Operational Risk Register

Date: September 2026

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
1588	Community & Integrated Medicine	Ceredigion Integrated System	Bronglais General Hospital	Carruthers, Andrew	Skitt, Peter	Cullum, Louise	Poole, Andrew	16-Apr-22	There is a risk of patients not receiving required diagnostic scans, which will impact upon the care provided to the patients presenting in an emergency and patients who become unwell whilst admitted. This is caused by Bronglais only having one CT scanner, so when a breakdown occurs, the CT scanner is taken out for maintenance and the nearest scanner is a 90 minute drive away. In recent times, CT scanning has become primary diagnostic for management of trauma and other emergency presentations and the hospital has had to divert patients to other centres meaning their care cannot be delivered within the required timescales. This will lead to an impact/affect on patients who do not receive a diagnosis with an appropriate timescale. WAST/transportation because of the diversions put in place. Flow at other sites, principally Glangwili, which will receive diverted patients. Risk location, Bronglais General Hospital.	New CT scanner now in place	Safety - Patient, Staff or Public	4	5	20	Since the new CT scanner has been installed there have been frequent and regular periods of outage that means BGH has been without access to a CT scanner. Risk increased by GM to reflect frequency of service outage. Having a second CT scanner in place would mitigate this risk. The consequences could be severe for specific patients (e.g. stroke patients) if the timing of attendance coincides with equipment downtime. Regular maintenance of the scanner and improved procedures for communication with the Radiology team have improved the chances of taking pre-emptive action. This risk has been decreased following a stable period with fewer break downs. To be reviewed regularly. This risk is due to be updated to ensure it articulates the current position.	Business case to be developed for second CT scanner	Cullum, Louise	~~30/06/2023~~ ~~31/03/2025~~ ~~31/08/2025~~ ~~31/12/2025~~ ~~31/03/2026~~ ~~30/06/2026~~ ~~30/09/2026~~ 31/12/2026	Therapies / radiology leading the development of a business case, however there has been delays due to current financial constraints. Completion date revised aligned with site re-configuration review	Quality, Safety and Experience Committee	3	2	6	Without significant financial investment and appropriate space identified, a 2nd CT scanner is unachievable. Target risk date amended to reflect this challenge	Treat	17-Sep-26
																Assurance regarding maintenance contract	Roberts-Davies, Gail	**Completed**	Awaiting further information from Radiology							
2409	Community & Integrated Medicine	Carmarthenshire Integrated System	Glangwili General Hospital: GGH	Carruthers, Andrew	Skitt, Peter	Andrews, Bethan	Andrews, Bethan	01-Apr-18	There is a risk of of poor outcomes for stroke patients. This is caused by a fragile service which lacks the skilled stroke MDT staff as per national stroke standards. BGH and GGH have only 1 consultant, and a lack of a 7 day service (no weekend service) across the Health Board. Radiology services do not have enough trained staff to run a CTP service for stroke. There are noticeable discrepancies in performance between the west and east side of the health board, as per SSNAP data. This will lead to an impact/affect on delayed assessments and treatments of patients	Mortality reviews being monitored. Compliance with agreed levels of treatment/therapy monitored annually via Royal College of Physician audit and monthly via Operational Stroke Group meetings with appropriate action taken as follows. Active recruitment for all vacancies. Allied Health Professional leads allocate staff to ensure staffing is as equitable and safe as possible. Nurse staffing levels are monitored	Safety - Patient, Staff or Public	4	5	20	Not enough funding available to recruit correct staffing levels. Evidence shows having one dedicated unit is best outcomes for patients, however Hywel Dda currently has 4 small units in a wide geographical area. Following the February 2026 Board meeting, they favoured the combined option of 106/210, which requires further engagement, which will be reported back to Board in November 2026. At present patients who wake up with stroke symptoms, the HB has not got	Present report to Board following public engagement public on the combined options 106/210	Andrews, Bethan	30/11/2026	Outcome of engagement will be finished in July 2026 with report to be presented to Board in November 2026	Quality, Safety and Experience Committee	2	3	6	Whilst the CSP is a 4 year programme, Stroke services has a 10 year plan to be agreed following the report to Board in November 2026, therefore this is reflected in the TRS date of March 2036. By having dedicated stroke unit the major and moderate stroke patients outcomes and recovery should be measurable improved, as outlined in the SSNAP targets and rehabilitation outcomes	Treat	22-Sep-26

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									assessments and treatments of patients. Increased length of stay due to insufficient therapy treatment. Failure to meet National Stroke Standards including the WHC national clinical guideline for stroke. Increased complaints and claims.□ □ Risk location, Health Board wide.	Nurse staffing levels are monitored through the NSL.□ □ Planned remote advice and support cover can sometimes be arranged □ □ Stroke part of the Clinical services Plan programme.□ □ Dedicated unit/ward with trained staff available to stroke patients.□ □ Any incidents will be investigated by the stroke team or SDM.□					stroke symptoms, the HB has not got the ability due to lack of CTP to establish time of stroke, and damage to the brain. Currently we have a 4 hour window for treatments, instead of and 9 hour window which the CTP can provide. Across the four sites, performance in April 2026 shows: â€¢Consistent challenges in early pathway metrics (scan times, thrombolysis rates) â€¢Variation between sites, particularly in stroke unit access and therapy provision â€¢Stronger performance in swallow screening and therapy delivery, though still variable â€¢Significant opportunity to improve ESD and discharge pathways, especially at GGH and WGH. Further performance data to be added once SSNAP data available.	To establish a business and governance framework within the CCG for Stroke Services	Andrews, Bethan	31/12/2026	This work is being led by Associate Medical Directorate.					rehabilitation outcomes.□ □		
1894	Operational Allied Health Professions & Health Sciences	AHP&HS: Speech & Language Therapy	AHP&HS: Speech and Language Therapy	Carruthers, Andrew	Quarrie, Sara	Thomas, Alison	Mallon, Sonia	01-Jun-23	There is a risk of that acute stroke patients will not receive the speech and language input they need. This is caused by there being no dedicated Stroke Speech and Language Therapists (SLT) in the Health Board. All of the current Speech & Language Therapy staff are working across the whole hospital site covering other wards as well as the stroke ward. □ □ and the Health Board will not meet the national standards for stroke rehabilitation. This will lead to an impact/affect on nutrition and hydration needs for prolonged nil-by-mouth patients and patients on modified diet, resulting in significant/long term consequences□ - Withholding or delaying medication can also have negative implications□ - Challenging for patients with communication difficulties to be included in decision-making and communicating with family and friends□ - Significant distress for those involved leading to challenges with mental health and wellbeing□ - Staff would not have support on how best to	There is a prioritisation system for patients who are nil by mouth. If patients are not seen for several days, they are moved up the prioritisation system. Reviewed quarterly.□ □ Regular review of the number of stroke inpatients across all sites to determine staffing levels and move Therapy Assistants according to demand.□ Stroke Operational Meetings are attended by Stroke Lead to raise awareness□ New Band 5 are now given time on the wards.□ Re-direction of funding to create a stroke focused band 6 role in WGH hospital.□ The redirecting of the stroke band 7 role from WGH to GGH where the highest number and most complex stroke patients are admitted.□ All therapists are generalist therapists to be able to work across the whole acute caseload.□ Development of ESD SLT therapists	Safety - Patient, Staff or Public	5	4	20	The current risk score is based on the current situation across the Health Board: the SLT staff provide cover across whole hospital sites and are not dedicated to Stroke SLT. Therapists are often reallocated to cover leave, sickness and training which impacts on availability for SLT staff to provide Stroke rehabilitation. There is a reliance on other sites to cover and therapists swapping non-work days to ensure cover for all acute and mental health wards and community hospitals. Current Impact score of 4 reflects the increased length of hospital stay for these patients and potential mismanagement of patient care with long-term effects, and patients not receiving the rehabilitation required in order to make therapy gains. The Likelihood score is 5 as 100% of stroke patients are not receiving the recommended rehabilitation.	New Band 5 to be given time on the wards at GGH	Thomas, Alison	Completed	2 x Band 5 therapists starting 02/09/24 - they're timetable will include time on Gwenllian Ward, GGH x 2 days a week each□ Band 5 therapists are in place and have begun working on Gwenllian ward	Quality, Safety and Experience Committee	2	4	8	Even with the control measures in place to mitigate the risk it is acknowledged that the SLT service to stroke patients will continue to not meet the national guidelines due to lack of funding for dedicated stroke posts. □ □ Current national guidelines advice 0.56wte per 5 beds. The work completed for the CSP shows that even with the control measures in place we are 6.28wte down across the HB. To achieve the TRS of 8, the SLT service would need to address this staffing deficit. □ □ The main challenges to mitigating this risk are therefore:□ - receiving funding for the	Treat	01-Sep-26
																Review clinical prioritisation tool every quarter	Thomas, Alison	Completed	Reviewed quarterly							
																Develop business plan to seek funding for stroke funded SLTS	Thomas, Alison	Completed	This is now being picked up through the CSP							

