CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 January 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risk Register
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Professor Philip Kloer, Chief Executive
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)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Corporate Risk Register (CRR) is presented to the Board to provide assurance that the corporate risks of Hywel Dda University Health Board (the Health Board) are being assessed, reviewed and managed appropriately.

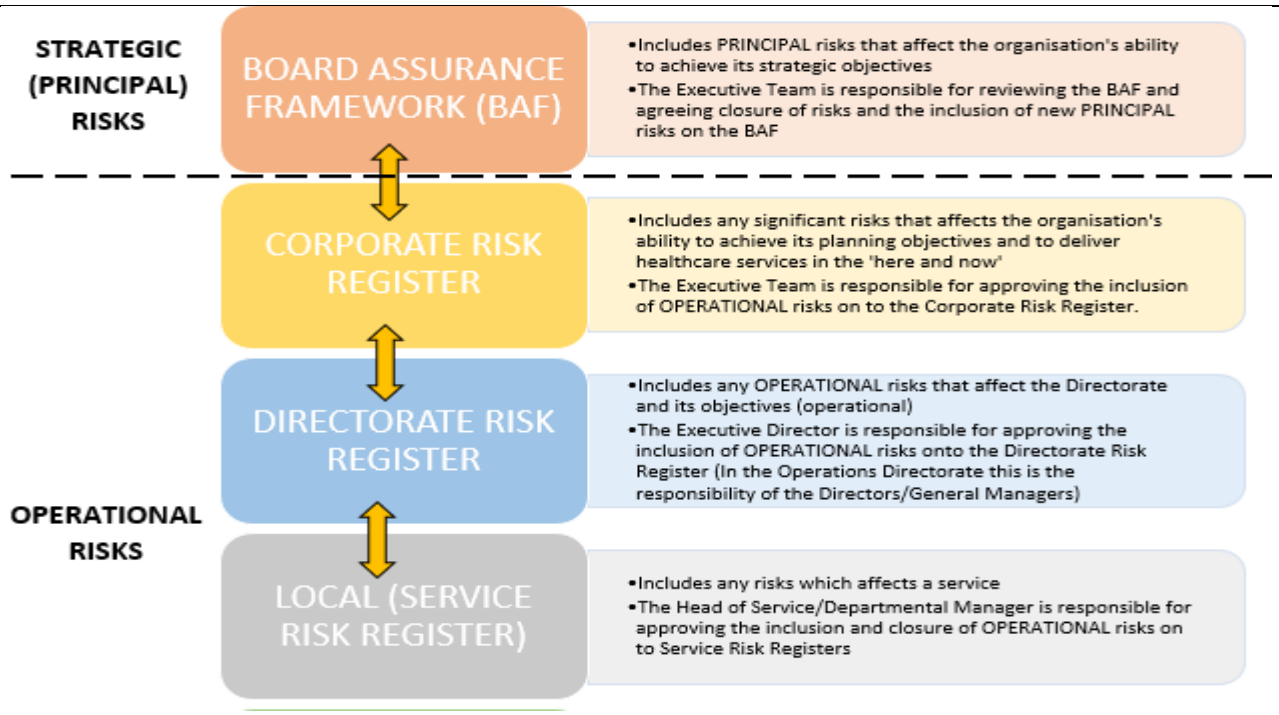
Cefndir / Background

Risk management is a key component of the governance framework, and should underpin organisational strategy, decision-making and the allocation of resources; as such the organisation is required to have effective risk management arrangements in place. The Board should receive sufficient and timely assurance information on the management of risk to enable it to exercise good oversight.

The Executive Directors, via monthly Executive Team meetings, are responsible for reviewing and discussing their corporate risks, and agreeing any new risks and the escalation/de-escalation of operational risks that are on directorate risk registers.

It is the role of the Executive Directors to review controls and ensure appropriate action plans are in place, which might include the development of corporate risk management strategies to manage risk(s). Effective management of these risks enables the organisation to improve its chances of success and reduce the likelihood of failure.

The CRR includes significant risks that affect the organisation's ability to deliver healthcare in the 'here and now' and its ability to achieve its planning objectives (linked to directorate objectives). This is how the CRR interacts with the principal risks on the Board Assurance Framework (BAF), and the operational risks that are on Directorate and Service risk registers.



Asesiad / Assessment

Since the CRR was previously presented to the Board in September 2024, the risks have been discussed in detail at its Board Committees and reported to the Board via the Committee Update Reports. Where assurance has not been received that corporate risks are being managed effectively, the Committees can request a more in-depth report at a subsequent meeting.

The CRR includes significant risks associated with delivering the 'here and now', whilst the BAF will identify the Health Board's principal risks to achieving its strategic objectives, and these will be long term in nature. The BAF dashboard is reported to every other Board meeting.

The following changes have taken place since the CRR was previously presented to the Board in September 2024:

Total Number of Risks as at September 2024	21	
New/Escalated	2	*See note 1*
De-escalated/Closed	2	*See note 2*
Increase in risk score ↑	2	*See note 3*
Reduction in risk score ↓	3	*See note 4*
No change in risk score →	14	
Total Number of Risks as at January 2025	21	

Attached to this report to provide the Board with assurance on the management of its corporate risks are:

Appendix 1 - CRR Summary
Appendix 2 - Each risk detailing the strategic objective, controls, assurances, performance indicators and action plans to address any gaps in controls and assurances.

Due to the sensitive nature of the following risks, the detail is being reported to In-Committee Board, to facilitate discussion and provide assurance:

- 1352 - Risk of business disruption and delays in patient care due to a cyber-attack
- 1860 – Risk of serious harm to staff due to violence & aggression in the workplace
- 1861 – Risk of harm to staff, patients public and critical assets due to insufficient physical security measures and systems

Details on the 18 remaining corporate risks are included in Appendix 2.

The 21 corporate risks are detailed on the below heat map:

HYWEL DDA RISK HEAT MAP

	LIKELIHOOD →				
IMPACT ↓	**RARE 1**	**UNLIKELY 2**	**POSSIBLE 3**	**LIKELY 4**	**ALMOST CERTAIN 5**
CATASTROPHIC 5			813 (→) 1745 (→) 1810 (→) 1859 (↓)	1027 (→) 1531 (→) 1664 (→)	
MAJOR 4			2000 (NEW) 1433 (→)	684 (→) 1350 (↑) 1352 (→) 1978 (NEW) 1708 (→) 1861 (→)	797 (→) 1032 (→) 1843 (↓)
MODERATE 3				1821 (↑) 1842 (↓)	1860 (→)
MINOR 2					
NEGLIGIBLE 1					

Note 1 – New Risks

Since the previous report in September 2024, 2 new risks have been added to the CRR:

Risk	Lead Director	Current Risk Score (Likelihood x Impact)	Rationale for Current Risk Score
1978 - Risk of insufficiently skilled workforce to deliver services due to	Deputy Chief Executive Officer and Director of Workforce & Organisational	**4x4=16**	This risk has been scored as 16 (the likelihood is "likely" and has the potential to have a "major" impact) as the number of staff impacted from staff sickness is high still in October 2024

limited labour market *(approved at Executive Team December 2024)*	Development (OD)		compared to identified All Wales benchmarks (c1-2% higher). Staffing levels (acute and community) continue to operate below established levels due to both vacancies and sickness/absence which is supplemented by additional hours, bank and agency. Further work has been undertaken to understand the level of risk across each staff group (Nursing, Medical, Allied Health Professionals (AHPs) and Health Care Support (HCS)) to comprehend the level of risk by each group. It is hoped as further action is taken through stabilisation, the Improving Together framework, and workforce planning to reduce the risk score during 2024/25. However, it should also be noted that due to the Health Board's current financial position and considering the wider financial context; this may result in the potential requirement to increase the risk score to 20 once Board decisions have been finalised regarding the utilisation of agency, bank and locum workforce. A summary of the gaps to enable a stable workforce in each professional group are noted below: 1) Nursing & Midwifery: a) Destabilisation of the nursing workforce linked to introduction of RNA role b) Destabilisation of the workforce due to the changes in Job Descriptions and Bandings 2 & 3 c) Gaps in specific nursing skills sets i.e. Public Health (new role), Critical Care, Theatres (although wider workforce implication), Midwifery (SCBU) and Health Visiting (dependent on model of care to be provided locally) d) Risk profile for nursing based on retirement and turnover generally in each branch of nursing 2) Medical and Maps Workforce

			a) Destabilisation of the medical workforce due to regulation of Anaesthesia Associates (AA), Physician Associates (PA) roles b) Specific skills gaps related to High Locum Usage/Recruitment Gaps i.e. Haematology c) Consultant cover in Emergency Departments (ED) at Glangwili General Hospital (GGH)/Withybush General Hospital (WGH), and Mental Health d) Medical rate card issues leading to "internal bidding across sites and HBs 3) Allied Health Professionals a) Destabilisation of the workforce due to capacity potentially outstripping demand/high locum usage in Physiotherapy (potential exacerbation by "recovery work" b) Specific establishment challenges in Paediatric SALT & Dietetics 4) Healthcare Science destabilisation due to a) Lack of clarity on benefit of regional models identified b) Gaps in Pathology and Radiology workforce per se with potential exacerbation of recovery work and possible consequential sickness increases (12% in month for GGH) c) Specific skills set challenges in sub specialities i.e. Sonography where national challenges exist d) Connected implications on broader work streams i.e. Cancer pathways i.e. Interventional Radiology 5) Ability to create true multi-disciplinary workforces. 6) Niche skills gaps due to an aging workforce and retirement risks in critical skills/niche specialities. However, that said, through a risk management approach and the aligned stabilisation programmes, there is growing confidence that with focused management effort, at a local,

			regional and national level we will be able to mitigate.
2000 - Risk of the Health Board significantly underspending in excess of its statutory Capital Resource Limit (CRL) for 2024/25 *(approved at Executive Team January 2025)*	Executive Director of Strategy and Planning	**4x3=12**	Significant uncertainty lies in the delivery of the Capital Programme in 2024/25 due to a number of factors. Whilst previous years demonstrate that the Health Board has met its statutory duty to breakeven against the CRL, there is an increased likelihood in 2024/25 that they will not be able to do so. Opportunities to mitigate against any slippages identified are reduced due to longer lead times for medical and digital equipment. A number of construction schemes are also due to finish before the end of the financial year, meaning opportunities to accelerate spend into the current financial year are reduced. In addition, reliance on third party contractors may exacerbate this issue and their ability to deliver by March 2025.

Note 2 – De-escalated / Closed Risks

Since the previous report to Board in September 2024, 2 risks have been closed or de-escalated:

Risk	Lead Director	Closed / De-escalated	Reason
1649 - Risk of insufficiently skilled workforce to deliver services in Annual Plan 23/24 due to limited labour market	Deputy Chief Executive Officer and Director of Workforce & OD	Closed	Risk agreed for closure at Executive Risk Group in December 2024, superseded by risk 1978 - Risk of insufficiently skilled workforce to deliver services due to limited labour market.
1812 - Risk of non-compliance with Medical Examiners (Wales) regulations due to the failure to fully resource internal processes	Interim Executive Medical Director	De-escalated	Risk confirmed for de-escalation to Directorate level at Formal Executive Team meeting held 8th January 2025, as mitigating actions in place to manage compliance, with no specific concerns raised by the Medical Examiners Service to date.

Note 3 – Increase in Current Risk Score

Since the previous report to Board in September 2024, 2 risks have increased in score:

Risk Title	Risk Owner	Previous Risk Score (Sept 2024) (Likelihood x Impact)	Current Risk Score (Jan 2025) (Likelihood x Impact)	Rationale for Current Risk Score
1350 - Risk of not meeting the 75% SCP waiting times target for 2022 - 2026 due to diagnostics capacity and delays at tertiary centre	Chief Operating Officer	**3x4=12**	**4x4=16 (↑)** (Reviewed 08/01/25)	The latest performance data as of November 2024 is 55.5%, an improvement from October 2024 data which was 44%. Despite the improvement in performance noted above, the Health Board is still not achieving its internal predicted target of 60% for the month of November 24 due to: 1.Legacy impact of radiology reporting delays, which increased during summer period due to dual impact of cessation of daytime Everlight external reporting, and an increase in emergency pathway demand 2.Negative impact on headline Single Cancer Pathway (SCP) performance of positive progress achieved in recovering the skin pathway backlog which developed in previous months due to sharp increase in skin cancer referral demand and sickness/absence amongst senior clinical team Although performance for December 2024 is predicted to improve further due to recovery actions within radiology, urology and skin pathway, the risk remains that cancer performance will not achieve 75% compliance by March 2025.
1821 - Risk to the welfare of Health Board staff due to current demands	Deputy Chief Executive Officer and Director of Workforce and OD	**3x3=9**	**4x3=12 (↑)** (Reviewed 08/01/25)	The Health Board is alert to the potential consequences of the staff welfare risk, and are monitoring a number of areas/metrics to assess if the risk may be increasing e.g. turnover, absence etc. Careful consideration is being taken at different organisational levels to

				mitigate through organisational planning approaches to manage workload at management level and then the consequences upon staff wellbeing. The score has been increased from 9 to 12 in October 2024 as it has been noted that sickness absence rates are increasing.

Note 4 – Reduction in Current Risk Score

Since the previous report to Board in September 2024, 3 risks have reduced in score:

Risk Title	Risk Owner	Previous Risk Score (Sept 2024) (Likelihood x Impact)	Current Risk Score (Jan 2025) (Likelihood x Impact)	Rationale for Current Risk Score
1843 - Risk that the cash consequences of the Health Board deficit cannot be covered due to significant deficit position	Executive Director of Finance	**5x5=25**	**4x5=20 (↓)** (Reviewed 19/12/24)	The annual plan for 2024/25 is now aligned to the restated target control total. The Board have been involved in the discussions and decisions in the development of the plan through our Committees, Board Seminar sessions, and Public Board meetings. The Board, at its meeting on the 28 March 2024, endorsed the annual plan, recognising the forecast financial out-turn was in breach of the Health Board's statutory requirement to achieve financial balance. Without further support, the Health Board will require further cash-backed support as the extent of the cash allocation will be insufficient to pay our liabilities as they fall due in February and March 2025. The Health Board has submitted a strategic cash request and awaits a response from WG. The latest assessment of the financial deficit is that the Health Board has a trajectory to achieve its re-stated annual plan deficit of £31.55m.

1859 - Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Interim Executive Director of Nursing, Quality and Patient Experie-nce	**4x5=20**	**3x5=15 (↓)** (Reviewed 30/12/24)	There are specific concerns relating to GGH and WGH in relation to cardiac arrests and unplanned admissions. There was an increase in cardiac arrest rates in GGH in the period Jan - Oct 2024 (30) compared to the same period Jan - Oct 2023 (15). The GGH senior management team have agreed to Datix all cardiac arrests and establish bi-monthly meetings to review cases and identify themes and learning opportunities, with a meeting held in November 2024. There has been a slight increase in unplanned admissions at WGH, with 81 noted in the period January - November 2024 at WGH (79 for the equivalent period of January - November 23). Following the recent WGH Recognition of Acute Deterioration and Resuscitation (RADAR) meeting, it was agreed that the Treatment Escalation Plan (TEPs) task & finish group in WGH would be re-established. There are also concerns across the Health Board as a whole relating to the National Early Warning Scores (NEWS), and appropriate escalation where required as part of observation processes. Currently working with Clinical Audit to develop an audit tool on Audit Management and Tracking (AMAT) system to audit on a monthly basis NEWS charts on wards and identify good practice and areas for improvement. A National Safe Care Collaborative meeting held in Cardiff in October 2024 began exploring the possibility of establishing a National Acute Deterioration Group. Work is underway investigating the opportunity to benchmark the position of Hywel Dda on an All Wales basis. Prior to COVID-19,

				the National Acute Deterioration Group for Wales (RRAILS) was in place, which gave direction on key initiatives such as Sepsis and NEWS, however this group is no longer supported which poses the risk on a national level regarding a disjointed approach across Wales. As of November 2024, compliance rates for Level 2 and Level 3 Resuscitation Training are at 40%. While there is no set compliance target, compliance has never been greater than 60%. Staff availability to attend resuscitation training is challenging due to operational pressures and demand, therefore, need to identify the most appropriate training level and method to deliver to meet mandatory requirements. As at December 2024, all actions are being processed within set dates / timeframes although many remain long term. Current controls are managing the risk and the increasing awareness of gaps in assurance and local actions to mitigate and manage the risk have been established.
1842 - Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 24/25 due to demand exceeding capacity	Chief Operating Officer	**3x5=15**	**3x4=12 (↓)** (Reviewed 10/01/25)	The combined impact of a mismatch between demand and current/forecast capacity in key specialties, workforce limitations and limitations on the amount of recovery funding agreed by the Board all pose a risk to full achievement of ministerial planned care recovery targets. The Annual Plan, approved by the Board in March 2024, highlighted delivery risks in orthopaedics and ophthalmology, and the additional recovery resource agreed by the Board is below the level required to ensure full delivery of the ministerial milestones. Whilst delivery plans for 2024/25 reflect positive progress in increasing outpatient activity &

				treatment capacity, underpinned by planned improvements in workforce availability and operational productivity and efficiency, the Annual Plan signalled expected delivery gaps in both specialties. Health Board performance in respect of planned care delivery milestones is also a key feature of its escalation to Targeted Intervention status. Opportunities have been explored to maximise capacity across Hywel Dda University Health Board and Swansea Bay University Health Board (SBUHB), to support further recovery of waiting times. Both specialties have been prioritised for active exploration of regional solutions, in partnership with SBUHB, to expand available capacity and address forecast shortfalls against anticipated demand. On 15 November 2024, the Health Board received confirmation of the additional recovery financial allocation to be allocated by Welsh Government (WG) to support clearance of outstanding forecast 104 week breaches by March 2025. Whilst this recovery funding is being used to support additional internal and external outsource and insource capacity solutions, the delayed confirmation of this allocation has given rise to additional delivery risks due to the limited time remaining in which to secure and deliver the required volume of additional capacity. Notwithstanding these delivery risks, breach volumes in respect of the Stage 1 52 week target have improved for six consecutive months (July - December 2024), and are expected to be resolved by March 2025. Forecast breach volumes in respect of the Total Pathway 104 week target remain in

				orthopaedics, although monthly breach performance shows continued improvement. Taking the above into account, the current risk score is assessed to be lower than the inherent risk score due to the significant progress achieved in the past 12 months in improving waiting times, and, whilst delivery risks remain, the current risk score has reduced to 12 reflecting the positive progress achieved.

Argymhelliad / Recommendation

The Board is asked to **CONSIDER** whether it has sufficient assurance that corporate risks are being assessed, managed and reviewed appropriately/effectively through the risk management arrangements in place, noting that these have been reviewed by Board level Committees.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Included within the body of the report.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Corporate Risk Register
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. **Risk appetite** can be defined as 'the amount of risk that an organisation is willing to pursue or retain' (ISO Guide 73, 2009). ISO (2009) defines **risk tolerance** as 'the organisation's readiness to bear a risk after risk treatment in order to achieve its objectives', however it can be simpler to see it as a series of limits such as lines in the sand beyond which the organisation does not wish to proceed.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Team

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 of individual risks.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Gweithlu: Workforce:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Risg: Risk:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Cyfreithiol: Legal:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Enw Da: Reputational:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Gyfrinachedd: Privacy:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Cydraddoldeb: Equality:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.

Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Jan-25	Trend	Target Risk Score	Risk on page no...
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	→	4×4=16	6
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	11
1843	Risk that the cash consequences of the Health Board deficit cannot be covered due to significant deficit position	Thomas, Huw	Finance inc. claims	6	5×5=25	4×5=20	↓	3×4=12	15
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	20
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	→	2×4=8	24
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	4×5=20	→	1×5=5	29
1708	Risk of increasing fragility in primary care contractor services due to external factors	Paterson, Jill	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	3×4=12	33
1978	Risk of insufficiently skilled workforce to deliver services due to limited labour market	Gostling, Lisa	Workforce/OD	8	NA	4×4=16	New risk	3×4=12	38
1350	Risk of not meeting the 75% SCP waiting times target for 2022 - 2026 due to diagnostics capacity and delays at tertiary centre	Carruthers, Andrew	Quality/Complaints/Audit	8	4×4=16	4×4=16	→	2×4=8	43
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	47
1745	Risk of not being able to safely deliver services due to ageing estate and infrastructure across the Health Board	Carruthers, Andrew	Safety - Patient, Staff or Public	6	3×5=15	3×5=15	→	2×5=10	52
1859	Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Daniel, Sharon	Safety - Patient, Staff or Public	6	4×5=20	3×5=15	↓	2×5=10	55
1810	Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Paterson, Jill	Service/Business interruption/disruption	6	3×5=15	3×5=15	→	1×5=5	62
813	Risk of non-compliance with the Regulatory Reform (Fire Safety) Order 2005 due to ageing infrastructure	Carruthers, Andrew	Statutory duty/inspections	8	3×5=15	3×5=15	→	1×5=5	65
1842	Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 24/25 due to demand exceeding capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×3=15	4×3=12	↓	3×3=9	71
1433	Risk to the ability to maintain routine and emergency services in the event of a severe pandemic	Gjini, Ardiana	Service/Business interruption/disruption	6	3×4=12	3×4=12	→	2×4=8	74
2000	Risk of the Health Board significantly underspending in excess of its statutory Capital Resource Limit for 2024/25	Davies, Lee	Statutory duty/inspections	8	NA	3×4=12	New risk	2×4=8	77
1821	Risk to the welfare of Health Board staff due to current demands	Gostling, Lisa	Workforce/OD	8	3×3=9	4×3=12	↑	3×2=6	79

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

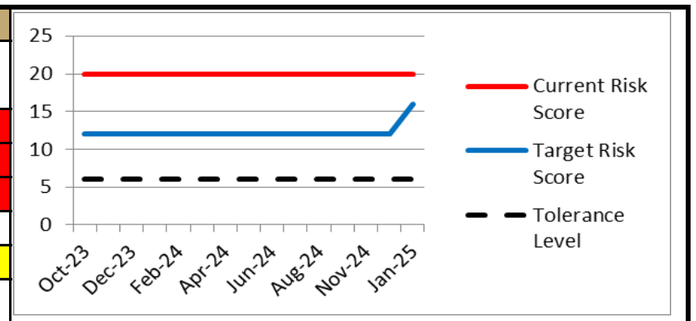
RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A 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:**	Dec-24
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-25

Risk ID:	**1032**	**Principal Risk Description:**	There is a risk to the delivery of timely diagnosis to those on the ASD and ADHD waiting lists within required timescales - Welsh Government performance standard of 26 weeks. This is caused by an increase in referrals, with demand outstripping capacity and lack of sustainable external funding. This could lead to an impact/affect on those currently awaiting diagnosis and intervention, resulting in delays in care and appropriate support and signposting 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/ADHD within 26 weeks) and the ability to meet the Health Board agreed trajectory of 1% improvement per month 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):	4×4=16
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 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. Recommendations received from NHS Executive in relation to Children's ND services are in the process of being implemented. The Directorate is working with Women and Children's Directorate to implement these. For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit to establish trajectories, along with the commissioned service which since have been agreed in March 2023. The DU were unable to provide trajectories, therefore Health Board has agreed to a 1% monthly improvement trajectory.

Rationale for TARGET Risk Score:
The Directorate is prioritising implementation of WPAS in key areas within MHLD and this will enable improved reporting and waiting list management and enable forward trajectories of improvement in waiting times to be determined. The target risk score will be dependent on securing recurring funding for the IAS and Children's ND service as well as having access to appropriate clinical venues and other agencies being able to undertake their associated assessments. While trajectory plans are in place as of March 2024, there is recognition that the Health Board will not achieve WG targets. The end of procurement contracts with external providers will further negatively impact trajectories

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Use of IT/virtual platforms such as Attend Anywhere when appropriate. Clinical prioritisation regarding assessment and treatment of service users by engaging in a dynamic process of reviewing waiting lists in line with any other referrals that may be received in respect of that service user. Additional WG funding received in 2022/23/24/25 for ND services - currently awaiting confirmation for the next three year cycle. Services are in contact with individuals to provide information regarding mainstream/Tier 0 support, wellbeing at home and guidance should their situation deteriorate. Process in place to ensure individuals on waiting lists are being contacted periodically through the wait for assessment/treatment to monitor any alteration in presentation. Autism Advice Hubs and pre-assessment workshops in place for Children and adults Neurodevelopmental Service. Rolling programme of workshops offering advice and support around neuro-divergence for parents of children aged 2-11 years and 12 years and over awaiting diagnostic assessment. Monthly meetings to meet recommendations of NHS Executive's Action Plan in respect of CYP ND services in place. ND Service Delivery Manager appointed and in place. All posts recruited in to Children's ASD service. With the exception of	Although dedicated premises have been sourced for ASD services, there is limited clinical space and Estate issues remain a challenge as identified in the risk narrative. Information not currently included on Health Board website or QR codes due to IT difficulties. Additional funding received in 2022/23 for ND service on fixed term annual basis until 2025. Current resource does not provide sufficient capacity to meet demand. Unable to recruit in to Clinical psychology in adult ASD service. 'Grow your own' scheme in place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme (3 year programme) however benefit will not be realised until 2027. Current procurement exercise to outsource portion of diagnostic assessments to external provider for children and adult services ends March 2025 and will further	Identify alternative venues/space/ virtual to hold clinics (Integrated Psychological Services).	Homfray, Andrew	Completed	Integrated Psychological Therapies Service de-escalated by NHS Executive from Targeted Intervention.
		Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic Training Needs Analysis that can be reviewed at regular intervals and monitored for compliance.	Temple-Purcell, Rebecca	~~30/11/2023~~ ~~31/12/2024~~ 31/03/2025	In progress, working with Workforce to develop a training needs and analysis tool. MH&LD to act as a pilot for this pending further roll out across the HB. Ongoing.

clinical psychology in adult autism services, all clinical substantive posts recruited in to, with no retention issues. Workforce Management Group has been established which meets monthly. Trajectories have been agreed for Children's ND by NHS Executive and there are systems in place to monitor waiting lists at service level performance-management meetings, IPAR and Directorate service review meetings. Monthly meetings with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint. Use of HB Third Party Contractor to send out Keeping in touch letters and sent to those on ASD waiting lists on a 3-4 monthly basis confirming place on waiting list and signposting to sources of support including access to ND services while waiting. Service Leads secured outsourcing for ASD services up to 2025. Commissioned external provider for ASD services across all ages. Additional NDIP funding secured to outsource a further portion of diagnostic assessments for Children and Young People this financial year. Quarterly meetings with the NHS Executive, Welsh Government and Service Leads at the Health Board. SMS functionality in place for ND to improve attendance and decrease instances of non attendance. Support workers recruited in to Children's ND service. Current staff received relevant training, and processes in place to assess training needs on induction for any new starters. Grow your own' scheme in place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme (3 year programme).	negatively impact trajectory. Rapid Design Event to achieve critical, systemic and needs led transformation of children's ND services held on 27th and 28th of November 2024. Awaiting outcome report from Welsh Government.	ND specific HB internet and intranet pages in development to give guidance and support whilst neuro-divergent individuals and parent carers are waiting.	vaughan, Catherine	~~31/10/2024~~ ~~31/12/2024~~ 31/03/2025	Series of meetings held with Communications team and ND services prioritised to include children's ADHD, Adult ADHD, Integrated Autism Service and Children's ASD service Website remains in development, although all material ready. Contact will be made with Comms Team to ascertain delay
		Grow your own' scheme is coming into place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme (3 year programme).	Carroll, Mrs Liz	~~31/12/2024~~ 31/12/2027	Three year training programme with graduates during 2027.

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 that the Directorate have at present. A	System to improve analysis of patient experience				
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd								
	MH&LD QSE Group overseeing patient outcomes	2nd								
	Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd								
	W-PAS Internal Audit	3rd								

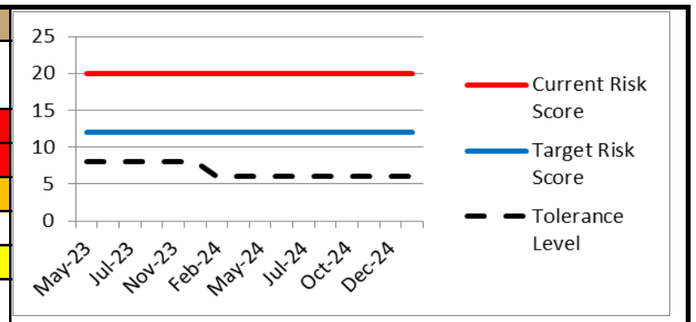
	An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.				present. A paper was presented at Board Seminar in June 2022 to provide assurance on current waiting times and control measures.					
	An updated paper was submitted to the December 2024 meeting of the Integrated Quality Finance Performance Delivery Group.									

Date Risk Identified:	Nov-19		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Dec-24
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-25

Risk ID:	**797**	**Principal Risk Description:**	There is a risk of being unable to provide a full range of ultrasound services including obstetric and non-obstetric ultrasound 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 and to implement national scanning guidance. 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. In the case of obstetric ultrasound, this could lead to failure to detect in utero anomalies, life long, limiting or changing duration which places the Health Board at significant risk of litigation.
Does this risk link to any Directorate (operational) risks?		1557, 1349, 1658, 1936	

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



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Despite best efforts, the service remains fragile. There are still vacancies which remain unfilled, but there was an improvement in recruitment due to the financial picture across Wales and the cessation of use of agency staff above AFC pay rates at HDd late 2023/early 2024. As of November 2024, remaining vacancies have been advertised as training posts under Annex 21 posts If all vacancies were recruited to, the Health Board would still not have the capacity to meet current demand (as at end October 2024) there were 1,224 patients waiting 8 weeks plus for non-obstetric ultrasound (Dec 2023:1547, February 2024:1288, March 2024:917, April 2024:962,May 2024:731,June 2024 608, July 2024 555), with the reduction seen From Feb -July 2024 as result from the use of insourcing and a small amount of overtime by substantive staff (utilising recovery monies). Long term vacancies exist in Withybush with maternity leave which started in summer of 2024 impacting the fragility further. There are 2 potential retirements at PPH in the near future and a number in BGH, which constitute a significant percentage of the workforce. There will be an inability to secure high cost agency staff due to the current financial climate of the Health Board. However, in the event of recovery monies being made available we will be able to re-initiate the current ultrasound insourcing contract Three Radiographer sonographers and two Midwife sonographers commenced training in January 2024, however training takes two years to complete for Radiographer Sonographers and 1 year for midwife sonographers (obstetric only). Only 16% of USC's carried out in 7 days, 39% carried out in 14 days at November 2024 There is increased capacity through conversion of room for ultrasound use.	The actions below will not in themselves reduce this risk significantly. Demand and capacity and the current establishment review is being undertaken by the Ultrasound control group via a needs assessment which was due to be completed by the end of Autumn 2024. 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. Radiology wide demand and capacity work has been undertaken by the Radiology Department which has included the non-obstetric element and has been described in the 2025-2026 annual plan.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Process in place for the movement of staff across the Health Board to maintain capacity where possible. Conversion of room to increase capacity (2022) @ GGH Ultrasound Control Group reconvened in Jan 2024 after having not met since July 2023 due to operational pressures. Meetings take place on a bi-monthly basis. Employment of Physiotherapists and Midwives to undertake scanning within scope of expertise The PPH modality lead vacancy was filled (Feb 2024) Utilising insourced ultrasound service to reduce backlogs of patients waiting >8weeks subject to the availability of recovery funding. Increase in hrs of an existing sonographer at WGH from 0.6 to 0.8 for a period of 6 months from August 2024. Advertise bank sonographer posts to assist on an ad hoc basis, subject to availability at WGH in line with vacancy. Clinical Educator recruited and in post which will facilitate the expansion of training across site. Cancer Watchtower meetings in place and held weekly, with a separate escalation meeting in place to cover Radiology concerns. Meetings chaired by General Manager of Cancer Services. Continuous recruitment training of sonographers within current establishment	Inability to recruit and retain staff. While process in place regarding the movement in staff, due to current staffing levels and pressures this is not being implemented, however the teams across sites are collaborating and look at all possibilities when gaps in rota arise and are foreseen.	Develop and implement a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Llewellyn, Cerian	~~31/12/2022~~ ~~31/10/2023~~ ~~31/01/2024~~ ~~30/06/2024~~ 31/01/2025	The date of completion of this action has been changed to 31/01/2025 as the current cohort of midwives that are training will qualify. Maternity and child health are required to advise of the plan to utilise the skills of the two trainee midwives and also any plans to train more staff.
		Train members of staff to become sonographers, the number of which dependant on capacity to take training.	Roberts-Davies, Gail	~~31/03/2020~~ ~~31/12/2022~~ ~~01/02/2023~~ ~~30/09/2024~~ 31/01/2026	Clinical Educator role has been developed and recruited. The successful candidate commenced employment on 01/06/2024. This has allow us to expand Ultrasound training an all sites and advertise existing vacancies in ultrasound as training positions under Annex 21 rules. As of November 2024, 1 vacant post each at BGH and WGH are in advertisement stage. With FCG approval obtained to advertise a third training post at GGH. Plan is on track to start the successful candidates training in January 2025.
		Work with the workforce planning team to build a sustainable workforce plan for ultrasound services.	Roberts-Davies, Gail	~~31/10/2023~~ ~~31/03/2024~~ ~~31/07/2024~~ ~~31/10/2024~~ ~~03/12/2024~~ 31/12/2024	A draft operational workforce plan has been developed as of June 2024 and requires revision prior to sign off. This has been delayed due to workload as a result of urgent TI actions and operational pressures during which workforce meetings ceased. This work is currently being reviewed by the Head of Radiology, but has been delayed due to acute operational pressures. Review planned to be completed on 31/12/2024

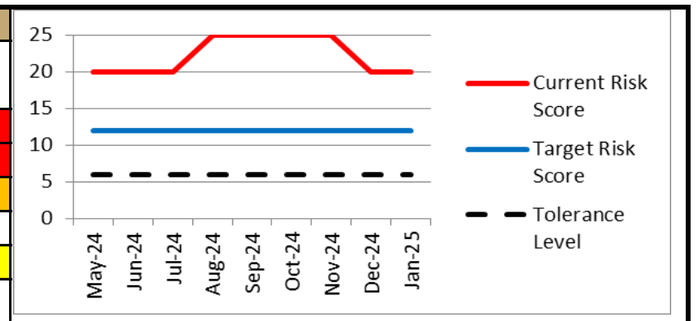
	Seek support to undertake a demand and capacity (D&C) review and detailed establishment review of the radiology service.	Jones, Keith	~~30/06/2022~~ ~~30/11/2022~~ ~~31/03/2023~~ ~~30/08/2023~~ ~~31/01/2024~~ ~~31/05/2024~~ ~~31/07/2024~~ ~~31/10/2024~~ 31/12/2024	An ultrasound needs assessment is currently being undertaken via the Ultrasound Control Group. The most recent Ultrasound Control Group Meeting arranged for September 2024, was cancelled. The Ultrasound Needs Assessment was due to be presented be presented to further inform the ultrasound workforce plan. We await a date to be rescheduled.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Non-Obs ultrasound - longest wait 37 weeks as at end November 2024 with 1,497 patients waiting over 8 weeks. Radiology Dashboard IPAR Reports WG Cancer PTL, reported monthly	Management review of sonography and SCP diagnostic waiting times	1st			Sonography Report to Acute Leadership Group (ALG) and Operation Planning and Delivery Programme meeting					
	Monthly review of USC performance undertaken monthly (16% of USC carried out in 7 days, 39% carried out in 14 days at end November. 2024), included in the IPAR & reported to WG	1st								
	Performance monitored at Directorate Improving Together Sessions	2nd								
	Performance monitored via IPAR, overseen SDODC & Board	2nd								
	Ultrasound Services Internal Audit, July 2024 reasonable assurance provided	3rd								

Date Risk Identified:	Apr-24	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Dec-24
Strategic Objective:	6. Sustainable use of resources	**Lead Committee:**	Sustainable Resources Committee	**Date of Next Review:**	Jan-25

Risk ID:	**1843**	**Principal Risk Description:**	There is a risk that neither the Health Board or Welsh Government (WG) are able to fully cover the cash consequences of the Health Board deficit, due to the Health Board submitting a deficit budget outside of a financially balanced integrated medium term plan (IMTP). This is caused by the financial plan for 2024/25 setting a £31.5m deficit plan, which is itself a consequence of: 1. Continued significant growth in expenditure across unscheduled care services; 2. Staffing pressures and reliance on locum and agency staff to fill gaps; 3. Continued pressure across services and sites as demand exceeds capacity, compromising patient flow, elective pathways and cancer; 4. Capacity and capability amongst budget holders and service leads to adequately engage with the financial agenda; 5. The ongoing operational organisation change process that is temporarily impacting formal accountability arrangements with interim arrangements in place, or gaps in structures; 6. Several services continually being escalated to level 3 within the Health Board's internal escalation framework regarding financial performance with no imminent recovery plans or solutions to de-escalate being put forward. The organisation has de-risked the financial position over the course of the first half of the financial year, with assured actions to deliver a deficit of no more than £31.5m. The recovery of the financial position has been hampered by insufficient assurance over the identification and operational delivery of the required level of savings on a recurrent basis; and by insufficient controls in place on the operational drivers of expenditure, most significantly in the management of beds, rostering controls and drugs expenditure. Given the scale of the deficit, further transformational change is required at a pan Health Board level in addition to ensuring there is a robust control environment at a Directorate level. The savings schemes put forward by Directorates to date do not capture the scale of change and financial impact required on a recurrent basis. This could lead to an impact/affect on 1. An inability to meet the Ministerial priority of operating within our budget; 2. An inability to develop an approvable Integrated Medium Term Plan; 3. A likely impact that the Health Board has insufficient cash available to make

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
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



payments to suppliers in February and March 2025;
4. A likely impact on the delivery of WG performance measures and consequential impact on patients having to wait longer for care or treatment;
5. A potential impact that the Health Board will be escalated further from Targeted Intervention to Special Measures.

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

Rationale for CURRENT Risk Score:
The annual plan for 2024/25 is now aligned to the restated target control total. The Board have been involved in the discussions and decisions in the development of the plan through our Committees, Board Seminar sessions, and Public Board meetings. The Board, at its meeting on the 28 March 2024 endorsed the annual plan, recognising the forecast financial out-turn was in breach of the Health Board's statutory requirement to achieve financial balance. Without further support, the Health Board will require further cash-backed support as the extent of the cash allocation will be insufficient to pay our liabilities as they fall due in February and March 2025. The Health Board has submitted a strategic cash request and awaits a response from Welsh Government. The latest assessment of the financial deficit is that the Health Board has a trajectory to achieve its re-stated annual plan deficit of £31.5m.

Rationale for TARGET Risk Score:
Given the historic challenges relating to operational controls of the drivers of our expenditure, and the operational delivery of savings schemes; it is unlikely that the risk tolerance or target will be achieved in year. Further work is needed to provide assurance that this risk target is achievable over the medium term.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1.Timely financial reporting to Directorates, Sustainable Resources Committee, Board and Welsh Government on the finances to inform central and local scrutiny, feedback and decision-making. 2.Oversight arrangements in place at Board level and through the Executive Team structure, including through: a. Value & Sustainability Group b. Integrated Quality, Finance, Performance and Delivery (IQFPD) Group c. Healthier Mid and West Wales Group d. The Executive Team Escalation framework. 3.Exploration of a number of funding streams, including: Local Health Board funding arrangements; Funding arrangements through the Regional Partnership Board and Local Authority partners. Funding from WG's own sources or from HM Treasury via WG. 4.Opportunities Framework refreshed with the expectation that identified areas of waste will present deliverable cost reductions/formal savings schemes. Linked to Planning Objectives workplan, which will be shaped by the Health Board's strategy, “A Healthier Mid and West Wales", and align to the design assumptions set out in that. 5.Accountability agreements in relation to the Opening Directorate Budgets issued to the Executive Team in April 2024. 6.Delivery of our Planning Objectives and the subsequent financial benefits. 7. Implementation of escalation framework to ensure that delivery issues are identified and escalated promptly, and that corrective actions and decisions are rapidly achieved.	The control of the operational drivers of financial risk has been a significant historic gap in control. This has included: 1. The effective management of rostering; 2. The effective management of beds; 3. Effective contract management arrangements; 4. Oversight arrangements over commissioned services; 5. A consistent rate card for Medical and AHP; 6. Operational accountability and governance arrangements. The delivery of savings plans through the effective and timely oversight of projects and the resulting corrective actions and decisions required.	The implementation of a rostering system across medical staff, and the extension of rostering to other staff groups.	Hill, Carly	~~30/09/2024~~ ~~31/10/2024~~ 31/01/2025	The latest assessment of the mitigation plan and route map to delivering £64.0m is that £2.3m of the £4.2m identified savings are now delivering. Each action is associated with either an Operational or Corporate Lead as appropriate and these leads are continually assessing what further actions must be implemented in order to meet the required delivery. Two key areas which remain outstanding relate to Variable Pay and Digitisation of Records.BankStaff+ is on track to 'go live' on 1st January 2025 to record all additional duty hours
		Operational adoption of the Welsh Patient Administration System (WPAS) Bed Module and its incorporation into daily site management meetings.	Carruthers, Andrew	31/10/2024	Progress to be provided at next risk review
		Implementation of new oversight arrangements across commissioned services.	Davies, Lee	~~30/09/2024~~ 31/12/2024	As of August 2024, terms of reference are currently being drafted.
		The cash management strategy will be updated and presented to the SRC for reassessment in October alongside a formal reassessment of the financial trajectory for the year to fully understand the scale of the cash risk which may be experienced.	Davies, Rhian	Completed	A paper has been drafted for presentation at Sustainable Resources In-Committee in October 2024, the outcomes of which will inform the next steps for this action. A strategic cash request was submitted to Welsh Government by their deadline of 5 December 2024. Board approved the approach, and SRC were updated with the final letter given the additional funding received in December 2024 reduced the cash request that was proposed to the November Board.

