Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	09 April 2024
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risks Assigned to the Quality, Safety and Experience Committee (QSEC)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Director of Operations Jill Paterson, Director of Primary Care, Community & Long Term Care Dr Ardiana Gjini, Director of Public Health Mr Mark Henwood, Interim Executive Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Director of Corporate Governance Charlotte Wilmshurst, Assistant Director of Assurance and Risk

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

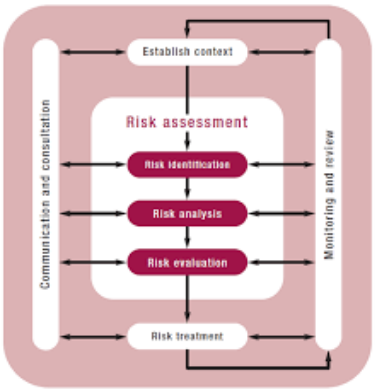
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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



(Risk Management Process, ISO 31000)

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

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

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

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

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

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

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

Asesiad / Assessment

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

The Terms of Reference state that:

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

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

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

There are 11 risks currently aligned to QSEC (out of the 20 that are currently on the CRR) as the potential impacts of the risks relate to the safety of patients, quality of services and patient outcomes. A summary of corporate risks can be found at Appendix 2.

Each of these risks have been entered onto a 'risk on a page' template, which includes information relating to the strategic objective, controls, assurances, performance indicators and action plans to address any gaps in controls and assurances. These can be found at Appendix 3.

Changes since the previous report to QSEC (December 2023):
The Committee is requested to seek assurance from risk owners (Executive Directors) that each risk is being managed effectively and will be brought within the UHB tolerance.

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

Total Number of Open Risks	11	
New Risks Being Reported	2	*See note 1*
De-escalated/Closed Risks	0	
Increase in Risk Score ↑	1	*See note 2*
Decrease in Risk Score ↓	2	*See note 3*
No Change in Risk Score →	6	*See note 4*

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

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	**RARE 1**	**UNLIKELY 2**	**POSSIBLE 3**	**LIKELY 4**	**ALMOST CERTAIN 5**
CATASTROPHIC 5			1531 (↓)	1810 (NEW)	
MAJOR 4				684(→) 1708 (→) 1812 (NEW)	797 (→) 1027(→) 1032 (→) 1664 (→) 1699 (↓)
MODERATE 3					1548 (↑)
MINOR 2					
NEGLIGIBLE 1					

Note 1- New risks being reported:
Since the previous report, 2 new risks have been added to the Corporate Risk Register:

Risk Reference & Title	Date risk identified	Lead Director	Current risk score	Update	Target Risk Score
1810 - Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS). **NEW** *(added 20/02/24)*	01/02/24	Director of Primary Care, Community & Long Term Care	**4×5=20** (Reviewed 20/02/24)	The facilities of Withybush General Hospital (WGH) aseptic unit are currently non-compliant with regulatory standards. The unit is subject to external audit by the National Pharmacy Quality Assurance Lead and the facilities were identified as being a high risk to patient safety in 2019. The most recent audit performed in February 2023 confirmed the facilities remain a high risk, and the unit is at risk of forced closure. The pharmacy aseptic unit based at Glangwili General Hospital (GGH) was forced to close in December 2018 as the facilities were deemed a risk to patient safety. Short term control measures have been implemented by the Health Board to reduce the risk of immediate forced closure. However, as the unit and equipment are beyond their useful expected life, there will come a time where the control measures will no longer be sufficient to allow the safe running of the unit. If the unit was forced to close, the Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. Some cancer treatments cannot be outsourced due to their short shelf life. There were 345 reported service and quality-related incidents (e.g. delayed or failed deliveries) linked to outsourcing from commercial suppliers between September 2022 and August 2023 at Hywel Dda. Without a functioning aseptic unit, the Health Board could not offer	**1x5=5**

				over 500 cancer treatments each year, and further treatments would be delayed/cancelled due to supplier service failures. A business case for the demountable unit at WGH was submitted to Welsh Government (WG) in February 2023. The business case also requested funding to convert the current aseptic unit into drug storage facilities. Based on budget cost estimates of £2.89m, the submission was for review and scrutiny by WG to provide assurance to the Health Board before resourcing, and underwriting the financial risk, of progressing a detailed design for tendering. In September 2023, WG requested submission of a fully tendered business justification case, which is currently being worked up by the Health Board. As part of the Transforming Access to Medicines (TrAMS) project programme, a regional manufacturing hub will be built in South West Wales that will prepare cancer therapy for Hywel Dda patients. The hub was originally estimated to open during 2028, however there have been delays to the project plan and the opening date is currently unknown. There is therefore a high risk that the current aseptic unit at WGH will be forced to close before the South West TrAMS manufacturing hub is operational. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality.	

1812 - Risk of non-compliance with Medical Examiners (Wales) Regulations due to the failure to fully resource internal processes **NEW** *(added on 27/02/24)*	16/11/21	Interim Executive Medical Director	**4x4=16** (Reviewed 27/02/24)	New processes are in place for mortality reviews in line with the All Wales Learning from Mortality Framework, supported by the Clinical Lead for Mortality and Mortality Review and Improvement Facilitator. However, these are not fully embedded across all acute sites due to the issues with scanning capacity. The risk score of 16 reflects additional resource requirements for the successful rollout at GGH ahead of the statutory introduction of the Medical Examiner Service, and the proximity to the statutory introduction in April 2024. GGH remains fragile and WGH has experienced some fragility due to long term absences within the team. There is currently insufficient scanning capacity to enable the scanning and sending of case notes to the Medical Examiner Service to enable the full roll-out to GGH wards. GGH scanning staff are currently scanning all of Prince Philip Hospital (PPH) case notes and a proportion of GGH (all Medical Wards and one Surgical). There is therefore an inability to complete the roll-out to GGH ahead of the statutory introduction of the Medical Examiner Service in April 2024. In addition, there is a lack of sufficient clinician capacity across all disciplines to screen Medical Examiner Service letters, which is causing a backlog that has the potential for urgent concerns highlighted by the Medical Examiner not being addressed.	**2x2=4**

Note 2 – Increase in risk score:

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

Risk Reference & Title	Date risk identified	Lead Director	Previous Risk Score	Current Risk Score	Update	Target Risk Score
1548 - Risk to the Health Board maintaining service provision due to industrial action	09/11/22	Executive Director of Public Health	**4x3=12**	**3x5=15** (Reviewed 07/02/24)	The British Medical Association (BMA) have declined an offer of 5% uplift (1.5% uplift for Junior Doctors including SAS Doctors) for 2023/24 to basic pay. Ballot notices were received by employers (both Hywel Dda University Health Board and NHS Wales Shared Services Partnership (NWSSP)) detailing that the ballot to members would run until 18 December 2023. This applied to Junior Doctors only. Confirmation was received that the BMA reached the 50% threshold required to mandate action for the period 8 January - 17 June 2024. Mitigation and contingency measures, together with command and control structures put in place during periods of previous action by Trade Unions resulted in a co-ordinated response to minimise impact as far as possible, and this has been re-established. Following the first round of industrial action held from 15-18 January 2024, the BMA have advised that they intend to take further 72 hours consecutive period of industrial action from 7am on 21 February to 7am on 24 February 2024 (taking us in to a weekend period). This will be a full walk out of all	**2x3=6**

					junior doctors including those providing emergency cover. The ballot relating to the Specialty and Specialist (SAS) Doctors and Consultants closes on 4 March 2024. No formal notice has been received from the British Dental Association (BDA) notifying of their intention to ballot members. However, other Health Boards and the Single Lead Employer (SLE) have received this notification. The SLE have now confirmed that the BDA members in the Health Board were not part of the ballot process.		

Note 3 – Decrease in risk score:
There have been decreases in current risk scores of the following risks since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Previous Risk Score	Current Risk Score	Update	Target Risk Score
1699 - Risk of loss of service capacity at WGH due to surveys and remedial work relating to reinforced autoclaved aerated concrete (RAAC)	13/06/23	Director of Operations	**5x5=25**	**4x5=20** (Reviewed 29/02/24)	The major internal incident was stood down on 19 January 2024, with updates now provided to Executive Team via the RAAC Control Group. Following the closure of Cleddau West at South Pembrokeshire Hospital and the re-opening of Wards 7, 9, 11 and 12, it is considered that the risk to inpatient services identified on August 25 2023 has been sufficiently mitigated to allow for the de-escalation of the Internal Major incident. Detailed surveys completed in Wards 7, 8/CCU, 10, 11 and 12. Works	**2x5=10**

					scheduled to complete the remaining two wards on the 22 March 2024 with re-opening planned for the 1 April 2024. Works completed in Wards 9 & 12 and reoccupied as medical capacity from 5 October & 9 November 2023. Throughput of inpatient elective surgery, as would ordinarily be delivered from ward 9, remains low with same day admission pathway to Day Surgery Unit (DSU). Medical patients vacated the DSU footprint on 5 October 2023 when it returned to service with resumption of day case surgery on site. Medical patients withdrawn from the Pembrokeshire Haematology and Oncology Day Unit (PHODU) in November following reopening of Ward 12. This enabled reinstatement of full service to PHODU. Remedial works started in Ward 11 in October 2023, and completed in December 2023. The suitability of this area to be utilised as outpatient and/or therapy capacity is being scoped. Visual survey in Outpatients A has identified significant RAAC related issues (P1 planks). Detailed survey completed on 10 November 2023 with remedial works to follow, scheduled to return to service at end of June 2024. Alternative locations for outpatient provision being		

					coordinated and scoped by scheduled care directorate. Schedule for detailed survey programme for ground floor areas developed with programme to complete by March 31 2024. Remedial works to follow detailed survey in physiotherapy area, resulting in need to decant from February until the end of June 2024.		
1531 - Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	10/11/22	Director of Operations	**4x5=20**	**3x5=15** (Reviewed 19/02/24)	The risk score has remained the same, due to the Medacs locum allowing the surgical emergency service at WGH, to continue on a 1:4, 24/7 rota with 2 substantive consultants, 1 NHS locum and 1 Medacs locum. The 1:4 rota has been in place since 3 November 2023, with no issues to date. The rota remains fragile due to the reliance on Medacs locum cover and the cost and risks that this involves. An NHS locum consultant was appointed in November 2023, but has since withdrawn There will now be a continued reliance on Medacs locum cover. The speciality doctor rota is also being supported by a Medacs locum due to 2 vacancies on the 1:5 rota. Discussions are being held about reducing the rota to a 1:5 and re-advertising 1 Whole Time Equivalent (WTE) as an exit strategy to the Medacs doctor.	**2x5=10**	

Note 4 - No change in risk score:

There have been no changes to the 6 risk scores included in the table below since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Current Risk Score	Update	Target Risk Score
1027 - Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	19/11/20	Director of Operations	**4x5=20** (Reviewed 19/03/24)	Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. This is driven by post pandemic demand and the broader impacts of COVID-19. Workforce deficits, handover delays, 4 and 12 hour performance, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating significantly worrying trends. The indirect legacy of the pandemic has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains at high levels of risk escalation across our acute sites on a daily basis. Notwithstanding these challenges, whilst positive progress has been achieved during 2023 in reducing peak levels of pressure with notable improvements achieved in key urgent and emergency care (UEC) pathway metrics relating to ambulance handover and emergency departments (ED) waiting times; this has not been sustained through the winter 2023/24 period, with a significant re-emergence of system-wide capacity pressures. Notwithstanding continuing progress in delivering the	**3x4=12**

				Health Boards TUEC (Transforming Urgent and Emergency Care) objectives, there has been a notable increase in the volume of patients with lengths of stay (LOS) in excess of 21 days across all hospital locations during this period. With specific reference to Withybush Hospital, UEC performance has been significantly impacted since the summer of 2023 due to the extent to which the RAAC infrastructure improvement project has reduced capacity. Consequently the risk score remains unchanged as at March 2024.	
1032 - Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	02/11/20	Director of Operations	**5x4=20** (Reviewed 20/02/24)	The service is experiencing significant waiting times as a result of increasing demand levels which are exceeding pre-pandemic levels, compounding the backlog due to Covid restrictions. Due to increasing Did Not Attend (DNA) rates, ongoing recruitment challenges and increasing demand, there is an impact on the services' ability to see the same volume of service users as they were previously able to. Some posts continue to be funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff. As at 31 January 2024, there are currently 3,025 (Oct 23: 2,478) clients on the waiting lists, with 2,614 waiting longer than 26	**3x4=12**

				weeks. The average wait has increased from 74 to 92 weeks. For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit (DU) to establish trajectories, along with the commissioned service which since have been agreed in March 2023. The DU were unable to provide trajectories, therefore Health Board has agreed to a 1% trajectory. For psychological services a trajectory is now in place for 1% per month. On the basis of an improved Child and Adolescent Mental Health Services (CAMHS) Part 1 position and a deterioration in ASD/ Attention deficit hyperactivity disorder (ADHD), the risk score remains the same.	
797 - Risk to the ability to deliver ultrasound services due to workforce pressures	07/11/19	Director of Operations	**5x4=20** (Reviewed 09/02/24)	Despite best efforts, the service remains fragile. There are still vacancies which remain unfilled, but there has been an improvement in recruitment due to the financial picture across Wales and the cessation of use of agency staff above Agenda for Change (AFC) pay rates. Even if all vacancies were recruited to, the Health Board would still not have the capacity to meet current demand (as at February 2024, there are 1288 patients waiting over 8 weeks for non-obstetric ultrasound (Dec 2023: 1547), with the reduction a result from the use of insourcing).	**3x4=12**

