

# Annual Plan 2026/27 - Deep Dive

Risk Landscape, Boundaries and Consequences

## Hywel Dda University Health Board

Finance and Performance Committee, 30 April 2026

For scrutiny and discussion: the boundary of the plan, the reconciled risk landscape, and the consequences of both.

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# Executive Summary

- The plan is a deliberate, balanced construct. It reflects disciplined prioritisation within a 1.11% allocation uplift (£12.8m) that covers unavoidable demand and inflation only - with no discretionary investment headroom.
- The boundary is explicit. Areas outside the plan are classified by constraint - affordability, workforce, capacity/infrastructure, dependency, and deliberate deferral - not by omission.
- The risk position is being actively managed. 656 risks at baseline (2 March 2026): 9 extreme (score 25), 54 further at 20-24, 391 at or above the escalation threshold of 12. All 63 risks scoring  $\geq 20$  remain carried forward at 01/04/2026.
- The financial position is the live unknown. Year 1 deficit £41.0m including Welsh Risk Pool (WRP) (£27.9m excluding WRP) against a savings requirement of £47.5m. The Board has tasked the Executive Team with identifying a route from £41m forecast to a £22.1 m Target Control Total — a gap of ~£18.9m of further mitigation yet to be assured.
- Quality and safety consequence is not abstract. Surge harm, Acute Medical Assessment Unit (AMAU) capacity, ENT procedure room displacement, medication safety and nutrition gaps represent current-year, real-world consequence — not future-tense risk.
- The Finance and Performance Committee is asked to **NOTE** the boundary, scrutinise the consequence of residual risk, acknowledge the financial unknown is being worked through, and endorse the discipline of managing within the envelope.

**Implication for the Committee:** *The plan is credible, deliverable and honest about its limits. Movement from this balanced position requires additional resource, re-prioritisation, or explicit acceptance of increased consequence elsewhere.*

# The planning construct - balance of demand, workforce, capacity, finance and risk

- Risk-led, not target-led. The 2026/27 plan was built from the Corporate and Operational Risk Registers - 656 risks reviewed, 391 escalated at score  $\geq 12$ , 15–20 top risks shaped the plan architecture.
- Three-layer prioritisation. Operational review → Clinical Care Group prioritisation (STEPP criteria) → Executive review of top 15-20 risks. Integrated with the £6m additional savings target, Strategy Refresh, Clinical Services Plan decisions and Targeted Intervention/Escalation status.
- Three Priority Bundles as the unit of delivery:
  - A - Flow and Frailty (Community and Integrated Medicine lead): orthogeriatric capacity, Same Day Emergency Care (SDEC) 7-day, Clinical Streaming Hubs (CSH).
  - B - Cancer, Diagnostics and Capacity (Planned and Specialist Care lead): radiology, cellular pathology, endoscopy stabilisation.
  - C - Scheduled Care Configuration and Sustainability (Planned and Specialist Care / Medical Directorate lead): theatres, Referral To Treatment (RTT) and productivity.
- Multiplier logic. Each priority tested across quality, performance, workforce and finance - not accepted unless it demonstrably impacts all four domains.
- Governance. Planning Co-ordination Group (fortnightly from July 2025); three planning workshops (October/November/January); Board Seminar February 2026; Finance and Performance Committee (FPC) scrutiny; Board approval 26 March 2026. Welsh Government (WG) Planning Maturity Self-Assessment applied throughout, with a further matrix to be completed.

**Implication for the Committee:** *The plan is a single integrated construct. Uplifting delivery expectation beyond the funded envelope requires additional resource, re-prioritisation against a funded commitment, or explicit acceptance of increased consequence elsewhere — there is no slack in the construct.*

# The boundary of the plan - what is included (not necessarily funded)

- Priority Bundle A - Flow and Frailty. 7-day Clinical Streaming Hubs; SDEC expansion (Withybush Hospital (WGH) fully-funded £1.2m); orthogeriatric investment. Weekend SDEC pilot 91% same-day discharge; SDEC absorbs 56% of Emergency Department (ED) medical takes. Cost avoidance potential £3.9m–£9.9m.
- Priority Bundle B - Cancer, Diagnostics and Capacity. Non-recurrent stabilisation of radiology (Risk 1547), cellular pathology (Risks 1309/2133) and endoscopy (Risk 1488). SCP trajectory 65.8% → 66% Q4 (above de-escalation criterion).
- Priority Bundle C - Scheduled Care Configuration and Sustainability. Safer staffing; theatre efficiency; RTT quarterly profile; productivity agenda as medium-term enabler.
- Cross-cutting enablers. Consultant job planning target >90% by Sept 2026 (82% Q1); 30% agency reduction; HCSW/A&C/clerical agency elimination; value-based healthcare; medicines management; digital enablers.
- Prevalence modelling capped at £12.4m (Executive decisions £10.5m). Covers demographic prevalence growth and selected planning priorities - all items within the £12.4m require business case scrutiny via in-year process.
- Ministerial priorities covered. Timely Access to Care; Community by Design (cluster planning, GP managed practice sustainability, OOH resilience); Quality & Safety (new for 2026/27); Population Health and Prevention; Mental Health and Learning Disabilities (MHL) Access (2 additional local crisis beds); Women's Health (Nurse-led Hysteroscopy, Point-of-Care USS interface service).
- Financial envelope. 1.11% allocation uplift £12.8m (inescapable demand and inflation only); £28.5m non-recurrent-to-recurrent conversion; £19.0m additional 2% savings target.

