Assurance and Risk Report

Finance and Performance Committee, 26 August 2025

Situation

This report provides the Finance and Performance Committee (FPC) with the current status of the risks, audits and inspections recommendations, Welsh Health Circulars (WHCs) and Ministerial Directions (MDs) within its remit. The Committee is asked to seek assurance from the Lead Executive Directors that risks are being managed effectively, and that recommendations from audit and inspections, WHCs and MDs are being implemented by the Hywel Dda University Health Board (HDdUHB).

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Risk Management - Overview

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

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

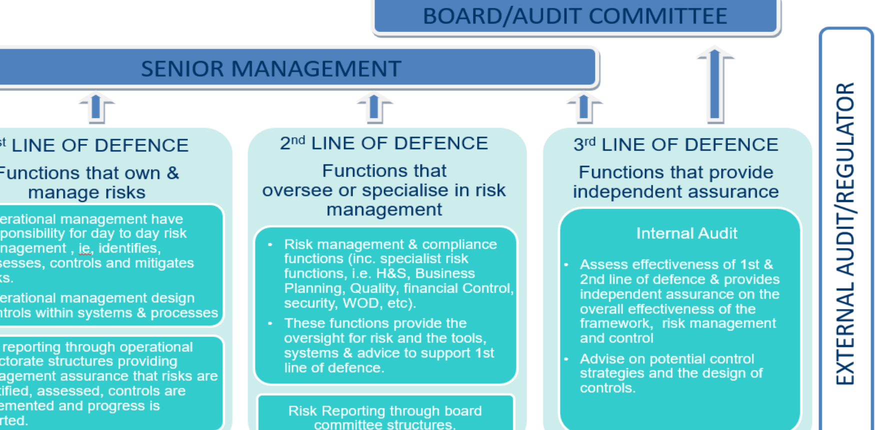
The Health Board operates within the widely accepted “Three Lines of Defence” model to ensure the appropriate responsibility is allocate for the management, reporting and escalation of risk.

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

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

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

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



Principal Risks Assigned to FPC

Each risk on the Principal Risk Register (PRR) has been mapped to a Board level Committee to ensure that risks on the PRR are being managed appropriately, taking into account gaps in controls, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

Following the implementation of new Board Committee structure on 1 April 2025, principal risks have been re-aligned to the most appropriate Board level Committee.

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

There is 1 principal risk currently aligned to FPC (out of the 15 that are currently on the PRR).

The following slide provides a summary of the reportable principal risk aligned to FPC.

The risk register attached at **Appendix 1**, provides full detail of the risk, including control measures in place, a risk action plan to further manage and mitigate the risk, and sources of assurance.

Principal Risks assigned to FPC

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1199 - Achieving financial sustainability	Director of Finance	**25 → (Reviewed 30/05/25)**	**8**	TBC

Rationale for Current Risk Score

The significant underlying financial deficit in the current and future years is likely to result in the Health Board being unable to meet its cash obligations as they fall due and presents a going concern risk. Early indications from Welsh Government (WG) is that the WG are unable to support both the revenue and cash implications. With the Health Board reporting a significant in-year and recurrent underlying deficit, WG initially escalated the Health Board into Targeted Intervention during October 2022, on the grounds of planning and financial performance, and in January 2024, the whole organisation was escalated into targeted intervention. The recurrent funding position confirmed by WG leaves a significant gap based upon draft iterations of the financial plan, with strategic and operational changes required in an attempt to erode the financial deficit.

The Health Board's underlying deficit is now well understood and articulated, with clear decisions tracked that have been made by budget holders that exceed their delegated limits. There is a need to not only shift resources to more appropriate settings but provide care at considerably lower cost. Significant workforce constraints remain; and the planning function remains small with significant opportunities to develop.

Rationale for Target Risk Score (TRS)

Achieving financial balance on a three-year rolling basis is a statutory requirement for the Board, and a clear requirement from the Board and WG. Strategic and operational planning in an integrated Health Board is inherently complex leading to potential disconnections between demand, operational capacity planning; workforce planning and financial planning. Given the challenge in delivering the savings required over a number of years, and the implications of this in the medium term, it is unlikely that the Health Board will achieve a risk which is in line with the tolerable risk for the year. Consequently, the target risk score exceeds the tolerable risk at this point. This is not an acceptable position, and further work is ongoing to manage this risk.

Corporate Risks Assigned to FPC

Hywel Dda Risk Heat Map					
	LIKELIHOOD →				
Impact ↓	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5				2086 (New)	
Major 4			2104 (New)	1350 →	
Moderate 3					
Minor 2					
Negligible 1					

Each risk on the Corporate Risk Register (CRR) has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account gaps in controls, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

Following the implementation of new Board Committee structure on 1 April 2025, corporate risks have been re-aligned to the most appropriate Board level Committee, with this report being the first report of corporate risks assigned to FPC.

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

- Associated with the delivery of the Health Board objectives; or
- Significant escalated operational risks that are of significant concern and require corporate oversight and management.

There are 3 risks currently aligned to FPC (out of the 20 that are currently on the CRR).

The following slide provides a summary of the reportable corporate risks aligned to FPC. The Risk Register attached at **Appendix 2**, provides full detail of the risk, including control measures in place, a risk action plan to further manage and mitigate the risk, and sources of assurance.

Corporate Risks assigned to FPC – New Risk

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2104 - Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 25/26 due to demand exceeding capacity	Chief Operating Officer	**12** **NEW** (Reviewed 25/07/2025)	**9**	30/09/25

Rationale for Current Risk Score

The combined impact of cohort demand in key specialties and workforce limitations risk full achievement of ministerial planned care recovery targets by March 2026. Theatre cancellations due to Glangwili Hospital (GGH) staff shortages have negatively impacted core capacity, and additional demand in longer waiting patients (cohort) verses recurrent demand in Orthopaedics. Recovery funding for 2025/26 has been prioritised for areas where high level Demand & Capacity (D&C) modelling identified capacity gaps. The Annual Plan for 2025/26 highlighted delivery risks in Ear, Nose and Throat, Rheumatology, Ophthalmology, Dermatology, Gynaecology, Urology and Cardiology, with WG recovery allocation (£2.8m) split accordingly to progress delivery solutions in these areas. Additional risks to delivery have arisen during Q1 2025/26 in General and Geriatric medicine. Whilst 2025/26 delivery plans reflect positive progress in increasing outpatient activity and treatment capacity, the Annual Plan signalled expected delivery gaps in the above specialties. Health Board performance of planned care delivery milestones is a feature of its Targeted Intervention escalation status. Opportunities have been explored to maximise capacity with Swansea Bay University Health Board in Ophthalmology and Orthopaedics. Both specialties have been prioritised for active exploration of regional solutions including utilising Neath Port Talbot theatres for Orthopaedic activity. Breach volumes in respect of the Stage 1 52 weeks are expected to be resolved by March 2026. Forecast breach volumes in respect of the Total Pathway 104-week target remain in Orthopaedics in Quarter 1 although monthly breach performance shows continued improvement.

Rationale for Target Risk Score (TRS)

The TRS of 9 reflects the continuing delivery ambitions which remain, despite workforce and resource limitations reflected in the Annual Plan. Positive progress achieved 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. The care group propose to be in balance by Quarter 2. Opportunities to make further progress towards the Ministerial targets in 2025/26 will continue to be explored, including exploration of the regional opportunities referred to.

Corporate Risks assigned to FPC

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2086 - Risk that the cash consequences of the Health Board deficit cannot be covered by WG should it exceed our Target Control Total	Director of Finance	**20** → (Reviewed 06/08/25)	**12**	31/12/25

Rationale for Current Risk Score

The Board endorsed and approved the submission of the annual plan to WG in March 2025, noting that the financial plan doesn't deliver against our statutory requirement to break-even. It recognised that the forecast financial outturn remained in-line with the target control total (TCT) set by WG of £31.5m, but a worsening position compared to the 2024/25 financial outturn. This followed a period of scrutiny through the Sustainable Resources Committee, Board Seminar and Public Board meetings in Q4 2024/25. Correspondence received from WG during Q1 of 2025/26 confirmed that our plan is not supportable, with a revised and clear requirement to achieve a TCT of £24m. The focus is therefore:

1. To improve the assurance over recurrent and non-recurrent savings delivery to achieve the original plan of £31.5m, and the now revised annual plan of £30.0m;
2. To take choices to reduce the position further to £24m. This requires actions to be taken over August and September for a Board Seminar in September 2025 and submit our actions for improvement to WG by 11 September.

As at Month 4 2025/26, savings identification was at £26.9m, with some operational cost pressures arising from medical staffing, the management of Long-Term Arrangements (LTAs) and clinical services and supplies within planned care and hospital sites.

Rationale for Target Risk Score (TRS)

The Health Board had a historic challenge of controlling its cost base and delivering change. While significant improvements have been made to our control environment, significant challenges remain in our change management capabilities. These need to be addressed to achieve the target risk score.

By 11 September 2025, the Executive Team are seeking to de-risk the financial plan to ensure its successful delivery. It is at this date we would envisage the current risk score being reduced to 16 if the savings gap has been materially closed with robust and deliverable schemes.

By 31 October 2025, the Executive Team are seeking to have fully de-risked the financial plan to ensure its successful delivery, in order to allow the organisation to focus on planning for delivery of the medium-term financial roadmap into 2026/27.

Corporate Risks assigned to FPC

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1350 - Risk of not meeting the 80% Single Cancer Pathway (SCP) waiting times target for March 2026 due to diagnostics capacity and delays at tertiary Centre	Chief Operating Officer	**16** **→** (Reviewed 25/07/25)	**12**	31/03/26

Rationale for Current Risk Score
The service has been de-escalated by WG from Level 4 to Level 3 in terms of Targeted Intervention status as there has been the consistent achievement of the 60% de-escalation criteria since February 2025. As at June month end, the service achieved 61.4%. Due to recovery actions within radiology and urology we may see variation in performance as we recover and treat those patients over 62 days, therefore the risk remains that cancer performance will not achieve 80% compliance by March 2026.
Rationale for Target Risk Score (TRS)
The aim is to treat patients within target waiting times, which has now been confirmed as 80% non-adjusted March 2026. The tolerance level will be met if plans to increase diagnostic capacity, utilising allocated recovery funding are realised. When the target of 60% for 3 consecutive months is achieved the risk score can be reduced to a 12. The risk score can be further reduced to an 8 once the target of 80% is achieved. There are underpinning trajectories in place which are monitored monthly and adherence to those will influence the ability to achieve the target risk score.

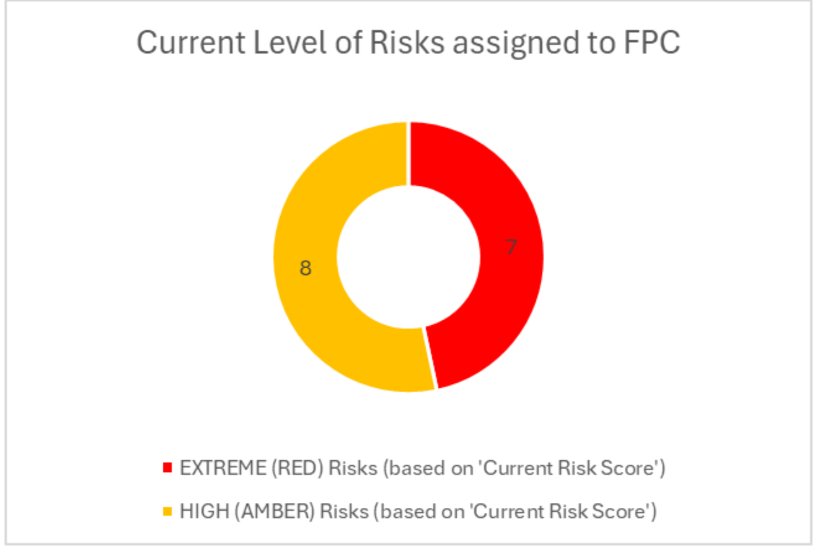
Operational Risks assigned to FPC

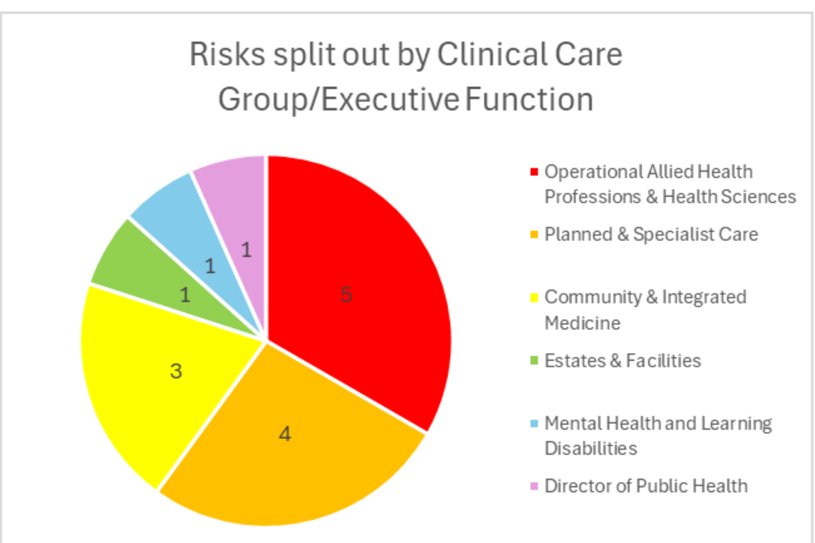
16 operational risks on Datix are aligned to FPC, all of which are within review date.

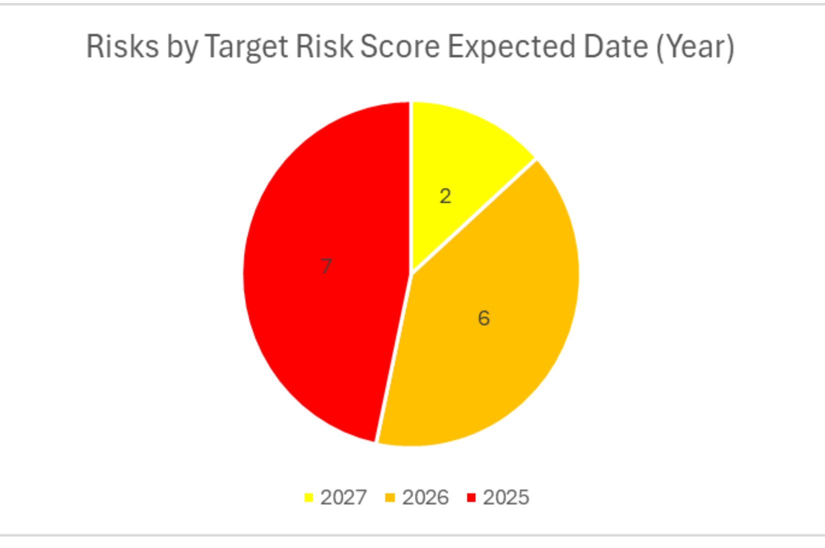
Of these, 15 have been identified as reportable to FPC based on the following criteria:

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

The following slides summarise the operational risks aligned to FPC. The Risk Register attached at **Appendix 3**, provides full detail of each risk, including control measures in place and the risk action plan to further manage and mitigate the risk.







Operational Risks Reportable to FPC

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
2110 - Risk of not achieving savings targets for 2025/26 due to significant, strategic change required across whole CCGs	Community & Integrated Medicine	Chief Operating Officer	20 NEW	16	31/10/2025	10/07/2025
1631 - If the delegation of budget manager responsibilities are unmet then finances will be adversely affected	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20 ↓	15	31/03/2026	11/07/2025
975 - Risk of failure to remain within allocated budget due to financial constraints (Estates & Facilities).	Estates & Facilities	Director of Allied Health Professions and Health Sciences	20 →	10	31/03/2026	22/07/2025
2107 - Risk of physiotherapy financial overspend due to unfunded respiratory on call services.	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	16 NEW	2	31/03/2026	09/07/2025
1906 - Risk of not achieving savings targets within our annual plan due to ongoing service demand	Community & Integrated Medicine	Chief Operating Officer	16 →	12	31/10/2025	29/07/2025
1892 - Risk of not achieving savings targets due to continued expenditure without mitigating savings plans	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	16 →	12	31/03/2026	04/07/2025

Operational Risks Reportable to FPC

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
971 - Risk of failure to remain within allocated budget over the medium term due to financial constraints (MH&LD).	Mental Health and Learning Disabilities	Chief Operating Officer	16 →	3	31/03/2026	10/07/2025
2124 - Risk of being unable to identify recurrent savings required due to spend on ad-hoc pay and non-pay	Planned & Specialist Care	Chief Operating Officer	12 NEW	4	31/03/2026	25/07/2025
2065 - Risk of not achieving the WG performance measure for CO validated quit attempts due to capacity and accessibility challenges	Director of Public Health	Director of Public Health	12 →	8	31/03/2027	24/07/2025
1951 - Risk of overspend against Specialist Palliative Care budget due to potential withdrawal of funding for permanent posts	Community & Integrated Medicine	Chief Operating Officer	12 →	4	29/08/2025	01/07/2025
1488 - Risk of major service disruption if decontamination equipment fails at BGH due to age	Planned & Specialist Care	Chief Operating Officer	12 ↓	8	31/03/2027	17/07/2025
1084 - Risk of unsustainable surgical rota in PPH due to reliance on locum doctors	Planned & Specialist Care	Chief Operating Officer	12 →	3	31/12/2025	17/07/2025

Operational Risks Reportable to FPC

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
2095 - Risk to delivery of urgent and suspected cancer hysteroscopy diagnostic pathway	Planned & Specialist Care	Chief Operating Officer	8 NEW	4	30/09/2025	17/06/2025
1646 - Risk of cost pressure (external test service level agreements PHW) due to increased workload/costs	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	8 →	8	23/04/2025	24/07/2025

Audits and Inspections - Overview

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

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan *(TI criteria 12)*; and
- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s *(TI criteria 38) – which has replaced the previous criteria of 'Effective response from the Health Board to external reports and reviews including those from Audit Wales, the Ombudsman, Royal Colleges and HIW resulting in sustainable improvements.'*
- The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW.