				Long term vacancies exist in WGH. There are 2 potential retirements at PPH in the near future and a number in Bronglais General Hospital (BGH), which constitute a significant percentage of the workforce, though there are maternity returns due back in the near future. There will be an inability to secure agency staff due to the current financial climate of the Health Board. Whilst a modality lead at WGH has been appointed and commenced in November 2023, the ability to undertake governance and audit requirements still needs to be embedded, however it is noted that a Radiology Ultrasound Governance group has been set up in June 2023. More sonographers are due to be trained from January 2024, however training takes two years to complete. 3 of the 4 vacancies as advertised in July 2023 were successfully appointed to, though this has not resulted in additional capacity to the service as roles have been given to previous locum staff.	
1664 - Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmolog-ists and the inability to recruit	23/05/23	Director of Operations	**4x5=20** (Reviewed 20/02/24)	Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for patients most at risk with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity.	**2x5=10**

				The service has provided additional Age-related Macular Degeneration (AMD) sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board. Patient delays continue across the Health Board. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. Additional staffing for Wet AMD was incorporated into IMTP but no funding was allocated. The service as at February 2024 has 6,383 patients (Nov 23: 5,713) that have been 100% delayed for their follow up appointment. The total new patient referrals is 7,088 (Nov 23: 5492) of which 713 (Nov 23: 403) are breaching 52 weeks (the longest wait from this cohort is 84 weeks (Nov 23: 67 weeks)). 4,040 patients are awaiting an Ophthalmic operation (Nov 23: 3,785) of which 46 (Nov 23: 24) are breaching 104 weeks (the longest wait from this cohort is 130 weeks). The current impact has been scored as 5 because patients suffering irreversible sight loss or damage is a reality and the		

				current likelihood has been scored 4 as Ophthalmology is a fragile service. It is unlikely that we will be able to achieve the Board tolerance score of 6 without a regionally agreed solution.	
1708 - Risk of increasing fragility in primary care contractor services due to recruitment challenges	07/07/23	Director of Primary Care, Community & Long Term Care	**4x4=16** (Reviewed 05/03/24)	Eight dental contracts and one General Medical Services (GMS) contract have been returned to the Health Board in the last 12 months. This has resulted in 25,000 dental patients being displaced. In addition. A further 8 dental practices have not signed up to the contract reform, and are signalling that they will return contracts once reform negotiations have concluded. Two out of the three GMS contracts have become Health Board managed practices, resulting in additional financial pressures as the workforce is salaried, and the third practice has been taken through the vacant practice panel process and a successful procurement process. It is recognised that any further managed practices would likely have a negative impact on the GMS budget. The number of complaints received from the public has increased due to returned contracts, and while the Health Board is currently containing the demand for urgent dental care, it is recognised that patients who do not fall in to this category but require a level of dental care are detrimentally impacted, and that any further contracts returned will exacerbate	**2x4=8**

				this situation. The capacity of the Health Board in terms of staffing to absorb further contract reform will impact on the ability to effectively deliver services, and a detrimental impact on staff welfare. With a new optometry contract implemented in October 2023, and new clinical pathways to commence from 1 April 2024, there is an expectation of a shift from hospital care to the community, however the model is untested in terms of contractor capacity and skill set. Due to the above, the current risk score remains 16 as at March 2024.	
684 – Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	04/01/19	Director of Operations	**4x4=16** (Reviewed 09/02/24)	The Health Board's stock of imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the Health Board's ability to meet its Referral to Treatment (RTT) target and impact to patients can include delays in diagnosis and treatment. Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scanners have been replaced and has reduced the frequency of machine downtime compared to previous experience. The risk score is noted as 16 reflecting that some equipment has been installed and is operational, however further investment is required given recent	**2x4=8**

				breakdowns of key imaging equipment. A costed plan along with a rolling programme for the installation of additional equipment is in place. The next batch of equipment for replacement has been prioritised and identified. For 2023/24, funding was obtained to replace one X-ray room and due to the Radiology Information Systems Procurement (RISP) risks of non-Digital Radiography (DR) compliant equipment, it was decided to replace the x-ray equipment at Tenby Cottage Hospital. The gamma camera at WGH is the only scanner of its nature in the Health Board, and has experienced a breakdown in August 2023 due to intermittent failures which resulted in several Healthcare Inspectorate Wales (HIW) reportable Ionising Radiation Medical Exposure Regulations (IRMER) incidents. This item of equipment is on the current priority list of items to replace. While a new CT scanner has been obtained and installed at GGH, the original CT scanner has had a number of breakdowns due to its age. The technology on this scanner is also now out of date and impacts directly on the resilience of the service at our major trauma site in the Health Board. Like-for-like replacement of existing equipment is not necessarily a cost effective		

				method of maintaining services and in certain circumstances does not meet updated regulatory compliance or meet the requirements of maintenance warranty agreements. This means there will need to be upgraded infrastructure such as air handling units, water chiller systems and the size/accommodation for modalities at an initial increased cost but representing long term savings and service resilience overall.		

Argymhelliad / Recommendation

The Committee is requested to seek assurance that:

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

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

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

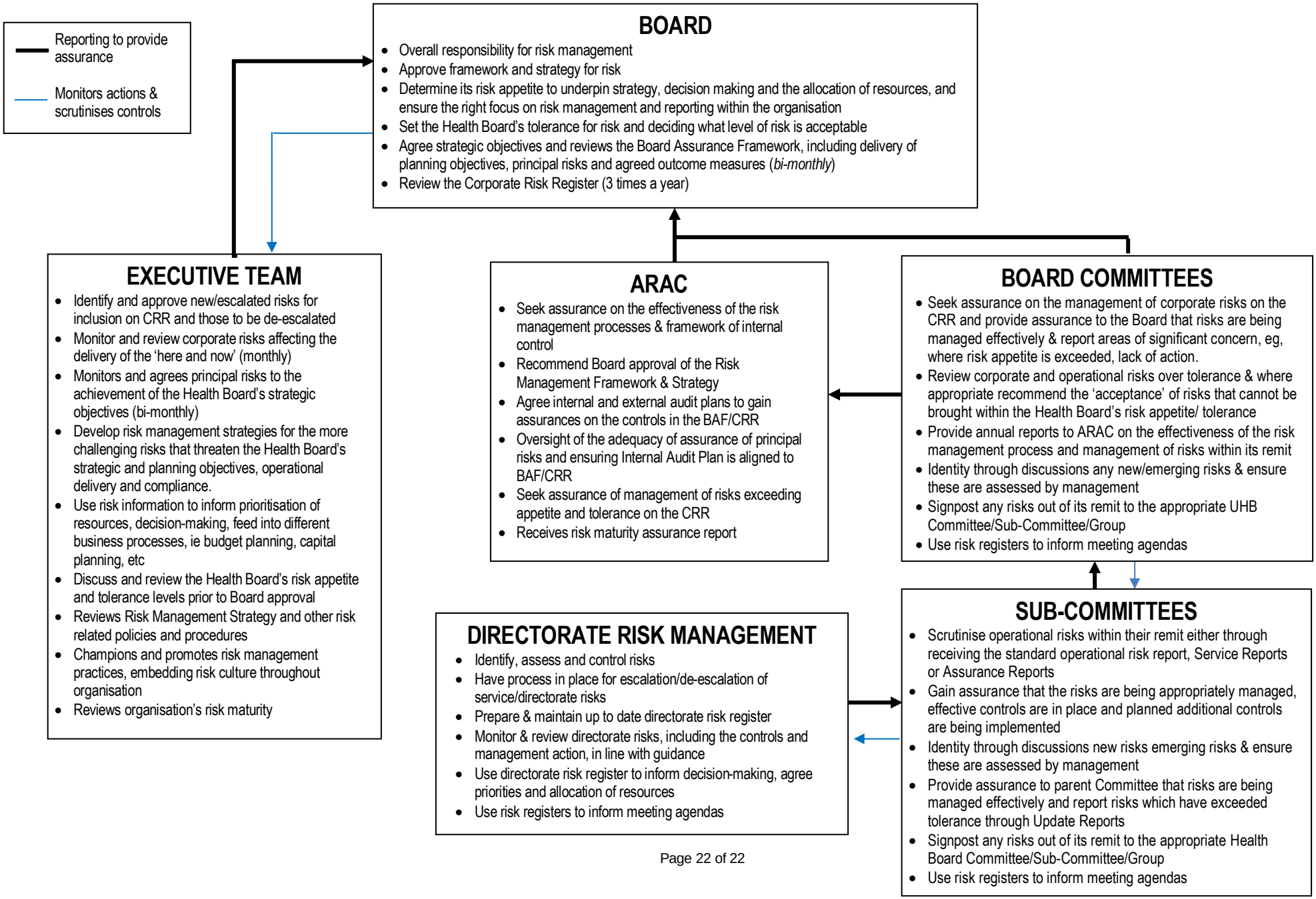
Quality and Engagement Act (sharepoint.com)	Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	Not Applicable Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from report however impacts of each risk are outlined in risk description.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from report however impacts of each risk are outlined in risk description.
Gweithlu: Workforce:	No direct impacts from report however impacts of each risk are outlined in risk description.

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

Appendix 1 – Committee Reporting Structure



Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Mar-24	Trend	Target Risk Score	Risk on page no...
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×5=20	→	3×4=12	6
1032	Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12	13
797	Risk to the ability to deliver ultrasound services due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12	21
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×5=20	→	2×5=10	26
1699	Risk of loss of service capacity at WGH due to surveys and remedial work relating to RAAC	Carruthers, Andrew	Service/Business interruption/disruption	6	5×5=25	4×5=20	↓	2×5=10	32
1810	Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Paterson, Jill	Safety - Patient, Staff or Public	6	N/A	4×5=20	New risk	1×5=5	36
1708	Risk of increasing fragility in primary care contractor services due to recruitment challenges	Paterson, Jill	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	2×4=8	40
684	Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Carruthers, Andrew	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	2×4=8	44
1812	Risk of non-compliance with Medical Examiners (Wales) regulations due to the Medical Examiner Service Roll-Out	Henwood, Mr Mark	Quality/Complaints/Audit	8	N/A	4×4=16	New risk	2×2=4	49
1531	Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	3×5=15	↓	2×5=10	54
1548	Risk to the Health Board maintaining service provision due to industrial action	Gjini, Ardiana	Safety - Patient, Staff or Public	6	4×3=12	5×3=15	↑	2×3=6	58

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

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.

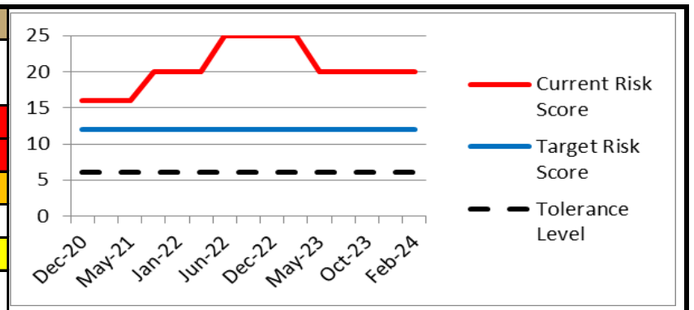
Date Risk Identified:	Nov-20
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Mar-24
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-24

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

Does this risk link to any Directorate (operational) risks?	1649, 1406, 1548, 1210, 750, 205, 86, 820, 232, 1298, 1281, 906, 1380, 1116, 878, 839, 1167, 1223, 111, 114, 199, 523, 136, 200, 1115, 1078, 572, 1295, 1231, 966, 967, 565, 852, 1295, 1435, 1377, 1083, 180, 1424, 1417, 1309, 291, 118, 925, 119, 1245, 695

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



Rationale for CURRENT Risk Score:
Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. This is driven by post pandemic demand and the broader impacts of COVID-19. Workforce deficits, handover delays, 4- and 12-hour performance, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating significantly worrying trends. The indirect legacy of the pandemic has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains at high levels of risk escalation across our acute sites on a daily basis. Notwithstanding these challenges, whilst positive progress has been achieved during 2023 in reducing peak levels of pressure with notable improvements achieved in key urgent and emergency care (UEC) pathway metrics relating to ambulance handover and emergency departments (ED) waiting times; this has not been sustained through the winter 2023/24 period, with a significant re-emergence of system-wide capacity pressures. Notwithstanding continuing progress in delivering the Health Boards TUEC objectives, there has been a notable increase in the volume of patients with lengths of stay (LOS) in excess of 21 days across all hospital locations during this period. With specific reference to Withybush Hospital, UEC performance has been significantly impacted since the Summer of 2023 due to the extent to which the RAAC infrastructure improvement project has reduced capacity. Consequently the risk score remains unchanged as at March 2024.

