Bundle BCU Health Board 31 July 2025

1 09:30 - SUPPORTING PAPERS

1.1 09:30 - 25/142 Supporting Papers for Corporate Governance Report

- 25.142a CG Appendix A - NWJCC Reservation of Powers and Scheme of Delegation
- 25.142a1 CG Appendix A.1 - NWJCC - Reservation of Powers
- 25.142a2 CG Appendix A.2 - NWJCC SoD V3.3 (1)
- 25.142b CG Appendix B - JCC Highlight Report - JCC 20 May 2025 Final
- 25.142c Appendix C - Approved Clinicians Data - July 2025 Board report
- 25.142c1 CG Appendix C.1 FV AC-Section 12 July 2025 Board report
- 25.142c2 CG Appendix C.2 - Section 12(2) Doctors Data - July 2025 Board Report

1.2 09:30 - 25/143 Supporting Papers for Corporate Risk Register

- 25.143.1 Health Board Corporate Risk Register Report July 2025 v3 220725

Agenda Item

Joint Commissioning Committee

Reservation of Powers and Scheme of Delegation

Dyddiad y Cyfarfod / Date of Meeting	01/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public
Awdur yr Adroddiad / Report Author	Stacey Taylor, Director of Finance & Value Jacqui Maunder, Committee Secretary
Cyflwynydd yr Adroddiad / Report Presenter	Stacey Taylor, Director of Finance & Value Jacqui Maunder, Committee Secretary
Noddwr yr Adroddiad / Report Sponsor	Chief Commissioner

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt /consideration at Committee/Group)		
Committee/Group/Individuals	**Date**	**Outcome**
NHS Wales Joint Commissioning Committee meeting Senior Leadership Team (SLT)	20 May 2025 7 May 2025	Approved Endorsed Endorsed

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf University Health Board
HA	Hosting Agreement
HB	Health Board
MOA	Memorandum of Agreement
NWJCC	NHS Wales Joint Commissioning Committee
SO	Standing Orders
SFI	Standing Financial Instructions

1. SITUATION/BACKGROUND

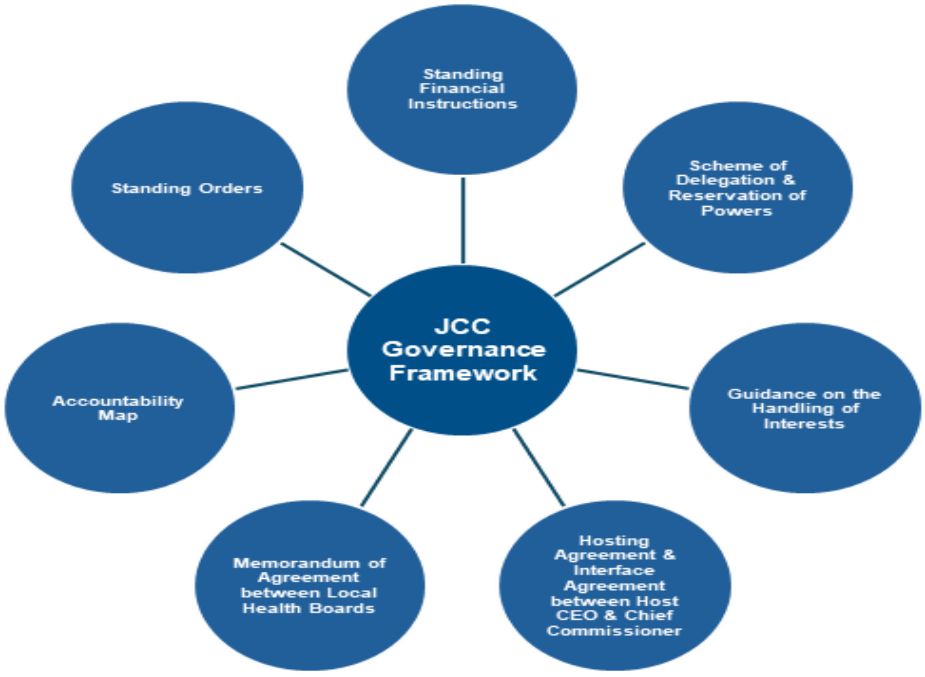
The purpose of this report is to request that the Board approves the updated Scheme of Delegation and Reservation of Powers for the matters further delegated from the NHS Wales Joint Commissioning Committee (NWJCC) to the Chief Commissioner (and other Officers as appropriate) as a schedule to the Health Board's (HB) Standing Orders.

Noting that the NWJCC approved the Scheme of Delegation and Reservation of Powers, for adoption, at its meeting on 20 May 2025.

1.1 GOVERNANCE FRAMEWORK FOR THE NHS WALES JOINT COMMISSIONING COMMITTEE

The Governance Framework for the NWJCC contains a number of key components which, combined, set out the legislative framework, constitution and ways of working for the NWJCC in its operations and handling of business. These documents are an integral part of the wider governance framework of Health Boards and have been developed within that context.

The Governance Framework for the NWJCC will contain the following and an update on each element is provided below:



Section 4 of the NWJCC Standing Orders (SOs) stipulates that the Joint Committee may make arrangements for certain functions to be carried out on its behalf, so that the day-to-day business of the Joint Committee may be carried

out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Joint Committee must set out clearly the terms and conditions upon which any delegation is being made. The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

- Schedule of matters reserved to the Joint Committee;
- Scheme of delegation to joint sub-Committees and others; and
- Scheme of delegation to the Chief Commissioner and others as appropriate all of which must be formally adopted by the Joint Committee and approved by LHB Boards as a schedule to their own SOs.

The Joint Committee retains full responsibility for any functions delegated to others to carry out on its behalf.

Each of the seven Health Boards are required to formally adopt the NWJCC's SOs, Scheme of Delegation and Reservation of Powers, and Standing Financial Instructions (SFIs), as part of its overall governance framework for the HB, with the NWJCC being a formal Joint Committee.

Joint Committee Meeting	Governance Document
9 April 2024	**1.Standing Orders** **2.Standing Financial Instructions,** **3.Scheme of Reservation and Delegation of Powers and** **4. NWJCC Transitional Delegated Financial authorisation matrix** The seven HBs approved the NWJCC SOs, the Scheme of Reservation and Delegation of Powers and SFIs in March 2024, and the Joint Committee adopted the NWJCC Standing SO's, the Scheme of Reservation and Delegation of Powers and SFIs at its inaugural meeting on 8 April 2024, and they were included as a schedule to each of the HBs own SOs and have effect as if incorporated within them. The Joint Committee also approved the NWJCC Transitional Delegated Financial authorisation matrix. It was recognised that the Scheme of Reservation and Delegation of Powers and the NWJCC Transitional Delegated Financial authorisation matrix would need to be updated further during the transition phase to reflect developments concerning delegated matters to the NWJCC, the Chief Commissioner, Directors and the new sub-committees once established.

Joint Committee Meeting	Governance Document
9 April 2024	**1.Accountability Map and** **2.Guidance on the Handling of Interests** The Accountability Map outlining the formal accountabilities and formal relationships between Welsh Government, Health Boards, Cwm Taf University Health Board (CTMUHB) as the Host Body, the NWJCC and its Team; and the Guidance on the Handling of Interests which sets out the arrangements for the appropriate handling of declarations of interests within the NWJCC's business, were both received by the Joint Committee at its inaugural meeting on 8 April 2024.
17 September 2024	**1.The Hosting Agreement (HA) and** **2.Memorandum of Agreement (MoA)** The Hosting Agreement (HA) and the Memorandum of Agreement (MoA) were endorsed by the Joint Committee on 17 September 2024 and were approved by the seven HBs at their September 2024 Board meetings. The Joint Committee were advised that work was ongoing during the transition phase to finalise the last part of the governance framework namely updating the Scheme of Reservation and Delegation of Powers.
20 May 2025	**Joint Commissioning Committee Scheme of Reservation and Delegation of Powers** The Joint Committee approved the adoption of the updated Scheme of Delegation and Reservation of Powers for the matters further delegated from the NWJCC to the Chief Commissioner (and other Officers as appropriate) all of which must be formally adopted by the Joint Committee and approved by HBs as a schedule to their own SOs, and reviewed and approved the updated financial scheme of delegation and the financial authorisation limits.

2.ASSESSMENT

2.1 Scheme of Delegation and Reservation of Powers

The NWJCC's Scheme of Reservation and Delegation of Powers forms an annex to the NWJCC's SOs, which form a schedule to each HBs own SOs and have effect as if incorporated within them. The Scheme of Delegation and Reservation of Powers, sets out in the context of the NWJCC's business:

- Those matters reserved for HBs;
- Those matters delegated from HBs and reserved for the NWJCC; and
- Those matters further delegated from the NWJCC to the Chief Commissioner (and other Officers as appropriate).

The Scheme of Reservation and Delegation of Powers is set out in two parts. The first part is the Schedule of Matters Reserved to the HBs and the Joint Committee see ***Appendix 1*** which is prescribed by Welsh Government; the second part is the Scheme of Delegation to the Chief Commissioner, Corporate Directors and Officers. Section 6.15 of the NWJCC SOs state:

"The JCC will delegate certain functions to the Chief Commissioner. For these aspects, the Chief Commissioner, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Commissioner will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers. (SO 6.15)"

In addition to the responsibilities delegated from the NWJCC, the Chief Commissioner will have delegated responsibilities from the Host Body (set out within the Hosting Agreement) and delegated responsibilities from Welsh Government (set out within an Accountable Officer Memorandum).

It is also necessary for the Host Body to confirm within its respective Scheme of Delegation and Reservation of Powers any functions delegated to the Chief Commissioner and the NWJCC team as the employer and provider of administrative (e.g. finance, workforce) services.

For completeness a mapping exercise has been undertaken to capture all of the delegations into one document, which is presented as the Scheme of Reservation and Delegation of Powers to the Chief Commissioner see ***Appendix 2.*** This includes delegations to the NWJCC, the Chief Commissioner and Tier 2 Directors.

2.2 Financial Authorisation Matrix Limits

The NWJCC's SFIs form an annex to the NWJCC's SOs, which form a schedule to each HB's own SOs and have effect as if incorporated within them. They are designed to translate statutory and Welsh Government financial requirements for the NHS in Wales into day-to-day operating practice. These SFIs will align with the NWJCC's Scheme of Delegation and Reservation of Powers and also be underpinned by an operational Scheme of Delegation which provides delegated authorisation levels and other delegated responsibilities in respect of financial management and control.

The SFIs were approved by the NWJCC at its meeting on 20 May 2025.

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC **Link to JCC Strategic Objectives(s)**	Maximise Value
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals** 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Leadership
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Effective
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / **Quality** Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	
Cydraddoldeb Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / **Equality** Have you undertaken an Equality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	A Regulatory Impact Assessment is contained with the Explanatory Memorandum to The National Health Service Joint Commissioning Committee (Wales) Regulations 2024.
Cyfreithiol / Legal	Section 4.2 of the NWJCC SOs state: Reservation and Delegation of Joint Committee Functions 4.2 Within the framework approved by each LHB Board and set out within these JCC SOs and subject to any directions that may be given by the Welsh Ministers; the Joint Committee may make arrangements for certain functions to be carried out on its behalf, so that the day-to-day business of the Joint Committee may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Joint Committee must set out clearly the terms and conditions upon which any delegation is being made. 4.3 The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a) Schedule of matters reserved to the Joint Committee b) Scheme of delegation to joint sub-Committees and others, and c) Scheme of delegation to the Chief Commissioner and others as appropriate all of which must be formally adopted by	

	the Joint Committee and approved by LHB Boards as a schedule to their own SOs. 4.4 The Joint Committee retains full responsibility for any functions delegated to others to carry out on its behalf.
Enw da / Reputational	There is no direct impact on the reputation of the Local Health Boards or the Joint Committee as a result of the activity outlined in this report.
Effaith Adnoddau (Pobl /Ariannol) / **Resource Impact** (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.
	There is not expected to be an additional cost associated with the proposal in this report. Determining and approving the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure) is reserved to the Joint Committee and the Chief Commissioner.

3. RECOMMENDATIONS

The Board are asked to:

- **Note** the development of the NWJCC's governance framework, as a key component of the Health Board's governance framework;
- **Note** that the Joint Committee approved the adoption of the updated Scheme of Delegation and Reservation of Powers on 20 May 2025;
- **Approve** the adoption of the updated Scheme of Delegation and Reservation of Powers for the matters further delegated from the NWJCC to the Chief Commissioner (and other Officers as appropriate) all of which must be formally adopted by the Joint Committee and approved by LHB Boards as a schedule to their own SOs.

GIG CYMRU NHS WALES | Cyd-bwyllgor Comisiynu Joint Commissioning Committee

NHS WALES JOINT COMMISSIONING COMMITTEE

SCHEME OF DELEGATION AND RESERVATION OF POWERS

A. MATTERS RELATING TO THE JCC, RESERVED FOR HEALTH BOARDS		
REF.	AREA	MATTER
A1.	Operating Arrangements	Approval of the Joint Committee's Governance Framework, including: • JCC Standing Orders • JCC Standing Financial Instructions • JCC Scheme of Delegation and Reservation of Powers • JCC sub-Committee Terms of Reference
A2.	Strategy & Planning	Endorse the long-term strategic plan for the development of those functions delegated to the NHS Wales Joint Commissioning Committee (the Joint Committee), as agreed by the Joint Committee
A3.	Strategy & Planning	Endorse the JCC Integrated Medium-Term Plan, as agreed by the Joint Committee for inclusion in LHB Integrated Medium-Term Plans
A4.	Strategy & Planning	Endorse the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure), as agreed by the Joint Committee

B. MATTERS RELATING TO THE JCC, DELEGATED FROM HEALTH BOARDS AND RESERVED FOR THE JOINT COMMITTEE		
REF.	AREA	MATTER
B1.	Operating Arrangements	Develop, vary, and amend the Joint Committee's Governance Framework for LHB approval, including: • JCC Standing Orders • JCC Standing Financial Instructions • JCC Scheme of Delegation and Reservation of Powers • JCC sub-Committee Terms of Reference
B2.	Operating Arrangements	Develop and approve arrangements for the handling of Interests declared by Joint Committee members, in alignment with the Host Body's Values and Standards of Behaviour Framework
B3.	Operating Arrangements	Develop and approve the Terms of Reference and Operating Arrangements for the following which are deemed necessary to provide the JCC with advice in the exercise of its functions: • Expert Panels – Established to review and make technical recommendations on specific subjects which generally consist of experts with relevant knowledge and experience within a particular field. • Advisory Groups – Established to provide advice over an issue/range of subject matters which generally consists of an external chair and internal and/or external stakeholders to make recommendations on a specific issue.
B4.	Strategy & Planning	Develop and approve the long-term strategic plan for the development of those functions delegated to the NHS Wales Joint Commissioning Committee (the Joint Committee)
B5.	Strategy & Planning	Develop and approve the JCC's Integrated Medium-Term Plan, for LHB approval
B6.	Operating Arrangements	Ratify any urgent decisions taken by the Chair, in-line with JCC Standing Order requirements

B7.	Operating Arrangements	Receive report and proposals, after consideration by the appropriate Audit Committee, regarding any non-compliance with JCC Standing Orders (and schedules contained within), and where required ratify in public session any action required in response to failure to comply with JCC SOs for onward reporting to LHBs
B8.	Operating Arrangements	Adopt the Host Body's Values and Standards of Behaviour Framework for the JCC
B9.	Strategy & Planning	Determine and approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
B10.	Operating Arrangements	Approve the Joint Committee's Risk and Assurance Framework, ensuring alignment with the Host Body
B11.	Operating Arrangements	Approve the Joint Committee's Performance Management Framework
B12.	Performance & Assurance	Receive reports from the Chief Commissioner on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans
B13.	Performance & Assurance	Receive assurance reports from the Joint Committee's sub-Committees and groups on the performance of those services commissioned by the JCC, and approve action required, including improvement plans, where required
B14.	Performance & Assurance	Receive reports produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc.) that raise issue or concerns impacting on the Joint Committee's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Joint Committee sub-Committees (as appropriate)
B15.	Performance & Assurance	Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required
B16.	Performance & Assurance	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Commissioner, set out in the JCC's SFIs, and in-line with any requirements of the Host Body
B17.	Performance & Assurance	Approve the Joint Committee's audit and assurance arrangements, in-conjunction with the Host Body as the provider of an internal audit function
B18.	Performance & Assurance	Receive assurance regarding the Joint Committee's performance against the Health and Care Quality Standards 2023 and the Duty of Quality and the arrangements for approving required action, including improvement plans, to provide onward assurance to LHBs and the Host Body.
B19.	Strategy & Planning	Approve policies for the equitable access to safe and sustainable, high quality health care services across Wales for those services which fall within the scope of the JCC
B20.	Strategy & Planning	Approve the JCC's key plans and programmes required to exercise its functions relating to the planning, securing and commissioning of those services delegated to it (excluding the Integrated-Medium Term Plan [B5]).

C. MATTERS RELATING TO THE JCC, <u>DELEGATED FROM</u> THE JOINT COMMITTEE TO THE CHIEF COMMISSIONER		
REF.	AREA	MATTER
C1.	Performance & Assurance	Responsibility for the leadership and overall delivery of the JCC's: • Integrated Medium-Term Plan; and

		• Budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
C2.	Performance & Assurance	Responsibility for the framework for planning and securing those services delegated to the JCC from LHBs, in-line with the approved Integrated Commissioning Plan (title to be confirmed)
C3.	Performance & Assurance	Responsibility for ensuring the Health and Care Quality Standards 2023 and the Duty of Quality is embedded within Joint Committee Team's activity
C4.	Performance & Assurance	Responsibility for implementing those policies approved by the JCC in relation to the planning and securing of those services delegated to the JCC from LHBs

D. MATTERS RELATING TO THE JCC, <u>DELEGATED FROM</u> THE JOINT COMMITTEE TO SUB-COMMITTEE AND OTHERS (INCLUDING INIDVIDUAL LAY MEMBERS)		
REF.	AREA	MATTER
		To be determined upon establishment of the JCC

	Welsh Government / Chief Executive of NHS Wales	NWJCC	Joint Committee Chair	CEO Host Body and host body committees	Chief Commissioner	Deputy Chief Commissioner and Director of Finance and Value	Director of Commissioning for Ambulance and 111 Services	Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups	Director of Commissioning for Specialised Services	Medical Director	Director of Nursing and Quality	Director of Corporate Planning and Strategy	Committee Secretary and Assistant Director of Corporate Services
Welsh Government Ministers and CEO NHS Wales													
NHS Wales JCC Directions WG24-06 (to health boards to establish a joint committee to exercise the relevant functions)	√												
NHS Wales JCC Regulations 2024 no 135 (W29)	√												
Accountable officer status from WG to Chief Commissioner (letter and memo)	√				√								
Role of the JCC (SO 2.20)													
Determine a **long-term strategy for the commissioning of services delegated to the JCC**		√			√								
Produce an **Integrated Medium-Term Plan** which describes how these services will be delivered on behalf of LHBs through clear 'commissioning intentions' which informs and compliments the LHBs Integrated Medium-Term Plans (IMTPs)		√			√							Lead	
In commissioning services, the JCC will act in accordance with the Directions and Scheme of Delegation of the health boards		√			√								Lead
Identify and evaluate existing, new and emerging services and treatments and advise on the way in which these services should be delivered		√			√					Lead			
Develop policies (service specifications) for the equitable access to safe and sustainable, high quality health care services across Wales for those services which fall within the scope of the JCC (see line 35)		√			√					Lead			
Determine annually those services that should be commissioned on a regional or national basis		√			√								
Determine the appropriate level of funding for the commissioning of directed and delegated services at a regional or national level and determine the contribution from each LHBs for those services (which will include the running costs of the JCC and the Joint Commissioning Team) in accordance with any specific directions set by the Welsh Ministers		√			√	Lead							
Secure the provision of services delegated at a regional and national level including those to be delivered by providers outside of Wales		√			√								
Ensure the JCC operates within an appropriate governance framework.		√			√								Lead
Matters delegated from HBs and reserved for JCC													
Develop, vary, and amend the Joint Committee's Governance Framework for LHB approval, including: •JCC Standing Orders •JCC Standing Financial Instructions •JCC Scheme of Delegation and Reservation of Powers •JCC sub-Committee Terms of Reference (B1)	Accountable for model SOs and SFIs	√		Responsible for inclusion in CTMUHB and all HBs SOs and SFIs									Lead
Develop and approve arrangements for the handling of Interests declared by Joint Committee members, in alignment with the Host Body's Values and Standards of Behaviour Framework (B2)		√			√								Lead
Develop and approve the Terms of Reference and Operating Arrangements for the following which are deemed necessary to provide the JCC with advice in the exercise of its functions: •Expert Panels – Established to review and make technical recommendations on specific subjects which generally consist of experts with relevant knowledge and experience within a particular field. •Advisory Groups – Established to provide advice over an issue/range of subject matters which generally consists of an external chair and internal and/or external stakeholders to make recommendations on a specific issue. (B3)		√			√								Lead
Develop and approve the long-term strategic plan for the development of those functions delegated to the JCC (B4)		√			√							Lead	
Develop and approve the JCC's Integrated Medium- Term Plan, for LHB approval B5		√			√							Lead	
Ratify any urgent decisions taken by the Chair, in- line with JCC SOs (B6)		√	√		√								Lead
Receive report and proposals, after consideration by the appropriate Audit Committee, regarding any non- compliance with JCC Standing Orders (and schedules contained within), and where required ratify in public session any action required in response to failure to comply with JCC SOs for onward reporting to LHBs (B7)		√			√								Lead
Adopt the CTMUHBs Host Body's Values and Standards of Behaviour Framework for the JCC (B8)		√		Responsible for Values and Standards of Behaviour Framework	√								Lead
Determine and approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure) (B9)		√			√	Lead							
Approve the JCC's Risk and Assurance Framework, ensuring alignment with the Host Body (B10)		√			√								Lead
Approve the JCC's Performance Management Framework (B11)		√			√	Lead							
Receive reports from the Chief Commissioner on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans (B12)		√			√							Lead	
Receive assurance reports from the JCC's sub-Committees and groups on the performance of those services commissioned by the JCC, and approve action required, including improvement plans, where required (B13)		√			√								Lead
Receive reports produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc.) that raise issue or concerns impacting on the JCC's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of JCC sub-Committees (as appropriate) (B14)		√			√								Lead
Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required (B15)		√			√							Lead	
Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Commissioner, set out in the JCC's SFIs, and in-line with any requirements of the Host Body (B16)		√		√	√	lead							
Approve the JCC's audit and assurance arrangements, in-conjunction with the Host Body as the provider of an internal audit function (B17)		√			√	co-lead							co-lead
Health and Care Quality Standards 2023 and the Duty of Quality and the arrangements for approving required action, including improvement plans, to provide onward assurance to LHBs and the Host Body. (B18)		√			√						Lead		
Approve policies (service specification) for the equitable access to safe and sustainable, high quality health care services across Wales for those services which fall within the scope of the JCC (B19)		√			√					Lead			
Approve the JCC's key plans and programmes required to exercise its functions relating to the planning, securing and commissioning of those services delegated to it (excluding the Integrated- Medium Term Plan [B5]) (B20)		√			√							lead	
Matters delegated by JCC to CC - page 40 of SOs)													
JCC's: •Integrated Medium-Term Plan; and •Budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure) (C1 - matters delegated from the JCC to CC)					√	Lead						Lead	
Responsibility for the framework for planning and securing those services delegated to the JCC from LHBs, in-line with the approved IMTP / Foundation Plan (C2 - matters delegated from JCC to CC)					√							Lead	
Responsibility for ensuring the Health and Care Quality Standards 2023 and the Duty of Quality is embedded within Joint Committee Team's activity (C3 - matters delegated from JCC to CC)					√						Lead		
Responsibility for implementing those policies approved by the JCC in relation to the planning and securing of those services delegated to the JCC from LHBs (C4 - matters delegated from the JCC to CC)					√							Lead	
Committee secretary role (SO 6.16)													
Providing advice to the Joint Committee as a whole and to individual Committee members on all aspects of governance -Facilitating the effective conduct of Joint Committee business through meetings of the Joint Committee, its joint sub-Committees and Advisory Groups -Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role -Ensuring that Joint Committee members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs; -Ensuring that in all its dealings, the Joint Committee acts fairly, with integrity, and without prejudice or discrimination; -Contributing to the development of a committee culture that embodies NHS values and standards of behaviour; and -Monitoring the Joint Committee's compliance with the law, JCC SOs and the framework set by the LHBs and Welsh Ministers.				√								Lead

The Committee Secretary is accountable to the Joint Committee Chair for all matters in relation to the responsibilities delegated in respect of the JCC's Governance Framework, within the context of the overarching Governance Framework of the 7 LHBs. The Committee Secretary is accountable to the Chief Commissioner for their performance as an employee of the Host Body and a member of the JCC Commissioning Team.		yes		√						Lead	
As a Joint Committee of LHBs, the Committee Secretary will have a relationship with the Directors of Corporate Governance of each of the 7 LHBs, in respect of the overarching governance framework of the 7 LHBs. As an employee of the Host Body (CTMUHB), the Committee Secretary will also have a relationship with the Host Body's Director of Corporate Governance with regard to the governance of those functions delegated to the JCC Team via				√						Lead	
Specifics											
The JCC will set out (SO 4.3): 1. Schedule of matters reserved to the Joint Committee 2. Scheme of delegation to joint sub-Committees and others 3. Scheme of delegation to the Chief Commissioner and others as appropriate all of which must be formally adopted by the Joint Committee and approved by LHB Boards as a schedule to their own SOs.	√										
Approve those policies relevant to the business of the Committee as delegated by the LHBs or the host Board (SO 5.1)	√			√				√			
The Joint Committee Chair will have a relationship with the Host Body's CEO given their respective accountability arrangements with regard to their role in holding a shared accountability for the Chief Commissioner (SO 5.4 more in Hosting Agreement		√	√	√							
The JCC will delegate certain functions to the Chief Commissioner. For these aspects, the Chief Commissioner, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Commissioner will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers. (SO 6.15)	√			√							
Lead on compliance with the Standing Financial Instructions			with DOF	√	Lead						
Lead on compliance with Standing Orders and the Governance Framework				√						Lead	
To fulfil its functions, the Joint Committee shall lead and scrutinise the operations, functions and decision making delegated to the Chief Commissioner and others undertaken at the direction of the Joint Committee (2.21).	√										
The Committee Secretary is accountable to the Joint Committee Chair for all matters in relation to the responsibilities delegated in respect of the JCC's Governance Framework, within the context of the overarching Governance Framework of the 7 LHBs. The Committee Secretary is accountable to the Chief Commissioner for their performance as an employee of the Host Body and a member of the JCC Commissioning Team. (SO 6.16)		√		√						Lead	
The Joint Committee Chair, in consultation with the Committee Secretary and the Chief Commissioner, will set the agenda. (SO 7.10)		√		√						Lead	
The Host Body's Standards of Behaviour Policy (Incorporating Declarations of Interest, Gifts, Hospitality, Sponsorship and Honoraria) applies to the Joint Committee's Chair, Lay Members and Chief Commissioner, and prohibits Joint Committee members from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way. (SOs 8.9)		√	√	√						√	
Agree Scheme of Delegation for JCC Team (reflecting SoD of JCC) and Approve Financial Limit for JCC Team Responsible Officers				√							
Determine JCC Team Annual Priorities				√							
Approve JCC Team Workplan (based on IMTP)				√							
Sign off DRAFT IMTP for submission to NWJCC prior to WG HSCEYG planning team		√		√							
Annual Review of Hosting Agreement			√	√							
Endorse amendments to any JCC Governance documents such as SOs, SFIs, Hosting Agreement, Memo of Agreement for approval at HBs		√		√						Lead	
Approve JCC Branding	√			√							
Sign off relevant reports/papers for Committees relating to professional area				√							
Approve draft annual operating budget for NWJCC		√		√							
Allocate annual budget allocation to relevant functions/programmes of the NWJCC		√		√	Lead						
Approve draft JCC Risk Register for reporting to the NWJCC				√							
Approve JCC staff engagement plan				√							
Approve JCC partnership and stakeholder engagement plan		√		√					Lead		
Approve appointment of Directors of JCC Team				√							
Approve appointment of Deputy Directors of JCC Team (in relevant professional area)				√	*						
Consider redundancy and Voluntary Early Release applications prior to submission to CTMUHB for approval noting WG approval required over £50k settlement			√	√	*						
Approve redundancy and Voluntary Early Release applications for submission to CTMUHB RATS noting WG approval required over £50k settlement			√	√							
Appraisal of Directors of the JCC Team				√							
Appraisal of Chief Commissioner RO in relation to compliance with Hosting Agreement		√	√	√							
Review ToRs for JCC SLT				√						Lead	
Approve ToRs for SLT				√							
Establish Sub Groups to report to SLT and agree ToRs				√						Lead	
Establish the Collaborative Commissioning Leadership Group				√						Lead	
Approve ToRs for CCLG				√							
Review JCC Team Operating Model and Structure to ensure fit for purpose				√	*						
Approve amendments to the JCC Team Operating Model and Structure				√	*						
Engagement of staff within funded establishment				√	√	√	√	√	√	√	
Engagement of staff outside funded establishment				√	√						
Approval of revised job resulting in change in grade in line with agreed policy and All Wales Terms and Conditions				√	√	√	√	√	√	√	√
Approve & manage overtime, travel expenses, absence and leave within funded establishment (in accordance with CTMUHB Policies)				√	√	√	√	√	√	√	√
Approval of mobile phones / IT equipment				√	√	√	√	√	√	√	√
Management of allocated budgets				√	√	√	√	√	√	√	√
Approval of in-year budget virements between Director Budgets				√							
Receive reports on progress against performance in delivery of the JCC Team Workplan				√							
Endorse Annual Report, Annual Governance Statement and Annual Quality Report of the JCC prior to submission to CTMUHB		√		√					Lead		Lead
Approve JCC Annual Report, Annual Governance Statement & Annual Quality Report		√		√							lead
Agree scope of planned internal audit		√		√	Lead						Lead
Receive internal audit reports to develop management response		√		√	Lead	√	√	√	√	√	Lead
Approve final internal audit reports	√			√	√						
Receive reports from external/independent parties for consideration and action where necessary	√			√							
Dismissal of staff (in accordance with delegations set out in CTM policy)			√	√	√	√	√	√	√	√	√
Approval of legal action				√							Lead
Approval of receipt of any gift, hospitality or sponsorship (of individuals) under CTM policy (NB Gifts above £25 should not be accepted; gifts over £25 where it is not possible to decline must be declared and seek approval; tickets to sporting events must not be accepted; all offers of gifts over £25 whether accepted or declined should be declared)				√						Lead	
Approval of receipt of sponsorship in line with CTMUHB policy http://ctuhb-intranet/dir/Corporate/Decs/GHSH/Spon/_layouts/15/start.aspx#/				√	√	√	√	√	√	Lead	
Approval of JCC Pulse Bulletin and information for publication				√							
Financial limits - See Financial Authorisation Matrix											
Payroll											
Payroll new starters				√	√	√	√	√	√	√	
Payroll leavers				√	√	√	√	√	√	√	
Establishment vacancy authorisation				√	√						
Payroll changes financial				√	√						
Payroll changes non financial e.g. financial coding				√	√	√	√	√	√	√	
Payroll travel expenses				√	√	√	√	√	√	√	
Payroll study leave				√	√	√	√	√	√	√	
Financial matters in line with additional delegations from the SFIs											
Funding releases (was WHSSC Management Group)				√	√		√				
Manage reserves and contingencies				√	√						
Manage and control of stocks				√	√					Lead	
Monitor and achievement of management cost targets				√	√						
Recording of payments under the losses and compensation regulations				√	√						
Issuing tenders and post tender negotiations				√	√						
Operation of detailed financial matters including bank accounts and banking procedures		with DOF of host body		√	√						
Corporate											
Information governance				√						Lead	with ctm
Management of concerns				√				Lead			
Lead on health and safety arrangements (not line management duties)				√					Lead		
Investigate any suspected cases of irregularity not related to fraud and corruption in accordance with Government directions				√	√						
Legal advice				√						Lead	
Action on litigation		with Director of Nursing		√						√	
Workforce		with Director of People host body		√						Lead	

