

**PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Risk Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Director of Corporate Governance / Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Wilmshurst, Assistant Director of Assurance and Risk Rachel Williams, Head of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The purpose of this report is to provide assurance to the Audit and Risk Assurance Committee (ARAC) on the effectiveness of the Risk Management Framework, and the implementation of the Risk Management Strategy.

Cefndir / Background

ARAC's terms of reference state that one of its principal duties is to review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical.

Asesiad / Assessment

The attached report aims to provide assurance by outlining the risk management activity that has taken place since the previous report presented to ARAC in April 2025 on the effectiveness of the Risk Management Framework, and the implementation of the Risk Management Strategy.

The Risk Management Framework, approved by the Board in July 2022, sets out the components that provide the foundation and organisational arrangements for supporting risk management processes in Hywel Dda UHB.

The Risk Management Strategy, approved by the Board in March 2024, provides a supportive framework that ensures the integration of risk management into policy making, planning and decision-making processes.

The revised Risk Management Framework and Strategy are being presented for approval at this Committee meeting, under the next agenda item.

This report provides ARAC with a high-level summary of each Clinical Care Group and Executive Function's internal escalation status in relation to their risk management processes.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to **TAKE ASSURANCE** on risk management arrangements and processes in order to report progress to the Committee, including the revised performance management arrangements.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

<p>Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:</p>	<p>2.4 The Committee's principal duties encompass the following: 2.4.1 Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical. 2.4.3 Work with the Quality, Safety and Experience Committee, the People Organisational Development and Culture Committee, Strategic Development and Operational Delivery Committee and Sustainable Resources Committee to ensure that governance and risks are part of an embedded assurance framework that is 'fit for purpose'.</p>
<p>Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:</p>	<p>Included within the report</p>
<p>Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)</p>	<p>7. All apply</p>
<p>Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)</p>	<p>6. All Apply</p>
<p>Amcanion Strategol y BIP: UHB Strategic Objectives:</p>	<p>All Strategic Objectives are applicable</p>
<p>Amcanion Cynllunio Planning Objectives</p>	<p>All Planning Objectives Apply</p>

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable
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Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Datix Risk Module Performance Dashboard
Rhestr Termau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Corporate Governance / Board Secretary

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from this report; however, late or non-reporting of risks could mean that the UHB is not addressing any gaps in control and exploiting opportunities to achieve value for money.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from this report; however, late or non-reporting of risks could mean that the UHB is not addressing any gaps in control in relation to patient quality and care.
Gweithlu: Workforce:	No direct impacts from this report; however, late or non-reporting of risks could mean that the UHB is not addressing any gaps in control in relation to workforce issues and risks.
Risg: Risk:	Risk implications are inherent within the report.
Cyfreithiol: Legal:	No direct impacts from this report; however, late or non-reporting of risks could mean that the UHB is less likely to defend itself in a legal challenge which could lead to larger fines/penalties and damage to reputation.
Enw Da: Reputational:	No direct impacts from this report; however, late or non-reporting of risks could mean that the UHB is less likely to defend itself in a legal challenge which could lead to larger fines/penalties and damage to reputation.
Gyfrinachedd: Privacy:	No direct impacts from this report.
Cydraddoldeb: Equality:	No direct impacts from this report.

Purpose of the report

The purpose of the report is to provide assurance to the Audit and Risk Assurance Committee (ARAC) on the effectiveness of the [Risk Management Framework](#) (the Framework), approved by Board in July 2022, and the implementation of the [Risk Management Strategy](#) (the Strategy), approved by Board in March 2024.

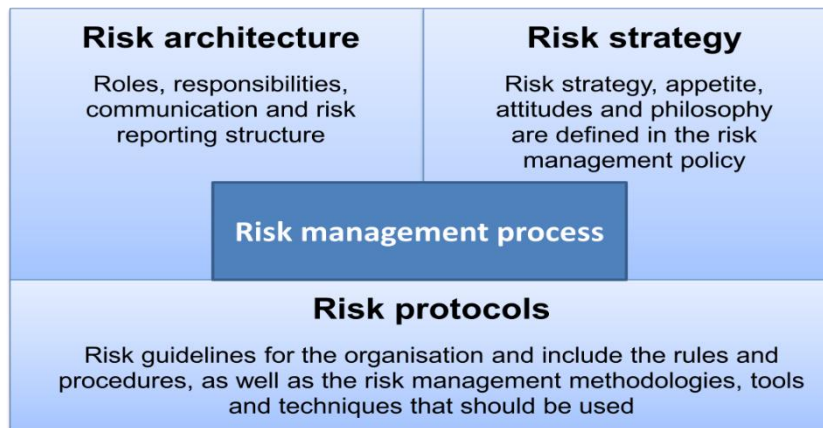
The Framework and Strategy are currently under review and being consulted upon, ahead of being presented to Board for approval at its meeting in September 2025.

The overall aim of risk management is to:

- Ensure conformity with applicable rules, regulation and mandatory obligations;
- Provide assurance to the Board and the Audit and Risk Assurance Committee (ARAC) that risk management and internal control activities are proportionate, aligned, comprehensive, embedded and dynamic;
- Support decision-making through risk based information; and
- Provide effective and efficient strategy, operations and compliance activities.

Risk Management Framework

The risk management framework is made up of the **risk architecture, strategy and protocols** (RASP), which wraps round the Health Board's risk management process.



In order to provide the Committee with assurance that the goals are being met and that the risk management framework is effective, this report will outline the risk management activity that has taken place since the previous report as presented to ARAC in April 2025.