Rationale for TARGET Risk Score:
There is a significant challenge across the Urgent and Emergency Care system. The combined impact of the multi-faceted pressures which underpin this risk have led to an incremental increase in the overall level of pressure as reflected in deteriorating delays for ambulance handover, access to urgent and emergency care and delayed discharges. The extent to which these combined pressures impact upon the timeliness and quality of care provided is related to the overall availability of staffing resources on a daily / weekly basis, which in turn is influenced by increasing levels of staff sickness/absence. In light of the positive progress achieved in since January 2023 in reducing peak levels of pressure with notable improvements achieved in key UEC pathway metrics relating to ambulance handover and ED waiting times, this risk and target risk score will continue to be regularly reviewed and revised accordingly..

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage unscheduled care risks on daily basis including multiple daily multi-site calls in times of escalation which include efficient handover from WAST into ED. # Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. # Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds. # Discharge lounge takes patients who are being discharged. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites. # Regular advice on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, Social services and the Long Term Care Team support. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Winter Plans developed to manage whole system pressures. # Joint workplan with Welsh Ambulance Services NHS Trust. # 111 implemented across Hywel Dda. # Transformation fund bids in relation to crisis response being implemented across the Health Board. # Ability to deploy Health Board staff where workforce compromise is immediately threatening to continuation of care for residents. # Care Home Risk & Escalation Policy to be applied to support failing	# Fragility of Care Home Sector exacerbated by COVID related issues such as financial viability, staffing deficits, recruitment and retention of workforce. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff # Nurse staffing availability to ensure safe levels of care as a consequence vacancies. # Inability to offload ambulances to release them back for use within community. # Increased pressures at ED as a result of WAST ambulance response policy resulting in very poorly patients self-presenting. # Better understanding of ED presentations to ensure development of alternative pathways in primary care / community to prevent ED attendance # Effective and timely communication to the public at times of pressure but also of safe alternatives to hospital admission / ED presentation that will	Refer CRR 1649 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	31/03/2024	Ref CRR 1649 for detailed progress.

care homes as required. # Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across Health Board # Integrated whole system, urgent and emergency care plan agreed. # Establishment of a Discharge to Assess (D2A) Group which reports to the Unscheduled Care group. # Establishment of a D2A Escalation Transfer panel which provides senior oversight of delays, assesses risk of the delay to the patient and organisation in terms of flow compromise # To optimise step down bed capacity in the community across care homes and community hospitals # SRO in place to lead agreed Urgent and Emergency Care (UEC) programme # Supernumery HCSWs aligned to the acute response teams to support failing community care capacity # Support for complex discharge caseload management tool (SharePoint) appointed # SDEC models continuously reviewed and refined to maximise impact on admission avoidance. # Alternative models of medical oversight i.e service level agreement with local GPs and HB salaried community GPs. # Service provision in the community for people pending ambulance conveyance, and where conveyance is not possible to manage ambulance handover delays. # Increased bedding capacity in community hospitals. # UEC live performance dashboard in place. # Local streaming hub.	contribute to changing public mind set / expectation and culture in terms of use of NHS resource and 'Home First' # Education and training for best practice in frailty management mandated to effect culture of 'unsafe to admit' for our very / severely frail # Supporting staff to be able to better manage family dispute relating to expectation eg home of choice, transfer pathways to short term placement in care home pending home care availability # Development of a 'tool' that supports staff to assess risk across the whole system to support decision making when discharge appears to be 'risky' to the individual patient. This includes decision making for 'further rehabilitation required in the acute environment' (why not at home?), further blood analysis to confirm medically fit to discharge, home care not available but family happy to take in the interim. # For all patients with LOS > 21 days	Incorporate and deliver actions that will address control gaps into the Health Board's UEC Plan.	Carruthers, Andrew	31/03/2025	The Annual Recovery Plan for 2023/24 outlines the UEC improvement actions being progressed during the current financial year in support of this longer-term objective. These are overseen and monitored by the TUEC steering group, chaired by the Director of Operations, with progress reported regularly to Board Committees.

# Direct referral into SDEC in WGH, GGH and PPH. # Operational joint meeting with WAST to identify and taking forward key action to help address conveyance. # Clinical Streaming Hub includes APP Navigator working with Physicians to triage and stream patients pending conveyance to more appropriate pathway in the community (In Hours).	the need for escalation and 'senior think tank' # If there is a paucity of home care to the extent that we are unable to provide > 28 hours per week (calls four times per day) - why are we advocating this level of commissioning? # Clarity regarding roles and responsibilities for discharge planning and coordination # The availability of live data at Cluster, County and Site level with sufficient analytical support # the ability to risk stratify for people at moderate to high risk of admission in the community to implement proactive anticipatory care plans to support avoidance of exacerbation / decompensation and hence increased risk of hospital admission # Optimising our bedded facilities in the community i.e we should aim for 'step up' from community and from 'front door' hospitals (within 72 hours) rather than as a 'step down' from acute hospitals after long length	To develop a plan with Local Authority partners that sets out a model for integrated community health and care provision for older adults and adults living with frailty	Paterson, Jill	30/11/2023	Work is underway across the three counties.

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

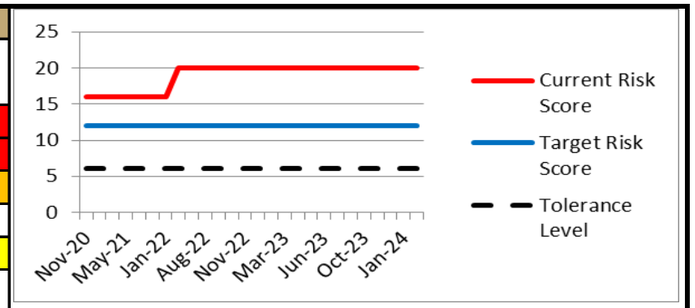
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance indicators. A suite of unscheduled care metrics have been developed to measure the system performance.	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st				None identified.				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Unscheduled Care Improvement Programme	2nd								
	Bi-annual reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	WAST IA Report Handover of Care	3rd								
	11 x Delivery Unit Reviews into Unscheduled Care	3rd								
	Delivery Unit Report on Complex Discharge	3rd								

Date Risk Identified:	Nov-20		
Strategic Objective:	5. Safe and sustainable and accessible and kind care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Feb-24
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Mar-24

Risk ID:	**1032**	**Principal Risk Description:**	There is a risk to the delivery of timely diagnosis to those on the ASD waiting lists, and the commencement of interventions for Psychological Therapies (Integrated Psychology Therapies - Adult and Learning Disability) within required timescales. This is caused by an increase in referrals, as well as recruitment challenges and lack of appropriate estates. This could lead to an impact/affect on those currently awaiting diagnosis and intervention, resulting in delays in care and appropriate treatments in a timely manner which may lead to poorer patient outcomes, and delayed adjustments to educational needs. There will also be an impact on the ability of the Health Board to meet Welsh Government targets (diagnosis of ASD within 26 weeks, and commencement of interventions for Psychological Therapies within 26 weeks) which could lead to increased scrutiny from regulators, and escalation from Welsh Government. This in turn could result in adverse publicity and a reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?		138, 1249, 1286, 1287, 1392, 1455, 1422, 1524, 1290, 1260, 1699, 1745, 1414	

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



Rationale for CURRENT Risk Score:
The service is experiencing significant waiting times as a result of increasing demand levels which are exceeding pre-pandemic levels, compounding the backlog due to Covid restrictions. Due to increasing Did Not Attend (DNA) rates, ongoing recruitment challenges and increasing demand there is an impact on the services' ability to see the same volume of service users as they were previously able to. Some posts continue to be funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff. As at 31 January 2024, there are currently 3,025 (Oct 23: 2,478) clients on the waiting lists, with 2,614 waiting longer than 26 weeks. The average wait has increased from 74 to 92 weeks. For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit to establish trajectories, along with the commissioned service which since have been agreed in March 2023. The DU were unable to provide trajectories, therefore Health Board has agreed to a 1% trajectory. For psychological services a trajectory is now in place for 1% per month. This risk was reviewed on the 21/12/2023 - on the basis on improved CAMHS Part 1 position and a deterioration in ASD/ADHD, this risk score remains the same.

Rationale for TARGET Risk Score:
The Directorate is prioritising implementation of WPAS in key areas within MHLD and this will enable improved reporting and waiting list management and enable forward trajectories of improvement in waiting times to be determined. The target risk score will be dependent on securing recurring funding for the IAS as well as having access to appropriate clinical venues and other agencies being able to undertaken their associated assessments. While trajectory plans are in place as of March 2023, there is recognition that the Health Board will not achieve WG targets.

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

not materialise. Workforce Management Group has been established which meets monthly. Trajectories have been identified for IPTS and there are systems in place to monitor waiting lists at service level, through IPAR and Directorate and service level review meetings. Monthly meetings with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint. Work underway across all services who have waiting times, be they intervention or assessment. Use of HB Third Party Contractor has begun and initial letters sent to those waiting appointments with the Integrated Autism Service. Public facing webpages with QR codes are also being developed to give further guidance and support whilst individuals are waiting. Keeping in touch template letters developed within further areas, and monitored by individual service leads. Service Leads secured opportunities for outsourcing for CAMHS ASD and Psychological Therapies. Commissioned external provider for ASD services across all ages, similar contract out to tender for Psychological Therapies. 'Grow your own' scheme is coming into place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme (3 year programme). Quarterly meetings with the NHS Executive, Welsh Government and Service Leads at the Health Board SMS functionality in place for ND and IPTS to improve attendance and decrease instances of DNA					support workforce modelling as part of service improvement work underway. • Additional up-skilling B4 techs • Reviewing universal offers of support/workshops for families and carers particularly around sensory processing referrals. • Reviewing use of caseload weighting tools and enhanced professional lead oversight of caseloads • Limited clinical support from AMH B7 in Pembs CTLD. • Additional 1.0WTE B6 OT post to cover Carmarthenshire, and 1.0WTE OT B6 post within WEIT being proposed as part of SIP. Physio LD Service Manager EOC will attend peer meetings in the absence of a professional lead. EOC has advised the Physiotherapist that she will be validating and monitoring the waiting list reporting to the Information Dept on a monthly basis until they have a Prof Lead in place. Services developing a professional lead physio for LD JD. All LD Therapies Service Manager EOC has advised the to adopt Psychology's approach of formally writing to each individual on the WL over 6/12 as part of the regular Waiting list review cycles.

					Identify alternative venues/space to hold clinics(CAMHS & Psychological therapies).	Lodwick, Angela	Completed	Challenges continue in access to Estates to undertake assessments across the three counties. Remains ongoing working with Estates and submitting capital bids to WG for monies to fund works within allocated buildings to make them fit for purpose. SBAR being developed to repurpose the use of Tudor House. RAAC issue is extenuating the estates position with some areas within Pembrokeshire/Ceredigion not being available to undertake assessments/interventions. Ongoing estates issues, movement of Directorate Management team from Ty Gwili to provide additional clinical space. Neuro / IAS moving to Ty Gwili for clinical space by March 2024. Other moves taking place throughout the service and additional funding and areas being explored. Moves have been completed from Ty Gwili to Tudor House to identify clinical space for Neuro in Ty Gwili. Continuing to pay for space within Nurture Centre for DBT and PMH/SiR teams for additional family sessions. Remain looking into additional funding and exploring areas.
					Identify alternative venues/space to hold clinics (Integrated Psychological Services).	Homfray, Andrew	~~31/07/2023~~ ~~31/11/2023~~ 31/08/2024	As many groups as possible are being set up to utilise online facilities and third sector venues to support any face to face meetings, ensuring that costs are managed appropriately. Phase 1 of groups completed in February 2024, targeting waiting lists. Phase 2 of group implementation to implement a tiered approach to intervention to commence April 2024 following further staff training, with full implementation expected by August 2024.

Identify alternative venues/space to hold clinics(Commissioning /CDAT).	Richards, Matthew	Completed	New North Dock premises are being progressed by APB to deliver new base in Llanelli with accessible clinic space. Currently going through planning and concerns about potential delays due to public objections. Due to a revision of the risk narrative, this action is no longer relevant and therefore noted as complete.
Directorate to transfer all service data collection processes to WPAS.	Amner, Karen	Completed	Delays to the Dementia Wellbeing Service, Integrated Autism Service, Perinatal, Memory Assessment Service migration delayed due to capacity within the Digital team to test and develop system at required pace. As at October 2023, all data for the relevant services noted on the risk have been transferred, therefore to close action.
Review workforce skill mix in light of any potential new funding received from WG for Neurodevelopmental services.	vaughan, Catherine	Completed	Workforce reviewed and skill mix within team expanded to ensure a multidisciplinary approach in order to deliver an integrated multi disciplinary service in respect of the fixed term funding for 2023/24 received on behalf of the Regional Partnership board(RPB). Skill mix introduced but unable to recruit in to some posts due to delay in funding received via RPB and fixed term nature

Monitor the use of SIFT monies for service development. The Director of Finance has given an undertaking that this will be funded as discussed and agreed at a Directorate Improving Together Session in April.	Carroll, Mrs Liz	Completed	During the budget setting process in Month 7, the £575k for procurement for EMDR and ASD was not factored into the Directorate position despite this having been agreed following agreement at Public Board in September 2022. This was raised by the Finance Business Partner during the budget setting process with Finance colleagues. This leaves a deficit in this years budget. To be reviewed in the DITS meeting on the 27th October 2023. This outsourcing has been absorbed by the Directorate.
As a result of Reinforced Autoclaved Aerated Concrete (RAAC) found at Withybush General Hospital site and the internal major incident that has been declared, some areas previously used by the Directorate have now been withdrawn. The Directorate attend the Outpatients RAAC Subgroup (Bronze) where the impact on the Directorate and potential solutions are being worked through in collaboration with the wider Health Board. Linked to Estates Risk 1711.	Carroll, Mrs Liz	29/03/2024	08.11.23 - Bronze RAAC Sub Group have identified no impact for MHLD services due to relocating or virtual clinics.
Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Temple-Purcell, Rebecca	~~30/11/2023~~ 31/12/2024	In progress, working with Workforce to develop a training needs and analysis tool. MH&LD to act as a pilot for this pending further roll out across the HB.

