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

Assurance and Risk Report

Finance and Performance Committee, 30 April 2026

Situation

This report provides the Finance and Performance Committee (FPC) with the current status of corporate risks, audits and inspections recommendations and Ministerial Directions (MDs) within its remit.

The Committee is asked to seek assurance from the Lead Executive Directors that corporate risks are being managed effectively, and that recommendations from audit and inspections and MDs are being implemented by the Health Board.

Principal risks, operational risks and Welsh Health Circulars aligned to the Committee will be presented at its next meeting in June 2026.

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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 (CCG) 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

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.

Hywel Dda Risk Heat Map					
	LIKELIHOOD →				
Impact ↓	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5				2326 NEW	
Major 4			1350 ↓ 2327 NEW		
Moderate 3					
Minor 2					
Negligible 1					

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 24 that are on the CRR as of 22 April 2026).

Risk 2326 supersedes the previous Corporate Risk ‘2086 - Risk that the cash consequences of the Health Board deficit cannot be covered by WG should it exceed our Target Control Total’.

Risk 2327 supersedes the previous Corporate Risk ‘2104 - Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 25/26 due to demand exceeding capacity’.

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 Assigned to FPC (1 of 4)

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Risk Reference and Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1350 - Risk of not meeting the 80% SCP waiting times target for March 2026 due to diagnostics capacity and delays at tertiary centre	**Planned & Specialist Care**	**Chief Operating Officer**	**16**	**12 ↓ (Reviewed 31/03/26)**	**8**	**31/03/2026**

Rationale for Current Risk Score (CRS)

The service has been de-escalated by Welsh Government (WG) in February 2026 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.

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

Confirmation received that target for March 2027 is 75%. Currently, no Health Board is achieving this target.
This risk is under review following approval of the Annual Plan 2026/27 by the Board in March 2026.

Rationale for Target Risk Score

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

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

Corporate Risks assigned to FPC (2 of 4)

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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
2326 - Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding	**Finance**	**Director of Finance**	**20 (NEW)**	**12**	**30/06/2026**

Rationale for Current Risk Score

The 2026/27 Financial Plan was submitted to WG in March 2026 with a £41.0m planned deficit. WG confirmed the plan is not supportable or acceptable, and restated the expectation to deliver £22.0m deficit. Of the £42.8m savings requirement, only £5.0m Amber/Green assured savings is evidenced, with £6.4m of Blue/Red ideas yet to be converted. Sensitivity analysis indicates 2026/27 predicted deficit range of £54.3m to £90.5m, with minimum £13.3m of new savings actions even in best-case scenario. Delivery depends on pace.

Director of Finance Improvement Plan issued on 31 March 2026. A 4-Step Financial Improvement Framework shared with Executive Team in April 2026. Chief Executive reviews scheduled for April 2026, and every open action to be delivered by 30 June 2026 with interim position to be reported to Board in May 2026. The May Board is critical as the Health Board must evidence a credible route from £41m to £22m, supported by first-month run-rate data and confirmed Executive ownership of each variable pay workstream. A draft revised Chief Operating Officer (COO) Operating Model (April 2026) introduces Clinical Care Group (CCG) Delivery Agreements and aligns Levels 1 to 4 Performance Escalation Framework. System Leaders Workshop held April 2026, and value opportunities catalogue (SBAR, April 2026) produced across 10 domains, drawing on over 25 national actions from NHS Wales 26/27 Planning Framework.

The current risk score reflects early-year uncertainty, WG rejection of submitted position, limited level of assured savings and several material controls in formation rather than operating.

Rationale for TRS on following slide

Corporate Risks assigned to FPC (3 of 4) (continued)

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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
2326 - Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding	**Finance**	**Director of Finance**	**20 (NEW)**	**12**	**30/06/2026**

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.

Timeline to the TRS:

1. May 2026: Variable pay governance structure with named leads per staff group; CCG Delivery Agreements issued under the revised Chief Operating Office (COO) Operating Model.
2. 28 May 2026 (Board): Interim position reported to Public Board, covering the improvement trajectory from £41m to £22m, the first-month run-rate data, confirmed Executive ownership of every variable pay workstream, and a credible plan for recruitment, deployment and configuration across nursing, medical and other staff groups.
3. 30 June 2026: All open actions completed. Variable pay plans deliverable in-year and evidenced. A credible, recurrent opening baseline has been confirmed, including April and May 2026 outturn, and the reliance on non-recurrent measures has been addressed. Value Opportunities Catalogue converted into a delivery programme with Executive portfolio ownership.

The TRS target date of 30 June 2026 aligns with this approach. Slippage beyond this date would signal that the Health Board has not been able to exert sufficient grip on the largest controllable in-year expenditure line.

Corporate Risks Assigned to FPC (4 of 4)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2327 - Risk to planned care and RTT recovery in 2026/27 due to demand–capacity gaps, estate fragility and non-recurrent funding.	**Planned & Specialist Care**	**Chief Operating Officer**	**12 (NEW)**	**9**	**31/03/2027**

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 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 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 2026/27.

Rationale for Target Risk Score

The target risk score of 9 reflects the continuing delivery ambitions which remain, despite the workforce and resource limitations reflected in the Annual Plan 2026/27. 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.

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 UHB 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 *Getting It Right First Time* (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 assigned to FPC

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:

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

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

Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendat-ions in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Peer Review	Colorectal Cancer (Third Cycle), **(issued Jan 22)**	Planned & Specialist Care	Chief Operating Officer	Mar-22	~~Mar-23~~ ~~Mar-24~~ Mar-28	8	0	0	7	0	1	0	0	Awaiting a regional approach for Pathology
Peer Review	GIRFT - Gynaecology Review **(issued Sep 22)**	Planned & Specialist Care	Chief Operating Officer	N/K	Sep-26	17	0	0	0	17*	0	0	0	n/a
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review **(issued Aug 23)**	Planned and Specialist Care	Chief Operating Officer	Apr-24	~~Nov-24~~ Jan-27	59	8	0	35	16	0	0	0	Linked to Clinical Services Plan (CSP) in GGH and BGH - workforce challenges and lack of accommodation
Peer Review	GIRFT - Urology Review **(issued Apr 24)**	Planned & Specialist Care	Chief Operating Officer	Jan-27	Jan-27	29	0	6	19	0	3	1	0	Linked to CSP, and reliance on the National Urology Clinical Implementation Network (CIN) rolling out agreed Coding criteria.
Peer Review	GIRFT - Emergency Medicine **(issued Jun 24)**	Community & Integrated Medicine	Chief Operating Officer	Oct-25	~~Oct-25~~ Aug-26	35	13	1	13	6	0	1	1	Workforce challenges and ageing infrastructure.

