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

Assurance and Risk Report

Quality, Safety and Experience Committee – 9 April 2026

Situation

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

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

Principal risks, operational risks and recommendations from audit and inspections are reported at alternate meetings and will be presented to QSEC at its next meeting in June 2026.

Corporate Risks:
10

Welsh Health Circulars
21

Ministerial Directions
0

Risk Management - Overview

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

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

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

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

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

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

Corporate Risks assigned to QSEC

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5			1531 1859	1027 1552 1810	797
MAJOR 4				684 1664 2190	1032
MODERATE 3					
MINOR 2					
NEGLIGIBLE 1					

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

Corporate risks have been aligned to the most appropriate Board level Committee.

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

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

There are 10 corporate risks currently aligned to QSEC (of the 24 that are on the CRR as at 18 March 2026).

The following slides provide a summary of the reportable corporate risks aligned to QSEC. The Risk Register attached at **Appendix 1,** provides full detail of the risk, including control measures in place, a risk action plan to further manage and mitigate the risk, an expected date to achieve the noted Target Risk Score, and sources of assurance.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
797 – Risk of adverse patient and workforce outcomes if health board wide ultrasound services are unsustainable	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	**25** ➔ (Reviewed 16/03/2026)	**10**	31/03/2030

Rationale for Current Risk Score (CRS)

This risk was escalated from 20 to 25 due to increased fragility in available workforce due to 2 Whole Time Equivalent (WTE) retirements in January 2026.

Impact score of 5 due to a totally unacceptable level or quality of treatment/service; patients on maternity and cancer pathways are waiting too long for scans required for intervention; gross failure of patient safety if findings not acted on; concerns regarding noncompliance with Welsh Maternity screening targets; gross failure to meet national standards/performance requirements; waiting times non-interventional ultrasound are up to 35 weeks; vascular ultrasound is not available 7 days a week

Probability score of 5/>95% likelihood. The service is no longer able to sustain a safe baseline capacity to provide routine and urgent non obstetric imaging alongside obstetric scanning Monday to Friday, 09:00–17:00 on the Withybush General Hospital (WGH) site (see separate risk 1349 - Risk of being unable to deliver ultrasound services at WGH due to a lack of appropriately trained obstetric staff).

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

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797 – Risk of adverse patient and workforce outcomes if health board wide ultrasound services are unsustainable	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	**25** ➔ (Reviewed 16/03/2026)	**10**	31/03/2030

Rationale for Target Risk Score (TRS)
Impact of service failure remains the probability of service failure is the aim of mitigating actions. Probability target of 5-25% (2). In January 2026 the target date was reviewed and extended due to the timeline for Radiology Leadership Organisational Change Process (OCP) and recruitment to bring in the leadership required to mitigate the gaps in controls. Extended timelines required due to pathways changes and training timelines. Annual Planning 2026/27 priorities for Allied Health Professions and Health Sciences Clinical Care Group include further mitigation of this risk via capacity being added of 13WTE. This timeline is due to training timelines it will take at least three years to train a workforce if 2026/27 Annual Planning funding is provided to Radiology.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1027 – Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Community & Integrated Medicine	Chief Operating Officer	**20** → (Reviewed 20/02/2026)	**8**	~~31/03/2026~~ 31/10/2028

Rationale for Current Risk Score (CRS)

The most recent available data highlights sustained high operational pressures across all acute sites with increased escalation levels throughout January and early February 2026. Although some key performance metrics show a slight improvement over the last year, all are above Targeted Intervention (TI) targets in January 2026 e.g. the average time to clinical assessment in Emergency Department (ED): 68 mins (TI target: 60 mins); Numbers of >1hr ambulance handovers: 716 (TI target: 680); Pathway of Care Delays (POCDs): 213 (TI target: 174).

Actions to improve flow include implementation of the 7-day Clinical Streaming, Hospital at Home and Optimal Same Day Emergency Care (SDEC) services, as agreed at Public Board in January 2026. Whilst the business case has been approved and additional control measures have been implemented, system pressures remain and TI targets are not consistently being met therefore the current risk score remains at 20 as at February 2026.

Rationale for Target Risk Score (TRS)

The target risk score of 8 reflects delivery of 6 Goals Programme and Accelerated Transformation Programme to address significant issues across the health and care system. TI measures such as ambulance handovers and 12-hour delays in ED will need to improve for a consecutive period of three months to reduce the risk score. The expected date to achieve the TRS has been amended from March 2026 to October 2028 to allow for the implementation and embedding of risk actions. The embedding of 7-day Clinical Streaming and SDEC services will significantly impact on patient flow, however time will be needed for recruitment and embedding of services.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1552 – Risk of insufficient mortuary capacity due to current and anticipated future demand	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	**20** → (Reviewed 09/03/2026)	**8**	31/08/2026

Rationale for Current Risk Score (CRS)

Significant risks due to insufficient mortuary capacity across Health Board. Ongoing dependence on temporary body storage and current infrastructure limitations present a challenge maintaining compliance with Human Tissue Authority (HTA), protecting staff wellbeing, ensuring safe manual handling practices, responding to unplanned disruptions, and upholding dignity of deceased. Pressures continue to intensify as future death rates are expected to continue rising. Suboptimal facilities compromise presentation of the deceased, increase emotional distress for families, and pose safety concerns for mortuary staff, especially manual handling. Current control measures, which serve only as temporary contingencies in line with the Human Tissue Authority (HTA) licence are not sufficient to manage the current volume of deaths within the mortuary service, particularly during periods of heightened demand and there is a growing need for enhanced storage capacity throughout the year, not solely during seasonal peaks. Furthermore, the extremely constrained footprint of the mortuary estate significantly restricts opportunities for external expansion or enhancement.

Rationale for Target Risk Score (TRS)

The TRS is based on the outcome of escalating the body storage capacity concerns to Integrated Quality Finance Performance and Delivery (IQFPD) in June 2025. Funding stream discussed with Executive Director of Finance (July 2025) with further meetings and support from planning team to ensure long-term sustainable solution implemented when reasonably possible. TRS and expected date to achieve agreed by Formal Executive Team (November 2025). Assurance provided by the Executive Director of Finance that financial support will be received to enact short-term measures to ensure appropriate capacity available for winter pressure period. Further discussions will be held with finance and planning to discuss a sustainable and future proof plan to ensure TRS achieved and maintained.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1032 – Risk to the timely diagnosis and treatment of mental health and learning disabilities clients due to demand and capacity	Mental Health & Learning Disabilities	Chief Operating Officer	**20** → (Reviewed 13/03/2026)	**12**	31/12/2030

Rationale for Current Risk Score (CRS)

Significant waiting times have developed due to exponential demand. Demand outstrips capacity with year-on-year increase in referral rates. Current team capacity can only accommodate 11% of total current demand, compounded by current funding arrangements which are non-recurring, making recruitment and service delivery challenging. Welsh Government (WG) provided funding for Children's Neurodevelopmental (ND) services for 2025/26 to reduce waiting lists (received September 2025). The delay in receipt of funding and the fact that it is non-recurring, along with recruitment delays, has hindered service planning and delivery. However, an improvement plan is in progress which includes stabilising and expanding the workforce, the use of outsourcing and data validation to manage waiting lists and meet ministerial targets, the re-design of our services, and the strengthening of regional partnership working to deliver a whole-system, needs-led approach aligned with ministerial priorities. The demand for diagnostic assessment remains high and in the absence of a regional strategy our focus is currently on meeting the government targets which hinders our ability to develop a needs-led model and reduce the need for diagnostic assessment.

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1032 – Risk to the timely diagnosis and treatment of mental health and learning disabilities clients due to demand and capacity	Mental Health & Learning Disabilities	Chief Operating Officer	**20** ➔ (Reviewed 13/03/2026)	**12**	31/12/2030

Rationale for Target Risk Score (TRS)

The Clinical Care Group has prioritised implementation of WPAS in Children's Autism Spectrum Disorder (ASD) service which has enabled improved reporting and waiting list management and to determine trajectories of improvement in waiting times. While trajectory plans are in place, the Health Board has recognised WG targets will not be achieved by the service in its current format, with a further deteriorating position in performance anticipated, compounded by the end of procurement contracts with external providers in March 2026.

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

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1810 – Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS).	Medical Director	Medical Director	**20** ↑ (Reviewed 10/03/2026)	**5**	31/12/2026

Rationale for Current Risk Score (CRS)

WGH Aseptic Unit is the only remaining aseptic unit in the Health Board capable of producing cancer treatments. It is currently non-compliant with regulatory standards. A 2024 audit deemed it a high risk to patient safety and a 2025 follow-up confirmed ongoing staffing issues and insufficient resources to maintain quality standards, putting the unit at risk of forced closure. Temporary control measures have been implemented to reduce microbial contamination and delay closure, but these measures may soon become ineffective due to aging infrastructure. If contamination increases, the unit may be forced to close and there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality. **The current risk score was increased in March 2026 from 15 to 20** reflecting that the service does not have enough staffing resilience, resulting in insufficient time being dedicated to maintaining the Quality System (a key control to prevent forced closure) and the current lack of resource increases the overall risk.

Rationale for Target Risk Score (TRS)

The TRS is based on the premise that a new demountable aseptic unit will be built at WGH in 2026. The unit would be compliant with regulatory standards and once operational, closure of the unit would be extremely unlikely. A new unit would allow the Health Board to continue safely preparing cancer therapy until the Transforming Access to Medicines (TRAMS) South-West manufacturing hub is operational. It is anticipated that the current risk score could be reduced to 10 once the unit is operational, expected to be September 2026. Achievement of the TRS of 5 is expected once workforce fragilities have been addressed, anticipated to December 2026.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1664 – Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Planned & Specialist Care	Chief Operating Officer	**16** → (Reviewed 17/03/2026)	**8**	31/03/2028

Rationale for Current Risk Score (CRS)

Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1 patients (high risk) with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional Age-related Macular Degeneration (AMD) sessions on weekends, however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the HB. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. The current R1 delivery at 42%. The WG target for R1 delivery is 95%. The current waiting list for new patients is 11,552. The service is currently delivering 0 patients waiting at stage 1 over 52 weeks for March 2026 and this is expected to be maintained through to the end of March 2026. The stage 4 104 weeks, is in a breach of 2 for March 2026 currently with potential solutions being worked through to be 0 by the end of March 2026. 7301 patients have been 100% delayed for their follow up appointment.

The Board decided in February 2026 to progress Clinical Service Plan Option 99 of the Clinical Service Plan and the Aberaeron Integrated Care Centre as a diagnostic hub. The service is currently reviewing the estates and workforce required on each site to deliver Option 99.

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

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1664 – Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Planned & Specialist Care	Chief Operating Officer	**16** → (Reviewed 17/03/2026)	**8**	31/03/2028

Rationale for Target Risk Score (TRS)
The service will be able to reduce the impact score of this risk as whilst the consequences to the patient remains high, recurrent funding has been invested into the service for the delivery of an R1 Eye Care Measures target of 65%. The ministerial Measures target will need to be 0 for 3 months and more and the Follow up delayed will need to be reduced by 12%. The 65% R1 delivery by January 2027 is dependent on all posts being recruited into and all estates needs being met. Further development would be required to reach a 95% R1 delivery score. With the required investment in Glaucoma and IVT and the additional workforce identified in the annual plan 2026/2027 and estates issues being resolved alongside the continued management of the waiting lists, the HB will potentially be able to reduce the score to 8.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
684 – Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	**16** → (Reviewed 25/02/2026)	**8**	Unknown

Rationale for Current Risk Score (CRS)

Aging equipment continues to break down, disrupting services and affecting Referral to Treatment (RTT) targets, with delays for patient diagnosis and treatment. Replacement of scanners has reduced downtime, but recurrent failures of other key equipment highlights need for further investment. A rolling programme and prioritisation process are in place to manage installations. The Gamma camera at WGH has broken down several times, leading to HIW-reportable Ionising Radiation (Medical Exposure) Regulations (IRMER) incidents and remains a priority for replacement. Due to insufficient physical space and electrical infrastructure, replacement has been delayed, with costs exceeding WG allocations for 2025/26 and the funding window closing, further impacting compliance with Nuclear Medicine specifications. Future plans must be coordinated with Estates to ensure facilities meet current and future nuclear medicine requirements. Like-for-like replacement of equipment is not always cost-effective or compliant with regulatory and warranty requirements, and infrastructure upgrades (e.g. air handling and water chillers) are needed to ensure long-term resilience.