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

AMaT enables services to directly update progress against all recommendations via one central system, promoting a consistent approach with regards to processes and reporting, improvement in transparency and accountability, supporting services with their governance arrangements, and improvement in information flow. Progress is monitored via the utilisation of a traffic light system based on performance against original completion dates.

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

Recommendations that have exceeded original timescales, along with the management responses management response, completion dates and barriers to implementation as provided by the lead officer on AMaT are included in **Appendix 3**.

Audits and Inspection Reports assigned to FPC

The following reports have been assigned to FPC to enable them to undertake the following responsibility set out in their Terms of Reference:

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

Date of report	Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendat-ions in original report	Red (behind schedule)	Amber (on schedule)	Green (complete)	External Recs	Any Barriers to Completion Noted?
Aug-23	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Planned and Specialist Care	Chief Operating Officer	Apr-24	~~Nov-24~~ Jan-27	59	0	9	50	0	Linked to Clinical Services Plan (CSP) in GGH and BGH
Hun-24	Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine	Community & Integrated Medicine	Chief Operating Officer	Oct-25	Oct-25	35	17	11	7	0	Awaiting outcome of CSP and, capital funding from WG.
Jun-23	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Mental Health & Learning Disabilities	Chief Operating Officer	Jun-24	~~Jun-24~~ ~~Jul-25~~ Oct-25	16	1	0	15	0	None noted
Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Planned & Specialist Care	Chief Operating Officer	Mar-22	~~Mar-23~~ ~~Mar-24~~ Mar-28	8	0	0	7	1	Awaiting regional approach
Sep-22	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Planned & Specialist Care	Chief Operating Officer	N/K	Sep-26	17	6	0	10	1	Engagement required with stakeholders outside the Clinical Care Group (CCG)
Apr-24	Peer Review	Getting It Right First Time (GIRFT) - Urology Review	Planned & Specialist Care	Chief Operating Officer	Jan-27	Jan-27	29	2	6	18	3	Linked to CSP, and reliance on the National Urology Clinical Implementation Network (CIN) rolling out agreed Coding criteria.

Audits and Inspection Reports assigned to FPC

Date of report	Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendat-ions in original report	Red (behind schedule)	Amber (on schedule)	Green (complete)	External Recs	Any Barriers to Completion Noted?
May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Planned & Specialist Care	Chief Operating Officer	Sep-23	~~Mar-24~~ ~~Jan-25~~ ~~May-25~~ N/K	22	0	0	22	0	Requires engagement from another Health Board and establishing a regional solution
Jun-25	Internal Audit	Continuing Healthcare – Database Maintenance & Finance Processes Final Internal Audit Report 2024/25 (Substantial rating)	Director of Finance	Director of Finance	Oct-25	Oct-25	1	0	1	0	0	None noted
Jan-25	Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	Planned & Specialist Care	Chief Operating Officer	Mar-26	Mar-26	32	0	24	6	2	Dependent on recruitment and funding being agreed through the Annual Planning process, awaiting outcome of tender process for standardised PAC process and pathway.
Jan-25	Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Allied Health Professions and Health Sciences (January 2025)	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Sep-25	Sep-25	10	0	7	3	0	Capacity issues, new plans being developed via the Network with Swansea Bay UHB.

Audits and Inspection Reports assigned to FPC

Date of report	Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendat-ions in original report	Red (behind schedule)	Amber (on schedule)	Green (complete)	External Recs	Any Barriers to Completion Noted?
Jan-25	Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) - Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	Community & Integrated Medicine	Chief Operating Officer	Mar-26	Mar-26	15	0	14	1	0	OCP Phase 2 recruitment
Oct-24	NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	Community & Integrated Medicine	Chief Operating Officer	Nov-25	Nov-25	58	0	58	0	0	None noted
Mar-25	NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	Community & Integrated Medicine	Chief Operating Officer	Apr-26	Apr-26	38	0	38	0	0	None noted

Welsh Health Circulars - Overview

Welsh Health Circulars (WHCs) provide a streamlined, transparent and traceable method of communication between NHS Wales and NHS organisations relating to different areas such as estates, finance, governance, health professional letters, information governance, quality and safety, legislation, planning, performance and delivery, policy, public health, research, science, and workforce. WHCs are published on the Welsh Government website.

Committees have responsibility to seek assurance that the Health Board is compliant with WHCs and that these are implemented in line with stated/agreed timescales, and where this has not been possible, to receive assurance the impacts resulting from late or non-delivery are understood and managed appropriately.

Where WHCs are not clear in terms of implementation timescales, leads are requested to provide the planned date for implementation by the Health Board. The following RAG status is applied to WHCs:

- **Red** = behind schedule to the timescale provided by the Lead officer, or a plan (with date for implementation) is not yet in place
- **Amber** = a plan is in place and on schedule to be completed by the timescale provided by the Lead Officer
- **Green** = completed
- **Blue** = External i.e., the means to achieve compliance is currently outside the gift of the Health Board.

WHCs included within this report are based on the following criteria:

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

Progress updates relating to the implementation of WHCs are extracted from the AMaT system.

Welsh Health Circulars assigned to FPC

Since the previous report to FPC, the following WHC has been implemented (**Green**):

WHC Ref	Name of WHC	Date Issued	Lead Director	Update
012-25	Interim Amendments to the Model Standing Financial Instructions Chapter 11 for Local Health Boards and NHS Trusts in Wales, and Chapter 12 for Health Education and Improvement Wales (HEIW) and Digital Health and Care Wales (DHCW) online link not available	29/05/2025	Director of Corporate Governance/ Board Secretary	The Health Board's Standing Financial Instructions have been updated with support from Finance colleagues, and approval by Board on 31 July 2025.

Ministerial Directions- Overview

Acts of Parliament, Acts of Senedd Cymru, Assembly Measures and Assembly Acts enable Welsh Ministers to develop more detailed legislation, known as secondary or subordinate legislation, usually by means of Statutory Instruments (SI).

Non-Statutory Instruments (NSI) are legislative in character; they alter legal rights and duties; however, they are not SIs. NSIs, which are issued by Welsh Ministers, include codes of practice and guidance.

In complying with the requirements of various governance codes and the Annual Governance Statement requirements, HDdUHB has a duty to provide assurance of compliance with the NSIs.

MDs that potentially form part of the process of approving expenditure of public money have been realigned to DDIC to receive a regular assurance report on compliance.

The following RAG status is applied to MDs:

- **Red** = behind schedule to the timescale provided by the Lead officer, or a plan (with date for implementation) is not yet in place
- **Amber** = a plan is in place and on schedule to be completed by the timescale provided by the Lead Officer
- **Green** = completed
- **Blue** = External i.e., the means to achieve compliance is currently outside the gift of the Health Board.

MDs included within this report are based on the following criteria:

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

Progress updates relating to the implementation of MDs are extracted from the AMAT system.

Ministerial Directions assigned to FPC

The following Ministerial Direction has been received and confirmed as having a plan in place and being on schedule to be completed by the timescale provided (**Amber**):

Direction Number	Name of Direction	Date issued	Lead Director	Update
WG21-59	The Directions to Local Health Boards and NHS Trusts in Wales on the Delivery of Autism Services 2021	26/07/2021	Chief Operating Officer	This Ministerial Direction is currently being implemented, with an implementation date of October 2025. The health board continues to work with the Regional Partnership Board (RPB) in the development and delivery of the Code of Practice Implementation Plan which requires a multi-agency response to address the recommendations outlined in the code.

Ministerial Directions assigned to FPC

Since the previous report to FPC, the following MDs have been confirmed as implemented (**Green**):

Direction Number	Name of Direction	Date issued	Lead Director	Update
WG25-33	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2025	09/06/2025	Director of Finance	Confirmation received from NHS Wales Shared Services Partnership (NWSSP) that MD has been complied with.

Recommendations

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

RISK MANAGEMENT

- **RECEIVE ASSURANCE** that identified controls are in place and working effectively;
- **RECEIVE ASSURANCE** that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise; and
- **CHALLENGE** where assurances are inadequate Acts of Parliament, Acts of Senedd Cymru, Assembly Measures and Assembly Acts enable Welsh Ministers to develop more detailed legislation, known as secondary or subordinate legislation, usually by means of Statutory Instruments (SI).

AUDITS, INSPECTIONS AND REGULATORY REPORTS

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

WELSH HEALTH CIRCULARS

- **RECEIVE ASSURANCE**, or otherwise, from the lead Executive Director or Supporting Officer on the management of WHCs within their area of responsibility, particularly in respect of understanding when the WHC will be delivered, any barriers to delivery, impacts of non/late delivery and assurance that the risks associated with these are being managed effectively.

MINISTERIAL DIRECTIONS

- **RECEIVE ASSURANCE** that the Health Board is compliant with the NSIs (MDs) issued by Welsh Government.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Jun-25	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score
1199	Achieving financial sustainability	Thomas, Huw -	Finance inc. claims	5×5=25	5×5=25	→	2×4=8	TBC

Risk Ref	Strategic Objectives	Risk Title (for more detail see individual risk entries)	Executive Director	Controls	Domain	Current Risk Score (L x I)	Target Risk Score (L x I) (tolerable score)	Performance Indicators	Assurance from What? (sources/providers of assurance) L1, L2 & L3 (see below key)	Latest paper	Assurance Sufficient? (Y/N)	Control RAG rating (see below key)	Risk on page no...
1199	6. Sustainable use of resources	Achieving financial sustainability	Thomas, Huw -	Considerable business intelligence available on where our expenditure differs from the rest of Wales - eg comparisons at service, site and condition level to understand in detail where we utilise resources, and identify opportunities to change the way we deliver services Long term financial model - with a view to crafting a long term strategic financial plan - currently being constructed, setting out key actions and policy / operational changes necessary to become more financially sustainable A Planning Steering Group is in place to co-ordinate activities across key corporate functions. Operational grip and control currently being strengthened, through Executive-led groups tackling specific issues eg use of high cost agency staff, transformation of urgent / emergency care etc The Planning Team are embedded within the operational management structures across the organisation.	Finance inc. claims	5×5=25	2×4=8	See Our Outcomes section on the BAF Dashboard Operational agreement to underlying deficit assessment. Welsh Government accept and approved Integrated Medium Term Plan (IMTP). Plan in place to develop a long-term financial plan. High level financial assessment of A Healthier Mid and West Wales in place.	Analysts engaged and have produced a bed opportunity analysis with consistent conclusions to the internal work (L1) Financial Reporting to Sustainable Resources Committee (L2) Integrated Quality, Finance, Performance and Delivery Group (reporting to Executive Team) oversee in-year delivery of financial performance and savings delivery (L2) Value and Sustainability Group (reporting to Executive Team) oversees opportunities which inform medium term financial roadmap (L2) Planning Objectives overseen by Sustainable Resources Committee (L2) Structured Assessment 2023	Annual Plan Update 2024/25 - SRC & Board Seminar (Feb24) Developing a roadmap to financial balance - SRC (Jun23) Medium term financial strategy- Board Seminar (Jun23) Annual Plan Update 2024/25 - Board Seminar (Feb24) Financial Strategy and Roadmap Update 2025/26 - SRC (Dec25) Annual Plan and Strategy Update 2025/26 - Board Seminar (Feb25)	Y		

				New Executive team governance and escalation structure and reporting groups (Value & Sustainability, A Healthier Mid and West Wales, and Integrated Quality, Finance, and Performance Delivery) to improve financial control and long term sustainability. Oversight provided into ET by the Targeted Intervention Coordination Group. Improving together aligned to an internal escalation framework - a programme to embed a quality management system to ensure consistency of approach in addressing quality and service improvement throughout the organisation. Agile Digital Business Group - a Group which reports into the Finance Committee which scrutinises business cases on digital investment to allow a rapid allocation, allocate resources promptly, learn from previous business case implementations and disinvest if appropriate. Value Based Health and Care Group: which ensures that the Health Board's rollout and deployment of VBHC is in line with plans and will facilitate the shift of resources over time.					(L3)	Annual Plan and Strategy Update 2025/26 - SRC (Feb25)			

1196	5. Safe, sustainable, accessible and kind care	Insufficient investment in facilities/equipment/digital infrastructure	Davies, Lee	Annual programme of replacement in place for equipment, IT and Estates which follows a prioritisation process. When possible, aligning replacement equipment to large All Wales Capital schemes to minimise the impact on discretionary capital within the UHB. Completion of the medical devices inventory by the operational management team which helps in the prioritisation of available funds. Communication with Welsh Government via Planning Framework and IMTP (Infrastructure & Investment Enabling Plans) including the prioritised 10 year capital plan and regular dialogue through Capital Review meetings. Preparation of priority lists for equipment, Estates and IM&T in the event of notification of additional capital funds from Welsh Government i.e. in year slippage and to enable where possible, the preparation of forward plans. This is also addressed through the identification of high priority	Business objectives/projects	5×4=20	2×3=6	See Our Outcomes section on the Dashboard	Development of Integrated Assurance and Approval Plan in support of PBC and SOC (L1) Governance structure to oversee delivery of the Business Cases (L1) Oversight by A Healthier Mid and West Wales Group which reports into Executive Team with Assurance sought by Strategy and Planning Committee (L2) Internal Audit Programme aligned to Business Case Development (L3) Internal Audit AHMWW Programme Forward Look Governance Review (L3) Gateway review of PBC and SOC by WG Assurance Hub (L3)	PCB - Implementing the Healthier Mid and West Wales Strategy - Board (Jan23, Mar23, May23, Jul23 & Sep23) & SDCODC (Apr23, Jun23, Aug23 & Jan24) AHMWW PBC Programme Group Update - Board Seminar (Apr22) TMH Update - Board Seminar (Jun22) Executive Team - Apr22 Planning Objectives Update (Planning) - SDODC ((Jun22, Oct22, Feb23, Jun23, Oct23, Feb24 & Jun24)	Y		

				issues through the annual planning cycle. Implementation of the Digital Strategy which is also funding dependant. A governance structure has been established with the Director of Strategy and Planning as SRO to develop the business cases required in support of the Health and Care Strategy, A Healthier Mid and West Wales. It is likely that all the capital mitigations for the over arching risk will be interim solutions only pending the major infrastructure investment plans to ensure the sustainability of the health and care strategy. Programme Business Case (PBC) for Business Continuity supported in principle by WG and funding for first phase BJC developments. Funding for Community Schemes are being progressed via the Integration and Rebalancing Fund (IRCF). Co-production of 10 Year Capital Investment Plan with the RPB.						Pentre Awel Update - SDODC (Dec23) DCP Update - SDODC (every meeting) Forward Look Governance Review - ARAC (Feb23) Regular reporting to Board and Board Seminar			

1197	5. Safe, sustainable, accessible and kind care	Implementing models of care that do not deliver our strategy	Davies, Lee	Healthier Mid and West Wales Strategy approved by Board Nov18. Delivery Groups and processes: 1. Programme Business Cases (PBC) steering groups 2. Cluster groups & locality plans 3. Regional Partnership Board, ARCH and other regional/national collaboratives 4. AHMWW Group, reporting to Executive Team, with underpinning governance structure overseeing alignment and delivery of the strategy working through a sub group structure of 6 Sub Groups including a Strategic Refresh Group. Assurance provided to Board via scrutiny of delivery of the above by relevant assurance committees.	Business objectives/projects	4×4=16	1×4=4	See Our Outcomes section in the BAF Dashboard	AHMWW Group reporting to Executive Team (L2) Board and Committee oversight of Planning Objectives (L2) QSEC to measure harms (L2) WG Gateway process re accessing capital (L2) Internal Audit reviews of Major Capital Programme (L3) Audit Wales Structured Assessment Process review delivery of Health Board Strategy & Planning (L3)	PBC - Implementing the Healthier Mid and West Wales Strategy - Board (Jul24) Annual Plan 2023/24 Update - Board (Jan25) Refreshing the Healthier Mid and West Wales Strategy - Board (Jan25)	Y		

1185	1. Putting people at the heart of everything we do, 2. Working together to be the best we can be	Consistent and meaningful engagement through our workforce	Davies, Lee	"Skills to Deliver Engagement Two additional posts were added to the Engagement team in early 2023. However, these roles have, due to staff departure and financial pressure, have been held. Recruitment to the Head of Engagement is currently underway in October 2024, with additional posts to follow. Additional resource has been requested to enable engagement during CSP. Expert engagement team in place with ongoing training needs reviewed regularly. Operational engagement lead for each county. Engagement training provided to operational on an ad hoc/as required basis. Organisational Structures to Support the Delivery of Engagement Stakeholder Reference Group provide oversight/ input from an advisory group perspective around key HB priorities. Close working relationship with Llais.	Business objectives/projects	4×4=16	2×3=6	See Our Outcomes section on the BAF Dashboard	Management process in pace to monitor Engagement Team objectives (L1) Key projects / programmes of work will be provided with advice, guidance and support around the design and delivery of robust engagement plans (and where required consultation plans) (L1) Reflective review of the engagement to ensure learning from the process is recorded and influences future work. This will include a programme / project group review to inform future learning and delivery of engagement. The operational reflection by the Engagement Team will form part of the team's learning log, to ensure there is continuous improvement embedded within engagement practice. Ongoing process in place (L1)	Continuous Engagement Plan - Board (May22)	N		

Voices of Children and Young People's Group established

Newly established 'improving the use of feedback across the organisation' group to explore how the triangulation of feedback from different parts of the organisation including engagement, corporate office, communications, diversity and inclusion, quality improvement, transformation, patient experience and workforce and organisational development can be used to inform key pieces of work around service change.