**meeting scheduled to review responses prior to obtaining formal approval.*

Audits and Inspection Reports Assigned to FPC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendat-ions in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion Noted
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site **(issued Oct 24)**	Community & Integrated Medicine	Chief Operating Officer	Nov-25	~~Nov-25~~ N/K	58	17	0	33	8	0	0	0	None noted
Ministerial Advisory Group (MAG)	MAG Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025) **(issued Jan 25)**	Planned & Specialist Care	Chief Operating Officer	Mar-26	N/K	32	15	0	9	6	2	0	0	Dependent on recruitment and service reviewing agreed funding outcomes of the 2026/27 Annual Planning process and awaiting outcome of tender process for standardised Pre-Operative Assessment Criteria process and pathway.
Ministerial Advisory Group (MAG)	MAG Observations following the site visits of health boards – Hywel Dda UHB - Allied Health Professions and Health Sciences **(issued Jan 25)**	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Sep-25	~~Jan-26~~ N/A	10	0	0	1	9	0	0	0	Complete -Pending formal approval for closure from the Chief Operating Officer.
Ministerial Advisory Group (MAG)	MAG - Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care **(issued Jan 25)**	Community & Integrated Medicine	Chief Operating Officer	Mar-26	~~Mar-26~~ Aug-26	15	6	0	9	0	0	0	0	None noted
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site**(issued Jan 25)**	Community & Integrated Medicine	Chief Operating Officer	Aug-25	N/K	19	6	0	12	0	0	0	1	None noted

Audits and Inspection Reports Assigned to FPC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendat-ions in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Any Barriers to Completion Noted?
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site **(issued Mar 25)**	Community & Integrated Medicine	Chief Operating Officer	Apr-26	Apr-26	38	4	1	22	11	0	0	0	None noted
Internal Audit	Financial Management Final Internal Audit Report 2024/25 **(issued Mar 25)**	Director of Finance	Director of Finance	Jan-26	~~Jan-26~~ Apr-26	5	1	0	2	2	0	0	0	None noted
Audit Wales	Tackling Planned Care Challenges- Hywel Dda University Health Board **(issued May 25)**	Planned & Specialist Care	Chief Operating Officer	Mar-26	N/K	6	2	0	2	1	0	1	0	Unable to create a post for the Head of Planning and Programmes due to funding constraints. Post of Head of Planning and Programmes agreed in principle however funding yet to be agreed.
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	N/A	1	0	0	0	1	0	0	0	Meeting scheduled 21 April 2026 with Assurance & Risk Officer and Finance colleagues to discuss evidence available to close report.
Peer Review	Getting It Right First Time (GIRFT) General Surgery Review **(issued May 23)**	Planned & Specialist Care	Chief Operating Officer	Sep-23	~~Mar-24~~ ~~Jan-25~~ ~~May-25~~ N/A		0	0	15	7	0	0	0	Complete - Pending formal approval for closure from the Chief Operating Officer.

Audits and Inspection Reports assigned to FPC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendat-ions in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Any Barriers to Completion Noted?
Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26 **(issued Sep 25)**	Community & Integrated Medicine	Chief Operating Officer	Dec-25	~~Dec-25~~ N/K	6	5	0	1	0	0	0	0	None noted - Follow up Internal Audit to take place in 2026/27.
Audit Wales	Review of Cost Savings Arrangements – Hywel Dda University Health Board **(issued Jul 24)**	Director of Strategy and Planning	Director of Strategy and Planning	Mar-25	N/K	10	0	0	9	0	0	1	0	Awaiting Executive approval to implement final recommendation regarding developing sufficient transformational capabilities and capacity.
Ministerial Advisory Group (MAG)	A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity **(issued Apr 25)** *NEW REPORT*	Chief Operating Officer Management	Chief Operating Officer	Mar-26	Mar-26	11	3	0	1	5	0	0	2	None noted

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	Contract Management Advisory Report **(issued Mar 25)**	Director of Finance	Director of Finance	Dec-25	Nov-25 – closed following approval by Internal Audit.	6	**Complete**

Ministerial Directions - Overview

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 at March 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.	0
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.	2
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:

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

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

MDs- Complete Pending Formal Approval For Closure

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 & Learning Disabilities	Chief Operating Officer	Feb-26	**Complete Pending Formal Approval**

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 their 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 March 2026);
- 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 March 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 March 2026).

Awaiting formal approval from Chief Operating Officer to close this MD.

MDs- Complete Pending Formal Approval for Closure

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The following Ministerial Directions are **Complete – Pending Approval**:

MD	Issued on	Lead CCG / EF	Lead Director	Implementation Date	Progress Status
WG25-84- Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 6) Directions 2025	02/12/2025	Assistant Director of Primary Care	Chief Operating Officer	Mar-26	**Complete Pending Formal Approval**
Statement of Financial Entitlement supports the contractual payment mechanisms. *Awaiting formal approval from Chief Operating Officer to close this MD.*					

MDs - Complete and Approved (1 of 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Ministerial Direction	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status	Update
WG25-72: The Primary Care (Contracted Services: Outpatients Waiting Lists First Appointment Scheme) Directions 2025	14/10/2025	Primary Care	Chief Operating Officer	Oct-25	Complete	MD forms part of the contracted services and has been actioned in line with the usual commissioning processes.
WG25-85: Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2026	03/12/2025	Primary Care	Chief Operating Officer	Jan-26	Complete	Payment system updated to enable GP practices to make claims
WG25-88: Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 7) Directions 2025	16/12/2025	Primary Care	Chief Operating Officer	Jan-26	Complete	This direction instructs new Global Sum Rate to apply from April 2025. Arrears payments were made to GP practices in December 2025 in respect of April-Dec 2025 and the new rate has been applied to payments from January 26 onwards
WG25-91: The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No. 5) Directions 2025	02/12/2025	Primary Care	Chief Operating Officer	Jan-26	Complete	Uplift has been applied to the COMPASS system by Dental Services for payment.

MDs - Complete and Approved (2 of 2)

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Ministerial Direction	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status	Update
WG25-92: The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No.5) Directions 2025	02/12/2025	Primary Care	Chief Operating Officer	Jan-26	**Complete**	Uplift has been applied to the COMPASS system by Dental Services for payment.
WG2025: Statement of General Ophthalmic Services Remuneration and Fee Directions	11/11/2025	Primary Care	Chief Operating Officer	Dec-25	**Complete**	Financial instructions underpin existing contractual arrangements.
NWSI-26-04: Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2026	16/01/2026	Primary Care	Chief Operating Officer	Jan-26	**Complete**	New monies to be applied to GP payments from April 2026.
NWSI-26-18 The Primary Care (Contracted Services: Immunisations) (RSV) (Wales) Directions 2026	23/02/2026	Primary Care	Chief Operating Officer	Mar-26	**Complete**	GP practices submit claims for Vaccinations via the Welsh Immunisation Service (WIS) therefore the Health Board is not involved in the claiming process; once a month the Health Board are sent a report which contains payments to be made to practices via the Family Practitioner Payments System (FPPS) portal.

