Shaping Our Future Wellbeing

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Board Assurance Framework

Updated 30 Jul 26

Introduction

The Board Assurance Framework (BAF) is the tool and document that seeks to articulate what strategic risks an organisation has identified that will, if not addressed, prevent it from delivering its strategy.

There is no definitive format, and it is intended that the below pages present in as clear a manner as possible the alignment between CAVUHB's 4 strategic objectives, the strategic portfolios that are led by the Executives in order to turn the strategy into delivery over the course of the strategy, the strategic risks that have been defined to best articulate the major themes that could prevent the delivery of the strategy, and the Board's Committees that are charged with seeking assurance on and scrutinising the delivery of each strategic objective.

While each strategic risk aligns to a Committee, the risks themselves are applicable to all 4 strategic objectives and have a whole organisation perspective and impact. Each has a risk appetite as determined by the Board.

Each risk seeks to identify the potential cause and effect of a manifestation of the risk becoming an issue. This 'uncontrolled' assessment makes use of a simple 5 x 5 scoring guide for likelihood against impact:

Likelihood / Impact	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Severe (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Moderate (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare (1)	1	2	3	4	5

Each risk is then assessed for the different controls and assurance measures or mechanisms that are in place, as well as identifying where there may be gaps in these facets. Once these have been applied a new assessment, using the above scoring system again, is then made.

However, the BAF is not a definitive mechanism or science. It is a vehicle for the organisation to articulate and expose some of the strategic level impacts on delivering the strategy, and for the Board and Committees to pull through and scrutinise those elements that are appropriate.

Finally, the BAF seeks to articulate the activity taking place relevant to each risk for assurance.

This document looks to capture and present this information so that the Board and members of the public can see all of the above information, the trends in scoring, the actions being undertaken and every change made to the document between one Board meeting and the next through the use of track changes.

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Strategic Framework

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Strategy	Putting People First	Providing Outstanding Quality			Delivering in the Right Places	Acting for the Future
Committee	People and Culture	Quality			Digital and Infrastructure	Finance and Performance
	Audit and Assurance | Charitable Funds | Remuneration and Terms of Service					
Strategic Portfolio	Shaping our People and Culture	Shaping our Population Health and Place based Partnerships	Shaping our Quality, Value and Sustainability	Shaping our Future Clinical Services	Shaping our Future Infrastructure	Shaping our Future Generations
Strategic Risk Theme	People	Quality			Digital	Sustainability
		Health Equity			Infrastructure	

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Strategic Objectives

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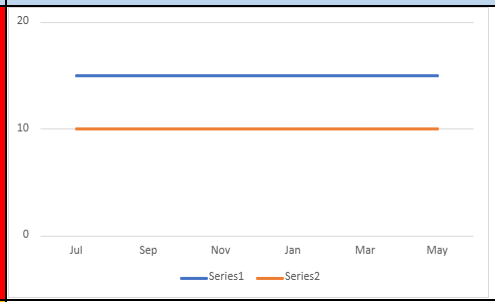
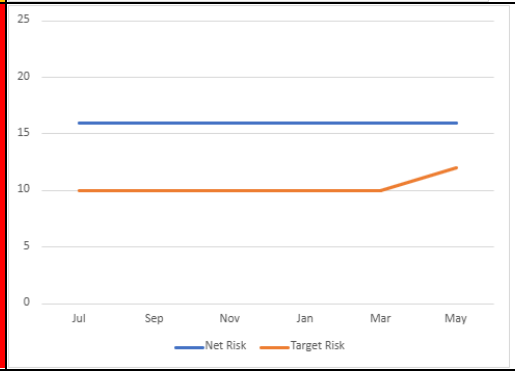
Strategic Objectives			
Putting People First	**Providing Outstanding Quality**	**Delivering in the Right Places**	**Acting for the Future**
We will be a great place to train, work and live, where we listen to and empower people to live healthy lives. By 2035, colleagues would recommend us a great place to work, our workforce will reflect the diversity of our communities and more people will be living healthier lives.	We will provide outstanding services which are equitable, timely and safe, where people are treated with kindness and are supported to achieve the outcomes that matter to them. We will have reduced inequities in prevention, improved access to clinical services and clinical outcomes.	By 2035 we will be using real time integrated data to inform joint decision making and multi-disciplinary team working, giving people access to and ownership of their data to enable them to manage their health and wellbeing. We will be well on our journey to provide care in the right place, in facilities that are fit for purpose, flexible and promote recovery.	We will work to ensure that what we do today does not compromise the wellbeing of our future generations. We will protect the environment and develop and use new technologies, treatments and techniques to provide the best possible health outcomes and sustainable health care into the future. By 2030 we will have reduced the Health Board's carbon footprint by 34% and will have increased our research and clinical innovation activities.
People will feel valued, developed, supported and engaged. We will have an inclusive culture where the diversity of the Health Board's people will be representative of the Health Board's local populations. Through our integrated population health improvement programme, we will enable and empower people to live healthy lives and reduce their risk of ill health.	Focus on minimising inequity in healthy behaviours, preventative services, access to clinical services, and health outcomes, to reduce current unfair, unjust differences experienced by people in the community Deliver outstanding quality of care every time - from the most complex care for the most critically ill to routine care that prevents and protects against ill health and disease – addressing physical and mental health needs. Achieve the best outcomes for patients in line with what matters most to them, their families and carers. Develop the Health Board's approach to continuous quality to improvement and make the best use of the Health Board's resources.	To achieve digital maturity enabling the Health Board to connect and communicate, supporting shared decision making in the planning and delivery of health care services. Refresh and deliver the Health Board's programme for creating integrated health and care facilities in our local communities where people can access the information and support they need under one roof. With Cardiff University and NHS partners, develop the Health Board's plans for ensuring hospitals providing acute care are fit for the future. Develop more shared infrastructure with public and private sector partners to get best value for the Health Board's investment.	Develop and expand the Health Board's research, teaching and innovation portfolios in collaboration with Cardiff University and other partners. Contribute to the development of and adopt cutting-edge and novel treatment, techniques and technologies where they deliver improved patient outcomes and improved value. Maximise the Health Board's contribution to the foundational economy Deliver the Health Board's carbon emissions targets and fully support active and sustainable travel for staff and visitors to patients. Promote, reward and embed successful waste reduction as part of our quality programme of continuous improvement.

Strategic Risks – Quality

What will prevent Cardiff and Vale University Health Board from delivering its strategy?
If any of the below risk themes cannot be controlled, then the strategic objectives are unlikely to be met.

Strategic Risk	Risk Appetite / Target Risk	Gross Risk *(no controls)*	Net Risk *(after controls)*	Trend	Context	Executive Lead(s)
Quality	Cautious **10**	**25**	**15**		Our ultimate priority - to continuously, reliably, and sustainably meeting the needs of the population that we serve. Our organisation will focus on delivering assurance on the six domains of quality with the ultimate aim of providing outstanding care to our patients. We will strive to deliver Safe; Timely; Effective; Efficient; Equitable and Person-Centred Care.	Exec Dir Nursing Exec Medical Dir Exec Dir AHPs and Health Science Chief Operating Officer
Health Equity	Open **12**	**16**	**12**		One of our two statutory responsibilities as a Health Board is to improve the health and well-being of our local population. The overall aim of our strategy is: 'Working together, we will help improve lives so that by 2035 people are healthier and unfair differences in health outcomes are reduced.' The goal is to improve health outcomes by reducing inequity in indicators of healthy behaviours and increasing the use of preventative services and access to clinical services.	Exec Dir Public Health
People	Open **12**	**20**	**16**		The most important asset of any organisation. Through the delivery of the People and Culture Plan, our strategy will be delivered with a key focus on these core People risks: Attract, Recruit, Retain | Culture | Wellbeing	Exec Dir People

