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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Cyfarfod Cyhoeddus y Bwrdd/ Public Board Meeting

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 September 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Chief Executive's Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Professor Phil Kloer, Chief Executive Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Professor Phil Kloer, Chief Executive Officer

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA **SBAR REPORT**

Sefyllfa / Situation

The purpose of this report is to update the Board on relevant matters undertaken as Chief Executive of Hywel Dda University Health Board (HDdUHB) since the Board meeting held on 30 July 2026.

Cefndir / Background

This report provides the opportunity to present items to the Board to demonstrate areas of work that are being progressed and achievements that are being made, which may not be subject to prior consideration by a Committee of the Board or may not be directly reported to the Board through Board reports.

Asesiad / Assessment

Escalation Board

Following the Escalation Board meeting on 4 August 2026, Welsh Government acknowledged some progress, while maintaining significant concerns regarding the pace of improvement, financial recovery, urgent and emergency care performance, planned care trajectories, and quality and safety risks. A number of actions were agreed ahead of the next review, with Welsh Government emphasising the need for accelerated and demonstrable improvement to support future de-escalation. The full response is attached as Appendix 1.

Welsh Government Accountability meeting

The Health Board has its Accountability Meeting with Welsh Government on 16 September 2026. The meeting will be held in person in the Welsh Government Offices in Carmarthen. An agenda has been received and the Health Board has submitted the required evidence pack. The meeting will incorporate both the four accountability pillars (Delivery/Performance, Quality, Workforce, Finance/Planning) and foundation domain (Leadership) and the content of previous Escalation Board meetings. A verbal update of the meeting can be provided at Public Board.

Meddygfa'r Sarn, Pontyates

Following feedback from patients, staff and the local community, the Health Board undertook a formal procurement process to explore whether a provider could be identified to deliver GP services from Meddygfa'r Sarn in Pontyates, in line with the commitment made by the Board to test the market before considering alternative options.

We are disappointed that no bids were received through the formal tender process. As a result, we find ourselves needing to consider the next steps. Working through the established Vacant Practice Panel process, we are also committed to continuing discussions with our community, patients, staff and stakeholders to explore the options available and determine the most sustainable solution for the future provision of GP services in Pontyates. We will continue to keep our staff and local people informed and involved as this work progresses.

National Clinical Plan

Work is progressing within Welsh Government to develop a National Clinical Services Plan. The aim is, by April 2027, to publish a clear national strategic direction on how clinical services should be organised and delivered to achieve a sustainable NHS Wales with improved health outcomes. An Oversight Board has been formed, chaired by the Chief Medical Officer, with representatives from across NHS Wales.

A Healthier Mid and West Wales (AHMWW) Strategy

A meeting was held on 8 July 2026 attended by the Chief Executive, Executive Director of Strategy and Planning and Deputy Chief Executive of NHS Wales to consider the next steps associated with the infrastructure required to support delivery of the A Healthier Mid and West Wales Strategy.

Discussion included the potential programme timeline, with current planning assumptions indicating that, even under an accelerated approach, delivery of a new major hospital solution is likely to require a programme of approximately seven years from commencement of the next phase of development to operational service delivery. It was also agreed that the Health Board should work with Welsh Government colleagues to develop an indicative resource schedule to better understand the organisational capacity, specialist support and associated costs required to progress the programme.

The Health Board understands that the Cabinet Minister is being briefed on the current programme position. Whilst this represents an important step in maintaining momentum and ensuring Ministerial awareness of the programme, there remain no guarantees regarding approval, funding support or progression to the next phase of development. Consequently, the work currently being undertaken should be regarded as preparatory activity to ensure the organisation is well positioned should Ministerial support be secured.

The Chair, Chief Executive Officer and Executive Director of Strategy and Planning are due to meet with the Cabinet Minister on 15 September 2026. It is hoped this will assist decisions to be made on the next steps for the programme.

Community Infrastructure Programme

Capital investment through the Integration and Rebalancing Capital Fund continues to support the delivery of integrated health and care facilities and improved access to services closer to home.

- **Cross Hands Health and Wellbeing Centre**

The scheme continues to progress through design development, with stakeholder engagement and service planning activity ongoing.

- **Carmarthen Hwb (Atriwm)**

The revised completion date remains Quarter 1 2027. Focus during the reporting period has been on commissioning, workforce planning and coordination with partners to support service transition and occupation.

- **Pentre Awel**

Clinical services have now commenced within Block B, representing an important milestone for the programme. The Health Board continues to capture lessons learned to inform future developments.

- **North Pembrokeshire Integrated Health and Care Centre (Fishguard)**

Discussions continue with Pembrokeshire County Council regarding site opportunities and potential options to support progression of the scheme.

- **Aberystwyth Integrated Care Centre**

The Health Board continues to await clarification from Welsh Government regarding wider estate considerations that may influence future opportunities for the scheme.

- **Cylch Caron**

The Integration and Rebalancing Capital Fund Panel considered a joint application from Ceredigion County Council and the Health Board to support refresh of the Outline Business Case. Positive feedback has been received and discussions regarding next steps are continuing.

Clinical Services Plan

The Clinical Services Plan programme continues to make progress, with activity focused on converting approved service options into deliverable implementation plans. Key progress includes multi-year phasing plans presented in the [July 2026 Board Paper](#), capital assessments to support future developments, workforce modelling for approved options, refreshed stroke modelling, and further speciality-specific analysis to inform emergency general surgery and planned care proposals. This provides assurance that the programme is moving from strategic decision-making into structured delivery planning, with dependencies and requirements being actively identified and tested.

Current focus remains on strengthening the evidence base and delivery readiness for the next phase of implementation. This includes refining detailed workforce, capital, estates and financial assessments; progressing impact assessment actions; completing remaining stroke consultation activity; and updating modelling for relevant clinical services. Next steps include finalising the requirements to support the Health Board three year planning cycle, developing targeted communications for services where change is imminent, and applying lessons learned from earlier phases to support effective and sustainable programme delivery.

NHS Wales Performance and Improvement (P&I) Review at the Urgent and Emergency Care Department, Glangwili Hospital

NHS Wales P&I undertook a visit to Glangwili Hospital (GGH) on 2 and 3 September 2026 to assess the organisation's grip and control of Urgent and Emergency Care (UEC). At the time of the visit, GGH was operating at Black/25 escalation status. The CEO and Executive colleagues attended a briefing session on the morning of 2 September and an initial feedback session during the afternoon of 3 September. Initial feedback was provided under 3 headings:

- **Escalation**

NHS Wales P&I challenged the appropriateness of the continued declaration of Black/25 and expressed concern that organisational and system responses were not commensurate with the level of escalation. Observations included a lack of visible command and control arrangements, inconsistent awareness of the escalation status across the site, and a perceived normalisation of operating under high levels of pressure.

- **Grip & Control**

NHS Wales P&I concluded that site-level arrangements required strengthening. Concerns were raised in relation to the effectiveness of board rounds, leadership visibility and opportunities to expedite patient discharge. It was recommended that improvement efforts focus on a small number of critical Key Performance Indicators (KPIs), including ambulance handover delays, 12-hour waits, early discharges and patients occupying clinical decision areas, to drive sustainable performance improvement. Greater focus on the use of daily performance data was also recommended. NHS Wales P&I offered targeted support, including engagement between its Medical Director, Anthony Gibson, and the Health Board to support medical workforce challenges.

- **Culture, Management and Accountability**

NHS Wales P&I advised that the need to further embed the triumvirate leadership model and provide greater clarity to operational teams regarding key priorities and objectives. Staff wellbeing emerged as a particular concern, with feedback indicating that some staff felt under considerable pressure to compensate for workforce gaps and wider operational demands. NHS Wales P&I also acknowledged the positive and constructive engagement observed during the multi-agency stakeholder event held on 2 September, noting a shared commitment amongst partners to work collaboratively to address the challenges identified.

The feedback session concluded with NHS Wales P&I acknowledging that many of the challenges identified are not unique to the Hywel Dda UHB and are being experienced across the wider NHS. However, it emphasised the need for a robust and timely organisational response. NHS Wales P&I advised that the Health Board had reached a critical juncture, with the actions taken in the coming weeks likely to determine whether the organisation progresses towards stabilisation and de-escalation, or the alternative prospect of further escalation measures.

Risk Management Objectives

The Health Board's risk management objectives (the objectives) were approved by Executive Team at its meeting held on 29 July 2026.

The two objectives below are for the period to September 2027 have been informed by the outcomes of the risk maturity assessment undertaken in Quarter 4 2026, in line with the Orange Book (a recognised risk management standard for the public sector):

- Implementation of a new risk management system by 30 November 2027; and
- Enhance risk maturity, culture and operational risk management across the Health Board

Each objective is underpinned by an action plan, with progress to be reported to the Audit and Risk Assurance Committee via the Risk Assurance Report.

The objectives aim to:

- improve decision making;
- drive continuous improvement;

- embed risk management in organisational planning, performance reporting and learning;
- Foster a blame-free, open culture;
- Adopt a dynamic and systematic approach to manage risk in a changing environment; and
- Identify, assess and manage risks in a timely manner.

Corporate Risk Register

The Corporate Risk Register (CRR) is presented to the Board to provide assurance that the corporate risks of Hywel Dda University Health Board (the Health Board) are being assessed, reviewed and managed appropriately. The CRR includes significant risks that affect the organisation's ability to deliver healthcare in the 'here and now' and its ability to achieve its planning objectives (linked to the objectives of the relevant Clinical Care Group / Executive Function).

The Executive Directors, via monthly Formal Executive Team meetings, are responsible for reviewing and discussing their corporate risks, and agreeing any new risks and the escalation/de-escalation of operational risks that are on the Functions risk registers.

All risks on the CRR have been discussed in detail at its Board Committees and the outcomes from these discussions are reported to the Board via the Committee Update Reports.

A summary of the changes that have taken place since the CRR was previously presented to the Board in January 2026 are noted below, with full risk register included at Appendix 2.

Due to the sensitive nature of the following risks, these are being reported in-committee:

- 1988 - Risk of prolonged outage following cyber-attack caused by insufficient measures to recover; and
- 2381 - Risk to compliance with Martyn's Law and site safety due to insufficient security infrastructure, capability and preparedness.

New Risks

Since the previous report, 4 new risks have been added to the Corporate Risk Register.

Risk	Executive Lead / Lead Function / Assurance Committee	Rationale for Current Risk Score
Risk 2378: Risk of being unable to consistently deliver safe, sustainable and timely Emergency Department services across all hospital sites Current risk score: 20 Target risk score: 9	Executive Lead: Chief Operating Officer Lead Function: Community and Integrated Medicine Assurance Committee:	Risk score reflects the persistent and system-wide nature of Emergency Department fragility across the Health Board. All three Emergency Departments are designated Tier 1 Emergency Services; however, current medical workforce models do not consistently meet Royal College of Emergency Medicine standards (1:12 at Withybush and Bronglais, and 1:18 at Glangwili). The Health Board remains funded to a 1:5 consultant rota at Glangwili and a 1:3 rota at Withybush, with no formal on-call arrangement

Date to achieve target risk score: 31 October 2027	Quality, Safety and Experience Committee	at Bronglais. These arrangements are insufficient to provide resilient senior decision-making, particularly overnight and at weekends. This has resulted in frequent reliance on agency cover, variable continuity of care and repeated escalation when minimum staffing thresholds cannot be maintained. In addition, there is no single, coordinated medical workforce strategy for Emergency Medicine or the supporting acute specialties. Gaps in specialty support, particularly at Withybush where there is no resident General Surgery or Trauma and Orthopaedics registrar out of hours, and no on-site Paediatric, Obstetric or Gynaecology services, further increase risk and limit mitigation options during periods of escalation. These workforce pressures coincide with sustained flow challenges, high-acuity presentations and constrained physical capacity, resulting in prolonged Emergency Department length of stay, care in non-designated areas and repeated system escalation. Adverse impacts are highly likely to recur and could have major consequences for patient safety, staff wellbeing and organisational performance.	
Risk 2379: Risk to effective climate adaptation and compliance due to insufficient resourcing, leadership and system-wide coordination Current risk score: 16 Target risk score: 9 Date to achieve target risk score: 31 March 2030	Executive Lead: Director of Public Health Lead Function: Public Health Assurance Committee: Strategy and Planning Committee	While key strategic plans and national policy alignment are in place, there are significant gaps in leadership, coordination, resourcing and governance. These gaps reduce the effectiveness of existing controls and increase the likelihood of the risk materialising. Given the scale of climate-related risks to service delivery, patient safety and infrastructure, the consequence remains high, with an impact score of 4. However, existing plans, partnerships and baseline activity provide some mitigation, reducing likelihood from very high (5) to high (4).	
Risk 2349: Risk of disruption to services and increased financial pressure arising from fuel	Executive Lead: Director of Public Health Lead Function: Public Health	The likelihood of adverse impact from fuel supply constraints and rising fuel costs has reduced from inherent levels due to active national fuel market monitoring, existing national and regional contingency arrangements, business continuity planning,	

supply constraints and rising fuel costs Current risk score: 12 Target risk score: 6 Date to achieve target risk score: 31 August 2026	Assurance Committee: Health and Safety Committee	and cost monitoring measures already in place. However, the impact remains high because the Health Board continues to rely heavily on fuel, for vehicles and heating, to operate a geographically dispersed estate, maintain patient transport, and support staff travel and community-based services. Sustained fuel price volatility therefore still presents a significant financial and operational risk, justifying a current risk score of 12.
Risk 2380: Risk to delivery of Single Cancer Pathway performance due to diagnostic capacity gaps, funding uncertainty and pathway fragility Current risk score: 12 Target risk score: 8 Date to achieve target risk score: 31 March 2027	Executive Lead: Chief Operating Officer Lead Function: Planned and Specialist Care Assurance Committee: Finance and Performance Committee	The service has been de-escalated by Welsh Government from Level 4 to Level 1 in terms of Targeted Intervention status as there has been the consistent achievement of the 60% de-escalation criteria since February 2025. As at June 2026 performance was at 60%. Due to recovery actions within radiology and urology there may be variation in performance as the Health Board recovers and treats those patients over 62 days. Funding from Welsh Government remains uncertain as at August 2026, with Tranche 1 monies received but less than requested. Work is ongoing to obtain Tranche 2 funding over September 2026. Confirmation of target for March 2027 is 75%, however no health board is achieving this target, and as per the Board approved Annual Plan 2026/27, the Health Board's aim is to maintain the current level of Single Cancer Pathway (SCP) performance between 64-66% (2025/26). Plans are in place for Q2 to maintain performance at the planned trajectory set out in the Annual Plan 2026/27.

Closed Risks

Since the previous report to Board in May 2026, the following corporate risks have been closed:

- Risk 1350 - Risk of not meeting the 80% SCP waiting times target for March 2026 due to diagnostics capacity and delays at tertiary centre, was closed as per agreement at Formal Executive Team held on 17 June 2026 and superseded by risk 2380 (see table above).
- Risk 2204 - Risk of HB being unable to meet statutory Capital Resource Limit (CRL) due to uncertainties around funding provision and capital commitments was closed on 13 May 2026 as the risk had not materialised by 31 March 2026.

Ceredigion Local Authority Rheidol Lease

A new lease is being agreed for accommodation comprising a clinic room and waiting area on the ground floor of the Rheidol Building to support the relocation of Speech and Language Therapy clinics and Community Children's Disability Team carer training currently delivered

from Pantyfedwen, Aberystwyth. The current Pantyfedwen lease ends on 12 October 2026. The lease terms are as follows:

- **Landlord** – Ceredigion Local Authority
- **Term**: 5-year with 3-year break option.
- **Financial** - Annual Rent: £2,800.00 (VAT not applicable)/ Service Charge circa £4 - £5,000 per annum, based on proportional occupancy (subject to actual cost review).

Risk overview – Low risk as this provides improved accommodation, access to parking, good accessibility and is located close to support offices based on the first floor at Rheidol. An engagement process is being arranged to manage this change.

Carmarthen Sexual Assault Referral Centre Spoke Lease Renewal

The Glangwili facility is part of the Welsh Sexual Assault Service (WSAS) Programme and operates as the Carmarthen SARC Spoke, complementing the acute forensic services delivered through the Aberystwyth SARC Hub which provides a critical role in supporting adult and child victims of rape and sexual violence across West Wales. There are currently no SARC facilities west of Carmarthen. Consequently, the site acts as a critical service hub for victims across much of West Wales. Whilst the Aberystwyth SARC Hub provides an excellent facility for acute forensic cases this Carmarthen facility continues to play a vital role in meeting the wider and substantially higher volume of non-acute sexual violence demand across the region.

New Lease Arrangements

- The existing lease was established on 20 July 2005 through agreement with the Dyfed Powys Police and Crime Commissioner, who now require a new lease. The following new terms are proposed:
- **Landlord** – Health Board / Tenant - Dyfed Powys Police and Crime Commissioner
- **Term** - 15 years (no option to renew).
- **Break Option** - Either party may terminate this lease after the eighth anniversary of the term providing no less than 24 months written notice.
- **Financial** – the tenant will cover all operating costs associated with the building. Both parties agreed to cover own legal fees.

Risk overview – Low risk as the proposal, if approved, will ensure continued agreement between the parties to maintain the SARC Spoke within the Carmarthen area. A break option has been included, this reflects the strategic plans for the site.

RJC update

Work on the agreed Regional Joint Committee (RJC) priorities and programmes has continued to progress during the reporting period. Regional sub-groups and programme teams have maintained delivery momentum, progressing key development, implementation and planning activities aligned to the RJC work programme and objectives. Ongoing oversight arrangements remain in place to monitor progress, manage risks and issues, and support delivery across the regional portfolio. This reflects the RJC's continued focus on strengthening regional collaboration, governance and system-wide improvement.

In response to Internal Audit's recent review of the Committee's governance arrangements which found that these were operating effectively in supporting oversight, reporting and decision-making across both Health Boards, the Terms of Reference for the Committee will be reviewed and those of its sub-groups will be formalised and standardised in order to further strengthen consistency and maturity across the governance landscape.

A further update on progress, risks, opportunities and key programme deliverables will be considered by the Regional Joint Committee at its next meeting on 13 October 2026, providing formal assurance on progress against the agreed work programme. A comprehensive Regional Joint Committee update will subsequently be presented to both Health Boards through the normal Board reporting arrangements at the next Board cycle in November 2026

Register of Sealings

The Health Board's Common Seal has been applied to legal documents and a record of the sealing of these documents has been entered into the Register kept for this purpose. The entries at Appendix 3 have been signed by the Chair and the Chief Executive, or the Deputy Chief Executive (in the absence of the Chief Executive) on behalf of the Board (Section 8 of the Health Board's Standing Orders refers).

Consultations

The Health Board receives consultation documents from a number of external organisations. It is important that the Health Board considers the impact of the proposals contained within these consultations against its own strategic plans and ensures that an appropriate corporate response is provided to highlight any issues that could potentially impact upon the organisation. A status report for Consultation Documents received and responded to is included at Appendix 4, should any Board Member wish to contribute.

Formal Executive Team Meetings

Since my previous report to Board, the Formal Executive Team (FET) has met regularly; key items considered are attached at Appendix 5.

Argymhelliad / Recommendation

- **APPROVE** the proposed lease agreement with Ceredigion Local Authority Rheidol to support the relocation of Speech and Language Therapy clinics and Community Children's Disability Team carer training services from Pantyfedwen, Aberystwyth, on the terms outlined within the report.
- **APPROVE** the renewal of the lease agreement between the Health Board and the Dyfed Powys Police and Crime Commissioner for the continued operation of the Carmarthen SARC Spoke, on the terms outlined within the report.
- **ENDORSE** the Register of Sealings since the previous report on 30 July 2026 (Appendix 3)
- **NOTE** the ongoing discussions with Welsh Government and NHS Wales regarding the strategic infrastructure programme supporting delivery of the *A Healthier Mid and West Wales* Strategy.
- **NOTE** progress across the Health Board's community infrastructure schemes.
- **NOTE** the Corporate Risk Register (CRR) (Appendix 2), report and summary
- **NOTE** the Risk Management Objectives for the period to September 2027
- **NOTE** the status report for Consultation Documents received/responded to (Appendix 4)
- **NOTE** Executive Team discussions (Appendix 5)

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply

Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply
Model Cymdeithasol ar gyfer Iechyd a Llesiant : (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing : (complete for strategic change and/or significant service changes)	7. All Apply
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Chief Executive's meetings (internal, external and NHS Wales wide), diary and correspondence
Rhestr Termau: Glossary of Terms:	Included within the body of the Report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Executive Team
Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Any issues are identified in the report
Ansawdd / Gofal Claf: Quality / Patient Care:	Any issues are identified in the report

Gweithlu: Workforce:	Any issues are identified in the report
Tegwch lechyd: Health Equity:	No assessment is considered necessary for a paper of this type.
Risg: Risk:	This report provides evidence of current key issues at both a local and national level, which reflect national and local objectives and development of the partnership agenda at national, regional and local levels. Ensuring that the Board is sighted on key areas of its business, and on national strategic priorities and issues, is essential to assurance processes and related risks.
Cyfreithiol: Legal:	Any issues are identified in the report
Enw Da: Reputational:	Any issues are identified in the report
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	No EqIA is considered necessary for a paper of this type.

Y Grŵp Iechyd, Gofal ac Atal
Dirprwy Brif Weithredwr, GIG Cymru

Health, Care and Prevention Group
Deputy Chief Executive, NHS Wales



Llywodraeth Cymru
Welsh Government

Phil Kloer
Chief Executive
Hywel Dda University Health Board
Philip.kloer@wales.nhs.uk

14 August 2026

Ref: NW/MR/HDdaEB

Dear Phil

Thank you for attending the Level 4 escalation board on 04 August and for the evidence submitted.

This letter sets out the key issues and the actions now required.

Overall position

The discussion reflected many of the themes raised at the previous meeting. While progress was acknowledged in some areas, there was continued challenge regarding the pace of delivery and the organisation's ability to translate plans into timely and measurable improvement. Concerns remain in relation to:

- the current financial position and the delivery of sustainable financial recovery;
- the absence of sufficiently credible trajectories for improvement, notably but not exclusively UEC;
- the urgency and pace at which change is being delivered; and
- ongoing quality and safety risks.

Overall, greater confidence is required in the Health Board's ability to deliver meaningful improvement at pace.

Finance and planning

Following the last meeting, we wrote to you explaining the financial position was unacceptable. You have since worked with NHSWPI colleagues, and the savings gap has reduced; you anticipate the month 4 position will show £34m of savings identified. You also described an intention to take a recovery plan to balance to your September Board meeting and asked for a discussion with Welsh Government prior to doing so. By the next meeting we will expect:

- you close the remaining gap by the end of September, as well as ensuring that the current non-recurrent savings are converted to recurrent.
- explore opportunities to improve on the forecast £41m deficit this year.

- arrange a meeting with Welsh Government to discuss the final paper on the recovery plan to balance before it is taken to your September Board meeting.

You noted that the consultation on stroke services had ended recently. A paper will be taken to the November Board meeting alongside the outcome of the consultation. You agreed:

- to maintain close links with Welsh Government colleagues as this progresses.
- that a copy of the Clinical Services implementation plan and the Board paper would be shared and discussed outside the meeting.

Performance and delivery

You have met with NHSWPI colleagues to look at the trajectories for urgent and emergency care, planned care and cancer. On ambulance handover, the current profile to get to 75% of handovers within 45 minutes is not acceptable. Whilst there has been some improvement, there remains challenges in:

- 12-hour ED performance,
- Ambulance handover.

By the next Escalation Board on 9 November 2026, we expect you to have delivered the UEC de-escalation criteria in both September and October of:

- No more than 680 ambulances handovers over 1 hour in each month.
- That no more than 7% of patients in your EDs across Hywel Dda stay over 12 hrs in each month.

On planned care, you remain our greatest risk. By the next meeting you need to:

- Improve the current end of year trajectory to an acceptable position.
- Submit the monthly trajectories for planned care and diagnostics to NHSWPI colleagues by 7 August 2026.

Quality and safety

You highlighted the top three risks on your risk register as being pathology (due to LIMS implementation), ultrasound and ED consultant workforce numbers. However, the top three areas of focus for the health board were urgent and emergency care, the CSP, and sustainability of workforce and finance.

At the previous meeting, we highlighted two never events concerning naso-gastric tubes, complaints handling and IPC. There has since been two further never events. In addition, there has been a scabies outbreak and an Early Warning Notice in relation to two deaths which may be associated with the extreme heat. You need to:

- Provide evidence that corrective actions are in place to ensure there has been learning from the never events and that specific actions are in place to prevent reoccurrence. You agreed to liaise with Aneurin Bevan UHB on their improvement approach to reducing never events.
- Provide a response to the letter from the CMO asking for assurance and learning from the extreme heat incidents and seek advice from the Health & Safety Executive as to whether these are reportable incidents.
- Deliver a sustainable IPC improvement plan.
- Maintain focus on closing the outstanding PTR cases and continue to see improvements in the closure rates of LTP cases towards the 85% target noted at the previous meeting.

Workforce

A brief update was provided on the actions being taken within the health board to improve the workforce position. You have six workstreams in place, including one around sickness absence, and one in relation to variable pay. You highlighted there was currently a recruitment freeze for clerical and admin staff, and you are working with finance colleagues to understand exactly what is included within the funded establishment.

Required actions

Ahead of the next meeting, you must:

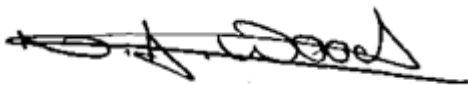
- submit an agreed route map to financial stability by the end of September;
- close the savings gap with full confidence to deliver, at most your current forecast deficit by the end of September, and consider actions to reduce this deficit further;
- submit to Welsh Government the Board paper and implementation plan for the CSP by the end of August;
- continue to work with NHSWPI to improve the expected end of year planned care position and submit trajectories by 7 August;
- Update the CMO on the two deaths where extreme heat may be a factor;
- Continue to focus on improving complaint responses, to include the backlog of PTR responses.

Conclusion

In summary, whilst there are some encouraging signs of progress, we remain very concerned that the pace of delivery is not yet commensurate with the scale of the challenges facing the organisation. We are committed to supporting the health board to succeed and achieve de-escalation, but we now need to see clear evidence of accelerated improvement and delivery. If this is not forthcoming, further consideration will need to be given to the most appropriate next steps.

Our next meeting will be an accountability review meeting on 16 September, held in the Welsh Government Carmarthen office.

Yours sincerely



Nick Wood

Cc: Jacqueline Totterdell, Director General, Health, Care and Prevention Group, Chief Executive, NHS Wales
Neil Wooding, Chair, Hywel Dda University Health Board

In attendance

Welsh Government: Nick Wood, Jeremy Griffith, Hywel Jones, Samia Edmonds, Rhiannon Frere (representing CNO), James Calvert (representing CMO), Caroline Lewis, Martyn Rees

Hywel Dda University Health Board: Phil Kloer, Andrew Carruthers, Mark Henwood, Sharon Daniel, Lee Davies, Lisa Gostling, Huw Thomas

NHS Performance and Improvement: Corrina Casey (representing the Managing Director)

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Sep-26	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score	Risk on page no...
2079	Risk of loss of Pathology services across the Health Board due to delayed implementation of LIMS	Carruthers, Andrew	Service/Business interruption/disruption	5×5=25	5×5=25	→	1×5=5	31/12/2026	6
797	Risk of adverse patient and workforce outcomes if health board wide ultrasound services are unsustainable	Carruthers, Andrew	Quality/Complaints/Audit	5×5=25	5×5=25	→	2×5=10	31/03/2030	11
2326	Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding	Thomas, Huw -	Finance inc. claims	4×5=20	5×5=25	↑	3×4=12	30/09/2026	17
1810	Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Henwood, Mr Mark	Service/Business interruption/disruption	4×5=20	4×5=20	→	1×5=5	31/12/2026	22
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	4×5=20	4×5=20	→	2×4=8	31/10/2028	25
1552	Risk of insufficient mortuary capacity due to current and anticipated future demand	Carruthers, Andrew	Safety - Patient, Staff or Public	4×5=20	4×5=20	→	2×4=8	30/08/2028	31
2378	Risk of being unable to consistently deliver safe, sustainable and timely ED services across all hospital sites.	Carruthers, Andrew	Safety - Patient, Staff or Public	4×5=20	4×5=20	→	3×3=9	31/10/2027	36
2305	Risk to staff wellness due to pace and breadth of organisational change	Gostling, Lisa	Workforce/OD	4×5=20	4×5=20	→	3×4=12	31/03/2030	40
1032	Risk to the timely diagnosis and treatment of mental health and learning disabilities clients due to demand and capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	5×4=20	5×4=20	→	3×4=12	31/12/2030	45
2212	Risk the Health Board will not have an approvable Integrated Medium-Term Plan (IMTP) by March 2028.	Davies, Lee	Statutory duty/inspections	4×4=16	4×4=16	→	1×4=4	31/03/2028	49
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Carruthers, Andrew	Safety - Patient, Staff or Public	4×4=16	4×4=16	→	2×4=8	31/03/2028	54
684	Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Carruthers, Andrew	Service/Business interruption/disruption	4×4=16	4×4=16	→	2×4=8	30/08/2050	58
2379	Risk to effective climate adaptation and compliance due to insufficient resourcing, leadership and system-wide coordination	Gjini, Ardiana	Statutory duty/inspections	4×4=16	4×4=16	→	3×3=9	31/03/2030	62
1978	Risk of insufficient skilled workforce capacity due to recruitment, retention and financial challenges	Gostling, Lisa	Workforce/OD	4×4=16	4×4=16	→	3×4=12	31/03/2027	65
1531	Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	3×5=15	3×5=15	→	1×5=5	01/05/2027	69
813	Risk of non-compliance with the Regulatory Reform (Fire Safety) Order 2005 due to ageing infrastructure	Severs, James	Statutory duty/inspections	3×5=15	3×5=15	→	1×5=5	31/08/2029	74
1745	Risk of not being able to safely deliver services due to ageing estate and infrastructure across the Health Board	Severs, James	Safety - Patient, Staff or Public	3×5=15	3×5=15	→	2×5=10	31/08/2032	79
1859	Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Daniel, Sharon	Safety - Patient, Staff or Public	3×5=15	3×5=15	→	2×5=10	31/03/2027	82
1860	Risk of staff harm and service disruption due to violence and aggression within healthcare settings	Severs, James	Safety - Patient, Staff or Public	5×3=15	5×3=15	→	4×3=12	01/04/2027	86
2349	Risk of disruption to services and increased financial pressure arising from fuel supply constraints and rising cost	Gjini, Ardiana	Service/Business interruption/disruption	3×4=12	3×4=12	→	3×2=6	31/08/2026	90
2380	Risk to delivery of Single Cancer Pathway performance due to diagnostic capacity gaps, funding uncertainty and pathway fragility	Carruthers, Andrew	Quality/Complaints/Audit	3×4=12	3×4=12	→	2×4=8	31/03/2027	93
1433	Risk to the ability to maintain routine and emergency services in the event of a severe pandemic	Gjini, Ardiana	Service/Business interruption/disruption	3×4=12	3×4=12	→	2×4=8	31/03/2027	98
2327	Risk to planned care and RTT recovery in 2026/27 due to demand-capacity gaps, estate fragility and non-recurrent funding	Carruthers, Andrew	Quality/Complaints/Audit	3×4=12	3×4=12	→	3×3=9	31/03/2027	101

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
		Corporate Risk Description:			
Likelihood	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	This will probably never happen/recur (except in very exceptional circumstances).	Do not expect it to happen/recur but it is possible that it may do so.	It might happen or recur occasionally.	It might happen or recur occasionally.	It will undoubtedly happen/recur, possibly frequently.
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	(0-5%*)	(5-25%*)	(25-75%*)	(75-95%*)	(>95%*)
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				
Risk Impact Domains	Negligible - 1	Minor - 2	Moderate - 3	Major - 4	Catastrophic - 5
Safety of Patients, Staff or Public	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention.	Moderate injury requiring professional intervention.	Major injury leading to long-term incapacity/disability.	Incident leading to death.
	No time off work.	Requiring time off work for >3 days	Requiring time off work for 4-14 days.	Requiring time off work for >14 days.	Multiple permanent injuries or irreversible health effects.
		Increase in length of hospital stay by 1-3 days.	Increase in length of hospital stay by 4-15 days.	Increase in length of hospital stay by >15 days.	An event which impacts on a large number of patients.
			Agency reportable incident. An event which impacts on a small number of patients.	Mismanagement of patient care with long-term effects.	
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. Reduced performance if unresolved.	Major patient safety implications if findings are not acted on.		