The plans presented at Board Seminar on 11 September, and following approval and due process, are operationalised through our savings tracker. This needs to be completed during September to inform the forecast reassessment for Month 6 in early October 2024.	Thomas, Huw	Completed	The latest assessment of the mitigation plan and route map to delivering £64.0m is that £2.3m of the £4.2m identified savings are now delivering. Each action is associated with either an Operational or Corporate Lead as appropriate and these leads are continually assessing what further actions must be implemented in order to meet the required delivery. Two key areas which remain outstanding relate to Variable Pay and Digitisation of Records. Completed, with final reporting for November 2024 period end. All items now included in Savings Tracker, and any additional delivery is to be updated as part of the routine savings process.
Agreement and universal implementation of one consistent medical/AHP rate card spanning all locations and all services to align the rates of pay paid to staff irrelevant of specific circumstances.	Hill, Carly	31/03/2025	Meeting being arranged with LNC Chair and BMA Representative for early January 2025
Finalise and implement a substantive operational management structure via the ongoing COO OCP, ensuring all audit recommendations are completed and accountability structures are consistently deployed.	Carruthers, Andrew	31/03/2025	Appointments made into the senior tier, further cascades now being undertaken with support from Workforce and Corporate Governance.

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 against operational plans and targets through Performance KPIs.	Performance against plan monitored through Improving Together Meetings.	1st			Mth 1 - Paper to May 2024 Board Mth 2 - Paper to SRC June 2024	None				

In-month financial monitoring.	Value and Sustainability Group	2nd			Mth 3 - Paper to Board July 2024					
	Sustainable Resources Committee oversight of current performance	2nd			Mth 4 - Paper to SRC August 2024					
	Financial Performance Report to Board and SRC	2nd			Mth 5 - Paper to Board September 2024					
	WG scrutiny through monthly monitoring returns and reply letter actions	3rd			Mth 6 - Paper to SRC October 2024					
	WG scrutiny through monthly reviews with NHS Executive Finance Performance & Delivery	3rd			Mth 7 - Paper to Board November 2024					
	Audit Wales Structured Assessment process	3rd			Mth 8 - Paper to SRC December 2024					

Date Risk Identified:	May-23		
Strategic Objective:	5. Safe and sustainable and accessible and kind care		

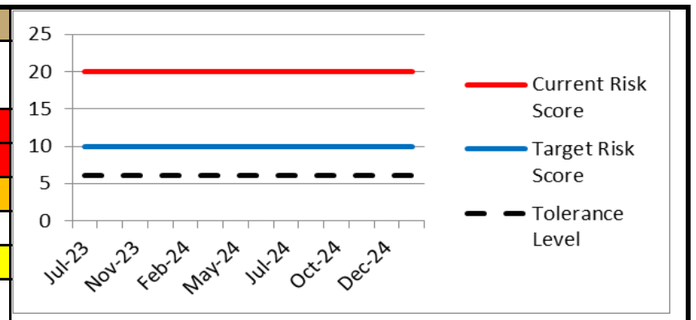
Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Dec-24
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-25

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 ability to deliver services within the Ophthalmology Referral to Treatment (RTT) plan, and the ability of the Health Board to comply with Welsh Government Eye Care Measures (ECMs). This impacts the ability to provide timely diagnosis and treatment, directly impacting on patient safety, with the potential for sight loss and long-term lifestyle impacts. The Health Board's ability to progress with the implementation of recommendations raised by various regulators and inspectorates is affected by the recruitment and estates issues, which in turn could lead to adverse publicity and reduction in stakeholder confidence, with increased scrutiny/escalation from Welsh Government.

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 R1 patients (high risk) with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional AMD sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the HB. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. There are delays to the delivery of R1 appointments for both Glaucoma and the delivery of Intravitreal injections for the Wet AMD pathway. The current non-medical workforce establishment is not aligned to service needs. Recently the service has transferred Glaucoma funding to the IVT service to create a new Band 7 post for IVT. Recruitment difficulties have lead to the Consultant on-call rota being covered by four substantive Consultants with a gap of 2. This gap is filled by the substantive consultants working additional duty hours to ensure the delivery of the Ophthalmology on call service. This is a fragile on call structure which is impacted by sickness and annual leave. The additional staffing needed for Wet AMD have been identified in the Eye Care Measures SBAR, which identifies the R1 delivery at 35%. The WG target for R1 delivery is 95%. The service as at December 2024 has as total of 6981 patients awaiting a new appointment, with the longest wait being 125 weeks. 8076 patients are awaiting an Ophthalmic Operation with the longest wait at 144 weeks. 7112 patients have been 100% delayed for their follow up appointment. The current impact has been scored as 5 because patients suffering irreversible sight loss is a reality and the current Likelihood has been scored 4 as Ophthalmology is a fragile service. It is unlikely that we will be able to achieve the Board tolerance score of 6 without significant investment or a regionally agreed solution.	It is unlikely that the service will be able to reduce the impact score of this risk as the consequences to the patient remains high, however an SBAR for the recovery of the R1 Eye Care Measures target has been produced, demonstrating a trajectory for recovery if the required investment is secured. This would allow the service to recover to a 75% R1 delivery target allowing the likelihood score of the risk to be reduced to 3. Should the investment be secured in April 2025, the service could recover to 75% by September 2026. Further development would be required to reach a 95% R1 delivery score, at which point the likelihood score of the risk could be further reduced to 2.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
The service is included within the Health Board's Clinical Service Plan (CSP). This will produce effciency gains but will not secure additional resources. Active recruitment to vacancies, grow your own innnitaives to secure Substantive Consultants and develop Consultants for the future. Collaborative working with Swansea Bay to deliver a Regional solution to address the workforce and estates constraints. Sub groups to be formulated to address, paediatrics, Glaucoma, AMD and on call pathways. Additional capacity has been funded for the delivery of Wet Age related Macular Degeneration (AMD). To reduce breach from 10 weeks to 8 weeks by March 2025. With further plans to secure an outsourcing	Whilst recurring money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, Orthoptists, Paediatrics, Corneal and VR) that require investment. ARCH programme closed, with a regional conversation around a regional clinical workshop to consider opportunities for a long-term regional model. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service.	Roll out and implementation of National Electronic Patient Record for Ophthalmology.	Barreiro, Marta	~~30/07/2021~~ ~~31/03/2022~~ ~~31/05/2022~~ ~~30/09/2022~~ ~~31/10/2023~~ ~~31/12/2023~~ ~~31/03/2024~~ ~~15/07/2024~~ 31/03/2027	Issues identified in the planning phase around data governance. DHCW are working to resolve issues. Update provided by the DHCW in September 2024 outlining options available and potential funding required to deliver. Regional planning scoped and aligned programme now proposed with Swansea Bay UHB, but is unlikely to be implemented before 2027. Further funding may be required from each HB to implement this model.

weeks by March 2025. With further plans to secure an outsourcing contract for the delivery of Intravitreal injections (IVT). Additional capacity has been funded for the delivery of Cataract surgery to recover the 104 week wait by March 2025. Continued Identification of patients suitable to undergo transfer out to the community to Wales General Ophthalmic Services (WGOS) for Glaucoma and Medical Retina. Continued Validation of waiting lists to remove any patients who no longer require treatment through the scheduled Care validation team. Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. Eye Care Measures co-ordinator in place to oversee and manage the management of all R1 referrals. Review of data quality inclusive of Health Risk Factor (HRF) code and clinical codes ongoing to improve data quality. Highly trained Optometrists working collaboratively with the Secondary Care Eye Service to reduce referrals to secondary care. Ongoing training of Optometrists within secondary care to continue to develop this service for continued delivery of WGOS. Ongoing arrangement of Optometrists enrolling in prescribing training to develop further Independent prescribers in the community. GIRFT review undertaken on the Ophthalmology service with progress made against recommendations raised monitored and updated via AMAT. Performance dashboards in place to monitor performance daily. IVT being offered at the refurbished OPD at Amman Valley Hospital Demand and capacity work undertaken associated with Wet AMD and Amman Valley Hospital	Long-term funding required in order to continue with current delivery of IVT, included within the Directorate's annual plans for 2025/26. Recovery funding is non-refunding and reviewed annually, this restricts delivery planning. There are concerns in data quality due to referral processes and system use. Fragility of on-call rota due to current workforce pressures	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	Completed	Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) was completed in March 2022. Long-term funding to support the continued delivery of service being requested as part of the Annual Plan 2025/26.
		Remodelling the capacity and demand associated with Wet AMD and Amman Valley	Coppack, Victoria	Completed	Remodelling exercise complete, with findings being incorporated in to annual planning process for 2025/26.
		Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.	Coppack, Victoria	~~30/09/2022~~ ~~31/10/2023~~ ~~30/11/2023~~ ~~31/03/2024~~ ~~30/06/2024~~ ~~30/09/2024~~ 31/03/2026	Validation of HCQ patient commenced in November 2023. Longest wait HCQ patients have been identified for tech review, however workforce pressures are negatively impacting on service delivery. Clinic spaces to be secured for patient review. This is an interim measure until WGOS 4 for HCQ can be rolled out. This will follow the roll out of Glaucoma and Medical Retina. HCQ qualified Optometrists will need to be in place in the community to proceed.
		Alignment in the Delivery of Eye Care Measures and Ministerial Measures and effective management of Ophthalmology waiting lists.	Coppack, Victoria	31/03/2027	A Regional Programme Board has now been established, and Ophthalmology has commenced a Regional Eye Care Programme. The Regional Eye Care Programme will meet bi-monthly to monitor and progress a Regional solution to the challenges faced in HDUHB and SBUHB, this will be fed to the Regional Programme Board. Identified first steps are to form sub-groups for the review of Paediatric Ophthalmology, Glaucoma, AMD and on call out of hours delivery.
		To recruit Orthoptists	Coppack, Victoria	30/04/2025	Orthoptist Band 6 posts have gone out to advert. Band 8A JD is being finalised.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Eye care measures monthly report. GIRFT review Cataracts. GIRFT review Glaucoma. Watchtower review of ministerial measures	WPAS	1st			Ophthalmology 'Deep Dive' paper to ARAC (Dec 2023) SBAR for IVT Service Delivery & SBAR for recovery of R1 position (October 2024)					
	GIRFT action plan cataracts	1st								
	GIRFT action plan Glaucoma	1st								
	WPAS, scheduled care performance indicators	1st								

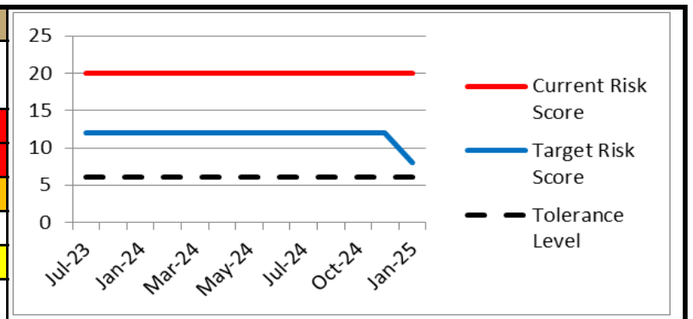
Date Risk Identified:	Nov-20		
Strategic Objective:	5. Safe and sustainable and accessible and kind care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jan-25
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Feb-25

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

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

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

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

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

Whilst recent experience suggests early signs of improvement against key UEC metrics, these remain outside target requirements. Data for December 2024 highlighted that the number of ambulance handovers taking over one hour was 1153, exceeding the target of 839. Breaches were also noted with the number of patients spending 12 hours of more in A&E / MIU, with actual figure of 1,543 exceeding the target of 1,137. The median time to assessment by a clinical decision maker in December 2024 was 89mins, exceeding the national target of 60 minutes. The Health Board were also over target in December 2024 in relation to Pathway of Care Delays, with actual figure of 208 exceeding the target of 184. As such, the current risk score remains unchanged as at January 2025, pending further review.

Recent external reviews (NHS Executive Same Day Emergency Care (SDEC) Review, NHS Executive ED Review and GIRFT Review on ED) continue to identify concerns with patient flow and quality of service, with further GIRFT reviews planned in January 2025 for BGH and WGH.

Rationale for TARGET Risk Score:

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

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

TI measures such as ambulance handovers and 12 hour delays in ED will need to improve in order to reduce the current risk score, for a consecutive period of three months.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Live Operational Dashboard in place and twice HB wide escalation meeting. # Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. Surge and boarding recorded on the twice a day escalation report. # Frontier system in place for recording DPOC and red days flagging required assessments to support discharge. # Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites with associated actions in collaboration with social care partners. # Regular advice on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, social services and the Long Term Care Team support. # Discharge arrangements are in place on all sites with a strategic review underway. # Standardised board rounds processes in place on all sites and D2RA processes are embedded with a 77% D2RA rate (Sep24). # Criteria-led discharge guidance and principles piloted across HB (Sep24). # Integrated Regional Winter Plans developed to manage whole system pressures over the winter period. # An operationally focussed 6 Goals Urgent and Emergency Care (UEC) programme with governance structure agreed where all UEC improvement is coordinated. # Welsh Ambulance Services NHS Trust involved in all 6 Goals UEC	# Fragility of Care Home Sector such as financial viability, staffing deficits, recruitment and retention of workforce. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff # Inability to handover ambulances to release them back for use within community due to lack of flow in acute sites. # Better understanding of ED presentations to ensure development of alternative pathways in primary care / community to prevent ED attendance # Ability to influence public mind set / expectation and culture in terms of use of NHS resource and 'Home First' Ability. # Gap in communication between secondary and primary care that could lead to poor discharge outcomes # Clarity regarding roles and responsibilities for discharge planning and coordination # The ability to risk stratify for people at moderate to high risk of admission in the community to implement proactive anticipatory care plans to support avoidance of exacerbation /	Delivery of 6 Goals Programme and Plan via the workstreams and closer working with WAST and primary care 1. Development of Regional Clinical Streaming Hub (CSH) for Health Professionals & Care Homes delivering 24/7 urgent care advice & support and onward referral to local deliver/resource hubs where appropriate	Skitt, Peter	31/10/2025	Piloting a 7 day model on the CSH across the Health Board as part of winter planning (utilising overtime and additional shifts) with a plan to produce a business case for substantive arrangements including the response model by February 2025.
		Develop a consultant led ED medical provision that is fit for purpose and meets the D&C requirements utilising all professions.	Skitt, Peter	31/03/2027	Discussions have started, with a lead for the discussion appointed. Current vacancy being advertised for a Lead ED Consultant, with the aim to being appointed in post by the end of February 2025.
		Winter Communication Plan for UEC to include advising the public on community pharmacy provision and avoiding falls	Skitt, Peter	Completed	Communications engagement leads contacted, with a plan in place and social media communications active.
		Utilise the risk stratification data set across the system proactively with the population	Skitt, Peter	30/04/2025	Part of First Home Hub plan and work is underway. Data is being used in primary care multi-disciplinary team meetings across the Health Board, and requires further embedding to ensure the impact within acute sector is realised.
		Review of Community bed based hospital capacity, with a view to ensuring proactive case load management and estate as part of the Alternative Care Model work. Develop & implement strategy for Alternative Care Community (ACP) Provision across the West Wales region.	Skitt, Peter	31/10/2025	Initial planning phase has started. Length of stay data being gathered.

workstreams. # 111 and 111 press 2 (MH) implemented across Hywel Dda. # Regional Integration Fund projects in place across Regional Partnership Board (RPB) footprint, along with Further Faster projects to ensure alignment with Ministerial objectives. # Whole system approach to deploy HB staff to ensure continuity of patient care. # Care Home Risk & Escalation Policy to support failing care homes to be applied as required. # Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across the RPB region. # Establishment of a Discharge to Recover and Assess (D2RA) Group which reports to the the 6 Goals Programme with a detailed D2RA improvement plan in place. # Establishment of a D2RA Escalation Transfer panel which provides senior oversight of delays at county level, assesses risk of the delay to the patient and organisation in terms of flow compromise # SRO in place to lead agreed 6 Goals for UEC programme. # Agreed SDEC model in place to maximise impact on admission avoidance. NHS Executive review with associate actions are part of the 6 goals UEC programme. # Local streaming (Home First) hubs developed with a HB wide approach agreed with clinical triage and screening systems in place, including APP Navigator in place. # Direct referral into SDEC in place. # OOH Pilot clinical streaming via GP route ongoing as of January 2025 with a view to full completion at the end of the month	decompensation and hence increased risk of hospital admission. # Optimising our bedded facilities in the community. # 24/7 integrated urgent primary care service aligned to Home First hubs. # Insufficient IPC single rooms across community and acute sites, negatively impacting on patient flow # Lack of level 1 / 2 falls response service during out of hours across the Health Board # Fragility of senior medical cover at EDs across the acute sites	Enhancements to local delivery / resource hubs to support the CSH providing access to enhanced community care services, third sector services and other pathways to provide safe alternatives to admission. Integration with GP OOHs and APP resources	Skitt, Peter	31/10/2025	Discussions ongoing on providing a single clinical streaming hub across the Health Board footprint, with response resources locally based at cluster level as a phased approach to introducing the care at home blueprint, as described during the 6 Goals review meetings.
		Development & implementation of consistent approach to Front Door Streaming / Assessment Units focused on our Frail Elderly cohort based on good practice and lessons learnt from Withybush Puffin / South Pembrokeshire model.	Skitt, Peter	31/12/2025	SDEC services available on all sites for medical patients. Surgical SDECs piloted in Glangwili and Bronglais (with further expansion during the next 6 months). Ongoing discussion with Glangwili relating to frailty provision, and further work required in Bronglais (nurse-led frailty team at the front door).
		Development and implementation of HDUHB optimal SDEC model following on from lessons learnt from peer review and alignment with CSH and local resource hubs.	Skitt, Peter	31/10/2025	An SBAR is being developed, due for completion by February 2025, to standardise the approach across the Health Board.
		Continued implementation of Optimal Flow Framework including Community sites supported by Frontier digital platform.	Skitt, Peter	31/10/2025	On track with roll out plan, and ensuring that all sites are using the framework is ongoing. This work will also feed in to the E-Obs and patient flow project going forward.
		Continuing education at ward level to ensure consistent approach to Board Rounds and Safety Patient Huddles utilising Frontier platform to capture and report information.	Skitt, Peter	31/03/2025	This action links with the management actions as noted in the Discharge Management internal audit issued, to deliver a consistent approach by the end of March 2025. Progress is being monitored via AMAT.
		Implementation of 7 focused areas within ED Quality statement.	Skitt, Peter	31/03/2026	Clinical lead for ED post currently out to advert. ED Quality Statement Action group in place, who report 6 weekly to Welsh Government. Action plan developed and in place, forming the basis of updates to WG, based around the national toolkit.