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Strategic Risks – Quality

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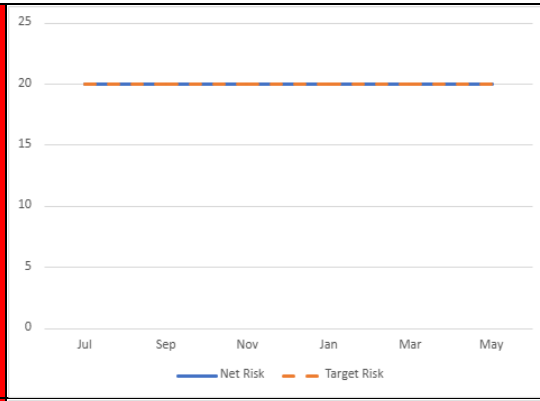
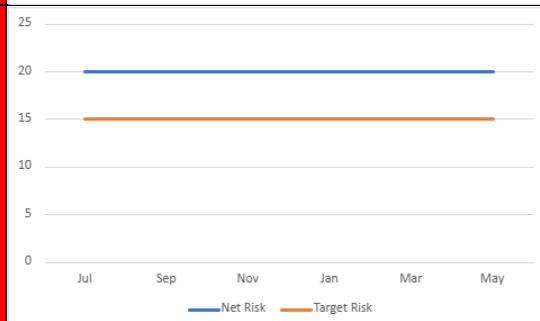
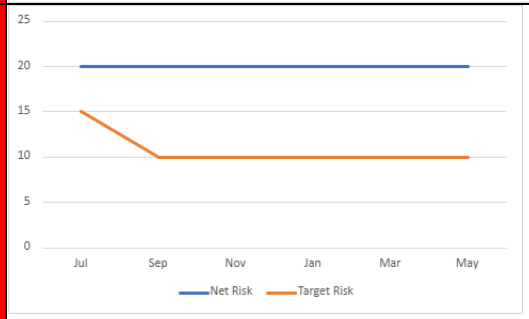
Digital	Cautious 20	**25**	**20**		Data is integral to our strategy. It empowers informed decision making about what we need to do, why, when and how we perform. Delivering our digital and data transformation road map will introduce actionable insights and capabilities that enable clinicians and patients in any setting delivery of safe, high-quality care, improving productivity, efficiency and communication through person centric digital solutions. The security, management and accessibility of data is essential.	Dir Digital
Infrastructure	Open 15	**25**	**20**		The Health Board has the largest hospital in Wales, a footprint across dozens of locations and integrated service locations with key partners. We must shape our future infrastructure to ensure facilities are fit for the delivery of modern healthcare, intelligent integration takes place with partners and the service is delivered in the right locations for our population.	Exec Dir Finance
Sustainability	Cautious 10	**25**	**20**		Sustainable, efficient services are a legal requirement, improve quality and ensure a sustainability of service for now and future generations. By articulating the strategy through the integrated mid-term plan and the proper alignment of resources and consideration of the environment the Health Board will meet its statutory duty and ensure value in delivery.	Exec Dir Finance

Strategic Risks – Quality

Risk Appetite			
Avoid	Avoidance of risk and uncertainty is a key organisation objective	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (VFM)
Minimal	Preference for ultra-safe delivery options which have a low degree of inherent risk and only for limited reward potential	Seek	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential reward	Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

Strategic Risks – Quality

Strategic Risk	Strategic Portfolio	Exec Leads	Committee	Date Added
Quality	Shaping our Quality, Value & Sustainability	Exec Dir Nursing | Exec Medical Dir | Chief Operating Officer Exec Dir Therapies and Health Science	Quality	30 Sep 24

Risk

There is a risk that workforce, digital, capacity and estate constraints, combined with weak escalation and organisational learning, lead to inconsistent and unsafe care, resulting in avoidable harm, poorer patient outcomes, long waits, reduced patient experience and diminished public trust.

Cause	Impact
Workforce Vulnerabilities in our Workforce including availability, retention, culture and leadership can impact on our ability to deliver safe effective timely and patient centred care **Digital Enablers** The absence of a joined up digital patient record and patient management system has resulted in omissions in care and disruption to patient pathways Ability to deliver effective care is impacted by outdated systems related to digital technology, clinical coding The challenge in accessing real time data to track care against a robust evidence base means that the organisation is dependent on retrospective data to inform its response to quality risk. The lack of data relating to population health and protected characteristics means that we are unable to effectively measure variation in outcomes. **Capacity and demand** Ability to deliver timely care is significantly impacted by the backlog of referrals following the covid-19 pandemic and the mismatch between demand and recurrent capacity within many clinical services. Pressure within the urgent and emergency care pathway is driven by extended length of stay. Opportunities to maximise out of hospital services have not been fully realised. **Environment** The ageing environment is leading to challenges including to disruption to services and Infection prevention and control risks and poor patient experience **Whole Systems approach** Gaps in our clinical governance structure means that risk is not clearly articulated and Escalated and that mitigation is often localised rather than delivered at an organisational level. **Improvement and learning capability** Learning from events is often undertaken at departmental level with infrequent evidence of embedding organisational learning	**Safe** The UHB continues to see a number of same cause patient safety incidents, complaints, redress cases and claims where the harm to patients is potentially avoidable. These include health care associated infections, failure to ensure continuity in clinical pathways, failure to recognise the deteriorating patient, failure to escalate, issues with communication and Never Events. The health, safety and welfare of our staff is not universally maintained. **Timely** Long waiting times for planned care and diagnostics means care is delivered at inappropriate timescales with a potential consequence of progression of disease, worsening wellbeing and associated psychosocial impact on patients and families. Care is ultimately costlier to provide. **Effective** Benchmarked data associated with national clinical audits demonstrates that we don't universally benchmark in the top 30% of organisations nationally for performance and outcomes. The pressure on estates, workforce capacity and wellbeing will impact on our ability to provide care in line with evidence base. **Efficient** The Health Board is not meeting some of its productivity and efficiency ambitions, including in relation to outpatients and length of stay. Care may be being delivered which does not provide value to the patient, wider population and health economy. Care can be duplicative and wasteful. Care is often delivered with a disproportionate focus on intervention vs prevention. Constraints around workforce availability results in a reliance on non UHB staff to provide core. **Person Centred** The Health Board is striving to deliver care that meets the patients right to empathy, compassion, privacy, dignity and respect. In some areas patient experience is below our ambition, for example in the Emergency Department which is below the 85% target in all but one measure. The Health Board is seeking to ensure patients and families views are sought and play a role in improving services.

Strategic Risks – Quality

.		**Equitable –** Our health outcomes between different population groups (e.g. most deprived and least deprived and different ethnic groups indicate that we have more work to do on this aspect of quality. We have developed an 'Equity, Equality and Patient Safety Framework for the Health Board' this describes a framework for change, provides examples of best practice from across the world, and finally outlines the key actions each Clinical Board has committed to. For example, our data collection of protected characteristics is poor, and each Clinical Board will need to make improvements in this area. Using a co-production approach supports equity.	
Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 10

Controls	Assurances
Safe – Corporate Quality and Safety team have oversight of all UHB patient safety incidence, the Duty of Candour supports systematic scrutiny of all incidents reported as having caused moderate harm and above. Quality Committee and the groups that report into the committee provide oversight of emerging trends. The clinical safety group brings together the clinical boards and clinical advisory groups to support the development of strategy and policy to deliver quality aligned to current risk. The Shaping our Future Quality Excellence Programme is designed to address emerging patient safety themes. The Theatres Together programme is overseeing improving work in theatres that has emerged from the recent theatres review. **Timely**- Planned Care programme and Operational Performance meetings delivering on plans to reduce waiting times. Patients prioritised in line with Health Board criteria – Urgent and Emergency Care; Cancer and Time-Critical; planned (in referral order). Recovery plans are in place for diagnostic long waits such as endoscopy and non-obstetric ultrasound. **Effective –** The Clinical Effectiveness Committee provides oversight of national clinical audit outcomes and improvements and implementation of NICE and HW guidance. Clinical Boards are bringing an overview of their local arrangements to providing continuous focus of national audit data and use it to transform clinical pathways as has been done in stroke and hip fracture. Work is planned as part of the Sharping our Future Quality Excellence – Quality Management System Project to standardise the collection of national audit data and to embed it into quality governance structures.	• Clinical Board Performance Meetings • Integrated Performance Report • QSE • Clinical Effectiveness Committee • Clinical Safety Group • Risk registers • Executive Reviews • People and communities experience framework • CIVICA • Benchmarking Information (Clinical) • Get It Right First Time • Peer Reviews • HIW and external assurance • PSOW REPORTS • WRP assessments • Accessibility standards • Equity, Equality, Experience and Patient Safety Framework and Action Plan at Quality Committee • Assurance of CAVHIS Business Case Implementation in 2024/25 • AMaT • Shaping Our Future Quality Excellence

Strategic Risks – Quality

Efficient – operational programmes in planned care and urgent and emergency care focused on delivering best practice. Benchmarking and use of GIRFT central to programme. Productivity and Efficiency ambitions in place and monitored. **Person Centred –** Value Based Healthcare programme supporting projects and programmes focused on delivering value to patients. The UHB is rolling out a new PROM platform "Promptly" throughout the organisation to provide reliable opportunities to collect this information. **Equitable –** We monitor performance against the actions outlined in the Equity, Experience and Patient Safety Framework and Action Plan. This goes to Quality Committee every six months.	
Gaps in Controls	**Gaps in Assurances**
A recent advisory audit of Clinical Governance demonstrated gaps in reporting and escalation The availability of data to support benchmarking and monitoring of performance is limited by poor coding compliance Participation in a number of National Clinical Audits is sub optimal with poor case ascertainment and data quality The availability of data relating to protected characteristics means that measures of variation in outcomes by population is limited. The Development of the Quality management system is underway, but this is a two-year programme to embed this work	The control gaps identified mean that assurance at Committee and Board level is undermined and so the Committee work is being reviewed and redeveloped.