CORPORATE RISK REGISTER SUMMARY SEPTEMBER 2026

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. Reduced performance levels if unresolved.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
			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.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

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

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

Assurance Key:

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

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

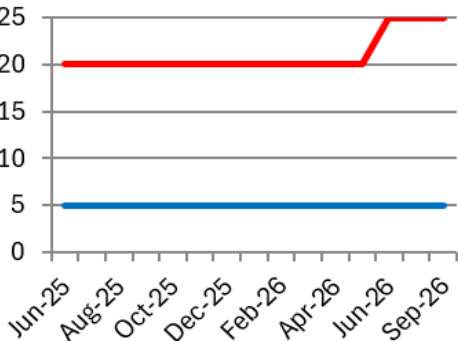
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective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

Date Risk Identified:	Nov-24
Strategic Objective:	3. Great Care

Risk ID:	2079	Corporate Risk Description:	There is a risk of loss of Pathology services across the Health Board from 31st December 2026 affecting a wide range of services across primary, community and secondary care including urgent and emergency care. This is caused by the potential inability of Digital Health Care Wales (DHCW) and the contracted supplier to provide a functional, reliable and safe system to enable Health Board approval and mobilisation before funding ceases to support the LIMS Programme at the end of December 2026 and the hardware becomes end of life in August 2026 (extension solution being investigated). The System Build milestone is 18 months behind schedule and a significant volume of work is outstanding to provide a safe minimal viable product. This could lead to an impact/affect on a total loss of service resulting in potential serious harm to patients. The financial implications would be significant, this would include approx £100k/annum for Telepath and £2m for hardware upgrade, these costs are circulated to CEOs and yet to be agreed by Health Boards. It would also detrimentally impact on the Health Board's ability to meet Ministerial priorities and targets including a significant proportion of diagnostic turn around and referral to treatment times. It would have an adverse impact on the reputation of the Health Board, and render it liable to increased complaints, litigation and scrutiny from external regulators, Welsh and UK governments. Outsourcing would be a difficult and costly approach and would need to be outside of Wales as this is a national concern. A year of contingency would be circa £4m
Does this risk link to any Directorate (operational) risks?			1526, 1352, 1310

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-26
Lead Committee:	Digital, Data and Innovation Committee	Date of Next Review:	Sep-26

Risk Rating:(Likelihood x Impact)		
Domain:	Service/Business interruption/disruption	
Inherent Risk Score (L x I):	5×5=25	
Current Risk Score (L x I):	5×5=25	
Target Risk Score (L x I):	1×5=5	
Expected Date To Achieve TRS:	31/12/2026	
Trend:		



25
20
15
10
5
0

Jun-25 Aug-25 Oct-25 Dec-25 Feb-26 Apr-26 Jun-26 Sep-26

Current Risk Score

Target Risk Score

Date	Current Risk Score	Target Risk Score
Jun-25	20	5
Aug-25	20	5
Oct-25	20	5
Dec-25	20	5
Feb-26	20	5
Apr-26	20	5
Jun-26	25	5
Sep-26	25	5

Rationale for CURRENT Risk Score:
The impact of loss of service would be considerable, Pathology is crucial for diagnosis and treatment of patient conditions and ultimately the loss of service could lead to catastrophic patient outcomes. The current national system (TCL2016) is provided by InterSystems on Digital Health and Care Wales (DHCW) hardware, the project involves development on the InterSystems Cloud as the software and hardware becomes end of life in Aug 2026. Programme funding is due to run out at the end of Q2 26/27. 22/05/26 - Increased likelihood from 4-5 as there is very little confidence that the delivery of LIMS will be complete by end of Q2, which will have a significant financial impact to each health board. 26/06/2026 - There is acceptance that a July go-live date is not feasible for Tranche 3 or 4 due to the number of outstanding product fixes. No revised dates have been confirmed, however Microbiology and Blood Science proposed to go live in Q2, which would result in Blood Transfusion extending into Q3. 22/07/26 - Tranche 3, due to go live 10th August, further expected delays to programme.

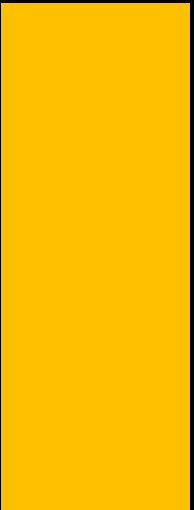
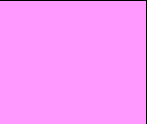
Rationale for TARGET Risk Score:
The reduction of the current risk score to the target risk score is reliant on DHCW and the wider system finding a robust mitigation plan and financial support to manage the risks of compressing the timescales or staying on end of life hardware and software until the system can be implemented. On risk review in September 2025, the expected date to achieve the TRS was amended from January 2026 to April 2026. On risk review in November 2025 the expected date to achieve the TRS was extended further to August 2026 as discussed in the LIMS Programme Board. 24/04/2026 - Tranche 5 scheduled for completion after Aug 26 but prior to 31st Dec 2026.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
Project plans in place both locally and nationally, they are monitored monthly. Local concerns are escalated to programme board. The Health Board have also raised concerns directly to the SRO. Project teams in place both locally and nationally, both meet weekly.	Only high level plans in place after tranche 3 go live (microbiology). Awaiting conformation of Tranche 4&5 plans. A local contingency plan is in place but	All Health Boards to work alongside DHCW and ISC to approve a national contingency plan, including extension of hardware and software provision for current system with costs and mechanisms to enact.	Jones*, Dylan	Completed	See audit trail for updates: action completed June 2025.

Weekly meetings scheduled: HDU/SBU Leads, Technical Delivery and Testing Progress Regional Risks, Assumption, Issues and Decisions (RAID) Log is updated weekly and discussed monthly in the regional programme board including representatives from DHCW and InterSystems. Governance process are in place, Hywel Dda have raised and escalated the risk to LIMS 2.0 Programme board and direct to the national SRO on multiple occasions including in Feb 2025 with a proposal of an alternative plan. A joint all Wales Health Board letter to the SRO on 7th April 2025 led to agreement that the project plan needs to be re-set. Local contingency plans are in place for short term LIMS downtime.	will only enable continuity for up to 5 days. More long term contingencies would involve reliance on supplier middleware solutions. Lack of resource to complete the build and configuration by DHCW and InterSystems; lack of resource to complete the volume of testing and validation currently required to meet current timescales. Ineffective and incomplete user acceptance testing as the system is not functional and reliable. Blood transfusion (BT) legacy data unavailable due to inaccuracies on upload, therefore BT testing cannot be completed and the service will not meet regulatory compliance via the Medicines and Healthcare products Regulatory Authority (MHRA). 26/06/2025 - Draft national contingency plan circulated to Health Board CEOs but not yet agreed. Additional funding will be required to support contingency plan, extending implementation into early 2026. 17/07/2025 - LIMS Programme Board wrote to CEOs requesting approval for the new service by service mitigation plan. The proposal will take the programme into 2026 and consequently will have financial impact. DoD has circulated summary paper of proposal to execs, waiting CEO decision. 26/09/2025 - All Health Boards have agreed with extension of mitigation plan to March 2026. Currently we have timelines for tranche 1,2 (Cell Path go live -Nov 25) and 3 (Micro Go Live - Jan	Review local contingency action plan and duration.	Jones*, Dylan	Completed	Short term contingency includes use of middle-ware and paper based processes which is not viable for more than 5 days. 28/05/2025 - Local Business Continuity Plan already established and captured in Pathology BCP SOP (found on QPulse) Long term would be to prioritise urgent samples to be done manually and outsource all others to English laboratories. This would be logistically difficult and involve manual transcribing of results into WCP requiring significant staff resource, training and testing. This is practically not a viable option. May 2025 - action complete.
		To review staff resourcing to support testing requirements	Jones*, Dylan	Completed	There has been no agreed funding from the programme to support overtime in 2025/26. Review has highlighted increased staff resource requirements are 4 Biomedical Scientists (Only Agency BMS likely to be available) for 6 months. £39k x 4 - £156,000 DHCW has explored the possibility of hiring an external resource company and will work with Health Boards on the approach in May/June. 28/05/2025 - On going. DHCW continue to explore resource opt 28/08/2025 - Blood Transfusion BMS appointed on a fixed term/ part time basis to support legacy data and UAT testing - action complete.

26) but yet to determine timelines for tranche 4,5 (Blood Science and Transfusion) 28/11/2025 - Further delays with Tranche 1 and 2 (go live now likely in Jan 26). This will push the programme beyond March 26. 27/02/2026 - Gone live with tranche 1&2 (cell Pathology), Tranche 3 scheduled for May 18th. Concerns remain with Blood Science and Transfusion. 24/04/2026 - Delays to Tranche 3 (approx go live 22nd June), May cause further delay to Tranche 4&5. 22/05/2026 - Tranche 3 go live extended again to 20th July 26. The current plans for Tranche 4 is also 20th July and September for Tranche 5. There is increased uncertainty with Tranche 4 and 5 timescales. Extension beyond Q2 will have financial impact on HBs (approx £300,000) 26/06/2026 - There is acceptance that a July go-live date is not feasible for Tranche 3 or 4 due to the number of outstanding product fixes. No revised dates have been confirmed. Approximate date of August for Tranche 3 and September for Tranche 4, but these are not confirmed. Tranche 5 has no date. The programme has given agreement to maintain order of the tranche deployment after the HB risk assessed the request to change deployment order.	Agree Telepath LIMS extension for Blood Transfusion from Dec 2025 - Dec 2026.	Jones*, Dylan	Completed	Oracle order has been approved. Once confirmation of extension has been received from company, this action can be closed - action complete.
	Sign off Tranche 1 and 2 prior to Cell Path Go live (19th Jan 2026)	Jones*, Dylan	Completed	New Action T1 - Dylan signed off on this for Cell Path. T2 - Dylan and Craig signed off on this for Cell Path. All internal approvals were collated via email (and saved as DHCW were having issues with electronic signatures) - action complete.
	Sign off tranche 3 (Microbiology - Feb 26)	Jones*, Dylan	30/01/2026 30/04/2026 31/05/2026 30/06/2026 31/07/2026 30/09/2026	tranche 3 go live further delayed due to clinical concerns. looking to roll out on the 24th August,
	Understand cost implications associated with extension to programme as a result of missing March deadline. DHCW to collate costs and impact to Health Boards.	Jones*, Dylan	Completed	costings collated and sent to CEO for decision - action complete.
	Escalated BT options SBAR to Execs for decision. include financial impact of decision.	Jones*, Dylan	Completed	Extension to dedulas contract until march 27. If further delays expected we may need to look at alternative solution. Review at end of August. July 2026 - action complete.
	Tranche 4 sign off (Blood Science)	Rooke, Lowri	30/06/2026 31/07/2026 31/10/2026	Progressing with incremental UAT excluding aliquots. Go live dates in discussion currently looking at late September or early October.

	22/07/2026 - Further delays expected to tranche 3 due to defect resolution, config and interface issues. This will have an impact to tranche 4 and 5 go live dates also.	Understand the likely impact of delays to to Tranche 3,4 and 5. Funding currently runs out at the end of Q2 2026/27 and there is a strong likelihood of programme extending beyond Q2. What is the impact in terms of finance and resource. expectation is that HBs pick up Q3 costs.	Jones*, Dylan	30/06/2026 31/07/2026 30/09/2026	Drafting delay paper for Execs. Paper drafted, awaiting confirmation prior to circulation. Awaiting information from DHCW
		Review BT contingency plans if further delays to programme.	Jones*, Dylan	31/08/2026 30/09/2026	Engaging with Dedulas and other health boards to get an understanding of contingency options if more delays occur. Arranging meeting at beginning of September to review options.

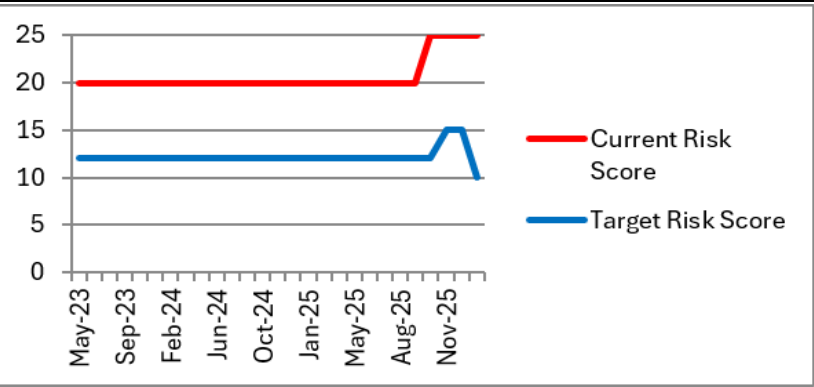
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance 			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
			Current Level							
All Wales Project Timelines	Pathology Strategy Group	1st			CCG Q&S IG meeting 16-07-2025 - Pathology Mitigation Paper submitted by DoD.					
	Quality And Safety	2nd								
	LIMS 2.0 National Programme Board	3rd								
	Regular Communication with DHCW	2nd								

Date Risk Identified:	Nov-19
Strategic Objective:	1. Thriving Teams and 2. Healthier Communities and 3. Great Care and 4. Positive Futures

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-26
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-26

Risk ID:	797	Corporate Risk Description:	There is a risk that health board wide ultrasound services are unsustainable. This is caused by - Demand increase across NOUS and Maternity Ultrasound pathways requires 34 148 additional scanning hours. - Workforce establishment does not match demand. - Workforce vacancies long standing (national shortage, training pipeline 3 years with large supervision requirement). - Unable to move staff between sites to cover as all sites unable to meet minimum standards required. - Occupational Health impact from workloads reducing workforce available (RSI). This could lead to an impact/affect on - Patient outcomes = delays to scans resulting in delays to treatment or death (cancer and maternity pathways) - Workforce outcomes = staff harm from RSI resulting in long term injury from too much scanning of similar types (unable to job plan appropriately due to demand and vacancies). Quality, complaints and audit - (5) Totally unacceptable level or quality of treatment/service. Gross failure of patient safety if findings not acted on. Inquest/ombudsman inquiry. Gross failure to meet national standards / performance requirements. Safety of patients - (4) Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects. Finance including Claims - (5) Claim(s) >£1 million. Probability = >95%
Does this risk link to any Directorate (operational) risks?			1349 (WGH), 1658 (RSI), 1936 (maternity)

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	5×5=25
Target Risk Score (L x I):	2×5=10
Expected Date To Achieve TRS:	31/03/2030
Trend:	



Rationale for CURRENT Risk Score:

This risk was escalated from 20 to 25 due to increased fragility in available workforce, due to 2.0WTE retirements in Jan 2026.

Impact score of 5 due to:

- A totally unacceptable level or quality of treatment/service:
- Patients on maternity and cancer pathways are waiting too long for scans required for intervention
- Gross failure of patient safety if findings not acted on.
- Concerns regarding noncompliance with Welsh Maternity screening targets
- Gross failure to meet national standards / performance requirements.
- Waiting times non-interventional ultrasound are up to 35 weeks
- Vascular ultrasound is not available 7 days a week

Probability score of 5 / >95% likelihood

The service is no longer able to sustain a safe baseline capacity to provide routine and urgent non obstetric imaging alongside obstetric scanning Monday to Friday, 09:00-17:00 on the WGH site (see separate risk 1349).

Rationale for TARGET Risk Score:

Impact of service failure remains the probability of service failure is the aim of mitigating actions.

Probability target of 5-25% (2)

In Jan 2026 target date was reviewed and extended. Justification for this change is the timeline for Radiology Leadership OCP and recruitment to bring in the leadership required to mitigate the gaps in controls thus requires extended timelines due to pathways changes and training timelines. In addition Annual Planning 2026/27 priorities for AH and HS CCG include further mitigation of this risk via capacity being added of 13WTE (£710 352) therefore likelihood scoring reduces to a 2 (5-25% probability). 2030 target date This timeline is due to training timelines it will take at least three years to train a workforce if 2026/27 Annual Planning funding is provided to Radiology.

Key CONTROLS Currently in Place:

(The existing controls and processes in place to manage the risk)

Insourcing NOUS undertaking 150 scans per week - funded by WG until 31.3.26. Funding for 26/27 from budget (4.0 vacancies).

Locum/Agency capacity - 1.0WTE secured. there are 2.0 agency requests unfilled.

Prioritisation of maternity growth scan workload by referring clinician - urgency allocated on referral form by referring clinicians.

Training pipeline (supported practice educator) - 5.0WTE in post (end of training Jan 2027), 1.0WTE Midwife sonographer (in preceptorship).

MSK and Vascular pathways via AHP extended practice roles (some Physiotherapy and Podiatry pathways in place to support ultrasound workload)

Demand vs capacity scanning gap is £710, 352 /13 WTE workforce - Annual Plan 26/27 approved.

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	By Who	By When	Progress
Health board wide governance of ultrasound pathways	Further action necessary to address the controls gaps			
Pathway workforce diversification -				
Training pipeline does not meet demand or workforce turnover.	Develop and implement a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Llewellyn, Cerian	Completed	The date of completion of this action has been changed to 31/01/2026 as the midwife identified for training did not start until Jan 2025 due to lack of process to support the clinical aspects and a change in maternity management.
Training capacity (trainees available but inadequate internal capacity to train)				Maternity and child health are required to advise of the plan to utilise the skills of the trainee midwife sonographer and also any plans to train more staff.
Centralised booking - due to commence June 26 to improve cross site cover.				June 2025: Midwife sonographer is now undertaking required training and expected to qualify in January 2026.
Insourcing/outsourcing/Agency/Locum capacity				Jan 26 - midwife sonographer has undertaken course and starting preceptorship

Radiology management restructuring as part of stabilisation plan. new posts needed to provide a longer term solution to issue. Not possible with current management structure and stability risk	Procter, Sarah	30/06/2026 31/03/2027	Informal consultation received alternative proposal Dec 2025, workshop with stakeholders scheduled early Jan 2026. Informal consultation extended until Feb 2026.Changes made to OCP awaiting exec approval - hoping to start April 26 OCP started JUne 26 - expected recruitment Mar 27
Training pipeline - 5.0WTE Trainee sonographers scheduled to complete training.	Procter, Sarah	31/01/2027	25/11/2025 - New action.
Training pipeline - 1.0WTE midwife sonographer completed training.	Procter, Sarah	Completed	midwife sonographer has completed the course.
Insourcing/Outsourcing - procurement conversation with current provider of ultrasound capacity relating to adding more scanning capacity for obstetric ultrasound capacity (2000 scans) on top of current contract	Procter, Sarah	Completed	25/11/2025 - new action 29/12/2025 - Chasing of provider who is reporting capacity to meet this demand but is not able to complete the scanning when we have handed over this scanning work. Now a meeting is required to push for this capacity to be released or statement that provider is unable to source the capacity so other options can be sourced.
Agency capacity - throughout 2025/26 2.0WTE out for advert with agency (AG1 (HR form for agency approval) valid until 2027)	Procter, Sarah	31/01/2027	25/11/2025 - AG1 approved for 2.0WTE until Jan 2027, out with Agencies during 2025/26. No interest this year as yet.
Insourcing/Outsourcing - Provider has confirmed capacity but has not been able to pick up scans when allocated. Therefore contract meeting with Deputy HoS (SP) and Director of Performance and Planning (KJ) scheduled (14.01.2026) to understand barrier to release in capacity,	Procter, Sarah	Completed	meeting undertaken - further capacity unlocked

Pathway workforce diversification - Maternity have indicated capacity within Midwifery workforce to complete growth scans. Analysis underway to identify % of scanning and therefore % WTE transfer.	Procter, Sarah	28/02/2026 31/10/2026	26/2/26 - SBAR shared with Director of midwifery - awaiting answer. 16/02/2026- meetings with Maternity continue. Paper shared with Director of Midwifery to outline governance around 1.26WTE Sonography capacity moving to Midwifery. Changes made to SBAR and validation by director of delivery's team. Further changes made to SBAR - agreed by director of midwifery. Paper to be submitted in May. Delay with approved from midwifery - work ongoing
Demand vs Capacity - Submit as a priority for 2026/27 Annual Planning (£710 352 / 13 WTE) additional funding required to meet demand	Quarrie, Sara	Completed	This demand and capacity gap funding was submitted as a priority by the AH and HS CCG in the Annual Planning 2026/27 workshop on the 21.11.2025.
Demand vs Capacity - Clinical validation support from NHS Performance & Improvement (intended outcome is to reduce inappropriate referrals to u/s modality and redirect to alternative and more appropriate modalities).	Procter, Sarah	Completed	Approval given to seek support meeting scheduled SP and NHS Performance and Improvement 16.01.2026 to agree implementation. validation Work started 19.1.26
Demand and Capacity - Skill mix vacancies in u/s to create 1.0WTE 8A - Job description to be sent to job matching	Procter, Sarah	28/02/2026 31/12/2026	Action agreed in Dec 2025. delay due to workload - JD in process - delay due to workload pressure on lead, looking to develop a data analysis post following OCP feedback.
Midwife sonographer undertaking preceptorship to be able to work independently - radiology supporting	Procter, Sarah	29/01/2027	new action

Workforce - Explore opportunity to follow UK countries and utilise Australia and New Zealand Sonography workforce (with additional governance and checks to assure without HCPC registration).	Quarrie, Sara	01/04/2026 31/10/2026	New action identified Dec 2025 SBAR in progress collab with workforce (TW) and Deputy Director of Health Science(JA). Requires alignment to HB professional policy, as recruitment would be outside of current policy. Service will develop an audit framework to assure of quality whilst working without prof registration.SBAR with JS for consideration
Recruit 2 trained sonographers to PPH	Osell, Fiona	30/10/2026	Two trained and experienced local sonographers have been recruited to PPH (1.8WTE) and will be commencing employment in September and October 2026. These individuals will work 10 hr shifts to increase weekday capacity for NOUS
Continue insourcing of NOUS services and fund additional activity of substantive staff where possible.	Procter, Sarah	31/03/2027	Bid to WG for recovery moneys has been submitted. If successful, this will ensure the continuity of NOUS insourcing opportunities and fund additional activity to increase capacity of substantive staff where possible.

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 			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
			Current Level							
8 week USC Ante-natal screening Wales	Waiting list monitoring - Live dashboard review by Radiology Leadership (daily) and monthly formal submission of performance * week data to Welsh government (see iPAR).	2nd			IQFPDG 26/11/2025 - SBAR - Ultrasound Fragility - Corporate risk 797					
	Performance monitored at Executive Improving Together Sessions	2nd								

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:	Aug-26
Lead Committee:	Finance and Performance Committee	Date of Next Review:	Oct-26

Risk ID:	2326	Corporate Risk Description:	There is a risk that the Health Board does not deliver a 2026/27 financial out-turn within the expected Target Control Total (TCT), and that Welsh Government (WG) is therefore unable to fund the cash consequences of the residual deficit. This is caused by an unsupportable 2026/27 Annual Plan position, with a £41.0m deficit requiring improvement to £22.0m, £42.8m of savings needed to deliver the plan, and a further £19.0m to achieve the Target Control Total. The risk is driven by a large opening run rate deficit of £54.3m to £90.5m, depending on plan delivery, low levels of assured savings against £42.8m requirement, reliance on unconfirmed and non recurrent measures, insufficiently developed variable pay controls, uncosted Planning Framework requirements, and significant unmitigated service risks. This could lead to an impact/affect on the Health Board's ability to meet supplier payments in the final quarter of 2026/27, the need for operational mitigations that may extend patient waiting times and affect performance, reputational damage with WG and other stakeholders, escalation of the finance domain from Targeted Intervention to Special Measures, and potential Level 4 internal 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):	5×5=25
Target Risk Score (L x I):	3×4=12
Expected Date To Achieve TRS:	30/06/2026
Trend:	

Month	Current Risk Score	Target Risk Score
Apr-26	20	12
May-26	20	12
Jun-26	20	12
Jul-26	20	12
Aug-26	20	12
Sep-26	25	12

Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
The 2026/27 Financial Plan submitted to Welsh Government (WG) in March 2026 forecast a deficit of £41m against WG's planning expectation of £22m. Since then, the Health Board has implemented a comprehensive programme of financial improvement, including the 4-Step Financial Improvement Framework, strengthened workforce plans, enhanced accountability arrangements, and Executive-led oversight of key delivery programmes. Progress has been made in establishing a more credible recurrent financial baseline, strengthening financial governance, evidencing variable pay plans, and completing actions arising from Welsh Government review processes. The revised COO Operating Model and Delivery Agreements aligned to the Levels 1-4 Performance Escalation Framework have also been implemented to support delivery. Notwithstanding this progress, the Month 4 forecast indicates that significant financial risk remains. Delivery of the financial plan continues to be dependent upon £19.4m of mitigating actions that require further development and evidencing to provide confidence in in-year delivery. In addition, savings delivery challenges remain within CIM and PSC, and the scale and pace of change required to achieve the planned financial position continues to place significant demand on organisational delivery capacity. Consequently, there remains a significant risk that the Health Board will not achieve its planned financial position for 2026/27.	The Target Risk Score (TRS) reflects the position expected once the 4-Step Financial Improvement Framework has been delivered and the supporting control architecture is operating. Pace is essential. The previous date to achieve the TRS of 30/06/2026 was aligned to the 4-Step Financial Improvement Framework, however this has now passed, and signals that the Health Board has not been able to exert sufficient grip on the largest controllable in-year expenditure line. There is a likelihood that the risk score could increase if the July 2026 position does not signal a run rate improvement closer to our monthly planned deficit. The date to achieve the TRS is therefore extended until 30 September 2026.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	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.	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	Further action necessary to address the controls gaps Nursing - configuration: review and confirm nursing establishments, ward and bed base alignment, skill mix and safe staffing levels. Configuration options to May Board (28 May 2026); decisions confirmed and consequential variable pay release evidenced by 30 June 2026.	Carruthers, Andrew	30/06/2026 30/09/2026	Linked to Choices and Value workbook beds-related opportunities and to the Value Opportunities Catalogue. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.

5. Financial control scrutiny of agency medical, agency AHP, Admin and Clerical and newly created roles for recruitment and procurement. 6. Opportunities compendium framework, updated and shared monthly. 7. Substantive operational structures in place since April 2025, providing managerial clarity and consistent accountability. 8. Business Controlling team alignment to CCG/CSG and Executive Function management structures. 9. CCG Accountability Agreements to be created and issued for 2026/27. 10. Director of Finance 4-Step Financial Improvement Framework cascaded on 31 March 2026 and reviewed by the Executive Team on 8 April 2026. 11. Financial accountability status by Executive Director included within Formal Executive Team to allow the accountable officer (CEO) to directly manage Alert areas. 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.	(i) recruitment assurance, (ii) deployment (rostering, sickness management, medical job planning), and (iii) configuration (establishment, service model, site working). Other open gaps: 1. Limited assured savings plans: only £5.0m of Amber/Green against the £42.8m 2026/27 requirement at the time of the submission to WG. 2. £6.4m of Blue/Red (unconfirmed) savings ideas not yet converted into deliverable plans at the point of the submission to WG. 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 - deployment: consultant job planning compliance trajectory toward the NHS Wales >90% standard (national deadline 30 September 2026); medical rostering system implementation; sickness absence management; tight controls over waiting list initiative and overtime usage. Interim position to May Board (28 May 2026); deployment plan and early compliance evidence by 30 June 2026.	Henwood, Mr Mark	30/06/2026 30/09/2026 31/10/2026	Job Planning compliance reached 77% in June 2026, with monthly escalation meetings in place for services that fall below the 90% compliance target to ensure improvement actions are implemented and monitored. The medical rostering system has been fully implemented. Ongoing discussions are taking place with clinical care groups (CCGs) regarding the prospective use of the system to support 6-4-2 roster planning, helping to reduce reliance on agency staffing and improve adherence to the agreed agency rate card.
		Medical - configuration: review service model, on-call arrangements and site working (including single-site and cross-site consolidation) with consequential release of variable pay requirement. Options to May Board (28 May 2026); preferred direction confirmed by 30 June 2026.	Carruthers, Andrew	30/06/2026 30/09/2026	Linked to Choices and Value workbook strategic opportunities (including Bronglais maternity/paediatrics, radiology OOH, pathology site model). Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.
		Allied Health Professions and Health Sciences: deliver trajectory toward 30% agency reduction against 2025/26 outturn; zero agency in HSW, Admin and Clerical, Estates and Ancillary (national deadline 30 September 2026); AHP Rate Card implementation; sickness absence reduction. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Severs, James	30/06/2026 30/09/2026	Targets drawn from NHS Wales 2026/27 Planning Framework. 30 June 2026 is the Health Board cadence deadline for deliverable plans; national zero-agency targets sit at 30 September 2026. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.

		Other staff groups (Admin and Clerical, Estates and Ancillary, Trainees): deliver trajectory toward 30% reduction against 2025/26 outturn for variable pay; zero agency in HSW, Admin and Clerical, Estates and Ancillary (national deadline 30 September 2026); sickness absence reduction. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026	Gostling, Lisa	30/06/2026 30/09/2026	Targets drawn from NHS Wales 2026/27 Planning Framework. 30 June 2026 is the Health Board cadence deadline for deliverable plans; national zero-agency targets sit at 30 September 2026. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update. No agency in Admin & Clerical and Estates and Ancillary, with MH&LD plans needed for HCSW elimination.
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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	Required Assurance			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
		(1st, 2nd, 3rd)	Current Level							
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	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) In-Board Committee 18	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.	Nursing - recruitment assurance: confirm substantive recruitment pipeline and fill rates against funded establishment; reduce routine reliance on on-contract nursing agency; HCSW agency trajectory to zero. Overall 30% reduction to be agency costs compared to the 2025/26 outturn. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Daniel, Sharon	30/06/2026 30/09/2026	Plan to be developed through the April 2026 CEO Review cycle; first cut to May 2026 Board. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update, with clarity of the newly qualified nursing intake.
	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 reliance on off-contract nursing agency.		Completed	All off-contract agency has ceased, with controls establishment within the Workforce rostering team to ensure no requests for off-contract agency are accepted.