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									communicate and adhere to HB values□ - Current staffing levels mean that patients are not receiving rehab as often as they should□ - Currently only 3 therapists in HB trained to complete these highly skilled assessments. There is currently only 1 video fluoroscopy (VF) clinic a month and 1 Fibreoptic evaluation of swallowing (FEES) clinic, both only in GGH, therefore not meeting current staffing and patient assessment standards □ - Increased pressure on fellow MDT members due to lack of attendan Risk location, Health Board wide.	from external funding□ □ Involvement with Health Board Clinical services plan to highlight staffing and service fragility.□ □ Annual audit of clinical stroke notes to ensure adherence to SLT clinical standards.□ □ Reduced capacity protocol implemented. □ Answerphone messages to be changed to include our response times so the wards are aware.					The current staffing levels are not fulfilling the required 5 day working, however, the national guidelines highlight the need and importance for 7 day working. There is no planned investment into SLT Stroke services. In addition it is based on there being only 1 SLT Stroke Lead that covers the whole HB. Her role and responsibility is nearly 3 times bigger than her equivalents in Physio and OT who have a lead in each county. She attends all service development meetings for each site and leads all stroke SLT service improvement projects. In addition to this, she is also the main clinical SLT covering the stroke ward in GGH.	Involvement with Health Board Clinical services plan to highlight staffing and service fragility	Thomas, Alison	Completed	On going engagement - moved to Control Measures					recommended number of posts □ - recruiting qualified Band 6 SLTs (there is an increasing national shortage of suitable candidates)□ - lack of accommodation for new staff□ - expansion of leadership team beyond current 1 SLT stroke lead□ □ The TRS date is based on successful implementation of the 5-year CSP.		
																Funding to be sourced via Clinical Service Plan.	Thomas, Alison	31/03/2027	New action							
																Recruit into current 0.8wte vacancy	Thomas, Alison	Completed	Successfully uplifted the vacancy to 1.0wte recruited into							
																Recruit into upcoming Band 5 vacancy	Thomas, Alison	Completed	B5 recruited to - start date of 29th Sept 26							
2179	rational Allied Health Professions & Health Sciences	AHP&HS: Dietetics & Nutrition	AHP&HS: Dietetics and Nutrition	Carruthers, Andrew	Quarrie, Sara	Roberts, Sarah	Francis, Kathryn	01-Oct-25	There is a risk of there is a risk that due to the 72hour targets and prioritisation of stroke patients within the acute setting impacts on patients with other urgent dietetic care needs This is caused by This is caused by staffing establishment not meeting minimum staffing requirements for stroke patient care across acute hospital sites, community and rehabilitation services, and prioritisation KPI targets for stroke intervention This will lead to an impact/affect on desired outcomes of care across wider inpatient population as existing dietetic capacity will be diverted to stroke care, impacting negatively on other acute patients who become lower priority and could lead to poorer outcomes, increased LOS . This is evidenced by inability to meet	Acute Dietitians currently triage / prioritise Stroke patients alongside other urgent admissions and inpatient presentations, with knock on impact on other presentations increasing DBS caseload □	Safety - Patient, Staff or Public	4	4	16	Currently patients are seen within targets however this is likely to create future risk and risk to other patients care as a result .□ The likelihood is 3 as this is not sustainable practice .April 2026 With CSP option of 59 bedded unit at GGH there are no staff to move to this unit and therefore require funding for 3.0wte dietitians dedicated to urgent Stroke care June 2026 - options continue to be out for consultation closing in July	To ensure dietetic representation at HB operational stroke meetings to highlight the gap in provision and articulate need	Roberts, Sarah	Completed	Kath francis and Sarah Roberts oversee attendance at HB meetings and dietitians on each acute site are involved in site discussions	Quality, Safety and Experience Committee	2	4	8	The Target impact of this risk remains 4 as serious risk without receiving additional dietetic resource. However if 3.0wte dedicated dietetic resource made available for proposed 59 bedded acute stroke unit and successfully recruited into the impact would be lower. The likelihood of this risk with the target of additional dietetic resource will be minimal		25-Aug-26
																Stroke dietetic funding has been applied for and additional resource has been highlighted at AHP annual planning and additional staffing mapped out using updated tools	Roberts, Sarah	Completed	Annual plan completed with projected numbers of staffing required to provide optimal care							