Risk Post-Controls and Mitigation			
Impact: 5	Likelihood: 3	Net Risk: 15	

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Strategic Risks – Quality

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Actions			
What	**Lead**	**By**	**Update**
Deliver stroke improvement plan to address quality concerns in acute stroke pathway	PB	31/03/27	• Business case approved for stroke model, funding to be released from Q4 2024/25 • Delays in recruitment for agreed stroke post • Recruitment is now underway to the additional posts, but it will be some time before all posts are in place. There is continued focus on stroke performance and a real increase in regional working to deliver sustainable models moving forwards. • Stroke performance remains stable – new SSNAP measures to be reported to Board in August. • Go-live of phase of regional thrombectomy service in July 25 • Performance is consistent despite operational pressures. Increases in thrombolysis rates, work remains on % in time. Detailed review of thrombectomy undertaken • Stroke summit highlighted improvements in performance for some parts of pathway alongside increased challenges – particularly rehab length of stay. Work ongoing • Stroke Summit 16th June - agreed actions were to continue on all workstreams, review SRC's accommodation and clinical model and facilitate Exec colleagues' conversations with available data in the stroke dashboard.
Develop and deliver improvement plan for cancer and long waiting patients, including a plan to reduce diagnostic waiting times.	PB	31/03/27	• Delivery against revised trajectories is monitored internally and by WG • Challenging position in select specialities including ophthalmology • End of year positions in Cancer and 104 weeks for 24/25 good in comparison to recent years but still too long and not in line with WG expectations. Revised plans in place to deliver reduction during 2025/26 • Cancer performance remains best in Wales – further work to do to reach 75% • Long waits significantly reduced, meeting agreed trajectories for each quarter. • Q2 performance slightly ahead of trajectory for 104 week waits. • On-track of 450 patients waiting longer than 104 weeks by end of March. • Diagnostic challenges mean improvements will be delivered but not to the level previously expected • End of year position significantly improved for 156 weeks, 104 weeks and 8-week waits • Recurrent demand and capacity mismatches will lead to worsening of position in 26/27 without further investment • Delivering productivity and efficiency opportunities key to mitigating position • Working closely with national colleagues to maximise productivity opportunities, backlog forecast position improved from April 2026. Still expect 104-breaches in challenges specialities.

Strategic Risks – Quality

Develop and deliver long term proposal for ITU capacity – Strategic Outline Case in production	PB	31/09/26	• The design development continues. However, discussions are ongoing with WG in relation to a combined ITU/Haematology and Hybrid theatres schemes. • Interim plan for releasing capacity on 3rd floor in progress through discretionary capital programme – work to C1 to accommodate Cardiology from C3 has commenced and is due to complete October 2025, releasing capacity ahead of the ITU work • C1 work will completed in December. Planning in place to install updated UPS • C1 work completed. UPS completed. • Detailed request for funding for C3 refurbishment, and indicating plans for subsequent A3, B3 upgrades, will be sent to WG in Q4 • Completion of proposal has been delayed due to capacity pressures, aiming for submission in Q2 26/27
Deliver the Theatres Together Programme which includes important quality elements such as the WHO checklist and productivity improvements	PB	31/03/2027	• Theatres Together Programme is underway, and updates provided through Board. Initial focus on 6 immediate actions and cultural priorities • Work on further tranches now underway • Progress made across programme with improvements in staff feedback. • A number of capital and estates improvements have been delivered with wider programme in development • Theatre efficiency and utilisation improvements form significant part of future work • Significant positive feedback from staff engagement sessions – indicating embedded imrpvoements
Review, design and improve mental health services which are noted to carry risks to quality	PB/DF	31/03/2027	• External consultancy appointed to support with review of mental health services – work ongoing • Plans for neurodevelopment services undergoing significant scrutiny • 3-year ND waits for children and young people likely to be >450 by March 2026 – working with WG and NHS P&I. • 3-year ND waits reducing for end of life but will increase in 26/27 • Implementation phase of transformation work to begin in 26/27 • Transformation plans developing and being delivered. Consideration of phase 2 opportunities from external support. Focus on out of area placements
Length of stay and continuity of care	PB	31/03/2027	• Length of stay programme in place – aiming to deliver, as a minimum, mean peer performance in medicine non-elective by the end of March 2026/27. • Performance and productivity board in place to monitor and drive change
Development of a Quality Outcomes Framework- To support a data informed approach to quality	JR/ RS	31.06.25	• Meetings underway with corporate teams to agree quality indicators • Work to extrapolate data relating to patient safety incidents commenced • Plan to develop a first draft by Q1 with digital support by June 2025 • Publication of a UHB mortality dashboard

Strategic Risks – Quality

			• Publication and analysis of clinical board and directorate mortality dashboards
Development of the Quality prospectus to populate the quality academy – Up skill staff across the clinical boards in patient safety review technique, improvement planning and clinical governance	JR	31.03.26	• PSLR training developed • Improvement plan training in development • Human factor prospectus planning • Development of a quality academy • Accredited audit training in place
Monitoring of the Equity, Equality, Experience and Patient Safety Action Plan and progress against actions by Clinical Boards	CB	Every six months	• Paper for Quality Committee on progress against the action plan. • Early discussions with Public health around equity measures as part of the quality outcome framework
			•

Strategic Risks – Health Equity

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Health Inequity	Shaping our Population Health and Place Based Partnerships	Executive Director of Public Health	Quality	29 July 2021

Risk

There is a risk that insufficient investment in prevention, worsening socio-economic determinants, inequitable access and poor data limit the Health Board's ability to address inequalities, resulting in widened life expectancy gaps, higher morbidity in deprived populations and increased long-term demand on services.

Cause	Impact
Risk: a lack of investment in prevention • Our organisation aims to shift spending from reactive hospital care towards prevention and proactive care in community settings. However, secondary care continues to receive an increasing share of NHS funding, leaving prevention under-resourced. Addressing this imbalance is essential for our long-term sustainability. • There is currently a lack of capacity to deliver evidence-based interventions at scale to tackle smoking, obesity, vaccination, alcohol, substance use etc. that drive the huge disparities in health outcomes we see across Cardiff and the Vale of Glamorgan. • There is also currently a lack of capacity to undertake more substantial work on the wider determinants of health with partners, such as improving housing, educational attainment and employment. • There is currently a lack of investment in prevention: the Faculty of Public Health recommends 15 public health consultants for a population of 500,000, we employ 5.5 WTE. **Risk: worsening socio-economic determinants of health** Health inequalities are well documented across the UK and arise in multiple ways, including structural issues e.g. income, employment, education and housing and unhealthy behaviours due to the environment, social norms and income levels. •	**Impact: widened life expectancy gaps and higher morbidity in deprived populations** The risks identified above contribute to worse health outcomes and a worsening of the gap in life expectancy and healthy life expectancy between different members of our population. **Impact: increased long-term demand on services** Health inequalities are already estimated to cost £3-4 billion annually in Wales through higher welfare payments, productivity losses, lost taxes, and additional illness. The total annual cost associated with inequality in hospital service utilisation to the NHS in Wales is estimated to be £322 million, equivalent to 8.7% of the total hospital service expenses, driven largely by higher service use among people living in more deprived areas compared to those living in the least deprived (PowerPoint Presentation (nhs.wales). A lack of investment in prevention will cause an increase in future health service costs associated with health inequities. However taking preventative action on health inequities can reduce premature mortality, reduce social disparities, and reduce the absolute time in ill-health for people in our communities. For example, using a NHS service such as 'Help Me Quit' can increase a person's chance of successfully quitting smoking. However, by locating 'Help Me Quit' clinics in areas where smoking prevalence and deprivation are highest and delivering clinics on different days and at different times of day, barriers to accessing these services can be further reduced.