CORPORATE RISK REGISTER SUMMARY SEPTEMBER 2026

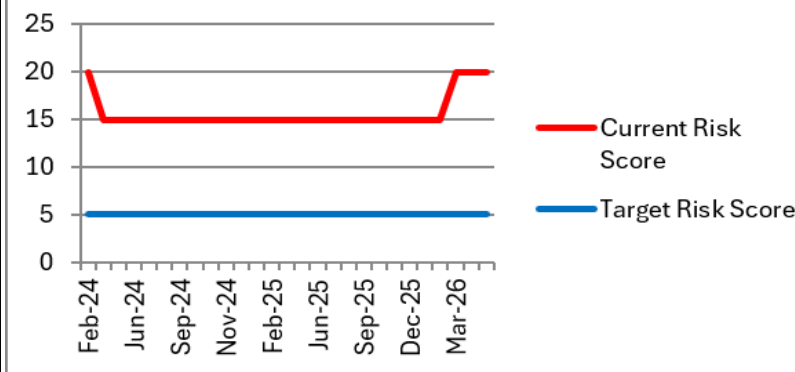
Framework (Levels 1 to 4).	Transformation and Financial Report to Board and Finance and Performance Committee.	2nd			June 2026 - opportunity decisions. Finance and Performance Committee 30 June 2026. Executive Team 8 July 2026. Senior leadership savings engagement event 9 July 2026 - to progress the pace of savings. Executive Team intervention to identify further rapid solutions - 12 August 2026. 27 August Finance and Performance Committee.	4. WG has rejected the £41m submitted position, so external assurance over plan acceptability is not yet in place. 5. Year 1 Value Opportunities Catalogue excludes digital, primary care, equity, workforce capability and prevention economics, limiting the assurance scope until year 2/3 iterations are developed.	Medical - recruitment assurance: confirm substantive and international medical recruitment plans against consultant and SAS vacancies; eliminate off-contract medical agency; reduce routine on-contract agency usage; enforce Medical Rate Card compliance. Overall 30% reduction to be agency costs compared to the 2025/26 outturn. Interim position to May Board (28 May2026); plan fully evidenced by 30/06	Henwood, Mr Mark	30/06/2026 30/09/2026 31/10/2026	The rate card has now been implemented across the Health Board. Work is underway with Finance and the Medical e-Rostering team to assess the impact of the introduction. Anaesthetics in Carmarthenshire and the Emergency Department (ED) have sought Executive approval for derogated rates to support ongoing workforce fragility. The ED derogation is scheduled to end in September 2026. Planned Care is developing and implementing improvement plans to address the underlying challenges within Anaesthetics. No off-contract agency is being used, with Workforce controls in place to decline requests.
	WG scrutiny through Monthly Monitoring Returns and NHS Exec Financial Planning and Delivery team.	3rd					Operational oversight and control will be consistently embedded following the review and implementation of Phase 2 of the Operational Organisations Change Process (OCP), providing clear, timely and specific escalation interventions for all Clinical Care Groups that are not delivering their targeted financial savings.	Carruthers, Andrew	30/06/2026 31/12/2026	The OCP2 task and finish group was formed in Apr26, with expertise from finance, workforce & od, and communications & engagement, chaired by the Deputy COO and meets weekly to review progress across the CCGs, monitor and mitigate emerging risks, and ensure that proposals are being developed in line with the All-Wales OCP. A paper was presented to PODCC in May 2026 providing a progress update and next steps. OCP2 documentation was approved by FET in Jul26 to commence the consultation process, closing 20Jul26, with implementation expected by Dec26.
	Audit Wales Structured Assessment process.	3rd								

Date Risk Identified:	Feb-24
Strategic Objective:	3. Great Care

Executive Director Owner:	Henwood, Mr Mark	Date of Review:	Aug-26
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-26

Risk ID:	1810	Corporate Risk Description:	There is a risk that the Health Board will be unable to continue manufacturing cancer treatments for our patients. This is caused by the facilities of the Pharmacy Aseptic Unit being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS) standards 5th edition (published 2016) and therefore at risk of closure, significantly exacerbated by a fragile workforce within the service. This could lead to an impact/affect on the Health Board's ability to provide all the cancer treatments currently offered. The Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. A fully outsourced service would cost an additional approximate £1m each year. Some therapies cannot be outsourced, meaning Hywel Dda could not offer over 500 cancer treatments each year. This would have a significant negative impact on patient care as patients would either be required to travel further from home to neighbouring Health Boards to receive their treatment (dependant on their capacity to absorb the additional demand) or would be offered less clinically appropriate treatments at Hywel Dda, negatively affecting clinical outcomes. The closure of the Aseptic unit would directly impact the ability of the Health Board to achieve ministerial priorities and targets such as the Single Cancer Pathway, A Healthier Wales, etc.
Does this risk link to any Directorate (operational) risks?			2004, 374, 1350, 716

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	1×5=5
Expected Date To Achieve TRS:	31/12/2026
Trend:	



Date	Current Risk Score	Target Risk Score
Feb-24	20	5
Jun-24	15	5
Sep-24	15	5
Nov-24	15	5
Feb-25	15	5
Jun-25	15	5
Sep-25	15	5
Dec-25	15	5
Mar-26	20	5

Rationale for CURRENT Risk Score:
Withybush Aseptic Unit is the only remaining aseptic unit within the Health Board capable of producing cancer treatments. It remains non-compliant with regulatory standards, with audits in 2024 and 2025 identifying significant risks relating to staffing, resources and maintenance of the Quality System, increasing the risk of closure. Temporary measures are in place to reduce contamination risks and delay closure (see control measures), but these are not sustainable due to the ageing infrastructure. Closure of the unit would leave no local means of supplying certain cancer treatments for Hywel Dda patients. The risk score was increased to 20 due to limited workforce resilience and insufficient capacity to maintain the Quality System. The service requires two pharmacists to undertake core daily operational activities yet only two substantive pharmacists are in post. This leaves little capacity for Quality System maintenance and development. Mitigating actions, including bank pharmacist arrangements and locum support, have been implemented; however, these do not provide long term resilience, as temporary staff may leave at short notice and there is no immediate contingency due to the lengthy training required for replacement staff. Consequently, the likelihood of service disruption or failure is increasing, and the risk score may need to rise to 25, as service failure is becoming almost certain without permanent additional staffing resilience.

Rationale for TARGET Risk Score:
The target risk score is based on the premise that a new demountable aseptic unit will be built at Withybush in 2026. The unit would be compliant with regulatory standards and once operational, it would be extremely unlikely for the unit to be forced to close. A new unit would allow the Health Board to continue to safely prepare cancer therapy until the TrAMS South West manufacturing hub is operational. It is anticipated that the current risk score could be reduced to 10 once the unit is operational, expected to be September 2026. Achievement of the Target Risk Score of 5 is expected once workforce fragilities have been addressed, anticipated to December 2026.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
Transfer of the radiopharmacy service to Singleton Hospital in October 2022; this means less overall activity through the Withybush Aseptic unit reducing the risk of contamination and errors. More time and resource provided to the Quality System (i.e. internal audits, investigation of near misses and microbial growths, maintaining SOPs). Increased training of aseptic staff to develop their skills and knowledge. Increase outsourcing from commercial suppliers; this limits the volume of products prepared within the unit, allowing products that must be made in-house to be prepared safely. New pharmaceutical isolators have been procured to replace the existing isolators that are beyond their working life of 10 years. The new isolators will be stored with the intention of installing into the demountable unit (if funding is secured) or will be installed into the existing unit if the current isolators fail mitigating the risk of equipment failure causing prolonged service disruption. Removal of outsourced dispensing from the Aseptic unit; this minimises the risk of contamination and potential for error. Preparation of products near to the time of use; this limits the pre-administration storage time. More stringent gowning process; this minimises contamination risk. Pharmacists from other areas have been identified to support tasks that do not specifically require aseptics expertise More stringent cleaning and monitoring programmes; this minimises contamination risk and allows early detection of microbial growth. Oversight and steer from Capital Sub-Committee.	Workforce resilience is critically limited, with a significant reliance on key individuals. The service requires two aseptic pharmacists to be available each day to operate safely, yet there are only two substantive full-time pharmacists in post. Additional support is limited to a part-time pharmacist whose primary role is outside the service. This dependency on a very small number of staff creates critical single points of failure and was highlighted as a key risk during the February 2025 audit.	More staffing resource is required to support the aseptic unit's quality system, to ensure that all other regulatory standards are adequately met to mitigate the risk of the non-compliant facilities.	Morgan, Cerith	30/09/2026 30/12/2026	Internal staffing model reviewed to allow the Health Board's lead quality assurance pharmacy technician to provide more support to the quality system. An Invest-to-Save SBAR, supported by a QIA, was presented to FCSG on 11 March 2026. The proposal would increase staffing capacity within the aseptic unit through reduced outsourcing of azacitidine, generating sufficient savings to fund the additional posts and deliver further savings to the Health Board. Posts have been approved by finance team and are waiting for approval on Trac.
		WG have approved funding for a new demountable aseptic unit. Aseptic project team to progress with planning for building the unit and confirm project timelines once finalised.	Morgan, Cerith	31/08/2026 30/11/2026	Project is underway and based on current timelines, the new unit will be operational by November 2026.
		Recruit bank pharmacists to take on clinical activities currently being performed by aseptics pharmacists	Morgan, Cerith	30/06/2026 30/09/2026	Recruitment process is in progress but those employed will not be able to start working until late August-September and can only offer a limited number of hours each week.
		Finalise Memorandum of Understanding with Cwm Taf UHB for quality assurance support	Morgan, Cerith	30/06/2026 30/10/2026	The Memorandum of Understanding is currently under review by Cwm Taf UHB Legal Services. However, Cwm Taf UHB has advised that it will only be able to provide a limited amount of QA support due to restricted capacity.

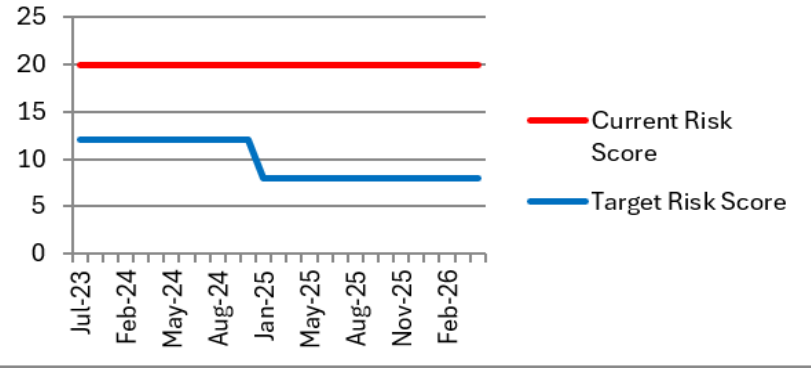
		To review workforce within pharmacy services to undertake clinical checks of chemotherapy prescriptions to release quality assurance capacity within technical services	Khandhia, Dilesh	30/09/2026	Review has been completed and plan has been developed, to be implemented by Sep26.
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ASSURANCE 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 			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
			Current Level							
Audit Reports from annual audits detailing areas of non-compliance KPI Dashboard in place to provide continuous oversight of unit performance, updated monthly.	Annual Audits by Lead Quality Assurance Pharmacist (NWSSP) .	3rd			Capital Sub Committee (22nd January 2024). MMOG report to QSEC for Feb 2024. BJC Board January 2025.					
	Quarterly self-assessments undertaken by Lead Aseptic Pharmacist, with outcomes fed back to Lead Quality Assurance Pharmacist at NWSSP	1st								
	Monthly Pharmacist Services Governance Meeting .	2nd								
	Updates to bi-monthly Capital Sub-Committee .	2nd								

Date Risk Identified:	Nov-20
Strategic Objective:	2. Healthier Communities and 3. Great Care

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-26
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-26

Risk ID:	1027	Corporate Risk Description:	There is a risk to the consistent delivery of high quality urgent and emergency care which is safe, timely, effective, efficient, equitable and person-centred (STEEEP). This is caused by significant fragility across the urgent and emergency care (UEC) system (acute, primary care (including out of hours), community and social care services), related to workforce compromise and increasing levels of demand and acuity. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays (WHC 2024/41) and overcrowding at Emergency Departments (ED), surge and care in non-designated clinical areas, and delayed ambulance response to community emergency calls, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?			1.21075E+62

Risk Rating:(Likelihood x Impact)		
Domain:	Safety - Patient, Staff or Public	
Inherent Risk Score (L x I):	5x5=25	
Current Risk Score (L x I):	4x5=20	
Target Risk Score (L x I):	2x4=8	
Expected Date To Achieve TRS:	31/10/2028	
Trend:		

Rationale for CURRENT Risk Score:
Data for July 2026 highlights sustained high operational pressures across all acute sites, with all key metrics, with the exception of ambulance handover >1hr, above targetted intervention levels. This is largely reflective of the position over the last year. However, July has seen slight improvements in Time to Clinical Assessment, >12 ED waits and Ambulance Handovers >1hr. PoCD has seen a slight deterioration in performance. Current key actions to improve flow include implementation of the 7-day Clinical Streaming, Hospital at Home and Optimal SDEC at WGH. Whilst the Board has approved the business case in January 2026 the implementation is currently being undertaken, expected operational launch is December 2026. Additionally, there has been a recent focus on Ambulance 45 Handover and the Call Before Convey project, which are expected to bring further benefits for system flow. Slight improvements have been noted for July and additional control measures have been implemented but system pressures remain and TI targets are not consistently being met, therefore the current risk score remains at 20.

Rationale for TARGET Risk Score:
The target risk score of 8 reflects the confidence in the delivery of the Urgent and Emergency Care Programme to address the significant issues across the health and care system. Plans for improvement during 2026/27 are reflected in the HB's Annual Plan, approved by the Board in March 2026. Hywel Dda's Urgent and Emergency Care Plan has been approved by WG in April 2026. TI measures such as ambulance handovers (Welsh Health Circular 2024/041 Ambulance patient handover guidance), PoCD and 12 hour delays in ED will need to improve in order to reduce the current risk score, for a consecutive period of three months below TI targets. Metrics will be monitored through the Formal Executive Report on a weekly basis, through the evaluation of the 7-day CSH and SDEC implementation on a monthly basis, and through the Urgent and Emergency Care Programme Group on a six-weekly basis. The expected date to achieve the TRS has been amended from May 2026 to October 2028 to allow for the implementation and embedding of relevant actions, as noted within the risk action plan. The embedding of 7-day Clinical Streaming and SDEC services will significantly impact on patient flow, however time will be needed for recruitment and embedding of services.

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	By Who	By When	Progress
Quality Planning - Integrated Regional Winter Plans developed and communicated to manage whole system pressures. - Operationally focused 6 Goals Urgent & Emergency Care (UEC) Programme established, with agreed governance and named SRO. - Welsh Ambulance Services NHS Trust embedded in all 6 Goals UEC workstreams. - Regional Integration Fund projects and Further Faster programmes aligned to Ministerial objectives. - Discharge arrangements in place on all sites, with a strategic review underway. - Establishment of a Regional Discharge Strategy Group to oversee workstreams and national/local policy alignment. - Establishment of a D2RA Group reporting to the 6 Goals Programme, with a detailed D2RA improvement plan in place. - Agreed SDEC model designed to maximise admission avoidance. - HB wide approach agreed for local streaming (Home First) hubs, including clinical triage models and APP Navigator. 111 and 111 Press 2 (Mental Health) implemented across Hywel Dda as part of planned access pathways. - Trusted Assessor Model designed and agreed to standardise assessment across the region. - Implementation of system wide escalation wide levels to recognise whole system risks rather than acute Quality Control - Live Operational Dashboard with twice daily HB wide escalation meetings. - Reviews of patients admitted to surge and clinical non designated areas to monitor acuity and dependency. - Care in non-designated beds protocol in place - Surge and care in non designated beds (boarding) activity recorded on twice daily escalation reports. - Daily review of surge and boarded beds via patient flow meetings to facilitate step down. - Regular weekly reviews of long stay patients (>7 days) with agreed	Quality Planning - Fragility of the care home sector due to financial viability issues and workforce recruitment and retention challenges. - Significant paucity of domiciliary care and wider social care capacity driven by workforce shortages. - Need to develop a 24/7 integrated urgent primary care service aligned to Home First hubs. - Requirement for 7 day community services, particularly for Clinical Streaming Hubs and Level 1 / 2 falls response (with CSS, SDEC and Hospital@Home implementation underway via County Implementation Groups). - Optimisation of bedded community facilities to better support step down and admission avoidance. - Insufficient IPC single room capacity across community and acute sites impacting future estate and infection control planning. - Need to influence public mindset, expectations and culture regarding use of NHS resources and the Home First model. - Fragility of senior medical cover in Emergency Departments across acute sites, requiring workforce and succession planning. - Lack of electronic digital triage assessment and scheduling system in place (single point of access)	Delivery of 6 Goals Programme and Plan via the workstreams and closer working with WAST and primary care 1. Development of Regional Clinical Streaming Hub (CSH) for Health Professionals & Care Homes delivering 24/7 urgent care advice & support and onward referral to local deliver/resource hubs where appropriate. 2. Development of SDEC in WGH in 2026/27.	Skitt, Peter	31/10/2025 30/09/2026 30/11/2026	At the public Board Meeting in January 2026, it was agreed to approve the implementation of a seven-day Clinical Streaming Service (CSS), Same Day Emergency Care (SDEC), and Hospital@Home model across Hywel Dda University Health Board. CCG currently progressing with implementation via County Implementation Groups.
		Utilise population health and cluster data and risk stratification data set across the system proactively with the population aligning with neighbourhood and local needs (such as the Borth model).	Skitt, Peter	30/04/2025 31/10/2025 31/03/2027	Part of First Home Hub plan and work is underway. Data is being used in primary care multi-disciplinary team meetings across the Health Board and WGH, and requires further embedding to ensure the impact within acute sector is realised.
		Review of Community bed based hospital capacity, with a view to ensuring proactive case load management and estate as part of the Alternative Care Model work. Develop & implement strategy for Alternative Care Community (ACP) Provision across the West Wales region.	Skitt, Peter	31/10/2025 31/10/2026	This has been action has been further aligned with, as the Health Board and Local Authorities now receive monies from Welsh Government (Pathways of Care Transformation Grant) to support development of community teams, being delivered ultimately by Local Authority with support provided by the Health Board, which reports to the National Support in Hospital Discharge Group. Therapies and community hospital strategic work will need to be considered as part of this action.

actions. • MIYA system used to record DPOC, red days and required assessments, supporting daily control of discharge progress. • Patient Flow Unit established as a single point of contact for flow issues and ambulance handovers, supported by dashboards. • D2RA Escalation Transfer Panel providing county level oversight of delays and flow risk. • Regional POCD Group reviewing trends and themes to inform timely corrective action. • Review of key themes and metrics of patients incidents and complaints related to emergency care areas		Enhancements to local delivery / resource hubs to support the CSH providing access to enhanced community care services, third sector services and other pathways to provide safe alternatives to admission. Integration with GP OOHs and APP resources.	Skitt, Peter	31/10/2025 30/09/2026	At the public Board Meeting in January 2026, it was agreed to approve the implementation of a seven-day Clinical Streaming Service (CSS), Same Day Emergency Care (SDEC), and Hospital@Home model across Hywel Dda University Health Board. CCG currently progressing with implementation via County Implementation Groups.
Quality Assurance • Standardised board round processes implemented on all sites. • D2RA processes embedded across wards to ensure consistent application. • Criteria led discharge guidance and principles embedded across the Health Board. • Clinical Care Group governance structure where risks are reviewed at quality meetings. • Winter Preparedness CELLS governance structure established with weekly oversight. • Care Home Risk & Escalation Policy applied to support failing providers. • Domiciliary Care Risk & Escalation Policy approved by the Integrated Executive Group and implemented region wide. • ED/MIU Redirection Policy ratified and implemented, enabling consistent clinical decision making. • Whole system workforce deployment arrangements to ensure continuity of care.	Quality Control • Inability to hand over ambulances within 45 minutes due to lack of flow through acute sites (Welsh Health Circular 2024/041 Ambulance patient handover guidance). • Nursing and Health Care Support Worker (HCSW) staffing shortages across all sites affecting safe operational delivery. • Lack of Level 1 / 2 falls response service out of hours, creating gaps in urgent unscheduled care pathways. • Insufficient number of isolation rooms (IP&C management) actively constraining patient placement and exacerbating flow problems.	Development & implementation of consistent approach to Front Door Streaming / Assessment Units focused on our Frail Elderly cohort based on good practice and lessons learnt from Withybush Puffin / South Pembrokeshire model.	Skitt, Peter	31/12/2025 31/03/2027	Frailty Lead appointed and developing plan, to be rolled out as part of the 6 Goals Programme during 2026/27.
Quality Improvement • D2RA improvement plan actively progressed through the D2RA Group and 6 Goals Programme. • Regular advice and capability building for ward teams via Community Discharge Liaison Teams, social services and Long Term Care Team. • Continued ward level education supporting consistent use of MIYA, board rounds and safety huddles. • SDEC model refinement and NHS Executive review actions embedded within the 6 Goals programme. • Direct referral into SDEC implemented to improve access and reduce avoidable admissions. • OOH pilot clinical streaming via GP route to test and learn new access models. • Trusted Assessor Model driving improvement by reducing duplication and variation across the system. • West Wales Hospital @ Home model to ensure consistent approach and delivery.	Quality Assurance • Gap in communication between secondary and primary care that risks poor discharge outcomes and discontinuity of care. • Lack of daily digital discharge summaries being sent to primary care • Lack of clarity regarding roles and responsibilities for discharge planning and coordination across organisations. • Inability to risk stratify people at moderate to high risk of admission in the community, limiting assurance that escalation risks are systematically identified and managed. • Lack of consistent assurance that discharge planning, community escalation and anticipatory care processes are applied equitably across sites and counties. Quality Improvement • Need for better use of ED presentation patterns to inform development of alternative primary care and community pathways. • Development of proactive anticipatory care planning for people at	Development and implementation of HDUHB optimal SDEC model following on from lessons learnt from peer review and alignment with CSH and local resource hubs.	Skitt, Peter	31/10/2025 31/10/2028	At the public Board Meeting in January 2026, it was agreed to approve the implementation of a seven-day Clinical Streaming Service (CSS), Same Day Emergency Care (SDEC), and Hospital@Home model across Hywel Dda University Health Board. CCG currently progressing with implementation via County Implementation Groups. There will be a phased approach to implementation starting with WGH (expected to complete October 2026), BGH (expected to complete October 2027) and GGH (expected to complete October 2028).
		Continued implementation of Optimal Flow Framework including Community sites supported by MIYA digital platform.	Skitt, Peter	31/10/2025 30/11/2026	Optimal Flow Framework is being embedded with support from Optimal Flow Coordinators across acute and community sites. MIYA digital platform was rolled out in December 2025 with training schedule ongoing. Revised date noted to reflect this ongoing training.

	moderate to high risk of admission to prevent exacerbations and decompensation. • Improvement required in integration between primary, community, acute and social care to support Home First model. • Strengthening discharge coordination and communication pathways to improve patient outcomes and flow.	Implementation of 7 focused areas within ED Quality statement.	Skitt, Peter	31/03/2026 31/10/2026	Clinical lead for ED post appointed. ED Quality Statement Action group in place, who report quarterly as part of combined UEC report to Welsh Government. Action plan developed and in place, forming the basis of updates to WG, based around the national toolkit.
		Develop West Wales Hospital @ Home model to ensure consistent approach and delivery.	Skitt, Peter	Completed	The Health Board Hospital at Home SOP has been agreed by the Community & Integrated Medicine Clinical Care Group Integrated Governance Group (focus on Quality, Health & Safety) and the Clinical Advisory Group.
		Review interim Use of Non-designated Areas Protocol following consultation and take through ratification process	Steele, Cathie	30/06/2026	Consultation has closed and feedback is being addressed.
		Review and re-draft the Health Board Escalation Policy and action cards.	Cottrell, Gareth	30/09/2026	Policies of other Health Boards have been received to inform revised policy development. Policy owner to be identified from within the Chief Operating Officers Function
		Development of OPEL scores to improve clinical risk recognition twice daily.	Skitt, Peter	31/10/2026	New action.
		Digital Discharge and Triage review to be undertaken with the Digital Team.	Skitt, Peter	31/07/2026 31/08/2026	New action.
		Review and update the Health Board Emergency Department Ambulance Off Load Policy.	Skitt, Peter	31/12/2026	Policy has review extension to 12/12/2026.

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	Required Assurance			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
		(1st, 2nd, 3rd)	Current Level							
• Ambulance handovers within 15 minutes • Ambulance handovers over 1 hour • Ambulance handovers over 4 hours • 4 & 12 hour waits in A&E • Time to triage in A&E • Time to see a Doctor in A&E • Pathway of care delays	• Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st			Seven-Day Business Case for Clinical Streaming Services (CSS), Same Day Emergency Care (SDEC), and Hospital@Home - Public Board January 2026 Unscheduled Emergency Care Accelerated Work Programme Update - Quality, Safety & Experience Committee February 2026	None identified.				
	• Daily performance data overseen by service management	1st								
	• Workstream Delivery Plans overseen by 6 Goals Programme	2nd								
	• 6 Goals Programme / UEC 3As report into IOG (Integrated Operational Group)	2nd								
	• Reports to FPC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	• IPAR Performance Report to SDODC & Board	2nd								
	• IA review on Transforming Urgent and Emergency Care	3rd								
	• NHS Executive Same Day Emergency Care (SDEC) Review	3rd								
	• NHS Executive ED Review	3rd								
	• GIRFT Review on ED	3rd								
	• MAG review	3rd								

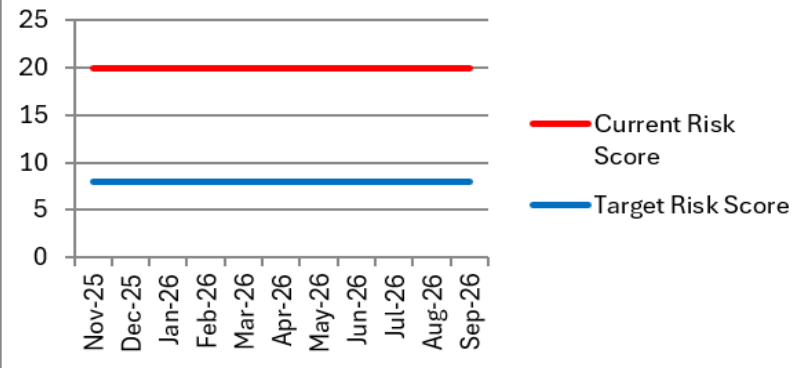
	• IA ED validation of Data	3rd									
	• AW Discharge local and regional	3rd									

Date Risk Identified:	Feb-22
Strategic Objective:	3. Great Care

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-26
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-26

Risk ID:	1552	Corporate Risk Description:	There is a risk of insufficient mortuary capacity (Fridge & Freezer capacity) Health Board wide to meet the current and future growing demand and provide adequate and appropriate sized storage for ward and community deaths. This is caused by the severe lack of storage capacity across all mortuaries within the Health Board, compounded by the fact that some of the refrigeration spaces are not big enough to accommodate the increasingly larger bodies that are being admitted into our mortuary facilities, and the inability for staff to safely access refrigeration spaces at WGH and BGH. In addition, the increase in economic, social, demographic, regulatory and legislative (Medical Examiner Service - MES) pressures have significantly increased both the quantity of deceased and length of stay within our Mortuary body storage facilities. This could lead to an impact/affect on the dignity, and condition of deceased patients within our care due to the inability to adequately store these patients in a suitable environment. There is also the potential impact of non-compliance with legislative requirements, including Human Tissue Authority, along with reputational damage to the Health Board. There could also lead to emotional distress to the families and friends of the deceased.
Does this risk link to any Directorate (operational) risks?			283, 1554

Risk Rating:(Likelihood x Impact)		
Domain:	Safety - Patient, Staff or Public	
Inherent Risk Score (L x I):	4×5=20	
Current Risk Score (L x I):	4×5=20	
Target Risk Score (L x I):	2×4=8	
Expected Date To Achieve TRS:	30/08/2028	
Trend:		



The graph displays two horizontal lines representing risk scores over time from November 2025 to September 2026. The y-axis is scaled from 0 to 25 in increments of 5. The 'Current Risk Score' is a red line fixed at a value of 20. The 'Target Risk Score' is a blue line fixed at a value of 8. A legend on the right identifies these two lines.

Date	Current Risk Score	Target Risk Score
Nov-25	20	8
Dec-25	20	8
Jan-26	20	8
Feb-26	20	8
Mar-26	20	8
Apr-26	20	8
May-26	20	8
Jun-26	20	8
Jul-26	20	8
Aug-26	20	8
Sep-26	20	8

Rationale for CURRENT Risk Score:
The Health Board is exposed to significant risks resulting from insufficient mortuary capacity across its estate.The ongoing dependence on temporary body storage, particularly during periods of excess deaths, presents challenges in maintaining regulatory compliance, protecting staff wellbeing, ensuring safe manual handling practices,and upholding the dignity of the deceased.The current infrastructure risks non-compliance with HTA standards. According to ONS projections,the death rate is expected to rise, peaking in 2044, further intensifying these pressures. Suboptimal facilities may lead to compromised presentation of the deceased, increased emotional distress for families, and safety concerns for mortuary staff,especially manual handling.While control measures are in place, they are not sufficient to manage the current volume of deaths within the mortuary service,particularly during periods of heightened demand.These control measures should serve only as temporary contingencies, in line with the HTA licence however,there is a growing need for enhanced storage capacity throughout the year,not solely during seasonal peaks. Current body storage provisions do not meet operational requirements, and there is limited flexibility to respond to unplanned disruptions, such as those involving MES, HMC, or PM Service interruptions. Furthermore, the extremely constrained footprint of the mortuary estate significantly restricts opportunities for external expansion or enhancement.

Rationale for TARGET Risk Score:
Target score is based on successful outcome from Body Storage Capacity paper being escalated via CCG (03.06.25) to IQFPD (11.06.25). Funding stream discussed with Executive Director of Finance on (21.07.25) along with further meetings and support from the Health Board's finance and planning team to ensure a long-term sustainable solution is implemented as soon as reasonably possible. Assurance has been provided by the Executive Director of Finance that financial support will be received in order to enact the short term measures to ensure appropriate capacity is available for the approaching winter pressure period. Further discussions will be held with finance and planning colleagues to discuss medium and long term mitigating plans. Long term solution need to be sustainable and future proof to ensure the target risk score is achieved and maintained. TRS and expected date to achieve agreed by Formal Executive Team in November 2025. Short term measures have been implemented in PPH, WGH and BGH to provide additional capacity, however further short term measures are required in order to address the immediate demand vs capacity gaps, whilst sustainable and resilient long term solutions are explored. A body storage capacity subgroup has been established to develop a long term body storage capacity solution plan. Enablement of short term plans have taken longer than expected and as a result the TRS date needs to be extended.

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	By Who	By When	Progress
1. At times of peak pressure, temporary body storage units are rented 2. Monitoring of numbers of deceased against storage capacity (Health Board wide) 3. Business continuity plans in place (Health Board wide) 4. Contracts with local funeral directors to utilise contingency storage of deceased (Health Board wide) 5. Deceased are relocated to other mortuary sites when needed (Health Board wide) 6. Bariatric blanket available for short-term use across all Health Board sites 7. Additional body refrigeration (Boxcold solution) has been installed into the old PM (Post Mortem) room at WGH site.	1. Despite owning 1x 15 BSS unit, we have insufficient storage provision for the upcoming winter pressure period 2. Insufficient suitable space and/or estate within mortuary facilities to increase body storage capacity. 3. Any delay in the death certification process (internal & external stakeholders) significantly impacts on the management of mortuary body storage. As these processes are outside of mortuary control, we frequently invoke contingency plans to accommodate the deceased. Death certification process be noted as a control measure, with the gap being	Requirement of additional body storage capacity health board wide. Capital funding needs to be secured.	Baker, Craig	Completed	Escalated at IQFPDG June 2025 - meeting to be scheduled with HT re short term capacity and LD for medium/long term capacity for analysis. Body storage capacity paper being submitted via CCG structure. Financial approval from Finance executive to increase temporary storage over winter period (2025 - 2026), this includes funding to cover adding of additional capacity at PPH and the increase of freezer capacity to cover HB. 29/12/25 - Capital funding secured to increase freezer capacity at BGH. 27.05.26 - works completed at PPH and BGH.

8. Participation, engagement and communication with the Health Board's Mortality Group, medical colleagues, Medical Examiner Service and external stakeholders	the delays in these processes as a result of sources beyond the Health Board's control (MES, HMC, PM service disruption etc)?	Explore options regarding temporary body storage rental and purchase of body storage capacity.	Brown , Yasmin	Completed	Ongoing Discretionary Capital bid to purchase a 15BSS Nutwell storage unit. 20.08.25 - Currently in discussions with suppliers regarding rental costs. 19.11.25 - The service has been successful in procuring a 15 BSS storage unit via a spend to save scheme. This unit will be delivered towards the end of November/start of December 2025. 19.11.25 - The service has also rented 2x additional 15 BSS nutwell units as contingency storage space as part of our winter preparedness plans and in readiness for the winter increase in death rates.
	4 & 5. Due to the national shortage of body storage capacity, death certification processes and current death rates, contingency plans utilising mutual aid are ineffective as all Health Boards are experiencing the same level of body storage capacity pressures and are therefore unable to assist. 6. During the recent Tier 1 National Mass Fatality Pandemic Exercise it was identified that nationally and locally we have insufficient levels of body storage capacity to handle a mass fatality or a period of excess death. Risk areas were identified by the Hywel Dda team that participated in the exercise and these along with suggestions for improvements were feedback to the Local Resilience Forum (LRF) who will escalate this feedback to Welsh Government.	Work with estates teams across the Health Board to undertake the minor works that are required to allow for the installation of the box cold body storage solutions.	Brown , Yasmin	Completed	Contact has been made with estates managers in WGH, PPH, and GGH. Quotations for minor building works to be undertaken within the PPH and BGH mortuary facilities and are being progressed 19.11.25 - Building works commissioned for PPH with the works scheduled to be completed at the beginning of December 2025 to allow for for the erection of the additional additional body storage capacity (boxcold). 05.01.26 - Building works commissioned for BGH with the works scheduled to be completed March 2026 to allow for for the erection of the additional additional body storage freezer capacity.