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

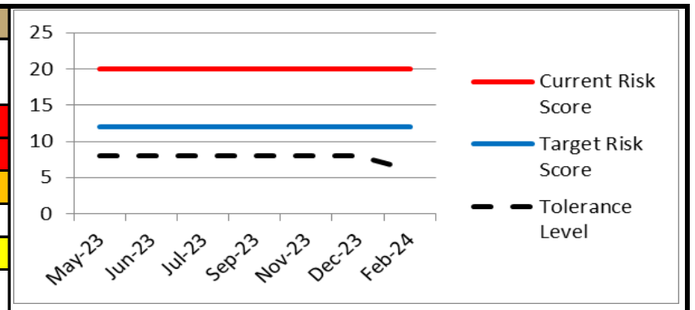
	MH&LD QSE Group overseeing patient outcomes	2nd			that the Directorate have at present. A paper was presented at Board Seminar in June 2022 to provide assurance on current waiting times and control measures.		Outcome measures to be in place to measure effectiveness/quality of services provided(Commissioning /CDAT).	Richards, Matthew	Completed	CDAT outcomes measures are gathered using TOP assessment for all service users and reported via quarterly KPI's to APB and WG. Commissioning outcomes measures are being reviewed and recent work with NCCU will support this. Possibly pilot an outcome framework with NCCU as a temaplate for national approach. Due to the reframing of the narrative of this risk, CDAT is now out of scope therefore action completed
	Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd								
	W-PAS Internal Audit (reasonable assurance)	3rd								
	An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.									

Date Risk Identified:	Nov-19		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Feb-24
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Mar-24

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

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



Rationale for CURRENT Risk Score:
Despite best efforts, the service remains fragile. There are still vacancies which remain unfilled, but there has been an improvement in recruitment due to the financial picture across Wales and the cessation of use of agency staff above AFC pay rates. Even if all vacancies were recruited to, the Health Board would still not have the capacity to meet current demand (as at February 2024 there are 1288 patients waiting 8 weeks plus for non-obstetric ultrasound (Dec 2023: 1547), with the reduction a result from the use of insourcing). Long term vacancies exist in Withybush. There are 2 potential retirements at PPH in the near future and a number in BGH, which constitute a significant percentage of the workforce, though there are maternity returns due back in the near future. There will be an inability to secure agency staff due to the current financial climate of the Health Board. Whilst a modality lead at Withybush has been appointed and commenced in November 2023, the ability to undertake governance and audit requirements still needs to be embedded, however it is noted that a Radiology Ultrasound Governance group has been set up in June 2023. More sonographers are due to be trained from January 2024, however training takes two years to complete. 3 of the 4 vacancies as advertised in July 2023 were successfully appointed to, though this has not resulted in additional capacity to the service as roles have been given to previous locum staff.

Rationale for TARGET Risk Score:
The actions below will not in themselves reduce this risk significantly. Support is required to undertake the demand and capacity and the current establishment reviews. It is likely that these reviews will lead to a need for further investment and additional funding to establish a sustainable service model to include a robust perpetual training programme, that will enable the Health Board to met expected diagnostic waiting times targets.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Process in place for the movement of staff across the Health Board to maintain capacity where possible. Ultrasound Control Group reconvened in Jan 2024 after having not met since July 2023 due to operational pressures. Meetings take place on a monthly basis. The PPH modality lead has been filled (Feb 2024)	Inability to release existing staff to train and develop to undertake sonography and growth scans. Inability to recruit and retain staff. While process in place regarding the movement in staff, due to current staffing levels and pressures this is not being implemented, however the teams across sites are collaborating and look at all possibilities when gaps in rota arise and are foreseen.	Develop a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Jones, Keith	~~31/12/2022~~ ~~31/10/2023~~ ~~31/01/2024~~ 30/06/2024	Discussions have taken place with Head of Maternity Services. Protocols and training being developed. Implementation date to be agreed. A meeting was scheduled for 20th June 2023 with CVUHB in order to assist with the development of a training plan but there was no midwifery representation available on the day. Midwifery services approached Powys for assistance with training midwives sonographers, and appointed 2 midwives to join the ultrasound Course for January intake 2024. However, Powys are unable to support training in the same original capacity and the certainty around midwife training in January is currently unknown. Ultrasound Control Group was arranged for 7th December, but re-arranged for January 4th 2024 due to availability. "midwife sonographers have started training, however support from Radiology will not be able to be enacted until the Sonographer Clinical Educator is in post due to the current training commitments within Radiology.

Train members of staff to become sonographers, the number of which dependant on capacity to take training.	Roberts-Davies, Gail	~~31/03/2020~~ ~~31/12/2022~~ ~~01/02/2023~~ ~~30/09/2024~~ 31/01/2026	As at November 2023, we are currently training 3 members of staff (2 at GGH and 1 at PPH) with a plan to train 1 more at GGH in September 2024. Training positions take two years to complete. Clinical Educator role has been developed, with job descriptions presented to panel in June 2023. To date, recruitment has been unsuccessful, however we have re-advertised this post and are due to interview on 19/02/2024. Successful recruitment will allow expansion of training to improve position.
Work with the workforce planning team to build a sustainable workforce plan for ultrasound services.	Roberts-Davies, Gail	~~31/10/2023~~ 31/03/2024	Fortnightly workforce planning meetings in place with colleagues from Radiology and Workforce in attendance. Stakeholder mapping exercise being undertaken as at December 2023. Work is ongoing in this area and is currently concerned with the Clinical Services Plan issues paper along with the Radiology Annual plan (Jan/Feb 2024).

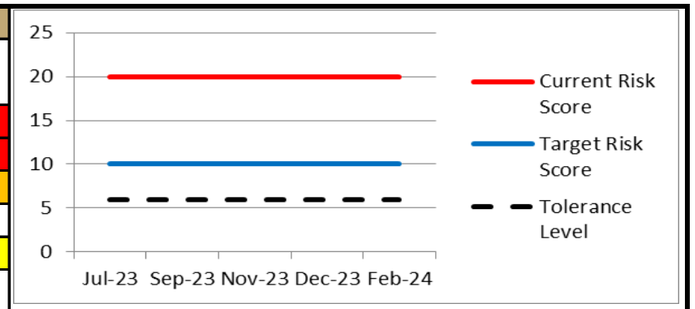
	Seek support to undertake a demand and capacity (D&C) review and detailed establishment review of the radiology service.	Jones, Keith	~~30/06/2022~~ ~~30/11/2022~~ ~~31/03/2023~~ ~~30/08/2023~~ ~~31/01/2024~~ 31/05/2024	Initial contact made with workforce planning team re: establishment review work. This has been discussed in the Radiology Use of Resources Meeting. Further discussions took place about establishing a Radiology Planning and Delivery Group to bring together all pieces of work with the necessary expertise. It is noted that this group has yet to be established as of December 2023, however a focussed Ultrasound Control Group has been set up, recognising the imminent loss of service. A Radiology dashboard is in place which provides activity and demand. A new dashboard was published in Jan 2024 which is aligned to ARCH development. As of November 2023 there have been some significant staff changes on various sites with the loss and gain of sonographer hours. D&C needs further review and is being linked into Workforce planning. Workforce planning work is taking place and as of Jan 2024 id concerned with the clinical services plan and annual plans.
	To consider possible insourcing options to support the service	Roberts-Davies, Gail	31/03/2024	Head of Radiology has liaised with contacts in NWSSP Procurement. The tender submissions have been received and evaluation of responses to undertaken in November 2023. In December 2023, confirmation received of allocation of recovery funding for the ultrasound insourcing contract approved to the end of the current financial year. As of Feb 2024, insourcing contract started utilising EOY recovery funding during Feb & March 2024.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Non-Obs ultrasound - currently >over 40 weeks Radiology Dashboard IPAR Reports WG Cancer PTL, reported monthly	Management review of sonography and SCP diagnostic waiting times	1st			Sonography Report to Acute Bronze and Operation Planning and Delivery Programme meeting					
	Monthly review of USC performance undertaken monthly (36% of USC carried out in 7 days, 56% carried out in 14 days at Dec. 2023), included in the IPAR & reported to WG	1st								
	Performance monitored at Directorate Improving Together Sessions	2nd								
	Performance monitored via IPAR, overseen SDODC & Board	2nd								

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

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

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



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for patients most at risk with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional AMD sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the HB. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. Additional staffing for Wet AMD was incorporated into IMTP but no funding was allocated. The service as at February 2024 has 6,383 patients (Nov 23: 5,713) that have been 100% delayed for their follow up appointment. The total new patient referrals is at 7,088 (Nov 23: 5492) of which 713 (Nov 23: 403) are breaching 52 weeks (the longest wait from this cohort is 84 weeks (Nov 23: 67 weeks)). 4,040 patients are awaiting an Ophthalmic operation (Nov 23: 3,785) of which 46 (Nov 23: 24) are breaching 104 weeks (the longest wait from this cohort is 130 weeks). The current impact has been scored as 5 because patients suffering irreversible sight loss or damage is a reality and the current Likelihood has been scored 4 as Ophthalmology is a fragile service. It is unlikely that we will be able to achieve the Board tolerance score of 6 without a regionally agreed solution.	It is unlikely that the service will be able to reduce the impact score of this risk as the consequences to the patient remains high, however due to recent re-structuring of the management team within Ophthalmology it is hoped that this will provide opportunities to review and improve service delivery with an initial focus on meeting eye care measure targets for the most high risk cohort of patients. The recent addition of a substantive WTE Consultant will help to address the longest waits. A Regional Consultant post has been recruited in Swansea Bay to provide an additional 10 sessions a week in HDUHB, however noting that 7 of these sessions relate to clinical delivery. With the above additional workforce and focused management of the waiting lists, HDUHB will potentially help to reduce the likelihood score on this risk.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	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**
Active recruitment to vacancies, x1 substantive Consultant has recently been appointed. X1 WTE post secured with Swansea Bay and x1 substantive Consultant post to go out to advert. Regional Business Case for a South West Wales Glaucoma Service. Regional discussions regarding a South West Wales Consultant On-call provision. Additional weekend working to provide Wet Age related Macular Degeneration (AMD) capacity. Currently funded for x2 all day lists per month. Lists cancelled due to AL are offered out to backfill. Review of service rota undertaken by Clinical lead to ensure stability to existing team and robust cover of emergency work. Identification of patients suitable to undergo Community Glaucoma data capture and virtual review by Consultant Ophthalmologists.	Whilst recurring money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, VR, plastics) that require investment. ARCH programme to be closed, with a regional conversation around a regional clinical workshop to consider opportunities for a long-term regional model. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. Recovery funding was in place until March 2023. Actions have assisted the backlog	Regional discussions to be arranged as a priority around Ophthalmology services to support a long-term sustainability plan for eye care services.	Coppack, Victoria	~~30/09/2023~~ ~~31/12/2023~~ ~~31/03/2024~~ 30/06/2024	Regional glaucoma pathway has been established. Outline discussion around regional support for a workforce development plan for HDUHB multi-disciplinary team development. Regional working for Open eyes digitalisation.
		Root and branch review of operational, workforce and sustainability models.	Coppack, Victoria	~~30/06/2021~~ ~~31/03/2022~~ ~~31/10/2022~~ ~~31/12/2023~~ ~~31/03/2024~~ 30/06/2024	Root and branch review to be undertaken through ARCH group. Regular meetings need to be undertaken for Glaucoma and Workforce plan. As at December 2023, there was the potential for this group to be replaced by an alternative regional group. Outcomes of discussions relating to this proposal are awaited.