Recommendations

The Committee is requested, in relation to the areas presented in this paper to **RECEIVE ASSURANCE** from the Lead Director or Supporting Officer:

Risk Management

- that identified controls are in place and working effectively; and
- that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise.

Audits, Inspections and Regulatory Reports

- on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations with any barriers to delivery noted.

Ministerial Directions

- that the Health Board is compliant with the MDs issued by Welsh Government.

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SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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Hywel Dda
University Health Board

CORPORATE RISK REGISTER SUMMARY APRIL 2026

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Apr-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	NA	4×5=20	New risk	3×4=12	30/06/2026	6
1350	Risk of not meeting the 80% SCP waiting times target for March 2026 due to diagnostics capacity and delays at tertiary centre	Carruthers, Andrew	Quality/Complaints/Audit	4×4=16	3×4=12	↓	2×4=8	31/03/2026	10
2327	Risk to planned care and RTT recovery in 2026/27 due to demand-capacity gaps, estate fragility and nonâ€‘recurrent funding.	Carruthers, Andrew	Quality/Complaints/Audit	NA	3×4=12	New risk	3×3=9	31/03/2027	14

RISK SCORING MATRIX

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

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

RISK MATRIX

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

RISK ASSESSMENT - FREQUENCY OF REVIEW

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

Assurance Key:

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

Key - Assurance Required	
	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:**	Apr-26
Lead Committee:	Finance and Performance Committee	**Date of Next Review:**	May-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 runâ€'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 nonâ€'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 escalation and jeopardy of conditionally-recurrent funding and undermining of medium-term financial sustainability.

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:	30/06/2026
Trend:	*New risk*

No trend information available.

Rationale for CURRENT Risk Score:

Rationale for TARGET Risk Score:

2026/27 Financial Plan submitted to WG in March 2026 with £41.0m planned deficit. WG confirmed plan is not supportable or acceptable,and restated expectation to deliver £22.0m deficit.Of £42.8m savings requirement, only £5.0m Amber/Green assured savings is evidenced, with £6.4m of Blue/Red ideas yet to be converted. Sensitivity analysis indicates 26/27 predicted deficit range of £54.3m to £90.5m, with min £13.3m of new savings actions even in best-case scenario. Delivery depends on pace. DOF Improvement Plan cascade issued 31 March 2026. A 4-Step Financial Improvement Framework shared with Executive Team in April 2026. Chief Executive reviews scheduled for April 2026, and every open action to be delivered by 30 June 2026 with interim position reported to Board in May 2026. May Board is critical: the Health Board must evidence a credible route from £41m to £22m, supported by first-month run-rate data and confirmed Exec ownership of each variable pay workstream. A draft revised COO Operating Model (April 2026) introduces CCG Delivery Agreements and aligns Levels 1 to 4 Performance Escalation Framework. System Leaders Workshop held April 2026, and value opportunities catalogue(SBAR, April 2026) produced across 10 domains, drawing on over 25 national actions from NHS Wales 26/27 Planning Framework. Current risk score reflects early-year uncertainty, WG rejection of submitted position,limited level of assured savings,& several material controls in formation rather than operating.

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.

Timeline to the Target Risk Score:
1. May 2026: Variable pay governance structure with named leads per staff group; CCG Delivery Agreements issued under the revised COO Operating Model.
2. 28 May 2026 (Board): interim position reported to Public Board, covering the improvement trajectory from £41m to £22m, first-month run-rate data, confirmed Executive ownership of every variable pay workstream, and a credible plan for recruitment, deployment and configuration across nursing, medical and other staff groups.
3. 30 June 2026: all open actions completed. Variable pay plans deliverable in-year and evidenced. A credible, recurrent opening baseline has been confirmed, including April and May 2026 outturn, and reliance on non-recurrent measures has been addressed. Value Opportunities Catalogue converted into a delivery programme with Executive portfolio ownership.

The TRS target date of 30 June 2026 aligns with this approach. Slippage beyond this date would signal that the Health Board has not been able to exert sufficient grip on the largest controllable in-year expenditure line.

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	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	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	Linked to Choices and Value workbook beds-related opportunities and to the Value Opportunities Catalogue.
		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	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.

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 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.	£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 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.	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	Linked to Choices and Value workbook strategic opportunities (including Bronglais maternity/paediatrics, radiology OOH, pathology site model).
		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	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.
		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	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.

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

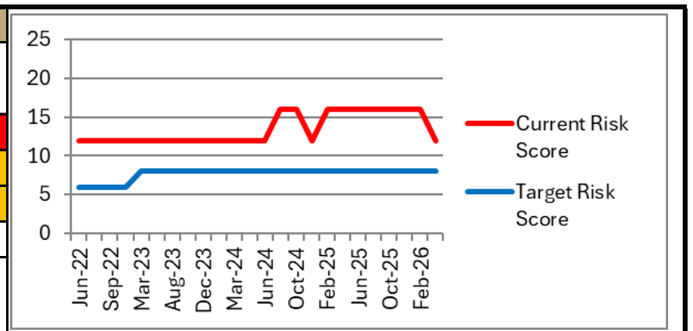
Performance against the 2026/27 operational plan and targets through key performance indicators. In-month financial monitoring and forecasting against the £41.0m plan, with trajectory toward the £22.0m improvement target. Implementation of CCG Delivery Agreements and Performance Escalation Framework (Levels 1 to 4).	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 Finance and Performance Committee 30 April 2026 Board - 28 May 2026 (plan improvement action from £41m to £22m) Finance and Performance Committee - scheduled 2026/27 cycle	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 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,	Nursing - recruitment assurance: confirm substantive recruitment pipeline and fill rates against funded establishment; eliminate off-contract nursing agency; HSW agency trajectory to zero. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Daniel, Sharon	30/06/2026	Plan to be developed through the April 2026 CEO Review cycle; first cut to May 2026 Board.
	Finance and Performance Committee oversight of 2026/27 plan delivery and improvement trajectory.	2nd					Nursing - recruitment assurance: confirm substantive recruitment pipeline and fill rates against funded establishment; eliminate off-contract nursing agency; HSW agency trajectory to zero. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Daniel, Sharon	30/06/2026	To be progressed through the COO Operating Model and Delivery Agreements (issued by 30 April 2026), with weekly drumbeat thereafter.
	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	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.