		Seek external advice on enhancement of mortuary storage capacity within current mortuary estate footprint.	Brown , Yasmin	Completed	Initial site visit has taken place with Wessex refrigeration to determine the art of the possible within the existing GGH mortuary facility footprint. Awaiting receipt of possible plans and quotations. 19.11.25 - Quotations have been received from Wessex refrigeration and engagement is ongoing with estates teams to work these up further.
		Develop a business case and explore options in order to secure capital funding to ensure capacity meets both current and future body storage demands.	Baker, Craig	30/11/2026 30/11/2027	Initial discussions held with Director of Finance and Director of Strategy and Planning regarding potential options to explore. Some of these options include - Building new estate and facilities - Commissioning body storage from private providers e.g. funeral directors - Working in collaboration with other Health Boards and Local Authority to develop combined regional solutions. CB to review. 20/07/26 - Body Storage Capacity subgroup established to progress this piece of work
		Work with capital planning team to develop additional short term options to address the immediate body storage capacity demand and capacity gaps.	Baker, Craig	03/01/2027	20/07/26 - Body storage capacity sub group established and first meeting held.

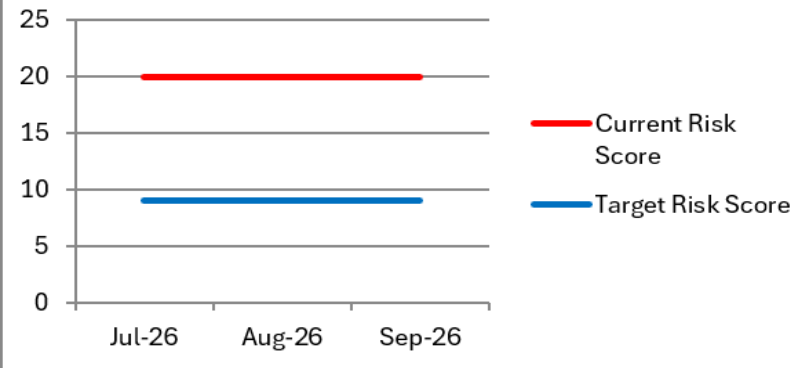
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
		(1st, 2nd, 3rd)	Current Level							
	Pathology Strategy Group.	1st			Presentation to IQFPD - June 2025.					
	Hywel Dda HTA Assurance Group.	1st								
	Regional HTA Assurance Group.	2nd								
	Quality & Safety Intelligence Group	2nd								
	AHP & HS CCG reporting up to IQFPD	2nd								
	IQPD	3rd								

Date Risk Identified:	Mar-26
Strategic Objective:	1. Thriving Teams and 2. Healthier Communities and 3. Great Care

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-26
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-26

Risk ID:	2378	Corporate Risk Description:	There is a risk that the Health Board being unable to consistently deliver safe, sustainable and timely Emergency Department services across all hospital sites. This is caused by sustained medical workforce fragility (including consultant and middle-grade gaps), limited estate and physical capacity, variable specialty support, and sustained system-wide patient flow pressures driven by rising demand. This could lead to an impact/affect on patients experiencing delays to assessment, treatment and admission, with care delivered in non-designated areas, increasing risks of harm and poor experience. Staff wellbeing and morale may decline, affecting recruitment, retention, public confidence, and the ability to meet national performance and regulatory requirements. This risk is exacerbated by sustained urgent and emergency care system pressures (Risk 1027) and a constrained national labour market with limited supply of skilled clinicians across all professional groups (Risk 1978), resulting in Emergency Departments bearing a disproportionate share of both operational and workforce-related risk.
Does this risk link to any Directorate (operational) risks?		1027, 2264, 2305, 2113, 750, 2241, 1424, 2161, 1924	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	3×3=9
Expected Date To Achieve TRS:	31/10/2027
Trend:	



25
20
15
10
5
0

Jul-26 Aug-26 Sep-26

— Current Risk Score

— Target Risk Score

Rationale for CURRENT Risk Score:
Risk score reflects persistent and system-wide nature of ED fragility across the HB. All three EDs are designated Tier 1 Emergency Services; however current medical workforce models do not consistently meet Royal College of Emergency Medicine (RCEM) standards (1:12 in WGH/BGH & 1:18 in GGH). The HB remains funded to a 1:5 consultant rota at GGH and 1:3 rota at WGH, with no formal on-call arrangement at BGH. These arrangements are insufficient to provide resilient senior decision-making, particularly overnight and weekends. This has resulted in frequent reliance on agency cover, variable continuity of care, and repeated escalation when minimum staffing thresholds cannot be maintained. In addition, there is no single, coordinated medical workforce strategy for Emergency Medicine or the supporting acute specialties. Gaps in specialty support(particularly WGH where there is no resident General Surgery or Trauma & Orthopaedics registrar out of hours, and no on-site Paediatric, Obstetric or Gynaecology services) further increase risk and limit mitigation options during periods of escalation. These workforce pressures coincide with sustained flow challenges, high acuity presentations, and constrained physical capacity, resulting in prolonged ED length of stay, care in non-designated areas, and repeated system escalation. Adverse impacts are highly likely to recur and could have major consequences for patient safety, staff wellbeing, and organisational performance.

Rationale for TARGET Risk Score:
The target risk score reflects a position where Emergency Department services are stabilised but remain under active management, recognising the scale and complexity of the challenge. Reduction to the target score would be achieved through incremental but sustained improvement rather than a single intervention. This includes implementation of a Health Board-wide ED medical workforce strategy aligned to national standards, improved rota resilience through substantive recruitment, and strengthened specialty support models - particularly for WGH. Further reduction would be supported by the establishment of robust, site-specific Business Continuity Plans, clearer escalation triggers linked to workforce and flow thresholds, and embedded senior oversight through strengthened governance structures. At the target score, while operational pressure and demand variability would remain, controls would be sufficient to reduce the likelihood and impact of harm, limit care in non-designated areas, and provide greater assurance of sustainability and staff wellbeing. Reducing this risk to a 9 will require alternative models for ED service delivery requiring consultation/engagement.

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	By Who	By When	Progress
Weekly Emergency Care Risk Mitigation Group lead and coordinate all required mitigations, oversee implementation, monitor risk, and escalate concerns and decisions to the Executive Team in accordance with Health Board governance requirements. Daily senior rota oversight, with real-time escalation to site triumvirates when minimum safe staffing thresholds cannot be met. Agency and locum mitigation, including use of Medacs and longer-term locum arrangements where available. Major Incident Policy and Action cards in place to support consistent operational responses during periods of high pressure. Patient Flow Unit established, providing a single point of coordination for system flow, ambulance handovers and escalation, supported by performance dashboards. ED / MIU Redirection Policy ratified and implemented, enabling appropriate clinical redirection to alternative services. ED workforce risks and mitigations are considered within wider UEC system governance (Risk 1027) and corporate workforce oversight arrangements (Risk 1978), ensuring alignment and escalation of interdependent risks.	Absence of robust, site-specific Business Continuity Plans for ED services that fully mitigate workforce and capacity-related failure.	ED specific Business Continuity Plans (GGH) will be developed for each site, aligned to existing UEC escalation arrangements (Risk 1027), to manage sustained medical staffing failure beyond short term escalation	Andrews, Bethan	30/09/2026	ED Closure Desktop Scenario exercise held on 16th July 2026 to test Business Continuity Plan. Report and recommendations to be agreed at CCG 20th August 2026 and Integrated Operational Meeting on 1st September 2026.
	Lack of a coordinated Health Board-wide ED medical workforce strategy, including alignment with supporting specialties.	ED specific Business Continuity Plans (WGH) will be developed for each site, aligned to existing UEC escalation arrangements (Risk 1027), to manage sustained medical staffing failure beyond short term escalation	Matthews, Joseph	30/09/2026	ED Closure Desktop Scenario exercise held on 16th July 2026 to test Business Continuity Plan. Report and recommendations to be agreed at CCG 20th August 2026 and Integrated Operational Meeting on 1st September 2026.
	Persistent ED rota fragility, particularly at consultant and middleâ€ˆgrade level, with limited resilience to sickness, leave or vacancies, resulting in recurrent reliance on agency staffing and escalation rather than sustained control.	ED specific Business Continuity Plans (BGH) will be developed for each site, aligned to existing UEC escalation arrangements (Risk 1027), to manage sustained medical staffing failure beyond short term escalation	Poole, Andrew	30/09/2026	ED Closure Desktop Scenario exercise held on 16th July 2026 to test Business Continuity Plan. Report and recommendations to be agreed at CCG 20th August 2026 and Integrated Operational Meeting on 1st September 2026.
	Insufficient specialty support at WGH, limiting the ability to safely manage high-acuity patients and cover ED rota gaps.				
	ED workforce capacity remains highly exposed to system flow failure, with limited controls to protect staffing sustainability during sustained overcrowding and ambulance handover delays	Create a Task and Finish group focused on ED rota resilience which will be strengthened incrementally through the Health Board wide Emergency Medicine workforce strategy and medical workforce planning mechanisms (Risk 1978), recognising labour market constraints	Cottrell, Gareth	30/09/2026	Task and Finish Group established on 12th June 2026. SBAR in development with Medical Directorate focused on Medicine Tier 1 and Tier 2, with Medical Consultant and Emergency Medicine medical workforce in the next phase.
	Current controls largely focused on short-term mitigation rather than sustainable long-term solutions, an alternative service delivery model.	As part of the Task and Finish Group, minimum specialty support standards for EDs, particularly at WGH, will be agreed at Health Board level and aligned to service and workforce planning decisions	Cottrell, Gareth	30/09/2026	Task and Finish Group established on 12th June 2026. SBAR in development with Medical Directorate focused on Medicine Tier 1 and Tier 2, with Medical Consultant and Emergency Medicine medical workforce in the next phase.

	Continue targeted consultant recruitment campaigns, with exploration of alternative workforce models where traditional recruitment remains challenging.	Skitt, Peter	30/09/2026	2 ED Consultants were successfully recruited to GGH.
	The establishment of a programme to identify options for alternative models for delivering emergency medicine and related emergency pathways by March 2027.	Carruthers, Andrew	31/03/2027	Progress update to be provided at next review.
	To agree a process for implementing an agreed process to engage, consult and enable board approval of a preferred option for delivering emergency medicine and related emergency pathways.	Carruthers, Andrew	31/10/2026	Progress update to be provided at next review.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance 			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
			Current Level							
ED consultant and middleâ€ˆgrade rota fill rates (planned vs actual)	ED Workforce Risk Mitigation Group established to oversee ED rota resilience, workforce capacity, escalation and mitigation actions across all sites .	1st			SBAR Urgent action needed to maintain services in WGH Emergency Department to CIM Q&S Governance Meeting Dec25	Limited independent assurance on the sustainability and resilience of ED clinical workforce models under sustained system pressure	Outputs from GIRFT Emergency Medicine / UEC reviews and HEIW visits will be used to strengthen independent assurance on ED workforce sustainability and training pipeline risks.	Skitt, Peter	31/03/2027	Progress update to be provided at next review.
Frequency and duration of ED staffingâ€ˆrelated escalations	Reported through weekly ED operational reviews and Site Management Meetings at BGH, GGH and WGH, including exception reporting on staffing gaps and escalation events .	1st			SBAR Urgent action needed to maintain services in WGH Emergency Department Update to Chief Operating Officer	GIRFT and HEIW activity provides recommendations, but assurance on implementation and impact is not yet available	Assurance will be refreshed following implementation of ED Business Continuity Plans and agreed workforce actions, with reporting through QSEC and to the Board.	Skitt, Peter	30/09/2026	ED Closure Desktop Scenario exercise held on 16th July 2026 to test Business Continuity Plan. Report and recommendations to be agreed at CCG 20th August 2026 and Integrated Operational Meeting on 1st September 2026.
Use of agency / locum shifts within ED										
ED length of stay >12 hours and care in nonâ€ˆdesignated areas (interface with Risk 1027)	Reported to monthly Community and Integrated Governance meeting .	2nd					Alignment of ED assurance with existing UEC governance (Risk 1027) and corporate workforce assurance (Risk 1978) to provide triangulated oversight.	Cottrell, Gareth	30/09/2026	Progress update to be provided at next review.
ED workforce					SBAR Urgent	Current assurance is				

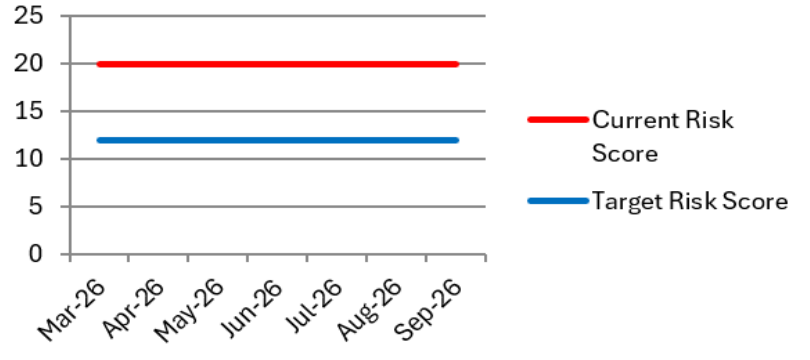
CORPORATE RISK REGISTER SUMMARY SEPTEMBER 2026

vacancy and turnover trends (interface with Risk 1978)	Workforce risks, vacancies and sustainability actions reported through Health Board workforce governance structures and Workforce Committee as part of corporate workforce assurance (Risk 1978) .	2nd			action needed to maintain services in WGH Emergency Department Update - Formal Executive Team 08Apr26	largely derived from operational escalation and reporting, rather than tested effectiveness of controls in reducing risk No completed scenarioâ€‘based assurance combining ED workforce fragility (Risk 1978) and system pressure (Risk 1027)	Consideration of targeted Internal Audit or structured independent review once key controls are embedded.	Cottrell, Gareth	30/09/2026	Progress update to be provided at next review.
	Reported to Quality, Safety and Experience Committee through exception and risk reporting on ED workforce staffing, safety incidents and escalation activity .	2nd								
	Assurance to be reported to the Board following implementation of ED Business Continuity Plans and agreed workforce interventions .	2nd								
	GIRFT Emergency Medicine / Urgent & Emergency Care review, including commentary on clinical workforce sustainability and service configuration .	3rd								
	HEIW visits and engagement relating to education, training capacity and clinical workforce sustainability within Emergency Medicine .	3rd								

Date Risk Identified:	Nov-25
Strategic Objective:	1. Thriving Teams and 2. Healthier Communities and 3. Great Care and 4. Positive Futures

Executive Director Owner:	Gostling, Lisa	Date of Review:	Aug-26
Lead Committee:	People, Organisational Development and Culture Committee	Date of Next Review:	Sep-26

Risk ID:	2305	Corporate Risk Description:	There is a risk that the required changes within the organisation are detrimentally impacting on staff wellness. This is caused by the pace and breadth of change, exacerbated by resource constraints, and increased level of scrutiny which the organisation is under. This could lead to an impact/affect on work/life balance, morale, psychological safety, staff burnout and satisfaction of staff at work. This could also result in poorer quality of care and outcomes for our patients.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		
Domain:	Workforce/OD	
Inherent Risk Score (L x I):	4×5=20	
Current Risk Score (L x I):	4×5=20	
Target Risk Score (L x I):	3×4=12	
Expected Date To Achieve TRS:	31/03/2030	
Trend:		

Rationale for CURRENT Risk Score:
Balancing financial pressures with the need to protect patient safety and deliver efficiency savings has placed significant strain on our workforce over the past year. This has been intensified by major organisational change across our Operations function, which has created uncertainty around job security, roles and future career paths. The prolonged implementation of OCPs is also generating growing unrest among staff directly and indirectly affected. WOD colleagues are increasingly hearing personal accounts from staff describing the emotional and professional impact of these changes. Trade Union partners have echoed these concerns, highlighting rising anxiety and declining wellbeing. The 2025 NHS Wales Staff Survey findings suggest staff burnout, presenteeism and unpaid hours are indicators of capacity strain needing operational response, rather than organisation’s wide wellbeing initiatives alone.

Rationale for TARGET Risk Score:
The organisation may need to consider that during periods of significant and impactful change, we will see, to some greater or lesser degree, this risk being exhibited by our staff. Therefore this may impact on levels of risk tolerance in the short to medium term. Changes to escalation status, governance arrangements for monitoring activity changes and clarity around financial plan will bring stability to the workplace and reduce the likelihood and impact on staff working in the organisation. Therefore for a sustainable change to be maintained, reduction in the risk score will be seen in incremental decreases year on year to 2030, as we address issues systemically. The 2026-27 financial year, and beyond, will see the organisation facing a number of challenges which are complex in nature and serve to impede the rate at which progression can be made. The current pace and scale of transformation, from fundamental restructuring to more subtle shifts in service delivery, are testing our teams' resilience. We will need to address each of the actions identified, being alert to the risk that new scenarios may impede progress.

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	By Who	By When	Progress
Policies and procedures, which are readily available to staff via the Health Board intranet and the Wellbeing Portal. This provides guidance and resources for managers and staff. Forums in place with Executive oversight to review performance against objectives - Executive Improving Together Sessions, Clinical Services Plan. Formal governance arrangements via Board and its sub-committees by Executives and Independent Members - People, Organisational Development and Culture Committee, Strategy and Planning Committee. Internal Escalation processes supports the monthly monitoring of key performance indicators e.g. sickness, vacancies, grievances Structure of Workforce and Organisational Development Directorate encompasses a number of pillars with a focus on supporting staff, promoting healthy working cultures, and providing support and resources. Recruitment Team remain fastest recruiter in Wales, with a number of successful campaigns for hard to fill roles and innovative recruitment strategies. Delivery of the WOD Planning Objective relating to a positive workplace culture. Workforce planning is engaged with c70 services to support the identification of current and future workforce challenges and work with services to address them through the "Regeneration Framework" which acts as a set interventions (Replenish, Rebuild, Retain etc) In essence, acting as a first step assessment of any future change required through a structured planning process - 6 steps methodology (HEIW/All Wales Standard).	Capacity constraints within the WOD due to reduced staffing within the directorate which impacts on the ability to delivery timely support to the organisation. This has resulted from the efforts made to contribute to increased requests to find corporate financial savings. Demand for support from WOD has not been static and has continued to increase. Therefore the impact of the reduced resourcing availability is having a more detrimental impact not only on services, but also on the staff working within WOD. Lack of staff engagement with NHS Staff Survey despite increased efforts to promote this and increase engagement in 2025. This is likely to be a further indicator of low morale. Additional external demands e.g. All Wales work on contract reform, is resulting in additional requirements for the Health Board (additional resource requirements to implement, financial impacts associated with changes).	Develop communication & intervention plan to build the resilience of individuals and teams and report on the actions within the plan on a quarterly basis.	Bird, Anna	31/03/2027	1) Embed reflective practice into 121s and hold stay conversations to proactively discuss workload, give staff a protected space to pause, think and make sense of their own wellbeing, and explore what they need to maintain their wellbeing and stay with the Health Board. 2) Equip staff with the tools and training needed for effective time management to enable focus and promote healthy wellbeing habits. 3) Set clear expectations and accountabilities so staff understand priorities to achieve clarity and sustain focus. 4) Empower staff to recognise their capacity, prioritise tasks and seek support
		To strengthen existing work and develop a focused plan to support the building of leadership capability for change across the Health Board responding to all change initiatives, including the CSP, and report on the actions on a quarterly basis.	Hinkin, Heather	31/03/2027	a) building leadership capability in relation to change by ensuring leaders understand and apply the HB's Organisational Change Policy, seeking professional WOD support where appropriate b) building the skills to recognise and respond to the human factors of change, including engagement and communication, psychological safety, emotional impact etc. The action will be co-ordinated by the Assistant Director of People Management and supported by Assistant Directors of OD and People Planning.

Develop and implement a data informed approach to identify and prioritise absence challenges, and create a targeted plan for implementing a structured quality improvement methodology to be embedded across the HB wide system within WOD. Progress will be reported on a quarterly basis.	Walmsley, Tracy	31/03/2027	WOD Business & Performance and Business Intelligence Groups working collaboratively to take a data informed approach to identifying and prioritising sickness absence challenges. Together, they establish discreet, multi disciplinary project teams that apply a structured quality improvement methodology to design, test and implement solutions. The action will be co-ordinated by the Assistant Director of People Planning and supported by the Assistant Director of People Management.
Develop a plan to create a streamlined set of All Wales workforce requirements to address WOD impacts on NHS wide performance (Contractual, Structural, Process/Systems).	Bird, Anna	30/09/2026	Progress update to be provided at next risk review. Engage through DEWODS to create a streamlined set of All Wales workforce requirements and provide practical, ready to use implementation tools that enable each Health Board and Trust to apply consistently. This is in place to some extent, strengthening coordination and leads for work is critical.
In line with the new operating model for Workforce and OD, implement a new structure to reshape workforce provision (within existing financial envelope).	Gostling, Lisa	31/03/2028	Phase 1: reshape workforce provision (2026/27) Phase 2: reshape in line with new workforce solution (2027/28)

		Develop a plan to promote neuroinclusivity across the Health Board and report progress on a quarterly basis.	Bird, Anna	31/03/2027	a) Promoting Health Board practice to embed neuroinclusive psychologically safe, and person centred behaviours across all services and influence change, performance, and quality systems actively protect staff and patient wellbeing while reducing avoidable personal and organisational harm. b) Establishing a programme of meetings with neurodivergent staff to inform actions that promote inclusion based on lived experiences for areas such as attraction and recruitment, retention, employee relations, sickness absence, personal development and training and organising/chairing meetings.
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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	Required Assurance			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
		(1st, 2nd, 3rd)	Current Level							
Performance Dashboards	Executive Team meetings (Risk led)	1st			PODCC Reports - Nov 2025 1. Assurance & Risk Report, 2. Planning Objectives Update Report, 3. Performance Assurance and Workforce	1) There is a gap in assurance for the oversight and governance of organisational change practices. 2) There is a gap in assurance that WOD	Introduce clear governance and oversight measures for all organisational change practices, to minimise the risk of personal or organisational harm ensuring they actively protect wellbeing, strengthen quality and performance.	Hinkin, Heather	31/03/2027	All managers will need to be aware of requirements through PADR/Supervision mechanisms as a first step

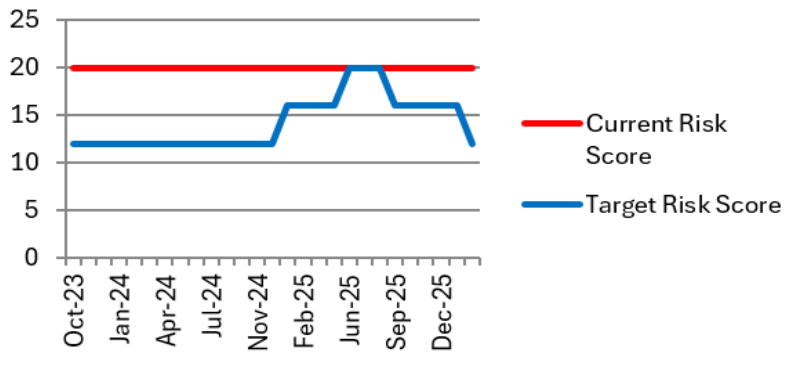
Escalation Recovery Meetings	1st			Metrics Report	capacity meets organisational demands or demand management is in place or resource requirements can be met. 3) There is a gap in assurance that our workforce capacity meets demands or demand management is in place or resources requirements can be met	Each Executive Director will implement a capacity assessment to prioritise and sequence work ensuring efficient use and deployment of resources which needs to be set against organisational priorities; with the intention of resetting work levels and focus. Address known resource gaps to mitigate significant/untenable risks as part of Annual Planning Cycle.	Walmsley, Tracy	31/03/2027	Progress to be provided at the next risk review
Executive Improving Together Sessions	1st					Each Executive Director will work to strengthen social partnership collaboration with staff and trade unions during times of increased change and transformation.	Hinkin, Heather	31/03/2027	Progress to be provided at next risk review
Workforce & OD Leadership Team Meetings (Risk led)	2nd					Greater focus on considering the impact of change on our workforce within the QIA integrated impact assessment assurance processes to ensure the impact on staff are considered and mitigating actions are in place to minimise/remove negative impact and maximise positive impacts.	Daniel, Sharon	31/03/2027	Progress to be provided at next risk review
Audit Wales - Workforce Planning - External Audit	3rd								
Staff Partnership Forum	3rd								
TI and JET assurance meetings	3rd								

Date Risk Identified:	Nov-20
Strategic Objective:	2. Healthier Communities and 3. Great Care and 4. Positive Futures

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-26
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-26

Risk ID:	1032	Corporate Risk Description:	There is a risk of delayed access to autism assessment for those on the CYP ASD waiting lists which is in breach of Welsh Government performance standard of 26 weeks. This is caused by an increase in referrals, sustained pressure on service. Internal back log of cases due to previous staffing issues and inefficient internal processes. This could lead to an impact/affect on provision of appropriate care and support. Inability to meet Welsh Government targets. Increase in complaints and adverse publicity as well as reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?			138, 1249, 1286, 1287, 1392, 1455, 1422, 1524, 1290, 1260, 1699, 1745, 1414

Risk Rating:(Likelihood x Impact)		
Domain:	Safety - Patient, Staff or Public	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	5×4=20	
Target Risk Score (L x I):	3×4=12	
Expected Date To Achieve TRS:	31/12/2030	
Trend:		



Date	Current Risk Score	Target Risk Score
Oct-23	20	12
Jan-24	20	12
Apr-24	20	12
Jul-24	20	12
Nov-24	20	16
Feb-25	20	16
Jun-25	20	20
Sep-25	20	16
Dec-25	20	12

Rationale for CURRENT Risk Score:
Significant waiting times have developed as a result of exponential demand. Demand outstrips capacity, with year-on-year increase in referral rates. Current team capacity can only accommodate 11% of total current demand, compounded by current funding arrangements which are non-recurring, making recruitment and service delivery challenging.
Welsh Government provided funding for Children’s Neurodevelopmental (ND) services for 2025/26 to reduce waiting lists (received September 2025). The delay in receipt of funding and the fact that it is non-recurring, along with recruitment delays, has hindered service planning and delivery. However, an improvement plan is in progress which includes stabilising and expanding the workforce, the use of outsourcing and data validation to manage waiting lists and meet ministerial targets, the re-design of our services, and the strengthening of regional partnership working to deliver a whole system, needs-led approach aligned with ministerial priorities. The demand for diagnostic assessment remains high and in the absence of a regional strategy our focus is currently on meeting the government targets which hinders our ability to develop a needs-led model and reduce the need for diagnostic assessment.

Rationale for TARGET Risk Score:
The Clinical Care Group has prioritised implementation of WPAS in Children’s ASD service which has enabled improved reporting and waiting list management and to determine trajectories of improvement in waiting times.
While trajectory plans are in place, the Health Board has recognised WG targets will not be achieved by the service in its current format, with a further deteriorating position in performance anticipated, compounded by the end of procurement contracts with external providers in March 2026.
The achievement of the target risk score is dependent on Welsh Government ring-fenced funding being made available on a recurrent basis, service re-design and waiting list initiatives are completed and implemented. Furthermore, the development of a regional, collaborative strategic approach with key stakeholders is imperative to creating whole system, needs-led integrated services. Digital enablers such as artificial intelligence and licenses for digital platforms essential along with access to appropriate clinical venues essential to help reduce 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	By Who	By When	Progress
Use of IT/virtual platforms such as Attend Anywhere when appropriate to encourage blended approach to working. Additional WG funding announced - £980,000 allocated to Health Board; funding ring-fenced for CYP service 2025-2026 Weekly Autism Advice Hubs in place for parent carers and CYP Rolling programme of workshops offering advice and support around neuro-diversity for parents of children awaiting diagnostic assessment. ND Service Delivery Manager in place to oversee 3 year performance improvement plan and drive innovative practice in line with WG policy and legislation. Workforce stabilised with no retention issues. Workforce Management Group established and workforce plans in place. Trajectories have been agreed for Children's ND by NHS Executive and systems in place to monitor waiting lists at service level performance-management meetings, IPAR and Clinical Care Group BPPP meetings. Outsourcing procurement exercise underway to eradicate 3 year waits by March 2026. Contract to the value of £4m to outsource over a 3 year period, commenced in 2025, with the option to increase to 5 years as funding allows Monthly touchpoint meetings with NHS Improvement & Performance to monitor progress against ministerial priorities. SMS text functionality in place for ND to improve attendance and decrease instances of non attendance. Fixed term posts made substantive	Estates - lack of appropriate dedicated child-centred premises to run clinics	Grow your own' scheme is coming into place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme (3 year programme).	Carroll, Mrs Liz	Completed	Psychology posts fully recruited in to within Children's ASD service
	Recruitment delays				
	Financial climate and associated cost pressures impacting on acquisition of appropriate IT infrastructure and hardware that could create more efficiencies	Develop further understanding of drivers for referral with potential for collaboration with partners for needs-based profiling	vaughan, Catherine	31/03/2026 31/03/2027	Commenced 1st October 2025 Work progressing with thematic analysis of drivers for referral underway in order to inform re-design of service to needs-led model. Education Strategic meeting with CCC attended to start to agree and develop profiling tool. Work un progress to develop a pilot between Children's ND and CCC Education Psychology service Assistant Psychologist recruited to undertake a thematic review
	Lack of certainty around future funding of ND services. Allocated monies 25/26 are non-recurrent.				
	Uncertainty around RPB infrastructure to help support and deliver regional transformation to needs-led, whole system approaches				
	Lack of capacity within ND services to work strategically to bring about transformational change across the 3 counties. Current capacity within ND services limited due to competing operational responsibility pressures.	Recruit into additional administrative and clinical posts and make existing fixed term posts substantive	vaughan, Catherine	Completed	Recruitment underway in October 2025. Delays gaining financial approval and recruitment delays, recruited into Band 4 Waiting List Coordinator and Band 3 Team Secretary of of 01.02.2026. All posts recruited in except for 1.0wte OT and 0.6wte ND practitioner. Interviews scheduled March 2026 Recruitment nearing completion for all posts
	Lack of a regional partnership strategic action plan to help bring about transformational change across the 3 counties involving all stakeholders.	Outsource a minimum of 585 diagnostic assessments to eradicate >3 year waits	vaughan, Catherine	Completed	Procurement exercise completed. Referrals identified and transferred to contract provider for 585 assessments, to be completed by 31.3.26.

Early Years pathway and toolkit for Health Visitors in place to encourage a 'watch and wait' approach. Professional consultation introduced across statutory sectors Website developed and in place for all-age ND services. Stakeholder mapping exercise completed and engagement plans in progress to develop needs-led model Looking at a Value Based Healthcare working with partners to develop needs led service.		Develop an all-age regional strategic action plan around neuro-divergence to promote whole system, needs-led services	vaughan, Catherine	31/03/2026 31/03/2027	This action has been included in the CCG Annual Plan for 26-27.
		Introduce an AI scribe across service to reduced administrative burden on clinical staff	vaughan, Catherine	Completed	Use of Magic Notes AI scribe commenced on 6.2.26 as pilot. Outcomes and feedback shared with Digital Director. Contract renewed to secure full package across MH&LD ND services for a further year, commencing 27.4.26.
		Develop and appoint into a strategic Head of Neuro-divergence post, to strengthen existing and further develop strategic partnership working	Temple-Purcell, Rebecca	Completed	This specific action is unrealistic at this present time. Opportunities, roles and responsibilities for the development of strategic partnership working to be undertaken collectively by the CCG leadership team.

