Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	05 December 2024
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risks Assigned to the Quality, Safety and Experience Committee (QSEC)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer Jill Paterson, Director of Primary Care, Community & Long Term Care Mark Henwood, Interim Medical Director Sharon Daniel, Interim Director of Nursing, Quality & Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Director of Corporate Governance Charlotte Wilmshurst, Assistant Director of Assurance and Risk

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

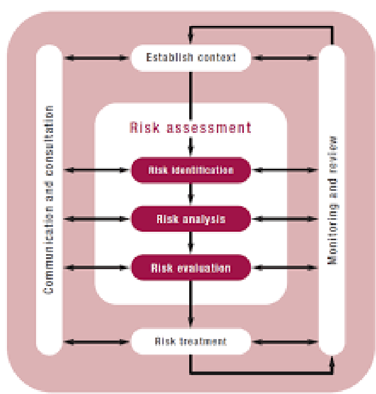
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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



(Risk Management Process, ISO 31000)

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

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

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

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

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

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

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

Asesiad / Assessment

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

The Terms of Reference state that:

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

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

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

There are 10 risks currently aligned to QSEC (out of the 21 that are currently on the CRR) as the potential impacts of the risks relate to the safety of patients, quality of services and patient outcomes.

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

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

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

Total Number of Open Risks	10	
New Risks Being Reported	0	
De-escalated/Closed Risks	0	
Increase in Risk Score ↑	0	
Decrease in Risk Score ↓	1	*See note 1*
No Change in Risk Score →	9	*See note 2*

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

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

Note 1 – Decrease in risk score:
The following risk has decreased in score since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Previous Risk Score	Current Risk Score	Update	Target Risk Score

1812 - Risk of non-compliance with Medical Examiners (Wales) Regulations due to the failure to fully resource internal processes	16/11/21	Executive Medical Director	**4x3=12**	**4x2=8** (Reviewed 01/10/24)	New processes are in place for mortality review which are in line with the All-Wales Learning from Mortality Framework, supported by the Clinical Lead for Mortality and the Mortality Review and Improvement Facilitator, with all wards engaged. As of October 2024, the risk score has been reviewed and reduced from 12 to 8, with the likelihood score reduced to reflect the increased capacity to scan, along with a review of existing processes and procedures to ensure compliance with Medical Examiner requirements. Regulations have come into force, with no instances of non-compliance to date. The capacity for clinical scanning remains below the required level, however it has increased recently due to the appointment of a Clinical Effectiveness Co-ordinator, who has commenced in post, and the Directorate will continue to review ongoing capacity requirements. Contingencies are also in place to manage the sustainability of the service, with cross-working in place. Glangwili General Hospital (GGH) scanning staff are currently scanning some of Prince Philip Hospital (PPH) case notes, and all GGH wards.	**2x2=4**

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

Note 2 - No change in risk score:
There have been no changes to the risk scores of the risks included in the table below since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Current risk score	Update	Target Risk Score
797 - Risk to the ability to deliver ultrasound services due to workforce pressures	07/11/19	Chief Operating Officer	**5x4=20** (Reviewed 15/11/24)	Despite best efforts, the service remains fragile. There are still vacancies which remain unfilled, but there was an improvement in recruitment due to the financial picture across Wales and the cessation of use of agency staff above Agenda for Change (A4C) pay rates at Hywel Dda. As of November 2024, remaining vacancies have been advertised as training posts under Annex 21 posts. If all vacancies were recruited to, the Health Board would still not have the capacity to meet current demand. As at the end of October 2024, 1,224 patients waiting 8 weeks plus for non-obstetric ultrasound (Dec 2023:1547, February 2024:1288, March 2024:917, April 2024:962, May 2024:731, June 2024 608, July 2024 555). The reduction seen during Feb -July 2024 was a result of the use of insourcing, and a small amount of overtime by substantive staff (utilising recovery monies). Long term vacancies exist in Withybush General Hospital (WGH), with potential retirements at PPH in the near future, as well as a number in Bronglais General Hospital (BGH) which constitute a	**3x4=12**

				significant percentage of the workforce. There will be an inability to secure agency staff due to the current financial climate of the Health Board. However, in the event of recovery monies being made available, the service will be able to re-initiate the current ultrasound insourcing contract. Three Radiographer sonographers and two Midwife sonographers commenced training in January 2024, however training takes two years to complete for Radiographer Sonographers and 1 year for midwife sonographers, with focus on obstetric only. Only 18% of USC's were carried out in 7 days, 58% carried out in 14 days as at October 2024. There is increased capacity through conversion of room for ultrasound use.	
1027 - Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	19/11/20	Chief Operating Officer	**4x5=20** (Reviewed 16/10/24)	Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. Workforce deficits, handover delays, 4 and 12-hour performance, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating lack of sustainable improvement. The situation remains at high levels of risk escalation across our acute sites on a daily basis. Whilst some positive progress has been achieved during 2024 in reducing ambulance handover delays and pathways of care delays, GGH remains under major pressure	**3x4=12**

				in the Urgent and Emergency Care (UEC) system. Whilst recent experience suggests early signs of improvement against key UEC metrics, these remain outside target requirements and therefore the risk score remains unchanged as at October 2024, pending further review. Recent external reviews (NHS Executive Same Day Emergency Care (SDEC) review, NHS Executive Emergency Department review and GIRFT Review on Emergency Department) continue to identify concerns with patient flow and quality of service.	
1032 - Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	02/11/20	Chief Operating Officer	**5x4=20** (Reviewed 08/11/24)	The service is experiencing significant waiting times as a result of increasing demand levels which are exceeding pre-pandemic levels, compounding the backlog due to COVID-19 restrictions. Due to increasing Did Not Attend (DNA) rates, ongoing recruitment challenges and increasing demand there is an impact on the service's ability to see the same volume of service users as they were previously able to. Some posts continue to be funded on a fixed term basis which can make staff retention challenging, along with having to train new incoming staff. As of July 2024, there are 3,356 on the waiting list. Recommendations received from NHS Executive in relation to Children's Neuro-Developmental (ND) services are in the process of being implemented. The Directorate is working with the Women and Children's Directorate to implement these.	**3x4=12**

				For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit to establish trajectories, along with the commissioned service, which were agreed in March 2023. However, the Delivery Unit were unable to provide trajectories, therefore the Health Board has agreed to a 1% monthly improvement trajectory. For psychological services a trajectory is now in place for 1% per month.	
1664 - Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmolog-ists and the inability to recruit	23/05/23	Chief Operating Officer	**4x5=20** (Reviewed 16/10/24)	Increased demand and reduced capacity continue to be a challenge. Balancing Eye Care Measures for patients most at risk, with Ministerial Measures for longest waiting patients, presents a conflicting priority to the service with limited capacity. The service has provided additional Age-related Macular Degeneration (AMD) sessions on weekends, however these additional sessions have not been enough to meet the demand across all counties in the Health Board and patient delays continue. AMD continues to be prioritised, impacting on the provision of general clinics and having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. Additional staffing for Wet AMD was incorporated into the Integrated Medium-Term Plan (IMTP), but no funding was allocated. Recently the service has transferred Glaucoma funding to the Intravitreal Therapy (IVT) service to	**2x5=10**

				create a new Band 7 post for IVT. The service as of October 2024 has 6,777 patients (November 2023: 5,713) that have been 100% delayed for their follow up appointment (the longest wait from this cohort is 109 weeks (November 2023: 67 weeks). 7,219 patients are awaiting an Ophthalmic operation (November 2023: 3,785) of which 582 (November 2023: 24) are breaching 104 weeks (the longest wait from this cohort is 136 weeks). The current impact has been scored as 5 because patients suffering irreversible sight loss is a reality and the current likelihood has been scored 4 as Ophthalmology is a fragile service. It is unlikely that we will be able to achieve the Board tolerance score of 6 without significant investment or a regionally agreed solution.	
1859 - Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	01/05/24	Director of Nursing, Quality & Patient Experience	**4x5=20** (Reviewed 16/10/24)	There are specific concerns relating to GGH and WGH in relation to cardiac arrests and unplanned admissions. There was an increase in Cardiac Arrest rates in GGH in the period January – July 2024 (22) compared to the same period January – July 2023 (13). However, from August – October there have been 4. GGH senior management team have agreed to Datix all cardiac arrests and establish bi-monthly meetings to review cases and identify themes and learning opportunities, the next meeting is scheduled for November 2024. There has been a significant increase in unplanned	**2x3=6**

				admissions at WGH, with 60 noted in the period January - July 2024 (40 for the equivalent period of January - July 2023). Following the recent WGH RADAR meeting it was agreed that the Treatment Escalation Plan (TEPs) task & finish group in WGH would be re-established. There are also concerns across the Health Board as a whole, relating to the National Early Warning Scores (NEWS), and appropriate escalation where required as part of observation processes. Currently working with Clinical Audit to develop an audit tool on AMAT to audit National Early Warning Score (NEWS) charts on a monthly basis on wards and identify good practice and areas for improvement. Work is underway, investigating the opportunity to benchmark the position of Hywel Dda on an All-Wales basis. Prior to Covid-19, the National Acute Deterioration Group for Wales (RRAILS) was in place, which gave direction on key initiatives such as Sepsis and NEWS, however this group is no longer supported which poses the risk on a national level regarding a disjointed approach across Wales. As of July 2024, compliance rates for Level 2 and Level 3 Resuscitation Training are at 40%. While there is no set compliance target, compliance has never been greater than 60%. Staff availability to attend resuscitation training is problematic due to operational pressures and demand, therefore, need to identify the most appropriate training level	

				and method to deliver to meet mandatory requirements.	
1531 - Risk of being unable to safely support the Consultant on-call rota at Withybush General Hospital (WGH) and Glangwili General Hospital (GGH) due to workforce pressures	10/11/22	Chief Operating Officer	**4x5=20** (Reviewed 11/11/24)	The risk score remains the same as the inherent risk score. This is based on recent short notice absences in addition to the existing gaps on both rotas (GGH and WGH), where the rotas have come close to collapse three times in recent months, with the rota being covered at the eleventh hour at an enhanced rate. This has further highlighted the fragility of these rotas. Due to the financial situation, there is an expectation to reduce variable pay and exit Medacs locum agencies. There is a risk that the WGH rota will collapse if a replacement agency locum is not found before the end of November 2024. The appointment of a locum consultant to GGH does not change the risk score as this is a temporary measure. Having two separate rotas at WGH and GGH increases the fragility of the service.	**1x5=5**
1708 - Risk of increasing fragility in primary care contractor services due to recruitment challenges	07/07/23	Director of Primary Care, Community & Long Term Care	**4x4=16** (Reviewed 09/10/24)	Eight dental contracts have been returned to the Health Board in the last twelve months, of which four contracts (totalling £958,500) confirmed as being awarded by NHS Wales Shared Services Partnership (NWSSP) Procurement Services in May 2024. In addition, a further eight dental practices have not signed up to the contract reform, signalling that they will return contracts once reform negotiations have concluded. The number of complaints received from the public has increased due to returned	**2x4=8**

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

				support the transition of patients into Welsh General Optometric Service (WGOS4) (clinical pathways for Glaucoma, Hydroxychloroquine (HQC) and Medical Retina) as part of the new Optometry contract implementation which commenced in September 2024.	
684 – Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	04/01/19	Chief Operating Officer	**4x4=16** (Reviewed 17/10/24)	The Health Board's stock of imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites, which has a significant impact on the Health Board's ability to meet its Referral to Treatment (RTT) target and impact to patients can include delays in diagnosis and treatment. Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scanners have been replaced and has reduced the frequency of machine downtime compared to previous experience. The risk score is assessed as 16, reflecting that some equipment has been installed and is operational, however further investment is required given recent breakdowns of key imaging equipment. A costed plan along with a rolling programme for the installation of additional equipment is in place. There is a continuous process locally by which equipment is prioritised for replacement. For 2023/2024, funding was obtained to replace two X-ray rooms and due to the Radiology Information Systems Procurement (RISP) risks of non-Digital Radiography (DR) compliant equipment, it was decided to replace the x-ray equipment at Tenby Cottage Hospital and	**2x4=8**

				the A&E X-ray room at Bronglais General Hospital. The gamma camera at WGH is the only scanner of its nature in the Health Board and experienced a breakdown in August 2023 due to intermittent failures which resulted in several Healthcare Inspectorate Wales (HIW) reportable Ionising Radiation Medical Exposure Regulations (IRMER) incidents. This item of equipment is on the current priority list of items to replace. While a new CT scanner has been obtained and installed at GGH, the original CT scanner has had a number of breakdowns due to its age. The technology on this scanner is also now out of date and impacts directly on the resilience of the service at our major trauma site in the Health Board. Like-for-like replacement of existing equipment is not necessarily a cost-effective method of maintaining services and in certain circumstances does not meet updated regulatory compliance or meet the requirements of maintenance warranty agreements. This means there will need to be upgraded infrastructure such as air handling units, water chiller systems and the size/accommodation for modalities at an initial increased cost but representing long term savings and service resilience overall.	
1810 - Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant	01/02/24	Director of Primary Care, Community & Long Term Care	**3x5=15** (Reviewed 04/11/24)	The facilities of WGH Aseptic unit are currently non-compliant with regulatory standards. The unit is subject to external audit by the National Pharmacy Quality Assurance Lead and the facilities were identified as	**1x5=5**

with Quality Assurance of Aseptic Preparation Services (QAAPS).				being a high risk to patient safety in 2019. An audit performed in February 2023 confirmed the facilities were a high risk, and the unit at risk of forced closure. A pharmacy Aseptic unit based at Glangwili General Hospital (GGH) was forced to close in December 2018 as the facilities were deemed a risk to patient safety. WGH Aseptic unit is the only functional unit that can manufacture cancer treatments remaining in the Health Board. Short term control measures have been implemented to reduce the risk of immediate forced closure and are currently successfully minimising the amount of microbial contamination present within the unit. This is demonstrated by ongoing environmental monitoring results undertaken by the Aseptic unit staff (combination of daily/weekly/monthly monitoring). However, as the unit and equipment are beyond their useful expected life, there will come a time where the control measures will no longer be sufficient to allow the safe running of the unit. If the stringent controls fail at limiting the amount of microbial contamination, the unit may be forced to close. This is because continued manufacture of cancer treatments within non-compliant facilities with unacceptable levels of microbial contamination would be a high risk to patient safety. Due to the age of the equipment and facilities, and the fact that the facilities were not designed against current regulatory standards, it is not	

				possible to predict if or when the current controls will fail. If the unit was forced to close, the Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. Some cancer treatments cannot be outsourced due to their short shelf life. There were 345 reported service and quality-related incidents (e.g. delayed or failed deliveries) linked to outsourcing from commercial suppliers between September 2022 and August 2023 at Hywel Dda (an average of 29 incidents each month). The number of service and quality-related incidents between September 2023 and February 2024 remained high at an average of 25 incidents each month. Without a functioning Aseptic unit, the Health Board could not offer over 500 cancer treatments each year, and further treatments would be delayed/cancelled due to supplier service failures. Demand for aseptically prepared cancer therapy increased by an average of 14% each year between 2021 and 2023. Therefore, the negative impact of not having a functioning aseptic unit is likely to grow each year. The most recent audit, conducted in February 2024, confirmed that the control measures employed are mitigating the risk and that all reasonable controls have been implemented, with the current risk score subsequently reduced from 20 to 15 reflecting the reduced likelihood of the risk of forced closure materialising (provided that these control measures remain effective).	