Full Business Case for OpenEyes software (National Electronic Patient Record for Ophthalmology) approved and funding for this project has been secured for 1.0 WTE Band 7 project manager and a 0.5 WTE band 5 application support manager. This project is being aligned with SBUHB. Validation taking place through scheduled care validation team. Clinical validation of all HCQ patients being undertaken by nurses (documentation has been approved for a pilot which started in November 2023). Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. ECM Coordinators in place. Review of data quality inclusive of HRF code and clinical codes ongoing to improve data quality. 7 prescribing hubs have now been set up across the Health Board, with the aim to reduce the number of patients requiring Secondary Care Eye Services, ensuring those with the need for secondary care intervention are referred. Highly trained Optometrists working collaboratively with the Secondary Care Eye Service to reduce referrals to secondary care. Ongoing training of Optometrists within secondary care to continue to develop this service. ARCH workstreams in place - looking at Glaucoma and funding has been secured to support this development. ARCH support around Diabetic retinopathy and cataracts has been completed and pathways are in place. Ongoing arrangement of Optometrists enrolling in prescribing training. Weekly monitoring of each sites AMD demand and capacity to allow for recovery planning of breaching patient waiting times. Funding obtained in November 2023 to outsource 330 cataracts patients from the longest waits (104+) until March 2024. Transformational funding from Welsh Government is in place until March 2024.	number of patients waiting to be managed in subspecialties such a Diabetic Retinopathy however other high volume areas such as AMD and Cataracts continue to see growth in waiting times. There are concerns in data quality due to referral processes and system use. The Ophthalmology service has continued to recruit over budget to sustain current services.	Roll out and implementation of National Electronic Patient Record for Ophthalmology.	Barreiro, Marta	~~30/07/2021~~ ~~07/06/2021~~ ~~31/10/2021~~ ~~31/03/2022~~ ~~31/05/2022~~ ~~30/09/2022~~ ~~31/10/2023~~ ~~31/12/2023~~ 31/03/2024	Issues identified in the planning phase around data governance. DHCW are working to resolve issues. Update provided by the DHCW in January 2024 outlining options available. Regional planning scoped and aligned programme now established with Swansea Bay UHB. Timeline to be established when options appraisal completed.
		Refurbish and establish a nursing team in the Outpatient Department in Amman Valley Hospital to provide intravitreal treatment for the patients currently attending the day theatre area for their treatment. This will ensure continuity of care for those patients when cataract surgery activity is returned to day theatre.	Coppack, Victoria	~~31/01/2022~~ ~~31/03/2022~~ ~~30/04/2022~~ ~~30/09/2022~~ ~~31/10/2023~~ ~~31/01/2024~~ 31/03/2024	Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) has been completed since March 2022. Recruitment into nurses posts to support out-patient activity has been successful and recruits are onboarding. This is currently on hold due to the space being utilised for WGH Ophthalmology patients (RAAC). However an alternate site has now been identified in Pembrokeshire, with a date for completion of works in January 2024. Move to be completed March 2024.
		Plan for Glaucoma pathways to be implemented through ARCH.	Barreiro, Marta	~~30/06/2022~~ ~~31/10/2023~~ ~~30/11/2023~~ 30/04/2024	Business case has been approved and pathway has been implemented with support from Swansea Bay Consultant. ODCT pathway x2 has been developed, Optometrists virtual pathway for Glaucoma A patients starting in November 2023. Swansea Bay Glaucoma consultants started in HDUHB in November 2023, and further modelling work is required to recover waiting times. Action to be considered for closure once improvements in waiting times observed.

Recruitment of approx. 7 nursing staff and 2 technicians.	Barreiro, Marta	~~30/06/2022~~ ~~31/10/2023~~ ~~31/12/2023~~ ~~31/03/2024~~ 30/06/2024	2.0 WTE Technicians secured 0.8 WTE Glaucoma practitioner secured. 3.3 WTE Nurses secured Outstanding 1.9 WTE Glaucoma practitioner and 1.0 WTE Nurse which have not been recruited into, and still outstanding as at February 2024. The Health Board are looking in to developing training programme prior to advertising in conjunction with Swansea Bay.
Recruitment drive for Glaucoma Consultant.	Barreiro, Marta	Completed	x2 Consultants secured through Swansea Bay. X1 WTE equivalent to work in HDUHB. Job plan agreed with start date 20th November 2023. Both recruits are now in place, therefore action to be closed.
Remodelling the capacity and demand associated with Wet AMD and Amman Valley	Coppack, Victoria	~~31/03/2023~~ ~~31/10/2023~~ ~~30/11/2023~~ 31/03/2024	Ongoing costs associated with additional activity. Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) has been completed since March 2022. Recruitment into nurses posts to support out-patient activity has been successful and recruits are onboarding. This is currently on hold due to the space being utilised for WGH Ophthalmology patients (RAAC). However an alternate site has now been identified in Pembrokeshire, with a date for completion of works in January 2024. Completion of move by March 2024.
Recruitment of theatre staff and admin support to enable the optimisation of AVH theatres for cataracts.	Barreiro, Marta	~~31/03/2022~~ ~~30/08/2022~~ ~~31/10/2023~~ ~~30/11/2023~~ ~~31/01/2024~~ ~~31/03/2024~~ 30/06/2024	When IVT service relocates from AVH Theatre to AVH Outpatients Department, the ability to undertake further cataract surgery in AVH Theatre will be increased.

Devise and approve plan for Diabetic retinopathy service through ARCH.	Barreiro, Marta	Completed	Funding was secured through transformational bid. Carmarthenshire and Pembrokeshire have secured timeliness of patient appointments for follow up and new patients. Ceredigion has been more challenging due to lack of Optometrist uptake. Aberaeron integrated care centre has now been secured for x1 session per week supported by a technician. The ARCH pathway as of December 2023 has ceased, with plans devised and approved. Action therefore to be closed.
Plan for Cataracts pathway to be implemented through ARCH.	Barreiro, Marta	~~30/06/2022~~ ~~30/09/2023~~ ~~30/11/2023~~ ~~31/03/2024~~ 30/06/2024	Locum Consultant secured to assist with delivery of Cataracts surgery/Substantive Consultant with specialism in plastics secured who can also undertake cataract surgery. Review of Demand and Capacity now undertaken to inform service recovery. The ARCH pathway as of December 2023 has ceased, with plans devised and approved. GIRFT review for cataracts is ongoing, with recommendations raised noted on the Audit and Inspection tracker and progress updates obtained. Action is linked to the ability to restructure service between AVH and Pembrokeshire, which is currently impacted by RAAC.
Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.	Coppack, Victoria	~~30/09/2022~~ ~~31/10/2023~~ ~~30/11/2023~~ ~~31/03/2024~~ 30/06/2024	Validation of HCQ patient commenced in November 2023. Longest wait HCQ patients have been identified for tech review. Virtual review process to be discussed with Clinical lead. Clinic spaces to be secured for patient review. This is an interim measure whilst community hub is being developed.

	Clinical validation rota to be established within the service to ensure validation of high risk patients and longest waits is undertaken to prioritise patient reviews and safety net patients	Coppack, Victoria	~~30/09/2023~~ ~~31/12/2023~~ 30/04/2023	Validation ongoing and R1/longest wait patients booked in terms of their priority for next quarter. Co-ordinator in place, and triage and validation ongoing, however the list has not been reviewed in full as at December 2023, therefore revised action date of April 2024.
	A sustainable model for AMD to be developed with continued support from performance team.	Coppack, Victoria	Completed	Demand and capacity planning for IVT service undertaken and detailed SBAR to be drawn up. Action duplication, with other actions noted on the risk relating to the AMD/AVH pathway.

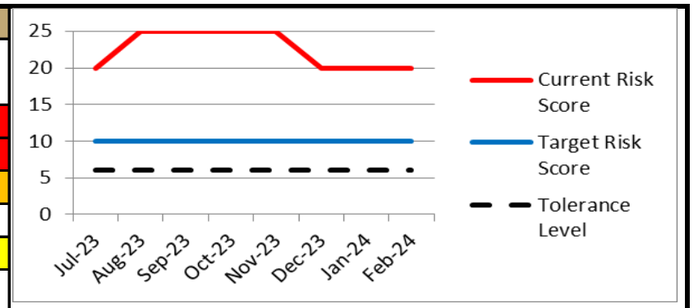
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

Date Risk Identified:	Jun-23		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jan-24
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Feb-24

Risk ID:	**1699**	**Principal Risk Description:**	There is a risk that there could be a significant loss of capacity to deliver elective, urgent and emergency and outpatient services at Withybush Hospital (WGH), and the delivery of the Health Board's Annual Plan 2023/24. This is caused by the requirement to undertake surveys and take immediate disruptive remedial works, where necessary, to address findings of reinforced autoclaved aerated concrete (RAAC) surveys at WGH, which may result in a number of wards being concurrently closed whilst surveys and remedial works are undertaken. This could lead to an impact/affect on the ability to safely manage demand across elective, urgent and emergency inpatient and outpatient services, including patients accessing specialist areas for care (including coronary care, complex oncology, gastroenterology, respiratory and stroke), disruption to pharmacy services, and poorer patient outcomes from overcrowding in the Emergency Department resulting in delays in accessing care and treatment. This will affect the Health Board's ability to achieve ministerial priorities as set out in the Annual Plan 2023/24 (eg, improvements to ambulance response times and emergency department waiting times). There may also be increased scrutiny from key stakeholders, including Welsh Government and other regulators which may lead to the loss of public confidence, and increased pressures on current workforce.
Does this risk link to any Directorate (operational) risks?		1382, 1385, 1657, 1027	

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):	2×5=10
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
The major internal incident was stood down on 19th January 2024, with updates now provided to Executive Team via Control Group. Following the closure of Cleddau West at South Pembrokeshire Hospital and the re-opening of Wards 7, 9, 11 and 12 it is considered that the risk to Inpatients services identified on August 25th 2023 has been sufficiently mitigated to allow for the de-escalation of the Internal Major incident. Detailed surveys complete in Wards 7,8/CCU,10, 11 & 12 have been completed. Works scheduled to complete the remaining 2 Wards on the 22nd March 2024 with re-opening planned for the 1st April 2024. Works completed in Wards 9 & 12 and reoccupied as medical capacity from 5th October & 9th November 2023. Throughput of inpatient elective surgery, as would ordinarily be delivered from Ward 9, remains low with same day admission pathway to Day Surgery Unit (DSU). Medical patients vacated the DSU footprint on 5th October 2023 when it returned to service with resumption of day case surgery on site. Medical patients withdrawn from the Pembrokeshire Haematology & Oncology Day Unit (PHODU) in November following reopening of Ward 12. This enabled reinstatement of full service to PHODU. Remedial works started in Ward 11 in Oct 2023 and completed at the of December 2023. Suitability of this area to be utilised as outpatient and/or therapy capacity is being scoped. Visual survey in Outpatients A has identified significant RAAC related issues (P1 planks). Detailed survey completed on 10th November with remedial works to follow, scheduled to return to service at end of June 2024. Alternative locations for outpatient provision being coordinated and scoped by scheduled care directorate. Schedule for detailed survey programme for ground floor areas developed with programme to complete by March 31st 2024. Remedial works to follow detailed survey in physio/therapy area, resulting in need to decant from February until the end of June 2024.

Rationale for TARGET Risk Score:
Surveys have been completed and remedial works with appropriate project plans being put in place, which once completed will reduce the likelihood of service disruption. There are a high number of "amber" planks which will require yearly monitoring & inspection over the coming years, with the possibility that they may also deteriorate and require additional remedial work in the future.

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 Cleddau Ward (East and West) in South Pembs Hospital, to reprovide 28 non acute inpatient beds to those meeting a pre-determined criteria Implementation of different model of care in Cleddau Ward to facilitate improved patient flow Emergency pathways, reviews and developments in place to minimise admissions and length of stay (LOS) in hospital Optimising available inpatient capacity, where possible. Reduced elective surgery activity on site pending completion of remedial works Maximising use of potential bed capacity in areas across WGH not affected by RAAC. Conveyance avoidance measures in place including clinical triaging of Health Care Professional referrals to secondary care Comprehensive plan in place to undertake planned surveys - contractor on site. Fast Track Visual Surveys and detailed surveys complete. Ground floor detailed surveys commenced mid October 2023.	Clarity on funding streams required to progress remedial works. Health Board Discretionary Capital allocation used to commence works in Wards 9 & 12. Funding has been approved to March 2024, however funding remains unapproved for FY 2024/25. To continue with this programme at pace is significantly beyond that which can be supported by our Discretionary Programme Clarity on scope and associated timelines of the required remedial works relating to physiotherapy outpatients Ability to manage impacts from loss of medical bed capacity is more challenging as numbers of bed losses increase and winter approaches Operational position on other sites does not easily support transfer of clinical pathways	To minimise scope and level of disruption as far as reasonably practicable by combining Phase 2 Fire Works with RAACs remedial works, where possible	Chiffi, Simon	~~31/07/2023~~ ~~30/09/2023~~ 31/03/2024	The scope document to reduce extent of Fire Investment at WGH was submitted in September 2023. In advance of a decision from Fire Service on this, the decision was made to proceed with the fire requirements as proposed in the submission. This was on the basis that as long as approval was received we would avoid further disruption to the 6 wards impacted by RAAC. As we have proceeded with the RAAC work, the fire elements have been incorporated, and envisaged completion of these works by March 2024. Formal approval now received from MWWFRS on revised scope, with BJC completed and being considered at next SDODC meeting on 29 February 2024.

