GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Assurance and Risk Report

Finance and Performance Committee, 27 August 2026

Situation

This report provides the Finance and Performance Committee (FPC) with the status of the corporate risks, audit and inspections, and Ministerial Directions (MDs).

The Committee is asked to seek assurance from the Lead Executive Directors that there are processes in place to oversee corporate risks to ensure these are being managed effectively, and that audit and inspection recommendations and Ministerial Directions are being implemented by the Health Board.

Principal risks, operational risks and Welsh Health Circulars are reported at alternate meetings and are due to be presented to FPC at its next meeting in October 2026.

Corporate Risks:	Audit and Inspection Reports	Ministerial Directions
3	23	1

Risk Management - Overview

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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.

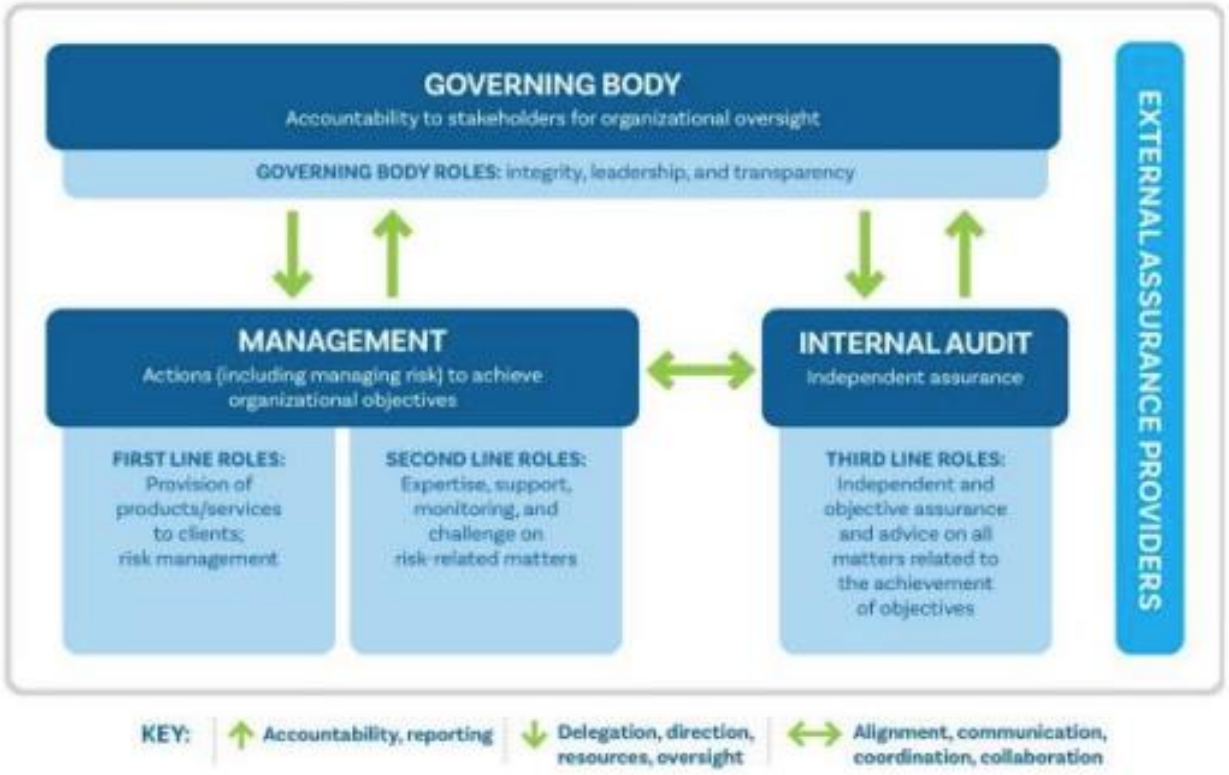
The Health Board's risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either Principal, Corporate or Operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval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



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				2326	
Major 4			2327 2380		
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.

Corporate risks have been aligned to the most appropriate Board level Committee.

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 corporate risks currently aligned to FPC (out of the 26 that are on the CRR on 22 July 2026).

The following slides provide a summary of the reportable corporate risks 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, an expected date to achieve the noted Target Risk Score, and sources of assurance.

Corporate Risks Aligned to FPC

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The corporate risks aligned to the Committee highlight that the Health Board faces challenges in:

- achieving financial sustainability and delivering the requirements of the financial plan;
- meeting national performance standards and targets whilst managing increasing demand and service pressures; and
- maintaining cancer pathway performance and planned care recovery activity whilst experiencing capacity, workforce and funding constraints.

The potential impact of the risks include:

- increased financial instability and regulatory escalation;
- longer waiting times, poorer patient experience and adverse patient outcomes;
- inability to achieve national performance targets, resulting in increased scrutiny and reputational damage; and
- reduced resilience and sustainability of key services.

Common actions noted across the risks demonstrate the need to:

- strengthen workforce capacity;
- improve productivity and efficiency;
- enhance financial control, savings delivery and accountability; and
- strengthen performance management, governance and assurance arrangements.

Corporate Risks Assigned to FPC

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
2326 – Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding.	Director of Finance	Director of Finance	**20**	**20** ➔ (Reviewed 06/07/26)	**12**	~~30/06/26~~ 30/09/26	N/A - New risk for current financial year, but linked to existing corporate risk re: Annual Planning (2212)

Rationale for Current Risk Score (CRS)

The 2026/27 Financial Plan submitted to Welsh Government (WG) in March 2026 projected a £41m deficit. WG advised that the plan was neither supportable nor acceptable and reiterated its expectation of a £22m deficit. Of the £42.8m savings requirement, only £5.0m was assessed as Amber/Green assured, with a further £6.4m of Blue/Red opportunities yet to be converted into deliverable schemes. Sensitivity analysis forecast a year-end deficit of between £54.3m and £90.5m, requiring a minimum of £13.3m of additional savings.

A 4-Step Financial Improvement Framework was issued on 31 March 2026, followed by Chief Executive reviews in April 2026. An interim update to the Board in May 2026 demonstrated improvement in the financial trajectory, confirmed Executive ownership of variable pay workstreams, and outlined workforce plans across nursing, medical and other staff groups. By June 2026, all open actions had been completed, , and variable pay plans deliverable in-year and evidenced. A credible, recurrent opening baseline was confirmed, and reliance on non-recurrent measures has been addressed. A revised COO Operating Model, including CCG Delivery Agreements aligned to the Levels 1–4 Performance Escalation Framework, was developed and approved by the Formal Executive Team in July 2026. A System Leaders Workshop and Executive-owned delivery programme were also established. WG has been advised that Quarter 2 activity is required to further de-risk delivery of the financial plan.

Corporate Risks Assigned to FPC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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Rationale for Target Risk Score (TRS)

The Target Risk Score (TRS) reflects the position expected once the 4-Step Financial Improvement Framework has been delivered and the supporting control architecture is operating. Pace is essential.

The previous date to achieve the TRS of 30/06/2026 was aligned to the 4-Step Financial Improvement Framework, however this has now passed, and signals that the Health Board has not been able to exert sufficient grip on the largest controllable in-year expenditure line. There is a likelihood that the risk score could increase if the July 2026 position does not signal a run rate improvement closer to our monthly planned deficit. The date to achieve the TRS is therefore extended until 30 September 2026.

Corporate Risks Assigned to FPC

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
2327 – Risk to planned care and RTT recovery in 2026/27 due to demand–capacity gaps, estate fragility and non-recurrent funding	Planned and Specialist Care	Chief Operating Officer	**12**	**12** → (Reviewed 19/06/26)	**9**	31/03/27	N/A - New risk for current financial year, but supersedes previous risk 2104 included in the Annual Plan

Rationale for Current Risk Score (CRS)

The Health Board faces delivery risks in achieving ministerial planned care recovery targets by March 2027 due to combined pressures of cohort demand in key specialties and workforce limitations. Theatre cancellations at Glangwili Hospital (GGH) have further reduced core capacity, particularly impacting Orthopaedics, where additional demand from long-waiting patients persists.

While delivery plans demonstrate progress in outpatient activity, treatment capacity and workforce improvements, gaps remain and performance against planned care milestones continues to underpin the Health Board's Targeted Intervention status.

Estates issues are impacting theatre list cancellations. Regional collaboration with Swansea Bay University Health Board (SBUHB) being actively pursued to expand capacity in Ophthalmology and Orthopaedics, including use of Neath Port Talbot theatres. In the absence of recovery funding, 104-week breaches are predicted in Orthopaedics, Urology, Trauma and Orthopaedics, Ear Nose and Throat (ENT), Ophthalmology and Dermatology. The current risk score is assessed at 12, lower than the inherent risk score, as the Board have accepted the trajectories set out in the Annual Plan.

Corporate Risks Assigned to FPC

GIG CYMRU NHS WALES
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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
2327 – Risk to planned care and RTT recovery in 2026/27 due to demand–capacity gaps, estate fragility and non-recurrent funding	Planned and Specialist Care	Chief Operating Officer	**12**	**12** → (Reviewed 19/06/26)	**9**	31/03/27	N/A - New risk for current financial year, but supersedes previous risk 2104 included in the Annual Plan

Rationale for Target Risk Score (TRS)

The TRS of 9 reflects 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.

Opportunities to make further progress towards Ministerial targets in 2026/27 will continue to be explored, including exploration of the regional opportunities referred to.

Corporate Risks Assigned to FPC

GIG CYMRU NHS WALES
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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
2380 – Risk to delivery of Single Cancer Pathway performance due to diagnostic capacity gaps, funding uncertainty and pathway fragility	Planned and Specialist Care	Chief Operating Officer	**12** (NEW)	**8**	31/03/27	N/A - New risk for current financial year, but supersedes previous risk 1350 included in the Annual Plan

Rationale for Current Risk Score (CRS)

The service has been de-escalated by WG from Level 4 to Level 1 in terms of Targeted Intervention status as there has been the consistent achievement of the 60% de-escalation criteria since February 2025. As at March 2026 performance was at 60%.

Due to recovery actions within Radiology and Urology, we may see variation in performance as we recover and treat those patients over 62 days. Confirmation of target for March 2027 is 75%, however no health board is achieving this target. Plans are in place for Q1 2026/27 to maintain performance at the planned trajectory set out in the Annual Plan 2026/27.

Rationale for Target Risk Score (TRS)

The aim is to treat patients within target waiting times, which has now been confirmed as 64-66% as per Annual Plan 2026/27.