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	Ope								Nutrition Support Standards. This will have further potential impact on patients nutritional status (especially if requiring artificial feeding / modified texture diets), risk of de-conditioning / poorer outcomes during rehabilitation phase as currently this population await general community service ongoing care with longer waits for specialist dietetic intervention and treatment. Achieving targets in acute stroke care is not sustainable without additional capacity. Risk location, Health Board wide.							Project applied for in EQUIP re dietetic input and prevention of deconditioning in stroke patients at PPH site . this will help support additional dedicated dietetic resource across the health board and the reduction in deconditioning and improvements in rehab and value based care this results in	Francis, Kathryn	**Completed**	Project not selected for EQIP 8 however is supported by Improvement team and will go ahead. Ongoing project July 2026.							
																to apply to convert current Band 6 acute vacancy into a Band 7 clinical lead acute role with a focus on Stroke at GGH where the CSP specifies acute stroke unit to support Band 6 dietitians covering stroke wards and highlight need for dedicated posts	Roberts, Sarah	**Completed**	This action was not felt helpful so has not been actioned as awaiting funding stream for dedicated specialist stroke dietitians							
																To continue to attend AHP stroke task and finish groups and planning meetings to highlight staffing required for new stroke CSP, both in Acute and rehabilitation services	Roberts, Sarah	30/11/2026	new action							
1317	ealth Professions & Health Sciences	AHP&HS: Occupational Therapy	AHP&HS: Occupational Therapy	Carruthers, Andrew	Quarrie, Sara	Adams, Jon	Davey, Rachel	10-Dec-21	There is a risk of Avoidable harm, delayed recovery and poorer outcomes for stroke patients across the Hywel Dda stroke pathway who require Occupational Therapy assessment, treatment and rehabilitation. This is caused by Insufficient recurrent Occupational Therapy workforce capacity to meet current and anticipated demand across the stroke pathway, including significant workforce gaps against Royal College of Physicians staffing recommendations increasing rehabilitation demand, reliance on prioritisation of acute	Expedite recruitment to funded posts and prioritise cover of vacancies for stroke.□ □ Prioritisation of acute, inpatient phase of stroke pathway within funded establishment or stroke.□ □ Utilise non stroke specific/stroke funded staff to support assessment and rehabilitation of stroke patients.□ □ Maximise rehabilitation delivery	Safety - Patient, Staff or Public	4	4	16	The Occupational Therapy workforce continues to operate below recommended stroke staffing levels. Whilst existing control measures, including prioritisation of acute stroke rehabilitation, use of integrated support staff, multidisciplinary working and implementation of the Integrated Community Stroke Service have mitigated some risk, demand continues to exceed available capacity across the pathway.	Develop Early Supported Discharge (ESD) Services to support stroke survivors and provide rehabilitation within home environment	Reed, Lance	**Completed**	Integrated Community Stroke Service providing ESD established across the whole Health Board - Complete	y, Safety and Experience Committee	3	4	12	The target risk score reflects the anticipated reduction in likelihood of patient harm through continued development of the stroke rehabilitation pathway, including implementation of the Integrated Community Stroke Service, ongoing demand and capacity modelling, strengthened workforce planning,	Treat	28-Aug-26

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	Operational Allied Hs								activity, cessation of unfunded voluntary weekend and Bank Holiday provision, and competing service pressures across wider Occupational Therapy services This will lead to an impact/affect on Delayed assessment and rehabilitation.□ Reduced rehabilitation intensity and frequency.□ Increased functional dependency and disability.□ Increased hospital length of stay.□ Delayed discharge and flow challenges.□ Increased risk of admission to long-term care.□ Increased burden on carers and community services.□ Failure to achieve SSNAP, Welsh Government and NHS Wales performance expectations.□ Increased financial pressures associated with longer admissions and avoidable care costs.□ Reputational risk to the Health Board. Risk location, Health Board wide.	through collaboration with and training of support staff, other professional groups as well as carers & patients.□ □ Maximise rehabilitation delivery through use of groups where clinically indicated.□ □ Clinical practice group in HB and links to All Wales stroke networks to share innovative and efficient practices and adoption into local practice where relevant.□ □ Community Integrated Stroke Service supporting ESD service implemented across Health Board □ □ Care Aims training provided to Senior Clinicians September & October 22□ □ Therapy Staffing Level / Rehabilitation needs included within Clinical Services Plan □ □					The service remains reliant on prioritisation decisions which frequently result in rehabilitation activity being reduced, delayed or displaced. The recent cessation of unfunded voluntary weekend and Bank Holiday Occupational Therapy cover further reduces resilience within the system and may impact timeliness of assessment and rehabilitation delivery. Whilst no significant patient harm events have been directly attributed to these workforce constraints, there remains an ongoing risk of poorer patient outcomes, increased length of stay, delayed discharge and failure to achieve national stroke standards. Consequently, the current score of 16 (Extreme) remains appropriate pending further workforce modelling, establishment review and identification of sustainable recurrent capacity.	Explore additional resources to support community based AHP capacity	Reed, Lance	**Completed**	Funding bid for additional community based AHP capacity to support ESD in Carmarthenshire and Ceredigion has been approved.	Quality				enhanced monitoring of rehabilitation outcomes and performance measures, and development of business cases to address identified workforce gaps. Whilst the impact of any workforce shortfall on stroke patient outcomes remains significant, these actions are expected to improve service resilience, rehabilitation capacity and pathway performance, reducing the likelihood of adverse patient outcomes from 4 to 3. However, due to the continued gap between existing workforce capacity and nationally recommended staffing levels, a residual high risk is expected to remain		
																Establish Early Supported Discharge in Ceredigion and Carmarthenshire	Reed, Lance	**Completed**	Funding confirmed and recruitment in progress							
																Share VBHC evaluation of ESD service within directorate and to stroke steering group	Bradburn, Jo	**Completed**	To share VBHC evaluation to directorate and stroke steering group to facilitate a discussion about future of ESD/need to revise model							
																Demand and capacity modelling required to inform future planning and contributions to both CSP and annual planning cycle for next financial year	Adams, Jon	~~31/03/2027~~ ~~30/01/26~~, ~~28/02/26~~, ~~31/03/26~~, ~~30/04/26~~, ~~30/05/26~~, ~~30/06/26~~, 30/09/26	New action. Including wider community capacity to support Stroke services. 27/09/26 SBAR taken to Stroke Ops meeting re cessation of weekend / BH voluntary cover which will reduced any additional demand on the team and services. This was approved.							
2182	Community & Integrated Medicine	Ceredigion Integrated System	Bronglais General Hospital	Carruthers, Andrew	Skitt, Peter	Cullum, Louise	Poole, Andrew	30-Jul-20	There is a risk of avoidable harm to the quality and provision of stroke services at Bronglais General Hospital This is caused by the fragility of the stroke service with a single handed locum consultant in post This will lead to an impact/affect on senior medical support for patients and staff negatively, increased emotional and mental pressure on the service and clinical staff, increased reliance on locum, poor sustainability, reduced options to	CNS for stroke in post for support □ SAS doctor for stroke in post, covering inpatients and OPD with supervision □ Substantive SAS acting up as locum consultant. Incumbent unable to be appointed substantively due to CESR requirements.□ Cross site cover arrangements in place when practicable □ Leave policies maintained	Workforce/OD	3	4	12	Longstanding locum consultant in post with substantive SAS contract. Unable to be appointed substantively. □ On a day to day basis the risk is managed with support from CNS and consultant colleagues, but this is not sustainable.	Recruit substantively to stroke consultant position	Cullum, Louise	31/12/2026	Recruitment to substantive consultant position is not currently possible due to budgetary constraints. Medical stabilisation work within the medical directorate ongoing.	Safety and Experience Committee	2	1	2	If sustainable and robust workforce model introduced with succession planning, the risk could be reduced within tolerance	Treat	28-Jul-26

