examiner Service - MES) pressures have significantly increased both the quantity of deceased and length of stay within our Mortuary body storage facilities. This could lead to an impact/affect on the dignity, and condition of deceased patients within our care due to the inability to adequately store these patients in a suitable environment. There is also the potential impact of non-compliance with legislative requirements, including Human Tissue Authority, along with reputational damage to the Health Board. There could also lead to emotional distress to the families and friends of the deceased.
Does this risk link to any Directorate (operational) risks?		283, 1554	

Risk Rating:(Likelihood x Impact)		**No trend information available.**
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):	2×4=8	
Expected Date To Achieve TRS:	31/08/2026	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:

The Health Board is exposed to significant risks resulting from insufficient mortuary capacity across its estate.The ongoing dependence on temporary body storage, particularly during periods of excess deaths, presents challenges in maintaining regulatory compliance, protecting staff wellbeing, ensuring safe manual handling practices,and upholding the dignity of the deceased.The current infrastructure risks non-compliance with HTA standards. According to ONS projections,the death rate is expected to rise, peaking in 2044, further intensifying these pressures.

Suboptimal facilities may lead to compromised presentation of the deceased, increased emotional distress for families, and safety concerns for mortuary staff,especially manual handling.While control measures are in place, they are not sufficient to manage the current volume of deaths within the mortuary service,particularly during periods of heightened demand.These control measures should serve only as temporary contingencies, in line with the HTA licence however,there is a growing need for enhanced storage capacity throughout the year,not solely during seasonal peaks.

Current body storage provisions do not meet operational requirements, and there is limited flexibility to respond to unplanned disruptions, such as those involving MES, HMC, or PM Service interruptions. Furthermore, the extremely constrained footprint of the mortuary estate significantly restricts opportunities for external expansion or enhancement.

Rationale for TARGET Risk Score:

Target score is based on successful outcome from Body Storage Capacity paper being escalated via CCG (03.06.25) to IQFPD (11.06.25). Funding stream discussed with Executive Director of Finance on (21.07.25) along with further meetings and support from the Health Board's finance and planning team to ensure a long-term sustainable solution is implemented as soon as reasonably possible. Assurance has been provided by the Executive Director of Finance that financial support will be received in order to enact the short term measures to ensure appropriate capacity is available for the approaching winter pressure period. Further discussions will be held with finance and planning colleagues to discuss medium and long term mitigating plans. Long term solution need to be sustainable and future proof to ensure the target risk score is achieved and maintained.

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**
1. At times of peak pressure, temporary body storage units are rented 2. Monitoring of numbers of deceased against storage capacity (Health Board wide) 3. Business continuity plans in place (Health Board wide) 4. Contracts with local funeral directors to utilise contingency storage of deceased (Health Board wide) 5. Deceased are relocated to other mortuary sites when needed (Health Board wide) 6. Bariatric blanket available for short-term use across all Health Board sites 7. Additional body refrigeration (Boxcold solution) has been installed into the old PM (Post Mortem) room at WGH site. 8. Participation, engagement and communication with the Health Board's Mortality Group, medical colleagues, Medical Examiner Service and external stakeholders	1. Despite owning 1x 15 BSS unit, we have insufficient storage provision for the upcoming winter pressure period 2. Insufficient suitable space and/or estate within mortuary facilities to increase body storage capacity. 3. Any delay in the death certification process (internal & external stakeholders) significantly impacts on the management of mortuary body storage. As these processes are outside of mortuary control, we frequently invoke contingency plans to accommodate the deceased. Death certification process be noted as a control measure, with the gap being the delays in these processes as a result of sources beyond the Health Board's control (MES, HMC, PM service disruption etc)?	Requirement of additional body storage capacity health board wide. Capital funding needs to be secured.	Baker, Craig	~~31/03/2025~~ 31/03/2026	To be escalated via CCG structure Escalated at IQFPDG June 2025 - meeting to be scheduled with HT re short term capacity and LD for medium/long term capacity for analysis. Body storage capacity paper being submitted via CCG structure. Financial approval from Finance executive to increase temporary storage over winter period (2025 - 2026), this includes funding to cover adding of additional capacity at PPH. In addition, currently reviewing BGH footprint to look at increase of freezer capacity to cover HB.

4 & 5. Due to the national shortage of body storage capacity, death certification processes and current death rates, contingency plans utilising mutual aid are ineffective as all Health Boards are experiencing the same level of body storage capacity pressures and are therefore unable to assist. 6. During the recent Tier 1 National Mass Fatality Pandemic Exercise it was identified that nationally and locally we have insufficient levels of body storage capacity to handle a mass fatality or a period of excess death. Risk areas were identified by the Hywel Dda team that participated in the exercise and these along with suggestions for improvements were feedback to the Local Resilience Forum (LRF) who will escalate this feedback to Welsh Government.	Explore options regarding temporary body storage rental and purchase of body storage capacity.	Brown , Yasmin	Completed	Ongoing Discretionary Capital bid to purchase a 15BSS Nutwell storage unit. 20.08.25 - Currently in discussions with suppliers regarding rental costs. 19.11.25 - The service has been successful in procuring a 15 BSS storage unit via a spend to save scheme. This unit will be delivered towards the end of November/start of December 2025. 19.11.25 - The service has also rented 2x additional 15 BSS nutwell units as contingency storage space as part of our winter preparedness plans and in readiness for the winter increase in death rates.
	Work with estates teams across the Health Board to undertake the minor and major works that are required to allow for the installation of the box cold body storage solutions.	Brown , Yasmin	~~30/12/2025~~ 30.04.2026	Contact has been made with estates managers in WGH, PPH, and GGH. Quotations have been received for minor building works to be undertaken within the PPH mortuary facility and are being progressed 19.11.25 - Building works have been commissioned with the support of PPH estates teams. Builders are currently on site with the works scheduled to be completed at the beginning of December 2025. This additional space created will allow for the erection of the additional rented nutwell units and therefore provide additional body storage capacity over the winter period.

			Seek external advice on enhancement of mortuary storage capacity within current mortuary estate footprint.	Brown , Yasmin	Completed	Initial site visit has taken place with Wessex refrigeration to determine the art of the possible within the existing GGH mortuary facility footprint. Awaiting receipt of possible plans and quotations. 19.11.25 - Quotations have been received from Wessex refrigeration and engagement is ongoing with estates teams to work these up further.
			Develop a business case and explore options in order to secure capital funding to ensure capacity meets both current and future body storage demands.	Baker, Craig	30/11/2026	Initial discussions held with Director of Finance and Director of Strategy and Planning regarding potential options to explore. Some of these options include - Building new estate and facilites - Commissioning body storage from private providers e.g. funeral directors - Working in collaboration with other Health Boards and Local Authority to develop combined regional solutions