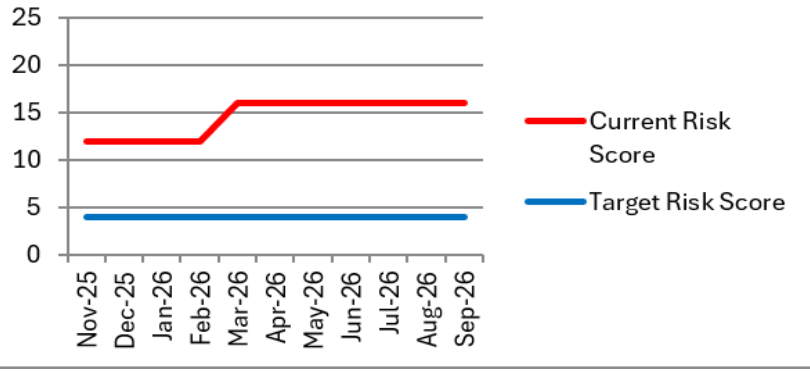
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed	By Who	By When	Progress
		(1st, 2nd, 3rd)	Current Level							
Welsh Government performance indicators along with internal monitoring arrangements will be used to ensure the actions are having the desired effect or whether there is more that needs to be done.	Management monitoring of referrals	1st			Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC (Oct21) MHLD progress update on Planning Objective 5G - Board (Mar22) Papers have been presented at the Quality	System to improve analysis of patient experience				

	Monthly MH&LD Integrated Governance Group (BPPP & QSEG)	1st			Safety and Experience Assurance Committee with a further update paper provided for the December 2021 meeting outlining control measures to manage the waiting times that the Directorate have at present.				
	An updated paper was submitted to the September 2025 Board meeting.	2nd			Papers were presented at Board Seminar in March & September 2025 to provide assurance on current waiting times and control measures.				

Date Risk Identified:	Sep-25
Strategic Objective:	3. Great Care

Executive Director Owner:	Davies, Lee	Date of Review:	Aug-26
Lead Committee:	Strategy and Planning Committee	Date of Next Review:	Sep-26

Risk ID:	2212	Corporate Risk Description:	There is a risk that the Health Board will not have an approvable Integrated Medium-Term Plan (IMTP) by March 2028. This is caused by the continued statutory planning breach, the 2026/27 Annual Plan not meeting approvable IMTP requirements, and the three-year financial trajectory not achieving breakeven This could lead to an impact/affect on continued Targeted Intervention, failure to de-escalate, reduced confidence, and adverse impacts on service quality, patient safety and financial sustainability.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		
Domain:	Statutory duty/inspections	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	4×4=16	
Target Risk Score (L x I):	1×4=4	
Expected Date To Achieve TRS:	31/03/2028	
Trend:	↔	

Rationale for CURRENT Risk Score:
The 26/27 Annual Plan sits within a three-year planning horizon (2026-29), but it has not been possible to submit an approvable IMTP. The statutory breach under Section 175(2A) of the NHS (Wales) Act 2006 continues and the Health Board remains in TI for Planning and Finance, Urgent and Emergency Care (UEC), and Hospital Acquired Infections. Following the Accountability Framework meeting in June 2026, the MD of NHS P&I issued a letter identifying three priorities: significant progress in UEC; action on fragile clinical services; and a credible trajectory to financial balance. It described the planned £41m deficit as neither agreed nor acceptable to Welsh Government, and required stronger savings delivery, clearer workforce and financial triangulation, and more ambitious but deliverable trajectories for planned care, diagnostics, cancer and UEC. Following the Level 4 Escalation Board on 4th August 2026, WG advised that concerns remain in relation to: - the current financial position and the delivery of sustainable financial recovery; the absence of sufficiently credible trajectories for improvement, notably but not exclusively UEC; the urgency and pace at which change is being delivered; and ongoing quality and safety risks. Our savings gap has reduced and as of month 4, the HB have shown £34 million of savings identified. Work will continue ahead of the next accountability meeting of 16th September 2026

Rationale for TARGET Risk Score:
The target risk score of 4 and expected achievement date of 31 March 2028 were agreed by the Formal Executive Team in November 2025. Achievement of a financially balanced and approvable plan remains a key driver for de-escalation from Targeted Intervention. The current gap between current and target risk score requires explicit Executive Team and Board consideration of whether the March 2028 target date remains realistic, given that the three-year financial trajectory does not achieve breakeven.

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	By Who	By When	Progress
1. A Healthier Mid and West Wales Strategy agreed by Board in 2018 continues to provide the strategic framework. 2. The 2026/27 Annual Plan has been produced within a three-year planning horizon, using risk-led prioritisation, Priority Bundles and demand and capacity modelling. 3. Strategy refresh and Clinical Services Plan decisions provide the basis for medium-term service planning, subject to delivery, capital and implementation constraints. 4. Financial roadmap, savings programme and recovery plan assumptions are subject to Executive and Finance and Performance Committee oversight. 5. Planning Co-ordination Group, Business Executive Team, Formal Executive Team, Strategy and Planning Committee and Board oversight arrangements are in place. 6. Welsh Government dialogue continues through JET, Targeted Intervention, IQPD and planning touchpoint meetings. 7. Operational management and assurance structures are in place through Clinical Care Groups, IQPFDG, Value and Sustainability Group and Board Committees. 8. The Annual Plan triangulates operational, corporate, quality and safety, workforce, estates and digital risks to inform priorities and Board understanding.	1. The Health Board does not yet have an approvable IMTP and the statutory breach continues. 2. The 2026/27 financial trajectory does not achieve breakeven within the three-year horizon; the £41.0m deficit including WRP is a deterioration against prior positions. 3. Recurrent savings delivery, WRP assumptions and recovery actions are not yet fully assured. 4. TI criteria cannot currently be met in full within available resources whilst maintaining safe services. 5. Operational, quality and safety, workforce, estates and digital risk exposure creates compound delivery risk.	The Annual Plan 2026/27 will be written in the context of a 3 year plan cycle, the implications of the strategy refresh and CSP will be factored into year 2 (2027/28).	Davies, Lee	31/03/2026 30/06/2026 31/08/2026 31/12/2026	The planning cycle will be continually reviewed throughout 2026/27 in the wider context of the delivery of an approvable IMTP. Operational risk registers have been fundamental in the approach to developing the annual plan for 2026/27. of Year 1 will focus on addressing the implications of the strategy refresh and CSP, which are due to be presented to Board in Q4 of 2025/26. Revised financial and performance outturns for 2026/27 were presented to Board in May 2026 and submitted to WG. This has resulted in further ongoing negotiation. Definitive update on CSP in November 2026 Board.
	6. External dependencies remain material, including Welsh Government recovery funding, capital, diagnostics, national priorities and post-election changes.	Sufficient and assured recurrent savings schemes are planned across Clinical Care Groups	Carruthers, Andrew	31/03/2026 30/06/2026	Progress update to be provided at next risk review - to be presented to Board in May 2026 before onward submission to WG.
	7. Annual Plan delivery requires clearer milestones, trajectories, benefits and accountable recovery actions.	Share WG feedback of last year's Annual Plan at the scheduled Planning Workshops throughout Autumn 2025 (Oct, Nov and Dec) with clear expectations of input and output, with support from the Planning Team.	Davies, Lee	Completed	Series of workshops held during Autumn 2025, with feedback from Welsh Government to date shared. The Health Board are still awaiting the Planning Framework to be published by Welsh Government, expected by the end of first week of December 2025 in order to fully address this action, which will also define the regional approach.
	8. The March 2028 target date requires review.				

	Refresh the 2026/27 Annual Plan delivery architecture so Priority Bundle milestones, benefits, risk treatment plans and escalation triggers are explicitly mapped to the route to an approvable IMTP and March 2028 target.	Davies, Lee	Completed	Planning Goals assurance reports are provided to the relevant Committees which feed into BAF. A single report that encompasses the Annual Plan, Performance and Finance are presented at each meeting, rather than separate papers to provide one overview, starting from July 2026.
	Strengthen financial recovery and savings assurance, including recurrent savings conversion, WRP assumptions, Q2 financial review and corrective actions if deficit or savings delivery moves off trajectory.	Carruthers, Andrew	30/09/2026	Financial roadmap and savings programme to be reviewed through Finance and Performance Committee and Executive oversight. Recurrent savings pipeline and WRP assumptions require further assurance.
	Review current score, target risk score and target date after Welsh Government formal assessment, Senedd election outcome, recovery funding decision and Q2 financial review.	Davies, Lee	31/07/2026 31/08/2026 31/12/2026	Current score increased to 16. Target date remains under review and should be considered explicitly by Formal Executive Team and Board.

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	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed	By Who	By When	Progress
		(1st, 2nd, 3rd)	Current Level							
1. Current risk score: 16 (4—4); target score: 4.	Planning Co-ordination Group oversight of the 2026/27 Annual Plan, planning cycle and IMTP route map.	1st			2026/27 Annual Plan Board report; SPC Annual Plan/IMTP updates; Clinical Services Plan and strategy refresh reports; FPC finance, savings and WRP updates; Welsh Government	1. Welsh Government’s formal assessment of the 2026/27 Annual Plan is awaited.	Present Welsh Government formal assessment and management response to Strategy and Planning Committee and Board; update risk 2212 and the IMTP trajectory once feedback is confirmed.	Davies, Lee	31/07/2026-31/08/2026 31/12/2026	Awaiting formal Welsh Government response. Risk score remains 16 pending review.
2. 2026/27 Annual Plan submitted; approvable IMTP not yet achieved.						2. Limited assurance that the three-year financial trajectory will reach breakeven by 31/03/2028.	Provide Q1/Q2 Annual Plan delivery reports showing Priority Bundle milestones, savings delivery, risk movement, benefits and corrective actions.			
3. Section 175(2A) statutory planning breach continues.	Business Executive Team and Formal Executive Team oversight of Annual Plan delivery, Priority Bundles, risk score and target date.	1st						Davies, Lee	30/09/2026	Delivery reports to be reviewed through Planning Co-ordination Group, Executive governance, SPC and Board.
4. Financial trajectory: £41.0m										

deficit including WRP; breakeven not achieved within three-year horizon. 5. Savings delivery: £42.8m programme and recurrent conversion requiring assurance. 6. Targeted Intervention: Planning and Finance, UEC and HCAI. 7. Risk profile: 656 risks; 391 score 12+; 63 score 20+; 9 extreme. 8. Quality, workforce, estates and digital exposure: 226 patient safety risks, surge/boarding harm, workforce fragility, e-prescribing discontinuation and 100+ estates risks.	Strategy and Planning Committee and Board assurance on the Annual Plan, strategy refresh and Clinical Services Plan implementation.	2nd			Planning Framework and formal assessment; Planning Maturity Matrix; IA Annual Planning - May 2025 (Reasonable); operational and corporate risk register reports.	3. Recurrent savings, WRP assumptions and recovery actions are not yet fully assured.	Deep-dive financial recovery, WRP and recurrent savings assurance through Finance and Performance Committee, with clear triggers for corrective action if off trajectory.	Carruthers, Andrew	30/09/2026	Q2 financial review required to test trajectory and savings deliverability.
	Finance and Performance Committee review of financial roadmap, savings delivery, WRP assumptions and Q2 financial review.	2nd				4. Further triangulation is required between quality and safety, workforce, estates, digital, finance and performance risks and the IMTP route map.	Triangulate quality and safety, workforce, estates and digital risks into the IMTP route map and committee assurance cycle.	Davies, Lee	31/10/2026	Risk profile identified in Annual Plan; thematic assurance to be scheduled.
	PODCC, FPC and IQPFDG assurance on people, workforce, finance, quality and performance elements of the Annual Plan.	2nd				5. FET and Board have not yet reviewed whether the target risk score and March 2028 date remain realistic	Formal Executive Team and Board to review whether the target risk score and March 2028 target date remain realistic.	Davies, Lee	31/07/2026 31/08/2026 31/12/2026	Target date under review following current risk score increase to 16.
	Planning Maturity Matrix and annual planning self-assessment presented to Board and Welsh Government.	2nd				6. External funding, capital, diagnostic and policy dependencies remain uncertain.	Update Planning Maturity Matrix and route map to reflect Welsh Government feedback, 2026/27 delivery learning and residual control gaps.	Warm, Daniel	31/12/2026	To inform the 2027/28 planning cycle and future IMTP development.
	Welsh Government oversight through JET, Targeted Intervention, IQPD and planning touchpoint meetings, including formal plan assessment.	3rd					Confirm external dependencies and funding, capital and digital assumptions after Welsh Government decisions and any post-election changes.	Davies, Lee	31/10/2026	Dependencies to be monitored through the planning cycle and risk review.
	Internal Audit Annual Planning - May 2025 (Reasonable) and subsequent internal/external assurance outputs.	3rd					Consider internal audit or independent assurance on 2026/27 planning delivery, benefits realisation and route to IMTP.	Davies, Lee	31/03/2027	To be considered through internal audit and assurance planning.

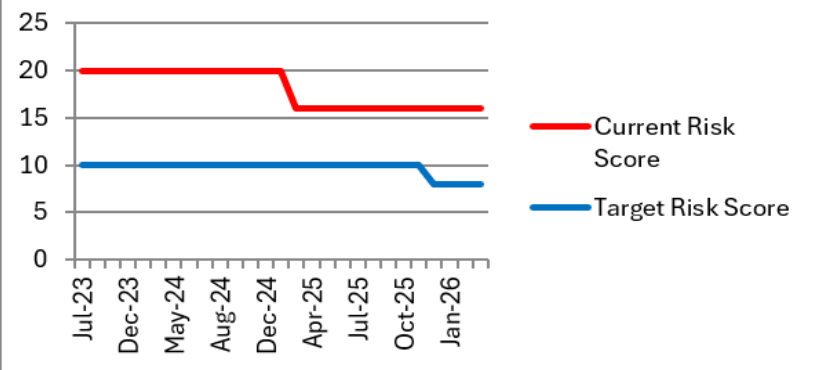
Operational and corporate risk registers, risk deep dives and thematic triangulation through Annual Plan and committee reporting.	2nd							
Quarterly operational and corporate risk register refresh process used to triangulate movement in the Annual Plan risk profile, control effectiveness and assurance gaps, drawing on Planning Co-ordination Group, IQPFDG (or as amended) and relevant committee reporting. This will inform any required change to risk score, target date, controls or further mitigating action.	1st							

Date Risk Identified:	May-23
Strategic Objective:	1. Thriving Teams and 3. Great Care

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-26
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-26

Risk ID:	1664	Corporate Risk Description:	There is a risk of an inability to provide sustainable and timely Ophthalmology services, including care for patients requiring Glaucoma, Cataract, Vitreoretinal, Paediatric and wet Age-Related Macular Degeneration treatment. This is caused by challenges in recruiting Consultant Ophthalmologists within a nationally constrained workforce, compounded by wider medical and nursing workforce shortages and limitations in clinical estate capacity. This could lead to an impact/affect on the Health Board's ability to meet referral to treatment and national eye care performance requirements, resulting in delays to diagnosis and treatment, increased risk of avoidable sight loss, reduced patient outcomes, and heightened regulatory scrutiny and reputational risk.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	31/03/2028
Trend:	↔



The graph displays two risk scores over time from July 2023 to January 2026. The Y-axis represents the risk score, ranging from 0 to 25 in increments of 5. The X-axis shows time in quarters. The 'Current Risk Score' (red line) starts at 20 in Jul-23, remains constant until Dec-24, then drops to 16 in Jan-25 and stays there. The 'Target Risk Score' (blue line) starts at 10 in Jul-23, remains constant until Oct-25, then drops to 8 in Nov-25 and stays there.

Date	Current Risk Score	Target Risk Score
Jul-23	20	10
Dec-23	20	10
May-24	20	10
Aug-24	20	10
Dec-24	20	10
Apr-25	16	10
Jul-25	16	10
Oct-25	16	10
Jan-26	16	8

Rationale for CURRENT Risk Score:
Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1 patients (risk of irreversible sight loss) with RTT (Referral to Treatment) longest waiting patients presents a conflicting priority to the service with limited capacity.
The service has provided additional AMD sessions on a weekend, and outsourcing however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the HB.
The current non-medical workforce establishment is not aligned to service needs. The current R1 delivery at 44%. The WG target for R1 delivery is 95%.
Patients attended has improved to 65% as at July 2026, the highest compliance since July 2025, with the average number of patients seen per month circa 2k. The number of patients waiting has improved to 46% (July 2026), highest compliance since September 2023. An additional 586 patients waiting in target in July 2026 compared to the previous month (1,616 compared to July 2025).
The Board has decided to progress Clinical Service Plan Option 99 of the Clinical Service Plan + Aberaeron Integrated Care Centre as a diagnostic hub. The service is currently reviewing the estates and workforce required on each site to deliver Option 99.

Rationale for TARGET Risk Score:
The service will not be able to reduce the impact score of this risk whilst the consequences to the patient remains high. R1 compliance for the number of patients waiting within target is at 46% (July 2026).
The completion of actions as noted within the risk action plan to December 2026 may allow a reduction in the CRS from 16 to 12, however to achieve the TRS of 8, R1 compliance will need to be significantly improved, and dependent on all posts being recruited into, and all estates and equipment needs being met.

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	By Who	By When	Progress
The service is included within the Health Board's Clinical Service Plan (CSP), with Option 99 being decided by Public Board as the most suitable option to improve efficiency gains, training and retention of staff. Active recruitment to vacancies through a regional approach, continue grow your own initiatives to secure Substantive Consultants and develop Consultants for the future. 1 post has been offered following interview (Vitreous Retinal) and the other post is going back out to advert (1.5WTE Medical retina) Collaborative working with Swansea Bay to deliver a Regional solution to address the workforce and estates constraints. SLA with SBUHB for regional consultant posts in place Draft Regional Eye Care Delivery Roadmap in place with agreed objectives. Additional funding for the delivery of Wet Age related Macular Degeneration (AMD).IVT outsourcing commenced in February 2025 continues to support the service, whilst service is developed. Wales General Ophthalmic Services (WGOS) for Glaucoma, Diabetic Retinopathy and Medical Retina ongoing monitoring. Continued Validation of waiting lists to remove any patients who no longer require treatment, with review of data quality inclusive of Health Risk Factor (HRF) code and clinical codes ongoing to improve data quality. Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. Highly trained Optometrists working collaboratively with the Secondary Care Eye Service to reduce referrals to secondary care and support the validation process. Ongoing training of Optometrists within secondary care for IPOS, Glaucoma and Medical Retina for continued delivery of WGOS and reduce referrals into secondary care.	High levels of staff absences due to sickness levels - to be managed in line with sickness absence policy. When recruiting to Clinical posts, delivery is restricted due to the reliance on Medical records and outpatient staff and the introduction of further clinics has been difficult. The Regional sub-groups have been established, but infrequently met in 2026. The regional cataract delivery plan is being re-developed and not fully implemented as of August 2026. Demand and Capacity work not yet completed to inform regional delivery requirements.	Roll out and implementation of National Electronic Patient Record for Ophthalmology.	Barreiro, Marta	30/07/2021 31/03/2022 31/05/2022 30/09/2022 31/10/2023 31/12/2023 31/03/2024 15/07/2024 31/03/2027	Application Support Manager started early December, undergoing induction with projects team & IT. Communication established with clinicians to explain Application Support Manager will start shadowing their clinics as soon as possible to determine pathways and support the build up of the system to match clinical activity.
	There still remains areas of the service (e.g. Glaucoma, AMD, Cataract, Paediatrics, Corneal and VR) that require investment. The regional programme board will need to consider further opportunities for a long-term regional model. Central capital investment in Estates, Infrastructure, Equipment and Workforce is required to develop a sustainable service. The required space for the expansion of the service in AVH secured for 3 days a week and not 5 as initially requested Workforce plans in place but not fully implemented	Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.	Jones, Amorelle	30/09/2022 31/10/2023 30/11/2023 31/03/2024 30/06/2024 30/09/2024 31/03/2026 30/09/2026	Recommence the validation of the HCQ patients. Ensure patients start to be discharged to primary care Optometrists when training has been completed. Primary Care still awaiting materials to be finalised and process rolled out.
		Alignment in the Delivery of Eye Care Measures and Ministerial Measures and effective management of Ophthalmology waiting lists.	Jones, Amorelle	31/03/2027	Recruit into 2 regional consultant posts. Deliver actions against regional programme board. AVH OPD to be secured for additional 2 days IVT. Deliver 52 week and 104 week target. Deliver 12% reduction in follow up delayed. Ensure all WGOS patients identified for pathway are discharged to primary care. Complete GIRFT recommendations. Continue with Clinical Services Plan.

GIRFT review undertaken on the Ophthalmology service with progress made against recommendations raised monitored and updated via AMAT. Performance dashboards in place to monitor performance.	6 GIRFT recommendations remain open as at August 2026. Recovery funding is non-recurring and delayed in its approval, reviewed annually, which restricts delivery planning.	Regional solutions to workforce gaps and estates to be explored through Regional programme	Jones, Amorelle	31/03/2027	Regional visit to SBUHB completed. Next Regional Eye Care programme Board meeting 20th March 2026. Action closed and superseded by two new actions in August 2026.
		Orthoptist posts to be recruited into	Jones, Amorelle	30/09/2025 31/03/2026 30/09/2026	Band 6 1.0 WTE Orthoptist post to be recruited into (via Annex 21 if necessary). Band 8B JD has been signed off by job matching panel. Currently going through CEGG process. Next steps to get approval of non-pay to pay to fund this post.
		Progression of Clinical Services Plan Option 99 + AICC as a diagnostic hub.	Carruthers, Andrew	31/03/2028	The Board has decided to progress Option 99 + AICC as a diagnostic hub. The service is currently reviewing the estates and workforce required on each site to deliver Option 99.
		Undertake an OPD workforce review to inform outpatient delivery.	Walsby, Alexandra	31/12/2026	New action - progress update to be provided at next risk review.
		Re-establish regional sub-group meetings.	Humphrey, Lisa	30/09/2026	New action - progress update to be provided at next risk review.
		Develop and finalise regional delivery plan	Humphrey, Lisa	31/03/2027	New action - progress update to be provided at next risk review.
		Implement regional delivery plan	Humphrey, Lisa	31/03/2028	New action - progress update to be provided at next risk review.

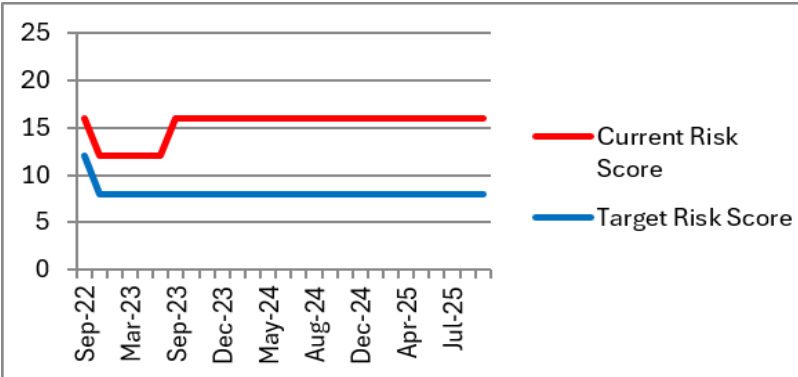
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance 			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
			Current Level							
Eye care measures monthly report. GIRFT review Cataracts. GIRFT review Glaucoma. Weekly RTT Optimisation to review Ministerial Measures.	WPAS	1st			SBAR for IVT Service Delivery & SBAR for recovery of R1 position Revised RISK SBAR. Planned Care Annual plan 2026/2027					
	GIRFT action plan cataracts	1st								
	GIRFT action plan Glaucoma	1st								
	WPAS, scheduled care performance indicators	1st								
	IPAR (goes to SPC and Board)	2nd								
	Regional Ophthalmology Groups	2nd								
	QSEC	2nd								
	CCG and CSG meetings	2nd								

Date Risk Identified:	Jan-19
Strategic Objective:	3. Great Care

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-26
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-26

Risk ID:	684	Corporate Risk Description:	There is a risk to the radiology service provision from breakdown of key radiology imaging equipment and associated infrastructure to enable equipment to function. This is caused by equipment not being replaced in line with RCR (Royal College of Radiologists) and other guidelines, and also lack of suitable physical space and electrical infrastructure. This could lead to an impact/affect on patient flows resulting from delays in diagnosis and treatments, delays in discharges, increased waiting times on cancer pathways, increased staffing costs to minimise the impact on patients when breakdowns occur and increased number of SCP breaches and breaches over 8 weeks due to increased downtime. Increased risk of IR(ME)R notifiable radiation incidents due to increased breakdowns as a result of malfunctions during exposures.
Does this risk link to any Directorate (operational) risks?			925, 114, 1668, 1785, 1706

Risk Rating:(Likelihood x Impact)		
Domain:	Service/Business interruption/disruption	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	4×4=16	
Target Risk Score (L x I):	2×4=8	
Expected Date To Achieve TRS:	30/08/2050	
Trend:		



Current Risk Score

Target Risk Score

Date	Current Risk Score	Target Risk Score
Sep-22	15	12
Mar-23	12	8
Sep-23	16	8
Dec-23	16	8
May-24	16	8
Aug-24	16	8
Dec-24	16	8
Apr-25	16	8
Jul-25	16	8

Rationale for CURRENT Risk Score:
The Health Board's aged imaging equipment continues to break down, disrupting diagnostic services and affecting Referral to Treatment (RTT) targets, with delays in diagnosis and treatment for patients. Replacement of CT and MRI scanners has reduced downtime, but recurrent failures of other key equipment highlight the need for further investment. A rolling programme and prioritisation process are in place to manage installations. The Gamma camera at WGH, the only unit of its kind in the Health Board, has suffered repeated breakdowns, leading to HIW reportable IRMER incidents. It remains a priority for replacement as of February 2025. At GGH, a new CT scanner has been installed, but the original unit continues to fail due to outdated technology, undermining resilience at the major trauma site. Like for like replacement is not always cost effective or compliant with regulatory and warranty requirements, and infrastructure upgrades such as air handling, water chillers, and accommodation adjustments are needed to ensure long-term resilience. Replacement of the Gamma camera at WGH has been delayed due to insufficient physical space and electrical infrastructure, with costs exceeding Welsh Government allocations for 2025/26. The funding window was closed, further impacting compliance with NRW specifications for Nuclear Medicine. Future plans must be coordinated with Estates to expand electrical capacity and ensure facilities meet current and future Nuclear Medicine requirements.

Rationale for TARGET Risk Score:
Modern equipment will reduce the likelihood of breakdowns, minimize downtime, and lessen the impact on diagnostic services across other hospital sites. Strengthened business continuity planning will further mitigate risks associated with equipment failure. However, funding is typically released in Q3/Q4 of the financial year, constraining the scheduling of large installations. The urgency of replacements often forces rapid decisions, resulting in lower priority equipment being replaced ahead of higher need installations. The Health Board's top replacement priority is the Nuclear Medicine SPECT scanner, the only unit available which has suffered frequent breakdowns since June 2023. A task and finish group has been convened to plan its replacement in anticipation of Welsh Government funding. The second CT scanner at GGH is the next priority, as it supports outpatient work and serves as a backup; it is increasingly unreliable, with long lead times for parts. Additionally, service variation in DEXA provision has worsened, as the Swansea scanner now performs Trabecular Bone Scoring (TBS), while the BGH scanner cannot. Patients have required repeat scans to obtain TBS results, and the BGH unit also runs on an unsupported Windows version, posing further risk. Replacement of the Nuclear Medicine SPECT CT, the second CT scanner at GGH, and the DEXA scanner at BGH would allow risks to be de-escalated to the operational risk register. Completion is dependent on WG funding and may extend to the end of the 2026-27 financial year due to infrastructure requirements.

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	By Who	By When	Progress
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Escalation process in place for service disruptions/breakdowns. # National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales. Replacement programme has been re-profiled by risk, usage and is influenced by service reports. # All equipment at main sites are now DR and are compliant with the RISP project	Limitation of spare parts for some older equipment leading to extended outages. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment. Inability to undertake specific replacements at this time due to the additional infrastructure within the locus of control required (insufficient physical space and electrical infrastructure leading to loss of funding due to lack of time/planning/resources to make necessary adaptations). Sites running with single points of failure. National Imaging and Capital Priorities Group outcomes do not always align with the Health Board priorities, and is subject to negotiations within the group.	Installation of replacement Gamma Camera, WGH Gamma camera is 9 years old and the only scanner in the Health Board providing a regional service. Recurrent breakdowns are resulting in HIW reportable incidents.	Roberts-Davies, Gail	31/07/2024 30/06/2025 31/03/2026 31/03/2027 31/03/2028	This will not be replaced in the 24/25 financial year. A specific T&F group is due to be set up as of June 24 to plan the necessary accommodation improvements required. July 2024 the T&F group has been set up and meets weekly Feb 2025 there is a draft plan for replacement. Business continuity plans being explored. The plan has been rejected by WAG for 25/26 due to cost and the electrical infrastructure. Resubmit for funding in 26/27. revised date extended further due to the infrastructure requirements for WGH. A paper of requirements and options is due to be taken to the ET in Sept 26.
		Replacement of aged CT Scanner at GGH	Procter, Sarah	31/03/2024 31/03/2027	The CT replacement of the aged at GGH has been recommended and is the highest priority for the health board. This was fed into the NIECP process - awaiting feedback from 27/28 funding.
		Replacement of Fluoroscopy room, WGH	Whitecross, Faith	Completed	Fluoroscopy room has been replaced.
		Replacement of CR X-Ray room, Llandovery Hospital	Osell, Fiona	Completed	CSP agreed closure of LDH - work ongoing to decide closure date. X-ray facility closed on 03/08/2026

	Replacement of Mammography Units, BGH and WGH	Roberts-Davies, Gail	31/03/2024 31/07/2024 30/06/2025 31/03/2027	Ageing equipment, exacerbated by the failure of Securview. These will not be replaced in the 23/24 financial year These will not be replaced in the 2024/2025 financial year These will not be replaced in the 2025/2026 financial year
	Upgrade or replacement of MRI scanner, GGH	Procter, Sarah	Completed	Replacement agreed and funding available for replacement in March 26
	To replace the DEXA scanner at BGH and ensuring suitable accommodation is found to meet regulatory compliance for a larger more modern scanner.	Edwards, David	Completed	Funding agreed by WG for replacement of gamma camera in 2026/27 March 2026 - Action complete
	Arrange meeting with head of capital planning and head of strategy and planning to discuss long term strategy for equipment replacements.	Procter, Sarah	Completed	meeting undertaken - business case for NM to be developed. Understanding of critical need.
	Meeting with head of capital planning to discuss plans for CT and NM replacement in near future.	Procter, Sarah	Completed	meeting has happened 23.1.26 - action develop business case in conjunction with capital planning and estates
	Business case to be developed for replacement of Gamma Camera - joint with capital planning team	Procter, Sarah	31/03/2026 31/09/2026	BC with capital/estates - met with ER and SBAR still in progress.
	Present Radiology Infrastructure SBAR to June CCG	Procter, Sarah	Completed	Presented at CCG IG June 2026. Can close.