				A business case for the demountable unit at WGH was submitted to Welsh Government in February 2023, and also requested funding to convert the current Aseptic unit into drug storage facilities. Based on budget cost estimates of £2.89m, the submission was for review and scrutiny by WG to provide assurance to the Health Board before resourcing, and underwriting the financial risk, of progressing a detailed design for tendering. In September 2023, WG requested submission of a fully tendered business justification case, which is currently being worked up. As part of the Transforming Access to Medicines (TrAMS) project programme, a regional manufacturing hub will be built in South West Wales that will prepare cancer therapy for Hywel Dda patients. The hub was originally estimated to open during 2028, however there have been delays to the project plan and the opening date is currently unknown. There is therefore a high risk that the current Aseptic unit at WGH will be forced to close before the South West TrAMS manufacturing hub is operational. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality.	

Argymhelliad / Recommendation

The Committee is requested to seek assurance that:

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

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

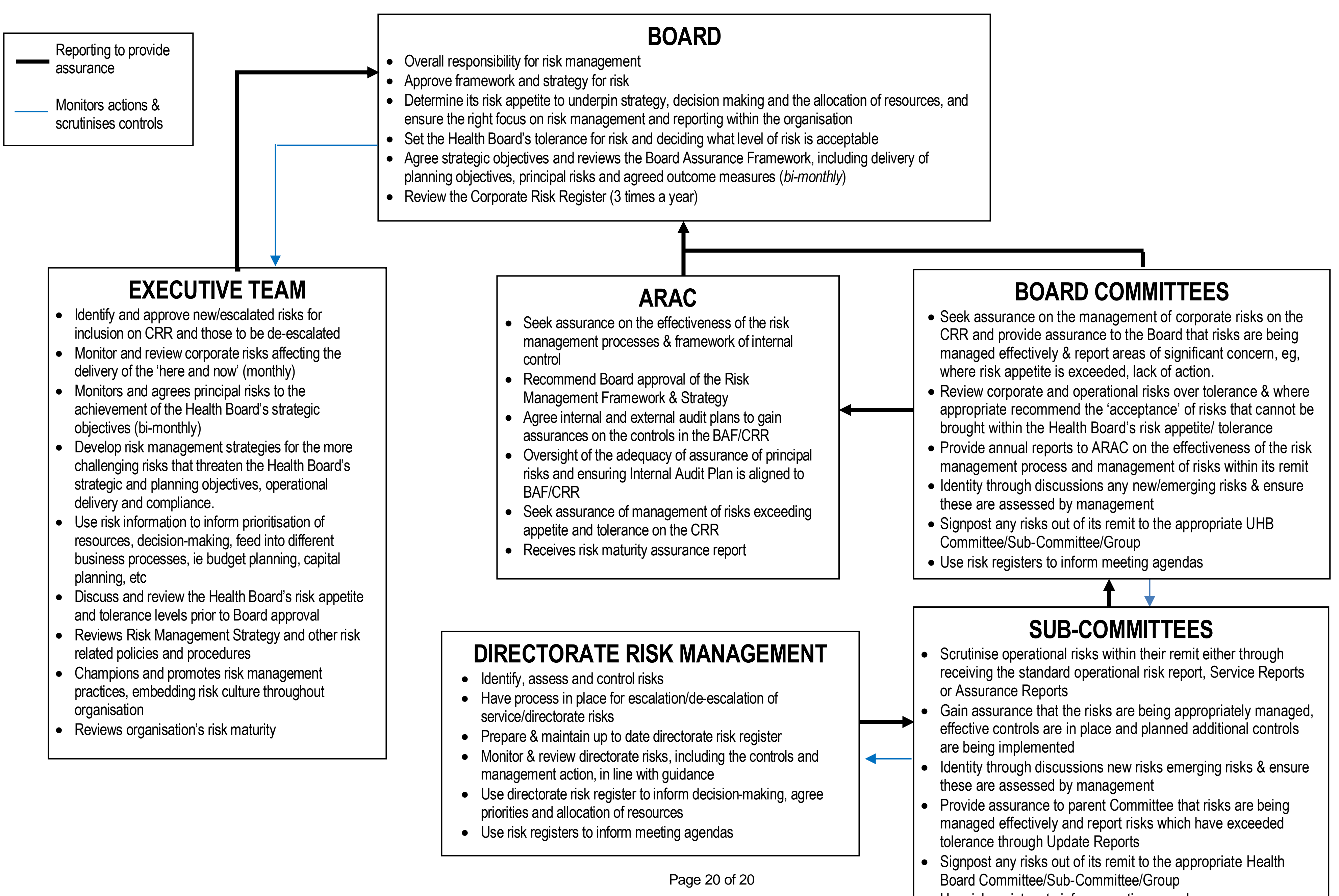
Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.2 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across the UHB's services reviewed by risk leads/owners

Rhestr Termau: Glossary of Terms:	Current Risk Score - Existing level of risk taking into account controls in place. Target Risk Score - The ultimate level of risk that is desired by the organisation when planned controls (or actions) have been implemented. Tolerable risk – this is the level of risk that the Board agreed for each domain in September 2018 – Risk Appetite Statement
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	N/A

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

Appendix 1 – Committee Reporting Structure



Appendix 2

Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Oct-24	Trend	Target Risk Score	Risk on page no...
797	Risk to the ability to deliver ultrasound services due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12	3
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×5=20	→	3×4=12	8
1032	Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12	13
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×5=20	→	2×5=10	17
1859	Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Daniel, Sharon	Safety - Patient, Staff or Public	6	N/A	4×5=20	→	2×3=6	21
1531	Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	3×5=15	4×5=20	→	1×5=5	27
1708	Risk of increasing fragility in primary care contractor services due to recruitment challenges	Paterson, Jill	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	2×4=8	33
684	Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Carruthers, Andrew	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	2×4=8	36
1810	Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Paterson, Jill	Service/Business interruption/disruption	6	4×5=20	3×5=15	→	1×5=5	42
1812	Risk of non-compliance with Medical Examiners (Wales) regulations due to the failure to fully resource internal processes	Henwood, Mr Mark	Quality/Complaints/Audit	8	4×4=16	4×2=8	↓	2×2=4	46

Assurance Key:

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

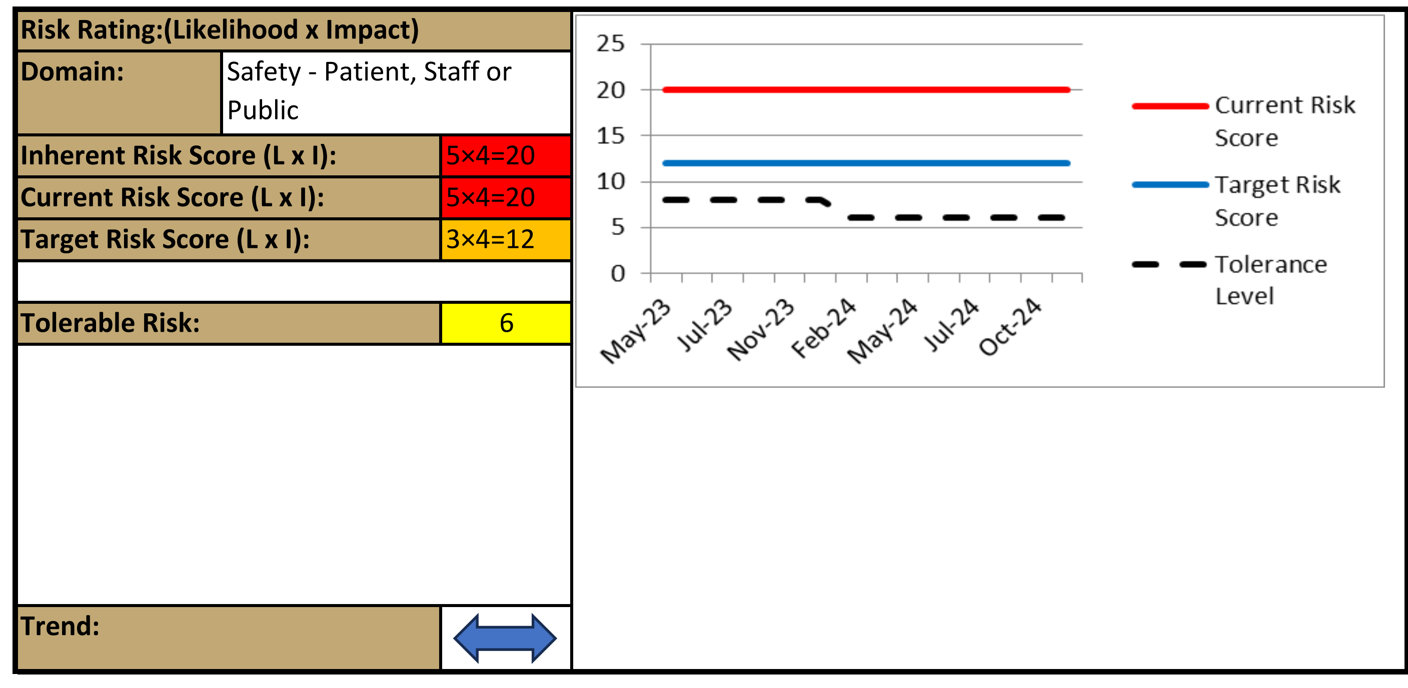
Key - Assurance Required		*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*
(blue)	Detailed review of relevant information	
(pink)	Medium level review	
(purple)	Cursory or narrow scope of review	

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

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

Risk ID:	797	Principal Risk Description:	There is a risk of being unable to provide a full range of ultrasound services including antenatal across the Health Board. This is caused by the retirement and resignation of current sonography staff, low availability of sonographers UK wide, and the inability to recruit to due national shortages of qualified staff, and the inability release existing workforce to train and develop to meet current service demands. This could lead to an impact/affect on delays in diagnosis which could result in detrimental outcomes for patients, inability to meet diagnostic targets and cancer pathway targets, and an inability to hold clinics to meet demand in ante natal screening services within required timescales. In addition, there is an impact on staff health and wellbeing in terms of the volume of patients examined within a shift/overtime, which could lead to increased incidents of repetitive strain injuries (RSI), along with increased incidents of staff stress and burnout. This could ultimately lead to increased errors when performing the dynamic diagnostic test.
Does this risk link to any Directorate (operational) risks?			1557, 1349, 1658, 1936

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



Rationale for CURRENT Risk Score:

Despite best efforts, the service remains fragile. There are still vacancies which remain unfilled, but there was an improvement in recruitment due to the financial picture across Wales and the cessation of use of agency staff above AFC pay rates at HDd late 2023/early 2024. As of November 2024, remaining vacancies have been advertised as training posts under Annex 21 posts

If all vacancies were recruited to, the Health Board would still not have the capacity to meet current demand (as at end October 2024) there were 1,224 patients waiting 8 weeks plus for non-obstetric ultrasound (Dec 2023:1547, February 2024:1288, March 2024:917, April 2024:962,May 2024:731,June 2024 608, July 2024 555), with the reduction seen From Feb -July 2024 as result from the use of insourcing and a small amount of overtime by substantive staff (utilising recovery monies).

Long term vacancies exist in Withybush with maternity leave which started in summer of 2024 impacting the fragility further. There are 2 potential retirements at PPH in the near future and a number in BGH, which constitute a significant percentage of the workforce. There will be an inability to secure high cost agency staff due to the current financial climate of the Health Board. However, in the event of recovery monies being made available we will be able to re-initiate the current ultrasound insourcing contract

Three Radiographer sonographers and two Midwife sonographers commenced training in January 2024, however training takes two years to complete for Radiographer Sonographers and 1 year for midwife sonographers (obstetric only).

Only 18% of USC's carried out in 7 days, 58% carried out in 14 days at October 2024

There is increased capacity through conversion of room for ultrasound use.

Rationale for TARGET Risk Score:

The actions below will not in themselves reduce this risk significantly. Demand and capacity and the current establishment review is being undertaken by the Ultrasound control group via a needs assessment which is due to be completed by the end of Autumn. It is likely that these reviews will lead to a need for further investment and additional funding to establish a sustainable service model to include a robust perpetual training programme, that will enable the Health Board to met expected diagnostic waiting times targets.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
Process in place for the movement of staff across the Health Board to maintain capacity where possible. Conversion of room to increase capacity (2022) @ GGH Ultrasound Control Group reconvened in Jan 2024 after having not met since July 2023 due to operational pressures. Meetings take place on a bi-monthly basis. Employment of Physiotherapists and Midwives to undertake scanning within scope of expertise The PPH modality lead vacancy was filled (Feb 2024) Utilising insourced ultrasound service to reduce backlogs of patients waiting >8weeks subject to the availability of recovery funding. Increase in hrs of an existing sonographer at WGH from 0.6 to 0.8 for a period of 6 months from August 2024. Advertise bank sonographer posts to assist on an ad hoc basis, subject to availability at WGH in line with vacancy. Clinical Educator recruited and in post which will facilitate the expansion of training across site. Cancer Watchtower meetings in place and held weekly, with a separate escalation meeting in place to cover Radiology concerns. Meetings chaired by General Manager of Cancer Services. Continuous recruitment training of sonographers within current establishment

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**
Inability to recruit and retain staff. While process in place regarding the movement in staff, due to current staffing levels and pressures this is not being implemented, however the teams across sites are collaborating and look at all possibilities when gaps in rota arise and are foreseen.	Develop 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	The date of completion of this action has been changed to 31/01/2025 as the current cohort of midwives that are training will qualify. Maternity and child health are required to advise of the plan to utilise the skills of the two trainee midwives and also any plans to train more staff.
	Train members of staff to become sonographers, the number of which dependant on capacity to take training.	Roberts-Davies, Gail	~~31/03/2020~~ ~~31/12/2022~~ ~~01/02/2023~~ ~~30/09/2024~~ 31/01/2026	Clinical Educator role has been developed and recruited. The successful candidate commenced employment on 01/06/2024. This has allow us to expand Ultrasound training an all sites and advertise existing vacancies in ultrasound as training positions under Annex 21 rules. As of November 2024, 1 vacant post each at BGH and WGH are in advertisement stage. With FCG approval obtained to advertise a third training post at GGH. Plan is on track to start the successful candidates training in January 2025.