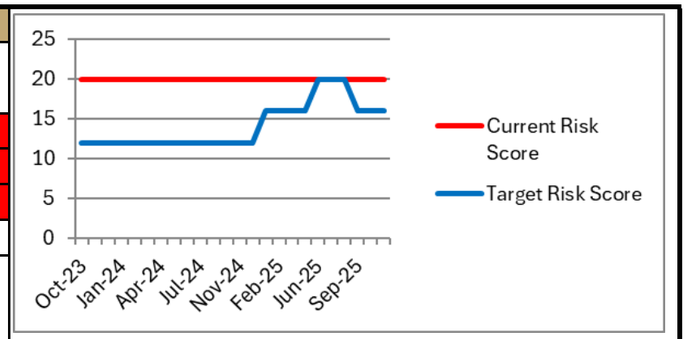
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
	Pathology Strategy Group.	1st			Presentation to IQFPD - June 2025.					
	Hywel Dda HTA Assurance Group.	1st								
	Regional HTA Assurance Group.	2nd								
	Quality & Safety Intelligence Group	2nd								
	AHP & HS CCG reporting up to IQFPD	2nd								
	IQPD	3rd								

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

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

Risk ID:	**1032**	**Corporate Risk Description:**	There is a risk to the delivery of timely diagnosis to those on the CYP ASD waiting lists within required timescales - Welsh Government performance standard of 26 weeks. This is caused by an increase in referrals, with demand outstripping capacity and lack of sustainable external funding. This could lead to an impact/affect on those currently awaiting diagnostic assessment and post diagnostic-intervention, resulting in delays in care and appropriate support and signposting in a timely manner which may lead to poorer patient outcomes compounded by a recognition of additional needs and delayed adjustments to meet those needs in other settings. There will also be an impact on the ability of the Health Board to meet Welsh Government targets (diagnosis of ASD 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, 1422, 1524, 1290, 1260, 1699, 1745, 1414	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	5×4=20
Target Risk Score (L x I):	4×4=16
Expected Date To Achieve TRS:	31/12/2050
Trend:	⇔



Rationale for CURRENT Risk Score:

Significant waiting times have developed as a result of exponential demand. Demand outstrips capacity, with year-on-year increase in referral rates. Current team capacity can only accommodate 11% of total current demand, compounded by current funding arrangements which are non-recurring, making recruitment and service delivery challenging.

Welsh Government funding has been allocated for Children's Neurodevelopmental (ND) services for 2025-26, with the emphasis on eradicating waits greater than 3 years, waits and an improvement plan is in progress. As at October 2025, funding thereafter is uncertain.

Meetings with NHS Performance & Improvement have established trajectories to eradicate 3 year waits by March 2026 and developing a transformation implementation plan.

An executive-sponsored ASD Task and Finish Group has been established to oversee development and implementation of a 3 year improvement plan, incorporating stabilising and increasing workforce, outsourcing, data validation and waiting list initiatives, service re-design and strengthening regional partnerships with key stakeholders to bring about whole system, needs-led approach in line with ministerial priorities.

Rationale for TARGET Risk Score:

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

While trajectory plans are in place, the Health Board has recognised WG targets will not be achieved by the service in its current format, with a further deteriorating position in performance anticipated, compounded by the end of procurement contracts with external providers in March 2025.

The achievement of the target risk score is dependent on Welsh Government ring-fenced funding being made available on a recurrent basis, being exempt from cost savings initiatives 2025-2026 in order to maximise opportunities to outsource diagnostic assessments this financial year, service re-design and waiting list initiatives are completed and implemented. Furthermore, the development of a regional, collaborative strategic approach with key stakeholders is imperative to creating whole system, needs-led integrated services. Digital enablers such as artificial intelligence and licenses for digital platforms essential along with access to appropriate clinical venues essential to help reduce target risk score.

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 to encourage blended approach to working. Additional WG funding announced - £980,000 allocated to Health Board; funding ring-fenced for CYP service 2025-2026 Weekly Autism Advice Hubs in place for parent carers and CYP Rolling programme of workshops offering advice and support around neuro-diversity for parents of children awaiting diagnostic assessment. ND Service Delivery Manager in place to oversee 3 year performance improvement plan and drive innovative practice in line with WG policy and legislation. Workforce stabilised with no retention issues. Workforce Management Group established and workforce plans in place. Trajectories have been agreed for Children's ND by NHS Executive and systems in place to monitor waiting lists at service level performance-management meetings, IPAR and Clinical Care Group BPPP meetings. Use of HB Third Party Contractor to send out Keeping in touch letters to those on ASD waiting lists on a 3-4 monthly basis confirming place on waiting list and signposting to sources of support including access to ND services and other services while waiting. Outsourcing procurement exercise underway to eradicate 3 year waits by March 2026. Contract to the value of £4m to outsource over a 3 year period,	Although dedicated premises have been sourced for ASD services, there is limited cRapid Design Event to achieve critical, systemic and needs led transforlinical space and Estate issues remain a challenge as identified in the risk narrative. Lack of certainty around future funding of ND services. Allocated monies 25/26 are non-recurrent. Uncertainty around RPB infrastructure to help support and deliver regional transformation to needs-led, whole system approaches Lack of capacity within ND services to work strategically to bring about transformational change across the 3 counties. Current capacity within ND services limited due to competing operational responsibility pressures. Lack of a regional partnership strategic action plan to help bring about transformational change across the 3 counties involving all stakeholders.	Grow your own' scheme is coming into place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme (3 year programme).	Carroll, Mrs Liz	~~31/12/2024~~ 31/12/2027	Three year training programme with graduates during 2027.
		Service have been asked to provide a range of options for the Exec Team to consider to improve the performance target.	vaughan, Catherine	Completed	Paper presented to Executive Board on 10th September. To be presented at Public board
		Development of an SBAR for IQFPD and Public Board outlining a 3 year improvement plan involving increasing workforce, substantiating posts, outsourcing and service re-design	vaughan, Catherine	Completed	Paper presented to executives and scheduled for next public Board meeting outlining phases of 3 year improvement plan
		Undertake a stratification of need of existing waiting list	vaughan, Catherine	31/03/2026	Commenced 1st October. Challenges centre on all assessments needing completion within 8 weeks of 1st appointment. Work progressing with thematic analysis of drivers for referral underway in order to inform re-design of service to needs-led
		Recruit into additional administrative and clinical posts and make existing fixed term posts substantive	vaughan, Catherine	31/01/2026	Recruitment underway in October 2025
		Outsource a minimum of 585 diagnostic assessments to eradicate >3 year waits	vaughan, Catherine	31/03/2026	Procurement exercise underway to award contracts to 2 providers

commenced in 2025, with the option to increase to 5 years as funding allows Monthly touchpoint meetings with NHS Improvement & Performance to monitor progress against ministerial priorities. SMS text functionality in place for ND to improve attendance and decrease instances of non attendance. Fixed term posts made substantive Early Years pathway and toolkit for Health Visitors in place to encourage a 'watch and wait' approach. Professional consultation introduced across statutory sectors Website developed and in place for all-age ND services. Quarterly 'keeping in touch' letters sent to parent carers of CYP on waiting list signposting to sources of support while they wait. Stakeholder mapping exercise completed and engagement plans in progress		Develop an all-age regional strategic action plan around neuro-divergence to promote whole system, needs-led services	Temple-Purcell, Rebecca	31/03/2026	New action, with progress update required at next risk review
		Introduce an AI scribe across service to reduced administrative burden on clinical staff	vaughan, Catherine	31/03/2026	Meetings in place with ND, CDPS, Digital and Information Governance services to pilot an AI Scribe - namely Magic Notes. DPIA underway
		Develop and appoint into a strategic Head of Neuro-divergence post, to strengthen existing and further develop strategic partnership working	Temple-Purcell, Rebecca	31/03/2026	Progress to be provided at next risk review

