CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 May 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Chief Executive's Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Professor Phil Kloer, Chief Executive
SWYDDOG ADRODD: **REPORTING OFFICER:**	Professor Phil Kloer, Chief Executive

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 26 March 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

Board Assurance Framework
Following the Strategy Refresh presented to the Board for approval in January 2026, the timetable to refresh the Board Assurance Framework has been extended to July 2026. The refresh will include a review of the principal risks and the associated planning goals and outcome measures that support them.

Below is the timeline to review principal risks ahead of Board presentation in July 2026, as agreed by the Executive Team at its meeting in January 2026.

A full review of the Health Board's risk appetite will be presented to the Board in July 2026, following the Strategy Refresh presented to the Board in January and May 2026.

Risk Maturity Assessment 2026

The Health Board completed its annual risk maturity self-assessment in February 2026, in accordance with the Orange Book (the recognised public sector risk management standard). The findings will inform the objectives of the Risk Management Strategy, which is due to be presented to the Audit, Risk and Assurance Committee (ARAC) in August 2026 for endorsement, ahead of Board approval in September 2026.

Corporate Risk Register

The Corporate Risk Register (CRR) is presented to the Board to provide assurance that the corporate risks of 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, through 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 through 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 details included in Appendix 1.

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
- 1861 - Risk of harm to staff, patients public and critical assets due to insufficient physical security measures and systems.

New Risks

Since the previous report, 3 new risks and 1 escalated risk have been added to the Corporate Risk Register.

Risk	Executive Lead / Lead Function	Rationale for Current Risk Score
2204 - Risk of HB being unable to meet statutory Capital Resource Limit (CRL) due to uncertainties around funding provision and capital commitments *Risk escalated to the Corporate Risk Register in March 2026* **Current Risk Score: 1** **Target Risk Score: 8** **Expected Date to achieve Target Risk Score: 31/03/2026**	Director of Strategy and Planning (Strategy and Planning)	There was a significant level of spend remaining within the capital programme, approximately 60% at end of January 2026 due to planned programmes of work in quarter 4. Whilst plans in place, spend has yet to be incurred. There are key projects which should they not be delivered, would have a significant impact on the ability of the Health Board to achieve the CRL. Approval of Welsh Government (WG) capital funding in latter half of the year - this equates to £8m to date from November 2025. Decrease in Current Risk Score from 12 to 1 due to CRL being achieved by 31/03/26. This risk for 2025/26 did not materialise therefore it will be proposed to close this risk.
2305 - Risk to staff wellness due to pace and breadth of organisational change *Risk added to the Corporate Risk Register in March 2026* **Current Risk Score: 20** **Target Risk Score: 12** **Expected Date to achieve Target Risk Score: 31/03/2030**	Director of Workforce (Workforce & Organisational Development (WOD))	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 2024 NHS Wales Staff Survey further indicates that burnout remains a significant issue for the Health Board. The wider effects of organisational change are well recognised. Without careful management, it can erode organisational culture and staff experience, leading to increased employee relations issues, team dysfunction, sickness absence and turnover. These pressures risk creating a negative cycle that undermines engagement, productivity and overall performance.

2326- Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding *Risk added to the Corporate Risk Register in April 2026* **Current Risk Score: 20** **Target Risk Score: 12** **Expected Date to achieve Target Risk Score: 30/06/2026**	Director of Finance (DOF) (Finance)	2026/27 Financial Plan was submitted to WG in March 2026 with £41.0m planned deficit. WG confirmed plan is not supportable or acceptable, and restated expectation to deliver £22.0m deficit. Of £42.8m savings requirement, only £5.0m Amber/Green assured savings is evidenced, with £6.4m of Blue/Red ideas yet to be converted. Sensitivity analysis indicates 26/27 predicted deficit range of £54.3m to £90.5m, with min £13.3m of new savings actions even in best-case scenario. Delivery depends on pace. DOF Improvement Plan cascade issued 31 March 2026. A 4-Step Financial Improvement Framework shared with Executive Team in April 2026. Chief Executive reviews took place during April 2026, with an interim position reported to Board in May 2026. The Health Board must evidence a credible route from £41m to £22m, supported by first-month run-rate data and confirmed Executive ownership of each variable pay workstream. A draft revised COO Operating Model (April 2026) introduces Community Care Group (CCG) Delivery Agreements and aligns Levels 1 to 4 Performance Escalation Framework. System Leaders Workshop held April 2026, and value opportunities catalogue produced across 10 domains, drawing on over 25 national actions from NHS Wales 26/27 Planning Framework. Current risk score reflects early-year uncertainty, WG rejection of submitted position, limited level of assured savings, and several material controls in formation rather than operating.	
2327- Risk to planned care and RTT recovery in 2026/27 due to demand–capacity gaps, estate fragility and non-recurrent funding. *Risk added to the Corporate Risk Register in April 2026* **Current Risk Score: 12** **Target Risk Score: 9**	Chief Operating Officer (COO) (Scheduled Care)	The Health Board faces delivery risks in achieving ministerial planned care recovery targets by March 2027 due to combined pressures of cohort demand in key specialties and workforce limitations. Theatre cancellations at Glangwili Hospital 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	

Expected Date to achieve Target Risk Score: 31/03/2027		Swansea Bay University Health Board (SBUHB) 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 has accepted the trajectories set out in the Annual Plan.

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

- Risk 1821 - Risk to the welfare of Health Board staff due to current demands, has been closed as per agreement at Formal Executive Team held on 4 March 2026, and superseded by risk 2305 (see table above).
- Risk 2086- Risk that the cash consequences of the Health Board deficit cannot be covered by WG should it exceed our Target Control Total, has been closed on 21 April 2026 and superseded by risk 2326 (see table above)
- Risk 2104 - Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 25/26 due to demand exceeding capacity, has been closed on 22 April 2026 and superseded by risk 2327 (see table above)

New Health Board Operating Model and Ways of Working

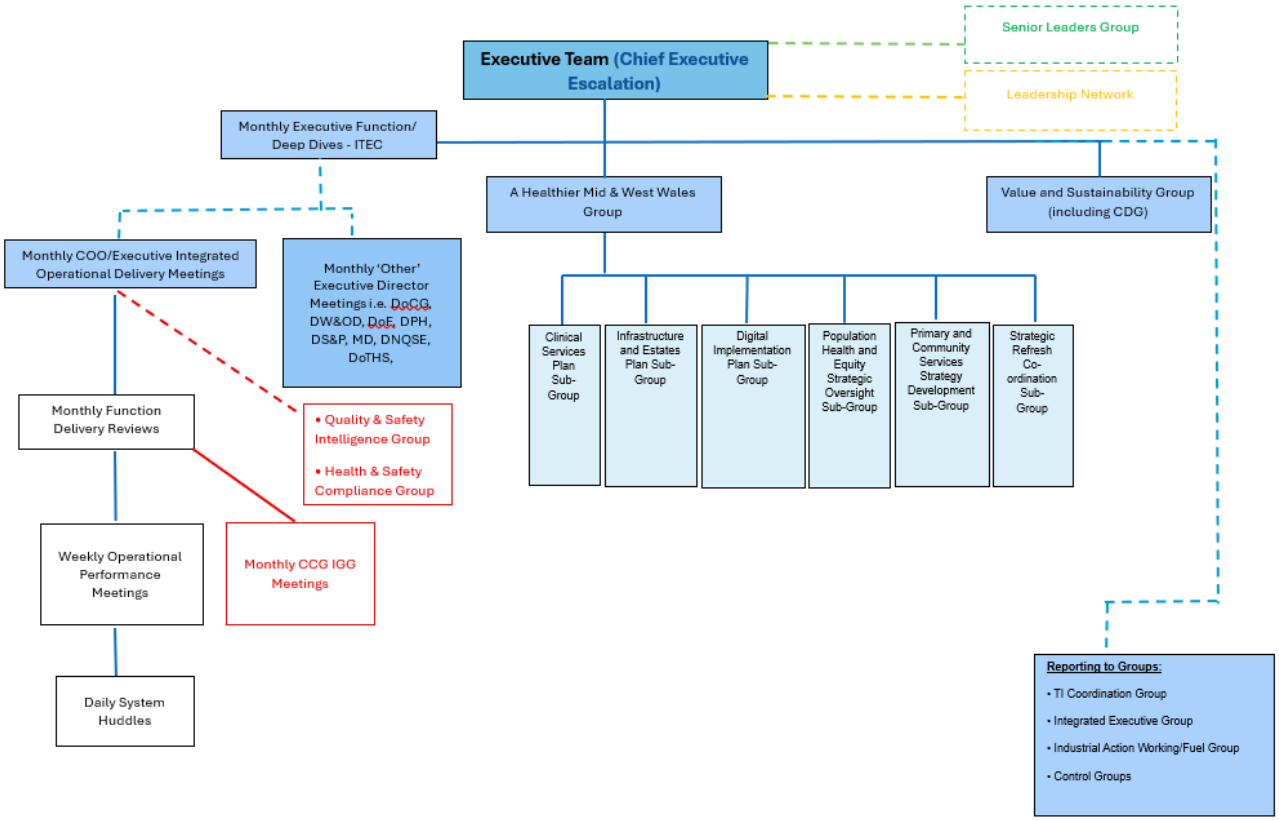
Following the joint leadership event that took place in April 2026, and the two day Executive Time Out held over 29 and 30 April to reflect on this event, work has taken place to shape a new way of working that is built on the valuable feedback and conversations held.

Operational teams have now been provided with a suite of documents designed to support them in this next phase of work:

1) A New Ways of Working pack – setting out how we will work together, the parameters within which we will all operate, and the ways we will support progress through a new meeting governance arrangement. To strengthen service delivery, two new groups have been introduced: a Senior Leaders Group to support service areas with cross-organisational programmes and local decision-making where appropriate; and a Leadership Network that will meet quarterly to share innovation, work through cross-organisational challenges, and provide valuable opportunities for networking and team development.
2) A brief financial and corporate governance pack - outlining decision-making responsibilities within our existing Board governance framework, intended to provide clarity on what sits within our respective remits.
3) The Performance and Delivery Agreement aligned to each service/function.

Meetings to support these new ways of working and tailored to each service/function will be introduced into diaries over the coming weeks, and any unnecessary meetings will be removed in order to streamline the governance arrangements in place.

See below for an organogram depicting these new meeting arrangements:



Changes to Welsh Government Oversight and Escalation Arrangements
Correspondence dated 14 April 2026 has been received from Jeremy Griffith, Director of Operations NHS Wales, providing an overview of changes to future governance assurance meetings following the introduction of the operating and accountability framework for NHS Wales from April 2026 which initiated a streamlined, risk-based oversight approach, with clearer consequences for non-delivery.

As part of these changes, an Escalation Board for HDdUHB is to be established with its first meeting scheduled for 3 June 2026, to oversee progress across the escalation domains which replaces the quarterly targeted intervention meetings. Draft Terms of Reference for this new Escalation Board were included with the correspondence, and both are attached at *Appendices 2 and 3.*

Cross Hands Community Hub: Novation Agreement and Deed of Cancellation and Termination of Parent Company Guarantee
The Project Management company appointed to work on the Cross Hands Health and Wellbeing Centre scheme to provide professional services was recently "demerged" as part of a third-party investment deal; they were formerly known as Mace Group and will now be called Mace Consult. Goldman Sachs Alternatives will own a majority shareholding in the company.

Mace Group was originally appointed under the Building for Wales (BfW) Framework and were required to provide a Parent Company Guarantee (PGC). Mace has advised that the PCG will be brought to an end.

The following documents are attached for consideration and background:
- Novation Agreement that applies to both the Cross Hands Community Hub and the Glangwili Fire Precaution Works (Appendix 4);

- Deed of Cancellation and Termination of Parent Company Guarantee that applies to the Cross Hands Community Hub only (Appendix 5).

Advice is that Mace Consult is in a stable condition with good financial strength and has a low risk of failure (probability 0.06% compared with industry average of 0.31%). NHS Wales Shared Services Partnership Specialist Estates Services has noted that the level of perceived risk in choosing to novate existing contracts with Mace Limited to Mace Consult without the continued provision of a PCG is low. The final decision on whether to enter into contract with Mace Consult without a PCG or bond, or enter into contract with Mace Consult with a bond, rest with the Health Board.

There is no current provision for a Bond within Call-Off Contracts through BfW1 or other legacy frameworks; it can be incorporated through mutual agreement of both parties. A bond has the advantage that the security is provided by a third party and bond providers rarely fold. However, it will typically only guarantee 10% of the contract value.

Based on this assessment, and the nature of their appointment, the Capital team do not believe that a Performance Bond would be necessary in this case.

Members are asked to approve the Novation Agreement (Appendix 4) that will be signed by the Executive Director of Strategy and Planning following Board approval, and agree to the Deed of Cancellation and Termination being sealed.

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 6 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 7, should any Board Member wish to contribute.

Formal Executive Team Meetings
Since my previous report to Board, the Formal Executive Team (ET) has met regularly; key items considered are attached at Appendix 8.

Argymhelliad / Recommendation

The Board is asked to:

- **NOTE** the timelines to review and refresh the Health Board's Board Assurance Framework
- **NOTE** the Corporate Risk Register (CRR) report (Appendix 1) and summary
- **NOTE** correspondence around changes to Welsh Government Oversight and Escalation Arrangements and Terms of Reference for the new HDdUHB Escalation Board (Appendices 2 and 3)

- **APPROVE** the Novation Agreement (Appendix 4) for the Cross Hands Community Hub and Glangwili Fire Precaution Works, that will be signed by the Executive Director of Strategy and Planning, following Board approval
- **AGREE** to the Deed of Cancellation and Termination of Parent Company Guarantee that applies to the Cross Hands Community Hub only (Appendix 5) being sealed
- **ENDORSE** the Register of Sealings since the previous report on 26 March 2026 (Appendix 6)
- **NOTE** the status report for Consultation Documents received/responded to (Appendix 7)
- **NOTE** Executive Team discussions (Appendix 8)

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr 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
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives 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 Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	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
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.

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Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score May-26	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score	Risk on page no...
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	7
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	12
2079	Risk of loss of Pathology services across the Health Board due to delayed implementation of LIMS	Carruthers, Andrew	Service/Business interruption/disruption	4×5=20	4×5=20	→	1×5=5	31/12/2026	15
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	31/08/2026	21
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	26
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	31
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	35
2326	Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding	Thomas, Huw -	Finance inc. claims	NA	4×5=20	New risk	3×4=12	30/06/2026	40
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	45
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	50
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
1978	Risk of insufficiently skilled workforce to deliver services due to limited labour market	Gostling, Lisa	Workforce/OD	4×4=16	4×4=16	→	3×4=12	31/03/2027	58
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	64
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	69
1860	Risk of serious harm to staff due to violence & aggression in the workplace	Severs, James	Safety - Patient, Staff or Public	5×3=15	5×3=15	→	3×3=9	01/04/2027	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	78
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	30/06/2026	81
2190	Risk of CHC service users experiencing a delay in their choice of care provision via Direct Payments.	Carruthers, Andrew	Quality/Complaints/Audit	4×3=12	4×3=12	→	2×4=8	31/08/2026	88
1350	Risk of not meeting the 80% SCP waiting times target for March 2026 due to diagnostics capacity and delays at tertiary centre	Carruthers, Andrew	Quality/Complaints/Audit	4×4=16	3×4=12	↓	2×4=8	31/03/2026	92
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	96

2327	Risk to planned care and RTT recovery in 2026/27 due to demand-capacity gaps, estate fragility and nonâ€‘recurrent funding	Carruthers, Andrew	Quality/Complaints/Audit	NA	**3×4=12**	New risk	**3×3=9**	31/03/2027	99
2204	Risk of HB being unable to meet statutory CRL due to uncertainties around funding provision and capital commitments	Davies, Lee	Finance inc. claims	**4×3=12**	**1×1=1**	↓	**4×2=8**	31/03/2026	103

RISK SCORING MATRIX

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

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

RISK MATRIX

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

RISK ASSESSMENT - FREQUENCY OF REVIEW

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

Assurance Key:

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

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

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

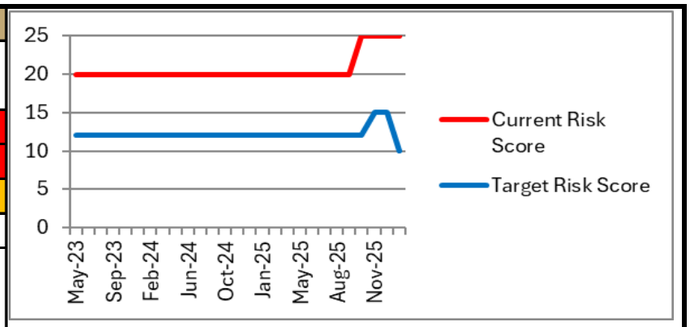
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective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

Date Risk Identified:	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:**	Apr-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	May-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)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
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.	Health board wide governance of ultrasound pathways Pathway workforce diversification - Training pipeline does not meet demand or workforce turnover. Training capacity (trainees available but inadequate internal capacity to train) Centralised booking - due to commence June 26 to improve cross site cover. Insourcing/outsourcing/Agency/Locum capacity	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. 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. June 2025: Midwife sonographer is now undertaking required training and expected to qualify in January 2026. Jan 26 - midwife sonographer has undertaken course and starting preceptership

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	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
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~~ 31/05/2026	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.
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~~ 31/05/2026	Action agreed in Dec 2025. delay due to workload - JD in process - delay due to workload pressure on lead,
Midwife sonographer undertaking preceptorship to be able to work independently - radiology supporting	Procter, Sarah	29/01/2027	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 (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
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								

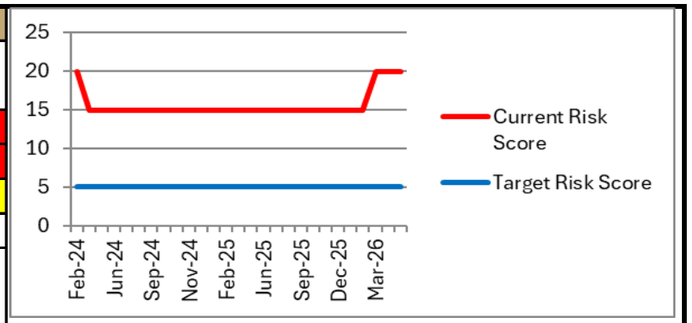
Date Risk Identified:	Feb-24		
Strategic Objective:	3. Great Care		

Executive Director Owner:	Henwood, Mr Mark	**Date of Review:**	Apr-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	May-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:	⟷



Rationale for CURRENT Risk Score:

Withybush Aseptic Unit is the only remaining aseptic unit in the Health Board capable of producing cancer treatments. However, it is currently non-compliant with regulatory standards. A 2024 audit deemed it a high risk to patient safety, and a 2025 follow-up confirmed ongoing staffing issues and insufficient resources to maintain quality standards, putting the unit at risk of forced closure.