**Implication for the Committee:** *The plan's delivery commitments sit within a defined financial and operational envelope. Commitments are deliberate, costed and governance-assured. Everything outside that envelope is the subject of slide 6.*

# The boundary of the plan — what is excluded, classified by constraint

Constraint	What is excluded (illustrative, not exhaustive)	Why excluded
<b>Affordability</b>	RTT recovery to national 26-week standard; full closure of 104-week breaches in 5 specialties; 12-hour ED ≤7.0% within Year 1; SCP cancer 75% target (plan: 64–67%); therapy waiting time breaches (physio, OT, stroke rehab).	Costed recovery plans exist (RTT alone £12.5m) but sit above the 1.11% uplift envelope. £19.0m savings target only £9.4m identified at Board Seminar.
<b>Workforce</b>	Sustainable ultrasound service (6.4 WTE deficit, 68,000 patient/yr demand gap); cellular pathology consultant cohort; acute OT capacity; weekend/OOH physiotherapy; MH workforce Ceredigion; unfunded respiratory on-call.	National shortage of sonographers means insourcing is not viable. Recruitment for senior clinical roles can exceed 6 months. No additional recurrent investment in therapy workforce within envelope.
<b>Capacity / infrastructure</b>	Glangwili theatre workforce and DSU/Theatre 6 fire safety suspension (min. 18-month reduced capacity from 2027); cellular pathology estate; roof failures at PPH and WGH; standby generators; end-of-life ophthalmic equipment; endoscopy decontamination at Bronglais.	Structural estate and equipment risks require capital investment and multi-year programme delivery; not resolvable within a single planning year.
<b>Dependency</b>	Welsh Government continuation of non-recurrent diagnostic funding (unconfirmed); £26m conditionally recurrent funding (at risk); Senedd election cycle; regional partner capacity (SW Wales Regional Joint Committee); local authority partnership on delayed pathways.	Outside the Health Board's direct operational control. Loss of WG diagnostic funding would materially worsen diagnostic and a potential impact on cancer positions.
<b>Deliberate deferral</b>	Broader productivity and performance programme benefits (signalled as medium-term enabler); Clinical Services Plan implementation (mostly 2027/28 and beyond); neurodevelopmental structural capacity expansion (dependent on national workforce programme).	Benefits not assumed within 2026/27 trajectories by design - to maintain realism and avoid untested assumptions.

**Implication for the Committee:** *Exclusions are classified and explicit, not oversights. Any decision to pull an excluded item into scope requires new funding, workforce release, capital, partner action, or explicit acceptance of increased consequence.*

# Exclusion → consequence framework

- For every material exclusion, three consequence dimensions are applied consistently across the pack. This framework is the standard lens through which residual risk is articulated for Committee scrutiny.
- **Operational consequence** - Impact on access, waiting times, performance standards. Real-world examples: 104-week and 26-week RTT breach trajectories; 12-hour ED % trajectory; diagnostic 8-week breaches; therapy 14-week breaches.
- **Quality and safety consequence** - Clinical risk, patient experience, harm indicators. Real-world examples: inappropriate bed surging (Risk 2033, current harm); avoidable harm in AMAU (Risk 1431); ENT procedure room loss under surge (Risk 2258); medication safety composite (multiple risks); clinical records fragmentation (Risk 1898, 1319).
- **Financial consequence.** - Cost pressures (variable pay, outsourcing), unmitigated pressures on the underlying deficit, future liabilities. Real-world examples: variable pay cost pressure (Risk 2132, score 25); outsourced radiology costs (Risk 2131); podiatry non-pay pressures (Risk 2167, score 25).
- *These are not abstract risk descriptions. Many are producing current-year harm, not only future exposure. The system is not in a steady state - pressure is live. Therefore, many risks must be actively managed in-year.*

**Implication for the Committee:** *Every worked example in this pack is articulated through this 3-dimension lens. The Committee's scrutiny should focus on whether the mitigations committed are adequate against the consequence sized through this framework.*

# Worked Example — Urgent and Emergency Care

- What is in. 7-Day Clinical Streaming Hubs; SDEC expansion (WGH fully funded £1.2m); Six Goals incremental improvements. Ambulance >1hr trajectory 918/mo (35-mo avg) → 650 Q1 → 590 Q2 → 560 Q3 → 590 Q4 against TI target ≤680/mo. 12-hour ED % 9.5% → 9.3% → 8.9% → 7.7% → 7.3% Q4 against ≤7.0% standard.
- What is out/Risks. Full achievement of ≤7.0% 12-hour ED target within Year 1; resolution of middle-grade medical staffing fragility (Risks 750, 1992, 2264, all score 20); full resolution of ED demand-capacity mismatch at WGH (Risk 2113) and Glangwili Hospital (GGH) (Risk 1115), both score 20.
- Operational consequence. Residual ED overcrowding and long waits for patients requiring admission; sustained pressure on ambulance handover despite improving trajectory; 12-hour standard deferred into the back end of the planning period.
- Quality and safety consequence. Inappropriate bed surging continues (Risk 2033 - current harm); avoidable harm in AMAU (Risk 1431); displaced elective activity from ENT procedure room loss under surge escalation at GGH (Risk 2258, score 20).
- Financial consequence. Continued premium medical locum and agency spend - a material contributor to the variable pay extreme risk (Risk 2132, score 25). Six Goals funding utilisation flagged at M12 2025/26 as requiring urgent review.