Rationale for Target Risk Score (TRS)

Modern equipment will reduce likelihood of breakdowns, minimise downtime and lessen impact on other hospital sites. Strengthened business continuity planning will further mitigate risks, however, funding is typically released Q3/Q4 of financial year, constraining the scheduling of large installations. The urgency of replacements often forces rapid decisions, resulting in lower-priority equipment being replaced ahead of higher-need installations. Replacement of Nuclear Medicine Single Photon Emission Computed Tomography (SPECT-CT) scanner, the second CT scanner at Glangwili General Hospital (GGH), and DEXA (bone density) scanner at Bronglais General Hospital (BGH) would allow risk to be de-escalated to operational risk register. Completion dependent on WG funding and may extend to end of 2026/27 financial year due to infrastructure requirements.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2190 – Risk of delay in Continuing Healthcare (CHC) direct payments due to short timescale, limited resources & lack of WG policy guidance	Community & Integrated Medicine	Chief Operating Officer	**16** ➔ (Reviewed 20/02/2026)	**12**	31/03/2026

Rationale for Current Risk Score (CRS)

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

Rationale for Target Risk Score (TRS)

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

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1531 – Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Planned & Specialist Care	Chief Operating Officer	**15** → (Reviewed 18/03/2026)	**5**	01/05/2027

Rationale for Current Risk Score (CRS)

A substantive Upper Gastro-Intestinal (GI) consultant has now been recruited following the exit of the Medacs agency locum consultant in Withybush General Hospital (WGH). A second substantive post is out to advert, with the Advisory Appointments Committee (AAC) planned for April 2026. Successful recruitment will result in 4 substantive consultants on the 1:4 rota at WGH. The Glangwili General Hospital (GGH) rota has one gap, covered by and internal locum at the Health Board card rate. The plan for this rota is to recruit a substantive colorectal consultant to replace the NHS locums. In February 2026, the Health Board made a decision on the Clinical Service Plan (CSP), which would involve the amalgamation of the surgical on-call rotas and Emergency General Surgery being moved from WGH to GGH. The timescale and details of this are not yet confirmed. The service will continue to engage with the CSP programme.

Rationale for Target Risk Score (TRS)

Achievement of the TRS is dependant on the successful appointment of substantive upper GI consultants along with the work currently being undertaken following the outcome of the CSP which would involve the amalgamation of the surgical on-call rotas and Emergency General Surgery being moved from WGH to GGH. The effectiveness of revised rota arrangements depends on several factors including availability of a labour market. There is 1 Upper GI substantive post out to advert and a substantive Lower GI post to be advertised for GGH in April 2026. The rotas at GGH and WGH are currently fully functioning without Medacs locums.
This will be further strengthened by further substantive recruitment and less NHS locum consultants. By May 2026, there should be a balance of upper and lower GI coverage on the rotas, providing recruitment is successful.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1859 – Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Director of Nursing, Quality & Patient Experience	Director Nursing, Quality & Patient Experience	**15** ➔ (Reviewed 17/03/2026)	**10**	~~31/12/2025~~ 30/06/2026

Rationale for Current Risk Score (CRS)

The most recent data (at the end of 2025) shows unplanned admissions into Intensive Treatment Unit (ITU) from ward areas in WGH had reduced by 10%. In GGH the same comparison was unchanged. Cardiac arrests rates for ward areas across all four sites have had varying results:
WGH – Increase of 40% (2024: 16, 2025: 23); all cases have been reviewed by the Resuscitation Team, albeit with less involvement from the Medical Team, which may impact on the opportunity to learn from events.
GGH – Decrease of 30% (2024: 34, 2025: 24); Senior Nurse Managers/Ward Managers/Resus Team & GGH RADAR Lead attend bi-monthly Cardiac Arrest Scrutiny meetings to review all cases; possibly resulting in better decision making, recognition and escalation of deteriorating patients.
BGH – Decrease of 30% (2024: 10, 2025: 7); no theme identified.
PPH – Increase of 70% (2024: 7, 2025: 12); scrutiny meetings established in January 2026. Downgrading of the ITU may have resulted in some patients being managed in ward areas were ITU may have been more appropriate.
It is important to note that in at least 50% of these cases across the Health Board the conclusion from the medical review was that a DNACPR should have been in place, therefore resuscitation should not have started.

Rationale for Target Risk Score (TRS)

The full implementation of the actions noted in the risk action plan will support the reduction in the likelihood and impact score of this risk to a target risk of 10. The TRS date was revised in March 2026 from December 2025 to 30 June 2026 as systems remain under development and have not yet been implemented.

Implementation of Welsh Health Circulars

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All Welsh Health Circulars (WHCs) are managed via the Audit Management and Tracking system (AMaT), which gives leads direct access to update and upload relevant evidence to demonstrate compliance with their requirements. Each WHC is assigned a status category. The table below outlines the definition of each category, the number of WHCs assigned to each as of March 2026, and the number completed since the previous report.

Status Category	Definition	Number of WHCs
Overdue	The WHC is behind schedule to the timescale provided by the Lead officer or as stipulated in the WHC, or a plan (with date for implementation) is not yet in place.	4
Unable to Complete	The WHC cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	1
Pending Decision	The WHC is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the WHC is overdue or not whilst decision pending.	3
In Progress	The WHC is currently in progress, and within the agreed original timeframe for implementation.	8
Reliant on External Factors	The WHC is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	2
Complete Pending Formal Approval	The Service / Function have completed the WHC and are currently awaiting formal approval to close.	3
Complete	The WHC has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	6

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

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

WHCs - Overdue

Name of WHC	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Overdue Status	Impact of non-compliance according to risk assessment	Next Steps
019-22: Non-Specialised Paediatric Orthopaedic Services **Issued June 2022**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	**Original implementation date not met** **Original Completion Date:** 30/04/2025 **Revised Completion Date:** Not Known	No risk identified on Datix.	The Trauma and Orthopaedics Service Leads are in the process of drafting a maturity matrix to address the requirements of this WHC. The maturity matrix will involve multiple CCGs due to the requirements set out in the service specification relating to this WHC. Once the Trauma and Orthopaedics Service Leads have completed their elements of the WHC, the WHC can then be re-assigned to Primary Care as per the action of January 2025 Escalation meeting.
006-24: National Clinical Guideline for Stroke, for the UK and Ireland **Issued March 2024**	Community & Integrated Medicine	Chief Operating Officer / CCG Service Director for Community & Integrated Medicine	**Original implementation date not met** **Original Completion Date:** 30/04/2025 **Revised Completion Date:** Not Known	**Risk Ref:** 233 **Current Risk Score:** 12 **Impacts:** Delayed assessment and treatment of patients; Increased length of stays	The QIA was presented to the panel in September 2025, however was not accepted by the panel, with further work required from the CCG. The panel agreed that future QIAs should be signed off by the Stroke Strategy Group or CCG, and that the process should ensure proposals are clear and supported by appropriate oversight. At the Extraordinary Board meeting on 19 February 2026, the Board combined alternative options 106 and 210, which were suggested as part of the consultation, as a new idea to be taken forward for further consideration for stroke services. This is a new idea and was not included in the consultation process. It will need further assessment and engagement with staff and communities.

WHCs - Overdue

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Name of WHC	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Overdue Status	Impact of non-compliance according to risk assessment	Next Steps
041-24: Ambulance patient handover guidance **Issued October 2024**	Community & Integrated Medicine	Chief Operating Officer / CCG Service Director for Community & Integrated Medicine	**Original implementation date not met** **Original Completion Date:** 31/12/2025 **Revised Completion Date:** Not Known	No risk identified on Datix.	Patient Flow Unit Plans to extend to a 7-day working model has commenced. A Winter Resilience Executive-led Incident Management Group established to test and support initiatives to enhance system flow. Introduction of the Digital MIYA flow system well received by clinical teams, with work underway to enhance value and functionality. Work underway with Welsh Ambulance Service NHS Trust to understand conveyance rates to our Health Board. Transformation Programme Office currently gathering evidence available to support implementation of the WHC.
051-25: Safety netting discharge leaflets for adults and children **Issued December 2025**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	**Awaiting implementation date**	No risk identified on Datix.	This WHC is being jointly led by the Assistant Directors of Nursing to effectively address the needs and compliance requirements for both adult and paediatric populations. A Core Team meeting was held in February 2026 to discuss the need for wider oversight of this WHC and potential realignment to Chief Operating Officer.

WHCs – Unable to Complete

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

WHCs – Pending Decision

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Pending Decision Status	Impact of non-compliance according to risk assessment	Next Steps
006-18: Framework of Action for Wales, 2017-2020 (Not Available Online) **Issued Feb 2018**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned and Specialist Care	Service unable implement due to funding requirements. WHC requirements and supporting systems have been incorporated into the Annual Planning work stream for 2026/27. **Original Completion Date**: 30/04/2022 **Revised Completion Date**: Not Known	**Risk Ref :**1457 **Current Risk Score:** 12 **Impacts:** Patients unable to access specialist care in a timely manner, closer to home; Additional pressures on GP capacity	Await the outcome of whether the relevant funding has been reallocated to the service as part of the Annual Planning 2026/27 to inform next steps required and revised completion date.
017-19: Living with persistent pain in Wales guidance – **Issued May 2019**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned and Specialist Care	Service unable implement due to funding requirements. WHC requirements and supporting systems have been incorporated into the Annual Planning work stream for 2026/27. **Original Completion Date:** 31/01/2025 **Revised Completion Date:** Not known	**Risk Ref:** 2120 **Current Risk Score:** 12 **Impacts:** Patients unable to access specialist care in a timely manner, breaches in achieving RTT	Await the outcome of whether the relevant funding has been reallocated to the service as part of the Annual Planning 2026/27 to inform next steps required and revised completion date.

WHCs – Pending Decision

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Pending Decision Status	Impact of non-compliance according to risk assessment	Next Steps
009-21: School Entry Hearing Screening pathway - **Issued March 2021**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Service unable implement due to funding requirements. WHC requirements and supporting systems have been incorporated into the Annual Planning work stream for 2025/26. **Original Completion Date**: 31/01/2023 **Revised Completion Date**: Not Known	**Risk Ref:** 1456 **Current Risk Score:** 8 **Impacts:** Detrimental impact on quality, accuracy and consistency of screening services provided	Await the outcome of whether the relevant funding has been reallocated to the service as part of the Annual Planning 2026/27 to inform next steps required and revised completion date.

WHCs - In Progress

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Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
002-24: Standards for Competency Assurance of Non-Medical Prescribers in Wales **Issued March 2024**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality and Patient Experience	Mar-26
004-25: NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2025/26 **Issued April 2025**	Medical Directorate	Medical Director	Mar-26
006-25: Recording of Mental Health Outcome Measures **Issued May 2025**	Mental Health & Learning Disabilities	Chief Operating Officer / CCG Service Director for Mental Health & Learning Disabilities	Apr-26
030-23: New 2023 National Safety Standards for Invasive Procedures (NatSSIPS2) by the Centre for Perioperative Care (CPOC) and Patient Safety Notice PSN 034 **Issued August 2023**	Medical Directorate	Medical Director	Sep-26
016-24: Healthy Child Wales Programme: for school aged children **Issued April 2024**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Sep-26
024-25: NHS Wales hearing care: future approach to audiology services **Issued December 2025 (NEW)**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Jan-31

WHCs - In Progress

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
039-25: AMR and HCAI Improvement Goals for 2025 – 2027 **Issued October 2025**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	Mar-27
001-26:Timelines and responsibilities for implementing the patient and family-initiated escalation approach, Call4Concern **Issued January 2026 (NEW*)**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality &Patient Experience	Dec-26

* Upon receipt of a new WHC, responsible leads are contacted by the Assurance and Risk Team and are required to provide an implementation date within 10 working days along with an appropriate response, during which time the WHC is noted as “In Progress”. After 10 working days, if no response is received, the WHC is noted as “Overdue”.