Develop West Wales Hospital @ Home model to ensure consistent approach and delivery.	Skitt, Peter	30/09/2025	Phased approach to the delivery of the model, with strategic document currently being developed, to be agreed by clinical leads and 6 Goals advisory group.
Establishment of a regional Discharge Strategy Group to provide oversight of all current work streams and actions being undertaken around discharge as well as work around national and local policies - Discharge and Transfer of Care Policy, Reluctant Discharge Policy, Care Home of Choice policy.	Skitt, Peter	31/03/2025	POCD group and Trusted Assessor group in place, and Discharge Strategy group to provide oversight and actions, chaired Assistant Director of Nursing. This work will align with the delivery of the management actions of the internal audit on Discharge Management, which is being monitored by the Health Board via AMAT.
Establish regional POCD group to focus on reviewing of trends and themes to develop robust regional or local action plans to deliver improvement.	Skitt, Peter	Completed	In place as at January 2025, and regular monthly meetings with Welsh Government, and onward submission of data. Monitored via the 50 Day Challenge Care Action Committee (CAC) group.
Develop robust regional Trusted Assessor (TA) Model to ensuring consistent approach to assessment across the region - residents can be an inpatient at any of the 4 x general hospital sites.	Skitt, Peter	31/10/2025	Trusted Assessor regional group in place focussing on the model and reporting required to Welsh Government, aligned to further faster monies.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**		
Ambulance handovers within 15 minutes	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st			
Ambulance handovers over 1 hour	Daily performance data overseen by service management	1st			
Ambulance handovers over 4 hours	Workstream Delivery Plans overseen by 6 Goals Programme	2nd			

Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
None identified.				

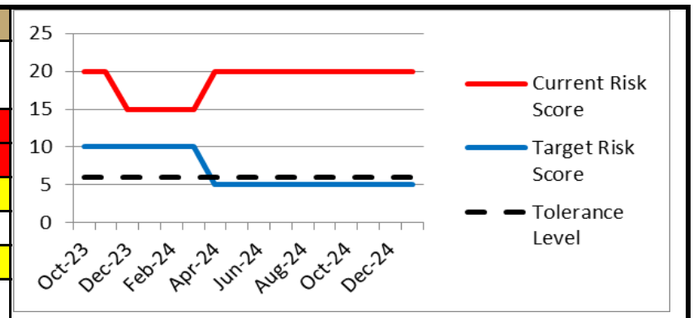
4 & 12 hour waits in A&E Time to triage in A&E Time to see a Doctor in A&E Pathway of care delays	6 Goals Programme / UEC IQFPD 3As report into IQFPD	2nd						
	Bi-annual reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd						
	IPAR Performance Report to SDODC & Board	2nd						
	IA review on Transforming Urgent and Emergency Care	3rd						
	NHS Executive Same Day Emergency Care (SDEC) Review	3rd						
	NHS Executive ED Review	3rd						
	GIRFT Review on ED	3rd						

Date Risk Identified:	Nov-22		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jan-25
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Feb-25

Risk ID:	**1531**	**Principal Risk Description:**	There is a risk of being unable to provide a safe and sustainable general surgery consultant on-call rota at WGH and GGH. This is caused by Unsustainable and fragile rotas, with a difficulty to recruit into substantive posts. This could lead to an impact/affect on on the ability to provide an emergency general surgery service at WGH and GGH affecting patient experience, causing clinical delays and poor outcomes for patients. The wellbeing of remaining consultants who are already working to full capacity is also affected and there is an increased expenditure on agency locum consultants and internal locum rates above the HB card rate. Consultants working additional on call locum weeks is resulting in a reduction in elective activity in OPD, endoscopy and theatre. This will have a negative impact on RTT and SCP targets.
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):	4×5=20
Target Risk Score (L x I):	1×5=5
Tolerable Risk:	6
Trend:	⇔



Rationale for CURRENT Risk Score:

The risk score remains the same as the inherent risk score. This is based on recent short notice absences in addition to the existing gaps on both rotas (GGH & WGH), where the rotas have come close to collapse, 3 times in recent months, with the rota being covered at the eleventh hour at an enhanced rate. This has further highlighted the fragility of these rotas.

Due to the financial situation, there is an expectation to reduce variable pay and exit Medacs locum agencies. There is a risk that the WGH rota will collapse if a replacement agency locum is not found before 21/11/2024. The appointment of a locum consultant to GGH does not change the risk score as this is a temporary measure. The rotas will remain fragile if they remain as two separate rotas and we try to sustain a 1:4 and 1:8 rota on two sites.

There is currently one vacancy and substantive consultant who is no longer taking part in the on call rota, due to health issues, on the General Surgery Consultant rota at WGH (1:5). This is now running as a 1:4 rota one gap is filled by an NHS locum, with the other filled by Medacs. A second NHS locum is due to commence in post on the 27th January 2025 who will replace the Medacs locum. In GGH (1:8 rota) there is one vacancy, one retire and return consultant, at the time of retirement the clinical director and GS team at GGH supported the retirement with the agreement they would cover the out of hours on call through additional hours. The vacancy has now been filled by an NHS locum upper GI consultant who started in September 2024. There is also one consultant on the General Surgery Consultant rota at GGH who is only able to undertake weekday on calls. Weekends are covered by a specialty doctor acting up under supervision. The GGH rota is now running as a 1:7, maintaining a 1:4 in WGH. A 1:7 in GGH with 1 gap is unsustainable.

In April 2024, an SBAR was presented to Board recommending amalgamating the two on call rotas to 1 site to either a 1:12 or a 1:10. There is clinical belief that these changes provide a more sustainable service and would make recruitment more attractive, when comparing to other health boards across Wales who provide emergency general surgery cover in this way. The condition of this change would be that consultants would be expected to change their base of work to participate in the amalgamated rota. This was recommended within the GIRFT report on General Surgery. Proposals relating to service changes and the amalgamation of the rotas

Rationale for TARGET Risk Score:

The target risk score is based on the work currently being undertaken as part of the Clinical Services Plan to identify and approve a more sustainable solution in order to reduce the likelihood of rota collapse and reduce the risk of not being able to provide a safe and sustainable emergency general surgery service to patients in the south of the Health Board. The effectiveness of revised rota arrangements will depend on several factors including availability of a labour market.

were presented to Acute Leadership Group (ALG) in October 2024, with the requirement to engage with relevant stakeholders noted as an action. An options appraisal paper was presented to Board in November 2024 via the Clinical Service Plan (CSP).

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Rotas monitored daily by the service delivery team When there is sickness or unexpected leave, due to emergency circumstances, the management team work to cover as follows: 1. Internal Additional Hours (ADH) on the site with the gap. 2. Internal ADH from the other sites across the health board. 3. In the event of steps 1 & 2 being unsuccessful, the service would escalate for agreement on transferring the surgical out of hours on call take to another site. (WGH to GGH) 4. Ensuring that all stakeholders are aware, including site teams, medical teams, WAST, any supporting services as appropriate. 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. On appointment, new consultants undertake an induction with Hospital Director at WGH and Clinical Director for Scheduled Care. SOP in place for the transfer and repatriation of patients Engagement with WGH Medical Staff Committee and public on changes to services	Ongoing rota gaps due to recruitment difficulties. The 4th slot on the WGH rota is being filled by a Medacs locum which incurs additional costs. Potential for locums to leave at short notice, causing the rota to collapse. Financial constraints impacting on the ability to recruit GGH consultants offer to cover the WGH gaps when required, on ADH, however WGH have never offered to cover any other site. No rota co-ordinator in place at WGH or GGH to support rota management, and currently undertaken by Service Manager There is a risk of consultants requesting rates that are higher than the HB card rate, going forward as they have been covering multiple gaps on the rota for a prolonged time.	Review the longer term sustainability of general surgery on-call rotas across Hywel dda (recommendation from Getting it Right First Time (GIRFT) review in Jan23)	Lewis, Caroline	Completed	The senior consultant leads for general surgery have suggested that the WGH and GGH on call rotas are amalgamated to one site. This would provide an increase of consultants on the rota to either a 1:10 (the 3 WGH consultants and the 7 GGH consultants) or a 1:12 (the 3 WGH consultants, 7 GGH consultants and 2 newly recruited posts). This recommendation is in line with the GIRFT report. SBAR's have bee drafted by the service to describe the fragility of the rotas.
		Seek replacement for the Medacs locum consultant and advertise for an NHS locum consultant at WGH.	Lewis, David	Completed	Agency locums has been appointed, and the NHS locum post has been offered, with commencement date confirmed as 27th January 2025.
		To develop an options appraisal paper with all relevant stakeholders, including WAST, Primary Care, and site teams	Hire, Stephanie	31/01/2025	The paper has been developed and is being discussed live at the health board planning session on 9/1/25

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When / Progress
	WGH Medical Staff Committee established to develop models of sustainability	1st			Management team have presented an SBAR to Acute Leadership Group (Feb23) SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23)	Assurance to Board on communication and repatriation arrangements			
	Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd			General Surgery Report to Board (Mar23) Management team to present updated SBAR to Acute Leadership Group (Oct23 & Nov23)				
	Reported to bi-monthly Scheduled Care Quality, Safety and Experience Group through exception reporting	2nd			Management team to present updated SBAR to Corporate Directorate Group (Apr24)				
	Assurance to be reported to the Board following introduction of temporary rota	2nd			Upper GI service SBAR presented at ALG (Sep24) Upper GI service SBAR presented at Quality, Safety and Experience committee				

	GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited				committee Meeting (Oct24) Updated SBAR to Executive Team (Nov24)				

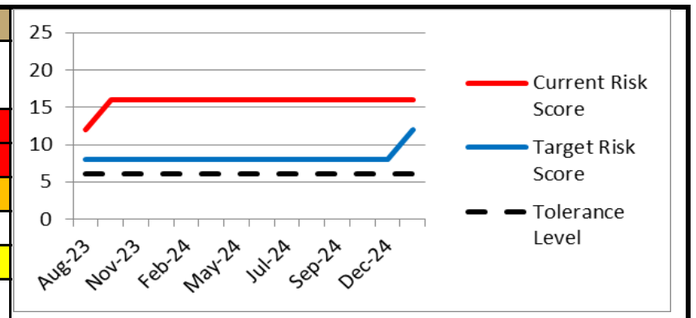
Date Risk Identified:	Jul-23		
Strategic Objective:			

Executive Director Owner:	Paterson, Jill	**Date of Review:**	Jan-25
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Feb-25

Risk ID:	**1708**	**Principal Risk Description:**	There is a risk of increasing fragility in Primary Care Contractor services. This is caused by several factors including pay-affecting Government decisions, 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, with potential for demand exceeding capacity. 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, 800. 912, 1823, 1869, 1109, 1851, 1823, 1993

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):	3×4=12
Tolerable Risk:	6
Trend:	⇔



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
8 dental contracts have been returned to the Health Board in the last 12 months, of which four contracts (totalling £958,500) confirmed as being awarded by NWSSP Procurement Services in May 2024. In addition, a further 8 dental practices have not signed up to the contract reform, and signalling that they will return contracts once reform negotiations have concluded. The number of complaints received from the public has increased due to returned contracts, and while the Health Board is currently containing the demand for urgent dental care, it is recognised that patients who don't fall in to this category but require a level of dental care are detrimentally impacted, and that any further contracts returned will exacerbate this situation. The capacity of the Health Board in terms of staffing to absorb further contract reform will impact on the ability to effectively deliver services, and a detrimental impact on staff welfare. There has been increased demand in urgent dental appointments resulting in appointments for the week being booked up early within the same week. The Dental Access Portal (DAP) pilot commenced in Powys in June 2024, with roll out due to at Hywel Dda in November 2024. 2 GMS contracts has been returned to the Health Board in the last 12 months. However from previous contract terminations, 2 out of the 3 GMS contracts have become Health Board managed practices, resulting in additional financial pressures as the workforce is salaried. The third practice has been awarded as of 1st April 2024 after a successful procurement process. The outcome of the contract which was returned in April 2024 was presented and agreed by Board in July 2024, with decision made to manage list dispersal. It is recognised that any further managed practices would likely have a negative impact on the GMS budget. Implementation plans are in place with Ophthalmology to support the transition of patients into Welsh General Optometric Service (WGOS4) (clinical pathways for Glaucoma, HQC and Medical Retina) as part of the new Optometry contract implementation which commenced in September 2024.	Achievement of the target score is subject to the development and agreement of a Primary Care Strategy at Board alongside successful national contract negotiations and subsequent implementation across the Primary Care contractor professional groups. There is a high dependency on external factors which make the reduction of the risk score challenging. It is unlikely that the risk score will reduce to the target risk score within 12 months without the approval of the Primary Care Strategy. Successful conclusion of contract negotiations with professional contractor groups also 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**
Primary Care Academy in place, which looks at workforce planning, training and development needs and opportunities 5 Facet Survey completed in 2022 to establish a baseline for the GMS estate GMS and Dental Practices undertake annual reporting which includes reviews of statutory compliance requirements 0.25 FTE Primary Care Development Manager for estates in post but with a focus on GMS Escalation tool for GMS and Community Pharmacy (SITREP) Continue effective engagement with struggling practices to support with their issues through close working relationships developed with practices. Programme of practice visits to review Estates provision, and if remedial action is required Requests sent to contractors to assess potential risk of RAAC, with outcomes reported to WG Nationally agreed Breach Management process in place for Community Pharmacies. Requests for contract variation (termination, merger, branch surgery closure etc) are considered in line with national guidance, with panels convened as stipulated. Recommendations are taken through the Primary Care Contract Review Group with papers to Board when required. Strategic Programme for Primary Care (SPCC) bids approved for 2024/25 and 2025/26 to support workforce initiatives A series of patient facing videos have been developed with Pocket Medic to support patient education in accessing Primary Care Services	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 completed, however this is a statutory requirement for the practices to complete. Limited requirements for practices to disclose information to the Health Board about their sustainability pressures, and rare for practices to disclose financial details (reliant on engagement and good will as this is not a contractual requirement). Insufficient resources to support the estates development across all Primary Care services, particularly with independent contractors. Due to national review of Premises Directions, there is no improvement grant funding for 2024/25. Whilst Community Pharmacy Breach Management process in place, which	Establish workforce plan and recruitment strategy in line with the development of the national Primary Care Workforce Strategy and as a component of the Primary Care Strategy.	Hughes, Samantha	~~31/03/2024~~ 31/03/2025	Workforce planning continues. GP Practice workforce plans using data from Welsh National Workforce Reporting System (WNWRS) have been pulled together at Cluster level for Collaborative consideration. This information now needs to inform and align to the Primary Care Workforce Strategy. Support is being provided to the Directorate with this work from colleagues in Workforce, and is also discussed via the Primary Care Academy. Through Strategic Programme for Primary Care (SPPC) fund, a Primary Care Workforce Planner has been appointed on a fixed term basis until March 2026, who will commence work on the workforce plan.
		To develop the Primary Care Strategy in consultation with statutory stakeholders and consultees, to cover areas including: •Workforce •Sustainable provision of Primary Care services •Estates •Managing contractual change •Developing pathways and new services •Improving access to services across all contractor professions	Bond, Rhian	~~30/09/2024~~ 31/03/2025	Paper submitted to Board in September 2023 setting out the scope of the Primary Care Strategy, with papers presented to Board at regular intervals. A further paper is due to SDODC in October 2024.
		Consider the potential to deliver a wider range of salaried NHS Dental Services through the Community Dental Service.	Owens, Mary	~~30/04/2024~~ ~~30/06/2024~~ ~~31/10/2024~~ 31/03/2025	Negotiations continuing in October 2024, and guidance still awaited from Welsh Government.

Whilst Community Pharmacy Breach Management process in place, which has been reviewed in light of appeals process. GMS contract management review process in place, reviewing escalation status, sustainability assurance framework and business continuity plans. Data is reviewed and challenged where necessary by Primary Care Service Managers.	has been reviewed in light of appeals process. Whilst RAAC declarations were requested, these were not mandatory for contractors to respond, and therefore effectiveness of responding to outcomes. Whilst challenge is provided via GMS contract reviews, feedback not consistently addressed by practices.	Implement the Managed Practice Strategy plan will give greater system resilience.	Swinfield, Anna	~~30/04/2024~~ ~~30/10/2024~~ ~~31/01/2025~~ 31/03/2025	The tender process for Neyland and Johnston concluded without a contract award. Re-procurement exercise completed in September 2024 with no success. Review of Managed Practice Strategy to be undertaken in line with the development of the Primary and Community Services Strategic Plan.

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

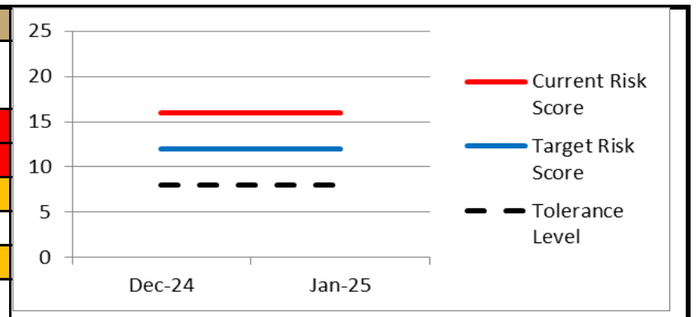
Assurance Framework - Business Service Authority dashboards, to identify outliers	GMS Practices are part of a rolling visiting programme, based on their annual return which is risk assessed against a framework of any other issues or concerns identified	1st								
	PCSMs tasked with regular discussions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

Date Risk Identified:	Apr-24		
Strategic Objective:	1. Putting people at the heart of everything we do and 2. Working together to be the best we can be and 3. Striving to deliver and develop excellent services		

Executive Director Owner:	Gostling, Lisa	**Date of Review:**	Dec-24
Lead Committee:	People, Organisational Development and Culture Committee	**Date of Next Review:**	Jan-25

Risk ID:	**1978**	**Principal Risk Description:**	There is a risk here will be insufficient skilled workforce within each of our professional groups (Nursing, Medical, Allied Health Professionals AHP, HCS, Pharmacists and Dental). This is caused by the scarce supply of healthcare professionals and a shrinking labour market, which is further exacerbated by the Health Board's current vacancy rates. This could lead to an impact/affect on the quality of care provided to patients, delays in care and poorer patient outcomes and experience. In addition, this may lead to the inability to meet statutory and professional requirements in terms of safe staffing levels that are needed to deliver quality patient care.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Workforce/OD
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	8
Trend:	*New risk*



Rationale for CURRENT Risk Score:

This risk has been scored as 16 (the likelihood is "likely" and has the potential to have a "major" impact) as the number of staff impacted from staff sickness is high still in Oct -24 compared to identified All Wales benchmarks (c1-2% higher). Staffing levels (acute & community) continue to operate below established levels due to both vacancies and sickness/absence which is supplemented by additional hours, bank and agency. Further work has been undertaken to understand the level of risk across each staff group (Nursing, Medical, AHP and HCS) to comprehend the level of risk by each group. It is hoped as further action is taken through stabilisation, Improving Together and workforce planning to reduce the risk score during 2024/25. However it should also be noted that due to the Health Board's current financial position and considering the wider financial context; this may result in the potential requirement to increase the risk score to 20 once board decisions have been finalised regarding the utilisation of agency, bank and locum workforce. A summary of the gaps to enable a stable workforce in each professional group are noted below: 1) Nursing & Midwifery: a) Destabilisation of the nursing workforce linked to introduction of RNA role b) Destabilisation of the workforce due to the changes in Job Descriptions and Bandings 2 & 3 (leading to potential litigation) with potential implications for higher bands, c) gaps in specific nursing skills sets i.e. Public Health (new role), Critical Care, Theatres (although wider workforce implication), Midwifery (SCBU) and Health Visiting (dependent on model of care to be provided locally). d) Risk profile for nursing based on retirement and turnover generally in each branch of nursing 2) Medical and Maps Workforce a) Destabilisation of the medical workforce due to regulation of AA, PA roles b) Specific skills gaps related to High Locum Usage/Recruitment Gaps i.e. Haematology c) Consultant cover in ED GGH/WGH and Mental Health. c) Medical rate card issues leading to "internal bidding across sites and HB's 3) Allied Health Professionals - destabilisation of the workforce due to capacity potentially outstripping demand/high locum usage in Physiotherapy (potential exacerbation by "recovery work" b) Specific establishment challenges in Paediatric SALT & Dietetics 4) Healthcare Science destabilisation due to a) Lack of clarity on benefit of regional models identified b) gaps in Pathology and Radiology workforce per se with potential exacerbation of recovery work and possible consequential sickness increases (12% in month for GGH), c) specific skills set challenges in sub specialities i.e. Sonography where national challenges exist d) connected implications on broader workstreams i.e. Cancer pathways i.e. Interventional Radiology. 5) Ability to create true multi disciplinary workforces. 6) Niche skills gaps due to an aging workforce and retirement risks in critical skills/niche specialities. However, that said, through a risk management approach and the aligned stabilisation programmes, there is growing confidence that with focused management effort, at a local, regional and national level we will be able to mitigate.