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	System to improve analysis of patient experience				
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd								
	MH&LD QSE Group overseeing patient outcomes	2nd								
	Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd								
	W-PAS Internal Audit (reasonable assurance)	3rd								

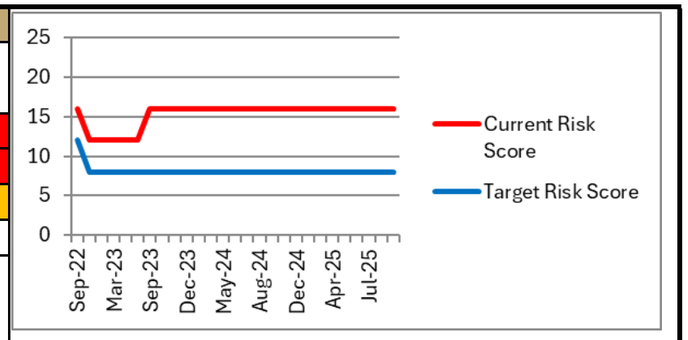
	Rapid Access Pilot Steering Group (add as action - look at other pathway options/digital) - renamed ASD Task and Finish group and run fortnightly, sponsored by Executives	1st			waiting times that the Directorate have at present. A paper was presented at Board Seminar in March 2025 to provide assurance on current waiting times and control measures.				

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

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

Risk ID:	**684**	**Corporate Risk Description:**	There is a risk to the radiology service provision from breakdown of key radiology imaging equipment and associated infrastructure to enable equipment to function. This is caused by equipment not being replaced in line with RCR (Royal College of Radiologists) and other guidelines, and also lack of suitable physical space and electrical infrastructure. This could lead to an impact/affect on patient flows resulting from delays in diagnosis and treatments, delays in discharges, increased waiting times on cancer pathways, increased staffing costs to minimise the impact on patients when breakdowns occur and increased number of SCP breaches and breaches over 8 weeks due to increased downtime. Increased risk of IR(ME)R notifiable radiation incidents due to increased breakdowns as a result of malfunctions during exposures.
Does this risk link to any Directorate (operational) risks?		925, 114, 1668, 1785, 1706	

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	30/08/2050
Trend:	⟺



Rationale for CURRENT Risk Score:
The Health Board’s aged imaging equipment continues to break down, disrupting diagnostic services and affecting Referral to Treatment (RTT) targets, with delays in diagnosis and treatment for patients. Replacement of CT and MRI scanners has reduced downtime, but recurrent failures of other key equipment highlight the need for further investment. A rolling programme and prioritisation process are in place to manage installations. The Gamma camera at WGH, the only unit of its kind in the Health Board, has suffered repeated breakdowns, leading to HIWâ€‘reportable IRMER incidents. It remains a priority for replacement as of February 2025. At GGH, a new CT scanner has been installed, but the original unit continues to fail due to outdated technology, undermining resilience at the major trauma site. Likeâ€‘forâ€‘like replacement is not always costâ€‘effective or compliant with regulatory and warranty requirements, and infrastructure upgradesâ€”such as air handling, water chillers, and accommodation adjustmentsâ€”are needed to ensure longâ€‘term resilience. Replacement of the Gamma camera at WGH has been delayed due to insufficient physical space and electrical infrastructure, with costs exceeding Welsh Government allocations for 2025/26. The funding window was closed, further impacting compliance with NRW specifications for Nuclear Medicine. Future plans must be coordinated with Estates to expand electrical capacity and ensure facilities meet current and future Nuclear Medicine requirements.

Rationale for TARGET Risk Score:
Modern equipment will reduce the likelihood of breakdowns, minimize downtime, and lessen the impact on diagnostic services across other hospital sites. Strengthened business continuity planning will further mitigate risks associated with equipment failure. However, funding is typically released in Q3/Q4 of the financial year, constraining the scheduling of large installations. The urgency of replacements often forces rapid decisions, resulting in lowerâ€‘priority equipment being replaced ahead of higherâ€‘need installations. The Health Board’s top replacement priority is the Nuclear Medicine SPECT scanner, the only unit available which has suffered frequent breakdowns since June 2023. A task and finish group has been convened to plan its replacement in anticipation of Welsh Government funding. The second CT scanner at GGH is the next priority, as it supports outpatient work and serves as a backup; it is increasingly unreliable, with long lead times for parts. Additionally, service variation in DEXA provision has worsened, as the Swansea scanner now performs Trabecular Bone Scoring (TBS), while the BGH scanner cannot. Patients have required repeat scans to obtain TBS results, and the BGH unit also runs on an unsupported Windows version, posing further risk. Replacement of the Nuclear Medicine SPECTâ€‘CT, the second CT scanner at GGH, and the DEXA scanner at BGH would allow risks to be de-escalated to the operational risk register. Completion is dependent on WG funding and may extend to the end of the 2026-27 financial year due to infrastructure requirements.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS** **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports. # Escalation process in place for service disruptions/breakdowns. # National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales. # All equipment at main sites are now DR and so will be compliant with the RISP project # Additional WGH EOY funding was secured (23-24 financial year) and replaced aged US units and upgraded the software on MRI scanners at BGH and WGH providing latest technology.	Limitation of spare parts for some older equipment leading to extended outages. This issue has been compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment. Inability to undertake specific replacements at this time due to the additional infrastructure required National Imaging and Capital Priorities Group outcomes do not always align with the Health Board priorities, and is subject to negotiations within the group.	Installation of replacement Gamma Camera, WGH 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.	Roberts-Davies, Gail	~~31/07/2024~~ ~~30/06/2025~~ ~~31/03/2026~~ 31/03/2027	No funding allocated as of 09/02/2024 This will not be replaced in the 24/25 financial year. A specific T&F group is due to be set up as of June 24 to plan the necessary accommodation improvements required. July 2024 the T&F group has been set up and meets weekly Feb 2025 there is a draft plan for replacement. Business continuity plans being explored. The plan has been rejected by WAG for 25/26 due to cost and the electrical instruction T&F looking to alternative sites and will resubmit for funding in 26/27.
		Replacement of aged CT Scanner at GGH	Procter, Sarah	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ 31/07/2026	Awaiting confirmation of funding as at December 2023. No funding allocated as of 09/02/2024 This will not be replaced in the 24/25 financial year. Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The CT replacement of the aged at GGH has been recommended, however funding has not yet been formally agreed.