**Implication for the Committee:** *The plan delivers measurable UEC improvement but not national standard in Year 1 or the full Targeted Intervention de-escalation criteria. Current-year harm from sustained surge is a live quality risk, not a future-tense one. Reliance on the Six Goals programme continuation is a delivery assumption worth re-testing through Q1.*

# Urgent and Emergency Care - front-door reform and same-day capacity

- Front-door architecture. 7-day Clinical Streaming Hubs (WGH, GGH, Bronglais Hospital (BGH)) providing triage, redirection and navigation at presentation; SDEC expansion with Withybush fully funded at £1.2m; Same-day discharge target  $\geq 75\%$  against streamed patients.
- SDEC evidence base. Weekend SDEC pilot achieved 91% same-day discharge. SDEC absorbs 56% of the medical takes currently presenting via ED at expanded sites — direct decompression of ED acuity.
- Surgical and ambulatory reach. Surgical SDEC development within Priority Bundle A; same-day ambulatory pathways (DVT, cellulitis, PE rule-out); nurse-led admission avoidance; Bundle A multiplier logic - quality, access, workforce, finance - applied to each component.
- Winter resilience. Surge plan tested October–February; ring-fenced escalation beds; geriatric liaison at front-door (Bundle A / Flow and Frailty); specialty surge protocols for medicine, care of the elderly and respiratory. Seasonal variance is anticipated and costed, not absorbed.
- Cost-avoidance modelling. Bundle A modelled at £3.9m (conservative) to £9.9m (ambitious). Avoidance is the counterpart to cost-out - same-day discharge avoids the admission cost and the downstream bed-day consumption.
- Risks carried forward. ED demand-capacity mismatch at WGH (Risk 2113, score 20) and GGH (Risk 1115, score 20); middle-grade medical staffing fragility (Risks 750, 1992, 2264 all score 20); Six Goals funding utilisation flagged at M12 as requiring urgent review.

**Implication for the Committee:** *Front-door reform is doing the heavy lifting. The SDEC evidence (56% absorption, 91% weekend same-day discharge) validates the investment case. But front-door investment cannot on its own compensate for exit-door constraints — the flow and discharge picture is on the next slide.*

# Urgent and Emergency Care - flow, discharge and the 12-hour ED residual

- 12-hour ED trajectory. Baseline 9.5% → 9.3% (Q1) → 8.9% (Q2) → 7.7% (Q3) → 7.3% (Q4) against the ≤7.0% Targeted Intervention standard. Residual Q4 gap is 0.3 percentage points - the last fraction the plan cannot close within envelope.
- Residual means residual harm. Inappropriate bed-surgings continues (Risk 2033 - current harm, not future exposure); avoidable harm events in AMAU (Risk 1431); ED overspill to ENT procedure room at GGH under surge (Risk 2258 score 20) potentially displaces elective activity.
- Delayed pathways of care. Pathway delays remain material; stranded (>7 days) and super-stranded (>21 days) volumes sustained. System-wide partnership with 3 local authorities sits beyond direct Health Board operational control - the dependency is named explicitly in the Accountable Officer letter, however, the Health Board recognises that they must improve their own processes
- Stranded-patient economics. Each super-stranded bed-day is £400-£500 of acute cost delivering community-equivalent care. The whole-system argument for pathway investment sits with partners, not the acute provider but the acute provider carries the operational, quality and financial consequence. The recent Structured Assessment Report highlighted circa £27-28m of cost associated with the DPOCs.
- Ambulance handover. 918/mo (35-month average) → 650 Q1 → 590 Q2 → 560 Q3 → 590 Q4 against the TI ceiling of 680/mo. The Q3 dip to Q4 rise is expected winter re-pressure, not a plan failure - seasonal variance is anticipated in the trajectory.
- Workforce reality check. The 30% agency reduction target and £26m conditional funding at risk (Risk 1199) both rest on substantive recruitment in a nationally competitive market. Failure to recruit extends locum reliance on middle-grade medical (Risks 750, 1992, 2264) - the extreme variable pay risk (Risk 2132 score 25).

**Implication for the Committee:** *The 12-hour ED Q4 residual is the last 0.3 percentage-point gap the plan cannot close within envelope. Closure depends on flow relief from internal processes and partner-dependent delayed pathways (especially in Carmarthenshire), not on further front-door investment – however, the SDEC being focused in WGH will provide a benefit to this metric, which is appropriate given WGH is the most challenged in relation to 12 hours.*

# Worked Example - planned and specialist care / RTT

- What is in. Day case rate >86% (vs 80% target); lowest follow-up waiting list in Wales; clinical validation programme; cataract cross-cover (Amman); safer staffing; theatre efficiency.
- What is out. National 26-week RTT standard; closure of 104-week breaches in 5 specialties; funded recovery programme (£12.5m costed but unfunded, not all RTT ADHD assessments were included). GGH theatre capacity (Risk 2028, score 20) constrained by fire safety suspension.