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	C								improve models of care, longer waiting times for patients to access care Risk location, Bronglais General Hospital.							Secure agency locum for stroke/ general medicine to cover the planned sick leave of the current locum consultant	Davies, Claire	**Completed**	AG1 approved by execs and submitted to agency, with locum consultant confirmed to cover planned sick leave	Quality, S						
199	Community & Integrated Medicine	Ceredigion Integrated System	Bronglais General Hospital	Carruthers, Andrew	Skitt, Peter	Cullum, Louise	Poole, Andrew	01-Apr-15	There is a risk of of avoidable detriment to the quality and timely provision of patient care. This is caused by the establishment of substantive consultant staff is no longer fit for purpose in a post COVID medical setting. This is exacerbated by a sustained inability to attract substantive consultants, an ageing consultant workforce and financial constraints which inhibits robust succession planning. This will lead to an impact/affect on increased reliance on locums, lack of senior decision making and clinical leadership, reduced support for SAS and junior doctors in training. Reputational damage and increase in incidents or concerns. Risk location, Bronglais General Hospital.	Engagement with HDUHB & Mid Wales Healthcare Collaborative (MWHCC) clinical strategy development forums.□ □ Human Resources Leave and Retirement policies followed.□ □ HB wide medical stabilisation working group to review establishment of medical staff in progress. □ □ Supporting existing SAS doctors to progress their CESR certification to be appointed substantively. 1 Substantive consultant in ED has been appointed with 2 medics currently completing the portfolio pathway.□ □ □ □	Safety - Patient, Staff or Public	3	4	12	Substantive appointment to cardiology following CESR pathway has increased substantive consultant numbers, but does not provide any additional resource. □ □ Successful "Grow your own" initiative underway for respiratory services and similar pathway for gastroenterology, diabetes and stroke medicine to be considered and encouraged.□ □ The need to increase our substantive consultant number is crucial for the sustainability of our services and succession planning. Robust workforce strategy for Bronglais Hospital to be developed by hospital management team and workforce colleagues, but due to financial constraints may not be achievable in this financial year. □ □ Medical stabilisation work currently being undertaken by workforce and the medical directorate to align budgets and establishment to Royal College recommendations.	Discuss with medical workforce re: increments for existing locum staff to boost morale and retention of experienced staff □	Cullum, Louise	~~31/03/2023~~ ~~30/06/2023~~ ~~31/12/2023~~ ~~31/03/2024~~ ~~31/12/2024~~ ~~31/12/2025~~ ~~31/03/2026~~ ~~30/05/2026~~ 31/12/2026	Initial discussion with medical workforce held. Awaiting guidance from All Wales and HB before any progression can be made. Completed date revised accordingly.	Quality, Safety and Experience Committee	1	4	4	Target date amended to reflect both the current financial and recruitment challenge whilst also reflecting the need for improvement at speed. Will be reviewed regularly.	Treat	14-Aug-26
																Appoint substantively to our consultant vacancies□	Cullum, Louise	~~30/09/2020~~ ~~30/06/2023~~ ~~31/12/2023~~ ~~31/12/2024~~ ~~31/12/2025~~ ~~31/08/2026~~ 31/12/2026	COTE, MAU and Cardiology consultant appointed substantively since risk first identified. Substantive A&E consultant appointed in December 2025. 2 locum consultants undergoing CESR pathway. Awaiting guidance from medical workforce regarding locum consultant posts. □ □ Completed date revised due to ongoing financial constraints. Many of our existing vacancies have SAS doctors acting up into the vacancy which limits our ability to recruit substantively without an increase in medical establishment. Vacancy in gastroenterology unable to be advertised due to lack of funding.							

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																Remove the risk of single practice consultants	Cullum, Louise	~~19/06/2020~~ ~~30/06/2023~~ ~~31/12/2023~~ ~~31/12/2024~~ ~~31/12/2025~~ ~~31/03/2026~~ ~~30/05/2026~~ 31/12/2026	The Health Board approved strategy included a plan to invest in more consultant posts in Bronglais. Site management exploring options around workforce to support, with an ANP in respiratory and irritable bowel disease providing some support for services. The Gastroenterologist post is currently not able to be funded/ recruited into A substantive rheumatology consultant is now in post to bolster consultant numbers. Recruitment and funding remains a challenge and completion date revised accordingly.							
																Develop internal process to identify current middle grade doctors to act up as consultants and support them with obtaining CESR	Cullum, Louise	~~01/11/2017~~ ~~30/06/2023~~ ~~31/12/2023~~ ~~31/12/2025~~ ~~31/03/2026~~ ~~30/05/2026~~ 31/12/2026	Four substantive middle grade physicians are "acting up" as locum consultants in Acute Medicine, A&E, Respiratory and Stroke Medicine. Supporting these SAS doctors with their own development and encouraging them to go through CESR pathway. Awaiting guidance from medical workforce re: locum consultants to feed into medical stabilisation work/ strategy.							

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																Explore new initiatives to support the consultant workforce	Cullum, Louise	~~30/06/2023~~ ~~31/12/2023~~ ~~31/12/2024~~ ~~31/08/2026~~ 31/12/2026	Discussion with medical recruitment and medical workforce re: specialist doctors to help support our consultants and junior doctors as part of medical stabilisation plan and workforce strategy. Completion date revised to allow this work to take place and for associated funding to be agreed if necessary							
																Develop a sustainable medical workforce strategy for Bronglais Hospital	Davies, Claire	~~31/12/2024~~ ~~01/02/2025~~ ~~31/08/2025~~ ~~31/12/2025~~ ~~31/03/2026~~ 31/12/2026	There is a need for a robust medical workforce strategy for BGH to be developed which is aligned to the HB's commitment to support fragile services and the need for succession planning and development of current medical staff. A medical stabilisation working group across the HB has been established to ensure medical workforce is aligned with the RCP safe staffing levels guidance of 2018. Completion date revised accordingly as progress to date has been slow							
																Develop IMT training provision at Bronglais Hospital to encourage career progression and development for existing staff and to aid recruitment and retention of our consultants of the future	Davies, Claire	**Completed**	Pilot IMT programme started in August 2025 with support from the medical education team, HEIW and medical directorate. 4 Clinical fellows to take part and will be regularly reviewed. Action completion date revised to reflect the need for feedback before closing							