WHCs – Reliant on External Factors

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for External Status	Impact of non-compliance according to risk assessment	UHB Implementation Date
040-23: The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC) **Issued November 2023**	Planned & Specialist Care	Chief Operating Officer / CCG Director for Planned & Specialist Care	The service is currently compliant with all aspects of this WHC apart from the data capture requirements, for which no national system is currently available. An all-Wales data system is awaited. As such, the implementation date for this WHC is currently noted as not known.	**Risk Ref:** 2019 **Current Risk Score:** 20 **Impacts:** Decrease in staff morale and a negative impact on service leads.	N/K

WHCs – Reliant on External Factors

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for External Status	Impact of non-compliance according to risk assessment	UHB Implementation Date
033-18: Airborne Isolation Room Requirements **Issued July 2018**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	Architectural Projects Team undertook Project Feasibility Report in July 2024 and provided estimate of costs £1,419,946.25 (including contingency fund of £109,416), with project time of 48 weeks from project brief development to completion of works to install negative pressure isolation suite in Clinical Decisions Unit (CDU) GGH. To date, funding not allocated for this project and whilst issue has been raised at 'All Wales High Consequence Infectious Disease Group' hosted by Public Health Wales, there has been no indication of central funding being considered by Welsh Government to support improvement and to move work forward. In the meantime, out turn costs continue to escalate and it is recognised that estimated costs of 2024 may have increased. As of March 2026, Head of Infection confirmed WHC remains unable to be progressed due to funding ('unable to complete'), noting Swansea Bay University Health Board and Aneurin Bevan University Health Board are in a similar position.	**Risk Ref:** 1640 **Current Risk Score:** 15 **Impacts:** Increased risk of transmitting infectious disease	N/K

WHCs – Complete Pending Formal Approval For Closure

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
017-25: Tranexamic Acid use: Recommendation 7a of the Infected Blood Inquiry (IBI) **Issued May 2025**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Jan-26
037-25: Infected Blood Inquiry: Implementation of Recommendation 7e: Implementing SHOT reports **Issued September 2025**	Operational Allied Health Professions & Health Sciences	Chief Operating Officer & Executive Director of Allied Health Professions & Health Sciences/ CCG Service Director for Operational Allied Health Professions & Health Sciences	Feb-26
007-26: Critical UK-wide Bone Cement Shortage – Immediate National Requirements for NHS Wales (no link currently available) **Issued February 2026 (NEW)**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Mar-26

WHCs – Complete and Approved

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Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
004-22: Guidance for the provision of continence containment products for children and young people: a consensus document **Issued October 2022**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Feb-26
015-24: People's Experience Framework and People's Experience Survey **Issued April 2025**	Nursing, Quality and Patient Experience	Director of Nursing, Quality & Patient Experience	Jun-25
035-24: Standardising the management of acute deterioration **Issued September 2024**	Nursing, Quality and Patient Experience	Director of Nursing, Quality & Patient Experience	Jan-26
018-25: Tirzepatide (Mounjaro®) for the management of obesity and overweight **Issued May 2025**	Operational Allied Health Professions & Health Sciences	Chief Operating Officer / Executive Director of Operational Allied Health Professions & Health Sciences	Dec-25
027-25: Changes to supply of Gluten Free Foods in Wales; All-Wales Gluten Free Subsidy Card Scheme **Issued July 2025**	Primary Care	Chief Operating Officer	Dec-25
031-25: 3Ps Waiting Well single point of contact (SPOC) activity and outcomes data reporting **Issued September 2025**	Nursing, Quality & Patient Experience	Director of Nursing, Quality & Patient Experience	Nov-25

Implementation of Ministerial Directions

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Ministerial Directives (MDs) are legislative in character as they alter legal rights and duties. MDs are issued by Welsh Ministers and include codes of practice and guidance. In complying with the requirements of various governance codes and the Annual Governance Statement requirements, the Health Board has a duty to provide assurance of compliance with MDs.

The table below shows the number of MDs assigned to each category as at March 2026, summarised over the next slides. Definitions for these categories are included in the table below.

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

MDs included within this report are based on the following criteria:

3.1.19 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies

Progress updates relating to the implementation of MDs are extracted from the AMAT system.

Complete Ministerial Directions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

MD	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Update
WG25-72: The Primary Care (Contracted Services: Outpatients Waiting Lists First Appointment Scheme) Directions 2025	14/10/2025	Primary Care	Chief Operating Officer	Dec-25	Forms part of the contracted services and will therefore be actioned in line with the usual commissioning processes.

Recommendations

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

Risk Management

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

Welsh Health Circulars

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

Ministerial Directions

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

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

CORPORATE RISK REGISTER SUMMARY MARCH 2026

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Mar-26	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score	Risk on page no...
797	Risk of adverse patient and workforce outcomes if health board wide ultrasound services are unsustainable	Carruthers, Andrew	Quality/Complaints/Audit	5×5=25	5×5=25	→	2×5=10	3/31/2030	6
1810	Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Henwood, Mr Mark	Service/Business interruption/disruption	3×5=15	4×5=20	↑	1×5=5	12/31/2026	11
1552	Risk of insufficient mortuary capacity due to current and anticipated future demand	Carruthers, Andrew	Safety - Patient, Staff or Public	4×5=20	4×5=20	→	2×4=8	8/31/2026	14
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	4×5=20	4×5=20	→	2×4=8	10/31/2028	19
1032	Risk to the timely diagnosis and treatment of mental health and learning disabilities clients due to demand and capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	5×4=20	5×4=20	→	3×4=12	12/31/2030	24
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Carruthers, Andrew	Safety - Patient, Staff or Public	4×4=16	4×4=16	→	2×4=8	3/31/2028	28
684	Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Carruthers, Andrew	Service/Business interruption/disruption	4×4=16	4×4=16	→	2×4=8	Not Known	32
2190	Risk of delay in CHC direct payments due to short timescale, limited resources & lack of WG policy guidance	Carruthers, Andrew	Quality/Complaints/Audit	4×4=16	4×4=16	→	3×4=12	3/31/2026	37
1531	Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	3×5=15	3×5=15	→	1×5=5	5/1/2027	40
1859	Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Daniel, Sharon	Safety - Patient, Staff or Public	3×5=15	3×5=15	→	2×5=10	6/30/2026	45

RISK SCORING MATRIX

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

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

RISK MATRIX

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

RISK ASSESSMENT - FREQUENCY OF REVIEW

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

Assurance Key:

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

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

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

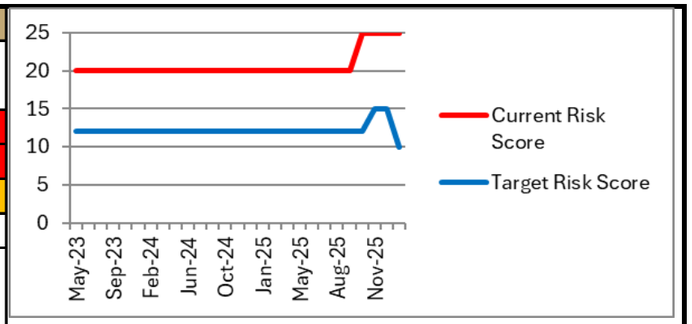
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective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

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Mar-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

Risk ID:	**797**	**Corporate Risk Description:**	There is a risk that health board wide ultrasound services are unsustainable. This is caused by - Demand increase across NOUS and Maternity Ultrasound pathways requires 34 148 additional scanning hours. - Workforce establishment does not match demand. - Workforce vacancies long standing (national shortage, training pipeline 3 years with large supervision requirement). - Unable to move staff between sites to cover as all sites unable to meet minimum standards required. - Occupational Health impact from workloads reducing workforce available (RSI). This could lead to an impact/affect on - Patient outcomes = delays to scans resulting in delays to treatment or death (cancer and maternity pathways) - Workforce outcomes = staff harm from RSI resulting in long term injury from too much scanning of similar types (unable to job plan appropriately due to demand and vacancies). Quality, complaints and audit - (5) Totally unacceptable level or quality of treatment/service. Gross failure of patient safety if findings not acted on. Inquest/ombudsman inquiry. Gross failure to meet national standards / performance requirements. Safety of patients - (4) Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects. Finance including Claims - (5) Claim(s) >£1 million. Probability = >95%
Does this risk link to any Directorate (operational) risks?		1349 (WGH), 1658 (RSI), 1936 (maternity)	

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	5×5=25
Target Risk Score (L x I):	2×5=10
Expected Date To Achieve TRS:	3/31/2030
Trend:	⟷



Rationale for CURRENT Risk Score:
This risk was escalated from 20 to 25 due to increased fragility in available workforce, due to 2.0WTE retirements in Jan 2026. Impact score of 5 due to: A totally unacceptable level or quality of treatment/service: Patients on maternity and cancer pathways are waiting too long for scans required for intervention Gross failure of patient safety if findings not acted on. Concerns regarding noncompliance with Welsh Maternity screening targets Gross failure to meet national standards / performance requirements. Waiting times non-interventional ultrasound are up to 35 weeks Vascular ultrasound is not available 7 days a week Probability score of 5 / >95% likelihood The service is no longer able to sustain a safe baseline capacity to provide routine and urgent non obstetric imaging alongside obstetric scanning Monday to Friday, 09:00-17:00 on the WGH site (see separate risk 1349).

Rationale for TARGET Risk Score:
Impact of service failure remains the probability of service failure is the aim of mitigating actions. Probability target of 5-25% (2) In Jan 2026 target date was reviewed and extended. Justification for this change is the timeline for Radiology Leadership OCP and recruitment to bring in the leadership required to mitigate the gaps in controls thus requires extended timelines due to pathways changes and training timelines. In addition Annual Planning 2026/27 priorities for AH and HS CCG include further mitigation of this risk via capacity being added of 13WTE (£710 352) therefore likelihood scoring reduces to a 2 (5-25% probability). 2030 target date This timeline is due to training timelines it will take at least three years to train a workforce if 2026/27 Annual Planning funding is provided to Radiology.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Insourcing NOUS undertaking 150 scans per week - funded by WG until 31.3.26. Funding for 26/27 from budget (4.0 vacancies). Locum/Agency capacity - 1.0WTE secured. there are 2.0 agency requests unfilled. Prioritisation of maternity growth scan workload by referring clinician - urgency allocated on referral form by referring clinicians. Training pipeline (supported practice educator) - 5.0WTE in post (end of training Jan 2027), 1.0WTE Midwife sonographer (in preceptorship). MSK and Vascular pathways via AHP extended practice roles (some Physiotherapy and Podiatry pathways in place to support ultrasound workload) Demand vs capacity scanning gap is £710, 352 /13 WTE workforce - Annual Plan 26/27 approved.	Health board wide governance of ultrasound pathways Pathway workforce diversification - Training pipeline does not meet demand or workforce turnover. Training capacity (trainees available but inadequate internal capacity to train) Centralised booking - due to commence June 26 to improve cross site cover. Insourcing/outsourcing/Agency/Locum capacity	Develop and implement a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Llewellyn, Cerian	Completed	The date of completion of this action has been changed to 31/01/2026 as the midwife identified for training did not start until Jan 2025 due to lack of process to support the clinical aspects and a change in maternity management. Maternity and child health are required to advise of the plan to utilise the skills of the trainee midwife sonographer and also any plans to train more staff. June 2025: Midwife sonographer is now undertaking required training and expected to qualify in January 2026. Jan 26 - midwife sonographer has undertaken course and starting preceptership

Radiology management restructuring as part of stabilisation plan. new posts needed to provide a longer term solution to issue. Not possible with current management structure and stability risk	Procter, Sarah	30/06/2026	Informal consultation received alternative proposal Dec 2025, workshop with stakeholders scheduled early Jan 2026. Informal consultation extended until Feb 2026.Changes made to OCP awaiting exec approval - hoping to start April 26
Training pipeline - 5.0WTE Trainee sonographers scheduled to complete training.	Procter, Sarah	31/01/2027	25/11/2025 - New action.
Training pipeline - 1.0WTE midwife sonographer completed training.	Procter, Sarah	Completed	midwife sonographer has completed the course.
Insourcing/Outsourcing - procurement conversation with current provider of ultrasound capacity relating to adding more scanning capacity for obstetric ultrasound capacity (2000 scans) on top of current contract	Procter, Sarah	Completed	25/11/2025 - new action 29/12/2025 - Chasing of provider who is reporting capacity to meet this demand but is not able to complete the scanning when we have handed over this scanning work. Now a meeting is required to push for this capacity to be released or statement that provider is unable to source the capacity so other options can be sourced.
Agency capacity - throughout 2025/26 2.0WTE out for advert with agency (AG1 (HR form for agency approval) valid until 2027)	Procter, Sarah	31/01/2027	25/11/2025 - AG1 approved for 2.0WTE until Jan 2027, out with Agencies during 2025/26. No interest this year as yet.
Insourcing/Outsourcing - Provider has confirmed capacity but has not been able to pick up scans when allocated. Therefore contract meeting with Deputy HoS (SP) and Director of Performance and Planning (KJ) scheduled (14.01.2026) to understand barrier to release in capacity,	Procter, Sarah	Completed	meeting undertaken - further capacity unlocked

Pathway workforce diversification - Maternity have indicated capacity within Midwifery workforce to complete growth scans. Analysis underway to identify % of scanning and therefore % WTE transfer.	Procter, Sarah	~~28/02/2026~~ 31/04/2026	26/2/26 - SBAR shared with Director of midwifery - awaiting answer. 16/02/2026- meetings with Maternity continue. Paper shared with Director of Midwifery to outline governance around 1.26WTE Sonography capacity moving to Midwifery. Changes made to SBAR and validation by director of delivery's team.
Demand vs Capacity - Submit as a priority for 2026/27 Annual Planning (£710 352 / 13 WTE) additional funding required to meet demand	Quarrie, Sara	Completed	This demand and capacity gap funding was submitted as a priority by the AH and HS CCG in the Annual Planning 2026/27 workshop on the 21.11.2025.
Demand vs Capacity - Clinical validation support from NHS Performance & Improvement (intended outcome is to reduce inappropriate referrals to u/s modality and redirect to alternative and more appropriate modalities).	Procter, Sarah	Completed	Approval given to seek support meeting scheduled SP and NHS Performance and Improvement 16.01.2026 to agree implementation. validation Work started 19.1.26
Demand and Capacity - Skill mix vacancies in u/s to create 1.0WTE 8A - Job description to be sent to job matching	Procter, Sarah	~~28/02/2026~~ 28/03/2026	Action agreed in Dec 2025. delay due to workload - JD in process
Midwife sonographer undertaking preceptorship to be able to work independently - radiology supporting	Procter, Sarah	29/01/2027	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
8 week USC Ante-natal screening Wales	Waiting list monitoring - Live dashboard review by Radiology Leadership (daily) and monthly formal submission of performance * week data to Welsh government (see iPAR).	2nd			IQFPDG 26/11/2025 - SBAR - Ultrasound Fragility - Corporate risk 797					
	Performance monitored at Executive Improving Together Sessions	2nd								

Date Risk Identified:	Feb-24
Strategic Objective:	3. Great Care

Executive Director Owner:	Henwood, Mr Mark	**Date of Review:**	Mar-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

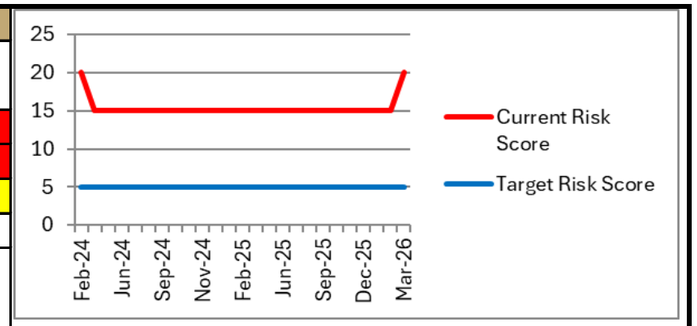
Risk ID:	**1810**	**Corporate Risk Description:**

There is a risk that the Health Board will be unable to continue manufacturing cancer treatments for our patients. This is caused by the facilities of the Pharmacy Aseptic Unit being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS) standards 5th edition (published 2016) and therefore at risk of closure, exacerbated by a fragile workforce within the service.