Replacement of Fluoroscopy room, WGH	Whitecross, Faith	~~31/03/2024~~ ~~31/07/2024~~ ~~31/03/2025~~ ~~31/08/2025~~ 31/03/2026	Additional infrastructure required to replace this piece of equipment and so will not be completed until the 2025-2026 financial year. Update feb 25: funding approved for installation of fluoroscopy equipment 25/26 financial year. Update Aug 25: Work starting Sept 25
Replacement of CR X-ray Room 1, WGH	Roberts-Davies, Gail	Completed	Ageing equipment. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. This will not be replaced in the 2023/24 financial year Confirmation that this piece of equipment will be replaced in the 24/25 financial year was received late May '24- action will be closed when this piece of equipment is operational. Equipment replacement complete as of 08/04/2025- awaiting acceptance testing. Update 04/07/2025 confirmation from Site Lead Faith Whitecross that the acceptance testing was completed 02.04.2025. SQ

Replacement of CR X-Ray room, Llandovery Hospital	Osell, Fiona	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ ~~01/12/2025~~ 31/03/2026	Equipment on site is incompatible with the incoming PACS system X Ray room continues to be in use one day per week (Tuesdays) staffed by 1 Radiographer (B5 or B6). Regular maintenance of equipment continues and required QA testing. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. This will not be replaced in the 2025/2026 financial year. Progression of this project reliant upon the outcome of the clinical services plan which is out to consultation
Replacement of Mammography Units, BGH and WGH	Roberts-Davies, Gail	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ 31/03/2027	Ageing equipment, exacerbated by the failure of Securview. These will not be replaced in the 23/24 financial year These will not be replaced in the 2024/2025 financial year These will not be replaced in the 2025/2026 financial year
Upgrade or replacement of MRI scanner, GGH	Procter, Sarah	~~31/03/2024~~ ~~30/06/2025~~ ~~31/03/2026~~ 31/05/2026	Replacement agreed and funding available for replacement in March 26

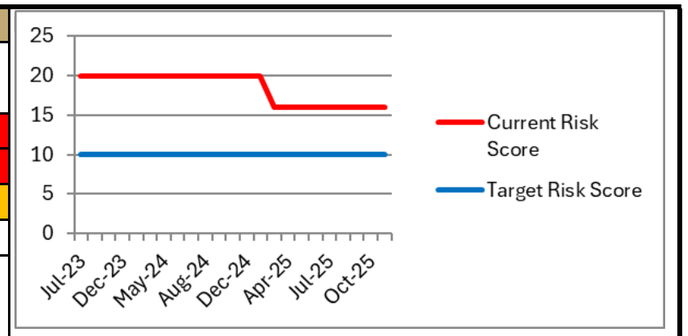
To replace the DEXA scanner at BGH and ensuring suitable accommodation is found to meet regulatory compliance for a larger more modern scanner.	Edwards, David	~~31/03/2024~~ ~~30/09/2024~~ ~~30/09/2025~~ 31/03/2026	Unit is 17 years old, and previously funded via charitable funds This has been added to the imaging priorities list and end of year additional funding projects as relative replacement costs are not high, however the infrastructure enablement costs are additional and a suitable location to accommodate a larger scanner needs to be found. Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The replacement of the aged DEXA scanner at BGH has been recommended, however funding has not yet been formally agreed.
Collaboration with Estates to ensure requirements for Radiology at all sites are considered and are integral to future decision-making for site allocation	Procter, Sarah	Completed	After discussion with Head of capital estates - it was decided to arrange a meeting with Strategy and Planning including estates. New action added Initial communication to be established in June 2025 to agree on timelines for future workplan. Estates are currently part of Task & Finish Group, however Head of Engineering to be invited. Further actions to be added based on outcomes.
Arrange meeting with head of capital planning and head of strategy and planning to discuss long term strategy for equipment replacements.	Procter, Sarah	30/11/2025	Meeting being arranged
Meeting with head of capital planning to discuss plans for CT and NM replacement in near future.	Procter, Sarah	30/01/2026	meeting to be arranged in Dec/ early jan

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

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

Risk ID:	**1664**	**Corporate Risk Description:**	There is a risk to service sustainability in Ophthalmology, and the inability to provide timely care to patients with Glaucoma, wet Age Related Macular Degeneration, Vitreoretinal, paediatrics and Cataract. 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. Recruitment difficulties are leading to the Consultant on-call rota being covered by four substantive Consultants with 2 gaps in the rota. To ensure the delivery of the Ophthalmology service the Consultants undertake additional duty hours. The first on call structure is currently reliant on 5 SAS doctors with 3 gaps in the rota, which is being covered by the substantive SAS doctors currently. This is a fragile on call structure which is impacted by sickness and annual leave. This could lead to an impact/affect on ability to deliver services within the Ophthalmology Referral to Treatment (RTT) plan, and the ability of the Health Board to comply with Welsh Government Eye Care Measures (ECMs). Impacting 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. The Health Board's ability to progress with the implementation of recommendations raised by various regulators and inspectorates is affected by the recruitment and estates issues, which in turn could lead to adverse publicity and reduction in stakeholder confidence, with increased scrutiny/escalation from Welsh Government. The service has undertaken successful recruitment of three specialty Doctors who have recently started in post, this will improve capability and capacity in part. Regional work regarding 2 Regional substantive Consultant posts to fill the vacancies within the team continues
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	31/03/2027
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1 patients (high risk) with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional AMD sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the HB. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. The current R1 delivery at 34%. The WG target for R1 delivery is 95%. The current waiting list for new patients is 15,074. The service is expected to reach 0 patients waiting at stage 1 over 52 weeks by March 2026. The stage 4 104 weeks, is breach of 8. 7518 patients have been 100% delayed for their follow up appointment. The current impact has been scored as 4 because patients are experiencing harm and the current likelihood has been scored 4 as ophthalmology is a fragile service. It is unlikely that this risk will be able to be significantly reduced without considerable investment.	the service has been able to reduce the impact score of this risk as whilst the consequences to the patient remains high, recurrent funding has been invested into the service for the delivery of an R1 Eye Care Measures target of 65%. The ministerial Measures target will need to be 0 for 3 months and more and the Follow up delayed will need to be reduced by 12%. Once these targets are reached, the likelihood score can be reduced to a 3 which would reduce the overall score to 12. The 65% R1 delivery by September 2026 is dependent on all posts being recruited into and all estates needs being met. Further development would be required to reach a 95% R1 delivery score, which would reduce the likelihood to a 2. With the required investment in Glaucoma and IVT and the additional workforce and estates and continued management of the waiting lists, the HB will potentially be able to reduce the likelihood score on this risk to a 2.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
The service is included within the Health Board's Clinical Service Plan (CSP). This will produce efficiency gains. Active recruitment to vacancies through a regional approach, continue grow your own initiatives to secure Substantive Consultants and develop Consultants for the future. Regional SBAR has been developed around 2 Regional Substantive posts. Collaborative working with Swansea Bay to deliver a Regional solution to address the workforce and estates constraints. Sub groups to be formulated to address, Glaucoma, AMD, Vitreoretinal, paediatric and cataract pathways.	Vacancies remain high within the service with a high turnover of staff. SBAR for Regional Consultant posts has been approved for funding to be allocated to SBUHB. An SLA needs to be agreed to move forward to recruitment. The Regional sub-groups are in their infancy with actions being taken to develop sub-specialties. The Posts for the (AMD) service need to	Roll out and implementation of National Electronic Patient Record for Ophthalmology.	Barreiro, Marta	~~30/07/2021~~ ~~31/03/2022~~ ~~31/05/2022~~ ~~30/09/2022~~ ~~31/10/2023~~ ~~31/12/2023~~ ~~31/03/2024~~ ~~15/07/2024~~ 31/03/2027	Application Support Manager recruitment successful, awaiting onboarding and a start date. Workshops planned for the varied subspecialties to go through needs for each to enable the build up of the system workflows as soon as the Application Support Manager is in post.