GIG CYMRU NHS WALES | Cyd-bwyllgor Comisiynu Joint Commissioning Committee

Joint Commissioning Committee

Highlight Report from the Joint Commissioning Committee

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Jacqui Maunder – Committee Secretary
Cyflwynydd yr Adroddiad / Report Presenter	Stacey Taylor - JCC Deputy Chief Commissioner/Director of Finance
Noddwr yr Adroddiad / Report Sponsor	Huw George JCC Chief Commissioner

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Health Boards	June/July 2025	Noted

1. SITUATION/BACKGROUND

This report had been prepared to provide Health Board (HB) Chief Executive Officer (CEO) Members of the Joint Committee with a summary of the key issues considered by the NHS Wales Joint Commissioning Committee (NWJCC) at its public meeting on 20 May 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the Joint Committee (JC) is set out in Paragraphs 2.18 and 2.20 of the NWJCC Standing Orders (SOs).

3. HIGHLIGHT REPORT

(Links to reports highlighted May 2025 – NHS Wales Joint Commissioning Committee)

Status	Update

Alert / Escalate	During the meeting, Members:
	• **Collaborative Commissioning Leadership Group (CCLG)** – Noted that the Terms of Reference for the Collaborative Commissioning Leadership Group (CCLG) included a specific request from HB CEOs that its membership should comprise of Executive Directors from HBs. CEOs were requested to ensure that designated Executive Directors attend to ensure quoracy
	• **Syndrome Without a Name (SWAN)** – Approved recurrent funding for the service
	• **Individual Patient Funding Request (IPFR) Policy** – Approved the updated policy and noted that it will be presented to the 7 x HBs and WG for final approval and adoption from 1 July 2025
	• **Recovered Plasma from Whole Blood Donations for Medicines –** Supported Velindre University NHS Trust/Welsh Blood Service in approaching WG to approve a revised policy position to:
	  ○ Commence supply of plasma recovered from whole blood donations for the manufacture of Immunoglobulin and Albumin products for clinical use in Wales under the terms of a UK-wide contract with Octapharma AG
	  ○ Use the price savings from the contract compared to the commercially sourced equivalent NHS Wales contracts, to cover the additional costs and lost income.
	• **Improving Patient Flow, Oversight and Repatriation in Mental Health Hospitals –** Members noted (i) the impact of a delayed discharge on the patient experience and outcomes and (ii) the longstanding process to recharge HBs for the cost of a medium secure patient placement three months after it has been identified that the patient is ready to move on to the next stage of care. Members approved the recommendation to recharge HBs after one month and to expand this process to cover all mental health placements.
	• **JCC Scheme of Reservation and Delegation of Powers –** Approved the adoption of these for the matters further delegated from the Chief Commissioner, all of which must be formally adopted by the JC and approved by HBs as a schedule to their own SOs. Members approved the financial delegations outlined within the updated financial authorisation matrix.

Status	Update
Advise	• The **Chair's Report** noted the recent end of year appraisal with the Cabinet Secretary for Health & Social Care including the discussion around the establishment and governance of the NWJCC, the progress made in the last 12 months, the priority in quarter 1 and 2 (2025-26) to develop a long-term strategy setting the road map for the Integrated Medium-Term Plan (2026-29) and a focus on recast objectives including quality, safety, culture, strategy, and governance. • The **Chief Commissioner's Report** included an update on: ○ **Quarter 4** – the progress made in relation to the transition including the establishment of the new organisational structure (with a 29% vacancy rate that is having an impact on capacity with the NWJCC) and a shift in focus to the delivery of the NWJCC Foundation Plan following its approval (with HB Executive leads identified for each of the strategic priorities) ○ **CCLG** – working to inform decision-making by the Chief Commissioner and the JC ○ **Internal Audit** – review undertaken to assess embedding the statutory governance framework and the establishment of operational governance arrangements to provide effective oversight. This report stated that the first year of operation was regarded very positively, the governance framework has largely been established and meetings are more strategic and collaborative than the previous arrangements. The report identified the need for quoracy in CCLG meetings and the need to take forward an organisational development plan to embed values and behaviours and new ways of working ○ **Annual Accounts** – reflected within governance and accountability arrangements, assurance was provided that the NWJCC Annual Accounts were submitted to CTMUHB and will be presented to their Board for approval on 26 June 2025 which Huw George will attend in his capacity as Accountable Officer. • Reports from each of the Commissioning Directors: ○ **Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups** – Members noted: ○ The findings of the Perinatal Mental Health Utilisation, Forecasting & Modelling Report (working with the Royal College of Psychiatrists Wales)

Status	Update
	○ Commissioning case management for specialised mental health services, the current variation in provision and the work being taken to address this ○ The impact of a fire incident at Taith Newydd low secure unit has had on medium secure bed availability in south Wales and ongoing discussions around this matter ○ Ongoing discussions with Welsh Government (WG) and NHS Wales Performance and Improvement regarding Sexual Assault Referral Centres ○ In relation to Continuing Healthcare, at the request of the Director General for Health and Social Services, the focus will be the deployment of a digital system and the training of CHC assessors, led by other organisations. ○ **Director of Commissioning for Ambulance Services and 111** – Members noted: ○ The outcome of the Emergency Medical Retrieval and Transfer Services (EMRTS) Judicial Review was anticipated by the end of May 2025 ○ The Emergency Ambulance Performance Framework would be implemented from July 2025 with a shift in focus from time-based targets to clinical outcomes ○ The transfer of the Save a Life Cymru programme to the Welsh Ambulance Services University NHS Trust (WAST), to be commissioned through the JCC enabling a more integrated approach and enhanced community cardiac arrest survival ○ The aim of the national handover improvement group to deliver a maximum 45-minute ambulance patient handover time within 6 months, handover improvement was noted as a recommendation in the Ministerial Advisory Group report ○ Capacity issues within the Non-Emergency Patient Transport Service due to HB service reconfiguration, increased patient complexities and increased costs, work is ongoing with WAST and HBs to address this ○ A review of NHS 111 Wales' roster arrangements with a view to better aligning capacity and demand. ○ **Director of Commissioning for Specialised Services**. Members noted: ○ Key commissioning risks and the reporting of services in escalation to the Quality, Safety and Outcomes Sub-Committee for detailed scrutiny ○ Key commissioning achievements including repatriation of Peptide Receptor Radionuclide Therapy (PRRT) for neuroendocrine tumours and the expansion of

Status	Update
	Stereotactic Ablative Body Radiotherapy (SABR) provision in Wales ○ The Paediatric Intensive Care Unit has been de-escalated to level 2 due to the assurances received in line with the NWJCC Escalation Framework. • **Strategic Development –** Members received a presentation outlining a proposal for the development of the NWJCC Strategy including timelines for engagement and approval process. Work will continue to develop the strategy and to ensure alignment with HB strategies. • **NWJCC Foundation Plan 2025-26 – Implementation Framework** – Members noted a report outlining the implementation framework for the Foundation Plan, including strategic priorities, outcomes, deliverables and milestones.
Assure	• **Governance & Risk Management**: ○ The Risk Register at 31 March 2025 was received and approved ○ The Corporate Governance Report was appended with the draft Annual Governance Statement, the Audit Enquiries Letter and the Annual Plan of Committee Business 2025-2026 for approval ○ Members noted: ○ The update on the Register of Interests/Related Parties ○ That the Health Board SOs (and subsequently NWJCC SOs) would be updated to reflect the recently issued Welsh Health Circular which reduced the timescale for publication of board papers to 5 clear days.
Inform	• Members heard the story of a former inpatient's experience in the Mother and Baby Unit at Tonna Hospital. The story presented the challenges as a physically disabled mother and how the unit had worked hard to address the environment, accessibility issues and the staff's willingness to listen and adapt. These lessons would be shared across other commissioned services • The Committee received the Month 12 Finance Report and the Month 12 Operational Performance Report • The Committee noted an update in relation to an extension of the Blueteq Electronic Prior Approval System contract • The Committee received the following assurance reports: ○ Quality Safety and Outcomes Sub-Committee ○ Planning Performance & Finance Sub-Committee

Status	Update
	○ Individual Patient Funding Request (IPFR) Panel Assurance Report ○ Welsh Kidney Network Board Assurance Report.
Appendices	None.

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC **Link to JCC Strategic Objectives(s)**	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals** 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Effective
	Efficient; Equitable; Person-centred; Timely; Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality**	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:

Have you undertaken a Quality Impact Assessment Screening?		This is a summary of the latest meeting of the JCC
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb?* / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

5. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 3 of this report.

APPENDIX 1

Update of Register of Approved Clinicians in Wales Reporting Period: 16th May 2025 – 3rd July 2025	
	Approved Clinicians
Approvals and Re-approvals	24
Approvals suspended	2
Approvals re-instated/ returned to work in Wales	1
Left Wales (Removed)	0
Retired	1
No longer Registered & Retired:	1
Transferred from AC register (to S12 Register)	0
Removed from S12 – Became AC approved	6
Approval Ended	1
Death in Service	0
Performance Metrics - Reporting period: 16th May 2025 – 3rd July 2025	
Total number of AC applications received	27
Pending approvals/awaiting completion of application by the applicant	5
Average processing time per application.	**Initial AC approval:** 6.7 days (includes fast track applications). **AC reapproval:** 11.4 days
Number of lapsed approvals due to missed deadlines by the applicant	1

APPENDIX 1

Mental Health Act 1983 (as amended by the Mental Health Act 2007)
Mental Health Act 1983 Approved Clinician (Wales) Directions 2018

Update of Register of Approved Clinicians - Wales

Reporting Period: 16th May 2025- 3rd July 2025

Approvals and Re-approvals: 24

Surname	First Name	Workplace	Date Approval Expires
Robbins	Laura	Betsi Cadwaladr University Health Board, Heddfan Psychiatric Unit, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham, LL13 7TD	15th May 2030
Lendon	Rebecca	Cardiff and Vale University Health Board, Community Forensic Team, Llanfair Unit, University Hospital Llandough, Penlan Road, Penarth, CF64 2XX	20th May 2030
Tokachichu	Gourinath	Cygnet Healthcare, Delfryn Lodge, Argoed Hall Lane, Mold, Flintshire, CH7 6FQ.	23rd November 2026
Ahmed	Mohammed	Cygnet Healthcare, Delfryn Lodge, Argoed Hall Lane, Mold, Flintshire, CH7 6FQ.	15th August 2028
Ogbolu	Raphael	Cygnet Healthcare, Delfryn Lodge, Argoed Hall Lane, Mold, Flintshire, CH7 6FQ.	20th July 2027
Rydzewski	Michal	Swansea Bay University Health Board, Mental Health Unit, Neath Port Talbot Hospital, Baglan Way, Port Talbot, SA12 7BX	29th May 2030
Doherty	Joanne	Cardiff and Vale University Health Board, St David's Hospital, Cowbridge Road East, Cardiff, CF11 9XB.	1st June 2030
Jurewicz	Izabela	Cardiff and Vale University Health Board, Vale CMHT, Barry Hospital, Colcot Road, Barry CF62 8YH.	1st June 2030
Shivashankar	Somashekara	Cardiff and Vale University Health Board, Links Centre CMHT, Block 11 First Floor, Cardiff Royal Infirmary, Glossop Road, Cardiff CF24 0SZ.	2nd June 2030
Richings	Ceri	Aneurin Bevan University Health Board, Torfaen Community Learning Disability Team, Torfaen Business Centre, Panteg Way, New Inn, Pontypool, NP4 0LS.	3rd June 2030

Surname	First Name	Workplace	Date Approval Expires
Mansour	Khalid	Swansea Bay University Health Board, Llwyneryr Unit, Clasemont Road, Morriston, Swansea, SA6 6AH	4th June 2030
Mehrpooya	Neda	Swansea Bay University Health Board, Taith Newydd, Glanrhyd Hospital, Tondu Road, Bridgend CF31 4LN	4th June 2030
Ogley	Robin	Betsi Cadwaladr University Health Board, Bryn y Neuadd Hospital, Aber Road, Llanfairfechan, LL33 OHH	9th October 2028
Uchendu	Nwamaka	Cwm Taf Morgannwg University Health Board, Mental Health Unit, Royal Glamorgan Hospital, Llantrisant, Ynysmaerdy, Pontyclun, CF72 8XR.	10th February 2030
Anjum	Usman	Powys Teaching Health Board, The Hazels Centre, Temple Street, Llandrindod Wells, Powys, LD1 5HF.	27th May 2029
Bhat	Prashant	Betsi Cadwaladr University Health Board, North Wales Adolescent Service, Abergele Hospital, Llanfair Road, Abergele LL22 8DP	11th June 2030
Adeitan	Oluwaseun	Cwm Taf Morgannwg University Health Board, CDAT Ysbyty Cwm Cynen, New Road, Mountain Ash, CF45 4BZ	15th June 2030
Abayomi	Olukayode	Swansea Bay University Health Board, Ty Einon Centre, Princess Street, Gorseinon, Swansea, SA4 4US.	16th June 2030
Huq	Fawziya	Elysium Healthcare, Ty Grosvenor, 16 Grosvenor Road, Wrexham, LL11 1BU	21st April 2027
Beer	Roger	Aneurin Bevan University Health Board, St Cadoc's Hospital, Lodge Road, Caerleon, Newport, NP18 3XQ	22nd June 2030
Marey	Mohamed	Cwm Taf Morgannwg University Health Board, Princess of Wales Hospital, Coity Road, Bridgend CF31 1RQ	24th June 2030
Hussain	Shahid	Elysium Healthcare, Ty Grosvenor, 16 Grosvenor Road, Wrexham, LL11 1BU	24th June 2030

Surname	First Name	Workplace	Date Approval Expires
Cardoza	Basil	Swansea Bay University Health Board, Learning Disability Services, Ty Penfro, 67a Pembroke Road, Cardiff, CF5 1QQ	24th June 2030
Rahman	Arifur	Cygnet Healthcare, Delfryn House, Alfonas, Argoed Hall Lane, Mold, Flintshire, CH7 6FQ	30th April 2030

Approvals Suspended: 2* (Awaiting CCT HST)

Surname	First Name	Workplace	Date Approval Expires
Rajan	*Sathyan Soundara	Betsi Cadwaladr University Health Board, Older Persons Community Mental Health Service, Plas Gororau, Ellice Way, Wrexham Technology Park, Wrexham, LL13 7YY	7th November 2029
Tomlinson	*Peter (later reinstated)	Cardiff and Vale University Health Board, University Hospital Llandough, Penarth, CF64 2XX.	4th March 2030

Approvals Reinstated/Returned to Work in Wales: 1

Surname	First Name	Workplace	Date Approval Expires
Tomlinson	Peter	Cardiff and Vale University Health Board, University Hospital Llandough, Penarth, CF64 2XX.	4th March 2030

Left Wales/Removed: 0

Surname	First Name	Workplace	Date Approval Expires

Retired: 1

Surname	First Name	Workplace	Date Approval Expired
Millington	Malcolm	Hywel Dda University Health Board, Sp-CAMHS,Ty Helyg, Bronglais Hospital, Caradoc Road, Aberystwyth, Ceredigion, SY23 1ER	25th June 2025

No longer Registered & Retired: 1

Surname	First Name	Workplace	Date Approval Expired
Nambiar	Amritha Surendran	Hywel Dda University Health Board, Bro Cerwyn Centre, Fishguard Road, Haverfordwest, Pembrokeshire SA61 2PG	25th June 2025

Transferred from AC Register to S12 Register: 0

Surname	First Name	Workplace	Date Approval Expires

Approval Expired/Ended:

Surname	First Name	Workplace	Date Approval Expired
Akenzua	Osaretin Anthony	Elysium Healthcare, Springwood Lodge, Elysium Healthcare, 1 Town Gate Close, Guiseley, Leeds, LS209PQ	27th May 2025

Death in Service: 0

Surname	First Name	Workplace	Date Approval Expired

Teitl adroddiad: ***Report title:***	Mental Health Act 1983 as amended by the Mental Health Act 2007. Mental Health Act 1983 Approved Clinicians (Wales) Directions 2018. Update of Registers of:- **1.** Approved Clinicians (All Wales) **2.** Section 12(2) Doctors (All Wales). Reporting Period: 16th May 2025 – 3rd July 2025			
Adrodd i: ***Report to:***	Betsi Cadwaladr University Health Board			
Dyddiad y Cyfarfod: ***Date of Meeting:***	31st July 2025			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides assurance of compliance with Mental Health Act legislation, policy, and process. The Board is asked to note the report's contents and formally ratify approvals granted through weekly action letters submitted by the Approval Team to the Executive Medical Director and their nominated deputy. The details presented are a summary of approvals for Approved Clinicians and Section 12(2) Doctor approvals across Wales. The report ensures governance records comply with the Mental Health Act 1983 (as amended 2007) and the Welsh Government Guidance Document. Approval is sought via Action Letters submitted to the Executive Medical Director, with final ratification by the Board. A bi-monthly approval process ensures transparency, as detailed in Appendices 1 and 2. The Board is asked to: **Note** the report's contents. **Ratify** approvals in line with Welsh Government Guidance and NHS Wales Mental Health Act Directions.			
Argymhellion: ***Recommendations:***	The Board is recommended to: **Formally ratify** approvals delegated to the Executive Medical Director, in accordance with the All Wales Approval Panel recommendations			
Arweinydd Gweithredol: ***Executive Lead:***	**Dr. Sreeman Andole** – Interim Executive Medical Director, Office of the Medical Director.			
Awdur yr Adroddiad: ***Report Author:***	**Meryl Roberts,** All Wales Approvals Manager for Approved Clinicians and Section 12(2) Doctors.			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒	Derbyniol *Acceptable* ☐	Rhannol *Partial* ☐	Dim Sicrwydd *No Assurance* ☐

	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Betsi Cadwaladr University Health Board successfully bid to take over the function of the Welsh Ministers for the Approval Process in 2009 on behalf of all former Local Health Boards. Betsi Cadwaladr University Health Board (BCUHB) acting in its capacity as the main Approving Board for Wales, has continued to effectively undertake the delegated function of the Welsh Ministers for the approval of Approved Clinicians and Section 12(2) Doctors on behalf of all the Health Boards in Wales. The Approving Board and Process of Approval continue to fully meet all objectives.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The approval process meets Approved Clinician regulatory requirements set out in the Mental Health Act 1983 (as amended) and the 2008 No.1204 Mental Health (Mutual Recognition) Regulations 2008. The Health Board continues to ensure an effective approval, re-approval, suspension and termination of approval processes for Approved Clinicians and Section 12(2) Doctors in Wales is in place.			
Yn unol â WP7 (sydd bellach yn cynnwys WP68), a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 (which now incorporates WP68) has an EqIA been identified as necessary and undertaken ?***	The approval process does not impact patient demographics or service provision. No disparities have been identified in the approval rates of different clinician groups. If future assessments indicate an impact, an EqIA will be undertaken.			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	There is currently a lack of Section 12(2) Wales Directions – which is recorded on Datix Risk Register (ID: 4134). The Approval Team and the All Wales Chair of the Approval Panel worked with Welsh Government to draft Section 12(2) Directions for Wales. Welsh Government advised the draft legislation would then be subject to legal review. We await the Directions to be legally reviewed and			

	have not yet been provided with a timeline for this. The Approval Team and Panel Chair continue to seek engagement with Welsh Government for the draft Instructions to be enacted. **Workforce risks are actively managed.** Delays in approvals could impact clinician availability, but proactive steps (automated reminders and engagement strategies) are in place. Clinicians receive one reminder to attend a one day MHA refresher training course and three reminders to apply for re-approval. There is in place an automated reminder system for expiring approvals and proactive engagement with at-risk clinicians The Approval Team also communicate at-risk clinicians to their Clinical Directors.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There are no budgetary implications. Resources for compliance oversight are managed by the Office of the Medical Director. Workforce risks are actively managed. Delays in approvals could impact clinician availability, but proactive steps (automated reminders and engagement strategies) are in place.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The ratification of approvals by the Approving Board for all Health Boards is the final step in the process of granting approval or reapproval to the workforce in all of the Health Boards in Wales.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This is an ongoing process.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Lack of Section 12(2) Wales Directions is recorded on Datix Risk Register number ID: 4134.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** Implementation of recommendations of this report will be the final step in the ratification of approval process and will fully accord with all legislative and process requirements.	

Rhestr o Atodiadau:
List of Appendices:

Appendix 1: Update of Register of Approved Clinicians - Wales.
Mental Health Act 1983 as amended by the Mental Health Act 2007,
Approved Clinician (Wales) Directions 2018.

Appendix 2: Update of Register of Section 12(2) Approved Doctors - Wales.
Mental Health Act 1983 as amended by the Mental Health Act 2007.
All Wales Section 12(2) Process and Criteria Document.

APPENDIX 2

Update of Register of Section 12(2) Approved Doctors - Wales Reporting Period:- 16th May 2025-3rd July 2025	
	Section 12(2) Approved Doctors
Approvals and Re-approvals	8
Approvals suspended	0
Approvals re-instated/ returned to work in Wales	1
Removed (Left Wales)	1
Retired	0
Registered without a licence to practise and retired	0
Transferred from AC register (to S12 Register)	0
Became AC approved	6
Approval Ended	0
Death in Service	1
Performance Metrics - Reporting period: 16th May 2025 – 3rd July 2025:	
Total number of Section 12(2) doctor applications received	10
Pending approvals	2
Average processing time per application	Section 12(2) initial approval: 24 days Section 12(2) reapproval: 5 days
Number of lapsed approvals due to missed deadlines by the applicant.	0

APPENDIX 2

Mental Health Act 1983 (as amended by the Mental Health Act 2007)
Mental Health Act 1983 – All Wales Section 12(2) Process and Criteria Document

Update of Register of Section 12(2) Doctors - Wales

Reporting Period: 16th May 2025-3rd July 2025

S12 Approvals and Re-approvals: 8

Surname	First Name	Workplace	Date Approval Expires
Ritchie	Mark	Independent practitioner. Care of private address. Cardiff and Vale University Health Board area	18th May 2030
Roufael	Rim	Aneurin Bevan University Health Board, Old Age Psychiatric Liaison Team (OAPL), Nevill Hall Hospital, Brecon Road, Abergavenny NP7 7EG and Royal Gwent Hospital Cardiff Rd, Newport NP20 2UB	4th June 2030
Rogers	Emily	Cardiff and Vale University Health Board, Hafan Y Coed, Penlan Road, Llandough Penarth, Cardiff, CF64 2XX.	5th June 2030
Abdelwahab	Mahmoud	Swansea Bay University Health Board, Ty Garngoch Hospital, Hospital Road, Gorseinon, Swansea, SA4 4LH	8th June 2030
Ramadan	Mohamed Ayman Abdelbadie	Swansea Bay University Health Board, Community Mental Health Team, Forge Centre, Forge Road, Port Talbot, SA13 1PA	15th June 2030
Linley-Adams	Elisabeth	Cardiff and Vale University Health Board, Llandough Hospital, Penlan Road, Penarth, CF64 2XX	16th June 2030

Surname	First Name	Workplace	Date Approval Expires
Hewawasam-Haggallage	Upul Hewawasam	Betsi Cadwaladr University Health Board, Memory Clinic, Bodnant Unit, Maesdu Road, Llandudno, LL30 1QY	29th June 2025
Yassein	Khaled	Swansea Bay University Health Board, Caswell Clinic, Glanrhyd Hospital, Tondu Road, Bridgend, CF31 4LN	2nd July 2030

S12 suspended: 0

Surname	First Name	Workplace	Date Approval Expires

S12 Approval Reinstated/Transferred/Returned to Wales: 1

Surname	First Name	Workplace	Date Approval Expires
Devasabai	Dushitharan	Swansea Bay University Health Board, CAMHS, Block D, Neath Port Talbot Hospital, Baglan Way, Port Talbot, SA12 7BX	22nd April 2026

Removed (Left Wales): 1

Surname	First Name	Workplace	Date Approval Expires
Duncan	Alice	Independent Practitioner, c/o Private Address. Betsi Cadwaladr University Health Board area.	7th April 2030

Retired: 0

Surname	First Name	Workplace	Date Approval Expired

Registered Without a Licence and Retired: 0

Surname	First Name	Workplace	Date Approval Expired

S12 Approval Ended and Became AC Approved:

Surname	First Name	Workplace	Date Approval Ended
Doherty	Joanne	Cardiff and Vale University Health Board, Haydn Ellis Building, Cardiff University, Maindy Road, Cardiff CF24 4HQ	9th June 2025
Loo	Jian Lin	Betsi Cadwaladr University Health Board, Heddfan Unit, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham LL13 7TD	18th June 2025
Azhar	Zeenish	Betsi Cadwaladr University Health Board/Velindre, Ty Derbyn, Maelor Hospital, Croesnewydd Road, Wrexham, LL13 7TD	18th June 2025
Morris	David	Swansea Bay University Health Board, Tonteg Hospital, Church Road, Pontypridd, CF38 1HE	18th June 2025
Speedy	Kathryn	Cwm Taf Morgannwg University Health Board, Ty Llidiard inpatient unit, Princess of Wales Hospital, Bridgend, CF31 1RQ	18th June 2025
Abayomi	Olukayode	Swansea Bay University Health Board, Ty Einon CMHT Centre, Princess Street, Gorseinon, SA4 4US	20th June 2025

S12 Approval Ended/Expired: 0

Surname	First Name	Workplace	Date Approval Expired

Death in Service: 1

Surname	First Name	Workplace	Date Approval Ended
Yule	Graeme	Aneurin Bevan University Health Board, St Julian's Medical Centre,13a Stafford Road, Newport NP19 7DQ	16th June 2025

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Corporate Risk Register

Corporate Risk Register Report

1.0 Purpose

The purpose of this report is to provide an update to the Board on the Corporate Risk Register.