The TRS will be met if plans to maintain diagnostic capacity, utilising internal allocated funding, are realised. The risk score can be further reduced to 8 once the target of 66% is achieved and maintained for 3 consecutive months. There are underpinning trajectories in place which are monitored on a monthly basis and adherence to those will influence the ability to achieve the TRS.

Audits and Inspections - Overview

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The Health Board remains in Level 4 status with 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 'Leadership and Governance' from Level 3 to Level 1, the Health Board must meet the revised criteria:

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda University Health Board (HDdUHB) are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan;
- Support the implementation and realisation of GIRFT and the national programme reviews opportunities;
- Support the implementation and realisation of the three Ps policy, GIRFT, theatre optimisation, CIN optimisation programmes and related national improvement recommendations;
- Financial controls at the health board that are robust in both design and implementation, including a self-assessment against model frameworks, review implementation of the Standing Financial Instructions, internal audit reviews, or other control reviews; and
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

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, and any barriers to completion clearly noted.

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 Category	Definition
Overdue	The recommendation is behind schedule to the timescale provided by the lead officer.
Unable to Complete	The recommendation cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.
Pending Decision	The recommendation is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.
In Progress	The recommendation is currently in progress, and within the agreed original timeframe for implementation.
Reliant on External Factors	The recommendation is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.
Complete Pending Formal Approval	The Service / Function have completed the recommendation and currently awaiting formal approval to close.
Complete	The recommendation has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.

Audits and Inspection Reports - Summary

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

3.1.18 Seek assurances on the requirements arising from the Health Board's regulators, WG and professional bodies

Full detail of recommendations that are overdue are included in **Appendix 2.**

Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommen-dations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Jan-22	Peer Review	Colorectal Cancer (Third Cycle)	Planned and Specialist Care	Chief Operating Officer	Mar-22	~~Mar-23~~ ~~Mar-24~~ Mar-28	8	0	0	7	0	1	0	0	Awaiting regional approach for Pathology
Sep-22	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review	Planned and Specialist Care	Chief Operating Officer	N/K	Sep-26	17	0	0	17	0	0	0	0	No barriers noted – awaiting formal approval to close.
May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Planned and Specialist Care	Chief Operating Officer	Sep-23	~~Mar-24~~ ~~Jan-25~~ ~~May-25~~ N/K	22	0	0	15	7	0	0	0	No barriers noted - awaiting formal approval to close.
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	8	0	35	16	0	0	0	Workforce and theatre capacity constraints, service resilience and staffing challenges, and Operational pressures affecting service delivery.
Apr-24	Peer Review	Getting It Right First Time (GIRFT) - Urology Review	Planned and Specialist Care	Chief Operating Officer	Jan-27	Jan-27	29	0	7	19	1	2	0	0	Reliance on roll-out of national Urology coding criteria

Audits and Inspection Reports - Summary

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommen-dations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Jun-24	Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine – BGH	Community and Integrated Medicine	Chief Operating Officer	Oct-25	N/K	11	2	0	3	6	0	0	0	Financial constraints and Workforce challenges
Jun-24	Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine - WGH	Community and Integrated Medicine	Chief Operating Officer	Oct-25	~~Oct-25~~ Nov-27	12	2	1	7	0	0	1	1	Financial constraints and Workforce challenges
Jun-24	Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine - GGH	Community and Integrated Medicine	Chief Operating Officer	Oct-25	~~Oct-25~~ ~~Apr-26~~ N/K	12	0	0	10	2	0	0	0	No barriers noted - awaiting formal approval to close.
Jul-24	Audit Wales	Review of Cost Savings Arrangements – Hywel Dda University Health Board	Director of Strategy and Planning	Director of Strategy and Planning	Mar-25	~~Mar-26~~ N/K	10	0	0	9	0	0	1	0	Awaiting approval to appoint senior service planners.
Oct-24	NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	Community and Integrated Medicine	Chief Operating Officer	Nov-25	Oct-26	58	8	0	35	15	0	0	0	No barriers noted

Audits and Inspection Reports - Summary

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommen-dations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Jan-25	Ministerial Advisory Group	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~~ ~~Jan-26~~ N/K	10	0	0	1	9	0	0	0	No barriers noted - awaiting formal approval to close.
Jan-25	Ministerial Advisory Group	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	Planned and Specialist Care	Chief Operating Officer	Mar-26	~~Mar-26~~ Sep-26	32	15	0	9	6	2	0	0	Funding and workforce resource constraints.
Jan-25	Ministerial Advisory Group	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~~ Oct-26	15	2	0	12	1	0	0	0	No barriers noted

Audits and Inspection Reports - Summary

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommen-dations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Jan-25	NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	Community & Integrated Medicine	Chief Operating Officer	Aug-25	~~Aug-25~~ N/K	19	5	0	14	0	0	0	0	No barriers 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~~ N/K	38	1	0	31	6	0	0	0	Pending outcomes of ongoing regional mortality review
Apr-25	Ministerial Advisory Group	A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity	Chief Operating Officer Management	Chief Operating Officer	Mar-26	~~Mar-26~~ Sep-26	11	2	0	1	6	2	0	0	Complexity of patients presenting, workforce constraints
May-25	Audit Wales	Tackling the Planned Care Challenges – Hywel Dda University Health Board	Planned and Specialist Care	Chief Operating Officer	Mar-26	~~Mar-26~~ N/K	6	2	0	2	1	0	0	1	Reliant on outcomes of Ophthalmology CSP
Sep-25	Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26	Community & Integrated Medicine	Chief Operating Officer	Dec-25	~~Dec-25~~ N/K	6	5	0	1	0	0	0	0	Internal Audit undertaking follow up in Q4 of 2026/27, with outstanding recommendations to be reviewed.

Audits and Inspection Reports - Summary

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommen-dations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Mar-26	Internal Audit	Space Utilisation Final Advisory Report 2025/26 (NEW REPORT)	Director of Strategy and Planning	Director of Strategy and Planning	Aug-27	Aug-27	8	0	4	4	0	0	0	0	No barriers noted – recommendations on track.
Mar-26	Internal Audit	Internal Escalation: Level 3 & 4 Functions Final Internal Audit Report 2025/26 (NEW REPORT)	Director of Finance	Director of Finance	Mar-26	~~Mar-26~~ N/K	7	4	0	3	0	0	0	0	No barriers noted
Apr-26	Internal Audit	Operational Governance Arrangements Final Internal Audit Report 2025/26 (NEW REPORT)	Chief Operating Officer Management	Chief Operating Officer	May-26	~~May-26~~ N/K	4	0	0	0	4	0	0	0	No barriers noted - awaiting formal approval to close.
May-26	Internal Audit	High-Cost Drugs Final Internal Audit Report 2025/26 (NEW REPORT)	Medical Director	Medical Director	Mar-27	Mar-27	7	1	5	0	1	0	0	0	No barriers noted
Jun-26	Internal Audit	WellSky Final (Advisory Report) 2025/26 (NEW REPORT)	Director of Finance	Director of Finance	Jul-26	Jul-26	1	0	1	0	0	0	0	0	No barriers noted – recommendations on track.

Audits and Inspection Reports closed since previous report

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Since the previous report presented to FPC, the following reports have been formally approved as closed:

Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Implementation Date	Number of recommendations in report	Report status
Internal Audit	Financial Management Final Internal Audit Report 2024/25 **(issued Mar 25)**	Director of Finance	Director of Finance	Jan-26	Jun-26 – closed following approval by Internal Audit	**5**	**Complete**
Internal Audit	Continuing Healthcare – Database Maintenance & Finance Processes Final Internal Audit Report 2024/25 (Substantial rating) **(issued June 25)**	Director of Finance	Director of Finance	Oct-25	Apr-26 – closed following approval by Internal Audit	**1**	**Complete**

Implementation of Ministerial Directions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Ministerial Directives (MDs) are legislative in character as they alter legal rights and duties. MDs are issued by Welsh Ministers and include codes of practice and guidance. In complying with the requirements of various governance codes and the Annual Governance Statement requirements, the Health Board has a duty to provide assurance of compliance with MDs.

The table below shows the number of MDs assigned to each category as of 22 July 2026, summarised over the next slides. Definitions of categories are included in the table below.

Status Category	Definition	Number of MDs
Overdue	The MD is behind schedule to the timescale provided by the lead officer.	1
Unable to Complete	The MD cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	0
Pending Decision	The MD is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.	0
In Progress	The MD is currently in progress, and within the agreed original timeframe for implementation.	0
Reliant on External Factors	The MD is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	0
Complete Pending Formal Approval	CCG / Function have confirmed compliance with the statutory requirements of the MD, and evidence send to relevant Lead Executive for confirmation.	0
Complete	CCG / Function have confirmed compliance with the statutory requirements of the MD, and receipt of approval to close obtained from Lead Executive.	8

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

3.1.18 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 - Overdue

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

MD	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status
WG21-59: The Directions to Local Health Boards and NHS Trusts in Wales on the Delivery of Autism Services 2021	26/07/2021	Mental Health and Learning Disabilities	Chief Operating Officer	~~30/03/2026~~ N/K	Overdue

The Health Board is exercising its functions in accordance with the relevant provisions of the Code of Practice on the Delivery of Autism Services (2021) with supporting evidence of this uploaded on AMaT. However, lengthy waiting times remain an issue.

WG is fully aware of the lengthy waiting times across Wales, as evidenced within their Neurodivergence Improvement Programme report; and the risk to patients of lengthy waiting times is recognised by the Health Board and is being monitored/managed by the Clinical Care Group with 1 corporate risk and 2 operational risks on the risk register: -

- Corporate Risk 1032 - Risk to the timely diagnosis and treatment of mental health and learning disabilities clients due to demand and capacity, which has a current risk score of 20 (last updated April 2026, noting that this is in the process of being refreshed before being presented to Formal Executive Team);
- Operational Risk 1287 - Risk of clients not being provided with timely interventions due to waiting lists for assessment & diagnosis of ASD, with a current risk score of 20 (updated June 2026);
- Operational Risk 1290 - Risk of increased Adult ADHD waiting list due to referrals exceeding service capacity, with a current risk score of 20 (updated June 2026).

Submitted to Chief Operating Officer for review, however MD not formally approved for closure due to waiting times still breaching. Deputy Chief Operating Officer has requested a full review of the MD in July 2026.