The report will also aim to provide assurance to ARAC on the effectiveness of the internal escalation framework in respect to risk management and will include detail on the escalation status of Clinical Care Groups (CCGs) and Executive Functions (hereafter referred to collectively as Functions) in line with the 3As assessment approach, complementing the Audit Tracker paper. Data will be assessed as at the most recent month-end position to align with the escalation framework (June 2025).

Risk Management Strategy

The Health Board's Risk Management Strategy provides a supportive framework that ensures the integration of risk management into policy-making, planning and decision-making processes, and specifically:

- To improve the quality of service and protect patients, carers, staff and others who come in to contact with the Health Board;
- To create awareness through the Health Board about the importance of recognising and managing risk in a timely manner and providing staff with the appropriate knowledge, skills and support;
- To promote positive risk taking in the context of clinical care and in controlled circumstances;
- To provide a robust basis for strategic and operational planning through structured consideration of key risk elements;
- To enhance partnership working with stakeholders in the delivery of services;
- To improve compliance with relevant legislation and national best practice standards; and
- To enhance openness and transparency in decision-making and management.

Risk Management Process

The Health Board's risk management process is recorded via the Datix Risk Register Module (Datix) and reported via risk register reports to both assurance and management meetings. Datix enables risks to be recorded at one of three risk levels:

- **Principal** – Risks that affect the organisation's ability to achieve its strategic objectives in the long-term
- **Corporate** – Significant risks that affect the organisation's ability to achieve its planning objectives and to deliver healthcare services in the 'here and now'
- **Operational** – Risks that affect the objectives of a Function (replaces the previous "service" and "directorate" level risks)

This ensures that risks are reported to, and scrutinised at, the most suitable forums. Following the recent operational Organisation Change Process (OCP), risk management processes have been reviewed and updated to:

- Ensure ownership by appropriate service leads in line with revised management hierarchies; and
- Support effective oversight and escalation through updated operational and executive governance arrangements within the Functions.

Following [Board approval in March 2025](#), a revised approach to risk tolerance is being embedded across the organisation. This replaces the previous model, which applied fixed tolerance levels across risk impact domains. The new approach is outlined in the [Risk Treatment](#) section of this report.

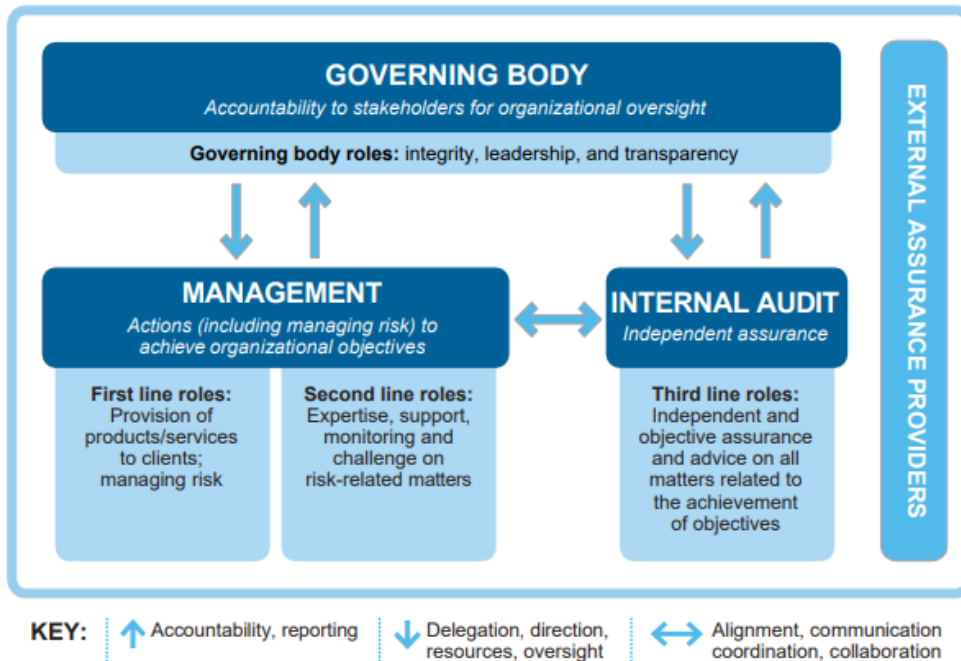
Risk Architecture

Risk architecture is the organisational arrangements for risk management which details the roles, responsibilities and the lines of communication for reporting on risk management and have recently been updated in light of the change to the Clinical Care Group operational structure to reflect revised management hierarchies and governance arrangements.

Three Lines of Defence for Risk Management

The Health Board operates within the widely accepted “Three Lines of Defence Model” which provides a simple and effective way to delegate and coordinate risk management roles and responsibilities within an organisation, to ensure the appropriate responsibility is allocated for the management, reporting and escalation of risk.