This could lead to an impact/affect on the Health Board's ability to provide all the cancer treatments currently offered. The Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. A fully outsourced service would cost an additional approximate £1m each year. Some therapies cannot be outsourced, meaning Hywel Dda could not offer over 500 cancer treatments each year. This would have a significant negative impact on patient care as patients would either be required to travel further from home to neighbouring Health Boards to receive their treatment (dependant on their capacity to absorb the additional demand) or would be offered less clinically appropriate treatments at Hywel Dda, negatively affecting clinical outcomes. The closure of the Aseptic unit would directly impact the ability of the Health Board to achieve ministerial priorities and targets such as the Single Cancer Pathway, A Healthier Wales, etc.

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

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	1×5=5
Expected Date To Achieve TRS:	12/31/2026
Trend:	



Rationale for CURRENT Risk Score:

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

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

The service does not have enough staffing resilience, resulting in insufficient time being dedicated to maintaining the Quality System. Because a robust Quality System is a key control to prevent forced closure, the current lack of resource increases the overall risk.

Rationale for TARGET Risk Score:

The target risk score is based on the premise that a new demountable aseptic unit will be built at Withybush in 2026. The unit would be compliant with regulatory standards and once operational, it would be extremely unlikely for the unit to be forced to close. A new unit would allow the Health Board to continue to safely prepare cancer therapy until the TrAMS South West manufacturing hub is operational.

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Transfer of the radiopharmacy service to Singleton Hospital in October 2022; this means less overall activity through the Withybush Aseptic unit reducing the risk of contamination and errors. More time and resource provided to the Quality System (i.e. internal audits, investigation of near misses and microbial growths, maintaining SOPs). Increased training of aseptic staff to develop their skills and knowledge. Increase outsourcing from commercial suppliers; this limits the volume of products prepared within the unit, allowing products that must be made in-house to be prepared safely. New pharmaceutical isolators have been procured to replace the existing isolators that are beyond their working life of 10 years. The new isolators will be stored with the intention of installing into the demountable unit (if funding is secured) or will be installed into the existing unit if the current isolators fail mitigating the risk of equipment failure causing prolonged service disruption. Removal of outsourced dispensing from the Aseptic unit; this minimises the risk of contamination and potential for error. Preparation of products near to the time of use; this limits the pre-administration storage time. More stringent gowning process; this minimises contamination risk. Pharmacists from other areas have been identified to support tasks that do not specifically require aseptics expertise 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. Availability of additional Pharmacists is limited due to their existing workloads. Findings from the audit undertaken in February 2025 highlighted the fragility of the workforce due to key person dependencies which could detrimentally impact on the service. Limited accommodation to employ additional staff to expand workforce within the existing unit at WGH. Limited accommodation to store starting materials and finished products or to perform the associated tasks that are required to safely supply cancer treatments. Between 2021 and 2023, the number of cancer treatments requiring aseptic preparation at Hywel Dda increased from 12,718 to 16,648 (average of 14% increase each year). There is limited space within the Pharmacy at WGH to manage this increase in demand.	More staffing resource is required to support the aseptic unit's quality system, to ensure that all other regulatory standards are adequately met to mitigate the risk of the non-compliant facilities.	Morgan, Cerith	~~30/09/2026~~ 30/12/2026	Internal staffing model has been reviewed to allow the Health Board's lead quality assurance pharmacy technician to provide more support to the quality system. Initial discussions held with other Health Boards to explore whether they have QA resource that could support Hywel Dda through a SLA. Invest to save SBAR developed that would support more staff to work within the aseptic unit through a cost saving opportunity (reducing outsourcing of Azacitidine). QIA has been submitted to the Patient Safety team. Jobs in this paper are being presented to FCSG on 11.03.2026.
		WG have approved funding for a new demountable aseptic unit. Aseptic project team to progress with planning for building the unit and confirm project timelines once finalised.	Morgan, Cerith	31/08/2026	Initial workshops with principal contractor and aseptic unit supplier have been undertaken. Based on current timelines - the new unit will be operational by September 2026.
		Recruit bank pharmacists to take on clinical activities currently being performed by aseptics pharmacists	Morgan, Cerith	30/06/2026	Progress is pending approval from the recruitment team.
		Finalise Memorandum of Understanding with Cwm Taf UHB for quality assurance support	Morgan, Cerith	30/06/2026	New action, with progress to be provided at next risk review

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

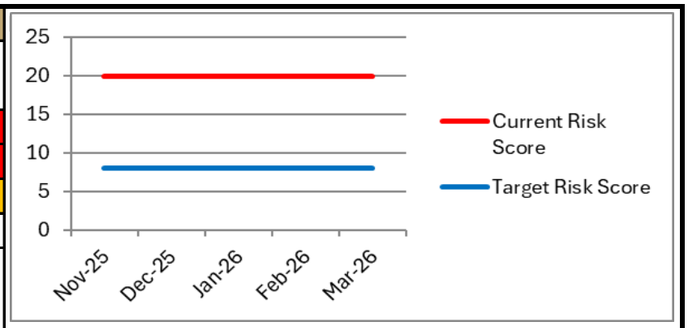
Date Risk Identified:	Feb-22		
Strategic Objective:	3. Great Care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Mar-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

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

Does this risk link to any Directorate (operational) risks?	283, 1554

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



Rationale for CURRENT Risk Score:

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

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

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

Rationale for TARGET Risk Score:

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

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1. At times of peak pressure, temporary body storage units are rented 2. Monitoring of numbers of deceased against storage capacity (Health Board wide) 3. Business continuity plans in place (Health Board wide) 4. Contracts with local funeral directors to utilise contingency storage of deceased (Health Board wide) 5. Deceased are relocated to other mortuary sites when needed (Health Board wide) 6. Bariatric blanket available for short-term use across all Health Board sites 7. Additional body refrigeration (Boxcold solution) has been installed into the old PM (Post Mortem) room at WGH site. 8. Participation, engagement and communication with the Health Board's Mortality Group, medical colleagues, Medical Examiner Service and external stakeholders	1. Despite owning 1x 15 BSS unit, we have insufficient storage provision for the upcoming winter pressure period 2. Insufficient suitable space and/or estate within mortuary facilities to increase body storage capacity. 3. Any delay in the death certification process (internal & external stakeholders) significantly impacts on the management of mortuary body storage. As these processes are outside of mortuary control, we frequently invoke contingency plans to accommodate the deceased. Death certification process be noted as a control measure, with the gap being the delays in these processes as a result of sources beyond the Health Board's control (MES, HMC, PM service disruption etc)? 4 & 5. Due to the national shortage of body storage capacity, death	Requirement of additional body storage capacity health board wide. Capital funding needs to be secured.	Baker, Craig	~~31/03/2025~~ 31/03/2026	To be escalated via CCG structure Escalated at IQFPDG June 2025 - meeting to be scheduled with HT re short term capacity and LD for medium/long term capacity for analysis. Body storage capacity paper being submitted via CCG structure. Financial approval from Finance executive to increase temporary storage over winter period (2025 - 2026), this includes funding to cover adding of additional capacity at PPH. In addition, currently reviewing BGH footprint to look at increase of freezer capacity to cover HB. 29/12/25 - Capital funding secured to increase freezer capacity at BGH.

certification processes and current death rates, contingency plans utilising mutual aid are ineffective as all Health Boards are experiencing the same level of body storage capacity pressures and are therefore unable to assist. 6. During the recent Tier 1 National Mass Fatality Pandemic Exercise it was identified that nationally and locally we have insufficient levels of body storage capacity to handle a mass fatality or a period of excess death. Risk areas were identified by the Hywel Dda team that participated in the exercise and these along with suggestions for improvements were feedback to the Local Resilience Forum (LRF) who will escalate this feedback to Welsh Government.	Explore options regarding temporary body storage rental and purchase of body storage capacity.	Brown , Yasmin	Completed	Ongoing Discretionary Capital bid to purchase a 15BSS Nutwell storage unit. 20.08.25 - Currently in discussions with suppliers regarding rental costs. 19.11.25 - The service has been successful in procuring a 15 BSS storage unit via a spend to save scheme. This unit will be delivered towards the end of November/start of December 2025. 19.11.25 - The service has also rented 2x additional 15 BSS nutwell units as contingency storage space as part of our winter preparedness plans and in readiness for the winter increase in death rates.
	Work with estates teams across the Health Board to undertake the minor and major works that are required to allow for the installation of the box cold body storage solutions.	Brown , Yasmin	~~30/12/2025~~ 30/04/2026	Contact has been made with estates managers in WGH, PPH, and GGH. Quotations for minor building works to be undertaken within the PPH and BGH mortuary facilities and are being progressed 19.11.25 - Building works commissioned for PPH with the works scheduled to be completed at the beginning of December 2025 to allow for for the erection of the additional additional body storage capacity (boxcold). 05.01.26 - Building works commissioned for BGH with the works scheduled to be completed March 2026 to allow for for the erection of the additional additional body storage freezer capacity.

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

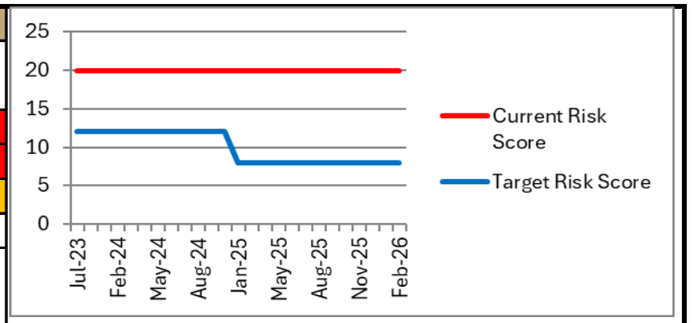
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

Date Risk Identified:	Nov-20		
Strategic Objective:	2. Healthier Communities and 3. Great Care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Feb-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Mar-26

Risk ID:	**1027**	**Corporate Risk Description:**	There is a risk to the consistent delivery of safe, 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?		1.21075E+57	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	10/31/2028
Trend:	⟷



Rationale for CURRENT Risk Score:
The most recent available data highlights sustained high operational pressures across all acute sites with increased escalation levels throughout January and early February 2026. Although some key performance metrics show slight improvement over the last year, all are above Targeted Intervention (TI) targets in January 2026 (e.g. average time to clinical assessment in ED Jan: 68 mins, TI target: 60 mins; Numbers of >1hr ambulance handovers Jan: 716, TI target: 680). POCDs in January were 213 , above the TI target of 174. Actions to improve flow include implementation of the 7-day Clinical Streaming, Hospital at Home and Optimal SDEC services were agreed at Public Board in January 2026. Whilst the Board has approved the business case in January 2026, and additional control measures have been implemented, system pressures remain and TI targets are not consistently being met therefore the current risk score remains at 20 as at February 2026.

Rationale for TARGET Risk Score:
The target risk score of 8 reflects the confidence in the delivery of 6 Goals Programme and the Accelerated Transformation Programme to address the significant issues across the health and care system. Plans for improvement during 2025/26 are reflected in the HB's Annual Plan, approved by the Board in March 2025, and are informing next year's Annual Plan. The 6 goals plan has been approved by WG in March 2025. TI measures such as ambulance handovers and 12 hour delays in ED will need to improve in order to reduce the current risk score, for a consecutive period of three months. UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly into Formal Executive Team. The expected date to achieve the TRS has been amended from March 2026 to October 2028 to allow for the implementation and embedding of relevant actions, as noted within the risk action plan. The embedding of 7-day Clinical Streaming and SDEC services will significantly impact on patient flow, however time will be needed for recruitment and embedding of services.