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1618	Medical Director	Medicines Management	Medicines Management	Henwood, Mr Mark	Williams, Owain	Williams, Owain	Treharne, Mari	14-Jul-22	There is a risk of that patients will not receive appropriate thromboprophylaxis when admitted to hospital This is caused by failure of completion and documentation of the thromboprophylaxis risk assessment for all hospital patients This will lead to an impact/affect on patients due to failure to prescribe or inappropriate prescribing of thromboprophylaxis. This could lead to patient harm, complaints and claims. Claims may not be indemnified by the Welsh Risk Pool if no risk assessment was completed. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Training - all junior doctors receive training on completion of thromboprophylaxis risk assessment as part of their induction using a standardised presentation.□ Pharmacists prompt prescribing or correct inappropriate prescribing as part of clinical review of all new admissions.□ Audits demonstrate that thromboprophylaxis is prescribed although risk assessment is not documented.	Safety - Patient, Staff or Public	3	4	12	.	All Wales thromboprophylaxis e-learning is being developed which will be part of mandatory training for junior doctors	Treharne, Mari	**Completed**	Now available on ESR all health professionals. However, this is not mandatory and compliance cannot be monitored. Being reviewed on an All Wales basis.□ Elearnin g to be updated and then relaunched on an all Wales basis	Quality, Safety and Experience Committee	1	4	4	Impact will remain high as risk of VTE will remain in place.□ Likelihood of VTE risk assessment not being completed will reduce once EPMA rolled out across all areas of the Health Board.		27-Jul-26
																Quality improvement teams on each acute hospital site and undertaking quality improvement projects around VTE	Treharne, Mari	~~31/05/2023~~ ~~31/03/2024~~ ~~30/09/25~~ ~~30/06/26~~ 31/12/26	Projects are ongoing.□ Audits - Application for 2024 forward programme has been completed. 2023 audits continue. This work will be part of an annual program of audits□ Quality improvement team are now doing monthly spot checks of VTE compliance and reporting back to clinical leads.□ Improvement plans agreed for PPH and GGH . Showcase events held in both PPH and GGH on 8/8/25 , well attended by medical staff. Annual audit 2025/6 showed some improvement overall. Annual audit to be repeated in 26/27.							

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																Raise awareness of VTE e-learning	Treharne, Mari	**Completed**	New action - progress at next update. Quality Improvement Team are planning a re-launch week commencing 6th October at each acute site. Site visits across a week in October, poster displays with QR codes and links to policy and guidance. Resources supplied by Thrombosis UK. Spoke to 120 Doctors across all 4 sites. Task adn finish group reviewing the risk assessment adn once approved will be relaunched. New VTE risk assessment approved , to be implemented once current supply used up 								
																Thromboprophylaxis policy updated and consultation period closed	Treharne, Mari	**Completed**	Meeting to discuss comments following consultation 28/06/23. Policy agreed and on the intranet.								
																Implementation of ePMA	Dunne, Helena	~~30/09/2025~~ ~~28/02/2026~~ ~~31/05/2026~~ ~~30/06/2026~~ 31/03/2027	New action. Awaiting WG funding followed by HB implementation schedule. Role out of EPMA due to begin in February 2026, now delayed until May 2026 22/1: use of thromboprophylaxis form hosted by Better Meds approved by Thrombosis Group and areas form to be mandated in agreed								

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																Thromboprophylaxis risk assessment to be reviewed by task and finish group and when completed will be relaunched	Treharne, Mari	**Completed**	Task and finish group has been established, Meetings have been held Draft version for discussion at Thrombosis meeting 3/10/24. review completed ,awaiting approval by Thrombosis group and MMOG. Once approved will be relaunched. Approved at Jan 2025 MMOG. Meeting to discuss roll out plan to be scheduled. New risk assessment with printers, to be implemented once current supply used up. new risk assessment launched at grand round , available in the printers for ordering by departments, some have started using and others will once current stock is finished. Now in use across all sites						
1791	Community & Integrated Medicine	Carmarthenshire Integrated System	Glangwili General Hospital: GGH	Carruthers, Andrew	Skitt, Peter	Skitt, Peter	Evans, Iona	07-Dec-22	There is a risk of to patient safety, privacy, dignity and comfort whilst waiting within the room 7 & 8 'surge' area of the Emergency Department (ED). This is caused by This is caused by room 7 & 8 adapted to manage pressures from ED waiting room at times of extreme pressure. (i.e. 'surge' area). The room, designed to care for a single patient, has piped oxygen, suction and nurse call bell for single patient occupation. The room is furnished with chairs for patients who are waiting admission to the wards. Patients can be waiting overnight within the area and consequently experience difficulty and discomfort trying to sleep in the chairs. The patients are exposed to general noise within the department which can exacerbate difficulty sleeping. The room does not allow for patient privacy or confidentiality as there is no separate area available to maintain patient confidentiality whilst being reviewed by Clinicians and patients are in close proximity to each other during busy times. This increases the risk of cross infection as well as increasing trip hazards from equipment required to provide treatment to patients.	Registered Nurse allocated to room 7 & 8. □ □ Daily safety huddles (9.15am & 2.45pm), providing opportunities to raise concerns and escalate issues including patient flow.□ □ Pillows and blankets provided to patients to make them more comfortable whilst waiting in the chairs. Repose cushions are also on the chairs to aid pressure relief.□ □ Recommendations highlighted in HIW Emergency Unit, Glangwili General Hospital (2022) have been actioned which include the following:□ • Standard Operational Procedure (SOP) in place which includes an assessment of the risks for use of additional surge capacity in the department e.g. additional capacity in room 7 & 8.□ • Risk assessment formalised to	Safety - Patient, Staff or Public	3	4	12	Whilst some control measures are in place the risk remains high as the â€˜surgeâ€™ area can be unsuitable during times of extreme pressures on the ED department.□ □ Recurring themes in complaints relating to a lack of privacy and dignity in consultations and treatment due to overcrowding within ED resulting in patients being cared for in surge areas, including around the bay, room 7&8 and the waiting area.□ □ In 2025 a serious incident review following an unwitnessed patient fall in the room resulting in decline and admission to ITU. In 2026 no serious incidents have been reported, however there remains poor patient experience and deconditioning. □ □ ENT currently support ambulatory ENT patients through red suite. Meetings held to discuss direct	Phase II Workstream to support Medical take through Medicine rather than ED currently in progress.	Standeven, Louisa	~~30/09/2024~~ ~~30/11/2024~~ ~~31/05/2025~~ ~~01/07/2025~~ ~~31/10/2025~~ 30/09/2026	The plan is to work up with the clinical teams, as subject matter experts, the expansion of services in Priory Day. This will include SDEC optimisation, collocation of front door frailty, IC-MDT and hot clinics to champion a HomeFirst approach to UEC. A weekly T&F group established in order to meet the inherent requirements/ critical time points to make this a success. 7 day Clinical Streaming hub approved at January 2026 Board, with discussions taking place to take this work forward.	Quality, Safety and Experience Committee	1	4	4	There are plans to move room 7 and 8 back to MH room/RESUS bay which will close this risk. This will require Capital to progress.□	Treat	21-Jul-26
																Surgical SDEC Development to remove surgical take from ED	Evans, Iona	**Completed**	Completed.							