The IIA’s Three Lines Model



Risk Management (1st line)

The Health Board has 579 open risks on the Datix Risk Module as of 30 June 2025 (February 2025: 583), split as follows:

Risks per Risk Level

Risk Level	April 2025	May 2025	June 2025
Principal Risks	15	15	15
Corporate Risks	21	21	21
Operational Risks	550	556	543

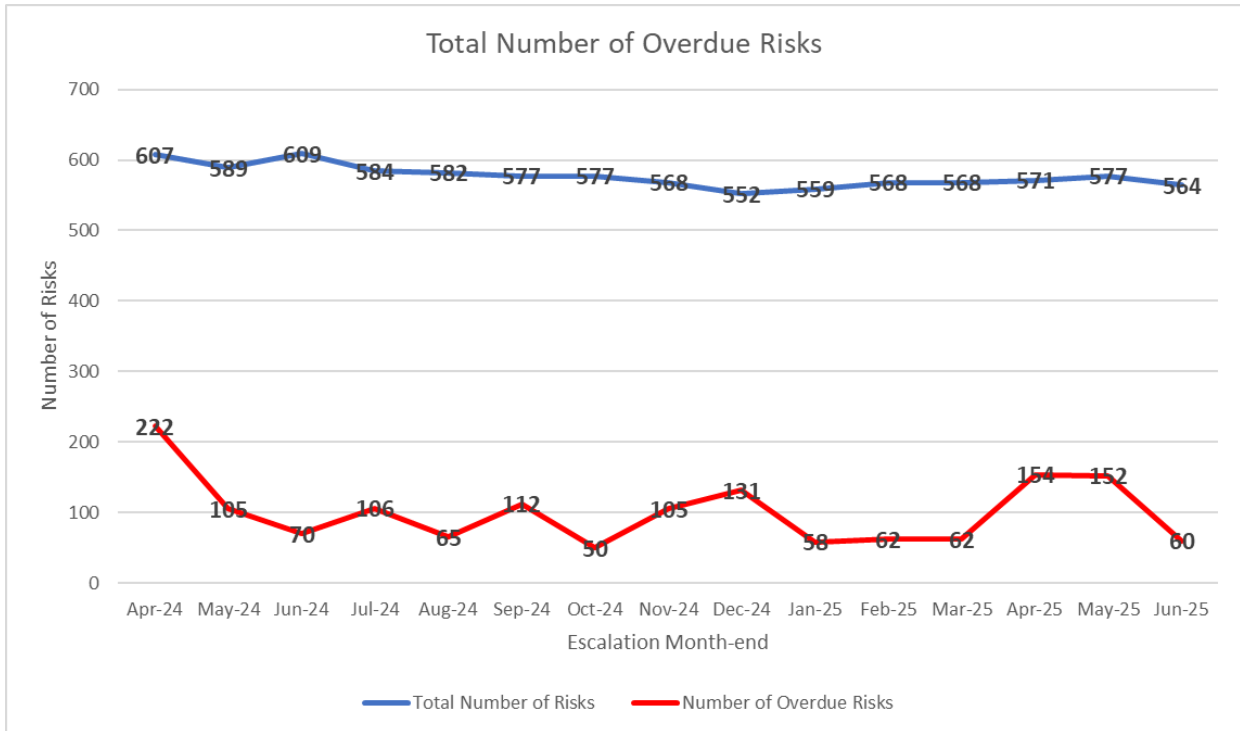
As Principal Risks are reviewed and updated by the Executive Team in line with the Board Assurance Framework, the focus of this paper and the Improving Together metrics are on Corporate and Operational Risks.

The table below provides a summary of open risks per Function in line with the internal escalation framework:

Clinical Care Group / Executive Function	Total number of risks as at 30 Jun 2025	%age of all Health Board risks as at 30 Jun 2025	Number of Overdue risks as at 30 Jun 2025	Total number of overdue risk actions as at 30 Jun 2025	%age of overdue risk actions as at 30 Jun 2025
Chief Operating Officer Management	9	2%	2	1	8%
Community & Integrated Medicine	93	16%	6	25	15%
Director of Allied Health Professions and Health Science	5	1%	0	6	29%
Estates & Facilities	130	23%	0	7	4%
Director of Finance	25	4%	2	7	22%
Director of Nursing	16	3%	2	5	21%
Director of Public Health	14	2%	0	0	0%
Director of Strategy and Planning	4	1%	0	0	0%
Director of Workforce	2	<1%	0	5	36%
Medical Director	5	1%	1	1	20%
Mental Health and Learning Disabilities	29	5%	0	6	9%
Operational Allied Health Professions and Health Sciences	84	15%	19	30	19%
Planned and Specialist Care	110	20%	26	64	38%
Primary Care, Community Strategy & Long Term Care	38	7%	2	12	17%
Corporate Services	0	0%	0	0	0%
Chief Executive	0	0%	0	0	0%
Total:	564		60	169	

Timeliness of Risk Reviews

Since the introduction of the internal escalation framework in April 2024, there has been an overall improvement in the timeliness of risk reviews, with 11% overdue for review as at 30 June 2025. The timeliness of risk reviews, however, has been inconsistent, with fluctuations in the number of overdue risks throughout the year which may reflect the impact of operational demands across the Health Board.