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. # MIYA system in place for recording DPOC and red days flagging required assessments to support discharge, within continued education at ward level ensuring consistent approach to Board Rounds and Patient Safety Huddles. # Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge and boarded beds via patient flow meetings to facilitate step down of beds. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites with associated actions in collaboration with social care partners. # Regular advice on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, social services and the Long Term Care Team support. # Discharge arrangements are in place on all sites with a strategic review underway. # Standardised board rounds processes in place on all sites and D2RA processes are embedded. # Criteria-led discharge guidance and principles continue to be embedded across HB. # Integrated Regional Winter Plans developed to manage whole system pressures over the winter period and communicated. # An operationally focussed 6 Goals Urgent and Emergency Care (UEC) programme with governance structure agreed where all UEC improvement is coordinated. SRO in place to lead agreed 6 Goals for UEC programme. # Welsh Ambulance Services NHS Trust involved in all 6 Goals UEC workstreams.	# Fragility of Care Home Sector such as financial viability, staffing deficits, recruitment and retention of workforce. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff. # Inability to handover ambulances to release them back for use within community due to lack of flow in acute sites. # Need to have better understanding of ED presentations to ensure development of alternative pathways in primary care / community to prevent ED attendance. # Ability to influence public mind set / expectation and culture in terms of use of NHS resource and ‘Home First’ Ability. # Gap in communication between secondary and primary care that could lead to poor discharge outcomes. # Clarity regarding roles and responsibilities for discharge planning and coordination. # The inability to risk stratify for people at moderate to high risk of admission in the community to implement proactive anticipatory care plans to support avoidance of exacerbation / decompensation and hence increased	Delivery of 6 Goals Programme and Plan via the workstreams and closer working with WAST and primary care 1. Development of Regional Clinical Streaming Hub (CSH) for Health Professionals & Care Homes delivering 24/7 urgent care advice & support and onward referral to local deliver/resource hubs where appropriate	Skitt, Peter	~~31/10/2025~~ 30/09/2026	At the public Board Meeting in January 2026, it was agreed to approve the implementation of a seven-day Clinical Streaming Service (CSS), Same Day Emergency Care (SDEC), and Hospital@Home model across Hywel Dda University Health Board. CCG currently progressing with implementation via County Implementation Groups.
		Utilise the risk stratification data set across the system proactively with the population	Skitt, Peter	~~30/04/2025~~ 31/10/2025	Part of First Home Hub plan and work is underway. Data is being used in primary care multi-disciplinary team meetings across the Health Board and WGH, and requires further embedding to ensure the impact within acute sector is realised.
		Review of Community bed based hospital capacity, with a view to ensuring proactive case load management and estate as part of the Alternative Care Model work. Develop & implement strategy for Alternative Care Community (ACP) Provision across the West Wales region.	Skitt, Peter	31/10/2025	This has been action has been superseded, as the Health Board and Local Authorities now receive monies from Welsh Government (Pathways of Care Transformation Grant) to support development of community teams, being delivered ultimately by Local Authority with support provided by the Health Board, which reports to the National Support in Hospital Discharge Group.

# 111 and 111 press 2 (MH) implemented across Hywel Dda. # Regional Integration Fund projects in place across Regional Partnership Board (RPB) footprint, along with Further Faster projects to ensure alignment with Ministerial objectives. # Whole system approach to deploy HB staff to ensure continuity of patient care. # Care Home Risk & Escalation Policy to support failing care homes to be applied as required. # Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across the RPB region. # Establishment of a Discharge to Recover and Assess (D2RA) Group which reports to the the 6 Goals Programme with a detailed D2RA improvement plan in place. # Establishment of a D2RA Escalation Transfer panel which provides senior oversight of delays at county level, assesses risk of the delay to the patient and organisation in terms of flow compromise # Agreed SDEC model in place to maximise impact on admission avoidance. NHS Executive review with associate actions are part of the 6 goals UEC programme. # Local streaming (Home First) hubs developed with a HB wide approach agreed with clinical triage and screening systems in place, including APP Navigator in place. # Direct referral into SDEC in place. # OOH Pilot clinical streaming via GP route. # Clinical Care Group structure in place where this risk is discussed at the quality meeting. # UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly into Formal Executive Team. # Regional Discharge Strategy Group established, providing oversight of all current work streams, and ongoing work on national and local policies # Regional POCD group established January 2025 with a focus on reviewing trends and themes to inform regional and local action plans # Winter Preparedness CELLS governance structure established and meeting weekly. #Trusted Assessor Model in place, ensuring consistent approach to assessment across the region # Patient Flow Unit established, acting as a single point of contact for all flow related matters including ambulance handovers, supported by performance dashboards # ED/MIU Redirection Policy ratified and in place, allowing appropriate clinical staff to redirect patients to alternative appropriate services	risk of hospital admission. # Optimising our bedded facilities in the community. # Need to develop 24/7 integrated urgent primary care service aligned to Home First hubs. # Insufficient IPC single rooms across community and acute sites, negatively impacting on patient flow. # Lack of level 1 / 2 falls response service during out of hours across the Health Board. # Fragility of senior medical cover at EDs across the acute sites. # Need to create a Health Board wide Frailty approach and appoint a Clinical Lead for Frailty. # 7 day services within the Community are required, particularly around Clinical Streaming Hubs and level 1 /2 Falls. Public Board January 2026 approved the implementation of a seven-day Clinical Streaming Service (CSS), Same Day Emergency Care (SDEC), and Hospital@Home model across Hywel Dda University Health Board. CCG currently progressing with implementation via County Implementation Groups. # UEC Transformation Acceleration Group (TAG) not currently meeting as of January 2026, awaiting restart date. # Nursing staff and Health Care Support Worker (HCSW) staff shortages across all four sites.			
Enhancements to local delivery / resource hubs to support the CSH providing access to enhanced community care services, third sector services and other pathways to provide safe alternatives to admission. Integration with GP OOHs and APP resources.	Skitt, Peter	~~31/10/2025~~ 30/09/2026	At the public Board Meeting in January 2026, it was agreed to approve the implementation of a seven-day Clinical Streaming Service (CSS), Same Day Emergency Care (SDEC), and Hospital@Home model across Hywel Dda University Health Board. CCG currently progressing with implementation via County Implementation Groups.
Development & implementation of consistent approach to Front Door Streaming / Assessment Units focused on our Frail Elderly cohort based on good practice and lessons learnt from Withybush Puffin / South Pembrokeshire model.	Skitt, Peter	~~31/12/2025~~ 31/03/2027	Frailty Lead appointed and developing plan, to be rolled out as part of the 6 Goals Programme during 2026/27.
Development and implementation of HDUHB optimal SDEC model following on from lessons learnt from peer review and alignment with CSH and local resource hubs.	Skitt, Peter	~~31/10/2025~~ 31/10/2028	At the public Board Meeting in January 2026, it was agreed to approve the implementation of a seven-day Clinical Streaming Service (CSS), Same Day Emergency Care (SDEC), and Hospital@Home model across Hywel Dda University Health Board. CCG currently progressing with implementation via County Implementation Groups. There will be a phased approach to implementation starting with WGH (expected to complete October 2026), BGH (expected to complete October 2027) and GGH (expected to complete October 2028).
Continued implementation of Optimal Flow Framework including Community sites supported by MIYA digital platform.	Skitt, Peter	31/10/2025	Optimal Flow Framework is being embedded with support from Optimal Flow Coordinators across acute and community sites. MIYA digital platform was rolled out in December 2025 with training schedule ongoing. Revised date noted to reflect this ongoing training.

Implementation of 7 focused areas within ED Quality statement.	Skitt, Peter	31/03/2026	Clinical lead for ED post currently out to advert. ED Quality Statement Action group in place, who report 6 weekly to Welsh Government. Action plan developed and in place, forming the basis of updates to WG, based around the national toolkit.
Develop West Wales Hospital @ Home model to ensure consistent approach and delivery.	Skitt, Peter	Completed	The Health Board Hospital at Home SOP has been agreed by the Community & Integrated Medicine Clinical Care Group Integrated Governance Group (focus on Quality, Health & Safety) and the Clinical Advisory Group.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Ambulance handovers within 15 minutes Ambulance handovers over 1 hour Ambulance handovers over 4 hours 4 & 12 hour waits in A&E Time to triage in A&E Time to see a Doctor in A&E Pathway of care	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st			Seven-Day Business Case for Clinical Streaming Services (CSS), Same Day Emergency Care (SDEC), and Hospital@Home - Public Board January 2026 Unscheduled Emergency Care Accelerated Work Programme Update - Quality, Safety & Experience	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								

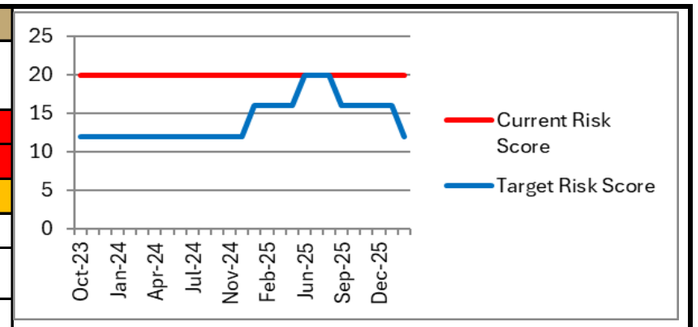
delays	IA review on Transforming Urgent and Emergency Care	3rd			Committee February 2026				
	NHS Executive Same Day Emergency Care (SDEC) Review	3rd							
	NHS Executive ED Review	3rd							
	GIRFT Review on ED	3rd							
	MAG review	3rd							

Date Risk Identified:	Nov-20		
Strategic Objective:	2. Healthier Communities and 3. Great Care and 4. Positive Futures		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Mar-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

Risk ID:	**1032**	**Corporate Risk Description:**	There is a risk of delayed access to autism assessment for those on the CYP ASD waiting lists which is in breach of Welsh Government performance standard of 26 weeks. This is caused by an increase in referrals, sustained pressure on service. Internal back log of cases due to previous staffing issues and inefficient internal processes. This could lead to an impact/affect on provision of appropriate care and support. Inability to meet Welsh Government targets. Increase in complaints and adverse publicity as well as 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
Expected Date To Achieve TRS:	12/31/2030
Trend:	⟷



Rationale for CURRENT Risk Score:

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

Welsh Government provided funding for Children's Neurodevelopmental (ND) services for 2025/26 to reduce waiting lists (received September 2025). The delay in receipt of funding and the fact that it is non-recurring, along with recruitment delays, has hindered service planning and delivery. However, an improvement plan is in progress which includes stabilising and expanding the workforce, the use of outsourcing and data validation to manage waiting lists and meet ministerial targets, the re-design of our services, and the strengthening of regional partnership working to deliver a wholeâ€'system, needsâ€'led approach aligned with ministerial priorities. The demand for diagnostic assessment remains high and in the absence of a regional strategy our focus is currently on meeting the government targets which hinders our ability to develop a needs-led model and reduce the need for diagnostic assessment.

Rationale for TARGET Risk Score:

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

While trajectory plans are in place, the Health Board has recognised WG targets will not be achieved by the service in its current format, with a further deteriorating position in performance anticipated, compounded by the end of procurement contracts with external providers in March 2026.

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Use of IT/virtual platforms such as Attend Anywhere when appropriate to encourage blended approach to working. Additional WG funding announced - £980,000 allocated to Health Board; funding ring-fenced for CYP service 2025-2026 Weekly Autism Advice Hubs in place for parent carers and CYP Rolling programme of workshops offering advice and support around neuro-diversity for parents of children awaiting diagnostic assessment. ND Service Delivery Manager in place to oversee 3 year performance improvement plan and drive innovative practice in line with WG policy and legislation. Workforce stabilised with no retention issues. Workforce Management Group established and workforce plans in place. Trajectories have been agreed for Children's ND by NHS Executive and systems in place to monitor waiting lists at service level performance-management meetings, IPAR and Clinical Care Group BPPP meetings. Outsourcing procurement exercise underway to eradicate 3 year waits by March 2026. Contract to the value of £4m to outsource over a 3 year period, commenced in 2025, with the option to increase to 5 years as funding allows Monthly touchpoint meetings with NHS Improvement & Performance to monitor progress against ministerial priorities. SMS text functionality in place for ND to improve attendance and decrease instances of non attendance. Fixed term posts made substantive Early Years pathway and toolkit for Health Visitors in place to encourage a 'watch and wait' approach.	Estates - lack of appropriate dedicated child-centred premises to run clinics Recruitment delays Financial climate and associated cost pressures impacting on acquisition of appropriate IT infrastructure and hard wear that could create more efficiencies Lack of certainty around future funding of ND services. Allocated monies 25/26 are non-recurrent. Uncertainty around RPB infrastructure to help support and deliver regional transformation to needs-led, whole system approaches Lack of capacity within ND services to work strategically to bring about transformational change across the 3 counties. Current capacity within ND services limited due to competing operational responsibility pressures. Lack of a regional partnership strategic action plan to help bring about transformational change across the 3 counties involving all stakeholders.	Grow your own' scheme is coming into place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme (3 year programme).	Carroll, Mrs Liz	Completed	Psychology posts fully recruited in to within Children's ASD service
		Develop further understanding of drivers for referral with potential for collaboration with partners for needs-based profiling	vaughan, Catherine	~~31/03/2026~~ 31/03/2027	Commenced 1st October 2025 Work progressing with thematic analysis of drivers for referral underway in order to inform re-design of service to needs-led model. Education Strategic meeting with CCC attended to start to agree and develop profiling tool. Work un progress to develop a pilot between Children's ND and CCC Education Psychology service Assistant Psychologist recruited to undertake a thematic review
		Recruit into additional administrative and clinical posts and make existing fixed term posts substantive	vaughan, Catherine	Completed	Recruitment underway in October 2025. Delays gaining financial approval and recruitment delays, recruited into Band 4 Waiting List Coordinator and Band 3 Team Secretary of of 01.02.2026. All posts recruited in except for 1.0wte OT and 0.6wte ND practitioner. Interviews scheduled March 2026 Recruitment nearing completion for all posts
		Outsource a minimum of 585 diagnostic assessments to eradicate >3 year waits	vaughan, Catherine	Completed	Procurement exercise completed. Referrals identified and transferred to contract provider for 585 assessments, to be completed by 31.3.26.
		Develop an all-age regional strategic action plan around neuro-divergence to promote whole system, needs-led services	vaughan, Catherine	~~31/03/2026~~ 31/03/2027	This action has been included in the CCG Annual Plan for 26-27.