establishment

Work with the workforce planning team to build a sustainable workforce plan for ultrasound services.	Roberts-Davies, Gail	~~31/10/2023~~ ~~31/03/2024~~ ~~31/07/2024~~ ~~31/10/2024~~ 03/12/2024	A draft operational workforce plan has been developed as of June 2024 and requires revision prior to sign off. This has been delayed due to workload as a result of urgent TI actions and operational pressures during which workforce meetings ceased. This work is currently being reviewed by the Head of Radiology, but has been delayed due to acute operational pressures.
Seek support to undertake a demand and capacity (D&C) review and detailed establishment review of the radiology service.	Jones, Keith	~~30/06/2022~~ ~~30/11/2022~~ ~~31/03/2023~~ ~~30/08/2023~~ ~~31/01/2024~~ ~~31/05/2024~~ ~~31/07/2024~~ ~~31/10/2024~~ 31/12/2024	An ultrasound needs assessment is currently being undertaken via the Ultrasound Control Group. The most recent Ultrasound Control Group Meeting arranged for September 2024, was cancelled. The Ultrasound Needs Assessment was due to be presented be presented to further inform the ultrasound workforce plan. We await a date to be rescheduled.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Non-Obs ultrasound - longest wait 36 weeks as at end October 2024 Radiology Dashboard IPAR Reports WG Cancer PTL, reported monthly	Management review of sonography and SCP diagnostic waiting times	1st			Sonography Report to Acute Leadership Group (ALG) and Operation Planning and Delivery Programme meeting					
	Monthly review of USC performance undertaken monthly (22% of USC carried out in 7 days, 55% carried out in 14 days at end October. 2024), included in the IPAR & reported to WG	1st								
	Performance monitored at Directorate Improving Together Sessions	2nd								

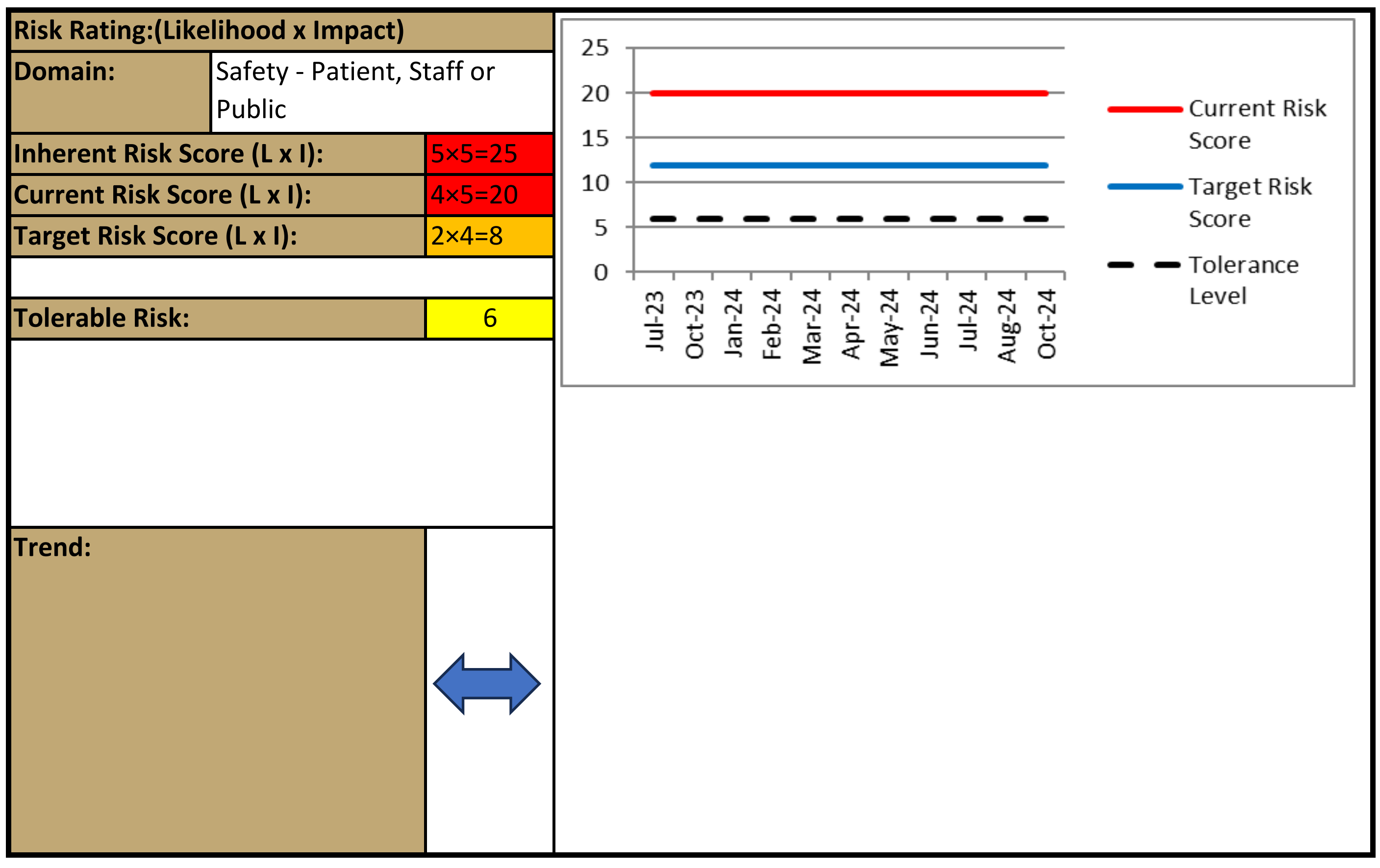
	Performance monitored via IPAR, overseen SDODC & Board	2nd									

1027	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Oct-24
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Nov-24

Risk ID:	**1027**	**Principal Risk Description:**	There is a risk to the consistent delivery of timely and high quality urgent and emergency care. This is caused by significant fragility across the urgent and emergency care (UEC) system (acute, primary care (including out of hours), community and social care services), related to workforce compromise and increasing levels of demand and acuity. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays and overcrowding at Emergency Departments (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
Tolerable Risk:	6
Trend:	⬌



Rationale for CURRENT Risk Score:

Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. Workforce deficits, handover delays, 4- and 12-hour performance, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating lack of sustainable improvement. The situation remains at high levels of risk escalation across our acute sites on a daily basis.

Whilst some positive progress has been achieved during 2024 in reducing ambulance handover delays and pathways of care delays, Glangwili Hospital (GGH) remains a major pressure in the UEC system.

Whilst recent experience suggests early signs of improvement against key UEC metrics, these remain outside target requirements and therefore the risk score remains unchanged as at October 2024, pending further review.
Recent external reviews (NHS Executive Same Day Emergency Care (SDEC) Review, NHS Executive ED Review and GIRFT Review on ED) continue to identify concerns with patient flow and quality of service.

Rationale for TARGET Risk Score:

the Target Risk Score has been reduced to 8 to reflect the confidence in the delivery of 6 Goals Programme to address the significant issues across the health and care system.

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Live Operational Dashboard in place and twice HB wide escalation meeting. # Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. Surge and boarding recorded on the twice a day escalation report. # Frontier system in place for recording DPOC and red days flagging required assessments to support discharge. # Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites with associated actions in collaboration with social care partners. # Regular advice on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, social services and the Long Term Care Team support. # # Discharge arrangements are in place on all sites with a strategic review underway.	# 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. # 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.	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 2.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. 3. 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. 4. Development and implementation of HDuHB optimal SDEC model following on from lessons learnt from peer review and alignment with CSH and local resource hubs. 5. Continued implementation of Optimal	Skitt, Peter	31/03/2026	On Schedule. Assurance provided to SDODC on 6 Goals Programme delivery. Regular updates provided to WG.

# Standardised board rounds processes in place on all sites and D2RA processes are embedded with a 77% D2RA rate (Sep24). # Criteria-led discharge guidance and principles piloted across HB (Sep24). # Integrated Regional Winter Plans developed to manage whole system pressures over the winter period. # An operationally focussed 6 Goals Urgent and Emergency Care (UEC) programme with governance structure agreed where all UEC improvement is coordinated. # Welsh Ambulance Services NHS Trust involved in all 6 Goals UEC workstreams. # 111 and 111 press 2 (MH) implemented across Hywel Dda. # Regional Integration Fund projects in place across Regional Partnership Board (RPB) footprint, along with Further Faster projects to ensure alignment with 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.	# Gap in communication between secondary and primary care that could lead to poor discharge outcomes # Clarity regarding roles and responsibilities for discharge planning and coordination # The ability 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. # 24/7 integrated urgent primary care service aligned to Home First hubs.	Flow Framework including Community sites supported by Frontier digital platform. 6. Continuing education at ward level to ensure consistent approach to Board Rounds and Safety Patient Huddles utilising Frontier platform to capture and report information. 7. Implementation of 7 focused areas within ED Quality statement. 8. Develop West Wales Hospital @ Home model to ensure consistent approach and delivery. 9. Establishment of a regional Discharge Strategy Group to provide oversight of all current work streams and actions being undertaken around discharge as well as work around national and local policies - Discharge and Transfer of Care Policy, Reluctant Discharge Policy, Care Home of Choice policy. 10. Establish regional POCD group to focus on reviewing of trends and themes to develop robust regional or local action plans to deliver improvement. 11. 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. 12. Develop & implement strategy for			

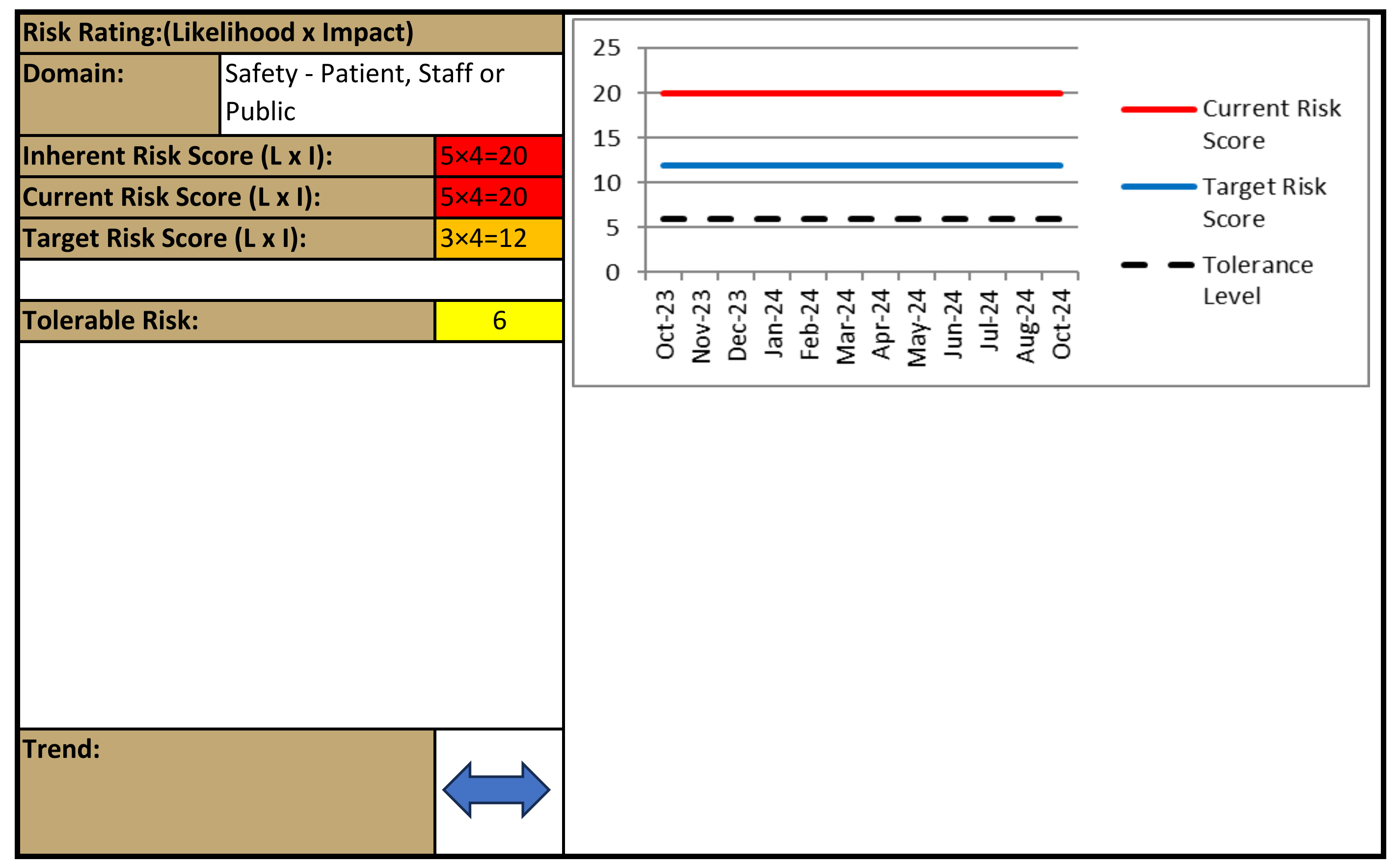
# Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across the RPB region. # Establishment of a Discharge to Recover and Assess (D2RA) Group which reports to the the 6 Goals Programme with a detailed D2RA improvement plan in place. # Establishment of a 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. # Live operational performance dashboard in place. # 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.		Alternative Care Community (ACP) Provision across the West Wales region. 13. Integration with GPOOHs and APP resources			
		Develop a consultation led ED medical provision that is fit for purpose and meets the D&C requirements utilising all professions.	Skitt, Peter	31/03/2027	Discussions have started.
		Winter Communication Plan for UEC to include advising the public on community pharmacy provision and avoiding falls	Skitt, Peter	30/11/2024	Regional plan under development and will be ready ahead of winter 2024.
		Utilise the risk stratification data set (Codebased8) in the Home First hubs to work proactively with population	Skitt, Peter	30/09/2025	Part of First Home Hub plan and work is underway.
		Review of Community bed based hospitals	Skitt, Peter	31/12/2025	Initial planning phase has started. Length of stay data being gathered.

