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Assurance and Risk Report
Quality, Safety & Experience Committee – 9 October 2025

Situation



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This report provides the Quality, Safety & Experience Committee (QSEC) with the status of the Principal risks, Operational Risks, and Audit and Inspections recommendations within its remit (the latter being the first time the items are being presented to the Committee).

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

Corporate risks, Welsh Health Circulars and Ministerial Directions are reported at alternate meetings, and due to be presented to QSEC at its next meeting in December 2025.

Principal Risks:
4

Operational Risks
389

Audit and Inspection
Reports
27

Risk Management - Overview



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

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

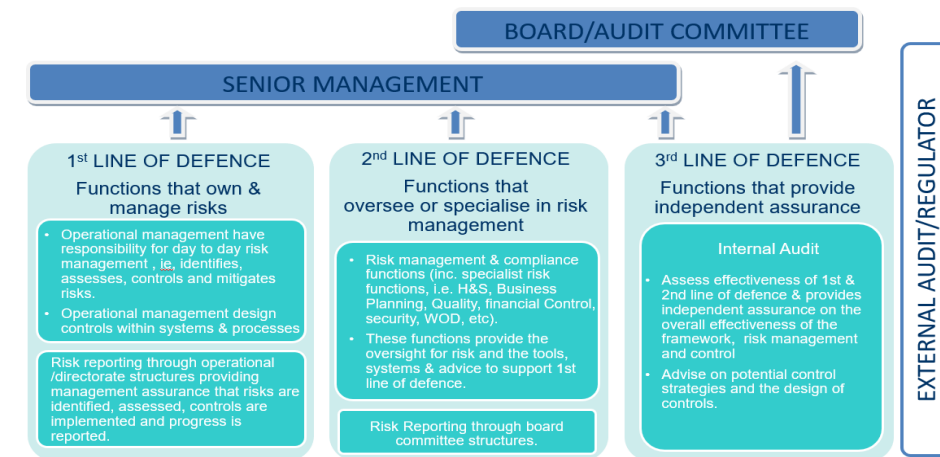
The Health Board operates within the widely accepted “Three Lines of Defence” model to ensure the appropriate responsibility is allocated for the management, reporting and escalation of risk.

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

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

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

A revised approach to risk tolerance was agreed by the Board at its meeting in March 2025 to reflect the organisation’s readiness to bear the risk after risk treatment, in order to achieve its objectives. Risk leads are required to provide a rationale for the target risk score (TRS), and an expected date when the TRS will be achieved. These are mandatory fields on Datix as of 1 July 2025, and therefore where risks do not currently have this detail, risk leads will be asked to provide by the next report to QSEC.



Principal Risks assigned to QSEC



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HYWEL DDA RISK HEAT MAP

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5					
MAJOR 4		1184	1191		
MODERATE 3			1195, 1189		
MINOR 2					
NEGLIGIBLE 1					

Each risk on the Principal Risk Register (PRR) has been mapped to a Board level Committee to ensure that risks on the PRR 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.

Principal risks have been identified by the Executive Team via a top down and bottom-up approach and are associated with the delivery of the Health Board’s strategic (long-term) objectives.

There are 4 risks currently aligned to QSEC (out of the 15 that are on the PRR as of 8 September 2025).

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

Principal risks will be reviewed as part of the strategy refresh that is currently underway.

Principal Risks assigned to QSEC



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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1191 - Underestimation of excellence	Medical Director	12 → (Reviewed 09/09/25)	6	To be reviewed as part of the strategy refresh

Rationale for Current Risk Score

The risk score has remained at 12 since May 2024 when it was reduced to reflect achievements made in Value Based Healthcare, Research and Innovation and Clinical Effectiveness. Further work proposed around job planning to enable protected Supporting Professional Activities (SPA) time for medics and a multi-professional workshop was established in October 2024 to strengthen continuous improvement, talent management and progression of clinical teams across the Health Board.

Rationale for Target Risk Score (TRS)

A review of clinical leadership at all levels/capacity and capability/multi-professional working/empowerment of more junior staff identifying change champions and empower local leadership models will be completed as part of the Health Board's response to Targeted Intervention and will facilitate the Health Board to develop and deliver excellent services.

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1195 - Comprehensive early indicators of shortfalls in safety	Director of Nursing, Quality and Patient Experience	9 → (Reviewed 24/06/25)	8	To be reviewed as part of the strategy refresh

Rationale for Current Risk Score

Systems are not yet established to enable easy triangulation of data and there are still some gaps in information collection. Since 1 April 2023, the introduction of the Quality and Engagement Act has refreshed the focus on quality and safety through the 6 domains and internal metrics developments. These developments have facilitated discussions at the appropriate forums such as Board, Committees and local governance arrangements.

Rationale for Target Risk Score

The target risk score is based on implementing a system to enable the capture of data across the breadth of our services with timely escalation reporting arrangements in place.

Principal Risks assigned to QSEC (continued)



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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1189 - Timely and sufficient learning, innovation and improvement	Director of Nursing, Quality and Patient Experience	6 ↓ (Reviewed 01/10/25)	3	To be reviewed as part of the strategy refresh

Rationale for Current Risk Score

The current risk score reflects the fact that the organisation has existing processes in place to value and embed learning and improvement but that it is not comprehensive. This means we may miss opportunities to enhance the care we provide and create a supportive environment for staff to develop and grow. There is increasing evidence that the mindset of the organisation is focussed on learning, the skillset is developing quickly, particularly in areas such as EQiP, Improving Together and Research, Innovation and Development, however further work is required to strengthen our toolset. Operational pressures are also likely to be causing challenges for people to enact change or improvement in their areas however Improving Together sessions with Directorates have facilitated and helped to embed learning and improvement. The new internal Escalation Framework is helping to improve learning and drive improvements in areas where performance issues are identified. There has been progress in more timely responses to ability to address our audit, inspectorate and regulatory requirements at pace, through CCG ownership and use of AMAT. The new Health and care quality standards have been embedded within reporting requirements and quality impact assessment. The use of the IPAR, Our Performance, Our Safety dashboard has improved the way data is used at operational and strategic levels. Data is available.

Rationale for Target Risk Score (TRS)

3 of our 4 strategic objectives are people-focussed and are aimed at making the Health Board a great place to work and receive care. The Board will be focussing on this for the long term which would result in an organisation which has learning, innovation and improvement threaded through everything it does.

The risk has been reviewed by the Executive Director of Nursing and Interim Assistant Director of Nursing for Assurance and Safeguarding in October 2025. Target likelihood reviewed. The risk needs a full review and consideration of whether the risk remains and what new mitigations are in place.

Principal Risks assigned to QSEC (continued)



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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1184 – Measuring how we improve patient and workforce experience	Director of Nursing, Quality and Patient Experience	6 ↓ (Reviewed 01/10/25)	4	To be reviewed as part of the strategy refresh
Rationale for Current Risk Score				
<p>The current risk score reflects the current maturity level of formal mechanisms to triangulate different sources of engagement and feedback from public, patients and staff across Hywel Dda. The information being used in Improving Together, Escalation and QSIG sessions/meetings which requires further development of dashboards requires further embedding, however this is facilitating a conversation regarding the utilisation of various metrics better. Value opportunities framework is embedded with EQIIP, and embedded into all service change and transformation activity.</p>				
Rationale for Target Risk Score (TRS)				
<p>Target score is predicated on developing the mechanisms to support the triangulation of various pieces feedback and quality and safety metrics.</p>				

Operational Risks assigned to QSEC



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Following the dis-establishment of Quality, Safety & Experience Sub Committee (QSESC) agreed by QSEC at its meeting in August 2025), operational risks previously aligned to the sub-committee have been realigned for reporting to QSEC. Of the 389 operational risks aligned to QSEC, 338 have been identified as reportable based on the following criteria:

- QSEC has been selected by the risk lead as the 'Assuring Committee' on Datix;
- Risks have been identified at operational level on Datix risk module;
- The current risk score is 'extreme' or 'high'; and
- The current risk score is either equal to or exceeds the target risk score.