Professional consultation introduced across statutory sectors Website developed and in place for all-age ND services. Stakeholder mapping exercise completed and engagement plans in progress to develop needs-led model Looking at a Value Based Healthcare working with partners to develop needs led service.		Introduce an AI scribe across service to reduced administrative burden on clinical staff	vaughan, Catherine	~~31/03/2026~~ 30/06/2026	Use of Magic Notes AI scribe commenced on 6.2.26 as pilot. Outcomes and feedback shared with Digital Director to inform HB procurement of a AI type system.
		Develop and appoint into a strategic Head of Neuro-divergence post, to strengthen existing and further develop strategic partnership working	Temple-Purcell, Rebecca	Completed	This specific action is unrealistic at this present time. Opportunities, roles and responsibilities for the development of strategic partnership working to be undertaken collectively by the CCG leadership team.

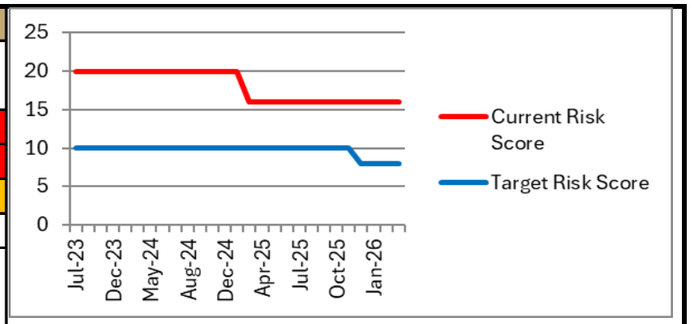
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

	Monthly MH&LD Integrated Governance Group (BPPP & QSEG)				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. Papers were presented at Board Seminar in March & September 2025 to provide assurance on current waiting times and control measures.					
	An updated paper was submitted to the September 2025 Board meeting.	2nd								

Date Risk Identified:	May-23	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Mar-26
Strategic Objective:	1. Thriving Teams and 3. Great Care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

Risk ID:	**1664**	**Corporate Risk Description:**	There is a risk to service sustainability in Ophthalmology, and the inability to provide timely care to patients with Glaucoma, wet Age Related Macular Degeneration, Vitreoretinal, paediatrics, and Cataract This is caused by a national shortage of Consultant Ophthalmologists and the inability to recruit to vacancies, exacerbated by nursing and medical staffing constraints and reduced service capacity due to lack of physical space. Recruitment difficulties are leading to the Consultant on-call rota being covered by substantive Consultants with 3 gaps in the rota, and Consultants undertaking additional duty hours, with use of agency consultant to fill 2 gaps on the rota. This is a fragile on call structure which is impacted by sickness and annual leave. This could lead to an impact/affect on ability to deliver services within the Ophthalmology Referral to Treatment (RTT) plan, and the ability of the Health Board to comply with Welsh Government Eye Care Measures (ECMs). Impacting the ability to provide timely diagnosis and treatment and directly impacting on patient safety, with the potential for sight loss and long-term lifestyle impacts. The Health Board's ability to progress with the implementation of recommendations raised by various regulators and inspectorates is affected by the recruitment and estates issues, which in turn could lead to adverse publicity and reduction in stakeholder confidence, with increased scrutiny/escalation from WG. The service has undertaken successful recruitment of two specialty Doctors who are now onboarding, this will improve capability and capacity in part. The Regional Programme Board continues to support development with 2 Regional substantive Consultant posts (1 post offered) to fill the vacancies within the team.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	3/31/2028
Trend:	⟺



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1 patients (high risk) with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional AMD sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the HB. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. The current R1 delivery at 42%. The WG target for R1 delivery is 95%. The current waiting list for new patients is 11,552. The service is currently delivering 0 patients waiting at stage 1 over 52 weeks for March 2026 and this is expected to be maintained through to the end of March 2026. The stage 4 104 weeks, is in a breach of 2 for March 2026 currently with potential solutions being worked through to be 0 by the end of March 2026. 7301 patients have been 100% delayed for their follow up appointment. The Board has decided to progress Clinical Service Plan Option 99 of the Clinical Service Plan + Aberaeron Integrated Care Centre as a diagnostic hub. The service is currently reviewing the estates and workforce required on each site to deliver Option 99.	The service will be able to reduce the impact score of this risk as whilst the consequences to the patient remains high, recurrent funding has been invested into the service for the delivery of an R1 Eye Care Measures target of 65%. The ministerial Measures target will need to be 0 for 3 months and more and the Follow up delayed will need to be reduced by 12%. The 65% R1 delivery by January 2027 is dependent on all posts being recruited into and all estates needs being met. Further development would be required to reach a 95% R1 delivery score. With the required investment in Glaucoma and IVT and the additional workforce identified in the annual plan 2026/2027 and estates issues being resolved alongside the continued management of the waiting lists, the HB will potentially be able to reduce the score to 8.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
The service is included within the Health Board's Clinical Service Plan (CSP). With Option 99 being decided by Public Board as the most suitable option to improve efficiency gains, training and retention of staff. Active recruitment to vacancies through a regional approach, continue grow your own initiatives to secure Substantive Consultants and develop Consultants for the future. 2 Regional Substantive posts have gone out to advert through the Regional programme. 1 post has been offered following interview (Vitreo Retinal) and the other post is going back out to advert (Medical retina)	Vacancies remain high within the service with a high turnover of staff. When recruiting to Clinical posts, delivery is restricted due to the reliance on Medical records and outpatient staff and the introduction of further clinics has been difficult. The SLA with SBUHB for the regional consultant posts needs to be finalised.	Roll out and implementation of National Electronic Patient Record for Ophthalmology.	Barreiro, Marta	~~30/07/2021~~ ~~31/03/2022~~ ~~31/05/2022~~ ~~30/09/2022~~ ~~31/10/2023~~ ~~31/12/2023~~ ~~31/03/2024~~ ~~15/07/2024~~ 31/03/2027	Application Support Manager started early December, undergoing induction with projects team & IT. Communication established with clinicians to explain Application Support Manager will start shadowing their clinics as soon as possible to determine pathways and support the build up of the system to match clinical activity.

Collaborative working with Swansea Bay to deliver a Regional solution to address the workforce and estates constraints. Sub groups to be formulated to address, Glaucoma, AMD, Vitreoretinal, paediatric and cataract pathways. Additional funding for the delivery of Wet Age related Macular Degeneration (AMD).IVT outsourcing commenced in February 2025 continues to support the service, whilst service is developed. Additional capacity has been funded for the delivery of Cataract surgery to maintain the 104 week wait for 2025/2026. Wales General Ophthalmic Services (WGOS) for Glaucoma, Diabetic Retinopathy and Medical Retina ongoing. Continued Validation of waiting lists to remove any patients who no longer require treatment. With review of data quality inclusive of Health Risk Factor (HRF) code and clinical codes ongoing to improve data quality. Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. The second regional ECCG meeting is being held on the 20th March 2026. Highly trained Optometrists working collaboratively with the Secondary Care Eye Service to reduce referrals to secondary care and support the validation process. Ongoing training of Optometrists within secondary care for IPOS, Glaucoma and Medical Retina for continued delivery of WGOS and reduce referrals into secondary care. GIRFT review undertaken on the Ophthalmology service with progress made against recommendations raised monitored and updated via AMAT. Performance dashboards in place to monitor performance.	The Regional sub-groups are in their infancy with actions being taken to develop sub-specialties. The SAS doctor post for the (AMD) service needs to be recruited into to start additional Injections clinics in NREC. Interviews were held on the 13th march 2026 and posts are onboarding. The required space for the expansion of the service in AVH needs to be secured for 5 days a week. Further meeting to discuss on the 25th March 2026 The regional cataract delivery plan needs to be developed and executed. A WGOS co-ordinator needs to be secured in primary care to support the discharge of patients to the community. The remaining 8 GIRFT recommendations need to be actioned and closed. There still remains areas of the service (e.g. Glaucoma, AMD, Cataract, Paediatrics, Corneal and VR) that require investment. The regional programme board will need to consider further opportunities for a long-term regional model. Central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. Recovery funding is non-recurring and reviewed annually, which restricts delivery planning.	Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.	Coppack, Victoria	~~30/09/2022~~ ~~31/10/2023~~ ~~30/11/2023~~ ~~31/03/2024~~ ~~30/06/2024~~ ~~30/09/2024~~ ~~31/03/2026~~ 30/09/2026	Recommence the validation of the HCQ patients. Ensure patients start to be discharged to primary care Optometrists when training has been completed. Primary Care still awaiting materials to be finalised and process rolled out.
		Alignment in the Delivery of Eye Care Measures and Ministerial Measures and effective management of Ophthalmology waiting lists.	Coppack, Victoria	31/03/2027	Recruit into 2 regional consultant posts. Deliver actions against regional programme board. AVH OPD to be secured for additional 2 days IVT. Deliver 52 week and 104 week target. Deliver 12% reduction in follow up delayed. Ensure all WGOS patients identified for pathway are discharged to primary care. Complete GIRFT recommendations. Continue with Clinical Services Plan.
		Long-term investment required for IVT and Glaucoma Delivery to recover R1 position	Jones, Keith -	Completed	New action - progress update to be provided at next risk review.
		Regional solutions to workforce gaps and estates to be explored through Regional programme	Coppack, Victoria	31/03/2027	Regional visit to SBUHB completed. Next Regional Eye Care programme Board meeting 20th March 2026
		Orthoptist posts to be recruited into	Coppack, Victoria	~~30/09/2025~~ ~~31/03/2026~~ 30/09/2026	Band 6 1.0 WTE Orthoptist post to be recruited into. Band 8B JD has been signed off by job matching panel. Next steps to identify the funding for this post and authorise through CCG and FCSG.

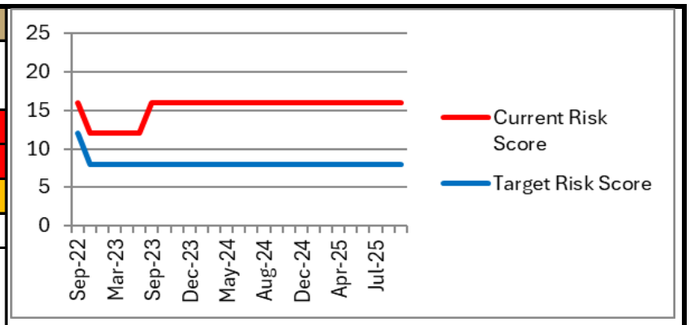
	There are ongoing concerns in data quality due to referral processes and system use.	Progression of Clinical Services Plan Option 99 + AICC as a diagnostic hub.	Carruthers, Andrew	31/03/2028	The Board has decided to progress Option 99 + AICC as a diagnostic hub. The service is currently reviewing the estates and workforce required on each site to deliver Option 99.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Eye care measures monthly report. GIRFT review Cataracts. GIRFT review Glaucoma. Weekly RTT Optimisation to review Ministerial Measures.	WPAS GIRFT action plan cataracts GIRFT action plan Glaucoma WPAS, scheduled care performance indicators	1st 1st 1st 1st			SBAR for IVT Service Delivery & SBAR for recovery of R1 position Revised RISK SBAR. Planned Care Annual plan 2026/2027					

Date Risk Identified:	Jan-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Feb-26
Strategic Objective:	3. Great Care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Mar-26

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

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



Rationale for CURRENT Risk Score:

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

The Gamma camera at WGH, the only unit of its kind in the Health Board, has suffered repeated breakdowns, leading to HIWâ€'reportable IRMER incidents. It remains a priority for replacement as of February 2025. At GGH, a new CT scanner has been installed, but the original unit continues to fail due to outdated technology, undermining resilience at the major trauma site. Likeâ€'forâ€'like replacement is not always costâ€'effective or compliant with regulatory and warranty requirements, and infrastructure upgradesâ€"such as air handling, water chillers, and accommodation adjustmentsâ€"are needed to ensure longâ€'term resilience.