Engagement mechanisms to support the delivery of continuous engagement across the organisation include:
- provision of engagement, advice, guidance and support around continuous engagement and consultation to services across the HB
- management of the Siarad Iechyd / Talking Health involvement and engagement scheme
- management of the stakeholder management system Tractivity
- Management of the online engagement tool Have Your Say (EngagementHQ)
- advice, guidance, support around the planning and delivery of traditional engagement methods"

SRG used a oversight assurance mechanism (L2)

For major pieces of engagement and consultation work sign off will be via Board (L2)

Where contentious engagement / consultation is identified the organisation can seek external advice and guidance through Consultation Institute to minimise risk of judicial review (L3)

The Health Board and Llais have key duties around changes to health services. Changes to health services should be presented to the CHC at Services Planning Committee (L3)

1198	6. Sustainable use of resources	Ability to shift care in the community	Carruthers, Andrew	Transformation Steering Group (TSG) & Strategic Enabling Group (SEG) to support strategic innovation and development in the UHB. Operations Innovation 'Board' (new Silver) to aid planning to optimal level, with workstreams and system overarching group. 5 Facet Survey completed in 2022 to establish a baseline for the GMS estate. CHC and UHB Protocol for managing low level service change. All Business Cases need to be taken through Transformation Steering Group. Plan on a page developed and included in the Health Board's Annual Plan 2024/25 for clusters. WHC (18) 025 - Improving Value through Allocative & Technical Efficiency: A Financial Framework to Support Secondary Acute Services Shift to Community/Primary Service Delivery confirmed as	Business objectives/projects	4×4=16	2×4=8	See Our Outcomes section in the BAF Dashboard	Lightfoot Viewer for urgent care to track improvements (L1), County Management Systems Leadership Forum focus on performance and delivery (L1), Locality Leads meeting oversee integrated locality development (L1), Primary Care & Long Term Care SMT meeting (L1), Regional Partnership Fund Group (L2), Board Seminar discussions (L2), Delivery of Planning Objectives overseen by Executive Team and Board Committees (L2),	TMH Update - Board (May22). Three Year Draft Plan for Children's Services - Board (Jul21). PCB- Implementing the Healthier Mid and West Wales Strategy - Board (Nov23). Implementing the Healthier Mid and West Wales Strategy - Board - (Jan23).	N		

1186	o, 2. Working together to be the best we can be, 3. Striving to deliver and develop excellent services	Attract, retain and develop staff with the right skills	Gostling, Lisa	A flexible and responsive recruitment process. A multidisciplinary approach to clinical education. A comprehensive package that enables local people to know what and how they can access workforce development initiatives in the Health Board HR policies (including those for employee relations) in place with programme of review Training programmes in place (a suite of programmes covering management and leadership, Making a Difference, etc) County workforce teams/OD Relationship Managers/Workforce Planners in place to provide workforce support to services (covering sickness absence, etc) Staff Well-being Service and Psychological Service in place Regular contact with Trade Union	Workforce/OD	3×5=15	2×5=10	See Our Outcomes section on BAF Dashboard	Workforce Leadership Group review progress of planning objectives, measures and staff feedback in detail (L1) Pulse surveys sampling 1000 employees each month, selecting different staff each month (L1) SSPEG oversees people planning and education development (L2) Oversight of Delivery of planning objectives, measures and staff feedback at People, OD & Culture Committee (L2) Staff Partnership Forum (L2) Medical Engagement scale feedback (L3) IA PADR Follow up - Reasonable (May-20) (L3)	Approach to Workforce Planning Paper (including WAO reports) and Workforce Risk Paper and Planning Objectives Update - PODCC (Oct23) Discovery Report: Understanding the Staff Experience in HDUHB during 2020-21 COVID-19 Pandemic - Board (Sep21) Workforce Planning Report provided to every other PODCC meeting (latest February 2025) Delivery Against Planning Objectives Aligned to the People, Organisational	N		

	1. Putting people at the heart of everything we d			representatives/Staff Partnership forums Annual NHS staff surveys providing feedback from staff Separate clinical education programmes in place Apprenticeship programme and work experience programmes in place Grow your Own programmes in place Leadership development programmes in place Internal and External talent programmes Directorate Improving Together Sessions aligned with Internal Escalation Framework Strategic Workforce Planning Forum (oversight of education commissioning) and People Profession Plans SPPEG (Strategic People Planning & Education Group)					Internal Audit on Workforce Planning - Substantial (Apr22) (L3) Wales Audit on Workforce Planning (Report Sep23) (L3) Strategic Workforce Planning Forum (oversight of education commissioning) and People Profession Plans SPPEG (Strategic People Planning & Education Group)	Development and Culture Committee (May 2025)		

1194	4. The best health and wellbeing for our individuals, families and our communities	Increasing uptake and access to public health interventions	Gjini, Ardiana	National screening programmes in place (including Breast, Bowel, Cervical, DES, AAA, new-born, etc). These programmes are national services, planned, delivered, monitored and quality assured by PHW, also the quality improvement sits with PHW. Local initiatives in place such as Cervical Screening and Refugees, and Barriers to Screening Uptake in Carers. Vaccination and immunisation programme in place, and recently has seen significant changes with introduction of national immunisation framework (NIF). Vaccination and Immunisation as programmes are planned in line with WG policy. Local health protection service in place. Local and National health promotion initiatives. Multi-agency Health Protection and Co-ordination Group established (with operational delivery groups for adult immunisation, infant and pregnancy immunisation and respiratory immunisation, school age immunisation, occupational immunisation) Tobacco Control Group in place. Area Planning Board (Alcohol and Substance Misuse).	Health Equity	4×3=12	2×2=4	See Our Outcomes section on the BAF Dashboard Wellbeing, Public Health Outcome and Health Inequality, Deprivation metrics to aid baseline setting to map progress	Population health measures collected by Public Health Wales (vaccinations, screening, etc) (L1) Oversight of delivery of delivery of Planning Objectives at Executive Team and SDODC (L2) A Healthier Mid and West Wales Group (L2) All Wales Wellbeing and Public Health Outcome indicators published by PHW Observatory. QA responsibility of PHW. Relevant ONS data - published resources. Other ad hoc published works/resources from various recognised and credible bodies/foundations (L3)		N		

1191	3. Striving to deliver and develop excellent services	Underestimation of Excellence	Henwood, Mr Mark	# Quality Assurance System including Clinical effectiveness # Process re NICE and professional guidance. # National & Local Clinical Audits Programme # Peer Reviews # Healthcare standards # Major cause of harm # National Quality setting. # AMAT system in place to monitor NICE compliance # TSG to learn from best in World. # Advisory Board. # Clinical Director for Clinical Effectiveness - role to secure clinical engagement. # Monitoring system in place for NICE guidance. # QSEC Approved Research & Development (RDI) Strategy with Implementation Plan # Research & Innovation Sub Committee with strengthened membership for improved scrutiny # Strengthened RDI Management Team # Partnership and collaborative working initiatives - some joint funded posts and research and innovation projects in place. # University partnership arrangements in	Business objectives/projects	3×4=12	2×3=6	See Our Outcomes section on the BAF Dashboard	# Participation in the NICE Welsh Health Network where specific guidelines are proposed for review on a national basis - to provide benchmark information (L1) # Senior management Team meeting monitor delivery of RDI activities and RDI Strategy/Plan (L1) # VBHC Programme Plan for rollout of PROM/PREM collection and capture of resource utilisation (L1) # Medical Leadership Forum (L2) # VBHC facilitated Service Review Meetings with operational and clinical staff followed by presentation to Executive colleagues for action (L2) # Reporting through the Effective Clinical Practice Advisory Panel and Clinical Standards and Guidelines Group (L2) # Alignment with Health Board	Update ECPAP Reports to QSEC (Oct23) Effective Clinical Practice Strategic Plan for ratification to ECPAP (Sep22) Effective Clinical Practice Delivery Plan to ECPAP (Dec22)	N		

				place. # Strategic Enabling Groups # Value Based Health Care Sponsoring Group # Value Based Health Care Programme Team # National Value Based Health Care Community of Practice # Improving Together Programme # Regular attendance at Directorate/ County Quality and Governance Groups to improve engagement on clinical effectiveness # Establishment of the Clinical Standards and Guidelines Group as a forum to support better engagement with service areas and promote excellence through a focus on clinical effectiveness standards and guidelines and support from teams across the quality system to identify gaps and improve services. # Multi-Professional Clinical Workshop, led by Clinical Executives					Quality and Governance Groups (L2) # Responses to letters from Welsh Government (DCMO) relating to specific guidelines (L2) # RDI Sub Committee & HCRW monitor delivery of RDI Strategy/Plan (L2) # Board Committees & Executive Team (through its reporting groups) oversee delivery of Planning Objectives (L2) # Annual Performance Review by WG/HCRW (L3) # RDI Activity overseen by UK RD - Peer Review to review arrangements in place for research activities (L3) # IA on NICE Guidelines Follow-up (Reasonable Assurance) (L3) IA on Job Planning - May24 (Limited Assurance) (L3) # HCRW Annual Review of R&D (awaiting final report - positive verbal feedback to date) (L3)				

1192	4. The best health and wellbeing for our individuals, families and our communities	Wrong value set for best health and well-being	Gjini, Ardiana	Statutory member of Public Service Boards (PSBs) with statutory members undertaken a Wellbeing Assessments in 2022, with a set of wellbeing objectives agreed by each of the PSBs the Board in March 2023 setting actions for partners to implement Key member of Regional Partnership Board (RPB) Engagement underpinning the Healthier Mid and West Wales Strategy Equality Impact Assessments, consultation and engagement undertaken on service change Patient participation groups in place for some services, eg maternity, respiratory Close links between services and voluntary sector groups, eg AgeConcern, MIND Speaking to people re outcomes (Prog7 of Trans Fund) Together for change (supporting community led programme)	Health Equity	3×4=12	2×4=8	See Our Outcomes section in the BAF Dashboard	Population health measures collected by Public Health Wales (vaccinations, screening, etc) (L1) Tracking of crude mortality, risk-adjusted mortality and other data (L1) Oversight of delivery of Planning Objectives undertaken by Assurance Committees (L2) Overseeing the development of Wellbeing Assessment as statutory member of PSB (L2) Oversight of Programme 7 of transformation fund by RPB (L2) Oversight of delivery of New Hospital Programme Business Case by SDODC (L2) SRG advisory role to the Board (L2)	PO Update Report to Committees (Feb24)	N		

				Relationship with Llais (2 weekly meeting with Chair and CEO and bi-monthly planning meetings) Community engagement and outreach work with disadvantaged/vulnerable groups Stakeholder Reference Group Staff Partnership Forum Development and sign up to the principles of the Social Model for Health & Wellbeing Charter in the region by all partners RPB Preventions Board ownership of elements of the Social Model for Health & Wellbeing					Director of Public Health Annual Report to Board (L2)				

1193	4. The best health and wellbeing for our individuals, families and our communities	Broadening or failure to address health inequalities	Gjini, Ardiana	Health inequalities is embedded across public health teams, working closer with the planning and CSP work. HB Planning Objectives on Health Population setting plan of work for 2024/25. Population Health and Strategic Equity Oversight Group working across the HB and strategic partners. Strategic Plan for Health Improvement and Wellbeing (3 year plan) going to Board for approval in July 2024. Immunisations Equities Strategy in place. Development of Health Equities Framework for Health Services. PSB Wellbeing Plans in place, developed and agreed by Public Service Boards identifying key priorities for population well-being (the self-assessments and new objectives were set in Apr23). Community Development Outreach Team engage with minority ethnic communities and those who face barriers to accessing health and care services.	Health Equity	3×3=9	2×1=2	See Our Outcomes section of the BAF Dashboard Wellbeing, Public Health Outcome and Health Inequality, Deprivation metrics to aid baseline setting to map progress	Oversight of delivery of delivery of Planning Objectives at Executive Team and SDODC (L2) Population Health and Strategic Equity Oversight Group (L2) Health Equity Group in place engage with different groups for feedback on service and wider inequities (L2) All Wales wellbeing and Public Health Outcome indicators published by PHW Observatory. QA responsibility of PHW Relevant ONS data - published sources. Other ad hoc published works/resources from various recognised and credible bodies/foundations (L3)		N		

1188	2. Working together to be the best we can be	Effective leveraging within partnerships	Gjini, Ardiana	The Health Board is a key member of strategic and statutory partnership groups, including Regional Partnership Board and Public Service Board. The Health Board approved a Partnership Governance Framework and Toolkit in September 2017 to provide a mechanism to ensure effective arrangements are in place for the governance of partnerships. Representatives on strategic partnerships groups to provide regular updates to the Board/Executive Team. ARCH Recovery and Strategic Delivery Plans Digital strategy Regular formal and informal contact with local authority partners via CEO/Chair and Integrated Executive Group Research, development and innovation strategy	Business objectives/projects	3×3=9	1×3=3	See Our Outcomes section in BAF Dashboard	Statutory Partnerships Update to Board (L2) Chief Executive and Chair Reports to Board (L2) ARCH Reports to Strategic Development and Operational Planning Committee (SDODC) (L2) Delivery of Planning Objectives are being overseen by Executive Team and Board Committees (L2)	Strategic Partnerships Update - every Board (May24)	N		

1189	3. Striving to deliver and develop excellent services	Timely and sufficient learning, innovation and improvement	Daniel, Sharon	Risk Management Framework and Board Assurance Framework (BAF) Established governance structures Established Assurance Trackers for audits, inspectorates & regulators, Welsh Health Circulars, Ministerial Directions Healthcare Standards (HCS) 6 Domains of Quality embedded within governance framework to improve clinical quality and patient experience Research, Development and Innovation Strategy approved by QSEC The Improving Together programme which aims to shift the organisation from one that manages performance to one that manages quality and embeds an improvement culture into all of its working arrangements Quality framework, with the Enabling Quality Improvement in Practice (EQIiP) programme, improvement coach development programme and access to supporting resources/ teams (QIST/ VBHC/	Business objectives/projects	3×3=9	1×3=3	See Our Outcomes section of BAF Dashboard	Tracker Performance reports issued to Lead Directors on bi-monthly basis (L1) Committee oversight of delivery of WHCs and MDs (L2) ARAC oversight of Audit Tracker (L2) RD&I Sub Committee overseeing delivery and success of RDI Strategy (L2) IQPFD overseeing quality performance (L2) Quality Impact Assessment Panel reporting to QSEC (L2) Quality and Safety Intelligence Group (L2) Internal Quality & Engagement Act Implementation Group (L2) Directorate Improving	Tracker Report - every ARAC Strategic Business intelligence - Board (Aug21)	N		

				TPO/ PMO/ OD/ workforce/ R&D etc) Effective clinical practice (Clinical Audit, Clinical Standards and Guidance, Clinical Written Control Documents, Mortality Reviews etc) OD Cultural Plans A comprehensive range of Leadership Development pathways in place to create cohorts of leaders (includes Medical Leadership Programme, Clinical Leads Forum, Consultant Programme, HEIW Clinical Leadership Programme, LEAP, CLIMB and increased coaching capacity) Quality Impact Assessment process and panel and Quality Safety Intelligence Group					Together Sessions aligned to the internal Escalation Framework (Bi-monthly) (L2) IA Health and Care Standards to review adequate procedures in place to ensure, and monitor, effective utilisation of the standards to improve clinical quality and patient experience - Reasonable Assurance (Feb21) (L3) AW & IA Plan includes annual review of risk management arrangements & BAF (L3)				

1195	5. Safe, sustainable, accessible and kind care	Comprehensive early indicators of shortfalls in safety	Daniel, Sharon	Range of performance measures/metrics in place Updated Datix Incident reporting system Standardised approach through a standard agenda in Quality Governance meetings CIVICA system is available and being rolled out to gain feedback to let us know issues in services Range of different mechanisms to capture feedback from service users and staff Speak Up Arrangements are in place, however further developing required in light of the Speak Up Framework as issued by Welsh Government in October 2023 Listening and Learning Sub-Committee Quality, Safety and Experience Committee Clinical Audit Programme Quality Safety Intelligence Group	Quality/Complaints/Audit	3×3=9	2×4=8	See Our Outcomes section of the BAF Dashboard	Quality and Safety Intelligence Group (L2) Directorate Quality Governance Meetings in place (L2) Patient and staff feedback (L2) Harms Dashboard is reported monthly to Formal Executive team with Our Performance and other intelligence for triangulation of data (L2) Improving Together performance sessions with clinical and corporate directorates aligned to the Internal Escalation Framework (L2) Performance reports through power BI and Committee reports (L2) PTHB/HDUHB LTA/CQPR	Patient Experience Report - every Board (May24) Healthcare Contracting Update - SRC (Aug22) QIA - QSEC (Oct 23) Quality and Commissioning Update - QSEC (Oct 23)	N		

				External reports (HIW, HSE, MWWFRS, Peer Reviews, etc) Mortality Reviews and Medical Examiners Service National Accreditation Standards for service specifications 6 Domains as noted in the Duty of Quality Act (STEEEP) PROMS and PREMs in identified services Directorate and Service Quality Governance Meetings established Directorate Improving Together Sessions Increased quality element of commissioned services from external organisations Harms Dashboard and our Performance Dashboard in place to facilitate triangulation of data with other intelligence, eg weekly hot and happening meetings. Quality Impact Assessments process now in place Quality Management System now in place Increased use of AMAT across the Health Board to track the implementation of recommendations raised.					Meeting and Hywel Dda & SBU (SLA & LTA) Meetings to review quality aspects from commissioning arrangements (L2) Commissioning arrangements overseen by Sustainable Resources Committee (SRC) (L2) GIRFT Reports reported to QSEC (L2) Quality Impact Assessments and Panel (L2) HIW patient complaints (L3) Quality Governance Follow up Report (Oct21) (L3) Annual Structured Assessments by Audit Wales (L3) Internal audit on Safety Indicators (Reasonable Assurance (L3) Internal Audit plans which include reviewing Quality Governance (L3)				