Strategic Risks – Health Equity

Worsening socio-economic determinants in the UK are impacting on health needs and outcomes in general, but particularly for those most vulnerable in our communities. People living in the most deprived areas die earlier on average and live more of their lives in poor health; this is well recognised and deeply entrenched, but it is preventable. Risk factors interact and multiple aspects of disadvantage come together, increasing the disease burden and widening equity gaps. Moreover, disadvantage experienced in childhood is often compounded and exacerbated through adult life and therefore often passes inter-generationally. Examples of the impacts of these inequities on health include: • Areas with higher unemployment have greater incidence of suicide; and people living in the most deprived areas experience the largest increase in mental illness and self-harm. • In 2021, in England, the *undiagnosed* diabetes rate was double for those in the bottom Index of Multiple Deprivation quintile compared to the top. This presents a challenge for the NHS in finding those with an unmet need for healthcare. • Lower levels of immunisation in the population have significantly increased the risk of outbreaks of diseases like measles. These will impact disproportionately more on our most deprived communities, with direct risks to health and by further negatively impacting on wider determinants such as education or employment. • Smoking is a major contributor to health inequalities; smoking prevalence is typically higher in areas of greatest deprivation and has a significant influence on morbidity and mortality. In Wales in 2020-2022, 14.5% of deaths in adults aged 35+ and living in the most deprived areas of Wales were attributable to smoking, compared to 7.7% of those living in the least deprived areas. In Cardiff and Vale in the same period, 9.8% of all deaths in adults aged 35+ were attributable to smoking involving 5,573 admissions to hospital. **Risk: inequitable access to services**	This preventative action can in turn reduce the burden on and costs to the Health Board and social care, while enabling our population to be more productive in our working lives. Spending on prevention has a superior return on investment when compared with acute hospital services. There is strong evidence that areas that invest more in prevention and community care see 15% lower non-elective admission rates and 10% lower ambulance conveyance rates, together with lower average activity for elective admissions and EU attendances. Changing both the distribution of resources and the operating model to deliver preventative care closer to home will also support the UHB to fulfil its organisational priorities as described in its Strategy, because they are derived from the changing needs of the population.

Strategic Risks – Health Equity

Access to, or experience of, services, public information or healthcare sites that may be relevant / pertinent to particular health and wellbeing needs, continues to be inequitable, including as a result of discrimination. The 'Inverse Care Law' has been recognised for over 50 years, with those experiencing disadvantage consistently experiencing more challenges in accessing health services. Inequity of access to healthcare continues to be evident in Cardiff and the Vale of Glamorgan. **Risk: limited and poor quality data** Evidence suggests that key population groups with multiple vulnerabilities include: • Some people in minority ethnic groups, especially some people in Black and Asian populations • People living in (or at risk of) deprivation and poverty • People in insecure/low income/informal/low-qualification employment, especially women. • People who are marginalised and socially excluded, such as people experiencing homelessness and other inclusion health groups However the quantity and quality of data on the health needs, outcomes and experiences of people from these and other disadvantaged groups is highly limited. This impacts on our ability to both understand and mitigate health inequities using evidence-based and effective approaches. •	

Uncontrolled Risk			
Impact: 4	Likelihood: 4	Gross Risk: 16	Target Risk: 12

Controls	**Assurances**
1. Statutory duty • The Health Board has a statutory duty to improve the health and well-being of the local population. • The Socio-economic Duty places a legal responsibility on public bodies in Wales when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. • **2. Role as an employer**	Board papers Committee papers to Quality Committee e.g. updates on Equity, Equality, Experience and Patient Safety Framework. Committee papers to People and Culture and Quality and Safety Committees e.g. updates on Welsh Language Standards.

Strategic Risks – Health Equity

• In our Equality, Inclusivity and Human Rights Policy, we have an active programme, which sets out the organisational commitment to promoting equality, diversity and human rights in relation to employment, and ensuring staff recruitment is conducted in an equal manner. • Our Strategic Equality Objectives and Plan 'Shaping our Inclusive Culture 2024-2028', has a number of key delivery objectives and is premised on the basis of embedding equality, diversity and human rights, and Welsh language, into UHB business processes. • All our Executives have taken up a leadership role as an Inclusion Ambassador covering different characteristics, including those specified in the Equality Act 2010. • The Head of Equity and Inclusion is a member of the Public Sector Equality Network, improving the collaboration between public sector organisations in the area. The UHB also now has an Equity & Inclusion Manager, together supporting Clinical and Service Boards, including with awareness and training on completing Equality Impact Assessments. **3. Our Strategy and plans** • The refreshed UHB Strategy 'Shaping our Future Wellbeing' shines a light on the issue of equity at the strategic level. • 'Shaping our Inclusive Culture 2024-2028' is closely aligned with the UHB's Strategy 'Shaping our Future Wellbeing'. • The Cardiff and Vale Long-term Public Health Plan 2024 – 2035 sets out how the UHB intends to achieve its ambitions of increasing life expectancy, reducing inequity and shifting more focus to prevention. • Through our Public Services Board (PSB) and Regional Partnership Board (RPB) plans we already prioritise areas of work to tackle inequalities and the refreshed needs assessments for both PSBs and RPB have further identified collective actions. • The future UHB organisational direction supports the 'shift upstream' by committing to develop an Integrated Community Health System, underpinned by care pathways that begin with prevention; prevention is a 'brilliant basic'. • An 'Equity, Equality, Experience and Patient Safety' action plan was approved by Board in May 2024, covering 24 initial actions across the Clinical Boards that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. Progress on actions is reported to Quality Committee on a 6-monthly basis (most recent update provided in April 2026). Ongoing review is undertaken to identify outstanding actions and create future actions using the framework. **4. Public Health priorities to reduce health inequalities** The Public Health Team have agreed three immediate priorities that will influence health inequalities (and other work that we will need to bring forward when capacity allows). Work to tackle inequalities needs to take place over prolonged time periods. We continue to work with PSB and RPB partnerships to address the three priority areas where we know we can make a significant impact on reducing health inequalities: smoking, vaccination	Risk Registers Integrated Performance Report Papers to Senior Leadership Team (SLT)

Strategic Risks – Health Equity

and obesity. The Amplifying Prevention Board, held jointly with Local Authority (LA) partners, provides governance oversight of this collective action and works to remove any blocks to it. The priority areas are:
- preventing obesity (focus 0-5 years)
- reducing smoking rates
- increasing levels of vaccination (using an outreach model to reduce inequity in uptake).

These priority areas are being developed through UHB-wide work, including:

- The UHB is continuing to implement and periodically review its strategy to tackle the lower and unequal uptake of vaccination in our most deprived communities, using an intelligence driven approach and involving targeted, behaviourally informed communications and engagement.
- The establishment of a Strategic Diabetes Programme Board is a key element to reducing health inequalities. It recognises that diabetes exacerbates health inequalities and aims to reduce the incidence of Type 2 diabetes and eliminate avoidable associated harms.
- The UHB has developed a co-ordinated programme of action to reduce smoking in areas/populations where prevalence is highest (often where levels of deprivation are high). It has also taken strong action to introduce enhanced enforcement of no smoking legislation on hospital sites across Cardiff and the Vale of Glamorgan, including introducing innovative approaches that are evidence-based but have not been delivered locally before. This is helping to protect vulnerable people and signpost people to stop smoking support services.

5. Work to support health equity through patient engagement and feedback
The All-Wales People's Experience Framework was launched in April 2025. There are now several methods being used to gather feedback with the aim of ensuring all patients can contribute (available from the Patient Experience SharePoint pages). Training tools and guidance are also now available to support staff in engaging more effectively with patients and service users, helping them gather meaningful feedback about their experiences. These are complemented by feedback-in-focus sessions held across sites to support patients, staff and carers in completing and understanding the many ways we collect feedback, offering support where needed. Translation and Interpretation pages have also been developed in line with the Welsh Government Accessible Standards Framework, launched in September 2025.

Gaps in Controls	Gaps in Assurances
There is an ongoing need to improve the routine collection of protected characteristics to support the introduction of new indicators. This will need to be addressed by each Clinical Board.	Monitoring data (e.g. on protected characteristics). A Population Health Management System to reduce inequalities by identifying those at risk. Ability to share information between Health Board teams on patient characteristics.

