Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 June 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Corporate Risks Assigned to Finance and Performance Committee
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Rachel Williams, Head of Assurance and Risk

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Committee is asked to request assurance from the Lead Executive Director for the Finance and Performance Committee (FPC) that the corporate risks in the attached report are being managed effectively.

Cefndir / Background

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

(Risk Management Process, ISO 31000)

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

- Seeking assurance on the management of risks on the Corporate Risk Register (CRR) and providing assurance to the Board that risks are being managed effectively and report areas of significant concern, for example, where risk appetite is exceeded, lack of action.

- Reviewing corporate and operational risks over tolerance and, where appropriate, recommend the 'acceptance' of risks that cannot be brought within Hywel Dda University Health Board's (HDdUHB) risk appetite/tolerance to the Board.
- Identity through discussions any new/emerging risks and ensure these are assessed by management.
- Signpost any risks outside of its remit to the appropriate HDdUHB Committee.
- Use risk registers to inform meeting agendas.

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. This supersedes the previous approach agreed in September 2018 which set the tolerance levels for risk aligned to risk impact domains.

The revised approach utilises the target risk score (TRS) of risks in order to demonstrate the lowest level of risk exposure that the Health Board is willing to tolerate, following the completion of all planned actions aligned to each risk. The TRS represents the ultimate level of risk achievable given the available means and resource. Once the TRS is achieved, if the risk continues to exist, it should then be tolerated or accepted unless further actions are identified or made possible (for example, additional resources).

If achieving the TRS is deemed unacceptable (for example, the TRS is too high), further discussion or escalation is required. The TRS should be quantified, and where possible aligned to performance targets (including quality metrics), with a set timescale for achieving the reduction of the Current Risk Score to the TRS.

Risks will be 'treated' until a discussion to 'tolerate' a risk is triggered – this would be when the Executive Risk Owner for corporate risks does not support the TRS. The Board will be asked to accept any risks where the Health Board is unable to treat within its available means.

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.

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

The Board has delegated a proportion of its role of scrutiny of assurances to its Committees to make the most appropriate and efficient use of expertise. Therefore, Committees should also ensure that assurance reports relevant to the principal risks are received and scrutinised, and an assessment made as to the level of assurance it provides, taking into account the validity and reliability, for example, source, timeliness, methodology behind its generation and its compatibility with other assurances.

This will enable the Board to place greater reliance on assurances, if they are confident that they have been robustly scrutinised by one of its Committees; and provide them with greater confidence regarding the likely achievement of strategic objectives, as well as providing a sound basis for decision-making. It is the role of Committees to challenge where assurances in

respect of any component are missing or inadequate. Any gaps should be escalated to the Board.

The process for risk reporting and monitoring within the Health Board is outlined at **Appendix 1**.

Asesiad / Assessment

The FPC Terms of Reference state that:

3.1.20 Seek assurance that the management of risks within the CRR and Directorate Risk Registers (including for hosted services and through partnerships and Joint Committees as appropriate) aligned to the Committee and its sub-committees, and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action. Where risks cannot be brought within the Health Board's risk appetite/tolerance, recommend acceptance of risks to the Board.

3.1.21 Receive assurance through Sub-Committee Update Reports and other management/task & finish group reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate)

Following the implementation of new Board Committee structure on 1 April 2025, corporate risks have been re-aligned appropriately to these Committees, with this paper being the first report of corporatel risks assigned to FPC.

There are 2 risks currently aligned to FPC (out of the 20 that are currently on the CRR) as the potential impacts of the risks relate to the workforce. This can be found at **Appendix 2**.