1184	1. Putting people at the heart of everything we do	Measuring how we improve patient and workforce experience	Daniel, Sharon	Central Communication Hub in place with workstreams established supporting 27 operational teams in communicating with patients Central Communication Hub lead appointed Civica system capturing feedback from patients implemented, with signficant roll out across services Change mechanisms established through improvement and transformation programmes with direct impact on how clinical services are structured liked to CSP Organisational Development Relationship Managers to influence the culture change journey and support the creation of transformational and compassionate culture within the Health Board, and actively work with services Methodology to manage change with services to facilitate clinical engagement and pace of delivery (Engagement Team, Quality Improvement Team and	Finance inc. claims	2×4=8	2×2=4	See Our Outcomes section of BAF Dashboard	Pulse surveys sampling 1000 employees each month, selecting different staff each month (L1) Communication Hub and WLSP Steering Group overseeing delivery of the plan and the workstreams (L2) Improving Together performance sessions with clinical and corporate directorates aligned to the Internal Escalation Framework (L2) Formal Executive Team review and triangulate data from the Harms Dashboard, Our Performance Dashboards and other intelligence (L2) Communication Hub Steering Group (L2) Executive Team, through its reporting groups, oversee	Single Point of Contact Report - Board (Mar21) Patient Experience Report - every Board (May24) Periodic update reports to Executive Team on the impact of the Communication Hub and WLSP Staff Feedback Reports - PODCC QIA reported to QSEC (Sep23)	Y		

				Transformation Team) underpinned by the Safe Care Collaborative and 6 Goals Urgent and Emergency Care programme of work Waiting List Support Programme (WLSP) Plan with workstreams established to support continued engagement with clinical staff and services following the National 3 Ps policy and directly supporting patients on waiting lists WLSP Phased Iterative Implementation Plan which is regularly reviewed Ongoing evaluation of WLSP now in place following initial evaluation to inform programme development Power BI Performance dashboards on IRIS Engagement in place with Llais Cymru (formal and informal arrangements in place) Staff Partnership Forum (UHB and County Partnership Forums) Mechanism in place to ensure charitable funding applications demonstrate impact					delivery of Planning Objectives (L2) Board Committee oversight of Planning Objectives (L2) Patient Experience Report to every Board (L2) Listening and Learning Sub Committee oversight of patient experience (L2) Periodic reporting of engagement index survey results to People, OD and Culture Committee and Board (from Nov21) (L2) Public Service Ombudsman for Wales Reports (L3) HIW Inspection Reports and Complaints, including implementation of recommendations(L3)				

funding applications demonstrate impact through agreed evaluation and metrics

Engagement Team facilitate stakeholder events to capture population feedback on consultations and key workstreams

Harms Dashboard and our Performance Dashboard in place to facilitate triangulation of data with other intelligence, eg weekly quality intelligence / surveillance meetings

Health Board wide Improving Together Sessions in place, which utilise dashboards

Staff Surveys and Pulse Surveys undertaken regularly to evaluate staff experience, and reported to People, Organisational Development and Culture Committee

Quality Impact Assessments introduced and reported to Quality, Safety and Experience Committee

1200	6. Sustainable use of resources	Maximising social value	Thomas, Huw -	Health Board active participation within the Public Service Boards across Hywel Dda UHB region. Local Needs Analysis has been completed based on the Wellbeing Goals. A Social Value framework has been developed with strands in workforce, facilities and estates, procurement. Decarbonisation plan in place, with its own risk assessment. Annual carbon reporting underway to WG.	Health Equity	2×3=6	2×3=6	Local expenditure is a key measure which is being tracked through the 'Our performance' dashboard.	Delivery of Planning Objectives overseen by Executive Team, and its supporting structure, and Board Committees (L2) Board meetings to consider the outcome measure (Our positive impact on society is maximised) (L2) Local measures are in place and used within the procurement space to ensure that decisions consider social value implications. (L2)	Social Value Workshop - SEG (Oct21) Social Value Workshop - SRC (Dec21) Public value action plan (004) (May23) Public Values Framework strategy (June23)	N		

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

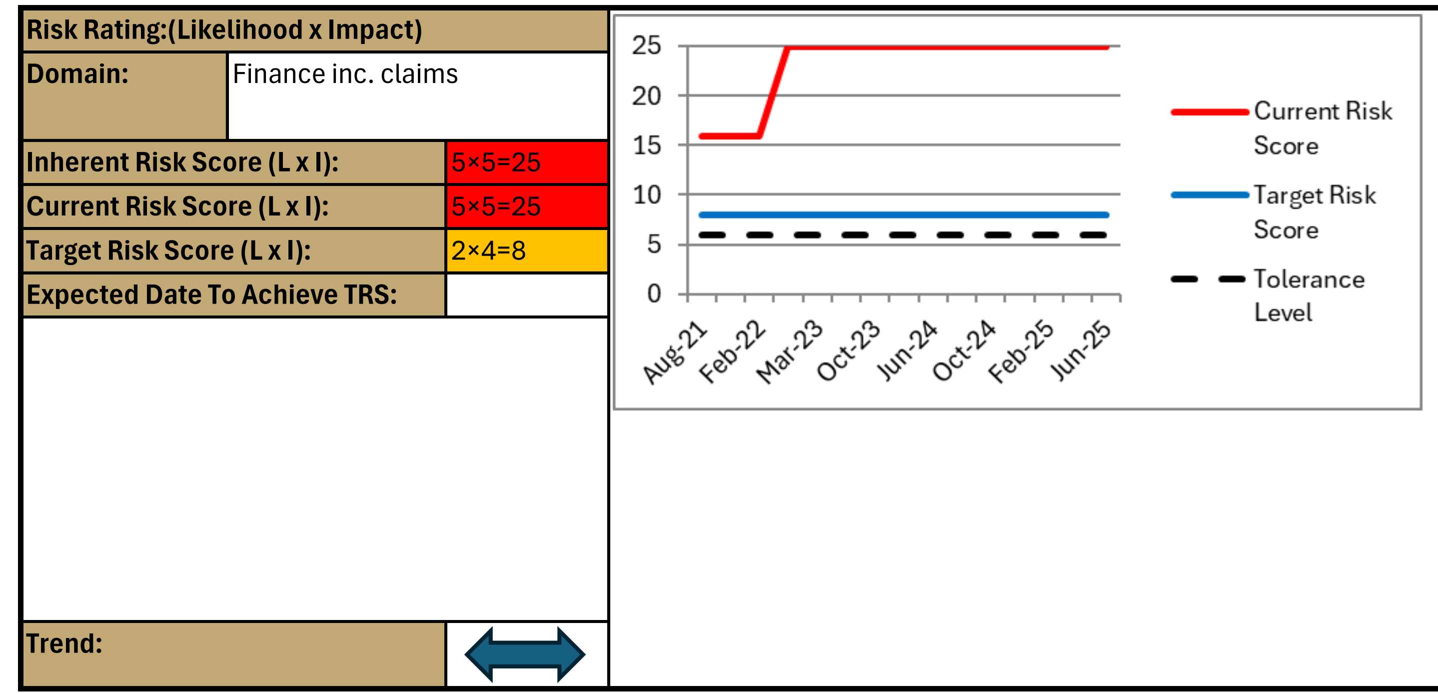
Key - Assurance Required	*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*
[Blue] Detailed review of relevant information	
[Pink] Medium level review	
[Purple] Cursory or narrow scope of review	

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

Date Risk Identified:	Jun-21	Executive Director Owner:	Thomas, Huw -	Date of Review:	May-25
Strategic Objective:	6. Sustainable use of resources	Lead Committee:	Finance and Performance Committee	Date of Next Review:	Jul-25

Risk ID:	1199	Principal Risk Description:	There is a risk that the Health Board does not develop or deliver a credible plan to achieve financial sustainability, or undertake the necessary actions identified in that plan. This is caused by insufficient identification of deliverable savings schemes; non-delivery of agreed savings schemes; change programmes not sufficiently resourced or well-managed; or changes made to services which do not result in financial benefits as they address unmet demand or have unintended consequences. Our financial performance - coupled with insufficient emphasis on planning - has led to the Health Board being placed into the "Targeted Intervention" category of NHS Wales Escalation and Intervention Arrangements. This could lead to an impact/affect on potential reputational impacts, as well as lead to consequences for retention of the workforce, staff morale, poor patient experience and poorer value healthcare with a reduction of confidence from our stakeholders.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	5×5=25
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	
Trend:	⟷



Rationale for CURRENT Risk Score:

Issues have been raised over the ability of the Health Board to plan at a strategic and operational level for a number of years. The Health Board's performance over the last year has demonstrated a significant improvement in the ability to operationally plan and a developing maturity within the organisation. However, the Health Board's financial deficit has significantly deteriorated; significant workforce constraints remain; and the planning function remains small with significant opportunities to develop. These issues are exacerbated given the Health Board's financial deficit, with the need to not only shift resources to more appropriate settings, but provide care at considerably lower cost. The Health Board's underlying deficit is now well understood and articulated, with clear decisions tracked that have been made by budget holders that exceed their delegated limits.

The underlying deficit remains a significant concern with a recurrent delivery gap, which will adversely impact future planning cycles, moving the health board further away from the target control total expectations of Welsh Government.

The significant underlying financial deficit in the current and future years is likely to result in the Health Board being unable to meet its cash obligations as they fall due and presents a going concern risk. Early indications from WG is that the WG are unable to support both the revenue and cash implications. With the Health Board reporting a significant in-year and recurrent underlying deficit, WG initially escalated the Health Board into Targeted Intervention during October 2022, on the grounds of planning and financial performance, however in January 2024, the whole organisation was escalated into targeted intervention. The recurrent funding position confirmed by WG leaves a significant gap based upon draft iterations of the financial plan, with strategic and operational changes required in an attempt to erode the financial deficit.

Rationale for TARGET Risk Score:

Achieving financial balance on a three-year rolling basis is a statutory requirement for the Board, and a clear requirement from the Board and Welsh Government. Strategic and operational planning in an integrated Health Board is inherently complex leading to potential disconnections between demand, operational capacity planning; workforce planning and financial planning. Given the challenge in delivering the savings required over a number of years, and the implications of this in the medium term, it is unlikely that the Health Board will achieve a risk which is in line with the tolerable risk for the year. Consequently, the target risk score exceeds the tolerable risk at this point. This is not an acceptable position, and further work is ongoing to manage this risk.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
Considerable business intelligence available on where our expenditure differs from the rest of Wales - eg comparisons at service, site and condition level to understand in detail where we utilise resources, and identify opportunities to change the way we deliver services Long term financial model - with a view to crafting a long term strategic financial plan - currently being constructed, setting out key actions and policy / operational changes necessary to become more financially sustainable A Planning Steering Group is in place to co-ordinate activities across key corporate functions. Operational grip and control currently being strengthened, through Executive-led groups tackling specific issues eg use of high cost agency staff, transformation of urgent / emergency care etc The Planning Team are embedded within the operational management structures across the organisation. New Executive team governance and escalation structure and reporting groups (Value & Sustainability, A Healthier Mid and West Wales, and Integrated Quality, Finance, and Performance Delivery) to improve financial control and long term sustainability. Oversight provided into ET by the Targeted Intervention Coordination Group. Improving together aligned to an internal escalation framework - a programme to embed a quality management system to ensure consistency of approach in addressing quality and service improvement throughout the organisation. Agile Digital Business Group - a Group which reports into the Finance Committee which scrutinises business cases on digital investment to allow a rapid allocation, allocate resources promptly, learn from previous

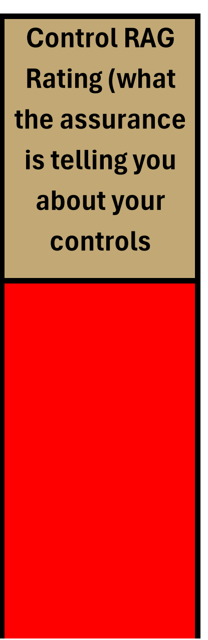
Gaps in CONTROLS				
Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Recovery of planned care activity - coupled with increasing complexity of patients presenting acutely ill - means that there is a lack of focus and ambition across the organisation on ensuring we live within the financial and staffing resources available. Conversion of the Opportunities Framework, Savings Framework and Value for Money Framework into deliverable recurrent savings schemes is not apparent. Focus from TI is on in-year recovery, and at best consideration of the next 12 months financial performance; development of a long term strategic plan would help move to a more strategic approach to managing resources. Two TI actions that remain in-progress are highlighted by WG as organisational challenges to ensure clear plans and delivery mechanisms are in place, monitoring and reviewing actions, to ensure financial challenges are mitigated, coupled with the balance on service. safety and quality.	To achieve workforce sustainability through the delivery of workforce planning, recruitment, retention, and development, and effectiveness initiatives. 1.Develop a Workforce Plan which sets out actions to achieve a balance between workforce demand and supply, supporting workforce stabilisation. 2. Delivery of a targeted Recruitment Plan which will reduce reliance on high cost agency staff through substantive recruitment (supply-side) supporting the Workforce Plan. 3. Delivery of a Retention Plan to support the supply-side elements of the Workforce Plan and underpin workforce stabilisation. 4.Delivery of a Workforce Education and Development Plan which supports the pipeline (supply-side) for staff progression. (PO 1)	Gostling, Lisa	31/03/2025	On track as per highlight report presented to PODCC in May 2025.
	To oversee financial recovery and develop a long term financial route map (PO2)	Thomas, Huw -	~~31/03/2025~~ 01/10/2025	On track as per highlight report presented to FPC in June 2025. Whilst the Roadmap had been developed, a refresh is being taken to a Board Seminar in September 2025 to gain further input and align it to clinical and operational plans in readiness for the 2026/27 planning cycle.

business case implementations and disinvest if appropriate.

Value Based Health and Care Group: which ensures that the Health Board's rollout and deployment of VBHC is in line with plans and will facilitate the shift of resources over time.

Transforming Urgent and Emergency Care (TUEC) Programme - TUEC / Implement the Six Goals To develop and implement a plan to by March 2024 to deliver Ministerial priorities by 2026 1. Delivery and Implementation of a 24/7 Urgent Care Service, accessible via 111 Wales, to support improved access and GMS sustainability. 2. Implementation of Same Day Emergency Care services /direct access pathways. 3. Improving patient flow through the acute sites. 4. Develop a strategy for our Alternative Care Provision to support care closer to home. 5. Minimise delays in hospital discharge due to assessment-related issues within Pathways of Care. 6. Improve the effectiveness and efficiency of community services, with an emphasis on avoiding unnecessary hospital admissions and facilitating timely discharges. (PO 3)	Carruthers, Andrew	31/03/2025	On track as per highlight report presented to FPC in June 2025.
Improve Planned Care and Cancer performance, with a focus on reducing the longest waits, and reduce the 8 week wait for diagnostics. (PO4)	Carruthers, Andrew	31/03/2025	Behind as per highlight report presented to FPC in June 2025.
Mental Health and Learning Disabilities service improvement though: 1. Mental Health Recovery Programme Optimisation 2. Section 136 3. Redesign the End-to-End Inpatient and Community Pathway (PO 5)	Carruthers, Andrew	31/03/2025	On track as per highlight report presented to FPC in June 2025.
To provide a set of plans for key clinical services to address critical sustainability risks up to the future hospital network. (PO 6)	Davies, Lee	31/03/2025	On track as per highlight report presented to SPC in June 2025.
Develop a Primary Care and Community Strategy which is inclusive of: - Enhancement of Primary Care Services - Integration of Technological Solutions - Workforce Development - Infrastructure and Estate Development - Alignment with Community Services (PO 7)	Paterson, Jill	31/03/2025	On track as per highlight report presented to SPC in June 2025.

		Progress against Business Case process for Implementation of A Healthier Mid and West Wales Strategy & Estates Rationalisation - Modernisation and rationalisation scheme year 1-4 implementation (PO 8)	Davies, Lee	31/03/2025	Behind schedule as per highlight report presented to SPC in June 2025.
		Implement the Digital Strategic Plan A. To appoint a Commercial Transformation Partner arrangement to support with the implementation of large-scale digital transformation projects across the Health Board and the region B. To work with WG to secure funding for the roll-out of ePMA, and a patient flow and e-observation system. C. To implement the following key system developments: 1. Welsh Intensive Care Information System, 2. PROMs and PREMs system & 3. Hybrid print and post. D. To ensure that future planning is progressed for the following key system developments: 1. Re-procurement of the Laboratory Information Management System, 2. The Integrated Eye Care Electronic Health Record, 3. Development of a Community Information System & 4. Development of Maternity and Paediatric record systems. (PO 9)	Thomas, Huw -	31/03/2025	Complete as per highlight report presented to DDIC in April 2025.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
See Our Outcomes section on the BAF Dashboard Operational agreement to underlying deficit assessment.	Analysts engaged and have produced a bed opportunity analysis with consistent conclusions to the internal work	1st			Annual Plan Update 2024/25 - SRC & Board Seminar (Feb24) Developing a roadmap to	None identified.				

Welsh Government accept and approved Integrated Medium Term Plan (IMTP). Plan in place to develop a long-term financial plan. High level financial assessment of A Healthier Mid and West Wales in place.	Financial Reporting to Sustainable Resources Committee	2nd			financial balance - SRC (Jun23) Medium term financial strategy- Board Seminar (Jun23) Annual Plan Update 2024/25 - Board Seminar (Feb24) Financial Strategy and Roadmap Update 2025/26 - SRC (Dec25) Annual Plan and Strategy Update 2025/26 - Board Seminar (Feb25) Annual Plan and Strategy Update 2025/26 - SRC (Feb25)					
	Integrated Quality, Finance, Performance and Delivery Group (reporting to Executive Team) oversee in-year delivery of financial performance and savings delivery	2nd								
	Value and Sustainability Group (reporting to Executive Team) oversees opportunities which inform medium term financial roadmap	2nd								
	Planning Objectives overseen by Sustainable Resources Committee	2nd								
	Structured Assessment 2023	3rd								

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Jul-25	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score
2086	Risk that the cash consequences of the Health Board deficit cannot be covered by WG should it exceed our Target Control Total	Thomas, Huw -	Finance inc. claims	**4×5=20**	**4×5=20**	→	**3×4=12**	31/10/2025
1350	Risk of not meeting the 80% SCP waiting times target for March 2026 due to diagnostics capacity and delays at tertiary centre	Carruthers, Andrew	Quality/Complaints/Audit	**4×4=16**	**4×4=16**	→	**2×4=8**	31/03/2026
2104	Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 25/26 due to demand exceeding capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	NA	**3×4=12**	New risk	**3×3=9**	30/09/2025

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.