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									This will lead to an impact/affect on possible deterioration of patient's condition as well as potential pressure damage to patients who are waiting in a chair for a long period of time. □ There is an increased risk of cross infection due to an inability to maintain adequate distance between patients, especially at times of extreme demand. This in turn can lead to increased morbidity and mortality, especially to frailer patients. There is an increased risk of falls due to trip hazards from equipment such as infusion pumps, which can also increase morbidity. These factors lead to a poor patient experience and increased complaints and claims. □ Risk location, Glangwili General Hospital.	strengthen the escalation procedure.□ • Mobile screens available if required.□ □ Notices in place to advise patients to request private room if they wish to speak to a staff member in private□ □ New initiative for all GP medical referrals are directed to the medical SDEC for review and treatment/admission decision.□ □					admissions of pathways to Merlin Ward.□ □ NHS Exec visit Sept 2025, recommendation from review advised to return room 7 & 8 back into a Mental Health room.□ □ Following the CSP Board meeting January 2026,impact on GGH in terms of Clinical Pathways (Stroke, Emergency Surgery), further work is required. There are plans to move room 7 and 8 back to MH room/RESUS bay which will close this risk. This will require Capital to progress.	Pathway of care delay review underway	Evans, Iona	**Completed**	Regular process now in place.							
																Implementation to streamline patient pathways out of ED to clinical areas. Focus on T&O, ENT and FAU.	Standeven, Louisa	~~30/04/2025~~ ~~01/07/2025~~ ~~31/10/2025~~ 30/09/2026	Teifi Trauma Ambulatory Care is live. Frailty scoping is part of the medical model and repurposing the SDEC area. ENT currently support ambulatory ENT patients through red suite. Meetings held to discuss direct admissions of pathways to Merlin Ward. □ All Clinical pathways are under review. Timescale extended to Sept 2026 in line with SDEC work.							
2080	National Allied Health Professions & Health Sciences	AHP&HS: Physiotherapy	AHP&HS: Physiotherapy	Carruthers, Andrew	Quarrie, Sara	Davies, John	Davies, John	23-May-25	There is a risk of Increased length of stay and delayed community physiotherapy assessment and follow up rehabilitation for stroke patients being discharged from PPH and GGH This is caused by The reduction in registrant capacity by 50% (band 7 x 1wte, band 5 x1wte) for stroke Early Supported Discharge (ESD) as a direct result of permanent loss of RIF funding from 25-26. This will lead to an impact/affect on Reduction in hospital flow Delay in Patients receiving a full physiotherapy assessment. rehabilitation and detailed care planning in community Potential increase in length of stay deterioration in SSNAP targets	The remaining physiotherapy team members will provide a restricted service based on the capacity of 2 registrants and 5 HCSW staff. □ Ward based staff will provide clinical and therapeutic advice to patients on discharge to bridge the gap between discharge and first physiotherapy community visit.□ Other MDT members (Occupational therapy and dietetics) can be the first point of community contact whilst patients are waiting for physiotherapy □	Safety - Patient, Staff or Public	4	3	12	Physiotherapy assessment will be provided at the earliest opportunity, and interdisciplinary working will ensure the patients will receive a basic intervention in the absence of a physiotherapist in the community. Whilst clinical risks are mitigated the Health Board clinical services plan heavily relies on the community workforce to support flow across the stroke pathway.	SBAR to be submitted to the CCG and the SDM for Stroke:□ □	Griffith, Susan	**Completed**	John Davies to present SBAR in the next PPP care group meeting. 28/5/26 no further update. No further funding received as yet. The physiotherapy service is contributing to workforce plans for CSP stroke programme which includes a the requirement for ESD / CIST	Quality, Safety and Experience Committee	2	3	6	The current team even when fully staffed falls short of the national staffing levels for stroke.	Treat	21-Sep-26
																CSP physiotherapy workforce requirements to be submitted	Griffith, Susan	**Completed**	information submitted							

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	Opera								Risk location, Carmarthenshire.							SBAR and QIA to be updated following CCG review.	Griffith, Susan	**Completed**	11/09/25 Non alternative funding source identified. Service is reviewing skill mix as part of SBAR option appraisal to reconfigure service delivery in stroke pathways with reduced funding for this specialty area. 18/11/25 Service reconfiguration in process to mitigate cost pressure. SBAR to be updated to inform CCG of reconfiguration approach and impact. 30/03/26-Service has reconfigured with loss of two posts. Delivering service within financial envelope. Closed action.							
																escalation email to be sent to Bethan Andrews requesting support to fund 0.5 wte band 6 physio which has been lost from the building community care cost code.	Davies, John	**Completed**	email sent , awaiting response							
2170	l Allied Health Professions & Health Sciences	AHP&HS: Occupational Therapy	AHP&HS: Occupational Therapy	Carruthers, Andrew	Quarrie, Sara	Adams, Jon	Adams, Jon	23-Sep-25	There is a risk of that patients admitted to acute hospitals do not receive timely occupational therapy assessment, treatment and discharge planning due to insufficient establishment and workforce gaps This is caused by This is caused by a combination of workforce shortages, sustained vacancies, recruitment challenges, maternity leave, sickness absence and baseline staffing establishments that do not meet recommended workforce standards for acute and stroke rehabilitation services, resulting in insufficient capacity to meet current and increasing levels of patient demand This will lead to [illegible]	Acute Hospital clinical Prioritisation used to ensure that patients with the highest level of need are seen as a priority.□ □ Deployment of staff from acute teams to support patients with highest level of need, in line with clinical prioritisation. □ □ Clinical triage by site clinical lead multiple times a day. □ □ Development of workforce 'bank' to support short term vacancies. □ □ [illegible]	Safety - Patient, Staff or Public	3	4	12	The current risk score remains High because baseline workforce capacity remains insufficient to meet demand across acute and stroke pathways despite daily prioritisation processes, temporary workforce deployment and recruitment activity. Workforce shortages continue to impact the service's ability to provide timely assessment, rehabilitation and discharge planning on a consistent seven-day basis. As a result, patients may experience delays to intervention, prolonged hospital stays and poorer rehabilitation outcomes. The persistence of vacancies, [illegible]	Reviewing community capacity for patients known to community and where they have capacity to support the acute team with inpatient assessment and discharge planning through daily calls with acute and community team	Davies, Sharon	**Completed**	Ongoing □ □ 04/05/2026 WGH Established x2 weekly calls with SPH Community Hospital, to discuss suitable rehab pathway for patients who may benefit.□ □ WGH ongoing work with PCC Reablement Team who are attending Board Round, identifying patients who would benefit from discharge home with Reablement programme.	Quality, Safety and Experience Committee	2	4	8	The target risk score assumes successful recruitment to vacant posts, establishment of a sustainable staffing model within acute and stroke services, reduced reliance on temporary staffing, improved workforce resilience and implementation of recommendations arising from the acute occupational therapy demand and capacity review. These measures [illegible]	Treat	31-Jul-26