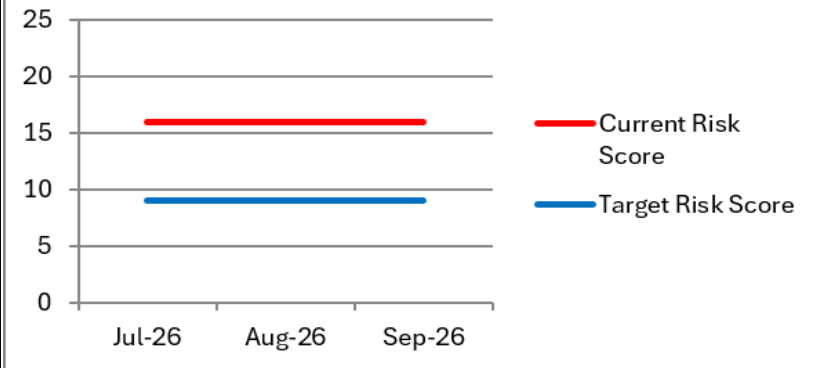
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed	By Who	By When	Progress
		(1st, 2nd, 3rd)	Current Level							
Reduction of waiting times to under 8 weeks. No SCP diagnostic breaches.	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team - Mar19 Further updates CEIMT Feb20 Further updates CEIMT Sep20 Radiology Diagnostic Imaging update to Capital Sub-Committee presented September 2024	Lack of process of formal post breakdown review.				
	IPAR report	2nd								

Date Risk Identified:	Jun-26
Strategic Objective:	2. Healthier Communities

Executive Director Owner:	Gjini, Ardiana	Date of Review:	Jul-26
Lead Committee:	Strategy and Planning Committee	Date of Next Review:	Aug-26

Risk ID:	2379	Corporate Risk Description:	There is a risk that Hywel Dda UHB is unable to effectively implement its Climate Adaptation Plan and meet Welsh Government Climate Change requirements. This is caused by a lack of resources and investment to deliver climate adaptation and sustainability requirements. This could lead to an impact/affect on compliance with Welsh Government climate adaptation requirements and failure to meet statutory Climate Change reporting obligations, and a failure to manage climate-related risks to patients, staff, services and infrastructure.
Does this risk link to any Directorate (operational) risks?			1544

Risk Rating:(Likelihood x Impact)		
Domain:	Statutory duty/inspections	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	4×4=16	
Target Risk Score (L x I):	3×3=9	
Expected Date To Achieve TRS:	31/03/2030	
Trend:		



Current Risk Score

Target Risk Score

Date	Current Risk Score	Target Risk Score
Jul-26	16	9
Aug-26	16	9
Sep-26	16	9

Rationale for CURRENT Risk Score:
While key strategic plans and national policy alignment are in place, there are significant gaps in leadership, coordination, resourcing and governance. These gaps reduce the effectiveness of existing controls and increase the likelihood of the risk materialising. Given the scale of climate-related risks to service delivery, patient safety and infrastructure, the consequence remains high (impact score 4). However, existing plans, partnerships and baseline activity provide some mitigation, reducing likelihood from very high (5) to high (4).

Rationale for TARGET Risk Score:
Following establishment of clear leadership, strengthened governance, dedicated resourcing, and full integration of climate adaptation into planning cycles, risk registers, and operational planning, the likelihood of the risk materialising will reduce to moderate. Impact will also be reduced through improved preparedness, resilience measures, and proactive service adaptation. Residual risk will remain due to external climate pressures and system constraints.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
Board-approved Climate Adaptation Plan (March 2026) providing strategic direction and governance framework
Establishment of Climate Adaptation Steering Group to provide oversight and coordination
Alignment with Welsh Government Climate Adaptation Strategy and WHC/2025/005 requirements
Existing Decarbonisation Programme (46 initiatives) embedded within business-as-usual delivery

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	By Who	By When	Progress
	Further action necessary to address the controls gaps			
Lack of resource with specific knowledge and expertise to provide leadership and coordination across the Health Board.	Dedicate resources to coordinate and assess the sustainability agenda and identify requirements for the ongoing future management of the portfolio across the Health Board.	Hussell, Sam	31/03/2027	Band 7 post temporarily aligned to agenda to commence coordination and assessment process.
Insufficient specialist knowledge and skills to inform climate adaptation actions across clinical and corporate services.	Scope and align with national training and upskilling opportunities for delivery across the Health Board.	Hussell, Sam	31/12/2026	Progress update to be provided at next risk review
Climate adaptation not consistently embedded within planning cycles and	Develop and implement Climate Adaptation workplan aligned to priority risks.	Hussell, Sam	31/10/2026	Progress update to be provided at next risk review

CORPORATE RISK REGISTER SUMMARY SEPTEMBER 2026

Participation in national climate change networks and Community of Experts groups Multi-agency severe weather and resilience plans via Dyfed-Powys LRF Existing business continuity, emergency preparedness and severe weather arrangements Estates and infrastructure risk management processes (backlog maintenance, capital programmes) Initial organisation-wide Climate Change Risk Assessment informing priority risks and actions	service planning.	Develop a process through the Climate Adaptation Steering Group for embedding climate risk into planning cycles, planning, service plans and risk registers across the Health Board.	Hussell, Sam	31/12/2026	Progress update to be provided at next risk review
	Adaptation measures not fully integrated into business continuity and critical infrastructure resilience planning.	Further integrate climate adaptation into BCP by adding specific climate adaptation references to HB BCP templates.	Hussell, Sam	30/09/2026	Progress update to be provided at next risk review
	Limited capital and revenue allocation to support adaptation priorities and mitigate identified risks.	Within a complete BC cycle, ensure all plans have considered and referenced specific climate adaptation mitigations and contingencies linked to their critical functions.	Conroy, Claire	31/03/2029	Progress update to be provided at next risk review
	Absence of defined metrics, thresholds and monitoring mechanisms for climate risk and adaptation effectiveness.	Explore and scope anticipated financial support required to delivery climate adaptation through the Climate Adaptation Steering Group workplan.	Hussell, Sam	31/12/2028	Progress update to be provided at next risk review
		Explore development of metrics, thresholds and monitoring mechanisms for climate risk and adaptation effectiveness.	Hussell, Sam	31/03/2027	Progress update to be provided at next risk review

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance	Required Assurance 			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed	By Who	By When	Progress
		(1st, 2nd, 3rd)	Current Level				Further action necessary to address the gaps			
	Programme and delivery reports	1st			Climate Adaption paper to FET Feb 2026					
	Sustainability Report section of the Annual Report	1st			Climate Adaption Plan paper to SPC Feb 2026 Climate Adaptation Plan paper to Board March 2026 Sustainability Report section of Annual Report to SPC June 2026					

Date Risk Identified:	Apr-24
Strategic Objective:	1. Thriving Teams and 3. Great Care

Executive Director Owner:	Gostling, Lisa	Date of Review:	Aug-26
Lead Committee:	People, Organisational Development and Culture Committee	Date of Next Review:	Sep-26

Risk ID:	1978	Corporate Risk Description:	There is a risk there will be insufficient skilled workforce within each of our professional groups (Specialist Nursing, Medical, Allied Health Professionals & Health Science (AHP&HS), Pharmacists and Dental). This is caused by by our ability to attract, retain and maintain participation alongside development in the workforce required to deliver our Annual Plan, which is further exacerbated by the Health Board's constrained financial envelope. This could lead to an impact/affect on the quality of care provided to patients, delays in care and poorer patient outcomes and experience. In addition, this may lead to the inability to meet statutory and professional requirements in terms of safe staffing levels that are needed to deliver quality patient care.
Does this risk link to any Directorate (operational) risks?			1186

Risk Rating:(Likelihood x Impact)	
Domain:	Workforce/OD
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×4=12
Expected Date To Achieve TRS:	31/03/2027
Trend:	

Date	Current Risk Score	Target Risk Score
Dec-24	16	12
Feb-25	16	12
May-25	12	12
Jul-25	16	12
Sep-25	16	12
Nov-25	16	12
Jan-26	16	12
Mar-26	16	12
May-26	16	12
Jul-26	16	12
Sep-26	16	12

Rationale for CURRENT Risk Score:
Staff sickness rates are fluctuating (reducing and increasing in different spaces) and our establishment levels are increasing. The use of contingent workforce is also fluctuating and plans i.e. agency and variable pay spend has reduced significantly over the last 12 months. Further work has been undertaken to understand the level of risk across each staff group (Nursing, Medical, Allied Health Professions and Health Care Support Workers) to comprehend the level of risk by each group. It is hoped, as further action is taken through stabilisation programmes, the Clinical Services Plan (operational and strategic workforce planning) and Improving Together, we will be able to reduce the risk score during 2026/27.

Rationale for TARGET Risk Score:
The TRS reflects a reduction in the likelihood & impact of the risk occurring. Other intelligence leads the Health Board to be alert to workforce issues as evidence suggests that patient acuity is increasing and therefore workforce requirements will increase by proxy until new models/methods to reduce or manage complexity can be identified. There could be concerns for the specific services and/or the annual risk based on season variation when at full capacity for recovery/ministerial priorities as we have a "finite" resource in our people that can only be stretched so far without causing detriment. Therefore, the probability sits between 75-90% when taking account of these factors. We hope we will be able to take mitigated actions through our interventions under the Regeneration Framework in the short term and, for the medium term begin to realign available workforce to new service design and models of care. This risk is wider than a 12-month period as actions taken or not taken today will have a long-term legacy on our available future workforce and capacity/capability to manage the associated challenges of service and workforce redesign. Taking account of our rurality, demographics and population health, a score of 12 is achievable within constraints identified.

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	By Who	By When	Progress
Organisational Governance Structure Improving Together approach to escalation and recovery Organisational Gap Analysis based on a 10 year profile developed and annual assessment strategic & operational review of workforce (including Education Commissioning Assessment) Joint Planning Goals Establishment Control Tool Rostering, agency use and variable pay approval process in place with mechanism for oversight Bank utilisation & ongoing onboarding of supply Overview of organisation and service wide risks (assessment of each service area based on workforce availability) WOD Policy framework in place overseen by PODCC Targeted prioritisation of recruitment/onboarding of new employees to the highest areas of risk in terms of maintaining service delivery (Strategic, People Planning & Education Group) Our Performance Dashboard covers vacancy, turnover, sickness Medical Workforce Planning and related subgroups i.e. Medical retention, MAPS etc provides oversight and implementation programmes for medical staffing Annual completion and submission of Education Commissioning Plan to HEIW and critical assessment to known service level plans Corporate Risks have been developed linked to Wellbeing as part of Risk Management approach.	Digital infrastructure currently not in place to support the short, medium and long term analysis and modelling for workforce and triangulation of data sources to develop coherent scenario plans based on available evidence. Improvements required to ensure efficient rostering is in place across the Health Board Pace and breadth of change can be constrained by resource availability to deliver Organisational Gap Analysis will need to be updated following CSP decision-making in February 2026 Review effectiveness of establishment control approach	Develop a workforce plan for Annual Plan by Professional Groups & agree via SPPEG (Ensure critical gaps are identified, supply route implementation plan and mitigations in place)	Walmsley, Tracy	31/12/2026	Workforce Plan ; Workshop for MDT/Professional leads review May 2026; Position Paper with SPPEG (Aug 26) Detailed plan to be developed for SPPEG for critical risks (in year only) (Work ongoing from 2025/26 Operational Workforce Plans) Consolidated paper required; CSP prioritised due to capacity of team diverting energy from normal programme of work)
		Understand the gap for workforce in CSP and develop a workforce plan by Professional Groups & agree via SPPEG	Walmsley, Tracy	31/03/2027	CSP Workforce Assessments in development; Workforce now added to Project Implementation Group. Risks in capacity flagged via Project Support Group; Operational/Corporate Risk being considered.
		Ensure scrutiny of Nursing Rostering Principles and Practice through appropriate forums (Communicate/Train, Assess/Audit as required) Identify improvement required and monitor	Cole-Williams, Janice	31/12/2026	Value & Sustainability workstream has oversight currently; New workforce improvement programmes being developed.
		Pilot Orgvue and feed learning into New Workforce Solution. Assess plan for development/purchase of new tool for workforce planning; link to NEW Workforce Solution	Walmsley, Tracy	31/03/2027	Org Vue/Health Dynamics commissioned. Outputs to be aligned to March 2027(Issue: IG to resolve)
		Establish Improvement Programmes across 6 themed programmes of work (note details below) Absence Grip & Control; Band 7-9 Workforce Analysis, A&C workforce deployment, Variable Pay, Establishment Control and Organisational Change Processes.	Gostling, Lisa	30/09/2026	Set up working groups programmes for 6 themed workforce improvement programmes; programmes will be managed through agreed governance structures

SPPEG (Strategic People Planning & Education Group) 3 Retention Groups for Nursing, Medical, AHP and HCSA From April 2025, new operational governance structure (phase 1) implemented allowing clinical care groups to escalate concerns Cultural Workforce & Experience Team supporting CCGs to focus on 3 key actions to respond the staff survey results		Develop a mechanism to ensure all work programmes feed into the Annual Workforce Planning process and benefits realisation is monitored against Risk 1978 to assess/amend risk score	Walmsley, Tracy	31/10/2026	Programmes in development and benefits/outcomes being worked through; to be aligned and incorporated to overarching workforce plan and scenario modelling.
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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
	Monitoring of workforce SIP and gaps in establishment control	1st			SPPEG June & August 2026	Maturity of workforce planning (Operational & Strategic) & National Alignment/ Third Party Assurance	Governance Review to be completed and presented to SPPEG and then a future PODCC	Walmsley, Tracy	30/11/2026	Review underway
	Risk management approach to Workforce themed Risks	1st					Assess maturity of workforce plans. Identify concerns and seek remedy (operational)	Walmsley, Tracy	31/10/2026	Maturity Matrix developed; Process to work with Service/CCG to be established
	Strategic People Planning & Education Group (Risk Supply Pipelines & Development mechanisms impact) & related sub groups	1st					Assess maturity of workforce plans. Identify concerns and seek remedy (Strategic)	Walmsley, Tracy	31/10/2026	Maturity Matrix developed; Process to work with CCGs to be established.
	People Professionals Planning Forum (oversight of education commissioning) and People Profession Plans (reports to SPPEG)	2nd					Assess maturity of workforce plans. Identify concerns and seek remedy (National)	Walmsley, Tracy	31/12/2026	Maturity Matrix developed; Assess national misalignment i.e. nurse streamlining and suggest remedy. Use MM to illustrate national issue. Meeting planned with HEIW re Matrix Tool and testing of scenario with practical application to HB and wider.

Workforce levels monitored at Service Level, Professional Groups and Operational Delivery Group & Improving Together meetings	2nd								
PODCC - IMTP Plan, and process mapped through Planning Steering Group	2nd								
Workforce Planning Internal Audit (Substantial Assurance) April 2022	3rd								
Wales Audit Office review of Workforce Planning (report - Summer 2023)	3rd								

Date Risk Identified:	Nov-22
Strategic Objective:	1. Thriving Teams and 3. Great Care

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-26
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-26

Risk ID:	1531	Corporate Risk Description:	There is a risk of being unable to provide a safe and sustainable general surgery consultant on-call rota at WGH and GGH. This is caused by Unsustainable and fragile rotas, with a difficulty to recruit into substantive posts. This could lead to an impact/affect on on the ability to provide an emergency general surgery service at WGH and GGH affecting patient experience, causing clinical delays and poor outcomes for patients. The wellbeing of remaining consultants who are already working to full capacity are also affected and there is an increased expenditure on agency locum consultants and internal locum rates at the HB card rate. Consultants working additional on call locum weeks is resulting in a reduction in elective activity in OPD, endoscopy and theatre. This could have a negative impact on RTT and SCP targets.
Does this risk link to any Directorate (operational) risks?			2067

Risk Rating:(Likelihood x Impact)		Legend: Current Risk Score (red line), Target Risk Score (blue line)
Domain:	Safety - Patient, Staff or Public	
Inherent Risk Score (L x I):	4×5=20	
Current Risk Score (L x I):	3×5=15	
Target Risk Score (L x I):	1×5=5	
Expected Date To Achieve TRS:	01/05/2027	
Trend:		↔

Rationale for CURRENT Risk Score:
A substantive Upper GI Consultant has been successfully recruited following the departure of the Medacs agency locum consultant at Withybush General Hospital (WGH). Following five unsuccessful recruitment campaigns for a second Upper GI Consultant at WGH, a decision has been taken to advertise the post at Glangwili General Hospital (GGH) while maintaining the current WGH rota arrangements. The job description and advert are currently being updated, and the post is scheduled to be advertised in July.

Rationale for TARGET Risk Score:
Achievement of the target risk score is dependant on the successful appointment of substantive upper GI consultant along with the work currently being undertaken following the outcome of the Clinical Services Plan which would involve the amalgamation of the surgical on-call rotas and Emergency General Surgery being moved from WGH to GGH. The effectiveness of revised rota arrangements will depend on several factors including availability of a labour market.

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	By Who	By When	Progress
Rotas monitored daily by the service delivery team. The WGH rota is a 1:4 frequency with 3 substantive consultants and 1 NHS locum consultant. The GGH rota is a 1:8 frequency with 1 gap on the on-call rota, due to health reasons. This gap is being covered by internal locum at the HB card rate. The rota consists of 4 substantive consultants and 3 NHS locum consultants. There is a plan to replace one of the NHS locum colorectal consultants with a substantive consultant. This will be going out to advert and the interview dates 19th May 2026, interviews will be taking place via an ACC panel on Tuesday 14th July. A substantive upper GI consultant post is currently out to advert, which will replace the NHS locum. The AAC is planned for April 2026. These are dual location posts between GGH and WGH, and they participate in the on-call rota at WGH. The interviews were arranged for the 1st May and the candidate did not attend the interview. As this was the 5th time the post was advertised a decision has been made via the CCG to advertise the post as with the on call being undertaken at GGH and the elective work at WGH. The 1:4 rota in WGH will remain the same and an extension to the locum consultants in line with EGS CSP work. Â Â When there is sickness or unexpected leave, due to emergency circumstances, the following process is followed by the management team to cover the on-call: 1. Internal Additional Hours (ADH) on the site with the gap. 2. Internal ADH from the other sites across the health board. 3. In the event of steps 1 & 2 being unsuccessful, the service would escalate for agreement on transferring the surgical out of hours on call take to another site. (WGH to GGH) 4. Ensuring that all stakeholders are aware, including site teams, medical teams, WAST, any supporting services as appropriate. Â Proactive sickness management Escalation to clinical leads	All posts are yet to be filled substantively. The Consultants at GGH also provide the support to the junior and SAS level doctors at PPH for the elective pathway. There is a part time rota co-ordinator in WGH covering maternity leave. This post is shared between surgery and T&O. The rest of the work is being undertaken by the service team which has had a detrimental impact on their workload. There is a risk of consultants requesting rates that are higher than the HB card rate, going forward as they have been covering multiple gaps on the rota for a prolonged time.	Review the longer term sustainability of general surgery on-call rotas across Hywel dda (recommendation from Getting it Right First Time (GIRFT) review in Jan23)	Lewis, Caroline	Completed	The senior consultant leads for general surgery have suggested that the WGH and GGH on call rotas are amalgamated to one site. This would provide an increase of consultants on the rota to either a 1:10 (the 3 WGH consultants and the 7 GGH consultants) or a 1:12 (the 3 WGH consultants, 7 GGH consultants and 2 newly recruited posts). This recommendation is in line with the GIRFT report. SBAR's have been drafted by the service to describe the fragility of the rotas.
		To develop an options appraisal paper with all relevant stakeholders, including WAST, Primary Care, and site teams	Hire, Stephanie	Completed	A discussion was due to be held live at the health board planning session on 09/1/25, this did not take place due to the clinical lead and clinical director not being able to attend. The EGS situation is regularly reviewed and appropriate action is taken by the service as and when required. It also forms part of the fragile services, which is discussed at escalation. We are awaiting confirmation as to when or if the stakeholder discussion will take place. Following the executive meeting on 12/03/2025 and the agreement to recruit substantive consultants into the gaps on the rotas, this options appraisal paper is no longer required. This will need to be reviewed, if the service is unable to recruit suitable candidates.

On appointment, new consultants undertake an induction with Hospital Director at WGH and Clinical Director for Scheduled Care. SOP in place for the transfer and repatriation of patients Engagement with the CSP programme. A decision has been made through the CSP programme, but there is currently no timescale confirmed for this.		To hold interviews to appoint NHS locum consultant	Lewis, David	Completed	Job descriptions have been sent for Royal College approval in April 2025.
		To agree job descriptions and advertise for three substantive consultant posts	Lewis, David	Completed	The two substantive upper GI consultant posts have been advertised and shortlisting is currently being undertaken. If there are suitable candidates, interviews will take place on 2nd September. The substantive lower GI consultant post will be advertised in Spring 2026, in readiness for the end date of the NHS locum that has been appointed.
		Successfully recruit 2 x substantive upper GI consultants.	Jones, Sara	30/09/2025 01/09/2026	1 consultant started in post on 27th January 2026. The second post will be going out to advert in August 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
	WGH Medical Staff Committee established to develop models of sustainability	1st			Management team have presented an SBAR to Acute Leadership Group (Feb23, Sep 24, Oct 24) SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23) General Surgery Report to Board (Mar23)	Assurance to Board on communication and repatriation arrangements				

Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd			Management team to present updated SBAR to Acute Leadership Group (Oct23 & Nov23)				
				Management team to present updated SBAR to Corporate Directorate Group (Apr24)				
				Upper GI service SBAR presented at ALG (Sep24)				
Reported to bi-monthly Scheduled Care Quality, Safety and Experience Group through exception reporting	2nd			Upper GI service SBAR presented at Quality, Safety and Experience committee Meeting (Oct24)				
				Updated SBAR to Executive Team (Nov24)				
Assurance to be reported to the Board following introduction of temporary rota	2nd			Options Appraisal via CSP to Board (Nov 24)				
				Upper GI service SBAR presented at scheduled care directorate QSEAC (Jan25)				
				CSP Public				

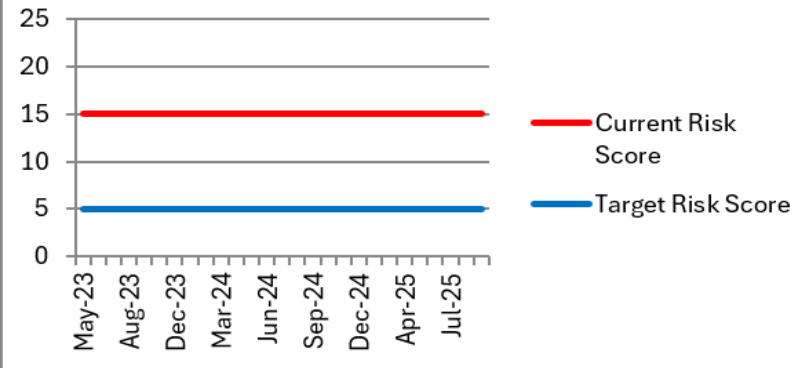
	GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited				Board (18/02/2026)							
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Date Risk Identified:	Oct-19
Strategic Objective:	3. Great Care

Executive Director Owner:	Severs, James	Date of Review:	Aug-26
Lead Committee:	Health and Safety Committee	Date of Next Review:	Sep-26

Risk ID:	813	Corporate Risk Description:	There is a risk of failing to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO). This is caused by 1: The age, condition and scale of physical backlog, circa £20m (+) relating to fire safety (i.e. non compliant fire doors, compartmentation defects and general fire safety management issues) across our estate significantly affects our ability to comply with the requirements of the RRO in every respect. 2:Difficulties managing the quantity of actions within the current fire safety risk assessment system (Boris) - assigned to responsible persons and action approvers. 3: Management responsibilities for fire safety not fully understood by all responsible managers. 4: Fire safety training attendance figures are not reaching HB agreed targets. This could lead to an impact/affect on the safety of patients, staff and general public, HSE investigations and further fire brigade enforcement (already served on Witybush and Glangwili General Hospitals and recently at Cwm Seren MH Facility), fines and/or custodial sentences, adverse publicity/reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?			1965, 1934, 1096, 951, 2085, 1040, 2062, 2042, 1929, 1596, 1539

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Expected Date To Achieve TRS:	31/08/2029
Trend:	



Date	Current Risk Score	Target Risk Score
May-23	15	5
Aug-23	15	5
Dec-23	15	5
Mar-24	15	5
Jun-24	15	5
Sep-24	15	5
Dec-24	15	5
Apr-25	15	5
Jul-25	15	5

Rationale for CURRENT Risk Score:
Phased fire safety improvement works are ongoing across our sites, with significant investments being made to address the recommendations in the Mid and West Wales Fire & Rescue Service (MWWFRS) letters and Enforcement Notices (EN).
All programme dates have been agreed with the Health Board, Welsh Government and MWWFRS senior inspecting officers. The progress of completed actions is regularly reviewed to determine the risk score as these works are progressed. Extensions of time particularly for EN schemes have been fully agreed by MWWFRS. A reduced scope of works has been agreed for Withybush General Hospital (WGH) and Glangwili General Hospital (GGH) Phase 2 on achievement of the following:
Fire alarm systems to L1 standard (achieved).
Health Board to achieve and maintain an 85% target for combined Fire Safety Training - MWWFRS have mandated that this must be achieved by 31/03/26, however the HB has not met this requirement. It has been escalated to the HB to address.
Night fire wardens are in place (WGH and GGH). Bronglais General Hospital (BGH) will also be in post by 1st Sept 26.
The BORIS software system has been implemented, and all fire risk assessments have been transferred across. Papers are submitted to the estates CCG meetings providing a high-level summary of the Estates and Hospital Management Risks. Currently, the risk is felt to still be extreme until further progress is made on the above fire safety improvement works.

Rationale for TARGET Risk Score:
Further improvements in culture and ownership for fire safety. It is the scale of physical backlog for fire safety compliance (additional surveys) that will remain until appropriate measures are put in place to address the deficit.
Despite annual investment from statutory capital and additional funding from EFAB/Tef for fire safety components, the scale of current investment is clearly not adequate to address the true scale of backlog the UHB has.
Based on the planned works for completion (November 2025), it is expected that the current risk score could be reduced, this will need to be assesses in relation to the governance challenges we also experience currently.
It is anticipated that when training attendance levels specifically for L2 training have reached > 85% targets and are sustained at this level continuously, coupled with the completion of all major fire enforcement schemes. The HB will then be in an informed position to look at the further reduction of risk score. The currently predicted expected date to achieve compliance across all areas is August 2029.This will be reviewed regularly inline with progress made to our infrastructure and obtaining appropriate levels of assurances that clearly evidence the HB has effective fire safety management arrangements in place.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
Pre Planned Maintenance (PPM) checks are carried out across the UHB on fire safety components.
A detailed physical estates backlog system is in place that identifies the scale (£) and risk of backlog for UHB. Data used to manage backlog maintenance & statutory decision making also regularly reported to WG.
Extensive fire safety improvement works are being undertaken at WBH, GGH, BGH and Cwm Seren (following fire enforcements notices served on the HB) from WG agreed funding. All phased timelines fully agreed with MWWFRS. Regular communications and dialogue is taking place between HB and MWWFRS.
Individual Fire Risk Assessments (FRA's) in place for all sites across the UHB identifying fire related risks. Boris fire safety system implemented

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	By Who	By When	Progress	
	Further action necessary to address the controls gaps				
Despite significant investments already in place following enforcement notices and letters of fire safety matters, additional investment is required to address fire safety defects at other sites within the UHB, which are being inspected by MWWFRS. We have firm plans in place to address a range of fire safety projects over the coming years and these are all fully identified as actions within this risk with anticipated timelines.	WBH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	30/04/2025 30/04/2025 31/07/2027	Full agreement has now been reached with Welsh Government (WG)/NHS Wales Shared Services Partnership - Special Estates Services (NWSSP-SES) to change the procurement approach for Phase 2. This following a wide-ranging lessons learned exercise undertaken jointly with NWSSP-SES. Start date Sept 2024 completion mid 2027. Will be regularly reviewed.	
Not all managers who are assigned actions on Boris are regularly					

across the UHB, giving the ability to review all risks from fire risk assessments via a dashboard and risk ownership. Training Needs Analysis (TNA) for fire safety training in place, as defined in Fire Policy. UHB has implemented new governance structure for fire safety reporting from FSG to Estates care groups. Estate plans with fire zones, fire doors, fire compartmentation, fire infrastructure items (alarm and detection system). UHB assesses its performance in respect of operational maintenance work carried out on fire safety components and presents this information as a formal paper at all UHB wide fire safety tech meetings. Annual prioritisation of investment against high risk backlog. The HB has now embedded a fully resourced fire safety management team, with appropriate reporting arrangements for fire safety training and maintaining fire risk assessments across the UHB. The UHB has improved fire safety management culture and management ownership for fire safety, through the implementation of Level 5 management training for staff above 8b grades. The fire team also issue a regular training global e-mail as a reminder for staff on when and how to book a session. Works already completed following issue of Enforcement Notices and LoFSM at various sites. For EN sites (p1 WBH and p2 GGH) - Advanced Works and Phase 1 works now completed. Also improvements carried out under LoFSM at Tregaron, Bronglais, Glangwili and Withybush Hospitals. Level 1 & 2 Fire Safety training is delivered via Teams. Level 3 Fire Safety training is provided face to face. Level 4 training (Fire Safety Warden training) is also a face to face session, with an external trainer. Level 5 training is provided on Teams as part of the H&S Managers induction	accessing the system to close off their actions. Despite recent invitations for staff to attend training sessions. Fire safety training performance (for L2) is currently below the agreed level at (85%) as set by MWWFRS for the HB but specifically for WBH and GGH (sites under enforcement). The Fire Safety Team with L&D staff have introduced new training material to offer a more interactive e-learning experience with questions for each section. Performance is being regularly reviewed. As such the HB's fire policy now needs to be re-drafted. Despite making improvements to the culture of fire safety management and ownership, the HB does need to ensure this is organisational wide and embedded within it's workforce and cascaded by management. A revised list of Named Responsible Persons for each site is needed to ensure the responsibilities for fire safety is fully understood. Improvements to fire safety governance has recently been introduced, there is a new chair person nominated for the fire safety group and membership has been altered. The FSG now reports to the Estates Governance Care Group. However, the performance reporting metrics have yet to be agreed.	GGH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	30/04/2024 30/08/2024 30/06/2025 30/11/2027	Full agreement has now been reached with Welsh Government (WG)/NHS Wales Shared Services Partnership - Special Estates Services (NWSSP-SES) to change the procurement approach for Phase 2. This following a wide-ranging lessons learned exercise undertaken jointly with NWSSP-SES.
		Completion of planned fire safety enforcement work at Cwm Seren MH Facility in Carmarthen, following enforcement notice.	Evans, Paul	Completed	works complete
		As a fire safety policy requirement, the HB is expected to have a record of all responsible persons for each premises, to ensure that legal fire safety responsibilities are understood and acknowledged. This must also include premises where the HB is not the landlord but may occupy the premises for HB use.	Jupp, Richard	Completed	Existing list will be issued to FSG for ownership and updating by the agreed date. Still awaiting some final names to complete the list. extension required due to resource pressures in fire team.
		To develop an initial fire safety strategy detailing specific arrangements and headings, which supports our agreed HB wide fire safety policy. To assess and measure our ability to demonstrate effectiveness of each element of the strategy and any potential gaps/timelines to address any shortcomings.	Jupp, Richard	Completed	Document template now complete, we are now populating the date of completion for each step of the process.

training. There is an improving performance in terms of uptake of training (except for L2). Regular communications processes in place to advertise L2 fire safety training. Papers are submitted to the estates CCG meetings providing a high level summary of the Estates and Hospital Management Risks.	Improvements to our fire strategy drawings is required to correctly identify fire compartmentation and fire door locations to inform maintenance teams. This will also require additional external surveys to be carried out and additional capital to fund these surveys.	To amend the existing Fire Safety Policy noting the revised governance changes and updates now required to the training needs analysis. The timeline given is specifically for documentation change and not HB approval. An additional action will be added once the document is ready for board approval.	Jupp, Richard	Completed	extension of time approved by HSCG due to fire resource pressures at senior level.
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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	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed	By Who	By When	Progress
		(1st, 2nd, 3rd)	Current Level							
Maintain a zero or as low as possible number of outstanding fire risk assessments. Monitor the number of risks now held in the new Boris Fire Safety System.	Bimonthly review of outstanding actions from fire risk assessments	1st			Fire safety performance reports now submitted to monthly Estates Governance Care Group for review. SBAR submitted to each HSAC meeting, which includes themes of all fire safety risks. Boris Fire Safety System (UPDATE) and Fire Training Performance SBAR's submitted HSC.	General site management checks/walkaro unds on all sites				
	Site Fire wardens reporting fire safety issues	1st								
	Annual Online Fire Audit Self-Assessment submitted to NWSSP	1st								
	Review of compliance through fire safety groups	2nd								
	4 Fire Safety Sub Groups (one at each site) which report into the UHB wide Fire Safety Group (reporting into the HSC)	2nd								
	Fire Safety SBAR (3A's) reports regularly issued to HSSC and estates governance care groups	2nd								
	Fire inspections by Fire Service & Fire Improvement Notices	3rd								

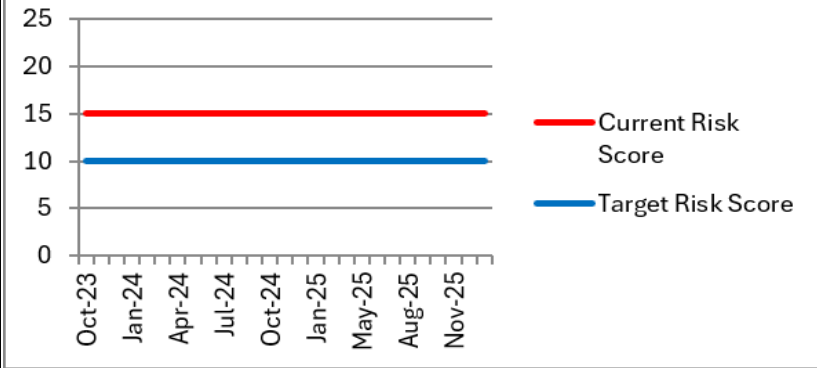
NWSSP fire advisor inspections	3rd								
High level action plan meetings with MWWFRS with very positive comments received from then on our commitment to improve fire safety performance in relation to the EN schemes in place.	2nd								

Date Risk Identified:	Aug-23
Strategic Objective:	3. Great Care

Executive Director Owner:	Severs, James	Date of Review:	Aug-26
Lead Committee:	Health and Safety Committee	Date of Next Review:	Sep-26

Risk ID:	1745	Corporate Risk Description:	There is a risk of not being able to deliver safe, effective and timely services across the HB estate, including acute, community and mental health facilities. This risk also impacts the HB's non clinical estate, educational facilities and managed practices. This is caused by further deterioration of our aging buildings and infrastructure with significant amount of the estate beyond its life expectancy. Multiple points of failure, delays in addressing reported defects and limited capital to address the increasing backlog of estate environmental issues. This could lead to an impact/affect on patient experience, our ability to deliver care in line with expected standards resulting in increased scrutiny and critical reports from auditors, regulators and inspectorates, such as HIW and HSE, and decreased public confidence and perception of our services, facilities and estate environment. Impacts also include increasing revenue costs to supplement the lack of capital funding available required to react to emerging issues, ability to comply with the Health and Safety at Work Act, including other legal regulations and engineering guidance documents such as Welsh Health Technical Memorandums (WHTMS).
Does this risk link to any Directorate (operational) risks?			1795,33,39, 838

Risk Rating:(Likelihood x Impact)		
Domain:	Safety - Patient, Staff or Public	
Inherent Risk Score (L x I):	4×5=20	
Current Risk Score (L x I):	3×5=15	
Target Risk Score (L x I):	2×5=10	
Expected Date To Achieve TRS:	31/08/2032	
Trend:		



Date	Current Risk Score	Target Risk Score
Oct-23	15	10
Jan-24	15	10
Apr-24	15	10
Jul-24	15	10
Oct-24	15	10
Jan-25	15	10
May-25	15	10
Aug-25	15	10
Nov-25	15	10

Rationale for CURRENT Risk Score:
The current risk score is based upon the level of detailed information the Estates department has for its buildings, plant and infrastructure, including external reports, risk information and Estates and Facilities Performance Management System (EFPMS) data submitted to Welsh Government (WG), clearly articulating the scale of backlog and deficiencies across the Health Board. The Programme Business Case (PBC) has been under development with WG since 2018/19. The score also reflects lack of capital support (noting this project dates back to 2018); the Health Board has therefore changed the approach entirely and have worked since October 2024 in a partnership arrangement with NWSSP-SES to jointly develop an estates priority and risk consequence paper written as far as possible with clearly understood language. This document explains in great clarity what the potential implication could be if a specific infrastructure item was to fail. This narrative was jointly supported by Estates and NWSSP-SES engineers. The Health Board undertook workshops directly with NWSSP-SES in August 2025 to determine the preferred options, accounting for risk mitigation, technical implications, deliverability and cost. The Health Board are engaging with WG directly to secure the resources to progress these works via the appropriate business process. On a positive note, this project is one of the supported priority projects by WG for investment in Health Board estate.