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		*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*
(blue)	Detailed review of relevant information	
(pink)	Medium level review	
(purple)	Cursory or narrow scope of review	

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

Date Risk Identified:	Apr-25
Strategic Objective:	6. Sustainable use of resources

Executive Director Owner:	Thomas, Huw -	**Date of Review:**	Aug-25
Lead Committee:	Finance and Performance Committee	**Date of Next Review:**	Sep-25

Risk ID: **2086**

Corporate Risk Description:

There is a risk that Welsh Government are unable to fund the cash consequences of our deficit should it exceed our Target Control Total (TCT) of £24m, which is the level indicated of cash coverage available.

This is caused by the Health Board's potential inability to achieve its required total savings of £52m for 2025/26 due to
1. insufficient conversion of the £19m operational and clinical determined recurrent savings plans into deliverable actions
2. insufficient conversion of required £31m non-recurrent savings into budgets in the year
3. the requirement to deliver further £2m of savings to address the Health Board's National Insurance shortfall
4. the requirement to reduce investments by £1.5m

This could lead to an impact/affect on our ability to meet our statutory targets, but exceeding the TCT would also mean that:
1.We will have insufficient cash available to make payments to suppliers in March 2026;
2.We will have to take actions which may have a detrimental impact on our performance measures, and may mean patients having to wait longer for care;
3.Our reputation with Welsh Government and other stakeholders is adversely affected;
4.Further escalation for finance from Targeted Intervention to Special Measures;
5.Our conditionally-recurrent funding of £26.0m being withdrawn by Welsh Government, impacting our ability to reach a sustainable medium term financial position.

Does this risk link to any Directorate (operational) risks? 1719, 1906, 1892, 1854, 1631, 1544, 1530, 975, [illegible]

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
Expected Date To Achieve TRS:	31/10/2025
Trend:	*New risk*

Rationale for CURRENT Risk Score:

The Board endorsed and approved the submission of the annual plan to Welsh Government in March 25, noting that the financial plan doesn't deliver against our statutory requirement to break-even. It recognised that the forecast financial outturn remained in-line with the target control total (TCT) set by WG of £31.5m, but a worsening position compared to the 2024/25 financial outturn. This followed a period of scrutiny through the Sustainable Resources Committee, Board Seminar and Public Board meetings.

Correspondence received from WG during Q1 of 2025/26 confirmed that our plan is not supportable, with a revised and clear requirement to achieve a TCT of £24m. The focus is therefore:
1. To improve the assurance over recurrent and non-recurrent savings delivery to achieve the original plan of £31.5m, and the now revised annual plan of £30.0m;
2. To take choices to reduce the position further to £24m. This requires actions to be taken over August and September for a Board Seminar in September 2025 and submit our actions for improvement to Welsh Government by 11 September.

As at Month 4 2025/26, savings identification was at £26.9m, with some operational cost pressures arising from medical staffing, the management of LTAs and Clinical Services and Supplies within Planned Care and Hospital sites.

Rationale for TARGET Risk Score:

The Health Board had a historic challenge of controlling its cost base and delivering change. While significant improvements have been made to our control environment, significant challenges remain in our change management capabilities. These need to be addressed to achieve the target risk score.

By 11 September 2025, the Executive Team are seeking to de-risk the financial plan to ensure its successful delivery. It is at this date we would envisage the current risk score being reduced to 16 if the savings gap has been materially closed with robust and deliverable schemes.

By 31 October 2025, the Executive Team are seeking to have fully de-risked the financial plan to ensure its successful delivery, in order to allow the organisation to focus on planning for delivery of the medium term financial roadmap into 2026/27.

Key CONTROLS Currently in Place:
(The existing controls and processes in place to manage the risk)

1.Working Day 1 principles adopted within the finance function to ensure timely 'Flash reports' provided to the Executive Team.
2.Timely, relevant and understandable reporting provided to budget managers, Executives, Committees, Board and Welsh Government. This will be available live for self-service budget holders via QlikSense and monthly for management information packs.
3.Oversight arrangements in place through Integrated Quality, Financial Performance and Delivery Group, Value and Sustainability Group and the Healthier Mid and West Wales Group.
4.Executive Improving Together meetings and the Escalation Framework embedded across the organisation, which focuses on seven key domains, including Finance as one.
5.Financial Control Sub Group weekly scrutiny of agency medical, agency AHP, Admin and Clerical and newly created roles for recruitment and procurement.
6.Opportunities framework in place to identify areas of improvement potential across the Health Board, updated and shared monthly.
7.New operational structures in place since April 2025, providing managerial clarity and consistency that was not in place in historically.

Gaps in CONTROLS

Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
There remain areas where there are gaps in controls. These are: 1. The effective management of rostering; 2. The effective management of beds; 3. Effective contract management arrangements; 4. Oversight arrangements over commissioned services. There is also a significant gap in the organisation's ability to deliver change.	The implementation of a rostering system across medical staff, and the extension of rostering to other staff groups.	Hill, Carly	~~31/07/2025~~ 30/11/2025	Progress update to be provided at next risk review
	Operational adoption of the new patient flow system across the Health Board.	Tracey, Anthony	31/01/2026	Progress is on plan to roll out by October 2025.
	Agreement and universal implementation of one consistent medical rate card spanning all locations and all services to align the rates of pay paid to staff irrelevant of specific circumstances.	Henwood, Mr Mark	31/01/2026	Progress update to be provided at next risk review
	Agreement and universal implementation of one consistent AHP rate card spanning all locations and all services to align the rates of pay paid to staff irrelevant of specific circumstances.	Severs, James	30/09/2025	Progress update to be provided at next risk review

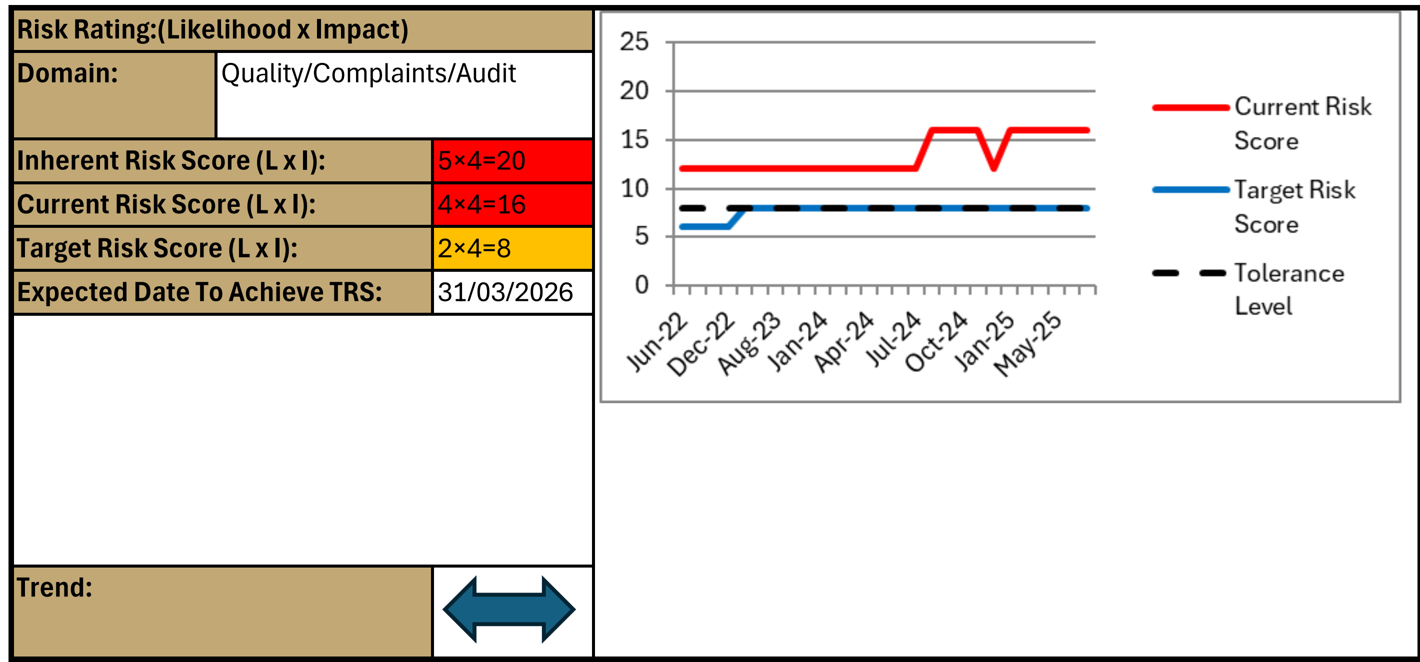
8.Aligned finance support via the Business Controlling team to support, scrutinise and advise CCG/CSG and Executive Function management structures. 9.Accountability agreements issued in March 2025, all signed and returned.		Finalise the implementation of the substantive operational management structure via the ongoing COO OCP, ensuring all audit recommendations are completed and accountability structures are consistently deployed.	Carruthers, Andrew	~~30/06/2025~~ ~~31/07/2025~~ 31/12/2025	Updates to Structured Assessment recommendations raised by Audit Wales have been confirmed as completed in June 2025, and will be submitted to Audit Wales for review in July 2025. Consistent deployment of governance arrangements are monitored via the Health Board's Internal Escalation Framework, and a review of the effectiveness of these arrangements is planned to be undertaken by Internal Audit during Q2/Q3 for evidencing the completion of the further action required. Action date has been revised to reflect the completion of noted internal audit.
		Consideration of the organisation's change management capacity and alignment of change and transformation management resources.	Gostling, Lisa	31/08/2025	Progress update to be provided at next risk review
		Embed a monthly routine within the Clinical Care Group and Executive Functions business meetings for the Compendium of Variation, creating a summary report for inclusion within the Financial Performance Report for Executive Team, Financial and Performance Committee and Board.	Jenkins, Sian	30/09/2025	Progress update to be provided at next risk review
		Further actions and choices to be taken based on discussion at Board in July which could deliver £6m of further savings. This requires QIAs to be delivered by 15 August for F&P consideration in August; a Board Seminar in September and submission to WG by 11 September.	Thomas, Huw	30/09/2025	In order to fully progress this action, input is required from all Executive Leads

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 In-month financial monitoring and forecasting for the remainder of the financial year	Performance against plan monitored through Executive Improving Together Meetings.	1st				Delivery of limited assurance audit reports. Particularly, in areas which have a financial impact: 1. Discharge management; 2. Bed management; 3. Nursing and healthcare support worker roster management. 4. Medical roster management. Delivery of change is a longstanding issue for the Health Board.	Closure of audit recommendations arising from Discharge Management and Management of Bed Capacity internal audits	Carruthers, Andrew	~~31/07/2025~~ 30/09/2025	Follow Up report presented to ARAC in June 2025, with one action outstanding with timescales to be confirmed by Anna Chiffi.
	Finance and Performance Committee oversight of current performance	2nd					Closure of audit recommendations arising from Nursing roster management audit	Daniel, Sharon	~~30/05/2025~~ 31/08/2025	Service have confirmed that all actions have been implemented, and currently awaiting formal approval by internal audit to close. Follow-up audit being presented to ARAC in August 2025.
	Transformation & Financial Report to Board & Finance and Performance Committee	2nd					Determination of change management capacity through alignment of resources across corporate functions.	Gostling, Lisa	31/08/2025	Progress update to be provided at next risk review
	WG scrutiny through revised Monthly Monitoring Returns (specific supplementary templates) and through NHS Exec Financial Planning and Delivery team	3rd								
	Audit Wales Structured Assessment process	3rd								

Date Risk Identified:	Feb-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jul-25
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Finance and Performance Committee	**Date of Next Review:**	Aug-25

Risk ID:	**1350**	**Corporate Risk Description:**	There is a risk of the Health Board not being able to meet the 80% target 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
Expected Date To Achieve TRS:	31/03/2026
Trend:	⟷



Rationale for CURRENT Risk Score:

The service has been de-escalated by Welsh Government from Level 4 to Level 3 in terms of Targeted Intervention status as there has been the consistent achievement of the 60% de-escalation criteria since February 2025. As at June month end, the service achieved 61.4%.

Due to recovery actions within radiology and urology we may see variation in performance as we recover and treat those patients over 62 days, therefore the risk remains that cancer performance will not achieve 80% compliance by March 2026.

Rationale for TARGET Risk Score:

The aim is to treat patients within target waiting times, which has now been confirmed as 80% non-adjusted March 2026.

The tolerance level will be met if plans to increase diagnostic capacity, utilising allocated recovery funding are realised. When the target of 60% for 3 consecutive months is achieved the risk score can be reduced to a 12. The risk score can be further reduced to a 8 once the target of 80% is achieved. There are underpinning trajectories in place which are monitored on a monthly basis and adherence to those will influence the ability to achieve the target risk score.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
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 are using of Quarterly Planning and Monitoring reports developed by the NHS Executive since July 23. This has facilitates the development of targeted improvement plans per tumour site and subsequent weekly monitoring thus providing assurance of the robustness of plans. # Virtual appointments are being undertaken via digital solutions e.g. Attend Anywhere. # Weekly Cancer Operational Delivery Group (ODG) 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 Operational Delivery Group. # 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 Planned Care and Cancer Services QSH meeting to ensure governance in line with the new operational structures implemented in April 2025. # 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 ODG leads and Tumour Site Service Managers for tumour sites that require intervention. # New Endoscopy booking process 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

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**
Anticipated significant gaps/service fragility within key diagnostic services to address required levels of activity to support SCP. Need for the implementation of new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways.	Work with multidisciplinary team to reallocate FIT pathway to primary care in line with NOP and rest of Wales	Humphrey, Lisa	~~30/06/2025~~ 30/09/2025	Planning complete, moved to implementation/working with Primary care
	Establish accelerated Neck lump pathway to reduce diagnostic pathway	Lewis, Caroline	~~31/12/2024~~ 31/10/2025	To be implemented as part of the agreed Radiology investment 25/26
	Work with NHSE to review referral rates and patterns within primary care to reduce and refine demand to secondary care	Humphrey, Lisa	~~30/06/2025~~ 30/09/2025	Mapping in progress
	Due to increased demand for dermatology treatments the service need to aquire 2 additional MOP Treatment areas	Wisdom, Ceri	Completed	SBAR being presented to the Care Group Board meeting in June.
	Highest volume of patients awaiting Urology diagnostic procedures. Urgent action required to reduce overall volumes and volumes waiting over 28 days.	Griffiths, Neil	Completed	Detailed demand capacity planning to include the RTT component to identify the actual demand capacity gap to inform the options for solution

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 Q1 of 2025/26. # 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. *Additional radiology reporting sessions in place agreed for 2025/26. *Skin treatment recovery plan in place to end June 25 to reduce overall treatment volumes. To be reviewed quarterly.		reduce Urology diagnostic volume by 100 patients by reducing cystoscopy and prostate awaiting MRI	Griffiths, Neil	31/08/2025	in progress

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		
Internal targets - Looking at the performance per tumour site individually that have the biggest impact on overall performance Skin Urology LGI Gynaecology Breast	Daily/weekly/monthly/ monitoring arrangements by management	1st			* Implementation of Single Cancer Pathway Report - BPPAC - Feb20 * COVID-19 Impact on Cancer Services - Board - May20 * Cancer Updated to
	IPAR Performance Report to S&PC & Board	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.	Establish Operational improvement group to track improvement projects in line with NOP and Annual Plans	Goode, Paula	Completed	Plans to establish a Cancer Transformation Task and Finish group which reports into the CCG transformation hub. On hold due to formation of Care Group structure

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	Monthly oversight by NHS Executive/WG	3rd			Updated to QSEAC Jun20 & OpQSESC Jul20 * Risk 633 QSEAC - Feb21 & Aug21 * IPAR Report - Board - Nov22					
	Revised Governance arrangements in place since April 2025 with matters escalated when required via the CCGs governance arrangement									

Date Risk Identified:	Apr-25
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jul-25
Lead Committee:	Finance and Performance Committee	Date of Next Review:	Sep-25

Risk ID:	2104	Corporate Risk Description:	There is a risk of non-delivery of planned care ministerial targets by March 2026. 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 2025/26, which limits the amount of recovery funding agreed by the Board to ensure full achievement of the respective ministerial delivery targets (No patients waiting over 52 weeks for their first outpatient appointment and no patients waiting over 2 years from referral to treatment). 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?			

Risk Rating:(Likelihood x Impact)		No trend information available.
Domain:	Safety - Patient, Staff or Public	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	3×4=12	
Target Risk Score (L x I):	3×3=9	
Expected Date To Achieve TRS:	30/09/2025	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:
The combined impact of cohort demand in key specialties and workforce limitations all pose a risk to full achievement of ministerial planned care recovery targets by March 2026. Additionally, Theatre cancellations due to staff shortages in Glangwili General Hospital have negatively impacted core capacity. Specifically in Orthopaedics there is an additional demand in longer waiting patients (cohort) verses recurrent demand. Recovery funding for 25/26 has been prioritised for areas where high level Demand & Capacity (D&C) modelling identified capacity gaps. The Annual Plan, approved by the Board in March 2025 highlighted delivery risks in Ear, Nose and Throat and Rheumatology (Stage 1) and Ophthalmology, Dermatology, Gynaecology, Urology and Cardiology at S4. The Welsh Government recovery allocation (£2.8m) has been split accordingly to progress delivery solutions in these areas. Sine approval of the annual plan additional risks to delivery have arisen in General and Geriatric medicine. Whilst delivery plans for 2025/26 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 the above 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 in Ophthalmology and Orthopaedics 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 including the utilisation of Neath Port Talbot theatres for Orthopaedic activity. Notwithstanding these delivery risks, breach volumes in respect of the Stage 1 52 weeks are expected to be resolved by March 2026. Forecast breach volumes in respect of the Total Pathway 104 week target remain in Orthopaedics in Q1 although monthly breach performance shows continued improvement after Q2. 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 been scored a 12.