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	Operationa								This will lead to an impact/affect on This could lead to delays in occupational therapy assessment and intervention, delayed discharge planning, increased length of stay, hospital deconditioning, increased risk of falls and deterioration, poorer rehabilitation outcomes, increased pressure on patient flow, failure to achieve national stroke standards, increased workforce pressure and reduced patient experience. These impacts may contribute to avoidable harm, increased financial costs and failure to achieve organisational planned care and flow objectives Risk location, .	The service requests financial control group support for within budget agency to cover short term vacancies that can not be covered by bank workforce.					recruitment delays and workforce turnover indicates that the likelihood of the risk materialising remains significant despite the mitigating controls in place.	Move band 5 into Acute team to support where we currently have a band 6 vacancy.	Davies, Sharon	**Completed**	Been out to advert x 3 and working with finance to relaunch advert □ □ x1.72wte Band 6 posts offered provisionally and undergoing employment checks. Delayed start dates due to MAT Leave and sponsorship required.□ □ 08/06/2026 Start of Agency Band 6 to assist in Acute Inpatients, Increase of x1day/week Band 7 tnime.					would significantly reduce the likelihood of patients experiencing delays in assessment, rehabilitation and discharge planning.		
																Review budget lines with finance team to explore options for recruitment of bank staff and agency staff. Agency requests for GGH approved. Review requirements in WGH following band 6 recruitment	Adams, Jon	**Completed**	Bank advert being progressed. Agency request has been approved. Expecting oversees candidate to start in post June / July. Bank advert recruited to. Action to be closed.							
																Undertake service review including D&C for acute OT teams	Adams, Jon	~~31/12/2025~~ ~~30/01/26~~, ~~28/03/26~~, ~~30/04/26~~ ~~30/05/26~~, ~~30/06/26~~, 30/10/26	ongoing							

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																Recruitment to x2Band 6 role has resulted in offer of 1.6wte. However candidates will be unable to take up roles until earliest late Oct 2026. □ Plan - submission of AG1 Form requesting Agency to provide capacity for 4-6months	Davies, Sharon	**Completed**	AG1 Form submitted. Awaiting response.□ □ 08/05/2026 AG1 approved.. Seeking Agency and/or Bank Band 6.□ 28/05/2026 Bank Band 6 Interview to take place 03/06/2026□ 08/06/2026 Agency Bank 6 started□ 04/08/2026 x1WTE Sponsorship - to start 24/08/2026 pending final checks. Delayed start of 11/01/2026 for Further OT on due to maternity							
																Benchmark workforce against national stroke and acute therapy standards.	Davey, Rachel	31/12/2026	Benchmarking work underway with CSP colleagues and within the service measuring against NHS benchmarking data							
																Establish agreed escalation matrix / thresholds when staffing falls below identifiable levels.	Davey, Rachel	31/12/2026	Escalation matrix is being developed							
2241	Community & Integrated Medicine	Pembrokeshire Integrated System	Withybush General Hospital: WGH	Carruthers, Andrew	Skitt, Peter	Svetz, Jess	Thomas, Carol	01-Sep-25	There is a risk of of delays in recognition of the deteriorating patient, fundamentals of care delivery This is caused by a large deficit of over 30 WTE Health Care support Workers across the Pembrokeshire system. This was caused by the hold on recruitment due to the impact of the delay in ability to try to recruit due to the National and Local work surrounding the re-banding of staff and ongoing band 2/3 HCSW scope of practice. This will lead to an impact/affect on Delayed fundamentals of care, reduced capacity to assist in toileting, feeding, hygiene and mobility. Increased pressure on existing nursing workforce. Delays in chaperones and supporting clinicians/ allied professionals' families and patients. Requirements for registered nurses to participate more frequently in non-clinical duties due to the	Vacant shifts are offered as additional hours, overtime and bank cover. □ □ Senior sisters continually monitor their staffing rosters and move staff wherever possible to reduce risk on their areas. □ □ Senior nurse Managers monitor and review daily to the staffing as a whole site and will more staff to mitigate the risk across areas. □ □ Sickness monitoring to be aware of thematics and support available to promote staff wellbeing. Teams working with relationships teams and Workforce to support. □ □ Escalated challenges through care	Safety - Patient, Staff or Public	3	4	12	Health Care support Workers play a vital role in delivering essential care tasks such as personal hygiene, mobility assistance, nutritional support and patient observations. These tasks directly impact patient safety, dignity, and overall experience. □ □ The staffing gap poses a significant risk to all wards to maintain safe and effective care. The potential impacts would at worst be catastrophic as the remainder of the workforce would need to support undertaking alternative roles, the opportunities for harm and negative impact on patient outcomes are vast some of the most significant impact would be delays in treatments such as medications, recognition of strokes, delays in neuro	Recruitment of HCSW workforce band 3 into vacancies being held supported by resourcing and SSRs	Thomas, Carol	~~31/12/2025~~ ~~31/03/2026~~ ~~30/04/2026~~ ~~30/06/2026~~ ~~31/07/2026~~ ~~31/08/2026~~ 31/10/2026	1st interviews undertaken and posts have been offered awaiting progress on onboarding by end December 2025 Second phase just open to applicants November 2025 □ As per notes in rational which has been escalated to corporate nursing. □ Shortlisting today 06/01/2026□ Still on boarding. Onboarding continues. 24/08/26 8 Apprentices will be onboarding over next few months. Onboarding 8 NSW over coming month through trac	Quality, Safety and Experience Committee	2	4	8	Risk will be significantly reduced with the appointment of increase HCSW positions being filled as it reduces the likelihood of delays in timely care, diagnostics and treatment this will continue to be monitored to ensure we fill all whole time equivalent gaps in the workforce. □ Have been slower with recruitment than we would of liked so target date changed to reflect this. □ Expected date changed due to staff still onboarding.		24-Aug-26