Risk Post-Controls and Mitigation

Strategic Risks – Health Equity

Impact: 4	Likelihood: 3	Net Risk: 12	

Actions			
What	**Lead**	**By**	**Update**
Within the UHB and through our PSB and RPB partnerships, continue to develop and deliver a suite of focused preventative actions to tackle inequalities in health.	Claire Beynon	March 2026 with further annual actions 2026/2027	• • • Across the UHB, work continues to meet targets in the existing Equity, Equality, Experience and Patient Safety Plan, especially in relation to data collection to support data availability, linkage and analysis. A new action includes creating and developing an equity indicator dashboard. The most recent updates on this work were presented to the Quality Committee in April 2026 and the next update on this work will be presented in a further 6 months. • Innovative approaches to help people quit are being trialled, such as the 'Allen Carr Easyway to Stop Smoking' method. In addition, the 'Help Me Quit' community service is working in partnership with local primary care practices and networks to take targeted action in deprived areas to promote smoking cessation services and encourage referrals and uptake amongst high-risk patient groups such as those with chronic respiratory diseases. • As part of the All-Wales Accessible Communication and Information Standards, the UHB has developed a draft Accessible Communication Policy. This is now in the process of ratification, ongoing over the coming months. We are also currently working closely with the British Deaf Association, the D/deaf community and the Wales Interpretation & Translation Service (WITS) to roll out a trial British Sign Language (BSL) interpreter patient self-booking process. • In the Cardiff City and South Primary Care Cluster of Cardiff, focused work has begun to understand barriers to vaccination uptake. A survey was launched in May 2026 translated into five community languages (alongside English and Welsh) and will run until the end of August. It will be shared via community networks and by health visitors as part of their immunisation conversations. This, alongside targeted engagement, will inform interventions to increase vaccination uptake in an area that consistently has the lowest levels within the Health Board area. • The Childhood & Teenage Immunisations Strategic Action Plan has been approved by the Strategic Immunisations Group and will be reviewed by the Quality Committee in July. Equity is a cross-cutting theme of this. Planned actions: • Write an Annual Director of Public Health report that highlights health inequalities and actions to take to reduce these.

Strategic Risks – Health Equity

			• Refresh sections of the Population Needs Assessments or undertake Health Needs Assessments for the population that highlight health inequalities and actions that can be taken to reduce these and share these with appropriate partners (e.g. RPB and PSB) • Refresh the UHB's Vaccination Equity Strategic Plan and embed equity as a cross-cutting theme in strategic action plans to address vaccination uptake in childhood, teenage and adult populations. •
Advocate for more resources for prevention as a percentage of the total health board budget.	Claire Beynon	2026/2027	• Continue to advocate for increased resources for prevention to improve the health and wellbeing of the local population. • Ongoing work on the business plans that would allow full implementation of evidenced based interventions to reduce health inequalities for smoking and obesity, to include time frame for benefits. • Suggest a methodology that supports the collection of data on spend on preventative activities, with a focus on primary prevention.
Improve the routine data collection in relation to equality and inequity across the UHB.	Claire Beynon	2026/2027	• Follow the advice and guidance from the internal audit on data collection on protected characteristics once report is finalised. • Request further analyses of aspects of access to health services by Welsh Index of Multiple Deprivation. • Expect Clinical Boards to take responsibility for understanding their data in relation to protected characteristics, and to take positive action in relation to this.

Strategic Risks – People

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
People	Shaping our People and Culture	Rachel Gidman	People and Culture	Revised 01/05/26

Risk

- . There is a risk that gaps in workforce planning, productivity, leadership and culture undermine workforce capability, capacity and engagement, resulting in an inability to maintain safe, affordable, high-quality services and deliver strategic transformation.

Cause	Impact
Domain 1: Workforce Sustainability **a) Workforce supply and capacity (recruitment, retention, skills)** • Workforce planning not aligned to demand and capacity (activity planning). • Variable workforce planning capability and inconsistent use of data to inform decisions. Workforce plans are not consistently aligned to future service models, productivity assumptions and population need, increasing reliance on short-term mitigations. • Limited workforce redesign (continued reliance on traditional models). Limited triangulation of workforce, quality, demand and finance data to identify emerging risks early. • Persistent gaps in critical and specialist roles creating service fragility Governance/compliance pressures (ESR/data quality, establishment control, safer staffing, mandatory training, professional registration, legal compliance) divert capacity Limited alignment between education, training and future workforce requirements **b) Workforce productivity and deployment (rostering, job planning, bank/agency optimisation)** • Lack of a unified E-Rostering system limits productivity and safe redeployment Variation in roster compliance and job planning impacting delivery of agreed KPIs. • Suboptimal temporary staffing controls increase cost and risk **c) Workforce affordability (pay bill, agency, variable pay)** • Over reliance on agency and variable pay • Financial constraints limit recruitment, growth and transformation	**Patient experience and outcomes will deteriorate, including:** • Increased waiting times and delays to treatment (• Increased length of stay and delayed discharges • Increased patient safety risk linked to staffing gaps and fatigue • Reduced continuity of care and patient experience **Workforce performance will deteriorate, including:** • Increased sickness absence (**>5.5% target**) • Increased turnover and reduced retention (**>10% turnover**) • Reduced productivity and increased reliance on temporary staffing (< required 30% reduction for agency and 10% for Bank) • Worsening staff engagement and wellbeing (<74% target engagement score) **Financial and operational performance will deteriorate, including:** • Increased agency and variable pay spend • Inefficient workforce deployment impacting service delivery

Strategic Risks – People

d) Sickness absence and wellbeing-related capacity loss • High and/or persistent sickness absence reduces workforce capacity and resilience Mitigation through temporary staffing increases cost and reduces continuity of care. **Domain 2: Culture, leadership, wellbeing & workforce experience** • Limited integration of workforce, culture, wellbeing and EDI data reduces early identification of risk Absence of clear, organisational leadership and management expectations and standards leads to inconsistent behaviours and accountability. • . • Variable management capability impacts staff experience, performance and retention.Psychological safety, dignity and respect concerns affect staff wellbeing and willingness to speak up. • Cultural signals are not consistently triangulated to inform proactive intervention. • Wellbeing model is predominantly reactive, with limited preventative interventions • Sustained operational pressure /inefficient systems reduce wellbeing, engagement and increases burnout risk. Inequity in workforce experience and outcomes across staff groups.	**Organisational sustainability and reputation will be impacted, including:** • Reduced ability to recruit and retain staff in critical roles • Widening inequalities in workforce experience and outcomes • Reduced staff trust and engagement **Strategic delivery will be compromised:** • Delay or failure to deliver service transformation and organisational priorities • .

Uncontrolled Risk			
Impact: 5	Likelihood: 4	Gross Risk: 20	Target Risk: 12

Controls	**Assurances**
Overarching: • People & Culture Plan aligned to UHB strategic priorities. • Workforce Planning Training programme in place. • Annual Plan with key deliverables, supported by Clinical Board delivery plans. • Speak up Safely system, SUS/WIC. • Clinical Board/CEF – bank and agency reduction plans • Strategic plans aligned to EDI priorities. • Medical & Dental workforce workplan. • Temporary pay controls in Clinical Boards. • Managing attendance at work policy and training.	Overarching: **People and Culture Committee** oversight of workforce risks, performance and delivery **Monitoring of People and Culture Plan** deliverables and performance trends (including KPIs)**Annual Plan reporting**, on workforce risks and delivery **External assurance**, including Welsh Government oversight and performance reviews, **Domain 1 Assurances: Workforce Sustainability**

Strategic Risks – People

Domain 1 Controls: Workforce Sustainability • Nursing workforce forecasting and safer staffing processes to identify and escalate capacity risks Recruitment, onboarding and retention approaches, including use of workforce data to inform interventions. • Workforce risks incorporated within IMTP and Annual Plan processes Improved education commissioning process. • Bank and agency governance/controls to manage use, authorisation and cost. • Sickness absence case management, OH/EHWS support and return-to-work processes. • Education, training and talent development pathways to support workforce pipeline **Domain 2 Controls: Culture, leadership, wellbeing & workforce experience** **Leadership & Culture** • Leadership development and OD interventions, supporting capability to lead teams effectively under pressure. • Raising Concerns / Speaking Up Safely framework, supporting staff voice and response. **Wellbeing** • Integrated health and wellbeing model (preventative, early intervention, specialist support). Occupational Health and Employee Wellbeing Services **Equality, Inclusion & Workforce Experience** • Strategic Equality Plan, Anti-Racist Action Plan and WRES, • Welsh Language Standards. **Engagement & Insight** • Staff survey and engagement mechanisms. • Wellbeing, Employee Relations and engagement data	• Workforce reporting (including Nursing Staff in Post) tracking vacancy, supply and capacity risks • Recruitment, retention and workforce experience data, including exit questionnaires and new starter insight . • Workforce planning outputs within Annual Plan and service planning processes. Workforce and financial performance data (including temporary staffing usage and cost) **Domain 2 Assurances: Culture, leadership, wellbeing & workforce experience** **Leadership & Culture Assurance** • Staff Survey and staff engagement data (leadership, psychological safety, dignity and respect). • Employee relations data and themes. • Speak Up / Work in Confidence data. **Wellbeing** • Occupational Health and Employee Wellbeing Service data (demand, access, outcomes) • Sickness absence data (including stress-related absence **Equality & Workforce Experience Assurance** • WRES, Strategic Equality Plan and Anti-Racist Action Plan reporting, • Analysis of differential workforce experience (,disciplinary, progression, access to opportunity). **Triangulated Insight** • Increasing triangulation of workforce, culture, wellbeing and EDI data to identify risk and hotspots.
Gaps in Controls	**Gaps in Assurances**