Complete Ministerial Directions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Since the previous report to the Committee, the following MDs have been confirmed as implemented and formally approved as closed (**Complete**):

MD	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status	Progress Update
WG25-84: Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 6) Directions 2025	02/12/2025	Primary Care	Chief Operating Officer	14/03/2026	**Complete**	Statement of Financial Entitlement supports the contractual payment mechanisms.
NWSI 2026 No.58: The Primary Medical Services (People Living with Severe Frailty in their own Homes) (Directed Supplementary Service) (Wales) (Amendment) Directions 2026	18/03/2026	Primary Care	Chief Operating Officer	10/04/2026	**Complete**	Global sum arrears paid this month to GP practices to correct error in rate
NWSI 2026 No.47: Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2026	10/03/2026	Primary Care	Chief Operating Officer	10/04/2026	**Complete**	MD removes end date for a Service claimed by GP practices to enable ongoing claims.
NWSI 2026 No.71: Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2026	31/03/2026	Primary Care	Chief Operating Officer	15/05/2026	**Complete**	Uplift to Global Sum Calculation rate which will apply to GP payments from April 26 onwards

Complete Ministerial Directions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Since the previous report to the Committee, the following MDs have been confirmed as implemented and formally approved as closed (**Complete**):

MD	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status	Progress Update
NWSI 2026 No.76: Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment No.2) Directions 2026	07/04/2026	Primary Care	Chief Operating Officer	15/05/2026	**Complete**	MD is for information only. No further action required by Primary Care.
NWSI 2026 No.83: Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 5) Directions 2026	02/04/2026	Primary Care	Chief Operating Officer	15/05/2026	**Complete**	Changes to payment rates for Access and Achievement under Quality Improvement domain
NWSI-26-116: The Primary Care (Contracted Services: Immunisations) (COVID19) (Wales) Directions 2026	23/06/2026	Primary Care	Chief Operating Officer	20/07/2026	**Complete**	Will be transacted as changes to the current contractual arrangements for the immunisation programmes. Direction informs the process for this year's campaign for GP practices to claim for these vaccinations (using the DHCW WIS system). When the campaign begins we receive a payment schedule every month informing us of totals to pay to practices.
NWSI-26-117: The Primary Care (Contracted Services: Immunisations) (Influenza) (Amendment) Directions 2026	23/06/2026	Primary Care	Chief Operating Officer	20/07/2026	**Complete**	Direction informs the process for this year's campaign for GP practices to claim for these vaccinations (using the DHCW WIS system). When the campaign begins we receive a payment schedule every month informing us of totals to pay to practices.

Recommendations

The Finance and Performance Committee is requested, in relation to the areas presented in this paper, to: -

RISK MANAGEMENT

- **RECEIVE ASSURANCE** that there are processes in place to oversee corporate risks to ensure these are being managed effectively.

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, any barriers to delivery and subsequent 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 MDs issued by Welsh Government.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Jul-26	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score	Risk on page no...
2326	Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding	Thomas, Huw -	Finance inc. claims	**4×5=20**	**4×5=20**	→	**3×4=12**	6/30/2026	6
2380	Risk to delivery of Single Cancer Pathway performance due to diagnostic capacity gaps, funding uncertainty and pathway fragility	Carruthers, Andrew	Quality/Complaints/Audit	NA	**3×4=12**	New risk	**2×4=8**	3/31/2027	11
2327	Risk to planned care and RTT recovery in 2026/27 due to demand-capacity gaps, estate fragility and non recurrent funding	Carruthers, Andrew	Quality/Complaints/Audit	**3×4=12**	**3×4=12**	→	**3×3=9**	3/31/2027	16

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
		Corporate Risk Description:			
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	
	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

Date Risk Identified:	Apr-26
Strategic Objective:	1. Thriving Teams and 2. Healthier Communities and 3. Great Care and 4. Positive Futures

Executive Director Owner:	Thomas, Huw -	**Date of Review:**	Jul-26
Lead Committee:	Finance and Performance Committee	**Date of Next Review:**	Aug-26

Risk ID:	**2326**	**Corporate Risk Description:**

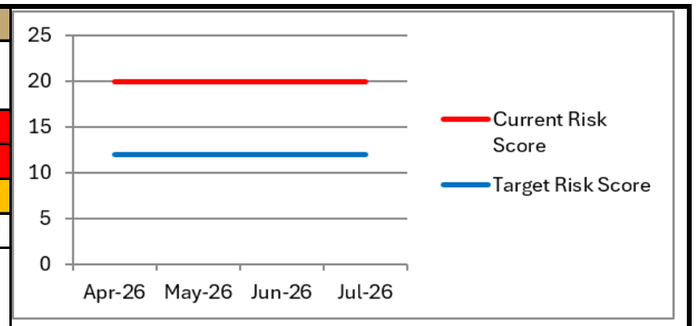
There is a risk that the Health Board does not deliver a 2026/27 financial out-turn within the expected Target Control Total (TCT), and that Welsh Government (WG) is therefore unable to fund the cash consequences of the residual deficit.

This is caused by an unsupportable 2026/27 Annual Plan position, with a £41.0m deficit requiring improvement to £22.0m, £42.8m of savings needed to deliver the plan, and a further £19.0m to achieve the Target Control Total. The risk is driven by a large opening run rate deficit of £54.3m to £90.5m, depending on plan delivery, low levels of assured savings against £42.8m requirement, reliance on unconfirmed and non recurrent measures, insufficiently developed variable pay controls, uncosted Planning Framework requirements, and significant unmitigated service risks.

This could lead to an impact/affect on the Health Board's ability to meet supplier payments in the final quarter of 2026/27, the need for operational mitigations that may extend patient waiting times and affect performance, reputational damage with WG and other stakeholders, escalation of the finance domain from Targeted Intervention to Special Measures, and potential Level 4 internal

Does this risk link to any Directorate (operational) risks?	2212, 2132, 2148, 2131, 2110, 1869, 1631, 975, 2107, 1906, 1892, 971, 2040, 2124, 2045, 1951, 716, 134, 1775, 1773, 1931, 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:	6/30/2026
Trend:	⟷



Rationale for CURRENT Risk Score:

The 2026/27 Financial Plan submitted to Welsh Government (WG) in March 2026 projected a £41m deficit. WG advised that the plan was neither supportable nor acceptable and reiterated its expectation of a £22m deficit. Of the £42.8m savings requirement, only £5.0m was assessed as Amber/Green assured, with a further £6.4m of Blue/Red opportunities yet to be converted into deliverable schemes. Sensitivity analysis forecast a year-end deficit of between £54.3m and £90.5m, requiring a minimum of £13.3m of additional savings.
A 4-Step Financial Improvement Framework was issued on 31 March 2026, followed by Chief Executive reviews in April 2026. An interim update to the Board in May 2026 demonstrated improvement in the financial trajectory, confirmed Executive ownership of variable pay workstreams, and outlined workforce plans across nursing, medical and other staff groups. By June 2026, all open actions had been completed, , and variable pay plans deliverable in-year and evidenced. A credible, recurrent opening baseline was confirmed, and reliance on non-recurrent measures has been addressed.
A revised COO Operating Model, including CCG Delivery Agreements aligned to the Levels 1-4 Performance Escalation Framework, was developed and approved by the Formal Executive Team in July 2026. A System Leaders Workshop and Executive-owned delivery programme were also established. WG has been advised that Quarter 2 activity is required to further de-risk delivery of the financial plan.

Rationale for TARGET Risk Score:

The Target Risk Score (TRS) reflects the position expected once the 4-Step Financial Improvement Framework has been delivered and the supporting control architecture is operating. Pace is essential.

The previous date to achieve the TRS of 30/06/2026 was aligned to the 4-Step Financial Improvement Framework, however this has now passed, and signals that the Health Board has not been able to exert sufficient grip on the largest controllable in-year expenditure line. There is a likelihood that the risk score could increase if the July 2026 position does not signal a run rate improvement closer to our monthly planned deficit. The date to achieve the TRS is therefore extended until 30 September 2026.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1. Working Day 1 principles retained within the finance function to ensure timely 'Flash reports' to the Executive Team. 2. Timely, relevant and understandable reporting to budget managers, Executives, Committees, Board and WG via QlikSense (live, self-service) and monthly management information packs. 3. Oversight arrangements through Integrated Quality, Financial Performance and Delivery Group, Value and Sustainability Group, and the Healthier Mid and West Wales Group. 4. Executive meetings and the Internal Escalation Framework embedded across the organisation, covering seven domains including Finance. 5. Financial control scrutiny of agency medical, agency AHP, Admin and Clerical and newly created roles for recruitment and procurement. 6. Opportunities compendium framework, updated and shared monthly. 7. Substantive operational structures in place since April 2025, providing managerial clarity and consistent accountability. 8. Business Controlling team alignment to CCG/CSG and Executive Function management structures. 9. CCG Accountability Agreements to be created and issued for 2026/27. 10. Director of Finance 4-Step Financial Improvement Framework cascaded on 31 March 2026 and reviewed by the Executive Team on 8 April 2026. 11. CEO-led review cycle on 22 and 29-30 April 2026 against the 4-Step Framework; Board update on 28 May 2026. 12. Revised COO Operating Model (draft, April 2026) introducing CCG Delivery Agreements covering Quality & Safety, Finance, Workforce, Risk, Performance and Transformation, to be issued by 30 April 2026, and a Performance Escalation Framework (Levels 1 to 4) aligned to a tiered meeting structure. 13. Value Opportunities Catalogue (SBAR, April 2026) covering ten clinical and operational domains and over 25 national enabling actions from the NHS Wales 2026/27 Planning Framework, providing a defined starting set for pathway and productivity improvement. 14. Director of Finance Choices and Value workbook (9 April 2026) consolidating specific cash-out and productivity opportunities across	Material residual gaps in control are: Primary controllable gap: Variable pay (substantive bank, overtime, waiting list initiatives and agency) is the single largest in-year controllable expenditure line. Across nursing, medical and other staff groups, there is not yet a deliverable plan covering the three dimensions of (i) recruitment assurance, (ii) deployment (rostering, sickness management, medical job planning), and (iii) configuration (establishment, service model, site working). Other open gaps: 1. Limited assured savings plans: only £5.0m of Amber/Green against the £42.8m 2026/27 requirement. 2. £6.4m of Blue/Red (unconfirmed) savings ideas not yet converted into deliverable plans. 3. Continued reliance on non-recurrent measures carried from 2025/26. 4. Effective management of beds and patient flow. 5. Effective contract management and oversight of commissioned services. 6. Organisational change delivery capacity, including transformation resourcing and alignment. 7. Revised COO Operating Model remains in draft; CCG Delivery	Nursing - configuration: review and confirm nursing establishments, ward and bed base alignment, skill mix and safe staffing levels. Configuration options to May Board (28 May 2026); decisions confirmed and consequential variable pay release evidenced by 30 June 2026.	Carruthers, Andrew	~~30/06/2026~~ 30/09/2026	Linked to Choices and Value workbook beds-related opportunities and to the Value Opportunities Catalogue. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.
		Medical - deployment: consultant job planning compliance trajectory toward the NHS Wales >90% standard (national deadline 30 September 2026); medical rostering system implementation; sickness absence management; tight controls over waiting list initiative and overtime usage. Interim position to May Board (28 May 2026); deployment plan and early compliance evidence by 30 June 2026.	Henwood, Mr Mark	~~30/06/2026~~ 30/09/2026	Medical rostering programme continues from 2025/26 with further milestones and quantified benefits to be articulated. 30 June 2026 is the Health Board internal deadline; 30 September 2026 remains the national job planning compliance target. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.
		Medical - configuration: review service model, on-call arrangements and site working (including single-site and cross-site consolidation) with consequential release of variable pay requirement. Options to May Board (28 May 2026); preferred direction confirmed by 30 June 2026.	Carruthers, Andrew	~~30/06/2026~~ 30/09/2026	Linked to Choices and Value workbook strategic opportunities (including Bronglais maternity/paediatrics, radiology OOH, pathology site model). Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.