Additional funding for the delivery of Wet Age related Macular Degeneration (AMD).IVT outsourcing commenced in February 2025 continues to support the service, whilst service is developed. Additional capacity has been funded for the delivery of Cataract surgery to maintain the 104 week wait for 2025/2026. Wales General Ophthalmic Services (WGOS) for Glaucoma, Diabetic Retinopathy and Medical Retina ongoing. Continued Validation of waiting lists to remove any patients who no longer require treatment. With review of data quality inclusive of Health Risk Factor (HRF) code and clinical codes ongoing to improve data quality. Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. The first regional ECCG meeting was held on the 19th September 2025. Highly trained Optometrists working collaboratively with the Secondary Care Eye Service to reduce referrals to secondary care and support the validation process. Ongoing training of Optometrists within secondary care for IPOS, Glaucoma and Medical Retina for continued delivery of WGOS and reduce referrals into secondary care. GIRFT review undertaken on the Ophthalmology service with progress made against recommendations raised monitored and updated via AMAT. Performance dashboards in place to monitor performance.	be recruited into and the space for the expansion of the service in AVH needs to be secured for 5 days a week. The regional cataract delivery plan needs to be developed and executed. A WGOS co-ordinator needs to be secured in primary care to support the discharge of patients to the community. The remaining 9 GIRFT recommendations need to be actioned and closed. There still remains areas of the service (e.g. Glaucoma, AMD, Cataract, Paediatrics, Corneal and VR) that require investment. The regional programme board will need to consider further opportunities for a long-term regional model. Central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. Recovery funding is non-recurring and reviewed annually, which restricts delivery planning. There are ongoing concerns in data quality due to referral processes and system use.		

Refurbish and establish a nursing team in the Outpatient Department in Amman Valley Hospital to provide intravitreal treatment for the patients currently attending the day theatre area for their treatment. This will ensure continuity of care for those patients when cataract surgery activity is returned to day theatre.	Coppack, Victoria	Completed	Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) was completed in March 2022. IVT recovery SBAR presented to the Board with associated workforce and drug costs identified. Long term funding is being considered as part of the annual plan.
Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.	Coppack, Victoria	~~30/09/2022~~ ~~31/10/2023~~ ~~30/11/2023~~ ~~31/03/2024~~ ~~30/06/2024~~ ~~30/09/2024~~ 31/03/2026	Recommence the validation of the HCQ patients. Ensure patients start to be discharged to primary care Optometrists when training has been completed. Primary Care still awaiting materials to be finalised and process rolled out.
Alignment in the Delivery of Eye Care Measures and Ministerial Measures and effective management of Ophthalmology waiting lists.	Coppack, Victoria	31/03/2027	Recruit into 2 regional consultant posts. Deliver actions against regional programme board. AVH OPD to be secured for additional 2 days IVT. Deliver 52 week and 104 week target. Deliver 12% reduction in follow up delayed. Ensure all WGOS patients identified for pathway are discharged to primary care. Complete GIRFT recommendations. Continue with Clinical Services Plan.
Long-term investment required for IVT and Glaucoma Delivery to recover R1 position	Jones, Keith -	Completed	New action - progress update to be provided at next risk review.
Regional solutions to workforce gaps and estates to be explored through Regional programme	Coppack, Victoria	31/03/2027	Regional visit to SBUHB completed. Next Regional Eye Care programme Board meeting 31st October 2025

		Orthoptist posts to be recruited into	Coppack, Victoria	~~30/09/2025~~ 31/03/2026	Band 6 1.0 WTE Orthoptist post to be recruited into. Band 8B JD has been signed off by job matching panel. Next steps to identify the funding for this post and authorise through CCG and FCSG.

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

Date Risk Identified:	Oct-25
Strategic Objective:	

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

Risk ID:	**2190**	**Corporate Risk Description:**	There is a risk that the Health Board will be unable to implement Direct Payments for Continuing Healthcare by 1 April 2026. This is caused by the reduced implementation timescale from December 2026 to 1 April 2026, the absence of WG policy guidance (which will not be issued until April 2026) and insufficient resource and capacity to support local implementation within the Health Board. This could lead to an impact/affect on service delivery, with service users not being treated fairly due to a disparate approach resulting from lack of National policy guidance and local governance arrangements. There is potential of increased complaints and Ombudsman queries, and reputational damage to the Health Board in failing to meet national policy. There is also a potential financial impact due to increased costs associated with Direct Payment implementation, and the number of cases that are likely to present in the future.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		**No trend information available.**
Domain:	Quality/Complaints/Audit	
Inherent Risk Score (L x I):	4×4=16	
Current Risk Score (L x I):	4×4=16	
Target Risk Score (L x I):	3×4=12	
Expected Date To Achieve TRS:	31/03/2026	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:
There is a lack of clarity and national guidance regarding the proposed model for the delivery of Direct Payments, and the time available for implementation which has reduced significantly with proposed date of implementation brought forward from December 2026 to 1 April 2026. There are serious concerns that governance and safety requirements will not be adequately established to meet the revised implementation date, which may increase the risk of inconsistent approaches across Health Boards. The Health Board does not currently have a system in place to manage or deliver Direct Payments in order to comply with the requirements of the forthcoming policy. Robust governance systems have yet to be developed, and there is a notable absence of dedicated resource, and specialist expertise. Delivery within such tight timescales will require additional resources, with a small core of dedicated staff based within a national Hub supported by professional and financial expertise. Each Health Board will also be expected to put in local arrangements to support delivery at a local level. Without additional resources, staff may be unable to allocate sufficient time to support implementation alongside existing duties.

Rationale for TARGET Risk Score:
A dedicated local resource is needed to meet legislative requirements by 1 April 2026. Clarity is needed from Welsh Government over guidance and implementation plans to enable robust governance and safety requirements. All Health Boards in Wales require a consistent approach to direct payments. Whilst the implementation date is end of March 2026, there is no certainty that this can be achieved without the additional governance and resources.