Following identification and assessment of risks, all operational risks are aligned to a specific Health Board committee or sub-committee. 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. Operational risks must be managed within Clinical Care Groups and Executive Functions (collectively referred to as Functions) under the ownership and leadership of individual Executive Directors, who must establish local arrangements for the review of their Risk Registers, which includes the validation of the information and risk scores, and the prioritisation and identification of solutions to their risks. Each Clinical Care Group Integrated Governance Group (CCG IGG) is provided with an Assurance and Risk Report, with any issues escalated to the Integrated Quality, Finance and Performance Delivery Group via the 3As Report following each CCG IGG meeting.

In addition to established local arrangements, Hywel Dda University Health Board has implemented formal monitoring and scrutiny mechanisms to provide assurance to the Board regarding the effective management of risks. A monthly assessment is made for each Clinical Care Group/Executive Function (hereto referred to as Functions) on their risk management which informs their overall level within the 'Governance' domain as part of the Health Board's internal escalation framework. One key metric in the Health Board's internal escalation process under the Governance domain is how Functions are managing risks in terms of the scale, significance, timeliness and quality, with measures extended from April 2025 to inform levels to be awarded. The criteria is noted on the next slide.

The Assurance and Risk Team provide focussed support for those Functions at levels 3 and 4 to aid their de-escalation/recovery, and to prevent those awarded level 2 status being escalated. Detail is provided within each report provided and presented at Function governance meetings the reasons behind their escalation status, and suggested actions in order to de-escalate (where appropriate).

Operational Risks assigned to QSEC



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Measures to assess against the Governance Domain (risks)

Level	Criteria
Level 4 – no assurance and insufficient actions / engagement	<p>No plan in place and no engagement, (eg no risk action plans, no expected date to achieve Target Risk Score).</p> <p>No evidence that risks are escalated via CCG management structures where necessary, no engagement and the ability for leadership to make informed decisions on prioritisation of resources</p>
Level 3 – no assurance	<p>Lack of evidence that risks are being managed and mitigated within expected timescales.</p> <p>Evidence where known risks are not articulated on the function’s risk register.</p> <p>Less than 80% compliance of risks and risk actions being updated within required timescales</p> <p>Limited evidence that risks are escalated via CCG management structures where necessary, therefore not demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources</p>
Level 2 – Limited assurance	<p>Relevant risks articulated on risk registers with action plans in place, but lack of evidence that risks are being managed and mitigated within expected timescales. <i>(eg risk action plans not being implemented within original action dates, limited evidence of reduction in current risk score).</i></p> <p>Between 80% - 89% compliance of risks and risk actions being updated within required timescales</p> <p>Some evidence that risks are escalated via CCG management structures where necessary, demonstrating engagement and the ability for leadership to make informed decisions on prioritisation of resources</p>
Level 1 – Reasonable assurance	<p>Relevant risks articulated on risk registers with action plans in place, and evidence that the function is delivering against these (eg specific and measurable risk action plans, current risk score and target risk score clearly articulated, achieving expected target risk dates)</p> <p>Over 90% compliance of risks and risk actions being updated within required timescales</p> <p>Evidence that risks are escalated via CCG management structures where necessary, demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources</p>

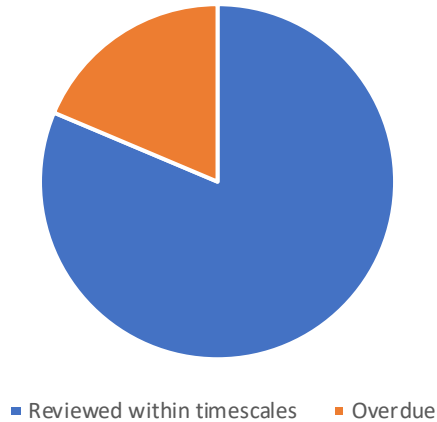
Operational Risks assigned to QSEC



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Operational Risks aligned to QSEC

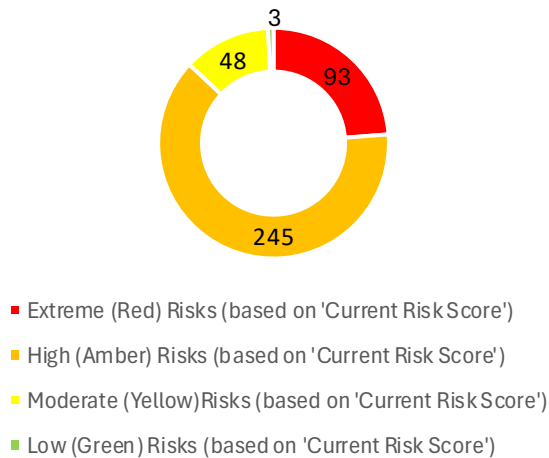


A summary of the 32 operational risks assigned to QSEC with a current risk score of 20 is provided over the next slides.

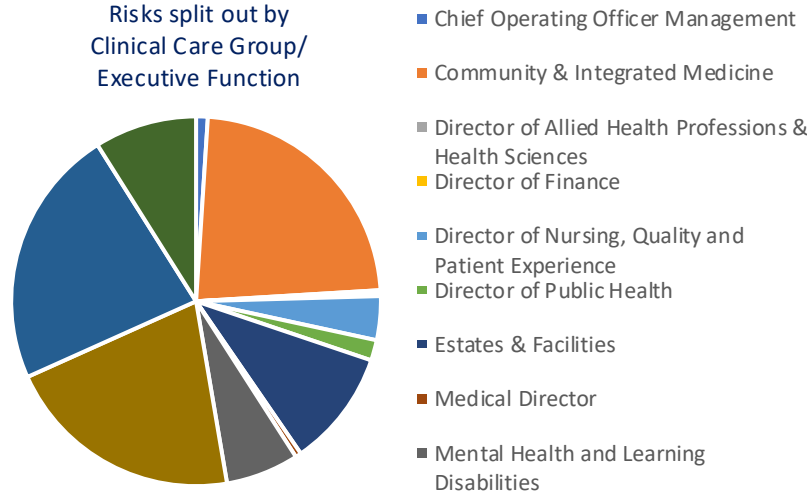
Details related to target risk scores (TRS) became mandatory fields on Datix as of 1 July 2025, and therefore for the 44 risks which do not currently have this detail, risk leads will be asked to provide by the next report to QSEC.

Where expected dates to achieve the TRS have lapsed (denoted in red on the following slides), the Assurance and Risk Team will remind risk leads to ensure the appropriate actions and updates are taken on Datis (eg has this risk now been fully managed and mitigated, or if TRS has not been met, what further actions are required and a revised TRS date provided and updated rationale).

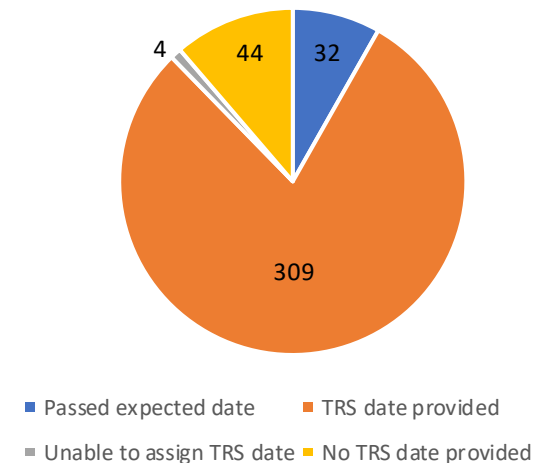
Current level of risks assigned to QSEC



Risks split out by Clinical Care Group/ Executive Function



Target Risk Score Status



Extreme Level Operational Risks Reportable to QSEC (Page 1 of 5)



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Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1290 - Risk of increased Adult ADHD waiting list due to referrals exceeding service capacity.	Mental Health and Learning Disabilities	Chief Operating Officer	20	16	30/04/2026	15/09/2025
1287 - Risk of clients not being provided with timely interventions due to waiting lists for assessment & diagnosis of ASD.	Mental Health and Learning Disabilities	Chief Operating Officer	20	16	30/04/2026	15/09/2025
2109 - Risk that we are not able to provide safe and robust clinical leadership to the Paediatric Occupational Therapy Service	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	15	29/08/2025	08/09/2025
2118 - Risk of harm to Physiotherapy patients due to inadequate Medical service capacity at GGH	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	12	31/03/2026	11/09/2025
2113 - Risk of patient harm in Emergency department Withybush hospital due to demand exceeding capacity,	Community & Integrated Medicine	Chief Operating Officer	20	12	30/04/2026	29/08/2025
1517 - Risk of poor outcome and poor experience due to breaches of routine Physiotherapy waiting times	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	12	31/12/2026	14/08/2025
1115 - Risk of increased time in A&E due to lack of inpatient beds, GGH	Community & Integrated Medicine	Chief Operating Officer	20	12	31/10/2025	29/08/2025

*Movement in current risk score since previously reported to Committee will be denoted at the next report to QSEC.