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									lack of HCSW support; leading to delay in clinical duties such as medications, discharge planning, effective communications, clinical observations, clinical treatments, communication processes. Increased patient safety incidents, Missed observations, treatments or delayed response to the deteriorating patient. Staff burnout and sickness, overworked staff due to increased workload. Increased complaints from patients and families. Risk location, Withybush General Hospital.	group to support recruitment. □ □ Mass recruitment currently underway - appointed over 20 wte which are proposed to on board within November /December 2025. □ □ New advert out early November for further recruitment to support deficits. □ □ All band 2 vacant posts in Sunderland appointed into - proposed onboarding in November /December 2025. □ □ Early escalation of any staff leaving to support early advertisement going forward. □ □ Escalation and review of HCSW offered post who have now declined posts to ensure we backfill their recruitment.					observations, and NEWS 2 which could have alerted us to a deterioration, ECGs, and pressure damage.□ 8/5/26 Risk reduced slightly due to now having 10.37 onboarding. □ 9/6/26 now onboarding over 30 WTE with 3.6 left to onboard. Sickness is currently 12.8% in a month which is impacting the shortfall. □ More success with recruitment, but still a issue which has been escalated again to corporate nursing as the NSL is not aliened on ward 1, 4, 8, 10, 12 and Sunderland. Impacting ability to recruit the appropriate number of band 3. Corporate are chasing finance. 24/08/26 Successful recruitment to 7 WTE Apprentices band 3 onboarding over next few months. Onboarding continues with vacancy gap reducing considerably with expectations of no significant vacancy gaps following onboarding in Sept/Oct 2026	Early escalation to TRAC of any upcoming vacancies across system by SSRS monitored by SNMs	Thomas, Carol	~~31/12/2025~~ ~~31/03/2026~~ ~~30/04/26~~ ~~30/06/26~~ ~~31/08/2026~~ 30/10/26	Constantly monitored							
291	Community & Integrated Medicine	Community & Integrated Medicine	Community & Integrated Medicine	Carruthers, Andrew	Skitt, Peter	Andrews, Bethan	Andrews, Bethan	10-Oct-17	There is a risk of patients having poorer outcomes and increased mortality due to the lack of 24/7 access to mechanical clot retrieval services (thrombectomy). This is caused by the current contract with North Bristol being a 7 day service, however not a 24hour service.□ This will lead to an impact/affect on increased mortality rates, increased dependency of patients and an inability to access a National Institute for Health and Care Excellence (NICE) approved intervention within 5 hours of onset of stroke symptoms. Risk location, Health Board wide.	WHSSC have commissioned a service in North Bristol.□ □ Below is a link for the thrombectomy pathway with Bristol. It has the referral criteria and pathway. They are developing an imaging pathway as well.□ https://www.nbt.nhs.uk/clinicians/services-referral/stroke-service-clinicians/stroke-thrombectomy-service-clinicians.□ □ New all wales Thrombectomy group has been set up to discuss issues and to finalise pathway. HDUHB patients can now access Bristol Thrombectomy services 7days a week (however not 24hours). They will provide a service from 8am-8pm. the patient must arrive at Southmead by 6pm. □ □ Incident reviewing in place.□ □	Quality/Complaints/Audit	2	3	6	Mechanical intervention for Stroke is available at North Bristol NHS Trust (NBT) (and Walton Centre NHS Foundation Trust for Bronglais Hospital). The service has expanded to a 7 day service 8am-8pm, cut off for patient arriving at NBT is 6pm. We still do not have 24/7 service, any patients presenting after the cut off point will not be accepted by NBT. □ □ As of January 2026 this is still being discussed at an All Wales level therefore an approximate revised timescale of December 2026. Wales still don't have a 24 hour service and performance remains poor, therefore will keep open.	Confirm the establishment of a 24/7 service.□	Andrews, Bethan	~~31/10/2022~~ ~~31/12/2025~~ 31/12/2026	Times extended but still not 24hr service. □ As of January 2026 this is still being discussed at an All Wales level therefore an approximate revised timescale of December 2026.□	Quality, Safety and Experience Committee	2	2	4	The uncertainty surrounding the changes proposed in the Transforming Clinical Services programme have a significant impact upon the development of acute and hyper acute services within the UHB. Thrombectomy services continue to be sought and escalated with English Neuroscience units until the Cardiff and Vale service is reinstated and the instigation of a WHSSC commissioned service with North Bristol NHS Trust.□ □ Mechanical intervention for Stroke is now available at Bristol (and Walton for Bronglais. The service in NBT has expended to 8am-	Treat	19-Aug-26
																Development of pathway and protocols for the referral of stroke patients within each of the Hywel Dda Acute Hospitals to suitable neuroscience in England.□	Mansfield, Simon	**Completed**	Briefing paper and protocols developed for the direct commissioning of ad hoc thrombectomy services from English Neuroscience units. □							
																Negotiate short-term commissioning arrangements with neuroscience units.□	Admin, Hywel Dda	**Completed**	Completed - however unable to secure new commissioning arrangements whilst WHSSC work to commission all Wales service □							

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
										Thrombectomy pathway is in place throughout the Health Board.						Develop and review the Thrombectomy pathway, throughout the Health Board.□	Andrews, Bethan	**Completed**	"Review of thrombectomy pathway undertaken, no facility to procure ad hoc services from North Bristol or Stoke. National Stroke Implementation Group have worked with WHSSC to commission an all Wales Thrombectomy service with North Bristol NHS Trust for Welsh patients. North Bristol Trust has issued a Thrombectomy check list and referral document. Pathway for referral is being worked on by clinicians who have been involved with WHSSC regarding setting up service with Bristol. However we are still waiting for full guidance.					[illegible] 8pm however we still do not have 27/7 service.The risk for out of hours would stay the same. □ March 21. There are ongoing meetings, to extend the service already offered. Ward staff will then be informed of the new process. □ □ As of January 2026 this is still being discussed at an All Wales level therefore an approximate revised timescale of December 2026 provided.		
																Development of pathway and protocols for the referral of stroke patients within each of the Hywel Dda Acute Hospitals to suitable neuroscience in England.□	Andrews, Bethan	**Completed**	Briefing paper and protocols developed for the direct commissioning of ad hoc thrombectomy services from English Neuroscience units. In the absence of a supported pathway the protocols will need to be redeveloped in December 2018 for the re-instigation of the Cardiff and Vale service and further to the WHSSC policy which will support the new service being commissioned in Bristol in May 2019.□							
																Work with WHSSC to ensure all Wales thrombectomy service is commissioned.□	Admin, Hywel Dda	**Completed**	A service is now available from Bristol 9 to 5 Monday to Friday. However no service out of hours, therefore this action stays open. There is a plan for Bristol to be available from Sep20 to be 9-5, 7 day a week service. □							
																Trying to source funding for Brainomix (AI)	Andrews, Bethan	**Completed**	Ongoing.□ first invoice has been paid. Waiting confirmation of funding for the rest of the costs. □ In the process of testing. □ This is now live so action completed.							

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																For Radiology to preform CT perfusions in line with Brain Omics to reduce the thrombolysis and thrombectomy times.	Roberts-Davies, Gail	~~30/09/2024~~ ~~31/10/24~~ ~~30/11/2024~~ ~~31/01/25~~ ~~30/06/25~~ ~~30/11/25~~ 31/12/2026	Radiology does not currently have the staffing to release in order to train to report and provide a sustainable service. There is no official training course and Radiology are unable to absorb this additional work which cannot currently be outsourced. There is no funding stream attributed to its implementation. This is the main barrier to implementing, alternative solutions are being explored.							