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. The care group propose to be in balance by Q2. Opportunities to make further progress towards the Ministerial targets in 2025/26 will continue to be explored, including exploration of the regional opportunities referred to.

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	# 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	Recommence insourcing / outsourcing solutions in July 2025/26 within Orthopaedics and to remain in place for duration of Q2 2025/26	Humphrey, Lisa	Completed	Agreed start date 1st August 2025
		To establish utilisation of NPT theatres as part of joint regional working	Humphrey, Lisa	31/08/2025	Progress update to be provided at next risk review
		Maximise GIRFT recommendations to increase capacity to four joints per list within Orthopaedics	Gregory, Lianne	30/09/2025	Progress update to be provided at next risk review
		Insource theatre staffing within GGH theatres for four lists ENT, and two lists Ophthalmology to commence in July 2025 and to remain throughout Q2	Humphrey, Lisa	30/09/2025	Progress update to be provided at next risk review
		Outsource tonsilectomies - 43 cases to commence in July 2025 and to remain throughout Q2	Lewis, Caroline	30/09/2025	Progress update to be provided at next risk review
		Outsource ocular plastics within Ophthalmology to commence in July 2025, and to remain throughout Q2	Coppack, Victoria	30/09/2025	Progress update to be provided at next risk review

# 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 established # South West Wales Regional Ophthalmology Programme # 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 (Pre Operative Assessment Clinic) service, enabling improved management of demand and prioritisation of patients to be clinical assessed. # Additional outsource & insource solutions in place to supplement capacity in orthopaedics and ophthalmology.		Q2 recovery actions being pursued to mitigate specialty specific delivery risks in Stage 1 Care of the Elderly (COTE)	Goode, Paula	31/08/2025	Progress update to be provided at next risk review

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
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 2025/26 Monthly performance is reported at each executive meeting, the Finance and Performance Committee and WG IPQD. Various Theatre papers have been to Board for discussion.	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								

Finance and Performance Risk Register

Date: July 2025

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Date expected to achieve target risk score	Detailed Risk Decision	Review date
975	Estates & Facilities	Estates & Facilities	E&F: Directorate Team	Severs, James	Chiffi, Simon	Chiffi, Simon	Chiffi, Simon	01-May-20	There is a risk of that the Estates & Facilities Clinical Care Group will be unable to achieve the required financial target savings in year. This is caused by 1. Inability to identify and deliver robust and realistic recurrent savings plans. 2. Inability to manage the impact on the underlying deficit of resulting non-delivery of the recurrent savings requirement. 3. Inability to identify and implement opportunities in such a way that the financial gains are realised and an improvement trajectory is achieved. 4. Identify and manage or mitigate cost pressures that threaten the Directorates position for the year, driven by the age of the estate and continual improvements to cleaning standards requirements, additional revenue due to RAAC issues. 5. From other related inflationary factors affecting budgets (external costs). 6. Ongoing resource pressures in Facilities. 7. Wider HB financial pressures and greater scrutiny of spend. This will lead to an impact/affect on a significant long term detrimental impact on the Health Board's financial sustainability and service deliverability. Risk location, Health Board wide.	Finance Business Partners work closely with budget holders to support informed decision making and ensure that there is sufficient focus on the financial implications of operational pressures and mitigating actions. The monthly finance cycle reviews the movement in month and forecasts the remainder of the year, ensuring the Health Board has regular updates on the Directorates financial position. Monthly establishments reviews within the service to ensure pay position is understood and actions are taking promptly, supported by Finance colleagues where appropriate. Care Group meetings now established where all service leads attend to ensure more scrutiny on financial positions and discuss potential savings strategies. The establishment of the care groups with greater emphasis on financial scrutiny will help to support financial stability over time.	Finance inc. claims	4	5	20	Key drivers include RAAC, maintenance overspend and provision cost increases. Maintenance overspend will be the focus of the Monthly establishments reviews going forward. The Directorate, Finance Business Partners and other supporting functions will enhance cost analysis cost review process and put controls into place to better understand and manage costs on an ongoing basis. Nature of aging estate means that dynamic failures are happening on a week by week basis therefore increasing non pay unforeseen overspend. Increase in statutory obligations faced by the Department.	Budget holders to work closely with finance Business Control colleagues to support informed decision making and ensure that there is sufficient focus on the financial implications of operational pressures and mitigating actions	Chiffi, Simon	~~31/08/2024~~ ~~30/11/2024~~ ~~31/03/2025~~ 30/09/2025	This is a key focus as part of new care group establishments.	Finance and Performance Committee	2	5	10	Discussed at meeting of 22nd July - SC to consider and update at next review.	31/03/2026	Treat	22-Jul-25

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Date expected to achieve target risk score	Detailed Risk Decision	Review date
1631	Operational Allied Health Professions & Health Sciences	Allied Health Professions and Health Sciences	Allied Health Professions and Health Sciences	Carruthers, Andrew	Quarrie, Sara	Quarrie, Sara	Quarrie, Sara	28-Mar-23	There is a risk of that the obligations of the Delegation of budget manager responsibilities for the 2025/26 financial year will not be achieved This is caused by Inadequate budget to meet organisational demands and increasing unit cost prices / SLA costs This will lead to an impact/affect on Clinical Governance - Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints/ independent review. Low achievement of performance/delivery requirements. Critical report. Workforce - Late delivery of key objective/ service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training. Finance - Non-delivery of key objective/ Loss of >1 per cent of budget Reputational Risk location, Health Board wide.	Budget holder 1-1 meetings with finance team (monthly) Forecast meetings monthly with CCG leadership and Finance CCG led finance meeting with finance team and each budget holder (monthly) CCG FCG weekly (vacancy control admin and new roles) Formally clarifying and escalation of cost pressures to executives via iQFPDG	Finance inc. claims	4	5	20	Finance - Non-delivery of key objective/ Loss of >1 per cent of budget (5). Likelihood / Probability - 75-95% (4)	Ensure that all requests relating to additional resource expenditure or allocation by budget holders are presented to and agreed at Therapy Operational Group with management team including workforce and finance colleagues	Reed, Lance	Completed	Process established at Therapy Operational Group 18.04.23. Introduction of Financial control total process within departments and therapy operational group following Financial Control Total letter from CEO	Finance and Performance Committee	3	5	15	Finance - Non-delivery of key objective/ Loss of >1 per cent of budget (5). Likelihood / Probability - 25-75% (3)	31/03/2026	Treat	11-Jul-25
																There is a financial risk associated with claims due to malpractice, failure to provide or poor care provision. All agreed claims with known financial impact to be discussed at Therapy QSEAR meeting and learning disseminated	Reed, Lance	Completed	All agreed claims with known financial impact to be discussed at Therapy QSEAR meeting and learning disseminated								
																Risk of delivering our financial control total and required savings plans	Bradburn, Jo	Completed	Draft financial savings plan in place, predicated upon budget holders delivering cash releasing recurring efficiencies against existing budgets, primarily via workforce redesign								
																Risk to be redrafted with guidance from FBP to align with new CCG structure.	Quarrie, Sara	Completed	Meeting to be scheduled to redraft new risk. Updated risk.								
																M4 saving meetings with each HoS to identify further mitigation for cost pressures and savings.	Quarrie, Sara	Completed	04/07/2025 - New action 11.07.2025 - M4 meetings completed.								
																Demand and capacity service review Podiatry	Mulroy, Mike	30/09/2025	11/07/2025 - New action								
																M5 saving meetings with each HoS to identify further mitigation for cost pressures and savings.	Quarrie, Sara	29/08/2025	11/07 - New action								

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Date expected to achieve target risk score	Detailed Risk Decision	Review date
2110	Community & Integrated Medicine	Carmarthenshire Integrated System	Carmarthenshire Integrated System	Carruthers, Andrew	Skitt, Peter	Perry, Sarah	Perry, Sarah	10-Jul-25	There is a risk of of Carmarthenshire Integrated System will be unable to achieve the financial target savings for 25/26. This is caused by being unable to identify the full savings as a result of requiring significant, strategic change required across the whole Clinical Care Groups. This will lead to an impact/affect on the Health Board's overall financial position and ability to adhere to our financial plan. Health Board remaining in Targeted Intervention (TI). Risk location, Carmarthenshire.	Finance team work closely with budget holders to support informed decision making and ensure that there is sufficient focus on the financial implications of operational pressures and mitigating actions. Clinical Care Group Financial Control Group in place which scrutinises all new and replacement posts. Monthly Business and Performance meetings to review financial outturns and sign-off of the year-end Forecast, with the Finance Business Controller, focusing on mitigating actions and consequence to reduce spend. Opportunities Framework, refreshed to identify alternative ways of working that may result in cost reductions/formal savings schemes identified. Monthly financial scrutiny meetings with senior nurses in order to gain assurance over budget management and scrutinise variable pay. Variable Pay weekly scrutiny meetings and monthly Variable Pay analysis meeting chaired by the Hospital Director.	Finance inc. claims	4	5	20	Risk remains extreme due to continued use of variable pay, locum and agency use due to workforce gaps, medical recruitment and continued surge and overcrowding in some key clinical areas such as Emergency Dept (ED). The system requires time to realise and deliver the savings due to strategic, high-level decisions to be made. The HEIW GGH June 2025 report highlighted additional doctors required to manage the workload and linked to risk to 2089 (risk of losing deanery doctors).	Annual plan to be revised with external scrutiny to the CCG.	Bancroft, Stuart	31/07/2025	In progress	Finance and Performance Committee	4	4	16	The system requires time to realise and deliver the savings due to strategic, high-level decisions to be made. Whilst the system is required to realise savings it must balance this with patient safety and quality of services, and other requirements of TI. Target date of October 2025 aligned with the next Executive Improving Together Sessions (EITS).	31/10/2025	Treat	10-Jul-25
																Communication of newly agreed rate card for Junior Doctors	Bancroft, Stuart	31/07/2025	In progress								
																Complete action plan response raised from the HEIW GGH June 2025 report.	Bancroft, Stuart	31/07/2025	To be updated at next review								

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Date expected to achieve target risk score	Detailed Risk Decision	Review date
2107	Operational Allied Health Professions & Health Sciences	AHP&HS: Physiotherapy	AHP&HS: Physiotherapy	Carruthers, Andrew	Quarrie, Sara	Davies, John	Davies, John	09-Jul-25	There is a risk of There is a risk of physiotherapy budget overspend. This is estimated to be £100,000 per year which constitutes on call availability payments , hours worked, travel claims. This is caused by This is caused by the unfunded service delivery of four Emergency respiratory on call services at all 4 DGH sites. This will lead to an impact/affect on This could lead to insufficient financial recovery or if no funding is sourced. There is likely to be reduction in waiting times recovery in planned care msk, paediatrics, lymphoedema and community services, if Mon-Fri core budget is utilised to fund out of hours emergency services. Risk location, Health Board wide.	on call costs are minimised through the development of highly skilled staff second on call rotas are only implemented when workload is exceptional and this is approved by senior physiotherapy managers. on call claims are scrutinised by respiratory and service leads. trends in inappropriate call outs are identified and wards / individuals are educated on appropriate inclusion criteria for the service. twilight shifts are in place in GGH to reduce call out rates as staff are on site in the early evening. work undertaken is now only urgent respiratory work that cannot be left until the next working day. work is underway to explore merging rotas in Carmarthenshire which may reduce costs slightly.	Finance inc. claims	4	4	16	Physiotherapy is currently overspent with an predicted end of year overspend if funding is not received to deliver on 4 on call rotas. Absorbing these costs within the budget will result in further risks to planned care capacity It is not clinically viable to withdraw on call services as this service maintains life.					Finance and Performance Committee	2	1	2	There will be no financial / clinical or quality risks for the physiotherapy service if the on-call rotas are fully funded	31/03/2026	Treat	09-Jul-25

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971	Mental Health and Learning Disabilities	Mental Health and Learning Disabilities	MHLD	Carruthers, Andrew	Carroll, Mrs Liz	Carroll, Mrs Liz	Carroll, Mrs Liz	01-May-20	There is a risk of the MH&LD Directorate failing to remain within their allocated budget over the medium term. This is caused by the inability to either: Identify and deliver robust and realistic recurrent savings plans. Manage the impact on the underlying deficit of resulting non-delivery of the recurrent savings requirement. Identify and implement opportunities in such a way that the financial gains are realised and an improvement trajectory is achieved. This will lead to an impact/affect on a significant long term detrimental impact on the Health Board's financial sustainability. Risk location, Health Board wide.	Finance Business Partners work closely with budget holders to support informed decision making and ensure that there is sufficient focus on the financial implications of operational pressures and mitigating actions. There are regular financial reviews where this risk is considered, including a monthly financial review of the Directorate's in-month performance, a monthly update of our full year annual forecast and an annual update of our following year financial plan. Risk Register is a standing agenda item at BP&PAG on a bi-monthly basis. End of month meeting with Directorate Finance Business Partner, KPI meetings and individual Head of Service meetings are also forums for monitoring the position and informing and managing the forecast. Mechanism in place to draw down funding to service cost codes inline with original bids. Weekly key performance meetings in place for areas working outside of allocated budgets in collaboration with Senior Finance Business Partner. MHLD is in Escalation for Finance due to the lack of a 6.5% recurrent savings plan. Directorate are meeting weekly to progress plans. Directorate also attend Health Boards Integrated Quality Financial Performance Delivery Group (IQFPDG).	Finance inc. claims	4	4	16	As at June 2025, the Clinical Care Group are only able to provide a work in progress figure for the end of year forecast as Finance Colleagues are in the process of finalising this by 5th June 2025. Presently, this is estimated to be a Â£487,000 overspend. The Clinical Care Group will endeavour to work towards a break even position whilst also looking at further non recurrent/recurrent saving opportunities.	Leon Popham to review impact of CHC uplift reserve on position and determine treatment and risk level on an ongoing basis.	Popham, Leon	Completed	Review undertaken as part of ongoing budget processes. While action unresolved, this will be picked up as part of the new action noted for the risk in September 2023.	Finance and Performance Committee	1	3	3	Working towards a position where 6.5% savings are identified and to remain within budget.	31/03/2026	Treat	10-Jul-25
																To provide an update for Executive Team to clarify the budget setting process and allocation for FY 2024/25.	Carroll, Mrs Liz	Completed	CHC overspend neutralised for 2024/25 allocation through £1.9M uplift relating to 2022/23 and operational driver funding remaining pressure. Directorate have undertaken to identify £2.6M of non-recurrent savings for 2024/25 for underspend in pay position, with a view of identifying recurrent saving 2025/26.								
																Following Executive Director led recovery workshops on the 26th of July and the 9th of August the Directorate were tasked to consider the impact on services should variable pay be eliminated. The ask also involved service reconfiguration on this basis.	Carroll, Mrs Liz	~~29/03/2024~~ ~~30/09/2024~~ ~~31/12/2024~~ ~~31/03/2025~~ ~~31/07/2025~~ 31/03/2026	The CCG continue to work with Corporate services to strengthen Nurse Bank capacity/eliminate spend. Further options being explored through international recruitment for Medical staff. Directorate joined Wales trip to India. Medical staff have reduced overspend in month 7 by £32K, No Ceredigion medical staff, Justification was sort from FCG who signed off Agency medical staff until March 2025, so remains a risk. Additional funding of £2.4m has been allocated with an associated recruitment plan.								
																Work to identify recurrent savings for 25-26 underway. First phase to be transacted by end of February 2025.	Carroll, Mrs Liz	Completed	Completed								

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1892	Operational Allied Health Professions & Health Sciences	AHP&HS: Radiology	AHP&HS: Radiology	Carruthers, Andrew	Quarrie, Sara	Roberts-Davies, Gail	Roberts-Davies, Gail	26-Jul-24	There is a risk of that Radiology will not achieve projected savings targets. This is caused by unidentified savings plans to reduce expenditure in the directorate. This will lead to an impact/affect on the Health Board's overall financial position and ability to adhere to our financial plan. Risk location, Health Board wide.	1. Monthly meetings with Head of Radiology, Site Leads and Finance Business Partner to oversee progress on saving plan workstreams 2. Introduction of 5/5 locum consultants to undertake reporting and emergency duty sessions to reduce outsourcing, via a graded approach of most costly elements of outsourcing, including out of hrs rotas to cover busiest times. 3. Scrutiny of individual budgets by finance and Head of Radiology to capture any erroneous spend 4. All vacancy proposed by sites to be approved by Head of Radiology prior to finance Trac sign off or application for FCG approval as appropriate. 5. Other cost avoidance measures, e.g. increased additional reporting sessions for HB consultants utilised in place of outsourcing at higher cost to maintain and improve quality and performance.	Finance inc. claims	4	4	16	Recurrent and non-recurrent savings were identified, however these did not achieve the 5% expected. The budget position at M12 24-25 for Radiology was Â£92k underspent (provisional figure)with savings of Â£669k achieved. As of 09/04/2025 Radiology investment in workforce has been agreed and is currently subject to case scrutiny by the Executive Team. The Allied Health Professions and Health Sciences CCG has an opening savings position of Â£3.744m to be achieved in 25-26, of this Â£873k is the opening savings target for Radiology.	To review historic charges for Powys patients attending Hywel Dda with a view to arranging an SLA and understand LTA arrangements.	Roberts-Davies, Gail	~~01/01/2025 31/03/2025~~ 31/03/2026	Due to staff availability this has not progressed at the pace intended and will now be completed by March-25. VBHC team are still working on a pricing structure which aligns with that done at other Health Boards across Wales. The VBHC team advised on the 23/12/2024 that they are awaiting information from informatics to progress the work. Informatics are making progress, however the requested information would not be available until the new year. Update from VBHC team as of 11/02/2025: We're currently working with Chris James from Data Development to move this piece of work forward, using the template from AB as a guide as theirs is tried and tested. What we have discovered is that there are some inconsistencies in the data that we hold and in what AB hold. Chris is going to make contact with Sarah Procter as he thinks that with her help, they will be able to clear up the inconsistencies so that we can move this forward. This action will form part of the savings opportunity for the 25/26 financial year and will be progressed via the new CCG structure, therefore timeline extended.	Finance and Performance Committee	3	4	12	Likelihood reduce therefore reduce in score	31/03/2026	Treat	04-Jul-25