Extreme Level Operational Risks Reportable to QSEC (Page 2 of 5)



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Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
2134 - Risk of harm to Occupational Therapy patients due to inadequate medical team cover	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	10	31/10/2025	04/09/2025
1309 - Risk to meeting demands for diagnostic reporting due to shortfall in Consultant Cellular Pathologist workforce	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	10	31/08/2028	28/08/2025
2151 - Risk of service users unable to access timely medical/prescribing interventions leading to poorer outcomes	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	9	31/08/2026	18/08/2025
1996 - Risk of reduced workforce recruitments and developments due to lack of funding	Planned & Specialist Care	Chief Operating Officer	20	8	31/07/2026	18/08/2025
1894 - Risk of stroke patients not receiving the therapy rehabilitation they need due to lack of staffing	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	31/03/2026	10/09/2025
1869 - Risk of NHS Dental Services not achieving Patient Charge Revenue Income targets due to lower activity/income at practices	Primary Care, Community Strategy & Long Term Care	Chief Operating Officer	20	8	31/03/2026	29/08/2025
1820 - Risk of patient harm due to the withdrawal of funding for the Diabetes Remission service	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	31/03/2026	11/09/2025

*Movement in current risk score since previously reported to Committee will be denoted at the next report to QSEC..

Extreme Level Operational Risks Reportable to QSEC (Page 3 of 5)



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Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1820 - Risk of patient harm due to the withdrawal of funding for the Diabetes Remission service	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	31/03/2026	11/09/2025
1552 - Risk of inadequate body storage capacity across Health Board mortuaries	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	31/08/2025	10/09/2025
1547 - There is a risk to timely and safe radiology provision as capacity does not match demand	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	30/03/2029	07/08/2025
834 - Risk of clinical deterioration due to reduced service resilience within the Clinical Haematology sub specialty	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	30/09/2026	12/09/2025
2145 - Risk of harm to patients due to insufficient capacity to meet rehabilitation demand in acute hospitals	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	6	14/08/2026	14/08/2025
2090 - Risk to patient care in the Ceredigion area due to workforce capacity	Mental Health and Learning Disabilities	Chief Operating Officer	20	6	03/08/2026	15/08/2025
2028 - Harm to Patients/Staff due to extreme theatre workforce shortages at GGH affecting ability to provide safe/essential care	Planned & Specialist Care	Chief Operating Officer	20	6	30/06/2026	19/08/2025

*Movement in current risk score since previously reported to Committee will be denoted at the next report to QSEC..

Extreme Level Operational Risks Reportable to QSEC (Page 4 of 5)



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Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1930 - Risk of harm to mortuary staff and porters when manual handling due to failure of hoist (Whisper 200)	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	6	Not yet assigned	10/09/2025
1717 - Risk of harm to children and young people living with obesity due to no weight management service provision	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	6	31/03/2027	11/09/2025
2141 - Risk of harm to patients, staff and public due to insufficient physical security measures in place at BGH	Community & Integrated Medicine	Chief Operating Officer	20	5	09/08/2028	13/08/2025
2136 - Risk of being unable to provide a haematology and blood transfusion service due to insufficient staffing	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	5	31/08/2025	01/09/2025
2156 - Risk of patient harm within the bone health service due to lack of clinical capacity across the Hywel dda University HB	Community & Integrated Medicine	Chief Operating Officer	20	4	31/03/2026	29/08/2025
2049 - Risk of being unable to support paediatric patients in acute respiratory distress due to ageing equipment	Planned & Specialist Care	Chief Operating Officer	20	4	31/03/2026	28/08/2025
1992 - Risk to patient safety due to insufficient Medical staffing to volume of medical patients severe & inpatient acuity	Community & Integrated Medicine	Chief Operating Officer	20	4	31/10/2025	31/07/2025

*Movement in current risk score since previously reported to Committee will be denoted at the next report to QSEC.

Extreme Level Operational Risks Reportable to QSEC (Page 5 of 5)



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Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1349 - Risk of being unable to deliver ultrasound services at WGH due to a lack of appropriately trained obstetric staff	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	4	31/03/2028	26/08/2025
1256 - Risk to safety and management of hip fracture patients due to lack of Orthogeriatric service at GGH	Planned & Specialist Care	Chief Operating Officer	20	4	31/03/2026	04/09/2025
104 - Risk of avoidable infection from contaminated waste due to failed autoclave at WGH	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	1	31/03/2026	01/09/2025
1706 - Risk of loss of Nuclear Medicine Service due to decline in condition of equipment and failure to comply with NRW compliance.	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	1	30/07/2027	26/08/2025

*Movement in current risk score since previously reported to Committee will be denoted at the next report to QSEC in January 2026.

Risk Themes (1 of 2)



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Risk owners can assign 'themes' to risks on Datix, allowing risk information to be shared on specific areas with relevant subject matter experts within the Health Board. They in turn can offer specific support and guidance to risk owners in the management of risk and identify trends and areas of concern. Each risk theme is aligned to a specific and relevant committee or sub-committee to provide assurance that processes are in place to deliver a holistic approach to risk management. Theme owners are provided with a thematic risk register on a bi-monthly basis to identify trends, or risk clusters, and to consider whether there are gaps in controls in the Health Board's control framework, and to determine whether further action is required to prevent risks from materialising.

The following themes are currently aligned to QSEC as of September 2025:

Risk Theme	Definition	Number of risks
Business continuity /service disruption	A risk that threatens to disrupt the functioning of the organisation, typically caused by an untoward incident or disaster that has a negative impact on operations.	139
Consent and Mental Capacity	Risks relating to consent to examination or treatment e.g. missing, illegible, incorrect consent form; failure to obtain consent; mismatch between consent form and list etc. Risks relating to people who may lack mental capacity e.g. failure or concerns relating to assessment of decision-making capacity; acting in the person's best interests; consulting with those close to the person etc.	0
Deprivation of Liberty Safeguards (DoLS)	Risks relating to a failure to submit DoLS referral when needed, a person being deprived of their liberty when they have capacity to consent to be in hospital, a lack of awareness of what actions can and cannot be taken when a DoLS authorisation is in place (e.g. you can stop someone from absconding), DoLS doesn't give authority for care and treatment decisions, a patient with a DoLS authorisation can be discharged).	1
Fragile Services	A fragile service is one where there is a risk of a diminished service being delivered, or a service being unable to be delivered	189
Infection Control	An incident that may compromise the effectiveness of infection prevention and control measures, leading to staff and/ or patients being exposed to a confirmed or suspected pathogen increasing the likelihood of a transmission event and a healthcare acquired infection (HAI) or outbreak	25

Risk Themes (2 of 2)



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Risk Theme	Definition	Number of risks
Medical Devices	A risk related to a medical device or devices, including any instrument (other than a medicine) that is used to diagnose, monitor, treat or manage a medical condition. The definition covers a wide range of products including syringes, dressings, surgical tools, scanners, software, apparatus, machines and some medical apps.	35
Medication	A risk that involves the prescribing, dispensing or supply, administration or monitoring of medicines.	19
NICE / National Guidance	Risks related to the Health Board's ability to comply with evidence-based guidance for health and care.	33
Safeguarding	Safeguarding in its wider context is everyone's responsibility and we have duty of care to support children and adults. It is expected that services and professionals "own" their concerns and take responsibility for the work that needs to be done to keep individuals safe. This includes taking action before, during and after a safeguarding referral has been made. Should risks arise whereby children and adults may be put at risk due to gaps in service provision, or training compliance for example, then a safeguarding theme may be assigned to the risk.	28

The Assurance and Risk Team are working with the Interim Assistant Director of Nursing, Assurance and Safeguarding to review existing risk themes to re-align them to the revised quality and safety operational governance structure which underpins the newly established Quality and Safety Intelligence Group (QSIG). It is anticipated that risk themes will be agreed, and operational risks aligned to these on Datix during Q3 of 2025/26.