beds, theatres, AHP, clinical variation, workforce and strategic opportunities to inform the £41m to £22m trajectory. 15. System Leaders Workshop (Nantgaredig, 15 April 2026) engaging CCG and Deputy leadership on value priorities, the financial outlook and collective capacity for delivery. 16. Financial Accountability Letters issued to all Executive Portfolios and Functional Deputies for return and signing by 31st March 2026.	Agreements not yet issued; Level 4 escalation triggers, finance authority at each operating layer, and the executive team mechanism between Level 3b and CEO are not yet defined. 8. Value Opportunities Catalogue identifies opportunities but is not yet converted into delivery at scale.	Allied Health Professions and Health Sciences: deliver trajectory toward 30% agency reduction against 2025/26 outturn; zero agency in HSW, Admin and Clerical, Estates and Ancillary (national deadline 30 September 2026); AHP Rate Card implementation; sickness absence reduction. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Severs, James	~~30/06/2026~~ 30/09/2026	Targets drawn from NHS Wales 2026/27 Planning Framework. 30 June 2026 is the Health Board cadence deadline for deliverable plans; national zero-agency targets sit at 30 September 2026. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.
		Other staff groups (Admin and Clerical, Estates and Ancillary, Trainees): deliver trajectory toward 30% agency reduction against 2025/26 outturn; zero agency in HSW, Admin and Clerical, Estates and Ancillary (national deadline 30 September 2026); AHP Rate Card implementation; sickness absence reduction. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Gostling, Lisa	~~30/06/2026~~ 30/09/2026	Targets drawn from NHS Wales 2026/27 Planning Framework. 30 June 2026 is the Health Board cadence deadline for deliverable plans; national zero-agency targets sit at 30 September 2026. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance against the 2026/27 operational plan and targets through key performance indicators. In-month financial monitoring and forecasting against	Performance against plan monitored through Executive Improving Together meetings, 4-Step Financial Improvement Framework and CCG monthly performance reviews.	1st			Executive Team - 8 April 2026 (4-Step Framework) System Leaders Workshop - 15 April 2026 (Nantgaredig) Chief Executive Reviews - 22 and 29-30 April 2026	Assurance gaps carried into 2026/27: 1. Limited Amber/Green assurance over 2026/27 savings delivery (£5.0m of £42.8m). 2. Outstanding Audit Wales and Internal Audit	Nursing - recruitment assurance: confirm substantive recruitment pipeline and fill rates against funded establishment; reduce routine reliance on on-contract nursing agency; HCSW agency trajectory to zero. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Daniel, Sharon	~~30/06/2026~~ 30/09/2026	Plan to be developed through the April 2026 CEO Review cycle; first cut to May 2026 Board. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.

the £41.0m plan, with trajectory toward the £22.0m improvement target. Implementation of CCG Delivery Agreements and Performance Escalation Framework (Levels 1 to 4).	Finance and Performance Committee oversight of 2026/27 plan delivery and improvement trajectory.	2nd			Finance and Performance Committee 30 April 2026 Board - 28 May 2026 (plan improvement action from £41m to £22m) In-Board Committee 18 June 2026 - opportunity decisions Finance and Performance Committee 30 June 2026 Executive Team 8 July 2026 Senior leadership savings engagement event 9 July 2026 - to progress the pace of savings	recommendations from 2025/26 (operational governance, discharge management, rostering). 3. Delivery of change remains a longstanding issue. 4. WG has rejected the £41m submitted position, so external assurance over plan acceptability is not yet in place. 5. Year 1 Value Opportunities Catalogue excludes digital, primary care, equity, workforce capability and prevention economics, limiting the assurance scope until year 2/3 iterations are developed.	Nursing - recruitment assurance: confirm substantive recruitment pipeline and fill rates against funded establishment; reduce routine reliance on on-contract nursing agency; HCSW agency trajectory to zero. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Daniel, Sharon	~~30/06/2026~~ 30/09/2026	To be progressed through the COO Operating Model and Delivery Agreements (issued by 30 April 2026), with weekly drumbeat thereafter. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.
	Transformation and Financial Report to Board and Finance and Performance Committee.	2nd					Medical - recruitment assurance: confirm substantive and international medical recruitment plans against consultant and SAS vacancies; eliminate off-contract medical agency; enforce Medical Rate Card compliance. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Henwood, Mr Mark	~~30/06/2026~~ 30/09/2026	Medical Rate Card implemented 1 March 2026 (estimated £380k annual cost increase; approved for fairness and governance). Recruitment assurance plan to be developed through April CEO Review cycle. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.
	WG scrutiny through Monthly Monitoring Returns and NHS Exec Financial Planning and Delivery team.	3rd					Operational oversight and control will be consistently embedded following the review and implementation of Phase 2 of the Operational Organisations Change Process (OCP), providing clear, timely and specific escalation interventions for all Clinical Care Groups that are not delivering their targeted financial savings.	Carruthers, Andrew	~~30/06/2026~~ 31/12/2026	The OCP2 task and finish group was formed in Apr26, with expertise from finance, workforce & od, and communications & engagement, chaired by the Deputy COO and meets weekly to review progress across the CCGs, monitor and mitigate emerging risks, and ensure that proposals are being developed in line with the All-Wales OCP. A paper was presented to PODCC in May 2026 providing a progress update and next steps. OCP2 documentation was approved by FET in Jul26 to commence the consultation process, closing 20Jul26, with implementation expected by Dec26.
	Audit Wales Structured Assessment process.	3rd								

Date Risk Identified:	Apr-26		
Strategic Objective:	3. Great Care and 4. Positive Futures		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jun-26
Lead Committee:	Finance and Performance Committee	**Date of Next Review:**	Aug-26

Risk ID:	**2380**	**Corporate Risk Description:**	There is a risk of the Health Board not being able to maintain the current level of Single Cancer Pathway (SCP) performance between 64-66% (2025/26) as per the Board approved Annual Plan 2026/27, and make further improvement towards the national 75% standard in 2026/27. This is caused by gaps in capacity to meet the expected demand for diagnostics (within radiology, cellular pathology and endoscopy), uncertainty over continuation of Welsh Government non recurrent funding, treatment delays internally due to theatre fragility and at our tertiary centres, compounded by fragility within key tumour sites (urology, lower GI, skin). This could lead to an impact/affect 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)		**No trend information available.**
Domain:	Quality/Complaints/Audit	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	3×4=12	
Target Risk Score (L x I):	2×4=8	
Expected Date To Achieve TRS:	3/31/2027	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:

The service has been de-escalated by Welsh Government from Level 4 to Level 1 in terms of Targeted Intervention status as there has been the consistent achievement of the 60% de-escalation criteria since February 2025. As at March 2026 performance was at 60%.

Due to recovery actions within radiology and urology we may see variation in performance as we recover and treat those patients over 62 days.

Confirmation of target for March 2027 is 75%, however no health board is achieving this target. Plans are in place for Q1 to maintain performance at the planned trajectory set out in the Annual Plan 2026/27.

Rationale for TARGET Risk Score:

The aim is to treat patients within target waiting times, which has now been confirmed as 64-66% as per Annual Plan 2026/27.

The target risk score will be met if plans to maintain diagnostic capacity, utilising internal allocated funding, are realised. The risk score can be further reduced to a 8 once the target of 66% is achieved and maintained for 3 consecutive months. 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**
Sustainable pathway change with the lower GI pathway (FIT Fecal Immmochemical test, NICE NG12) from primary to secondary care commenced Nov25 resulting in 75% reduction in new outpatient demand, 45% reduction in radiology demand and improvement of straight to test compliance in Q1. Accelerated imaging from Endoscopy to CT within the GI pathway now in place across all sites, reduction time on patient pathway by 23 days Established cancer tracking team in place to allow patients to be proactively tracked through their pathways. A cancer dashboard developed by Informatics with the support of Business Intelligence (BI) SCP funding from the Wales Cancer Network 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 Performance & Improvement. 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.	Anticipated significant gaps/service fragility within key diagnostic services to address required levels of activity to support SCP Uncertainty on WG recovery funding for 2026/27 Lack of resilience within theatre estate (no decant theatre to manage future fire & estate works) Capacity at tertiary centres causes delays in surgical pathway resulting in patients exceeding 62 days Limited patient tracking resource available for all tumour sites 480 patients (34% of which will be a confirmed cancer and awaiting treatment) waiting in excess of 62 days for either diagnostic or treatment	Agree additional diagnostic capacity for Q2 taking into account the absence of WG recovery allocation.	Humphrey, Lisa	30/06/2026	Progress to be provided at next risk review
		Undertake a full gap analysis between assessed workload and funded establishment within the anaesthetic workforce to stabilise services, reduce risk, and mitigate ongoing variable pay expenditure	Humphrey, Lisa	31/05/2026	Progress to be provided at next risk review
		Producing a full recruitment plan for theatre workforce in line with Nurse Staffing Act and allocation of new investment of £1.4m for 2026/27	Humphrey, Lisa	30/06/2026	Progress to be provided at next risk review