## 104-week trajectory at March 2027 (year-end, 4-specialty validated – please note there is a range on some cases T&O could be 472-808):

Specialty	Ophthalmology	T&O	Urology	ENT	Dermatology
Patients >104 wks	3,607	472	465	374	589

- 26-week trajectory. 9,316 patients against zero-breach national standard by March 2027.
- Operational consequence. Extended waits across 5 specialties; continued prioritisation of urgent/cancer over routine elective; outsourced activity where clinically suitable.
- Quality and safety consequence. Clinical deterioration whilst waiting; equity-of-access risk; (Risk 1786 off action listing at 01/04/26, underlying clinical risk persists)
- Financial consequence. Outsourced theatre activity (driving £4.5m Planned and Specialist Care CCG 2025/26 overspend); Risk 21 31 outsourced radiology cost pressures (AHP CCG); continued premium-cost elective delivery.

**Implication for the Committee:** 5,507 patients projected >104 weeks at March 2027 across 5 specialties. Accelerating closure requires the £12.5m costed (Circa £10m for RTT) recovery programme to be funded or prioritised against another funded commitment - there is no headroom in the envelope. The only viable solution is a further increase within the enabling actions and better productivity and efficiency.

# Orthogeriatrics - hip fracture pathway (UEC ↔ planned care interface) – not in the Annual Plan

- Why this matters. Risk 1256 is one of the Health Board's 9 extreme risks (score 25). Hip fracture patient safety is compromised at GGH by the absence of a dedicated orthogeriatric service. Hip fracture is the archetypal UEC-to-planned-care transition: emergency admission, time-critical theatre access, prolonged ward-based recovery
- Evidence base. Best-practice models (National Hip Fracture Database, BOAST standards) show consultant geriatrician input from admission reduces 30-day mortality, shortens length of stay by 2-4 days, cuts delirium incidence and medication error rates, and accelerates discharge readiness. The clinical case is settled (links to DPOCs)
- Current state at GGH. No dedicated orthogeriatric service; intermittent geriatric input on demand; trauma ward nursing model not tailored to frailty; medication review and delirium screening inconsistent. Risk 1256 captures this as current-year harm.
- What was proposed in - Priority Bundle A (Flow and Frailty). Investment in geriatrician and AHP capacity sits within the Bundle A cost-avoidance case. The multiplier logic applies: rehabilitation (quality), length of stay (LOS) reduction (performance), agency reliance reduction (workforce), bed-day savings (finance).
- What is out within Year 1. Full operational orthogeriatric service at Glangwilli to BOAST standard; dedicated orthogeriatric ward configuration; 7-day consultant geriatrician cover across the acute Trauma and Orthopaedic (T&O) caseload. Year 1 delivers phased progression, not the full model.
- Consequence - operational. Length of stay for the hip fracture cohort remains elevated above national peers; discharge planning deferred; T&O elective admissions blocked when trauma beds are held open (which affects the previous slide around RTT performance). Financial - Extended LOS on acute orthopaedic beds blocks elective T&O admissions - a direct upstream driver of the planned care 104-week position (T&O 589 (noting range on previous slide) patients >104 weeks at March 2027). Theatre throughput, elective bed availability and agency cover are interlinked.

**Implication for the Committee:** *Orthogeriatrics is the clearest case study in the plan where a UEC/acute investment directly closes a planned-care harm and a planned-care bottleneck. Sustaining Priority Bundle A investment is the mechanism.*

# Planned Care — 104-week, 26-week RTT and cancer trajectories

## 104-week breach closure at March 2027 (year-end validated projection by specialty):

Specialty	Ophthalmology	T&O	Urology	ENT	Dermatology	Total (4-spec)
Patients >104 wks	3,607	472	465	374	589	5,507

- RTT 26-week standard. 9,316 patients projected at March 2027 against zero-breach national standard. A £12.5m costed recovery programme would deliver the dedicated capacity to accelerate closure — currently unfunded, sitting above the 1.11% uplift envelope.
- SCP cancer 75% trajectory. 65.8% → 66% (Q4) against 75% national standard. Above the de-escalation criterion but below target. Cancer de-escalated to Level 1 (routine arrangements) in February 2026 after sustained focused recovery through 2025/26- a significant achievement to defend.
- The delivery engine (what is in). Day case rate >86% (vs 80% target); lowest follow-up waiting list in Wales; clinical validation programme reduces low-priority backlog; cataract cross-cover (Amman) absorbs ophthalmology volume; safer staffing; theatre efficiency programme.
- The unfunded tier (what is out). Acceleration to the 26-week national standard within Year 1; full 104-week breach closure across 5 specialties; the £12.5m dedicated recovery programme (does include non-RTT metrics). Costed, not funded.
- Patient-harm flagging. Clinical deterioration-whilst-waiting risk persists (low baseline score but live); CTD/systemic vasculitis (Risk 1786, off action listing, underlying clinical issue active); equity-of-access risk across 5 specialties.