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

Rationale for TARGET Risk Score:

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

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

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports. # Escalation process in place for service disruptions/breakdowns. # National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales. # All equipment at main sites are now DR and so will be compliant with the RISP project # Additional WGH EOY funding was secured (23-24 financial year) and replaced aged US units and upgraded the software on MRI scanners at BGH and WGH providing latest technology.	Limitation of spare parts for some older equipment leading to extended outages. This issue has been compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment. Inability to undertake specific replacements at this time due to the additional infrastructure required National Imaging and Capital Priorities Group outcomes do not always align with the Health Board priorities, and is subject to negotiations within the group.	Installation of replacement Gamma Camera, WGH Gamma camera is 9 years old and the only scanner in the Health Board providing a regional service. Recurrent breakdowns are resulting in HIW reportable incidents.	Roberts-Davies, Gail	~~31/07/2024~~ ~~30/06/2025~~ ~~31/03/2026~~ 31/03/2027	No funding allocated as of 09/02/2024 This will not be replaced in the 24/25 financial year. A specific T&F group is due to be set up as of June 24 to plan the necessary accommodation improvements required. July 2024 the T&F group has been set up and meets weekly Feb 2025 there is a draft plan for replacement. Business continuity plans being explored. The plan has been rejected by WAG for 25/26 due to cost and the electrical instruction T&F looking to alternative sites and will resubmit for funding in 26/27.
		Replacement of aged CT Scanner at GGH	Procter, Sarah	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ 31/07/2026	Awaiting confirmation of funding as at December 2023. No funding allocated as of 09/02/2024 This will not be replaced in the 24/25 financial year. Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The CT replacement of the aged at GGH has been recommended, however funding has not yet been formally agreed.

Replacement of Fluoroscopy room, WGH	Whitecross, Faith	~~31/03/2024~~ ~~31/07/2024~~ ~~31/03/2025~~ ~~31/08/2025~~ 31/03/2026	Additional infrastructure required to replace this piece of equipment and so will not be completed until the 2025-2026 financial year. Update feb 25: funding approved for installation of fluoroscopy equipment 25/26 financial year. Update Aug 25: Work starting Sept 25
Replacement of CR X-Ray room, Llandovery Hospital	Osell, Fiona	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ ~~01/12/2025~~ 31/03/2026	Equipment on site is incompatible with the incoming PACS system X Ray room continues to be in use one day per week (Tuesdays) staffed by 1 Radiographer (B5 or B6). Regular maintenance of equipment continues and required QA testing. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. This will not be replaced in the 2025/2026 financial year. Progression of this project reliant upon the outcome of the clinical services plan which is out to consultation
Replacement of Mammography Units, BGH and WGH	Roberts-Davies, Gail	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ 31/03/2027	Ageing equipment, exacerbated by the failure of Securview. These will not be replaced in the 23/24 financial year These will not be replaced in the 2024/2025 financial year These will not be replaced in the 2025/2026 financial year
Upgrade or replacement of MRI scanner, GGH	Procter, Sarah	~~31/03/2024~~ ~~30/06/2025~~ ~~31/03/2026~~ 31/05/2026	Replacement agreed and funding available for replacement in March 26

To replace the DEXA scanner at BGH and ensuring suitable accommodation is found to meet regulatory compliance for a larger more modern scanner.	Edwards, David	~~31/03/2024~~ ~~30/09/2024~~ ~~30/09/2025~~ 31/03/2026	Unit is 17 years old, and previously funded via charitable funds This has been added to the imaging priorities list and end of year additional funding projects as relative replacement costs are not high, however the infrastructure enablement costs are additional and a suitable location to accommodate a larger scanner needs to be found. Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The replacement of the aged DEXA scanner at BGH has been recommended, however funding has not yet been formally agreed.
Arrange meeting with head of capital planning and head of strategy and planning to discuss long term strategy for equipment replacements.	Procter, Sarah	Completed	meeting undertaken - business case for NM to be developed. Understanding of critical need.
Meeting with head of capital planning to discuss plans for CT and NM replacement in near future.	Procter, Sarah	Completed	meeting has happened 23.1.26 - action develop business case in conjunction with capital planning and estates
Business case to be developed for replacement of Gamma Camera - joint with capital planning team	Procter, Sarah	31/03/2026	new action

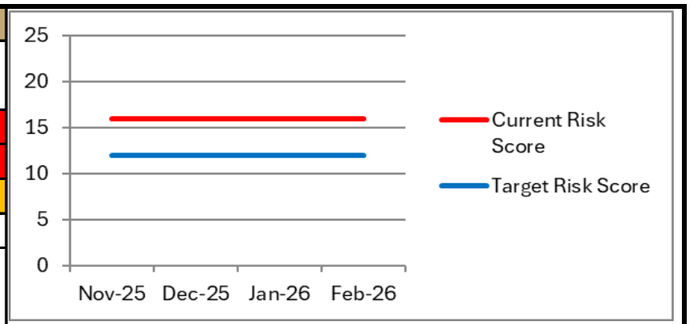
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

Date Risk Identified:	Oct-25		
Strategic Objective:	3. Great Care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Feb-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Mar-26

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

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×4=12
Expected Date To Achieve TRS:	3/31/2026
Trend:	⟷



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

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Local Working Group which includes LTC , MHLD and Children's services as well as finance colleagues which meets monthly. However additional resources have not been identified or clarity on whether a national hub or resources will be available. National CHC leads group meeting already in situ with direct payments regularly discussed. Welsh Government direct payments policy team meeting with Health Boards on a monthly basis. 150k is being held by Powys Health Board and they have appointed the Implementation lead to support Health Boards on implementation. Task and Finish groups set up to review key workstreams: Commissioning Care and Support, DP Eligibility in Care Needs and Safety, DP advice Support& Coordination, Health Board Training staff. Implemented Lead and National Director for Complex Care (Corporate Services) meet regularly with Welsh Government.	No local or national implementation plan in place No development yet of a suite of all Wales protocols and operational guidance. Lack of dedicated resource to implement requirements. No financial protocols designed to support payments.	Hywel Dda input required to support Welsh Government national consultation and development of guidance	McCarthy, Julia	Completed	Health Board to attend Welsh Government policy team monthly meetings. Welsh Government have recently issued the consultation paper regarding the regulation of direct payments for response by 15 October 2025. In addition a further CHC DP draft guidance was given and comments needed by 19th Nov this has been submitted by the Service.
		Identify workforce resources required to action and implement a working plan to deliver direct payments.	McCarthy, Julia	31/03/2026	Director of Finance agreed in Nov 2025 EITS to provide support for potential resources for Direct Payments (DP) being implemented in the Health Board. Local working group established to receive updates from DP workstreams. LTC and MHLD teams have engaged with the three Local Authorities (LA). The LAs are keen to work with the Health Board in supporting implementation of DPs. The Health Board is unclear of the workforce resource required within the Health Board.
		Agreeing the training spec to increase the skills and knowledge base in the Health Board for direct payments and their operation.	McCarthy, Julia	31/03/2026	An All Wales training spec is being developed as part of one of the workstreams for Health Board staff. The draft spec will be circulated end of February 2026 for all Health Boards to agree. In addition we are still waiting the draft policy guidance from Welsh Government.

Implementation lead appointed to lead on Direct payments. Task and Finish groups set up to start to review key workstreams: Commissioning Care and Support, DP Eligibility in Care Needs and Safety, DP advice Support& Coordination, Health Board Training staff.	Devantier, Tracy	Completed	Task and Finish groups have commenced in January 2026 under the leadership of the new Implementation Lead. Long Term Care and MHLD have provided the names of Health Board staff who will participate in the workstreams.
Implement an Electronic DP referral system to support internal Health Board colleagues and LA colleagues. Also to support patients self-referring into the service.	Devantier, Tracy	31/03/2026	Email has been sent to Digital Director to request support for Digital resource to implement an Electronic DP referral.

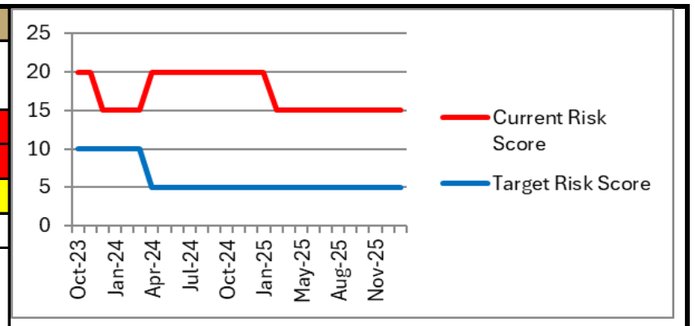
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**		
Reviews completed in line with the national framework. Number of packages and costs reported monthly to local governance forums. Papers are submitted via the CCG IGG. Welsh Government may require reporting but that is yet to be confirmed	There are current finance reporting and review monitoring arrangements in place that could be adapted when direct payments are implemented and would be reported through the CCG and IQFPD. .	1st			
	Recent internal audit of finance procedures received substantial assurance .	2nd			

Gaps in ASSURANCES				
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**

Date Risk Identified:	Nov-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Mar-26
Strategic Objective:	1. Thriving Teams and 3. Great Care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

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

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Expected Date To Achieve TRS:	5/1/2027
Trend:	



Rationale for CURRENT Risk Score:

A substantive Upper GI consultant has now been recruited following the exit of the Medacs agency locum consultant in Withybush General Hospital. A second substantive post is out to advert, and the Advisory Appointments Committee (AAC) is planned for April 2026. Successful recruitment will result in 4 substantive consultants on the 1:4 rota at WGH. The GGH rota has only 1 gap which is being covered by internal locum at the HB card rate. The plan for this rota is to recruit a substantive colorectal consultant to replace 1 of the NHS locums. On 19/02/2026, The Health Board made a decision on the Clinical Service Plan (CSP), which would involve the amalgamation of the surgical on-call rotas and Emergency General Surgery being moved from WGH to GGH. The timescale and details of this are not yet confirmed, but the service will continue to engage with the CSP programme.

Rationale for TARGET Risk Score:

Achievement of the target risk score is dependant on the successful appointment of substantive upper GI consultants along with the work currently being undertaken following the outcome of the Clinical Services Plan which would involve the amalgamation of the surgical on-call rotas and Emergency General Surgery being moved from WGH to GGH. The effectiveness of revised rota arrangements will depend on several factors including availability of a labour market.

A substantive Upper GI (UGI) consultant has now been recruited following the exit of the Medacs agency locum consultant in Withybush General Hospital. There is 1 UGI substantive post out to advert and a substantive LGI post to be advertised for GGH in April 2026. The rotas at GGH and WGH are currently fully functioning with no Medacs locums. This will be further strengthened by further substantive recruitment and less NHS locum consultants. By May 2026, there should be a balance of upper and lower GI coverage on the rotas, providing recruitment is successful.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Rotas monitored daily by the service delivery team. The WGH rota is a 1:4 frequency with 3 substantive consultants and 1 NHS locum consultant. The GGH rota is a 1:8 frequency with 1 gap on the on-call rota, due to health reasons. This gap is being covered by internal locum at the HB card rate. The rota consists of 4 substantive consultants and 3 NHS locum consultants. There is a plan to replace one of the NHS locum colorectal consultants with a substantive consultant. This will be going out to advert in April 2026. A substantive upper GI consultant post is currently out to advert, which will replace the NHS locum. The AAC is planned for April 2026. These are dual location posts between GGH and WGH, and they participate in the on-call rota at WGH. Â Â When there is sickness or unexpected leave, due to emergency circumstances, the following process is followed by the management team to cover the on-call: 1. Internal Additional Hours (ADH) on the site with the gap. 2. Internal ADH from the other sites across the health board. 3. In the event of steps 1 & 2 being unsuccessful, the service would escalate for agreement on transferring the surgical out of hours on call take to another site. (WGH to GGH) 4. Ensuring that all stakeholders are aware, including site teams, medical teams, WAST, any supporting services as appropriate. Â Proactive sickness management Escalation to clinical leads On appointment, new consultants undertake an induction with Hospital Director at WGH and Clinical Director for Scheduled Care. SOP in place for the transfer and repatriation of patients Engagement with the CSP programme. A decision has been made through the CSP programme, but there is currently no timescale confirmed for this.	All posts are yet to be filled substantively. It is unknown whether the service will be able to successfully appoint to the second substantive upper GI post, due to previous withdrawals of applicants. The Consultants at GGH also provide the support to the junior and SAS level doctors at PPH for the elective pathway. There is a part time rota co-ordinator in WGH covering maternity leave. This post is shared between surgery and T&O. The rest of the work is being undertaken by the service team which has had a detrimental impact on their workload. There is a risk of consultants requesting rates that are higher than the HB card rate, going forward as they have been covering multiple gaps on the rota for a prolonged time.	Review the longer term sustainability of general surgery on-call rotas across Hywel dda (recommendation from Getting it Right First Time (GIRFT) review in Jan23)	Lewis, Caroline	Completed	The senior consultant leads for general surgery have suggested that the WGH and GGH on call rotas are amalgamated to one site. This would provide an increase of consultants on the rota to either a 1:10 (the 3 WGH consultants and the 7 GGH consultants) or a 1:12 (the 3 WGH consultants, 7 GGH consultants and 2 newly recruited posts). This recommendation is in line with the GIRFT report. SBAR's have bee drafted by the service to describe the fragility of the rotas.
		To develop an options appraisal paper with all relevant stakeholders, including WAST, Primary Care, and site teams	Hire, Stephanie	Completed	A discussion was due to be held live at the health board planning session on 09/1/25, this did not take place due to the clinical lead and clinical director not being able to attend. The EGS situation is regularly reviewed and appropriate action is taken by the service as and when required. It also forms part of the fragile services, which is discussed at escalation. We are awaiting confirmation as to when or if the stakeholder discussion will take place. Following the executive meeting on 12/03/2025 and the agreement to recruit substantive consultants into the gaps on the rotas, this options appraisal paper is no longer required. This will need to be reviewed, if the service is unable to recuit suitable candidates.
		To hold interviews to appoint NHS locum consultant	Lewis, David	Completed	Job descriptions have been sent for Royal College approval in April 2025.