Rationale for TARGET Risk Score:

The Target Risk score indicates the likelihood of the risk occurring (absence target 4.8%). Other intelligence leads the Health Board to be alert to workforce issues as evidence suggests that patient acuity is increasing and therefore workforce requirements will increase by proxy until new models/methods to reduce or manage complexity can be identified. Also, it may be that there could be concerns for the specific services and/or the annual risk of a winter surge developing when at full capacity for recovery/ministerial priorities as we have a "finite" resource in our people that can only be stretched so far without causing detriment. Therefore, the probability sits between 75-90% when taking account of multiple factors - respiratory infections, increased patient acuity, the longer term impacts of COVID-19 on the population i.e. inability to access services needed, and workforce resilience. We hope we will be able to take mitigated actions noted below predominantly through our interventions under the Regeneration Framework in the short term and for the medium term begin to realign available workforce to new service design and models of care. This risk is wider than a 12 month period as actions taken or not taken today will have a long term legacy on our available future workforce and capacity/capability to manage the associated challenges of service & workforce redesign (linked to Principal Risk 1186 - Attract, retain and develop staff with the right skills).

Key CONTROLS Currently in Place:	**Gaps in CONTROLS**

(The existing controls and processes in place to manage the risk)	**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**
Organisational Governance Structure Improving Together approach to be align to People Planning approach supported by People Planning Team to create an organisational wide approach to in year service challenges Organisational Gap Analysis based on a 10 year profile developed and annual assessment strategic & operational review of workforce (including Education Commissioning Assessment) Inter-People and Corporate Team & Planning Objectives Establishment Control Agency usage Bank Utilisation & ongoing onboarding of supply Efficient Rostering practice Roll out of new rostering system Overview of organisation and service wide risks (assessment of each service area based on workforce availability) Continuous process of assessment of services to be stood down and deployment options based on service needs (CDG) Targeted prioritisation of recruitment/onboarding of new employees to the highest areas of risk in terms of maintaining service delivery (People & OD Strategic Group) Temporary People Utilisation reports shared regularly to monitor levels of supply Align and iterate to implementation groups i.e. Medical retention. Annual completion and submission of Education Commissioning Plan to HEIW and critical assessment to known service level plans Digital support with workforce planning to support speed in decision making at local, regional & national levels. Corporate Risks have been developed linked to Wellbeing as part of Risk Management approach. Close Out Report completed for PODCC 15 April 2024: Further actions	Recruitment Plan in place to appoint to substantive workforce. Workforce planning groups need time to mature and develop focus underpinning SPPEG. Establishment control cannot be relied on as one source of truth for information as a) partially due to temporary changes linked with pathways, b) 9 sources of information not all feed into the establishment control tool, c) data management issues in ESR, e.g., single employer status for some of our medical workforce and d) Changes in the funded establishment not reflective of "on the ground" situations. Tools to enable modelling in short, medium and long term to enable alignment of population health, labour market, internal labour market, activity & performance analysis aligned to financial constraints (work arounds utilised but gaps/issues exist). Critical analysis of people alignment to priorities for delivery within financial considerations for short, medium & long term; striving to develop a Health Board/System wide approach A robust framework of competency based people planning and related training to underpin the Team around the Patient initiatives and new model development of care. Essential and necessary reliance on educational frameworks rather than new role development, which is an evolutionary aspiration. Practical next steps will be assessed linking into	Draft Workforce Plan in Place for Each Professional Group identified to address concerns above & monitored through relevant fora i.e. SPPEG, MDT Forum and PODCC	Walmsley, Tracy	31/03/2025	In progress, analysis of professional groups and alignment to Workforce Planning Forum supported by professional leads to be put in place December for sign off of approach to align to Education Commissioning for HEIW.
		Each Professional Workforce Plan in place with an implementation action plan developed within 25/26. (This will be maintained as an iterative plan with ongoing monitoring and review by relevant fora i.e. SPPEG, MDT Forum and PODCC. The Professional groups relate to each "Staff Group" identified under ESR i.e. Estates and Ancillary, Admin and Clerical (although service level plans may need specific tailoring), Nursing and Midwifery, Medical and Dental, Healthcare Science, Allied Health Professionals, and Additional Professional and Technical.	Walmsley, Tracy	31/05/2025	As above to be continued and supported by Annual Plan Workforce Workshop 9 January 2025
		Design an approach to primary and community workforce model for 25/26 against agreed priorities for Primary Workforce Planner and Annual Planning Objectives (NB Requires alignment to UEC, Primary Care and Community Programmes of work)	Walmsley, Tracy	31/05/2025	Ongoing, requires "Forum" to align Service, Programmes and Strategy discussion for Workforce to develop integrated approach to link with Workforce Planning Forum and Professional Group Plans. Appointment of Primary Care workforce planner to complement team appointed 4/12/24.
		Create task and finish group to analyse establishment control and develop tool to accurately reflect staffing requirements in partnership with Finance to ensure effective alignment to workforce changes and future profiling to include Education and Commissioning (3 year forward workforce "shape & spend" profile)	Walmsley, Tracy	30/06/2025	To link to Annual Plan & Education Commissioning work; in train. Profiling of People Regeneration Framework required to inform, in train.

Close Out Report completed for PUDCC 15 April 2024, Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.	steps will be assessed linking into skills gaps within the workforce and the educational infrastructure to support.	Ensure effective methods of workforce utilisation across each professional group in place: Nursing, Medical, AHP and HCS. Critically assess and design plan for work that can be implemented by end of March 2026.	Walmsley, Tracy	31/03/2026	Roll out of Job Planning & Allocate across professional groups; plans required to a) strengthen current approach and b) develop for new professional groups as prioritised against resources. AHP/HCS workshop intended for Jan/Feb 2025.
		Completion of Education Commissioning Plan to HEIW and critical assessment to known service level plans as at January 2025 submission to Welsh Government.	Walmsley, Tracy	31/03/2025	In progress, roll out of meetings and Workshop in January followed by Workforce Planning Forum to enable critical sign off; need to assess alignment to "Professional Leaders Forum"
		Recruitment plan aligned to each professional group (priority for medical for 25/26)	Walmsley, Tracy	31/03/2025	Analysis in train, based on in year and projections
		Education Plan aligned to each professional group (to 24/25 and reframed for 25/26)	Glanville, Amanda	31/03/2025	Analysis in train, based on in year and projections
		Retention Plan aligned to each professional group (to 24/25 and reframed for 25/26)	Davies, Christine	Completed	Analysis in train, based on in year and projections
		Evaluation of effectiveness of plans 24/25 & Lessons Learnt. (to 24/25 and reframed for 25/26)	Walmsley, Tracy	30/06/2025	Analysis in train; medical stabilisation plan in development.

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
	Monitoring of workforce SIP and gaps in establishment control	1st				Assessment & continuous development mechanisms linked to Capacity and Capability (including any negative impacts on Wellbeing)	Maturity Matrix developed 31 June 20024 a) ongoing assessment & testing b) locally, c)regionally, d)nationally The intention over the next 12 months to achieve output a) and b) by March 2025, output c) by September 2025 and d) by December 2025 with any refinements of process/mechanics/content achieved by March 2026.	Walmsley, Tracy	31/03/2025	External stakeholder engagement ongoing i.e. other SWP colleagues and HEIW. Shared with HEIW, Strategic Workforce Planning Institute. Discussed with HEIW in November 2024 as part of Strategic Engagement. Meeting with regional colleagues separately to link in as part of regional work programmes. Shared in November 2024 meeting of Regional Network - scheduled for review in workshop January 2025.
	Risk management approach to Workforce themed Risks	1st					Overarching Implementation Plan & Assessment of Impact (Approach defined 30/9/23) and delivered no later than 31/03/25 to link to Annual Planning cycles (identified in Audit Wales initial draft report)	Walmsley, Tracy	31/03/2025	Workforce Plan will take account of the needs to address the actions in the Wales Audit Office Report. Assessment of work by Service, Professional and People Pillar to develop a costed plan for P&OD and HB.
	Strategic People Planning & Education Group	1st					Value & Sustainability Group to receive updates on variable pay and temporary staffing usage	Walmsley, Tracy	31/03/2025	Regular updates presented: standard agenda item agenda.
	Workforce levels monitored at Service Level, Professional Groups and Operational Delivery Group & Improving Together meetings	2nd								

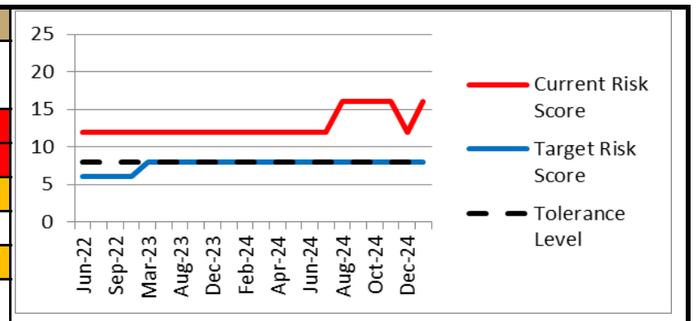
PODCC - IMTP Plan, and process mapped through Planning Sub Group	2nd								
Workforce Planning Internal Audit (Substantial Assurance) April 2022	3rd								
Wales Audit Office review of Workforce Planning (Fieldwork underway - report expected Summer 2023)	3rd								

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jan-25
Lead Committee:	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Feb-25

Risk ID:	**1350**	**Principal Risk Description:**	There is a risk of the Health Board not being able to meet the 75% target by March 2025, and 80% by March 2026 for waiting times in the ministerial measures for the Single Cancer Pathway (SCP). This is caused by by reduced capacity to meet the expected demand for diagnostics and treatment delays at our tertiary centre, and the fragility within key tumour sites. This could lead to an impact/affect on on increased number of patients waiting in excess of 62 days and meeting patient expectations in regard to timely access for appropriate treatment which could potentially lead to poorer outcomes and patient experience, adverse publicity/reduction in stakeholder confidence, and increased scrutiny/escalation from Welsh Government. This could lead to adverse reputational damage as a result of inconsistent performance delivery over time.
Does this risk link to any Directorate (operational) risks?		1223, 114, 111, 1537, 1699, 1722, 1723, 797	

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
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:	8
Trend:	⇔



Rationale for CURRENT Risk Score:
The latest performance data as of November 2024 is 55.5%, this is an improvement from October 2024 data which was 44%. Despite the improvement in performance noted above the health board is still not achieving its internal predicted target of 60% for the month of November 24 due to: Legacy impact of Radiology reporting delays, which increased during summer period due to dual impact of cessation of daytime Everlight external reporting, and an increase in emergency pathway demand. Negative impact on headline Single Cancer Pathway (SCP) performance of positive progress achieved in recovering the Skin pathway backlog which developed in previous months due to sharp increase in skin cancer referral demand and sickness/absence amongst senior clinical team. Although performance for December 24 is predicted to improve further due to recovery actions within radiology, Urology and Skin pathway, the risk remains that cancer performance will not achieve 75% compliance by March 2025

Rationale for TARGET Risk Score:
The aim is to treat patients within target waiting times, which has now been confirmed as 75% non-adjusted 2022-2026. The tolerance level will be met if plans to increase diagnostic capacity, utilising allocated recovery funding are realised. Publication of performance data by WG recommenced in Feb21 with health boards only reporting against the SCP, with no wait adjustment.

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**
# A GI Improvement Group has been established to support the implementation of the NOP for the GI Pathways. # Accelerated imaging from Endoscopy to CT within the GI pathway now in place across all sites, reduction time on patient pathway by 23 days # Fully established cancer tracking team in place to allow patients to be proactively tracked through their pathways. # A new cancer dashboard developed by Informatics with the support of Business Intelligence (BI) SCP funding from the Wales Cancer Network. This is now live with access for Cancer Services staff and Service Managers, allowing MDTs to actively monitor tumour site specific patients on a SCP. # The health board have been piloting the use of Quarterly Planning and Monitoring reports developed by the NHS Executive since July 23. This has facilitated the development of targeted improvement plans per tumour site and subsequent weekly monitoring thus providing assurance of the robustness of plans. # As per the Wales Bowel Cancer Initiative, a successful FIT10 screening in the management of USC patients on a colorectal pathway was implemented in Jun20. A Straight to FIT test is being implemented within the health board, where depending on the result of the FIT test, as to whether an OPA or any further investigations are required, which will reduce the pathway by 14 days. On 6th April the health board introduced FIT10 screening into Primary care. This has resulted in a reduction in demand of 30% for first OPA. # Virtual appointments are being undertaken via digital solutions e.g. Attend Anywhere. # Weekly Cancer Watchtower meetings where services managers are in attendance. The function of this group is to monitor and address service demand, capacity and risk issues. # Monthly performance meetings with Welsh Government. # Trajectory performance plans have been developed for each tumour site by the relevant services, with regards to improving performance. This also includes Backlog Trajectory plans on how these improvements will be achieved. # Robust Urology diagnostic recovery plan to eliminate patients waiting more than 28 days in place, with committed resource allocation from recovery money. Monitoring of Urology diagnostic improvement trajectory via Cancer watchtower. # Cancer Pathway Review to be discussed at the MDT Business meetings and plans put in place to address and improve any bottlenecks or issues. Pathway reviews will also be a standing agenda item on the Oncology Quality & Safety meeting to ensure governance and part of the relevant	Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP. Key diagnostic information systems do not support effective demand / capacity planning. Need for the implementation of new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways. Delays in data reporting, with a lag of 2 months.	Work with multidisciplinary team to reallocate FIT pathway to primary care in line with NOP and rest of Wales	Humphrey, Lisa	31/03/2025	Planning in progress
		Radiology to work with NHSE to refine demand and capacity planning	Roberts-Davies, Gail	~~31/12/2024~~ 28/02/2025	in progress revised date due to needing extended time
		Radiology to work with cancer services and the NHSE to improve productivity and efficiency processes	Roberts-Davies, Gail	~~31/12/2024~~ 28/02/2025	In progress - mapping complete meeting arranged for implementation
		Roll out gynaecology one stop hysteroscopy to reduce diagnostic pathway across all sites	Freeman, Lyndon	~~31/12/2024~~ 31/01/2025	One stop in place for BGH and GGH - planning for WGH by end of December now revised to end of January 25
		Establish accelerated Neck lump pathway to reduce diagnostic pathway	Lewis, Caroline	~~31/12/2024~~ 31/03/2025	engagement required with Radiology and SBUHB - part of annual planning process
		Work with NHSE to review referral rates and patterns within primary care to reduce and refine demand to secondary care	Humphrey, Lisa	31/03/2025	Mapping in progress

update TOR as per internal audit recommendation	Bennett, Debra	~~31/10/2024~~ 01/02/2025	In progress reviewing governance structure for Cancer improvement board in line with HB governance processes
Assess the impact of OPA Laryngeal biopsy on overall performance for Head and Neck	Lewis, Caroline	~~30/10/2024~~ 31/12/2024	In progress. Requires 6 months data in order to commence.
Recovery plan in progress to undertake 200 additional CT scans as agreed over a 5 week period commencing week 23rd December, the impact of which will reduce overall WL volume to 0 and therefore improve turnaround time from 18 days to under 7 days as agreed by IQFPD utilising recovery money	Procter, Sarah	31/01/2025	in progress
Recovery plan in progress for Urology LATP to remove 50 patients in the backlog over a 5 week period as agreed by IQFPD utilising recovery money	Griffiths, Neil	31/01/2025	in progress

Quality & Safety meeting to ensure governance and part of the relevant Directorate Quality & Safety meetings
Process in place to improve component wait times and reduce patients waiting more than 14 day for first Outpatient Appointments (OPA) and 28 days for Diagnostics.
One to one escalation meetings held with Cancer Watchtower leads and Tumour Site Service Managers for tumour sites that require intervention.
New Endoscopy booking process implemented in November 2023 which tracks all patients referred for an endoscopy on a USC priority. If capacity is identified as a trending breach reason, the Service Management team supports targeted intervention to address these concerns in order to reduce time on patient pathways.
One Stop Hysteroscopy within Gynaecology implemented in May 2024 at Bronglais General Hospital, with plan to implement across all sites during Q2 of 2024/25
Pathway changes in Head and Neck to include Laryngeal Biopsy at first OPA, reducing reliance on pan-endoscopy
Health Board wide internal escalation framework now in place to support the monitoring of performance targets, with a TI de-escalation target of 60% for three months (as at May 2024)
FIT review complete to inform planning to realign FIT pathway to Primary care in line with NOP.
* 8 additional radiology reporting sessions in place agreed up to March 25
Skin treatment recovery plan in place to end March 25 to reduce overall treatment volumes to a sustainable level of 100
Radiology recovery plan in place to end Jan 25 to see and additional 200 patients awaiting a CT scan.
Urology recovery plan in progress to address 50 patients in the backlog awaiting a LATP to end of January 25

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
Internal targets - Looking at the performance per tumour site individually that have the biggest impact on overall performance Skin Urology	Daily/weekly/monthly/ monitoring arrangements by management	1st			* Implementation of Single Cancer Pathway Report - BPPAC - Feb20 * COVID-19 Impact on Cancer Services	None identified.				

Urology LGI Gynaecology Breast Reducing component waits Patient waiting more than 14 days for first OPA Patients waiting a diagnostic procedure and report more than 28 days Patients with a confirmed diagnosis of cancer waiting more than 62 days	Monitor outpatient appointments booked beyond 10 days to identify common themes	1st			Cancer Services - Board - May20 * Cancer Updated to QSEAC Jun20 & OpQSESC Jul20 * Risk 633 QSEAC - Feb21 & Aug21 * IPAR Report - Board - Nov22				
	IPAR Performance Report to SDODC & Board	2nd							
	Monthly oversight by Delivery Unit, WG	3rd							

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

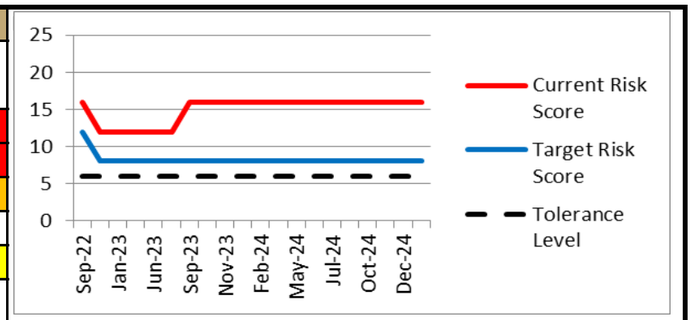
Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Dec-24
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-25

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 SCP breaches and breaches over 8 weeks due to increased downtime. Increased risk of IR(ME)R notifiable radiation incidents due to increased breakdowns as a result of malfunctions during exposures.

Does this risk link to any Directorate (operational) risks?	925, 114, 1668, 1785

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



Rationale for CURRENT Risk Score:

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

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

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

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

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

Rationale for TARGET Risk Score:

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

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

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

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

Once the Nuclear Med SPECT-CT scanner and the 2nd CT scanner at GGH have been replaced we would look to seek permission to reduce this risk score and to move the risk directorate level. This is dependent on WG funding, and may not be complete until the end of the 26-27 financial year due to the additional infrastructure required. However, the WG budget announcement of NHS funding on 10/12/2024 may significantly reduce this timeline and de-escalate this risk, should it be directed towards equipment replacements as early indications suggest.