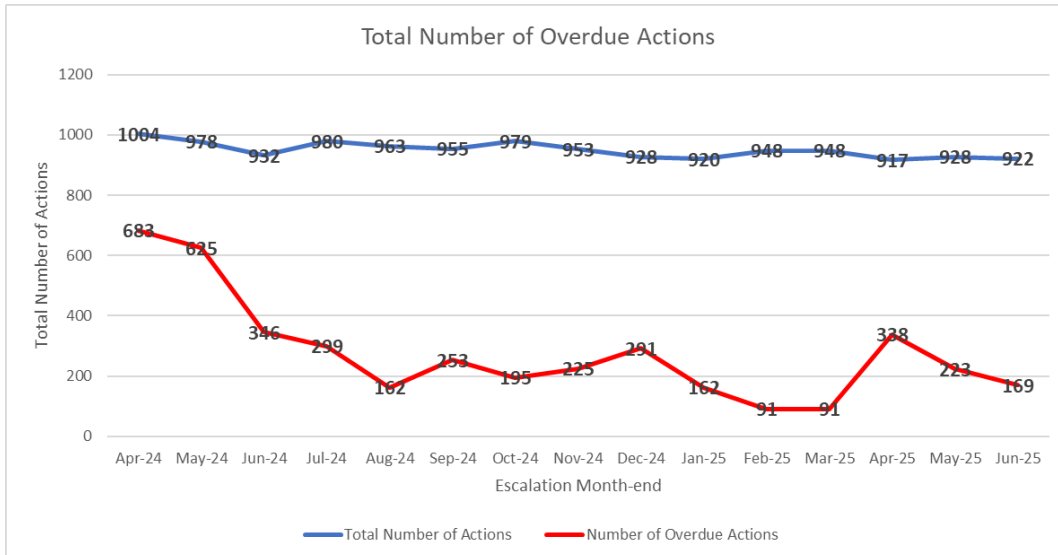


Of the 60 risks noted as overdue at June 2025, 54 have recently lapsed, i.e., not overdue by more than one month (April 2025: 55), with 6 risks becoming overdue as at May 2025, 2 of which are noted as being overdue by 3 months. The data demonstrates an overall improvement in the timeliness of risk reviews since the implementation of the internal escalation process, with the majority of risks now being reviewed within expected timeframes (April 2024: 222); however recognising there continue to be inconsistencies across the year. Due to Datix system maintenance being undertaken during March 2025, risk leads were unable to access the risk register at this time, leading to an increase in overdue risks during April and May 2025.

Risk Action Plans

While the introduction of the internal escalation framework in April 2024 has led to a notable reduction in the number of overdue risk actions, further progress is required to ensure the timely review and completion of, and improved quality of, risk actions. This is evidenced by the increase in overdue actions from 91 (10%) in the previous report to 169 (18%) as at 30 June 2025 (recognising that some of these may also be attributable to risk leads not having access to Datix whilst system maintenance was being undertaken).

Risk Assurance Report



Although the trend in reviewing overdue actions has significantly improved, actions remain which may have either been assigned unrealistic or unachievable timescales or are not being updated fully during risk reviews.

The number of overdue or long-standing risk actions may also reflect the difficulties currently faced by management including staff absences and workforce challenges, in addition to the number of action plans that are reliant on additional funding to progress, which results in these actions not being updated due to a lack of any notable progress to report. These limiting factors should be reflected in the rationales being provided by risk leads relating to the achievement of the Target Risk Score (TRS), and the expected date of its achievement, in line with the revised approach to risk tolerance.

Risk leads are advised to provide realistic revised action dates where original dates have lapsed, with sufficient narrative noted in the progress update noting the reasons behind any delays and justification for the new date. The timeliness of risk reviews, along with the progression of risk actions, are key components in determining the levels awarded under the governance domain of the escalation framework.

Risk leads are also advised to ensure that risk actions are aligned to the Health Board's Annual Plan. Functions have been requested by 31 July 2025 to complete a comprehensive review of their risks, quantified and linked where possible to operational, workforce, quality, financial and infrastructure domains, and the identification of any risks that cannot be mitigated within current means and resources to inform the planning process for financial year 2026/27.

Risk Profile

As of June 2025, the average age of a risk is 3 years and 5 months, with 120 (21%) risks having been identified as a risk pre-Covid (April 2025: 129 (22%)). 57% of these risks are aligned to the Estates and Facilities Function, who are currently in the process of reviewing and cleansing their risk register. To date, the Function has removed 6 risks due to the installation of new equipment, and a review of risks being undertaken where it was identified that some were recognised as managed issues. However, as their risks primarily relate to the condition of the Health Board's ageing estate and equipment (e.g., air handling units, heating, water and electrical systems) it

is unlikely the remaining aged risks will be fully mitigated until capital funding has been agreed and obtained.

Since the mandatory requirement for a 'Rationale for Target Risk Score (TRS)' and 'expected date to achieve TRS' were introduced to risks on Datix in April 2025, many risks are citing lack of available funds as a barrier to setting and achieving low TRS. The Assurance and Risk team will be supporting services to escalate risks via the appropriate management and governance structures for discussion at Executive level for guidance and permission to 'accept' risks (i.e. the amount of risk an organisation is willing to accept once all mitigating actions have been undertaken in order to achieve its objectives).

The following graph shows the trend in the number of extreme, high, moderate and low-level risks (risk level) since the introduction of the internal escalation framework. This data demonstrates the dynamic nature of the risk register, with risks being reviewed and re-scored during this period.



The number of extreme and high risks indicates that the organisation is taking risks beyond an acceptable capacity (the maximum level of risk to which the organisation should be exposed, having regard to financial and other resources).

Risk Treatment

The strengthened approach adopted by the Health Board to risk treatment reinforces the Target Risk Score (TRS) to define the minimum residual risk the Health Board is willing to accept once all planned mitigating actions have been completed. Developments to the Datix risk register system since April 2025, where risk leads are required to note an expected date of achieving the TRS is aimed to support the process for informed decision making, and to facilitate the appropriate escalation of risks.