1.1 Key Highlights

The Board and Committees in reviewing the Corporate Risk Register have agreed that this needs refinement to ensure that the Corporate Risks are fully understood and that the controls and assurances are clear. Discussions at the Board and Committees have focussed on the need for a small set of actions which clearly will result in risk reduction and to ensure that the risks are withing the appetite and tolerance set by the Board.

The Executive Team held an informal discussion on the Corporate Risk Register on 16th July 2025 where the Executive Team were tasked to review the current corporate risks, drawing the Executive's attention to the latest management analysis, agreeing action to be taken to ensure all action plans going forward are to be high impact, a focus on target dates, scoring of risks was discussed, in particular around alignment with the organisation's risk appetite, and those risks exceeding tolerance levels. An action was taken to arrange a second, longer session, to review each risk in further detail. The Board will review and agree the risk appetite as planned on the 28th of August 2025.

Key highlights of changes:

- **CRR24-08** 'Delivering a population health approach to health and wellbeing' – Risk **re-drafted** and refreshed. Risk has been re-drafted by the service to update with current risk position and to reflect the work that has been undertaken in 24/25 (as indicated in the new wording for the risk descriptor, controls, gaps) and also to pick up the links to planned delivery in 25/26.
- **CRR24-23** 'Vascular Services' – **Increase** to the current risk score. Following deep dive into the risk during the April 2025 Risk Scrutiny Group, increase to the current risk score from 16 (Impact = 4 x Likelihood = 4) to a current score of 20 (Impact = 4 x Likelihood = 5) resulting in the risk score above the tolerance set in the risk appetite due to the lack of medical staff within the Vascular Service.
- **CRR24-24** 'Renal Services' – **Reduce** the Target risk score. Following a deep dive into the risk during the April 2025 Risk Scrutiny Group, decrease in the target risk score from 12 (Impact = 4 x Likelihood = 3) to a score of 8 (Impact = 4 x Likelihood = 2) and reduce the risk tolerance level for the risk in relation to patient safety.

- **CRR24-11** – Planned Care

Noting that the risk needs to be re-framed as part of the Planned Care Programme and that this will be actioned for the next cycle of meetings. The Board will receive an item on the agenda in relation to planned care and the actions to address the actions to address the planned care trajectories and plan will be covered in the additional paper.

The following risks were subject to a deep dive at the May 2025 Risk Scrutiny Group where the group discussed and reviewed, the risks and were presented to the group by the relevant risk lead and service:

- **CRR24-08 –** Delivering a population health approach to health and wellbeing
- **CRR24-25** – Dermatology and Plastic Surgery Services

1.2 Changes in Score

- **CRR24-23** 'Vascular Services' – Following deep dive into the risk during the April 2025 Risk Scrutiny Group, increase to the current risk score from 16 to a current score of 20, resulting in the risk score above the tolerance set in the risk appetite due to the lack of medical staff within the Vascular Service.

1.3 New Risks

The risk(s) added to the Corporate Risk Register since the last update are:

Risk Ref	New Risks	Lead Exec Director	Current Risk Score (and IxL)
CRR24-28	Pharmacy Technical Services	Chief Operating Officer	**20 (4x5)**

- CRR24-28 'Pharmacy Technical Services' – Following initial presentation to the Risk Scrutiny Group during the January 2025 meeting, the risk was re-presented to the group for escalation consideration during the May 2025 meeting following further work to develop the risk as recommended by the group, current score 20 (Impact = 4 x Likelihood = 5). Resulting in the risk score above the tolerance set in the risk appetite

1.4 Overdue/Delayed Actions

The corporate risk register report was produced during May 2025 for review and approval by the Executive Team. At the time of producing two actions were 'delayed' due to unforeseen absence and time constraint/work priorities.

As per the normal cycle of reporting, the next updates are being sought for current updates on all of these actions. The status of these actions of will be included in the next update/iteration of the risk register.

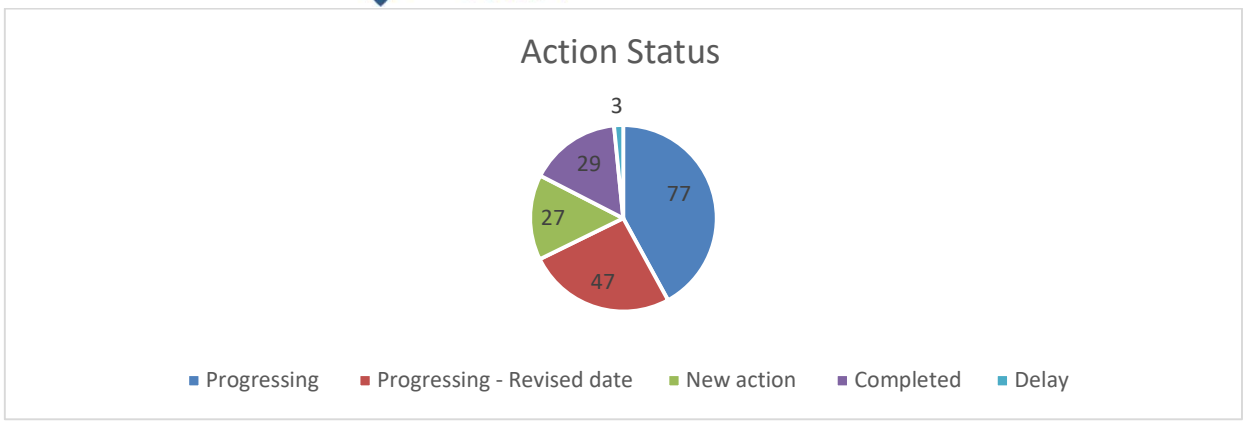
1.5 Risks above Health Board 24/25 appetite

Eleven risks reported to committee score **above** the tolerance range set in the appetite (including one new risk CRR24-28).

Risk Ref	Risks	Lead Exec Director	Current Risk Score	Risk Tolerance Range in Appetite Score
CRR24-05	Financial Sustainability	Executive Director of Finance	**20**	**Financial <16**
CRR24-06	Suitability and Safety of Sites	Director of Environment	**20**	**Quality <16**
CRR24-09	Primary Care	Chief Operating Officer	**20**	**Quality <16**
CRR24-10	Urgent and Emergency Care	Chief Operating Officer	**20**	**Quality <16**
CRR24-11	Planned Care	Chief Operating Officer	**20**	**Quality <16**
CRR24-13	Timely Diagnostics	Chief Operating Officer	**20**	**Quality <16**
CRR24-19	Community Care Provision	Chief Operating Officer	**20**	**Quality <16**
CRR24-21	Ophthalmology Service	Chief Operating Officer	**20**	**Quality <16**
CRR24-23	Vascular Services	Chief Operating Officer	**20**	**Quality <16**
CRR24-27	Neurodevelopmental Waiting List	Chief Operating Officer	**20**	**Quality <16**
CRR24-28	Pharmacy Technical Services	Chief Operating Officer	**20**	**Quality <16**

1.6 Action Plan status of Corporate Risks

Out of the 26 corporate risks, 183 actions have been developed to mitigate the risks, 124 actions are progressing and on track (47 of which have revised due dates), 27 new actions have been identified, and 29 actions have been closed since the last update, with 3 delayed actions.



Next steps

1. Further scrutiny of all corporate risks by Executive Team as per normal reporting cycle.
2. Submission of Corporate Risks to Board.

Appendix

1. Appendix 1 – Corporate Risk Register Dashboard May 2025.
2. Appendix 2 – Corporate Risk Register May 2025.

Appendix 1 – Corporate Risk Register Dashboard May 2025

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Risk Management Commentary
EDoW	CRR24-01	People, Culture and Wellbeing	4 x 4 = 16 ⟷	8	Quality / Open <16	People & Culture Committee	Opened Dec 23. 10 actions identified, 4 completed, 5 progressing with 4 progressing with revised due dates and 1 new action.
EDoN	CRR24-02	Patient Safety	4 x 4 = 16 ⟷	12	Quality / Open <16	Quality, Safety and Experience Committee	Opened Dec 23. Risk revised to become broader patient safety risk, 5 actions identified, 2 completed, and 3 new actions
EDoN	CRR24-04	Failure to Embed Learning	5 x 3 = 15 ⟷	5	Quality / Open <16	Quality, Safety and Experience Committee	Opened Dec 23, 3 actions identified, 1 completed, 2 progressing with revised due date. Reduction in current risk score from 20 to 15 – September 2024.
EDoF	CRR24-05	Financial Sustainability	5 x 4 = 20 ⟷	12	Financial / Open <16	Performance, Finance, and Information Governance Committee	Risk score has remained at 20 since opened in March 2023, 1 action pending completion dependent upon audit outcome. **Risk Score above tolerance set in risk appetite.**
DoE	CRR24-06	Suitability and Safety of Sites	4 x 5 = 20 ⟷	12	Quality / Open <16	Performance, Finance and Information Governance Committee	Opened March 24, 4 actions identified, 3 progressing and 1 completed action **Risk Score above tolerance set in risk appetite.**
CDIO	CRR24-07	Fragmented Patient Care Record	4 x 4 = 16 ⟷	12	Quality / Open <16	Planning, Population Health & Partnership Committee	Opened Dec 23, 7 actions identified, 7 progressing (**with 7 revised dates**) Reduction in current risk score from 20 to 16 – September 2024.
EDoPH	CRR24-08	Delivering a Population Health Approach to Health and Wellbeing	4 x 4 = 16 ⟷	12	Quality / Open <16	Planning, Population Health & Partnership Committee	Opened Nov 2023. Revised and re-draft the risk to align with current risk position. Reduction in current risk score from 20 to 16 – September 2024.

COO	CRR24-09	Primary Care	4 x 5 = 20 ⟷	12	Quality Open <16	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions identified, 5 progressing, with 3 revised due dates and 1 new action identified. The **inherent and current risk scores are both 20**, indicating the controls are not yet reducing the risk. **Risk Score above tolerance set in risk appetite.**
COO	CRR24-10	Urgent and Emergency Care	5 x 4 = 20 ⟷	12	Quality Open <16	Performance, Finance and Information Governance Committee	Opened Feb 24, 5 actions identified, with 3 progressing, 1 completed and 1 new action. **Risk Score above tolerance set in risk appetite.**
COO	CRR24-11	Planned Care	5 x 4 = 20 ⟷	8	Quality Open <16	Performance, Finance and Information Governance Committee	Opened Feb 24, 5 actions identified, 3 progressing, with 2 action completed. **Risk Score above tolerance set in risk appetite.** **To be updated in line with the programme**
COO	CRR24-13	Timely Diagnostics	5 x 4 = 20 ⟷	5	Quality Open <16	Quality, Safety and Experience Committee	Opened Feb 24, 7 actions identified, 6 progressing, with 2 revised dates, and 1 new action **Risk Score above tolerance set in risk appetite.**
EDoTH	CRR24-14	Harm from the Medical Devices/ Equipment	4 x 4 = 16 ⟷	8	Quality Open <16	Quality, Safety and Experience Committee	Opened Feb 24, 4 actions identified, all 4 progressing with revised due dates.
DoE	CRR24-15	Health and Safety	4 x 4 = 16 ⟷	8	Regulatory Seek 20-25	People & Culture Committee	Opened Nov 2023. 10 actions identified, 2 completed, 6 progressing, 2 further revised actions
EDoW	CRR24-16	Leadership	4 x 4= 16 ⟷	8	Reputational Seek 20-25	People & Culture Committee	Opened Dec 23. 6 actions identified, 2 completed, and 4 progressing with 1 revised due date
CDIO	CRR24-17	ICT Failure and Cyber	5 x 4 = 20	15	Reputational		Opened Feb 24, 8 actions identified with 3 revised due dates

			⟷		Seek 20-25	Planning, Population Health & Partnership Committee	**Target score of 15 not in line with appetite**.
EDoPH	CRR24-18	Operational Planning for Transmittable Diseases and Outbreaks	4 x 4= 16 ⟷	12	Quality Open <16	Planning, Population Health & Partnership Committee	Opened June 24. 5 actions identified, 5 actions progressing with revised due date. Reduction in current risk score from 20 to 16 - November 2024, resulting in the risk now within the tolerance set within the risk appetite.
COO	CRR24-19	Community Care Provision	4 x 5 = 20 ⟷	12	Quality Open <16	Quality, Safety and Experience Committee	Risk reviewed Jan 2025, 10 actions identified, 5 actions completed, with 1 action progressing and 4 new actions identified. **Risk Score above tolerance set in risk appetite.**
EMD	CRR24-20	Oncology Services	3 x 5 = 15 ⟷	9	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 4 progressing.
COO	CRR24-21	Ophthalmology Services	4 x 5 = 20 ⟷	9	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 5 actions in total, 5 progressing. **Risk Score above tolerance set in risk appetite.**
COO	CRR24-22	Orthodontic Services	4 x 4 = 16 ⟷	4	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 3 progressing with 1 new action
COO	CRR24-23	Vascular Services	5 x 4 = 20 ↑	12	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 11 actions in total, 9 progressing with 2 new actions Current score increased from 16 to 20, May 2025.
COO	CRR24-24	Renal Services	4 x 4 = 16 ⟷	12	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 3 progressing with revised dates
EMD	CRR23-25	Dermatology & Plastic Surgery Services	3 x 5 = 15 ⟷	9	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 6 actions in total, 5 progressing, 1 new action

EMD	CRR24-26	Urology Services	4 x 4 = 16 ⟷	6	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 1 completed actions, 2 progressing and 1 action delayed. No update from service.
COO	CRR24-27	Neurodevelopment Waiting Lists	5 x 4 = 20 ⟷	15	Quality Open <16	Quality, Safety and Experience Committee	Risk approved March 2025, 14 actions identified, 13 progressing with 1 revised date **Target score of 15 not in line with appetite**.
COO	CRR24-28	Pharmacy Technical Services	4 x 5 = 20 ⟷	8	Regulatory Open <16	Quality, Safety and Experience Committee	New Risk approved May 2025, 4 action identified Following approval of the risk onto the Corporate Risk Register, risk to be reviewed by the service to align with current risk position,

Committee	
Performance, Finance and Information Governance Committee	PFIGC
Quality, Safety and Experience Committee	QSE
People & Culture Committee	P&C
Audit Committee	AC
Planning, Population Health & Partnership Committee	PPHP

Trend
No trend/Score remains the same ⟷
Increase ⬆
Decreased ⬇

Executive Lead	
Executive Director of Workforce	EDoW
Executive Director of Nursing & Midwifery	EDoN
Executive Director of Finance	EDoF
Chief Digital Information Officer	CDIO
Executive Director of Public Health	EDoPH
Director of Environment	DoE
Executive Medical Director	EMD
Chief Operating Officer	COO
Director of Corporate Governance	DCG
Executive Director of Therapies and Allied Health Professions	EDoTH

Appendix 2 – Corporate Risk Register May 2025

CRR 24-01	**Risk Title:** People, Culture and Wellbeing		**Date Opened:** 07/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 10/04/2025
Date Last Reviewed: 06/05/2025	**Director Lead:** Deputy Director of People & Organisational Development	**Link to BAF**:	**Target Risk Date:** 31/03/2026
There is a risk that BCU do not have a **highly skilled**, engaged and **motivated** workforce which could impact on safe delivery of care. This could be caused by **staffing shortfalls**, organisational reputation and staff not feeling psychologically safe which could lead to burnout. This could lead to the inability to attract and retain high quality and skilled people.			

Mitigations/Controls in place	Additional Controls required
1. The Strategic Recruitment team in place to oversee efficient and effective professional recruitment for all senior leadership and medical & dental consultant appointments across the Health Board 2. Local IHC Resourcing Teams are in place across all IHC/Pan Services to drive forward recruitment and staffing priorities. 3. The Recruiting well and Joining Well programmes in operation. 4. Organisational Retention lead in post for BCU linked with national retention work through Heath Education Improvement Wales (HEIW) 5. Dedicated Nurse Retention Lead in place to deliver the Nurse Retention Implementation Plan for the organisation 6. New All Wales Flexible working policy has been ratified and is in place 7. Staff feedback conjunction with the NHS Wales Staff Survey in place. Development of Pulse surveys to ensure staff have a voice across the organisation 8. Speak out Safely Multi-Disciplinary Team in place 9. Work in Confidence platform for staff to safely raise concerns. 10. Workstreams associated with this risk which links into the Special Measures Framework are monitored via the governance of the Framework and reported to Executive Team and Board	a) Implementation of the Employee Engagement plan and having a suite of clear indicators that measure employee engagement b) Development of a programme of work to ensure line manager's full involvement in employee engagement c) Feedback from the HEIW Nurse retention tool. d) Targeted management of sickness absence rates e) Engagement and operational effectiveness with Medical and Dental workforce f) an embedded workforce planning function

11. The Culture Change Plan, which incorporated the results from the Staff Survey 12. Staff facing version of the Learning Organisation Framework developed for use in work-based learning contexts 13. The key themes of the 2023 staff survey have been shared with the organisation 14. Approval of the new culture change and Behaviours Framework (ref CRR24-16). This incorporates a detailed action plan of deploying the new V&B 15. International recruitment drives, both local and all Wales 16. People Managers Forums in place that include sessions on compassionate leadership and our values and behaviours framework 17. A new Education Steering Group has been setup to oversee the development of education and training across the Health Board 18. 2024 Staff Survey Results shared across the HB with ongoing work from services to address key issues identified	

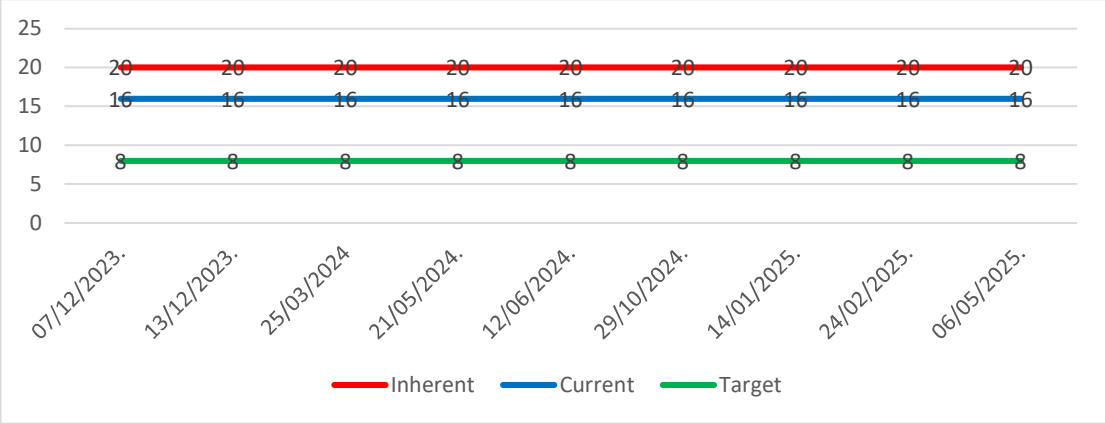
Actions	Due Date	Progression Analysis
REF Gaps in controls; A. Education and Learning Committee is being established as a control measure A Nursing specific educational and development group has been established. However, it has been identified that an Education Governance Group is required to oversee compliance and operational performance of Education. This is in development and a term of reference is expected to be ready by the end of October 2024 Work to setup the Education Governance Group is still ongoing however, the Terms of Reference and membership is still to be agreed. Due to unforeseen absences in the People Service Leadership team this action was extended. Work is underway with the Nursing Leadership Team to establish this group. The Education Steering Group has been setup, and the first meeting has been held. Meeting bi-monthly, the group has been put in place to oversee the development of education and training across the health Board. See point 17 mitigations in place	30/04/2025	Completed

REF Gaps in controls; B 2024 NHS Staff Survey has not closed with a 17.2% response rate. Quantitative data is due by end of January which will be distributed out to the organisational staff survey leads. This will inform actions to address issues and promote positive findings The qualitative data of the 2024 survey will be shared with the organisation when they are available, likely to be late spring 2025. An update will be provided in May. See Mitigation point 18. The action to share the 2024 staff survey findings is now closed, they have been published on BetsiNet. The CEO wrote out to Directors before Easter outlining expectations for action around the survey results. Directors have been asked to share their action plans with in Q1 and once those are received an overarching action plan will be drawn together on key themes. HEIW will be publishing (on their website) a Wales-wide results report in Q1.	30/05/2025	Completed
REF Gaps in controls; C. Findings from the wider review of the 2022 Operating Model restructure presented via an appropriate Executive governance process and next steps agreed The Discovery Report in Foundations for the future (FoTF) has been presented to the Board and the Organisation, it has now moved into the design phase. A series of workshops with senior leaders will take place in Dec 24 and Jan 25. The outputs from the workshops will produce design options to be tested in the organisation prior to final option paper going to Board in May 2025	01/06/2025	Progressing (Revised date from 31/10/2024)
REF Gaps in controls; B. Revisit the values of the organisation: Views on the existing values and suggestions for modifications presented to Exec Team prior to scheduling for review at Board. Previously collected staff feedback on the existing values to be analysed and proposals of methods of co-production with the staff including comms and engagement plans to be submitted via an appropriate Executive governance process. Culture World Café to take place at Leadership Conference 04.06.24 Following extensive engagement over 5 months the Board formally approved our refreshed values and behaviours framework in November 2024. There is a Communication & Socialisation plan in place and a high-level Embedding Plan in place was agreed by ET and P&CC. A more detailed version of the Embedding Plan will be provided to the CEO for approval. A Design Group is in place which supports the co-production and co-design of all work related to Culture Development.	31/03/2025	Completed

A more detailed deployment plan to embed the values and behaviours has been drafted and will be submitted to the Executive Team in March 2025. Action Closed - See mitigation 14; Detailed deployment plan presented to Executive Team in April with operational leads to be allocated by each Executive to embed in their areas of responsibility. Deployment plan to be returned to Execs end of May and to include named operational leads and measures of success. Some actions within the plan have already been implemented or in progress including embedding in recruitment process, orientation, leadership development programmes, staff recognition		
REF Gaps in controls; B, A toolkit on how to use the values and behaviours is in development This is progressing and is expected to be completed in March 2025 The first draft of Values & Behaviours toolkit sent out for feedback in March. Changes applied with launch to organisation in May 2025.	31/07/2025	Progressing (revised date from 31/03/2025)
The Culture, Leadership & Engagement high level annual plan is in place for 2024/25. A subsequent plan for 2025/26 is in draft and will be finalised by March 2025 This is on track to be completed in March, notwithstanding any requested changes. The quarterly plans have been drafted and are being reviewed DDPOD	31/07/2025	Progressing (revised date from 31/03/2025)
Ref Gaps in controls; E. A new risk specifically detailing actions to manage sickness absence, both physical and mental health related, has been drafted and will be ratified through People & Organisational Development (POD) leadership in February 2025. This will be discussed at POD leadership on 3rd March then will be added to Datix. The Absence risk has been added to Datix and the action plans will be monitored through the People Risk Group (PRG)	31/03/2025	Completed

Ref Gaps in controls; f. A Medical Staffing function will be re-introduced into the People Services directorate. Resource requirements will be identified in January/February with the intention to introduce the new function in Q1 2025/26 A new Medical Staffing Specialist role is be advertised in early May with an anticipated start date in July, pending successful recruitment	30/06/2025	Progressing
REF Gaps in controls; D. The Recruiting Well, Joining Well, Leaving Well Programme is being developed to ensure we recruit, support and retain a skilled motivated workforce. The programme for Recruiting Well, Joining Well, Leaving Well will now be incorporated into the **Staff Journey** programme of work. An illustrative map is currently being developed showing all areas within People Services and OD that employees typically encounter, from 'Hire to Retire'. Work in being undertaken to identify gaps in each of the services with regards to policies and procedures. This will enable the Staff journey programme plan, which will include timescales, to be drafted. The draft illustrative map is under review and analysis of gaps in policy and process are being identified through a number of workstreams. The initial focus is on *Corporate and Local Induction*, *Shortlisting timescales*, *Advertising in recruitment* and the *Leaving Well booklet.* These initial workstreams are planned to be completed by the end of December 2024. The mapping work to identify development opportunities for our People (WP) policies and procedures is underway which informs the annual schedule led by the corporate governance team. Furthermore, an operational group is in place to review and update the corporate and local induction policy. Due to resource being allocated to the Foundations for the Future programme, the remaining workstreams within this action will continue to be worked on but the expected completion is delayed until later in 2025 a. The leaving well booklet b. Improving shortlisting timescales c. Advertising well in recruitment	31/12/2025	Progressing (Revised date from 31/12/2024)
REF Gaps in controls; G. A workforce planning lead was recruited earlier in 2024. A new Health Board approach to workforce planning is expected to be ratified in February 2025and will be submitted in the 2025/26 IMTP. The new approach contains a series of milestones that will improve workforce planning skills and knowledge across	31/03/2026	New action

the organisation, improve guidance and resources for service leads and will incorporate a detailed workforce plan for the 2026/27 IMPT		



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Quality		<16

Position & Intended Outcome for Risk

KPIs to that inform our risk in this area as at April 2025;

Overall Vacancy rate of 8.8%, risen from 8.2% since the last report. All staff groups have seen slight increases since last month. Although, the overall trend for Nursing are showing a positive downturn in vacancy rates compared to this time last year with effective international recruitment campaigns contributing.

Turnover remained the same for March 25 compared to last month, maintaining a steady downward trend, currently our lowest score since January 2022, at 7.9% and down 0.6% in the last 12 months. Additional clinical services, AHPs and Healthcare scientists reporting increased turnover in the last 12 months. This is mirrored by a steady improvement in staff retention over the previous 12 months.

	Rolling sickness absence spiked in December 2024 and has reduced in the last three consecutive months to 5.6%. Stress, anxiety and depression continues as the highest reported reason despite also showing a reduction in time lost. KPIs to monitor how well our people are being treated; There has been a decline in the number of emergency salary payments in the past 12 months. Furthermore, E-rosters approved within policy timescales has improved in the last we months but work still needs to be done to meet the 80% KPI.

CRR 24-02	**Risk Title:** Patient Safety		**Date Opened:** 02/07/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 24/04/2025	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**:	**Target Risk Date**: 30/09/2025

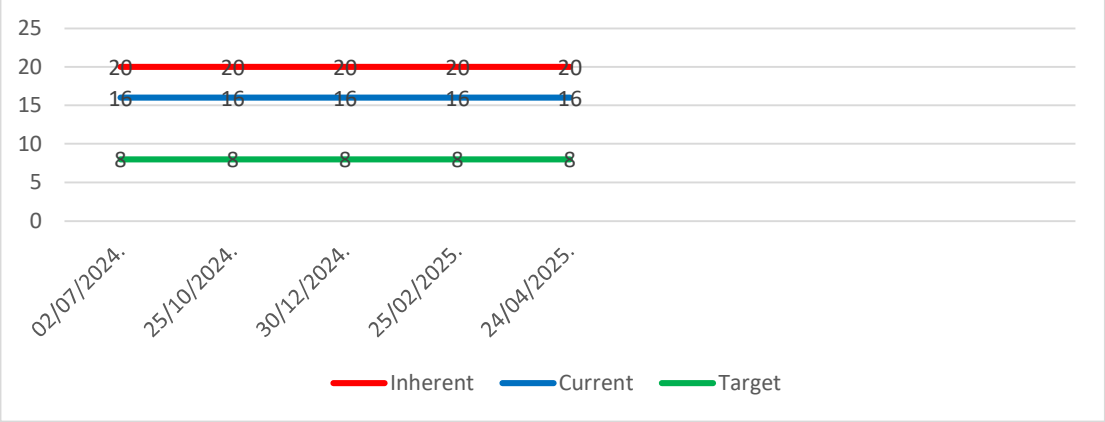
There is a risk that patients may experience preventable harm and a poor experience whilst receiving care due to inadequate preventative measures, not following correct procedures , adhering to best practice and/or learning from concerns . This could lead to poor quality of care resulting in severe complications, prolonged hospital stays, decreased quality of life, psychological distress, reputational damage, increased costs, and potential legal and financial consequences for the organisation.