Strategic Risks – People

Workforce Sustainability • No consistent, organisation-wide workforce planning framework (standards, tools, governance) . • Variable workforce planning capability resulting in reactive decision-making . • Stronger controls for nursing than other staff groups (e.g. medical, AHP, A&C) • Over-reliance on temporary staffing and short-term mitigations . • Sickness absence controls more focused on case management than prevention • Limited integration of digital, automation and role redesign into workforce planning. • External workforce supply constraints (national shortages) increase residual risk. • Sustained operational pressure increases demand for cover, stressing existing controls. • Talent management and succession planning is not consistently defined. **Domain 2: Culture, leadership, wellbeing & workforce experience** **Leadership & Culture** • No agreed organisational leadership and management standards • Inconsistent management capability, particularly in leading teams under sustained pressure and supporting staff wellbeing • No organisational cultural dashboard to monitor risk systematically. **Wellbeing** • Wellbeing model remains predominantly reactive • Increasing demand and complexity within Occupational Health and Employee Wellbeing Services. • Limited organisational controls to address sickness absence at a structural level. • No organisational Wellbeing Framework. **Workforce Experience, Access & Inclusion**	**Workforce Sustainability** • Limited assurance on the quality and use of workforce plans to inform decision-making. • Assurance focused on current-state metrics, rather than future sustainability and modelling. • Inconsistent assurance across staff groups (stronger for nursing than others). • Limited outcome-based assurance on sickness absence reduction. • Limited assurance on effectiveness of actions to reduce reliance on temporary staffing beyond activity/cost monitoring. • Limited visibility of digital and workforce productivity impact. **Domain 2: Culture, leadership, wellbeing & workforce experience** **Leadership & Culture** • Limited assurance on leadership and management capability, beyond staff perception measures. • No structured mechanism (e.g. dashboard) to identify emerging cultural risks early. • **Insight and Early Warning** • Limited triangulation of workforce, culture, wellbeing and EDI data for early risk identification. **Wellbeing**

Strategic Risks – People

• Inconsistent communication and access to information and support. • Variable awareness of, and access to, wellbeing and support services. • Inconsistent clarity of support pathways for staff and managers. • Inequities in workforce experience and outcomes not consistently addressed.	• Assurance focused on service demand/activity, not preventative impact or outcomes. • **Equality & Workforce Experience** • Limited assurance on differential experience and outcomes across staff groups,

Risk Post-Controls and Mitigation			
Impact: 4	Likelihood: 4	Net Risk: 16	

Actions			
What	**Lead**	**By**	**Update**
Agree and publish an organisation-wide Workforce Planning Framework (scope, required inputs/outputs, templates, scenario rules, governance/approvals, annual cycle and escalation), plus additional targeted short training/implementation plan for managers.	Donna Davies	Sept-26	HEIW Workforce Planning methodology has been adopted, supported by their online introductory training.
Medical & Dental workforce deployment, including implementation of a unified E-Rostering system, robust job planning, implementation of the Welsh Resident Doctor Contract (WRDC), etc	Martyn Capel	Aug-26 (phase 1)	WRDC/E-Rostering presentation to P&C Committee in July 26.
Continue to reduce the reliance on temporary workforce through agency and bank reduction & improve monitoring through development of a dashboard.	Lianne Morse	Mar-27	P&C Committee receive updates via Workforce KPI report (bi-monthly) Board receive updates via IPR.
Strengthen leadership accountability and early intervention through a consistent, data-led attendance management and wellbeing approach to sustainably reduce sickness absence.	Katrina Griffiths	Mar-27	P&C Committee receive updates via Workforce KPI report (bi-monthly) Board receive updates via IPR.
Develop and implement organisational leadership and management standards, including defining how capability will be assessed and assured at organisational level in collaboration with HEIW national work.	Claire Whiles	Mar-27	Leadership & Management Conference planned for 02/07/26 to engage all leaders.

Strategic Risks – People

Develop a proportionate organisational cultural dashboard, drawing on existing data sources, to support early identification and monitoring of cultural risk.	Claire Whiles	Aug-26 (phase 1)	Presentated to P&C Committee in May 26, follow up in Sept 26.
Redesign and implement an organisational wellbeing model to ensure appropriate balance between preventative, early intervention and specialist support.	Claire Whiles	Sept- 26	Presentation to P&C Committee in July 26.
Transition from WTD% payments to AfC Average payments, aligned to national programme of work to ensure the UHB are legally compliant.	Lianne Morse	Mar-27	National Programme Board to be established, paper going to the National W&OD Directors peer group on 19/06/26.
Organisational readiness for the new Future Workforce Solution (replacement for ESR), prior to implementation	Lianne Morse	Dec-26	NWSSP will commence working with CAV from July/August 2026. Priority is currently with organisations that are early adopters of the system.

Strategic Risks – Digital

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Digital	Shaping our Future Digital Services	Director Digital and Health Intelligence (D&HI)	Digital and Infrastructure	4 October 2022

Risk

There is a risk that legacy systems, underinvestment and limited digital capability constrain transformation, resulting in inefficient care delivery, increased cyber risk, missed productivity opportunities and failure to realise strategic ambitions.

Cause	Impact
CAVUHB IT and digital services are known to be historically underfunded resulting in a legacy and deficit in infrastructure, applications and informatics capability that has built up over at least a decade (e.g. our core applications for UEC, inpatients and outpatients were developed in-house-c20 years ago). There are plans to rectify these issues however they are unachievable with the current resource (people, finance) allocation We have some capability in human resources but insufficient capacity or funding to execute the digital and data transformation plans and road map. Existing resources are fully consumed with tactical short-term on the day-to-day urgency of UHB operational needs Recruitment of suitably skilled D&HI staff is a national challenge as well as affecting CAV. This often requires the use of interim agency support in key areas, especially whilst we continue with legacy solutions as we are tied to old technologies. This of itself diminishes further our existing capacity as resources need to be familiarised with the technical environment and then supervised. Historically CAV has looked to provide much of its core IT and digital services inhouse. This is not always necessarily the optimum route however 'legacy lock' and the resource to support forward plans keeps us where we are. Meanwhile with new initiatives the technical estate grows and the gap between what we have and what we can support/refresh widens.	Colleagues need mobile, scalable, agile solutions that enable data collection and sharing. This is unachievable whilst we are locked into legacy. Legacy Lock makes improving our cyber posture more challenging (e.g. securing our data) The impact of not managing this risk is that the improvements in safety, quality, outcomes, productivity and financial efficiency that staff and patients expect from D&HI cannot be fully realised, therefore putting at risk the deliverability of the SOFW Strategy.

Strategic Risks – Digital

Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 20

Controls	Assurances
• Digital strategy approved by Board in 20/21 with roadmap for 21/22/23 - these will be refreshed by April 2025 • Roadmap to support the strategy shared with DHIC covering 2024/27 - these will be refreshed by April 2025 as part of the Digital Foundations PBC work • Digital components described in IMTP – focussed on in year national and clinical board priorities • £466K is being invested by CAVUHB in the development of a Digital Programme Business Case (PBC) to seek All Wales Major Capital Funding alongside a Business Justification case (BJC) for phase 1 of the 5 annual phases. This work will complete in 12 months. • The work will deliver a clear trajectory, costs and plans on how CAV will achieve its target of HIMSS[1] Level 3 in pursuit of its intention towards a modular EPR, consistent with national and regional initiatives. The capabilities the PBC and business justification cases will describe are harmonious with and would segue into any nationally agreed and funded EHR solutions through interoperability and concordance with the "All Wales" Infrastructure review. o Work is expected to begin Oct/Nov 2024. o This follows positive discussions with WG IIB and NHS CDIO, • An audit by Audit Wales on our approach and plans for Digital Transformation has now been completed. This audit has concluded that CAVUHB has a clear digital ambition and recognises digital as a key enabler of service quality, safety and sustainability. However, there are areas where greater clarity is needed for some Members of the Board on how this ambition will be achieved. Despite this, the Board shows strong ownership of digital transformation and has put governance arrangements in place to highlight key digital risks and priorities. The Audit makes several recommendations, which are detailed below.	• All Controls are shared and discussed with the DHI Committee which meets quarterly. • The Digital Foundations case was scrutinised and approved by the Investment Group and Strategic Leadership Board. • The Director D&HI shared the intentions of the Digital Foundations investment case and updated WG's chief digital officer, whilst the DoF has discussed with IIB Lead. Both are supportive of approach and our intentions • Recruitment and procurement is underway for the resource to produce the PBC and BJCs • Risk register articulates the risks of not being able to deliver digital solutions to support delivery of healthcare (1) • Internal audit report highlights the risk in delivering digital strategy citing the investment challenges that will prevent full implementation.