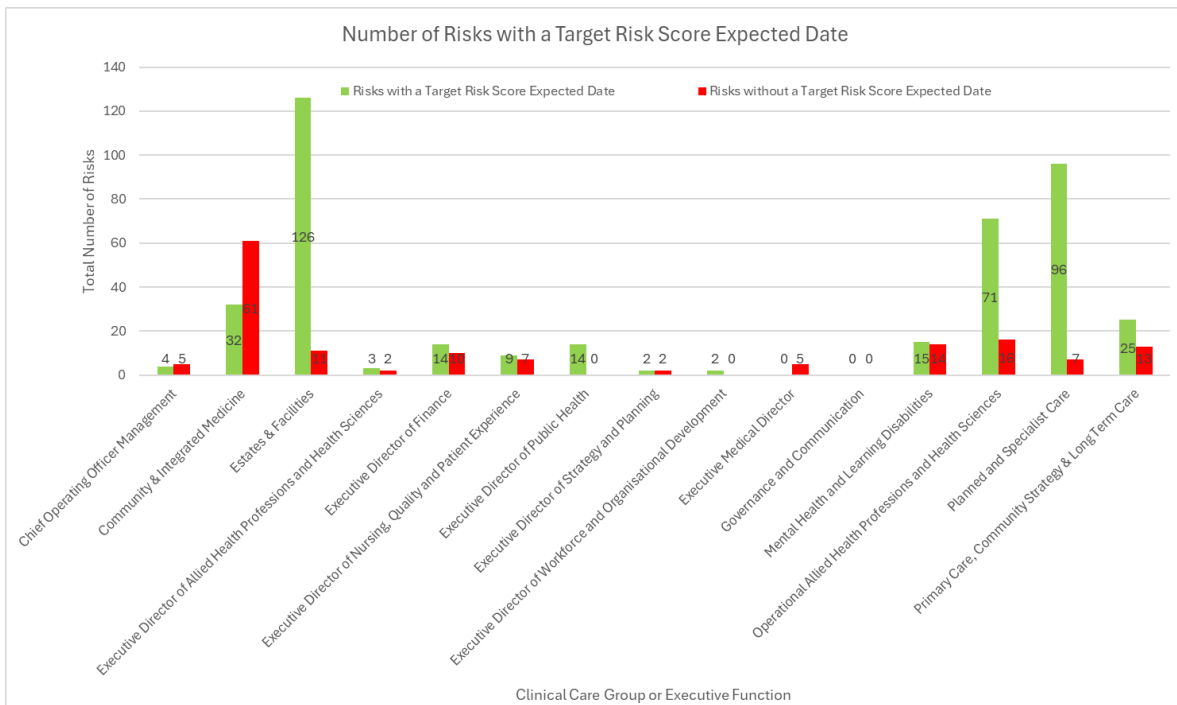
This model strengthens the link between proposed actions and their expected impact on the risk score, introduces timelines to illustrate the risk score trajectory, and supports informed decisions to tolerate risks based on measurable indicators and the organisation’s capacity to further mitigate.

The TRS represents the ultimate level of risk achievable, given the available means and resource. Once the TRS is achieved, if the risk continues to exist, it should then be tolerated/accepted unless further actions are identified or made possible, such as through additional funding or capacity. If the TRS is deemed unacceptable, (i.e., too high), further discussion or escalation is required.

The TRS should be quantified and where possible aligned to performance targets, including quality metrics, with a set timescale for achieving the reduction to the target risk score. Trajectories could be used to provide assurance that the right actions are being taken to reduce the risk to its TRS. If the trajectory is not being met, this becomes a decision point for risk owners to identify further actions required to bring the risk back on trajectory.

If further action cannot be taken within available means and resource, the risk should be escalated through management structures using metrics, such as quality, to support decision-making. This approach would require risk leads to set a realistic TRS and a date by which it will be achieved.

Risks will be ‘treated’ until a discussion to ‘accept’ a risk is triggered, or when the TRS is not supported by the Executive Risk Owner for corporate risks and Executive Director/Clinical Care Group Director for operational risks.



Management teams across the Health Board are responsible for identifying risks that affect their services, with the Assurance and Risk team providing technical risk management advice to support the consistency in risk scoring across the organisation.

Risk management training is provided to managers and service leads to address gaps in knowledge and increase risk awareness across the organisation. Since the previous report presented to ARAC, risk management training material has been updated to reflect revised operational hierarchies as a result of the OCP, along with the new approach to risk tolerance. This information is supplemented within reports provided by the Assurance and Risk team to Function governance meetings.

Oversight of Risk (2nd Line)

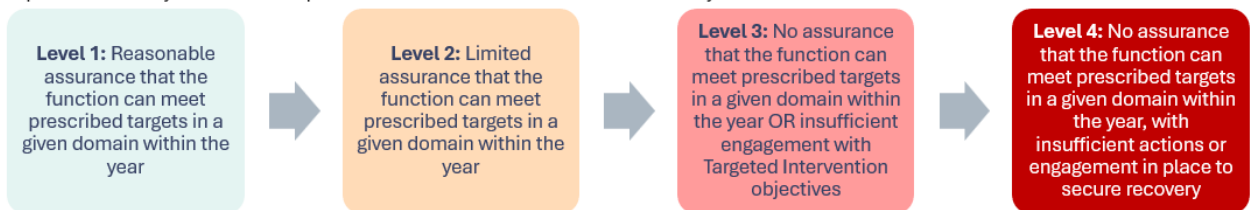
Internal Escalation Framework

The Health Board has an internal escalation process, as part of the Executive Improving Together (EIT) Framework, whereby Functions are assessed monthly against the following seven domains to drive improvement in performance:

- Quality and safety;
- Governance;
- Workforce;
- Finance;
- Strategy, planning and fragile services;
- Population health; and
- Performance.

Escalation levels

The lead Executive (or nominated deputy) will assign one of the escalation levels below for their domain for each function. Function leads can replicate internally the escalation process for each of their services/teams if they so wish.