Mitigations/Controls in place	Additional Controls required
1. Policies and Procedures to support risk assessment, guidance and escalation in place e.g.NU06 Prevention and Management of Adult Inpatient Falls, NU03 Pressure Ulcers, MM01 Medicines, National Early Warning Score. 2. Review of patient safety incidents at a local level supported by integrated concerns meetings and harms reviews for learning meetings. 3. Strategic groups that report into the Health Board Patient Safety Group, e.g. Falls Group, Prevention and Management of Pressure Ulcers Group, Improving Nutrition and Catering Standards , Safer Medicines Steering Group, Sepsis Triggers Escalation & Antibiotic Stewardship Review for learning and improvement. 4. Escalation to Quality Delivery Group and Quality, Safety and Experience Committee. 5. Cycle of business to PSG that includes IHC/Divisional deep dives of progress and action. 6. BCUHB wide Improvement plans for falls, HAPUs Nutrition and Medicines safety 7. Incident management process including rapid reviews, focused reviews and learning panels. 8. All Staff induction, training and competency 9. Organisational Learning Forum for shared learning and improvement 10. Regular patient safety incident alerts issued to staff as and when required	a. Sustained compliance of >85% of patient safety related mandatory training b. Timely update of policies and procedures in line with evidence based practice and as per governance cycle for review. c. Continued work on the 6 goals and Urgent and Emergency Care pathways to reduce the risk of patient safety Incidents. d. Continued work on the planned care delays and backlog harms reviews associated with long delays. e. Continued work with People services to ensue robust assurance measures are in place for our temporary workforce to ensure they have the skills and competencies required to maintain patient safety.

11. Integrated concerns policy and framework implementation. 12. Bi-annual Nurse Staffing reviews are undertaken in line with the Nurse Staffing Levels (Wales) Act 2016 for all acute adult medical and surgical inpatient wards, and paediatric inpatient wards (Section 25B). Additionally, and in keeping with the principles of the legislation nurse staffing reviews are also undertaken in other areas of the Health Board such as Community Hospitals, Mental Health, and other 24hr services. 13. Roster Policy WP28A in place and monthly roster KPI reports are issued to the Directors of Nursing to enable roster performance to be actively managed. Additionally allocate Safe Care compliance reports are also sent to the Directors of Nursing, to enable maximum utilisation of nursing workforce.	

Actions	Due Date	Progression Analysis
Strategy for Increasing compliance with patient safety related mandatory training Positive Increase noted in both falls part a and b and manual handling and will be ongoing as 02 has just come online as mandatory training. Action complete and will be ongoing as training will need updating and new starters will need to complete.	31/03/2025	Complete
Planned Care Programme board in place to monitor progress and improvements to reduce patient risk of harm	30/09/2025	New Action
Urgent & Emergency Care (UEC) & 6 Goal Programme Board in place to monitor and implement improvements in patient safety and reduce harm.	30/09/2025	New Action
Temporary Staffing assurance and improvement group in place let by the assistant director of people service	30/09/2025	New Action
Deliver all the actions from the Internal Audit of falls Combined HSE and Internal Audit action plan in place. Evidence compiled for action plan and submitted and reviewed at bimonthly Falls Steering Group.	31/03/2025	Complete

Action closure as all actions completed and Internal Audit are revisiting the initial audit in Q1, any further identified actions will be included on the risk following review.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite			

Rationale for Corporate Risk

There are circa 38,000 patient safety incidents reported in the last financial year of which approximately 25% graded as moderate harm or above by the reporter. Feedback has also been received from His Majesty's Coroner in the form of regulation 28 prevention of future deaths around risks from timely investigation and implementation of actions to improve patient safety.

To support the planned target score improvement have been noted in the reduction of all open incidents, NRI and overdue NRI. Falls and HAPU as our highest number of incidents are on a reducing trajectory.
No Reg 28 or Never events have been reported in 2025.
Reduction in RIDDOR reportable incidents noted.

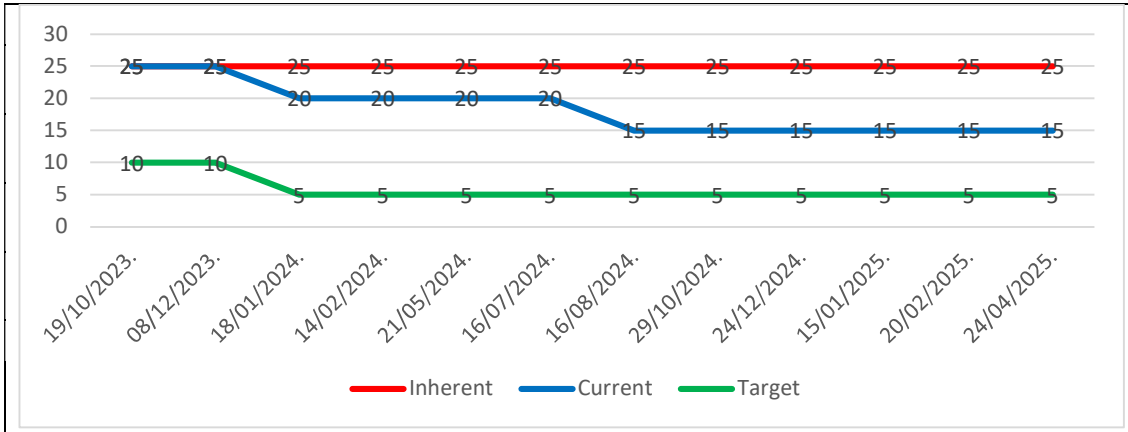
CRR 24-04	**Risk Title:** Failure to Embed Learning		**Date Opened:** 19/10/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 24/04/2025	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**:	**Target Risk Date:** 30/09/2025

There is a risk that the Health Board could fail to meet requirements for **timely review and learning** from mortality cases, claims, inspections, incidents and complaints. This could be caused by insufficient resources, lack of unified processes, outdated IT systems, duplication of effort, and overreliance on single personnel. The impacts may include missed opportunities for improvement, lack of family/carer engagement, potential patient harm events going undetected, non-compliance with national frameworks or legislation, and reputational damage.

Mitigations/Controls in place	Additional Controls required
1. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. Integrated Concerns Policy 2. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints 3. Clinical staff recruitment, induction, mandatory and professional training, registration & re-validation 4. Putting Things Right and clinical review processes and monitoring 5. Quality governance framework of meetings and reporting structured 6. Quality Dashboard and access to quality data from ward/team to Board 7. Patient and carer feedback and involvement processes 8. Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act 9. Ward accreditation schemes and ward manager/matron checks/audits. 10. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans 11. Organisational Learning Forum (OLF)**:** This forum promotes sharing of learning for continuous improvement and encourages sharing best practices and lessons learned to enhance safety and quality 12. Organisational Learning Forum (OLF) Betsinet shared learning page	a. Implementation of a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement (dashboard completed). b. Clarity on quality leadership, structures and accountabilities c. Development of a quality learning framework, aligned to the overall learning organisation programme d. Resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests e. Ongoing embedding and training of a new Learning from Events (LEFR) process to improve divisional ownership and completion of a recovery plan to address the overdue position f. Medical engagement to ensure active participation and commitment from medical staff in learning and improvement. g. Integration of LFER/Claims – To enhance the management and resolution of claims, ensuring they are addressed promptly and effective

13. Exec Oversight Group**:** This group provides strategic direction and high-level oversight for risk management, ensuring alignment with organisational goals and adequate resource allocation. It also monitors and adjusts risk mitigation strategies. 14. Inquest Review Group**:** Focused on cases with significant adverse outcomes, this group conducts thorough investigations to recommend changes in policies and practices, ensuring accountability and transparency. 15. Rapid Review Process: Designed for urgent issues, this process uses streamlined methods to quickly identify risks and implement corrective actions, minimizing the impact of emerging risks. 16. New Thematic Review Group: This group conducts in-depth reviews of specific themes or patterns, developing targeted recommendations to address systemic issues and continuously improve the organisation.	h. Ensure learning from deaths – Provide the mortality panel with access to a process that ensures thematic learning from deaths is taken forward to facilitate continuous improvement.

Actions	**Due Date**	**Progression Analysis**
A central and digital library of learning will be established which will be launched alongside a revised approach to the collation, analysis and dissemination of learning. Development work continues with a revised aim of May 2025. Work continues to develop the new Quality Learning Portal. Due to other work pressures, development on the Solution has slowed and little progress has been made since the previous update. These additional work pressures are being addressed, and the development continues, the admin app that will allow administrators to review learning prior to being published to the organisation. The first of three apps, which will allow users to enter learning into the system, which has been finalised. The second app is due to be tested in early May with plans to be finalised end of May 25, with the final part of the Solution due to be complete early in mid to late june 25. Whilst this is later than hoped in the original ambitious plan, this work is an entirely new project being developed and the first of its kind in Wales, so an agile development approach is being taken to ensure the solution is reliable, sustainable and delivers a real benefit to BCUHB.	01/06/2025 – delayed due to DDAT priorities	Delayed (Date Revised from 30/03/2025)
Implementation of the new/approved QMS assessment Framework within the identified pilot sites. Implementation of the QMS progressing in the test sites with other early adopters identified, this will be ongoing.	31/03/2025	Completed
Delivery of overdue LFER recovery plans by each IHC/Division to eliminate the overdue position	31/06/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	3	15
Target Risk Score	5	1	5
Risk Appetite	Quality		<16

Position & Intended Outcome for Risk

Learning is now being embed through Organisational Learning Forum (OLF) and the Integrated Concerns Forum (ICF), complaints and incidents position on a positive improvement trajectory. The monitoring of the sustained improvement is required prior to de-escalating the risk. Improvement trajectory for complaints reached with performance currently over 75% - sustainability will be monitored weekly. The number of Prevention of Future Death (PFD) / Regulation 28 Notices issued to BCUHB since February 2023 currently stands at 32. The Health Board saw a large number issued in 2023/24 (23) which was a significant outlier compared to previous years and other NHS Wales bodies. However, 5 were received in 2024/25 (to date), a significant reduction compared to the number issued in same period of the prior year and more in-line with the average of previous years and other NHS Wales bodies. Coroners have raised a number of common themes through these Regulation 28 reports, the quality of investigations and effectiveness of actions being the most common. The Health Board completed a Learning from Investigations Programme to assess and improve its investigation process and improve the assurances it can take on existing action plans. The programme had direct oversight from the Chief Executive and wider executive team and reported to the Quality, Safety and Experience Committee with a clear escalation process in place. The learning from this programme directly informed the new Integrated Concerns Policy which was approved by the Board in July and launched in September 2024 providing a new, integrated approach to patient safety investigations, complaint investigations and mortality reviews.

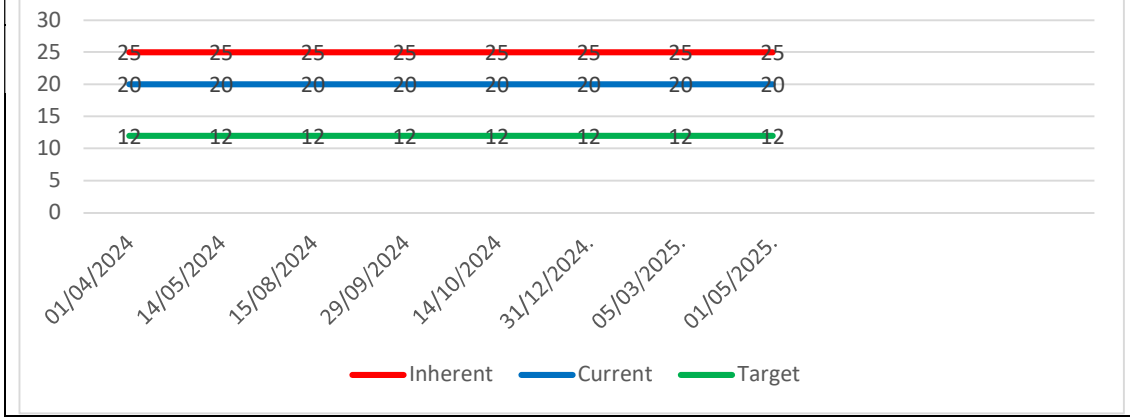
CRR 24-05	**Risk Title:** Delivery of the Annual Financial Plan		**Date Opened:** 01/04/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 06/05/2025.
Date Last Reviewed: 01/05/2025	**Director Lead:** Executive Director of Finance	**Link to BAF**: BAF24-03	**Target Risk Date:** 31/03/2025
There is a risk that the Health Board does not achieve the in year Financial Plan and Welsh Government control total (noting the key duty being to deliver break-even). Failure to achieve the financial plan could result in conditionally recurrent investment being withdrawn from the Health Board and central intervention to support attainment of the key financial duty in this or future financial years.			

Mitigations/Controls in place	Additional Controls required
1. Core Savings targets for IHCs, Non-IHC Directorate and Corporate functions have been issued and performance to be challenged at Integrated Performance Executive Delivery Group – chaired by the Chief Executive. 2. Accountability Agreements issued to the budget managers for sign off in support of funding and deliverables required for each financial year. The signing off for these agreements monitored for review by Internal Audit and performance reported through Committees of the Health Board 3. Value and Sustainability programme approach to 2024/25 savings has been endorsed by the Executive and Board. Executive Leads have been assigned and a flow chart issued setting out the governance process for sharing of costed savings opportunities and Divisional delivery. 4. Continuation of the Enhanced Establishment Control Group (executive approval before advertising) to review all requests for A&C posts and all Band 7+ posts, moratorium on requests for Permanent recruitment to Band 8D and above (non-clinical posts) and minimising interim staff appointments. 5. Cease use of non-patient facing agency with exceptionality process put in place through the enhanced establishment control process 6. Non-Pay – all discretionary non-clinical expenditure to be directed to Executive Director of Finance for scrutiny and approval 7. Internal scrutiny by Central Finance Team, of the Divisional financial assumptions, overspends and forecasts.	a. Welsh Government (WG) expectation to achieve financial balance, due to the financial settlement/allocations to Health Boards and to enter into financial stability. b. The 24/25 Annual Plan and forecast financial outturn based on a level of expenditure controls and savings delivery that the Health Board considers to be sufficiently challenging and deliverable, whilst maintaining quality and patient care. c. The Month 6 position showed a material deficit to date and therefore additional actions are required to control the run rate and recover the deficit above plan. These were endorsed for implementation through the Integrated Performance – Executive Delivery Group d. Performance is reported and scrutinised through the IP – EDG monthly meetings where officers are held to account for delivery and bi-monthly within the Performance, Finance and Information Governance Committee and Health Board. e. Escalation meetings where improvements are not realised are held with leadership teams by the Chief Executive. In these forums support is offered to improve performance and trajectories supported for improvement.

8. Financial reporting to Welsh Government on a monthly basis, with the Monthly Monitoring Return (MMR). 9. Regular communication with Welsh Government regarding £82m strategic funding with regards to making this recurrent. 10. Early identification of emerging issues through horizon scanning and trends in run rate and alerting Operational Management to changes to regularity requirements. 11. Monitoring the adequacy and effectiveness of internal control, accuracy and completeness of financial reporting and forecast, compliance with laws and regulations, and timely remediation of deficiencies.	

Actions	Due Date	Progression Analysis
The Integrated Performance – Executive Delivery Group (IP-EDG) endorsed implementation of expenditure controls within the areas and directorates (from November 2024) as a measure to cease the run rate deterioration above plan and recover the year to deficit, to attain the forecast control total deficit for the financial year as agreed with Welsh Government. These measures were expanded to cover controls over expenditure discretionary expenditure (non-patient related) in January 2025 within IP-EDG. Enhanced 'Check and Challenge' discussions with Chief Finance Officers, on a monthly basis, to ensure the forecast expenditure is robust. Escalation of Out of Area Mental Health Placements, through the Chief Executive Officer. Maintain increased controls, continued oversight and holding to account via the Integrated Performance Executive Delivery Group, and holding to account against expenditure control reductions identified for the remainder of the financial year. Action pending closure as based on unaudited accounts, required outturn achieved (better by £1m), results subject to audit. Risk to be updated to reflect current Financial year for 2025/26.	31/03/2025	Completed (Pending)

	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	3	12



Risk Appetite	Financial	<16

Position & Intended Outcome for Risk

M12 (unaudited) - Full year position is reporting a deficit of £7.61m, this is £1m below the full year £8.6m planned deficit. The deficit is driven by additional capacity areas remaining open (substantial patients clinically stable and medically fit awaiting discharge), Out of Area Mental Health placements, CHC increased activity and Primary & Secondary Care Drug costs.

CRR 24-06	**Risk Title:** Suitability and Safety of Sites		**Date Opened:** 04/01/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 06/05/2025
Date Last Reviewed: 02/05/2025	**Director Lead:** Director of Environment and Estates	**Link to BAF**:	**Target Risk Date:** 31/03/2026 (10 year capital investment requests aligns with the capital prioritisation form that will be submitted to Welsh Government – completion target date 2035).

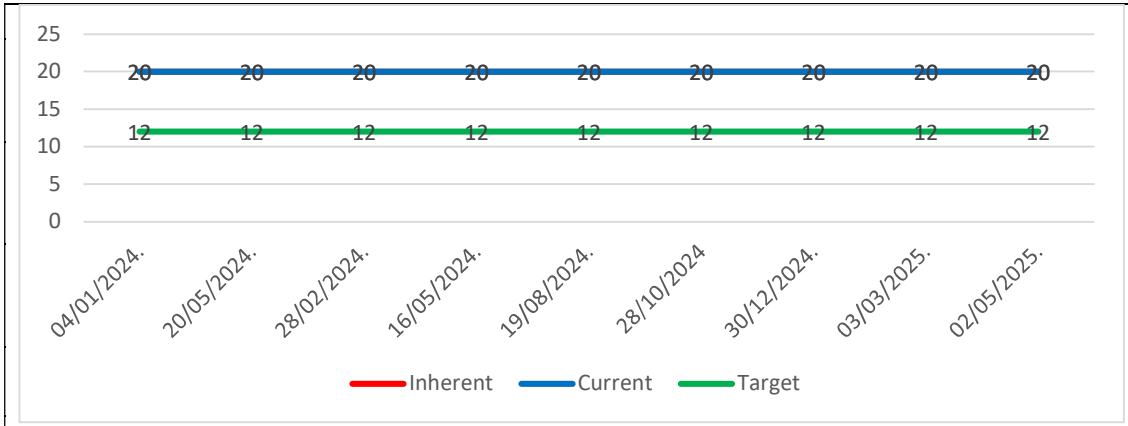
There is a risk that the suitability and safety of the estates and infrastructure across BCU could severely impact on service delivery, staff and patient safety. This could be caused by aging and unsuitable buildings, backlog maintenance issues, non-compliance with regulations, inadequate space capacity, and lack of capital funding. The impacts may include inability to meet service needs, reduced access to diagnostics and treatment, risks of infection, fire, asbestos, legionella and other hazards, increased costs, regulatory enforcement action, and significant reputational damage. This presents risks to the continuity of care, patient outcomes, staff wellbeing, and the Health Board's ability to provide safe, therapeutic environments across the region.

Mitigations/Controls in place	Additional Controls required
1. Estates Strategy developed and approved by the Health Board in January 2023. 2. Internal Governance for capital allocation in place within the Health Board. 3. Business Cases to Welsh Government to resolve major infrastructure issues in line with the Estates Strategy 4. Priority bids against Welsh Government Estates Funding Advisory Board (EFAB) for the allocation and prioritisation of funding in relation to infrastructure funding, decarbonisation, fire and Mental Health and Learning Disability. 5. Discretionary Capital Allocation of £12.448m for 24/25 approved by Welsh Government with an allocation of approximately £3.208m aligned to improvements within the Estates. Prioritisation is based on Operational Estates Risk Register 6. Regular Welsh Government /Health Board Capital Meetings – which provides a direct link with Welsh Government to raise concerns regarding the funding available to effectively manage	a. 6 facet survey to be undertaken to obtain an updated report of the condition of the Estate' this will inform the risk status by site, which will be assessed against the controls currently in place. Additional mitigation or strengthening of controls will also be considered. b. Assurance around the Capital Prioritisation Plans that it is aligned with both the Estates strategy and the Clinical strategy. c. Business Case Review Group to be set up to review all business cases to provide scrutiny prior to submission to Executive team. d. Standardised approach by the Health Board in relation to management of Estates and Capital between the Integrated Health Community IHC's) and other services and the Estates/Capital teams – linked to the changes to the Operating Model.

the condition of the estate and ensure safety of patients and staff. 7. Operational Estates Safety Groups in place to provide assurance, the safety groups are as detailed below and oversee risks relevant to the groups: a. Fire Management b. Asbestos Management c. Water Safety, d. Ventilation Safety e. Electrical Safety 8. Welsh Government Capital Resource Meetings in place to provide route for escalation. 9. Estates and Facilities Performance Management System (EFPMS) reporting template and recording of backlog maintenance 10. Capital Allocation from Welsh Government – additional capital funding of £4.16M allocated to the Health Board to focus on Backlog Maintenance 11. The Health Board submitted the Major Capital prioritisation plan to Welsh Government (WG) to identify required investment. The end date is dependant of how much capital investment is provided to the Health Board from WG. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government. 12. Updated agreed protocol for use of Annual Discretionary Slippage in place for developing Business Justification Cases (BJC) for essential estates works and discretionary capital schemes that could be aligned with in-year additional Capital Funding provided by WG. 13. Capital Funding from Welsh Government – additional capital funding of £2M allocated to the Health Board in year for slippage bids. 14. Review of Reinforced Autoclaved Aerated Concrete (RAAC) completed by the Health Board's approved structural engineers –	e. Ensure that the Health Board has an Estates rationalisation programme in place that will support the capital prioritisation programme and reduce backlog maintenance. f. Internal Audit review of Fire Safety – Agreed Management Action Plan being implemented and being managed through the Fire Safety Management Group g. Timely progression of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase

Curtins and a report will be presented at the Strategic Occupational Health and Safety Group 15. Targeted Estates Funding (TEF) approved by Welsh Government and allocation of £15.390m awarded over a 2-year period (2025-2026 / 2026/2027) to progress the national programme of capital schemes for Fire, Infrastructure, Decarbonisation, Mental Health, Infection Prevention Control and Decontamination	

Actions	Due Date	Progression Analysis
Undertake action to deliver a Health Board Estates Rationalisation Programme. Estates Rationalisation Programme being developed and in draft format. Document to be presented to the Capital Investment Group (CIG) on 12th June 2025. Estate's rationalisation plan is being reviewed and updated taking into account disposal that have been approved in 2024-2025 and opportunity for disposals in 2025-2026 as part of rationalisation of our estates that supports the Caledfryn Project.	30/06/2025	Progressing (revised date from 31/01/2025)
Undertake actions to deliver a 6 facet survey across the Health Board over the next 5 years. The 6 Facet survey contract is currently being procured through the SBS framework via mini-competition, the contract is due to be awarded by January 2025. A Phase 1 approach for the Acute Hospitals, is expected to be completed by 30/09/25. The completion of the full survey has been brought forward from the original 5 year time frame to a 1 year programme. A review of the 6 facet survey programme is to be undertaken with support from Director of Environment and Estates with a plan to adopt an All Wales approach to surveys which is being led by NWSSP Specialist Estates Services.	31/03/2026	Progressing
Review and update Capital Prioritisation Plans	31/03/2025	Complete
Develop a standardised Terms of Reference to be considered and endorsed by Capital Investment Group	31/05/2025	Progressing



N.B. Inherent and Current score lines stacked as both are 20.

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	2	4	12
Risk Appetite	Quality		<16

Position & Intended Outcome for Risk

Current Risk score of 20 aims to be reduced to a 12 by April 2035.
Backlog maintenance is the cost to bring estate assets that are below acceptable standards (either physical condition or compliance with mandatory fire safety requirements and statutory safety legislation) up to an acceptable condition. Total 2021/22 backlog costs for all BCUHB properties was £348.4m. Cost to achieve physical condition B is c. £213m. Cost to achieve condition B for fire and safety statutory compliance is c. £136m. Total risk adjusted backlog is c. £240m. The majority (73%) of backlog relates to the 3 acute hospitals. Backlog for MH&LD, Community and Local Hospitals, and Community Facilities each comprise c.10% of total backlog.
The estate is facing significant risks and challenges and severe limitations on expected future funding. The current estate is not sustainable or viable in the long term and will not support the implementation of key BCUHB strategies and is a significant risk to the Board.
To aid with supporting a Capital Programme the Health Board will commence with a programme to deliver a 6 facet survey for the Estates, these surveys will commence in 2024 focussing on Acute sites and then community hospitals with a target to complete within 2 years. This will be a significant part of the estates portfolio and backlog maintenance cost. As sites are completed the cost associated with backlog maintenance will be identified and capital funding requested. The end date is dependant of how much capital investment is provided to the

	Health Board from Welsh Government. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government. In addition, significant works have been undertaken on the fire project at Ysbyty Gwynedd which will result in approx £2M being invested and works completed by March 2025. Wrexham Resilience Programme has undertaken a risk-based approach to address key findings of the original Business Case. The Health Board has disposed of 2 sites (Ala Road and Cilan) this financial year which were vacated as 'not being fit for purpose', approval has also been received to dispose of Rossett HC and Ruthin HC which have been vacated due to condition of the Estate and these are expected to progress to auction in early 2025.

CRR 24-07	**Risk Title:** A Fragmented Patient Care Record		**Date Opened:** 06/12/2023
	Assuring Committee: Partnerships, People and Population Health Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 02/04/2025	**Director Lead:** Chief Digital and Information Officer	**Link to BAF**:	**Target Risk Date:** 31/03/2029
There is a risk that patient harm will be caused due to the lack of a joined up longitudinal Electronic Healthcare Record system that digitalises clinical workflow, alerts, hand overs and scheduling under a single patient identifier, which could lead to deaths and harm.			

Mitigations/Controls in place	Additional Controls required
1. Current paper file identified as the Master Copy of the full record. 2. Access to current clinical systems to print clinical information ready to store in the Master File. 3. CITO (System Supplier) Contract in place to house scanned document as a repository. 4. Mandate process in place to control the adoption of new functionality within existing systems to capture patient data. 5. Current system training and standard operating procedures around searching for and registering new patients to prevent the creating of duplicate records in place. 6. Dashboard in place which flags any new duplicate patient record created to allow record merge. 7. Standard operating procedures involving searching for and storing patient information to prevent harm in cases where duplicate records exist is in place within Patient Administration System. 8. Optimisation Programme in place for the four main patient administration systems to review usage and reduce duplication across the systems. This will also support the removal of obsolete systems. 9. Assistant Director of Patient Records now member of Clinical Effectiveness Group and Patient Safety and Quality Group to ensure harms associated with patient records are addressed.	a. Lack of current system capabilities to integrate into the fuller Electronic Health Record. Optimisation programme underway with a focus on Electronic Point of Care (EPOC), EPRO (Digital Dictation System Supplier) and Welsh Clinical Portal (WCP) to review current systems interoperability and functionality. CITO has been agreed as the Electronic Document Management System for the Health Record. b. Availability of current paper records within digital environment. The business case for a scanning strategy for the Health Board is currently in draft and will provide options, costs and resource requirements for scanning of records. c. Standard practice registration across the three acute sites. Proposal developed including resource funding required based on the East Health Records service coverage. Non-recurrent allocation of resource secured which will support addressing the standardisation across the three sites on a limited timeframe. Further request has been presented to secure recurrent funding. d. No agreement to fund additional Health Records staff to address backlog of duplicate patient records / identifiers. Standardised procedures in place to prevent re-occurrence

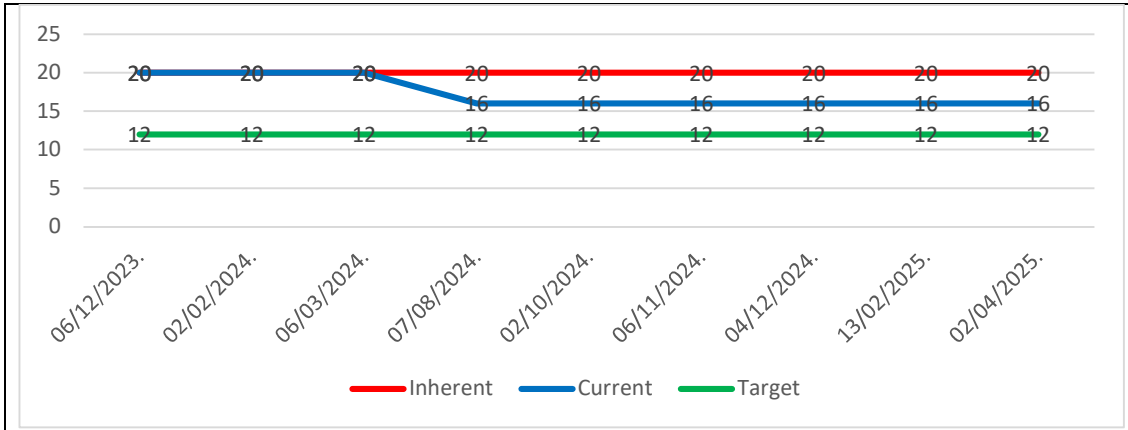
10. The work underway with the Mental Health Electronic Health Record Programme is the first part of the future Electronic Health Record journey with the governance route agreed. 11. Clinical Design Authority now in place with agreed terms of reference and meeting on a bi-monthly basis to ensure that the design and use of digital systems does not compromise the safety, quality and effectiveness of care. 12. Patient Numbering update provided regularly to the WPAS Operational Steering Group and the WPAS Programme Board.	with request for additional resources currently being presented for consideration. e. Lack of quality within the content of current patient records. Office of the Medical Director accepted ownership and will consider as part of professional standards. f. Correct use of current clinical systems. Current review underway to establish usage with a future plan including training on the use and capability of all systems. g. Standardised use of NHS number across the Health Board. Work underway with DHCW to import all NHS numbers for North Wales patients.