It will be the responsibility going forward of the relevant QSIG sub-group to review those operational risks aligned to them to oversee and monitor (second line of defence) to help ensure that operational leads (first line of defence) are effectively managing risks.

A thematic analysis will be provided to QSEC in February 2026, when operational risks are next due to be reported to the Committee.

Audits and Inspections - Overview



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The Health Board remains in Targeted Intervention (TI) (Level 4) status with Welsh Government (WG) as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for 'Governance' from TI (Level 4) to Enhanced Monitoring (Level 3), the Health Board must meet the revised criteria:

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan;
- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s; and
- The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW.

All reports from audits, inspections and reviews undertaken across the Health Board are logged and tracked on AMaT (Audit Management and Tracking), with progress updated by relevant service leads against each recommendation, with evidence required to be uploaded to demonstrating progress and implementation.

AMaT enables services to directly update progress against all recommendations via one central system, promoting a consistent approach with regards to processes and reporting, improvement in transparency and accountability, supporting services with their governance arrangements, and improvement in information flow.

Progress is monitored via the utilisation of a traffic light system based on performance against original completion dates.

Status	Explanation
Green	Recommendation has been confirmed as completed by the service / directorate lead (<i>AMAT Status: Complete and awaiting approval / Fully Complete</i>)
Amber	Recommendation is currently in progress, and within the agreed original timeframe for implementation (<i>AMAT Status: Partially Complete / In Progress</i>)
Red	Recommendation is in progress, but has exceeded its agreed original timeframe for implementation (i.e. overdue) (<i>AMAT Status: Overdue / Partially Complete (Overdue)</i>)
External	Recommendations considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation. Due to current system limitations, the action title has been amended to include the phrase "external" to denote this status.

Audits and Inspection reports assigned to QSEC

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There are currently 27 reports assigned to QSEC to enable them to undertake the following responsibility set out in their Terms of Reference:

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

HIW inspection activity is monitored by the Quality & Safety Team (QAST) and further detail is presented to QSEC via item 4.1 on the agenda (Quality Assurance Report).

Date of report	Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendations in original report	Red (behind schedule)	Amber (on schedule)	Green (complete)	External Recs	Any Barriers to Completion Noted?
Oct-19*	Delivery Unit	Review of Dermatology Services in Wales Hywel Dda University Health Board	Planned and Specialist Care	Chief Operating Officer	Sep-25	Sep-25	5	0	5	0	0	No barriers noted
Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Medical Director	Medical Director	Jul-23	N/K	7	0	0	2	5	Access to funding in an outbreak and awaiting completion of actions by PHW.
Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Sep-23	N/K	19	1	0	18	0	Recurrent and non-recurrent finance required
Apr-23	Peer Review	Out of Hours Peer Review	Primary Care, Community Strategy & Long Term Care	Chief Operating Officer	Dec-23	Dec-25	17	5	0	12	0	Lack of Urgent Primary Care Centre in HB.
May-23	HIW	Mental Health Discharge Review	Mental Health and Learning Disabilities	Chief Operating Officer	Mar-24	Oct-25	40	5	0	32	3	Awaiting publication of national standards

* Report was added to AMAT in August 2025 after its presentation to IQFPD by Planned and Specialist Care leads.

Audits and Inspection reports assigned to QSEC (Page 2 of 4)



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Date of report	Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendations in original report	Red (behind schedule)	Amber (on schedule)	Green (complete)	External Recs	Any Barriers to Completion Noted?
Jun-23	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return,	Planned and Specialist Care	Chief Operating Officer	Nov-22	N/K	10	0	0	9	1	No barriers noted
Sep-23	NHS Exec	Children and Young Person's Neurodevelopmental Services All Wales Review	Planned and Specialist Care	Chief Operating Officer	Nov-24	Oct-25	9	1	0	8	0	No barriers noted
Sep-23	HIW	Review of Psychology & Psychological Interventions for Children and Young People	Planned and Specialist Care	Chief Operating Officer	Dec-24	N/K	9	2	0	7	0	Consensus on the proposed pathway is still being finalised.
Oct-23	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-24	Oct-25	19	2	0	17	0	Fragility of current medical workforce capacity.
Oct-23	Peer Review	Cervical Screening Wales Quality Assurance Visit Report	Planned and Specialist Care	Chief Operating Officer	N/K	N/K	58	15	0	43	0	No barriers noted
Jan-24	HIW IRMER	Diagnostic Imaging x-ray department Withybush Hospital January 2024	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Apr-26	Apr-26	9	2	0	7	0	No barriers noted
Feb-24	HIW	Children and Young People Mental Health Review	Mental Health and Learning Disabilities	Chief Operating Officer	Feb-26	Feb-26	9	3	3	3	0	No barriers noted
Jun-24	Welsh Risk Pool	Welsh Risk Pool Concerns Assessment (December 2024)	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Mar-25	N/K	11	7	0	4	0	No barriers noted

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Date of report	Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendations in original report	Red (behind schedule)	Amber (on schedule)	Green (complete)	External Recs	Any Barriers to Completion Noted?
Jul-24	HIW	Glangwili Hospital – Morlais Ward	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-25	N/K	9	1	0	8	0	No barriers noted
Sep-24	Internal Audit	Bryngolau Ward, Prince Philip Hospital September 2024	Mental Health and Learning Disabilities	Chief Operating Officer	Aug-25	Sep-25	40	1	0	39	0	Lack of capacity to release workforce for training
Oct-24	Internal Audit	Falls Management Final Internal Audit Report October 2024	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	May-25	Dec-25	6	2	0	4	0	No barriers noted
Oct-24	HIW IRMER	IRMER Regulations	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Jul-25	N/K	9	2	0	7	0	No barriers noted
Jan-25	Internal Audit	Reinforced Autoclaved Aerated Concrete – Withybush General Hospital Final Report 2024/25	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	Mar-26	6	0	1	5	0	No barriers noted
Jan-25	Internal Audit	Learning Lessons Final Internal Audit Report 2024/25	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	May-25	N/K	4	2	0	2	0	No barriers noted
Jan-25	Internal Audit	Mortuary Services Final Internal Audit Report 2024/25 Swansea Bay University Health Board Hywel Dda University Health Board	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Mar-25	Mar-26	1	1	0	7	1	No barriers noted

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Date of report	Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendations in original report	Red (behind schedule)	Amber (on schedule)	Green (complete)	External Recs	Any Barriers to Completion Noted?
Mar-25	HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Mar-26	Mar-26	21	1	19	1	0	No barriers noted
May-25	HIW	HIW GGH Maternity Services	Planned and Specialist Care	Chief Operating Officer	Sep-26	Sep-26	13	4	6	3	0	No barriers noted
May-25	Internal Audit	Standards of Cleanliness Final Internal Audit Report 2024/25	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-25	Oct-25	6	0	2	4	0	No barriers noted
Jun-25	HIW	Nuclear Medicine IRMER WGH	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Apr-27	Apr-27	26	2	23	1	0	No barriers noted
Jun-25	Internal Audit	Discharge Management (Follow Up) Final Internal Audit Report 2024/25	Community & Integrated Medicine	Chief Operating Officer	Mar-25	N/K	1	1	0	0	0	No barriers noted
Jul-25	Internal Audit	Nursing Management Final Internal Audit Report 2025/26	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Sep-25	Sep-25	3	0	3	0	0	No barriers noted
Aug-25	HIW	Mynydd Mawr Ward, Prince Philip Hospital	Community & Integrated Medicine	Chief Operating Officer	Oct-25	Oct-25	3	2	1	0	0	No barriers noted



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

Risk Management

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

Audits, Inspections and Regulatory Reports

- **RECEIVE ASSURANCE** from the lead Executive Director or Supporting Officer on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations with any barriers to delivery noted.