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 Ambualance handovers over 1 hour Ambualance handovers over 4 hours 4 & 12 hour waits in A&E Time to triage in A&E Time to see a Doctor in A&E Pathway of care delays	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st				None identified.				
	Daily performance data overseen by service management	1st								
	Workstream Delivery Plans overseen by 6 Goals Programme	2nd								
	6 Goals Programme / UEC IQFPD 3As report into IQFPD	2nd								
	Bi-annual reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	IA review on Transforming Urgent and Emergency Care	3rd								
	NHS Executive Same Day Emergency Care (SDEC) Review	3rd								
	NHS Executive ED Review	3rd								
	GIRFT Review on ED	3rd								

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

Risk ID:	1032	Principal Risk Description:	There is a risk to the delivery of timely diagnosis to those on the ASD waiting lists, and the commencement of interventions for Psychological Therapies (Integrated Psychology Therapies - Adult and Learning Disability) within required timescales. This is caused by an increase in referrals, as well as recruitment challenges and lack of appropriate estates. This could lead to an impact/affect on those currently awaiting diagnosis and intervention, resulting in delays in care and appropriate treatments in a timely manner which may lead to poorer patient outcomes, and delayed adjustments to educational needs. There will also be an impact on the ability of the Health Board to meet Welsh Government targets (diagnosis of ASD within 26 weeks, and commencement of interventions for Psychological Therapies within 26 weeks) which could lead to increased scrutiny from regulators, and escalation from Welsh Government. This in turn could result in adverse publicity and a reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?			138, 1249, 1286, 1287, 1392, 1455, 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):	3×4=12
Tolerable Risk:	6
Trend:	↔



Rationale for CURRENT Risk Score:

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

As of July 2024, there are 3,356 on the waiting list. Recommendations received from NHS Executive in relation to Children's ND services are in the process of being implemented. The Directorate is working with Women and Children's Directorate to implement these.

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

Rationale for TARGET Risk Score:

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

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

While trajectory plans are in place as of March 2024, there is recognition that the Health Board will not achieve WG targets. The end of procurement contracts with external providers will further negatively impact trajectories

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS** **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Use of IT/virtual platforms such as Attend Anywhere when appropriate. Clinical prioritisation regarding assessment and treatment of service users by engaging in a dynamic process of reviewing waiting lists in line with any other referrals that may be received in respect of that service user. Additional WG funding received in 2022/23/24/25 for ND services Services are in contact with individuals to provide information regarding mainstream/Tier 0 support, wellbeing at home and guidance should their situation deteriorate. Process in place to ensure individuals on waiting lists are being contacted periodically through the wait for assessment/treatment to monitor any alteration in presentation. Autism Advice Hubs and pre-assessment workshops in place for Children and adults Neurodevelopmental Service Rolling programme of workshops offering advice and support around neuro-divergence for parents of children aged 2-11 years and 12 years and over awaiting diagnostic assessment. Monthly meetings to meet recommendations of NHS Executive's Action Plan in respect of CYP ND services in place. ND Service Delivery Managers appointed and in place. All posts recruited in to Children's ASD service. With the exception of clinical psychology in adult autism services, all clinical substantive posts recruited in to, with no retention issues Workforce Management Group has been established which meets monthly. Trajectories have been agreed for IPTS and Children's ND by NHS	Although dedicated premises have been sourced for ASD services, there is limited clinical space and Estate issues remain a challenge as identified in the risk narrative. Information not currently included on Health Board website or QR codes due to IT difficulties Additional funding received in 2022/23 for ND service on fixed term annual basis until 2025 Current resource does not provide sufficient capacity to meet demand Unable to recruit in to Clinical psychology in adult ASD service Current procurement exercise to outsource portion of diagnostic assessments to external provider for children and adult services ends March 2025 and will further negatively impact trajectory.	Identify alternative venues/space/ virtual to hold clinics (Integrated Psychological Services).	Homfray, Andrew	~~31/07/2023~~ ~~31/11/2023~~ ~~31/08/2024~~ ~~30/09/2024~~ 31/10/2025	As many groups as possible are being set up to utilise online facilities and third sector venues to support any face to face meetings, ensuring that costs are managed appropriately. Phase 1 of groups completed in February 2024, targeting waiting lists. Phase 2 of group implementation to implement a tiered approach to intervention commenced 27th May 2024 following further staff training. Full implementation completed by September2024 with everyone on the waiting list has been offered extra support through groups virtually while awaiting 1-1. Ours services are part of the Carmarthen Hwb which will provide clinic space/venue in October 2025.
		Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic Training Needs Analysis that can be reviewed at regular intervals and monitored for compliance.	Temple-Purcell, Rebecca	~~30/11/2023~~ 31/12/2024	In progress, working with Workforce to develop a training needs and analysis tool. MH&LD to act as a pilot for this pending further roll out across the HB. Ongoing.
		ND specific HB internet and intranet pages in development to give guidance and support whilst neuro-divergent individuals and parent carers are waiting.	vaughan, Catherine	31/10/2024	Series of meetings held with Communications team and ND services prioritised to include children's ADHD, Adult ADHD, Integrated Autism Service and Children's ASD service

executive and there are systems in place to monitor waiting lists at service level performance-management meetings, IPAR and Directorate service review meetings. Monthly meetings with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint. Use of HB Third Party Contractor to send out Keeping in touch letters and sent to those on ASD waiting lists on a 3-4 monthly basis confirming place on waiting list and signposting to sources of support including access to ND services while waiting. Service Leads secured opportunities for outsourcing for ASD services and Psychological Therapies. Commissioned external provider for ASD services across all ages, similar contract out to tender for Psychological Therapies. Quarterly meetings with the NHS Executive, Welsh Government and Service Leads at the Health Board SMS functionality in place for ND and IPTS to improve attendance and decrease instances of DNA		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	New action

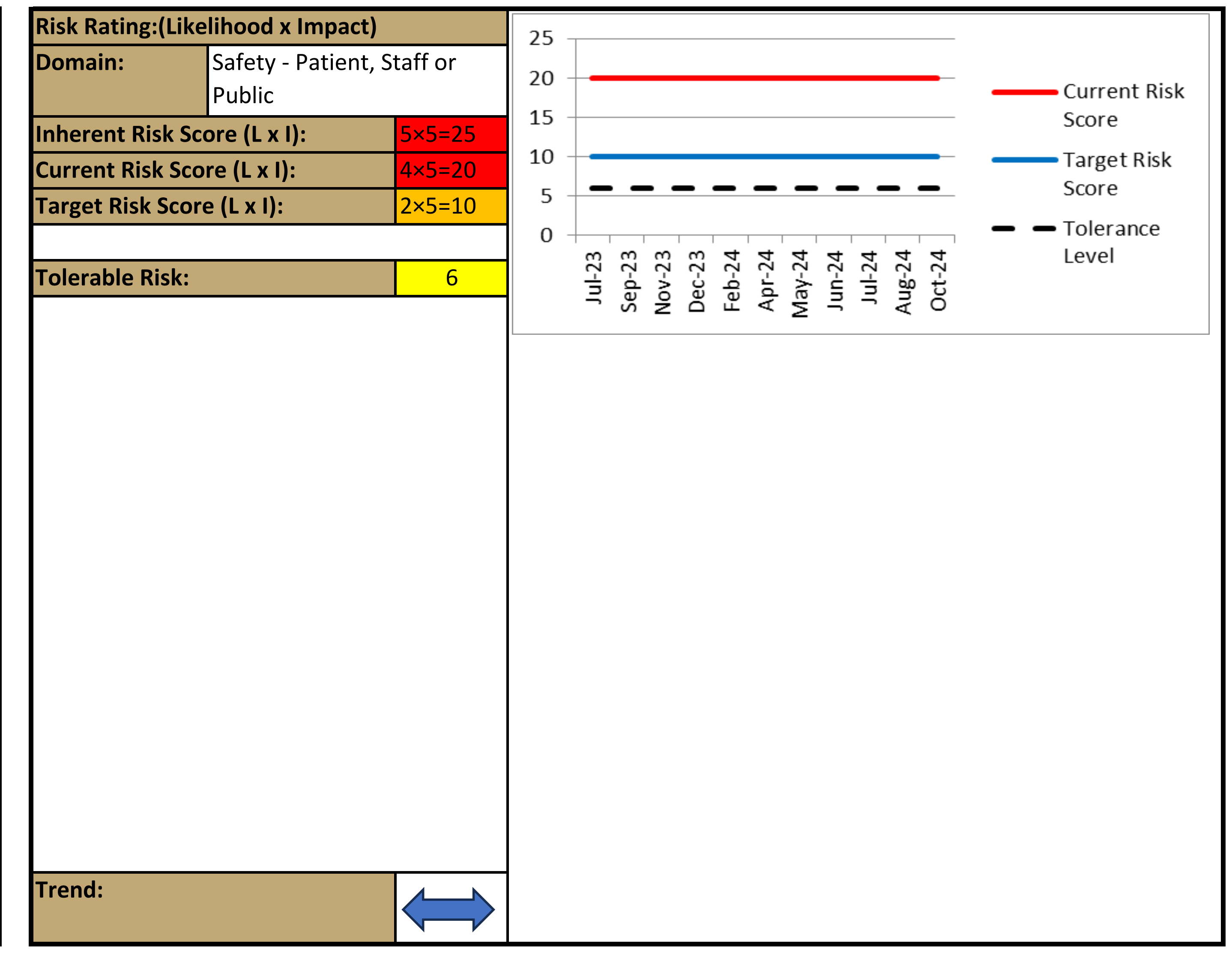
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Welsh Government performance indicators along with internal monitoring arrangements will be used to ensure	Management monitoring of referrals	1st			Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC (Oct21)	System to improve analysis of patient experience				

the actions are having the desires effect or whether there is more that needs to be done.	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd			MHLD progress update on Planning Objective 5G - Board (Mar22) Papers have been presented at the Quality Safety and Experience Assurance Committee with a further update paper provided for the December 2021 meeting outlining control measures to manage the waiting times that the Directorate have at present. A paper was presented at Board Seminar in June 2022 to provide assurance on current waiting times and control measures.					
	MH&LD QSE Group overseeing patient outcomes	2nd								
	Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd								
	W-PAS Internal Audit	3rd								
	An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.									

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

Risk ID:	1664	Principal Risk Description:	There is a risk to service sustainability in Ophthalmology across the Health Board, and the inability to provide timely care to patients with Glaucoma, wet Age Related Macular Degeneration (wAMD), and Cataracts. This is caused by a national shortage of Consultant Ophthalmologists and the inability to recruit to vacancies. The workforce position is exacerbated by nursing and medical staffing constraints and a reduction in service capacity due to lack of physical space, and long-term funding. Recruitment difficulties are leading to the Consultant on-call rota being covered by three substantive Consultants and a high cost Locum Consultant (Medacs) to ensure the delivery of the Ophthalmology service. This is a fragile on call structure which is impacted by sickness and annual leave. This could lead to an impact/affect on the Health Board's ability to deliver services within the Ophthalmology Referral to Treatment (RTT) plan, and delays in the NICE guidance 14-day pathway for AMD appointments, impacting on the ability to provide timely diagnosis and treatment and directly impacting on patient safety with the potential for sight loss and long-term lifestyle impacts. This will also affect the Health Board's ability to comply with Welsh Government Eye Care Measures (ECMs), and service pressures are impeding on the Health Board's ability to progress with the implementation of recommendations raised by various regulators and inspectorates. This in turn could lead to adverse publicity and reduction in stakeholder confidence, with increased scrutiny/escalation from Welsh Government. Workforce pressures could also impact staff well-being and morale.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for patients most at risk with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional AMD sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the HB. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. Additional staffing for Wet AMD was incorporated into IMTP but no funding was allocated. Recently the service has transferred Glaucoma funding to the IVT service to create a new Band 7 post for IVT. The service as at October 2024 has 6,777 patients (Nov 23: 5,713) that have been 100% delayed for their follow up appointment (the longest wait from this cohort is 109 weeks (Nov 23: 67 weeks). 7,219 patients are awaiting an Ophthalmic operation (Nov 23: 3,785) of which 582 (Nov 23: 24) are breaching 104 weeks (the longest wait from this cohort is 136 weeks). The current impact has been scored as 5 because patients suffering irreversible sight loss is a reality and the current Likelihood has been scored 4 as Ophthalmology is a fragile service. It is unlikely that we will be able to achieve the Board tolerance score of 6 without significant investment or a regionally agreed solution.	It is unlikely that the service will be able to reduce the impact score of this risk as the consequences to the patient remains high, however due to recent re-structuring of the management team within Ophthalmology it is hoped that this will provide opportunities to review and improve service delivery with an initial focus on meeting eye care measure targets for the most high risk cohort of patients. The recent addition of a substantive WTE Consultant will help to address the longest waits. A Regional Consultant post has been recruited in Swansea Bay to provide an additional 10 sessions a week in HDUHB, however noting that 7 of these sessions relate to clinical delivery. With the above additional workforce and focused management of the waiting lists, HDUHB will potentially help to reduce the likelihood score on this risk.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
The service is included within the Health Board's Clinical Service Plan (CSP). Active recruitment to vacancies and success in creating additional posts in practice development and medical retina. Collaborative working with Swansea Bay to deliver a South West Wales Glaucoma Service. On call rota in place Additional weekend working to provide Wet Age related Macular Degeneration (AMD) capacity. Currently funded for x2 all day lists per month. Lists cancelled due to annual leave are offered out to backfill. Liaising with external companies to explore options to support with service improvement. Identification of patients suitable to undergo transfer out to the community to Wales General Ophthalmic Services (WGOS) management. Validation taking place through Scheduled Care validation team. Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. ECM Coordinators in place. Review of data quality inclusive of Health Risk Factor (HRF) code and clinical codes ongoing to improve data quality. Highly trained Optometrists working collaboratively with the Secondary Care Eye Service to reduce referrals to secondary care. Ongoing training of Optometrists within secondary care to continue to develop this service for continued delivery of WGOS. Pathways in place for Diabetic retinopathy, which will be expanded into the community with the introduction of WGOS 4. Ongoing arrangement of Optometrists enrolling in prescribing training to develop further Independent prescribers in the community. Weekly monitoring of each sites AMD demand and capacity to allow for recovery planning of breaching patient waiting times.