Actions	**Due Date**	**Progression Analysis**
Develop a Health Board Scanning Strategy Work is continuing and still on target to complete the business case by the end of May 2025.	31/10/2025	Progressing (revised date from 31/03/2025)
Standardise the way in which using existing systems (paper and electronic) as part of the DDaT optimisation workstreams The Draft Optimisation blueprint has been presented and approved at the DDaT Senior Leadership Team meeting held on the 27th March 2025. A Workplan is being prepared to focus optimisation activities on key clinical systems which will be approved by the Clinical Design Authority.	30/09/2025	Progressing (revised date from 31/03/2025)
Undertake a review of all current systems to ensure these can be integrated into an Electronic Health Record The Electronic Health Record Outline Business Case is in its final stages of review. Further readiness activities are being planned post Outline Business Case socialisation which will incorporate more detailed work in relation to current and future integration of systems.	30/09/2025	Progressing (revised date from 30/04/2025)
Accelerating the business case, approvals, procurement and implementation of an Electronic Patient Record for Mental Health (minimum 2-year project)	30/11/2025	Progressing (revised date from 30/04/2025)

This is still progressing through procurement activity with Invitation to Tender to be published within the coming weeks.		
Recruitment of additional health records staff to standardise the registration practice across three acute sites. Proposal submitted to Planned Care Board, awaiting outcome of future funding.	31/07/2025	Progressing (revised date from 31/11/2024)
Engage with the Estates Rationalisation Programme to secure the future of "fit for purpose" file libraries for legacy paper records. Proposal to move the action due date to September 2025 to align with the records audit cycle. This will help to identify areas of risk, which will include a recent proposal to demolish the Ablett Unit. This will have a significant impact on the Patient Records Service as it stores over 55,000 patient records. This will also impact on patient care and the ability to provide paper records at the point of care if they have to be stored off site. Introductory meeting to be set up with the new Director of Estates and Facilities to raise this matter.	30/09/2025	Progressing (revised date from 30/06/2025)
Following completion of the Baseline assessment of the location of all records, a review and recommendations will be developed and presented Planning, Population Health and Partnerships Committee. Bringing community and acute findings into 1 area report which will then be presented to the West Integrated Health Community Governance Meeting. Due date extended to coincide with the above action and allow the risks associated with each site to be identified.	30/11/2025	Progressing (revised date from 31/08/2025)

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		<16

Position & Intended Outcome for Risk



Organisational wide risk based on potential patient safety and negative impact if the risk were to materialise. In addition, the financial and resource requirement to implement the controls and mitigations required are significant.

CRR 24-08	**Risk Title:** Delivering a Population Health approach to Health and Wellbeing		**Date Opened:** 01/11/2023
	Assuring Committee: Partnerships, People and Population Health Committee (PPHP)		**Date Last Committee Review: add (risk since** revised risk **considerably)**
Date Last Reviewed: 02/04/2025	**Director Lead:** Executive Director of Public Health	**Link to BAF**:	**Target Risk Date:** 31/03/2028

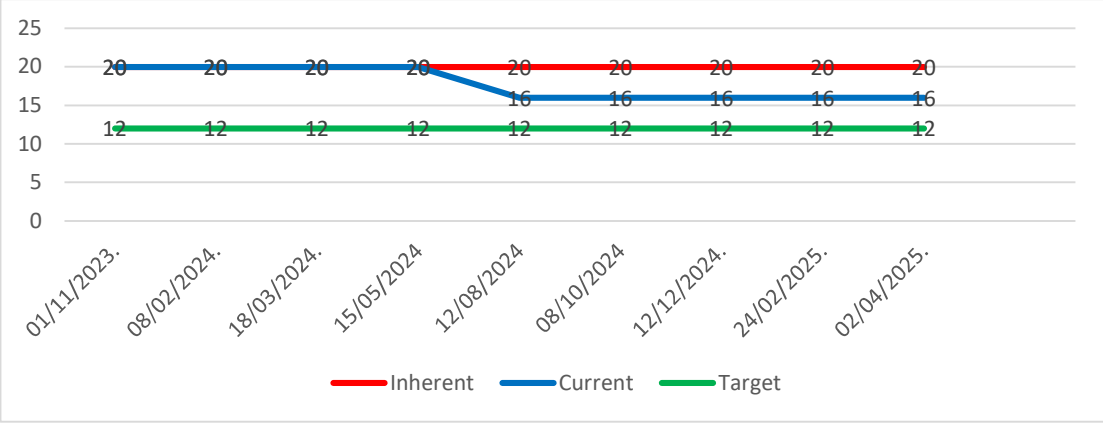
There is a risk that the Health Board fails to implement evidence based pathways and co-designed holistic models of care which focus on prevention and can improve population health outcomes.This may be caused by: a lack of population health intelligence to inform decision making and delivery, an inability to identify and address health inequalities and variation in care, the implementation or continuation of models of care which fail to address population health needs.
This may lead to increased prevalence and worsening health inequalities and variation in largely preventable non-communicable diseases (both individually and as multiple co-morbidities) including: Type 2 Diabetes, Respiratory conditions, Cardiovascular disease, Cancer, Musculoskeletal conditions, mental ill-health and poor wellbeing, alongside increasing rates of infectious disease. Failure to address the risk could potentially lead to avoidable morbidity and mortality within the population of North Wales and increasing pressure on healthcare systems.

Mitigations/Controls in place	Additional Controls required
1. Population Health Executive Delivery Group provides strategic direction ensuring alignment with health priorities and effectively mitigating the risk of misalignment or lack of focus in population health initiatives 2. Consultants in Public Health are linked to delivery of key programmes of work, Public Health Wales, transformation and with IHC areas, providing expertise and guidance. 3. The Diabetes Case for Change provides opportunity to test out the population health focused approach to major conditions. 4. Funding associated with Healthy Weight Healthy Wales which was formerly non-recurrent grants has now been added recurrently to the Health Board core budget. The Weight Management Service review provides an analysis of the current offer to inform a service redesign for 26/27. 5. Prevention and health inequalities form a key part of the Health Board Integrated plan 25-28, ensuring that these critical areas are prioritised and integrated into strategic initiatives to mitigate the risk of neglecting health equity and prevention efforts	a. Clinical services have a clear focus on opportunities for early intervention and prevention identifying the resources required to deliver interventions enabling people to live with major conditions. b. Developing primary and community care models to keep people at home for longer, designed with communities c. Develop whole system and system leadership approach to keeping people healthy d. Developing the role of clusters and pan-clusters to lead the development of preventive models of primary and community care e. Improved management of non-acute patients outside of acute settings and better associated controls f. Controls associated with empower people to manage their health and wellbeing, so that they can access the right services at the right time, using approaches including self management and digitally supported care

6. Digital and Public Health Team shared deliverables in relation to progressing linked clinical and population health data. 7. Well North Wales Paper received by Board, outlining the direction for this integral programme approved (Oct 24). This provides a framework for change which supports the reduction of health inequalities in collaboration with partners. 8. Strategic Arts in Health Plan received by Board, approved (Oct 24). This provides clear direction together with partners to support health and wellbeing through the use of arts. 9. Health Protection Corporate Risk CRR24-18 and associated plan. 10. A continuation of non-recurrent grant funds for Smoking and Weight (prevention and early years fund) and also Healthy Schools and Whole School Approach to Mental wellbeing have been confirmed for 25/26. 11. Prevention budget 25/26 enables the development of key areas identified in the programme plans. 12. Core funding identified as part of budget setting 25/26. 13. Key Programmes within Public Health are linked to Health Board Prevention priorities with activity captured on the PMO Portal.	g. Integrated prevention services and community based diagnostics h. Better linkage of data and analysis – whilst we may be able to easily access data in regard to postcodes or age, it is not always easy to identify the groups of people who are likely to most drive specific demands. i. Risk stratification – utilising population health management approaches, develop greater understanding of low, medium and high risk groups on health systems to improve cost effectiveness and quality of provision j. Use of data to ensure we understand impact of services we deliver on different groups in the population - Person level data is required to understand where to prioritise for greatest impact. k. The use of population health data to identify variation in access, experience and healthcare outcomes between different groups and communities l. Recognising that there are similar preventable factors affecting health of the individual across all major conditions (e.g. socio-economic, housing, access) and develop an integrated health improvement offer for the health board and population m. Progress and embed Well North Wales programme – working on collaborative and sustainable models including funding which support holistic approaches to health and wellbeing n. Ensure that we can address the health needs of vulnerable groups and communities by having appropriate health inclusion and service delivery models

Actions	Due Date	Progression Analysis
Deputy Director of Public Health post to be appointed to	31/07/2025	New action
Population Health EDG membership and activity reflects prioritisation of prevention and early intervention within the health board Currently under review	31/0720/25	New action
Health Intelligence Programme - deliverables are met 25/26	31/03/2026	New action
Healthcare Public Health Programme - deliverables are met 25/26	31/03/2026	New action
Health Improvement Programme - deliverables are met 25/26	31/03/2026	New action
Health Inequalities Programme - deliverables are met 25/26	31/03/2026	New action
Health Protection Programme - deliverables are met 25/26	31/03/2026	New action
Ministerial priority – Vaccination and Immunisations performance targets 25/26	31/03/2026	New action
Ministerial priority - % Diabetes patients 12+ who receive 8 Care processes 25/26	31/03/2026	New action
Commence change programme Diabetes – 25/26 Case for change report – April 2025 which outline options	31/07/2025	New action
Weight Management Service review – A plan to implement changes Review is in progress	30/09/2025	New action
Health Board population health needs assessment	30/09/2025	New action
The revised/new Health Board Strategy establishes the health board position and activities which will happen to shift to prevention – population health profile	31/03/2026	New action
IHC Plans (as part of the Health Board 3-year plan) 25/26-27/28 evidence response to the IHC Population Health data packs and deliverables. BCU Planning Framework has now been approved. The BCUHB draft 3 year plan December 2024 acknowledges Prevention as a key theme.	31/03/2025	Completed

A review of the impact of specific preventative services has commenced. This action will be closed given the inclusion in Health Board plan, however new actions added below which reflect further activity to respond to the risk.	31/03/2025	Completed
Health Board Annual Plan / 3 year milestones and associated activity. The Health Board plan approved for 24-27 reflects prevention priorities and deliverables. BCU Planning Framework has now been approved. BCUHB Plan December 2024 evidence Prevention as a key cross cutting theme. Delivery Plan reflects actions to address the risk.	31/03/2025	Completed
Executive Director of Public Health will agree the Prevention Priorities and Prevention Deliverables as part of the BCUHB Plan development 25-28, as the identified Executive lead – which contribute to delivery of the Health Board 5 Strategic Objectives. Draft deliverables have been submitted and approved by the Executive Director of Public Health. Delivery Plan reflects actions to address the risk.	31/03/2025	Completed
The Public Health Team will carry out a review of existing programmes of work and agree Directorate priorities 25/26.Programmes of work have been agreed and included in the health board plan 25-28. Supporting infrastructure is now being developed to ensure delivery.	31/03/2025	Completed
Programme plans developed for Health Protection, Health Improvement, Health Inequalities and Healthcare Public Health which contribute to the additional controls required.Programme Plans have been uploaded to the PMO Portal.	31/03/2025	Completed



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

	Life expectancy / healthy life expectancy is declining, and there are worsening health inequalities. This has significant impact on demand for services and potentially on the wider community due to the loss of people from the workforce, and through the subsequent economic impacts on our communities. Worsening health outcomes, increasing ill health and widening inequalities directly affects the Health Board's ability and capacity to deliver excellent healthcare services, meaning the Health Board's purpose must retain clear focus on prevention and early intervention to improve the health and wellbeing of the population

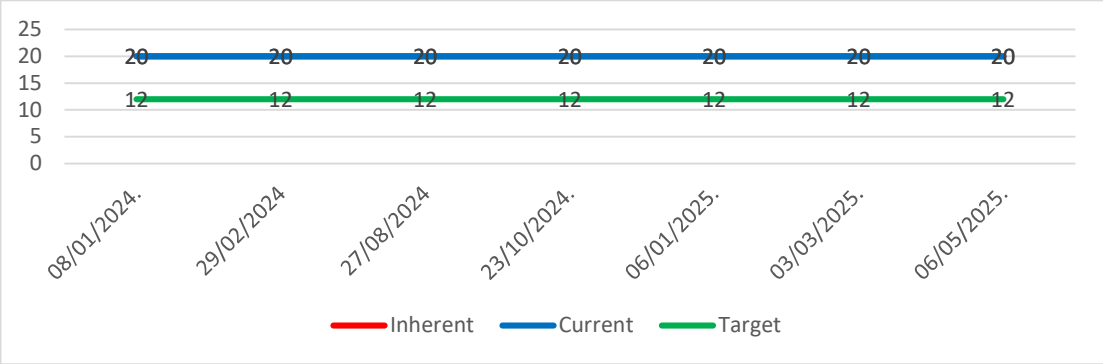
CRR 24-09	**Risk Title:** Primary Care		**Date Opened:** 08/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 06/05/2025	**Director Lead:** Executive Director Transformation and Strategic Planning	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2026

There is a risk that the Health Board's ability to meet its statutory obligation to provide primary care services will be impacted by growing patient demand, workforce and financial pressures. This could be caused by financial pressures due to factors such as rising operational costs and insufficient funding. This could lead to ineffective or failing primary care function would increase the likelihood of declining population health, poor service performance, regulatory non-compliance, poor staff morale and an increase in activity in other parts of the system such as emergency departments.

Mitigations/Controls in place	Additional Controls required
1. Primary Care Board established in 2024 to ensure executive oversight of services. 2. Primary Care sub groups established in 2024 that focus on specific key elements of service overview including governance and quality, workforce and contracting. 3. Primary care team working closely with national team to deliver Strategic Programme for Primary Care (SPPC) in North Wales Focuses on elements including Accelerated Cluster Development, Pan-Cluster Planning Groups, Primary Care Professional collaboratives and the Primary Care Academies. 4. Established Cluster and Collaborative governance framework, with leads across the 14 cluster areas in BCU, 5. Pan Cluster Planning Groups (PCPGs) are now in place across each IHC in the Health Board, and are supported by the Local Authorities and Public Health.	a. Primary care plan needed to set out long term strategy for services b. Programme management approach needed to monitor and drive strategic and operational priorities. c. Consistent approach to managing primary care services across BCU is needed. Currently most services are managed at an IHC level. d. A clear governance framework is needed for each primary care service that will ultimately feed into the Primary Care Board. This will allow risk and other areas of assurance to be discussed and monitored. e. Developing stronger working relationships with internal and external stakeholders in order to optimise the management of services and patient flow in the wider system

Actions	Due Date	Progression Analysis
Primary Care strategic plan	30/06/2025	Progressing

A plan needs to be created that looks at all areas of primary care, and describes what the long term strategy is and how it will be delivered.		
Implementation of recommendations from the National Strategic Programme for Primary Care. Workshop planned to review the recommendations and programme of work for 24/25 in April	30/06/2025	Progressing (revised date from 30/06/2024)
Primary Care Academy to utilise SPPC monies to further progress multi-professional working. Work ongoing to develop local health board response to the national strategy and year 1 priorities as set out by HEIW/SPPC.	30/06/2025	Progressing (revised date from 31/12/2024)
A review of cluster monies spends to allow introduction of new roles, ways of working and models of service delivery	30/06/2025	Progressing (revised date from 31/12/2024)
Deep dive / diagnostic into general dental and community dental services Report is with Executives for consideration	30/06/2025	Progressing
Ongoing review of current risk actions to be updated as per annual plan once finalised.	30/06/2025	New action



N.B. Inherent and Current score lines stacked as both are 20.

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		<16

Position & Intended Outcome for Risk

This risk sits across all primary care services within BCU. The risk of having an ineffective or failing primary care function would increase the likelihood of declining population health, poor service performance, regulatory non-compliance, poor staff morale and an increase in activity in other parts of the system such as emergency departments.

CRR 24-10	**Risk Title:** Urgent and Emergency Care (UEC)		**Date Opened:** 26/02/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 06/05/2025
Date Last Reviewed: 02/05/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**: BAF24-07	**Target Risk Date:** 30/06/2026

There is a risk of mortality in relation to **critically ill** patients being seen in a **timely** manner through unscheduled **care** routes. This may be caused by delayed dispatching of ambulances, ambulance queues at emergency departments, Out of Hours access and Emergency Departments (ED) and Urgent Treatment Centres (UTCs) being at capacity. This could impact on pressures for other services, reputation and litigation implications.

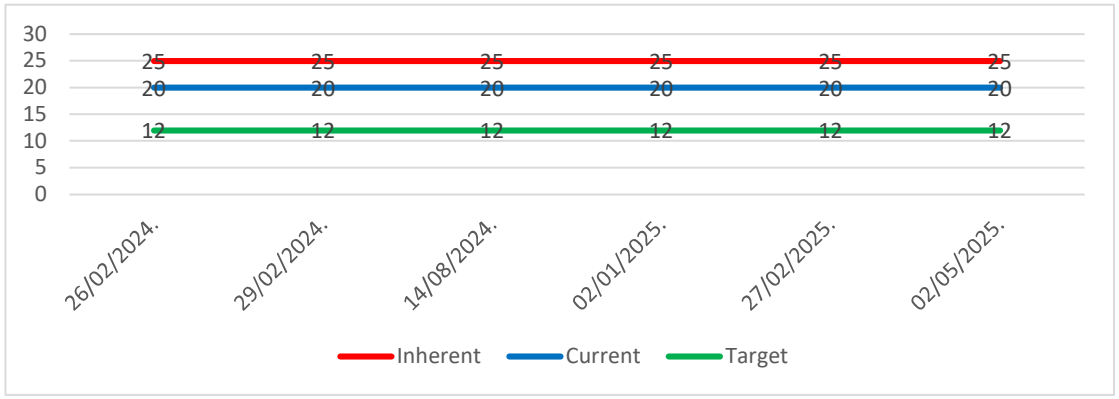
Mitigations/Controls in place	Additional Controls required
1. System resilience hub introduced in December to ensure consistent approach to daily resilience calls BCUHB wide focused on prevention of and mitigating actions in response to reducing delays already in the system. Hospital full protocols reviewed and updated to support rapid de-escalation during peak periods of demand. Winter resilience plan, and festive period plans, developed to manage whole system pressures. 2. Ambulance handover guidance shared and utilised as part of the system resilience calls. Ambulance escalation process to support peak periods of demand. 3. UEC programme governance and reporting structure realigned into 4 workstreams (brings together all relevant improvement projects into a single improvement programme). 4. Workstream 1 focused on the community wrap around care ensuring that care, wherever safe to do so, is delivered closer or at home to avoid unnecessary conveyance and admission. 5. Single Integrated Clinical Advice Triage (SICAT) and GPOOHs services working together to provide 24/7 model across North Wales. Health Care Professional line available alongside review of the ambulance stack to avoid long waits. 6. Workstream 2 focused on providing direct access to services as a safe alternatives to Emergency Departments (EDs) 7. EDs working to the All-Wales ED quality statement; Same Day Emergency Care (SDEC) services at all acute sites for those emergency admissions that would have had an overnight stay to be	a. A number of key roles within the UEC Improvement Programme remain as temporary / secondments and this will impact on the inability to drive the required system change. b. Fragility and gaps in social care assessment, delivery and social care market provision (including both domiciliary care and independent care home sector) resulting in substantial delays and patients being stranded in community hospitals and out of county beds. c. Trusted assessors development, ongoing work for the last 18 months, support required to progress at pace.

managed and discharged home the same day. Direct access to SDEC is available to health care professionals including Primary Care, 111 and WAST. 8. Workstream 3 in place improving patient flow and therefore reducing overcrowding in EDs and subsequent ambulance handover delays at the front door 9. Optimal Hospital Flow framework (OHFF) supported by daily board rounds to ensure every day is a green or value added day for the individual thereby avoiding delays in the patient pathway and reducing the time spent in hospital and deconditioning. Two OHFF facilitators commenced January 2025 through funding secured from national Six Goals programme to deliver training to front line staff. 10. Regular reviews of long stay patients in acute & community hospitals to reduce average length of stay. 11. Workstream 4 in place (continuous focus on reducing delays for health and social care reasons including complex care management, fast track cases and implementation of a home first ethos). 12. Review of Complex Care arrangements in place to improve system improvements and to reduce delays, managed each IHC's Clinically optimised weekly meetings. 13. Discharge Improvement meetings across 3 x IHCs with membership from local authority partners, in place as real time feedback, ensure lessons learnt and build trust across organisations. 14. Trusted Assessors (in 4 areas) reducing time for assessment. 15. Workstreams are all in place focused on key areas within the patient pathway, with reporting of progress through the UEC programme structure and operational delivery groups at IHC level.	d. Get it Right First Time (GIRFT)/SEDIT reports to support demand management across North Wales need to be implemented through workstream 1 delivered by IHC operational teams e. All audit reports need to be reviewed to ensure all recommendations have been implemented and learning shared.

Actions	Due Date	Progression Analysis
Review of all outstanding audit, Get It Right First Time (GIRFT) and Health Inspectorate Wales (HIW) reports to ensure that actions plans are captured and any outstanding actions delivered within the relevant workstreams and lessons learnt used to inform sustained improvement. Reports are being reviewed along with NHS Executive reports. A process is being established to ensure that all audit reports relating to UEC are managed through one central point to ensure recommendations are implemented and learning is shared. Improvement actions will sit within the relevant workstream. Recommendations from GIRFT and discharge audit reports reviewed and completed. Awaiting key audit reports from NHS Executive; SDEC and front door improvements audit undertaken January 2025 and ambulance handover process undertaken March 2025.	30/06/2025	Progressing (revised date from 31/03/2025)

Annual plan narrative for 25/26 delivery drafted, awaiting planning guidance for 25/26, dues 23rd December 2024, to ensure that annual plan for UEC and subsequent workstream plans are aligned to the ministerial priorities for 25/26 and the de-escalation framework. Ministerial templates utilising planning guidance, which incorporates the national 6 goals planning framework, completed and out for review. Annual plan narrative to be reviewed to ensure alignment with changes in the planning framework. Draft 6 goals plan developed based on the above and submitted for feedback. UEC trajectories developed aligned to Ministerial Priorities, 6 goals expectations and de-escalation measures. UEC narrative for IMTP, annual plan and cabinet Secretary expectations all completed including trajectories against key performance indicators.	31/03/2025	Completed
As part of workstream 4 a rapid improvement cycle 'Recovering What matters' was completed in February 2025. This focused on ensuring all patients D2RA pathway, PDD were in place within 24 hours and themes of constraints for complex patients were identified and escalated within the same day with LA colleagues. The final evaluation report is being completed and recommendations will be taken forward as part of workstream 4 to ensure that discharge pathways are efficient and the correct process/protocols in place for escalation when required.	31/06/2025	Progressing
New model for Single Point of Access to be developed through workstream 1 with implementation to be undertaken and supporting alternative pathways	30/06/2025	Progressing
Implementation of the acute front door frailty framework will be managed through workstream 2 focused on adopting Home First same day emergency care (SDEC) principles for tor this cohort wherever possible with short stay acute units where an inpatient stay is required. This will be direct access for health care professionals reducing overcrowding and waits in ED for this cohort and reducing length of stay by adopting a targeted approach	31/03/2026	New action

	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	3	12



Risk Appetite	Quality	<16

Position & Intended Outcome for Risk

The number of Prevention of Future Death (PFD) / Regulation 28 Notices issued to BCUHB since February 2023 currently stands at 32.The Health Board saw a large number issued in 2023/24 (23) which was a significant outlier compared to previous years and other NHS Wales bodies. However, 5 were received in 2024/25 (to date), a significant reduction compared to the number issued in same period of the prior year and more in-line with the average of previous years and other NHS Wales bodies. 9 cases directly related to the impact of delays in the health and social care system on the timeliness of responses by the Welsh Ambulance Service. Goal to be in line with WG targets.

CRR 24-11	**Risk Title:** Planned Care		**Date Opened:** 04/12/2023
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 25/06/2025
Date Last Reviewed: 18/07/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**: BAF24-07	**Target Risk Date:** 31/12/2025 (interim review)

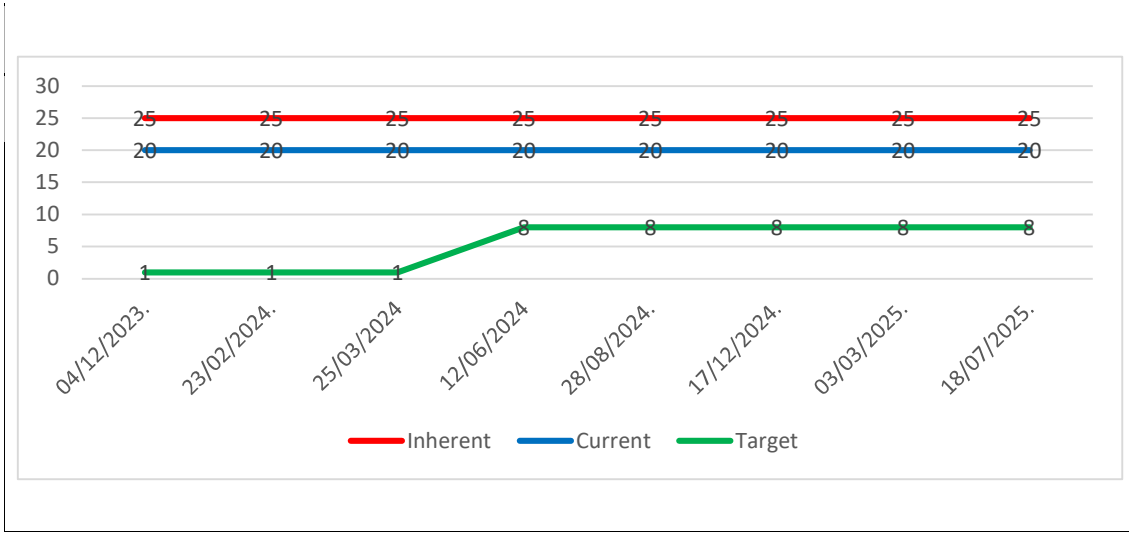
As a result of insufficient **capacity**, staffing shortages, increasing demand, and backlogs exacerbated by COVID, there is a risk of **long waits and delays** for planned care, which may lead to worsening patient outcomes and experiences, including avoidable harm, or the need for more complex treatment in relation to planned care services. It may also lead to a failure to meet national access targets, which may cause financial penalties for target breaches, and reputational damage.