**Implication for the Committee:** *The 5,507-patient 104-week position at March 2027 is the planning position, not a worst case. Accelerating closure requires recovery money/further Productivity and efficiency, or a re-prioritisation against another funded commitment, or Committee acceptance of extended waits. There is no structural (or at the very least), limited structural slack in the current envelope.*

# Planned care - Glangwili theatre capacity and conversion to recurrent

- GGH Day Surgery Unit (DSU) / Theatre 6. Fire-safety suspension results in a minimum 18-month reduced theatre capacity from 2027. Risk 2028 (score 20) captures workforce impact; the capacity impact is multi-specialty - T&O, ophthalmology, ENT, urology, general surgery.
- Knock-on to 104-week trajectory. Sustained reduced theatre capacity at GGH from 2027 means the 2026/27 planning envelope must deliver most of the 104-week closure before the reduction bites - a front-loading requirement that is not costed separately within the envelope.
- ENT procedure room under UEC surge. Risk 2258 (score 20) - the ENT procedure room is displaced to medical overspill during urgent care surge at GGH, cutting into scheduled elective throughput. UEC flow therefore directly determines planned care output at this site - the two cannot be managed in isolation.
- Outsourcing - current position. Outsourced theatre activity is driving a material share of the 2025/26 Planned and Specialist Care CCG overspend (£4.5m). Outsourced radiology (Risk 2131) is a separate non-recurrent cost pressure (Allied Health Professions CCG), contingent on WG funding continuation.
- Non-recurrent to recurrent conversion. £28.5m of the £47.5m savings requirement is NR-to-recurrent conversion (2025/26). Conversion lands substantive recruitment, in-house delivery and sustainable unit cost. Failure to convert extends outsourcing and agency reliance - a direct contributor to Risk 2132 (variable pay, score 25, extreme).
- Insourcing and productivity. Selective insourcing complements the theatre productivity programme. The broader productivity programme is a medium-term enabler (signalled for 2027/28+), not a 2026/27 cost-out lever - a deliberate deferral classification.
- Capability vulnerability. Every outsourced pathway carries three structural risks: continuity (provider exit), cost (premium pricing), and clinical governance (visibility of patient care). The strategic direction is towards repatriation; the financial direction must be matched.

**Implication for the Committee:** *Capacity and capability are interlocked. Reduced Glangwili theatre capacity from 2027, ENT procedure room displacement under UEC surge, and unconverted non-recurrent funding compound into sustained outsource and agency reliance - directly fuelling the extreme variable pay risk. 2026/27 is the critical window to convert.*

# Worked Example — mental health, learning disabilities and women's health

- What is in. Two additional local crisis beds (reducing out-of-area placements - WG enabling action); suicide and self-harm prevention from a strong baseline; CAMHS de-escalated to Level 1 (July 2025); Women's Health Plan aligned to ministerial priority (Nurse-led Hysteroscopy, Point-of-Care USS interface).
- What is out. Children and Young People (CYP) Autistic Spectrum Disorder (ASD) 26-week assessment target (current 14% vs 40% target; Risk 1032 score 20); adult Attention-Deficit Hyperactivity Disorder (ADHD) waiting list pressure (Risk 1290 score 20); adult ASD assessment capacity (Risk 1287 score 20); mental health workforce Ceredigion (Risk 2090 score 20); selective eating referrals demand (Risk 1603 score 20).
- Operational consequence. CYP ASD waits continue to grow despite pathway redesign and outsourcing as pressure relief. Structural demand-capacity gap in neurodevelopmental services is a multi-year challenge.
- Quality and safety consequence. Delayed diagnosis with downstream impact on onward treatment; restrictive/harmful practice risk from low MH&LD training compliance (Risk 2191); staff wellbeing in weight management service (Risk 2169, score 25 - extreme); MH&LD dietetic access gap (Risk 1836).
- Financial consequence. Outsourced Paediatric Intensive Care Unit (PICU) bed costs continuing (Risk 2133/2219 activity flagged at M12); net Continuing Healthcare (CHC) package movement; regional commissioning under review.
- Dependencies. Structural demand-capacity gap requires national workforce development and regional partnership extending beyond a single planning year. Outside Health Board's direct control.

**Implication for the Committee:** *The neurodevelopmental structural gap cannot be closed in 2026/27 within the current envelope. Regional partnership and national workforce development are the critical unlocks. The Committee should note that CAMHS Level 1 is a de-escalation achievement that must be actively maintained.*

# Worked example - diagnostics, theatres and pathology

- Radiology stabilisation (non-recurrent funding, Risk 1547); cellular pathology priority within Bundle B; endoscopy focus (Risk 1488); theatre efficiency programme; ultrasound pathway optimisation and skill-mixing (Risk 797 mitigation).
- What is out. Sustainable ultrasound service - 6.4 WTE sonographer structural deficit; demand exceeds capacity by -68,000 patients per year; national shortage means insourcing is not viable. Risks 797 and 1349 both score 25 (two of nine extreme risks).
- Cellular pathology estate (Risk 2133 score 20) and consultant workforce (Risk 1309 score 20). Specimen volumes 27,406 (22/23) → 38,800 (24/25) → 49,281 projected (26/27). USC share 24.5% (2019) → 37.7% (2025). Estate in extremely poor condition.
- Clinical haematology resilience (Risk 834 score 25 - extreme). Haematology/blood transfusion staffing (Risk 2136 score 20). Nuclear medicine equipment decline (Risk 1706 score 20). LIMS implementation delay (Risk 2079 score 20).
- Operational consequence. SCP trajectory 64-67% vs national 75%; diagnostic 8-week breach trajectory 5,138 projected; ongoing displaced elective activity; cancer pathway resilience depending on structurally fragile base.
- Quality and safety consequence. Risk of cellular pathology service collapse - noted explicitly in residual risk narrative. Cancer de-escalation from Level 3 to Level 1 (Feb 2026) is a significant achievement but is not secure without continued diagnostic capacity.
- Financial consequence. Non-recurrent funding exposure; WG diagnostic funding continuation unconfirmed for 2026/27 - its loss would materially worsen both diagnostic and cancer positions.