Temporary control measures have been implemented to reduce microbial contamination and delay closure (see control measures), but the aging infrastructure means these measures may soon become ineffective. If contamination increases, the unit may be forced to close. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality.

The risk has been recently been increased to 20 to reflect that the service does not have enough staffing resilience, resulting in insufficient time being dedicated to maintaining the Quality System. Because a robust Quality System is a key control to prevent forced closure, the current lack of resource increases the overall risk. An invest to save proposal has been developed which has been to the quality impact assessment panel, the OAHP&HS CCG igg and financial control steering group, who requested further scrutiny on the financial impact, with the aim to complete this work by end of April 2026.

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** Further action necessary to address the controls gaps	**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.	Controls are reliant on a key group of skilled staff (i.e to maintain Quality System, to follow cleaning and monitoring procedures) therefore subject to key person dependencies. Availability of additional Pharmacists is limited due to their existing workloads. Findings from the audit undertaken in February 2025 highlighted the fragility of the workforce due to key person dependencies which could detrimentally impact on the service. Limited accommodation to employ additional staff to expand workforce within the existing unit at WGH. Limited accommodation to store starting materials and finished products or to perform the associated tasks that are required to safely supply cancer treatments. Between 2021 and 2023, the number of cancer treatments requiring aseptic preparation at Hywel Dda increased from 12,718 to 16,648 (average of 14% increase each year). There is limited space within the Pharmacy at WGH to manage this increase in demand.	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. Discussions held with other Health Boards to explore whether they have QA resource that could support Hywel Dda through a SLA. Invest to save SBAR, with QIA, which would support more staff to work within the aseptic unit through a cost saving opportunity (reducing outsourcing of Azacitidine) presented to FCSG on 11.03.2026 who requested further scrutiny on the financial impact by end of Apr26.
		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	Project is underway and based on current timelines, the new unit will be operational by September 2026.
		Recruit bank pharmacists to take on clinical activities currently being performed by aseptics pharmacists	Morgan, Cerith	30/06/2026	Recruitment process is underway.
		Finalise Memorandum of Understanding with Cwm Taf UHB for quality assurance support	Morgan, Cerith	30/06/2026	Memorandum of Understanding is with Corporate Legal Services to review.
		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 is underway and due to be completed by May, with a plan to be developed and implemented by Sep26.

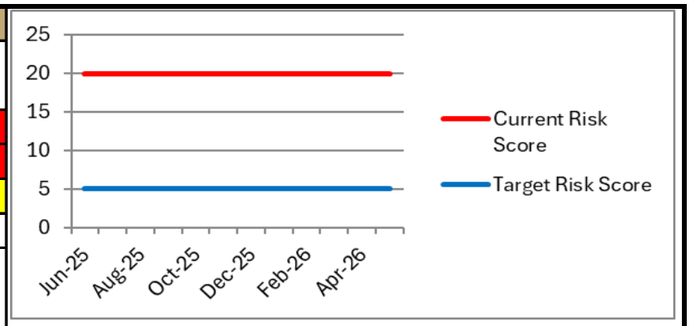
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
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								

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Apr-26
Lead Committee:	Digital, Data and Innovation Committee	**Date of Next Review:**	May-26

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		

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:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET 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. User Acceptance Testing (UAT) began on a system which was not built and integrated, leading to inefficient and repetitive testing, there is a lack of Health Board resource to support the volume of testing and validation subsequently required. The project plan milestones have consistently not been met by DHCW and there is significant build, configuration and testing work to be completed to provide a safe, functional and reliable minimal viable product by the end of the year. The delay affects the pace and scale of pathology service transformation as set out in the HDUHB Annual Plan 25/26. The December LIMS 2.0 Programme Board acknowledged that the original timescales for delivery by March 2026 are no longer achievable. The revised plan anticipates delivery commencing in January 2026, with completion extending beyond March 2026; however, a definitive completion date has not yet been confirmed. The Programme Board has advised that no further funding will be available beyond March 2026. No certainty on funding beyond this date. 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.	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** Further action necessary to address the controls gaps	**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. 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.	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 will only enable continuity for up to 5 days. More long term contingencies would involve reliance on supplier middleware solutions and outsourcing for histology. 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.	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	DHCW presented the current position to Health Board CEOs on 8th April and they have requested a detailed, costed, contingency plan is developed by DHCW and ISC for review by Health Boards. 28/05/2025 - No contingency plan agreed at last LIMS Programme Board. Revised plan and costings to be provided by next programme board. 26/06/2025 - Mitigation plan agreed in June Programme Board, changing from HB deployment to discipline deployment with Microbiology commencing in July and the final discipline (Blood transfusion) going live in Jan 2026. National contingency plan inc costings has been submitted to Health Board CEOs via DHCW.

	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 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	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.
		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.

Transfusion.

24/04/2026 - Delays to Tranche 3 (approx go live 22nd June), May cause further delay to Tranche 4&5.

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.
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)
Sign off tranche 3 (Microbiology - Feb 26)	Jones*, Dylan	~~30/01/2026~~ ~~30/04/2026~~ ~~31/05/2026~~ 30/06/2026	tranche 3 moved to later in 2026
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.
Escalated BT options SBAR to Execs for decision. include financial impact of decision.	Jones*, Dylan	~~31/03/2026~~ ~~07/04/2026~~ ~~30/04/2026~~ 31/05/2026	SBAR drafted and discussed with CCG and DoD. waiting costings from Dedulas

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
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								

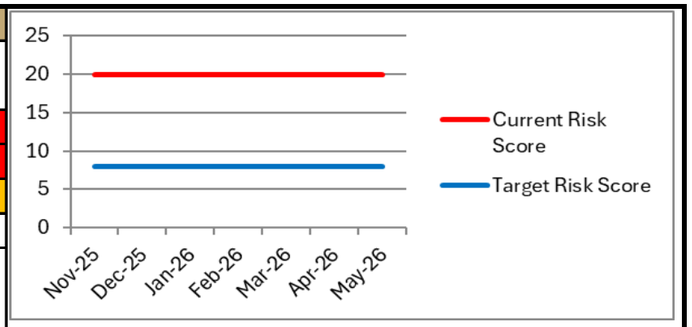
Date Risk Identified:	Feb-22		
Strategic Objective:	3. Great Care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Apr-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	May-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:	31/08/2026
Trend:	⟷



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.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1. 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. 8. Participation, engagement and communication with the Health Board's Mortality Group, medical colleagues, Medical Examiner Service and external stakeholders	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 the delays in these processes as a result of sources beyond the Health Board's control (MES, HMC, PM service disruption etc)? 4 & 5. Due to the national shortage of body storage capacity, death	Requirement of additional body storage capacity health board wide. Capital funding needs to be secured.	Baker, Craig	~~31/03/2025~~ ~~31/03/2026~~ ~~30/04/2026~~ 31/12/2026	To be escalated via CCG structure 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. In addition, currently reviewing BGH footprint to look at increase of freezer capacity to cover HB. 29/12/25 - Capital funding secured to increase freezer capacity at BGH.

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.	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.
	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.

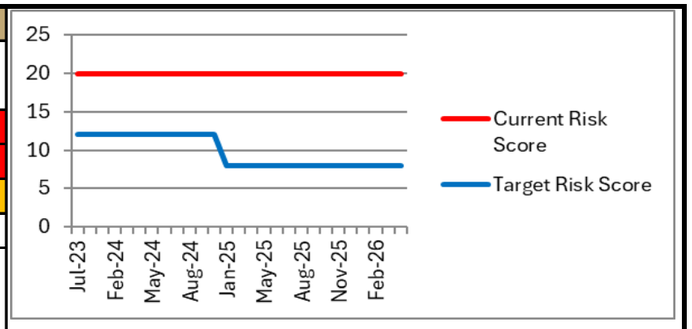
Seek external advice on enhancement of mortuary storage capacity within current mortuary estate footprint.	Brown , Yasmin	Completed	Initial site visit has taken place with Wessex refrigeration to determine the art of the possible within the existing GGH mortuary facility footprint. Awaiting receipt of 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	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 facilites - 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

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
	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:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Feb-26
Strategic Objective:	2. Healthier Communities and 3. Great Care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Mar-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 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+65	

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):	2×4=8
Expected Date To Achieve TRS:	31/10/2028
Trend:	⟷



Rationale for CURRENT Risk Score:
The most recent available data highlights sustained high operational pressures across all acute sites with increased escalation levels throughout January and early February 2026. Although some key performance metrics show slight improvement over the last year, all are above Targeted Intervention (TI) targets in January 2026 (e.g. average time to clinical assessment in ED Jan: 68 mins, TI target: 60 mins; Numbers of >1hr ambulance handovers Jan: 716, TI target: 680). POCDs in January were 213 , above the TI target of 174. Actions to improve flow include implementation of the 7-day Clinical Streaming, Hospital at Home and Optimal SDEC services were agreed at Public Board in January 2026. Whilst the Board has approved the business case in January 2026, and additional control measures have been implemented, system pressures remain and TI targets are not consistently being met therefore the current risk score remains at 20 as at February 2026.

Rationale for TARGET Risk Score:
The target risk score of 8 reflects the confidence in the delivery of 6 Goals Programme and the Accelerated Transformation Programme to address the significant issues across the health and care system. Plans for improvement during 2025/26 are reflected in the HB's Annual Plan, approved by the Board in March 2025, and are informing next year's Annual Plan. The 6 goals plan has been approved by WG in March 2025. TI measures such as ambulance handovers 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. UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly into Formal Executive Team. The expected date to achieve the TRS has been amended from March 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** Further action necessary to address the controls gaps	**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. 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	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. • Need to create a Health Board wide Frailty approach, including appointment of a Frailty Clinical Lead. • 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.	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	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.
		Utilise the risk stratification data set across the system proactively with the population	Skitt, Peter	~~30/04/2025~~ 31/10/2025	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	This has been action has been superseded, 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.

facilitate step down. • Regular weekly reviews of long stay patients (>7 days) with agreed 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. 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 Improvement • UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly to the Executive Team. • 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	• Fragility of senior medical cover in Emergency Departments across acute sites, requiring workforce and succession planning. Quality Control • Inability to hand over ambulances promptly due to lack of flow through acute sites. • 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. • UEC Transformation Acceleration Group (TAG) not meeting as of January 2026, reducing operational oversight and grip on improvement delivery. • Insufficient number of isolation rooms (IP&C management) actively constraining patient placement and exacerbating flow problems. Quality Assurance • Gap in communication between secondary and primary care that risks poor discharge outcomes and discontinuity of 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. • Paused TAG reducing formal assurance to Executive level on progress against the UEC improvement	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.
		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.
		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	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.

variation across the system.	agenda. Quality Improvement • Need for better understanding of ED presentation patterns to inform development of alternative primary care and community pathways. • Development of proactive anticipatory care planning for people at 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 delivery. • Strengthening discharge coordination and communication pathways to improve patient outcomes and flow. • Restart and re energising of the UEC Transformation Acceleration Group (TAG) to drive, track and accelerate improvement delivery.	Implementation of 7 focused areas within ED Quality statement.	Skitt, Peter	31/03/2026	Clinical lead for ED post currently out to advert. ED Quality Statement Action group in place, who report 6 weekly 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.	Steele, Cathie	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

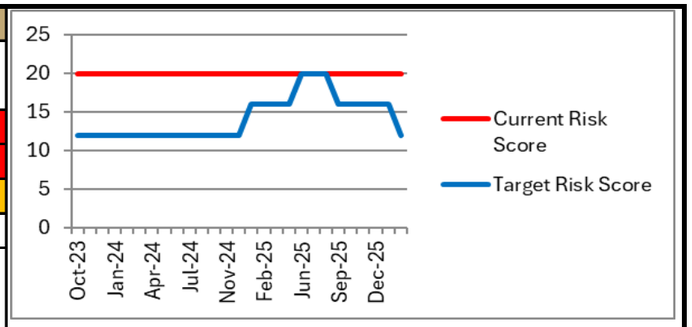
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
• 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 IQFPD 3As report into IQFPD	2nd								
	• Bi-annual reports to SDODC 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								

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:**	Apr-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	May-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:	⟺



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 wholeâ€'system, needsâ€'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** Further action necessary to address the controls gaps	**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 Early Years pathway and toolkit for Health Visitors in place to encourage a 'watch and wait' approach. Professional consultation introduced across statutory sectors	Estates - lack of appropriate dedicated child-centred premises to run clinics Recruitment delays Financial climate and associated cost pressures impacting on acquisition of appropriate IT infrastructure and hard wear that could create more efficiencies 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. Lack of a regional partnership strategic action plan to help bring about transformational change across the 3 counties involving all stakeholders.	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
		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
		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
		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.
		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.

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.	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.

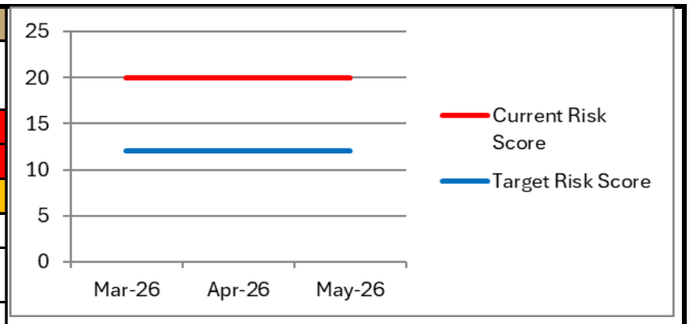
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Welsh Government performance indicators along with internal monitoring arrangements will be used to ensure the actions are having the desires 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	System to improve analysis of patient experience				

	Monthly MH&LD Integrated Governance Group (BPPP & QSEG)	1st			been presented at the Quality 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. Papers were presented at Board Seminar in March & September 2025 to provide assurance on current waiting times and control measures.					
	An updated paper was submitted to the September 2025 Board meeting.	2nd								

Date Risk Identified:	Nov-25	**Executive Director Owner:**	Gostling, Lisa	**Date of Review:**	Apr-26
Strategic Objective:	1. Thriving Teams and 2. Healthier Communities and 3. Great Care and 4. Positive Futures	**Lead Committee:**	People, Organisational Development and Culture Committee	**Date of Next Review:**	May-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:	*New risk*



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 2024 NHS Wales Staff Survey further indicates that burnout remains a significant issue for the Health Board.

The wider effects of organisational change are well recognised. Without careful management, it can erode organisational culture and staff experience, leading to increased employee relations issues, team dysfunction, sickness absence and turnover. These pressures risk creating a negative cycle that undermines engagement, productivity and overall performance.

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** Further action necessary to address the controls gaps	**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 timeâ€‘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 dataâ€‘informed approach to identifying and prioritising sickness absence challenges. Together, they establish discreet, multiâ€‘disciplinary project teams that apply a structured qualityâ€‘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 Allâ€‘Wales workforce requirements and provide practical, readyâ€‘toâ€‘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 personâ€‘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.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Performance Dashboards	Executive Team meetings (Risk led) (1st line,	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 line,	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 line,	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 line,	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 line,	3rd								
	Staff Partnership Forum (3rd line,	3rd								
	TI and JET assurance meetings (3rd line,	3rd								

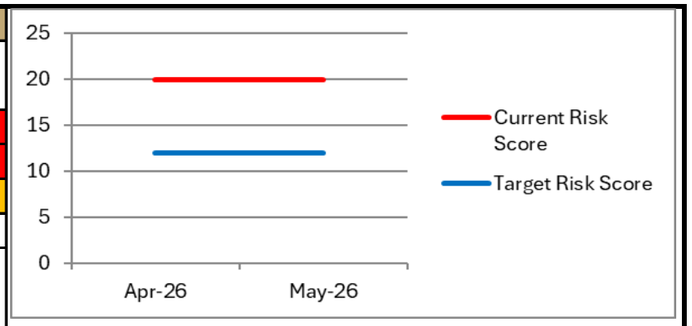
Date Risk Identified:	Apr-26		
Strategic Objective:	1. Thriving Teams and 2. Healthier Communities and 3. Great Care and 4. Positive Futures		

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

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

Does this risk link to any Directorate (operational) risks?	2212, 2132, 2148, 2131, 2110, 1869, 1631, 975, 2107, 1906, 1892, 971, 2040, 2124, 2045, 1951, 716, 134, 1775, 1773, 1931, 1646.