To agree job descriptions and advertise for three substantive consultant posts	Lewis, David	Completed	The two substantive upper GI consultant posts have been advertised and shortlisting is currently being undertaken. If there are suitable candidates, interviews will take place on 2nd September. The substantive lower GI consultant post will be advertised in Spring 2026, in readiness for the end date of the NHS locum that has been appointed.
Successfully recruit 2 x substantive upper GI consultants.	Lewis, David	~~30/09/2025~~ 01/05/2026	1 consultant started in post on 27th January 2026. There was an AAC planned for the second consultant in February 2026, but both candidates withdrew. The post is now back out to advert with the AAC anticipated for April 2026.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
	WGH Medical Staff Committee established to develop models of sustainability	1st			Management team have presented an SBAR to Acute Leadership Group (Feb23, Sep 24, Oct 24) SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23)	Assurance to Board on communication and repatriation arrangements				

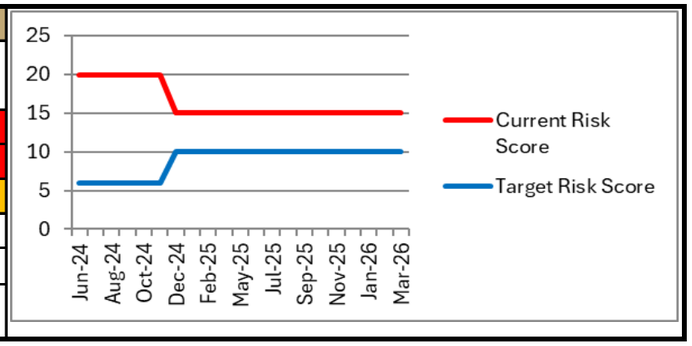
	Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd			General Surgery Report to Board (Mar23) Management team to present updated SBAR to Acute Leadership Group (Oct23 & Nov23) Management team to present updated SBAR to Corporate Directorate Group (Apr24) Upper GI service SBAR presented at ALG (Sep24) Upper GI service SBAR presented at Quality, Safety and Experience committee Meeting (Oct24) Updated SBAR to Executive Team (Nov24) Options Appraisal via CSP to Board (Nov 24)					
	Reported to bi-monthly Scheduled Care Quality, Safety and Experience Group through exception reporting	2nd								
	Assurance to be reported to the Board following introduction of temporary rota	2nd								

	GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited				Upper GI service SBAR presented at scheduled care directorate QSEAC (Jan25) CSP Public Board (18/02/2026)				

Date Risk Identified:	May-24	**Executive Director Owner:**	Daniel, Sharon	**Date of Review:**	Mar-26
Strategic Objective:	1. Thriving Teams and 3. Great Care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

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

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	2×5=10
Expected Date To Achieve TRS:	6/30/2026
Trend:	⟷



Rationale for CURRENT Risk Score:

At the end of 2025 Unplanned Admissions into ITU (from Ward areas) in WGH had reduced by 10%. In GGH the same comparison was unchanged.
Cardiac arrests rates for Ward Areas across all 4 sites have had varying results:
WGH - Increase of 40% (2024: 16, 2025: 23); unfortunately although all cases have been reviewed by the Resuscitation Team there has been less involvement from the Medical Team in WGH in undertaking reviews, possibly leading to less scrutiny and less opportunity to learn from events.
GGH - Decrease of 30% (2024: 34, 2025: 24); significant amount of work has been undertaken by the SNMs/Ward Managers/Resus Team & GGH RADAR lead to undertake monthly/bi-monthly Scrutiny meetings to review all cardiac arrest cases. It is possible that this added scrutiny and feedback and lead to better decision making, recognition & escalation of deteriorating patients.
BGH - Decrease of 30% (2024: 10, 2025: 7); no theme identified
PPH - Increase of 70% (2024: 7, 2025: 12); Scrutiny meetings only established in Jan 2026. Difficult to fully attribute but has the down grading of the ITU resulted in sicker patients being managed in ward areas were ITU may have been more appropriate.

In at least 50% of these cases across the HB the conclusion from the medical review was that a DNACPR should have been in place, therefore resuscitation should not have started.

Rationale for TARGET Risk Score:

The full implementation of the actions noted in the risk action plan will support the reduction in the likelihood and impact score of this risk to a target risk of 10.

As at March 2026, TRS date has been revised from 31/12/2025 to 30/06/2026 as systems remain under development and have not yet been implemented.

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

hospital mechanical CPR device equipment within the hospital setting. Networks in place across the wider Health Board, including support from QIST (Quality Improvement Service Transformation) Team and practice development. Organisational training plan in place, including mandatory training Critical Outreach Services in GGH and WGH (not in place at PPH/BGH), managed by Planned and Specialist Care Clinical Care Group (i.e not fully linked to Acute Deterioration resource) Dedicated resource in Quality Improvement Team monitoring AKI alerts for the Health Board Bi-monthly scrutiny meetings have been set up in GGH, BGH and WGH to review Cardiac arrests. Cardiac arrest reviews presented at Medical Education sessions Review of feedback from any Medical Examiner reviews, highlighting issues relating to resuscitation/cardiac arrests and lessons learned. Call for Concern in place at GGH and WGH for inpatient adult patients only. Process for implementation in Paediatrics, Mental Health and remaining sites under review. Cascade Trainers in place across the Health Board (community and acute)	Training requirement to meet recommended Resus Council Standards greater than current allocate Resuscitation Team resource 60 - 70& attendance of courses, even if fully booked. Current resource not being used to full potential with financial implications. Inconsistent and irregular site RADAR meetings which report in to HB-wide RADAR Group, with lack of medical leadership Whilst there is a dedicated Resuscitation Team in place, the HB does not have a Mechanical CPR Device in any of its Acute Sites. The Resuscitation Council Guidelines for Resuscitation state thatÂ a LUCAS is a good alternative for situations where it may be difficult or to maintain continuous high-quality compressions, or when it may be too strenuous on the medic to do so. There have been occasions when WAST have remained with the patient and allowed the HB to utilise their pre hospital mechanical device equipment within the hospital setting. However, this is not routinely or officially suitable practice.	As part of the Quality Dashboard, agree the matrix needed for patient deterioration. Include these matrix in the Health Board Quality Dashboard to inform escalation and create a specific dashboard for RADAR (Recognition of Acute Deterioration and Resuscitation).	Wastell, David	~~30/05/2025~~ ~~30/09/2025~~ ~~31/12/2025~~ 31/03/2026	Supporting metrics for the dashboard identified: sepsis, AKI, NEWS audits, cardiac arrests, number of MET calls, treatment escalation plans are in place, call for concern rates and training compliance for ILS and BLS. Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system. Data being supplied however further work required to align to the new operational CCG structures on the dashboards.
		Put in place process for Health Board compliance with Martha's Rule by establishing a Task and Finish Group to implement Call for Concern	Wastell, David	~~31/03/2025~~ ~~31/12/2025~~ ~~31/03/2026~~ 31/12/2026	Task and Finish Group is in place, chaired by Mandy Davies. Call for Concern has been implemented in Adult Inpatient areas in GGH and WGH due to these sites having outreach services. Discussions are underway with PPH and BGH on how this programme can be implemented. Paediatric Services have set up a group to review how this could be worked in their area. The National Group have a timeline of March 2027 for full implementation.

Put in place All Wales Policy for treatment escalation plans to enable safe and effective care management when patient deteriorating.	Edmunds, Dr Eiry	Completed	Discussed at Withybush RADAR meeting in July 2024 where agreement reached for pilot. Task and Finish group being established by Lead for Critical Care Outreach in Withybush to devise an implementation plan. RADAR to review following evaluation and consider roll out across other sites. As of September 2025, the situation remains unchanged. TEPS sub group meetings have been held at WGH but there is no set plan at the moment to implement or trial. To discuss at RADAR meeting scheduled for October 2025. Palliative Care Consultant has been appointed as the TEP Lead for the Health Board.
To feedback the audit to clinical leads so that they can implement improvements on the use of sepsis bundles at the bedside.	Wastell, David	~~31/12/2025~~ ~~31/03/2026~~ 31/12/2026	Ongoing quality improvement in place. Has demonstrated improvements in Glangwili and Prince Phillip and now being used in Withybush. Reviewing process for assessing impact on patient outcomes as a result of the response and management of sepsis. Implemented in July 2025, and audits have commenced to monitor compliance. Scrutiny of compliance is underway to ensure improvements are embedded, in consideration of an electronic system being launched early 2026.

Improve compliance with DNACPR National Guidance	Steele, Cathie	Completed	DNACPR Review Group formed and actions identified including development of a SharePoint page (which is now complete) and undertaken an improvement project through EQIiP (complete). Annual audits undertaken by junior doctors, and reviews of medical examiner reports and cardiac arrest to identify learnings. More robust communication between mortality review group and RADAR being established. Training needs have been identified in relation to DNACPR and patients who are considered having learning disabilities, or diagnosed with dementia. Work is commencing with the MHLD directorate to progress this. A full action plan as been agreed in response to the HIW National Report on DNACPR (see AMAT)
Development of an Acute Deterioration Sharepoint page for all advice, guidance, updates, for staff on issues relating to resuscitation, DNACPR, sepsis, call for concern, MET calls, training, etc.	Wastell, David	Completed	Senior nurse for acute deterioration is working with Interim ADN for Quality and Safety to develop SharePoint page. Refinement of the Sharepoint site underway to finalise and launch as of September 2025.
Acute Deterioration E-learning modules - topics include NEWS, sepsis, DNACPR and A-E assessment being developed by the Lead Nurse for Acute Deterioration in conjunction with NHS Executive and other leads. Work to develop a process for using these modules with clinical areas in response to issues of concern.	Wastell, David	~~31/01/2025~~ ~~30/09/2025~~ ~~31/12/2025~~ ~~31/03/2026~~ 30/09/2026	Acute Deterioration Nursing Leads from across Wales are in the process of reviewing. Awaiting the National decision.

To develop mechanisms to review and monitor the Acute Deterioration position via Escalation Framework via the Quality domain (including the implementation of the Safety Dashboard)	Davies, Mandy -	Completed	Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system. This phase completed.
Following assessment and interpretation of the All Wales Direction, the Health Board is engaging in National work, namely roll out of Call for Concern.	Wastell, David	30/09/2026	National Guidance now issued - Call for Concern has to be implemented by December 2026. This has to be implemented in all adult inpatient areas including Maternity Services, Paediatrics, Neonates and Mental Health. Task and Finish Group has been established. Mark Henwood is the Executive sponsor and work continues.
Capital Bid to be submitted for 3-4 LUCAS machines (mechanical CPR machines).	Wastell, David	Completed	4 machines now delivered and training on each site is planned March/April 2026. Action complete.

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	EWS (Early Warning Scores)/NEWS2 Audits undertaken by RESUS Team on AMAT and action plans for Ward Managers are requested where necessary	1st			RADAR Group Update presented to QSIG, 13th November 2025. RADAR Group update presented to QSIG, 15th January 2026.	Ward based NEWS audits in place but may be unreliable as self assessed.	Once dashboards in place, to develop a monthly audit process to address key hotspots / areas of concern relating to RAILS	Wastell, David	~~30/09/2025~~ ~~31/12/2025~~ 31/03/2026	Progress to be provided once dashboards in place and functional for reporting to future RADAR meetings. Awaiting feedback from Performance Team.
	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								
	DNAR/CPR group chaired by Deputy Medical Director - group needs to be re-established (as of January 2026).	2nd								