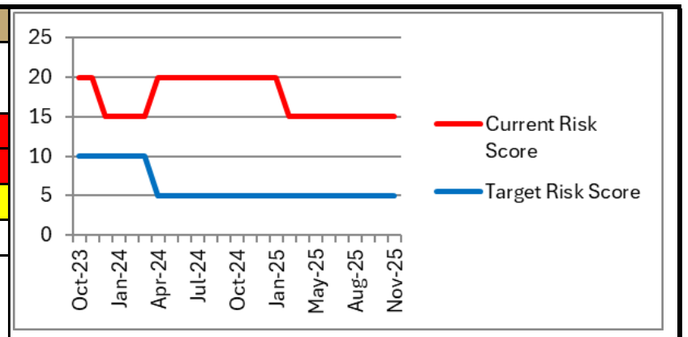
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Local Working Group which includes LTC , MHLD and Children's services as well as finance colleagues which meets monthly. However additional resources have not been identified or clarity on whether a national hub or resources will be available. National CHC leads group meeting already in situ with direct payments regularly discussed. There is also a Welsh Government direct payments policy team meeting with Health Boards on a monthly basis. 150k is being held by Powys Health Board and they have appointed a lead to support Health Boards on implementation.	No local or national implementation plan in place No development yet of a suite of all Wales protocols and operational guidance. Lack of dedicated resource to implement requirements. No financial protocols designed to support payments.	Hywel Dda input required to support Welsh Government national consultation and development of guidance	McCarthy, Julia	Completed	Health Board to attend Welsh Government policy team monthly meetings. Welsh Government have recently issued the consultation paper regarding the regulation of direct payments for response by 15 October 2025. In addition a further CHC DP draft guidance was given and comments needed by 19th Nov this has been submitted by the Service.
		Identify resources required to action and implement a working plan to deliver direct payments.	McCarthy, Julia	31/03/2026	Executive support has been asked at EITS on the 10th Nov. Local working group established.
		Develop and increase the skills and knowledge base in the Health Board for direct payments and their operation	McCarthy, Julia	31/03/2026	Will require dedicated resource. Has been discussed at last EITS 10th Nov for support needed.

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
Reviews completed in line with the national framework. Number of packages and costs reported monthly to local governance forums. Papers are submitted via the CCG IGG. Welsh Government may require reporting but that is yet to be confirmed	There are current finance reporting and review monitoring arrangements in place that could be adapted when direct payments are implemented and would be reported through the CCG and IQFPD. .	1st								
	Recent internal audit of finance procedures received substantial assurance .	2nd								

Date Risk Identified:	Nov-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Oct-25
Strategic Objective:		**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Nov-25

Risk ID:	**1531**	**Corporate Risk Description:**	There is a risk of being unable to provide a safe and sustainable general surgery consultant on-call rota at WGH and GGH. This is caused by Unsustainable and fragile rotas, with a difficulty to recruit into substantive posts. This could lead to an impact/affect on on the ability to provide an emergency general surgery service at WGH and GGH affecting patient experience, causing clinical delays and poor outcomes for patients. The wellbeing of remaining consultants who are already working to full capacity are also affected and there is an increased expenditure on agency locum consultants and internal locum rates at the HB card rate. Consultants working additional on call locum weeks is resulting in a reduction in elective activity in OPD, endoscopy and theatre. This could have a negative impact on RTT and SCP targets.
Does this risk link to any Directorate (operational) risks?		2067	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Expected Date To Achieve TRS:	27/02/2026
Trend:	⟷



Rationale for CURRENT Risk Score:
Whilst surgical consultant on-call rotas at GGH and WGH are covered, the service is still reliant on NHS locums and agency locum consultants. This situation will remain the same until substantive upper GI consultants are recruited to address the emergency on-call rota risk and the Upper GI service risk at WGH. Recruitment has been successful to the substantive post at GGH with the candidate commenced in post. One post has been successfully recruited to at WGH with the applicant onboarding, and the second post re-advertised as at November 2025. It is anticipated that both will have fully onboarded by February 2026.

Rationale for TARGET Risk Score:
The target risk score is based on the work currently being undertaken as part of the Clinical Services Plan to identify and approve a more sustainable solution in order to reduce the likelihood of rota collapse and reduce the risk of not being able to provide a safe and sustainable emergency general surgery service to patients in the south of the Health Board. The effectiveness of revised rota arrangements will depend on several factors including availability of a labour market. Achievement of the target risk score is dependant on the outcomes of the Clinical Services Plan which will inform future plans or the successful appointment of substantive upper GI consultants to the current model at WGH. The risk score will reduce on the appointment of substantive consultants. Should the service be able to recruit suitable candidates to the three upper GI substantive posts, it is anticipated that they rotas at GGH and WGH will be fully functioning by February 2026.

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

	To hold interviews to appoint NHS locum consultant	Lewis, David	Completed	Job descriptions have been sent for Royal College approval in April 2025.
	To agree job descriptions and advertise for three substantive consultant posts	Lewis, David	Completed	The two substantive upper GI consultant posts have been advertised and shortlisting is currently being undertaken. If there are suitable candidates, interviews will take place on 2nd September. The substantive lower GI consultant post will be advertised in Spring 2026, in readiness for the end date of the NHS locum that has been appointed.
	Successfully recruit 2 x substantive upper GI consultants.	Lewis, David	~~30/09/2025~~ 31/01/2026	2 candidates were successfully recruited and 1 is currently onboarding. The service withdrew the offer to the second candidate and the post is currently back out to advert.

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, Sep 24, Oct 24) SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23) General Surgery	Assurance to Board on communication and repatriation arrangements				

Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd			Report to Board (Mar23) Management team to present updated SBAR to Acute Leadership Group (Oct23 & Nov23) Management team to present updated SBAR to Corporate Directorate Group (Apr24) Upper GI service SBAR presented at ALG (Sep24) Upper GI service SBAR presented at Quality, Safety and Experience committee Meeting (Oct24) Updated SBAR to Executive Team (Nov24) Options Appraisal via CSP to Board (Nov 24)					
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								

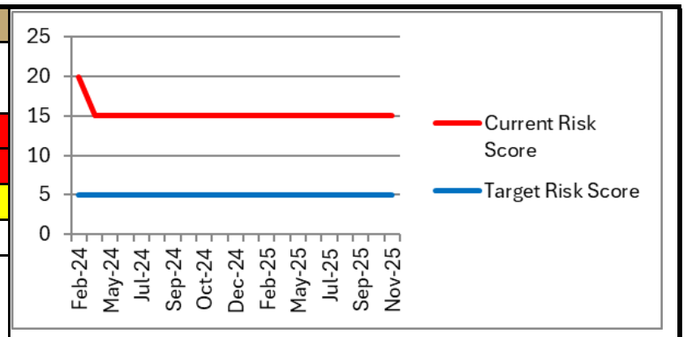
	GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited(3rd,				Upper GI service SBAR presented at scheduled care directorate QSEAC (Jan25)			

Date Risk Identified:	Feb-24		
Strategic Objective:			

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

Risk ID:	**1810**	**Corporate Risk Description:**	There is a risk that the Health Board will be unable to continue manufacturing cancer treatments for our patients. This is caused by the facilities of the Pharmacy Aseptic Unit being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS) standards 5th edition (published 2016) and therefore at risk of closure, exacerbated by a fragile workforce within the service. 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 approximate £1m each year. Some therapies cannot be outsourced, meaning Hywel Dda could not offer over 500 cancer treatments each year. This would have a significant negative impact on patient care as patients would either be required to travel further from home to neighbouring Health Boards to receive their treatment (dependant on their capacity to absorb the additional demand) or would be offered less clinically appropriate treatments at Hywel Dda, negatively affecting clinical outcomes. The closure of the Aseptic unit would directly impact the ability of the Health Board to achieve ministerial priorities and targets such as the Single Cancer Pathway, A Healthier Wales, etc.
Does this risk link to any Directorate (operational) risks?		2004, 374, 1350, 716	

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Expected Date To Achieve TRS:	31/12/2026
Trend:	⟷



Rationale for CURRENT Risk Score:
Withybush Aseptic Unit is the only remaining aseptic unit in the Health Board capable of producing cancer treatments. However, it is currently non-compliant with regulatory standards. A 2024 audit deemed it a high risk to patient safety, and a 2025 follow-up confirmed ongoing staffing issues and insufficient resources to maintain quality standards, putting the unit at risk of forced closure. Temporary control measures have been implemented to reduce microbial contamination and delay closure (see control measures), but the aging infrastructure means these measures may soon become ineffective. If contamination increases, the unit may be forced to close. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality.