	WG scrutiny through Monthly Monitoring Returns and NHS Exec Financial Planning and Delivery team.	3rd				equity, workforce capability and prevention economics, limiting the assurance scope until year 2/3 iterations are developed.	Operational oversight and control will be consistently embedded following the review and implementation of Phase 2 of the Operational Organisations Change Process, 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	Task and Finish Group established with the deadline of the May 2026 People Committee to provide a comprehensive proposal and implementation timeline, following Executive Team approval.
	Audit Wales Structured Assessment process.	3rd								

Date Risk Identified:	Feb-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Mar-26
Strategic Objective:	3. Great Care and 4. Positive Futures	**Lead Committee:**	Finance and Performance Committee	**Date of Next Review:**	Apr-26

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

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	31/03/2026
Trend:	↓



Rationale for CURRENT Risk Score:
The service has been de-escalated by Welsh Government (WG) 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. Due to recovery actions within radiology and urology we may see variation in performance as we recover and treat those patients over 62 days, therefore the risk remains that cancer performance will not achieve 80% compliance by March 2026. The WG has confirmed that the target for March 27 is 75%. currently no health board within Wales are on track to achieve this target

Rationale for TARGET Risk Score:
The aim is to treat patients within target waiting times, which has now been confirmed as 80% non-adjusted March 2026. The target risk score will be met if plans to increase diagnostic capacity, utilising allocated recovery funding are realised. When the target of 60% for 3 consecutive months is achieved the risk score can be reduced to a 12. The risk score can be further reduced to a 8 once the target of 80% is achieved. There are underpinning trajectories in place which are monitored on a monthly basis and adherence to those will influence the ability to achieve the target risk score.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Accelerated imaging from Endoscopy to CT within the GI pathway now in place across all sites, reduction time on patient pathway by 23 days # Fully established cancer tracking team in place to allow patients to be proactively tracked through their pathways. # A new cancer dashboard developed by Informatics with the support of Business Intelligence (BI) SCP funding from the Wales Cancer Network. This is now live with access for Cancer Services staff and Service Managers, allowing MDTs to actively monitor tumour site specific patients on a SCP. # The health board are using of Quarterly Planning and Monitoring reports developed by the NHS Executive since July 23. This has facilitates the development of targeted improvement plans per tumour site and subsequent weekly monitoring thus providing assurance of the robustness of plans. # Virtual appointments are being undertaken via digital solutions e.g. Attend Anywhere. # Weekly Cancer Operational Delivery Group (ODG) meetings where services managers are in attendance. The function of this group is to monitor and address service demand, capacity and risk issues. # Monthly performance meetings with Welsh Government. # Trajectory performance plans have been developed for each tumour site by the relevant services, with regards to improving performance. This also includes Backlog Trajectory plans on how these improvements will be achieved. # Robust Urology diagnostic recovery plan to eliminate patients waiting more than 28 days in place, with committed resource allocation from recovery money. Monitoring of Urology diagnostic improvement trajectory via Cancer Operational Delivery Group. # Cancer Pathway Review to be discussed at the MDT Business meetings and plans put in place to address and improve any bottlenecks or issues. Pathway reviews will also be a standing agenda item on the Planned Care and Cancer Services QSH meeting to ensure governance in line with the new operational structures implemented in April 2025. # Process in place to improve component wait times and reduce patients waiting more than 14 day for first Outpatient Appointments (OPA) and 28 days for Diagnostics. # One to one escalation meetings held with Cancer ODG leads and Tumour Site Service Managers for tumour sites that require intervention. # New Endoscopy booking process which tracks all patients referred for an endoscopy on a USC priority. If capacity is identified as a trending breach	Anticipated significant gaps/service fragility within key diagnostic services to address required levels of activity to support SCP. Need for the implementation of new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways.	Work with multidisciplinary team to reallocate FIT pathway to primary care in line with NOP and rest of Wales	Humphrey, Lisa	Completed	Planning complete, moved to implementation/working with Primary care
		Establish accelerated Neck lump pathway to reduce diagnostic pathway	Lewis, Caroline	Completed	To be implemented as part of the agreed Radiology investment 25/26 Target date for recruitment January 2026
		Work with NHSE to review referral rates and patterns within primary care to reduce and refine demand to secondary care	Humphrey, Lisa	Completed	complete
		Due to increased demand for dermatology treatments the service need to aquire 2 additional MOP Treatment areas	Wisdom, Ceri	Completed	SBAR being presented to the Care Group Board meeting in June.
		Highest volume of patients awaiting Urology diagnostic procedures. Urgent action required to reduce overall volumes and volumes waiting over 28 days.	Griffiths, Neil	Completed	Detailed demand capacity planning to include the RTT component to identify the actual demand capacity gap to inform the options for solution
		reduce Urology diagnostic volume by 100 patients by reducing cystoscopy and prostate awaiting MRI	Griffiths, Neil	Completed	Work now completed and delivered
		Outsourcing of MRI for Urology increasing capacity - from 4 per week to 20 per week	Griffiths, Neil	Completed	Outsourcing for MRI commenced 27th October 2025
		Overall 28 day diagnostic reduction plans to be developed to include all specialties where applicable	Humphrey, Lisa	Completed	complete
		map existing breast pain pathway against new National pathway released 23rd October 2025 as per MAG recommendation	Lewis, Caroline	Completed	Funding proposal submitted to WCN
		Implement pilot for Capsule Sponge as per MAD recommendation and associated funding from NHSE	Humphrey, Lisa	Completed	Pilot started

reason, the Service Management team supports targeted intervention to address these concerns in order to reduce time on patient pathways. # One Stop Hysteroscopy within Gynaecology implemented in May 2024 at Bronglais General Hospital, with plan to implement across all sites during Q1 of 2025/26. # Pathway changes in Head and Neck to include Laryngeal Biopsy at first OPA, reducing reliance on pan-endoscopy # Health Board wide internal escalation framework now in place to support the monitoring of performance targets, with a TI de-escalation target of 60% for three months. *Additional radiology reporting sessions in place agreed for 2025/26. *Skin treatment recovery plan in place to end June 25 to reduce overall treatment volumes. To be reviewed quarterly.		Agree backlog clearance of CTC with radiology for LGI pathway	Humphrey, Lisa	Completed	additional activity now agreed
		implement pilot for galleas urine test for bladder pathway urology - 300patients for Q4	Griffiths, Neil	Completed	Plan now agreed start date January 2026

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Internal targets - Looking at the performance per tumour site individually that have the biggest impact on overall performance Skin Urology LGI Gynaecology Breast Reducing component waits Patient waiting more than 14 days for first OPA Patients waiting a diagnostic procedure and report more than 28 days Patients with a confirmed diagnosis of cancer waiting more than 62 days	Daily/weekly/monthly/ monitoring arrangements by management	1st			* Implementation of Single Cancer Pathway Report - BPPAC - Feb20 * COVID-19 Impact on Cancer Services - Board - May20 * Cancer Updated to QSEAC Jun20 & OpQSESC Jul20 * Risk 633 QSEAC - Feb21 & Aug21 * IPAR Report - Board - Nov22	None identified.	Establish Operational improvement group to track improvement projects in line with NOP and Annual Plans	Goode, Paula	Completed	Plans to establish a Cancer Transformation Task and Finish group which reports into the CCG transformation hub. On hold due to formation of Care Group structure
	IPAR Performance Report to S&PC & Board	2nd								
	Monthly oversight by NHS Executive/WG	3rd								
	Revised Governance arrangements in place since April 2025 with matters escalated when required via the CCGs governance arrangement	1st								