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APPENDIX 1 - QSEC PRINCIPAL RISKS

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Oct-25	Trend	Target Risk Score (tolerable score)
1191	Underestimation of Excellence	Henwood, Mr Mark	Business objectives/projects	3×4=12	3×4=12	→	2×3=6
1195	Comprehensive early indicators of shortfalls in safety	Daniel, Sharon	Quality/Complaints/Audit	3×3=9	3×3=9	→	2×4=8
1189	Timely and sufficient learning, innovation and improvement	Daniel, Sharon	Business objectives/projects	3×3=9	2×3=6	↓	1×3=3
1184	Measuring how we improve patient and workforce experience	Daniel, Sharon	Finance inc. claims	2×4=8	3×2=6	↓	2×2=4

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? <small>(how many times will the adverse consequence being assessed actually be realised?)</small>	This will probably never happen/recur (except in very exceptional circumstances). Not expected to occur for years.*	Do not expect it to happen/recur but it is possible that it may do so. Expected to occur at least annually.*	It might happen or recur occasionally. Expected to occur at least monthly.*	It might happen or recur occasionally. Expected to occur at least weekly.*	It will undoubtedly happen/recur, possibly frequently. Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? <small>(what is the chance the adverse consequence will occur in a given reference period?)</small>	(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. Agency reportable incident. An event which impacts on a small number of patients.	Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	An event which impacts on a large 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.					

APPENDIX 1 - QSEC PRINCIPAL RISKS

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. Reduced performance levels if unresolved.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
			Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty. Improvement notices.	Prosecution. 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.

APPENDIX 1 - QSEC PRINICIPAL RISKS

Assurance Key:

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

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

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

APPENDIX 1 - QSEC PRINCIPAL RISKS

Date Risk Identified:	May-21
Strategic Objective:	3. Great Care

Executive Director Owner:	Henwood, Mr Mark	Date of Review:	Sep-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Dec-25

Risk ID:	1191	Principal Risk Description:	There is a risk that the Health Board has suboptimal ambition for our services. This is caused by an underestimation of excellence by the Health Board. This could lead to an impact/affect on our ability to recognise opportunities for improvement or relative deterioration in the quality of our services in the future, inability to improve recruitment and retention of the workforce, staff morale, poor patient experience or harm, poorer value healthcare and reduction of confidence from our stakeholders.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Business objectives/projects
Inherent Risk Score (L x I):	4x4=16
Current Risk Score (L x I):	3x4=12
Target Risk Score (L x I):	2x3=6
Expected Date To Achieve TRS:	
Trend:	↔

Date	Current Risk Score	Target Risk Score	Tolerance Level
Aug-21	12	6	6
Feb-22	12	6	6
Nov-22	16	6	6
Jun-23	16	6	6
Feb-24	12	6	6
Jun-24	12	6	6
Oct-24	12	6	6
Feb-25	12	6	6
Jun-25	12	6	6

Rationale for CURRENT Risk Score:

Striving for Excellence is a continuous process where the HB will always be looking to strengthen and maximise its clinical effectiveness systems and processes. The risk score has been reduced to reflect that the achievements that have been made in Value Based Healthcare, Research and Innovation and Clinical Effectiveness. Further work is required to embed this through job planning to enable protected SPA (Supporting Professional Activities) time for medics.

A multi professional workshop has been established, with initial meeting held in October 2024 to strengthen continuous improvement, talent management and progression of clinical teams across the Health Board.

Rationale for TARGET Risk Score:

As part of the current escalation framework (level 4 Targeted Intervention) there are key areas to address specifically to clinical engagement and leadership specifically to ensure that that clinical leadership is visible and effective; there is leadership development support in place and the consultant body as a whole is actively engaged in driving forward service improvement. A review of clinical leadership at all levels/capacity and capability/multi-professional working/empowerment of more junior staff identifying change champions and empower local leadership models will be completed as part of the Health Board's response to Targeted Intervention and will facilitate the Health Board to develop and deliver excellent services.

Assurance & Risk Officer has entered placeholder TRS date whilst undertaking housekeeping on this risk. Risk lead to input 'Expected date to achieve Target Risk Score' at next review.

APPENDIX 1 - QSEC PRINCIPAL RISKS

<p>support from teams across the quality system to identify gaps and improve services. # Multi-Professional Clinical Workshop, led by Clinical Executives</p>	<p>Based Health Care across the Health Board</p> <p>Development of governance arrangements to encompass the Value Based Health Care work being undertaken as part of the Mid Wales Health Collaborative</p> <p>Clinical services configuration and current resource constraints</p>	<p>Implement the Digital Strategic Plan</p> <p>A. To appoint a Commercial Transformation Partner arrangement to support with the implementation of large-scale digital transformation projects across the Health Board and the region</p> <p>B. To work with WG to secure funding for the roll-out of ePMA, and a patient flow and e-observation system.</p> <p>C. To implement the following key system developments: 1. Welsh Intensive Care Information System, 2. PROMs and PREMs system & 3. Hybrid print and post.</p> <p>D. To ensure that future planning is progressed for the following key system developments: 1. Re-procurement of the Laboratory Information Management System, 2. The Integrated Eye Care Electronic Health Record, 3. Development of a Community Information System & 4. E. Development of Maternity and Paediatric record systems. (PO 9)</p>	<p>Thomas, Huw -</p>	<p>31/03/2025</p>	<p>Complete as per highlight report presented to DDIC in April 2025.</p>
		<p>Review of the Medical Leadership Forum (MLF) to adopt the form of a 'working MLF' to reset, refocus and reignite the MLF to encourage continued engagement and generate an enthusiasm that is taken back into clinical teams.</p>	<p>Henwood, Mr Mark</p>	<p>31/03/2025 30/09/2025 30/11/2025</p>	<p>The review of Medical Leadership within Clinical Care Groups, aligned with the Chief Operating Officer's OCP process, is progressing. Associate Medical Directors (AMDs) have now been appointed, with recruitment for Clinical Directors and subsequently Clinical Leads to follow.</p> <p>Upon completion of the recruitment process, successful candidates will be co-opted onto the Medical Leadership Forum to support strategic clinical leadership.</p> <p>Due to the ongoing nature of the OCP, the September meeting of the Medical Leadership Forum has been stood down and will be rescheduled for November.</p>

APPENDIX 1 - QSEC PRINICPAL RISKS

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
See Our Outcomes section on the BAF Dashboard	# Participation in the NICE Welsh Health Network where specific guidelines are proposed for review on a national basis - to provide benchmark information	1st			Update ECPAP Reports to QSEC (Oct23) Effective Clinical Practice Strategic Plan for ratification to ECPAP (Sep22) Effective Clinical Practice Delivery Plan to ECPAP (Dec22)	Due to gaps in the historic system, it is not always possible to provide assurance to DCMO re: specific guidelines				
	# Senior management Team meeting monitor delivery of RDI activities and RDI Strategy/Plan	1st								
	# VBHC Programme Plan for rollout of PROM/PREM collection and capture of resource utilisation	1st								
	# Medical Leadership Forum	2nd								
	# VBHC facilitated Service Review Meetings with operational and clinical staff followed by presentation to Executive colleagues for action	2nd								
	# Reporting through the Effective Clinical Practice Advisory Panel and Clinical Standards and Guidelines Group	2nd								
	# Alignment with Health Board Quality and Governance Groups	2nd								
	# Responses to letters from Welsh Government (DCMO) relating to specific guidelines	2nd								
	# RDI Sub Committee & HCRW monitor delivery of RDI Strategy/Plan	2nd								