Gaps in CONTROLS				
Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Whilst recurring money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, Orthoptists, Paediatrics, Corneal and VR) that require investment. ARCH programme closed, with a regional conversation around a regional clinical workshop to consider opportunities for a long-term regional model. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. Recovery funding is non-refunding and reviewed annually, this restricts delivery planning. There are concerns in data quality due to referral processes and system use. Fragility of on-call rota due to current workforce pressures	Root and branch review of operational, workforce and sustainability models.	Coppack, Victoria	~~30/06/2021~~ ~~31/03/2022~~ ~~31/10/2022~~ ~~31/12/2023~~ ~~31/03/2024~~ ~~30/06/2024~~ 31/03/2025	A Regional Update Status Report has been developed for review by executives from SBUHB and HDUHB. Next steps will be to organise a Regional Meeting to discuss current service pressures and explore possible regional solution.
	Roll out and implementation of National Electronic Patient Record for Ophthalmology.	Barreiro, Marta	~~30/07/2021~~ ~~31/03/2022~~ ~~31/05/2022~~ ~~30/09/2022~~ ~~31/10/2023~~ ~~31/12/2023~~ ~~31/03/2024~~ ~~15/07/2024~~ 31/03/2027	Issues identified in the planning phase around data governance. DHCW are working to resolve issues. Update provided by the DHCW in September 2024 outlining options available and potential funding required to deliver. Regional planning scoped and aligned programme now proposed with Swansea Bay UHB, but is unlikely to be implemented before 2027.
	Refurbish and establish a nursing team in the Outpatient Department in Amman Valley Hospital to provide intravitreal treatment for the patients currently attending the day theatre area for their treatment. This will ensure continuity of care for those patients when cataract surgery activity is returned to day theatre.	Coppack, Victoria	~~31/01/2022~~ ~~30/09/2022~~ ~~31/10/2023~~ ~~31/01/2024~~ ~~31/03/2024~~ ~~15/07/2024~~ 31/03/2025	Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) was completed in March 2022. SBAR to outline recovery of IVT service is in draft format and costs associated are being worked up for submission before the end of October 2024.
	Remodelling the capacity and demand associated with Wet AMD and Amman Valley	Coppack, Victoria	~~31/03/2023~~ ~~31/10/2023~~ ~~30/11/2023~~ ~~31/03/2024~~ ~~15/07/2024~~ 31/03/2025	Ongoing costs associated with additional activity. SBAR to outline recovery of IVT service is in draft format and costs associated are being worked up for submission before the end of October 2024.

Funding obtained via recovery funding in April 2024 to outsource 797 cataracts patients from the longest waits (104+) until March 2025.

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

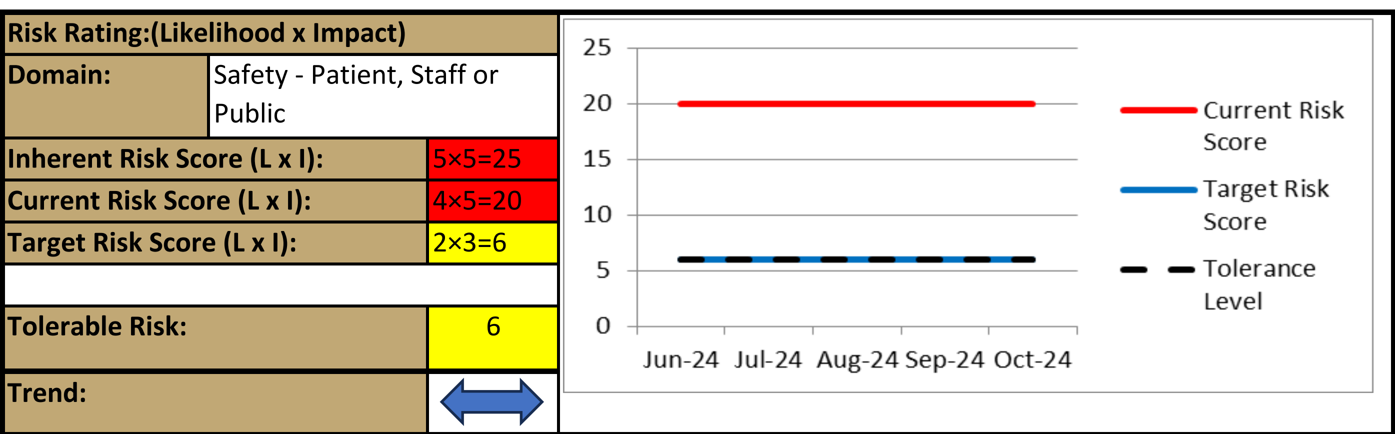
Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.	Coppack, Victoria	~~30/09/2022~~ ~~31/10/2023~~ ~~30/11/2023~~ ~~31/03/2024~~ ~~30/06/2024~~ ~~30/09/2024~~ 31/03/2025	Validation of HCQ patient commenced in November 2023. Longest wait HCQ patients have been identified for tech review, however workforce pressures are negatively impacting on service delivery. Clinic spaces to be secured for patient review. This is an interim measure until WGOS 4 for HCQ can be rolled out.

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. Watchtower review of ministerial measures	WPAS	1st			Ophthalmology 'Deep Dive' paper to ARAC (Dec 2023) SBAR for IVT Service Delivery & SBAR for recovery of R1 position (October 2024)					
	GIRFT action plan cataracts	1st								
	GIRFT action plan Glaucoma	1st								
	WPAS, scheduled care performance indicators	1st								

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

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

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	6
Trend:	⟺



Rationale for CURRENT Risk Score:

There are specific concerns relating to GGH and WGH in relation to Cardiac Arrests and unplanned admissions. There was an increase in Cardiac Arrest rates in GGH in the period Jan - July 2024 (22) compared to the same period Jan - July 2023 (13). However, from Aug - Oct there have been 4. GGH senior management team have agreed to Datix all cardiac arrests and establish bi-monthly meetings to review cases and identify themes and learning opportunities, the next meeting is 14th November 2024.

There has been a significant increase in unplanned admissions at WGH, with 60 noted in the period Jan - July 2024 at WGH (40 for the equivalent period of Jan-July 23). Following the recent WGH RADAR meeting is was agreed that the Treatment Escalation Plan (TEPs) task & finish group in WGH would be re-established.

There are also concerns across the Health Board as a whole relating to the National Early Warning Scores (NEWS), and appropriate escalation where required as part of observation processes. Currently working with Clinical Audit to develop an audit tool on AMAT to audit on a monthly basis NEWS charts on wards and identify good practice and areas for improvement.

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

As of July 2024, compliance rates for Level 2 and Level 3 Resuscitation Training are at 40%. While there is no set compliance target, compliance has never been greater than 60%. Staff availability to attend resuscitation training is problematic due to operational pressures and demand, therefore, need to identify the most appropriate training level and method to deliver to meet mandatory requirements.

Rationale for TARGET Risk Score:

The full implementation of the actions noted in the risk action plan will support the reduction in the likelihood and impact score of this risk to a target risk of 6.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**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, T&F Group chaired by HB RADAR Lead with focus on Sepsis, DNA/CPR group chaired by Deputy Medical Director. RADAR directly reports to Operational QSE. Health Board Resus policy in place (currently out of date requiring updating - however waiting on national guidance) All Wales DNA/CPR policy in place, which is due for update in 2024 Lead for Acute Deterioration Dedicated Resusciation Team in place, consisting of 5 full time and 2 part time employees Networks in place across the wider HB, including support from QIST Organisational training plan in place, including mandatory training Critical Outreach Services in GGH and WGH (not in place at PPH / BGH), managed by Planned Care Directorate (i.e not fully linked to Acute Deterioration resource) New Acute Kidney Injury (AKI) Lead appointed for GGH (12 months) Dedicated resource in Quality Improvement Team monitoring AKI alerts for the HB	No treatment escalation plans in place No call for concern in place Training demand outstrips capacity to deliver, with time limited in training sessions Inconsistent application of policies and processes eg DNA/CPR, new escalation policy, sepsis assessment tool, National Early Warning Score (NEWS). Reliance on manual / paper based documentation to record patient deterioration and subsequent escalation Critical Outreach Services not in place at PPH / BGH Inability to release staff to complete L2 and L3 training	Health Board Recognition of Acute Deterioration and Resuscitation (RADAR) group to develop a workplan to address gaps in control to improve the recognition and management of acute deterioration across the Health Board.	Davies, Mandy	~~30/09/2024~~ 30/11/2024	Quarterly meetings in place, and sub-groups being established to report to Recognition of Acute Deterioration and Resuscitation (RADAR) group on sepsis, NEWS, treatment escalation plans, call for concern (Martha's Law) DNA/CPR, acute kidney injury (AKI). Agenda at August meeting didn't allow for discussion on the development of a workplan. Plan is to confirm RADAR Action Plan at next meeting in October 2024. To reflect impact of the workplan in risk actions.
		Develop an organisation-wide training needs analysis to appropriately identify staff across all staff groups complete the most appropriate level of training to improve recognition and management of acute deterioration.	Wastell, David	~~30/09/2024~~ 30/11/2024	The directorate is working with ESR to ensure that staff training attendance is accurately recorded. Work is ongoing with individual line managers to identify the training needs of all their staff groups across all four sites and community. Meetings commenced with all senior nurse managers to discuss current training uptake and training needs to identify the most appropriate training for each staff group across acute and community. Meetings are to be arranged with Heads of Service for other clinical services. As at June 2024, it has been identified that 84 ILS sessions are required in order to ensure compliance with targets for GGH alone. Heads of Nursing requested to discuss training attendance with all ward sisters, and to appropriately prioritise. Monthly analysis of training available, and attendance to be shared with Heads of Service and

						Senior Nurse Managers. The provision of training continues at current levels, given current resource availability. First draft to be taken to Ops QSEC advising that final approval is required from RADAR (26th November 2024).
			To implement an electronic observations systems across the Health Board to capture real-time bedsite capture of patient assessments and monitoring, in line with the Health Board's Digital Plan	Williams, Carolyn	30/09/2025	Tender process completed. Business case to be presented to Board in July 2024, with a view to implement on a site by site basis over in 18 months, in line with the current Digital Plan.
			As part of the Quality Dashboard, agree the matrix needed for patient deterioration. Include these matrix in the Health Board Quality Dashboard to inform escalation and create a specific dashboard for RADAR (Recognition of Acute Deterioration and Resuscitation).	Wastell, David	30/05/2025	Meeting of 25th July 2024 has identified the following supporting metrics for the dashboard: sepsis, AKI, NEWS audits, cardiac arrests, number of MET calls, treatment escalation plans are in place, call for concern rates and training compliance for ILS and BLS for each Directorate. DW to work with Performance Team to agree the process for data collection to inform the Dashboard. DW met with Performance Team on 28th August 2024. Work ongoing.
			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	Task and Finish Group is in place, chaired by Ceri Griffiths. An SOP Patient leaflet is being developed and a pilot to commence in GGH in October 2024. Approval is being sought from Operational QSEC w/c 9th September. This pilot will test the process to roll out across the organisation for Adult Inpatients.

Put in place All Wales Policy for treatment escalation plans to enable safe and effective care management when patient deteriorating.	Wastell, David	31/12/2024	Discussed at Health Board Recognition of Acute Deterioration and Resuscitation (RADAR) group Group (March 2024) - no agreement to move forward with proposed pilot in Withybush. Discussed at Withybush RADAR meeting in July 2024 where agreement reached for pilot. Task and Finish group being established by Lead for Critical Care Outreach in Withybush to devise an implementation plan. RADAR to review following evaluation and consider roll out across other sites.
Implement a model for CASCADE training for basic life support and monitor impact on basic life support training compliance rates.	Wastell, David	31/03/2025	Model devised by Resuscitation Team - first training session held. 6 Cascade Trainers from across the Health Board Community Teams, trained in July 2024. Training will continue. Training session planned for Midwife Cascade Trainers in September 2024. Plans for health visitors and school nurses for January 2025.
Following assessment and interpretation of the All Wales Direction, the Health Board is engaging in National work, namely roll out of NEWS2 and Call 4 Concern and contribute to the National Improvement for Acute Deterioration being led through the Safe Care Partnership.	Wastell, David	~~30/09/2024~~ 30/03/2025	Launch of this initiative anticipated on 17th September 2024 (World Patient Safety Day). WHCs have been received in relation to NEWS2 and Call 4 Concern. There is an All Wales Safe Care Partnership meeting on 22nd October 2024 to design a national improvement programme for acute deterioration which the Health Board are engaged in and will contribute to. A group led by the Assistant Director of Nursing for Acute Inpatient Services is designing a first phase approach to pilot Call 4 Concern from November 2024.

			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.
			Monitor cardiac arrest rates and learn lessons from review of cardiac arrests.	Wastell, David	Completed	Scrutiny Meetings have been set up in GGH to review Cardiac arrests, bi monthly. First meeting 5th September 2024. The lessons learned will be transferred across other sites, if applicable. Cardiac arrest reviews being presented at Medical Education sessions and plan to present at PPH Grand Round. County RADAR groups review local cardiac arrest rates. Learning to be fed in through Health Board RADAR group. Feedback from any medical examiner reviews is proving beneficial in highlighting issues relating to resuscitation/cardiac arrests. We appear to be seeing a reduction in cardiac arrest rates which will be reviewed at the RADAR meeting in December 2024.
			Improve compliance with DNACPR National Guidance	Steele, Cathie	30/10/2024	DNACPR Review Group in place, a sharepoint page is being developed and we are anticipating an updated All Wales policy in September 2024. An EQiP Project Team has been established to develop and implement an improvement plan in relation to DNACPR processes.
			Development of an Acute Deterioration Sharepoint page for all advice, guidance, updates, for staff on issues relating to resuscitation, DNACPR, sepsis, call for concern, MET calls, training, etc.	Wastell, David	31/05/2025	New Action

How are the Gaps in CONTROL will be addressed	By Who	By When	Progress
Trial starting in October 2024 for 3 months re NEWS Audit, NEWS Charts - 5 charts every ward, every month on every site utilising the AMaT system. To review compliance and whether escalation processes are being followed with outcomes being fed back to wards.	Wastell, David	31/01/2025	New Action
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	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 OQSEC, Feb-24	Ward based NEWS audits in place but may be unreliable as self assessed.	Once dashboards in place, to develop a monthly audit process to address key hotspots / areas of concern relating to RAILS	Wastell, David	30/09/2025	Next RADAR meeting - October 2024.
	Review of DATIX incidents, complaints, cardiac arrest reports and Medical Examiners reports relating to acute deterioration	1st								
	Outreach review all unplanned admissions to Intensive Care	1st								
	RADAR Group	2nd								
	T&F Group chaired by HB RADAR Lead with focus on Sepsis	2nd								
	DR/CPR group chaired by Deputy Medical Director	2nd								

Date Risk Identified:	Nov-22	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Oct-24
Strategic Objective:		Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Nov-24

Risk ID:	1531	Principal Risk Description:	There is a risk of being unable to provide a safe and sustainable general surgery consultant on-call rota at WGH and GGH. This is caused by One vacancy and one substantive consultant who is no longer taking part in the on call rota, due to health issues, on the General Surgery Consultant rota at WGH (1:5). This is now running as a 1:4 rota with one Medacs and one NHS Locum filling the gaps. In GGH (1:8 rota) there is one vacancy, one retire and return consultant, at the time of retirement the clinical director and GS team at GGH supported the retirement with the agreement they would cover the out of hours on call through ADH. This was not a cost pressure, as the reduction in job plan sessions offset the internal locum cover. The vacancy has now been filled by an NHS locum upper GI consultant who started on 30/09/2024. There is also one consultant on the General Surgery Consultant rota at GGH who has is now only doing weekday on calls, due to health reasons. The weekends are covered by a specialty doctor acting up under supervision. The GGH rota is now running as a 1:7, maintaining a 1:4 in WGH and a 1:7 in GGH with 1 gap is unsustainable. This could lead to an impact/affect on The ability to provide an emergency general surgery service at WGH and GGH affecting patient experience, causing clinical delays and poor outcomes for patients. The wellbeing of remaining consultants who are already working to full capacity is also affected and there is an increased expenditure on agency locum consultants.