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Apr-26
Lead Committee:	Finance and Performance Committee	**Date of Next Review:**	Jun-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)		**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):	3×3=9	
Expected Date To Achieve TRS:	31/03/2027	
Trend:	*New risk*	

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 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	# 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 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	Agreed continuation of ophthalmology outsourcing for Q1, utilising ophthalmology and dermatology underspend with core budget	Humphrey, Lisa	30/06/2026	In progress
		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	30/06/2026	In progress
		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	Sheldon, James	30/06/2026	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	15/05/2026	In progress.
		Develop trajectories of improvement per specialty based on the optimisation framework assessment to identify productivity and efficiency gains	Humphrey, Lisa	30/06/2026	In progress.
		Develop a model of standardised assessment for the pre-assessment process to streamline pre-assessment and eliminate bottlenecks	Sheldon, James	30/09/2026	In progress.
		Develop mitigation plans for areas that are reliant on PAAR (neurology, outpatients)	Humphrey, Lisa	30/06/2026	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	31/05/2026	In progress.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
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	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								
	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								

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date	Barriers
Audit Wales- Tackling the Planned Care Challenges – Hywel Dda University Health Board	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.	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	
Audit Wales- Tackling the Planned Care Challenges – Hywel Dda University Health Board	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	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	The consultation of CSP remains a risk to the Ophthalmology entries as are the Urology ones outside the gift of the HB
Internal Audit - Financial Management Final Internal Audit Report 2024/25 (Reasonable)	R2. Budget Holder Training With the exception of QlikSense system training and LEAP leadership programme, budget holders do not have access to suitable training to enable them to perform their role effectively.	Budget holder training is being developed in conjunction with Swansea Bay University Health Board and will be rolled out later in 2025/26. We have set out an intention to develop a series of products, starting with a broad introductory piece for budget holders and later more specific subject areas.	Director of Finance	Director of Finance	31/01/2026	31/01/2026	
Internal Audit - Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26 (Limited)	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.	Community & Integrated Medicine	Chief Operating Officer	30/11/2025	30/11/2025	
Internal Audit - Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26 (Limited)	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.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date	Barriers
Internal Audit - Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26 (Limited)	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.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	
Internal Audit - Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26 (Limited)	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.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	
Internal Audit - Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26 (Limited)	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.	Community & Integrated Medicine	Chief Operating Officer	30/11/2025	30/11/2025	
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R1. Ensure maximum productivity at surgical hubs at Amman Valley (ophthalmology) and Prince Phillip (orthopaedics).	Ophthalmology: Secure rooms in AVH OPD 5 days per week.	Planned and Specialist Care	Chief Operating Officer	31/12/2025	31/12/2025	AVH OPD is utilised for other clinics on a Thursday and Friday and these clinics need to be accommodated elsewhere for Ophthalmology to proceed.
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R1. Ensure maximum productivity at surgical hubs at Amman Valley (ophthalmology) and Prince Phillip (orthopaedics).	Ophthalmology: Move the IVT delivery to AVH OPD	Planned and Specialist Care	Chief Operating Officer	31/12/2025	31/12/2025	Barriers to implementation? Ophthalmology: This is dependent on funding being agreed through the Annual Planning process. All delivery through OPD AVH currently would need to be housed somewhere else to free the OPD in AVH 5 days a week. Recurrent funding for cataract delivery would need to be secured. Other clinics currently utilise AVH OPD on a Thursday and Friday, these would need to be accommodated elsewhere before Ophthalmology can move forward.
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R1. Ensure maximum productivity at surgical hubs at Amman Valley (ophthalmology) and Prince Phillip (orthopaedics).	Ophthalmology: Identify in a Business Case the requirements needed to run cataracts through AVH theatre 5 days per week.	Planned and Specialist Care	Chief Operating Officer	31/12/2025	31/12/2025	IVT will need to vacate the theatre in AVH for the cataract delivery to be increased. This is dependent on a solution being found to accommodate other clinics in AVH OPD elsewhere to free the space for IVT delivery 5 days a week.

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Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R1. Ensure maximum productivity at surgical hubs at Amman Valley (ophthalmology) and Prince Phillip (orthopaedics).	Orthopaedics: Continue flexible backfill and additional internal activity to ensure delivery of zero breaches against 104 week Referral To Treatment targets during Q2-Q4 2025/2026..	Planned and Specialist Care	Chief Operating Officer	31/12/2025	31/12/2025	Barriers to implementation? Orthopaedics: There is no current allocation of recovery funding to support the delivery of flexible backfill and additional activity. The costs to support this will therefore have to be identified from core budget. List loading is often challenging due to limited capacity in Pre-assessment. Sickness levels and vacancies within theatre workforce as well as delays in recruitment of anaesthetics will impact the ability to develop and deliver sustainable plans to maximise productivity. The current 24/7 medical cover for Orthopaedics in PPH is heavily reliant on locums. An SBAR with a proposal around substantive Clinical Fellow recruitment will be submitted to FCSG which will provide a sustainable plan for cover. This plan also delivers a saving when compared with the current level of variable pay spend.
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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.	Planned and Specialist Care	Chief Operating Officer	31/12/2025	31/12/2025	
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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	Planned and Specialist Care	Chief Operating Officer	31/12/2025	31/12/2025	Barriers to implementation? Orthopaedics: There is no current allocation of recovery funding to support the delivery of flexible backfill and additional activity. The costs to support this will therefore have to be identified from core budget. List loading is often challenging due to limited capacity in Pre-assessment. Sickness levels and vacancies within theatre workforce as well as delays in recruitment of anaesthetics will impact the ability to develop and deliver sustainable plans to maximise productivity. The current 24/7 medical cover for Orthopaedics in PPH is heavily reliant on locums. An SBAR with a proposal around substantive Clinical Fellow recruitment will be submitted to FCSG which will provide a sustainable plan for cover. This plan also delivers a saving when compared with the current level of variable pay spend.
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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	Planned and Specialist Care	Chief Operating Officer	31/12/2025	31/12/2025	
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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	Planned and Specialist Care	Chief Operating Officer	31/10/2025	31/10/2025	Barriers to implementation? Currently patients are travelling significant distances on day of surgery; timely arrival and fitness to travel home will impact on patient cohort as day case.
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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.	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	Barriers to implementation? Theatre efficiencies in GGH are impacted by theatre and ward location logistics. No space in theatre to make a wait area, no space to accommodate Tysul on the same floor with theatres. Logistics would need to be resolved in order to increase efficiency