APPENDIX 1 - QSEC PRINICIPAL RISKS

# Board Committees & Executive Team (through its reporting groups) oversee delivery of Planning Objectives	2nd						
# Annual Performance Review by WG/HCRW	3rd						
# RDI Activity overseen by UK RD - Peer Review to review arrangements in place for research activities	3rd						
# IA on NICE Guidelines Follow-up (Reasonable Assurance)	3rd						
IA on Job Planning - May24 (Limited Assurance)	3rd						
# HCRW Annual Review of R&D (awaiting final report - positive verbal feedback to date)	3rd						

APPENDIX 1 - QSEC PRINCIPAL RISKS

Date Risk Identified:	May-21
Strategic Objective:	3. Great Care

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

Risk ID:	1195	Principal Risk Description:	There is a risk that the Health Board is not yet consistently recognising and reporting early indications of shortfalls in quality and safety across all services within the Health Board as required by the Quality and Engagement Act (which came in to force on 1st April 2023) This is caused by no comprehensive and consistent way of measuring safety aligned to the standards adopted by the Health Board for all the services we provide and commission on behalf of people requiring health care interventions. This could lead to an impact/affect on public and patient confidence, organisational reputation, positive patient reported outcomes.
Does this risk link to any Directorate (operational) risks?			1184

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4x4=16
Current Risk Score (L x I):	3x3=9
Target Risk Score (L x I):	2x4=8
Expected Date To Achieve TRS:	
Trend:	↔

Date	Current Risk Score	Target Risk Score	Tolerance Level
Aug-21	12	8	5
Jan-22	12	8	5
Oct-22	12	8	5
Jun-23	12	8	5
Mar-24	9	8	5
Sep-24	9	8	5
Jan-25	9	8	5
Apr-25	9	8	5
Aug-25	9	8	5

Rationale for CURRENT Risk Score:
Systems are not yet established to enable easy triangulation of data and there are still some gaps in information collection. Since 1st April 2023, the introduction of the Quality and Engagement Act has refreshed the focus on quality and safety through the 6 domains and internal metrics developments. These developments have facilitated discussions at the appropriate forums such as Board, Committees and local governance arrangements.

Rationale for TARGET Risk Score:
The target risk score is based on implementing a system to enable capture data across the breadth of our services with timely escalation reporting arrangements in place.

APPENDIX 1 - QSEC PRINCIPAL RISKS

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
<p>Range of performance measures/metrics in place</p> <p>Updated Datix Incident reporting system</p> <p>Standardised approach through a standard agenda in Quality Governance meetings</p> <p>CIVICA system is available and being rolled out to gain feedback to let us know issues in services</p> <p>Range of different mechanisms to capture feedback from service users and staff</p> <p>Speak Up Arrangements are in place, however further developing required in light of the Speak Up Framework as issued by Welsh Government in October 2023</p> <p>Listening and Learning Sub-Committee</p> <p>Quality, Safety and Experience Committee</p> <p>Clinical Audit Programme</p> <p>Quality Safety Intelligence Group</p> <p>External reports (HIW, HSE, MWWFRS, Peer Reviews, etc)</p> <p>Mortality Reviews and Medical Examiners Service</p> <p>National Accreditation Standards for service specifications</p> <p>6 Domains as noted in the Duty of Quality Act (STEEEP)</p> <p>PROMS and PREMs in identified services</p>	<p>There is no standardised way of joining existing systems in place</p> <p>Ability to triangulate sources of data and provide meaningful analysis</p> <p>Not all services have clear pathways and variance trackers in place to enable consistent monitoring and interpretation to enable rationale for variance.</p> <p>Consistent interrogation and reporting of data within RL Datix Incident Reporting system is not yet embedded, resulting in lack of staff confidence in reporting incidents.</p> <p>Not yet consistently using the information from PROMs, PREMs and FROMs as part of triangulation process</p>	<p>Further action necessary to address the controls gaps</p> <p>Urgent and Emergency Care / 6 Goals Programme - UEC / Implement the Six Goals To develop and implement a plan to by March 2025 to deliver Ministerial priorities by 2026</p> <p>1. Delivery and Implementation of a 24/7 Urgent Care Service, accessible via 111 Wales, to support improved access and GMS sustainability. 2. Implementation of Same Day Emergency Care services /direct access pathways. 3. Improving patient flow through the acute sites. 4. Develop a strategy for our Alternative Care Provision to support care closer to home. 5. Minimise delays in hospital discharge due to assessment-related issues within Pathways of Care. 6. Improve the effectiveness and efficiency of community services, with an emphasis on avoiding unnecessary hospital admissions and facilitating timely discharges</p> <p>(PO 3)</p> <p>Improve Planned Care and Cancer performance, with a focus on reducing the longest waits, and reduce the 8 week wait for diagnostics. (PO4)</p> <p>Mental Health and Learning Disabilities service improvement though:</p> <p>1. Mental Health Recovery Programme Optimisation</p> <p>2. Section 136</p> <p>3. Redesign the End-to-End Inpatient and Community Pathway</p> <p>(PO 5)</p>	<p>Carruthers, Andrew</p> <p>Carruthers, Andrew</p> <p>Carruthers, Andrew</p>	<p>31/03/2025</p> <p>31/03/2025</p> <p>31/03/2025</p>	<p>On track as per highlight report presented to FPC in June 2025.</p> <p>Behind schedule as per highlight report presented to FPC in June 2025.</p> <p>On track as per highlight report presented to FPC in June 2025.</p>

APPENDIX 1 - QSEC PRINICIPAL RISKS

<p>Directorate and Service Quality Governance Meetings established</p> <p>Directorate Improving Together Sessions</p> <p>Increased quality element of commissioned services from external organisations</p> <p>Harms Dashboard and our Performance Dashboard in place to facilitate triangulation of data with other intelligence, eg weekly hot and happening meetings.</p> <p>Quality Impact Assessments process now in place</p> <p>Quality Management System now in place</p> <p>Increased use of AMAT across the Health Board to track the implementation of recommendations raised.</p>		<p>To provide a set of plans for key clinical services to address critical sustainability risks up to the future hospital network. (PO 6)</p>	<p>Davies, Lee</p>	<p>31/03/2025</p>	<p>On track as per highlight report presented to SPC in June 2025.</p>
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ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
See Our Outcomes section of the BAF Dashboard	Quality and Safety Intelligence Group	2nd	 		Patient Experience Report - every Board (May24)	Assurance on triangulation of data				
	Directorate Quality Governance Meetings in place	2nd	 							
	Patient and staff feedback	2nd	 							
	Harms Dashboard is reported monthly to Formal Executive team with Our Performance and other intelligence for triangulation of data	2nd	 							
	Improving Together performance sessions with clinical and corporate directorates aligned to the Internal Escalation Framework	2nd	 							
	Performance reports through power BI and Committee reports	2nd	 							
					Healthcare Contracting Update - SRC (Aug22)					
					QIA - QSEC (Oct 23)					
					Quality and Commissioning Update - QSEC (Oct 23)					

APPENDIX 1 - QSEC PRINICIPAL RISKS

PTHB/HDUHB LTA/CQPR Meeting and Hywel Dda & SBU (SLA & LTA) Meetings to review quality aspects from commissioning arrangements	2nd						
Commissioning arrangements overseen by Sustainable Resources Committee (SRC)	2nd						
GIRFT Reports reported to QSEC	2nd						
Quality Impact Assessments and Panel	2nd						
HIW patient complaints	3rd						
Quality Governance Follow up Report (Oct21)	3rd						
Annual Structured Assessments by Audit Wales	3rd						
Internal audit on Safety Indicators (Reasonable Assurance)	3rd						
Internal Audit plans which include reviewing Quality Governance	3rd						