Strategic Risks – Digital

Gaps in Controls	Gaps in Assurances
Current annual discretionary funding is insufficient to cover the maintenance upkeep of the core infrastructure and there is no headroom for innovation	Unable to currently provide assurance that the finance will be provided

Risk Post-Controls and Mitigation			
Impact: 5	Likelihood: 4	Net Risk: 20	

Actions			
What	**Lead**	**By**	**Update**
Internal investment case to support the Digital Foundations case approved	Director of DHI	Mar 26	Programme Business Case completed and shared with WG setting out detailed roadmap plans and the associated costs, funded accessed by annual Business Justification Cases to WG's Major capital budget. Statement of works produced against which a suitable external partner will be sought Digital Foundations Programme Business Case and supporting Business Justification Cases for Year 1 (of the 5 year case) complete. PBC being taken through the internal governance process comprising Capital Management Group, Value & Benefits Realisation Group, Senior Leadership Team, F&P and D&I committees before presenting to the November Board meeting and thereafter submission to Welsh Government for their consideration/approval. The existing Digital Foundations PBC seeks funding from the all Wales major capital budget but has a revenue tail which is currently unfunded. additional work is taking place, including detailed discussion with each Clinical Board, to identify the funding source to enable the PBC to progress through internal CAV UHB governance process – this will likely not happen until the new financial year. May 26: Meeting with WG's Head of Capital, CAV DoF and CAV DoD took place on 13/05/26 to provide update and share summary information in advance of a formal submission if agreed by CAV Board following due governance process. July 26: Capital bids invited by WG specifically to address Estates Backlog and DIgital Maintenance (back-log) costs, resulting in CAV submitting a digital maintenance bid for £7.8m in June 2026. There has been no further update on the consideration of the Digital Foundations PBC and associated year 1 BJCs submitted earlier in the year.
Development of the Digital Programme Business case to support the digital foundations ambitions is underway.	Director of DHI	May 26	External partner identified and service procured which has enabled the works to commence on the Programme Business Case. Co-production approach with all Clinical Boards and corporate services involved via workshops taking place during May and June 2025.

			July 25: Draft plans and outputs from workshops shared with Clinical Boards for comment prior to feeding into the Programme Business Case in Sept/October 25. Digital Foundations work to support the development of the Programme Business Case and supporting Year 1 Business Justification Cases complete. Workshops held with input from all Clinical Boards and services to ensure full co-production and alignment with the organisation's strategic objectives. Nov 25: Further scoping and detailed workshop being held with each Clinical Board during November and December to capture the detail of where savings can be made arising from automation and digital changes which will be used to off-set the revenue shortfall. The DF PBC has been shared with digital team at WG following the Digital presentation made at the November IQPD meeting. The intention is to submit the final case to Board for approval prior to formally submitting to WG for consideration via the Infrastructure Investment Board Jan 26 – additional work to identify the funding source for the associated revenue costs – especially in year 1 of the PBC means that the process will slip into 26/27. Decisions on allocating WG major capital are not expected until well into Qtr 1 26/27. May 26: An updated PBC and Year 1 BJCs have been developed and are in the process of working through the internal governance process having been reviewed by the D&I committee, SLT and Value & Benefits Realisation Group and Capital Management Group, with the case to be considered at the Finance & Performance Committee prior to submission to Board on 28/05/26. July 26: Audit Wales have completed their audit into CAV's Digital Transformation, resulting in 8 specific recommendations: Strengthen strategic delivery and affordability Develop the Board's understanding of Digital Improve assurance over digital and cyber risks Establish a clear approach to AI Build workforce readiness for digital transformation Have clear contingency plan for funding digital transformation Embedding how it works with staff and patients in its digital developments Reporting on digital programme benefits The management response to the above recommendations sets out the actions to be taken, which will be shared in more detail at the D&I committee meeting in August 2026.

Strategic Risks – Infrastructure

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Infrastructure	Shaping our Future Infrastructure	Exec Dir Finance	Digital and Infrastructure	12 November 2018

Risk

There is a risk that ageing estate, insufficient capital investment and delays in major programmes impair service environments and infrastructure, leading to safety risks, service disruption, poor experience and inability to modernise services.

Cause	Impact
• Significant proportion of the estate is over-crowded, not suitable for the function it performs, or falls below condition B (assessed regularly on an all-Wales basis by NHS Shared Services Partnership). • Investment in replacing facilities and proactively maintaining the estate has not kept up the requirements, with compliance and urgent service pressures being prioritised. • Lack of investment in IT also means that opportunities to provide services in new and efficient ways are not always possible and core infrastructure upgrading is behind schedule. • Insufficient resource to provide a timely replacement programme, or meet needs for small equipment replacement • Lack of timely decisions regarding the development of strategic business cases required to address the significant estates challenges we face.	• The health board is not able to always provide services in an optimal way, leading to increased inefficiencies and costs. • Service provision is regularly interrupted by estates issues and failures. • Patient safety and experience is sometimes adversely impacted. • Medical equipment is replaced in a risk priority order where possible, insufficient resource for new equipment or timely replacement. • Staff facilities needed to support good staff wellbeing are inadequate in many areas.

Uncontrolled Risk

Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 15

Strategic Risks – Infrastructure

Controls	Assurances
• Estates strategic plan in place which sets out how over the next ten years, plans will be implemented to secure estate, which is fit for purpose, efficient and is 'future-proofed' as much as possible, recognising that advances in medical treatments and therapies are accelerating. This will be updated following the conclusion of the conditions survey, clinical services plan and the site masterplanning work. • Statutory compliance estates programme in place • The strategic plan sets out the key actions required in the short, medium and long term to ensure provision of appropriate estates infrastructure. • The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP/annual plan, with regular oversight of the programme of discretionary and major capital programmes. The 2026/27 Capital Plan will be submitted for Board with the Annual plan • Medical Equipment prioritisation is managed through the Medical Equipment Group and there is a process in place for rapid decision making if there is a urgent need to replace a piece of equipment. This is managed within the remit of the Capital Management Group. • Business Case production or delivery is managed through the Capital Management Group/Investment and benefits realisation group . • Welsh Governments stated priorities are Theatres including Vascular/MTC theatres, Haematology including BMT and ITU refurbishment. • Welsh Government has agreed regarding the Shaping Our Future Acute Hospital Programme a series of activities which will support the Health Board to refresh its estates strategy.	• The Health board teams including estates and capital team work with Welsh Government to identify opportunities to improve the estate sustainability and manage any emergent or urgent risks. • The statutory compliance areas are managed and monitored within the Health Board • The Capital Management Group, Senior Leadership Team the Digital and Infrastructure committee and Finance & Performance Committee
Gaps in Controls	**Gaps in Assurances**
• The current annual discretionary capital funding is insufficient to meet all the priorities identified through risk assessment, Annual Plan and Strategic ambitions of the organisation. • further impact the teams and resources available • Traceability of Medical Equipment • The Welsh Government capital funds are insufficient to meet the capital requirement	• the regular statutory compliance surveys remedial works .

Risk Post-Controls and Mitigation		
Impact: 5	Likelihood: 4	Net Risk: 20

Strategic Risks – Infrastructure

Actions			
What	**Lead**	**By**	**Update**
Infrastructure risk management	Geoff Walsh	Q2	The Vision document is in progress although it is now anticipated that it will be finalised and presented to Board for approval in Q3 26/27 to submit to Welsh Government for the future of critical services at UHW to include EU , ITU, Diagnostics, theatres and inpatient surgical beds. Review of the condition survey data to bring forward a plan to address the highest risk elements identified in the report to inform discussions with the D&I committee and WG for funding Q3 2026/27 BMT/Haematology Strategic Outline Case submitted to WG in June 2026 Response to JACIE followinginpection report has been returned PBC for ITU refurbishment to be considered by Board in Q2 2026/27 Theatres refurbishment no progress on the Business Case Development. However, funding for 2nd phase of refurbishment included in Discretionary capital programme. Ophthalmology theatres business case Project team established, and design team appointed. Clinical Board to re-visit project mandate. Commencement of the Park View (Ely) health and wellbeing centre infrastructure project in Q2 26/27. Delay in agreeing construction contract clauses, now resolved. Capital management group to oversee a review of medical equipment risk across the assets and support the development of a management plan Q4 26/27 Work with Welsh Government to highlight and mitigate risks and opportunities to manage infrastructure issues in a proactive and sustainable way.
Estate utilisation a programme of decommission, disposal or demolition is undertaken to minimise the estate and infrastructure which the Health Board needs to maintain.	Geoff Walsh	As per individual actions	Decommission priorities – Denbeigh and Carmarthen house have been vacated, and planning permission is being sought for their demolition. Tenders to be issued and funding support to be sought from WG. Anticipated to commence demolition in Q3 26/27 Demolition of Brecknock House to be completed in August 2026. Demolition of Sports and Social Club is practically complete.