In addition to this the variation between the DEXA services provided via the SBUHB SLA and at BGH has been made worse by the fact that the Swansea scanner now undertakes Trabecular Bone Scoring (TBS) which is a new and very important way of assessing bone structure. The BGH scanner is unable to do this and there have been a few recent cases of patients who have recently had a DXA in BGH who are now having another DXA in the SBUHB mobile unit because we need obtain the TBS result.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports. # Escalation process in place for service disruptions/breakdowns. # National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales. # All equipment at main sites are now DR and so will be compliant with the RISP project # Additional WGH EOY funding was secured (23-24 financial year) and replaced aged US units and upgraded the software on MRI scanners at BGH and WGH providing latest technology.	Limitation of spare parts for some older equipment leading to extended outages. This issue has been compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment. Inability to undertake specific replacements at this time due to the additional infrastructure required No dedicated diagnostic equipment replacement funding for the 2023-24 financial year delayed replacement of key pieces of equipment and so maintained the risk at it's current score. National Imaging and Capital Priorities Group outcomes do not always align with the Health Board priorities, and is subject to negotiations within the group.	Installation of replacement Gamma Camera, WGH	Roberts-Davies, Gail	~~31/07/2024~~ 30/06/2025	Gamma camera is 9 years old and the only scanner in the Health Board providing a regional service. Recurrent breakdowns are resulting in HIW reportable incidents. Awaiting confirmation of funding as at December 2023. No funding allocated as of 09/02/2024 This will not be replaced in the 24/25 financial year. A specific T&F group is due to be set up as of June 24 to plan the necessary accommodation improvements required. July 2024 update- the T&F group has been set up and meets weekly
		Replacement of CT Scanner at GGH	Procter, Sarah	~~31/03/2024~~ ~~31/07/2024~~ 30/06/2025	CT scanner is 11 years old, with increased failures noted and that new technologies are now available. Colleagues in Estates are currently looking at options and prices, and as at December 2023 no capital bid yet provided as awaiting works costs. Significant infrastructure works will be required due to the size of the accommodation and the requirements of more modern scanners, including footprint. Will not be replaced in the 24/25 financial year

Replacement of Fluoroscopy room, WGH	Whitecross, Faith	~~31/03/2024~~ ~~31/07/2024~~ 31/03/2025	Equipment is 17 years old with significant downtime experienced. Routine testing by Medical Physics department in January 2024 has found that image quality has deteriorated and the equipment is delivering increased doses to account for this. Confirmation that this piece of equipment will be replaced in the 24/25 financial year was received late May '24- action will be closed when this piece of equipment is operational. The replacement is currently delayed as of November 2024 due to additional the discovery of additional infrastructure which is required.
Replacement of CR A&E DR room and OPT (Dental) units, BGH	Edwards, David	~~31/03/2024~~ 31/10/2024	The equipment for the A&E room has been replaced as at October 2024, with handover and training underway. OPT units have been set up however awaiting engineers and medical physics to complete installation, upon which the action will be closed..
Replacement of CR X-ray Room 1, WGH	Roberts-Davies, Gail	~~31/03/2024~~ ~~31/07/2024~~ 31/03/2025	Ageing equipment. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. This will not be replaced in the 2023/24 financial year Confirmation that this piece of equipment will be replaced in the 24/25 financial year was received late May '24- action will be closed when this piece of equipment is operational.

Replacement of CR X-Ray room, Llandovery Hospital	Osell, Fiona	~~31/03/2024~~ ~~31/07/2024~~ 30/06/2025	Equipment on site is incompatible with the incoming PACS system, and interim solution required. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. Awaiting confirmation of funding as at April 2024. This will not be replaced in the 2024/2025 financial year
Replacement of Mammography Units, BGH and WGH	Roberts-Davies, Gail	~~31/03/2024~~ ~~31/07/2024~~ 30/06/2025	Ageing equipment, exacerbated by the failure of Securview. These will not be replaced in the 23/24 financial year These will not be replaced in the 2024/2025 financial year
Upgrade or replacement of MRI scanner, PPH	Osell, Fiona	~~31/03/2024~~ ~~31/07/2024~~ 31/03/2025	Ageing equipment with increasing failures, with new technologies now available. Awaiting confirmation of funding as at April 2024. Confirmation that this piece of equipment will be upgraded in the 24/25 financial year was received late May '24- action will be closed when this new piece of equipment is operational.
Upgrade or replacement of MRI scanner, GGH	Procter, Sarah	~~31/03/2024~~ 30/06/2025	Ageing equipment with increasing failures, with new technologies now available. Awaiting confirmation of funding as at April 2024. This will not be replaced in the 24/25 financial year.
Replacement of Room 3 (Digital x-ray room), BGH	Edwards, David	~~31/03/2024~~ ~~31/10/2024~~ 30/06/2025	Mobile unit currently being used. Awaiting confirmation of funding as at April 2024. This will not be replaced in the 24/25 financial year

		To consider alternative funding options for the DEXA unit, BGH	Edwards, David	~~31/03/2024~~ ~~30/09/2024~~ 30/09/2025	Unit is 17 years old, and previously funded via charitable funds This has been added to the imaging priorities list and end of year additional funding projects as relative replacement costs are not high. A business case for charitable funding will be pursued in due course, however operational pressures have taken priority to date.

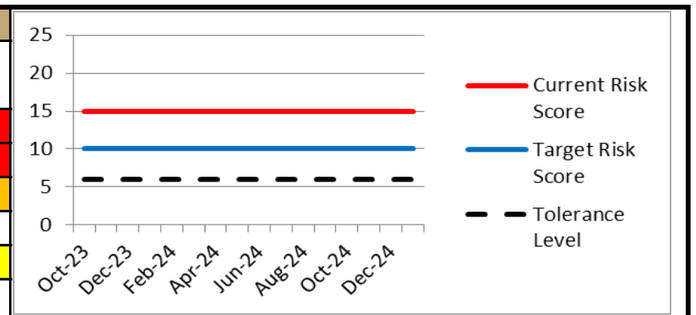
ASSURANCE MAP						Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level	Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Identified Gaps in Assurance:	How are the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

Date Risk Identified:	Aug-23		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Dec-24
Lead Committee:	Health and Safety Committee	**Date of Next Review:**	Jan-25

Risk ID:	**1745**	**Principal Risk Description:**	There is a risk of not being able to deliver safe, effective and timely services across the HB estate, including acute, community and mental health facilities. This risk also impacts the HB's non clinical estate, educational facilities and managed practices. This is caused by further deterioration of our aging buildings and infrastructure with significant amount of the estate beyond its life expectancy. Multiple points of failure, delays in addressing reported defects and limited capital to address the increasing backlog of estate environmental issues. This could lead to an impact/affect on patient experience, our ability to deliver care in line with expected standards resulting in increased scrutiny and critical reports from auditors, regulators and inspectorates, such as HIW and HSE, and decreased public confidence and perception of our services, facilities and estate environment. Impacts also include increasing revenue costs to supplement the lack of capital funding available required to react to emerging issues, ability to comply with the Health and Safety at Work Act, including other legal regulations and engineering guidance documents such as Welsh Health Technical Memorandums (WHTMS).
Does this risk link to any Directorate (operational) risks?		1795,33,39	

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 current risk score is based upon the level of detailed information the Estates department has for its buildings, plant and infrastructure, including external reports, risk information and Estates and Facilities Performance Management System (EFPMS) data submitted to Welsh Government (WG), clearly articulating the scale of backlog and deficiencies across the Health Board. The programme business case (PBC) has been under development with WG since 2018/19. NHS Wales Shared Services Partnership (NWSSP) has supported a three year investment programme for Major Infrastructure. WG are in support of this plan (With a £5m capital expenditure per year limit), however they have not yet supported the fees to deliver the three year programme. The current funding status is WG support for Year 1 of a three year plan in 2024-25 together with a small number of priority schemes. Negotiations are ongoing with WG to secure funding for the three year plan but unable to confirm a date as yet. At present minimal funding has been received circa £1.5m for lift shaft improvements at BGH and Electrical Infrastructure at GGH, with fees for the first year of plan secured. A draft document developed by Major Infrastructure Team detailing the consequences of infrastructure failure in relation to patient services and its impact on patient care.

Rationale for TARGET Risk Score:
The target risk score, is directly linked to the amount of funding the Health Board (HB) will receive to address the current issues faced across the organisation and our ability to successfully deliver these improvements to reduce 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**
Planned and Preventative Maintenance regimes CAFM system to report and prioritise breakdowns across site. Questionnaires have now been included in CAFM, to measure the performance of our maintenance service. Also to feedback any suggestions on improvements. Condition appraisals (estate survey) and NWSSP-SES audits Backlog database identifies costs of works across the estate Operational Estates staff on site to deal with breakdowns (on-call 24/7) EFAB funding to support DCP (£5.5m over 2 years 2023/24 & 2024/25) WG additional funding in 24/25 for priority items. Risks are identified by Estates and services and these inform prioritisation of DCP funding Skilled and trained Estates workforce in place.	Limited Discretionary Capital Programme (DCP) funding to address the £124m backlog WG support for the Major Infrastructure Programme has not been confirmed Statutory, mandatory and essential maintenance jobs are prioritised over routine helpdesk jobs (on average only 50% of helpdesk jobs are completed) Reduction in annual capital funding and statutory allocations to address key items. Increased backlog of circa £250m	Undertake general environmental monthly walkarounds across the 4 acute sites to increase understanding and proactive management of day to day estate defects.	Evans, Paul	Completed	Completed
		Development of Major infrastructure Programme for 4 main hospitals and securing external funding	Elliott, Rob	~~31/03/2024~~ ~~31/12/2024~~ 31/03/2025	NWSSP Shared Services has supported a 3 year investment programme for Major Infrastructure. WG are in support of this plan (With a £5m CapX per year limit) however they have not yet supported the fees to deliver the 3 year programme. Note reductions of plans from earlier proposals costing several hundred millions, which WG were unable to support. Current funding status is WG support for year 1 of a 3 year plan in 2024-25 together with a small number of priority schemes. Negotiations are ongoing with WG to secure funding for the 3 year plan but unable to give a date. A revised date for this action has been included and will be reviewed if the situation changes. At present minimal funding has been received circa £1.5m for lift shaft improvements at BGH and Electrical Infrastructure at GGH, also secured are the fees for 1st year plan. Risk actions will be reviewed quarterly.

Undertake general environmental quarterly walkarounds for all community in-patient facilities (including Mental Health facilities) to increase understanding and proactive management of day to day estate defects.	Evans, Paul	Completed	Completed
AHMWW PBC submitted to WG in February 2022 remains not endorsed. Agreement required with Welsh Government on next steps and broader strategic direction.	Davies, Lee	31/10/2024	Nuffield Trust report on clinical strategy received and presented to Board. Management response to be agreed through SDODC. Meeting with Deputy Chief Executive, NHS Wales and Director of Finance, NHS Wales has been held and there will be an IIB meeting in February (date to be confirmed).

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
	Regular review of 'environment' themed risks identified on operational service risk registers	1st								
	Feedback questionnaire on CAFM maintenance system to measure effectiveness of maintenance service and to offer additional feedback or suggestions on all closed maintenance requests	1st								
	Health and Safety Committee review of risks above tolerance	2nd								
	Independent Member & Executive Director Walkabouts	2nd								
	External surveys are undertaken	3rd								

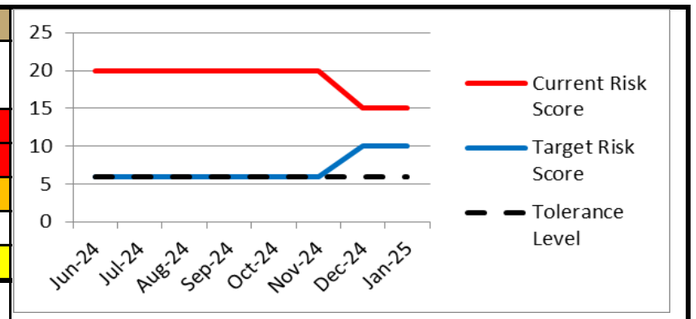
NWSSP-SES Internal Audit on Estates Condition	3rd									

Date Risk Identified:	May-24		
Strategic Objective:			

Executive Director Owner:	Daniel, Sharon	**Date of Review:**	Dec-24
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-25

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

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	↓



Rationale for CURRENT Risk Score:

There are specific concerns relating to Glangwili General Hospital (GGH) and Withybush General Hospital (WGH) in relation to Cardiac Arrests and unplanned admissions. There was an increase in Cardiac Arrest rates in GGH in the period Jan - Oct 2024 (30) compared to the same period Jan - Oct 2023 (15). GGH senior management team have agreed to Datix all cardiac arrests and establish bi-monthly meetings to review cases and identify themes and learning opportunities, the next meeting is 14th November 2024.

There has been a slight increase in unplanned admissions at WGH, with 81 noted in the period Jan - November 2024 at WGH (79 for the equivalent period of Jan-November 23). Following the recent WGH RADAR meeting is was agreed that the Treatment Escalation Plan (TEPs) task & finish group in WGH would be re-established.

There are also concerns across the Health Board as a whole relating to the National Early Warning Scores (NEWS), and appropriate escalation where required as part of observation processes. Currently working with Clinical Audit to develop an audit tool on AMAT to audit on a monthly basis NEWS charts on wards and identify good practice and areas for improvement. A National Safe Care Collaborative meeting held in Cardiff in October 2024 began exploring the possibility of establishing a National Acute Deterioration Group.

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

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

As at December 2024, all actions are being processed within set dates / timeframes although many remain long term. Current controls are managing the risk and the increasing awareness of gaps in assurance and local actions to mitigate and manage the risk have been established.

Rationale for TARGET Risk Score:

The full implementation of the actions noted in the risk action plan will support the reduction in the likelihood and impact score of this risk to a target risk of 10. With recruitment into the Resus Team and the establishment of a supported Cascade Training process the aim will be to see an increase in training compliance in both Level 2 & Level 3 training by October 25 to >60%. We will aim to see a reduction in Cardiac Arrest rates across all 4 sites and unplanned admissions into ITU from ward areas by October 2025.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Governance structures in place eg RADAR Group (Recognition of Acute Deterioration and Resuscitation). Increased awareness of gaps in assurance and local actions in place to manage and mitigate the risk. T&F Group chaired by HB RADAR Lead with focus on Sepsis, DNA/CPR group chaired by Deputy Medical Director. RADAR directly reports to Operational QSE. Local RADAR groups (across all sites, counties, MHLD and Paediatrics) which report to HB wide RADAR group - chaired by a commission. Mechanisms in place across all sites to monitor cardiac arrest rates. Health Board Resus policy in place (currently out of date requiring updating - however waiting on national guidance) All Wales DNA/CPR policy in place, which is due for update in 2024 Lead for Acute Deterioration Dedicated Resuscitation Team in place, consisting of 5 full time and 2 part time employees Networks in place across the wider HB, including support from QIST Organisational training plan in place, including mandatory training Critical Outreach Services in GGH and WGH (not in place at PPH / BGH), managed by Planned Care Directorate (i.e not fully linked to Acute Deterioration resource) New Acute Kidney Injury (AKI) Lead appointed for GGH (12 months) Dedicated resource in Quality Improvement Team monitoring AKI alerts for the Health Board Bi-monthly scrutiny meetings have been set up in GGH to review Cardiac arrests. Cardiac arrest reviews presented at Medical Education sessions Review of feedback from any Medical Examiner reviews, highlighting	No treatment escalation plans in place No call for concern in place Training demand outstrips capacity to deliver, with time limited in training sessions Inconsistent application of policies and processes eg DNA/CPR, new escalation policy, sepsis assessment tool, National Early Warning Score (NEWS). Reliance on manual / paper based documentation to record patient deterioration and subsequent escalation Critical Outreach Services not in place at PPH / BGH Inability to release staff to complete L2 and L3 training	Health Board Recognition of Acute Deterioration and Resuscitation (RADAR) group to develop a workplan to address gaps in control to improve the recognition and management of acute deterioration across the Health Board.	Davies, Mandy	~~30/09/2024~~ ~~30/11/2024~~ 30/04/2025	Quarterly meetings in place, and sub-groups being established to report to Recognition of Acute Deterioration and Resuscitation (RADAR) group on sepsis, NEWS, treatment escalation plans, call for concern (Martha's Law) DNA/CPR, acute kidney injury (AKI). Agenda at August meeting didn't allow for discussion on the development of a workplan. Plan is to confirm RADAR Action Plan at next meeting 26th November 2024, with risk actions to be updated accordingly.
		Develop an organisation-wide training needs analysis to appropriately identify staff across all staff groups complete the most appropriate level of training to improve recognition and management of acute deterioration.	Wastell, David	~~30/09/2024~~ ~~30/11/2024~~ 28/02/2025	The directorate is working with ESR to ensure that staff training attendance is accurately recorded. Work is ongoing with individual line managers to identify the training needs of all their staff groups across all four sites and community. Meetings commenced with all senior nurse managers to discuss current training uptake and training needs to identify the most appropriate training for each staff group across acute and community. Meetings are to be arranged with Heads of Service for other clinical services. As at June 2024, it has been identified that 84 ILS sessions are required in order to ensure compliance with targets for GGH alone. Heads of Nursing requested to discuss training attendance with all ward sisters, and to appropriately prioritise. Monthly analysis of training available, and attendance to be shared with Heads of Service and

issues relating to resuscitation/cardiac arrests and lessons learned.			Senior Nurse Managers. The provision of training continues at current levels, given current resource availability. First draft to be taken to Ops QSEC advising in January 2025.
	To implement an electronic observations systems across the Health Board to capture real-time bedsite capture of patient assessments and monitoring, in line with the Health Board's Digital Plan	Williams, Carolyn	30/09/2025	Tender process completed. Business case to be presented to Board in July 2024, with a view to implement on a site by site basis over in 18 months, in line with the current Digital Plan. Board approved the business case in Sept 24 however funding has not yet been identified to enable the project to proceed.
	As part of the Quality Dashboard, agree the matrix needed for patient deterioration. Include these matrix in the Health Board Quality Dashboard to inform escalation and create a specific dashboard for RADAR (Recognition of Acute Deterioration and Resuscitation).	Wastell, David	30/05/2025	Meeting of 25th July 2024 has identified the following supporting metrics for the dashboard: sepsis, AKI, NEWS audits, cardiac arrests, number of MET calls, treatment escalation plans are in place, call for concern rates and training compliance for ILS and BLS for each Directorate. Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system.

Put in place process for Health Board compliance with Martha's Rule by establishing a Task and Finish Group to implement Call for Concern	Wastell, David	~~31/03/2025~~ 31/12/2025	Task and Finish Group is in place, chaired by Ceri Griffiths. SOP Patient leaflet is being developed and a pilot was due to commence in GGH in Nov 24, however due to the CCOT service and Site Management Team having staff shortages due to sickness the pilot has been placed on hold subject to a further review in Dec 24. This pilot will test the process to roll out across the organisation for Adult Inpatients. Pilot scheme at GGH is aiming to be completed by March 2025, with a view to rolling out to other three acute sites by December 2025.
Put in place All Wales Policy for treatment escalation plans to enable safe and effective care management when patient deteriorating.	Wastell, David	31/12/2024	Discussed at Health Board Recognition of Acute Deterioration and Resuscitation (RADAR) group Group (March 2024) - no agreement to move forward with proposed pilot in Withybush. Discussed at Withybush RADAR meeting in July 2024 where agreement reached for pilot. Task and Finish group being established by Lead for Critical Care Outreach in Withybush to devise an implementation plan. RADAR to review following evaluation and consider roll out across other sites.
Implement a model for CASCADE training for basic life support and monitor impact on basic life support training compliance rates.	Wastell, David	31/03/2025	Model devised by Resuscitation Team - first training session held. 6 Cascade Trainers from across the Health Board Community Teams, trained in July 2024. Training will continue. Training session for Midwife Cascade Trainers in development, with plans for health visitors and school nurses for February 2025.

Following assessment and interpretation of the All Wales Direction, the Health Board is engaging in National work, namely roll out of NEWS2 and Call 4 Concern and contribute to the National Improvement for Acute Deterioration being led through the Safe Care Partnership.	Wastell, David	~~30/09/2024~~ 30/03/2025	Launch of this initiative on 17th September 2024 (World Patient Safety Day). WHCs have been received in relation to NEWS2 and Call 4 Concern. A group led by the Assistant Director of Nursing for Acute Inpatient Services is designing a first phase approach to pilot Call 4 Concern from November 2024. All Wales Safe Care Partnership meeting held on 22nd October 2024 to design a national improvement programme for acute deterioration, which the Health Board are engaged in and are contributing towards. National group not yet established as of November 2024.
Work to improve compliance with Sepsis Bundles at the front door.	Wastell, David	31/12/2025	Ongoing quality improvement in place. Has demonstrated improvements in Glangwili and Prince Phillip and now being used in Withybush. Reviewing process for assessing impact on patient outcomes as a result of the response and management of sepsis.
Improve compliance with DNACPR National Guidance	Steele, Cathie	~~30/10/2024~~ 31/05/2025	DNACPR Review Group formed and actions identified including development of a SharePoint page (which is now complete) and undertaken an improvement project through EQIiP (underway). Annual audits undertaken by junior doctors, and reviews of medical examiner reports and cardiac arrest to identify learnings. Training needs have been identified in relation to DNACPR and patients who are considered having learning disabilities, or diagnosed with dementia. Work is commencing with the MHLD directorate to progress this. A full action plan as been agreed in response to the HIW National Report on DNACPR (see AMAT)

Development of an Acute Deterioration Sharepoint page for all advice, guidance, updates, for staff on issues relating to resuscitation, DNACPR, sepsis, call for concern, MET calls, training, etc.	Wastell, David	31/05/2025	Senior nurse for acute deterioration is working with Interim ADN for Quality and Safety to develop SharePoint page.
Trial starting in October 2024 for 3 months re NEWS Audit, NEWS Charts - 5 charts every ward, every month on every site utilising the AMaT system. To review compliance and whether escalation processes are being followed with outcomes being fed back to wards.	Wastell, David	31/01/2025	Training plan developed and to roll out in early January 2025 with 1st audit to be done by CCOT / Resus by end of January 2025
Acute Deterioration E-learning modules - topics include NEWS, sepsis, DNACPR and A-E assessment being developed by the Lead Nurse for Acute Deterioration in conjunction with NHS Executive and other leads. Work to develop a process for using these modules with clinical areas in response to issues of concern.	Wastell, David	31/01/2025	Currently awaiting national updates in order to progress with this action.
Review efficacy of local RADAR groups, and frequency of meetings being held	Davies, Mandy	30/06/2025	Support being given to Chair of RADAR to liaise with Chairs of local RADAR groups delays due to limited availability and operational pressures.
Develop standardised template to report into Health Board RADAR group	Wastell, David	30/06/2025	Template to be developed following meetings with Chairs of local RADAR - draft template shared and awaiting further comments
To develop mechanisms to review and monitor the Acute Deterioration position via Escalation Framework via the Quality domain (including the implementation of the Safety Dashboard)	Davies, Mandy	30/06/2025	Meeting of 25th July 2024 has identified the following supporting metrics for the dashboard: sepsis, AKI, NEWS audits, cardiac arrests, number of MET calls, treatment escalation plans are in place, call for concern rates and training compliance for ILS and BLS for each Directorate. Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system.