Mitigations/Controls in place	Additional Controls required
1. Routine prioritisation of patients by clinical risk according to national Referral to Treatment Time (RTT) guidance (Cancer > Urgent > Routine) 2. Board level deployment and activity plan to reduce the number of longest waits 3. Twice-weekly performance monitoring at executive level against activity targets 4. Additional capacity (insource and outsource provision) to increase capacity 5. Clerical and clinical validation of waiting lists 6. Validation of patient treatment 7. Central booking team to ensure maximum utilisation of clinic and theatre lists 8. Executive-led major change programme to ensure sustainable improvements in planned care delivery	a. Performance dashboard monitored at pathway and Board level, to review activity and to provide oversight of the major change programme b. Monitoring of productivity and clinic/theatre utilisation at IHC and corporate levels c. Monitoring of allocation of clinical resources d. Clinical and operational accountability at a pathway, service and portfolio level

Actions	Due Date	Progression Analysis
Recruiting clinical leads and project management capacity to support clinically led specialty programmes of work in order to secure successful design and delivery of sustainable models of care	30/06/2025	Completed

Procurement for insourcing for endoscopy and diagnostics Insourcing endoscopy business case approval at Executive Team	01/11/2024	Completed
Ensure completion of demand and capacity analysis to inform forward looking activity and produce mitigations for shortfalls. Demand and capacity plan (in progress) completed to inform specialty level position for 2025/26 and targeted support where shortfalls identified	31/03/2025	Completed
Process to minimise escalation into elective capacity through UEC improvement programme. Monitoring and escalated impact on elective care will be BAU.	31/01/2025	Completed
Ensure specialty plans reflect sustained additional capacity to the existing baseline aligned to the demand and capacity outputs for 2025/26.	30/06/2025	Completed
Delivery of Planned Care Major Change programme, to include 1. Review of clinical pathways, including interventions not normally undertaken (INNU), and criteria for follow-up care 2. Review of referral and triage pathways, including access to advice and guidance 3. Review of capability and capacity against demand modelling 4. Clinically led development of sustainable service models to secure long term safe quality provision 5. Implementation of Get it Right First Time (GiRFT) and wider recommendations from service review processes (including from Clinical Implementation networks nationally) 6. Application of GiRFT and other performance improvement approaches (monitor progress of implementation via planned care board and performance outputs via access). 7. Development of performance dashboard to enable local, service and Board level monitoring		Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	2	8



Risk Appetite	Quality	<16

Position & Intended Outcome for Risk

RTT 52 week waits stage one - NHS Wales Performance Framework 2024-25 Target = 0. Current positions RTT >52 Stage 1 – 27,880 (unbooked)

RTT 104 week waits all stages - NHS Wales Performance Framework 2024-25 Target 0. Current positions RTT 104 all Stages -11,993 (9,706 over 104w +1,198 over 156w + 10 over 208w – unbooked position) To achieve this within 12 months would mean in the order of an additional 2,417 cases per month, at least 1,459 of which would be stage ones.

RTT 52 week waits all stages - NHS Wales Performance Framework 2024-25 Target 0 by 30.06.2025 Follow up backlog 100% overdue - Target reduction compared to same month last year. East has a bigger share of stage ones over 52w by 2k so there is room to make the pan-BCU list more equitable. Continue to prioritise eliminating 156 or 208 weeks as early in the new financial year as possible.

CRR 24-13	**Risk Title:** Timely Diagnostics		**Date Opened:** 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 28/04/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/12/2025

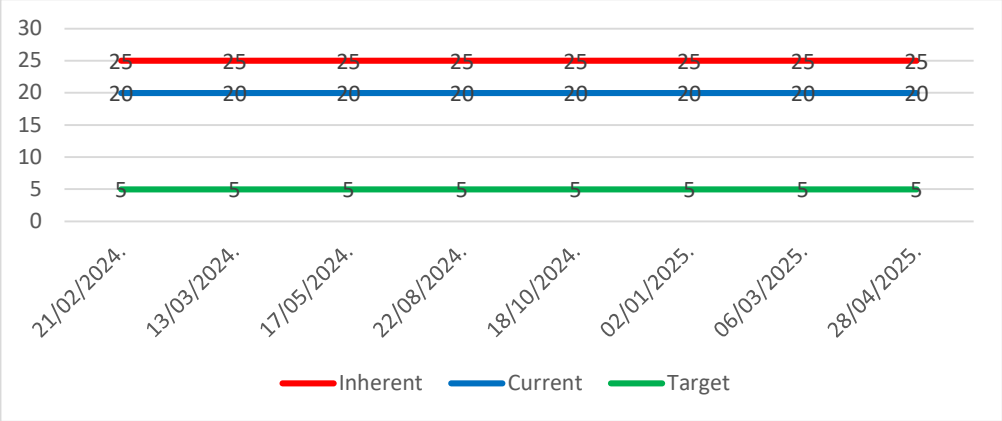
There is a risk of delay in diagnostics, service failure, poor performance or disruption to **radiology**, **pathology and other diagnostic** services across BCU. This could be caused by shortages of specialist staff, aging or inadequate IT systems and infrastructure, and insufficient governance structures. The impacts may include delays in diagnosis, treatment and discharge, increased outsourcing costs, patient harm events, preventable deaths, regulatory non-compliance, and significant reputational damage. There is also additional risk related to clinicians failing to act on results of diagnostic tests leading to patient harm and increased litigation

Mitigations/Controls in place	Additional Controls required
1. Insourcing of CT, MRI and ultrasound to deliver required capacity 2. Significant guidance and steer with National Imaging Programme workforce work. 3. Outsourcing of radiology reporting to maintain Welsh government turnaround times 4. Waiting list & capacity and demand management is in place to monitor radiology required resources. 5. New all Wales contract with Everlight from 1st November 2024 to maintain provision of radiology reporting 6. Active participation by pathology in the nation pathology programme 7. Diagnostic services have well embedded QMS (Quality Management System) systems for accreditation and regulation. Supporting the BCU QMS development with knowledge and learning 8. Endoscopy insourcing 9. OBC for PETCT/Nuclear Medicine consolidation approved by board and submitted to WG	a. Replacement of Radiology Informatics System (RISP) – implementation underway go live delayed till July 2025 b. Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally c. Radiology workforce model not suitable for meeting the current demands being placed on the service from both clinical activity and supporting activity required to deliver service e.g. governance, regulatory and accreditation requirements d. Escalate to BCU Clinical Effectiveness Group – issues around failure to act. Procedure MD (Office of the Medical Director) 23 – 'Mitigation of the risk of failure to act on diagnostic results' needs updating which is being led by the Executive medical director. Discussions held with OMD and a plan is being put in place for a task and finish group to update procedure MD23 - Revision drafted and almost ready for wider consultation e. PHW Collaborative Executive group. f. Diagnostic Strategy for BCU needs to be developed g. Work commenced on new radiology staffing model for the identification of significant restructuring of the service with succession planning, career development, staff wellbeing etc.

10. Establish Diagnostics PTL group(s) from April 2025 to monitor performance across all diagnostic areas including all physiological measurement services	h. Complete demand and capacity reviews across diagnostic services to identify improvement plans i. Progression the development of the medical illustration service to support the teledermoscopy service j. Complete estates reviews for all diagnostic services, with prioritisation and progression of identified improvement projects k. Progression of Regional Diagnostics Hub project within the Planned Care Programme l. Progression of diagnostic business cases e.g. Endoscopy, Nuclear Medicine / PET-CT and Digital Cellular Pathology business cases m. Identify capacity for work focused on transformational change including opportunities for AI

Actions	Due Date	Progression Analysis
Replacement of Radiology Informatics System (RISP) – implementation with anticipated go live date of the 19/05/2025. Delayed till July 2025	01/07/2025	Progressing (revised date from 14/04/2025)
Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally	30/09/2025	Progressing
Procedure MD23 (Mitigation of the risk of failure to act on diagnostic results) to be updated	31/12/2025	Progressing
National Digital Cellular Pathology Business justification case for scrutiny / approval at Board and relevant committees	31/07/2025	New action
Radiology workforce revised model to be developed by June 2025	30/06/2025	Progressing
Diagnostic Strategy to be developed by diagnostic group	30/06/2025	Progressing (Revised date from 30/09/2024)

Escalate failure to act risks to CEG	31/03/2025	Overdue



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	5	1	5
Risk Appetite	Quality		<16

Position & Intended Outcome for Risk

Increasing demand for both radiology and pathology and other diagnostic services. Outdated IT infrastructure in both Radiology and Pathology that carry significant clinical and operational risks. – National programmes in place to resolve these issues. Additional work required to mitigate the risks from failure to act and update procedure MD23. Waiting lists longer than the national targets which results in delay in diagnosis which results in harm to patients. In addition, staffing stress related to demand in the service leading to burn out. 31st January 6,801 diagnostic waits over 8 weeks with Endoscopy (2,163) and Cardiology (1,552) being the largest. Endoscopy capacity at most risk as the insourcing into Wrexham stopped as of 1st April 2024. Demand in radiology continues to increase.
MDT demand in terms of numbers of patients on an MDT is at unsafe levels. Workforce and organisation development have escalated risks within DSCSS about the health and wellbeing of the radiology senior team due to the number of competing priorities and the unsustainable amount of TOIL being accrued and unable to be taken by radiology SMT to manage the higher number of major projects and the operational delivery

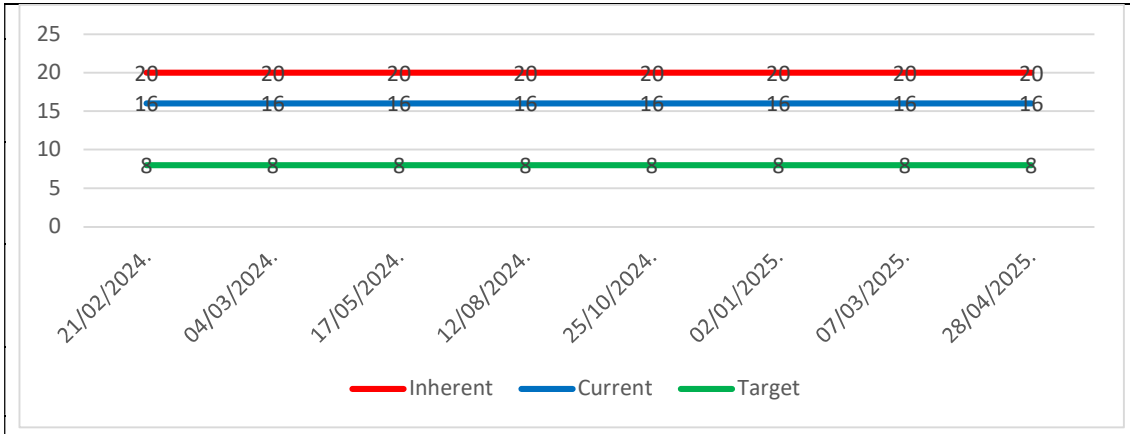
CRR 24-14	**Risk Title:** Harm from the Medical Devices/Equipment		**Date Opened:** 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 28/04/2025	**Director Lead:** Executive Director of Allied Health Professions & Health Science	**Link to BAF**: BAF 24-07	**Target Risk Date:** 31/03/2026

There is a risk of harm and infection from aging, **unsuitable** or unreliable **medical equipment** and devices. This could be caused by equipment breakdowns, **lack of replacement funding**, ineffective cleaning and **decontamination**, insufficient **staff training**, improper use and poor traceability. The impacts may include inability to deliver essential services, delays in diagnostic and treatment leading to incidents and poor patient outcomes, increased costs and reputational damage.

Mitigations/Controls in place	Additional Controls required
1. Medical Devices Governance and Assurance Group leads on selection and procurement, processes and procedures of significance, learning from incidents, safety communications and risk management of medical devices. 2. Annual capital planning process reflects known priorities taking account of key pieces of equipment due for replacement with a risk assessment that support the overall outcome. 3. Scrutiny and assessment of the capital programme at Capital Programme Management Team (CPMT) and Capital Investment Group (CIG). 4. Welsh Government Capital review meeting to escalate and discuss potential risks and requirements for key medical equipment e.g. Linac. 5. An effective medical devices management system is utilised through Electric Biomedical Engineer Department (EBMD)	a. Internal risk assessment and priorities are flagged in the context of fully depreciated equipment (£34.659m) to understand priorities and potential risks. b. Lack of medical device training and good governance of safety of equipment has been lacking and documented as a risk since 2016. c. Robust risk assessments of how often certain equipment breaks down, the scale of difficulty sourcing spare parts to be considered for included in requests for capital replacement to be taken forward as part of the 26/27 submission for capital bids. d. The number of capital bids not approved now exceeding circa £30million in capital and resources required. Backlog of equipment beyond end of life, some 10 years+. SBAR submitted to Executive Director AHPS and Health Science for escalation to Executive team.

6. EBMD uses the management system to monitor the condition and performance of medical devices including device failures and issues; utilisation, performance, maintenance; repair and calibration history. 7. Audits on affected equipment in line with regulatory compliance completed. 8. Radiology fully engaged with the National Imaging Capital Equipment Group peer review programme. 9. External links with National Imaging and Pathology Diagnostic Programmes are documented and appropriately reported through correct channels to ensure transparency and potential benchmarking. 10. Working group assessing compliance with the Medical Devices Regulations and confirm governance arrangements for medical devices 11. Head of Clinical engineering appointed to oversee medical devices work 12. SES announced £30K for 25/26 for replacement of imaging equipment and also BCU Linac. The current round of the National Imaging Capital Equipment programme peer review took place in April BCU fully participating in this process 13. Start date of Head of Clinical Engineering agreed	e. Medical Device regulations work ongoing – see additional risk ID 5282 'Medical Devices Regulations 2002(SI 2002 No 618, as amended) (UK MDR 2002) compliance'. External review completed. Workplan now needs to be developed following review of current preparedness f. Review of the local medical devices groups governance and membership

Actions	Due Date	Progression Analysis
CPMT and CIG to review annual planning process to ensure risk scoring to inform prioritisation	31/03/2025	Progressing (Revised from 31/03/2024)
Directorate teams to review their medical devices capital replacement plans to ensure all services have a medical device replacement programme in place. Directorate teams are linking with Capital to update their replacement plans.	31/03/2025	Progressing (Revised from 31/09/2024)
Long term management plans with equipment, regulation and compliance and discussions around improving governance	30/06/2025	Progressing
Audit of Medical Devices readiness of services to be completed	30/06/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Open		<16

Position & Intended Outcome for Risk

Significant capital funding required, robust controls and governance required to ensure safety of equipment, £33M represents the value of capital medical equipment which is fully depreciated and at end of life. Intended outcome to ensure compliance and any gaps in medical device regulation supported by robust process for medical equipment capital replacement.

CRR24-15	**Risk Title:** Health and Safety		**Date Opened:** 01/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 10/04/2025
Date Last Reviewed: 08/05/2025	**Director Lead:** Director of Environment and Estates	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2026

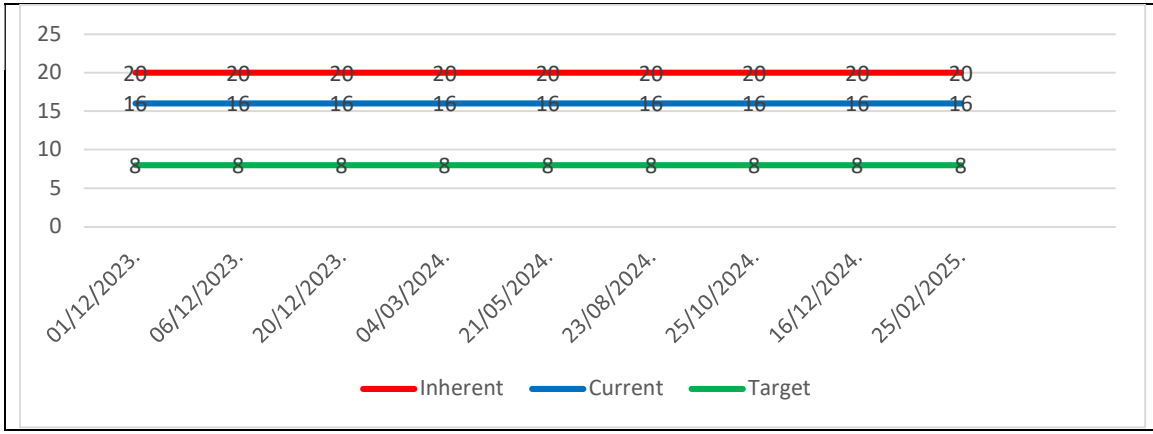
There is a risk of avoidable harm to patients and staff. This may be a failure of the Health Board to provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation due to the lack of Health and Safety Leadership. The impact is patient and staff harm, financial implications, and reputational impact to the Health Board.

Mitigations/Controls in place	Additional Controls required
1. Three-year Occupational Health, Safety and Security strategy. 2. Health and Safety Policies report into the Strategic Occupational Health & Safety Group (SOSHG). 3. Health and Safety eLearning and short courses in place. 4. Gap Analysis has been reviewed. Strategy and plan to March 2026. 5. Health and Safety Policies and Procedures are on BetsiNet. 6. Programme of Health and Safety Reviews are in place. 7. Programme of Health and Safety Self-Assessments are in place for completion twice yearly. 8. Health and Safety presentation delivered to Board members in February 2025, to raise awareness of requirements.	a. NHS Employer Health and Safety Standards are being developed b. A review of resources required following the internal audit. c. BCUHB Executive Team and Board of Directors to complete health and safety training. d. The business model aligned to the NHS Manual Handling Passport Scheme to be reviewed e. Investment in training venues is required for manual handling training delivery. f. Senior Leaders to nominate staff to support with Divisional delivery of manual handling refresher training. g. Review of health and safety policies within the next 12-24 months. h. A Health and Safety Risk Assessment and Management Framework needs developing. i. A pan BCUHB Health, Safety and Security Training Needs Analysis is required. j. Utilise the Violence Prevention and Reduction Standards to provide a framework for a safer environment. k. Intranet pages for Health, Safety and Security Services require development.

Actions	Due Date	Progression Analysis

A new approach is required supplemented by a clear strategy and framework.	31/12/2025	Progressing (Revised date from 31/12/2024)
The Health and Safety Policies and procedures require a review. Compliance spreadsheet included in the SOSHG Agenda.	31/03/2025	Complete
In-house security service model not being pursued. 22/01/2025: Extension of current Security SLA and Technical specification awaiting sign off.	31/07/2025	Progressing (Revised date from 31/12/2024)
Health and Safety presentation to be arranged for the Board. Presentation delivered on the 27/02/2025.	31/03/2025	Complete
Updated strategy and plan developed with key service objectives identified to March 2026.	31/12/2025	Progressing (Revised date from 31/12/2024)
A process to monitor and review department self-assessments is under development and will be issued in readiness for the April Self-Assessment Cycle.	31/12/2025	Progressing (Revised date from 31/12/2024)
A review of resources within the Health, Safety and Security Service is required following the internal audit findings.22/01/2025: Structure reviewed and remodelled. A business case to be developed. Target date extended. Newly appointed Director of Environment and Estates now manages HS&S Service and review will potentially include whole service.	31/12/2025	Progressing (Revised date from 31/03/2025)
The BCUHB business model aligned to the All-Wales NHS Manual Handling Passport Scheme 2020 to be reviewed. Target date extended. Following meeting with DDoNs and Service Leads, further meetings scheduled to discuss bespoke service requirements. Work is progressing.	31/07/2025	Progressing (Revised date from 31/03/2025)
A Health and Safety Risk Assessment and Management Framework is needed. Work to commence FY 2025/26	31/03/2026	Not Started
An electronic document management system (EDMS) for reporting of health and safety compliance and risk management pan BCUHB. Risk Management software approved. Implementation 2026	01/01/2027	Not Started

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Regulatory		20-25



Position & Intended Outcome for Risk

There is an inherent risk that the failure of Health & Safety management systems could lead to RIDDOR Reportable. Specified Injuries to Workers. Patient mismanagement, long-term effects. Death or significant irreversible harm which will result in prosecution by the Health and Safety Executive consequently leading to loss of reputation and financial penalties. The risk is extenuated by Non-compliance with national standards with significant risk to patients/public. An unacceptable level or quality of treatment/service. Gross failure of patient safety leading. Inquests and Coroners reports. Low staffing level that reduces the service quality. Low staff morale. Poor staff attendance for mandatory/key professional training. Uncertain delivery of key objective/ service due to lack/loss of staff within the Health and Safety team. Structural changes will be implemented in summer 2024, with Health and Safety moving from Workforce Directorate to a new role of Director of Environment, reporting directly to CEO.

CRR 24-16	**Risk Title:** Leadership		**Date Opened:** 07/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 10/04/2025
Date Last Reviewed: 06/05/2025	**Director Lead:** Deputy Director of People & OD	**Link to BAF**:	**Target Risk Date:** 31/03/2026

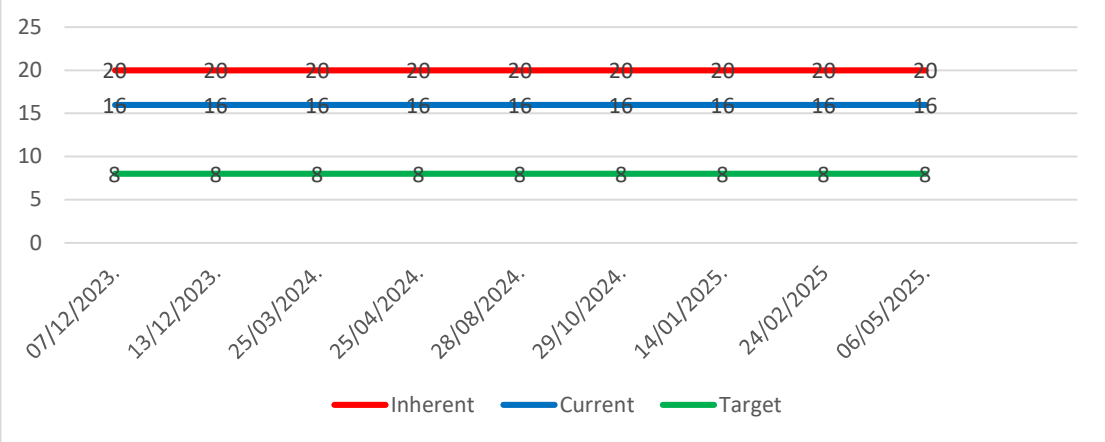
There is a risk of traditional models of leadership which do not define the expectations, values and behaviours of our leaders to transform the organisation. We recognise a compassionate leadership approach supports the delivery of safe and reliable care. This could be caused by inadequate governance arrangement and lack of integrated leadership development pathways across the Health Board. This could have an impact on the sustainability of staffing and subsequently patient care and safety and service delivery.

Mitigations/Controls in place	Additional Controls required
1. Integrated Leadership Development Framework (ILDF) with a set of measurement metrics to assess the ongoing effectiveness of the programme 2. Culture change and Behaviours Framework. 3. Suite of leadership conferences, networking and masterclasses on compassionate, inclusive leadership and engagement. Three conferences have been held so far with over 750 attendees 4. Work associated with this risk which links into the Special Measures Framework now monitored via the governance of the Framework and reported to Executive Team and Board. 5. Full Board now in place and all committees now chaired and attended by full complement of Independent Members 6. Culture change agents in place across the organisation 7. The Board formally signed the NHS Wales' Compassionate Leadership Pledge in September 2024. 8. A compassionate behaviour resources, video co-produced with HEIW. 9. Compassionate leadership modules are now integrated into all leadership and management development programmes. 10. An approved Culture Leadership and Development Plan	a. Further embedding of Integrated Leadership Development Framework. b. Implementation and measurement of compassionate approach to leadership and how to adopt it, aligned with the work on values and behaviours c. Formal Culture Change Plan and accompanying Comms and Engagement plan d. A Behaviours Framework (will be derived from the culture change workstream) e. Appropriately resourced Culture Change programme and realignment of resources within the OD function. f. Extended gaps in Executive Team

11. A reorganised OD team in place to support the delivery of the ILDF and Culture Change programmes	

Actions	Due Date	Progression Analysis
REF Gaps in controls; A, Define the indicators (quantitative and qualitative) that will enable the organisation to measure the on-going effectiveness of the ILDF. Participation scores and feedback mechanisms are now in place for those attending ILDF courses which will help assess the content and course structure. The new Culture BI dashboard, used alongside the People Operations Report, provides a suite of KPIs to monitor the effectiveness of leadership in the organisation. The next step is to confirm the benchmarks for each of our KPIs that will determine the level of risk. Thematic analysis of the participant feedback received on programmes has been undertaken; this style of analysis will be used to inform the programme content for 2025/26. Used in conjunction with the new culture dashboard and related workforce data, the OD team are now well equipped to monitor the impact the ILDF is having ongoing. See point 1 in the mitigation section	31/03/2025	Completed
REF Gaps in controls; A, The ILDF courses and development resources for mid-level management/leadership will be designed and implemented across 2025/26	31/03/2026	Progressing
REF Gaps in controls; A, B, D, A suite of masterclasses and workshops will be launched in Q1 2025/26 which are aimed to give wrap-around support to our leaders across the organisation.	30/06/2025	Progressing
REF Gaps in controls; B & C, A further Leadership conference will be held in Q1; the topic and content is currently being ratified and will be confirmed by March 2025 In light of the three conferences in 2024 and further development of the topics to be covered, the next conference has been pushed back and will be held in the summer 2025.	30/09/2025	Progressing (revised from 31/03/2025)
REF Gaps in controls; E, Alignment of OD resource is still underway. The permanent structure is in place but a number of the non-recurrent posts remain vacant with ongoing discussion regarding funding. It is hoped to have the posts filled by Q1 2025/26. The funding allocation for posts has been completed, this action is closed. See point 11 in the mitigation section	30/06/2025	Completed

Whilst it is not unusual to have a vacant Executive position, there are a small number of posts that have not been filled substantively for some time which may impact the overall scoring of this risk; Executive Director of People & OD – On hold Executive Director of Finance – Post filled Executive Medical Director – Interview May 25	30/05/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Reputational		20-25

Position & Intended Outcome for Risk

KPIs to that inform our risk in this area as at April 2025;

Staff retention is 90.6% In April 2025 compared to 90.2% last year.

PADR compliance showed improvement increasing to 9.6%

The number of Grievance cases has dropped in the previous three months to 3, from a spike of 17 in July 2024.

The percentage of stress & anxiety absences remains high at 1.6% although has dropped 0.2% since January. Avoidable turnover has dropped from 5.9% to 4.5% compared to January 2023.

Speak out safely cases have dropped from 9 to 6 since the last report in January 2025

CRR24-18	**Risk Title:** Operational Planning for Transmittable Diseases and Outbreaks - Health Protection		**Date Opened:** 03/04/2024
	Assuring Committee: Planning, Population Health and Partnerships Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 28/04/2025	**Director Lead:** Executive Director of Public Health	**Link to BAF**:	**Target Risk Date:** 31/03/2026
There is a risk that the Health Board does not plan adequately for outbreaks and incidents of communicable disease such as (but not solely) Measles, M.Pox, COVID-19, Pertussis etc.. This may be caused by the unpredictability of when the disease may first occur, the varierty of new and emerging threats, the variations in the nature of the required response to specific diseases, the availability and cost of associated resources (e.g. pharmaceutical products, workforce, estate, contact tracing, sampling, vaccination, communications), the scale of potential outbreaks, the difficulties in protecting specific vulnerable groups and members of staff in a timely way. This could lead to greater exposure of the public and staff members to communicable diseases causing an increase in cases, further transmission, interuption of health board services and in some cases death.			