Changes Since Risks last reportable to Board level Committee

Total Number of Open Risks	2	
New Risks since last reportable to Board level Committee (including risks previously assigned to other committee)	2	*See note 1*
De-escalated/Closed Risks since last reportable to Board level Committee	1	*See note 2*
Increase in Risk Score since last reportable to Board level Committee ↑	0	
Decrease in Risk Score since last reportable to Board level Committee ↓	0	
No Change in Risk Score since last reportable to Board level Committee →	0	
EXTREME (RED) Risks (based on 'Current Risk Score')	2	
HIGH (AMBER) Risks (based on 'Current Risk Score')	0	

Note 1 – New Risks added since last reportable to Board level Committee (including risks previously at service level)

Risk Reference & Title	Date risk identified	Lead Director	Current risk score	Update	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 *(Finance) NEW RISK*	01/04/25	Director of Finance	**4x5=20** (Reviewed 04/06/25)	The Board, at its meeting on the 27 March 2025 endorsed and approved the submission of the annual plan to Welsh Government (WG), noting that the financial plan does not deliver against our statutory requirement to break-even. It recognises that the forecast financial outturn remains in-line with the target control total (TCT) set by WG of £31.5m, but is 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 on 11 April 2025 suggests that our plan is not supportable by Welsh Government. The focus for the coming year will be to: 1. Q1: de-risk the in-year financial plan with robust delivery plans confirmed for the full savings target of £44.4m. 2. Q2: consider further options to improve the financial forecast beyond the financial plan of £31.5m. 3. By September 2025, develop options to deliver medium term improvement as part of a strategic sustainability plan.	**3x4=12**
1350 - Risk of not meeting the 80% SCP waiting times target for March 2026	04/02/22	Chief Operating Officer	**4x4=16** (Reviewed 21/05/25)	The latest performance data as of March 2025 65.4%, an improvement from February 25 is 63.5%. The requirement is to achieve 60% for 3	**2x4=8**

due to diagnostics capacity and delays at tertiary centre (*Cancer & Scheduled Care*) *Realigned from Strategy and Planning Committee*				consecutive months to be de-escalated from Targeted Intervention status. The target of 60% has been achieved consecutively in March and April 2025. There is a risk that due to recovery actions within radiology and urology we may see variation in performance during Q1/Q2 as we recover and treat those patients over 62 days the risk remains that cancer performance will not achieve 80% compliance by March 2026.	

Note 2- Closed Risks since last reportable to Board level Committee

Risk Reference & Title	Date risk identified	Lead Director	Rationale
1843 - Risk that the cash consequences of the Health Board deficit cannot be covered due to significant deficit position (*Finance*).	01/04/24	Director of Finance	The latest assessment of the financial deficit is that the Health Board has a trajectory to achieve its re-stated annual plan deficit of £31.5m

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **SEEK ASSURANCE** that all identified controls are in place and working effectively;
- **SEEK ASSURANCE** that all planned actions will be implemented within stated timescales and will reduce the risk further and/or mitigate the impact if the risk materialises; and
- **CHALLENGE** where assurances are inadequate

This will enable FPC to provide the necessary assurance (or otherwise) to the Board through its Update Report, that the Health Board is managing these risks effectively.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.19 Seek assurance that the management of risks within the Corporate Risk Register (CRR) and Directorate Risk Registers (including for hosted