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Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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.	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	Barriers to implementation? Theatre efficiencies in GGH are impacted by theatre and ward location logistics. No space in theatre to make a wait area, no space to accommodate Tysul on the same floor with theatres. Logistics would need to be resolved in order to increase efficiency
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R6. Increase Intra-vitreal injections to 15 per list and undertaken in procedure rooms	Continue to onboard for 1.3 WTE posts	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	Barriers to implementation? This plan is dependent on recruitment and funding through the Annual Planning cycle.
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R6. Increase Intra-vitreal injections to 15 per list and undertaken in procedure rooms	Advertise band 7 post when JD has been approved.	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	Barriers to implementation? This plan is dependent on recruitment and funding through the Annual Planning cycle.
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R6. Increase Intra-vitreal injections to 15 per list and undertaken in procedure rooms	Increase lists when safe to do so in terms of staffing.	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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.	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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.	Planned and Specialist Care	Chief Operating Officer	31/12/2025	31/12/2025	
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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.	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	Barriers to implementation? Ophthalmology: Theatre efficiencies in BGH/GGH is reliant on portering and theatre staffing which currently impacts start and finish times on the lists, these issues will need to be resolved in order to increase efficiency.
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R12. Improve cataract, orthopaedic and other day case activity to GIRFT and Royal College standards.	Ophthalmology: Review theatre efficiencies in GGH/BGH to see where there is a possibility to increase theatre delivery further.	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	Barriers to implementation? Ophthalmology: Theatre efficiencies in BGH/GGH is reliant on portering and theatre staffing which currently impacts start and finish times on the lists, these issues will need to be resolved in order to increase efficiency.
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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.	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	Barriers to implementation? Orthopaedics: Current DSU workforce issues as a result of sickness and vacancies means that we do not have access to all funded PPH DSU theatre sessions currently. Delivery of activity against GIRFT metrics will require adequate workforce and theatres improvement works. Delivery against GIRFT metrics will also require engagement with multiple stakeholders, wider than just orthopaedic clinical staff.
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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.	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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	Planned and Specialist Care	Chief Operating Officer	31/10/2025	31/10/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date	Barriers
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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.	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	Barriers to implementation? Theatre efficiencies in BGH/GGH is reliant on portering and theatre staffing which currently impacts start and finish times on the lists, these issues will need to be resolved in order to increase efficiency
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	Barriers to implementation? Theatre efficiencies in BGH/GGH is reliant on portering and theatre staffing which currently impacts start and finish times on the lists, these issues will need to be resolved in order to increase efficiency
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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.	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	Barriers to implementation? Theatre efficiencies in BGH/GGH is reliant on portering and theatre staffing which currently impacts start and finish times on the lists, these issues will need to be resolved in order to increase efficiency
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R23. Procedure Rooms: Ensure intra-vitreal procedures are performed in a procedure room.	Secure rooms in AVH OPD 5 days per week.	Planned and Specialist Care	Chief Operating Officer	31/12/2025	31/12/2025	
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R23. Procedure Rooms: Ensure intra-vitreal procedures are performed in a procedure room.	Move the IVT delivery to AVH OPD.	Planned and Specialist Care	Chief Operating Officer	31/12/2025	31/12/2025	Which ones we cannot or will not be implementing and why? This is dependent on funding being agreed through the Annual Planning process. All delivery through OPD AVH currently would need to be housed somewhere else to free the OPD in AVH 5 days a week. Recurrent funding for cataract delivery would need to be secured.
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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.	Planned and Specialist Care	Chief Operating Officer	31/12/2025	31/12/2025	Which ones we cannot or will not be implementing and why? This is dependent on funding being agreed through the Annual Planning process. All delivery through OPD AVH currently would need to be housed somewhere else to free the OPD in AVH 5 days a week. Recurrent funding for cataract delivery would need to be secured.
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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	Planned and Specialist Care	Chief Operating Officer	30/09/2025	30/09/2025	
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	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.	Planned and Specialist Care	Chief Operating Officer	31/07/2025	31/07/2025	Barriers to implementation: 03/10/2025 - TNE - Capital funding for purchase of transnasal endoscope and associated equipment. Funding for dedicated workforce to deliver the service
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R1. The ED is seriously overcrowded, and some clinicians reported that they had not seen patients in cubicles for over 18 months	Undertake a review of other specialty pathways including Urology, ENT and Gynaecology.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	

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Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R1. The ED is seriously overcrowded, and some clinicians reported that they had not seen patients in cubicles for over 18 months	ENT SDEC T&F group to review score and capacity issues within procedure room. 28/08/2025 - Refer to MD1/3 actions. Proposed insourcing of ENT elective work for September is likely to impact on ability to ringfence SDEC capacity. Review to be arranged towards mid-October (following insourcing completion) to discuss further planning for SDEC ringfence. . Revised target date 31/10/2025.	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	Requires clinical engagement from ENT Team to utilise treatment room as SDEC.
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R1. The ED is seriously overcrowded, and some clinicians reported that they had not seen patients in cubicles for over 18 months	Undertake Carmarthenshire System Review of frailty pathways across the 3rd sector	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R1. The ED is seriously overcrowded, and some clinicians reported that they had not seen patients in cubicles for over 18 months	Undertake review of Rehab Pathway to progress levels of rehab and review current pathway and capacity	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	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)	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	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	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	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.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R12. There remain challenges due to local authorities being unwilling to accept the trusted assessor role, leading to assessment-related pathway of care delays. While challenging, this model should be pursued with LAs.	The Six Goals Programme Plan 2025 / 2026 aim to deliver in Q1 the review of TA schemes to ensure they align to the National principles and strengthen governance and monitoring of TA within the region. This will be done jointly with health and LA colleagues.	Community & Integrated Medicine	Chief Operating Officer	31/03/2026	31/03/2026	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R13. Board rounds to be done consistently and daily across all areas and health boards should look to increase the frequency of weekly 'fishbowls' with local authorities to create momentum.	Utilising regional innovation hub funding to deliver a Strengths Based Collaborative Communication Training Programme for staff in both health and LA to support a "fishbowl" approach	Community & Integrated Medicine	Chief Operating Officer	31/03/2026	31/03/2026	Capacity within the Quality Improvement and Service Transformation team to support implementation of the Optimal Hospital Flow Framework due to multiple improvement priorities across the HB.
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R15. Review the digital infrastructure to ensure that health boards can track the full patient journey.	Operational governance and escalation - SOP to be worked up.	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	
Ministerial Advisory Group (MAG) - A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity - April 2025	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. [Action mirrors R15 on the MAG Planned and Specialist Care report Jan 2025]	Chief Operating Officer Management	Chief Operating Officer	31/10/2025	31/03/2026	