Rationale for TARGET Risk Score:
Backlog figures and risks are being reviewed regularly in order to inform the current risk score, and to determine any future risk reductions. The currently predicted expected date to achieve improved compliance is 2032. The achievement is directly linked to the amount of funding the Health Board (HB) will receive to address the current issues faced across the organisation and our ability to successfully deliver these improvements to reduce risk over time. This will be reviewed regularly as schemes progress.

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	By Who	By When	Progress
Planned and Preventative Maintenance regimes CAFM system to report and prioritise breakdowns across site. Questionnaires have now been included in CAFM, to measure the performance of our maintenance service. Also to feedback any suggestions on improvements. Condition appraisals (estate survey) and NWSSP-SES audits Backlog database identifies costs of works across the estate Operational Estates staff on site to deal with breakdowns (on-call 24/7) Tef funding bids have been successful to support DCP (25/26 investment of circa £6.347m including HB's 30% contribution) Tef project group established to deliver this investment. Risks are identified by Estates and services and these inform prioritisation of DCP funding Skilled and trained Estates workforce in place. Site walkarounds in place across the 4 sites.	Limited Discretionary Capital Programme (DCP) funding to address the £250m backlog	Development of Major infrastructure Programme for 4 main hospitals and securing external funding	Chiffi, Simon	Completed	The HB are now undertaking workshops directly with NWSSP-SES to determine the preferred options, accounting for risk mitigation, technical implications, deliverability and cost. This exercise is due for completion August 2025. At this point we will be engaging with WG directly to secure the resources to progress these works via the appropriate business process. On a positive note this project is one of the supported priority project by WG for investment in HB estate.
	WG support for the Major Infrastructure Programme has not been confirmed				
	Statutory, mandatory and essential maintenance jobs are prioritised over routine helpdesk jobs (on average only 50% of helpdesk jobs are completed)				
	Reduction in annual capital funding and statutory allocations to address key items.				
	Increased backlog of circa £250m+	AHMWW PBC submitted to WG in February 2022 remains not endorsed. Agreement required with Welsh Government on next steps and broader strategic direction.	Davies, Lee	10/10/2025 31/03/2026	The Health Board has had further constructive discussions with Welsh Government on the infrastructure challenges facing the organisation, in particular at the Withybush and Glangwili sites. Welsh Government (WG) has recently requested the Health Board produce, by early in the New Year, an addendum to the Programme Business Case (PBC) submitted in February 2022. This is a significant piece of work, which is currently being scoped, but at this stage the intention is to present this to Public Board in January 2026
	Operational resource pressures across the acute sites.				
	Increasing number of maintenance checks, specifically in relation to fire compliance.				
		the re-introduction of regular (documented) site walkabouts by operational estates and general hospital management. To potentially identify and target defects or site issues that can potentially be quickly addressed, minimising the impact of compounding backlog issues across our sites.	Day, Simon	Completed	Walkabouts are in place

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
Backlog figures Number of failures Cost increases due to inflation Number of call- outs	Regular review of 'environment' themed risks identified on operational service risk registers	1st								
	Feedback questionnaire on CAFM maintenance system to measure effectiveness of maintenance service and to offer additional feedback or suggestions on all closed maintenance requests	1st								
	Health and Safety Committee review of risks above tolerance	2nd								
	Independent Member & Executive Director Walkabouts	2nd								
	External surveys are undertaken, including Authorised Engineers Audits across each engineering discipline in line with Welsh Health Technical Memorandums (WHTMs)	3rd								
	NWSSP-SES Internal Audit on Estates Condition October 2024 (Limited Assurance)	3rd								
	Receipt of WHTM audit reports from NWSSP	3rd								

Date Risk Identified:	May-24
Strategic Objective:	1. Thriving Teams and 3. Great Care

Executive Director Owner:	Daniel, Sharon	Date of Review:	Aug-26
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-26

Risk ID:	1859	Corporate Risk Description:	There is a risk that patients are at increased risk of poor outcomes, and a poor patient experience. This is caused by the Health Board's inability to effectively recognise and manage acute deterioration. This could lead to an impact/affect on increased length of stays, increased admissions to Critical Care, increased risk of cardiac arrests for patients, and poorer patient outcomes who may experience permanent injuries or irreversible health effects.
Does this risk link to any Directorate (operational) risks?			1758

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	2×5=10
Expected Date To Achieve TRS:	31/03/2027
Trend:	

Score Type	Score
Inherent Risk Score (L x I)	25
Current Risk Score (L x I)	15
Target Risk Score (L x I)	10

Rationale for CURRENT Risk Score:
The Resuscitation Council UK suggests that the national average cardiac arrests per 1000 admissions is 0.9. HDUHB has compared variably to this statistic however, it is noted that some sites did see an increase in Cardiac Arrest rates in 2025 and this has also been seen in the early part of 2026. BGH 1.32 (0.66), GGH 0.57 (0.51), PPH 0.66 (0.45), WGH 0.31 (0.71). From the data 86% of patients who had a Cardiac arrest were in hospital >24 hours, 70% of patients were over the age of 70 and as an outcome measure 83% were not alive after 30 days and at least 50% of the cases reviewed the conclusion from the medical review was that a DNAR CPR should have been in place, therefore resuscitation should not have started. To understand the impact of NEWS2 on MET calls we reviewed the data Jan - May 2025 & Jan - May 2026 . There has been a significant increase in MET calls in most areas of 20 - 50%. This increase could be attributed to many factors including MET call at NEWS2 of 7, roll out of new chart, escalation pathway at bottom of chart, increase in training or increased hospital admissions and patient acuity. Over the last 4 years Unplanned Admissions to ITU in both GGH and WGH have been consistent.

Rationale for TARGET Risk Score:
The full implementation of the actions noted in the risk action plan will support the reduction in the likelihood and impact score of this risk to a target risk of 10. As at March 2026, TRS date has been revised from 31/12/2025 to 30/06/2026 as systems remain under development and have not yet been implemented. As of June 2026, situation remains unchanged. TRS date moved to March 2027 to allow time for systems to be implemented by year end.

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	By Who	By When	Progress
Governance Health Board RADAR Group (Recognition of Acute Deterioration and Resuscitation). RADAR directly reports to Quality and Safety Intelligence Group (QSIG) Local RADAR groups (across all sites, counties, MHL and Paediatrics) which report to Health Board wide RADAR group. Health Board Resus policy in place (currently under review and updated to reflect National Guidance) Operational Mechanisms in place across all sites to monitor cardiac arrest rates. Bi-monthly scrutiny meetings have been set up on all 4 sites to review Cardiac arrests. Cardiac arrest reviews presented at Medical Education sessions. Review of feedback from any Medical Examiner reviews, highlighting issues relating to resuscitation/cardiac arrests and lessons learned. All Wales DNAR policy in place and has been uploaded onto the Health Board intranet. Critical Outreach Services in GGH and WGH (not in place at PPH/BGH), managed by Planned and Specialist Care Clinical Care Group (i.e., not fully linked to Acute Deterioration resource) Networks in place across the wider Health Board, including support from QIST (Quality Improvement Service Transformation) Team and practice development. Call for Concern in place on all 4 sites for inpatient adult patients only. Planned implementation in Paediatrics, Neonates, Mental Health and Midwifery by December 2026. Training Dedicated Resuscitation Team in place, consisting of 5.2WTE across the Health Board (acute, community, mental health and primary care) and one 1WTE admin support. Organisational training plan in place, including mandatory training Cascade Trainers in place across the Health Board (community and acute)	Treatment escalation plans not in place, however Task & Finish Group established and first phase of implementation planned for GGH (Padarn Ward) & WGH (Ward 12) late July 26. Call for Concern to be implemented in all in-patient adult areas, Mental Health, Paediatrics, Neonates & Maternity by December 2026. Currently in place on all 4 acute sites, Maternity, Paediatrics, Neonates and Mental Health on target to meet deadline. Inconsistent application of policies and processes eg DNACPR, sepsis assessment tool, National Early Warning Score (NEWS). Reliance on manual / paper based documentation to record patient deterioration and subsequent escalation Critical Outreach Services not in place at PPH / BGH Inability to release staff to complete L2 and L3 training Training requirement to meet recommended Resus Council Standards greater than current allocate Resuscitation Team resource 60 - 70% attendance of courses, even if fully booked. Current resource not being used to full potential with financial implications. Inconsistent and irregular site RADAR meetings which report into HB-wide RADAR Group	As part of the Quality Dashboard, agree the matrix needed for patient deterioration. Include these matrix in the Health Board Quality Dashboard to inform escalation and create a specific dashboard for RADAR (Recognition of Acute Deterioration and Resuscitation).	Wastell, David	30/05/2025 30/09/2025 31/12/2025 31/03/2026 31/05/2026 31/12/2026	Supporting metrics for the dashboard identified: sepsis, AKI, NEWS audits, cardiac arrests, number of MET calls, treatment escalation plans are in place, call for concern rates and training compliance for ILS and BLS. Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system. Data being supplied however further work required to align to the new operational CCG structures on the dashboards.
		Put in place process for Health Board compliance with Martha's Rule by establishing a Task and Finish Group to implement Call for Concern	Wastell, David	31/03/2025 31/12/2025 31/03/2026 31/12/2026	Task and Finish Group is in place, chaired by Mandy Davies. Call for Concern has been implemented in Adult Inpatient areas in GGH and WGH due to these sites having outreach services. Discussions are underway with PPH and BGH on how this programme can be implemented. Paediatric Services have set up a group to review how this could be worked in their area. The National Group have a timeline of March 2027 for full implementation.

To feedback the audit to clinical leads so that they can implement improvements on the use of sepsis bundles at the bedside.	Wastell, David	31/12/2025 31/03/2026 31/12/2026	Ongoing quality improvement in place. Has demonstrated improvements in Glangwili and Prince Phillip and now being used in Withybush. Reviewing process for assessing impact on patient outcomes as a result of the response and management of sepsis. Implemented in July 2025, and audits have commenced to monitor compliance. Scrutiny of compliance is underway to ensure improvements are embedded, in consideration of an electronic system being launched early 2026.
Acute Deterioration E-learning modules - topics include NEWS, sepsis, DNACPR and A-E assessment being developed by the Lead Nurse for Acute Deterioration in conjunction with NHS Executive and other leads. Work to develop a process for using these modules with clinical areas in response to issues of concern.	Wastell, David	31/01/2025 30/09/2025 31/12/2025 31/03/2026 30/09/2026 31/10/2026	Acute Deterioration Nursing Leads from across Wales are in the process of reviewing. Awaiting the National decision from WG re funding (as one of the modules was being paid for by WG).
Following assessment and interpretation of the All Wales Direction, the Health Board is engaging in National work, namely roll out of Call for Concern.	Wastell, David	30/09/2026 31/12/2026	National Guidance now issued - Call for Concern has to be implemented by December 2026. This has to be implemented in all adult inpatient areas including Maternity Services, Paediatrics, Neonates and Mental Health. Task and Finish Group has been established. Mark Henwood is the Executive sponsor and work continues.
A Health Board wide workplan in relation to Acute Deterioration to be developed, in agreement with the care group clinical leads. Vicky Hughes (HB RADAR Lead).	Wastell, David	31/03/2026 30/05/2026 30/09/2026 31/10/2026	RADAR meeting planned for 2nd September 2026.

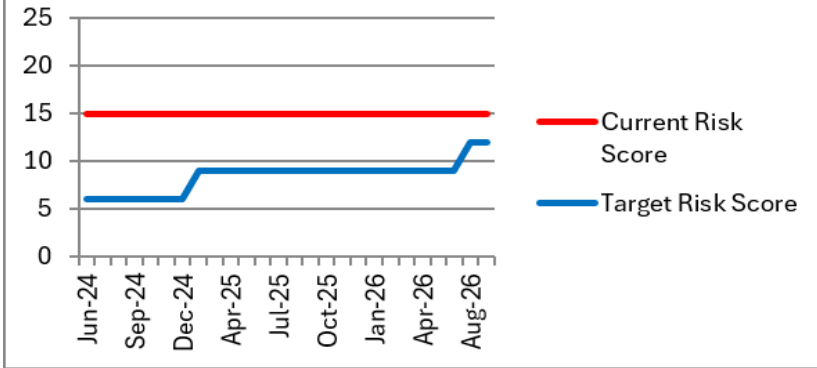
			Oversight Group to implement the All Wales treatment escalation plan policy document to report into the Clinical Care Groups and RADAR.	Wastell, David	31/03/2026 31/12/2026	Victoria Wheatley is the medical lead (palliative care consultant) and pilots are planned for GGH and WGH in May 2026 with a plan for health board rollout by December 2026.
			145 Life Pack 20E Defibrillators are out of manufacturer support 2027/28. A replacement plan is required and a capital bid to be submitted with projected costs of £1.8 million.	Wastell, David	30/06/2026 31/12/2026	Capital bid submitted. Partial capital funding has been obtained. Tender process underway.

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 			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
			Current Level							
Training compliance via ESR Cardiac Arrest Audits Unplanned Admissions to Intensive Care Units. SEPSIS compliance.	EWS (Early Warning Scores)/NEWS2/MEWS/PEWS/NEWTT2 Audits undertaken by Ward Teams on AMAT and action plans for Ward Managers are requested where necessary	1st			RADAR Group Update presented to QSIG, 13th November 2025. RADAR Group update presented to QSIG, 15th January 2026. RADAR Group update presented to QSIG, 12th June 2026.	Ward based NEWS audits in place but may be unreliable as self assessed.	Once dashboards in place, to develop a monthly audit process to address key hotspots / areas of concern relating to RAILS	Wastell, David	30/09/2025 31/12/2025 31/03/2026 30/05/2026 31/12/2026	Progress to be provided once dashboards in place and functional for reporting to future RADAR meetings. To discuss further with Performance Team.
	Review of DATIX incidents, complaints, cardiac arrest reports and Medical Examiners reports relating to acute deterioration	1st								
	Outreach review all unplanned admissions to Intensive Care	1st								
	RADAR Group	2nd								

Date Risk Identified:	May-24
Strategic Objective:	1. Thriving Teams and 3. Great Care

Executive Director Owner:	Severs, James	Date of Review:	Sep-26
Lead Committee:	Health and Safety Committee	Date of Next Review:	Oct-26

Risk ID:	1860	Corporate Risk Description:	There is a risk that staff may be exposed to physical and/or verbal assault from patients, service users, visitors or members of the public. This is caused by incidents of violence and aggression within healthcare settings. This could lead to an impact/affect on staff experiencing physical injury, psychological harm, reduced wellbeing, and disruption to service delivery, as well as potential non-compliance with Health and Safety legislation.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		
Domain:	Safety - Patient, Staff or Public	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	5×3=15	
Target Risk Score (L x I):	4×3=12	
Expected Date To Achieve TRS:	01/04/2027	
Trend:	↔	

Rationale for CURRENT Risk Score:
The high frequency of violence and aggression incidents contributes greatly to the current risk score, with over 1400 incidents recorded during 2025. More recent figures show that this trend is continuing in 2026 (April 107, May 120, June 99). The likelihood remains at 5 as these incidents occur numerous times daily.
Due to the number of patients with complex needs (e.g. cognitive impairment, medical confusion or substance misuse) it is unlikely that the likelihood score will reduce greatly. The lack of adequate and suitably qualified security staff to deal with these incidences means the consequences and impact of any incidents can be catastrophic, resulting in physical injury to staff, psychological harm , reduced well-being and service disruption.
Inconsistent compliance with Violence & Aggression (V&A) risk assessments and training and a lack of process surrounding the management of lone working safety measures are also contributory factors.

Rationale for TARGET Risk Score:
Whilst the likelihood of the risk occurring remains high, the impact score can be reduced by employing suitably qualified security staff at acute sites.

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	By Who	By When	Progress
There is a Violence and Aggression Policy in place to support the management of V&A risks as well as the identification and assessment of foreseeable risks. Aligned to the policy is the existence of V&A Risk Assessments. There is a V&A risk assessment toolkit in place to aid managers to assess the risk of V&A at a service level. There is a V&A case manager, employed by the Health Board to support and promote this process. Education and training - there is anational NHS Violence and Aggression Training Scheme Standard in place to recognise and manage the risk of V&A in the workplace. There is a Reducing Restrictive Practice (RRP) training team in place to ensure that relevant staff are trained to restrain violent or aggressive individuals. There is a Violent Patient Warning Marker Procedure in place to provide early warning for staff caring for recorded patients. This applies to primary and secondary care settings. Lone working policy to promote the principles of safer workin for lone workers. There is a Security Management Group in place to provide oversight on Violence and Aggression matters, which reports to the Health and Safety Compliance Group.	There is no mechanism in place to monitor compliance with the number of V&A Risk Assessments being completed and monitored. There is inconsistent application of the NHS Violence and Aggression Training Scheme standard. Better assurance required on compliance with the HB Patient Warning Marker Procedure. Service Managers are required to review within 12months the need for a warning marker to remain on the patients record. Low compliance in the use of 'People Safe' lone working devices. A lack of dedicated and suitably qualified security staff on sites to respond to V&A incidents. Some portering staff are unable to complete RRP training due to physical constraints.	Develop a process to improve oversight of V&A risk assessments.	Jenkins, Brett	30/04/2025 31/06/2026 31/10/2026	MS Forms template has been devised. Incident data supplied to management to inform their V&A risk assessments. V&A Case Manager will review the process and bring a revised process to the Security Management Group in Jul26. All managers were asked to confirm that they have a V&A risk assessment in place and report back to the V&A Case Manager by end of January 2025. Unfortunately responses have been poor and the V&A Case Manager is currently chasing assessments from all areas yet to submit. The request is reiterated via the CCG update reports.
		Undertake a thorough training needs analysis against the National V&A Training Scheme standard and improve access to training.	Wood, Rachel	31/08/2025 31/12/2026	The original TNA was submitted to the HSS IGG. The TNA is now being split into two parts. Part 1 is the TNA for physical restraint training for general staff (module D), which will be presented to the HSCG in September 2026. The TNA Part 2 will be for staff that need personal safety training - this requires further updates. (Note: Part 2 is delayed due to a bereavement to the RRP Lead)

		Review the HB Patient Warning Marker procedure to ensure the actions are clear and precise and to develop a mechanism for measuring compliance. To be monitored through the security group.	Jenkins, Brett	31/12/2025 30/06/2026 30/11/2026	Security Management Group have discussed compliance with the patient warning marker procedure and agreed how to progress with a procedure review. Document was reviewed and returned to SMG for key stakeholder comment. Policy widened to include other risks such as violent relatives, dangerous dogs, house risks etc, with risk assessments hosted in a central location. IG issues with this to be overcome - additional 3 month extension agreed by HSCG in August 2026.
		Review effectiveness of the use of PeopleSafe devices by staff and develop an action plan to improve access and take up.	Jenkins, Brett	30/04/2025 30/06/2026 31/12/2026	512 devices issued. Review of compliance shows 4-6% compliance. The V&A manager will develop an asset register to list all registered devices and which service they have been allocated to. A paper outlining the issues, including an action plan for improvement, will be submitted to HSCG in September 2026.
		Review incident reports to determine the severity, location by site across the Health Board. Incidents will be available via the H&S Dashboard this will include V&A incident data.	Jenkins, Brett	Completed	Reports are now submitted to the Security Management Group and are presented to the Health and Safety compliance group for scrutiny.
		Seek Executive support to employ a security resource at each acute site.	Brock, Elin	16/10/2026	A paper was presented to the Exec Team in March 2026 with further details on possible options available. A follow up paper was presented in June 2026. Work is on-going with the procurement team to consider outsourcing the security resource.
		If Executive Team approve the establishment of a security resource at each acute site, commence recruitment and procurement process	Springthorpe, Adam	16/10/2026	New action

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	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed	By Who	By When	Progress
		(1st, 2nd, 3rd)	Current Level							
Violence and aggression incident data. Training figures in line with the All Wales NHS Violence and Aggression Training Scheme.	Security incident breaches are reported via Datix and investigated	1st			Escalation paper provided to Public Board June 2023 A cost and risk analysis has been undertaken to compare the use of external security providers against the cost to employing via the Health Board, and a paper was presented to the Executive Team in December 2023	Security Report - Executive Team (Mar26)	Reports on security arrangements and related incidents are to be provided to Health and Safety Committee	Springthorpe, Adam	Completed	V&A/Security incident data is now reported to the H&S Committee via the Health & Safety Assurance Paper. V&A/Security data is also shared with each CCG on a monthly basis via the Health, Safety and Security Summary Reports.
	Reports on security arrangements and related incidents are provided to Health and Safety Committee	2nd				Security Report - HSC In-Committee (May26)				
	Reports on security arrangements and related incidents are provided to the Health and Safety Committee .	2nd				Security Report - Executive Team (Jun26)				

Date Risk Identified:	Apr-26
Strategic Objective:	1. Thriving Teams and 3. Great Care

Executive Director Owner:	Gjini, Ardiana	Date of Review:	Jul-26
Lead Committee:	Health and Safety Committee	Date of Next Review:	Sep-26

Risk ID:	2349	Corporate Risk Description:	There is a risk of disruption to services and increased financial pressure arising from fuel supply constraints and rising fuel costs across Hywel Dda University Health Board. This is caused by volatility in global and national fuel markets, ongoing inflationary pressures, reliance on fuel to support a geographically dispersed estate and fleet, dependence on fuel for staff travel and community based service delivery, and limited short term alternatives to fossil fuel use for patient transport, logistics and emergency resilience. This could lead to an impact/affect on increased operational and estates costs, reduced financial sustainability, challenges for staff in travelling to work and delivering community and domiciliary services, reduced capacity to maintain patient transport and service continuity, heightened risk to business continuity and emergency response capability, and reduced ability to invest in frontline care, estate resilience and decarbonisation objectives.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		Current Risk Score: 12 Target Risk Score: 6
Domain:	Service/Business interruption/disruption	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	3×4=12	
Target Risk Score (L x I):	3×2=6	
Expected Date To Achieve TRS:	31/08/2026	
Trend:	↔	

Rationale for CURRENT Risk Score:
The likelihood of adverse impact from fuel supply constraints and rising fuel costs has reduced from inherent levels due to active national fuel market monitoring, existing national and regional contingency arrangements, business continuity planning, and cost monitoring measures already in place. However, the impact remains high because the Health Board continues to rely heavily on fuel (vehicle and heating) to operate a geographically dispersed estate, maintain patient transport, and support staff travel and community based services. Sustained fuel price volatility therefore still presents a significant financial and operational risk, justifying a current risk score of 12.

Rationale for TARGET Risk Score:
With continued implementation of mitigating actions such as nationally strengthened fuel supply resilience, optimisation of fuel (heating and vehicle) procurement, review of fleet usage, increased use of hybrid and low emission vehicles, enhanced digital and remote service delivery where appropriate, enhanced business continuity planning and longer term investment in decarbonisation the potential impact of fuel disruption can be substantially reduced. While external market volatility means the likelihood cannot be reduced further in the short to medium term, these measures are expected to limit operational disruption and financial exposure, reducing the impact to a tolerable level and achieving the target risk score of 6 by the end of August .

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
Fuel Supply Planning Group established to coordinate risk identification and mitigations
Corporate procurement arrangements and framework contracts in place for fuel supply for 8 estates vehicles
Cost pressures monitored through executive performance and finance reporting and escalated via corporate financial governance routes

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	By Who	By When	Progress
Further action necessary to address the controls gaps				
Medium term financial planning assumptions relating to bunkered fuel procurement	Identify critical users to inform fuel plans going forward	Hussell, Sam	Completed	Exploring processes for identification of Essential Services/Choices Framework and criteria identifying critical workers during Covid.
Only approximately a fifth of the workforce are able to work from home	Exploring extending lease contracts for use by organisation	Skye, Gareth	Completed	Completed.
Prioritisation process for fleet and pool cars should there be a fuel supply				

CORPORATE RISK REGISTER SUMMARY SEPTEMBER 2026

Communication Strategy drafted and ready for activation as required. Business continuity plans in place for all sites, including fuel dependent infrastructure (e.g. emergency generators on key sites) Fleet management arrangements in place to support patient transport, logistics and community service delivery Estates Energy and Decarbonisation programmes underway to reduce longer term reliance on fossil fuels Flexible working arrangements and local service planning to mitigate disruption to staff travel where possible Use of community based fleet and pooled vehicles to support delivery of district nursing and other community services in rural areas Failure of key supplier included in Business Continuity arrangements identify fuel disruption as a risk scenario. Executive oversight of emergency preparedness through designated executive and committee structures. Agreement via the Dyfed Powys Local Resilience Forum (LRF) multiagency fuel sharing protocol Health Board a member of LRF Fuel Group UK Government National Fuel Plan in place Increase of fuel expenses via the All-Wales Fuel Cost Protocol from NHS Employers agreed from 01 June 2026	disruption Opportunities to strengthen heating fuel contingencies to be explored.	Develop a process of prioritisation for pool car bookings	Skye, Gareth	Completed	This action has been closed as this is on hold. A prioritisation process will be agreed if the situation deteriorates.
		Seek confirmation of data held corporately to inform critical user identification.	Hussell, Sam	Completed	Complete. Information has been provided from the Corporate Archive which will be used to inform critical user identification. Further conversations will be had with a number of teams to ascertain if they would be able to work remotely if the need arose.
		Fuel supply disruption element of Estates Business Continuity Plan to be reviewed.	Day, Simon	31/05/2026 31/08/2026	Draft developed
		Undertake medium term financial planning assumptions include fuel scenarios.	Shaw, Terri	Completed	In progress and reported to the Fuel Supply Planning Group.

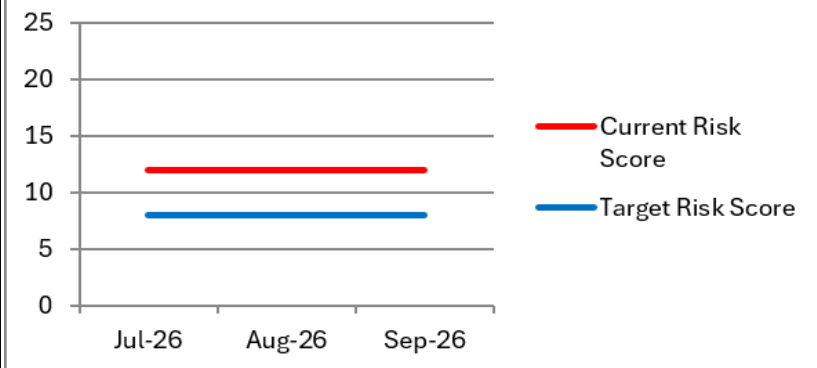
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
		(1st, 2nd, 3rd)	Current Level							
	Terms of Reference for Fuel Supply Planning Group	1st				Service level plans need to be reviewed with a specific fuel supply focus	To include fuel supply in the business continuity template and request business continuity plan owners consider impact to services	Hussell, Sam	Completed	Fuel supply disruption now included in Business Continuity template. Ongoing communications with services to consider fuel supply disruption contingency measures.
	SBAR to Formal Executive 25Mar26	1st								
	Service level business continuity plans	1st								
	Ratified multi agency LRF fuel sharing protocol in place	2nd								
	Fuel Supply Planning Group reports to the Emergency Preparedness, Resilience and Response Group	2nd								

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

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Sep-26
Lead Committee:	Finance and Performance Committee	Date of Next Review:	Nov-26

Risk ID:	2380	Corporate Risk Description:	There is a risk of the Health Board not being able to maintain the current level of Single Cancer Pathway (SCP) performance between 64-66% (2025/26) as per the Board approved Annual Plan 2026/27, and make further improvement towards the national 75% standard in 2026/27. This is caused by gaps in capacity to meet the expected demand for diagnostics (within radiology, cellular pathology and endoscopy), uncertainty over continuation of Welsh Government non- recurrent funding, treatment delays internally due to theatre fragility and at our tertiary centres, compounded by fragility within key tumour sites (urology, lower GI, skin). This could lead to an impact/affect on increased number of patients waiting in excess of 62 days and meeting patient expectations in regard to timely access for appropriate treatment which could potentially lead to poorer outcomes and patient experience, adverse publicity/reduction in stakeholder confidence, and increased scrutiny/escalation from Welsh Government. This could lead to adverse reputational damage as a result of inconsistent performance delivery over time.
Does this risk link to any Directorate (operational) risks?		1223, 114, 111, 1537, 1699, 1722, 1723, 797	

Risk Rating:(Likelihood x Impact)		
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:	31/03/2027	
Trend:		



Score Type	Jul-26	Aug-26	Sep-26
Current Risk Score	12	12	12
Target Risk Score	8	8	8

Rationale for CURRENT Risk Score:
The service has been de-escalated by Welsh Government from Level 4 to Level 1 in terms of Targeted Intervention status as there has been the consistent achievement of the 60% de-escalation criteria since February 2025. As at June 2026 performance was at 60%.
Due to recovery actions within radiology and urology we may see variation in performance as we recover and treat those patients over 62 days. Funding from Welsh Government remains uncertain as at August 2026, with Tranche 1 monies received but less than requested. Work is ongoing to obtain Tranche 2 funding over September 2026.
Confirmation of target for March 2027 is 75%, however no health board is achieving this target. Plans are in place for Q2 to maintain performance at the planned trajectory set out in the Annual Plan 2026/27.