Date Risk Identified:	May-21
Strategic Objective:	3. Great Care

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

Risk ID:	1189	Principal Risk Description:	There is a risk that services fail to learn, innovate and improve to a sufficient level in a timely manner. This is caused by a culture that does not facilitate learning (mindset); that skills are not developed across the organisation to implement the approach (skillset) and that the systems required to support the rollout are not implemented (toolset). This could lead to an impact/affect on services failing to see evidence of continuous improvement.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Business objectives/projects
Inherent Risk Score (L x I):	3x4=12
Current Risk Score (L x I):	2x3=6
Target Risk Score (L x I):	2x3=6
Expected Date To Achieve TRS:	01/01/1900
Trend:	↔

Month	Current Risk Score	Target Risk Score	Tolerance Level
Aug-21	9	6	5
Jan-22	9	6	5
Jun-22	12	6	5
Feb-23	9	6	5
Oct-23	9	6	5
Feb-24	9	6	5
Jun-24	9	6	5
Oct-24	9	6	5
Feb-25	9	6	5
Jun-25	9	6	5
Sep-25	6	6	5

Rationale for CURRENT Risk Score:

The current risk score reflects the fact that the organisation has existing processes in place to value and embed learning and improvement but that it is not comprehensive. This means we may miss opportunities to enhance the care we provide and create a supportive environment for staff to develop and grow. There is increasing evidence that the mindset of the organisation is focussed on learning, the skillset is developing quickly, particularly in areas such as EQIIP, Improving Together and Research, Innovation and Development, however further work is required to strengthen our toolset. Operational pressures are also likely to be causing challenges for people to enact change or improvement in their areas however Improving Together sessions with Directorates have facilitated and helped to embed learning and improvement which has enabled an overall score of 9 to be maintained.

The new internal Escalation Framework is helping to improve learning and drive improvements in areas where performance issues are identified.

There has been progress in more timely responses to ability to address our audit, inspectorate and regulatory requirements at pace, through CCG ownership and use of AMAT.

The new Health and care quality standards have been embedded within reporting requirements and quality impact assessment.

The use of the IPAR, Our Performance, Our Safety dashboard has improved the way data is used at operational and strategic levels. Data is available.

Rationale for TARGET Risk Score:

3 of our 6 strategic objectives are people-focussed and are aimed at making the Health Board a great place to work and receive care. The Board will be focussing on this for the long term which would result in an organisation which has learning, innovation and improvement threaded through everything it does.

Assurance & Risk Officer has entered placeholder TRS date whilst undertaking housekeeping on this risk. Risk lead to input 'Expected date to achieve Target Risk Score' at next review.







01/10/2025 Risk reviewed by EDON and IADON, Assurance and Safeguarding. Target likelihood reviewed.

This risk needs a full review and consideration of whether the risk remains and what new mitigations are in place

CORPORATE RISK REGISTER SUMMARY OCTOBER 2025

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
<p>Risk Management Framework and Board Assurance Framework (BAF)</p> <p>Established governance structures</p> <p>Established Assurance Trackers for audits, inspectorates & regulators, Welsh Health Circulars, Ministerial Directions</p> <p>Healthcare Standards (HCS) 6 Domains of Quality embedded within governance framework to improve clinical quality and patient experience</p> <p>Research, Development and Innovation Strategy approved by QSEC</p> <p>The Improving Together programme which aims to shift the organisation from one that manages performance to one that manages quality and embeds an improvement culture into all of its working arrangements</p> <p>Quality framework, with the Enabling Quality Improvement in Practice (EQIIP) programme, improvement coach development programme and access to supporting resources/ teams (QIST/ VBHC/ TPO/ PMO/ OD/ workforce/ R&D etc)</p> <p>Effective clinical practice (Clinical Audit, Clinical Standards and Guidance, Clinical Written Control Documents, Mortality Reviews etc)</p> <p>OD Cultural Plans</p> <p>A comprehensive range of Leadership Development pathways in place to create cohorts of leaders (includes Medical Leadership Programme, Clinical Leads Forum, Consultant Programme, HEIW Clinical Leadership Programme, LEAP, CLIMB and increased coaching capacity)</p> <p>Quality Impact Assessment process and panel and Quality Safety Intelligence Group</p>	<p>Staff not being clear of the expectation of their contribution to the delivery of the strategic objectives/planning objectives</p>	<p>Improve Planned Care and Cancer performance, with a focus on reducing the longest waits, and reduce the 8 week wait for diagnostics. (PO4)</p>	<p>Carruthers, Andrew</p>	<p>31/03/2025</p>	<p>Behind schedule as per highlight report presented to FPC in June 2025.</p>
	<p>Having an effective process to find new opportunities to improve what the HB does and how it does it through new POs and enablers</p>	<p>To provide a set of plans for key clinical services to address critical sustainability risks up to the future hospital network. (PO 6)</p>	<p>Davies, Lee</p>	<p>31/03/2025</p>	<p>On track as per highlight report presented to SPC in June 2025.</p>
	<p>Alignment of BAF to strategic objectives</p> <p>Having ambitious comprehensive RDI programme</p> <p>Having an effective process to collate and disseminate learning across the organisation</p> <p>Cohesive engagement and capacity of operational teams to engage in programmes listed in the 'key controls'</p>	<p>Implement the Digital Strategic Plan. A. To appoint a Commercial Transformation Partner arrangement to support with the implementation of large-scale digital transformation projects across the Health Board and the region B. To work with WG to secure funding for the roll-out of ePMA, and a patient flow and e-observation system. C. To implement the following key system developments: 1. Welsh Intensive Care Information System, 2. PROMs and PREMs system & 3. Hybrid print and post. D. To ensure that future planning is progressed for the following key system developments: 1. Re-procurement of the Laboratory Information Management System, 2. The Integrated Eye Care Electronic Health Record, 3. Development of a Community Information System & 4. E. Development of Maternity and Paediatric record systems. (PO 9)</p>	<p>Thomas, Huw -</p>	<p>31/03/2025</p>	<p>Complete as per highlight report presented to DDIC in April 2025.</p>

		Urgent and Emergency Care (UEC) / 6 Goals Programme - Implement the Six Goals To develop and implement a plan to by March 2025 to deliver Ministerial priorities by 2026 1. Delivery and Implementation of a 24/7 Urgent Care Service, accessible via 111 Wales, to support improved access and GMS sustainability. 2. Implementation of Same Day Emergency Care services /direct access pathways. 3. Improving patient flow through the acute sites. 4. Develop a strategy for our Alternative Care Provision to support care closer to home. 5. Minimise delays in hospital discharge due to assessment-related issues within Pathways of Care. 6. Improve the effectiveness and efficiency of community services, with an emphasis on avoiding unnecessary hospital admissions and facilitating timely discharges (PO 3)	Carruthers, Andrew	31/03/2025	On track as per highlight report presented to FPC in June 2025.
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ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance  Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
See Our Outcomes section of BAF Dashboard	Tracker Performance reports issued to Lead Directors on bi-monthly basis	1st			Tracker Report - every ARAC Strategic Business intelligence - Board (Aug21)	Assurance arrangements for overseeing development and delivery of BI and modelling				
	Committee oversight of delivery of WHCs and MDs	2nd								
	ARAC oversight of Audit Tracker	2nd								
	RD&I Sub Committee overseeing delivery and success of RDI Strategy	2nd								

CORPORATE RISK REGISTER SUMMARY OCTOBER 2025

IQPFD overseeing quality performance	2nd						
Quality Impact Assessment Panel reporting to QSEC	2nd						
Quality and Safety Intelligence Group	2nd						
Internal Quality & Engagement Act Implementation Group	2nd						
Directorate Improving Together Sessions aligned to the internal Escalation Framework (Bi-monthly)	2nd						
IA Health and Care Standards to review adequate procedures in place to ensure, and monitor, effective utilisation of the standards to improve clinical quality and patient experience -Reasonable Assurance (Feb21)	3rd						
AW & IA Plan includes annual review of risk management arrangements & BAF	3rd						

Date Risk Identified:	Apr-21
Strategic Objective:	3. Great Care

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

Risk ID:	1184	Principal Risk Description:	There is a risk that the Health Board will not be able to measure whether the transformational changes it is investing in are improving the experience for our workforce and the delivery of care, and will enable it to meet or exceed patient and families expectations. This is caused by the lack of an effective, systematic way to continuously engage with and capture feedback from our workforce, patients and public across the breadth of our services. This could lead to an impact/affect on poor patient experience, poor staff experience, lack of public confidence, missed opportunities and the inability to offer patients and staff a great experience.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
Inherent Risk Score (L x I):	4x4=16
Current Risk Score (L x I):	2x3=6
Target Risk Score (L x I):	2x2=4
Expected Date To Achieve TRS:	01/01/1900
Trend:	↔

Rationale for CURRENT Risk Score:
 The current risk score reflects the current maturity level of formal mechanisms to triangulate different sources of engagement and feedback from public, patients and staff across Hywel Dda. The information being used in Improving Together, Escalation and QSIG sessions/meetings which requires further development of dashboards requires further embedding, however this is facilitating a conversation regarding the utilisation of various metrics better.
 Value opportunities framework is embedded with EQIIP, and embedded into all service change and transformation activity.