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Ministerial Advisory Group (MAG) - A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity - April 2025	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. (Action mirrors R16 on the MAG Planned and Specialist Care report - January 2025)	Chief Operating Officer Management	Chief Operating Officer	31/10/2025	31/10/2025	
Ministerial Advisory Group (MAG) - A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity - April 2025	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.	Chief Operating Officer Management	Chief Operating Officer	31/03/2026	31/03/2026	
Ministerial Advisory Group (MAG) - A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity - April 2025	R11. In addition to the plan for pathology and endoscopy (see Recommendations 6 and 7), health boards should work together as regions to identify two priority fragile services to be addressed in 2025/26 and thereafter a further two on an annual and ongoing basis. To facilitate this work, resources and support will be provided by the PPU.	Awaiting formal response	Planned and Specialist Care	Chief Operating Officer	31/03/2026	31/03/2026	
NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	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.	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R26. We recommended that there is greater senior nursing input and oversight on the wards supporting and challenging ward activity. This needs to be ongoing until such a time that there is assurance that this level of scrutiny and challenge is embedded into the normal practice on the ward.	In line with recent flow improvements which includes the implementation of Senior Decision Maker led board rounds. The Q.I team have the full support of the Senior Leadership Team in delivering the necessary improvements. This will include increased senior nurse viability which includes the System Head of Nursing.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R28. We recommended that the site escalation process and action cards are explicitly clear to all relevant personnel within the hospital to ensure that there is a consistent and clear approach adopted throughout the hospital. Whilst this is being embedded, we recommend senior leadership presence to provide assurance that this in place in all clinical areas.	System GM and System Head of Nursing working on escalation cards in line with Hospital full Protocols	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R36. We recommended that there is greater senior nursing leadership presence in all areas until complete assurance regarding the implementation of the optimal flow framework is embedded.	In line with recent flow improvements which includes the implementation of Senior Decision Maker led board rounds. The Q.I team have the full support of the Senior Leadership Team in delivering the necessary improvements. This will include increased senior nurse viability and presence which will also include the System Head of Nursing OCP Phase 2 is considering the development of a corporate function whose primary focus is clinical governance- this will enable Locality based senior nurses the capacity to provide greater presence and visibility in clinical areas.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R28. We recommend that the Manager of the Day that is supporting patient flow for the site is visible throughout the day and can support the patient flow team and add value by taking additional decisions and actions that will support the site to de-escalate into a safer position. Consideration should be given to how this role is rostered as a specific role ie. diaries of the individuals are cleared of all non-essential meetings for a day and the senior manager is based within the patient flow hub and physically attends all site meetings and huddles throughout the day to provide input and support the operational delivery of patient flow. This provides a number of benefits: additional senior support during times of high escalation, a clear point of contact for tactical and strategic leaders to gain real-time information 'from the floor' and provide further learning and development opportunities for individuals in managing an acute hospital and dealing with the associated challenges this presents.	28b. Review OOH support and cover.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	

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NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R34. We recommend the HB enacts a zero tolerance regarding inaccurate information regarding query and confirmed discharge activity from ward areas. We appreciate that there are times when unexpected discharges occur later in the day. However, this should be on the minority of occasions rather than what appears to be the norm. We recommend that there is greater senior leadership presence in all areas where this practice occurs until complete assurance regarding accurate bed positions is achieved.	34b. RTDC Task and Finish Group to be implemented with QIST support for data capture and outcome tools. Invitation extended to Ward Sister Champions.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R35. Utilising the RTDC tool and recording a daily dataset of declared vs total discharges by area would give a high-level indication of the ward areas that require additional support to improve within this area.	35. Review of RTDC Tool as part of RTDC Task and Finish Group.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R36. We recommend the HB share examples whereby data generated by the RTDC tool has led to improvements in practice.	36. Review data with QI Team to determine key improvements and agree next focus steps.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	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 escalation steps if full and no capacity. Discharge Lounge Task and Finish Group to establish more efficient ways of working.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	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 escalation steps if full and no capacity. Review of opening times based on activity peaks.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	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).	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	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.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R41. Ensure all patients are spoken to and they are aware of the planned move.	41. review of Discharge Lounge Patient Leaflet	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	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.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R43. We recommend that a column is added to the sitrep report to input confirmed discharges for the following day, so those identified patients can be 'pulled' to discharge lounge as soon as it opens, releasing early capacity that can be utilised.	43. Complete- Column available on Sitrep to capture next day discharges	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	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.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	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.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	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 achievable for a 400 bed site.	45. Review Discharge Lounge use/data to determine efficiency and capacity constraints	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R46. The HB could look at the utilisation and occupancy of discharge lounge on a daily basis as a performance KPI to embed the early and proactive use of the facility as much as possible.	46. Review performance capture. Part of Discharge Lounge working group.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R47. Discharge activity occurs later in the day at GGH. We recommend that the HB explore this in more detail to be able to clearly understand the root cause of this and be able to put measures in place to, where possible ensure that discharge activity occurs earlier in the day.	47a. Review of RTDC tool with aim to bring discharges before 12 midday (from 2pm).	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R47. Discharge activity occurs later in the day at GGH. We recommend that the HB explore this in more detail to be able to clearly understand the root cause of this and be able to put measures in place to, where possible ensure that discharge activity occurs earlier in the day.	47b. Review of discharges after 2pm to determine delay reasons to provide feedback and key learning to achieve optimal flow.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R48. In collaboration with informatics colleagues in the NHS executive, we have the ability to provide admission/ discharge modelling data which would highlight the impact that earlier discharge could have on flow capacity throughout the day. We would like the opportunity to work with you to advance this concept further in the future	48. Action to be confirmed by the service	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R56. We recommend that senior leaders within the organisation endorse the implementation of the framework 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.	56a. Safe Hospital Care Actions reviewed and discussed monthly for progression and monitoring of Optimal Flow framework.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	