Rationale for TARGET Risk Score:
The aim is to treat patients within target waiting times, which has now been confirmed as 64-66% as per Annual Plan 2026/27.
The target risk score will be met if plans to maintain diagnostic capacity, utilising internal allocated funding, are realised. The risk score can be further reduced to a 8 once the target of 66% is achieved and maintained for 3 consecutive months. There are underpinning trajectories in place which are monitored on a monthly basis and adherence to those will influence the ability to achieve the target risk score.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
Sustainable pathway change with the lower GI pathway (FIT Fecal Immmochemical test, NICE NG12) from primary to secondary care commenced Nov25 resulting in 75% reduction in new outpatient demand, 45% reduction in radiology demand and improvement of straight to test compliance in Q1. Accelerated imaging from Endoscopy to CT within the GI pathway now in place across all sites, reduction time on patient pathway by 23 days Established cancer tracking team in place to allow patients to be proactively tracked through their pathways. A cancer dashboard developed by Informatics with the support of Business Intelligence (BI) SCP funding from the Wales Cancer Network for Cancer Services staff and Service Managers, allowing MDTs to actively monitor tumour site specific patients on a SCP. The health board are using of Quarterly Planning and Monitoring reports developed by the NHS Performance & Improvement. This has facilitates the development of targeted improvement plans per tumour site and subsequent weekly monitoring thus providing assurance of the robustness of plans. Virtual appointments are being undertaken via digital solutions e.g. Attend Anywhere. Weekly Cancer Operational Delivery Group (ODG) meetings where services	Anticipated significant gaps/service fragility within key diagnostic services to address required levels of activity to support SCP Uncertainty on WG recovery funding for 2026/27 Lack of resilience within theatre estate (no decant theatre to manage future fire & estate works) Capacity at tertiary centres causes delays in surgical pathway resulting in patients exceeding 62 days Limited patient tracking resource available for all tumour sites 480 patients (34% of which will be a confirmed cancer and awaiting treatment) waiting in excess of 62 days for either diagnostic or treatment	Explore outsourcing for prostatectomies	Humphrey, Lisa	30/06/2026 20/10/2026	being progressed via procurement
		Undertake weekly oversight of backlog trajectory plan in place for all tumour sites for Q1 to reduce 180 by March 2027	Humphrey, Lisa	31/03/2027	Progress to be provided at next risk review

managers are in attendance. The function of this group is to monitor and address service demand, capacity and risk issues.

Trajectory performance plans have been developed for each tumour site by the relevant services, with regards to improving performance. This also includes Backlog Trajectory plans on how these improvements will be achieved.

Robust Urology diagnostic recovery plan to eliminate patients waiting more than 28 days in place, with committed resource allocation from recovery money in Q1 2026/27. Pilot of Galeas bladder urine test to early diagnosis, surveillance and recurrence monitoring risk stratification in haematuria pathways, and reduce unnecessary cystoscopies, improving patient experience and freeing diagnostic and endoscopy capacity. Monitoring of Urology diagnostic improvement trajectory via Cancer Operational Delivery Group.

Agreement to continue outsourcing MRIs for patients on prostate pathway within urology.

Cancer Pathway Review to be discussed at the MDT Business meetings and plans put in place to address and improve any bottlenecks or issues. Pathway reviews will also be a standing agenda item on the Planned Care and Cancer Services QSH meeting to ensure governance in line with the new operational structures implemented in April 2025.

Process in place to improve component wait times and reduce patients waiting more than 14 day for first Outpatient Appointments (OPA) and 28 days for Diagnostics.

One to one escalation meetings held with Cancer ODG leads and Tumour Site Service Managers for tumour sites that require intervention.

Pathway changes in Head and Neck to include Laryngeal Biopsy at first OPA, reducing reliance on pan-endoscopy

One stop hysteroscopy in Gynaecology across all sites.

Health Board wide internal escalation framework now in place to support the monitoring of performance targets.

Additional Radiology scanning capacity in place for Q1 and Q2 2026/27.

Await outcome pf funding request to WG for 7 day turn around for cancer for Radiology, pathology and Endoscopy	Humphrey, Lisa	19/10/2026	in progress
new trajectories for performance and backlog in line with funding request submitted	Humphrey, Lisa	19/10/2026	awaiting outcome of funding
additional lists for flexi cystoscopy and LATP for urology agreed utilising residual recovery until end of Q3	Griffiths, Neil	28/12/2026	in progress

New Endoscopy booking process which tracks all patients referred for an endoscopy on a USC priority. If capacity is identified as a trending breach reason, the Service Management team supports targeted intervention to address these concerns in order to reduce time on patient pathways. Allocation of recovery funding for Q1 and Q2 for Pathology and Radiology secured. Gap analysis completed between assessed workload and funded establishment within anaesthetic workforce Full recruitment plan for theatre workforce in place, in line with Nurse Staffing Act, phased over financial years 2026/27 and 2027/28. Utilisation of insourcing while theatre workforce recruitment plan is implemented.		Gyneacology to implement pentrox as an hysteroscopy under sedation to mitigate the need for 15 per week hysteroscopy requiring GA	Davies, Lauren	19/10/2026	in progress
		CPG1 for urology to be agreed that they are removed from the tracker at the point of diagnosis as treated to improve performance	Griffiths, Neil	19/10/2026	In progress. Awaiting national agreement, with outcomes expected September 2026.
		Funding bid to be submitted to WG re gynaecology endometrial swab to reduce the reliance on hysteroscopy	Humphrey, Lisa	19/10/2026	In progress, with submission due on 3rd September 2026.

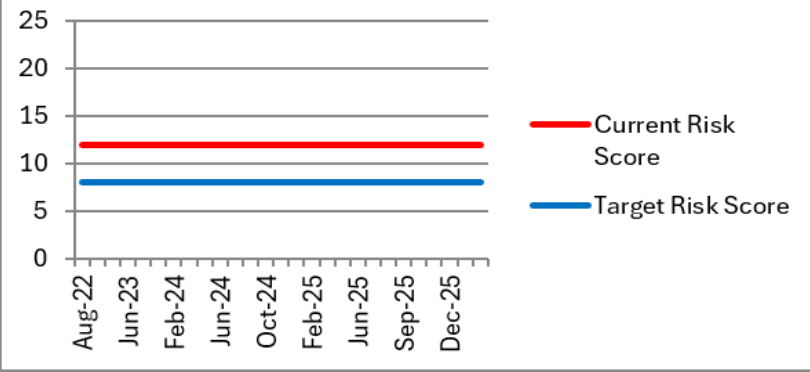
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Performance Indicators	Sources of ASSURANCE	Type of Assurance	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed	By Who	By When	Progress
		(1st, 2nd, 3rd)	Current Level							
Internal targets - Looking at the performance per tumour site individually that have the biggest impact on overall performance Skin Urology LGI Gynaecology Breast	Daily/weekly/monthly/ monitoring arrangements by management	1st			Annual Plan 2026/27 sets out Cancer trajectories for 2026/27 - Board (Mar27)	Currently there is no Cancer Oversight Group (Board) in the Health Board	Establish a HDdUHB Cancer Oversight Group to provide strategic oversight and planning	Goode, Paula	Completed	Due to start in September Chaired by Keith Jones
	IPAR Performance Report to FPC & Board	2nd					Establish an Internal Clinical Care Group Oversight Rereferral to Treatment and Cancer Group	Goode, Paula	30/06/2026-30/09/2026	Progress to be provided at next risk review
	Monthly oversight by NHS Performance & Improvement/WG	3rd								

Reducing component waits Patient waiting more than 14 days for first OPA Patients waiting a diagnostic procedure and report more than 28 days Patients with a confirmed diagnosis of cancer waiting more than 62 days	Monthly operational oversight via the CCG Integrated Governance Group	1st								
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Date Risk Identified:	May-22
Strategic Objective:	1. Thriving Teams and 2. Healthier Communities and 3. Great Care

Executive Director Owner:	Gjini, Ardiana	Date of Review:	Jul-26
Lead Committee:	Health and Safety Committee	Date of Next Review:	Sep-26

Risk ID:	1433	Corporate Risk Description:	There is a risk the Health Board being unable to maintain routine and emergency service provision across the organisation in the event of a severe pandemic event. This is caused by a novel virus/bacteria (or emerging variant or mutation of concern) causing a pandemic as declared by the World Health Organisation (WHO) and the subsequent ability of the Health Board to respond to the scale and severity of the outbreak. This could lead to an impact/affect on patients being able to access appropriate and timely treatment, the UHB being able to maintain safe and effective levels of staffing, financial loss, adverse publicity/reduction in stakeholder confidence, increased mortality and ill-health across our population.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		
Domain:	Service/Business interruption/disruption	
Inherent Risk Score (L x I):	4×5=20	
Current Risk Score (L x I):	3×4=12	
Target Risk Score (L x I):	2×4=8	
Expected Date To Achieve TRS:	31/03/2027	
Trend:		

Rationale for CURRENT Risk Score:
The national security and risk assessment was reviewed and re-published in November 2025, this remains unaltered. The previous pandemic influenza risk was changed into three new risks; one generic pandemic event (1433) and two emerging infectious diseases reflected on the operational risk register (1879 re: measles and 2093 re: tuberculosis). Current likelihood scored at a 3 to reflect the risk of the Health Board being unable to respond to the scale and severity of the pandemic - not the likelihood of the pandemic actually occurring.

Rationale for TARGET Risk Score:
Following Exercise Pegasus, the UK Gov exercise report is due Winter 2026 which will identify recommendations at both government and local levels. This will be followed by the publication of the UK Gov Respiratory Pandemic Plan/Guidance which our regional and Health Board plans will need to dovetail with. Following review of our Pandemic Response Framework in April 2026 a follow up table top exercise is planned for the autumn which will further inform our own pandemic preparedness. The Target Risk Score has been amended to reflect these timescales and provide time to analyse and incorporate recommendations.

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	By Who	By When	Progress
# Major Incident Plan (detailing internal command and control structures) # Well established command and control structures for managing pandemic response both nationally and locally # Continuation of current COVID-19 and wider national immunisation programmes # Choices Framework which sets out which services could be stood down in a pandemic # Extensive knowledge across Health Board in managing a pandemic event # COVID-19 response measures which can be adapted to respond to any future pandemic event # Local Resilience Forum (LRF) multi-agency plans for managing pandemic influenza reviewed and incorporate Ex Pegasus/Solaris & Bite Back lessons, but still awaiting the UK Gov Respiratory Pandemic Response Plan/Guidance) # LRF Excess Deaths Plan (which supports the LRF multi-agency pandemic influenza management arrangements) developed as a recommendation from Exercise Cygnus. Plan was ratified by the LRF Health Group. # Health Board Pandemic Response Framework reviewed April 2026 and incorporates Ex Pegasus/Solaris & Bite Back lessons).Approved by Board in May26. # Quality assurance process via national & local exercise programmes. # Access to national counter measures stockpile # Regional Health Protection service across HB and key partners # Continuous learning from COVID-19 # Pandemic Planning Group re-established # HB participated in Exercise Pegasus - national Tier 1 Pandemic Exercise scheduled across 3 phases played in Sept, Oct and Nov 2025. # HB participated in Exercises Solaris (pre-cursor to Pegasus) and Bite Back (invasive mosquito scenario) during 2025. # Pandemic Response Framework approved at May26 Board	Further testing of service preparedness Still awaiting publication of UK Government Respiratory Pandemic Planning Guidance	Deliver internal multi-disciplinary table top exercise to inform further development of HB pandemic response arrangements.	Hussell, Sam	31/07/2026 30/09/2026	Exercise endorsed by FET as next step and is being scheduled for Autumn 2026.
		Analyse and incorporate recommendations from Exercise Pegasus Final Report and UK Gov Respiratory pandemic Plan/Guidance following anticipated publication in Winter 2026.	Hussell, Sam	31/03/2027	New action

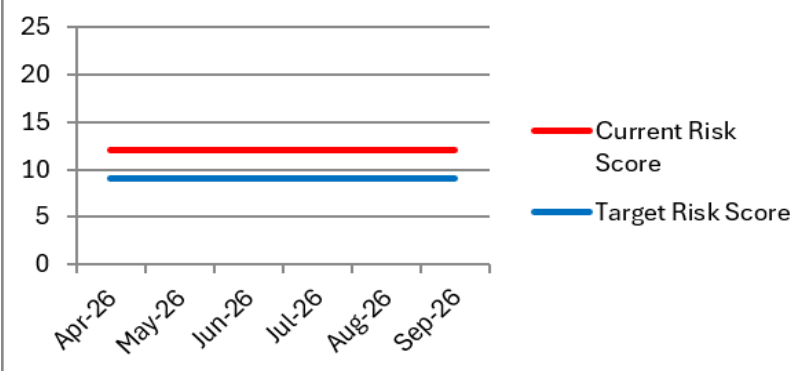
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Performance Indicators	Sources of ASSURANCE	Type of Assurance	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed	By Who	By When	Progress
		(1st, 2nd, 3rd)	Current Level							
	Planning via Emergency Preparedness, Resilience & Response (EPRR) including LRF workstream reports to Health & Safety Committee	1st			Vaccine Equity Strategy - Board 30 May 2024	None identified.				
	Operational pandemic reporting structures from HB to WG	2nd			Vaccination Delivery Programme Update - Board via SDODC (Sep 23)					
	National, regional & local command & control structures	2nd			Major Incident Plan - Board via H&SC and Exec Team (Jul 25)					
	National groups operational for vaccination programme planning & delivery	3rd			Pandemic Response Framework - FET Apr26, HSC May26 & Board May26					
	Emergency Planning Advisory Group (EPAG) Wales meetings re Pandemic response and future planning	3rd			Pandemic Response Framework (scheduled 05 May 2026)					

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

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-26
Lead Committee:	Finance and Performance Committee	Date of Next Review:	Oct-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 non 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 (104 week backlogs), reduced resilience in planned and cancer care pathways, potential re escalation of national performance interventions, and associated adverse impacts on patient experience, clinical outcomes, and organisational reputation.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	3×3=9
Expected Date To Achieve TRS:	31/03/2027
Trend:	



The graph displays two horizontal lines representing risk scores over time from April 2026 to September 2026. The Y-axis is labeled from 0 to 25 in increments of 5. A red line, labeled 'Current Risk Score' in the legend, is positioned at the value of 12. A blue line, labeled 'Target Risk Score' in the legend, is positioned at the value of 9. Both lines are perfectly horizontal, indicating that the scores do not change over the period shown.

Date	Current Risk Score	Target Risk Score
Apr-26	12	9
May-26	12	9
Jun-26	12	9
Jul-26	12	9
Aug-26	12	9
Sep-26	12	9

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	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)	Agreed continuation of ophthalmology outsourcing for Q1, utilising ophthalmology and dermatology underspend with core budget	Humphrey, Lisa	Completed	Q1 activity paused for month of June and beyond in the absence of recovery allocation
	# Lack of resilience within theatre estate (no decant theatre to manage future fire & estate works)	Progress proposal for recruitment of fixed term locum to utilise NPT theatres to mitigate loss of activity as a result of theatre estate issues at block 32 at GGH (c.150 cases)	Humphrey, Lisa	Completed	This program was rejected
	# Workforce staffing availability to support further expansion of theatre capacity	Increase capacity to four primary joints on 90% of Orthopaedic lists (Enabling Actions)	Gregory, Lianne	31/03/2027	In progress
	# 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	Producing a full recruitment plan for theatre workforce in line with Nurse Staffing Act and allocation of new investment of £1.4m for 2026/27	Walsby, Alexandra	Completed	In progress
	# Sufficiency of Anaesthetic medical staffing capacity to support existing capacity and further expansion of required operating lists	Complete optimisation framework assessment to address WG 3 top priorities which are referral management, waiting list validation across stages and conversation of follow up activity to new outpatient capacity	Humphrey, Lisa	Completed	Optimisation frameworks complete and submitted
	# Widespread adoption of national best practice guidance to improve elective optimisation and utilisation of available operating capacity	Develop trajectories of improvement per specialty based on the optimisation framework assessment to identify productivity and efficiency gains	Humphrey, Lisa	Completed	New Trajectories have been produced that improved the board approved position from 5,500 to 3,800
	# Deficiencies within pre-operative assessment process and overall capacity to support required volume of Pre-Operative Assessment Clinic (POAC) assessments	Develop a model of standardised assessment for the pre-assessment process to streamline pre-assessment and eliminate bottlenecks	Carmody, Sarah	19/10/2026	In progress being progressed by Craig Tout
	# Cessation of PAAR in delivery of waiting list initiatives	Develop mitigation plans for areas that are reliant on PAAR (neurology, outpatients)	Humphrey, Lisa	Completed	Monitoring impact of PAAR cessation during Apr26. Ongoing communication with A4C staff has improved the uptake of agreed additional activity in Q1.
		Continuation of insourcing at GGH theatres utilising £1.6m until established staffing is sustainable	Humphrey, Lisa	31/03/2027	In progress

To produce outline of aspiration aligned to GIRFT Report with associated timescales with the GIRFT Theatres Implementation Group, chaired by Medical Director, established to produce plan on a page that assesses current position, utilisation, staffing, effectiveness, patient outcomes, quality & safety, and estates.	Humphrey, Lisa	31/03/2027	In progress. Monthly reporting required to Formal Executive Team.
To undertaken a full gap analysis between assessed workload and funded establishment within the anaesthetic workforce to stabilise services, reduce risk, and mitigate ongoing variable pay expenditure	Humphrey, Lisa	Completed	In progress. No being progressed by Craig Tout Interim GM for Theatres, Aneasthetics and Critical Care
Implement surgical hub accreditation	Saw, Mr Ngjaw	31/03/2027	In progress
Create action plan following the board approved Planned Care Sustainability and Delivery Plan 26/27 submitted to WG on 31st July 2026	Humphrey, Lisa	19/10/2026	In progress
Implement DNA mitigation plan to create 9000 additional new OPD appointments from October to March 27 to reduce patients waiting in excess of 26 weeks	Humphrey, Lisa	19/10/2026	In progress
awaiting recovery funding allocation submitted for delivery of 104 weeks submitted 31st July 2026	Jones, Keith -	19/10/2026	in progress

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 			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
			Current Level							
104 week delivery remains below trajectory agreed at board in March 27	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								

Register of Sealings 8 July 2026 – 3 September 2026

Entry Number	Details	Date of Sealing
551	Contract between Hywel Dda University Health Board and T Richard Jones (Betws) Limited relation to the provision of second generator and associated works at Prince Phillip Hospital (PPH) incorporating the conditions of the JCT Intermediate Form Building Contract 2016 Edition.	16.07.2026
552	Lease relating to 30 Car Parking Spaces adjacent to Units B1-B3, Llanelli Gate Business Park, Dafen. Llanelli SA14 8LQ between Hywel Dda University Health Board and the Trustees of MMR Holdings Limited Retirement Benefit Scheme.	16.07.2026
553	Lease relating to Units 1, 2B and 3 Lllys Aur, Llanelli Gate, Dafen. Llanelli between Hywel Dda University Health Board and Edward Vivian Mansel Lewis.	16.07.2026
554	Contract between Hywel Dda University Health Board and T Richard Jones (Betws) Ltd. relating to Proposed Refurbishment Works and modernisation of the gardens at Amman Valley Hospital, Carmarthenshire incorporating the conditions of the JCT Minor Works Building Contract 2016 Edition.	06.08.2026
555	Contract relating to Window Replacement & Elevation Improvement Works at Glangwili & Prince Philip Hospital, incorporating the conditions of the JCT Intermediate Form Building Contract 2016 Edition, between Hywel Dda University Local Health Board and Lewis Construction Building Contractors Wales Ltd.	20.08.2026
556	Licence to Underlet relating to Phase 1 Building B, Pentre Awel, Llanelli, Carmarthenshire between 1. Carmarthenshire County Council, 2. Swansea University and 3. Hywel Dda University Local Health Board.	20.08.2026
557	Underlease by Reference to Superior Lease relating to Premises at Part Ground Floor, Phase 1, Building B, Pentre Awel, Llanelli, Carmarthenshire between Swansea University and Hywel Dda University Local Health Board.	20.08.2026

Register of Sealings 8 July 2026 – 3 September 2026

558	Licence for Alterations relating to Phase 1 Building B, Pentre Awel, Llanelli, Carmarthenshire between (1) Carmarthenshire County Council, (2) Swansea University and (3) Hywel Dda University Local Health Board.	20.08.2026
559	Deed of Surrender relating to Unit 3 Heol Cropin Dafen Park Llanelli SA14 8QE between Peter Reynolds Properties Limited (1) and Hywel Dda University Local Health Board (2).	20.08.2026
560	Lease relating to Unit 3 Dafen Industrial Estate, Dafen, Llanelli, SA14 8QE between Peter Reynolds Properties Limited and Hywel Dda University Local Health Board.	20.08.2026
561	Lease relating to Unit D2A Dafen Industrial Estate, Dafen, Llanelli, SA14 8QE between Peter Reynolds Properties Limited and Hywel Dda University Local Health Board.	20.08.2026
562	Parent Company Guarantee from Contractor's Parent Company relating to a project at Amman Valley Hospital, Amman Valley Hospital garden refurbishment and modernisation works, including new accessible pathways, planting, seating and landscaping improvements to create a therapeutic outdoor space for patients, visitors and staff between TRJ CYF Ltd and Hywel Dda University Local Health Board.	27.08.2026

Consultations Update Status Report up to 3 September 2026

Ref No	Name of Consultation (hyperlink included for online consultations)	Consulting Organisation	Consultation Executive Lead(s)	Received On	CLOSING DATE	Response Sent
C669	Reforms of zero hours and similar contracts	UK Government	Director of Workforce and OD/ Deputy CEO	04.06.2026	25.08.2026	No response submitted - the consultation was reviewed and, following consideration, a decision was made not to submit a response as there are no material comments or issues to raise on behalf of the organisation.
C670	Commissioning Policy and Service Specification (CP342 and SS342) Adult Kidney, Kidney-Pancreas Transplantation	NHS Wales Joint Commissioning Committee	Medical Director	29.04.2026	08.06.2026	05.06.2026
C671	Making Work Pay - employment rights for unpaid carers and parents of seriously ill children	UK Government	Director of Workforce and OD/ Deputy CEO	09.06.2026	01.09.2026	01.09.2026
C672	Pharmaceutical Needs Assessment (PNA) by Betsi Cadwaladr University Health Board	Betsi Cadwaladr University Health Board	Chief Operating Officer	11.06.2026	07.08.2026	11.06.2026
C673	Carmarthenshire Local Development plan (LDP) 2018 – 2033	Carmarthenshire County Council	Director of Strategy and Planning	26.05.2026	26.06.2026	26.06.2026

Consultations Update Status Report up to 3 September 2026

Ref No	Name of Consultation (hyperlink included for online consultations)	Consulting Organisation	Consultation Executive Lead(s)	Received On	CLOSING DATE	Response Sent
C674	CP87 and SS87 Lymphovenous Anastomosis (LVA) microsurgery for adults with primary and secondary lymphoedema, Commissioning Policy and Service Specification	NHS Wales Joint Commissioning Committee	Director of Nursing, Quality and Patient Experience	16.05.2026	26.06.2026	26.06.2026
C675	Make Work Pay: holiday pay compliance and enforcement	UK Government	Director of Workforce and OD/ Deputy CEO	06.07.2026	22.09.2026	
C676	Tobacco and Vapes: packaging, appearance and display	UK Government	Ardiana Gjini	13.07.2026	02.10.2026	
C677	All Wales guide to prescribing gluten-free foods	All Wales Therapeutics and Toxicology Centre	Associate Clinical Director of Pharmacy & Medicines Management	14.07.2026	14.08.2026	11.08.2026
C678	Equal pay and pay discrimination	UK Government	Director of Workforce and OD/ Deputy CEO	11.08.2026	27.10.2026	
C679	Health and Care Research Wales' draft Guidance on the Allocation of Research Supporting Professional Activities (SPA) Time for NHS Wales Consultants	Health and Care Research Wales	Medical Director	05.08.2026	18.09.2026	01.09.2026
C680	National Development Framework	Welsh Government	Communications and Engagement Director	25.08.2026	23.10.2026	

Consultations Update Status Report up to 3 September 2026

Ref No	Name of Consultation (hyperlink included for online consultations)	Consulting Organisation	Consultation Executive Lead(s)	Received On	CLOSING DATE	Response Sent
C681	Pegzilarginase for treating arginase-1 deficiency in people 2 years and over, Policy Position Statement (PPS350)	NHS Wales Joint Commissioning Committee	Associate Clinical Director of Pharmacy & Medicines Management	11.08.2026	21.09.2026	07.09.2026
C682	Welsh Government Draft Budget 2027-28	Welsh Parliament	Director of Finance	06.08.2026	25.09.2026	
C683	Moving children's social care to a not-for-profit model	Welsh Government	Director of Nursing, Quality and Patient Experience	07.07.2026	23.09.2026	

Executive Team Discussions

Since my previous report to Board, the following items have been presented to the Formal Executive Team (FET) for consideration:

- **St Davids Branch Closure:** a proposal to commence engagement on the closure of the Meddygfa Penrhyn branch surgery in St Davids was considered. FET requested further work on engagement, equality impacts and alternative premises before approval could be granted.
- **Programme Management:** discussions focused on the need to formalise the Health Board's programme management and turnaround approach in response to concerns regarding delivery of the Annual Plan.
- **Section 136 Place of Safety Provision:** FET supported the principle of a single-location Section 136 facility at Cwm Seren, Carmarthen, although requested further refinement of the engagement plan and legal considerations before final approval.
- **Annual Review of Formal Executive Team Reporting Groups Terms of Reference:** approved the Executive Team and reporting group Terms of Reference to reflect new ways of working and revised operational structures.
- **Withybush Hospital (WGH) Creche:** significant operational, estate and financial challenges were noted. FET approved continuation of the temporary closure.
- **Collaborative Working with GSK:** the proposed partnership to support improved vaccination uptake was agreed in principle, subject to governance, procurement, information governance and contractual approvals being completed.
- **Violence And Aggression Update:** progress implementing national requirements for preventing violence and aggression against NHS staff was noted, with support given to enhanced governance arrangements and further updates requested following training and implementation.
- **Women's Health Plan update:** progress on the Programme was noted, including women's health hubs, training and pathway redesign, with further discussion needed on the future model and outcomes.
- **St Davids Branch Closure Verbal Update:** an update was received on the proposed closure of the Meddygfa Penrhyn branch surgery following confirmation that its current premises would no longer be available. Members noted the requirement for public engagement and the absence of suitable alternative premises.
- **Macmillan Cancer Support Neighbourhood Investment Partnership:** FET supported the strategic intent of the Macmillan Cancer Support Neighbourhood Investment Partnership and its innovative prevention-focused approach. However, significant concerns remained regarding benefits realisation, financial, workforce, governance and legal implications, and it was agreed that these issues must be addressed before the Full Business Case could progress through the formal approval process.
- **AHP&HS Directorate Integrated Governance Group:** the principal advisory issue identified was a lack of executive accountability for psychological therapies and social work. A report is being prepared for consideration by the Executive Team to support further discussion and resolution.

- **Pharmaceutical Needs Assessment (PNA) Update:** the PNA is a statutory document with confirmation received that the review had been completed within a five-year cycle, receiving FET approval ahead of presentation to the Strategy and Planning Committee (SPC) meeting on 20 August 2026.
- **Transport and Accessibility Plan:** FET emphasised the need for the Plan to deliver tangible benefits for patients and staff through improved access to healthcare, including transport and digital solutions. FET approved the Plan for onward consideration by SPC and Board, noting that its success would be measured by how effectively it informed future service planning and access decisions.
- **Patient Safety Plan 2026–31:** the Plan sets out a framework to strengthen a system-wide approach to patient safety by integrating quality, operational, workforce and cultural considerations. FET endorsed the overall direction of travel in principle, emphasising the need for clear governance, Executive leadership, prioritisation of key risks and robust implementation arrangements, with detailed delivery plans to be developed through the governance process.
- **Well-Being and Future Generations (WBFG) Annual Report:** FET welcomed the report's positive examples of progress against the Health Board's well-being objectives and approved its submission to SPC, while emphasising the need for future reports to demonstrate impact more clearly and align more closely with other annual reporting arrangements.
- **Perinatal Strategic Plan 2026-31:** FET supported its ambition to improve outcomes through an integrated approach across maternity, neonatal and paediatric services. Members requested further refinement to clarify the Plan's purpose, scope, governance route, executive ownership and intended outcomes before it progresses through the remaining governance and approval processes.
- **Patient Safety Plan:** Members endorsed the Health Board's response to the National Patient Safety Plan for NHS Wales 2026–2031 and proposed local priorities and executive oversight arrangements. The need for clear accountability, robust assurance and alignment with existing improvement programmes was emphasised, before the Plan progressed to QSEC and wider implementation.
- **Cylch Caron Update:** the project remains a key integrated care development for the Tregaron area. A joint phased proposal with Ceredigion County Council has been submitted for Welsh Government funding, with positive initial feedback, and will progress through a refreshed Outline Business Case process subject to approval.

In addition to the above, FET also receives regular updates on the following:

- **Corporate and Principal Risks:** reviewed the Corporate Risk Register and progress against agreed actions, focusing on high-scoring risks and strengthening arrangements for the scrutiny, escalation and de-escalation of corporate risks. The de-escalation of risk 2190 to operational level was approved, with plans for a new risk management system noted.
- **Escalation Status Update:** reviewed progress against escalation actions, highlighting the need for realistic performance trajectories aligned to workforce capacity, financial constraints and Annual Plan ambitions. Discussions focused on Urgent and Emergency Care challenges, performance improvement, and

strengthening the links between workforce, quality, planning and financial risks to support sustainable improvement.

- **Finance Update:** Members discussed delivery of savings schemes, conversion of forecast underspends into savings, and the need to identify a further £19m of cost reductions in 2026/27. Significant financial challenges remain, with limited recurrent savings opportunities requiring strengthened financial control and a more action-oriented recovery approach.
- **A Healthier Mid and West Wales (AHMWW) Group Update:** noted progress within the A Healthier Mid and West Wales programme, including completion of the stroke services consultation and ongoing engagement with Welsh Government regarding future stroke service developments and the wider business case.
- **Quality and Safety Intelligence Group:** alerts were raised regarding governance, service capacity and infection control, with Members emphasising the need for strengthened oversight and mitigation of workforce and patient safety risks.
- **Value & Sustainability (V&S) Group Update:** FET reviewed progress on savings delivery, variable pay, medicines management, medical rostering and planned care improvement, emphasising the need for strong governance, executive ownership and oversight to support efficiency, productivity and transformation programmes.
- **Operational Delivery Group Update:** concerns were highlighted regarding diagnostic, cancer and planned care performance, including data quality, waiting times, ambulance handovers and urgent care pressures. Risks associated with workforce, funding and service sustainability were highlighted, alongside the need for robust recovery plans and continued Welsh Government support to deliver recovery trajectories.
- **Waiting List Management Incident Control Group Update:** progress continued on reviewing a cohort of patients using a validated triage tool, with the review expected to conclude within eight weeks and learning to be shared through established governance processes.
- **Sleep Apnoea Incident Control Group:** the initial phase of the incident control work had been completed with a review of all patients who had had contact with the Service.