Does this risk link to any Directorate (operational) risks?	

Risk Rating:(Likelihood x Impact)	
Domain:	Workforce/OD
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	1×5=5
Tolerable Risk:	6
Trend:	⟺

Rationale for CURRENT Risk Score:

The risk score remains the same as the inherent risk score. This is based on recent short notice absences in addition to the existing gaps on both rotas (GGH & WGH), where the rotas have come close to collapse, 3 times in recent months, with the rot being covered at the eleventh hour at an enhanced rate. This has further highlighted the fragility of these rotas. Due to the financial situation, there is an expectation to reduce variable pay and exit Medacs locum agencies. The rotas will collapse without the support of these and it will be a withdrawal of the control measures we have put in place. The appointment of a locum consultant to GGH does not change the risk score as this is a temporary measure. The rotas will remain fragile if they remain as two separate rotas and we try to sustain a 1:4 and 1:8 rota on two sites. There is also a risk to emergency upper GI patients at WGH, due to there being no upper GI specialists on the site.

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 current SBARs that are being discussed recommend that the amalgamation of the two rotas should happen sooner than the CSP work allows, no decision has been made by the health board about these recommendations as yet.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
The WGH General Surgery consultant on call rota currently runs as a 1:4. There are currently 4 consultants on the rota, 2 substantive, 1 NHS locum and 1 Medacs locum who joined the team on 06/11/2023. An NHS locum consultant post was advertised and appointed to on the 20/11/2023 as an exit strategy for the Medacs locum. The successful candidate withdrew on 29/11/2023. A job description for an emergency general surgeon is currently being developed for WGH. However, as the EGS rota is part of the CSP, it was decided by the clinical director of scheduled care not to advertise for WGH for the time being. 1 gap on the 1:8 General Surgery consultant on call rota at GGH is currently being covered by internal staff on a locum basis at the HB locum card rate. An NHS locum Upper GI consultant has been recruited to GGH on 22/08/2024, and started on 30/09/2024. The 0.5 gap, due to health issues is being covered by a specialty doctor acting up under supervision, bringing the rota to a 1:8 with 7 staff on the rota. Continuously liaising with the rota coordinator at WGH for potential gaps on the rota. When there is sickness or unexpected leave, due to emergency circumstances, the management team work to cover as follows: 1. Internal ADH on the site with the gap.	The 1:4 model at WGH, which commenced on 03/11/2023 continues to be fragile, with only 2 substantive consultants on the rota. The 4th slot on the WGH rota is being filled by a Medacs locum which incurs additional costs. There are also risks of the locum leaving at short notice, causing the rota to collapse. With current financial situation and the expectation to reduce variable pay, there is a risk that the service will be asked to terminate the Medacs locum. The locum consultant who started in WGH on 04/09/2023 was an associate specialist and part of the SAS level rota at WGH. This has now left a gap on the SAS level rota. This is currently being covered by a Medacs locum. We advertised and appointed a specialty doctor but the successful candidate withdrew on 13/11/2023. The post went back out to advert and we appointed on 01/12/2023. This person withdrew on 07/02/2024. The	Recruitment of 1 Consultant upper GI surgeon for GGH. Agreement to recruit 1 consultant emergency general surgeon for WGH or 1 consultant general surgeon for GGH.	Lewis, Caroline	Completed	One NHS locum has been recruited to WGH and has been in post since 04/09/2023. Following previous withdrawals and a further vacancy in GGH. The plan for recruitment has changed with a consultant upper GI surgeon post to be advertised for GGH in April 2024. A job description for a consultant emergency general surgeon is being devised for WGH, if rotas are amalgamated, a consultant general or upper GI surgeon could be appointed to the new rota. 22/08/2024 - One NHS Locum upper GI consultant was recruited to GGH and is currently onboarding with a hope to start in 6-8 weeks time. 11/10/2024 - Successful candidate started on 30/09/2024.

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

Medacs locum has been briefed on clinical pathways and procedures within Hywel Dda Health Board and expectations have been made clear by the surgical team.

Engagement with WGH Medical Staff Committee and public on changes to services

In response to the fragility of the rotas and the recruitment difficulties that have been faced. A plan for relocating emergency surgical on call from WGH has been submitted as part of the directorates annual plan and the health board Clinical Service Plan.

In April 2024, an updated SBAR was populated to go to board with the recommendation of amalgamating the two on call rotas to 1 site to either a 1:12 or a 1:10. There is clinical belief that these changes provide a more sustainable service and would make recruitment more attractive, when comparing to other health boards across Wales who provide emergency general surgery cover in this way. The condition of this change would be that consultants would be expected to change their base of work to participate in the amalgamated rota, this is likely to require an OCP. In October 2024, a further updated SBAR is being developed which will include confirmation of the clinical support for the amalgamation of the rota.

EGS is part of the ongoing CSP work program in the health board.

An SBAR has been populated, highlighting the risk to emergency upper GI patients in WGH. The recommendation from the senior clinical team is for these patients to be admitted directly to GGH. The reason of this is that there are no specialist upper GI consultants based at WGH and no ERCP service available on the site. This SBAR was presented at ALG on 25/09/2024 and at the Quality, Safety and Experience committee on 08/10/2024. The outcome was for this to be discussed at ET level alongside the CSP work program.

One of the GIRFT recommendations was to reduce the number of surgical on call takes across the Health Board from 3 to 2 sites.

post went back out to advert in April 2024 with no successful candidates. We have successfully appointed to this post on 15/08/2024, but they have since withdrawn. The vacancy is currently being shortlisted after going back out to advert again.

GGH consultants offer to cover the WGH gaps when required, on ADH, however WGH have never offered to cover any other site.

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.

An increase in consultants at GGH, working additional on call locum weeks is resulting in a reduction in elective activity in OPD, endoscopy and theatre. This will have a negative impact on RTT and SCP targets.

The fragility of the GGH rota and it's impact on elective activity became evident during the summer months with further short notice sickness in the team, causing a further reduction in activity.

A prolonged unsustainable service could impact on the training of surgical doctors and, in turn, increase the number of HEIW vacant posts, leaving the SAS and junior rotas at risk of collapse.

Concerns regarding the service provided to upper GI patients admitted to WGH.

The GGH rota remains unsustainable with the NHS locum consultant and specialty doctor in place as both of these are temporary solutions.

Concerns from WGH physicians on the

To introduce a contingency model of day time consultant on-call rota in WGH with support from GGH and BGH consultant cover out of hours.	Lewis, Caroline	Completed	Report discussed at Acute Leadership Group, Executive Team and Operational Planning and Delivery Programme (OPDP) meetings. A 1:3 rota was agreed and will commence from 01May23.
Review the longer term sustainability of general surgery on-call rotas across Hywel dda (recommendation from Getting it Right First Time (GIRFT) review in Jan23)	Lewis, Caroline	Completed	The senior consultant leads for general surgery have suggested that the WGH and GGH on call rotas are amalgamated to one site. This would provide an increase of consultants on the rota to either a 1:10 (the 3 WGH consultants and the 7 GGH consultants) or a 1:12 (the 3 WGH consultants, 7 GGH consultants and 2 newly recruited posts). This recommendation is in line with the GIRFT report. SBAR's have bee drafted by the service to describe the fragility of the rotas.

	Concerns from WGH physicians on the wider implications on the emergency service model at WGH. Risk of further vacancies over the coming years, due to retirements or requests to reduce working hours across both rotas, given the age demographic of the surgical consultant body in place. Whilst EGS is part of the CSP work programme. This is a 2-4 year plan and the rotas are fragile and at risk of collapse at present.	Robust plans to be developed for transfer and repatriation of patients	Lewis, Caroline	Completed	SOP has been developed and discussed with clinicians.

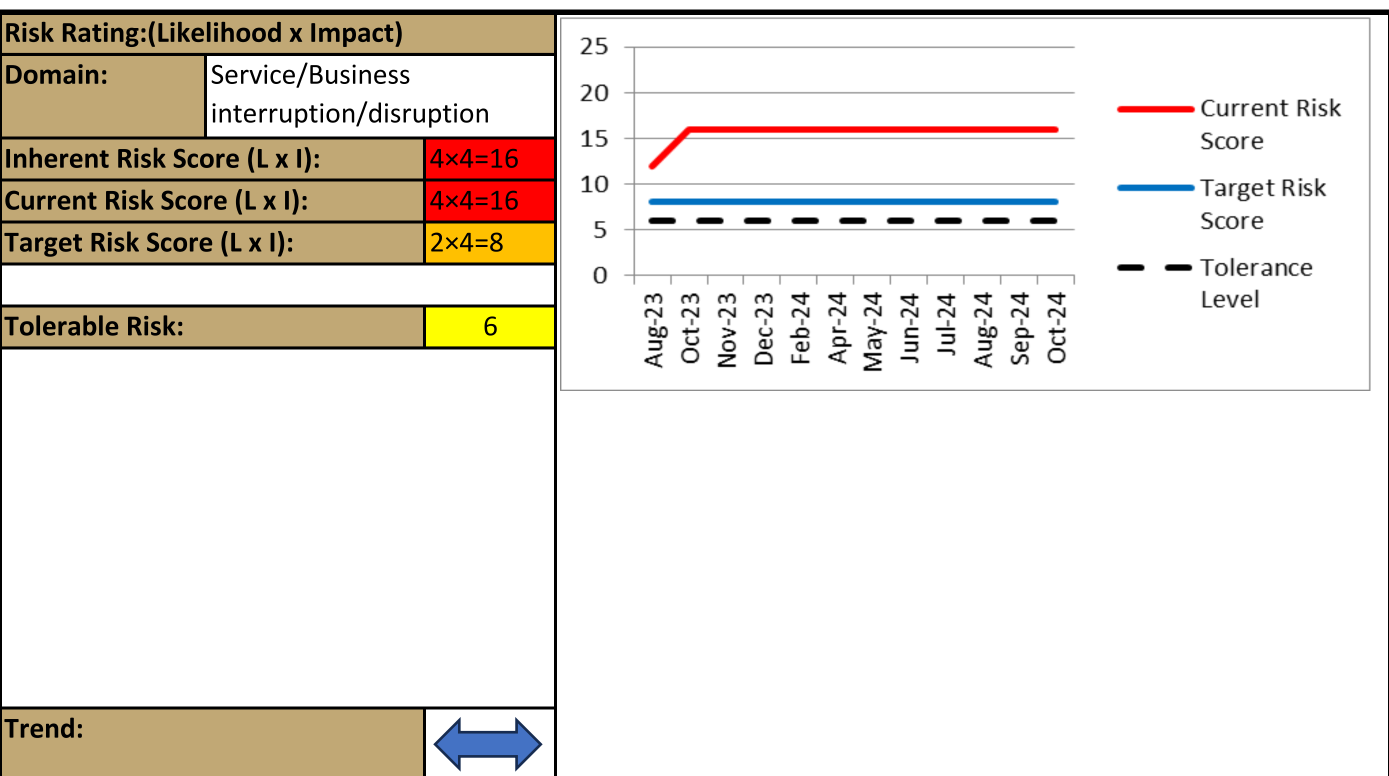
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
	WGH Medical Staff Committee established to develop models of sustainability	1st			Management team have presented an SBAR to Acute Leadership Group (Feb23) SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23)	Assurance to Board on communication and repatriation arrangements	Produce update report to Board in May23 to include details on communications with clinicians and the public, details of repatriation arrangements and accommodation and support for families, the patient experience and the governance arrangements for onward scrutiny	Lewis, Caroline	Completed	on 10/05/2023, an update was provided to Ben Rogers of the clinical services programme for the draft SBAR clinical services update which is what was taken to board.

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

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

Risk ID:	**1708**	**Principal Risk Description:**	There is a risk of increasing fragility in Primary Care Contractor services. This is caused by challenges in recruiting new clinicians into salaried or partnership roles which impacts on succession planning for contractor professions. There are further challenges in relation to premises not being fit for purpose and not having the capacity to flex to a more modern approach to service delivery e.g. MDT working. In addition, contract reform against the background of significant pressures on the wider system, and exacerbated by financial pressures for the independent contractor business model. This could lead to an impact/affect on undermining the independent contractor model, and therefore the ability for patients to access timely and local primary care services. If service users are unable to access these services, this may lead to additional pressures on other primary care services, and wider Health Board services such as Out of Hours and Urgent and Emergency Care. As a result of contract terminations, there will be a detrimental impact on the financial position of the directorate relating to dental contracts.
Does this risk link to any Directorate (operational) risks?			1688, 1451, 1403, 1164, 1660, 933

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



Rationale for CURRENT Risk Score:

Rationale for TARGET Risk Score:

8 dental contracts have been returned to the Health Board in the last 12 months, of which four contracts (totalling £958,500) confirmed as being awarded by NWSSP Procurement Services in May 2024. In addition, a further 8 dental practices have not signed up to the contract reform, and signalling that they will return contracts once reform negotiations have concluded. The number of complaints received from the public has increased due to returned contracts, and while the Health Board is currently containing the demand for urgent dental care, it is recognised that patients who don't fall in to this category but require a level of dental care are detrimentally impacted, and that any further contracts returned will exacerbate this situation. The capacity of the Health Board in terms of staffing to absorb further contract reform will impact on the ability to effectively deliver services, and a detrimental impact on staff welfare. There has been increased demand in urgent dental appointments resulting in appointments for the week being booked up early within the same week. The Dental Access Portal (DAP) pilot commenced in Powys in June 2024, with roll out due to at Hywel Dda in November 2024. 2 GMS contracts has been returned to the Health Board in the last 12 months. However from previous contract terminations, 2 out of the 3 GMS contracts have become Health Board managed practices, resulting in additional financial pressures as the workforce is salaried. The third practice has been awarded as of 1st April 2024 after a successful procurement process. The outcome of the contract which was returned in April 2024 was presented and agreed by Board in July 2024, with decision made to manage list dispersal. It is recognised that any further managed practices would likely have a negative impact on the GMS budget. Implementation plans are in place with Ophthalmology to support the transition of patients into Welsh General Optometric Service (WGOS4) (clinical pathways for Glaucoma, HQC and Medical Retina) as part of the new Optometry contract implementation which commenced in September 2024.	Achievement of the target score is subject to the development and agreement of a Primary Care Strategy at Board alongside successful national contract negotiations and subsequent implementation across the Primary Care contractor professional groups.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**