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	3×4=12
Expected Date To Achieve TRS:	30/06/2026
Trend:	*New risk*



Rationale for CURRENT Risk Score:

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

Rationale for TARGET Risk Score:

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

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

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1. Working Day 1 principles retained within the finance function to ensure timely 'Flash reports' to the Executive Team. 2. Timely, relevant and understandable reporting to budget managers, Executives, Committees, Board and WG via QlikSense (live, self-service) and monthly management information packs. 3. Oversight arrangements through Integrated Quality, Financial Performance and Delivery Group, Value and Sustainability Group, and the Healthier Mid and West Wales Group. 4. Executive meetings and the Internal Escalation Framework embedded across the organisation, covering seven domains including Finance. 5. Financial control scrutiny of agency medical, agency AHP, Admin and Clerical and newly created roles for recruitment and procurement. 6. Opportunities compendium framework, updated and shared monthly. 7. Substantive operational structures in place since April 2025, providing managerial clarity and consistent accountability. 8. Business Controlling team alignment to CCG/CSG and Executive Function management structures. 9. CCG Accountability Agreements to be created and issued for 2026/27.	Material residual gaps in control are: Primary controllable gap: Variable pay (substantive bank, overtime, waiting list initiatives and agency) is the single largest in-year controllable expenditure line. Across nursing, medical and other staff groups, there is not yet a deliverable plan covering the three dimensions of (i) recruitment assurance, (ii) deployment (rostering, sickness management, medical job planning), and (iii) configuration (establishment, service model, site working). Other open gaps: 1. Limited assured savings plans: only	Nursing - configuration: review and confirm nursing establishments, ward and bed base alignment, skill mix and safe staffing levels. Configuration options to May Board (28 May 2026); decisions confirmed and consequential variable pay release evidenced by 30 June 2026.	Carruthers, Andrew	30/06/2026	Linked to Choices and Value workbook beds-related opportunities and to the Value Opportunities Catalogue.
		Medical - deployment: consultant job planning compliance trajectory toward the NHS Wales >90% standard (national deadline 30 September 2026); medical rostering system implementation; sickness absence management; tight controls over waiting list initiative and overtime usage. Interim position to May Board (28 May 2026); deployment plan and early compliance evidence by 30 June 2026.	Henwood, Mr Mark	30/06/2026	Medical rostering programme continues from 2025/26 with further milestones and quantified benefits to be articulated. 30 June 2026 is the Health Board internal deadline; 30 September 2026 remains the national job planning compliance target.

10. Director of Finance 4-Step Financial Improvement Framework cascaded on 31 March 2026 and reviewed by the Executive Team on 8 April 2026. 11. CEO-led review cycle on 22 and 29-30 April 2026 against the 4-Step Framework; Board update on 28 May 2026. 12. Revised COO Operating Model (draft, April 2026) introducing CCG Delivery Agreements covering Quality & Safety, Finance, Workforce, Risk, Performance and Transformation, to be issued by 30 April 2026, and a Performance Escalation Framework (Levels 1 to 4) aligned to a tiered meeting structure. 13. Value Opportunities Catalogue (SBAR, April 2026) covering ten clinical and operational domains and over 25 national enabling actions from the NHS Wales 2026/27 Planning Framework, providing a defined starting set for pathway and productivity improvement. 14. Director of Finance Choices and Value workbook (9 April 2026) consolidating specific cash-out and productivity opportunities across 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.	£5.0m of Amber/Green against the £42.8m 2026/27 requirement. 2. £6.4m of Blue/Red (unconfirmed) savings ideas not yet converted into deliverable plans. 3. Continued reliance on non-recurrent measures carried from 2025/26. 4. Effective management of beds and patient flow. 5. Effective contract management and oversight of commissioned services. 6. Organisational change delivery capacity, including transformation resourcing and alignment. 7. Revised COO Operating Model remains in draft; CCG Delivery Agreements not yet issued; Level 4 escalation triggers, finance authority at each operating layer, and the executive team mechanism between Level 3b and CEO are not yet defined. 8. Value Opportunities Catalogue identifies opportunities but is not yet converted into delivery at scale.	Medical - configuration: review service model, on-call arrangements and site working (including single-site and cross-site consolidation) with consequential release of variable pay requirement. Options to May Board (28 May 2026); preferred direction confirmed by 30 June 2026.	Carruthers, Andrew	30/06/2026	Linked to Choices and Value workbook strategic opportunities (including Bronglais maternity/paediatrics, radiology OOH, pathology site model).
		Allied Health Professions and Health Sciences: deliver trajectory toward 30% agency reduction against 2025/26 outturn; zero agency in HSW, Admin and Clerical, Estates and Ancillary (national deadline 30 September 2026); AHP Rate Card implementation; sickness absence reduction. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Severs, James	30/06/2026	Targets drawn from NHS Wales 2026/27 Planning Framework. 30 June 2026 is the Health Board cadence deadline for deliverable plans; national zero-agency targets sit at 30 September 2026.
		Other staff groups (Admin and Clerical, Estates and Ancillary, Trainees): deliver trajectory toward 30% agency reduction against 2025/26 outturn; zero agency in HSW, Admin and Clerical, Estates and Ancillary (national deadline 30 September 2026); AHP Rate Card implementation; sickness absence reduction. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Gostling, Lisa	30/06/2026	Targets drawn from NHS Wales 2026/27 Planning Framework. 30 June 2026 is the Health Board cadence deadline for deliverable plans; national zero-agency targets sit at 30 September 2026.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance against the 2026/27 operational plan and targets through key performance indicators. In-month financial monitoring and forecasting against the £41.0m plan, with trajectory toward the £22.0m improvement target. Implementation of CCG Delivery Agreements and Performance Escalation Framework (Levels 1 to 4).	Performance against plan monitored through Executive Improving Together meetings, 4-Step Financial Improvement Framework and CCG monthly performance reviews.	1st			Executive Team - 8 April 2026 (4-Step Framework) System Leaders Workshop - 15 April 2026 (Nantgaredig) Chief Executive Reviews - 22 and 29-30 April 2026 Finance and Performance Committee 30 April 2026 Board - 28 May 2026 (plan improvement action from £41m to £22m) Finance and Performance Committee - scheduled 2026/27 cycle	Assurance gaps carried into 2026/27: 1. Limited Amber/Green assurance over 2026/27 savings delivery (£5.0m of £42.8m). 2. Outstanding Audit Wales and Internal Audit recommendations from 2025/26 (operational governance, discharge management, rostering). 3. Delivery of change remains a longstanding issue. 4. WG has rejected the £41m submitted position, so external assurance over plan acceptability is not yet in place. 5. Year 1 Value Opportunities Catalogue	Nursing - recruitment assurance: confirm substantive recruitment pipeline and fill rates against funded establishment; eliminate off-contract nursing agency; HSW agency trajectory to zero. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Daniel, Sharon	30/06/2026	Plan to be developed through the April 2026 CEO Review cycle; first cut to May 2026 Board.
	Finance and Performance Committee oversight of 2026/27 plan delivery and improvement trajectory.	2nd					Nursing - recruitment assurance: confirm substantive recruitment pipeline and fill rates against funded establishment; eliminate off-contract nursing agency; HSW agency trajectory to zero. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Daniel, Sharon	30/06/2026	To be progressed through the COO Operating Model and Delivery Agreements (issued by 30 April 2026), with weekly drumbeat thereafter.
	Transformation and Financial Report to Board and Finance and Performance Committee.	2nd					Medical - recruitment assurance: confirm substantive and international medical recruitment plans against consultant and SAS vacancies; eliminate off-contract medical agency; enforce Medical Rate Card compliance. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Henwood, Mr Mark	30/06/2026	Medical Rate Card implemented 1 March 2026 (estimated £380k annual cost increase; approved for fairness and governance). Recruitment assurance plan to be developed through April CEO Review cycle.

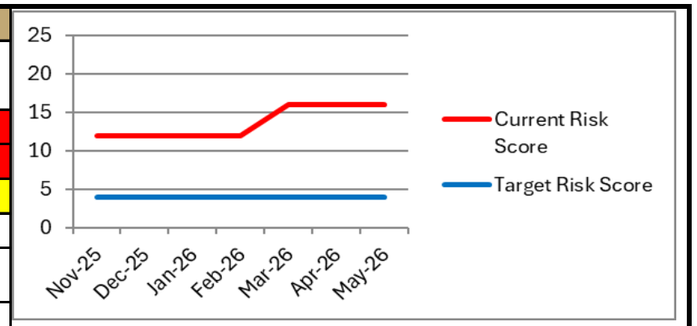
	WG scrutiny through Monthly Monitoring Returns and NHS Exec Financial Planning and Delivery team.	3rd			excludes digital, primary care, equity, workforce capability and prevention economics, limiting the assurance scope until year 2/3 iterations are developed.	Operational oversight and control will be consistently embedded following the review and implementation of Phase 2 of the Operational Organisations Change Process, providing clear, timely and specific escalation interventions for all Clinical Care Groups that are not delivering their targeted financial savings.	Carruthers, Andrew	30/06/2026	Task and Finish Group established with the deadline of the May 2026 People Committee to provide a comprehensive proposal and implementation timeline, following Executive Team approval.
	Audit Wales Structured Assessment process.	3rd							

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

Executive Director Owner:	Davies, Lee	**Date of Review:**	May-26
Lead Committee:	Strategy and Planning Committee	**Date of Next Review:**	Jun-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, UEC, and Hospital Acquired Infections. The score has been reviewed through a multi-criteria weighted analysis comparing the 25/26 baseline score of 12 with the 26/27 Annual Plan position. 6 of 10 dimensions have worsened, 3 are unchanged and 1 has improved. Likelihood remains 4, but consequence has moved from 3 to 4, leading to an increase in current risk score to 16.

The plan is a stronger planning product, with risk-led prioritisation, Priority Bundles, demand & capacity modelling, strategy refresh and Clinical Services Plan decisions. However, it makes a more challenging position clear: projected £41.0m deficit including WRP is a deterioration against the previous £31.5m control total and 2025/26 £22.0m outturn, and TI criteria cannot be met in full within available resources whilst maintaining safe services. The consequence is greater because the plan identifies 656 risks, incl.391 scoring 12+, 63 scoring 20+ and 9 extreme risks. This includes 226 patient safety risks, current harm from surge and boarding pressures, e-prescribing discontinuation, workforce fragility and more than 100 estates-related risks. This supports the current risk score of 16.

Rationale for TARGET Risk Score:

The target risk score of 4 and expected achievement date of 31/03/2028 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 increase from 12 to 16 widens the gap to target and 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.

The score should be reviewed following Welsh Government's formal assessment of the 2026/27 plan; the Senedd election and any resulting funding or priority changes; the Q2 financial review and savings delivery assessment; and the Welsh Government recovery funding decision.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1. 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. 6. External dependencies remain material, including Welsh Government recovery funding, capital, diagnostics, national priorities and post-election changes. 7. Annual Plan delivery requires clearer milestones, trajectories, benefits and accountable recovery actions. 8. The March 2028 target date requires review.	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	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 are being considered and will be presented to Board in May 2026. These will then be submitted to WG for their consideration and feedback.
		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.
		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.

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	30/06/2026	Annual Plan submitted. Planning cycle and Priority Bundle delivery to be monitored through Planning Co-ordination Group, Business Executive Team, Strategy and Planning Committee and Board, with Q1 review to confirm milestones.
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	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 (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
1. Current risk score: 16 (4Ã—4); target score: 4. 2. 2026/27 Annual Plan submitted; approvable IMTP not yet achieved. 3. Section 175(2A) statutory planning breach continues. 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	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 Planning Framework and formal assessment; Planning Maturity Matrix; IA Annual Planning - May 2025 (Reasonable); operational and corporate risk register reports.	1. Welsh Government's formal assessment of the 2026/27 Annual Plan is awaited. 2. Limited assurance that the three-year financial trajectory will reach breakeven by 31/03/2028. 3. Recurrent savings, WRP assumptions and recovery actions are not yet fully assured. 4. Further triangulation is required between quality and safety, workforce, estates, digital, finance and performance risks and the IMTP route map. 5. FET and Board	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	Awaiting formal Welsh Government response. Risk score remains 16 pending review.
	Business Executive Team and Formal Executive Team oversight of Annual Plan delivery, Priority Bundles, risk score and target date.	1st					Provide Q1/Q2 Annual Plan delivery reports showing Priority Bundle milestones, savings delivery, risk movement, benefits and corrective actions.	Davies, Lee	30/09/2026	Delivery reports to be reviewed through Planning Co-ordination Group, Executive governance, SPC and Board.
	Strategy and Planning Committee and Board assurance on the Annual Plan, strategy refresh and Clinical Services Plan implementation.	2nd					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					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					Formal Executive Team and Board to review whether the target risk score and March 2028 target date remain realistic.	Davies, Lee	31/07/2026	Target date under review following current risk score increase to 16.

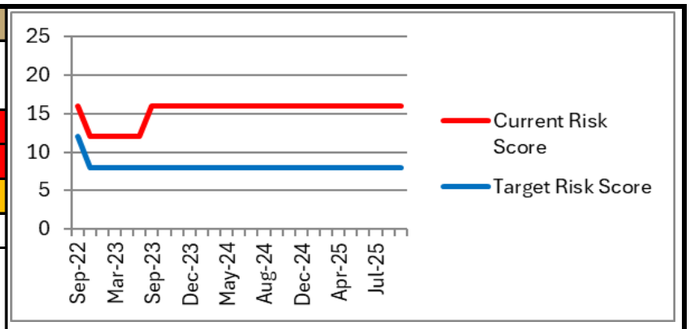
12+; 63 score 20+; 9 extreme. 8. Quality, workforce, estates and digital exposure: 226 patient safety risks, surge/boarding harm, workforce fragility, e-prescribing discontinuation and 100+ estates risks.	Planning Maturity Matrix and annual planning self-assessment presented to Board and Welsh Government.	2nd				have not yet reviewed whether the target risk score and March 2028 date remain realistic following the increase to 16. 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:	Jan-19		
Strategic Objective:	3. Great Care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Apr-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	May-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:	⟷



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 HIWâ€‘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. Likeâ€‘forâ€‘like replacement is not always costâ€‘effective or compliant with regulatory and warranty requirements, and infrastructure upgradesâ€"such as air handling, water chillers, and accommodation adjustmentsâ€"are needed to ensure longâ€‘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 lowerâ€‘priority equipment being replaced ahead of higherâ€‘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 SPECTâ€‘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** Further action necessary to address the controls gaps	**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. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports. # 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. # All equipment at main sites are now DR and so will be compliant with the RISP project # Additional WGH EOY funding was secured (23-24 financial year) and replaced aged US units and upgraded the software on MRI scanners at BGH and WGH providing latest technology.	Limitation of spare parts for some older equipment leading to extended outages. This issue has been compounded by Brexit. 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 required 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	No funding allocated as of 09/02/2024 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 instruction T&F looking to alternative sites and will resubmit for funding in 26/27.
		Replacement of aged CT Scanner at GGH	Procter, Sarah	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ 31/07/2026	Awaiting confirmation of funding as at December 2023. No funding allocated as of 09/02/2024 This will not be replaced in the 24/25 financial year. Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The CT replacement of the aged at GGH has been recommended, however funding has not yet been formally agreed.
		Replacement of Fluoroscopy room, WGH	Whitecross, Faith	Completed	Fluoroscopy room has been replaced.
		Replacement of CR X-Ray room, Llandovery Hospital	Osell, Fiona	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ ~~01/12/2025~~ ~~31/03/2026~~ 31/08/2026	CSP agreed closure of LDH - work ongoing to decide closure date.

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	~~31/03/2024~~ ~~30/06/2025~~ ~~31/03/2026~~ 31/05/2026	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
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~~ 31/05/2026	BC with capital/estates

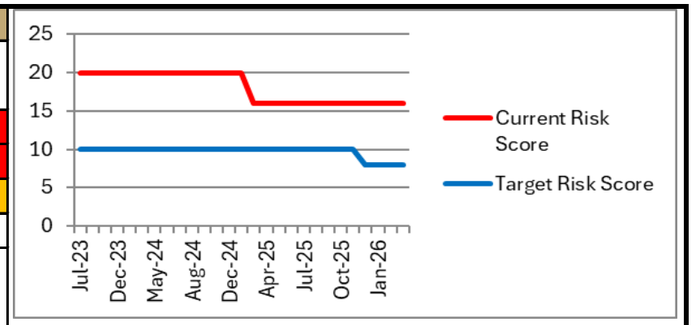
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
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:	May-23
Strategic Objective:	1. Thriving Teams and 3. Great Care

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Apr-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	May-26

Risk ID:	**1664**	**Corporate Risk Description:**	There is a risk to service sustainability in Ophthalmology, and the inability to provide timely care to patients with Glaucoma, wet Age Related Macular Degeneration, Vitreoretinal, paediatrics, and Cataract This is caused by a national shortage of Consultant Ophthalmologists and the inability to recruit to vacancies, exacerbated by nursing and medical staffing constraints and reduced service capacity due to lack of physical space. Recruitment difficulties are leading to the Consultant on-call rota being covered by substantive Consultants with 3 gaps in the rota, and Consultants undertaking additional duty hours, with use of agency consultant to fill 2 gaps on the rota. This is a fragile on call structure which is impacted by sickness and annual leave. This could lead to an impact/affect on ability to deliver services within the Ophthalmology Referral to Treatment (RTT) plan, and the ability of the Health Board to comply with Welsh Government Eye Care Measures (ECMs). Impacting the ability to provide timely diagnosis and treatment and directly impacting on patient safety, with the potential for sight loss and long-term lifestyle impacts. The Health Board's ability to progress with the implementation of recommendations raised by various regulators and inspectorates is affected by the recruitment and estates issues, which in turn could lead to adverse publicity and reduction in stakeholder confidence, with increased scrutiny/escalation from WG. The service has undertaken successful recruitment of two specialty Doctors who are now onboarding, this will improve capability and capacity in part. The Regional Programme Board continues to support development with 2 Regional substantive Consultant posts (1 post offered) to fill the vacancies within the team.
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:	⟺



Rationale for CURRENT Risk Score:
Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1 patients (high risk) with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional AMD sessions on a weekend, 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. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. The current R1 delivery at 42%. The WG target for R1 delivery is 95%. The current waiting list for new patients is 11,552. The service is currently delivering 0 patients waiting at stage 1 over 52 weeks for March 2026 and this is expected to be maintained through to the end of March 2026. The stage 4 104 weeks, is in a breach of 2 for March 2026 currently with potential solutions being worked through to be 0 by the end of March 2026. 7301 patients have been 100% delayed for their follow up appointment. The Board has decided to progress Clinical Service Plan Option 99 of the Clinical Service Plan + AICC as a diagnostic hub. The service is currently reviewing the estates and workforce required on each site to deliver Option 99. VR Consultant being onboarded for Region.