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. 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 in Q1 2026/27. Pilot of Galeas bladder urine test to early diagnosis, surveillance and recurrence monitoring risk stratification in haematuria pathways, and reduce unnecessary cystoscopies, improving patient experience and freeing diagnostic and endoscopy capacity. Monitoring of Urology diagnostic improvement trajectory via Cancer Operational Delivery Group. Agreement to continue outsourcing MRIs for patients on prostate pathway within urology. 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.			
Explore outsourcing for prostatectomies	Humphrey, Lisa	30/06/2026	Progress to be provided at next risk review
Explore reallocation of funding within the Planned Care and Cancer cost centres to increase patient tracking capacity	Humphrey, Lisa	30/06/2026	Progress to be provided at next risk review

Pathway changes in Head and Neck to include Laryngeal Biopsy at first OPA, reducing reliance on pan-endoscopy One stop hysteroscopy in gynaecology across all sites. Health Board wide internal escalation framework now in place to support the monitoring of performance targets. Additional radiology scanning capacity in place for Q1 2026/27. 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. Allocation of recovery funding for Q1 for pathology turnaround plan.		Undertake weekly oversight of backlog trajectory plan in place for all tumour sites for Q1 to reduce 180 by March 2027	Humphrey, Lisa	31/03/2027	Progress to be provided at next risk review

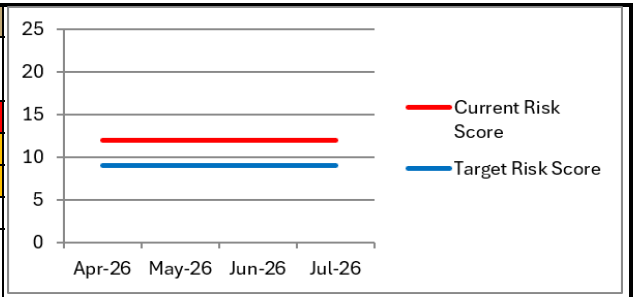
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
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			Annual Plan 2026/27 sets out Cancer trajectories for 2026/27 - Board (Mar27)	Currently there is no Cancer Oversight Group (Board) in the Health Board	Establish a HDdUHB Cancer Oversight Group to provide strategic oversight and planning	Goode, Paula	30/06/2026	Progress to be provided at next risk review
	IPAR Performance Report to FPC & Board	2nd					Establish an Internal Clinical Care Group Oversight Rereferral to Treatment and Cancer Group	Goode, Paula	30/06/2026	Progress to be provided at next risk review
	Monthly oversight by NHS Performance & Improvement/WG	3rd								
	Monthly operational oversight via the CCG Integrated Governance Group	1st								

Date Risk Identified:	Apr-26		
Strategic Objective:	2. Healthier Communities and 3. Great Care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jun-26
Lead Committee:	Finance and Performance Committee	**Date of Next Review:**	Aug-26

Risk ID:	**2327**	**Corporate Risk Description:**	There is a risk that the Health Board will be unable to fully deliver planned care and RTT recovery trajectories for 2026/27, including sustained improvement in key diagnostic specialties and planned care waiting times, as set out in the Health Board's Annual Plan 2026/27. This is caused by a structural mismatch between demand and capacity that remains after all credible productivity, absence of recovery funding, efficiency, and enabling actions have been exhausted, alongside specific service pressures such as theatre estate disruption at Glangwili, general theatre estate fragility across remain sites and absence of decant theatre, and reliance on nonâ€'recurrent diagnostic stabilisation funding. This could lead to an impact/affect on the Health Board's ability to meet national RTT and diagnostic performance requirements, increased waiting times (including 26-for first outpatient appointment and no patient waiting over 2 years for treatment (104â€'week backlogs), reduced resilience in planned and cancer care pathways, potential reâ€'escalation of national performance interventions, and associated adverse impacts on patient experience, clinical outcomes, and organisational reputation.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
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:	3/31/2027
Trend:	⟷



Rationale for CURRENT Risk Score:

The Health Board faces delivery risks in achieving ministerial planned care recovery targets by March 2027 due to combined pressures of cohort demand in key specialties and workforce limitations. Theatre cancellations at Glangwili General Hospital have further reduced core capacity, particularly impacting Orthopaedics, where additional demand from long-waiting patients persists. While delivery plans demonstrate progress in outpatient activity, treatment capacity, and workforce improvements, gaps remain, and performance against planned care milestones continues to underpin the Health Board's Targeted Intervention status. Estates issues are impacting theatre list cancellations. Regional collaboration with Swansea Bay UHB is being actively pursued to expand capacity in Ophthalmology and Orthopaedics, including the use of Neath Port Talbot theatres. In the absence of recovery funding, 104-week breaches are predicted in Orthopaedics, Urology, T&O, ENT, Ophthalmology and Dermatology. The current risk score is assessed at 12, lower than the inherent risk score, as the Board have accepted the trajectories set out in the Annual Plan.

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.

Opportunities to make further progress towards the Ministerial targets in 2026/27 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. # 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	# Additional Planned Care Recovery proposals developed however no recovery allocation planned in 2026/27 to date (this includes inability to fund insourcing and outsourcing activity in ophthalmology and dermatology) # Lack of resilience within theatre estate (no decant theatre to manage future fire & estate works) # Workforce staffing availability to support further expansion of theatre capacity # 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 # Sufficiency of Anaesthetic medical staffing capacity to support existing capacity and further expansion of required operating lists # Widespread adoption of national best practice guidance to improve elective optimisation and utilisation of available operating capacity # Deficiencies within pre-operative	Agreed continuation of ophthalmology outsourcing for Q1, utilising ophthalmology and dermatology underspend with core budget	Humphrey, Lisa	Completed	Q1 activity paused for month of June and beyond in the absence of recovery allocation
		Progress proposal for recruitment of fixed term locum to utilise NPT theatres to mitigate loss of activity as a result of theatre estate issues at block 32 at GGH (c.150 cases)	Humphrey, Lisa	Completed	This program was rejected
		Increase capacity to four primary joints on 90% of Orthopaedic lists (Enabling Actions)	Gregory, Lianne	31/03/2027	In progress
		Producing a full recruitment plan for theatre workforce in line with Nurse Staffing Act and allocation of new investment of £1.4m for 2026/27	Walsby, Alexandra	19/08/2026	In progress
		Complete optimisation framework assessment to address WG 3 top priorities which are referral management, waiting list validation across stages and conversation of follow up activity to new outpatient capacity	Humphrey, Lisa	Completed	Optimisation frameworks complete and submitted
		Develop trajectories of improvement per specialty based on the optimisation framework assessment to identify productivity and efficiency gains	Humphrey, Lisa	Completed	New Trajectories have been produced that improved the board approved position from 5,500 to 3,800
		Develop a model of standardised assessment for the pre-assessment process to streamline pre-assessment and eliminate bottlenecks	Carmody, Sarah	30/09/2026	In progress.

weekly RTT Optimisation Group # Working with Johnson and Johnson to review and develop a model of standardised assessment for the Pre-assessment process # Insourced capacity to support theatre staffing workforce deficits at GGH	assessment process and overall capacity to support required volume of Pre-Operative Assessment Clinic (POAC) assessments # Cessation of PAAR in delivery of waiting list initiatives	Develop mitigation plans for areas that are reliant on PAAR (neurology, outpatients)	Humphrey, Lisa	Completed	Monitoring impact of PAAR cessation during Apr26. Ongoing communication with A4C staff has improved the uptake of agreed additional activity in Q1.
		Continuation of insourcing at GGH theatres utilising £1.6m until established staffing is sustainable	Humphrey, Lisa	31/03/2027	In progress
		To produce outline of aspiration aligned to GIRFT Report with associated timescales with the GIRFT Theatres Implementation Group, chaired by Medical Director, established to produce plan on a page that assesses current position, utilisation, staffing, effectiveness, patient outcomes, quality & safety, and estates.	Humphrey, Lisa	31/03/2027	In progress. Monthly reporting required to Formal Executive Team.
		To undertaken a full gap analysis between assessed workload and funded establishment within the anaesthetic workforce to stabilise services, reduce risk, and mitigate ongoing variable pay expenditure	Humphrey, Lisa	19/08/2026	In progress. No being progressed by Craig Tout Interim GM for Theatres, Aneasthetics and Critical Care

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		
	Activity volumes are reported daily on situation reports	1st			
	Daily performance data overseen by service management	1st			
	Delivery Plans overseen by Planned Care Clinical Care Group Integrated Governance Group	1st			

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

IQFPD	2nd						
Executive Recovery / Improving Together Sessions	2nd						
Bi-monthly reports to SPC on progress on delivery plans and outcomes (and to Board via update report)	2nd						
IPAR Performance Report to SPC & Board	2nd						
Welsh government Scrutiny via NHS Performance and Improvement	3rd						