Primary Care Academy in place, which looks at workforce planning, training and development needs and opportunities 5 Facet Survey completed in 2022 to establish a baseline for the GMS estate GMS and Dental Practices undertake annual reporting which includes reviews of statutory compliance requirements 0.25 FTE Primary Care Development Manager for estates in post but with a focus on GMS Escalation tool for GMS and Community Pharmacy (SITREP) Continue effective engagement with struggling practices to support with their issues through close working relationships developed with practices. Programme of practice visits to review Estates provision, and if remedial action is required Requests sent to contractors to assess potential risk of RAAC, with outcomes reported to WG Nationally agreed Breach Management process in place for Community Pharmacies. Requests for contract variation (termination, merger, branch surgery closure etc) are considered in line with national guidance, with panels convened as stipulated. Recommendations are taken through the Primary Care Contract Review Group with papers to Board when required. Strategic Programme for Primary Care (SPCC) bids approved for 2024/25 and 2025/26 to support workforce initiatives	A series of patient facing videos have been developed with Pocket Medic to support patient education in accessing Primary Care Services, and due to launch during Q1 2024/25. Requests for support on addressing the GMS sustainability agenda are with the Strategic Programme for Primary Care as a result of a review paper across all Health Boards on their sustainability pressures. National work on the development of the escalation tool for Dental and Optometry is ongoing but not live. Five Facet Survey and annual reporting of practices has highlighted non-compliance with statutory requirements such as Health and Safety, Fire and IP&C which have now all been addressed. Limited requirements for practices to disclose information to the Health Board about their sustainability pressures, and rare for practices to disclose financial details (reliant on engagement and good will as this is not a contractual requirement as at June 2023). Insufficient resources to support the estates development across all Primary Care services, particularly with independent contractors. Due to national review of Premises Directions, there is no improvement grant funding for 2024/25.	Establish workforce plan and recruitment strategy in line with the development of the national Primary Care Workforce Strategy and as a component of the Primary Care Strategy.	Hughes, Samantha	~~31/03/2024~~ 31/03/2025	Workforce planning continues. GP Practice workforce plans using data from Welsh National Workforce Reporting System (WNWRS) have been pulled together at Cluster level for Collaborative consideration. This information now needs to inform and align to the Primary Care Workforce Strategy. Support is being provided to the Directorate with this work from colleagues in Workforce, and is also discussed via the Primary Care Academy.
		To develop the Primary Care Strategy in consultation with statutory stakeholders and consultees, to cover areas including: •Workforce •Sustainable provision of Primary Care services •Estates •Managing contractual change •Developing pathways and new services •Improving access to services across all contractor professions	Bond, Rhian	~~30/09/2024~~ 31/03/2025	Paper submitted to Board in September 2023 setting out the scope of the Primary Care Strategy, with papers presented to Board at regular intervals. A further paper is due to SDODC in October 2024.
		Consider the potential to deliver a wider range of salaried NHS Dental Services through the Community Dental Service.	Owens, Mary	~~30/04/2024~~ ~~30/06/2024~~ ~~31/10/2024~~ 31/03/2025	Negotiations continuing in October 2024, and guidance still awaited from Welsh Government.

	Whilst Community Pharmacy Breach Management process in place, 2 notices are currently under the appeals process - the Health Board is awaiting confirmation on the outcomes of these by Welsh Government, which to date has taken over a year. Outcomes of these appeals will directly influence the approach taken going forward, and may result in the nationally agreed process unable to be fully implemented. Whilst RAAC declarations were requested, these were not mandatory for contractors to respond.	Implement the Managed Practice Strategy plan will give greater system resilience.	Swinfield, Anna	~~30/04/2024~~ ~~30/10/2024~~ ~~31/01/2025~~ 31/03/2025	The tender process for Neyland and Johnston concluded without a contract award. Re-procurement exercise completed in September 2024 with no success. Review of Managed Practice Strategy to be undertaken in line with the development of the Primary and Community Services Strategic Plan.

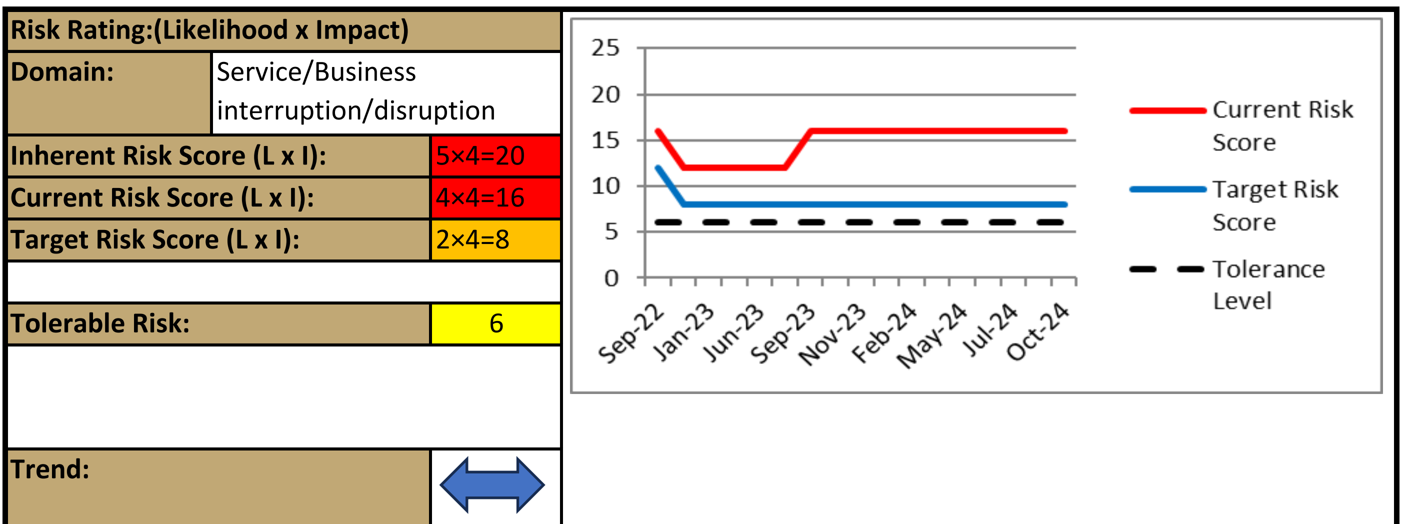
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Sustainability Matrix Contract performance to monitor volume metrics (identifies if dental practices have issues in service delivery) Monthly assurance reports and Dental Assurance	GMS practices are asked to complete a WG sustainability matrix every 6 months to track the main risk areas and this contributes to a heatmap. Practices are also asked to report regularly on operational pressures	1st			OQSEC Primary Care Exception Report	Varying levels of engagement from practices in the regular reporting of operational pressures.				
	Dental Management Team undertake annual reviews	1st								

Assurance Framework - Business Service Authority dashboards, to identify outliers	GMS Practices are part of a rolling visiting programme, based on their annual return which is risk assessed against a framework of any other issues or concerns identified	1st								
	PCSMs tasked with regular discussions with Practices that report L4 to understand the issues	1st								

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

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

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



Rationale for CURRENT Risk Score:

The Health Board's stock of aged imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the Health Board's ability to meet its Referral to Treatment (RTT) target and impact to patients can include delays in diagnosis and treatment. CT and MR scanners have been replaced and has reduced the frequency of machine downtime compared to previous experience.

The risk score is noted as 16 reflecting that some equipment has been installed and is operational, however further investment is required given recent breakdowns of key imaging equipment. A costed plan along with a rolling programme for the installation of additional equipment is in place. There is a continuous process locally by which equipment is prioritised for replacement.

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

Gamma camera at Withybush General Hospital is the only scanner of its nature in the Health Board, and has experienced a series of breakdowns in 2023 due to intermittent failures which resulted in several HIW reportable IRMER incidents. This item of equipment is on the current priority list of items to replace as at November 2024.

While a new CT scanner has been obtained and installed at Glangwili, the original CT scanner is having regular breakdowns. The technology on this scanner is also now out of date and impacts directly on the resilience of the service at our major trauma site in the Health Board. Like-for-like replacement of existing equipment is not necessarily a cost effective method of maintaining services and in certain circumstances does not meet updated regulatory compliance or meet the requirements of maintenance warranty agreements. This means there will need to be upgraded infrastructure such as air handling units, water chiller systems and the size/accommodation for modalities at an initial increased cost but representing long term savings and service resilience overall.

Rationale for TARGET Risk Score:

WG funding has been secured to replace a fluoroscopy unit and a CR x-ray unit at WGH along with a much needed MRI upgrade at PPH during the 24-25 financial year.

With more modern equipment, breakdowns will be less likely and less significant in terms of downtime together with a reduced impact on the diagnostic services at the remaining hospital sites. Improved business continuity plans will also help reduce the impact of equipment breakdown across the UHB.

Due to the nature of the release of funding which is usually in Q3/Q4 of the financial year it is difficult to plan large installations due to the speed at which the replacement need to be completed. This means that sometimes equipment of lesser priority is replaced before the bigger installations which have a greater need.

The number 1 replacement priority in the Health Board is to replace the Nuclear Medicine SPECT scanner. This is a service risk as it is the only scanner in the HB (Risk 1706, score 20) and has suffered frequent breakdowns since June 2023. A specific task and finish group has been convened to forward plan the replacement in anticipation of WG funding. The second CT scanner at GGH is a second priority as this is relied upon to undertake outpatient work and as a back up scanner. This is aged and is having increasing breakdown outages with long lead time to source parts.

Once the Nuclear Med SPECT-CT scanner and the 2nd CT scanner at GGH have been replaced we would look to seek permission to reduce this risk score and to move the risk directorate level. This is dependent on WG funding, and my not be complete until the end of the 26-27 financial year due to the additional infrastructure required.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports. # Escalation process in place for service disruptions/breakdowns. # National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales. # All equipment at main sites are now DR and so will be compliant with the RISP project # Additional WGH EOY funding was secured (23-24 financial year) and replaced aged US units and upgraded the software on MRI scanners at BGH and WGH providing latest technology.	Limitation of spare parts for some older equipment leading to extended outages. This issue has been compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment. Inability to undertake specific replacements at this time due to the additional infrastructure required No dedicated diagnostic equipment replacement funding for the 2023-24 financial year delayed replacement of key pieces of equipment and so maintained the risk at it's current score. National Imaging and Capital Priorities Group outcomes do not always align with the Health Board priorities, and is subject to negotiations within the group.	To confirm the capital funding to replace existing aged equipment for FY 2023/24	Roberts-Davies, Gail	Completed	A prioritisation list of aged equipment to be replaced has been devised, however confirmation needed on funding in order to undertake the required work. Funding has been given to replace Tenby DR equipment by the end of financial year 2023/24, and a task and finish group set up to monitor. Additional EOY funding has been secured to replace US units across the HB and 2 image intensifiers (BGH & WGH). Tenby equipment has been replaced and work is underway to replace an x-ray set at BGH. US and Image intensifiers recieved.
		To confirm funding arrangements for the remaining equipment that needs to be replaced, supported by individual DCP bids or dedicated replacement funds for 2024/25.	Roberts-Davies, Gail	Completed	Directorate has compiled a list of equipment requirements, which have been prioritised dependant on finance availability and functionality of the existing equipment and presented at Capital Sub-Committee in September 2023. Priority list has also been submitted to the National Imaging Equipment Capital Priorities group (NHS Executive Group) via assessment process, with outcomes provided in late May 2024. It is noted that funding has been given to replace Tenby DR equipment by the end of financial year 2023/24, and a task and finish group set up to monitor. NIECP meeting was held in April 2024 where the prioritised list of equipment replacements was be presented for consideration along with those of all HB's. Priorities were reiterated and a list ranked for WG. The outcome of this for Hywel Dda is that the final CR piece of equipment at a main site (WGH) will be replaced

			with DR equipment, along with the fluoroscopy room at WGH and an upgrade of the aged MRI scanner at PPH will also be undertaken.
Installation of replacement Gamma Camera, WGH	Roberts-Davies, Gail	~~31/07/2024~~ 30/06/2025	Gamma camera is 9 years old and the only scanner in the Health Board providing a regional service. Recurrent breakdowns are resulting in HIW reportable incidents. Awaiting confirmation of funding as at December 2023. No funding allocated as of 09/02/2024 This will not be replaced in the 24/25 financial year. A specific T&F group is due to be set up as of June 24 to plan the necessary accommodation improvements required. July 2024 update- the T&F group has been set up and meets weekly
Replacement of CT Scanner at GGH	Procter, Sarah	~~31/03/2024~~ ~~31/07/2024~~ 30/06/2025	CT scanner is 11 years old, with increased failures noted and that new technologies are now available. Colleagues in Estates are currently looking at options and prices, and as at December 2023 no capital bid yet provided as awaiting works costs. Significant infrastructure works will be required due to the size of the accommodation and the requirements of more modern scanners, including footprint. Will not be replaced in the 24/25 financial year.
Replacement of digital x-ray rooms at Tenby Cottage Hospital and South Pembrokeshire Hospital	Roberts-Davies, Gail	Completed	Funding has been given to replace Tenby DR equipment by the end of financial year 2023/24, and a task and finish group set up to monitor. Tenby equipment has been replaced. SPH will not be replaced in the 23/24 financial year.

Replacement of ultrasound systems at BGH & GGH, image intensifier units at BGH & WGH, and Vacuum Assisted Biopsy (VAB) unit for PPH Breast Clinic	Osell, Fiona	Completed	Ageing equipment with replacements required for obstetric scanning, and resilience of services provided to Theatres. BGH and GGH Image intensifiers replaced. VAB equipment not to be replaced at this time. DCP bids have been collated for BGH ultrasound and WGH image intensifier, and exploring opportunities for charitable funding to support VAB unit for PPH Breast Clinic. Outcomes are still pending as at December 2023.
Replacement of Fluoroscopy room, WGH	Whitecross, Faith	~~31/03/2024~~ ~~31/07/2024~~ 31/03/2025	Equipment is 17 years old with significant downtime experienced. Routine testing by Medical Physics department in January 2024 has found that image quality has deteriorated and the equipment is delivering increased doses to account for this. Confirmation that this piece of equipment will be replaced in the 24/25 financial year was received late May '24- action will be closed when this piece of equipment is operational. The replacement is currently delayed as of November 2024 due to additional the discovery of additional infrastructure which is required.
Replacement of CR A&E DR room and OPT (Dental) units, BGH	Edwards, David	~~31/03/2024~~ 31/10/2024	The equipment for the A&E room has been replaced as at October 2024, with handover and training underway. OPT units have been set up however awaiting engineers and medical physics to complete installation, upon which the action will be closed..