Following a review of the internal escalation process, a new Level 4 has been introduced from April 2025 for functions that are unable to provide any assurance that prescribed targets are being met within the year, are taking insufficient actions, or have unsatisfactory levels of engagement.

One key metric in the Health Board's internal escalation process under the Governance domain is **how Functions are managing risks in terms of the scale, significance, timeliness and quality**, with measures extended from April 2025 to inform levels to be awarded. Levels awarded ranging between 1-4 to highlight progress being made as outlined in the table below:

Risk Assurance Report

Measures to assess against the Governance Domain - Risks

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

For Level 4, the Executive for the escalated function alongside the triumvirate senior management for a Clinical Care Group and the Domain Lead Executives will attend a one-off **Chief Executive Officer CEO Recovery Meeting** with the Chief Executive, supported by the Director of Finance as the Executive Lead for performance to determine next steps.

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

A summary of each Function's performance for the Governance domain since April 2025 can be found in the following table:

Clinical Care Group/Executive Function	April 2025	May 2025	June 2025
Chief Operating Officer Management	2	2	1
Community & Integrated Medicine	2	2	2
Estates & Facilities	3	3	2
Executive Director of Allied Health Professions and Health Science	1	2	1
Executive Director of Finance	2	2	2
Executive Director of Nursing, Quality and Patient Experience	2	2	2
Executive Director of Public Health	2	1	1
Executive Director of Strategy and Planning	2	2	2

Executive Director of Workforce and Organisational Development	1	1	2
Executive Medical Director	2	2	1
Governance and Communication	1	1	1
Mental Health and Learning Disabilities	3	3	2
Operational Allied Health Professions and Health Sciences	2	2	2
Planned and Specialist Care	3	3	3*
Primary Care, Community Strategy & Long Term Care	2	2	2

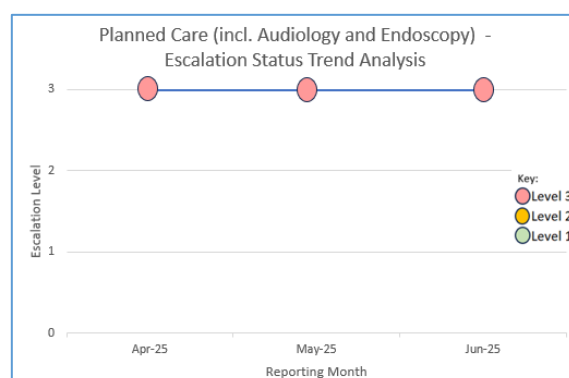
*Escalated for Governance due to risk management, as well as factors outside the remit of this paper ie. implementation of external recommendations /compliance with WHCs /governance arrangements

As at end of June 2025, one Function met the Level 3 escalation criteria for risk management under the Governance domain. A detailed analysis can be found below. Whilst nine Functions met the Level 2 escalation criteria under the Governance Domain, their escalation status was not attributable to risk management, as it was predominantly based on the management of their audit and inspection recommendations and other factors such as implementation of Welsh Health Circulars/Ministerial Directions and general governance arrangements.

Level 3 – No Assurance

Planned and Specialist Care

At June 2025, the CCG had 110 open risks, of which 26 were overdue (24%), therefore meeting the Level 3 escalation criteria for risk management (less than 80% compliance of risks and risk actions being updated within required timescales). Of the 26 overdue risks, 6 (5%) were overdue by more than one month. Additionally, the CCG had 168 open risk actions, of which 64 were noted as overdue for review (38%). Since the data was extracted, General Managers and risk leads within the CCG have held risk review sessions, supported by the Assurance and Risk team, with further scheduled for August 2025.



Risk Themes

Risk owners can assign multiple ‘themes’ to their risks on Datix, which allows the Health Board to share risk information on specific areas, such as health and safety, information governance and workforce with the relevant subject matter experts within the Health Board. They, in turn, can offer specific support and guidance to risk owners in the management of risk and identify trends and areas of concern. Each risk theme is aligned to a specific and relevant committee or sub-committee, to provide assurance that processes are in place to deliver a holistic approach to risk management. This further enables the Health Board to better identify and define its risk appetite, risk capacity and total risk exposure in relation to each risk, and to group similar risks or generic type of risk.

Each risk theme has assigned owners based on their subject matter expertise, who receive notifications when risks are added to the system and are also provided with the relevant thematic risk register on a bi-monthly basis. Upon receipt, theme risk owners are required to review themed risks to ensure that:

- they have been correctly allocated;
- the risk, controls and planned actions are reviewed from an expert perspective; and
- oversight and guidance are provided to the relevant manager of any further controls that need to be undertaken to manage the risk to an acceptable level.

Theme owners are provided with a thematic risk register on a bi-monthly basis to identify trends, or risk clusters, and to consider whether there are gaps in controls in the Health Board's control framework, and to determine whether further action is required to prevent risks from materialising.

The Assurance and Risk team is currently reviewing existing risk themes to ensure their validity and usefulness, with a view to further strengthening the approach to risk management within the Health Board.

Independent Assurance (3rd line)

The third line of defence are those who provide independent assurance over the risk management arrangements in place, and where appropriate can advise on control strategies.

On 11 March 2025, Welsh Government considered the Health Board's escalation status and in recognition of governance improvements, related to improved Board stability and an increased degree of confidence in the organisation's governance, the Health Board was de-escalated for Governance from level 4 (targeted intervention) to level 3 (enhanced monitoring), and remain at level 3 per the review undertaken in July 2025. Risk management is one of the criteria considered in the governance domain and therefore reflects confidence across the Health Board's governance framework, including its risk management framework.