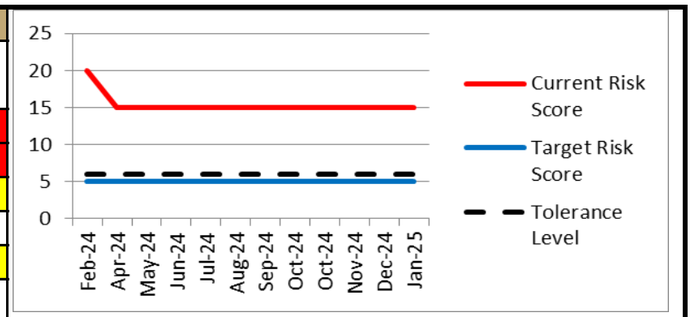
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Training compliance via ESR Cardiac Arrest Audits	RRAILS Audits undertaken by ward staff monthly, and inform the Nursing dashboards	1st			RADAR Group Update to OQSEC, Feb-24	Ward based NEWS audits in place but may be unreliable as self assessed.	Once dashboards in place, to develop a monthly audit process to address key hotspots / areas of concern relating to RAILS	Wastell, David	30/09/2025	Next RADAR meeting scheduled for 26 November 2024.
	Review of DATIX incidents, complaints, cardiac arrest reports and Medical Examiners reports relating to acute deterioration	1st								
	Outreach review all unplanned admissions to Intensive Care	1st								
	RADAR Group	2nd								
	T&F Group chaired by HB RADAR Lead with focus on Sepsis	2nd								
	DR/CPR group chaired by Deputy Medical Director	2nd								

Date Risk Identified:	Feb-24		
Strategic Objective:			

Executive Director Owner:	Paterson, Jill	**Date of Review:**	Dec-24
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-25

Risk ID:	**1810**	**Principal Risk Description:**	There is a risk that the Health Board will be unable to continue manufacturing cancer treatments for our patients. This is caused by the facilities of the Pharmacy Aseptic Unit being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS) standards 5th edition (published 2016) and therefore at risk of closure. This could lead to an impact/affect on the Health Board's ability to provide all the cancer treatments currently offered. The Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. A fully outsourced service would cost an additional c£1 each year. Some therapies cannot be outsourced, meaning Hywel Dda could not offer over 500 cancer treatments each year. This would have a significant negative impact on patient care as patients would either be required to travel further from home to neighbouring Health Boards to receive their treatment (dependant on their capacity to absorb the additional demand) or would be offered less clinically appropriate treatments at Hywel Dda, negatively affecting clinical outcomes. The closure of the Aseptic unit would directly impact the ability of the Health Board to achieve ministerial priorities and targets such as the Single Cancer Pathway, A Healthier Wales, etc.
Does this risk link to any Directorate (operational) risks?		374, 1350, 716	

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



Rationale for CURRENT Risk Score:
Withybush Aseptic unit is the only functional unit that can manufacture cancer treatments remaining in the Health Board. The facilities of Withybush Aseptic unit are currently non-compliant with regulatory standards. An audit by the National Pharmacy Quality Assurance Lead was performed in February 2024 confirmed the facilities were a high risk to patient safety, and the unit is at risk of forced closure. Short term control measures have been implemented by the Health Board's aseptic team to reduce the risk of immediate forced closure (see control measures). The controls are currently successfully minimising the amount of microbial contamination present within the unit, demonstrated by ongoing daily/weekly/monthly environmental monitoring. However, as the unit and equipment are beyond their useful expected life, there will come a time where the control measures will no longer be sufficient to allow the safe running of the unit. If the stringent controls fail at limiting the amount of microbial contamination, the unit may be forced to close. 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

Rationale for TARGET Risk Score:
The target risk score is based on the premise that funding for a new aseptic unit is approved by Welsh Government. The unit would be compliant with regulatory standards and once operational, it would be extremely unlikely for the unit to be forced to close. A new unit would allow the Health Board to continue to safely prepare cancer therapy until the TrAMS South West manufacturing hub is operational.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Transfer of the radiopharmacy service to Singleton Hospital in October 2022; this means less overall activity through the Withybush Aseptic unit reducing the risk of contamination and errors. More time and resource provided to the Quality System (i.e. internal audits, investigation of near misses and microbial growths, maintaining SOPs). Increased training of aseptic staff to develop their skills and knowledge. Increase outsourcing from commercial suppliers; this limits the volume of products prepared within the unit, allowing products that must be made in-house to be prepared safely. New pharmaceutical isolators have been procured to replace the existing isolators that are beyond their working life of 10 years. The new isolators will be stored with the intention of installing into the demountable unit (if funding is secured) or will be installed into the existing unit if the current isolators fail mitigating the risk of equipment failure causing prolonged service disruption. Removal of outsourced dispensing from the Aseptic unit; this minimises the risk of contamination and potential for error. Preparation of products near to the time of use; this limits the pre-administration storage time. More stringent gowning process; this minimises contamination risk. More stringent cleaning and monitoring programmes; this minimises contamination risk and allows early detection of microbial growth. Oversight and steer from Capital Sub-Committee.	Controls are reliant on a key group of skilled staff (i.e to maintain Quality System, to follow cleaning and monitoring procedures) therefore subject to key person dependencies. Limited accommodation to employ additional staff to expand workforce within the existing unit at WGH. Limited accommodation to store starting materials and finished products or to perform the associated tasks that are required to safely supply cancer treatments. Between 2021 and 2023, the number of cancer treatments requiring aseptic preparation at Hywel Dda increased from 12,718 to 16,648 (average of 14% increase each year). There is limited space within the Pharmacy at WGH to manage this increase in demand. Lack of funding to build a new unit at WGH. Progress dependent on feedback received from Welsh Government	To submit revised business case for demountable unit to Welsh Government (estimated £2.89m).	Morgan, Cerith	31/01/2025	As part of the tendering process, no suppliers had submitted a bid for the contract for the demountable aseptic unit as of 03/09/2024. The tender was repackaged to the principal contractor of the project (Lewis Construction) noting the following specialist cleanroom subcontractors; Angstrom, Enbloc, Scitech, T-squared, Cleanroom projects. The quality of the submissions was scored by members of the project team and representatives from NWSSP on 20.11.2024. As no suppliers submitted a bid during the original tender return, this may have an impact on the project timelines (the revised business case was originally planned to be submitted to WG during January 2025). The project team are currently trying to mitigate against delays.
		To work with estates and capital planning team to source temporary accommodation at Withybush to increase the storage capacity for outsourced cancer therapy. This will help the aseptics service to meet the increasing demand for cancer therapy and will allow cost efficiencies related to outsourcing to be achieved whilst the business case for a demountable aseptic unit is being developed.	Morgan, Cerith	~~30/09/2024~~ ~~31/12/2024~~ 31/01/2025	Capital bids proforma submitted to Health Board capital planning team 11/06/2024. Ratification paper signed off and contract awarded to Portakabin on 02/08/2024. 05.09.2024, awaiting for contract to be signed by the Head of Service - Procurement before order can be placed. Portacabin has now been installed and now awaiting fittings to be installed by the company before unit is operational.

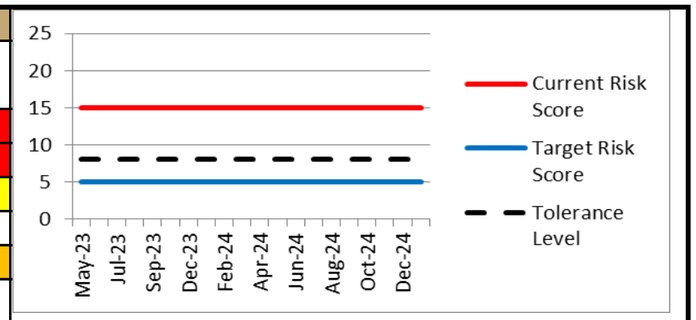
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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.					
	Quarterly self-assessments undertaken by Lead Aseptic Pharmacist, with outcomes fed back to Lead Quality Assurance Pharmacist at NWSSP	1st								
	Bi-monthly Senior Pharmacist Leads Business Meeting .	2nd								

Date Risk Identified:	Oct-19		
Strategic Objective:	3. Striving to deliver and develop excellent services		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Dec-24
Lead Committee:	Health and Safety Committee	**Date of Next Review:**	Jan-25

Risk ID:	**813**	**Principal Risk Description:**	There is a risk of failing to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO). This is caused by 1: The age, condition and scale of physical backlog, circa £20m (+) relating to fire safety (i.e. non compliant fire doors, compartmentation defects and general fire safety management issues) across our estate significantly affects our ability to comply with the requirements of the RRO in every respect. 2:Difficulties managing the actions within the current fire safety risk assessment system - to enable complete transparency and ongoing management of actions assigned to responsible persons. The new Boris system will address this issue. 3: Management responsibilities for fire safety not fully understood by all responsible managers. 4: Fire safety training attendance figures are not reaching HB agreed targets. This could lead to an impact/affect on the safety of patients, staff and general public, HSE investigations and further fire brigade enforcement (already served on Withybush and Glangwili General Hospitals), fines and/or custodial sentences, adverse publicity/reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?		708, 951, 503	

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Tolerable Risk:	8
Trend:	⇔



Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**

Phased fire safety improvement works are ongoing across our sites, with significant investments being made to address the recommendations in the Mid and West Wales Fire and Rescue Service (MWWFRS) letters and Enforcement Notices. All programme dates have been agreed with the Health Board, Welsh Government (WG) and MWWFRS senior inspecting officers. We intend to review the progress of our completed actions to determine the risk score as we progress with these works. MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position. Extensions of time particularly for GGH Phase 1 (Nov 24) and GGH Phase 2 (30th June 2025) have been fully agreed by MWWFRS. WBH phase 2 date TBA. The BORIS system is now in place and all fire risk assessments have been transferred across. A paper was submitted to the HSC in September 2024 indicating this achievement and a high level summary of the Estates and Hospital Management Risks. Currently, the risk is felt to still be extreme until further progress is made on the above Fire safety improvement works. This will be reviewed regularly.	Further improvements in culture and ownership for fire safety. It is the scale of physical backlog for fire safety compliance (additional surveys) that will remain until appropriate measures are put in place to address the deficit. Despite annual investment from statutory capital for fire safety components (circa £200k), the scale of current investment is clearly not adequate to address the true scale of backlog the UHB has. It is anticipated that when training attendance levels specifically for L2 training have reached > 85% targets and are sustained at this level continuously, coupled with the completion of key fire safety investment programmes and phases across our acute sites (completing in circa April 2025), the HB will then be in an informed position to look at the reduction of risk score for risk 813. This decision will be reviewed regularly.

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**
Pre Planned Maintenance (PPM) checks are carried out across the UHB on fire safety components. A detailed physical estates backlog system is in place that identifies the scale (£) and risk of backlog for UHB. Data used to manage backlog maintenance & statutory decision making also regularly reported to WG. Extensive fire safety improvement works are being undertaken at WBH, GGH and at BGH from WG agreed funding (EFAB bids for BGH and funding and From submitted business cases), with phased timelines fully agreed with MWWFRS. Regular communications and dialogue is taking place between HB and MWWFRS. Individual Fire Risk Assessments (FRA's) in place for all sites across the UHB identifying fire related risks. Training Needs Analysis (TNA) for fire safety training in place, as defined in Fire Policy. UHB has implemented a governance structure for fire safety reporting	Despite significant investments already in place following enforcement notices and letters of fire safety matters, additional investment is required to address fire safety defects at other sites within the UHB, which are being inspected by MWWFRS. We have firm plans in place to address a range of fire safety projects over the coming years and these are all fully identified as actions within this risk with anticipated timelines. Not all managers who are assigned actions on Boris are regularly accessing the system to close off their actions. Despite recent invitations for staff to attend training sessions. Fire safety training performance (for	Implementation of a new software system to manage the content of the HB's fire risk assessments. Boris software has now been purchased and is currently being implemented. Date agreed as part of internal fire safety governance review.	Evans, Paul	Completed	Boris software now purchased Dec 2020, initial implementation planned for March 2021. Implementation of risk assessments will now be planned for July 2021. System now supports the use of mobile technology therefore risk assessments can be completed live on the system. System now being tested on site, fully operational by Jan (now Feb) 2022
		Additional fire surveys are required across various sites to obtain costs for all fire compartmentation defects, doors, fire alarm systems and other associated items.	Evans, Paul	Completed	fire safety team and compliance team are working with site operations to determine what the gaps are and to agree what surveys will be required.

UHB has implemented a governance structure for fire safety reporting. Estate plans with fire zones, fire doors, fire compartmentation, fire infrastructure items (alarm and detection system). UHB assesses its performance in respect of operational maintenance work carried out on fire safety components and presents this information as a formal paper at all UHB wide fire safety meetings. Annual prioritisation of investment against high risk backlog. Internal governance review (2019/20) initiated by the CEO and all action implemented from review. The HB has now embedded a fully resourced fire safety management team, with appropriate reporting arrangements for fire safety and addressing the backlog of out of date fire risk assessments across the UHB. The UHB has improved fire safety management culture and management ownership for fire safety. The fire team will also look to implement a regular training global e-mail as a reminder for staff on when and how to book a session. Works already completed following issue of Enforcement Notices and LoFSM at various sites. For EN sites (WBH and GGH) - Advanced Works to vertical escape routes now completed. Also improvements carried out under LoFSM at Tregaron, Bronglais, Glangwili and Withybush Hospitals. Level 1 & 2 Fire Safety training is delivered via Teams. Level 3 Fire Safety training is provided face to face. Level 4 training (Fire Safety Warden training) is also a face to face session, with an external trainer. Level 5 training is provided on Teams as part of the H&S Managers induction	Fire safety training performance (for L2) is currently below the agreed level at (85%) as set by MWWFRS for WBH and GGH (sites under enforcement). Despite making improvements to the culture of fire safety management and ownership, the HB does need to ensure this is organisational wide and embedded within it's workforce and cascaded by management.	Introduce new innovative ways of improving fire training attendance across the HB to increase the percentage figures agreed and set by the HB. As part of the next risk review the fire team intend to split this action into individual sections so we can track and close off action as and when completed.	Evans, Paul	Completed	The fire safety team have been trialing the use of MS teams for L2 Fire training, which has proved to be very successful. We are planning to roll this out to other areas of fire training levels, such as L5/L4 & L3. This will have a positive impact on staff being able to attend the session. We will need to improve communications on this and to ensure staff are made fully aware of the sessions taking place and the dates.
		To introduce ways to help improve the culture and ownership of fire safety across the HB. Although management training is taking place at the "Managers Induction Programme" and this is well received. The HB still needs to do more to avoid areas of poor practice that is sometimes identified.	Evans, Paul	Completed	To look at improving the current training content and programme that's currently on offer for management. Regular global communications of do's and don'ts. Having a fire safety share point system, with links to interesting info on effective fire safety management.
		Now the new Boris fire safety system is being implemented across the HB (training planned for June 22 for staff), fire risk assessment actions from this need to be monitored by those responsible. These actions need to be communicated at all fire safety sub groups and fed to the HB wide FSG for complete transparency.	Evans, Paul	Completed	System now live in the HB and staff training programme in place. From this point all fire risk assessment actions will be closely monitored using this system.

training. There is an improving performance in terms of uptake of training (except for L2). Boris fire safety system implemented across the UHB, giving the ability to review all risks from fire risk assessments via a dashboard and risk ownership. Fire Team issued recent Global communications to request additional Fire Safety Wardens, to seek engagement from staff and colleagues across the Health Board. RAAC plank surveys are also being undertaken at the same time as the fire works to minimise the disruption to clinical services where at all possible.	Introduce a system to manage fire risk assessment recommendations more effectively. System to have the ability to assign risks to risk owners, to track/manage risk and to demonstrate progress on the actions.	Evans, Paul	Completed	The fire team are utilising the current system as best as possible. An Excel system is being introduced (completion Jun20) however a more robust automated system is needed by the HB to track the significant number of actions. Progressing this has been delayed due to COVID-19, however quotes have now been obtained and are under discussion with the Director of Facilities. Approval has now been provided to purchase a system. Completion date for system trial on site by July 2021. System now being tested on site on a few Fire Risk Assessments, we plan to go fully live in Nov/Dec 2021.
	Establish a teams training platform to deliver the level 3 and level 4 fire safety training programmes. Although this will also be supported by face to face sessions.	Evans, Paul	Completed	Following a review of level 3 & 4 fire safety training programmes it has been established that these cannot be delivered via Teams. These are now delivered as follows: Level 3 training has been reviewed and requires a face to face practical delivery. Level 4 training (Fire Safety Warden training) is also a face to face session, with an external trainer.
	WBH - Completion of Phase 1 works - For all remaining horizontal escape routes.	Elliott, Rob	Completed	Completed on Dec 15th 2023

WBH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	~~30/04/2025~~ 30/04/2025	Full agreement has now been reached with Welsh Government (WG)/NHS Wales Shared Services Partnership - Special Estates Services (NWSSP- SES) to change the procurement approach for Phase 2. This following a wide-ranging lessons learned exercise undertaken jointly with NWSSP-SES. Noting the change in procurement and the new appointments the HB will be making we need to consider now formally the future programme for Phase 2. This is currently being reviewed by the full team and will be reported to the next Phase 2 Fire Project Team.
GGH - Completion of Phase 1 works - For all remaining horizontal escape routes.	Elliott, Rob	~~28/04/2023~~ ~~22/01/2024~~ ~~31/10/2024~~ ~~31/07/2024~~ ~~31/12/2024~~ ~~30/11/2024~~ 31/01/2025	Completion by the end of November 2024. This programme is being maintained but there is potential for a small amount of slippage taking the completion date into Jan 2025.
GGH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	~~30/04/2024~~ ~~30/08/2024~~ 30/06/2025	The MWWFRS have now formally extended the FEN to 30/06/2025. Further extensions will be necessary, and we will work closely with MWWFRS to manage this process as the works proceed. We have already briefed the MWWFRS on GGH Phase 2 programme uncertainty given the revised approach which will be necessary. We agreed to keep in close contact on this as the project develops to keep MWWFRS fully informed.
Develop a Fire Training information pack for distributing to agency staff across all 4 sites.	Elliott, Rob	Completed	Completed - We have supported the HoN on this recommendation and issued our current training material to all agency companies. We will continue to support the HoN with any new welcome packs they introduce.