Rationale for TARGET Risk Score:
The service will be able to reduce the impact score of this risk as whilst the consequences to the patient remains high, recurrent funding has been invested into the service for the delivery of an R1 Eye Care Measures target of 65%. The ministerial Measures target will need to be 0 for 3 months and more and the Follow up delayed will need to be reduced by 12%. The 65% R1 delivery by January 2027 is dependent on all posts being recruited into and all estates needs being met. Further development would be required to reach a 95% R1 delivery score. With the required investment in Glaucoma and IVT and the additional workforce identified in the annual plan 2026/2027 and estates issues being resolved alongside the continued management of the waiting lists, the HB will potentially be able to reduce the score to 8.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
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. 2 Regional Substantive posts have gone out to advert through the Regional programme. 1 post has been offered following interview (Vitreo Retinal) and the other post is going back out to advert (Medical retina)	Vacancies remain high within the service with a high turnover of staff. 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 SLA with SBUHB for the regional consultant posts needs to be finalised.	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.

Collaborative working with Swansea Bay to deliver a Regional solution to address the workforce and estates constraints. Sub groups to be formulated to address, Glaucoma, AMD, Vitreoretinal, paediatric and cataract pathways. 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. Additional capacity has been funded for the delivery of Cataract surgery to maintain the 104 week wait for 2025/2026. Wales General Ophthalmic Services (WGOS) for Glaucoma, Diabetic Retinopathy and Medical Retina ongoing. 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. The second regional ECCG meeting is being held on the 20th March 2026. 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. 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.	The Regional sub-groups are in their infancy with actions being taken to develop sub-specialties. The SAS doctor post for the (AMD) service needs to be recruited into to start additional Injections clinics in NREC. Interviews were held on the 13th march 2026 and posts are onboarding. The required space for the expansion of the service in AVH needs to be secured for 5 days a week. Further meeting to discuss on the 25th March 2026 The regional cataract delivery plan needs to be developed and executed. A WGOS co-ordinator needs to be secured in primary care to support the discharge of patients to the community. The remaining 8 GIRFT recommendations need to be actioned and closed. 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 investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. Recovery funding is non-recurring and reviewed annually, which restricts delivery planning.	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.
		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
		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. Band 8B JD has been signed off by job matching panel. Next steps to identify the funding for this post and authorise through CCG and FCSG.

	There are ongoing concerns in data quality due to referral processes and system use.	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.

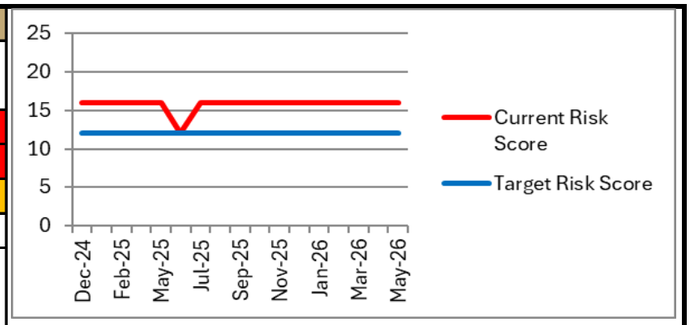
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

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

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

Risk ID:	**1978**	**Corporate Risk Description:**	There is a risk there will be insufficient skilled workforce within each of our professional groups (Nursing, Medical, Allied Health Professionals AHP, HCS, Pharmacists and Dental). This is caused by the scarce supply of healthcare professionals and a shrinking labour market, which is further exacerbated by the Health Board's current vacancy rates. 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:	⟷



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** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Organisational Governance Structure Improving Together approach to be align to People Planning approach supported by People Planning Team to create an organisational wide approach to in year service challenges Organisational Gap Analysis based on a 10 year profile developed and annual assessment strategic & operational review of workforce (including Education Commissioning Assessment) Inter-People and Corporate Team & Planning Objectives Establishment Control Agency usage Bank Utilisation & ongoing onboarding of supply Efficient Rostering practice Roll out of new rostering system Overview of organisation and service wide risks (assessment of each service area based on workforce availability) Continuous process of assessment of services to be stood down and deployment options based on service needs (CDG) Targeted prioritisation of recruitment/onboarding of new employees to the	To mature and develop focus underpinning SPPEG and alignment to new Clinical Care Group structure to ensure that service workforce establishments have the correct skill mix/skills mix etc 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.	Workforce Plan in Place for Each Professional Group identified to address concerns above & monitored through relevant fora i.e. SPPEG, MDT Forum and PODCC	Walmsley, Tracy	Completed	Built into medical stabilisation and reports to V&S; Refreshed as part of annual planning cycle; continuous review. Challenge in consolidating 70+ operational plans aligned to professional identify and strategic direction. Requires "Forum" for dialogue and design. Planning Coordination Group acting in interim capacity. Draft Plans completed - final versions will be in place by March 26 (Revised action). Completed.
		Each Professional Workforce Plan in place with an implementation action plan developed within 25/26. (This will be maintained as an iterative plan with ongoing monitoring and review by relevant fora i.e. SPPEG, MDT Forum and PODCC. The Professional groups relate to each "Staff Group" identified under ESR i.e. Estates and Ancillary, Admin and Clerical (although service level plans may need specific tailoring), Nursing and Midwifery, Medical and Dental, Healthcare Science, Allied Health Professionals, and Additional Professional and Technical.	Walmsley, Tracy	Completed	Plans in train for September 2025 with review by groups i.e. SPPEG by February 2026 (due to agenda moved from December 2025). Completed.

highest areas of risk in terms of maintaining service delivery (People & OD Strategic Group) Temporary People Utilisation reports shared regularly to monitor levels of supply Align and iterate to implementation groups i.e. Medical Workforce Planning and related subgroups i.e. Medical retention, MAPS etc 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. Strategic Workforce Planning Forum (oversight of education commissioning) and People Profession Plans SPPEG (Strategic People Planning & Education Group) From April 2025, new operational governance structure implemented allowing clinical care groups to escalate concerns to IQFPDG.			
Design an approach to primary and community workforce model for 25/26 against agreed priorities for Primary Workforce Planner and Annual Planning Objectives (NB Requires alignment to UEC, Primary Care and Community Programmes of work)	Walmsley, Tracy	~~31/05/2025~~ ~~30/12/2025~~ ~~31/03/2026~~ 30/06/2026	A summary report developed compiling challenges and opportunities has been developed. Meetings held with PC; revised approach determined. Paper intended for SPEGG Dec 2025 from Primary Care Academy but deferred to Feb 2026. Extra ordinary meeting took place 6th January 2026 and paper to follow. SBAR and plan taken to Public Board on 5th February. Action now superceded by Community By Design National Programme. Primary Care Workforce planner in post, contract extended by one year to March 2027.
Create task and finish group to analyse establishment control and develop tool to accurately reflect staffing requirements in partnership with Finance to ensure effective alignment to workforce changes and future profiling to include Education and Commissioning (3 year forward workforce "shape & spend" profile)	Walmsley, Tracy	~~30/06/2025~~ ~~30/12/2025~~ ~~31/03/2026~~ 30/06/2026	May need to align to National group. National Group meeting took place in July 2025. Consensus on value achieved; on mechanics more challenging discussions. No further actions coming from National Group. Establishment Control Tool and Regeneration Framework in place along with national minimum data set which is reviewed annually. As part of Annual Planning Cycle (March 2026) ensure financial profiling is aligned. Requires support from Finance colleagues. National Group stood down. Awaiting other dates. Need to move forward with local plan.

Ensure effective methods of workforce utilisation across each professional group in place: Nursing, Medical, AHP and HCS. Critically assess and design plan for work that can be implemented by end of March 2026.	Walmsley, Tracy	~~31/03/2026~~ ~~31/03/2026~~ 30/06/2026	Roll out of Job Planning & Allocate across professional groups; plans required to a) strengthen current approach and b) develop for new professional groups as prioritised against resources. Workshop with Allocate Held. Business Plan to be developed for AHP/HCS. Medical progressing with challenges. OOH service progressing with challenges. All progressing with challenges with June completion date for Medical but no funding allocated to roll out AHP and HCS.
Education Plan aligned to each professional group (to 24/25 and reframed for 25/26)	Glanville, Amanda	~~31/03/2025~~ 30/11/2026	Analysis in train, based on in year and projections. To be tested by 30 September 2025; work capacity to be assessed. Further work needed to put training plans in place based on TNA. Actions for study leave/higher wards part of BAU
A robust framework of competency based people planning and related training to underpin the Team around the Patient initiatives and new model development of care. Essential and necessary reliance on educational frameworks rather than new role development, which is an evolutionary aspiration. Practical next steps will be assessed linking into skills gaps within the workforce and the educational infrastructure to support.	Walmsley, Tracy	~~31/03/2026~~ 30/06/2026	Competency based workforce planning was undertaken in 2022/23 with support from HEIW. Refresh of training needed prior to delivery. Delivery may need to commence from June 2026 due to team levels.
Machanisms & Process for International Recruitment to be devised to enable transparency and engagement	Walmsley, Tracy	Completed	Engagement with NWSSP/Medical Director to clarify WG position. Meet with HEIW. Design process from local to national in line with partners. Owned by Medical Workforce Planning Group, linked to revision of establishments and ongoing plans led by Medical Directorate with support from Workforce Planning.

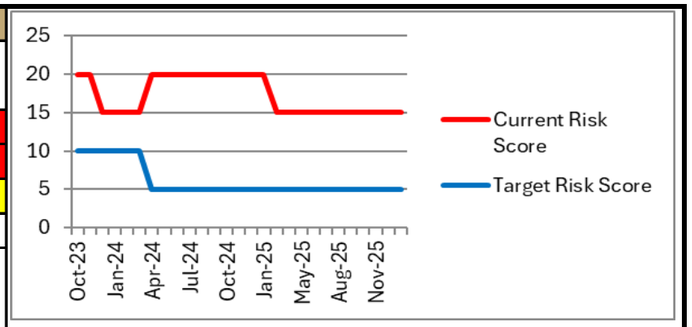
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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				Assessment & continuous development mechanisms linked to Capacity and Capability (including any negative impacts on Wellbeing)	Overarching Implementation Plan & Assessment of Impact (Approach defined 30/9/23) and delivered no later than 31/03/25 to link to Annual Planning cycles (identified in Audit Wales (AW) initial draft report) Refresh of Strategy to be aligned. In draft.	Walmsley, Tracy	~~31/03/2025~~ ~~30/03/2026~~ 30/04/2026	Workforce Plan will take account of the needs to address the actions in the Wales Audit Office Report. Assessment of work by Service, Professional and People Pillar to develop a costed plan for P&OD and HB. Meeting With AW Auditor to agree "close off" based on evidence available. For example, current Workforce plan, MDS and People Plans. The issue is related to the 10 Year Strategy and Implementation Plan for Workforce. The Clinical Services Plan (CSP) work is critical here. Completion Date revised to 30 April 2026 to account for CSP. Met with WAO lead. Draft Paper to be signed off & uploaded.
	Risk management approach to Workforce themed Risks	1st					Pilot the Maturity Matrix independent assessment process across 2/3 Health Boards including Hywel Dda in 2025/2026.	Walmsley, Tracy	~~31/12/2025~~ ~~31/03/2026~~ 30/06/2026	New Action. Refreshing matrix based on All Wales Feedback. Meeting July 2025/26 of subgroup to agree process for pilot process. Being fed into AWOD for SWFP. Sub Group has met (October 2025) provisional engagement from DCHW, Cwm Taf, WAST and Cardiff & Vale to support revision of framework being undertaken to be presented at future AWOD Strategic Workforce Planning and supported by HEIW.
	Strategic People Planning & Education Group	1st								

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

Date Risk Identified:	Nov-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Apr-26
Strategic Objective:	1. Thriving Teams and 3. Great Care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	May-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)	
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 now been recruited following the exit of the Medacs agency locum consultant in Withybush General Hospital. A second substantive post is out to advert, and the Advisory Appointments Committee (AAC) is planned for April 2026. Successful recruitment will result in 4 substantive consultants on the 1:4 rota at WGH. The GGH rota has only 1 gap which is being covered by internal locum at the HB card rate. The plan for this rota is to recruit a substantive colorectal consultant to replace 1 of the NHS locums. On 19/02/2026, The Health Board made a decision on the Clinical Service Plan (CSP), which would involve the amalgamation of the surgical on-call rotas and Emergency General Surgery being moved from WGH to GGH. Option A was the preferred option and the service is working with CSP colleagues to work through implementation details.

Rationale for TARGET Risk Score:

Achievement of the target risk score is dependant on the successful appointment of substantive upper GI consultants 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.

A substantive Upper GI (UGI) consultant has now been recruited following the exit of the Medacs agency locum consultant in Withybush General Hospital. There is 1 UGI substantive post out to advert and a substantive LGI post to be advertised for GGH in April 2026. The rotas at GGH and WGH are currently fully functioning with no Medacs locums. This will be further strengthened by further substantive recruitment and less NHS locum consultants. By September 2026, there should be a balance of upper and lower GI coverage on the rotas, providing recruitment is successful.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
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 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. 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 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.	All posts are yet to be filled substantively. It is unknown whether the service will be able to successfully appoint to the second substantive upper GI post, due to previous withdrawals of applicants. 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 bee 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 recuit suitable candidates.

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.	Lewis, David	~~30/09/2025~~ 01/05/2026	1 consultant started in post on 27th January 2026. There was an AAC planned for the second consultant in February 2026, but both candidates withdrew. The post is now back out to advert with the AAC anticipated for April 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) 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)	Assurance to Board on communication and repatriation arrangements				
	Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd								

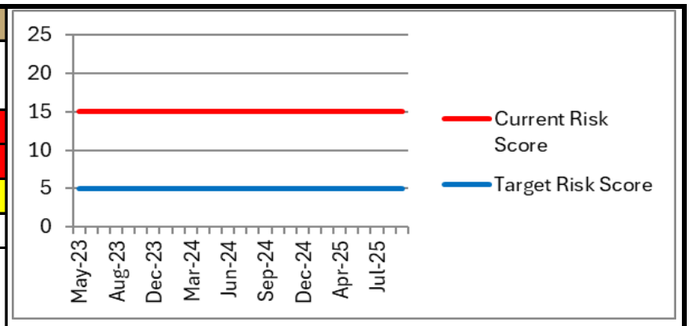
	Reported to bi-monthly Scheduled Care Quality, Safety and Experience Group through exception reporting	2nd			Upper GI service SBAR presented at Quality, Safety and Experience committee Meeting (Oct24) Updated SBAR to Executive Team (Nov24) Options Appraisal via CSP to Board (Nov 24)				
	Assurance to be reported to the Board following introduction of temporary rota	2nd			Upper GI service SBAR presented at scheduled care directorate QSEAC (Jan25) CSP Public Board (18/02/2026)				
	GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited								

Date Risk Identified:	Oct-19	**Executive Director Owner:**	Severs, James	**Date of Review:**	Apr-26
Strategic Objective:	3. Great Care	**Lead Committee:**	Health and Safety Committee	**Date of Next Review:**	May-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 Withybush 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:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET 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, with the Health Board to present formal position statement at end of May 2026. Night fire wardens are in place (WGH and GGH). Bronglais General Hospital (BGH) also now agreed and out to advert for these. 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. This will be reviewed regularly.	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)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
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	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. Not all managers who are assigned actions on Boris are regularly	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.

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 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.	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. 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.	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. Start date Sept 2024 completion mid 2027. Will be regularly reviewed.
		Completion of planned fire safety enforcement work at Cwm Seren MH Facility in Carmarthen, following enforcement notice.	Evans, Paul	~~28/11/2025~~ ~~31/01/2026~~ ~~31/03/2026~~ 31/05/2026	works almost complete, some final doors to be delivered and fitted which will conclude all works, delay due to incorrect doors from principle contractor.Letter to MWWFRS to inform them of this slight delay. Some further delays have been incurred linked to patient activity and access restrictions to some areas of the building. Confirmation from contractor that completion is 31.05.26
		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.

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.