Commenced programme of works, Pot Wash area & Wards 9 and 12 complete. Ward 7 and 11 ongoing (planned completion mid December). Potential to accommodate physiotherapy outpatient activity being scoped on Ward 3. Wards 8 & 10 due to complete works end March 2024. Utilising Acrowprop and/or hybrid measures to mitigate impact and reduce risk until repair works are undertaken Internal and External Communications undertaken and planned approach going forward Liaise with affected services and departments to communicate the expected impact of service disruption on their areas WGH RAAC Implementation Group, consisting of key estates and service management Control Group directly reports to Executive Team since major internal incident was stood down on 19th January 2024 Liaising with other hospital sites in England to understand how they've managed the situation	Ability to transport emergency and non-emergency patients to alternative sites				

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
Project plans in place dependant on outcomes of surveys, and monitored via the WGH RAAC Implementation Group	Fortnightly WGH RAAC Implementation Group meetings	1st			RAAC paper to SDODC (Apr 23) RAAC paper to HSC (Jul 2023) RAAC included in Director of Operations Report to Board (Jul23)	Unaware of the extent and impact of the risk until all surveys have been completed. All inpatient areas now surveyed as at September 2023, with P1 planks identified, and works schedule confirmed. Ground floor detailed survey have now been completed. Amber planks remain in situ and require ongoing monitoring with risk of deterioration unknown.	Urgent programme of assessment to be undertaken to assess remaining areas	Elliott, Rob	~~30/09/2023~~ 30/03/2024	Risk assessments currently being undertaken by the Estates and Facilities Directorate on remaining areas, the outcomes of which will assist in the decision on next steps regarding ward closures. Fast track visual inspection commenced to rapidly identify and mitigate risks over the c. 10-week programme Main surveys are still being undertaken, and due for completion by the end of March 2024, in order to prepare works schedules for next phases of work. Fast track surveys completed. A paper is being presented to SDODC on 29th February 2024 detailing the progress of these works.
	Command and Control Structure established to coordinate Health Board response	2nd								
	RAAC survey findings by external contractor	3rd								

Date Risk Identified:	Feb-24
Strategic Objective:	

Executive Director Owner:	Paterson, Jill	**Date of Review:**	Feb-24
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Mar-24

Risk ID:	**1810**	**Principal Risk Description:**

There is a risk that the Health Board will be unable to deliver an effective and timely cancer service to its patients. This is caused by the facilities of the Aseptic Unit being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS) standards 5th edition (published 2016) and therefore at risk of closure.

This could lead to an impact/affect on the ability to prepare cancer therapy and deliver the service within the Hywel Dda area for our patients. The Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. A fully outsourced service would cost an additional £1.3m each year. Some therapies cannot be outsourced, meaning Hywel Dda could not offer over 500 cancer treatments each year. This would have a significant negative impact on patient care as patients would either be required to travel further from home to neighbouring Health Boards to receive their treatment (dependant on their capacity to absorb the additional demand) or would be offered less clinically appropriate treatments at Hywel Dda, negatively affecting clinical outcomes. The closure of the Aseptic unit would directly impact the ability of the Health Board to achieve ministerial priorities and targets such as the Single Cancer Pathway, A Healthier Wales, etc.

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

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):	1×5=5
Tolerable Risk:	6
Trend:	*New risk*

No trend information available.

Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
The facilities of Withybush Aseptic unit are currently non-compliant with regulatory standards. The unit is subject to external audit by the National Pharmacy Quality Assurance Lead and the facilities were identified as being a high risk to patient safety in 2019. The most recent audit in performed in February 2023 confirmed the facilities remain a high risk and the unit is at risk of forced closure. A pharmacy Aseptic unit based at Glangwili General Hospital was forced to close in December 2018 as the facilities were deemed a risk to patient safety. Short term control measures have been implemented by the Health Board to reduce the risk of immediate forced closure (see control measures). However, as the unit and equipment are beyond their useful expected life, there will come a time where the control measures will no longer be sufficient to allow the safe running of the unit. If the unit was forced to close, the Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. Some cancer treatments cannot be outsourced due to their short shelf life. There were 345 reported service and quality-related incidents (e.g. delayed or failed deliveries) linked to outsourcing from commercial suppliers between September 2022 and August 2023 at Hywel Dda. Without a functioning Aseptic unit, the Health Board could not offer over 500 cancer treatments each year, and further treatments would be delayed/cancelled due to supplier service failures. A business case for the demountable unit at Withybush General Hospital was submitted to Welsh Government in February 2023. The business case also requested funding to convert the current Aseptic unit into drug storage facilities. Based on budget cost estimates of £2.89m the submission was for review and scrutiny by Welsh Government to provide assurance to the Health Board before resourcing, and underwriting the financial risk, of progressing a detailed design for tendering. In September 2023, Welsh Government requested submission of a fully tendered business justification case, which is currently being worked up by the Health Board. As part of the Transforming Access to Medicines (TrAMS) project programme, a regional manufacturing hub will be built in South West Wales that will prepare cancer therapy for Hywel Dda patients. The hub was originally estimated to open during 2028, however there have been delays to the project plan and the opening date is currently unknown. There is therefore a high risk that the current Aseptic unit at Withybush will be forced to close before the South West TrAMS manufacturing hub is operational. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality.	The target risk score is based on the premise that funding for a new aseptic unit is approved by Welsh Government. The unit would be compliant with regulatory standards and once operational, it would be extremely unlikely for the unit to be forced to close. A new unit would allow the Health Board to continue to safely prepare cancer therapy until the TrAMS South West manufacturing hub is operational.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Transfer of the radiopharmacy service to Singleton Hospital in October 2022; this means less overall activity through the Withybush Aseptic unit reducing the risk of contamination and errors. More time and resource provided to the Quality System (i.e. internal audits, investigation of near misses and microbial growths, maintaining SOPs). Increased training of aseptic staff to develop their skills and knowledge. Increase outsourcing from commercial suppliers; this limits the volume of products prepared within the unit, allowing products that must be made in-house to be prepared safely. New pharmaceutical isolators have been procured to replace the existing isolators that are beyond their working life. The new isolators will be stored with the intention of installing into the demountable unit (if funding is secured) or will be installed into the existing unit if the current isolators fail mitigating the risk of equipment failure causing prolonged service disruption. Removal of outsourced dispensing from the Aseptic unit; this minimises the risk of contamination and potential for error. Preparation of products near to the time of use; this limits the pre-administration storage time. More stringent gowning process; this minimises contamination risk. More stringent cleaning and monitoring programmes; this minimises contamination risk and allows early detection of microbial growth. Oversight and steer from Capital Sub-Committee.	Controls are reliant on a key group of skilled staff (i.e to maintain Quality System, to follow cleaning and monitoring procedures) therefore subject to key person dependencies. Limited accommodation to employ additional staff to expand workforce within the existing unit at WGH. Limited accommodation to store starting materials and finished products or to perform the associated tasks that are required to safely supply cancer treatments. Between 2021 and 2023, the number of cancer treatments requiring aseptic preparation at Hywel Dda increased from 12,718 to 16,648 (average of 14% increase each year). There is limited space within the Pharmacy at WGH to manage this increase in demand. Lack of funding to build a new unit at WGH.	To commence tender process for building a demountable aseptic unit on site at Withybush General Hospital.	Morgan, Cerith	30/04/2024	To be updated at next risk review.
		To submit revised business to Welsh Government.	Morgan, Cerith	31/01/2025	To be updated at next risk review.

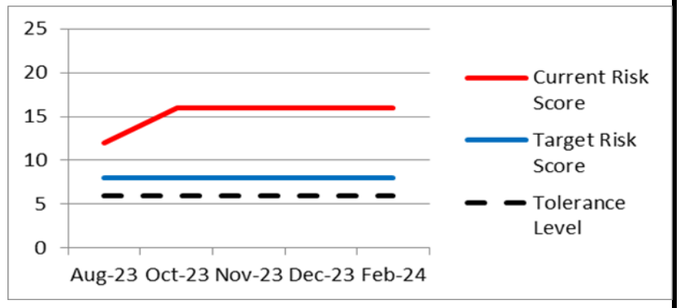
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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.		To partake in annual audit (EL Audit) by the Lead Quality Assurance Pharmacist.	Morgan, Cerith	29/02/2024	To be updated at next risk review.

Date Risk Identified:	Jul-23		
Strategic Objective:			

Executive Director Owner:	Paterson, Jill	**Date of Review:**	Dec-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-24

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

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



Rationale for CURRENT Risk Score:
8 dental contracts and 1 GMS contract have been returned to the Health Board in the last 12 months. This has resulted in 25,000 dental patients being displaced. In addition, a further 8 dental practices have not signed up to the contract reform, and signalling that they will return contracts once reform negotiations have concluded. 2 out of the 3 GMS contracts have become Health Board managed practices, resulting in additional financial pressures as the workforce is salaried, and third practice has been taken through the vacant practice panel process and has been through a successful procurement process. It is recognised that any further managed practices would likely have a negative impact on the GMS budget. The number of complaints received from the public has increased due to returned contracts, and while the Health Board is currently containing the demand for urgent dental care, it is recognised that patients who don't fall in to this category but require a level of dental care are detrimentally impacted, and that any further contracts returned will exacerbate this situation. The capacity of the Health Board in terms of staffing to absorb further contract reform will impact on the ability to effectively deliver services, and a detrimental impact on staff welfare. With a new Optometry contract implemented in October 2023, and new Clinical pathways to commence from 1 April 2024, there is an expectation of a shift from hospital care to the community, however the model is untested in terms of contractor capacity and skill set. Due to the above, the current risk score remains 16 as at March 2024.

Rationale for TARGET Risk Score:
Achievement of the target score is subject to the development and agreement of a Primary Care Strategy at Board alongside successful national contract negotiations and subsequent implementation across the Primary Care contractor professional groups.

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

convened as stipulated. Recommendations are taken through the Primary Care Contract Review Group with papers to Board when required.	pressures, and rare for practices to disclose financial details (reliant on engagement and good will as this is not a contractual requirement as at June 2023). Insufficient resources to support the estates development across all Primary Care services, particularly with independent contractors. Whilst Community Pharmacy Breach Management process in place, 2 notices are currently under the appeals process - the Health Board is awaiting confirmation on the outcomes of these by Welsh Government, which to date has taken 10 months. Outcomes of these appeal will directly influence the approach taken going forward, and may result in the nationally agreed process unable to be fully implemented.	Implement the Managed Practice Strategy plan will give greater system resilience.	Swinfield, Anna	30/10/2024	The tender process for Neyland and Johnston concluded without a contract award, however taking lessons learnt thre is a plan to reprocure for the contract with an estimated contract award date of 1 October 24.

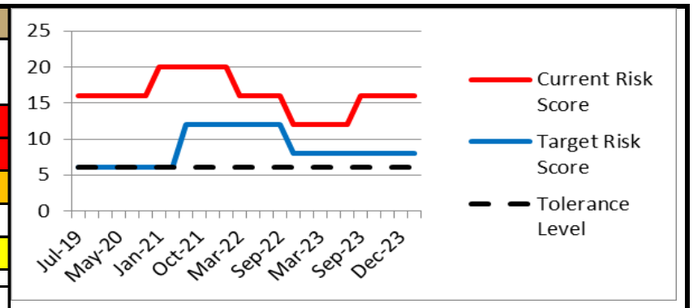
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Sustainability Matrix Contract performance to monitor volume metrics (identifies if dental practices have issues in service delivery) Monthly assurance reports and Dental Assurance Framework - Business Service Authority dashboards, to identify outliers	GMS practices are asked to complete a WG sustainability matrix every 6 months to track the main risk areas and this contributes to a heatmap. Practices are also asked to report regularly on operational pressures	1st			OQSEC Primary Care Exception Report (Jun 23)	Varying levels of engagement from practices in the regular reporting of operational pressures.				
	Dental Management Team undertake annual reviews	1st								
	GMS Practices are part of a rolling visiting programme, based on their annual return which is risk assessed against a framework of any other issues or concerns identified	1st								
	PCSMs tasked with regular discussions with Practices that report L4 to understand the issues	1st								

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Feb-24
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Mar-24

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

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



Rationale for CURRENT Risk Score:

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

The risk score is noted as 16 reflecting that some equipment has been installed and is operational, however further investment is required given recent breakdowns of key imaging equipment. A costed plan along with a rolling programme for the installation of additional equipment is in place. The next batch of equipment for replacement has been prioritised and identified. For 23/24 funding was obtained to replace one X-ray room and due to the RISP risks of non-DR compliant equipment, it was decided to replace the x-ray equipment at Tenby Cottage Hospital.

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

While a new CT scanner has been obtained and installed at Glangwili, the original CT scanner has had a number of breakdowns due to its age. The technology on this scanner is also now out of date, and impacts directly on the resilience of the service at our major trauma site in the Health Board.

Like-for-like replacement of existing equipment is not necessarily a cost effective method of maintaining services and in certain circumstances does not meet updated regulatory compliance or meet the requirements of maintenance warranty agreements. This means there will need to be upgraded infrastructure such as air handling units, water chiller systems and the size/accommodation for modalities at an initial increased cost but representing long term savings and service resilience overall.

Rationale for TARGET Risk Score:

While equipment has been installed as part of the current WG funding allocations, there is uncertainty as at November 2022 with regards to continued equipment replacements for financial year 2023/24 due to the discontinuation of a dedicated imaging equipment replacement allocation. New All Wales PACS procurement requires all equipment to be DR for compatibility. This has meant that replacement priorities have changed, and that some of the older DR compliant equipment are now overdue for replacement, and at risk of being de-prioritised.