Replacement of CR X-ray Room 1, WGH	Roberts-Davies, Gail	~~31/03/2024~~ ~~31/07/2024~~ 31/03/2025	Ageing equipment. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. 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.
Replacement of CR X-Ray room, Llandovery Hospital	Osell, Fiona	~~31/03/2024~~ ~~31/07/2024~~ 30/06/2025	Equipment on site is incompatible with the incoming PACS system, and interim solution required. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. This will not be replaced in the 2024/2025 financial year
Replacement of Mammography Units, BGH and WGH	Roberts-Davies, Gail	~~31/03/2024~~ ~~31/07/2024~~ 30/06/2025	Ageing equipment, exacerbated by the failure of Securview. These will not be replaced in the 2024/2025 financial year
Upgrade or replacement of MRI scanner, PPH	Osell, Fiona	~~31/03/2024~~ ~~31/07/2024~~ 31/03/2025	Ageing equipment with increasing failures, with new technologies now available. Awaiting confirmation of funding as at April 2024. Confirmation that this piece of equipment will be upgraded in the 24/25 financial year was received late May '24- action will be closed when this new piece of equipment is operational.
Upgrade or replacement of MRI scanner, GGH	Procter, Sarah	~~31/03/2024~~ 30/06/2025	Ageing equipment with increasing failures, with new technologies now available. This will not be replaced in the 24/25 financial year.

		Action	By Who	By When	Progress
		Replacement of Room 3 (Digital x-ray room), BGH	Edwards, David	~~31/03/2024~~ ~~31/10/2024~~ 30/06/2025	Mobile unit currently being used. Awaiting confirmation of funding as at April 2024. This will not be replaced in the 24/25 financial year
		To consider alternative funding options for the DEXA unit, BGH	Edwards, David	~~31/03/2024~~ ~~30/09/2024~~ 30/09/2025	Unit is 17 years old, and previously funded via charitable funds This has been added to the imaging priorities list as relative replacement costs are not high. A business case for charitable funding will be pursued in due course, however operational pressures have taken priority to date.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Reduction of waiting times to under 8 weeks.	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team - Mar19 Further updates CEIMT Feb20 Further updates CEIMT Sep20 Radiology Diagnostic Imaging update to Capital Sub-Committee presented September 2024	Lack of process of formal post breakdown review.				
	IPAR reports	2nd								
		3rd								
		3rd								

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

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

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

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

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Transfer of the radiopharmacy service to Singleton Hospital in October 2022; this means less overall activity through the Withybush Aseptic unit reducing the risk of contamination and errors. More time and resource provided to the Quality System (i.e. internal audits, investigation of near misses and microbial growths, maintaining SOPs). Increased training of aseptic staff to develop their skills and knowledge. Increase outsourcing from commercial suppliers; this limits the volume of products prepared within the unit, allowing products that must be made in-house to be prepared safely. New pharmaceutical isolators have been procured to replace the existing isolators that are beyond their working life of 10 years. The new isolators will be stored with the intention of installing into the demountable unit (if funding is secured) or will be installed into the existing unit if the current isolators fail mitigating the risk of equipment failure causing prolonged service disruption. Removal of outsourced dispensing from the Aseptic unit; this minimises the risk of contamination and potential for error. Preparation of products near to the time of use; this limits the pre-administration storage time. More stringent gowning process; this minimises contamination risk. More stringent cleaning and monitoring programmes; this minimises contamination risk and allows early detection of microbial growth. Oversight and steer from Capital Sub-Committee.	Controls are reliant on a key group of skilled staff (i.e to maintain Quality System, to follow cleaning and monitoring procedures) therefore subject to key person dependencies. Limited accommodation to employ additional staff to expand workforce within the existing unit at WGH. Limited accommodation to store starting materials and finished products or to perform the associated tasks that are required to safely supply cancer treatments. Between 2021 and 2023, the number of cancer treatments requiring aseptic preparation at Hywel Dda increased from 12,718 to 16,648 (average of 14% increase each year). There is limited space within the Pharmacy at WGH to manage this increase in demand. Lack of funding to build a new unit at WGH.	To commence tender process for building a demountable aseptic unit on site at Withybush General Hospital.	Morgan, Cerith	Completed	The Mechanical and Electrical Engineering Professional Services evaluation was undertaken on 28.02.2024. A preferred provider was selected. The project timelines are currently running to schedule. Based on current schedule, the demountable aseptic unit will be operational by November 2025 if business case approved by WG.
		To submit revised business case for demountable unit to Welsh Government (estimated £2.89m).	Morgan, Cerith	31/01/2025	Based on current schedule, the revised business case will be submitted to WG during January 2025. As part of the tendering process, no suppliers had submitted a bid for the contract as of 03/09/2024. 24/09/2024 - the tender will be repackaged to the principal contractor of the project (Lewis Construction) noting the following specialist cleanroom subcontractors; Angstrom, Enbloc, Scitech, T-squared, Cleanroom projects. Lewis construction to work with Hywel Dda procurement team to organise that the quality of the submissions by these companies is scored by members of the project team. This may have an impact on the project timelines.

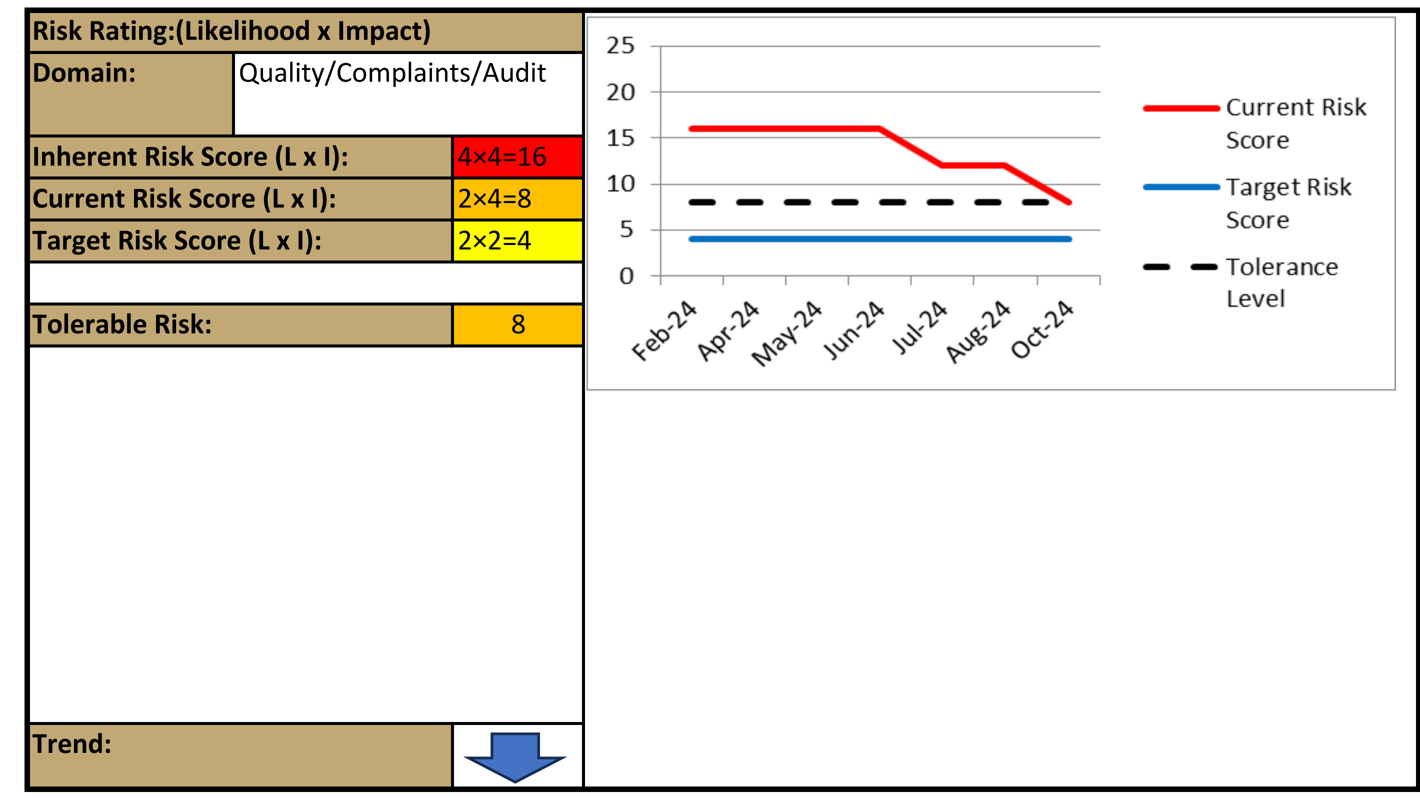
Further action	By Who	By When	Progress
To work with estates and capital planning team to source temporary accommodation at Withybush to increase the storage capacity for outsourced cancer therapy. This will help the aseptics service to meet the increasing demand for cancer therapy and will allow cost efficiencies related to outsourcing to be achieved whilst the business case for a demountable aseptic unit is being developed.	Morgan, Cerith	~~30/09/2024~~ 31/12/2024	Capital bids proforma submitted to Health Board capital planning team 11/06/2024. Ratification paper signed off and contract awarded to Portakabin on 02/08/2024. 05.09.2024, awaiting for contract to be signed by the Head of Service - Procurement before order can be placed. 24.09.2024 - awaiting for PO number to be raised to place order with Portacabin. Expected 8 week turnaround time once PO has been raised for portacabin and equipment to be delivered.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Audit Reports from annual audits detailing areas of non-compliance KPI Dashboard in place to provide continuous oversight of unit performance, updated monthly.	Annual Audits by Lead Quality Assurance Pharmacist (NWSSP) .	3rd			Capital Sub Committee (22nd January 2024). MMOG report to QSEC for Feb 2024.		To partake in annual audit (WHC 2024-004) by the Lead Quality Assurance Pharmacist.	Morgan, Cerith	Completed	Audit by Lead Quality Assurance Pharmacist was undertaken during February 2024. The audit confirmed that the facilities remain a high risk to patient safety but the control measures in place are appropriate.
							To commence "self-inspection" process where the Health Board pharmacy aseptics team will internally assess compliance of the service against QAAPS standards. Results of self-inspection to be discussed with Lead Quality Assurance Pharmacist or deputy to provide ongoing assurance that the aseptic unit complies with all other standards despite the facilities not meeting the standards.	Morgan, Cerith	~~31/07/2024~~ 31/10/2024	Initial meeting held between Cerith Morgan and Lead Quality Assurance Pharmacist. "Self-inspection" will commence July 2024 and results reviewed with Lead Quality Assurance Pharmacist or deputy during October 2024.

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

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

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



Rationale for CURRENT Risk Score:

New processes are in place for mortality review, in line with the All Wales Learning from Mortality Framework, supported by the Clinical Lead for Mortality and Mortality Review and Improvement Facilitator with all wards on board.

As of October 2024, the risk score has been reviewed and revised to 8, with the likelihood score reduced reflecting the increased capacity to scan, along with a review of existing processes and procedures to ensure compliance with Medical Examiner requirements. Regulations have come into force, with no instances of non-compliance to date.

The capacity for clinical scanning remains below the required level, however it has increased recently due to the appointment of a Clinical Effectiveness Co-ordinator, who has commenced in post, and the Directorate will continue to review ongoing capacity requirements. Contingencies are also in place to manage the sustainability of the service, with cross-working in place.

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

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

Rationale for TARGET Risk Score:

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

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

of Effective Clinical Practice and Quality Improvement, Assistant Director, Medical Directorate, County Director representative, General Manager (Community & Primary Care (Ceredigion), Head of Pathology, Lead Biomedical Scientist for Histology and Mortuary Services, Cellular Pathology Services Manager, Regional Mortuary Manager, Regional Mortuary Manager, Assistant Director Acute Services Nurse Representative, Head of Patient Experience, Clinical Nurse representative Women and Children, Clinical Nurse representative Mental Health and Learning Disabilities, Clinical Nurse representative Primary, Community and Intermediate Care, Specialist Bereavement Counselling Service, Chaplaincy Representative, Transplant Co-Ordinator representative, Learning and Development representative, General Practitioner representative, Psychological Services representative.		Ensure engagement on and communication of new processes to all Doctors across sites, using information, training sessions (e.g. Grand Rounds) and promotion of SharePoint information.	Hill, Carly	Completed	Engagement and communication is ongoing. Discussions with Hospital and Directorate Triumvirates and other Quality and Governance groups. Regular global communications have commenced, and will continue until September 2024. SharePoint pages developed not live until processes are fully in place by 15 August 2024. Training plan developed, with training remaining to be given for the two remaining wards. Wider communications need to be issued when process is fully operational. Discussion has taken place with Medical Education on programme of training for completion of MCCD. Grand Rounds session undertaken in February 2023. Communication to all Doctors has taken place in relation to responsibilities for completion of MCCD, and communications also sent via Global e-mails.
		Identify additional clinical staff across disciplines to screen letters received from the Medical Examiner Service.	Hill, Carly	Completed	Inclusion of request within the Autumn 2023 and Spring 2024 Medical Directorate newsletter for anyone interested in screening cases to come forward. Attempt to secure an additional Medical screener has failed over negotiations around service release. Clinical Effectiveness Coordinator has commenced in post, who is a registrant and has increased screening resources screening. Quality Improvement team are also supporting the screening effort when possible. Medical Directorate will continue to request additional screening support from operational teams.

	Explore the solution of the Internal Scanning Bureau, once operational.	Bennett, Mr Steven	~~30/09/2024~~ 31/03/2025	Shortlisting, interviews and contracts awarded July 2024. Demonstrations now being organised with Informatics colleagues, before the contact can be signed off by the Finance Director. There is a 90 day lead in time for delivery of the scanners (3 in dafen), so realistically scanning won't commence until January 2025. Assistant Director of Medical Directorate to liaise with Head of Health Records to discuss further progress and ownership of this action.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Number of deaths not scrutinised. Number of Delayed MCCD's completed. Number of deaths not registered due to lack of Medical Examiner involvement.	Number of deaths and number of case notes shared with Medical Examiner Service	1st			Effective Clinical Practice Advisory Panel (05/12/2023) Effective Clinical Practice Advisory Panel (19/03/2024) Quality, Safety and Experience Committee (13/02/2024) Operational Quality, Safety and Experience Sub-Committee (14/05/2024)	The process from death to registration is not captured on one system therefore gaps in completion and delays are dependent on information sharing across organisations including Health Board, Medical Examiner Service and Registrar Offices in Carmarthenshire, Ceredigion and Pembrokeshire.	Discuss with stakeholders improved information sharing arrangements.	Hill, Carly	Completed	Continued discussions with Health Records service to identify one system, however, scanning bureau not yet operational to support this function. Once a central scanning team has been established this will support the assurance on this risk. As at July 2024, systems are in place across the four sites bespoke to their arrangements that are appropriate for the current situation, whilst awaiting the implementation of a centralised scanning bureau. No concerns have been raised by the Medical Examiners Service.
	Mortality Scrutiny Group Medical Examiner Service	1st								
	Monitored by Medical Examiner Service	1st								