Report Issued By	Report Title	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R12. Introduce standardised risk (in line with College guidance) and priority ratings for cataract surgery and change waiting list forms to support this	1) Review current waiting list forms and agree clear priority ratings. 2) Develop protocol to align with waiting list forms with clear priority ratings. 3) Implement new waiting list forms.	Nadia Randazzo/ Amorelle Jones	Oct-25	~~Oct-25~~ ~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R15. Introduce high flow principles and processes to cataract lists and patients of ANY complexity to drive higher numbers of cases in all lists. Send for patient early enough to ensure they are ready in the anaesthetic room to enter theatre once the last case finished.	1) Review BGH and GGH suitability for high flow lists 2) If environment is not deemed suitable review process for current delivery of complex patients. 3) Review patient pathway and reduce delays with patient arriving in theatre.	Nadia Randazzo/Marta Barreiro Martins	Mar-26	~~Mar-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R17. Non-medical MDT staff admitting the cataract patients should be trained and empowered to mark the eye, check or take consent etc – consider whether to involve the clinical nurse and optometrist practitioners and/or train the day surgery staff. Do not do routine obs on the day.	1) Review staff training to mark the eye with Senior Nurse Manager. 2) Review process for baseline obs	Amorelle Jones/ Marta Barreiro Martins	Apr-24	~~Apr-24~~ ~~Jul-24~~ ~~Dec-24~~ ~~Jul-25~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R21. Do not have patients climbing on and off a trolley in the operating room - position patients in the anaesthetic room and wheel the patient in and out on trolley or couch.	1) Check if theatre trolleys are fixed in theatres or if surgical trolleys can be wheeled in AVH- BGH- GGH-	Marta Barreiro Martins	Mar-26	~~Mar-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R24. Rationalise cataract surgery to only units that are, or can be changed to be, suitable for high flow. Move other work out of the most suitable units to accommodate this.	1) Move IVT out of AVH OPD back to Pembrokeshire. 2) Move IVT service out of day theatre into AVH OPD. 3) Increase cataract delivery through AVH theatre.	Amorelle Jones/ Marta Barreiro Martins	Mar-26	~~Mar-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R35. Establish staggered patient arrival times to reduce the patient journey time. Explore how discharge process can be shorter.	1) Align staggered arrival times in line with consent in pre-assessment (outlined above). 2) Review of current discharge processes across site and standardise documentation and processes.	Marta Barreiro Martins	Apr-24	~~Dec-24~~ ~~Jul-25~~ Sep-26	Overdue
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R46. Review the footprint and usage of all the outpatient areas and create ophthalmology and subspecialist areas with teams and all equipment in one or two area/sites for glaucoma.	1) Review current structure and delivery. 2) Plan new structure and delivery. 3) Commence new structure and delivery. This action may be restricted by cost to implement.	Amorelle Jones/ Marta Barreiro Martins	Mar-26	~~Mar-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R47. Work with the health board and the regional team to find a better outpatient solution, fit for modern ophthalmic care and the longer-term rising population demand which can support training the MDT. Consider all options for the regional collaboration with other relevant health boards.	1) Review where SAS doctors currently support Consultant clinics to identify training opportunities. 2) Develop SAS doctors and non medical staff in line with training needs and liaise with SBUHB for support with development.	Amorelle Jones/ Marta Barreiro Martins	Mar-26	~~Mar-26~~ N/K	Overdue
Audit Wales	Tackling the Planned Care Challenges – Hywel Dda University Health Board	N/A	R1. The Health Board should ensure that updated strategies and plans (A Healthier Mid and West Wales Strategy and the clinical services plan) sufficiently set out a route map to sustainable planned care services. The plan should be costed, with realistic but challenging milestones within it	The Clinical Services Plan programme was established to develop a set of plans for the provision of key services over the medium term. Currently in Phase 3 – Public Consultation. Public consultation will enable the Board to make a formal decision on the nine services in scope, which include Dermatology, Ophthalmology, Urology, Endoscopy, Orthopaedics, and Emergency General Surgery within the Planned Care domain, as well as the potential roles of the hospitals until the full implementation of the 'A Healthier Mid and West Wales' strategy. The results of this consultation and subsequent decisions are planned to be made in Winter 2025. It is therefore anticipated that the adoption of significant actions in relation to implementation plans will commence following this gateway to Phase 4 - Implementation. Anticipated completion date for CSP Phase 3 Board decision: Winter 2025 NLT JAN2026 The refresh of the A Healthier Mid and West Wales has just begun, with initial work to scope what elements need to be revised and where additional matters may need to be included. It is envisioned that a refreshed strategy will be informed by the Clinical Services Plan, as well as set out the scope for any future service transformation that may be required for the future, as the strategy will be refreshed to consider up to 2040 (the existing strategy considered up to 2038). The expectation is that the Discovery phase of the strategy refresh will be concluded by January 2026, with the intention to inform the 1st year of the 3-year plan for 2026/2027, as well as initiate the development of strategic delivery plans (where not already in place) to shape planningprocesses.	Lee Davies	Mar-26	~~Mar-26~~ N/K	Overdue

Report Issued By	Report Title	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Audit Wales	Tackling the Planned Care Challenges – Hywel Dda University Health Board	N/A	R5. The Health Board should ensure timely completion of recommendations arising from the Getting It Right First-Time reports	GIRFT recommendations are put onto the AMAT system (Audit Management & Tracking) where recommendations, timescales and completion dates are tracked to ensure timely completion. AMAT progress is scrutinised via the HB performance management arrangements and escalation process, with assurance on progress provided via the Board governance process. Overdue actions are scrutinised by ARAC • Urology GIRFT - there are currently 0 overdue recommendations, 6 on track, 16 complete, 4 partially complete and 3 'external' (outside the gift of the HB currently). • General Surgery GIRFT - there are currently 0 overdue & 21 complete. • Ophthalmology GIRFT – 16 actions are linked to CSP, additional funding or regionalisation, 4 are on track and 39 complete	Paula Goode	Mar-26	~~Mar-26~~ N/K	Overdue
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)	N/A	R21. Cataracts per lists to rise to 8 urgently will increase productivity by 100%-125%.	Review theatre efficiencies in GGH/BGH to see where there is a possibility to increase theatre delivery further.	Amorelle Jones	Mar-26	~~Mar-26~~ N/K	Overdue
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).	N/A	R5. Frailty is challenging. ED staff were not aware of the frailty pathway, despite being award winning. Specific focus on delayed pathways of care in the frailty ward should be prioritised, and improved links between the FAU and the ED to reduce the significant corridor care in the ED.	Undertake a review of the acute and community frailty pathway to join the pathways across the system, with a POCS deep dive on Cadog and Dewi wards (long stay frailty)	Iona Evans	Aug-25	~~Aug-25~~ ~~Feb-26~~ Oct-26	Overdue
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).	N/A	R5. Frailty is challenging. ED staff were not aware of the frailty pathway, despite being award winning. Specific focus on delayed pathways of care in the frailty ward should be prioritised, and improved links between the FAU and the ED to reduce the significant corridor care in the ED.	Undertake review of Frailty SOP to review current length of stay challenges, pathway of care delays, and to determine immediate actions to improve on pathway review communication	Louisa Standeven	Aug-25	~~Aug-25~~ ~~Feb-26~~ Oct-26	Overdue
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).	N/A	R6. Executive presence in the ED was reported as low, a survey of staff could be done to gauge if this is consistently felt among staff, and if so look to increase presence of exec team.	Weekly ED big room meetings are in place, chaired by the Executive Director of Nursing. A Glangwili ED staff survey has been undertaken in May 2025, with a review of outcomes to be undertaken and an action plan developed as appropriate. Outcomes will be fed-back to the Clinical Care Group. An additional staff survey is to be scoped and approved.	Louisa Standeven	Jul-25	~~Jul-25~~ Jul-26	Overdue
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)	N/A	R1. Ensure maximum productivity at surgical hubs at Amman Valley (ophthalmology) and Prince Phillip (orthopaedics).	Orthopaedics: Wider work is required to undertake a review of theatre workforce models in order to improve theatre efficiencies. Key enablers of this work being theatre staffing and anaesthetics.	Lianne Gregory	Dec-25	~~Dec-25~~ N/K	Overdue
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)	N/A	R1. Ensure maximum productivity at surgical hubs at Amman Valley (ophthalmology) and Prince Phillip (orthopaedics).	Orthopaedics: Implement plans for robust 24/7 medical cover for Orthopaedics in PPH	Lianne Gregory	Dec-25	~~Dec-25~~ N/K	Overdue
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)	N/A	R2. Maximise Day Case surgery at Withybush supporting Swansea Bay UHB by undertaking in benign upper GI surgery e.g. cholecystectomy, hernia repair etc.	There is capacity in the current theatre template for ambulatory surgery and theatre staff available which is serviced by GA anaesthetics but a full review of HB job plans would be required .Executive team approval to recruit urgently two replacement Consultant appointments of upper GI post that will join the WGH on call rota and undertake their elective surgery at WGH and clinics at GGH	Caroline Lewis	Dec-25	~~Dec-25~~ N/K	Overdue
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)	N/A	R3. Ensure day case and IP activity is maximised at Bronglais.	With funding, open and expand further theatre sessions (as noted in Bronglais Strategy and IMTP submission of Nov21). Would need to fully re-scope anaesthetics and theatre staff profile. Would need to scope specialty expansion and procedure baskets	Diane Knight	Oct-25	~~Oct-25~~ N/K	Overdue
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)	N/A	R4. Increase productivity by 30% for HVLC cataracts at Glangwili and Amman Valley.	Pilot started in AVH for 8 cataracts per list to roll out to all 3 lists in AVH if successful.	Amorelle Jones	Mar-26	~~Mar-26~~ Sep-26	Overdue
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)	N/A	R4. Increase productivity by 30% for HVLC cataracts at Glangwili and Amman Valley.	Review theatre efficiencies in GGH/BGH to see where there is a possibility to increase theatre delivery further.	Amorelle Jones	Mar-26	~~Mar-26~~ Dec-26	Overdue
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)	N/A	R6. Increase Intra-vitreal injections to 15 per list and undertaken in procedure rooms	Continue to onboard for 1.3 WTE posts	Amorelle Jones	Mar-26	~~Mar-26~~ N/K	Overdue

Report Issued By	Report Title	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
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)	N/A	R6. Increase Intra-vitreal injections to 15 per list and undertaken in procedure rooms	Advertise band 7 post when JD has been approved.	Amorelle Jones	Mar-26	~~Mar-26~~ N/K	Overdue
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)	N/A	R7. Run Prince Phillip as cold elective orthopaedic hub with ring fenced beds	With funding, open and expand further main theatre sessions. Would need to fully re-scope anaesthetics and theatre staff profile. Would need to scope specialty expansion and procedure baskets. Orthopaedics: Ensure all PPH funded DSU theatre sessions are operational to allow increased scope for delivery of arthroplasty activity in main theatre. This will require filling theatre staffing and anaesthetic vacancies.	Diane Knight	Mar-26	~~Mar-26~~ N/K	Overdue
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)	N/A	R8. Encourage cross health board working with orthopaedic surgeons from Swansea Bay HB invited into the hub.	Been implemented in Q3. Not required in Q4 Regional MDT's, close lines of communication and joint operating has been operationalised for Hand and Wrist, Shoulder and Elbow and Foot and Ankle. A regional MDT has also been established for sort tissue knee. Utilisation of PPH by Swansea Bay surgeons will depend on discussions that progress through Regional Programme Board. Utilisation of NPT by Hywel Dda surgeons is currently being explored.	Lianne Gregory	Dec-25	~~Dec-25~~ N/K	Overdue
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)	N/A	R12. Improve cataract, orthopaedic and other day case activity to GIRFT and Royal College standards.	Ophthalmology: Pilot started in AVH for 8 cataracts per list to roll out to all 3 lists in AVH if successful.	Amorelle Jones	Mar-26	~~Mar-26~~ N/K	Overdue
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)	N/A	R12. Improve cataract, orthopaedic and other day case activity to GIRFT and Royal College standards.	Orthopaedics: Work on list loading and efficiency improvements in line with GIRFT and Royal College standards is underway categorised by various procedure bundles.	Lianne Gregory	Mar-26	~~Mar-26~~ N/K	Overdue
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)	N/A	R15. Use GIRFT documents to guide setting up, staffing and running hubs, agree nationally the number of cases per list for at GIRFT standards and support health boards to deliver	Increase volume of cases in Orthopaedics to 4 arthroplasty patients on an all day list. A standby patient has been added with the aim of achieving 4 arthroplasty patients per all day list. Some Consultants are already achieving 4 joints on an all day list whilst others will only achieve this with theatre enablers.	Diane Knight	Mar-26	~~Mar-26~~ N/K	Overdue
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)	N/A	R16. Implement best practice in theatre productivity, capped theatre utilisation set at 85%, day case rates combined with RPRP (procedures undertaken outside theatre in procedure rooms) aspire to 85%.	Continue to work with Swansea Bay UHB to consolidate current practice and further scope opportunities via regional working	Diane Knight	Oct-25	~~Oct-25~~ N/K	Overdue
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)	N/A	R20. Deliver specific improvements in operational productivity for ophthalmology	Pilot started in AVH for 8 cataracts per list to roll out to all 3 lists in AVH if successful.	Amorelle Jones	Mar-26	~~Mar-26~~ N/K	Overdue
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)	N/A	R20. Deliver specific improvements in operational productivity for ophthalmology	Review theatre efficiencies in GGH/BGH to see where there is a possibility to increase theatre delivery further	Amorelle Jones	Mar-26	~~Mar-26~~ Oct-26	Overdue
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)	N/A	R21. Cataracts per lists to rise to 8 urgently will increase productivity by 100%-125%.	Started a pilot in AVH for 8 cataracts per list to roll out to all 3 lists in AVH if successful.	Amorelle Jones	Mar-26	~~Mar-26~~ N/K	Overdue
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)	N/A	R23. Procedure Rooms: Ensure intra-vitreal procedures are performed in a procedure room.	Identify in a Business Case the requirements needed to run cataracts through AVH theatre 5 days per week.	Amorelle Jones	Dec-25	~~Dec-25~~ Dec-26	Overdue
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)	N/A	R29. Conduct an audit of FIT testing to assess its impact and integrate findings into health pathways for further optimisation.	Continue to explore collaborative working across primary and secondary care	Sara Jones / Caroline Lewis	Sep-25	~~Sep-25~~ N/K	Overdue