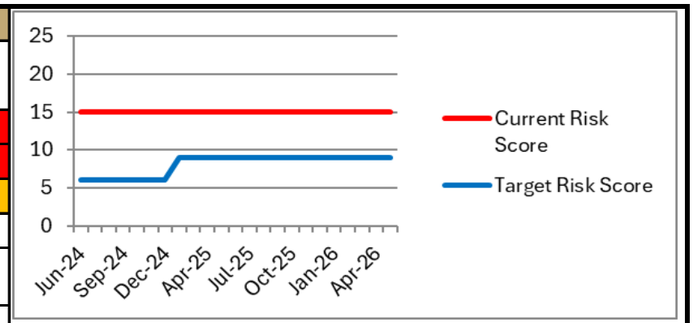
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
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 to Sept 24 HSAC.	General site management checks/walkarounds 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:	May-24	**Executive Director Owner:**	Severs, James	**Date of Review:**	Apr-26
Strategic Objective:	1. Thriving Teams and 3. Great Care	**Lead Committee:**	Health and Safety Committee	**Date of Next Review:**	May-26

Risk ID:	**1860**	**Corporate Risk Description:**	There is a risk of serious harm to staff from assault. This is caused by violence & aggression in the workplace by patients, visitors and others. This could lead to an impact/affect on the health, safety and wellbeing of employees. Risk of non compliance with Health and Safety at Work Act and Management of Health and Safety at Work Regulations.
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):	3×3=9
Expected Date To Achieve TRS:	01/04/2027
Trend:	⟷



Rationale for CURRENT Risk Score:
70% of reported incidents with staff affected are violence and aggression with 1400 incidents recorded during 2025. The likelihood remains at 5 as these incidents occur numerous times daily. Due to the unpredictability and profile of patients with complex and cognitive issues it is unlikely that these figures will reduce below their current rating. This is further compounded with long stay social care and complex patients with behaviour issues as results of both older mental health and age associated complications such as urinary tract infections.

Rationale for TARGET Risk Score:
This is based upon reduction in incidents/severity of impact of incidents. It also relates to the ability to train General Ward staff in the skills to safely manage clinically challenging behaviour and the appointment of suitably trained Security Staff.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
V&A Risk Assessment Process: There is a Violence and Aggression (V&A) Risk Assessment toolkit available to aid managers to assess the risk of V&A at department level. This is promoted by the V&A Case Manager. Education and Training: There is a national NHS Violence and Aggression Training Scheme standard to recognise and manage the risk of violence and aggression in the work place. V&A Case Management: There is a process for V&A Case Management across the Health Board. Violent Patient Warning Marker Procedure in place: This procedure provides early warning for staff caring for certain patients. This applies to Primary and Secondary Care settings. Lone Working Policy: There is a policy to promote principles of safer working for lone workers. Violence and Aggression Poster/Information: Posters are displayed in key locations across the HB premises. Informing the public of Health Board tolerance towards unacceptable behaviour towards staff. Security Management Group monthly meeting to monitor progression of actions relating to this risk. 'People Safe' lone working devices in operation across various areas in the Health Board (primarily Community teams).	Whilst V&A Case Manager requests V&A risk assessments are undertaken following incidents no mechanism exists to monitor compliance with the numbers 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. Understanding of correlation of V&A incidents to location. Lack of dedicated trained SIA licenced or equivalent security staff to respond to V&A incidents.	Develop a process to improve oversight of V&A risk assessments.	Jenkins, Brett	~~30/04/2025~~ 31/06/2026	MS Forms template has been devised. Incident data supplied to management to inform their V&A risk assessments. 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~~ 31/06/2026	TNA has been revised following input from Clinical Education Manager. SBAR Paper to be drafted for Health and Safety Sub-Committee in October 2025. Further work required. New Exec-led Task & Finish group commenced November 2025 to address TNA and Training Venue Needs (V&A training, Manual Handling and Resus).
		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~~ 31/06/2026	Security Management Group have discussed compliance with the patient warning marker procedure and agreed how to progress with a procedure review. Document to be reviewed and returned to SMG for key stakeholder comment.

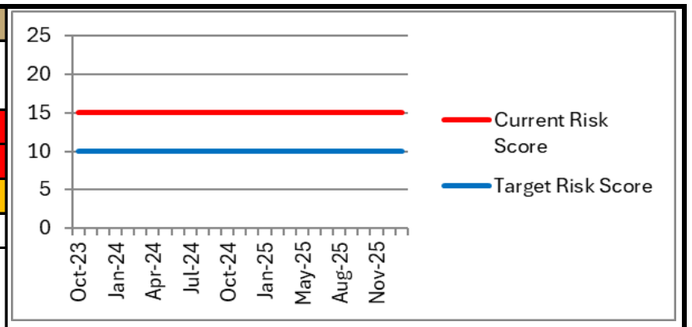
Review effectiveness of the use of PeopleSafe devices by staff and develop an action plan to improve access and take up.	Jenkins, Brett	~~30/04/2025~~ 30/06/2026	512 devices issued. Review of compliance shows 4-6% compliance. SMG discussed moving to the People Safe mobile phone application. A free trial has been discussed with the supplier, however the Peoplesafe agenda has not progressed in the absence of a Head of Health, Safety & Security.
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	V&A Case Manager produces incident reports for CCG until dashboard in place. Incident Dashboard is live and contains information on V&A/assaults/behaviour incidents. CCG's have been notified
Require £1.3-£2m investment to employ staff at each General Hospital site.	Jenkins, Brett	30/09/2026	Consideration by Exec Team: 02/07/2025. An additional paper was presented to the Exec Team in March 2026 with further details on possible options available..
A number of actions are required in order to comply with Wales's adoption of Sections 119 and 120 of the Criminal Justice and Immigration Act 2008.	Jenkins, Brett	31/12/2026	An executive briefing on Sections 119 and 120 of the Criminal Justice and Immigration Act 2008 has been drafted which includes a proposed detailed action plan for compliance. Actions are to be agreed at the next Security Management 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 (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
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		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								
	CTSA updated review undertaken in February 2023 .	3rd								

Date Risk Identified:	Aug-23	**Executive Director Owner:**	Severs, James	**Date of Review:**	Apr-26
Strategic Objective:	3. Great Care	**Lead Committee:**	Health and Safety Committee	**Date of Next Review:**	May-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:	⟷



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.

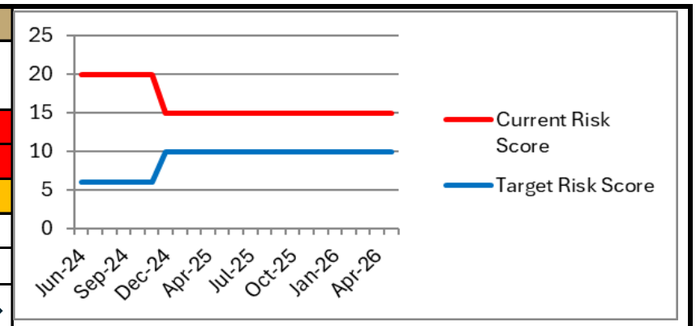
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**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 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+ Operational resource pressures across the acute sites. Increasing number of maintenance checks, specifically in relation to fire compliance.	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.
		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
		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	**Executive Director Owner:**	Daniel, Sharon	**Date of Review:**	Apr-26
Strategic Objective:	1. Thriving Teams and 3. Great Care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	May-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:	30/06/2026
Trend:	⟷



Rationale for CURRENT Risk Score:

At the end of 2025 Unplanned Admissions into ITU (from Ward areas) in WGH had reduced by 10%. In GGH the same comparison was unchanged.
Cardiac arrests rates for Ward Areas across all 4 sites have had varying results:
WGH - Increase of 40% (2024: 16, 2025: 23); unfortunately although all cases have been reviewed by the Resuscitation Team there has been less involvement from the Medical Team in WGH in undertaking reviews, possibly leading to less scrutiny and less opportunity to learn from events.
GGH - Decrease of 30% (2024: 34, 2025: 24); significant amount of work has been undertaken by the SNMs/Ward Managers/Resus Team & GGH RADAR lead to undertake monthly/bi-monthly Scrutiny meetings to review all cardiac arrest cases. It is possible that this added scrutiny and feedback and lead to better decision making, recognition & escalation of deteriorating patients.
BGH - Decrease of 30% (2024: 10, 2025: 7); no theme identified
PPH - Increase of 70% (2024: 7, 2025: 12); Scrutiny meetings only established in Jan 2026. Difficult to fully attribute but has the down grading of the ITU resulted in sicker patients being managed in ward areas were ITU may have been more appropriate.

In at least 50% of these cases across the HB the conclusion from the medical review was that a DNACPR should have been in place, therefore resuscitation should not have started.

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.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Governance structures in place eg RADAR Group (Recognition of Acute Deterioration and Resuscitation). Increased awareness of gaps in assurance and local actions in place to manage and mitigate the risk. T&F Group chaired by HB RADAR Lead with focus on Sepsis. RADAR directly reports to Quality and Safety Intelligence Group (QSIG) Local RADAR groups (across all sites, counties, MHLD and Paediatrics) which report to Health Board wide RADAR group. Mechanisms in place across all sites to monitor cardiac arrest rates. Health Board Resus policy in place (currently under review and updated to reflect National Guidance) All Wales DNA/CPR policy in place and has been uploaded onto the Health Board intranet. Clinical Lead Nurse for Acute Deterioration 1WTE 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. WAST have remained with the patient and allowed the HB to utilise their pre	Treatment escalation plans not in place but continued to be discussed at WGH and GGH Call for Concern only for inpatient adult patients only and at the moment is only across 2 sites. Inconsistent application of policies and processes eg DNA/CPR, 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 High number of newly qualified new nurses to the HB including overseas requiring support to develop their expertise in recognising acute deterioration.	Health Board Recognition of Acute Deterioration and Resuscitation (RADAR) group to develop a workplan to address gaps in control to improve the recognition and management of acute deterioration across the Health Board.	Davies, Mandy -	Completed	Quarterly meetings in place, and sub-groups being established to report to Recognition of Acute Deterioration and Resuscitation (RADAR) group on sepsis, NEWS, treatment escalation plans, call for concern (Martha's Law) DNA/CPR, acute kidney injury (AKI). Agenda at August meeting didn't allow for discussion on the development of a workplan. Plan is to confirm RADAR Action Plan, with risk actions to be updated accordingly. RADAR next scheduled to meet on 7th October 2025.
		To implement an electronic observations systems across the Health Board to capture real-time bedsite capture of patient assessments and monitoring, in line with the Health Board's Digital Plan	Williams, Carolyn	~~30/09/2025~~ 30/04/2026	Tender process completed. Business case presented to Board in July 2024, with a view to implement on a site by site basis over in 18 months, in line with the current Digital Plan. Board approved the business case in Sept 24 however funding has not yet been identified to enable the project to proceed.

hospital mechanical CPR device equipment within the hospital setting. Networks in place across the wider Health Board, including support from QIST (Quality Improvement Service Transformation) Team and practice development. Organisational training plan in place, including mandatory training 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) Dedicated resource in Quality Improvement Team monitoring AKI alerts for the Health Board Bi-monthly scrutiny meetings have been set up in GGH, BGH and WGH 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. Call for Concern in place at GGH and WGH for inpatient adult patients only. Process for implementation in Paediatrics, Mental Health and remaining sites under review. Cascade Trainers in place across the Health Board (community and acute)	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 in to HB-wide RADAR Group, with lack of medical leadership Whilst there is a dedicated Resuscitation Team in place, the HB does not have a Mechanical CPR Device in any of its Acute Sites. The Resuscitation Council Guidelines for Resuscitation state thatÂ a LUCAS is a good alternative for situations where it may be difficult or to maintain continuous high-quality compressions, or when it may be too strenuous on the medic to do so. There have been occasions when WAST have remained with the patient and allowed the HB to utilise their pre hospital mechanical device equipment within the hospital setting. However, this is not routinely or officially suitable practice.	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	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.

Put in place All Wales Policy for treatment escalation plans to enable safe and effective care management when patient deteriorating.	Edmunds, Dr Eiry	Completed	Discussed at Withybush RADAR meeting in July 2024 where agreement reached for pilot. Task and Finish group being established by Lead for Critical Care Outreach in Withybush to devise an implementation plan. RADAR to review following evaluation and consider roll out across other sites. As of September 2025, the situation remains unchanged. TEPS sub group meetings have been held at WGH but there is no set plan at the moment to implement or trial. To discuss at RADAR meeting scheduled for October 2025. Palliative Care Consultant has been appointed as the TEP Lead for the Health Board.
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.

Improve compliance with DNACPR National Guidance	Steele, Cathie	Completed	DNACPR Review Group formed and actions identified including development of a SharePoint page (which is now complete) and undertaken an improvement project through EQIiP (complete). Annual audits undertaken by junior doctors, and reviews of medical examiner reports and cardiac arrest to identify learnings. More robust communication between mortality review group and RADAR being established. Training needs have been identified in relation to DNACPR and patients who are considered having learning disabilities, or diagnosed with dementia. Work is commencing with the MHLD directorate to progress this. A full action plan as been agreed in response to the HIW National Report on DNACPR (see AMAT)
Development of an Acute Deterioration Sharepoint page for all advice, guidance, updates, for staff on issues relating to resuscitation, DNACPR, sepsis, call for concern, MET calls, training, etc.	Wastell, David	Completed	Senior nurse for acute deterioration is working with Interim ADN for Quality and Safety to develop SharePoint page. Refinement of the Sharepoint site underway to finalise and launch as of September 2025.
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	Acute Deterioration Nursing Leads from across Wales are in the process of reviewing. Awaiting the National decision.

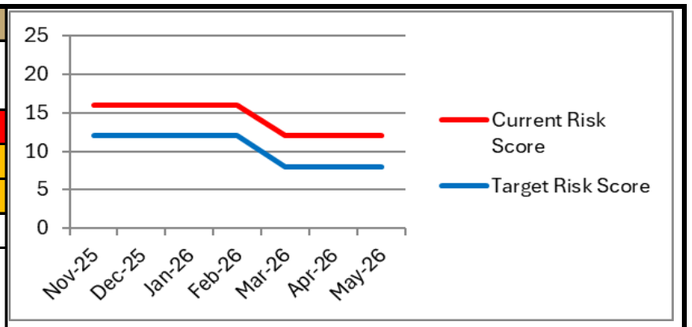
To develop mechanisms to review and monitor the Acute Deterioration position via Escalation Framework via the Quality domain (including the implementation of the Safety Dashboard)	Davies, Mandy -	Completed	Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system. This phase completed.
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	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.
Capital Bid to be submitted for 3-4 LUCAS machines (mechanical CPR machines).	Wastell, David	Completed	4 machines now delivered and training on each site is planned March/April 2026. Action complete.

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
Training compliance via ESR Cardiac Arrest Audits	EWS (Early Warning Scores)/NEWS2 Audits undertaken by RESUS Team 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.	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	Progress to be provided once dashboards in place and functional for reporting to future RADAR meetings. Awaiting feedback from Performance Team.
	Review of DATIX incidents, complaints, cardiac arrest reports and Medical	1st								
	Outreach review all unplanned admissions to Intensive Care	1st								
	RADAR Group	2nd								
	DNAR/CPR group chaired by Deputy Medical Director - group needs to be re-established (as of January 2026).	2nd								

Date Risk Identified:	Oct-25	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Mar-26
Strategic Objective:	3. Great Care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	May-26

Risk ID:	**2190**	**Corporate Risk Description:**	There is a risk of service users experiencing a delay in their choice of care provision via Direct Payments and managing their expectations of what Heath Care tasks can be safely delegated. This is caused by delays in the implementation process and governance of Direct Payments for individuals receiving Continuing Healthcare. The removal of nine months of previously identified implementation time led to a condensed approach to the preparations to support implementation of the responsibility and governance process of Direct Payments from 1 April 2026 resting with each individual Health Board. The absence of a finalised WG policy guidance (which will not be issued until April 2026) and unknown resource and capacity to support local implementation due to the unknown level of demand. This could lead to an impact/affect on additional pressure/expectations on community staff as care coordinators. Staff will be undertaking case management of this new requirement to delegate health care tasks safely, in addition to their other responsibilities. This could affect staff wellbeing, morale and resilience. A lack of robust governance processes which may result in service users experiencing a delay in their choice of care provision, and potential to not receive their care provision of choice, which may result in increased complaints and Ombudsman queries, and reputational damage to the Health Board in failing to meet national policy. There is also a potential financial impact due to the increased costs associated with Direct Payment implementation, and the number of cases that are likely to present in the future.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×3=12
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	31/08/2026
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
It is impossible to quantify demand. The Regulatory Impact Assessment (RIA) identified the likelihood of 5 cases per LA of individuals who had previously declined a CHC assessment now likely to seek assessment and a DPs package of care, with estimated costs of £5.5m new costs to Health Boards. There will also be additional requests from newly eligible individuals and from those already eligible who may now seek to have their needs met through DPs rather than through other models. The Health Board does not have a system in place to manage or deliver Direct Payments in order to comply with the requirements of the forthcoming WG policy, which is due April 2026. However procurement process underway in March 2026 for an appropriate system/model provider. Robust governance systems have yet to be developed, and a notable absence of dedicated resource and specialist expertise. Without additional resources, staff may be unable to allocate sufficient time to support implementation alongside existing duties. Implementation Lead in place and Task and Finish groups established working on policies and processes. The Health Board is in discussion with our 3 Local Authorities (LAs) to help clarify what capacity and support each LA can support in the transition period. Ongoing considerations of other providers that can support the Health Board in managing Direct Payments. Risk has been reduced from 20 to 12 to reflect the significant amount of work undertaken to prepare for the 1st April.	A dedicated local resource is needed to meet legislative requirements by 1 April 2026. Clarity is needed from Welsh Government over guidance and implementation plans to enable robust governance and safety requirements. All Health Boards in Wales require a consistent approach to direct payments. Whilst the implementation date is end of March 2026, there is no certainty that this can be achieved without the additional governance and resources. Expected date to achieve Target Risk Score extended to 31st August 2026 in line with the action to procure a managed direct payment system/model.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
National CHC leads group meeting weekly to discuss direct payments implementation. Welsh Government direct payments policy team meeting with Health Boards on a monthly basis. Task and Finish groups working on policies and processes. WG made £150k available in 25/26 to support the following: *Appoint an Implementation Lead on a temporary basis, until 31 March 2026 (however an extension is being considered by WG). *provide programme management support for the implementation lead, initially primarily via the JCC. *support the development of a training proposal. *support the development of the required procedures HB discussions with our 3 Local Authorities (LAs) underway to help clarify what capacity and support each LA can support in the transition period. Ongoing considerations of other providers that can support the Health Board in managing Direct Payments. All Wales update papers regularly shared with CEO, COO and Director of	No local or national implementation plan in place No development yet of a suite of all Wales protocols and operational guidance. Lack of dedicated resource to implement requirements. No financial protocols designed to support payments. The Implementation Lead is on a temporary basis, until 31 March 202, however an extension is being considered by WG).	Hywel Dda input required to support Welsh Government national consultation and development of guidance	McCarthy, Julia	Completed	Health Board to attend Welsh Government policy team monthly meetings. Welsh Government have recently issued the consultation paper regarding the regulation of direct payments for response by 15 October 2025. In addition a further CHC DP draft guidance was given and comments needed by 19th Nov this has been submitted by the Service.
		Identify workforce resources required to action and implement a working plan to deliver direct payments.	McCarthy, Julia	~~31/03/2026~~ 30/06/2026	Director of Finance agreed in Nov 2025 EITS to provide support for potential resources for Direct Payments (DP) being implemented in the Health Board. However the Health Board is awaiting confirmation of funding from Welsh Government. In addition the Health Board is not yet clear on the service demand that will take place from 1st April 2026 onwards.