**Implication for the Committee:** *Two of the Health Board's nine extreme risks sit in ultrasound alone. Cancer performance rests on a diagnostic base that remains structurally fragile. Loss of non-recurrent WG diagnostic funding is the single most significant external dependency risk to cancer de-escalation.*

# Worked Example - workforce and enabling actions

- What is in. Consultant job planning >90% target by Sept 2026 (82% Q1); 30% agency expenditure reduction; elimination of agency in Healthcare Support Worker (HCSW), administrative and clerical roles; value-based healthcare programme; medicines management; digital enablers; productivity and performance programme (medium-term enabler).
- What is out. Closure of the structural gap between funded establishment and the workforce required for safe services (Risk 2132 score 25 — extreme); full recurrent therapy workforce investment (Risks 1517, 2170, 1894, 2107, 2242 all at score 20); neurodevelopmental specialist capacity; aseptic services establishment (running at 130% capacity). Not all risks are financially driven; the plan reflects the realism of recruitment challenges too.
- Workforce footprint of risk. 1,459 risk actions linked to workforce themes; 1,291 linked to fragile services. Workforce is the single most pervasive theme across the register.
- Recruitment timelines. Senior clinical roles in diagnostics, theatres and acute medicine can exceed 6 months - a phased programme delivery risk.
- Operational consequence. Continued variable pay reliance; delivery risk to phased programmes (Bundles A/B/C); therapy gaps within recovery trajectory.
- Quality and safety consequence. Staff wellbeing pressure (Risk 2169 extreme); continued retention pressure; reduced training compliance risk in some services (Risk 2191 MHLD).
- Financial consequence. Variable pay cost pressure is an extreme risk (Risk 2132 score 25). The 30% agency reduction target is contingent on successful substantive recruitment in a nationally competitive market - a material delivery risk to the savings programme.

**Implication for the Committee:** *Workforce underpins the entire plan. The 30% agency reduction is an enabler for the savings programme but is contingent on recruitment that is not assured. Failure to land substantive recruitment will materially worsen both the operational and financial trajectories.*

# Financial Position - the live unknown as savings work continues

- 2025/26 exit. Unaudited outturn £22.1m deficit against £30.0m planned deficit - improvement of £8m.
- 2026/27 deficit. Year 1 projects £40.9m including WRP (£27.8m excluding WRP). Two non-recurring drivers account for £20.1m of the deterioration: £13.1m WRP increase + £7.0m accountancy gains not repeating. Underlying trajectory is improving.
- Savings requirement £47.5m. £28.5m NR-to-recurrent conversion + £19.0m additional 2%. At Board Seminar, £9.4m of the £19.0m was identified (95% of schemes Blue/Red on FYE).
- Target Control Total £22.1m. Board has tasked the Executive Team with describing what would close the gap from £41m to the TCT £18.9m of further mitigation yet to be identified and assured – however, work is very much on-going and linked to points in the previous slides, re-variable pay etc.
- Five key financial plan risks (FPC February 2026): conditional funding £26m; WRP risk-share; rebuttable NR savings not landing; quantum of pre-year management actions; quality/performance trade-offs.
- Conditional funding. £26m at risk if the Health Board does not meet breakeven criterion in 2027/28 - which the current plan does not.
- £12.4m prevalence cap. Executive Team decisions totalled £10.5m (11 Feb 2026); all items require in-year business case scrutiny before spend.

Metric (£m, 2026/27 Plan)	Value
Underlying deficit entering 2026/27	58.4
Year 1 deficit inc. Welsh Risk Pool	40.9
Year 1 deficit exc. Welsh Risk Pool	27.8
2025/26 outturn (unaudited, M12)	22.1
Board-set Target Control Total	22.1

**Implication for the Committee:** *The financial position is a working position, not a settled number. Closing the savings residual introduces additional pressure on service, workforce and quality. Governance (including EIAs) mitigates change but does not remove consequence.*

# Financial Position - the live unknown as savings work continues

## What the Annual Plan 2026/27 set out

- Year 1 deficit £41.0m including WRP (£27.9m excluding WRP); three-year trajectory improves to £29.7m by Year 3.
- Year 1 cost pressures £42.9m: £10.8m inflation, £19.7m contractual or unavoidable, £12.4m prevalence (capped by the Executive Team).
- Savings requirement £42.8m in the plan (£23.8m carried forward from 2025/26 plus £19.0m additional), uplifted to £47.5m at the F&PC SBAR in Feb/Mar 2026 as the non-recurrent to recurrent conversion need crystallised.
- Welsh Government target control total £22.1m - closing the gap from £41.0m to the target control total requires a further £18.9m of mitigation, yet to be identified and assured.
- Five named financial plan risks: £26m conditional funding, Welsh Risk Pool risk-share, rebuttable non-recurrent savings not landing, pre-year management actions, and quality or performance trade-offs.