Rationale for TARGET Risk Score:
The target risk score is based on the premise that a new demountable aseptic unit will be built at Withybush in 2026. 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. It is anticipated that the current risk score could be reduced to 10 once the unit is operational, expected to be September 2026. Achievement of the Target Risk Score of 5 is expected once workforce fragilities have been addressed, anticipated to December 2026.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** 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. Findings from the audit undertaken in February 2025 highlighted the fragility of the workforce due to key person dependencies which could detrimentally impact on the service. 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.	More staffing resource is required to support the aseptic unit's quality system, to ensure that all other regulatory standards are adequately met to mitigate the risk of the non-compliant facilities.	Morgan, Cerith	~~30/09/2026~~ 30/12/2026	Internal staffing model has been reviewed to allow the Health Board's lead quality assurance pharmacy technician to provide more support to the quality system. Initial discussions held with other Health Boards to explore whether they have QA resource that could support Hywel Dda through a SLA. Invest to save SBAR developed that would support more staff to work within the aseptic unit through a cost saving opportunity (reducing outsourcing of Azacitidine).
		WG have approved funding for a new demountable aseptic unit. Aseptic project team to progress with planning for building the unit and confirm project timelines once finalised.	Morgan, Cerith	31/08/2026	Initial workshops with principal contractor and aseptic unit supplier have been undertaken. Based on current timelines - the new unit will be operational by September 2026.

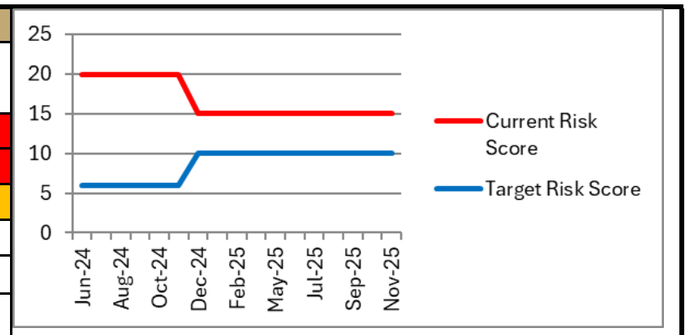
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

Date Risk Identified:	May-24
Strategic Objective:	

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

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

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



Rationale for CURRENT Risk Score:

There were specific concerns relating to Glangwili and Withybush General Hospitals regarding cardiac arrests and unplanned admissions. There was an increase in cardiac arrest rates in GGH in the period Jan-Dec 2024 (35) compared to the same period Jan - Dec 2023 (20). The first 10 months of 2025 noted a decrease in the Cardiac Arrest rates in GGH compared to the same period 2024, with 20 noted (2024:30).

There had been a 22% increase in unplanned admissions at WGH in 2024. In the first 8 months of 2025 there has been a reduction in the number of unplanned admissions into WGH ITU compared to the same period in 2024 (Jan-August 2025:50 (2024:67)).

As of 8th August 2025, compliance rates for Level 3 Resuscitation Training Adults is 64%, Paediatrics 45%, and Level 2 Training (BLS) is at 51% for adults, and 48% for Paediatrics, an improved position since June 2025. All planned actions to mitigate the risk are being processed within set dates/timeframes although many remain long term.

Current controls are managing the risk and the increasing awareness of gaps in assurance and local actions to mitigate and manage the risk have been established.

Rationale for TARGET Risk Score:

The full implementation of the actions noted in the risk action plan will support the reduction in the likelihood and impact score of this risk to a target risk of 10. With recruitment into the Resus Team and the establishment of a supported Cascade Training process the aim will be to see an increase in training compliance in both Level 2 & Level 3 training by October 2025 to >60%. This will enable the risk to be reduced to the Target Risk Score of 10, >85% would enable the risk score to be reduced further to 5. We will aim to see a reduction in Cardiac Arrest rates across all 4 sites and unplanned admissions into ITU from ward areas by October 2025.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Governance structures in place eg RADAR Group (Recognition of Acute Deterioration and Resuscitation). Increased awareness of gaps in assurance and local actions in place to manage and mitigate the risk. T&F Group chaired by HB RADAR Lead with focus on Sepsis. RADAR directly reports to Quality and Safety Intelligence Group (QSIG) Local RADAR groups (across all sites, counties, MHLD and Paediatrics) which report to Health Board wide RADAR group. Mechanisms in place across all sites to monitor cardiac arrest rates. Health Board Resus policy in place (currently under review and updated to reflect National Guidance) All Wales DNA/CPR policy in place and has been uploaded onto the Health Board intranet. Clinical Lead Nurse for Acute Deterioration 1WTE Dedicated Resuscitation Team in place, consisting of 5.2WTE across the Health Board (acute, community, mental health and primary care) and one 1WTE admin support. WAST have remained with the patient and allowed the HB to utilise their pre hospital mechanical device equipment within the hospital setting.	Treatment escalation plans not in place but continued to be discussed at WGH and GGH Call for Concern only for inpatient adult patients only and at the moment is only across 2 sites. Inconsistent application of policies and processes eg DNA/CPR, sepsis assessment tool, National Early Warning Score (NEWS). Reliance on manual / paper based documentation to record patient deterioration and subsequent escalation	Health Board Recognition of Acute Deterioration and Resuscitation (RADAR) group to develop a workplan to address gaps in control to improve the recognition and management of acute deterioration across the Health Board.	Davies, Mandy	Completed	Quarterly meetings in place, and sub-groups being established to report to Recognition of Acute Deterioration and Resuscitation (RADAR) group on sepsis, NEWS, treatment escalation plans, call for concern (Martha's Law) DNA/CPR, acute kidney injury (AKI). Agenda at August meeting didn't allow for discussion on the development of a workplan. Plan is to confirm RADAR Action Plan, with risk actions to be updated accordingly. RADAR next scheduled to meet on 7th October 2025.
	Critical Outreach Services not in place at PPH / BGH Inability to release staff to complete L2 and L3 training High number of newly qualified new nurses to the HB including overseas requiring support to develop their expertise in recognising acute deterioration. Training requirement to meet	To implement an electronic observations systems across the Health Board to capture real-time bedsite capture of patient assessments and monitoring, in line with the Health Board's Digital Plan	Williams, Carolyn	~~30/09/2025~~ 30/04/2026	Tender process completed. Business case presented to Board in July 2024, with a view to implement on a site by site basis over in 18 months, in line with the current Digital Plan. Board approved the business case in Sept 24 however funding has not yet been identified to enable the project to proceed.