Community & Integrated Medicine, and updates provided internally to the Clinical Service Group governance meeting.				
	Agree the finalised suite of All-Wales documents to support the implementation of Direct Payments.	McCarthy, Julia	31/03/2026	A suite of all-Wales documents were developed, including a draft all Wales policy and a SOP which were shared with HB leads on 4 March 2026, and the draft Toolkit and Quality Framework circulated on 5 March 2026. Health Boards will now consider these and provide comments prior to final versions being issued.
	Implementation lead appointed to lead on Direct payments. Task and Finish groups set up to start to review key workstreams: Commissioning Care and Support, DP Eligibility in Care Needs and Safety, DP advice Support& Coordination, Health Board Training staff.	Devantier, Tracy	Completed	Task and Finish groups have commenced in January 2026 under the leadership of the new Implementation Lead. Long Term Care and MHLD have provided the names of Health Board staff who will participate in the workstreams.
	Procure a managed direct payment system/model.	McCarthy, Julia	31/08/2026	Discussions have taken place with procurement and the tender is out until 31st March 2026.

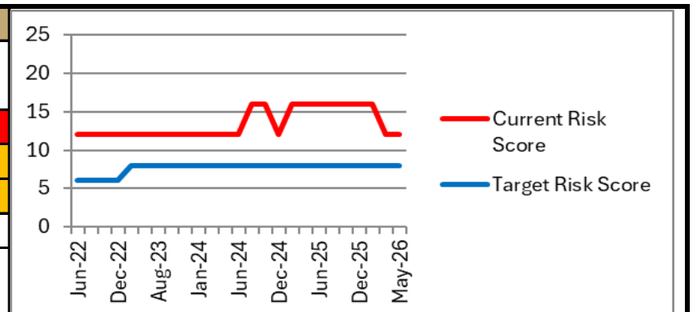
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Reviews completed in line with the national framework. Number of packages and costs reported monthly to local governance forums. Papers are submitted via the CCG IGG. Welsh Government may require reporting but that is yet to be confirmed	There are current finance reporting and review monitoring arrangements in place that could be adapted when direct payments are implemented and would be reported through the CCG and IQFPD. .	1st								
	Recent internal audit of finance procedures received substantial assurance .	2nd								

Date Risk Identified:	Feb-22		
Strategic Objective:	3. Great Care and 4. Positive Futures		

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

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

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



Rationale for CURRENT Risk Score:
The service has been de-escalated by Welsh Government (WG) to Level 1 in terms of Targeted Intervention status as there has been the consistent achievement of the 60% de-escalation criteria since February 2025. Due to recovery actions within radiology and urology we may see variation in performance as we recover and treat those patients over 62 days, therefore the risk remains that cancer performance will not achieve 80% compliance by March 2026. The WG has confirmed that the target for March 27 is 75%. currently no health board within Wales are on track to achieve this target

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

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

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

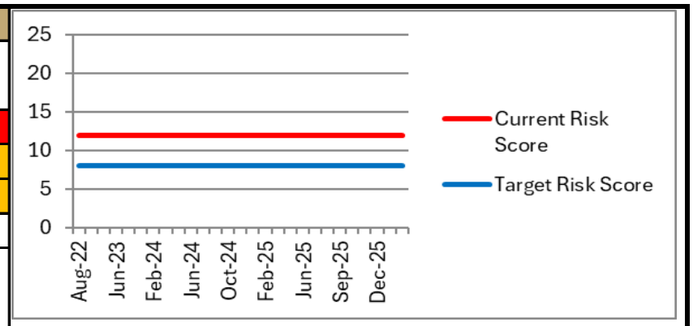
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Internal targets - Looking at the performance per tumour site individually that have the biggest impact on overall performance Skin Urology LGI Gynaecology	Daily/weekly/monthly/ monitoring arrangements by management	1st			* Implementation of Single Cancer Pathway Report - BPPAC - Feb20 * COVID-19 Impact on Cancer Services - Board - May20	None identified.	Establish Operational improvement group to track improvement projects in line with NOP and Annual Plans	Goode, Paula	Completed	Plans to establish a Cancer Transformation Task and Finish group which reports into the CCG transformation hub. On hold due to formation of Care Group structure
	IPAR Performance Report to S&PC & Board	2nd								
	Monthly oversight by NHS Executive/WG	3rd								

Breast Reducing component waits Patient waiting more than 14 days for first OPA Patients waiting a diagnostic procedure and report more than 28 days Patients with a confirmed diagnosis of cancer waiting more than 62 days	Revised Governance arrangements in place since April 2025 with matters escalated when required via the CCGs governance arrangement	1st			* Cancer Updated to QSEAC Jun20 & OpQSESC Jul20 * Risk 633 QSEAC - Feb21 & Aug21 * IPAR Report - Board - Nov22				

Date Risk Identified:	May-22	**Executive Director Owner:**	Gjini, Ardiana	**Date of Review:**	Apr-26
Strategic Objective:	1. Thriving Teams and 2. Healthier Communities and 3. Great Care	**Lead Committee:**	Health and Safety Committee	**Date of Next Review:**	Jun-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 has been 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 summer 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** Further action necessary to address the controls gaps	**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 # 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) # 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-curso to Pegasus) and Bite Back (invasic mosquito scenario) during 2025.	Test of recently reviewed Pandemic Response Framework - table top exercise planned for Summer 2026.	Pandemic Response Framework reviewed which broadens remit from Influenza focus to generic pandemic events.	Hussell, Sam	Completed	Pandemic Response Framework endorsed at FET April 2026. Being presented at H&S Committee May 2026. Still awaiting publication of UK Gov Respiratory Pandemic Planning Guidance.
		Learning from participation in Exercises Solaris and Pegasus, to inform the review of existing pandemic framework.	Hussell, Sam	Completed	Completed
		Deliver internal multi-disciplinary table top exercise to inform further development of HB pandemic response arrangements.	Hussell, Sam	31/07/2026	Exercise endorsed by FET as next step and is being scheduled for Summer 2026.

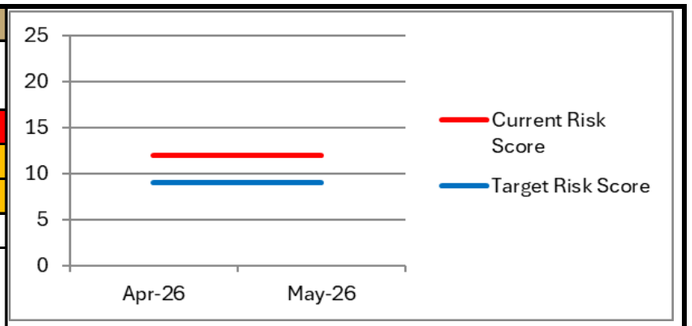
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Planning via Emergency Preparedness, Resilience & Response (EPRR) including LRF workstream reports to Health & Safety Committee	1st			Vaccine Equity Strategy - Board 30 May 2024 Vaccination Delivery Programme Update - Board via SDODC (Sep 23) Major Incident Plan - Board via H&SC and Exec Team (Jul 25) Pandemic Response Framework - FET 08 April 2026 Pandemic Response Framework (scheduled 05 May 2026)	None identified.				
	Operational pandemic reporting structures from HB to WG	2nd								
	National, regional & local command & control structures	2nd								
	National groups operational for vaccination programme planning & delivery	3rd								
	Emergency Planning Advisory Group (EPAG) Wales meetings re Pandemic response and future planning	3rd								

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

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

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

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



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

Rationale for TARGET Risk Score:
The target score of 9 reflects the continuing delivery ambitions which remain, despite the workforce and resource limitations reflected in the Annual Plan. Of note, positive progress achieved both in respect of effective demand management and transformation of outpatient pathways has ensured that overall waiting list demand has not grown with waiting list volumes at their lowest level for 2 years. Opportunities to make further progress towards the Ministerial targets in 2026/27 will continue to be explored, including exploration of the regional opportunities referred to.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage planned care risks on daily basis including multiple daily multi-site calls in times of escalation. # Prioritised review of patients based on an agreed risk stratification model. # Provision of dedicated elective beds on 3 sites. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Quarterly deep dive reviews of all specialty delivery plans and delivery assumptions to ensure full account of OP transformation and theatre productivity and efficiency opportunities # Escalation plans for acute and community hospitals (within limits of staffing availability). # Outpatient transformation programme in place with a continuing focus on alternatives to face to face delivery of outpatient care to enable increases in care volumes delivered. # Robust sickness absence management arrangements in place. # Quarterly review of job plans, with ongoing recruitment. # Elective care delivery plan developed for inclusion within Annual Delivery Plan. # Elective optimisation improvement programme in place to improve theatre activity productivity and efficiency, including improvements to waiting list scheduling and pre-operative assessment processes # Productive & Effective Elective Care Improvement Plan produced to drive productivity and efficiency improvements # Planned Care Delivery Workstream established, reporting to Integrated Quality, Financial Performance Delivery (IQFPD) fortnightly, as part of revised Targeted Intervention governance arrangements. # South West Wales Regional Orthopaedic Delivery Programme established # South West Wales Regional Ophthalmology Programme # Assurance monitoring arrangements in place via mechanisms including weekly RTT Optimisation Group # Working with Johnson and Johnson to review and develop a model of standardised assessment for the Pre-assessment process # Insourced capacity to support theatre staffing workforce deficits at GGH	# Additional Planned Care Recovery proposals developed however no recovery allocation planned in 2026/27 to date (this includes inability to fund insourcing and outsourcing activity in ophthalmology and dermatology) # Lack of resilience within theatre estate (no decant theatre to manage future fire & estate works) # Workforce staffing availability to support further expansion of theatre capacity # Sustainability challenges remain in a number of specialty areas which have been targeted for in-depth review via regional planning programmes for key specialties and the Clinical Services Plan review # Sufficiency of Anaesthetic medical staffing capacity to support existing capacity and further expansion of required operating lists # Widespread adoption of national best practice guidance to improve elective optimisation and utilisation of available operating capacity # Deficiencies within pre-operative assessment process and overall capacity to support required volume of Pre-Operative Assessment Clinic (POAC) assessments # Cessation of PAAR in delivery of waiting list initiatives	Agreed continuation of ophthalmology outsourcing for Q1, utilising ophthalmology and dermatology underspend with core budget	Humphrey, Lisa	30/06/2026	In progress
		Progress proposal for recruitment of fixed term locum to utilise NPT theatres to mitigate loss of activity as a result of theatre estate issues at block 32 at GGH (c.150 cases)	Humphrey, Lisa	30/06/2026	In progress
		Increase capacity to four primary joints on 90% of Orthopaedic lists (Enabling Actions)	Gregory, Lianne	31/03/2027	In progress
		Producing a full recruitment plan for theatre workforce in line with Nurse Staffing Act and allocation of new investment of £1.4m for 2026/27	Sheldon, James	30/06/2026	In progress
		Complete optimisation framework assessment to address WG 3 top priorities which are referral management, waiting list validation across stages and conversation of follow up activity to new outpatient capacity	Humphrey, Lisa	15/05/2026	In progress.
		Develop trajectories of improvement per specialty based on the optimisation framework assessment to identify productivity and efficiency gains	Humphrey, Lisa	30/06/2026	In progress.
		Develop a model of standardised assessment for the pre-assessment process to streamline pre-assessment and eliminate bottlenecks	Sheldon, James	30/09/2026	In progress.
		Develop mitigation plans for areas that are reliant on PAAR (neurology, outpatients)	Humphrey, Lisa	30/06/2026	Monitoring impact of PAAR cessation during Apr26. Ongoing communication with A4C staff has improved the uptake of agreed additional activity in Q1.
		Continuation of insourcing at GGH theatres utilising £1.6m until established staffing is sustainable	Humphrey, Lisa	31/03/2027	In progress

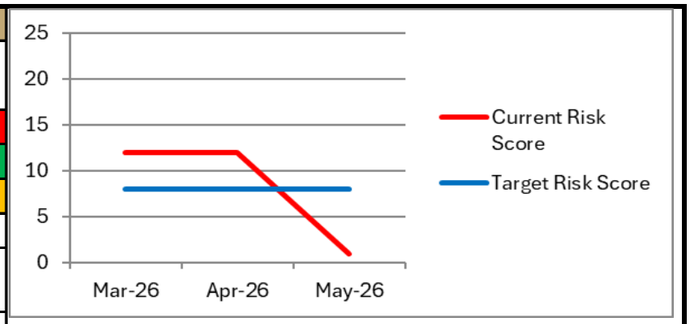
	To produce outline of aspiration aligned to GIRFT Report with associated timescales with the GIRFT Theatres Implementation Group, chaired by Medical Director, established to produce plan on a page that assesses current position, utilisation, staffing, effectiveness, patient outcomes, quality & safety, and estates.	Humphrey, Lisa	31/03/2027	In progress. Monthly reporting required to Formal Executive Team.
	To undertaken a full gap analysis between assessed workload and funded establishment within the anaesthetic workforce to stabilise services, reduce risk, and mitigate ongoing variable pay expenditure	Humphrey, Lisa	31/05/2026	In progress.

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

Date Risk Identified:	Oct-25	**Executive Director Owner:**	Davies, Lee	**Date of Review:**	Mar-26
Strategic Objective:	2. Healthier Communities	**Lead Committee:**	Strategy and Planning Committee	**Date of Next Review:**	May-26

Risk ID:	**2204**	**Corporate Risk Description:**	There is a risk that the Health Board is unable to maximise the opportunities presented by capital funding made available to it. This is caused by the uncertainty on levels of funding provided by Welsh Government, and capital commitments within the financial year being lower than anticipated. This could lead to an impact/affect on the ability of the Health Board to meet the statutory Capital Resource Limit requirements, and detrimentally impact on the health Board's Discretionary Capital Programme in future years.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	1×1=1
Target Risk Score (L x I):	4×2=8
Expected Date To Achieve TRS:	31/03/2026
Trend:	



Rationale for CURRENT Risk Score:

There is a significant level of spend remaining within the capital programme, approximately 60% at end of January 2026 due to:
-Planned programmes of work in quarter 4. Whilst plans in place, spend has yet to be incurred. There are key projects which should they not be delivered, would have a significant impact on the ability of the Health Board to achieve the CRL
-Approval of Welsh Government capital funding in latter half of the year - this equates to £8m to date from November 2025.
Given the significant value and volume of schemes to be delivered the risk profile is increased. The Health Board have currently declined any additional end of year capital funding from Welsh Government.
The consequences of significantly underspending against the Health Boards capital programme would be:-
-a breach of the Health Boards statutory duty to breakeven against its CRL;
-commitments being carried forward to the next financial year, detrimentally impacting on capital allocations in 26/27; and
-Underspending 25/26 schemes would need to be funded from the 26/27 DCP, leading to an adverse impact on future years DCP.

CRL achieved 31/03/26

Rationale for TARGET Risk Score:

In order to achieve the target risk score the Health Board will need to demonstrate that it is able to manage its capital position effectively and meet its CRL requirements for the financial year, cognisant of the risks which are inherent in the delivery of safe and timely care.

A prioritised list of capital purchases with associated timelines for delivery is available to mitigate against any slippages / underspends which are identified. which when actioned will support the reduction of the current risk score.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
1. Timely financial reporting to Capital Monitoring Group, Capital Sub-Committee, Strategy and Planning Committee, Finance and Performance Committee, Board and Welsh Government as key areas of concern emerge. 2. Bi-Monthly reporting to the Capital Sub-Committee, Strategy and Planning Committee and Finance and Performance Committee regarding the capital risk. 3. Prioritised replacement Medical and Digital equipment lists developed with lead times for delivery included. 4. Vesting / Bonding of equipment where delivery is unable to be achieved by the 31 March. 5. Enhanced reporting to scheme Project Managers with immediate escalation where underspends / slippage are identified.