## What the Month 12 pack now confirms for 2025/26

- Unaudited outturn £22.086m -delivered to the target control total (£22.100m) and £7.9m better than the £31.5m planned deficit (annual plan 25/26).
- Savings £52.3m delivered against a £46.4m target - but distribution is uneven: Executive Functions over-delivered by £10.9m whilst the clinical care groups are £9.8m short in aggregate (Community and Integrated Medicine £4.0m; Operational Allied Health and Health Sciences £3.3m; Planned and Specialist Care £2.5m).
- Route to the target control total relied on £1.6m of soft-close adjustments (continuing healthcare invoice release £0.8m; VAT recovery £0.8m), which moved the soft close of £23.7m down to £22.1m.

## What this means for 2026/27 and for the Committee

- We exit 2025/26 on a strong number - but materially underpinned by non-recurrent items (WellSky £6.1m, accountancy gains c. £7.0m) that do not repeat in 2026/27.
- The clinical care group savings shortfalls in 2025/26 roll directly into the £23.8m brought-forward element of the 2026/27 savings requirement.
- Until the £18.9m gap to the target control total is identified and assured, plus the £42m of savings required to get to the 26/27 annual plan figure of £41m; the 2026/27 financial position is a live working number, not a settled one - and any action to close it carries consequences for service, workforce and quality, managed through governance but not eliminated by it.

**Implication for the Committee:** *The financial position is a working position, not a settled number. Closing the savings residual introduces additional pressure on service, workforce and quality. Governance (including EIAs) mitigates change but does not remove consequence.*

# Risk Landscape - reconciled position, baseline vs current

Measure	Baseline 02/03/2026	Post-plan 01/04/2026	Movement
Total risks on register	656	661 (action listing)	+5 net
Extreme risks (score 25)	9	9 (all retained)	Stable
Risks scoring 20–24	54	54 (all retained)	Stable
Risks scoring ≥20 (total)	63	63	Stable
Risks scoring ≥12 (escalation threshold)	391	-	-
New risks appearing	-	18 (Refs 1857, 2301–2317)	+18
Risks no longer on action listing	-	13 (lower-score)	-13
Actions marked 'Done' (02/03 → 01/04)	-	91 across 60 risks	Active management

## Landscape weighting (baseline)

- By directorate: Estates and Facilities 146; Community & Integrated Medicine 124; AH&HS 120; Planned & Specialist Care 117.
- By theme (risks ≥12): Patient safety 212; Workforce 196; Quality 168; Fragile Services 142; Business continuity 92.

## Key reconciliation findings

- All 63 risks scoring ≥20 remain carried forward. No material risk has been closed within the month – score level reconciliation is subject to forthcoming Risk Listing Reporting
- 18 new risk refs have emerged (themes: Capital Estates/Equipment, Fragile Services, Patient Safety, Workforce, Business Continuity).
- 13 risks have dropped from the action listing - all lower-score (none ≥20).
- 2,647 active progress updates across the register — evidence of active management, not inertia, but the very real challenges across the Health Board.

**Implication for the Committee:** *The landscape is stable in shape and weighted at extreme/very-high. No material movement at the most severe tier. Planning assumptions remain valid. The question is not whether the landscape has changed - but whether committed mitigations are adequate against a landscape that has not.*

# Line of sight - inclusion, exclusion, risk and consequence

Area	Included	Excluded	Named risks	Named consequence
UEC	Bundle A / SDEC 7-day / Six Goals	Full 12-hour ED standard in Year 1; medical staffing fragility resolution	2113, 1115, 750, 1992, 2264, 2033	Sustained surge harm; 12-hour % at 7.3% Q4 vs ≤7.0% standard; variable pay exposure
Planned & Specialist Care	Theatre efficiency, safer staffing, validation	National 26-wk RTT; 104-wk full closure; £12.5m recovery	2028, 2296, 2258, 2265	5,507 patients >104 weeks at Mar 2027 across 5 specialties
MH&LD / Women's Health	2 crisis beds; CAMHS L1; Women's Health Plan	CYP ASD 40% target; adult ADHD closure	1032, 1287, 1290, 2090, 1603, 2169	Waits continue to grow; extreme staff wellbeing risk in weight management
Diagnostics / Pathology	Radiology, cellular pathology, endoscopy stabilisation	Sustainable ultrasound; cellular pathology estate	797, 1349, 2133, 1309, 1488, 1706, 2079, 2102, 2136	SCP 64–67% vs 75% target; cancer resilience fragile
Theatres	Theatre efficiency; safer staffing	GGH theatre capacity restoration; fire-lift programme	2028, 2258	Displaced elective; ENT procedure room loss under surge; min. 18-mo reduced capacity from 2027
Workforce	JP >90% by Sept 26; agency –30%	Structural establishment gap; therapy recurrent investment	2132, 1517, 2170, 1894, 2107, 2242, 2090, 2169	Variable pay extreme (score 25); delivery risk to all three Bundles
Finance	£12.8m uplift; £47.5m savings	Breakeven by 2027/28	1199, 2132, 2167, 2148, 1631, 2131	£26m conditional funding at risk; TI criteria breach; qualified regularity opinion
Estates	Unavoidable cost pressures (Hwb, fire safety, RAAC, digital)	Capital remediation at scale	1968, 2211, 1077, 2092, 1196, 1488, 2265	Structural service continuity risks; ageing/unfit estate cumulative effect