Networks in place across the wider Health Board, including support from QIST (Quality Improvement Service Transformation) Team and practice development. Organisational training plan in place, including mandatory training Critical Outreach Services in GGH and WGH (not in place at PPH/BGH), managed by Planned and Specialist Care Clinical Care Group (i.e not fully linked to Acute Deterioration resource) New Acute Kidney Injury (AKI) Lead appointed for GGH until October 2025 Dedicated resource in Quality Improvement Team monitoring AKI alerts for the Health Board Bi-monthly scrutiny meetings have been set up in GGH, BGH and WGH to review Cardiac arrests. Cardiac arrest reviews presented at Medical Education sessions Review of feedback from any Medical Examiner reviews, highlighting issues relating to resuscitation/cardiac arrests and lessons learned. Call for Concern in place at GGH and WGH for inpatient adult patients only. Process for implementation in Paediatrics, Mental Health and remaining sites under review. Cascade Trainers in place across the Health Board (community and acute)	Training requirement to meet recommended Resus Council Standards greater than current allocate Resuscitation Team resource 60 - 70& attendance of courses, even if fully booked. Current resource not being used to full potential with financial implications. Inconsistent and irregular site RADAR meetings which report in to HB-wide RADAR Group, with lack of medical leadership Whilst there is a dedicated Resuscitation Team in place, the HB does not have a Mechanical CPR Device in any of its Acute Sites. The Resuscitation Council Guidelines for Resuscitation state thatÂ a LUCAS is a good alternative for situations where it may be difficult or to maintain continuous high-quality compressions, or when it may be too strenuous on the medic to do so. There have been occasions when WAST have remained with the patient and allowed the HB to utilise their pre hospital mechanical device equipment within the hospital setting. However, this is not routinely or officially suitable practice.	As part of the Quality Dashboard, agree the matrix needed for patient deterioration. Include these matrix in the Health Board Quality Dashboard to inform escalation and create a specific dashboard for RADAR (Recognition of Acute Deterioration and Resuscitation).	Wastell, David	~~30/05/2025~~ ~~30/09/2025~~ 31/12/2025	Supporting metrics for the dashboard identified: sepsis, AKI, NEWS audits, cardiac arrests, number of MET calls, treatment escalation plans are in place, call for concern rates and training compliance for ILS and BLS. Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system. Data being supplied however further work required to align to the new operational CCG structures on the dashboards.
		Put in place process for Health Board compliance with Martha's Rule by establishing a Task and Finish Group to implement Call for Concern	Wastell, David	~~31/03/2025~~ 31/12/2025	Task and Finish Group is in place, chaired by Anna Chiffi. SOP Patient leaflet is being developed and a pilot was due to commence in GGH in Feb25. This pilot will test the process to roll out across the organisation for Adult Inpatients. Pilot scheme at GGH implemented in March 2025, with a view to rolling out to other three acute sites by December 2025.

Put in place All Wales Policy for treatment escalation plans to enable safe and effective care management when patient deteriorating.	Edmunds, Dr Eiry	Completed	Discussed at Withybush RADAR meeting in July 2024 where agreement reached for pilot. Task and Finish group being established by Lead for Critical Care Outreach in Withybush to devise an implementation plan. RADAR to review following evaluation and consider roll out across other sites. As of September 2025, the situation remains unchanged. TEPS sub group meetings have been held at WGH but there is no set plan at the moment to implement or trial. To discuss at RADAR meeting scheduled for October 2025. Palliative Care Consultant has been appointed as the TEP Lead for the Health Board.
Work to improve compliance with Sepsis Bundles at the front door.	Wastell, David	31/12/2025	Ongoing quality improvement in place. Has demonstrated improvements in Glangwili and Prince Phillip and now being used in Withybush. Reviewing process for assessing impact on patient outcomes as a result of the response and management of sepsis. Implemented in July 2025, and audits to be undertaken to monitor compliance.

Improve compliance with DNACPR National Guidance	Steele, Cathie	Completed	DNACPR Review Group formed and actions identified including development of a SharePoint page (which is now complete) and undertaken an improvement project through EQIiP (complete). Annual audits undertaken by junior doctors, and reviews of medical examiner reports and cardiac arrest to identify learnings. More robust communication between mortality review group and RADAR being established. Training needs have been identified in relation to DNACPR and patients who are considered having learning disabilities, or diagnosed with dementia. Work is commencing with the MHLD directorate to progress this. A full action plan as been agreed in response to the HIW National Report on DNACPR (see AMAT)
Development of an Acute Deterioration Sharepoint page for all advice, guidance, updates, for staff on issues relating to resuscitation, DNACPR, sepsis, call for concern, MET calls, training, etc.	Wastell, David	Completed	Senior nurse for acute deterioration is working with Interim ADN for Quality and Safety to develop SharePoint page. Refinement of the Sharepoint site underway to finalise and launch as of September 2025.
Acute Deterioration E-learning modules - topics include NEWS, sepsis, DNACPR and A-E assessment being developed by the Lead Nurse for Acute Deterioration in conjunction with NHS Executive and other leads. Work to develop a process for using these modules with clinical areas in response to issues of concern.	Wastell, David	~~31/01/2025~~ ~~30/06/2025~~ ~~30/09/2025~~ 31/12/2025	Currently awaiting national updates in order to progress with this action. Links to the modules have still not been established (as of September 2025) because the guidance around NEWS2 and Sepsis is still under development.

To develop mechanisms to review and monitor the Acute Deterioration position via Escalation Framework via the Quality domain (including the implementation of the Safety Dashboard)	Davies, Mandy	Completed	Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system. This phase completed.
Following assessment and interpretation of the All Wales Direction, the Health Board is engaging in National work, namely roll out of Call for Concern.	Wastell, David	30/09/2026	Awaiting national guidance in order to progress further with this action as of September 2025.
Capital Bid to be submitted for 3-4 LUCAS machines (mechanical CPR machines).	Wastell, David	31/03/2026	New 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
Training compliance via ESR Cardiac Arrest Audits	RRAILS Audits undertaken by ward staff monthly, and inform the Nursing dashboards	1st			RADAR Group Update to QSESC,May 2025.	Ward based NEWS audits in place but may be unreliable as self assessed.	Once dashboards in place, to develop a monthly audit process to address key hotspots / areas of concern relating to RAILS	Wastell, David	~~30/09/2025~~ 31/12/2025	Progress to be provided once dashboards in place and functional for reporting to future RADAR meetings.
	Review of DATIX incidents, complaints, cardiac arrest reports and Medical Examiners reports relating to acute deterioration	1st								
	Outreach review all unplanned admissions to Intensive Care	1st								
	RADAR Group	2nd								

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