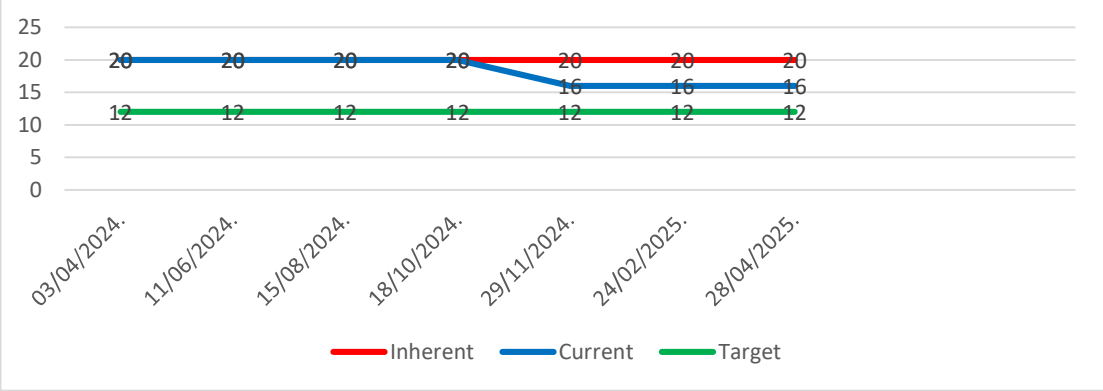
Mitigations/Controls in place	Additional Controls required
1. Health Protection Service established within BCUHB with a clear remit for enhancing the response to incidents and outbreaks in North Wales in accordance with the Communicable Disease Outbreak Control Plan for Wales. 2. Standard Operating Procedures relating to community sampling for specific diseases, including Measles, M pox, Avian Influenza, COVID-19 (although some remain to be developed) 3. Pathways established for response measures to specific diseases, for example, HNIG pathway and vaccination outbreak response for measles. 4. Health Protection Service responsible for the management of COVID-19 incidents in closed settings in North Wales 5. Strong links with Health Protection Partners including Public Health Wales and each of the 6 Local Authority Environmental Health teams.	a) No approved comprehensive procedure/plan in place for the management of communicable disease outbreaks (in and out-of-hours) within BCUHB (and as a result, there is no testing/simulation of approved plans to ensure effectiveness) b) Communicable disease preparedness group identified with a first meeting planned for 29th April 2025. c) Initial discussions begun around exercise Pegasus – to take place in Autumn 2025 d) BCUHB representatives attending exercise Solaris on 30th April, a national multi-agency exercise to test pandemic response arrangements

6. Strong links with the Communicable Disease Surveillance Center to support the monitoring of trends in communicable diseases 7. Multi-agency simulation exercise undertaken in September 2023 in North Wales to test preparedness measures for specific outbreaks. 8. Access to and use of the national Case and Incident Management System: Tarian 9. Significant lessons identified from preparedness activities associated with national increase in Measles cases, leading to the development of tools, assets and pathways that could be adapted for use with other communicable diseases 10. IHC engagement with outbreak planning and preparedness activities highlighted in the IHC packs 24/25 11. Appointment of an EPRR Lead who is able to support with the development of an outbreak plan for the Health Board 12. Additional focus placed on staff (occupational health) vaccinations, with additional support provided for staff influenza and MMR uptake from the Health Protection Service 13. Strategic group established within the Health Board to lead on the development of plans and pathways for the management of suspected and confirmed cases of High Consequence Infectious Diseases (particular focus on Mpox Clade I). Preparedness activities to date include the testing of 'green routes' with the WAST Epi-Shuttle on each acute site, the preparation and testing of IPC guidance and sampling plans, confirmation of appropriate isolation areas on each acute site. and the initiation of preparedness activities within each IHC for the management of suspected and confirmed HCID cases. 14. National multi-agency simulation event to test local preparedness plans and processes for HCID Mpox Clade I – 'Fad Felen' 15. Contributions made to the development of national action cards for HCID cases. 16. NHS Executive audit of HCID preparedness measures identified areas of good practice in relation to highlighting the HCID pathway within primary care	

17. Awareness sessions held with primary care practices across North Wales in December and January to highlight responsibilities for the identification and management of possible HCID cases. 18. Multi-agency training event (PHW, Local Authorities) attended in February 2025 on enteric fevers and the management of food-borne illness. 19. Identification of scope of health-protection medicines to include in a BCUHB communicable disease plan 20. BCUHB are representing other Health Board Health Protection services on a national group to discuss arrangements for health protection medicines.	

Actions	Due Date	Progression Analysis
To establish an operational group within BCUHB for the developing and shaping a communicable disease outbreak management plan The High Consequence Infectious Disease (HCID) group has been officially stood-down but will be reconvened on 29th April 2025 as a Strategic Communicable Disease Preparedness Group. Terms of Reference and membership to be confirmed.	01/05/2025	Progressing (revised date from 01/03/2025)
To prepare a draft copy of a communicable disease outbreak management plan This will extend as Strategic Communicable Disease Preparedness Group will be meeting for the first time on the 29t April 2025.	01/10/2025	Progressing (revised date from 01/12/2024)
To run a simulation exercise across the Health Board to test the functionality and contents of the communicable disease outbreak management plan	01/02/2026	Progressing (revised date from 01/02/2025)
Further revision of the plan following simulation exercises	14/02/2026	Progressing (revised date from 01/04/2025)

Approval and agreement of the communicable disease outbreak management plan with an agreed schedule of simulation events.	31/03/2026	Progressing (revised date from 31/03/2025)



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		15-19

Position & Intended Outcome for Risk

There are a number of unpredictable situations that could arise and would have a potentially significant impact on the population.

CRR 24-19	**Risk Title: Community Care Provision**		**Date Opened:** 01/05/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 15/04/2024	**Director Lead:** Executive Director Transformation and Strategic Planning	**Link to BAF**:	**Target Risk Date:** 31/03/2026

There is a risk that the Health Board may not be able to provide safe, effective and timely care to patients in the community, and the Health Board not fully meeting its obligation to commission and provide accessible and high-quality community care, D2RA, Care Home support services and continuing health care (CHC) services. This may be caused by insufficient provision of care in the community, the fragility of independent providers (domiciliary care and care homes), delays of joint assessments, staffing shortages and gaps in service provision out of hours.
This may also be caused by a lack of investment in services and skill mix development, restrictions in IT systems and communication between different parts of the integrated team. This may lead to unnecessary admissions, delayed transfers of care, increased length of stay in hospital and poorer outcomes for patients, people not receiving end of life care in their place of choice.
There is a risk that we cannot meet current and future requirements set out by the Care Action Committee and requirements within the Ministerial Priorities and enabling actions.

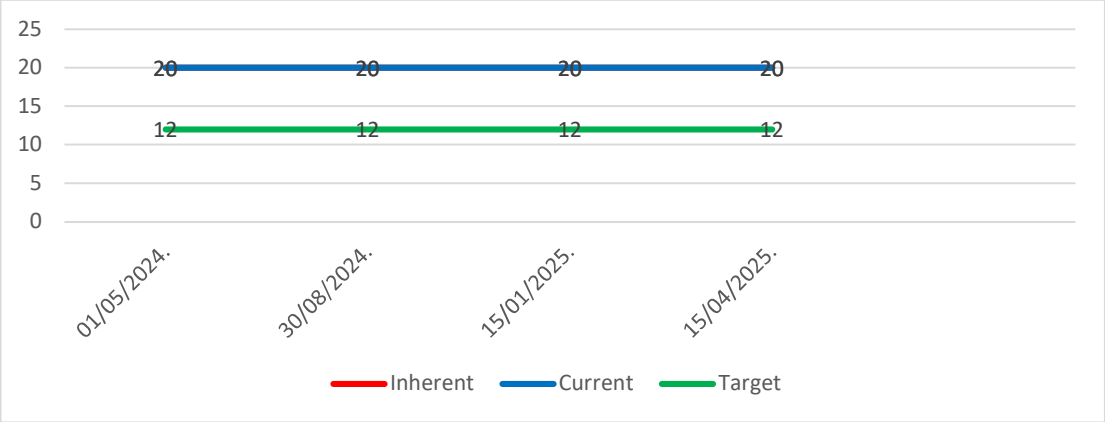
Mitigations/Controls in place	Additional Controls required
6. Daily patient flow meetings including focus on long-stay patients and partnership with Local Authorities 7. Primary Care Board has been established with the first meeting held May 2024, monthly meetings planned moving forwards. Community Care is reporting into the Primary Care Board around this risk. 8. Community Resources Team model bringing together agencies and professionals supporting locality populations.	a. Escalation and sustainability report requires commissioning to address risks associated with workforce and workload pressures allows for early identification and management. b. Programme management to be implemented to monitor and drive strategic priorities. c. Community Care Quality and Delivery Group to be established or investigate feasibility of implementing Community Care reporting to Primary Care Quality and Delivery Group d. Strategy, focus and resources including staff, training and IT to deliver joined up planning, innovation and delivery for place based, integrated prevention, health and care services across NHS/Local Authorities to deliver on place based care and care closer to home. e. Additional Resourcing of CIVICA system (scheduling system for District Nurses), access to EMIS (GP Patient record system) community for teams. Connecting Care Implementation for community services.

9. North Wales care homes single action plan overseen by Regional Commissioning Board and Regional Partnership Board. 10. Care home Quality Assurance Framework and tools in place 11. Established Continuing Healthcare (CHC funding) teams and processes including escalation where delays occur 12. Agreed joint escalation processes with Local Authorities for care homes of concern 13. Greater Health Board oversight of Community Care issues and risks via PPHP Committee with first report to committee during April 2024 with further reporting in June 2024.	f. Financial systems that support transformative systems in line with Primary Care Model for Wales outcome 13. g. Improved joint planning with local Mental Health services. h. Improved planning for access to diagnostics in the community setting i. Community Care and CHC services audits of sustainability matrix ongoing periodically – Programmes to be put in place to undertake the audits j. Equity of resource to support community care and CHC transformation, innovation, management and governance. k. Improved discharge planning and support in line with All Wales good practice guidance, this is being taken forward by UEC workstream 4 l. Implementation of Pathways of Care Regional Action Plan m. Develop surge plans jointly with Local Authorities for winter pressures – did not happen to be progressed again. n. Complete pre-placement agreements with all providers and implement strengthened contract monitoring (Still Draft and currently being reviewed by Legal prior to engagement with providers) o. Undertake 'block purchasing' expressions of interest for specialist care e.g. OPMH

Actions		**Due Date**	**Progression Analysis**
1.	Primary Care Board established.	30/05/2024	Completed
2.	Community Care and CHC strategic plan to be drafted to inform the Health Board strategic plans, including block purchasing of specialist OPMH beds	30/09/2025	Progressing
3.	Escalation process in place for community hospitals, community nursing and Continuing Healthcare.	31/12/2024	Complete
4.	Programme management to be implemented to monitor and drive strategic priorities. Raised through 25/26 Ministerial Template process that programme management approach is required but not in place, a request has been made through the planning process for identified Executive Leadership and Programme Management Resource.	31/05/2025	New action
5.	Community Care and Continuing Healthcare services audits of sustainability matrix ongoing periodically – Audit programme already in place, this is now available to view on IRIS dashboard	31/03/2025	Complete

6.	Equity of resource to support community care and Continuing Healthcare transformation, innovation, management and governance. Value and Sustainability CHC Group established and will finalise priorities for 25/26. Complex, VFM & High Risk CHC panel established. Terms of Reference drafted – will meet fortnightly – focus will be on Packages of Care / Placements > 200k / annum	31/05/2025	New action
7.	Establish a health board group to agree a strategy, vision and aligned resources to deliver joined up planning, innovation and delivery for place based, integrated prevention, health and care services across NHS/Local Authorities to deliver on place based care and care closer to home.	30/06/2025	New action
8.	Joint commissioning plan with Local Authorities to increase domiciliary care capacity Following evaluation panels there is now a list of domiciliary care workers that are able to provide the more complex care. All will go on the new framework that is due to go live April 2025. 97 providers have now been successful and contracts will be issued on 11/3/25	25/04/2025	Completed
9.	Review of community services model and development of business case to address gaps in capacity. Linked to action 4.	31/03/2026	New action
10.	Determine required level of Quality Assurance Framework increased frequency of visits, resource requirement and plans to implement. Final version of SOP for Clinical Quality Support Tools under the QAF is awaiting approval at the next Patient Safety Group on January 28th.	28/02/2025	Complete

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		–<16



Rationale for Corporate Risk

The data on reduced care home placement, number of care homes in escalation due to quality concerns, significant numbers of patients delayed in hospital awaiting domiciliary care and reablement packages, and a current inability to meet Welsh Government unscheduled care targets - all of which indicate risk of harm due to insufficient safe provision in the community. –

Wider impacts resulting in the impacted access to and delivery of Community Care and CHC services is severely impacted and is affecting patient flow through secondary care, Primary care and Emergency/Urgent Service delivery, LA Care provision delivery and exacerbating patients' health conditions.
Recognition of inherent score currently further controls needed.

Lack of adequate investment and provision in domiciliary care.

The Ministerial Priorities referred to - Building Community Capacity.

CRR 24-20	**Risk Title:** Oncology Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 06/05/2025	**Director Lead:** Executive Medical Director	**Link to BAF**:	**Target Risk Date:** 31/03/2026

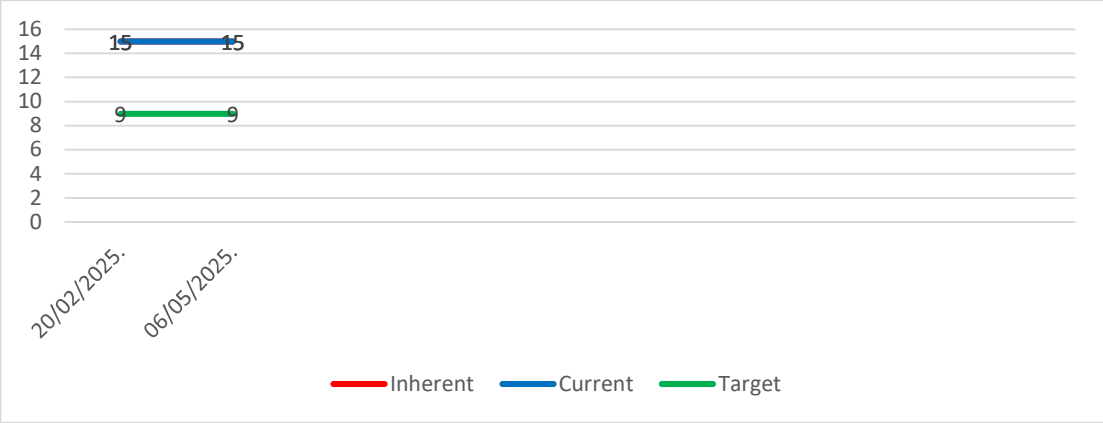
There is a risk that patients may not experience a safe, effective and timely Oncology service provided by the Health Board. This may be caused by reduced substantive medical workforce, demands for oncological care, increasing numbers of NICE approved treatments for cancer, and patients remaining within the service due to ongoing/long term oncological treatment. This could lead to poor patient outcomes, failure to meet Single Cancer Pathway target of 62 days and detrimental impact on the organisations reputation to the public, government and others.

Mitigations/Controls in place	Additional Controls required
1. Medical locums in place to support gaps in substantive provision 2. Escalated requirement to support recruitment of medical oncology trainees within next 12 months 3. Supporting 2 NHS Locums to complete *Certificate of Eligibility of Specialist Registration* (CESR) and additional competencies to be eligible to become substantive in the future. 4. Development plan in place for 2 Senior Clinical Fellows with aim to train them to become substantive Consultants within 2-3 years. 5. Systemic anti-cancer treatment (SACT) Operational group established to improve processes and systems – collaboration with pharmacy. 6. Radiotherapy Oversight meeting established to monitor progress against plan and maintenance of target. 7. Developed extended non-medical nursing roles to support medical gaps including immunotherapy toxicity, cancer of unknown primary and metastatic breast and colorectal services.	a. Remaining substantive medical vacancies unfilled despite active recruitment – in line with national picture of vacancies and report by Royal College of Radiologists for Clinical Oncologists, medical locums use 34% - 50%. b. Lack of available high-quality data to provide robust capacity and demand modelling per tumour site, per clinical/medical oncologist c. Recurrent funding needs to be secured for 7 consultants and a number of temporary nursing and administrative roles (and other elements subject to RIGA) d. Inability to respond effectively to increasing demand for oncological treatments and new NICE-approved regimes e. Home care service is saturated meaning no further treatments can be transferred out of the day units to

8. Developed an extended non-medical radiotherapy role to support prostate cancer patients who require radiotherapy 9. Clinical Leads (Joint role) appointed.	release capacity (this would also release funding as VAT is exempt). f. Lack of physical estate to expand services and/or recruit more staff. g. Outsourcing opportunities for the highest risk tumour sites, remains a gap, further exploration required. h. Gap and lack of clinical oncology trainees with multiple gaps limiting ability to 'grow our own'. i. Collaboration with recruitment agencies to explore overseas consultant opportunities. j. There is an aim to implement nursing staff rotational opportunities to improve cover arrangements and skill mix but this is limited due to vacancies and amount of fixed term funded posts

Actions	**Due Date**	**Progression Analysis**
Establish potential of a joint Consultant Oncologist role with Bangor University A Meeting was held, and the plan is for the university to provide 4 sessions to support a full-time position. Professor-level post agreed with medical school, job description awaiting approval from Royal College – position confirmed	30/08/2025	Progressing (revised date from 30/01/2025)
Complete Planning to repatriate the delivery of Stereotactic Ablative Radiotherapy into the Health Board A letter is being submitted to the JSCC requesting approval to proceed according to the established process commence as per process. JSCC meeting arranged awaiting approval at Executive Leadership Team meeting	30/06/2025	Progressing (revised date from 30/04/2025
Establish potential of undertaking shared recruitment with other cancer centres Discussions need to be initiated to address operational concerns, particularly the high risks associated with specific tumour sites Initial conversations have happened with Clatterbridge but needs further executive to executive conversations – date to complete needs to be extended	30/08/2025	Progressing revised date from 30/04/2025)
Work with informatics to support development of quality data Regular meetings are being held, and training plans are being developed to support correct use of the Welsh Patient Administration System. National queries have been raised regarding the duplication of work with SACT on Chemocare and WPAS, however, it is necessary to establish a secure link between the systems to improve quality and efficiency. Process mapping has been undertaken identifying areas to be resolved. Specific	31/03/2026	Progressing (revised date from 31/03/2025)

Oncology training for managing the waiting list has been undertaken; data quality issues regarding BANO has been resolved as backlog has been agreed to be removed by the 'robot'; plan to improve more data issues has been established for 25/26		



	Impact	Likelihood	Score
Inherent Risk Rating	3	5	15
Current Risk Rating	3	5	15
Target Risk Score	3	3	9
Risk Appetite	Quality		15-19

Position & Intended Outcome for Risk

The combination of multiple factors, *including;*

- the inability to recruit substantially to Senior Medical posts,
- increasing reliability on availability of Locums
- large number of temporary staff, as a result of RIGA and increasing demand for oncological treatments, which has resulted in service gaps which have increased waiting times for patients to be seen and treated.

Delays to commencing treatment will result in significant patient harm and potentially premature death**.** NICE approved regimes indicate optimum time frames and that delay will decrease effectiveness of treatment. In general research has shown that every 4 week delay to commence (any cancer) treatment increases the likelihood of death by 10%. Escalation paper to Executive Lead and Chief Operating Officer indicated waiting times in east and centre were now 6 weeks (Dec 24)

Waiting times to see a Consultant following referral range from 0 to 12 weeks depending on tumour site and clinical priority. The

	aim is to see patients within 2 weeks, so that treatment can commence quickly. This is not reported externally. Extreme risk within gynae, breast and upper GI remain as a result of unavailability of suitable locums and lack of capacity within current staffing. The highest risk is with the availability of a consultant to cover the medical oncology element of care to patients with a gynae cancer in East.

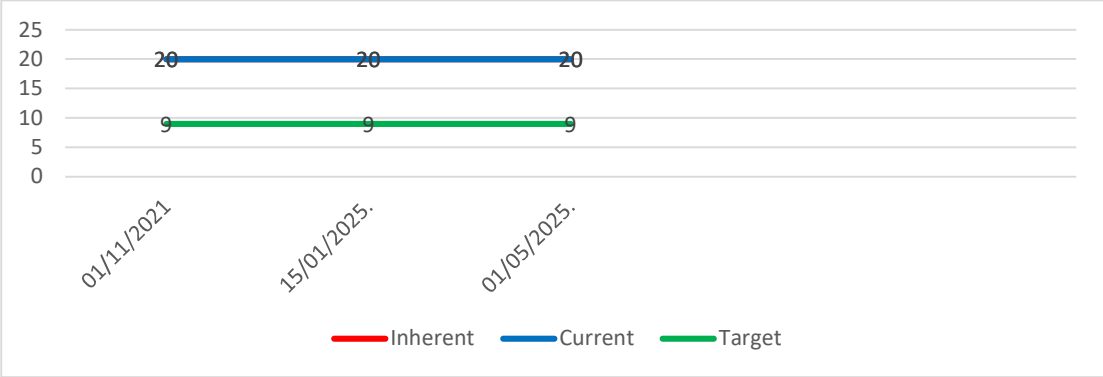
CRR 24-21	**Risk Title:** Ophthalmology Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 01/05/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**: BAF24-07	**Target Risk Date:** 31/12/2025

There is a risk that patients may come to harm casued by the lack of a sustainable service model, unmanaged demands and the current capacity not being able to meet incoming demands. This could lead to, and result in, increased waiting lists and an increased risk of harm including irreversible sight loss, and litigattion due to prolonged wait times.

Mitigations/Controls in place	Additional Controls required
1. Train and Treat initiative in place to increase the number of procedures that can be done in a community/high street optometry setting. Train and Treat embedded and successfully expanded to two site delivery (Deeside Glaucoma and Holywell Hospital Independent Prescribing: meeting delivery targets. 2. Outsourcing solution for cataract procedures in place. 3. Development of High flow lists for cataracts in place with West	a. Appoint Health Board clinical lead to secure professional oversight and leadership b. Development of a sustainable service model c. Ensure specialty demand, capacity and planning is delivered along with further mitigations to be developed to close any gaps in delivery. d. Release planned care funding to cover funding cut in RIGA2 process, this will enable significant positive mitigation for loss of high risk follow ups

Actions	Due Date	Progression Analysis
b. Develop a Speciality Plan for agreement through governance process. Workforce review component has commenced, to inform service redesign. Funding clarification for delivery being explored with Clinical Lead Operations. New date to be determined with COO.	31/07/2025	Progressing (revised date from 28/02/2025)
c. Delivery of High flow lists for cataracts embedded in West: with two lists with 8 patients consistently delivered/month. Delivery of 6 patients/list consistently achieved in East: with a working group supporting delivery of HVLC (7 per list) sessions. Central have a firm plan in place to deliver 4 lists / month, with 7 patients/list: to commence June 2025. Pathway currently being reviewed against All Wales pathway to inform short medium and	31/07/2025	Progressing

long term improvement plan, initial draft delivered May 25: to be reviewed by Service Teams in Pan BCU Cataract Network by close of July 2025 .		
a.To Appoint a Health Board Pan BCU Clinical Lead. The Office of Medical Director is progressing recruitment. (progression/funding clarification being explored with Clinical Lead Operations)	30/06/2025	Progressing (revised date from 31/12/204)
d. Develop a work programme for delivery of Speciality plan service design. New date to be determined with COO. Operational workforce review key enabler commenced April 2025	31/08/2025	Progressing (revised date from 28/02/2025)
Reinstate Eye Care Performance resources to prior fundinglevels reduced through RIGAII financial prioritisation. Funding clarification being explored with Clinical Lead Operations and Finance	01/07/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	3	3	9
Risk Appetite	Quality		<16

Position & Intended Outcome for Risk

Significant harm may occur including irreversible sight loss in high risk R1 & R2 patients (Glaucoma and Retinopathy). Large volume of patients on Patient Treatment List currently stands at 23,544 un-booked of which 963 are 2 years+

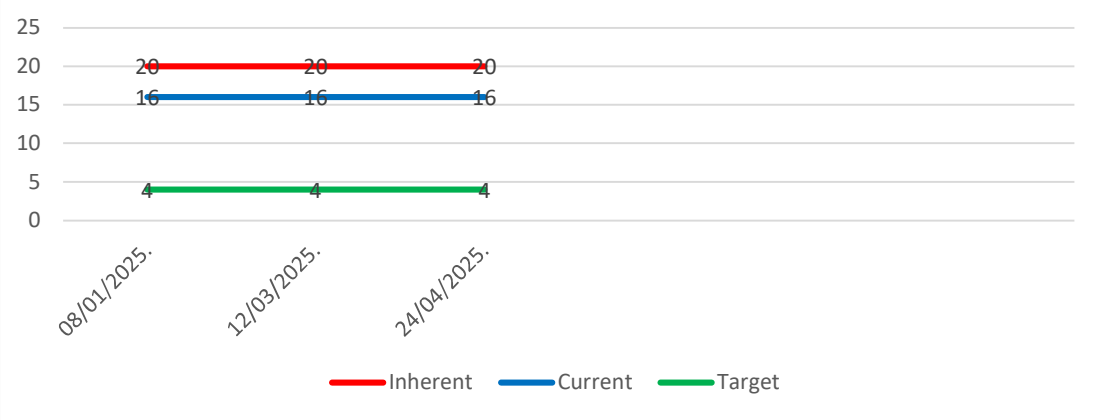
CRR 24-22	**Risk Title:** Orthodontics Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 24/04/2025	**Executive Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/03/2026

There is a risk that patients under the Orthodontics Service may come to harm, this could be caused by the lack of consultant capacity to provide an effective and timely Orthodontics service care provided by the Health Board, backlog demand outweighs capacity available in both primary and secondary care, driving less favourable patient outcomes (psycho-social vulnerability amongst younger patient groups). Less conservative/preservative treatment options – meeting urgent need. Increased chance of requiring intervention general anaesthetics, intravenous antibiotics. This may lead to reputational damage and increased litigation.

Mitigations/Controls in place	Additional Controls required
1. Appropriate referrals pathway/ triage implementation (as per national pathway) 2. Dentist with Specialist Interest (DESI) and Tier 2 – wider, easily accessible pathways 3. PAN BCUHB approach dating patients according to length of wait into additional Waiting List Initiative (WLI) activity 4. Health prevention/promotion within primary care 5. Reviewing Academy Model to increase attractiveness of North Wales as a place to work to include upskilling/additional training for suitable Health Care Practitioners 6. Supporting hosting of undergrad training in North West Wales, online Continued Professional Development and microcredentials course for local people (including consideration for maternity leave, single parent etc.)	a. Continued shortfall of workforce across BCUHB needs recruitment strategy b. Continued conversations with external providers indicates limited outsourcing opportunity c. No restorative consultant service available d. No proactive comms to patients and stakeholders agreed e. Current service provision indicates ongoing service delivery shortfalls with recovery in excess of 5 years

Actions	Due Date	Progression Analysis
Attempted but unsuccessful recruitment of Agency & NHS Locums – further attempt in progress 2025	31/09/2025	Progressing
Restorative Consultant re-advertisement	31/12/2025	Progressing

SBAR submission recommendation 2024: Continued procurement exercise to determine full treatment plan capacity with external providers-funding noted as available	31/12/2025	Progressing
GiRFT Recommendations following completion of the review. Report to be formally signed off by Health Board and to then implement the recommendations for service improvement.	31/03/2026	New action



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	2	2	4
Risk Appetite	Quality		15-19

Position & Intended Outcome for Risk

Waiting lists and waiting times have continued to grow with patients waiting in excess of 156 weeks for initial clinical assessment. Impact of vacant sessions across Health Board on capacity provision with limited opportunity to resolve the backlog position with a current BCUHB active workforce establishment at 2.2 WTE. Poor provision in some geographical areas. Lack of stability from Welsh Government around future Dental contracts. Patients awaiting treatment completion are dating back to referrals first received in 2017 highlighting significant delays in treatment pathways. Patients awaiting Patients referred for Max Fax treatment (waiting up to 156 weeks) are being returned to Orthodontics due to timescale lapsed since orthodontic referral. No current service provision for Restorative Dentistry for new or existing patients across BCUHB. Delays in Orthodontic provision impact surgical cleft optimisation delivered via Alder Hey Cleft outreach service. Clinical risk being held within the waiting lists. National shortage in Orthodontic consultants Infrastructure & estate restrictions on expanding Medical workforce. Current model of care is disjointed and lacking fluidity between primary & secondary care. Delay in sustainable service planning across BCUHB. Patients and parents reports the mental and physical challenges associated with unaddressed orthodontic issues as a result of delays into teenage years. Parents have reported orthodontic related bullying which has resulted in their child's withdrawal from education and social aspects of their childhood; also the inability to meet ministerial targets as required by Welsh Government.

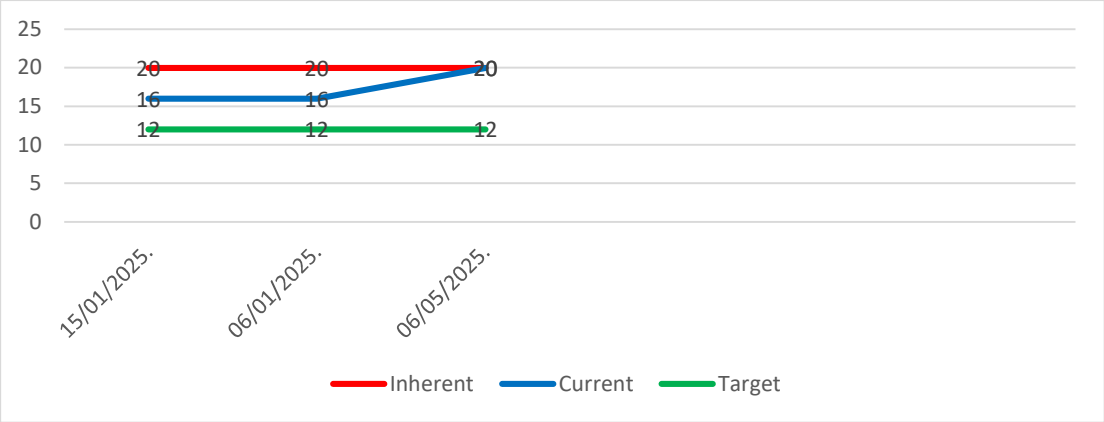
CRR 24-23	**Risk Title:** Vascular Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 06/05/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/03/2026
There is a risk that individuals may expeirence preventable harm and a poor experience whilst receiving care from the North Wales Vascular Service.This may be caused by current and projected future staffing challenges,a lack of capacity across the network a lack of clarity with regards secondary care and/ or end-to-end, vascular pathways, as well as the recent decision taken by HEIW to suspend FY1 trainees into the service from August 2025 This could lead to increased morbidity and mortality, poor quality of care, reduced quality of life, psychologcial distress, difficulties recruiting and retaining staff, difficulties in maintaining staffing levels, staff health and well-being, reputational damange, increased costs, increased legal and financial claims.			