**Implication for the Committee:** *A single coherent map connecting plan scope to live consequence. No item sits in isolation; every consequence has a named risk owner and a named exclusion driver.*

# Implications for the Committee - the aggregate position

- The plan is a deliberate, balanced construct, reflecting disciplined prioritisation within a constrained envelope. Exclusions are classified; trade-offs are explicit.
- The Health Board will not meet all Targeted Intervention criteria, nor its statutory breakeven duty, in 2026/27. Board approved the submission on 26 March 2026 as a novel or contentious action; the Accountable Officer notification has been made.
- The risk landscape is stable and weighted at extreme/very-high. 9 extreme risks (score 25) and 54 further at score 20-24 continue to be managed actively. All 63 risks scoring  $\geq 20$  remain carried forward to 01/04/2026. Net +5 risks in the month - incremental, not transformational.
- The financial position is a working position. A material portion of the £47.5m savings requirement remains unidentified. The Board has tasked the Executive Team with describing a route from £41m forecast to a £22.1m Target Control Total - approximately £18.9m of further mitigation to be assured, further, an in-year delivery of £42m of savings/run rate reduction is needed to achieve the £41m in the annual plan.
- Quality and safety consequence is current-year, not only future-tense. Surge harm, AMAU capacity, ENT room loss, medication safety, incident-reporting infrastructure, nutrition and rehabilitation gaps - these are producing live consequence.
- External dependencies are material. WG diagnostic funding continuation (unconfirmed); £26m conditional funding (at risk); regional partner capacity; internal processes and local authority partnership on delayed pathways; Senedd election cycle.
- De-escalation achievements must be actively maintained. CAMHS (Level 1 Jul 25), cancer (L1 Feb 26), planned care (L3 Mar 25), leadership & governance (L1 Dec 25). Sustaining these positions depends on the continued management of the residual exposure set out in this pack.

**Implication for the Committee:** *Movement from this position requires additional resource, re-prioritisation, or increased consequence. The Committee's scrutiny should focus on the adequacy of mitigation against the known risks, and on the credibility of the work to close the financial residual through Q1 2026/27.*

# Recommendations - the ask of the Committee

## The Finance and Performance Committee is asked to:

- **NOTE** the boundary of the Annual Plan 2026/27 and the classification of excluded items by constraint type (affordability, workforce, capacity/infrastructure, dependency, deliberate deferral).
- **SCRUTINISE** the reconciled risk landscape at April 2026, noting the stability of the 63 risks scoring  $\geq 20$ , the emergence of 18 new risk refs within the month, and the data caveat around per-risk score reconciliation.
- **RECOGNISE** the consequence framework (operational / quality & safety / financial) as the standard lens for residual-risk scrutiny through 2026/27
- **ACKNOWLEDGE** that the financial position is a working position. Further savings identification, scrutiny and assurance through Q1 is the principal mechanism for closing the gap between £41m forecast and the £22.1m Target Control Total.
- **CONSIDER** that any movement in delivery expectation beyond the approved plan is likely to require either additional resource, re-prioritisation against another funded commitment, or explicit acceptance of increased consequence.

# Appendix - baseline risk landscape and extreme risks

Ref	Directorate / Area	Title (abridged)
1199	Director of Finance	Achieving financial sustainability
2228	Medical Director	Patient safety - discontinuation of Vision electronic prescribing system
1349	AH&HS	Ultrasound services at WGH — lack of appropriately trained obstetric sonographers
797	AH&HS	Adverse patient/workforce outcomes -HB-wide ultrasound unsustainable
834	AH&HS	Clinical deterioration - reduced service resilience in Clinical Haematology
2132	AH&HS	Overspend -cost pressures related to variable pay
2167	AH&HS	Non-pay cost pressures in Podiatry impacting effective patient care
2169	AH&HS	Staff wellbeing in weight management - unrealistic expectations, limited capacity
1256	Planned & Specialist Care	Hip fracture patient safety - lack of Orthogeriatric service at GGH

## Baseline score distribution (02/03/2026)

- Extreme (score 25) - 9
- Extreme (20–24) - 54
- Very High (15–19) - 115
- High (12–14) - 213
- Medium (8–11) - 176
- Low (<8) - 89

**Total - 656 risks**

## New risk refs on post-plan action listing (01/04/2026)

1857, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317  
*Themes: Capital (Estates/Equipment), Fragile Services, Patient Safety, Workforce (Culture/Recruitment), Business Continuity, Medical Devices, Digital Transformation, NICE/National Guidance.*

**Implication for the Committee:** *The 9 extreme risks and 54 at score 20-24 define the top of the residual landscape. Six of nine extreme risks sit within Operational AH&HS -reflecting concentrated structural fragility in diagnostic and specialist therapy services (797, 834, 1349, 2132, 2167, 2169).*