		To ensure all fire risk assessments are transferred from NWSSP-SES system to Boris	Evans, Paul	Completed	Boris system transfer now completed, review of data now being undertaken		

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
Maintain a zero or as low as possible number of outstanding fire risk assessments. Monitor the number of risks now held in the new Boris Fire Safety System.	Bimonthly review of outstanding actions from fire risk assessments	1st			IA Fire Precautions Report - ARAC Jun18 SBAR submitted to each HSAC meeting, which includes themes of all fire safety risks. Boris Fire Safety System (UPDATE) and Fire Training Performance SBAR's submitted to Sept 24 HSAC.	General site management checks/walkarounds on all sites				
	Site Fire wardens reporting fire safety issues	1st								
	Annual Online Fire Audit Self-Assessment submitted to NWSSP	1st								
	Review of compliance through fire safety groups	2nd								
	4 Fire Safety Sub Groups (one at each site) which report into the UHB wide Fire Safety Group (reporting into the HSC)	2nd								
	Fire Safety SBAR reports regularly issued to HSC	2nd								
	Fire inspections by Fire Service & Fire Improvement Notices	3rd								
	NWSSP fire advisor inspections	3rd								
	NWSSP IA Fire Precautions Follow Up May-18 - Reasonable Assurance	3rd								
	IA Fire Governance follow up in July 2022 - Substantial assurance.	3rd								
	IA WGH Fire Precautions Works: Phase 1 in Aug 22 - Reasonable rating.	3rd								

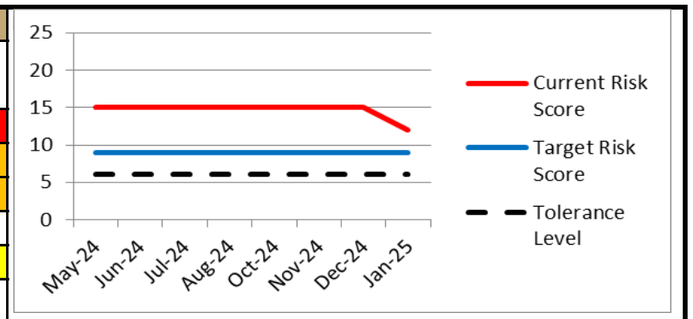
	High level action plan meeting with MWWFRS (Dec 8th 22) - with very positive comments received from then on our commitment to improve fire safety performance.	2nd									

Date Risk Identified:	Apr-24		
Strategic Objective:	5. Safe and sustainable and accessible and kind care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jan-25
Lead Committee:	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Mar-25

Risk ID:	**1842**	**Principal Risk Description:**	There is a risk of non-delivery of planned care ministerial targets by March 2025. This is caused by a mismatch between demand and current/forecast capacity in key specialties, workforce limitations, and the impact of the Health Boards' financial forecast for 2024/25, which limits the amount of recovery funding agreed by the Board to ensure full achievement of the respective ministerial delivery targets. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increasing pressure of adverse publicity/reduction in stakeholder confidence, and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?		1548, 180, 523, 525, 632, 958, 1083, 1027, 1628, 1629	

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):	4×3=12
Target Risk Score (L x I):	3×3=9
Tolerable Risk:	6
Trend:	↓



Rationale for CURRENT Risk Score:

The combined impact of a mismatch between demand and current/forecast capacity in key specialties, workforce limitations and limitations on the amount of recovery funding agreed by the Board all pose a risk to full achievement of ministerial planned care recovery targets. The Annual Plan, approved by the Board in March 2024 highlighted delivery risks in Orthopaedics and Ophthalmology, and the additional recovery resource agreed by the Board is below the level required to ensure full delivery of the ministerial milestones.

Whilst delivery plans for 2024/25 reflect positive progress in increasing outpatient activity & treatment capacity, underpinned by planned improvements in workforce availability and operational productivity and efficiency, the Annual Plan signalled expected delivery gaps in both specialties. Health Board performance in respect of planned care delivery milestones is also a key feature of its escalation to Targeted Intervention status.

Opportunities have been explored to maximise capacity across Hywel Dda University Health Board and Swansea Bay University Health Board to support further recovery of waiting times. Both specialties have been prioritised for active exploration of regional solutions, in partnership with Swansea Bay University Health Board (SBUHB), to expand available capacity and address forecast shortfalls against anticipated demand.

On 15th November 2024, the Health Board received confirmation of the additional recovery financial allocation to be allocated by WG to support clearance of outstanding forecast 104 week breaches by March 2025. Whilst this recovery funding is being used to support additional internal and external outsource and insource capacity solutions, the delayed confirmation of this allocation has given rise to additional delivery risks due to the limited time remaining in which to secure and deliver the required volume of additional capacity.

Notwithstanding these delivery risks, breach volumes in respect of the Stage 1 52 week target have improved for six consecutive months (July-Dec 2024), and are expected to be resolved by March 2025. Forecast breach volumes in respect of the Total Pathway 104 week target remain in Orthopaedics although monthly breach performance shows continued improvement.

Taking the above into account, the current risk score is assessed to be lower than the inherent risk score due to

Rationale for TARGET Risk Score:

The target score of 9 reflects the continuing delivery ambitions which remain, despite the workforce and resource limitations reflected in the Annual Plan. Of note, positive progress achieved both in respect of effective demand management and transformation of outpatient pathways has ensured that overall waiting list demand has not grown with waiting list volumes at their lowest level for 2 years. This offers positive indications for future improvements in waiting times in 2025/26 onwards.

Opportunities to make further progress towards the Ministerial targets in 2024/25 in Orthopaedics will continue to be explored, including exploration of the regional opportunities referred to.

The tolerable risk (6) reflects the longer term recovery ambitions of the Health Board to reduce waiting lists and length of wait to the lowest levels possible.

the significant progress achieved in the past 12 months in improving waiting times, and, whilst delivery risks remain, the current risk score has reduced to 12 reflecting the positive progress achieved.

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 planned care risks on daily basis including multiple daily multi-site calls in times of escalation. # Prioritised review of patients based on an agreed risk stratification model. # Provision of dedicated elective beds on 3 sites. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Quarterly deep dive reviews of all specialty delivery plans and delivery assumptions to ensure full account of OP transformation and theatre productivity and efficiency opportunities # Escalation plans for acute and community hospitals (within limits of staffing availability). # Outpatient transformation programme in place with a continuing focus on alternatives to face to face delivery of outpatient care to enable increases in care volumes delivered. # Robust sickness absence management arrangements in place. # Quarterly review of job plans, with ongoing recruitment. # Elective care delivery plan developed for inclusion within Annual Delivery Plan. # Additional Planned Care Recovery proposals developed to utilise the additional recovery funding committed by the Board # Elective optimisation improvement programme in place to improve theatre activity productivity and efficiency, including improvements to waiting list scheduling and pre-operative assessment processes # Productive & Effective Elective Care Improvement Plan produced to drive productivity and efficiency improvements # Planned Care Delivery Workstream established, reporting to Integrated Quality, Financial Performance Delivery (IQFPD) fortnightly, as part of revised Targeted Intervention governance arrangements. # South West Wales Regional Orthopaedic Delivery Programme	# Workforce staffing availability to support further expansion of theatre capacity # Sufficiency of Anaesthetic medical staffing capacity to support further expansion of required operating lists. # Sustainability challenges remain in a number of specialty areas which have been targeted for in-depth review via regional planning programmes for key specialties and the Clinical Services Plan review. # Widespread adoption of national best practice guidance to improve elective optimisation and utilisation of available operating capacity # Deficiencies within pre-operative assessment process and overall capacity to support required volume of Pre-Operative Assessment Clinic (POAC) assessments	Recruitment of additional orthopaedic surgeons to increase operating capacity within specialty to maximise utilisation of remaining sessions	Hire, Stephanie	Completed	2 further arthroplasty surgeons have been appointed, with start dates of January & February 2025.
		Monitor progress with implementation of revised pre-operative assessment protocols to ensure alignment with best practice (Getting It Right First Time - GIRFT)?	Hire, Stephanie	Completed	Supported by the Regional Orthopaedic Programme, an AI based assessment tool has been introduced to enhance the risk stratification of patients to be assessed by the POAC service. This is enabling improved management of demand and prioritisation of patients to be clinical assessed.
		Additional outsource & insource solutions to be explored to supplement internal capacity in orthopaedics and ophthalmology.	Jones, Keith	Completed	Additional insourcing solution implemented - additional capacity commenced January 2025. Outsource capacity already in place to support orthopaedics and ophthalmology

established # South West Wales Regional Ophthalmology Programme established in November 2024 # Assurance monitoring arrangements in place via mechanisms including weekly RTT Watchtower and monthly reviews with NHSE # AI based assessment tool, enhancing risk stratification of patients to be assessed by the POAC service, enabling improved management of demand and prioritisation of patients to be clinical assessed.		Q4 recovery actions being pursued to mitigate specialty specific delivery risks in Stage 1 Care of the Elderly (COTE), Vascular % ENT specialties.	Hire, Stephanie	31/03/2025	Daily monitoring of delivery progress in each specialty.

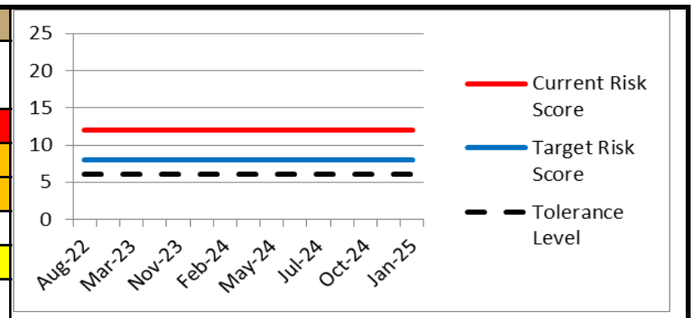
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
A suite of planned care metrics have been developed to measure the system performance.	Activity volumes are reported daily on situation reports	1st			Annual Plan 2024/25	None				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Acute Services Triumvirate	1st								
	Bi-monthly reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	Welsh Government IQFPD & Enhanced Monitoring Meetings	3rd								

Date Risk Identified:	May-22		
Strategic Objective:	4. The best health and wellbeing for our individuals and families and our communities		

Executive Director Owner:	Gjini, Ardiana	**Date of Review:**	Dec-24
Lead Committee:	Health and Safety Committee	**Date of Next Review:**	Feb-25

Risk ID:	**1433**	**Principal Risk Description:**	There is a risk the Health Board being unable to maintain routine and emergency service provision across the organisation in the event of a severe pandemic event. This is caused by a novel virus (or emerging variant or mutation of concern) causing a pandemic as declared by the World Health Organisation (WHO) and the subsequent ability of the Health Board to respond to the scale and severity of the outbreak. This could lead to an impact/affect on patients being able to access appropriate and timely treatment, the UHB being able to maintain safe and effective levels of staffing, financial loss, adverse publicity/reduction in stakeholder confidence, increased mortality and ill-health across our population.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
The national security and risk assessment was reviewed and re-published in November 2022, this remains unaltered. The previous pandemic influenza risk has been changed into 2 new risks, one generic pandemic event and 2 emerging infectious diseases. Current likelihood scored at a 3 to reflect the risk of the Health Board being unable to respond to the scale and severity of the pandemic - not the likelihood of the pandemic actually occurring.

Rationale for TARGET Risk Score:
A Cabinet Review of Influenza Preparedness was due just prior to COVID-19 which delayed publication. This workstream has now recommenced and together with outcomes and learning points from COVID-19 will inform our future planning approach for pandemic response. The Government Respiratory Pandemic Guidance is now due late Summer 2024. It is hoped to reduce either the likelihood and/or impact score following consideration and implementation of these reviews/recommendations and subsequent review of internal planning arrangements.

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**
# Major Incident Plan (detailing internal command and control structures) # Well established command and control structures for managing pandemic response both nationally and locally # Continuation of current COVID-19 national vaccination programme until at least March 2025 # Extensive knowledge across Health Board in managing a pandemic event # COVID-19 response measures which can be adapted to respond to any future pandemic event # Local Resilience Forum (LRF) multi-agency plans for managing pandemic influenza (approved by Strategic LRF 14/11/18 now under review also awaiting the Gov Respiratory Pandemic Guidance) # LRF Excess Deaths Plan (which supports the LRF multi-agency pandemic influenza management arrangements) developed as a recommendation from Exercise Cygnus. Plan was ratified by the LRF Health Group. # Health Board Pandemic Influenza Response Framework and associated plan(currently under review) # Quality assurance process via national & local exercise programmes. # Access to national counter measures stockpile # Surge Plans in place to enable HB to respond to future spikes/waves of infection requiring recommencement of contact tracing, testing & vaccination # Continuous learning from COVID-19 # Pandemic Planning Group re-established		Pandemic Response Framework reviewed which broadens remit from Influenza focus to generic pandemic events.	Hussell, Sam	~~31/01/2024~~ ~~31/05/2024~~ ~~31/08/2024~~ ~~31/10/2024~~ ~~31/12/2024~~ 12/02/2025	Awaiting publication of UK Gov Respiratory Pandemic Planning Guidance prior to progressing to ratification process. Delayed due to election process.

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
	Planning via Emergency Preparedness, Resilience & Response (EPRR) including LRF workstream reports to Health & Safety Committee	1st			Vaccine Equity Strategy - Board 30 May 2024 Vaccination Delivery Programme Update - Board via SDODC (Sep 23) Major Incident Plan - Board via HSC (Jul 23 and scheduled for July 2024)	None identified.				
	Operational pandemic reporting structures from HB to WG	2nd								
	National, regional & local command & control structures	2nd								
	National groups operational for vaccination programme planning & delivery	3rd								
	Emergency Planning Advisory Group (EPAG) Wales meetings re Pandemic response and future planning	3rd								

Date Risk Identified:	Dec-24	**Executive Director Owner:**	Davies, Lee	**Date of Review:**	Jan-25
Strategic Objective:	6. Sustainable use of resources	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Mar-25

Risk ID:	**2000**	**Principal Risk Description:**	There is a risk that the Health Board may significantly underspend in excess of of it statutory Capital Resource Limit for 2024/25. This is caused by the inability in the current financial year to manage the spend profiles over current and the next financial year This could lead to an impact/affect on the Health Boards ability to meet its statutory duty to breakeven, and may detrimentally impact on the Health Board's Discretionary Capital Programme in 2025/26.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		**No trend information available.**
Domain:	Statutory duty/inspections	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	3×4=12	
Target Risk Score (L x I):	2×4=8	
Tolerable Risk:	8	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:
Significant uncertainty lies in the delivery of the Capital Programme in 2024/25 due to a number of factors. Whilst previous years demonstrate that the Health Board has met its statutory duty to breakeven against the Capital Resource Limit, there is an increased likelihood in 2024/25 that they will not be able to do so. Opportunities to mitigate against any slippages identified are reduced due to longer lead times for medical and digital equipment. A number of construction schemes are also due to finish before the end of the financial year meaning opportunities to accelerate spend into the current financial year are reduced. In addition, reliance on third party contractors may exacerbate this issue and their ability to deliver by March 2025.

Rationale for TARGET Risk Score:
The Health Board needs to demonstrate that it is able to manage its capital position effectively, cognisant of the risks which are inherent in the delivery of safe and timely care. Given the challenge in delivering the capital position this year, the Health Board will achieve a risk which is in line with the tolerable risk for the year.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1. Timely financial reporting to Capital Monitoring Group, Capital Sub-Committee, Strategic Development and Operational Delivery Committee, Sustainable Resources Committee, Board and Welsh Government as key areas of concern emerge. 2. Bi-Monthly reporting to the Capital Sub-Committee, Strategic Development and Operational Delivery Committee and Sustainable Resources Committee regarding the capital risk. 3. Prioritised replacement Medical and Digital equipment lists developed with lead times for delivery included. 4. Vesting / Bonding of equipment where delivery is unable to be achieved by the 31st March.	Uncertainty remains as at December 2024 which impacts on the effectiveness of the control.				

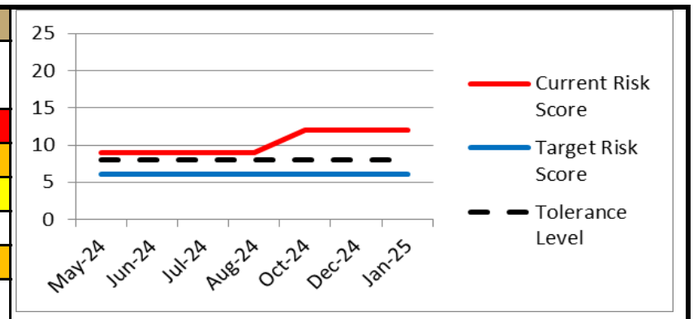
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance against the Capital Resource Limit	1) Performance against plan monitored through Capital Monitoring Group with key internal stakeholders Detailed review of relevant information)	1st			N/A	N/A				
	2) Detailed prioritisation to be agreed through Capital Planning Group Detailed review of relevant information)	1st								
	3) Performance reports through to Capital Sub-Committee Detailed review of relevant information)	1st								
	4) Sustainable Resources Committee oversight of current performance Medium level review)	2nd								
	5) Capital report to Strategic, Development and Operational Delivery Committee Medium level review)	2nd								
	6) WG Scrutiny through bi-monthly monitoring Detailed review of relevant information)	3rd								

Date Risk Identified:	Oct-23		
Strategic Objective:	1. Putting people at the heart of everything we do and 2. Working together to be the best we can be and 3. Striving to deliver and develop excellent services		

Executive Director Owner:	Gostling, Lisa	**Date of Review:**	Jan-25
Lead Committee:	People, Organisational Development and Culture Committee	**Date of Next Review:**	Mar-25

Risk ID:	**1821**	**Principal Risk Description:**	There is a risk that staff will have a poor experience while at work. This is caused by the inability of leaders to lead compassionately due the current climate within which the Health Board is operating within and competing demands. This could lead to an impact/affect on the work life balance, morale and satisfaction of staff at work, and negatively impact the culture which staff experience at work. This could cause detriment to staff wellbeing and create a negative cycle which could lead to increased employee relations issues, team dysfunction, increased sickness absence and a higher number of staff choosing to leave the organisation with a negative effect on staff engagement, productivity and performance.
Does this risk link to any Directorate (operational) risks?		Workforce themed risk register	

Risk Rating:(Likelihood x Impact)	
Domain:	Workforce/OD
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×3=12
Target Risk Score (L x I):	3×2=6
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:
We are alert to the potential consequences of the Staff Welfare Risk, and are monitoring a number of areas/metrics to assess if the risk may be increasing e.g. turnover, absence etc. Careful consideration is being taken at different organisational levels to mitigate through organisational planning approaches to manage workload at management level and then the consequences upon staff wellbeing. The score has been increased from 9 to 12 in October 2024 as it has been noted that sickness absence rates are increasing.

Rationale for TARGET Risk Score:
The target risk score is based on assessment of the work ongoing across the Health Board within the management and executive tiers to ensure clarity and focus of work programmes. Reviewing and streamlining where appropriate. The actions below are across all staff groups and focus on specific actions that are within the gift of the Workforce and OD function to drive and support with managers.

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**
Policies and procedures, which are readily available to staff via the Health Board intranet and the Wellbeing Single Portal. This provides guidance and resources for managers and staff. Forums in place with Executive oversight to review performance against objectives - Core Delivery Group, Directorate Improving Together Sessions, Clinical Services Plan Formal governance arrangements via Board and its sub-committees by Executives and Independent Members - People, Organisational Development and Culture Committee, Strategic Development and Operational Delivery Committee. Performance dashboards to monitor sickness, vacancies, grievances Structure of Workforce and Organisational Development Directorate encompasses a number of pillars with a focus on supporting staff, promoting healthy working cultures, and providing support and resources.	Review of the WHC for the Non Pay Deal has identified specific gaps to be addressed and strengthened as identified under actions opposite.	Review the Staff Retention Discovery Work and ensure high level actions are delivered.	Gostling, Lisa	31/12/2024	Deep dive report into the Retention Planning Objective and the Staff Retention Discovery report action plan was approved by PODCC in Dec 24
		Ensure promotion of compassionate leadership principles through a) PADR quantity and quality b) compassionate management and leadership programmes c) localised cultural progression plans	Gostling, Lisa	Completed	Complete
		Review the Best Practice Guidance on Health & Wellbeing Launched for All Wales by HEIW and map across actions to Hywel Dda Cultural Toolkit	Davies, Christine	~~30/09/2024~~ 28/02/2025	In progress. Mapping into Cultural toolkits is on track

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 Dashboards	Wales Audit - Workforce Planning - External Audit	3rd			No specific papers. Recent papers to PODCC highlighted the deep dive on Workforce Themed Risks in October 2023.	Monitoring of actions aligned to wider PO and alignment to Wellbeing for Management and Staff	Evaluation of Action Plans to be fed back to PODCC	Walmsley, Tracy	~~30/09/2024~~ 30/03/2025	Paper shared with WOD Leadership Team for PODCC in review of risk.
	Core Delivery Group	1st								
	Directorate Improving Together Sessions	1st								
	Workforce & OD Leadership Team Meetings (Risk led)	2nd								
	PODCC	3rd								
	Executive Team meetings (Risk led)	1st								
	Escalation Framework Meetings	1st								