Strategic Risks – Infrastructure

			Disposal plans – Rookwood the UHB continue to work with the successful bidder to exchange contarct for conditional sale . However, there remain some contractual clauses to be agreed, completion now anticipated in Q2 2026/27 Roath Clinic and Fairwater Road sites to be declared surplus in Q2 2026 Clinical service plans are being developed for the future of the ALAS and other Rookwood legacy services as well as Treforest. These are expected to be in place with a site solution by Q4 26/27 Education and clinical service plans are being developed with Cardiff University to develop a future model of delivery for dental education, training and service provision. Q3 26/27 Estates planning around the Dental Hospital will be undertaken in light of the future model. From Q4 26/27. Decommissioning of the Tenovus building in conjunction with Cardiff University
Condition Survey	Geoff Walsh		Develop a management and action plan for the results of the condition survey in two parts, firstly the highest risk issues (Category D & Dx) and then for all other issues identified in the survey. Highest risk management plan to be approved in Q3 26/27. Whole report management plan to be developed in following 9 months and used to inform the 27/28 capital programme for Welsh Government and the Health Board.

Strategic Risks – Sustainability

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Sustainability	Shaping our Future Generations	Exec Dir Finance	Finance and Performance	1 April 2022

Risk

There is a risk that persistent financial pressures and limited progress on service redesign and decarbonisation undermine long-term sustainability, resulting in continued external intervention, investment paralysis, failure to meet statutory duties and weakened organisational resilience.

Cause	Impact
Decarbonisation and Climate	
The world has breached the 1.5°C pathway set by the Paris Agreement in 2024. Growing evidence shows that the magnitude of climate impacts is increasing day by day, and Cardiff is projected to be one of the most affected cities in the UK.	Interim findings from the 2026 Heatwave Staff Impact Survey demonstrate the growing impact of extreme heat on workforce wellbeing, productivity, and healthcare delivery. A total of **91.8% of respondents reported poor comfort levels**, **88.5% reported reduced productivity**, and **35.4% experienced heat-related illness** during heatwave conditions. Among clinical respondents, **43% reported increased patient footfall** and **42.5% reported increased patient length of stay** during periods of extreme heat. Combined with climate projections indicating more frequent and severe heatwaves, these findings emphasise the need for accelerated adaptation measures to protect staff, patients, and service resilience.
In 2024-25 the UHB's emissions increased by 44% to c260,000 Tons of Co2 compared to 2023-24 emission of c180,000.	Both of the above factors present a financial risk. The UHB has already missed Welsh Government target of reducing its emission by 16% by 2025.
Currently, UHB has undertaken an initial climate risk assessment however a comprehensive assessment of current and future climate risks is yet to be conducted.	CAV UHB does not have a line of sight to achieve the 40% reduction in directly controlled emissions required by the strategy by 2027 nor the 34% emission by 2030. (from a 18/19 baseline). This renders UHB vulnerable to unidentified climate risks that have a direct impact on healthcare delivery and its financial situation.

Strategic Risks – Sustainability

CAV UHB has limited resource for Sustainability and Climate response.	This will impact on embedding sustainability and building climate response.
Finance	
The conditions required to stabilise the financial position are not yet in place. The organisation does not currently have a sustainable medium-term service/financial plan, and recurrent cost growth continues to exceed available resources. The Health Board does have a model demonstrating a five-year financial sustainability trajectory. It illustrates the potential scale of improvement that could be achieved through service redesign, productivity gains, workforce optimisation and better alignment of capacity with need. However, delivery depends on significant assumptions and enabling actions that are not yet fully developed. Achieving the trajectory would require detailed service and workforce plans, quantified savings schemes, strong programme management and effective governance. As such, it should be viewed as an indication of what may be achievable over time rather than a confirmed route to financial sustainability. Planned deficit of £86.5m in 2026/27 with no identified recurrent route to balance. Recurrent cost growth (pay, workforce, drugs, CHC, demand pressures) outpacing allocation uplift. Limited progress to stop, reduce, or redesign low-value services. High reliance on non-recurrent mitigations as part of savings plans. Growth in unfunded operational commitments. Underdeveloped internal commissioning and weak demand and cost control. Variable financial delivery and accountability across Clinical Boards. Planning cycles not grounded in realistic workforce, activity or cost parameters.	It is unlikely that the continuation of this situation will enable the delivery of the Health Board's objectives or meet Welsh Government expectations. The HB will need to demonstrate strengthened financial grip, consistent decision-making, and alignment between performance, workforce and resource allocation to de-escalate from targeted intervention. The collective impact may be: Breach of statutory financial duty. Continued or escalated NHS Wales intervention. Inability to invest in service redesign, digital, estates or workforce. Requirement for short-term corrective action with potential impact on quality and performance. Reduced flexibility and organisational resilience. Loss of credibility with Welsh Government. Inability to deliver the Health Board's strategy.

Strategic Risks – Sustainability

Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 10

Controls	**Assurances**
Decarbonisation and Climate	
A decarbonisation action plan is in place to deliver decarbonisation actions aligned with the NHS Wales Decarbonisation Strategic Delivery Plan 2021-2030. SusQI has been implemented to embed sustainability in Q&I projects. The Welsh Government has mandated yearly reporting, such as Decarbonisation Co-Ordination Reporting and Emission Reporting, along with all other health boards in Wales. The Welsh Government has made it mandatory to report qualitatively on progress regarding climate adaptation. A Working group has been established to identify pathways for climate risk assessment and climate adaptation pathways.	Climate Response plan is under development and will be overseen by Finance and performance committee First Iteration of CAV UHB Climate Risk Assessment has been undertaken and a Climate Adaptation plan is under development. The identified risks will be uploaded in AMaT. Successful in outline stage of the NIHR-funded HASTE research bid with the Institute of Occupational Medicine, Met Office and UKHSA. This is a research study to understand and design adaptation approaches for heat impacts on health care delivery.
Finance	
Scheme of Delegation and financial governance framework for expenditure approval. Annual Operational Plan aligned to savings requirements and control totals. Savings Program monitoring through: – Senior Leadership Team – Monthly Executive performance reviews / Finance deep dives	Monthly financial reports and savings delivery updates to the Finance & Performance Committee. Board receives monthly Integrated Performance Report including financial risk assessment. Internal audit provides assurance on the adequacy of financial systems and controls.

Strategic Risks – Sustainability

– CEO-chaired Financial Summits Finance Business Partnering providing forecasting, reporting and corrective action support. Monthly Finance & Performance Committee scrutiny. Internal audit reviews of financial controls, planning and budget management. Workforce controls and recruitment approval processes aligned to financial plan compliance.	Welsh Government oversight through Targeted Intervention with regular feedback. Forecasts and financial deep-dives reviewed by SLT and Management Executive.
Gaps in Controls	**Gaps in Assurances**
Decarbonisation and Climate	
Given the complexity of decarbonisation actions across various departments of the UHB, there is a lack of continuous, robust monitoring. This would require the reestablishment of a digital climate change program dashboard, setting of qualitative and quantitative KPIs aligned with targets, and a seamless data collection process for all decarbonisation actions. Sustainability needs to be embedded in decision-making. The business plan template needs to capture sustainability from decarbonisation and climate risk perspectives and should be given appropriate weight. Climate Impacts needs to be included in appropriate risk registries, and risk thresholds needs to be set.	A working group or delivery group needs to be established, comprising staff who are owners of decarbonisation actions, to highlight progress and barriers.
Finance	
No approved medium-term financial strategy addressing the recurrent deficit. No formal decommissioning framework for low-value or unaffordable services. Internal commissioning and demand management not sufficiently developed. Structural savings pipeline incomplete and over-reliant on non-recurrent measures.	No independent validation of savings assumptions or deliverability. Insufficient triangulation of financial, workforce, activity and quality data. Improving but limited benefits-realisation reporting for previous investments.

Strategic Risks – Sustainability

Weak enforcement of accountability for non-delivery of financial targets. Decision-making not consistently aligned with affordability constraints.	

Risk Post-Controls and Mitigation			
Impact: 4	Likelihood: 5	Net Risk: 20	

Actions			
What	**Lead**	**By**	**Update**