Committee and Reporting Structures

Effective risk management requires a reporting and review structure to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place. The Health Board's risk reporting structure is outlined in Appendix 2 of the [Risk Management Strategy](#).

1. The Board

The Board is responsible for oversight of the Health Board's principal risks, which are those that affect its ability to achieve its strategic objectives. Since the Board meeting in March 2025, the 2024/25 planning objectives, outcome measures and principal risks have been realigned to the Health Board's 4 new strategic objectives which are included within the Board Assurance Framework (BAF), namely Thriving Teams, Healthier Communities, Great Care and Positive Futures.

Principal risks are reported to the Board 3 times a year, with the last report provided in [July 2025](#) as part of the BAF Dashboard. The Health Board will be looking to update

the planning objectives which support the four strategic objectives during 2025/26, upon which the BAF will be refreshed and the associated principal risks.

The Board is also responsible for oversight of corporate risks, which are defined as significant risks that affect the Health Board’s ability to deliver the healthcare services in the ‘here and now’. Corporate risks are reported to the Board 3 times a year, with the last report provided in [July 2025](#). The Health Board has 21 corporate risks as at June 2025.

The formal Executive Team reviews the corporate risk register on a monthly basis, and the principal risk register on tri-monthly basis, ahead of Board reporting. The Executive Team is able to:

- Approve or escalate new risks for addition to corporate/principal level;
- Approve the closure or de-escalation of corporate/principal risks to operational level.

The table below summarises the changes to the Corporate Risk Register (CRR) since the previous report presented to ARAC in April 2025:

Risk Ref and Title	Risk Score Jul-25	Change in Risk	Date of change on CRR
2086 - Risk that the cash consequences of the Health Board deficit cannot be covered by WG should it exceed our Target Control Total	20	New risk (added June 2025), superseding closed risk 1843	04/06/25
2079 - Risk of loss of Pathology services across the Health Board due to delayed implementation of LIMS	20	New risk (added May 2025)	23/05/25
1032 - Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	20	TRS increased from 16 to 20	21/05/25
1861 - Risk of harm to staff, patients public and critical assets due to insufficient physical security measures and systems	16	TRS increased from 9 to 12	10/06/25
1664 - Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	16	TRS increased from 9 to 10	31/05/25
2104 - Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 25/26 due to demand exceeding capacity	12	New risk (added June 2025), superseding closed risk 1842	01/04/25
1843 - Risk that the cash consequences of the Health Board deficit cannot be covered due to significant deficit position	10	Risk closed (May 2025)	16/05/25

1842 - Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 24/25 due to demand exceeding capacity	9	Decrease in risk score from 12 to 9 and risk closed.	21/05/25
2000 - Risk of the Health Board significantly underspending in excess of its statutory Capital Resource Limit for 2024/25	4	Risk score decreased from 12 to 4 and risk closed	21/05/25

All changes are included in risk reports presented to Board and Committees.

2. Board Committees and Sub-Committees

Terms of References (TORs) are in place for each committee at the Health Board, outlining their responsibility to review and to seek assurance that risks aligned to Committees are being effectively managed across the Health Board and report any areas of significant concern. Due to the change in reporting arrangements, all risks (Principal, Corporate and Operational) will be reported to each Committee meeting via the “Assurance on Governance Arrangements” paper. Risks are also reported to sub-committees, each of whom have delegated authorities from the parent committee, who received update reports at each meeting.

All open risks have been realigned to the new Board Committee governance structure implemented on 1 April 2025, as well as other system changes implemented on Datix Risk Module. Risk reporting to committees resumed in June 2025 following these updates.

3. Clinical Care Group and Executive Function Level Monitoring Arrangements

Risks are discussed at the CCG Integrated Governance Group meetings, which occur fortnightly, alternating the agendas of Quality, Health & Safety, and Business, Planning, Performance & People. The CCG’s remit is to evidence to the Integrated Quality, Finance and Performance Delivery Group (IQFPDG) that these risks are being managed and monitored effectively in line with the Health Board’s Risk Management Framework.

Executive Functions have local governance arrangements for risk, with the frequency of these meetings varying, dependent on the Function. Continuing local governance arrangements, including frequency of stood down meetings, are considered when awarding the escalation status for Governance.

Risk Management Strategy

The [Risk Management Strategy](#) (the Strategy), approved by Board in March 2024, sets out the Health Board’s risk management policy statement and objectives in respect of strengthening risk management for the period up to September 2025. This report provides a progress update against the three objectives for this period.

The Strategy has been refreshed during Quarter 1 of 2025/26 and has been included on the agenda for ARAC at its meeting in August 2025, for endorsement ahead of formal approval by Board at its meeting in September 2025. The revised Strategy

contains three objectives to strengthen risk management within the Health Board for the next 12 months.

The Strategy aims to support a dynamic and systematic approach to risk management, and to ensure prompt and comprehensive identification, assessment and management of risks that threaten the delivery of its strategic objectives and day-to-day operations.

The Strategy, which covers the period April 2024 – September 2025 contains the following three objectives, with progress against each objective detailed below:

1. Implement and embed the UHB's refreshed risk appetite statements Appetite and Tolerance Statement

We will further develop the Health Board's risk appetite by:

- Developing an implementation strategy to embed revised risk appetite statement across the UHB;*
- Reviewing our approach to risk tolerance and how it aligns to the refreshed risk appetite statements (approved by Board in January 2025);*
- Providing practical support to services in the utilisation of refreshed risk appetite statement; and*
- Reviewing the risk appetite statement after 6 months with the Executive Risk Group (ERG) to ensure it remains fit for purpose and support effective decision making.*

The risk appetite statements (approved by Board [in January 2024](#)), were reviewed and refreshed by the Executive Team in December 2024 as part of the required annual review, and approved by Board at its meeting in [January 2025](#).