As of Feb 2024, funding was allocated and work underway to replace the x-ray unit at Tenby. Additional WGH EOY funding has been secured to replace aged US units and upgrade the software on MRI scanners at BGH and WGH providing latest technology.

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports. # Escalation process in place for service disruptions/breakdowns. # Newly created National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales.	Limitation of spare parts for some older equipment leading to extended outages. This issue may be compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment. Competing demands for replacement equipment due to RISP, as four pieces of equipment will be non-compliant No dedicated diagnostic equipment replacement funding has meant that DCP bids are having to be developed for all equipment replacement. National Imaging and Capital Priorities Group held its first meeting in September 2023 therefore in its infancy, and has a further work required to ensure a fair and robust process is undertaken to appropriately assess all imaging modalities and which understands individual HB risks to equipment replacement.	To confirm the capital funding to replace existing aged equipment for FY 2023/24	Roberts-Davies, Gail	~~31/03/2023~~ ~~30/06/2023~~ ~~31/12/2023~~ 31/03/2024	A prioritisation list of aged equipment to be replaced has been devised, however confirmation needed on funding in order to undertake the required work. Funding has been given to replace Tenby DR equipment by the end of financial year 2023/24, and a task and finish group set up to monitor. Additional EOY funding has been secured to replace US units across the HB and 2 image intensifiers (BGH & WGH)
		To confirm funding arrangements for the remaining equipment that needs to be replaced, supported by individual DCP bids or dedicated replacement funds for 2024/25.	Roberts-Davies, Gail	~~30/09/2023~~ ~~31/12/2023~~ 31/07/2024	Directorate has compiled a list of equipment requirements, which have been prioritised dependant on finance availability and functionality of the existing equipment and presented at Capital Sub-Committee in September 2023. Priority list has also been submitted to the National Imaging Equipment Capital Priorities group (NHS Executive Group) via assessment process, with outcomes currently pending as at November 2023. It is noted that funding has been given to replace Tenby DR equipment by the end of financial year 2023/24, and a task and finish group set up to monitor. The next NIECP meeting is due to be held in April 2024 where the prioritised list of equipment replacements will be presented for consideration.

Installation of replacement Gamma Camera, WGH	Roberts-Davies, Gail	31/07/2024	Gamma camera is 9 years old and the only scanner in the Health Board providing a regional service. Recurrent breakdowns are resulting in HIW reportable incidents. Awaiting confirmation of funding as at December 2023. No funding allocated as of 09/02/2024
Replacement of CT Scanner at GGH	Procter, Sarah	~~31/03/2024~~ 31/07/2024	CT scanner is 11 years old, with increased failures noted and that new technologies are now available. Colleagues in Estates are currently looking at options and prices, and as at December 2023 no capital bid yet provided as awaiting works costs. Will not be replaced in 23/24 this financial year
Replacement of digital x-ray rooms at Tenby Cottage Hospital and South Pembrokeshire Hospital	Roberts-Davies, Gail	31/03/2024	Funding has been given to replace Tenby DR equipment by the end of financial year 2023/24, and a task and finish group set up to monitor. SPH will not be replaced in the 23/24 financial year.
Replacement of ultrasound systems at BGH & GGH, image intensifier units at BGH & WGH, and Vacuum Assisted Biopsy (VAB) unit for PPH Breast Clinic	Osell, Fiona	31/03/2024	Ageing equipment with replacements required for obstetric scanning, and resilience of services provided to Theatres. DCP bids have been collated for BGH ultrasound and WGH image intensifier, and exploring opportunities for charitable funding to support VAB unit for PPH Breast Clinic. Outcomes are still pending as at December 2023.
Replacement of Fluoroscopy room, WGH	Roberts-Davies, Gail	31/03/2024	Equipment is 17 years old with significant downtime experienced. Awaiting confirmation of funding as at October 2023.

Replacement of CR A&E DR room and OPT (Dental) units, BGH	Edwards, David	31/03/2024	Ageing equipment, with the dental unit 26 years old. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract.
Replacement of CR X-ray Room 1, WGH	Roberts-Davies, Gail	~~31/03/2024~~ 31/07/2024	Ageing equipment. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. This will not be replaced in the 2023/24 financial year
Replacement of CR X-Ray room, Llandovery Hospital	Osell, Fiona	31/03/2024	Equipment on site is incompatible with the incoming PACS system, and interim solution required. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. Awaiting confirmation of funding as at December 2023.
Replacement of Mammography Units, BGH and WGH	Roberts-Davies, Gail	~~31/03/2024~~ 31/07/2024	Ageing equipment, exacerbated by the failure of Secureview. These will not be replaced in the 23/24 financial year
Upgrade or replacement of MRI scanner, PPH	Osell, Fiona	31/03/2024	Ageing equipment with increasing failures, with new technologies now available. Awaiting confirmation of funding as at October 2023.

Upgrade or replacement of MRI scanner, GGH	Procter, Sarah	31/03/2024	Ageing equipment with increasing failures, with new technologies now available. Awaiting confirmation of funding as at October 2023.
Replacement of Room 3 (Digital x-ray room), BGH	Edwards, David	31/03/2024	Mobile unit currently being used. Awaiting confirmation of funding as at October 2023.
To consider alternative funding options for the DEXA unit, BGH	Edwards, David	31/03/2024	Unit is 17 years old, and previously funded via charitable funds

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Reduction of waiting times to under 8 weeks .	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team - Mar19 Further updates CEIMT Feb20 Further updates CEIMT Sep20	Lack of process of formal post breakdown review.				
	IPAR report overseen by PPPAC and Board bi-monthly	2nd								
	Internal Review of Radiology Service Report (Reasonable Rating	3rd								
	WAO Review of Radiology - Apr17	3rd								
	External Review of Radiology - Jul18	3rd								

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

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

Risk Rating:(Likelihood x Impact)		**No trend information available.**
Domain:	Quality/Complaints/Audit	
Inherent Risk Score (L x I):	4×4=16	
Current Risk Score (L x I):	4×4=16	
Target Risk Score (L x I):	2×2=4	
Tolerable Risk:	8	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
New processes are in place for mortality review, in line with the All Wales Learning from Mortality Framework, supported by the Clinical Lead for Mortality and Mortality Review and Improvement Facilitator. However, these are not fully embedded across all acute sites due to the issues with scanning capacity. Risk score was previously increased to 12 to reflect additional resource requirements for the successful rollout at GGH ahead of the statutory introduction of the Medical Examiner Service in April 2024. Subsequently, the risk score has increased to 16 due to the proximity to the statutory introduction in April 2024. GGH remains fragile and WGH has experienced some fragility due to long term absences within the team. There is currently insufficient scanning capacity to enable the scanning and sending of casenotes to the Medical Examiner Service to enable the full roll-out to Glangwili wards. Glangwili scanning staff are currently scanning all of Prince Philip casenotes and a proportion of Glangwili Hospital (all Medical Wards and 1 Surgical). There is therefore an inability to complete the roll-out to Glangwili ahead of the statutory introduction of the Medical Examiner Service in April 2024. In addition, there is a lack of sufficient clinician capacity across all disciplines to screen Medical Examiner Service letters, and is causing a backlog which has the potential for urgent concerns highlighted by the Medical Examiner to become lost.	The ability to scan and send notes to the Medical Examiner Service across all sites will enable the Health Board to meet the statutory responsibilities, by providing the information required by the Medical Examiner Service in a timely manner. Full roll-out of this service across all Health Board sites will allow for global communications to be issued, with information about the processes and responsibilities of Doctors. This will also allow for reminders to be sent when there are issues with the process, e.g. support for timely completion of the Medical Certificate of Cause of Death. The Internal Scanning Bureau being developed may provide a potential sustainable, long-term solution however won't be operational prior to 1st April 2024.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Processes have been developed and implemented in line with the All Wales Learning from Mortality Review Framework to manage cases received from the Medical Examiner Service, covering Bronglais, Prince Philip, Withybush and parts of Glangwili Hospitals. The Medical Examiner Service has delivered some sessions at Grand Rounds previously and there are another two sessions planned for February (to outline the basic principles of the Medical Examiner Service and how to complete a Medical Certificate of Cause of Death), and in March to introduce the legislative changes once the system becomes statutory in April 2024. Fortnightly Multidisciplinary Review Panel in place, which is Chaired by the Clinical Lead for Mortality and has membership including Deputy Associate Medical Director - Primary Care; Hospital Director; Head of Quality and Governance; Head of Nursing; Assistant Director of Nursing and Quality Improvement; Head of Legal Services; Clinical Pharmacy Lead for Patient Services; Clinical Effectiveness Co-ordinator; Senior Nurse Infection Prevention and Patient Safety Officer. The Mortality Review and Improvement Facilitator is responsible for co-ordinating the Panel. Datix module now being used to record all cases received from the Medical Examiner Service. Community Hospital Roll-out complete and primary care roll-out ongoing (which is required to be in place by April 2024), managed by the Medical Examiner Service, with the Health Board assisting with supporting communications.	Different processes are in place across acute sites currently to enable the scanning of casenotes to the Medical Examiner Service, with fragility remaining across sites and Glangwili Hospital being only partially rolled out. An interim solution to transfer casenotes from Prince Philip to Glangwili Hospital to be scanned also needs to be addressed. An SBAR has been developed with resource requirements to resolve this and enable the processes to be fully rolled out. The SBAR has been shared at Executive level. The potential solution of the Internal Scanning Bureau will be explored as a long term, sustainable solution, however this will not be operational by 1st April 2024. Full roll-out in Glangwili still to be achieved due to scanning resources. This is having an impact on global communications and training programmes as there is an inability to inform all staff of the new processes whilst there are different processes in operation in Glangwili. Processes for primary and community deaths in progress. This is being led by the Medical Examiner Service. While a	Acceleration of local plans to support the full implementation in Glangwili General Hospital, and provide a sustainable solution for Prince Philip Hospital (as outlined in the SBAR).	Perry, Sarah	04/01/2024	National date amended to 1st April 2024. Local plans being accelerated to support implementation in Glangwili General Hospital however awaiting agreement of SBAR for additional scanning resources before roll out can be completed. Medical Examiner Service is almost fully operational in Hywel Dda UHB for acute and community hospital sites. Bronglais, Prince Philip and Withybush all fully operational, however there are delays being experienced with implementation in Glangwili Hospital, due to scanning capacity. Interim arrangements to scan Prince Philip case notes in Glangwili need to be addressed - the SBAR includes this. There is also some service fragility in Withybush. Detailed conversations are ongoing with regards to clinical engagement, scanning capacity and mortuary provision. Community Hospitals are fully operational. Discussions with Primary Care ongoing.

A Care After Death Steering Group has been established and is scheduled to meet bi-monthly. The Group is Chaired by the Assistant Director of Nursing, Legal Services and Patient Experience and is attended by: Head of Bereavement Services, Senior Care After Death Project Manager, Clinical Lead for Mortality, Assistant Director of Nursing and Quality Improvement, Head of Effective Clinical Practice and Quality Improvement, Assistant Director, Medical Directorate, County Director representative, General Manager (Community & Primary Care (Ceredigion), Head of Pathology, Lead Biomedical Scientist for Histology and Mortuary Services, Cellular Pathology Services Manager, Regional Mortuary Manager, Regional Mortuary Manager, Assistant Director Acute Services Nurse Representative, Head of Patient Experience, Clinical Nurse representative Women and Children, Clinical Nurse representative Mental Health and Learning Disabilities, Clinical Nurse representative Primary, Community and Intermediate Care, Specialist Bereavement Counselling Service, Chaplaincy Representative, Transplant Co-Ordinator representative, Learning and Development representative, General Practitioner representative, Psychological Services representative.	Care After Death Steering Group has been established, due to operational pressures, meetings have been postponed.	Ensure engagement on and communication of new processes to all Doctors across sites, using information, training sessions (e.g. Grand Rounds) and promotion of SharePoint information.	Hill, Carly	31/03/2024	Engagement and communication is ongoing. Discussions with Hospital and Directorate Triumvirates and other Quality and Governance groups. Global communications are delayed until the process is fully operational on all sites, to avoid any confusion. SharePoint pages developed but as above, not live until processes are fully in place. Training plan in development. Wider communications need to be issued when process is fully operational. Discussion has taken place with Medical Education on programme of training for completion of MCCD.Grand Rounds session undertaken in February 2023. Communication to all Doctors has taken place in relation to responsibilities for completion of MCCD. Awaiting agreement of SBAR to provide additional resources to enable completion of GGH roll-out.
		Identify additional clinical staff across disciplines to screen letters received from the Medical Examiner Service.	Hill, Carly	31/03/2024	Inclusion of request within the Autumn 2023 Medical Directorate newsletter for anyone interested in screening cases to come forward. Attempt to secure an additional Medical screener has failed over negotiations around service release.
		Explore the solution of the Internal Scanning Bureau, once operational.	Hill, Carly	30/09/2024	The tender for the scanners is due out by week ending 19/01/2024 and there is a lead in time of around 8 weeks, once a contract is awarded. Estimated time for service to be fully operational not anticipated until Summer 2024.