Rationale for TARGET Risk Score:
 Target score is predicated on developing the mechanisms to support the triangulation of various pieces feedback and quality and safety metrics.
 Assurance & Risk Officer has entered placeholder TRS date whilst undertaking housekeeping on this risk. Risk lead to input 'Expected date to achieve Target Risk Score' at next review.

CORPORATE RISK REGISTER SUMMARY OCTOBER 2025

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
<p>Central Communication Hub in place with workstreams established supporting 27 operational teams in communicating with patients</p> <p>Central Communication Hub lead appointed</p> <p>Civica system capturing feedback from patients implemented, with significant roll out across services</p> <p>Change mechanisms established through improvement and transformation programmes with direct impact on how clinical services are structured linked to CSP</p> <p>Organisational Development Relationship Managers to influence the culture change journey and support the creation of transformational and compassionate culture within the Health Board, and actively work with services</p> <p>Methodology to manage change with services to facilitate clinical engagement and pace of delivery (Engagement Team, Quality Improvement Team and Transformation Team) underpinned by the Safe Care Collaborative and 6 Goals Urgent and Emergency Care programme of work</p> <p>Waiting List Support Programme (WLSP) Plan with workstreams established to support continued engagement with clinical staff and services following the National 3 Ps policy and directly supporting patients on waiting lists</p>	<p>Communications Hub and WLSP in place but further consideration needed to identify other areas that will benefit.</p> <p>Routine periodic reporting during and after service change to reflect on the impact /improvement to patients, staff and performance remains in its infancy.</p> <p>No agreed method of aligning PROMs, PREMs and other measures to service change or development</p> <p>Whilst there have been developments in the collection of data, work remains in order to strengthen the triangulation of qualitative data collected.</p>	<p>To achieve workforce sustainability through the delivery of workforce planning, recruitment, retention, and development, and effectiveness initiatives.</p> <p>1.Develop a Workforce Plan which sets out actions to achieve a balance between workforce demand and supply, supporting workforce stabilisation.</p> <p>2. Delivery of a targeted Recruitment Plan which will reduce reliance on high cost agency staff through substantive recruitment (supply-side) supporting the Workforce Plan.</p> <p>3. Delivery of a Retention Plan to support the supply side elements of the Workforce Plan and underpin workforce stabilisation. 4.Delivery of a Workforce Education and Development Plan which supports the pipeline (supplieside) for staff progression. (PO 1)</p>	Gostling, Lisa	31/03/2025	On track as per highlight report presented to PODCC in May 2025.
		To provide a set of plans for key clinical services to address critical sustainability risks up to the future hospital network. (PO 6)	Davies, Lee	31/03/2025	On track as per highlight report presented to SPC in June 2025.

CORPORATE RISK REGISTER SUMMARY OCTOBER 2025

<p>WLSP Phased Iterative Implementation Plan which is regularly reviewed</p> <p>Ongoing evaluation of WLSP now in place following initial evaluation to inform programme development</p> <p>Power BI Performance dashboards on IRIS</p> <p>Engagement in place with Llais Cymru (formal and informal arrangements in place)</p> <p>Staff Partnership Forum (UHB and County Partnership Forums)</p> <p>Mechanism in place to ensure charitable funding applications demonstrate impact through agreed evaluation and metrics</p> <p>Engagement Team facilitate stakeholder events to capture population feedback on consultations and key workstreams</p> <p>Harms Dashboard and our Performance Dashboard in place to facilitate triangulation of data with other intelligence, eg weekly quality intelligence / surveillance meetings</p> <p>Health Board wide Improving Together Sessions in place, which utilise dashboards</p>	<p>Transforming Urgent and Emergency Care (TUEC) Programme - TUEC / Implement the Six Goals To develop and implement a plan to by March 2024 to deliver Ministerial priorities by 2026</p> <ol style="list-style-type: none"> 1. Delivery and Implementation of a 24/7 Urgent Care Service, accessible via 111 Wales, to support improved access and GMS sustainability. 2. Implementation of Same Day Emergency Care services /direct access pathways. 3. Improving patient flow through the acute sites. 4. Develop a strategy for our Alternative Care Provision to support care closer to home. 5. Minimise delays in hospital discharge due to assessment-related issues within Pathways of Care. 6. Improve the effectiveness and efficiency of community services, with an emphasis on avoiding unnecessary hospital admissions and facilitating timely discharges <p>(PO 3)</p>	<p>Carruthers, Andrew</p>	<p>31/03/2025</p>	<p>On track as per highlight report presented to FPC in June 2025.</p>
<p>Staff Surveys and Pulse Surveys undertaken regularly to evaluate staff experience, and reported to People, Organisational Development and Culture Committee</p> <p>Quality Impact Assessments introduced and reported to Quality, Safety and Experience Committee.</p> <p>A system has been developed to support triangulation of data d. Performance Team are actively working on mechanism to facilitate easier triangulation.</p>	<p>Implement the Digital Strategic Plan</p> <ol style="list-style-type: none"> A. To appoint a Commercial Transformation Partner arrangement to support with the implementation of large-scale digital transformation projects across the Health Board and the region. B. To work with WG to secure funding for the roll-out of ePMA, and a patient flow and e-observation system. C. To implement the following key system developments: 1. Welsh Intensive Care Information System, 2. PROMs and PREMs system & 3. Hybrid print and post. D. To ensure that future planning is progressed for the following key system developments: 1. Re-procurement of the Laboratory Information Management System, 2. The Integrated Eye Care Electronic Health Record, 3. Development of a Community Information System & 4. Development of Maternity and Paediatric record systems. (PO 9) 	<p>Thomas, Huw -</p>	<p>31/03/2025</p>	<p>Complete as per highlight report presented to DDIC in April 2025.</p>

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
See Our Outcomes section of BAF Dashboard	Pulse surveys sampling 1000 employees each month, selecting different staff each month	1st			Single Point of Contact Report Board (Mar21) Patient Experience Report - every Board (May24) Periodic update reports to Executive Team on the impact of the Communication Hub and WLSP Staff Feedback Reports - PODCC QIA reported to QSEC (Sep23)	Routine reporting of triangulated performance metrics				
	Communication Hub and WLSP Steering Group overseeing delivery of the plan and the workstreams	2nd								
	Improving Together performance sessions with clinical and corporate directorates aligned to the Internal Escalation Framework	2nd								
	Formal Executive Team review and triangulate data from the Harms Dashboard, Our Performance Dashboards and other intelligence	2nd								
	Communication Hub Steering Group	2nd								
	Executive Team, through its reporting groups, oversee delivery of Planning Objectives	2nd								
	Board Committee oversight of Planning Objectives	2nd								
	Patient Experience Report to every Board	2nd								

CORPORATE RISK REGISTER SUMMARY OCTOBER 2025

Listening and Learning Sub Committee oversight of patient experience	2nd						
Periodic reporting of engagement index survey results to People, OD and Culture Committee and Board (from Nov21)	2nd						
Public Service Ombudsman for Wales Reports	3rd						
HIW Inspection Reports and Complaints, including implementation of recommendations	3rd						