Risk tolerance is the *organisation's readiness to bear the risk after risk treatment in order to achieve its objectives*.

The revised approach to risk tolerance was included in the [CEO report](#) to Board at its meeting in March 2025, and approved. The new approach to risk tolerance has been outlined [earlier in this report](#), which links proposed actions to their anticipated impact on risk score, and shows the risk score trajectory over time.

Where barriers to the achievement of the TRS are noted, these should be escalated appropriately via management structures to support decision-making, these processes which have been further strengthened with the introduction of the CCG structures, with clear management structures in place to escalate as appropriate to IQFPD ahead of Executive Team. Risk leads will therefore be required to set realistic TRS, and an expected date for which they will achieve it.

The decision to 'accept a risk' should be informed by metrics and the ability to support further actions, and the Board will be asked to accept any risks where the Health Board is unable to treat within its available means.

Work continues to develop an integrated impact assessment (IIA) process for the Health Board. This will incorporate an assessment of risk appetite and ensure that the

Board are cognisant of making decisions that are within or even above their risk appetite.

2. Support the strengthening of operational risk management arrangements

We will do this by:

- Ensuring risk management arrangements and systems are realigned to the new Operations Directorate structure (when approved), and systems used to capture this process are appropriately updated;*
- Supporting corporate and operational directorates via quality and business meetings and Directorate Improving Together sessions to identify, assess and manage risks and improve outcomes;*
- Reviewing current partnership risk management arrangements with key partners and to utilise learning to develop a plan for all partnerships to strengthen these arrangements which will support the UHB to achieve its objectives;*
- Reviewing the training needs analysis and provision of risk management training to implement the operationalisation of revised risk appetite statements across the UHB;*
- Implement the new Once for Wales Concerns Management system when it has been developed and is ready to be rolled out; and*
- Providing practical support to services with operational risk management arrangements via business partnering arrangements to ensure risk management outcomes inform and prioritise organisational decision making.*

The Datix risk register system has been realigned to the new structures and hierarchies to support the implementation of the revised arrangements within the Operations Directorate from April 2025. Refresher training sessions were held for colleagues across the Health Board during Quarter 1 2025/26, as well as governance meeting updates to inform them of changes made, and relevant procedural documents are in the process of being updated to reflect these changes. Notable system changes include:

- Updated risk management ownership levels to reflect revised operational management structures;
- Updated naming conventions to mirror new structures; and
- Inclusion of a rationale for TRS for operational risk, and expected date of achievement of TRS.

The Assurance and Risk team operates within a business-partnering approach to support operational and corporate teams to meet their obligations in respect of risk management. Each Function is assigned a dedicated Assurance and Risk Officer (ARO), who are either fully qualified risk professionals with the Institute of Risk Management (IRM), or working towards accreditation. AROs prepare risk reports and attend relevant service governance meetings, in addition to meeting risk leads to facilitate and support discussions on risk management. Performance dashboards are also in place, which allow staff across the organisation access to a summary of all Health Board risks.

The Assurance and Risk team provides both system and technical risk training to operational managers and risk leads across the Health Board, with guidance issued

on Risk Management within the Manager's Passport Programme. Relevant materials are also available to further support colleagues via the Assurance and Risk Sharepoint site.

A desktop review of the Health Board's key partnerships has been undertaken by the Corporate Legal team. Ascertaining whether we feel appraised of relevant risks with our partnership organisation that could impact our organisation was one area of focus during the risk maturity self-assessment, which has informed the objectives included within the revised Risk Management Strategy for 2025/26. While key people are aware of areas of potential risk with partnerships, there are currently no defined approaches and processes for addressing risk with all our key partners.

The Health Board completed a Readiness Report for the new Once for Wales Concerns Management system in which it stated it would not be migrating to the new system and would continue to use the current Datix Web system which has been extended to 30 November 2027. This allows the Health Board to continue using the existing Datix Risk Module system, with meetings currently being set up with alternative providers to identify a suitable alternative from 1 December 2027.

3. Understand how established risk management processes currently contribute to the overall health of the UHB (i.e. achievement of objectives, delivery of plans and performance), and how this can be strengthened.

We will do this by:

- Engaging with relevant teams across the UHB to establish how risk information is currently utilised within their areas to support the achievement of the delivery of our objectives and performance targets to inform our risk maturity assessment, and how this could be strengthened; and*
- Engaging with service leads across the UHB to assess the risk culture within the organisation to identify areas of improvement to support individuals in undertaking risks in an informed manner to support the achievement of our objectives and performance targets.*

The previous report to ARAC provided the Committee with the outcomes of the risk maturity self-assessment undertaken during Quarter 3 of 2024/25, in accordance with the Orange Book (a recognised risk management standard for the public sector).

The outcomes and identified next steps of the assessment have been used to inform the revised Strategy, with the Head of Assurance and Risk developing an implementation plan to ensure the delivery of the refreshed objectives. Progress against these will be reported to future ARAC meetings.

Next steps

As outlined within this report, the following key actions will be undertaken, with progress provided to ARAC in the next Risk Assurance Report in December 2025:

- To identify a suitable risk management system and commence work on its implementation and roll-out ahead of 30 November 2027; and
- Complete the review of risk themes.