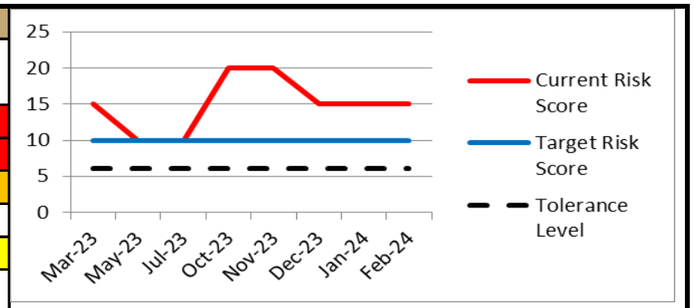
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Number of deaths not scrutinised. Number of Delayed MCCD's completed. Number of deaths not registered due to lack of Medical Examiner involvement.	Number of deaths and number of case notes shared with Medical Examiner Service	1st			Effective Clinical Practice Advisory Panel (05/12/2023) Quality, Safety and Experience Committee (13/02/2024)	The process from death to registration is not captured on one system therefore gaps in completion and delays are dependent on information sharing across organisations including Health Board, Medical Examiner Service and Registrar Offices in Carmarthenshire, Ceredigion and Pembrokeshire.	Discuss with stakeholders improved information sharing arrangements.	Hill, Carly	31/03/2024	Not commenced.
	Mortality Scrutiny Group Medical Examiner Service	1st								
	Monitored by Medical Examiner Service	1st								

Date Risk Identified:	Nov-22		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Feb-24
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Mar-24

Risk ID:	**1531**	**Principal Risk Description:**	There is a risk of being unable to provide a safe and sustainable general surgery consultant on-call rota at WGH. This is caused by vacancies across the General Surgery Consultant rota (1:5) at WGH and one substantive consultant who is no longer taking part in the on call rota, due to health issues. There is reduced capacity to support rotas internally (BGH/GGH Consultants). This could lead to an impact/affect on the ability to provide an emergency general surgery service at WGH, patient experience, clinical delays, deterioration, and outcomes for patients, the wellbeing of remaining consultants who are already working to full capacity and increased expenditure on agency locum consultants.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

The risk score has remained the same, due to the Medacs locum allowing the surgical emergency service at WGH, to continue on a 1:4, 24/7 rota with 2 substantive consultants, 1 NHS locum and 1 Medacs. The 1:4 rota has been in place since 03/11/2023, with no issues to date. The rota remains fragile due to the reliance on Medacs locum cover and the cost and risks that this involves. An NHS locum consultant was appointed on 20/11/2023, this candidate has since withdrawn on 29/11/2023. There will now be a continued reliance on Medacs locum cover.
The speciality doctor rota is also being supported by a Medacs locum due to 2 vacancies on the 1:5 rota. Discussions are being held about reducing the rota to a 1:5 and re-advertising 1 WTE as an exit strategy to the Medacs doctor.

Rationale for TARGET Risk Score:

The target risk score remains high due to the intended recruitment of a second NHS locum to fill the gap and maintain a 1:4 24/7 on call rota at WGH. However, this will not address the longer term sustainability of the rota and lack of substantive staff to fill the rota. This will prioritised as part of the development of the Clinical Service Plan in 2023/24.

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**
There are currently 4 consultants on the rota, 2 substantive, 1 NHS locum and 1 Medacs locum who joined the team on 06/11/2023. An NHS locum consultant post was advertised and appointed to on the 20/11/2023 as an exit strategy for the Medacs locum. The successful candidate withdrew on 29/11/2023 and a decision on re-advertising is yet to be finalised. In response to the fragility of this rota and the recruitment difficulties that have been faced. A plan for relocating emergency surgical on call from WGH has been submitted as part of the directorates annual plan.	The 1:4 model which commenced on 03/11/2023 continues to be fragile, with only 2 substantive consultants on the rota. The 4th slot on the rota is being filled by a Medacs locum which incurs additional costs. There are also risks of the locum leaving at short notice, causing the rota to collapse.	Recruitment of 2 x substantive and 1 x locum positions	Lewis, Caroline	20/11/2023	One NHS locum has been recruited and has been in post since 04/09/2023. Currently out to advert for a second NHS locum (following a previous withdrawal of application) Interviews are due to take place on 20/11/2023.

Current staff from WGH and GGH continue to provide backfill to maintain the rota. Continuously liaising with the rota coordinator at WGH for potential gaps on the rota. Proactive sickness management Escalation to clinical leads Medacs locum has been briefed on clinical pathways and procedures within Hywel Dda Health Board and expectations have been made clear by the surgical team. Engagement with WGH Medical Staff Committee and public on changes to services An interim 1:3 model with day consultant cover being provided by WGH consultants and night consultant cover being provided by BGH or GGH on a rota, came to an end on 03/11/2023. Board approval was received for a 1:4 24/7 surgical consultant on call rota to commence from 03/11/2023. The rota consists of 2 substantive consultants, 1 NHS locum, 1 Medacs locum. Clinical pathways in place and concerns are dealt with in a timely manner.	An NHS locum consultant post was advertised and appointed to on the 20/11/2023 as an exit strategy for the Medacs locum. The successful candidate withdrew on 29/11/2023 and a decision on re-advertising is yet to be finalised by the HB. To maintain the current rota model, we will now be reliant on the Medacs locum for a longer period. The locum consultant who started on 04/09/2023 was an associate specialist and part of the MG rota, this has now left a gap on that rota. Currently being covered by a Medacs locum. We advertised and appointed a specialty doctor but the successful candidate withdrew on 13/11/2023. The post went back out to advert and we appointed on 01/12/2023. This person withdrew on 07/02/2024 and a decision is yet to be made about re-advertising the post. Concerns raised about a transfer, which is being managed by an IMG process.	To introduce a contingency model of day time consultant on-call rota in WGH with support from GGH and BGH consultant cover out of hours.	Lewis, Caroline	Completed	Report discussed at Acute Leadership Group, Executive Team and Operational Planning and Delivery Programme (OPDP) meetings. A 1:3 rota was agreed and will commence from 01May23.
		Review the longer term sustainability of general surgery on-call rotas across Hywel dda (recommendation from Getting it Right First Time (GIRFT) review in Jan23)	Lewis, Caroline	31/12/2023	We have now received the final GIRFT report and the action plan has been received at executive level. A full action plan is now supported and clinically led by the health board general surgical clinical lead, nursing and operational teams.

	Vacancies remain due to inability to appoint permanent Consultants to WGH. Risk of short notice sickness, with limited options of sourcing internal cover for this. Due to the fragility of the on call rota there is limited elective capacity for locum consultants, which makes this post less attractive than other Health Boards. Reduced capacity to support this rota internally (BGH/GGH Consultants). Prolonged change to rota may impact on training of surgical doctors in WGH. Concerns from WGH physicians on the wider implications on the emergency service model at WGH.	Robust plans to be developed for transfer and repatriation of patients	Lewis, Caroline	Completed	SOP has been developed and discussed with clinicians.

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

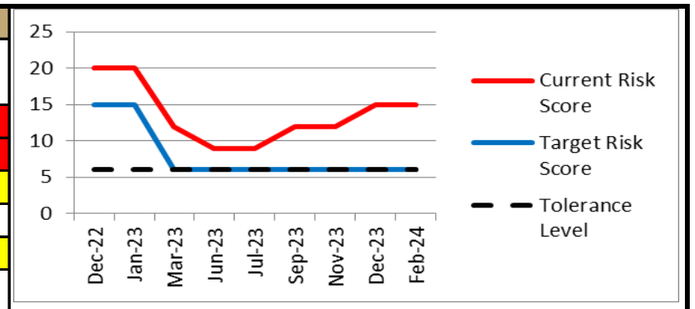
Reported to bi-monthly Scheduled Care Quality, Safety and Experience Group through exception reporting	2nd			Management team to present updated SBAR to Acute Leadership Group (Oct23)					
Assurance to be reported to the Board following introduction of temporary rota	2nd								
GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited				Management team to present updated SBAR to Acute Leadership Group (Nov23)					

Date Risk Identified:	Nov-22		
Strategic Objective:	5. Safe and sustainable and accessible and kind care		

Executive Director Owner:	Gjini, Ardiana	**Date of Review:**	Feb-24
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Mar-24

Risk ID:	**1548**	**Principal Risk Description:**	There is a risk of the Health Board being unable to maintain routine, urgent and emergency service provision across the organisation in the event of industrial action by Health Board staff and staff in other NHS/partner organisations, eg Welsh Ambulance Service Trust (WAST). This is caused by the British Medical Association (BMA) announcing dates of strike action following a ballot to members which received support for industrial action. This could lead to an impact/affect on patient care, patient safety, delivery of services and organisational reputation. Additionally this could also impact delivery of the Health Board's delivery plan, waiting lists (and associated initiatives) and financial position.
Does this risk link to any Directorate (operational) risks?		1027, 1407, 1550, 1641, 1666	

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):	5×3=15
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	6
Trend:	⬆



Rationale for CURRENT Risk Score:

The British Medical Association (BMA) have declined an offer of 5% uplift (1.5% uplift for Junior Doctors including SAS Doctors) for 2023/24 to basic pay. Ballot notices were received by employers (both Hywel Dda UHB and NWSSP) detailing that the ballot to members would run until 18 December 2023. This applies to Junior Doctors only. Confirmation was received that the BMA reached the 50% threshold required to mandate action for the period 8th January - 17th June 2024.

Mitigation and contingency measures, together with command and control structures put in place during periods of previous action by Trade Unions resulted in a co-ordinated response to minimise impact as far as possible, and this has been re-established.

Following the first round of industrial action held from 15th-18th January 2024, the BMA have advised that they intend to take further 72 hours consecutive period of industrial action from 7am on 21st February to 7am on 24th February 2024 (taking us in to a weekend period). This will be a full walk out of all junior doctors including those providing emergency cover. The ballot relating to the Specialty and Specialist (SAS) Doctors and Consultants closes on 4th March 2024.

No formal notice has been received from the British Dental Association notifying of their intention to ballot members. However, other Health Boards and the Single Lead Employer (SLE) have received this notification. The SLE have now confirmed that the BDA members in Hywel Dda UHB were not part of the ballot process.

Rationale for TARGET Risk Score:

The likelihood currently remains the same as the BMA has announced further dates of industrial action in February. It is expected that the risk score will increase in March as provisional notice (yet to be formally confirmed) has been received on further junior doctor action from 7am on 25th to 7am on 29th March, 2024 (an increase from 72 to 96 hours duration). Coupled with this being the first week of the Easter school holidays and the run up to two bank holidays plus the end of the annual leave year, equates to significant operational challenges for the Health Board.

If the Consultant and SAS doctors' ballot reaches its mandate for action, then the BMA have indicated that the 25th March will be the earliest these groups would also take industrial action (but indications are this is likely to be 30th March or even 02 April 2024).

The risk will increase if the two groups take action concurrently or immediately following each other, either side of the bank holidays.

Executive ownership is joint (Directors of Public Health, Workforce and Operations) but will be supported by the Medical Director and Director of Nursing, Quality and Patient Experience as required.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Industrial Action Planning Group formed for planning, developing contingency measures and response arrangements. Chair and Vice-Chair confirmed. Command & Control structures in place at local, regional and national level. Proactive compilation of critical service areas from a HB perspective (based on Essential Services Guide) completed. Process developed for scoping scale of staff intentions to take industrial action in place. Process developed for scoping of staff groups in planned action in place. Data capture process in place to determine impact on service delivery, patient care and financial position. Process for measurement of "harm" in place. Communication strategic approach agreed with staff FAQs, public communications, internal staff communications and partner agencies. Local support in place to enable accurate completion of derogation forms if required. Range of contingency measures ready should any derogations be refused. Medical representation secured for the Industrial Action Planning Group All Wales Industrial Action Workforce & Derogations Group established now merged with the All Wales Operational Planning Group. System Resilience Planning and Response Group National Co-ordination Industrial Action Working Group established. Health and Social Services Executive Director Team (HSS EDT) Contingencies Group - Industrial Action Oversight Group established in Welsh Government.	Outcome of the Consultant/SAS ballot will not be known until 04 March 2024 (at the earliest). Formal confirmation of the dates for the March junior doctors industrial action still to be received from the BMA.	Specific response plans will be developed following notification from the B,A on dates they intend to take strike action on. These will include early contact between NHS Employers ((on our behalf) and the BMA; derogation process; student arrangements; and links to national process. The updating of previous key controls will be instigated as necessary following the previous action in January 2024.	Gjini, Ardiana	~~05/06/2023~~ ~~21/08/2023~~ ~~05/11/2023~~ ~~03/01/2024~~ ~~15/01/2024~~ 21/02/2024	Will progress via the Industrial Action Planning Group as dates now confirmed.
		To confirm new chair and vice chair of Industrial Action Planning Group	Gjini, Ardiana	Completed	Executive Director of Public Health has been appointed Chair of IA Planning Group, and deputised by Executive Director of Workforce.
		Range of contingency measures to be developed should any last minute in service plans occur. This will include submission of emergency derogations if necessary.	Gjini, Ardiana	~~15/01/2024~~ 21/02/2024	In progress.

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
	Industrial Action Planning Group Meeting regularly	1st			Remuneration & Terms of Service Committee 11 January 2024					
	Regular updates to Executive Team and OPDP	1st								