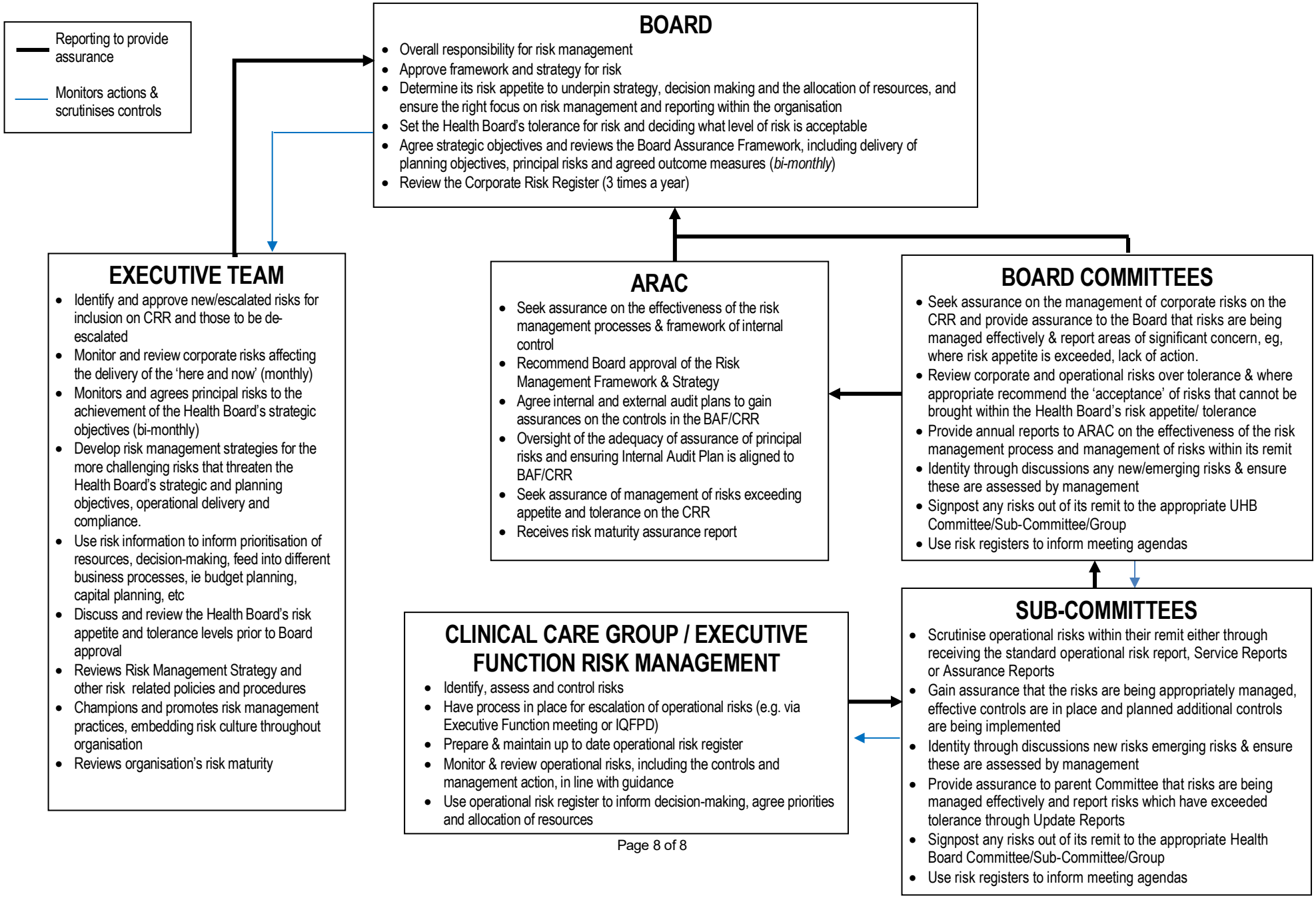
	services and through partnerships and Joint Committees as appropriate) aligned to the Committee and its sub-committees, and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action. Where risks cannot be brought within the Health Board's risk appetite/tolerance, recommend acceptance of risks to the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained in the report.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across HDdUHB's services reviewed by risk leads/owners.
Rhestr Termau: Glossary of Terms:	Current Risk Score - Existing level of risk taking into account controls in place. Target Risk Score - The ultimate level of risk that is desired by the organisation when planned controls (or actions) have been implemented.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy:	Relevant Executive Directors.

Parties / Committees consulted prior to Sustainable Resources Committee:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from report however impacts of each risk are outlined in risk description.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from report however impacts of each risk are outlined in risk description.
Gweithlu: Workforce:	No direct impacts from report however impacts of each risk are outlined in risk description.
Risg: Risk:	No direct impacts from report however impacts of each risk are outlined in risk description.
Cyfreithiol: Legal:	No direct impacts from report however proactive risk management including learning from incidents and events contributes towards reducing/eliminating recurrence of risk materialising and mitigates against any possible legal claim with a financial impact.
Enw Da: Reputational:	Poor management of risks can lead to loss of stakeholder confidence. Organisations are expected to have effective risk management systems in place and take steps to reduce/mitigate risks.
Gyfrinachedd: Privacy:	No direct impacts from report.
Cydraddoldeb: Equality:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.