Gaps in CONTROLS				
Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Significant level of spend remaining at end of January approximately 60% spread across circa 200 different capital schemes. Operational capacity due to current demand to ensure all required purchase orders are on the system for processing and payment during Q4 2025/26	Develop a programme of capital schemes to an advanced stage to ensure that the UHB can maximise on funding availability and allow for earlier commitment and spend during the financial year.	Chiffi, Simon	30/09/2026	To be provided at next risk review
	Ongoing identification of slippage on capital projects by Finance and allocation of slippage on projects that are deliverable by 31Mar26. List of projects are managed by the Capital Planning and Finance teams.	Rosser, Eldeg	Completed	Daily ongoing monitoring of capital expenditure during March to enable early indication of any slippage or delivery problems. Capital Programme delivered by 31/03/26

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance** **(1st, 2nd, 3rd)**	**Required Assurance** **Current Level**		
Performance against the Capital Resource Limit	Performance against plan monitored through Capital Monitoring Group with key internal stakeholders	1st			Strategy and Planning Committee (26/02/2026) Finance and Performance Committee (24/02/2026) Capital Sub-Committee (17/03/2026)
	Detailed prioritisation to be agreed through Capital Planning Group	1st			
	Performance reports through to Capital Sub-Committee	1st			
	Finance and Performance Committee oversight of current performance	2nd			
	Capital report to Strategy and Planning Committee	2nd			
	WG Scrutiny through bi-monthly monitoring	3rd			

Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed** **Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**

Y Grŵp Iechyd, Gofal Cymdeithasol a'r Blynyddoedd Cynnar
Cyfarwyddwr Gweithrediadau, GIG Cymru

Health, Social Care & Early Years Group
Director of Operations, NHS Wales

Llywodraeth Cymru
Welsh Government

Phil Kloer
Chief Executive
Hywel Dda University Health Board

Philip.kloer@wales.nhs.uk

14 April 2026

Dear Phil,

Changes to the Oversight and Escalation Arrangements

I am writing to provide an overview of changes to future governance assurance meetings following the introduction of the operating and accountability framework for NHS Wales from April 2026. This framework introduces a streamlined, risk-based oversight approach, with clearer consequences for non-delivery.

As part of these changes, an Escalation Board will be established to oversee progress across the escalation domains, replacing the quarterly targeted intervention meetings. The Escalation Board will take place on 03 June 2026 between 2–4pm; an invite will follow shortly. The draft terms of reference for the meeting are attached to this letter. Please could you submit any comments and confirm health board attendance to performanceandescalation@gov.wales by 07 May. The agenda will follow.

Ahead of the meeting, could you please submit any current improvement plans for finance, strategy and planning, clinical services, urgent and emergency care, HCAIs and planned care to performanceandescalation@gov.wales by 07 May to inform the discussion and identify any support or intervention work required.

Please can the health board also provide an evidence pack in response to the agenda items seven working days prior to the meeting via performanceandescalation@gov.wales.

Yours sincerely

Jeremy Griffith
Director of Operations - NHS Wales

Health, Social Care and Early Years Group

Hywel Dda University Health Board

Escalation Board

TERMS OF REFERENCE

March 2026

Llywodraeth Cymru
Welsh Government

Overview

The purpose of the Hywel Dda University Health Board Escalation Board is to ensure that the health board is taking the appropriate actions as set out in the health board escalation framework and is making the required improvements in line with the de-escalation criteria.

Escalation framework

The NHS Wales oversight and escalation framework sets out the process by which the Welsh Government maintains oversight of NHS bodies and gains assurance across the system. It describes the escalation, de-escalation and intervention process, the five levels of escalation and the domains against which each health board will be assessed.

The Hywel Dda UHB escalation framework sets domains that require improvement in response to the concerns that led to the health board's escalation.

Role and remit of the Escalation Board

The Escalation Board been established to ensure that progress and improvements are made across the escalation domains and the serious issues that resulted in the health board's escalation related to finance, strategy and planning, clinical services and performance.

The Escalation Board forms part of the suite of governance assurance meetings established as part of the accountability framework:

- Escalation Board chaired by the NHS Wales Chief Executive and a small number of the health board and Welsh Government Executive Team members based on the agenda items for discussion at each meeting.
- Oversight between the Chair and the Cabinet Secretary in line with the Oversight and Escalation Framework.
- Regular NHSP&I operational performance and delivery meetings to support operational improvements across a range of areas.

The purpose of the Escalation Board is to:

- Establish the progress the organisation is making against the de-escalation criteria contained within the escalation framework and to support escalation discussions where necessary.

- Scrutinise progress against each of the escalation domains and the agreed de-escalation criteria.

Membership, governance and accountability

The Escalation Board will be chaired by the Director General of Health, Social Care and Early Years Group / Chief Executive of NHS Wales or their nominated deputy and brings together:

- Health, Social Care and Early Years Group Executive Director team.
- Hywel Dda University Health Board Executive Director team.
- Managing Director, NHS Wales Performance and Improvement or their nominated deputy.

The meetings will typically last no more than two hours and take place bi-monthly, face to face at a Welsh Government office where possible but hybrid arrangements will be available as necessary.

Agendas, updates and action logs will be co-ordinated by the Performance, Escalation and Intervention Team in Welsh Government.

The agenda will be circulated three weeks prior to the meeting, and the health board will provide a slide pack seven days in advance of the meeting.

Meetings will be recorded to support minute taking and the drafting of notes. Recordings will be deleted in accordance with Welsh Government guidelines.

Following the meeting, a note of the meeting will be shared by Welsh Government outlining the key discussion points and any actions from the meeting.

Responses to actions should be provided in advance of the following meeting, with any documentation shared with the performanceandescalation@gov.wales mailbox for record keeping.

Review

These terms of reference will be reviewed annually.

Version Control

Created	Updated	Approved by	Review date
March 2026	N/A	HSCEY Director of Operations	March 2027

19 May 2026

FAO: Lee Davies
Hywel Dda University Local Health Board,
Ystwyth,
St David's Site,
Jobs Well Road,
Carmarthen,
SA31 3BB

CC: lee.davies3@wales.nhs.uk
kevin.morgan2@wales.nhs.uk

Our Reference: BMS 38025; BMS 37510

Dear Sir / Madam,

Mace Consult Demerger – novation of contract(s)

RE: Novation of the contracts as set out in Appendix 1, as amended, varied or extended from time to time (collectively "the Contracts").

1. The following definitions apply to this letter:

   "Mace Consult": *Mace Consult Limited and its subsidiaries*

   "Original Party": *Mace Limited*

   *"**Mace Group":** Mace Finance Limited and its subsidiaries and holding companies (where "**holding company**" and "**subsidiary**" shall have the same meaning as their respective definitions in the Companies Act 2006) from time to time which, following the completion of the Transaction, shall exclude Mace Consult.*

   *"**Effective Date**": the 1st of January 2026.*

2. In order to enable third-party investment into the Mace Consult business by Goldman Sachs Alternatives, Mace Group is demerging its Consult business to be wholly owned by Mace Consult Holding Limited. Following the demerger, Goldman Sachs Alternatives will indirectly own a majority shareholding in Mace Consult (the investment together with the demerger, the "**Transaction"**).

3. As part of the process to complete the Transaction, we are undertaking a transfer of the Contracts. This will involve the transfer of all of the Original Party's rights, obligations and liabilities under the Contracts to Mace Consult and Mace Consult will, save in respect of such claims, demands and liabilities notified to the Original Party in writing prior to the Effective Date, be responsible in place of the Original Party for all of the Original Party's obligations and liabilities under the Contracts as if Mace Consult were, and always had been, named in the Contracts in place of the Original Party.

   Novation

4. Subject to paragraph 6, from the Effective Date you release and discharge the Original Party from further performance of obligations under the Contracts and from all claims, demands and liabilities whatsoever, arising out of or in respect of the Contracts.

5. Subject to paragraph 6, from the Effective Date the Original Party releases and discharges you from further performance of obligations under the Contracts and from all claims, demands and liabilities whatsoever arising out of or in respect of the Contracts.

6. PROVIDED THAT:

    a. the Original Party retains the benefit of, and remains entitled to be paid any invoices issued by the Original Party (whether issued before or after the Effective Date) in respect of the period prior to the Effective Date on equivalent terms to the Contracts; and

    b. in respect of such claims, demands and liabilities vested in you and notified to the Original Party in writing prior to the Effective Date: (i) any rights of action, defences and remedies against the Original Party in respect of such claims, demands and liabilities are preserved and remain vested in you; and (ii) the Original Party's relevant rights of action, defences and remedies are preserved and remain vested in the Original Party, in each case, as if this letter did not exist.

    c. For the avoidance of doubt, no payment shall be due to both the Original Party and Mace Consult in respect of the same services or deliverables, and the parties shall ensure that all invoices clearly specify the relevant period and services to which they relate.

7. Subject to paragraph 6(a):
    a. you warrant and undertake to Mace Consult that you have performed and will continue to perform all your duties and have discharged and will continue to discharge all your obligations under, and be bound by the terms of, the Contracts as if Mace Consult were, and always had been, named in the Contracts in place of the Original Party;

    b. without limiting the generality of the foregoing, you agree that Mace Consult shall have the right to enforce the Contracts and in its own right and interest to pursue all claims and demands whatsoever arising out of or in respect of the Contracts, whether arising prior to, on, or subsequent to the Effective Date.

8. Save in respect of such claims, demands and liabilities notified to the Original Party in writing prior to the Effective Date:

    a. Mace Consult warrants and undertakes to you that it will perform all the duties and discharge all the obligations under, and be bound by the terms of, the Contracts as if Mace Consult were, and always had been, named in the Contracts in place of the Original Party.

    b. Without limiting the generality of the foregoing, Mace Consult agrees that it will receive and shall be responsible for all claims and demands against the Original Party arising out of or in respect of the Contracts, whether arising prior to, on, or subsequent to the Effective Date.

9. Except as set out in paragraph 10, you and the parties agree that the Contracts shall remain unchanged and in full force and effect as novated by this letter.

10. With effect from the Effective Date, notwithstanding any provision(s) in the Contracts:

    a. any notices shall be sent to: The Company Secretary, Mace Consult Limited, 155 Moorgate, London EC2M 6XB and ConsultCoSec@macegroup.com;

b. payments that are due to the Original Party (pursuant to paragraph 6(a) or otherwise) shall be paid to the Original Party using its existing account details, or as otherwise directed on the relevant invoice; and

c. any payments that are due to Mace Consult shall be made to Mace Consult, using the bank account details set out below, or such other bank account details as may be subsequently notified by Mace Consult in writing.

Bank:	JPMorgan Chase Bank, N.A. London, 25 Bank Street, Canary Wharf, London, E14 5JP, UK
Currency:	GBP
Sort Code:	60-92-42
Account No:	76971657
IBAN:	GB34CHAS60924276971657
SWIFT:	CHASGB2L
Account Name:	Mace Consult Limited
Registered company address:	155 Moorgate London EC2M 6XB
Company registration number:	7094851
VAT registration number:	TBC
Remittance advice to be sent to:	accountsreceivable@macegroup.com

Project Data

11. Notwithstanding any provision(s) in the Contracts or any other agreement(s) between you and the Mace Group, you agree that Mace Group shall be entitled to disclose, and Mace Consult shall be entitled to access or receive from the Mace Group, any data or information which the consulting business of the Mace Group has access to, or created, in connection with engagements between the Mace Group and you.

Change of Control

12. As a result of the Transaction, Goldman Sachs Alternatives will hold an indirect majority shareholding in Mace Consult. We therefore also wish to take this opportunity to provide you with notice of the upcoming change of control as may be required under the Contracts, which will become effective after customary regulatory approvals have been obtained.

13. If, and to the extent, the Contracts contain provisions in respect of a change of control, following the Effective Date,

    a. Mace Consult notifies you by this letter that the Transaction (as described in paragraph 2 of this letter) will result in a change of control of Mace Consult ("Change of Control");

    b. you, if and as applicable, hereby: (i) consent to the Change of Control; and (ii) agree that you will not exercise any rights or remedies under the terms of the Contracts, in respect of the Change of Control.

14. We can confirm that from an operational perspective, there will be little change. Your Mace client management team and client representative will not change as a result of this Change of Control.

Miscellaneous

15. You and each of the parties to this letter agree to perform (or procure the performance of) all further acts and things and execute and deliver (or procure the execution and delivery of) such further documents as may be required by law or as any party may reasonably require to effect the release and discharge of the obligations, and novation of the Contracts, referred to in paragraphs 4 – 10 (inclusive), and to give you and any party the full benefit of this letter.

16. If any provision in this letter shall be held to be illegal, invalid or unenforceable, in whole or in part, such provision or part shall to that extent be deemed not to form part of this letter but the legality, validity or enforceability of the remainder of this letter shall not be affected.

17. Each of the parties (including you) shall bear its own expenses that may arise out of the negotiation, preparation, and execution of this letter.

18. Except for members of the Mace Group, a person who is not a party to this letter shall have no rights under the Contracts (Rights of Third Parties) Act 1999 (or similar legislation) to enforce any term of, or enjoy any benefit, under this letter. For the avoidance of doubt, you are a party to this letter.

19. No variation of this letter shall be effective unless in writing and signed by or on behalf of each of the parties.

20. Should you require any further information regarding the above, please do not hesitate to contact us at Miles.Brown@macegroup.com.

21. The construction, validity and performance of this letter (including any non-contractual obligations) shall be governed by and construed in accordance with the law of England and Wales.

22. You and each of the parties to this letter, as applicable, agrees to abide by the dispute resolutions provisions set out in the Contracts (including any requirement to undertake arbitration or mediation, if any) and submits to the jurisdiction of the courts or other forum for dispute specified in the Contracts, in connection with any disputes that may arise out of or in connection with this letter.

23. We are committed to making this transaction as smooth as possible for you and are confident that it will strengthen our ability to support you. With the backing of Goldman Sachs Alternatives, we will have access to greater resources and increased financial standing, enabling us to deliver even more value to our clients.

24. For the avoidance of doubt, your continuing instruction of, and payment to, Mace Consult will amount to your acceptance of the novation(s) to which this letter relates and the Change of Control notification, but to formalise such conduct please sign and return this letter to acknowledge your agreement to the novation of the Contracts and the terms set out in this letter.

Many thanks for your assistance.

Yours faithfully

SIGNED

_____

Jason Millett

Group Chief Executive on behalf of **Mace Limited**

155 Moorgate, London, EC2M 6XB

DATE:

SIGNED

_____

Matthew Fitzgerald

Commercial Director on behalf of **Mace Consult Limited**

155 Moorgate, London, EC2M 6XB

DATE:

SIGNED

_____

Lee Davies

on behalf of **Hywel Dda University Local Health Board**

DATE:

Appendix 1

The following contracts shall constitute the "Contracts" and shall be novated in accordance with, and subject to, the terms of this letter:

- Call-Off Contract for Regional Project Manager, relating to Fire Precaution Upgrade Works at Glangwili General Hospital, Carmarthen Phase 1, between Mace Limited and Hywel Dda University Local Health Board, dated 29 July 2021; and

- Call-Off Contract for Regional Project Manager at Cross Hands Community Hub, between Hywel Dda University Local Health Board and Mace Limited, dated 20 September 2019.

Dated:

HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD

and

MACE GROUP LIMITED

DEED OF CANCELLATION AND TERMINATION OF PARENT COMPANY GUARANTEE IN CONNECTION WITH CROSS HANDS COMMUNITY HUB

This DEED is dated

PARTIES

1. **HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD** of Second Floor, Block C, Government Buildings, Picton Terrace, Carmarthen SA31 3BT (the "**Client**");

2. **MACE GROUP LIMITED** a company registered in England under Company Number 04228706, whose registered office is at 155 Moorgate, London, EC2M 6XB (the "**Guarantor**"),

each a Party and together the Parties.

RECITALS

A. The Guarantor executed a Guarantee in favour of the Client in respect of the obligations and/or liabilities of Mace Limited under the Appointment. Mace Limited and the Client have subsequently novated the Appointment to the Client and the Consultant (the "**Novation**").

B. The Mace Group is demerging its Consult business to be wholly owned by Mace Consult Holding Limited (the "**Transaction**").

C. "**Mace Group**" means Mace Finance Limited and its subsidiaries and holding companies from time to time, which, following the completion of the Transaction, shall exclude the Consult Group (where "**Consult Group**" means Mace Consult and its subsidiaries and "**holding company**" and "**subsidiary**" shall have the same meaning as their respective definitions in the Companies Act 2006).

D. As a result of the Transaction, the Guarantor will no longer be part of the same group of companies as the Consultant.

E. Following the Novation, the Parties have agreed that the Guarantee shall be cancelled and terminated with effect from the Effective Date on the terms of this Deed.

In consideration of the payment of £10 by the Client to the Guarantor (receipt of which is hereby acknowledged), it is hereby agreed by the Parties that:

1 DEFINITIONS

1.1 The following definitions apply in this Deed:

Appointment means the appointment dated 20 September 2019 between (1) the Client and (2) Mace Limited under which the Client has employed Mace Limited to carry out and complete the Services (and as subsequently novated to (1) the Client and (2) the Consultant as detailed in Recital A).

Consultant means Mace Consult Limited, a company registered in England under Company Number 07094851, whose registered office is at 155 Moorgate, London, EC2M 6XB.

Effective Date means 1st January 2026.

Guarantee means the parent company guarantee dated 20 September 2019 between (1) the Client and (2) the Guarantor.