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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)	N/A	R30. Systematically evaluate and implement alternative diagnostic methods such as capsule sponge and nasal endoscopy to reduce demand on conventional services	Cytosponge - To introduce a cytosponge service, dedicated workforce would need to be recruited and trained. The NHS executive have advised that funding may be available in 25/26 - the Health Board is due to meet with the NHS executive clinical lead for cytosponge in June 2025. A service specification document for the rollout of the service has already been developed at a national level and can be adopted within the Health Board. TNE - Explore options to allocate workforce already dedicated to Endoscopy - however, this could result in key Endoscopy staff being pulled from delivery of other service elements which could present a risk to service delivery plans.	Sara Jones	Jul-25	~~Jul-25~~ ~~Mar-26~~ N/K	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	N/A	R15. We recommend therefore that the final report for this mortality review is shared with us at the earliest opportunity with an update on any of the actions and recommendations from this.	There is a regional mortality review ongoing.	Karen Brown	Aug-25	~~Aug-25~~ N/K	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R37. We recommend the HB considers sourcing a larger location for the discharge lounge acknowledging the added value this would bring to system flow.	37. Review Discharge Lounge use/data to determine efficiency and capacity constraints - determine esclation steps if full and no capacity. Discharge Lounge Task and Finish Group to establish more efficient ways of working.	Louisa Standeven	Jul-25	~~Jul-25~~ N/K	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R38. Consider opening the DL earlier and allow patients being discharged to have their breakfast there prior to leaving the site.	38. Review Discharge Lounge use/data to determine efficiency and capacity constraints - determine esclation steps if full and no capacity. Review of opening times based on activity peaks.	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R39.Establish a 'pull' model for Discharge Lounge where staff from the unit actively visit wards to review patients with a definite discharge date the following day.	39. Review Discharge Lounge use/data to determine efficiency and capacity constraints - review of next day discharges (as part of MOD rota).	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R40. Ensure all discharge paperwork is completed the day prior to discharge	40. Review Discharge documentation compliance as well as review of DAL completion and sign off. Link in with pharmcy to scope this.	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R41. Ensure all patients are spoken to and they are aware of the planned move.	41. review of Discharge Lounge Patient Leaflet	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R42. Communicate on ward boards and patient notes clearly that a patient is being transferred to DL early the next day	42. Review of Discharge Documentation and ward use of Discharge Lounge.	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R44. Consider supporting additional portering/ HCSW resource to transfer suitable patients, removing the onus from ward staff.	44a. Review of portering capacity to maximise flow.	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R44. Consider supporting additional portering/ HCSW resource to transfer suitable patients, removing the onus from ward staff.	44b. Review of Synbiotix data relating to delays in transfer to Discharge Lounge.	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R45. If DL is filled to capacity by 8am, this will release some immediate pre ward round capacity into the site each day, this should be achieveable for a 400 bed site.	45. Review Discharge Lounge use/data to determine efficiency and capacity constraints	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	N/A	R6. It is recommended that when there have been 48-hour breaches in AMAU a short investigation is undertaken in collaboration between the AMAU and specialty involved i.e. Respiratory, to review the patient journey as a timeline. This will inform future learning for all departments involved to take forward and share with their teams, again fostering a whole system approach to patient flow.	Action accepted and completed by service	Catrin Rooney (Hywel Dda UHB- Senior Nurse Manager	Aug-25	~~Aug-25~~ N/K	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	N/A	R15. When a medical specialty is unable to accept a 'new' patient from AMAU, there should be an escalation to a senior clinical decision maker to review the entire caseload and make a risk-based decision on how to balance the available inpatient capacity against the current level of demand.	Action accepted and completed by service	Robin Ghosal	Aug-25	~~Aug-25~~ N/K	Overdue

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NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	N/A	R16. We recommend that a senior clinical decision maker is present at each board round and places an emphasis on exploring alternative options to deliver the clinical care required for each patient outside of a hospital wardthrough a 'deep dive' approach. We have seen evidence of the proactive approach that the Health Board has in utilising the skills of community based clinical services e.g. District Nursing, ACT/CRT and the Carmarthenshire Intermediate Care Team, we feel that these resources could offer additional options to provide an adequate level of care to some patients who would benefit from an earlier discharge home. • Whilst this describes a risk-based approach to clinical decision making, we are cognisant that this would require careful planning and a clear governance structure in order to be successful, this approach is promoted under the 'right patient, right place' ethos that NHS Wales is advocating. • This approach could be embedded with patients at the point of admission by actively starting the discharge planning process and clinical teams identifying the earliest opportunity to facilitate a safe discharge out of hospital utilising a criteria led discharge approach	Awaiting full management response from service to be added to AMaT	Robin Ghosal	Jul-25	~~Jul-25~~ N/K	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	N/A	R17. Every clinical specialty should have a cohort of patients who are suitable for criteria led discharge to aid decision making and ensure inpatient capacity is only used for patients who have no other clinically viable option to receive care.	Awaiting full management response from service to be added to AMaT	Robin Ghosal	Jul-25	~~Jul-25~~ N/K	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	N/A	R18. It is recommended that the senior leaders within the organisation endorse the implementation of the framework (board rounds) and promote a culture shift within the hospital that sees some current practices and ways of working challenged. Support from senior teams including medical director and chief operating officer is paramount for this to succeed	Awaiting full management response from service to be added to AMaT	Robin Ghosal	Jul-25	~~Jul-25~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine - BGH		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.	Louise Cullum	N/K	~~Aug-25~~ ~~Dec-25~~ ~~Mar-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine - BGH		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	Immediate release requests are almost always supported especially for red release calls- and any non adherence is investigated and lessons learned are shared- clear communication with ODU in place to support decision making and assessment of pressures in area- with a view to minimising risk. Pre-alerts are also prioritised which in turn would release ambulance capacity- and corridor care (surge) is frequently utilised to support urgent ambulance calls	Claire Davies	Mar-25	~~Mar-25~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine - WGH		R20. (WGH) There is definitely a case for an increase in SDEC and urgent clinic spaces. The current SDEC is limited in scope and specialties involved. This is an important way of getting more specialty involvement in emergency care and will reduce the proportion of emergency admissions that traverse the ED and the number of admissions.	SDEC is open form 8-8 Fully staffed Approx 60% of the medical take does attend SDEC. Planning for complex streaming at front door. Frailty SDEC – need to de surge unit. Unit to take direct from ED and will start to take referral direct form WAST, therefore, to avoid ED. HOT clinics in medical specialities already in place (manged by the medical Consultants)	Bethan Andrews	Oct-25	~~Oct-25~~ Nov-27	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine - WGH		R21. (WGH) Transfer arrangements to other hospitals must also be improved. There is no onsite paediatrics, and we were told that visiting paediatricians, working in outpatient clinics, refuse to support the ED in emergency situations. Moreover, children who require transfer to paediatric inpatient units are not accompanied by an anaesthetist, unless an endotracheal tube is in-situ. This lack of support for the ED is unacceptable and does not reflect a positive view of the importance of safe patient care.	Clear pathway already in place for paediatrics. A designated ambulance is on standby outside ED for transfers.	Lyndon Freeman	Oct-25	~~Oct-25~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine - WGH		R23. (WGH) Data quality must be improved.	Regarding validation of breaches WGH does have admin staff working with the SNM to undertake this request. SNM to ensure clinical team engagement and discussion relating to thematics surrounding breaches and assurance of correct data validation.	Jo Dyer	Oct-25	~~Oct-25~~ Aug-26	Overdue