Appendix 1 – Committee Reporting Structure



Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Clinical Care Group/Executive Function	Domain	Previous Risk Score	Risk Score May-25	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score	Risk on page no...
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	Director of Finance	Finance inc. claims	NA	4×5=20	New risk	3×4=12	31/10/2025	6
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	Planned & Specialist Care	Quality/Complaints/Audit	4×4=16	4×4=16	→	2×4=8	31/03/2026	9

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required	
	Detailed review of relevant information
	Medium level review
	Cursory or narrow scope of review

NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

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

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
Likelihood	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	This will probably never happen/recur (except in very exceptional circumstances).	Do not expect it to happen/recur but it is possible that it may do so.	It might happen or recur occasionally.	It might happen or recur occasionally.	It will undoubtedly happen/recur, possibly frequently.
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	**(0-5%*)**	**(5-25%*)**	**(25-75%*)**	**(75-95%*)**	**(>95%*)**
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				
Risk Impact Domains	**Negligible - 1**	**Minor - 2**	**Moderate - 3**	**Major - 4**	**Catastrophic - 5**
Safety of Patients, Staff or Public	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention.	Moderate injury requiring professional intervention.	Major injury leading to long-term incapacity/disability.	Incident leading to death.
	No time off work.	Requiring time off work for >3 days	Requiring time off work for 4-14 days.	Requiring time off work for >14 days.	Multiple permanent injuries or irreversible health effects.
		Increase in length of hospital stay by 1-3 days.	Increase in length of hospital stay by 4-15 days.	Increase in length of hospital stay by >15 days.	An event which impacts on a large number of patients.
			Agency reportable incident.	Mismanagement of patient care with long-term effects.	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	Peripheral element of treatment or service suboptimal.	Overall treatment or service suboptimal.	Treatment or service has significantly reduced effectiveness.	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment/service.
	Informal complaint/inquiry.	Formal complaint.	Formal complaint -	Multiple complaints/ independent review.	Gross failure of patient safety if findings not acted on.
		Local resolution.	Escalation.	Low achievement of performance/delivery requirements.	Inquest/ombudsman inquiry.
		Single failure to meet internal standards.	Repeated failure to meet internal standards.	Critical report.	Gross failure to meet national standards/performance requirements.
		Minor implications for patient safety if unresolved.	Major patient safety implications if findings are not acted on.		
		Reduced performance if unresolved.			

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage
					Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

RISK MATRIX

IMPACT ↓	LIKELIHOOD →				
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

Date Risk Identified:	Apr-25	**Executive Director Owner:**	Thomas, Huw -	**Date of Review:**	Jun-25
Strategic Objective:	6. Sustainable use of resources	**Lead Committee:**	Finance and Performance Committee	**Date of Next Review:**	Jul-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 £31.5m. This is the level for which Welsh Government have indicated that they have cash coverage. This is caused by 1.Insufficient conversion of the £19.0m of operationally-determined savings plans into deliverable actions. 2.Insufficient conversion of the required £25.4m of non-recurrent savings (which is 75% of the level delivered in 2024/25) into budgets in the year. 3.Cost control issues arising during the year. While macroeconomic pressures have subsided, there are potential issues arising from: a. The impact of National Insurance on our suppliers, including primary care practitioners; b. The impact of global tariff shocks impacting on global supply chains, particularly on drugs; c. While nursing agency has reduced significantly, there is a continued use of high cost staffing solutions, in particular medical and Allied Health Professionals agency and overtime. 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, 2002, 1793, 971, 1876, 1646

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*

No trend information available

Rationale for CURRENT Risk Score:
The Board, at its meeting on the 27 March 2025 endorsed and approved the submission of the annual plan to Welsh Government (WG), noting that the financial plan does not deliver against our statutory requirement to break-even. It recognises that the forecast financial outturn remains in-line with the target control total (TCT) set by WG of £31.5m, but is 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 on 11 April 2025 suggests that our plan is not supportable by Welsh Government. The focus for the coming year will be to: 1. Q1: de-risk the in-year financial plan with robust delivery plans confirmed for the full savings target of £44.4m. 2. Q2: consider further options to improve the financial forecast beyond the financial plan of £31.5m. 3. By September 2025, develop options to deliver medium term improvement as part of a strategic sustainability plan.