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																To scope the feasibility of and any potential savings from changing the current on-call arrangements for Radiographers to a shift system across the four main sites.	Roberts-Davies, Gail	Completed	This is progressing but is very complex so will take longer to deliver. In line with the annual plan, the first step will be to increase the numbers of MRI and CT Radiographers and reporting Radiologists via investment to extend the working day and week to increase capacity and reduce variable pay and improve VFM. Shift systems in these areas is not possible at this time due to the low numbers of existing staff. This action is to be closed as the workforce investment opportunity work supersedes this action which was not able to be progressed due to low staffing numbers. Shift system feasibility is described as part of the 2024/25 annual plan which has been set over a 3 year context								
																Recruit a fourth locum Radiologist to enact the proposed level of savings from reduction in outsourcing	Roberts-Davies, Gail	Completed	Action complete								

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																Explore opportunities for income from dental practices referring for OPT examinations	Roberts-Davies, Gail	~~01/01/2025~~ ~~31/03/2025~~ 31/03/2026	Discussed at TI meeting August 2024 and responded to the collective submission for permission from WG on 21/1/2024. Awaiting feedback following this. Feb 2025 update- GRD has received queries from SN- due to discuss on 26/02/2025. This will be taken forward to the 25/26 financial year and progressed via the new CCG structure.								
																Review charges which constitute the historic SLA with SBUHB for Medical Physics Services to ascertain potential opportunities.	Roberts-Davies, Gail	**Completed**	The review ascertained that historically Radiology have been charged for Medical Physics Support to Theatre and Community Dental Services. This has been since separated out and costs past on to the respective services.								
																To review cardiac catheter consumables and ascertain if less expensive alternatives can be purchased.	Roberts-Davies, Gail	**Completed**	Action complete								
																Provide mitigating actions for the projected EOY overspend at Month 3 of £39.5K	Roberts-Davies, Gail	**Completed**	Mitigating Action was provided to the Monthly Radiology Escalation Meeting								
																To formulate savings scheme plans for the 25/26 financial year	Roberts-Davies, Gail	~~30/06/2025~~ 31/10/2025	Savings plan to be reviewed in September 2025								

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1906	Community & Integrated Medicine	Pembrokeshire Integrated System	Withybush General Hospital: WGH	Carruthers, Andrew	Skitt, Peter	Andrews, Bethan	Johns, Helen	16-Aug-24	There is a risk of that the Directorate will overspend against its delegated budget and declared savings plans. This is caused by Multiple factors including: - Demand exceeding capacity on site, resulting in reliance on nursing agency to staff surge beds - Inability to decrease the numbers in Emergency Department leading to increased Registered Nursing roster filled by agency shifts - High cost Locum cover filling vacant Medical roles - Rising drugs costs, particularly biologics usage. This will lead to an impact/affect on remaining within Statutory Financial Duty in year and the inability to de-escalate from Welsh Government's Target Intervention status. Risk location, Withybush General Hospital.	Finance Business Partners work closely with budget holders to support informed decision making and ensure that there is sufficient focus on the financial implications of operational pressures and mitigating actions. Monthly finance meetings to review financial outturns and sign-off of the year-end Forecast, with the Finance Business Partner, focusing on mitigating actions and consequence to reduce spend. Opportunities Framework, refreshed to identify alternative ways of working that may result in cost reductions/formal savings schemes identified. Monthly financial scrutiny meetings with senior nurses in order to gain assurance over budget management and scrutinise variable pay. Whilst plans are in place to remove more beds (Puffin ward in August) and integrate Internationally Educated Nurses (IENs) and Newly Qualified Nurses (NQN) into the Withybush General Hospital workforce, these will not come into effect until September 2024 with the full effect in the next financial year reducing all ward nursing variable pay.	Finance inc. claims	4	4	16	June 25: Advised by finance to keep risk the same currently. July: Risk remains extreme due to continued use of variable pay, locum and agency use due to workforce gaps, medical recruitment and continued surge and overcrowding in some key clinical areas such as Emergency Dept (ED). The system requires time to realise and deliver the savings due to strategic, high level decisions to be made.	5% reduction in costs of revenue within annual plan.	Andrews, Bethan	~~30/09/2024~~ 31.10.25	ongoing, on plan for the savings.	Finance and Performance Committee	3	4	12	The system requires time to realise and deliver the savings due to strategic, high-level decisions to be made. Whilst the system is required to realise savings must balance this with patient safety and quality of services and other requirements of TI. Target date of October 2025 aligned with the next Executive Improving Together Sessions (EITS)	31/10/2025		29-Jul-25
																reduction of in patient beds by 25 since pre RAAC. Puffin ward now closed	Andrews, Bethan	**Completed**	completed								
																Recruitment of newly qualified nurses and international nurses.	Thomas, Carol	**Completed**	ongoing Recruitment continues were required.								
																Recruitment of medical staffing to reduce reliance on locums.	Andrews, Bethan	~~30/09/2024~~ 31.10.25	recruitment continues as required to reduce reliance. Recruitment continues								

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1084	Planned & Specialist Care	Cancer & Scheduled Care	Scheduled Care: General Surgery	Carruthers, Andrew	Goode, Paula	Humphrey, Lisa	Lewis, Caroline	13-Jul-20	There is a risk of to the sustainability of the surgical out of hours rota in PPH. This is caused by The elective service for USC pathway patients being moved to PPH during covid. There was no additional funding provided to support an additional on-call resident doctor and SAS Level rota at PPH. This is a cost pressure on the General Surgery cost code 0009 budget. This will lead to an impact/affect on the protected delivery of the quality elective service provided at PPH for breast, colorectal and urology patients. with a post-operative facility of an Enhanced Care Unit (ECU). This service needs to remain at PPH, due unscheduled care and theatre staffing pressures at GGH. Risk location, Prince Philip Hospital.	The service manager along with support from a locum consultant manages the rota to ensure that there is sufficient cover. The rota cover at PPH entails the below: F1 resident doctors, 8am-4pm Monday to Friday - Covered as part of the GGH F1 rota, this costs the service travelling, taxi and accommodation at PPH. Locum cover is also sourced during sickness and annual leave as is required for daily ward cover. F2/CT resident doctors, 8am-4pm Saturday, Sunday and bank holidays - Covered entirely by medical bank locums at the standard bank rate. SAS Level 8am-5pm Monday to Friday, for ward rounds and assist in theatres. This allocated as part of the GGH SAS rota this costs the service travelling, taxi and accommodation at PPH. Locum cover is also sourced during sickness and annual leave as is required for daily ward cover. SAS Level out of hours cover 5pm - 8am, Monday to Friday and 24 hrs cover at weekends and bank holidays. Covered entirely by medical bank locums at the standard bank rate. Consultant cover is provided by the GGH Surgical consultant on call.	Workforce/OD	4	3	12	The risk score has increased to reflect the pressure being felt by the GGH SAS level doctors and the difficulty in sustaining the GGH and PPH rotas by the service team and locum consultant. If cover is not sourced, there is a risk to surgery being cancelled for USC patients. The risk rating reflects the financial implications to recruiting to these posts as they are not in the service budget. It also reflects the need to sustain this service at PPH. This service is mainly used to treat patients on the cancer pathway. Moving the service back to GGH will put patients at significant risk of cancellation due to unscheduled care pressures. The service are assessing options on the impact and resourcing challenge identified as part of their delivery of this years plan.	Request agreement for 3 RMO posts to be advertised for PPH. Seek funding to make the posts permanent to ensure a sustainable elective pathway at PPH.	Lewis, Caroline	**Completed**	There is currently one clinical fellow in post, on a 12 month fixed term contract. This is a cost pressure on the service. This is because there is no longer a Covid cost code. The rest of the cover is provided by medical bank doctors at the locum rate as per rate card. The whole rota is a cost pressure on the service. Action completed as no escalated to exec and no funding to recruit.	Finance and Performance Committee	1	3	3	The target risk score will be achieved when the workforce has been sufficiently increased and funded, to provide a safe and sustainable SAS Level cover for both PPH and GGH. The alternative is to return the service as it stands in PPH, to GGH. The target risk score would only be achieved with sufficient theatre capacity and protected elective beds at GGH.	31/12/2025	Treat	17-Jul-25
																Service under CSP programme for long term service provision. Await outcome of CSP programme.	Lewis, Caroline	31/07/2026	Await CSP developments								
																Service team and finance business partner to establish the current locum cost to consider conversion into posts. Small task and finish group to be set up to meet and discuss what a new rota to cover both sites would look like.	Lewis, Caroline	**Completed**	Task and finish group established								

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1951	Community & Integrated Medicine	Carmarthenshire Integrated System	Carmarthenshire County	Carruthers, Andrew	Skitt, Peter	Perry, Sarah	Jenkins, Angharad	31-Mar-24	There is a risk of overspend against the Specialist Palliative Care budget. This is caused by the potential withdrawal of funding from Ty Bryn Gwyn Trustees for permanent posts. Historically a decision was made that staff would be appointed 'at risk', given permanent contracts with these permanent posts being funded by Ty Bryn Gwyn Trustees (year on year funding). The posts are: 1 Specialty Doctor and 0.5 Clinical Nurse Specialist Palliative Care. This will lead to an impact/affect on the stability of the budget within specialist palliative care. It will also impact on recruitment into the team as the service will need to balance the books and this will have a negative effect upon service delivery. Risk location, Carmarthenshire.	Regular meetings are held with the Trustees to discuss what their priorities are and to inform them of the Health Board's position. Recent recruitment has converted permanent posts into fixed term in order to minimise the impact on the budget.	Finance inc. claims	3	4	12	The risk remains high because the decision-making remains with the Trustees - the Health Board has no control over this and therefore there is no assurance that funding will be secured in the future (year on year funding). As staff leave we are recruiting into temporary positions rather than permanent to reduce the risk.	To submit the business case and an SBAR outlining our work with the Trustees for Executive Team approval.	Jenkins, Angharad	Completed	Closed completed.	Finance and Performance Committee	1	4	4	Business case cycle now in process with the trustees to review and agree funding streams and priorities on an annual basis.	29/08/2025	Treat	01-Jul-25
																Awaiting full report from finance business partner regarding current status of posts (including fixed term/secondments) so that recommendations can be made to the HoN and System GM.	Jenkins, Angharad	30/09/2025	New action								

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2124	Planned & Specialist Care	Children, Women & Family Health	Children, Women and Family Health	Carruthers, Andrew	Goode, Paula	Owen, Tracy	Owen, Tracy	01-Apr-25	There is a risk of that 1. the Children, Women and Family Health Clinical Service Group will be unable to identify the level of recurrent savings in-year required (£3.6m) which includes under delivery of savings in 24/25. 2. further risk of CSG being overspent as due to ad-hoc variable pay. This is caused by 1. fragile services requiring service planning and wider Health Board engagement to enact service change within the financial year. 2. fragile services and workforce pressures driving spend on ad-hoc variable pay. This will lead to an impact/affect on a worsening of the overall financial position of the Health Board. Risk location, Health Board wide.	Finance Business Partner assigned to the Clinical Service Group, with weekly meetings in place with Clinical Service Group management, and ad hoc meetings as and when required 2. Weekly review of nursing and medical staff rotas 3. Regular job planning reviews 4. Weekly Operational team meetings 5. Monthly Clinical Service Group Business meetings 6. Continual onboarding of substantive locum staff in order to reduce reliance on premium locum staff and spend 6. We are reducing the O&G spend and working with Medical Sustainability project 7. Scrutiny of budget/Savings schemes via TI escalation meetings	Finance inc. claims	3	4	12	CIP tracker in place and monitored monthly for progress and shared with Clinical Care Group at the Business Planning and Performance monthly meetings. Monthly meeting take place with the Commissioning team are monitoring progress of SLA reviews.	Remodel Paediatric medical rotas at consultant and SAS levels to reduce variable pay	Davies, Nick	31/12/2025	Work in progress, required in readiness for allocate medical rostering	Finance and Performance Committee	2	2	4	If all schemes are achieved then the risk will reduce however if partial schemes achieved it will improve the financial position however the full savings target will not be met for 25/26.	31/03/2026	Treat	25-Jul-25
																Continue to progress CIP schemes identified with CW&FH	Owen, Tracy	31/03/2026	in progress								

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2065	Director of Public Health	Public Health -	Public Health: Health Improvement & Wellbeing	Gjini, Ardiana	Dainton, Joanna	Hughes, Lisa -	Hughes, Lisa -	15-Jan-25	There is a risk of Hywel Dda University Health Board will not achieve the NHS Wales performance measure of 40% of adult smokers who make a quit attempt being CO validated This is caused by •Service delivery model changes following Covid which resulted in a move to telephone support •Loss of dedicated rooms and venues for locality teams on the hospital sites •A need to train new staff commencing work after the service delivery model changes •Delay in purchase and distribution of monitors and consumables •Issues with on site storage of monitors and consumables •Increase in patients choosing telephone support over face to face meetings •Rurality issues including venue provision for low numbers and travel costs This will lead to an impact/affect	- Secured an increase in venues across the 3 counties - CO monitors supply to other HB professionals with access to vulnerable clients eg. Oxygen assessment nurses, mental health professionals, maternity and respiratory nurses - input into a national pharmacy service level agreement to enable local pharmacies to co validate with patients. All local pharmacists have been provided with CO monitors and have a dedicated practitioner to support and train as appropriate - Trained admin to encourage assessments to be booked into face to face venues rather than telephone support. Hybrid model of working	Quality/Complaints/Audit	3	4	12	There is still a possible likelihood of not achieving targets.	Scoping further community and outpatient clinics to maximise CO validating sessions	Hughes, Lisa -	Completed	Validation figure has increased from 8% - 21.2% SWOT Analysis & Action Plan developed to improve CO validation rates	Finance and Performance Committee	2	4	8	Target risk score of 8 due to likelihood score of 2 (unlikely) due to the uptake national target being 40%	31/03/2027	Treat	24-Jul-25

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									on •Reduced Productivity: Increasing face-to-face support will reduce practitioner productivity, leading to longer waiting times for appointments. •Decreased Treated Smoker Numbers: Shifting staff capacity to face-to-face CO validation and travel will reduce the number of treated smokers. •Higher Costs and Admin Time: Ensuring accessible venues across a large geographical area will increase costs and require significant administrative time for sourcing, booking, organizing payment, and covering staff sickness. •Lower Productivity at Venues: Staff at venues are less productive, and appointments are more prone to no-shows and cancellations. Weekly sessions need to be booked, leading to higher dropout rates compared to telephone support. •Additional Costs: There will be increased costs associated with room hire, travel, consumables, and additional CO monitors for staff. •Patient Choice: Vulnerable patients or those with caring responsibilities or chronic diseases may face challenges if telephone support is reduced. Risk location, Health Board wide.																		

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1488	Planned & Specialist Care	Cancer & Scheduled Care	Scheduled Care: Endoscopy	Carruthers, Andrew	Goode, Paula	Humphrey, Lisa	Edwards, Sara	26-Sep-22	There is a risk of of frequent decontamination equipment failure within the endoscopy unit, causing delays in the return of decontaminated endoscopes to front facing patients services requiring the use of flexible endos This is caused by One endoscope washer disinfector and drying cabinet were originally installed and commissioned in 2009, and are now 13 years in service and therefore 4 years beyond the recommended life cycle of 8 years. A second endoscope washer disinfector was added to augment capacity issues at Bronglais Hospital in 2014 and is nearing its 8 year recommended life cycle. This will lead to an impact/affect on The majority of endoscope decontamination equipment at Bronglais Hospital is now 4 years beyond its recommended life cycle of 8 years and fail on a not infrequent basis, causing delays in the return of decontaminated endoscopes to front facing patient services requiring the use of flexible endoscopes. As the equipment becomes older, it will become more problematic, and will inevitably present more significant impacts, which will have an effect on Referral to Treatment Time Performance. These equipment failures causes avoidable delays in the supply of decontaminated flexible endoscopes to	1. Regular servicing of current decontamination equipment. 2. Decontamination trained estate staff supporting daily with breakdowns and maintenance of decontamination equipment 3. Contract in place for current decontamination equipment inclusive of breakdown cover and engineer can attend hours within 48 hours	Service/Business interruption/disruption	3	4	12	Impact on service remains high risk as interruption in provision impacts on Urgent Suspected Cancer Pathway and emergency patients. Likelihood is often impacting for a 24-hour period but potentially could result in loss of service for a longer period if engineers are unable to attend or unable to source parts for repair in short timescale. Reviewed and risk updated.	Develop feasibility case for transfer of decontamination facility from the endoscopy unit to central HSDU within Bronglais. The proposed centralisation project will ensure the replacement of aging decontamination equipment to provide a more efficient turnaround of endoscopes, improving the provision of this service to endoscopy. This will ensure lists are running efficiently and ensure the patient pathway is improved. One endoscope washer disinfector and drying cabinet were originally installed and commissioned in 2009, and are now 13 years in service and therefore 4 years beyond the recommended life cycle of 8 years. A second endoscope washer disinfector was added to augment capacity issues at Bronglais Hospital in 2014 and is nearing its 8 year recommended life cycle.	Edwards, Sara	Completed	Feasibility case has been developed and presented to Gareth Rees and Keith Jones. Further actions to be progressed - including development of a PID document to be sent to the Board.	Finance and Performance Committee	2	4	8	Impact on service remains high risk as interruption in provision impacts on Urgent Suspected Cancer Pathway and emergency patients. Likelihood is often impacting for a 24-hour period but potentially could result in loss of service for a longer period if engineers are unable to attend or unable to source parts for repair in short timescale. The funding received nationally will address this but the plan will require 6-12months to implement at minimum.	31/03/2027	Treat	17-Jul-25
																Monthly meetings with BGH HSDU to support current arrangements whilst feasibility case is being developed.	Edwards, Sara	Completed	Monthly meetings in place.								
																SDM to get an update from HSDU service re. the outcome of the feasibility case.	Edwards, Sara	Completed	Capital bid submitted to National Decontamination Group								