Services means the execution and completion of the services as described in the Appointment.

2 INTERPRETATION

2.1 Unless otherwise expressly stated, the rules of interpretation set out in this clause 2 apply in this Deed.

2.2 The headings and sub-headings in this Deed are for ease of reference only and do not affect the meaning of this Deed.

2.3 Words in the singular include the plural and vice versa.

2.4 A reference to a party is to a party to this Deed and includes the respective successors or permitted assigns of the original parties.

2.5 General words do not have a restrictive meaning because they are preceded or followed by specific words indicating a particular type, class or category.

2.6 Any words following the terms "include" and "including" or any similar expression are illustrative and do not limit the meaning of the words preceding those terms.

2.7 A reference to a clause is to a clause in this Deed.

2.8 A reference to particular legislation is a reference to that legislation as amended, modified, consolidated, re-enacted or replaced from time to time and to all subordinate legislation made under it from time to time.

2.9 A reference to a person includes an individual, firm, partnership, company, association, organisation or trust (in each case whether or not having a separate legal personality).

2.10 A reference to a document in this Deed is to that document as amended, varied or novated from time to time as permitted by the terms of that document.

3 TERMINATION OF GUARANTEE

3.1 The Parties agree that, with effect from the Effective Date, the Guarantee is irrevocably cancelled and terminated and shall be of no further force or effect. The Parties agree that the Client shall have no recourse whatsoever against the Guarantor once the Guarantee is irrevocably cancelled and terminated.

3.2 The Parties agree, and in particular the Client warrants, that the Consultant shall not be in breach of the Appointment in any way arising as a result of or in connection with the cancellation and termination of the Guarantee.

3.3 The Client warrants that the Client has not assigned, novated, transferred or in any way disposed of the Guarantee.

4 RELEASE OF GUARANTOR

4.1 The Client fully and unconditionally releases and discharges the Guarantor from all claims, demands and liabilities (including without limitation, all past, present and future claims, demands and liabilities) arising under and in connection with the Guarantee.

5 SEVERANCE

5.1 Each provision of this Deed is distinct and severable from the others. If at any time one or more of those provisions is or becomes invalid, unlawful or unenforceable (whether wholly or partly), the validity, lawfulness and enforceability of the remaining provisions (or the same provision to any other extent) shall not be affected or impaired in any way.

5.2 If any provision of this Deed is or becomes invalid, unlawful or unenforceable (whether wholly or partly) but the provision would be valid, lawful or enforceable if deleted in part or reduced

in application, then the provision shall apply with the minimum deletion or modification necessary to make the provision valid, lawful, enforceable.

5.3 If any original provision or part-provision of this Deed is invalid, unlawful or unenforceable and is not saved by the operation of clause 5.2 above, the parties may negotiate in good faith to agree a replacement provision that, to the greatest extent possible, achieves the intended commercial result of the original provision.

6 GOVERNING LAW AND JURISDICTION

6.1 This Deed and any dispute or claim arising out of or in connection with it or the subject matter or formation of it (including non-contractual disputes or claims) is governed by the governing law of the Guarantee.

6.2 The parties irrevocably agree that the courts with jurisdiction to determine any claim or dispute under or in connection with the Guarantee shall have exclusive jurisdiction to determine any dispute or claim that arises out of or in connection with this Deed or the subject matter or formation of this Deed (including non-contractual disputes or claims).

7 COUNTERPARTS

7.1 This Deed may be executed in counterparts and by the parties on separate counterparts, each of which when executed and delivered shall constitute an original, all the counterparts together constituting the same agreement. Transmission of an executed counterpart of this Deed by email (in PDF, JPEG or other agreed format) shall take effect as delivery of an executed counterpart of this Deed and each party shall provide the others with the original of such counterpart as soon as reasonably possible thereafter.

This Deed has been executed as a deed and is delivered by the parties on the date stated at the beginning of this Deed.

Executed as a deed by **GUARANTOR** acting by two directors or a director and secretary

.....

Director's signature

.....

Name (in BLOCK CAPITALS)

.....

Director's /Secretary's signature

.....

Name (in BLOCK CAPITALS)

Executed as a **Deed** by affixing the Seal of **HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD**	……... (Chair or Vice Chair, **HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD**) PRINT NAME: ……
The application of the **SEAL** of **HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD** is authenticated by the following who are duly authorised for that purpose:	……..…… (Chief Executive, **HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD**) PRINT NAME: ……..……..

Register of Sealings 13 March 2026 – 6 May 2026

Entry Number	Details	Date of Sealing
538	Ceredigion Flying Start Collaboration Agreement for the provision of Speech and Language Therapy Service 2024/27 between Ceredigion County Council and Hywel Dda University Local Health Board	02.04.2026
539	Ceredigion Flying Start Collaboration Agreement for the provision of Health Visiting Services 2024/27 between Ceredigion County Council and Hywel Dda University Local Health Board	02.04.2026
540	Memorandum of Understanding relating to the procurement of the Carer Support Service in Ceredigion between Ceredigion County Council and Hywel Dda University Local Health Board	02.04.2026
541	Collaboration Agreement for Flying Start and Families First Grant Programmes between Hywel Dda University Local Health Board and Pembrokeshire County Council	02.04.2026
542	Lease of premises at Prince Phillip Hospital, Bryngwyn Mawr, Llanelli Glangwili General Hospital, Dolgwilli Road, Carmarthen Withybush Hospital, Fishguard Road, Haverfordwest, Bronglais Hospital, Caradoc Road, Aberystwyth between Hywel Dda University Local Health Board and Welsh Ambulance Services NHS Trust	02.04.2026
543	Consultancy Agreement for the provision of project management services to the Fire Safety Precaution Works project at Bronglais Hospital between Hywel Dda University Local Health Board and Welsh Ambulance Services NHS Trust and MACE CONSULT LTD	02.04.2026
544	Parent Company Guarantee relating to Phase 2 Fire Enforcement Project between TRJ CYF Limited and Hywel Dda University Local Health Board	23.04.2026

Register of Sealings 13 March 2026 – 6 May 2026

545	Form of Agreement for the provision of Cost Advisor Services incorporating the NEC4 Professional Services Short Contract June 2017 incorporating amendments January 2019 and October 2020 between Hywel Dda University Local Health Board and Lee Wakemans Limited	23.04.2026
546	Contract relating to AA&E Y-Delyn & Cwm Seren Glangwili Hospital & Hafan Derwen, incorporating the conditions of the JCT Minor Works Contract 2016 Edition, between Hywel Dda University Local Health Board and Lewis Construction Building Contractors Wales Ltd	23.04.2026

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Consultations Update Status Report up to 13 May 2026

Ref No	Name of Consultation (hyperlink included for online consultations)	Consulting Organisation	Consultation Executive Lead(s)	Received On	CLOSING DATE	Response Sent
C660	Draft dementia strategy for Wales 2026 to 2036	Welsh Government	Director of Allied Health Professions and Health Science	05.01.2026	01.04.2026	26.03.2026
C661	Efanesoctocog alfa for treating and preventing bleeding episodes in haemophilia in people 2 years and over (PPS327), Policy Position Statement	NHS Wales Joint Commissioning Committee	Clinical Director of Pharmacy and Medicines Management	05.01.2026	16.02.2026	11.02.2026
C662	History-based penicillin allergy de-labelling	All Wales Therapeutics and Toxicology Centre	Clinical Director of Pharmacy and Medicines Management	09.01.2026	06.02.2026	No response submitted -the antimicrobial pharmacists had no comments for this consultation from the service, therefore no response needed to be submitted.
C663	All Wales guidance for medicine training and education: for support workers in health and social care	All Wales Therapeutics and Toxicology Centre	Clinical Director of Pharmacy and Medicines Management	14.01.2026	10.02.2026	10.02.2026
C664	All Wales gabapentinoid resources for chronic pain	All Wales Therapeutics and Toxicology Centre	Clinical Director of Pharmacy and Medicines Management	30.01.2026	24.02.2026	24.02.2026

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Consultations Update Status Report up to 13 May 2026

Ref No	Name of Consultation (hyperlink included for online consultations)	Consulting Organisation	Consultation Executive Lead(s)	Received On	CLOSING DATE	Response Sent
C665	Talk with Me Phase 2: Speech, Language and Communication (SLC) Delivery Plan 2026 to 2030	Welsh Government	Director of Allied Health Professions and Health Science	02.02.2026	30.04.2026	30.04.2026
C666	Draft National Strategy for Unpaid Carers	Welsh Government	Director of Workforce and OD/ Deputy CEO	05.02.2026	13.04.2026	10.04.2026
C667	Proposed changes to guidance for local VAWDASV strategies	Welsh Government	Director of Nursing, Quality and Patient Experience	06.02.2026	30.04.2026	28.04.2026
C668	All Wales guidance on adherence aids	All Wales Therapeutics and Toxicology Centre	Clinical Director of Pharmacy and Medicines Management	17.04.2026	14.05.2026	13.05.2026

Executive Team Discussions

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

- **Draft Three-Year Financial Plan 2026/29 & Month 11 2025-26 Finance Update:** the draft medium-term financial plan highlighted a £19.5m shortfall, challenges in converting non-recurrent to recurrent savings, and the need for urgent additional recurrent savings for 2026/27, alongside key risks relating to workforce, cost pressures, and system discipline ahead of Board submission.
- **Enabling Actions: Progress Since Board Seminar:** following the February 2026 Board Seminar, updates identified risks related to productivity assumptions, outsourcing, theatre capacity, estates, and RTT performance. Members underscored the importance of establishing a robust productivity programme, ensuring clear accountability, and implementing practical mitigation strategies.
- **Enabling Actions: Value Opportunities:** national and local case studies supported value-based approaches, with clearer oversight through the Value and Sustainability Group.
- **Concerns Management:** an updated Concerns and Investigations Model aims to reduce complaint backlogs and improve timeliness ahead of new regulations in April 2026, prioritising higher-severity cases, though investigation capacity remains a key risk.
- **PSOW PI Report – Ophthalmology:** the Ombudsman's preliminary findings, scheduled for publication in March 2026, indicated that although the responses primarily address ophthalmology, the report also identified broader patient safety concerns related to follow-up procedures and waiting list-related harm. Oversight of the resulting recommendations and learning is managed by the Listening and Learning Sub-Committee.
- **HEIW Targeted Visit to General Medicine (GGH):** Following HEIW's visit, General Medicine has been placed under enhanced GMC monitoring due to training concerns, with limited progress to date and further work required on rotas, staffing, and engagement with regulators.
- **PPH MIU Implementation Update:** the transition of Prince Philip Hospital from a Minor Injuries Unit to a 12-hour Urgent Care Centre is progressing, with oversight provided by a dedicated Project Group. Current priorities include finalising workforce arrangements, establishing governance structures, and appointing a single clinical lead.
- **Security Risk:** a security risk update addressed Corporate Risks 1860/1861 and the Terrorism (Protection of Premises) Act 2025, identifying trends, security gaps, and three delivery options. While approving Option 3 (resource reconfiguration and security outsourcing), it was agreed that further scoping should be undertaken, noting that doing nothing requires explicit Board risk acceptance.
- **Organisational Level Staff Survey Results:** the 2025 NHS Staff Survey, highlighted a 21.9% response rate and strong positive themes including compassionate and inclusive leadership, flexible working, and staff feeling able to speak up. While improvements were noted in patient safety reporting and flexible working, challenges remained around staffing levels and staff involvement in change, identified as a key area for improvement and system-wide impact.
- **Annual Plan Update:** The Annual Plan addressed Health Board escalation, ambulance handover strengths, and key risks in care delays, planned care,

cancer performance, workforce capacity, and financial sustainability. Although credible, the Plan faces system fragility, uncertain funding including £26m conditional funds and required clearer quality and safety implications before Board approval.

- **Programme Management Architecture:** Proposals were made for a revised architecture with two PMOs Value and Productivity, and Savings to better support CCG delivery and align with executive governance, while reducing duplication. The approach was generally supported, pending clarification of reporting, operations, and alignment with broader governance, and further consideration was deferred.
- **September 2026 Nursing and Midwifery Graduates:** plans include reallocating variable pay, aligning funding to UEC, and offering rotational acute/community roles to boost nursing graduate employment. Challenges remain for midwifery graduates. This approach and its submission to the National Streamlining process was supported, pending detailed cost approval.
- **Emergency Department at Withybush Hospital:** ET commissioned a business continuity framework, endorsed workforce strategy development, and approved data-driven risk escalation to support sustainable staffing and funding.
- **Provision of a Second Generator at PPH:** the contract award was approved, to enable delivery within the current financial year, with onward submission to the Strategy and Planning Committee and Board for scrutiny and approval given the value exceeding £1m.
- **TriTech Internal Commissioning and Funding Arrangements:** the proposal to use the Value Delivery Fund to pilot TriTech's internal commissioning workstreams was approved, with an evaluation to follow assessing feasibility and risks.
- **Anaesthetic Derogation – Escalated Rates:** a request to apply escalated anaesthetic rates for a strictly time-limited six-week derogation period following the introduction of a standardised medical rate card was approved.
- **Pandemic Response Framework:** the updated framework, aligned with the UK model, details planning streams, surveillance triggers, and coordinated command structures informed by national exercises. After reviewing governance, clinical input, scalability, and preparedness, ET endorsed as the tactical pandemic framework and approved submission to the Health and Safety Committee.
- **Pathology Laboratory Information System (LIMS):** the replacement of LIMS is experiencing national delays due to blood transfusion issues. Support for the current system has been extended. ET acknowledged the status and risks, endorsed a safety-led phased rollout, supported ongoing national escalation for funding and timelines, and requested regular updates, especially for Blood Sciences and Blood Transfusion.

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

- **Corporate and Principal Risks**: a comprehensive review of the Corporate and Principal Risk Registers was presented, covering proposed refinements, new risks, the end-of-year Risk Maturity Assessment, and planned Executive feedback. Discussion focussed on the structuring and wording of specific risks, ultrasound and non-designated clinical area boarding risks, supporting leaders to communicate service change, and short-term capital pressures with opportunities

identified through digital investment, alongside progress on updates to the Risk Management Strategy.

- **Financial Month 12 Update**: there was an underspend against the 2025/26 Capital Resource Limit and limited progress on savings, prompting Welsh Government to question the deficit and raise concerns over planned bed cuts. End-of-year overspends and workforce issues led to a £25m deficit, restricting flexibility for 2026/27. ET approved stronger financial governance and a de-risking framework to boost oversight and improvement.
- **A Healthier Mid and West Wales (AHMWW) Group Update**: external support for Primary and Community development is being considered, with 17 interested providers. Discussions are ongoing to define the project scope. CSP progress includes implementation planning, developing stroke service options, and WG's expected review of the programme business case addendum after the Senedd elections.
- **Quality, Financial Performance and Delivery (IQFPD) Group:** updates were received from the five CCGs and the Primary Care Service Group with an alert relating to the fragility of the ED at WGH and anaesthetics medical cover.
- **Value & Sustainability (V&S) Group Update**: recent meetings highlighted ongoing issues with high agency spend, especially in radiology due to demand exceeding price caps. International recruitment was identified as a possible solution for Allied Health Professional shortages. The Group also expressed concern over nursing agency costs and roster non-compliance, and requested a detailed review.
- **Integrated Executive Group:** updates were provided on progress in finalising the regional Integrated Executive Group governance structure, including arrangements linking the three county Healthier groups to provide regional oversight while retaining local connections, alongside briefing workshops on the current RIF funding position. Further assurance was required on governance arrangements, Health Board representation, and the rationalisation of bodies titled as “Boards”.
- **Urgent and Emergency Care (UEC) Programme**: The UEC Accelerated Transformation programme reports better 45-minute ambulance handovers throughout Health Board sites, though WGH remains challenged due to the Business Continuity Incident (BCI) and staffing issues amid increasing demand. Discussions included lessons learned across Wales, staff communication on service changes, enhanced GP Out-of-Hours capacity, ongoing pressures from boarded patients, and improving care for clinically-optimised patients. Funding flexibility and WAST data insights, such as higher conveyance rates related to an ageing population and falls, were also considered.
- **UEC Workstreams Update – Flow:** outlined how short-term measures implemented alongside the Winter Resilience Control Group had focused on easing pressure across the patient pathway, with low-cost actions such as additional administrative and phlebotomy support delivering the greatest impact. While some actions remained outstanding, progress had been made in clinical engagement, and further work was identified to optimise the use of available capacity and improve patient flow.
- **UEC Accelerated Transformation Group Update:** reported ongoing progress in ambulance handovers and system control, but highlighted continued shortfalls in WG de-escalation targets, inconsistent lengths of stay, and slow improvement in

discharge rates. ET recognised positive effects from winter sprints and stronger system collaboration, identifying lengths of stay as a priority for 2026/27.

- **Waiting List Management Incident Control Group Update:** the group is reviewing patient harm from extended waiting times and expects to reduce the number under investigation.
- **Sleep Apnoea Incident Control Group:** The inaugural meeting in February 2026 focused on governance and assurance. Members requested clearer documentation, especially on Terms of Reference and organisational learning links, to be revised for approval. Both the Incident Control Group and Scrutiny Panel have been established, with ongoing quality scrutiny of multi-patient incidents, and formal 3As update reports now required for ET assurance.
- **Winter Resilience Incident Management Control Group:** updates noted that the Group was reviewing progress against its Terms of Reference and whether current arrangements remained fit for purpose. While noting that the Flow system was live and that the manual eObs trial was progressing positively, lessons-learned report was requested. It was agreed that further discussion was needed before confirming whether the Group could be formally stood down.