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 July 2025, the Executive Team are seeking to fully 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. By 13 October 2025, the Executive Team are seeking to have fully de-risked the financial plan to ensure its successful delivery, and to have identified improvements beyond the financial plan. It is at this date we would envisage the target risk score of 12 being achieved, with sufficient actions in place to have closed the majority of gaps and to have demonstrated actual delivery with a three month evidence of actual results.

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 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. 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.

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	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 update to be provided at next risk review
	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
	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	Progress update to be provided at next risk review

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.	Spratt, Andrew	30/09/2025	Progress update to be provided at next risk review

ASSURANCE MAP

Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level	Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance against operational plans and targets through Performance KPIs In-month financial monitoring	Performance against plan monitored through Executive Improving Together Meetings.	1st			
	Finance and Performance Committee oversight of current performance	2nd			
	Transformation & Financial Report to Board & Finance and Performance Committee	2nd			
	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			

Gaps in ASSURANCES

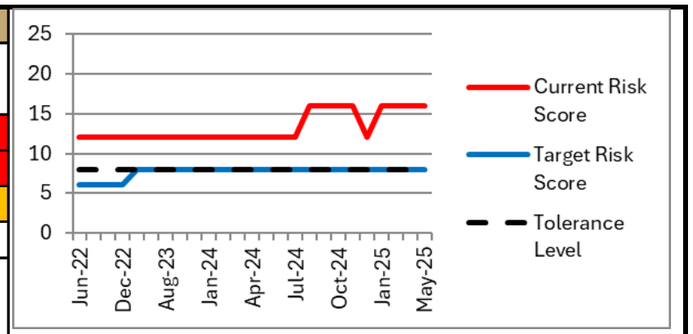
Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Delivery of limited assurance audit reports. Particularly, in areas which have a financial impact: 1. Discharge management; 2. Bed management; 3. Nursing 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	New action
	Closure of audit recommendations arising from Nursing roster management audit	Daniel, Sharon	30/05/2025	New action
	Determination of change management capacity through alignment of resources across corporate functions.	Gostling, Lisa	31/08/2025	New action

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-25
Lead Committee:	Finance and Performance Committee	**Date of Next Review:**	Jun-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 latest performance data as of March 2025 65.4%, an improvement from February 25 is 63.5%. The requirement is to achieve 60% for 3 consecutive months to be de-escalated from Targeted Intervention status. The target of 60% has been achieved consecutively in March and April 2025. There is a risk that due to recovery actions within radiology and urology we may see variation in performance during Q1/Q2 as we recover and treat those patients over 62 days 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)

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**

# 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 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	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	Planning in progress
		Establish accelerated Neck lump pathway to reduce diagnostic pathway	Lewis, Caroline	~~31/12/2024~~ 30/06/2025	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	Mapping in progress
		Due to increased demand for dermatology treatments the service need to aquire 2 additional MOP Treatment areas	Wisdom, Ceri	30/06/2025	SBAR being presented to the Care Group Board meeting in June.

*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.		Highest volume of patients awaiting Urology diagnostic procedures. Urgent action required to reduce overall volumes and volumes waiting over 28 days.	Griffiths, Neil	30/05/2025	Detailed demand capacity planning to include the RTT component to identify the actual demand capacity gap to inform the options for solution

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Internal targets - Looking at the performance per tumour site individually that have the biggest impact on overall performance Skin Urology LGI Gynaecology Breast Reducing component waits Patient waiting more than 14 days for first OPA Patients waiting a diagnostic procedure and report more than 28 days Patients with a confirmed diagnosis of cancer waiting more than 62 days	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 QSEAC Jun20 & OpQSESC Jul20 * Risk 633 QSEAC - Feb21 & Aug21 * IPAR Report - Board - Nov22	None identified.	Establish Operational improvement group to track improvement projects in line with NOP and Annual Plans	Goode, Paula	~~30/04/2025~~ 30/06/2025	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
	IPAR Performance Report to S&PC & Board	2nd								
	Monthly oversight by NHS Executive/WG	3rd								
	Revised Governance arrangements in place since April 2025 with matters escalated when required via the new management structures.									