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									endoscopy, theatres, outpatient departments, cardiology and intensive care units, and therefore create operational difficulties for patient endoscope procedures Due to the use of Peracetic Acid within the decontamination process, there is often a strong smell of peracetic acid within the current endoscopy unit, which on occasions can be intrusive. The current air handling unit is insufficient in removing this odour. JAG accreditation was originally deferred due to this concern until actions were put in place to eliminate this smell. Should the endoscope decontamination equipment remain within the endoscopy department there is a possibility that JAG accreditation could be withdrawn. This would have an impact on junior doctors training as all endoscopy units must be JAG accredited for training. Furthermore compliance with Welsh Government recommendations would also be of concern as it is now recommended that endoscope decontamination units are centralised into HSDU departments and managed by decontamination staff. Risk location, Bronglais General Hospital.							Endoscopy subject to CSP programme. Await options developments and decisions re. endoscopy pathway.	Edwards, Sara	31/07/2026	CSP programme								
																Await decision from National Decontamination Group re: funding to transfer decontamination from the endoscopy unit to HSDU	Flear, Philip	30/03/2027	Funding approved via National Decontamination Team - Awaiting next steps from John Prendergast								

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2095	Planned & Specialist Care	Children, Women & Family Health	CW&FH: Gynaecology	Carruthers, Andrew	Goode, Paula	Owen, Tracy	Davies, Nick	16-Dec-24	There is a risk of to the delivery of gynaecological hysteroscopy services at Glangwili site. This is caused by The malfunction of the hysteroscopy camera- in a device which is out of maintenance contract / warranty and is now considered obsolete. This will lead to an impact/affect on women needing timely diagnosis of gynaecological illness to include cancer- which in turn may adversely affect patient outcomes and HB performance. Risk location, Glangwili General Hospital.	Ability to access alternate equipment from theatre services.	Safety - Patient, Staff or Public	2	4	8	Lack of access to equipment is having a negative impact on capacity for patients needing urgent hysteroscopy. Unable to prevent risk of damage to the theatre device while being transported between departments	Procurement of replacement Mediscan HD system as per quotation ref SQU328972	Davies, Nick	30/09/2025	17.6.25- Quotation received (05.3.25) and accepted by central ops team ref CO230 for capital funding consideration/ allocation	Finance and Performance Committee	1	4	4	Dedicated equipment with associated warranty and support will mitigate this risk to level 4- and the risk would subsequently be closed.	30/09/2025	Treat	17-Jun-25

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1646	Operational Allied Health Professions & Health Sciences	AHP&HS: Pathology	AHP&HS: Pathology	Carruthers, Andrew	Quarrie, Sara	Jones*, Dylan	Jones*, Dylan	24-Jan-23	There is a risk of of overspending against funding allocated for external tests. There is also a risk to the health board if funding for COVID/respiratory testing is not supported by Welsh Government funding. This is caused by increased workload sent for testing and changes in test repertoire resulting in higher costs. This will lead to an impact/affect on financial overspend. Risk location, Health Board wide.	1. Regular SLA meetings to review spend 2. Reviewed external testing sites 3. Clinical Scientist test vetting 4. Demand management in place to prevent sending duplicate samples.	Finance inc. claims	4	2	8	This remains a significant financial risk for Pathology as the increase in high cost tests (genetic/ genomic tests) and general workload growth has resulted in considerable overspend. Currently we have no firm process in place to scrutinise and agree what new tests are introduced and/or if there are changes in protocol that creates variations to test frequency and volumes. A Value Based Healthcare (VBHC) steering group is in the process of being established to review new tests and changes in protocols that may have an impact to Pathology. The group will also look at key tests that the service has identified as opportunities to either reduce unwarranted testing or may have benefits to other areas. The service is also working closely with Swansea Bay University Health Board (SBU) as part of the Regional Pathology Programme at opportunities to repatriate tests to the region so they can be performed at reduced cost.	Regional collaboration providing opportunities to repatriate tests.	Peters, Lee	Completed	On going and linked to the ARCH Regional Solution. discussions ongoing. 05/06/2024 - update, exploring opportunities with SBU in laboratory medicine workstream. ongoing 31/05/25 - teicoplanin being reviewed to bring in house as a regional test. this is now being discussed in SBU CIG with both HD and SBU representatives	Finance and Performance Committee	4	2	8	The risk has been mitigated a far as it can within the means of the Pathology service. There are no further actions possible at this time. Monthly SLA reviews are no in place and the service is now challenging areas where there is potential overspend. It has been proposed that this risk remains open, but with a tolerated score of 8.	23/04/2025	Treat	24-Jul-25
																Review main SLAs to look at repatriating service	Peters, Lee	Completed	FIT, MPO and PR3 testing being considered for repatriation 5.4.24 - linked to ARCH regional solution 31/1/25 - these tests are now being discussed in CIG meetings by HD and SBU representatives.								
																Standardising clinical haematology processes, reducing send away tests	Peters, Lee	Completed	Continually reviewing opportunities to standardise processes. Looking at subspecialising the service in the future. 30/1/24 - reviewed send away tests. haemoglobinopathy being reviewed to bring house 5.4.24 - new managed service now in place								
																Establish VBHC Steering Group to review demand optimisation opportunities within Pathology.	Jones*, Dylan	Completed	Steering group established and workstreams identified to progress demand optimisation work. 5.4.24 - ongoing.								
																Review Public Health Wales SLA CMR data. To look at test costs and volumes.	Williams, Mike	Completed	SLAs being scrutinised to check they deliver value for HB etc. Several tests have been challenged.								

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Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R1. (BGH) The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.	Work to improve hospital flow (as also identified in NHS Exec and 6 goals actions) is underway and has been factored into performance trajectories currently awaiting Executive sign off.	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	Fragmented care pathways and lack of community capacity. Estate - ageing infrastructure and lack of physical capacity in BGH Undeveloped digital systems Inadequate workforce - delayed decision making, inefficiencies, delayed diagnostics Financial barriers, Ceredigion is currently 509K over Month 2
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R1. (BGH) The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.	Revision of nurse staffing position underway to support dedicated triage and ambulance bay nurses to enhance care offered at times of handover delay/ support handover into RATS area- paper for Exec Team currently being prepared (06/03/25)	Community & Integrated Medicine	Chief Operating Officer	31/03/2025	31/03/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R2. (BGH) The delays in ambulance to ED handovers of patients impair the response times for emergency ambulances and thus also cause harm to patients	Work to introduce a discharge lounge has now been proposed for 2025/26 with a view to supporting up to 6 patients per day who currently would be delayed on wards – this will have a positive impact on flow.	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	31/07/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R2. (BGH) The delays in ambulance to ED handovers of patients impair the response times for emergency ambulances and thus also cause harm to patients	A review of hospital flow (to include re-allocation of ward spaces) is due in 2025/26 to minimise bed clocking within the trauma / surgical pathway beds- which will improve emergency pathway access.	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	If funding is not released this will delay things further.
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R4. (BGH) The lack of ED senior medical staff must be addressed. However, the future viability of the department may require a different model in the long-term	Consultant lead currently employed on a locum basis (only 1 wte). This is currently subject to recruitment to substantiate the post.	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R4. (BGH) The lack of ED senior medical staff must be addressed. However, the future viability of the department may require a different model in the long-term	Interim County Director has instigated a review of ED staffing models in March 2025 with a view to generating a proposal to increase consultant cover.	Community & Integrated Medicine	Chief Operating Officer	31/03/2025	31/03/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R5. (BGH) The high catchment attendance level suggests that there are poor alternatives to ED attendance in the local area, probably including primary care	There is no significant local health provision with the exception of primary care services and the 111 system along with community nursing teams. In the south of the county, a Same Day Urgent Care (SDUC) facility has been introduced. The ambition is to launch a phased SDUC model from Aberaeron ICC- which will have a positive benefit/ reduction in ED attendances, and this has been considered in planning and trajectory assumptions for the 2025/6 financial year. Ceredigion is currently supported by a streaming hub- in line with the SDUC expansion, development of a HB wide streaming facility will improve patient flow by signposting to more appropriate resources. Decision making on a HB basis will ensure consistency in approach to advice offered to patients following clinical assessment of need.	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R8. (BGH) There are no housekeepers, dedicated porters or several other non-clinical roles in the ED. With a relative shortage of nursing and other clinical staff, it makes no sense not to have a wide range of supporting non-clinical staff.	2 dedicated domestic assistants currently deployed within dept. Budgetary constraints prevent dedicated porter and housekeeper appointments. Review of nurse staffing position is a priority in terms of any financial considerations at this time	Community & Integrated Medicine	Chief Operating Officer	31/03/2025	31/03/2025	

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Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R11. (BGH) Patients with strokes get a very timely and efficient service at Bronglais Hospital. It seems a great shame that plans are now in place to move these patients south to Withybush Hospital for their rehabilitation. This will undoubtedly cause inconvenience to many elderly relatives.	The clinical services plan for HDUHB stroke services is currently out to public consultation. While options are being finalised, and there are no currently preferred solutions	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R17. (WGH) The lack of ED senior medical staff must be addressed	Review of medical workforce required Need Healthboard collaboration	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R18. (WGH) The relatively high number of hospital admissions per WTE consultant (all health board consultants) suggests that there is an insufficient senior medical workforce to “power” the hospital beds in a timely and efficient way that ensures good patient flow.	Review of medical workforce required Need Healthboard collaboration	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R24. (GGH) The ED is small and cramped and desperately needs more space, if it is to accommodate large numbers of patients waiting for a hospital bed. However, better patient outflow from the ED is obviously required. The current situation is clearly causing increased risk and harm to patients and is distressing for staff.	Review of ED space completed. Limited capacity within existing footprint. Exploring alternative space within Medical Day (Podiatry) to support increased medical take away from ED. Front Door T&F Group implemented with alternative options being explored.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	30/05/2025	Capital Funding (WG)
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R24. (GGH) The ED is small and cramped and desperately needs more space, if it is to accommodate large numbers of patients waiting for a hospital bed. However, better patient outflow from the ED is obviously required. The current situation is clearly causing increased risk and harm to patients and is distressing for staff.	Review of current GGH space (ED/CDU/MDU and external environment) to explore additionality/re-purpose of space to support and reduce impact at front door (ED).	Community & Integrated Medicine	Chief Operating Officer	16/05/2025	16/05/2025	Workforce challenges/culture/resistant to change/ environmental factors/ equipment.
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R25. (GGH) The ED is used by the hospital as a general waiting room for all specialties and input to the ED by inpatient specialists is poor. The implementation of Internal professional standards is urgently required.	Speciality Pathway Reviews underway. Surgical SDEC (Phase 1 Complete). Pilot of Trauma Ambulatory Care Unit underway. Review of Urology, ENT & Gynae Pathways. Internal Professional Standards have been disseminated by Deputy Medical Director. Formal monitoring arrangements to be agreed. Deputy Medical Director currently aligning speciality specific pathways from ED in line with professional standards.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	

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Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R27. (GGH) Ambulances wait outside the ED for long periods.	Boarding protocol implemented with patients boarded against predicted discharges. Safety Huddles, Patient Flow review. Emergency Pressures and Escalation Policy (489) Role of the Senior Nurse Manager, Clinical Site Manager and 'Manager of the Day' strengthened, supporting key escalation of actions, status and risk. Optimal Flow Framework implementation: -LOS Reviews & Escalation process review -Board round monitoring & Frontier usage -Criteria Led Discharge -Repatriation Database -POCD monitoring Initiatives to facilitate admission avoidance: -Streaming Hub -Virtual Ward -Re-direction Policy (Draft) -Perfect week (Jan 25) completed with some initiatives adopted as business as usual (GP medical take via SDEC). -Optimised Weekend working Pilot planned (22/23 March). Weekly Big Room Advertising for a 6th Acute Physician to enable SDEC, CDU and Medical Liaison in ED rotation to provide sufficient medical cover across the front door. Recruitment process instigated.	Community & Integrated Medicine	Chief Operating Officer	30/06/2025	30/06/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R28. (GGH) The departmental configuration makes imaging difficult to access in a timely way. However, the suspected cauda equina syndrome (CES) pathway is good	Review completed and ED & SDEC radiology request prioritisation agreed – requires further measurement of data to determine impact. OOH Cauda Equina pathway review being undertaken.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R29. (GGH) Training opportunities are poor.	ED Big Room. Training Needs Analysis underway ED Practice Educator in place. Weekly Roster efficiency monitoring – monitoring of Study Leave compliance.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R31. (GGH) SDEC will take GP referrals (and some ambulance referrals) directly but closes at 8pm and only accepts new patients up to 5pm. There is a poor flow of patients to SDEC from the ED.	Change in pathway for medical referrals from GP to GGH SDEC (embedded since perfect week). SOP being updated. Optimised Weekend working Pilot planned (22/23 March) will include SDEC	Community & Integrated Medicine	Chief Operating Officer	30/06/2025	30/06/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R32. (GGH) The co-located MIU is ENP-led, with patients streamed from the ED reception. The out-of hours primary care centre will not accept patients from the ED	OOH's primary will accept patients as per re-direction policy – pending sign off.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R33. (GGH) The shortage of senior medical staff and registered nurses must be addressed.	ED Consultant Recruitment – process underway. Safe Staffing Review (RN) has been progressed over last 18 months with key recruitment. Further reviews planned (B2/B3)	Community & Integrated Medicine	Chief Operating Officer	30/06/2025	30/06/2025	

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Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R35. (GGH) Data quality must be improved.	ED Breach Validation assurance in progress. Review data quality and validity.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	
Peer Review - Getting It Right First Time (GIRFT) - Urology Review	R17. Addressing the waiting time for men with lower urinary tract symptoms should be a priority for the Health Board. This is an area where networking between Health Boards is also vital as HDUHB could lead on this initiative and support neighboring cancer centres with a movement of benign work. Investment is require to increase the number of surgical modalities that are available for men requiring BOO surgery. Nurse-led, one-stop assessment is part of an exemplar model and this will require investment in staff.	Prioritise waiting times for men with lower urinary tract symptoms	Planned & Specialist Care	Chief Operating Officer	31/12/2024	31/12/2024	
Peer Review - Getting It Right First Time (GIRFT) - Urology Review	R20. There needs to be clear protocols in place for the common urological emergencies. As a minimum, these should include pathways for urosepsis, hematuria, acute ureteric colic, urinary retention and epididymo-orchitis.	Develop clear protocols in place for the common urological emergencies.	Planned & Specialist Care	Chief Operating Officer	31/12/2024	31/12/2024	
Peer Review - Getting It Right First Time (GIRFT) - Urology Review	R26. Swansea Robotic Surgery. The HDUHB team should be involved in decision-making regarding the future model for provision of robotically-assisted surgery. Consideration should be given to the workforce requirements and whether there are joint opportunities to train and or appoint surgical staff.	(EXTERNAL) HDUHB team to be involved in decision-making regarding the future model for provision of robotically-assisted surgery.	Planned & Specialist Care	Chief Operating Officer	31/12/2024	31/12/2024	
Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	As part of understanding of the challenges within the service, a multi-stakeholder survey was conducted which has yet to be analysed. There were 37 replies in the first round and three in the second round. The results of these will form a baseline on the current understanding and expectations of the service. These could be presented to all stakeholders including experts by experience. To use the results of the survey to empower workshops involving all stakeholders including experts by experience to discuss meaningful change. The same survey i.e., the Purple Light Toolkit could be rolled out in another 12-18 months' time to understand how things have changed locally in the community and what are the critical gaps remaining. (Medium term plan (6 months to a year))	To liaise with research and development colleagues to establish the stakeholder's current understanding and expectations of the service.	Mental Health and Learning Disabilities	Chief Operating Officer	29/03/2024	29/03/2024	

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Peer Review Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	HDUHB to establish a robust mechanism for capturing procedure level data of in-patient, day case and out-patient (ambulatory) procedures in gynaecology. HDUHB should also develop a mechanism to capture diagnostic procedure coded operations of emergency Surgery (management of ovarian cysts, miscarriage/ectopic pregnancy and sepsis requiring surgery). This will be a recommendation in our all Wales Report.	Awaiting management response from service	Planned & Specialist Care	Chief Operating Officer	30/09/2022	30/09/2022	
Peer Review Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	HDUHB to develop a relationship between clinical coders and consultants to improve data capture. HDUHB also to consider arranging regular meetings to review a sample of operation notes and develop an improvement strategy.	Awaiting management response from service	Planned & Specialist Care	Chief Operating Officer	30/09/2022	30/09/2022	
Peer Review Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	HDUHB to encourage the development of minimal access and vaginal surgery for benign and malignant conditions where appropriate and open abdominal surgery for a decreasing proportion with the emphasis on reducing length of stay for gynaecological inpatients along the lines of the BADS targets and the GIRFT “top decile” performance. This should include post-operative catheterisation.	Awaiting management response from service	Planned & Specialist Care	Chief Operating Officer	30/09/2022	30/09/2022	
Peer Review Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	. HDUHB to review consultant job plans to facilitate two consultant operating for situations where there may be a skills gap and or significant risk of surgical complications to improve surgical confidence and the learning of techniques such as minimal access surgery	Action is complete	Planned & Specialist Care	Chief Operating Officer	30/09/2022	30/09/2022	
Peer Review Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	HDUHB to undertake a review of the therapeutic pathway of early pregnancy complications in order to improve timely management of care. The availability of staff able to perform ultrasound scanning to be included in this review.	Awaiting management response from service	Planned & Specialist Care	Chief Operating Officer	30/09/2022	30/09/2022	
Peer Review Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	HDUHB to undertake a review of emergency readmission within 30 days for patients (less than 50 years) receiving hysterectomy for benign condition readmission rates especially at WGH and develop an improvement strategy.	Action is complete	Planned & Specialist Care	Chief Operating Officer	30/09/2022	30/09/2022	