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Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26	Medium	R2. Standard Operating Procedure • the SOP does not identify the author, implementation or review dates and we have been unable to identify the source of the SOP. • it is not clear if or when the SOP has been communicated to or how it is accessible to staff. During our site visits some staff were of unaware of the document. • the SOP requires "validated non-breaches" (i.e. where an exemption applies) to be changed to 3:59 wait time but this is not done in practice and not necessary because breach reporting is based on the selected breach flag rather than the time in department.	The SOP will be updated to address the issues identified, and approved by an appropriate forum. The revised SOP will be formally communicated with relevant staff and accessible on the intranet.	Peter Skitt	Nov-25	~~Nov-25~~ N/K	Overdue
Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26	Medium	R3. Audit Trail WPAS does not have the functionality to evidence or record where an ED attendance/breach has been validated, although the system does maintain an audit trail of amendments made as part of the validation process. Reports of amendments were requested for the sample of 40 ED attendances we reviewed, but we were advised that this could not be provided. This information could support the identification of common errors or areas with frequent errors (both in terms of documenting the ED attendance, and the subsequent validation process) to support learning, enhance data quality and improve the efficiency of breach validation.	The ED attendance reports used for validation will be annotated to identify the records subject to validation. Information Services to provide routine reports of amendments to records as part of the validation process, to facilitate learning and improve data quality.	Peter Skitt	Dec-25	~~Dec-25~~ N/K	Overdue
Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26	Medium	R4. Requirement for Validation by Clinical Role The SOP states that "all relevant ED clinical notes and information will be reviewed by an ED Unit Manager" (a band 7 clinical role). This is case in GGH and PPH, but in WGH and BGH validation is undertaken by administrative (non-clinical) staff.	The validation process and associated roles and responsibilities as per the SOP will be reassessed to determine the extent of clinical involvement required and ensure appropriate use of clinical time. Training needs of any non-clinical roles involved will be assessed and fulfilled.	Anna Chiffi	Dec-25	~~Dec-25~~ Aug-26	Overdue
Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26	High	R5. Breach Validation at BGH Validation was reperformed for a sample of 40 breaches across the four sites. Our sample was selected from a WPAS report of ED attendances (pre-validation) during the period 1 May – 7 August 2025. Three instances were identified for BGH where a breach was incorrectly flagged as exempt by the clinician and this had not been corrected as part of validation. It transpired that in these instances the breach reason had not been stipulated by the clinician and where this is the case, the validator is unable to amend the breach flag/reason due to a system access restriction. Analysis of WPAS data for ED attendances (pre-validation) during the period 1st May – 7 August 2025 identified 1225 instances (out of 3244 ED attendances where time in department exceeded 4 hours) where the breach reason for BGH had not been populated by the clinician and therefore the record would not be editable by the validator. We were advised that these records (37.8%) are not validated for this reason. There is a risk that these breaches have been under/over reported to WG.	The system access issue will be escalated to IT to resolve as a matter of urgency, to ensure that 100% breach validation can resume for BGH at the earliest opportunity. The outcome of finding/action 4 may impact on the longer-term validation arrangements.	Peter Skitt	Dec-25	~~Dec-25~~ N/K	Overdue
Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26	High	R6. Inconsistent Monitoring Arrangements There is no evidence that 4-hour breach data for WGH and BGH is monitored or reported to appropriate forum(s) to aid learning and to improve performance.	The performance monitoring arrangements for GGH and PPH will be implemented for BGH and WGH.	Peter Skitt	Nov-25	~~Nov-25~~ N/K	Overdue
Ministerial Advisory Group (MAG)	A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity	N/A	R4. All health boards should reduce unwarranted variation in treatment waiting times and adopt best practice in theatre management. This can be achieved through the implementation of the existing GIRFT review reports including the theatre reviews. This recommendation should be supported by the establishment of local Theatre Optimisation Boards, with a remit to deliver increased productivity within theatre sessions including the implementation of best practice standards of cases per session, particularly in ophthalmology and orthopaedics (in ophthalmology 8 cataracts in a 4 hour theatre session if a training session and 10 if consultant only, and in elective orthopaedics a minimum requirement of 4 Joints or their equivalent in an all day orthopaedic elective list).	Pilot started in AVH for 8 cataracts per list to roll out to all 3 lists in AVH if successful.	Amorelle Jones	Mar-26	~~Mar-26~~ Sep-26	Overdue

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Ministerial Advisory Group (MAG)	A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity	N/A	R4. All health boards should reduce unwarranted variation in treatment waiting times and adopt best practice in theatre management. This can be achieved through the implementation of the existing GIRFT review reports including the theatre reviews. This recommendation should be supported by the establishment of local Theatre Optimisation Boards, with a remit to deliver increased productivity within theatre sessions including the implementation of best practice standards of cases per session, particularly in ophthalmology and orthopaedics (in ophthalmology 8 cataracts in a 4 hour theatre session if a training session and 10 if consultant only, and in elective orthopaedics a minimum requirement of 4 Joints or their equivalent in an all day orthopaedic elective list).	Review theatre efficiencies in GGH/BGH to see where there is a possibility to increase theatre delivery further.	Amorelle Jones	Mar-26	~~Mar-26~~ Sep-26	Overdue
Ministerial Advisory Group (MAG)	A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity	N/A	R4. All health boards should reduce unwarranted variation in treatment waiting times and adopt best practice in theatre management. This can be achieved through the implementation of the existing GIRFT review reports including the theatre reviews. This recommendation should be supported by the establishment of local Theatre Optimisation Boards, with a remit to deliver increased productivity within theatre sessions including the implementation of best practice standards of cases per session, particularly in ophthalmology and orthopaedics (in ophthalmology 8 cataracts in a 4 hour theatre session if a training session and 10 if consultant only, and in elective orthopaedics a minimum requirement of 4 Joints or their equivalent in an all day orthopaedic elective list).	Increase volume of cases in Orthopaedics to 4 arthroplasty patients on an all day list. A standby patient has been added with the aim of achieving 4 arthroplasty patients per all day list. Some Consultants are already achieving 4 joints on an all day list whilst others will only achieve this with theatre enablers.	Sarah Carmody	Mar-26	~~Mar-26~~ N/K	Overdue
Ministerial Advisory Group (MAG)	A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity	N/A	R4. All health boards should reduce unwarranted variation in treatment waiting times and adopt best practice in theatre management. This can be achieved through the implementation of the existing GIRFT review reports including the theatre reviews. This recommendation should be supported by the establishment of local Theatre Optimisation Boards, with a remit to deliver increased productivity within theatre sessions including the implementation of best practice standards of cases per session, particularly in ophthalmology and orthopaedics (in ophthalmology 8 cataracts in a 4 hour theatre session if a training session and 10 if consultant only, and in elective orthopaedics a minimum requirement of 4 Joints or their equivalent in an all day orthopaedic elective list).	Continue to work with Swansea Bay UHB to consolidate current practice and further scope opportunities via regional working	Sarah Carmody	Oct-25	~~Oct-25~~ N/K	Overdue
Ministerial Advisory Group (MAG)	A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity	N/A	R6. Health Boards should make improvement in processes, partnerships and investment in specific community pathways to reduce delayed pathways of care.	Health Board and Local Authority partners to update and refresh the Regional Pathways of care action plan for the financial year 2026-27. The Regional Pathways of care action plan is an integrated plan between LAs and the Health Board to address Pathway of Care Delays.	Rachel Williams	Mar-26	~~Mar-26~~ N/K	Overdue
Internal Audit	Internal Escalation: Level 3 & 4 Functions Final Internal Audit Report 2025/26	Medium	R2. Sufficient & Appropriate Actions The five functions sampled collectively had 17 domains in in L3 escalation as at September 2025. Review of the Executive Recovery meeting slide packs confirmed that all 12 domains assessed as Alert were included for discussion at the October 2025 meetings. We identified four instances where actions had either not been identified within the slide pack or did not sufficiently address the stated reasons for escalation. Actions were generally considered to be SMART in nature although some exceptions were identified.	Following a review of activity, we have agreed to move to monthly touchpoints with escalated CCGs and build into the Improving Together Executive Collaboration approach. The Terms of Reference will include this requirement.	Huw Thomas	Mar-26	~~Mar-26~~ N/K	Overdue
Internal Audit	Internal Escalation: Level 3 & 4 Functions Final Internal Audit Report 2025/26	Medium	R4. Gap in Domain Review at EITS Review of EITS slide packs noted that for Community & Integrated Medicine the Quality & Safety domain is excluded –we were advised that this is being managed via the CCG Integrated Governance Group meetings (which by design cover all seven domains regardless). The reason for this variation was not clear.	As for Recommendation 2 Following a review of activity, we have agreed to move to monthly touchpoints with escalated CCGs and build into the Improving Together Executive Collaboration approach. The Terms of Reference will include this requirement.	Huw Thomas	Mar-26	~~Mar-26~~ N/K	Overdue

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Internal Audit	Internal Escalation: Level 3 & 4 Functions Final Internal Audit Report 2025/26	High	R5. Gaps in Executive Recovery Meetings Executive Recovery meetings should take place monthly where the function has assessed one or more domains as Alert. Across the five functions reviewed, 23 Executive Recovery meetings should have been held during the period July – December 2025*. Only 12 meetings actually took place. The Performance Team, responsible for facilitating the meetings, cited difficulty in scheduling meetings due to availability of senior leadership at both Executive at function level. Furthermore, no meetings had been held since October 2025 (reviewing August/September data) due to EITS in November and service pressures in December, although meetings are scheduled for January/February 2026. *excluding June & November where EITS took place instead	As for Recommendation 2 Following a review of activity, we have agreed to move to monthly touchpoints with escalated CCGs and build into the Improving Together Executive Collaboration approach. The Terms of Reference will include this requirement.	Huw Thomas	Mar-26	~~Mar-26~~ N/K	Overdue
Internal Audit	Internal Escalation: Level 3 & 4 Functions Final Internal Audit Report 2025/26	Medium	R6. Escalation Route for Alerts The Chair of the meeting is required to complete a 3A assessment for each area reviewed, this is captured on the Escalation Meetings Action Tracker. However, it is not clear and we were unable to determine the escalation route for domains assessed as Alert.	As for Recommendation 2 Following a review of activity, we have agreed to move to monthly touchpoints with escalated CCGs and build into the Improving Together Executive Collaboration approach. The Terms of Reference will include this requirement.	Huw Thomas	Mar-26	~~Mar-26~~ N/K	Overdue
Internal Audit	High-Cost Drugs Final Internal Audit Report 2025/26	Medium	R2. Immunoglobulins Nine of our sample (accounting for 75% of the total value of our sample) related to immunoglobulins. Some brands are included on the formulary, those in our sample weren't and we were unable to determine a rationale for this. However, the brands dispensed were confirmed to be in line with all-Wales product selection guidance issued by the all-Wales Immunoglobulin Strategy Group. Hywel Dda is one of two health boards in Wales where immunoglobulins are ordered and dispensed via hospital pharmacies. The health board needs to review its approach to immunoglobulins to decide which should be included on the formulary and whether other formal governance/formulary approval processes are required. This needs to be considered in the context of any national governance arrangements for immunoglobulins.	Supply of immunoglobulins will continue to align with all-Wales product selection guide. Hywel Dda formulary to be updated to reflect the range of products available for use, with clarity on first-line options.	Aled Richards	May-26	~~May-26~~ N/K	Overdue