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NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	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	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	R8. Ensure all discharge paperwork is completed the day prior.	Awaiting full management response from service to be added to AMaT	Community & Integrated Medicine	Chief Operating Officer	18/07/2025	18/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	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	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	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 ward through 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	Community & Integrated Medicine	Chief Operating Officer	18/07/2025	18/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	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	Community & Integrated Medicine	Chief Operating Officer	18/07/2025	18/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	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	Community & Integrated Medicine	Chief Operating Officer	18/07/2025	18/07/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R1. (BGH) The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.	Dedicated NOF pathway QI project commenced march 25.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	partially complete as yes there is no dedicated trauma list
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R4. (BGH) The lack of ED senior medical staff must be addressed. However, the future viability of the department may require a different model in the long-term	A medical staffing stabilisation programme has commenced at BGH with the support of the medical workforce team with a view to improving workforce intelligence- to include confirming total locum opportunities and any opportunities to substantiate positions	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	The barriers centre around the appropriate appointment of senior medical staff and the length of the recruitment process. There will also be a requirement for any new employee to adjust to the local system and policies and a necessary delay in becoming effective.
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R9. (BGH) The relatively high number of hospital admissions per WTE consultant (all health board consultants) suggests that there is an insufficient senior medical workforce to "power" the hospital beds in a timely and efficient way that ensures good patient flow.	A medical staffing stabilisation programme has commenced at BGH with the support of the medical workforce team with a view to improving workforce intelligence- to include confirming total locum opportunities and any opportunities to substantiate positions.	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date	Barriers
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R15. (WGH) There are long stays in the ED for all patients that should be reduced.	WGH do have clear pathways for patients. Medical teams in reach to start the treatment plan from admission. Need to reduce access points to in-patients wards. Need to de- surge assessments units to keep flow active. Boarding protocol in place. Need to consider continues flow.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	Community capacity to facilitate discharges and admission avoidance and workforce fragility in radiology, therapies, HCSW and doctors. Financial resources not aligned to requirements for bed base or staffing models Limited applications for posts from those with the necessary knowledge, skills and experience to take on senior positions Fragile rotas across all specialities including support services Aging digital systems Paper based referral and requests
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	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)	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	It needs financial investment
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	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.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R24. (GGH) The ED is small and cramped and desperately needs more space, if it is to accommodate large numbers of patients waiting for a hospital bed. However, better patient outflow from the ED is obviously required. The current situation is clearly causing increased risk and harm to patients and is distressing for staff.	Review of current GGH space (ED/CDU/MDU and external environment) to explore additionality/re-purpose of space to support and reduce impact at front door (ED).	Community & Integrated Medicine	Chief Operating Officer	16/05/2025	16/05/2025	Workforce challenges/culture/resistant to change/ environmental factors/ equipment.
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R25. (GGH) The ED is used by the hospital as a general waiting room for all specialties and input to the ED by inpatient specialists is poor. The implementation of Internal professional standards is urgently required.	Speciality Pathway Reviews underway. Surgical SDEC (Phase 1 Complete). Pilot of Trauma Ambulatory Care Unit underway. Review of Urology, ENT & Gynae Pathways. Internal Professional Standards have been disseminated by Deputy Medical Director. Formal monitoring arrangements to be agreed. Deputy Medical Director currently aligning speciality specific pathways from ED in line with professional standards. 05/09/2025 - Internal Professional Standards now drafted. Implementation through the Medical Directorate and Clinical Leads required.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date	Barriers
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R27. (GGH) Ambulances wait outside the ED for long periods.	Boarding protocol implemented with patients boarded against predicted discharges. Safety Huddles, Patient Flow review. Emergency Pressures and Escalation Policy (489) Role of the Senior Nurse Manager, Clinical Site Manager and 'Manager of the Day' strengthened, supporting key escalation of actions, status and risk. Optimal Flow Framework implementation: -EOS Reviews & Escalation process review -Board round monitoring & Frontier usage -Criteria Led Discharge -Repatriation Database -POCD monitoring Initiatives to facilitate admission avoidance: -Streaming Hub -Virtual Ward -Re-direction Policy (Draft) -Perfect week (Jan 25) completed with some initiatives adopted as business as usual (GP medical take via SDEC). -Optimised Weekend working Pilot planned (22/23 March). Weekly Big Room Advertising for a 6th Acute Physician to enable SDEC, CDU and Medical Liaison in ED rotation to provide sufficient medical cover across the front door. Recruitment process instigated.	Community & Integrated Medicine	Chief Operating Officer	30/06/2025	30/06/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R28. (GGH) The departmental configuration makes imaging difficult to access in a timely way. However, the suspected cauda equina syndrome (CES) pathway is good	Review completed and ED & SDEC radiology request prioritisation agreed – requires further measurement of data to determine impact. OOH Cauda Equina pathway review being undertaken.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R31. (GGH) SDEC will take GP referrals (and some ambulance referrals) directly but closes at 8pm and only accepts new patients up to 5pm. There is a poor flow of patients to SDEC from the ED.	Change in pathway for medical referrals from GP to GGH SDEC (embedded since perfect week). SOP being updated. Optimised Weekend working Pilot planned (22/23 March) will include SDEC	Community & Integrated Medicine	Chief Operating Officer	30/06/2025	30/06/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R32. (GGH) The co-located MIU is ENP-led, with patients streamed from the ED reception. The out-of hours primary care centre will not accept patients from the ED	OOH's primary will accept patients as per re-direction policy – pending sign off.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R33. (GGH) The shortage of senior medical staff and registered nurses must be addressed.	ED Consultant Recruitment – process underway. Safe Staffing Review (RN) has been progressed over last 18 months with key recruitment. Further reviews planned (B2/B3)	Community & Integrated Medicine	Chief Operating Officer	30/06/2025	30/06/2025	
Peer Review Getting It Right First Time (GIRFT) Ophthalmology Review	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.	Planned and Specialist Care	Chief Operating Officer	30/04/2024	31/10/2025	
Peer Review Getting It Right First Time (GIRFT) Ophthalmology Review	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.	Planned and Specialist Care	Chief Operating Officer	30/04/2024	31/03/2026	Linked to CSP in GGH and BGH as high flow principles challenged on these sites.
Peer Review Getting It Right First Time (GIRFT) Ophthalmology Review	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	Planned and Specialist Care	Chief Operating Officer	30/04/2024	30/09/2025	Staffing sickness levels impacts upon training and development within the ophthalmology roles.
Peer Review Getting It Right First Time (GIRFT) Ophthalmology Review	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-	Planned and Specialist Care	Chief Operating Officer	31/12/2023	31/03/2026	
Peer Review Getting It Right First Time (GIRFT) Ophthalmology Review	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.	Planned and Specialist Care	Chief Operating Officer	30/04/2024	31/03/2026	The IVT service is extremely fragile and we cannot afford to lose capacity. The IVT capacity needs to be increased to meet demand and this is a sight affecting service. This will need to be considered when proposing a move to the OPD department in AVH.

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Peer Review Getting It Right First Time (GIRFT) Ophthalmology Review	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.	Planned and Specialist Care	Chief Operating Officer	30/04/2024	31/07/2025	
Peer Review Getting It Right First Time (GIRFT) Ophthalmology Review	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.	Planned and Specialist Care	Chief Operating Officer	30/04/2024	31/03/2026	Other services would need to move to accommodate this and the Clinical Services Plan is mapping these services and their requirements
Peer Review Getting It Right First Time (GIRFT) Ophthalmology Review	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.	Planned and Specialist Care	Chief Operating Officer	30/04/2024	31/03/2026	Other services will need to move to accommodate bigger Ophthalmology clinics. SB are discussing a training programme we have proposed, this will need to be accepted by them in order to progress.