Mitigations/Controls in place	Additional Controls required
1. Management of bed base through assessment of clinical risk in place. 2. Optimising and streamlining management of inpatients and ensuring clear communication across site to ensure timely transfer and repatriation 3. Additional funding to support delivery of robust vascular services across hub and spoke sites, approved. This will allow capacity to be increased in key areas (i.e., Cardio Pulmonary Exercise Testing and Ward 3 staffing) and a number of agency/ locum appointments to be made permanent 4. Weekly case-note audits in place to monitor standards of record keeping, with results discussed at clinical governance meetings 5. Pathways are co-designed with an extensive group of delivery partners across the 3 sites 6. Local Vascular Delivery Groups in place for 2/3 IHCs (West and Central) in order to proactively identify performance concerns and manage risk 7. Development of Abdominal Aortic Aneurism (AAA) Quality Improvement programme. 8. Consultant vascular surgeon is picking up IR sessions	a. Development of Vascular Intranet pages to help share information, including clinical pathways, with staff, in a way that is simple and accessible b. Local vascular delivery groups to be operational across each IHC. c. Review of AAA surveillance protocol / pathway, to include management of persons turned down for AAA repair d. Implementation of deep-dive audit tool to enable quality audit of case notes e. Workforce and resource review to support development of Phase 2 Business Case f. Development of vascular workforce strategy aimed at improving recruitment. g. Improve the way that information relation to service quality via patient, carer and staff satisfaction and well-

9. Weekly Multi-Disciplinary Team meeting to allocate patients onto the waiting list and ensuring consultants are aware of patients that need Interventional Radiology provision and/or can have an open Abdominal Aortic Aneurism (AAA)repair 10. Enhanced clinical and programme governance to ensure learning from events and focus on quality 11. Ops teams seeking to recruit additional agency staff to cover absent FY1 posts from August 12. Close working with current FY1s to ensure positive experience during their time with the service 13. Introduction of a pan-BCU vascular theatre utilisation group	being questionnaires is used to inform continuous improvement h. Development of Quality dashboard, to support improved use of service and outcome data i. Development of improvement plan to support return of FY1s into the service j. Introduction of a series of actions aimed at improving the culture and behaviour across the service

Actions	Due Date	Progression Analysis
Finalise vascular intranet page as key place for network and wider Health Board staff to access the full range of information, policies, procedures and pathways relating the vascular network	31/09/2025	Progressing (revised date from 31/03/2025)
Work with East IHC Medical Director to establish Local Vascular Delivery Group	31/07/2025	Progressing (revised date from 31/03/2025)
Review AAA surveillance protocol / pathway to ensure timely monitoring of persons with an AAA not identified by Welsh Abdominal Aortic Aneurism screening programme.	31/07/2025	Progressing (revised date from 31/03/2025)
Strengthen information, advice and support provided to people turned down for AAA repair, and ensure 'register' of persons turn down is maintained	30/07/2025	Progressing (revised date from 30/05/2025)
Implement quarterly quality audit tool to enable network to proactively identified areas for improvement	31/07/2025	Progressing (revised date

		from 31/03/2025)
Work with key delivery partners to develop a (Phase 2) vascular and diabetic foot business case	31/03/2026	Progressing
Develop and implement vascular training and workforce strategy to improve recruitment and retention across the network	31/03/2026	Progressing
Revised patient, carer and staff satisfaction and well-being questionnaires to be regularly disseminated, and findings analysed in order to inform continuous improvement	31/03/2026	Progressing
Build pan-BCU and local quality dashboard to support improved use of service and outcome data	30/03/2026	Progressing
Development of improvement plan to support return of FY1s into the service	30/03/2026	New action
Introduction of a series of actions to support improvements in culture and behaviour within the service	30/06.2026	New action



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		15-19

Position & Intended Outcome for Risk

Demand for vascular care in North Wales is increasing, however, recruitment to vascular services is not increasing as at the same rate. Whilst this is a UK-wide issue, the history of vascular services in North Wales, makes recruitment and retention across the network a particular concern. Whilst the network has been successful in embedding a wide-ranging improvement programme, the impact of this unstable workforce risks undermining the quality and safety of care provided, both now, and in the future. Work ongoing to develop a workforce framework for the service to allow monitoring.

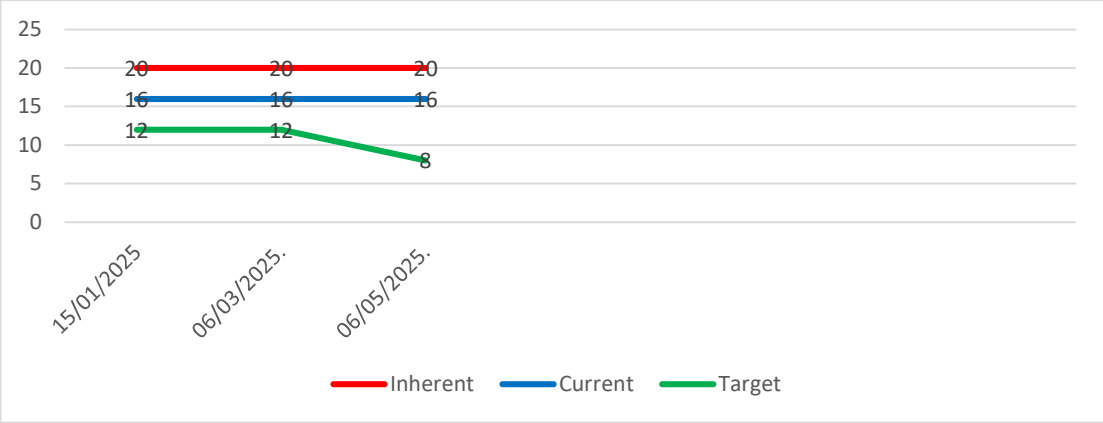
CRR 24-24	**Risk Title:** Renal Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 06/05/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/03/2026

There is a risk that individuals may expereince preventable harm, and have a poor experience whilst waiting for dialysis. This may be caused by extended waiting times for vascular access procedures, a lack of capacity, inequity in resource allocation across the Health Board. This could lead to, increased hospital admissions, longer hospital stays, increased morbidity and mortality, poor quality of care, reduced quality of life, psychologcial distress, reputational damange, increased costs, legal costs and financial claims.

Mitigations/Controls in place	Additional Controls required
1. Close regular scrutiny of waiting lists at a vascular and renal network level. 2. Informal management of waiting lists on a networked basis to support prioritisation of cases, where possible 3. Additional capacity provided by Locum Consultant.	a. Formal agreement to the establishment of a single Pan-BCU list, rather than 3 separate Integrated Health Community (IHC) Clinic and Theatre lists. b. Additional capacity to support reduction of current wating list in the East, to a more manageable position. c. Recruitment to 2x vacant Consultant posts d. Re-allocation of resources across the Network, to enable equitable access to interventions locally.

Actions	Due Date	Progression Analysis
Submit Waiting List Initiative (WLI) request to facilitate additional theatre lists, in order to reduce current backlog Continue to undertake additional lists and WLIs to help reduce backlog	30/08/2025	Progressing (revised date from 30/12/2024
Undertake Workforce review across entire Service to ensure equity across the Region	30/08/2025	Progressing (revised date from 30/12/2024

Review Theatre provision, particularly in relation to overrunning lists, which result in Renal access patients being cancelled Theatre utilisation group, first meeting 19/02/2025, has been established and will lead on this work.	30/05/2025	Progressing (revised date from 30/12/2024
Work with new Locum consultants to ensure cover for any vacant theatre lists and clinic sessions	30/05/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

There is currently a significant backlog of people waiting for Vascular Access Clinics and Theatre Appointments in the East IHC. This situation has arisen for a variety of reasons, but principally, because:

a. Higher **demand** in the East due to its larger population size, together with the fact that it has the largest dialysis unit.
b. An inequity in **capacity** across the three IHCs to support renal access – the East having the fewest number of clinics sessions and theatre lists.

Reducing the current backlog and waiting list is critical to preventing further in-line sepsis. A peer review of Renal Vascular Access (2022) concluded that whilst BCU outcomes from renal vascular procedures were excellent, further work was required in order to:

- Ensure a dedicate group of Vascular Surgeons to complete renal access procedures – with flexibility to move across sites
- Dedicated Clinics for Renal VANS alongside surgeons (on each site)
- Dedicated Theatre lists on each site – reflecting the demand of each site's renal population

Whilst these recommendations have been implemented in Central and West IHCs, it has not been possible to secure such provision in the East.

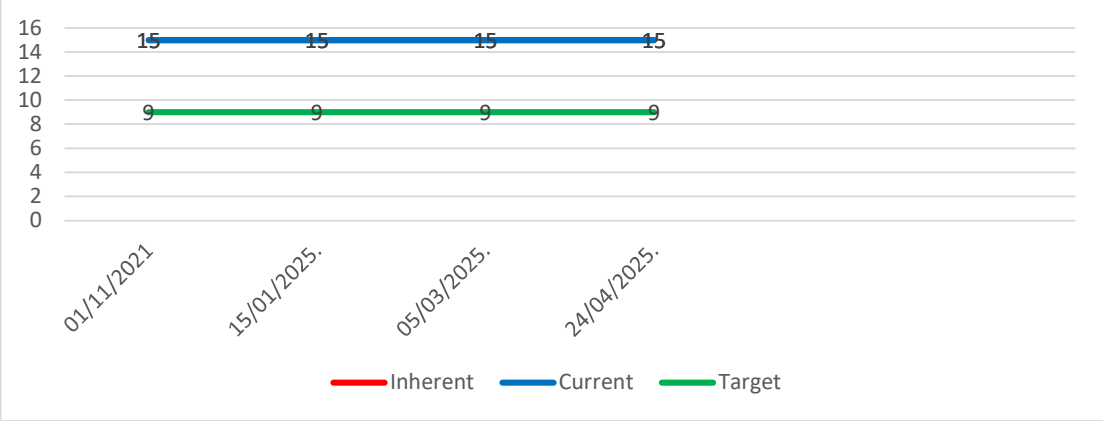
CRR 24-25	**Risk Title:** Dermatology and Plastic Surgery Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 24/04/2025	**Director Lead:** Executive Medical Director	**Link to BAF**: BAF24-07	**Target Risk Date:** 30/07/2025

There is a risk that patients for the Dermatology and Plastic Surgery Services will come to harm, this may be caused by lack of a sustainable service model, unmanaged demand and current capacity not able to meet incoming demand, this may lead to increasing waiting list increasing risk of harm caused by length of wait.

Mitigations/Controls in place	Additional Controls required
1. Prioritisation of urgent suspected cancer to mitigate clinical risk 2. Provision of Waiting List Initiative activity to provide short term additionality 3. Development of insourced arrangements to provide interim additional capacity for a 12-18 month period 4. Appointment of clinical leads to support service redesign 5. Introduction of Teledermoscopy with a commensurate increase in treatment capacity (minor operating procedures) 6. Appointment of Specialty Managerial Lead to take forward service redesign. 7. Increased treatment capacity through the insourcing contract and appointment of further locum commenced in East.	a. Support for the Clinical Leads in Dermatology as part of a single Dermatology Service for North Wales b. Funding for Minor Operating Procedure capacity to support expansion of Teledermoscopy. c. Expanded GP with Special Interest Model for referrals to Secondary Care. d. Service Level Agreement between Partner Organisations. e. Additional dressings clinics to address current variation across North Wales.

Actions	Due Date	Progression Analysis
Dermatology - Maintain support for the Clinical Leads in Dermatology as part of a single Dermatology Service for North Wales. Monitoring BAU.	30/06/2025	Progressing

Dermatology – Fund requisite MoPS Minor Operating Procedure capacity to support expansion of Teledermoscopy	01/07/2025	Progressing
Dermatology - Establish the viability of an expanded GP with Special Interest Model for referrals to Secondary Care	30/06/2025	Progressing
Plastic Surgery - Agree and Sign updated SLA between Partner Organisations	30/06/2025	Progressing
Plastic Surgery - Implement additional dressings clinic to address current variation across North Wales	01/07/2025	Progressing
Specialty Managerial Lead to lead on redesign of Service Away afternoon scheduled for June 2025 to begin discussions on redesign	01/07/2025	New action



	Impact	Likelihood	Score
Inherent Risk Rating	3	5	15
Current Risk Rating	3	5	15
Target Risk Score	3	3	9
Risk Appetite	Quality		<16

Position & Intended Outcome for Risk

Significant volumes of patients remain in the list (currently 13,212 unbooked), within these there will be undiagnosed cancers and the obvious risk follows regarding delayed diagnosis and treatment.

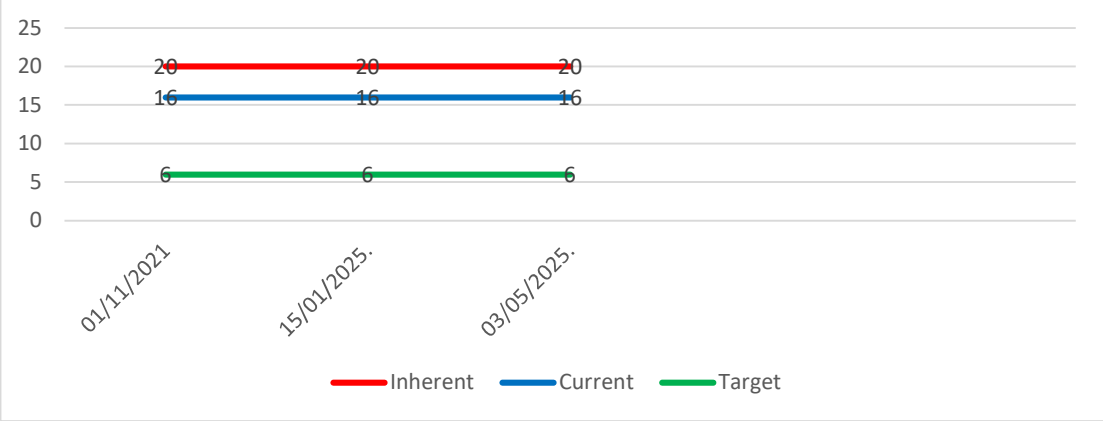
CRR 24-26	**Risk Title:** Urology Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 20/02/2025
Date Last Reviewed: 05/03/2025	**Director Lead:** Executive Medical Director	**Link to BAF**: BAF24-07	**Target Risk Date:** 31/12/2025

There is a risk of increased avoidable harm caused by unsustainable service configuration for Urology in North Wales This could be caused by the inability to recruit to consultant posts driven by unattractive on call rota and lack of recognised best practice equipment (robotic assisted surgery), the lack of specialist knowledge for cancer pathways, issues with access to estates and a lack of network clinical leadership. This may lead to the inability of the Health Board to deliver timely and appropriate care to the population of North Wales. As detailed in the RCS and GIRFT reviews, there is a need to develop a provision within a network model to ensure that the service achieves the recommendations from external reviews and complies with national/professional guidance.
If the actions within the Urology Improvement Plan are not achieved, the ability to mitage the known risks will not be possible, which will have an adverse impact on patients access to the service in North Wales, as well as the reputuation of the Health Board.

Mitigations/Controls in place	Additional Controls required
1. High use of locum provision 2. Outsource of service, case by case, whilst commissioning discussions take place. 3. Anuual commissioning of service in place 4. Commission of Robotic Assisted Surgery prostates to UCL 5. Office of the Medical Director currently supporting with Clinical Lead input 6. Monthly meeting with Welsh Government and NHSE to provide assurance and update on the risks currently identified and actions within the Improvement Group.	a. Agree mitigation to move to 2 site model if staff becomes unsafe at 1 site. b. Review purchase of an appropriate Robotic Assisted Surgery platform for prostatectomies c. Clinical facilities and equipment investment identified in the Urology Improvement Plan under the Planned care theme not yet in place

Actions	Due Date	Progression Analysis
Scoping, development and implementation of a revised network model of care for on call. (*Delayed due to SRO and Network manager unplanned absence).*	01/04/2025	Delayed

Review current outsource provision and align Multi-Disciplinary Team meeting for in-reach support in specialist discussion and decision. Review current outsourced/commissioned agreements to provide care closer to home and review opportunities to repatriate cancer procedures at BCU. New arrangements being onboarded with Arrowe Park	01/12/2024	Complete
Cancer services with support from the OMD to advertise for a Urology Cancer lead.	01/11/2025	Progressing
Agreement to fund the MyMR PSA tracking license internally through the Planned Care funds for 24/25 whilst Digital, Data a Technology colleagues look at the integration with AB colleagues and supplier.	01/04/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	2	3	6
Risk Appetite	Quality		<16

Position & Intended Outcome for Risk

Urology service is one of the areas of Clinical Concern and has been subject to an invited review by The Royal college of Surgeons. The identified risk for the services are:

- Increased financial expenditure due to locum provision on the on call rota
- Fragile Out Of Hours on-call rota across BCU
- Delay in patient care with an inability to meet targets for cancer diagnosis and treatment.
- Failure to deliver care closer to home.
- Difficulty in recruiting to provide a sustainable cancer service

CRR 24-27	**Risk Title:** Neurodevelopment Waiting List		**Date Opened:** 02/05/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 01/05/2025	**Executive Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:**02/05/2027

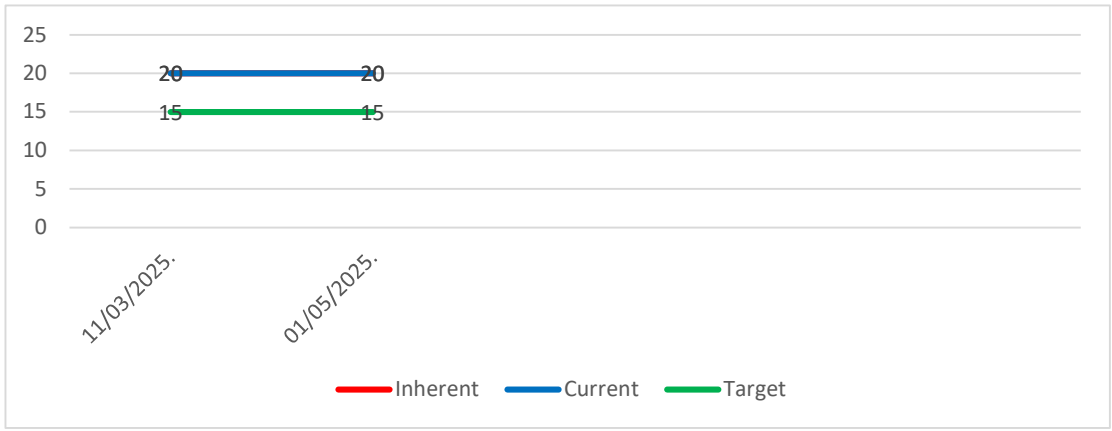
There is a risk that the Health Board may not meet the target set by the Welsh Government (WG) for Neurodevelopment (ND) services which requires that 80% of assessments commence within 26 weeks of the date of referral. Currently Children and young people referred into the service now will not be seen (not assessed) before their 18th birthday. This could be caused by an increase in demand on the service without the support and funding to increase capacity within the team. This may lead to children and young people not being assessed in a timely manner.

Mitigations/Controls in place	Additional Controls required
1. BCUHB transformation programme commenced, and a full programme of work has been developed to support the move to a needs led service. 2. Welsh Government have issued short term funding to support longest waiters on the list, the service are looking to staff overtime, Agency staff and waiting list validation.	1. Programme Manager essential for delivery of revised service model – only approved until end June 25. 2. Support from external stakeholders (Schools, Local Authority and Third sector) for a new service model to implement significant change. 3. The National work programme needs to be implemented at pace with the recognised changes required in BCUHB. 4. Profile of Needs Training has commenced with Conwy and Denbighshire Local Authorities to support Children on the waiting list and will be rolled out to all local authorities as their capacity allows. 5. Recurrent funding is required to allow the team to recruit to substantive posts and funding often given with short notice/time limited with specific aim, such constraints become difficult to navigate. 6. Approval of a Business case to support additional staffing structures, and support the improvement programme. 7. Greater engagement with external stakeholders such as schools and upskilling staff.

	8. An agreed current plan to address the backlog waiting list, excessive backlog would require £20m* investment based on current model (e.g. if outsourced). 9. A consistent Executive Director to lead on ND challenges 10. The Regional Partnership Board workshop in March 2025 will produce short, mid and long term actions with regards to providing support, information and advice for those both on the waiting list and those at early identification. This will include support from Third Sector, Local Authority and Education colleagues. 11. Agree a transfer policy for Children and young people approaching 18 - to Adult Mental Health Services/Integrated Autism Service . 12. Development of a new prudent assessment to standardise the process and align to best practice. The prudent assessment process will allow all assessment processes to be streamlined and aligned across the Region and reduce inequity. 13. The ND services across the Region have an approximate workforce of 70 staff including Clinical and Non-clinical which is in adequate to support the demand on the service. However, additional staffing would not be supported by the current Health Board Estate. 14. A single digital information system in place to support the sharing of information across teams eg ND teams, CAMHS, Therapies, Education, Social care 15. The Health Board compliance against the Welsh Government 26 week target currently stands at 11% against the target of 80 %

Actions	**Due Date**	**Progression Analysis**

The Regional Partnership Board have agreed to prioritise ND services for 2025-2026 as part of their work plan. The ND programme team are working with the Regional Partnership Board and wider stakeholders eg schools, Local authorities and Third Sector to agree a cohesive way of working to support Children and Young People on the waiting list	31/03/2026	Progressing
Work with one Local Authority to train staff to undertake profiling for children on the waiting list. This will provide support for Children, young people and their families whilst waiting for assessment. This will be a pilot project with Ynys Mon and further roll out with other local authorities as they have capacity to support the process. The aim would be for all local authorities to be trained in profiling by March 2026.	30/06/2025 (pilot) March 2026	Progressing
Agreement and production of a new draft service model with key partners to promote a whole system approach embedded within a social model of disability that focuses on changing attitudes, environments and systems in collaboration with all stakeholders..	April 2026	Progressing
Commence implementation of a new service model to support CYP with early support and intervention. This should reduce referral numbers	31/03/2028	Progressing
Development of agreed Transfer policies between Child and Adult Services to provide support and timely assessment for those moving into adulthood.	31/03/2026	Progressing
Maintain close working relationships with the National Programme of work and the Regional Partnership Board to ensure a consistent approach to whole system approach.	31/03/2026	Progressing
Ensure recommendations from the National event in Lampeter are reviewed and implemented as necessary following their release from Welsh Government. Actions will be measured and reviewed	31/12/2025	Progressing
Submission of Business case to support key roles including the programme and operational staffing (Clinical Lead). Approval will be required by the Health Board	30/07/2025	Progressing
Validation of current waiting list (waiters over 3 years) to ensure all patients wish to remain on the list. Currently 600 patients on the long waiters list.	30/06/2025	Progressing
Identification of an Executive Lead for the service to support the programme of work	31/05/2025	Progressing
Implement new prudent assessment process to decrease the length of the process and provide a more streamlined process for CYP and their families. Revised assessment processes are currently being identified by our Clinical Leads	31/07/2025	Progressing
Stratification of the waiting list to identify those at greater risk and agree their prioritisation. It is envisaged that this work will support those most in need and allow a more timely assessment.	30/09/2025	Progressing
Approval of waiting list options paper by ND Strategic Improvement and Development Group. Prudent assessment (streamlined processes aligned to NICE guidance) options will be measured during the monthly performance meeting.	30/05/2025 Ongoing	Progressing
Funding is being used from Welsh Government to support pilot projects, with the aim to develop new ways of working, increase capacity/support for Children and Young People on the waiting lists. All projects are currently undergoing evaluation via the Regional Partnership Board and findings are expected by the end of April for approval to continue funding in 2025/2026	30/06/2025	Progressing (revised date from 30/04/2025)



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	5	3	15
Risk Appetite	Quality		<16

Rationale for Corporate Risk

Waiting list time approaching 20 years for new referrals based on current capacity, with an average monthly capacity gap of approximately 200 assessments. A key ministerial priority for 2025/26 is to deliver an improvement in the target compliance rate to 15% by Q4, for which additional investment will be required. The pressures on the ND waiting list are national with no Health Board in Wales meeting the WG 26-week target, BCUHB are currently the second worse performer against the target.

There was a significant increase in demand during the Covid pandemic with accepted referrals rising by 130% from 20/21 to 22/23 , and a further increase of 43% in accepted referrals from 22/23 to 23/24. – Year to date in 24/25 accepted referrals are 10% lower partially due to demand management initiatives implemented

The ND waiting list is forecast to be over 7,000 by the end of March 25.

Whilst the target date for this risk is identified as 2027, it must be noted that delivery of a supported and sustainable service will not be achievable within this timescale due to current capacity, funding and support required from external partner organisations. The above actions have been identified to support the mitigation of the current risk.

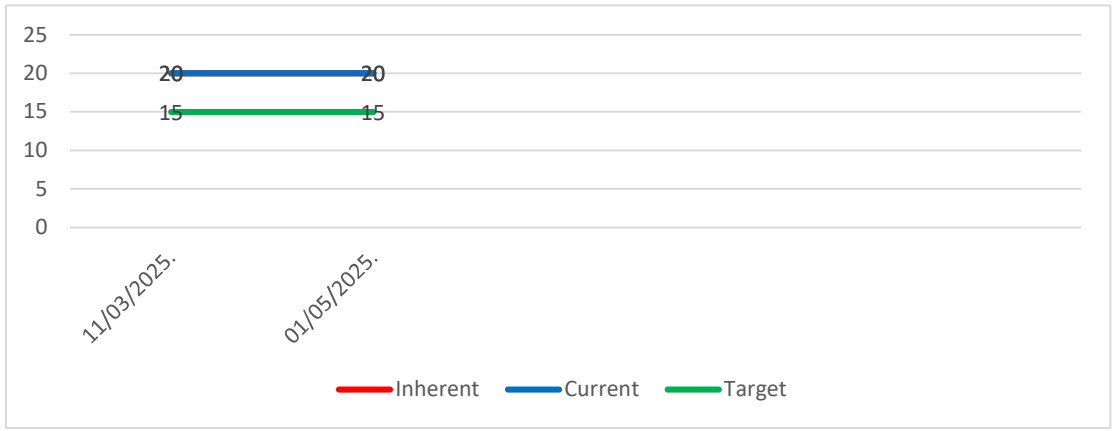
CRR 24-28	**Risk Title: Pharmacy Technical Services**		**Date Opened:** 15/01/2025
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 09/05/2025	**Executive Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 01/01/2026

There is a risk that Pharmacy Technical Services for the delivery and the preparation of high risk injectable medicines including chemotherapy, radiotherapy, total parenteral nutrition for adults and babies at BCUHB will fail to maintain operational capacity and regulatory compliance.
This could be caused by increasing demand for aseptic products, with each unit currently operating above capacity, exacerbated by pandemic recovery demands, workforce shortages, and escalating regulatory requirements.
This could lead to significant patient safety risks, delays in treatment, regulatory intervention or Service restrictions and unit closures.

Mitigations/Controls in place	Additional Controls required
1. Capacity monitoring through a validated model assessing daily workload against workforce and facility resources. 2. Existing quality management systems, including validation and documentation control. 3. Monitoring of incidents, errors, near misses and complaints through the departmental quality management system and Datix 4. Monitoring and oversight of key performance indicators and escalating concerns through senior leadership teams. 5. Reallocation of resources to prioritise high-risk areas such as Systemic Anti-Cancer Treatments (SACT), radiopharmaceuticals, and ready-injectable medicines. 6. External validated monitoring arrangement. Medicines and Healthcare products Regulatory Agency (MHRA) inspection for the MHRA licensed unit at Wrexham Maelor Hospital and National Quality Assurance audits for all three units.	a. Further workforce controls required. Current workforce levels are below requirements, with all units operating above the recommended 70-80% capacity. Appropriate workforce levels will be put in place to meet demand from a production and regulatory perspective once funding has been approved. b. Appropriate investment in quality assurance and regulatory compliance roles to ensure gaps in regulatory compliance are closed to further control the risk. This will reduce the risk of regulatory intervention or closure of units. c. Increasing the range of outsourced products and ensure there is a robust process and infrastructure in place to manage them efficiently. d. Delays in recruitment causing a gap in control. Delays due to protracted processes and lack of training for specialised roles. The significance of vacancies in relation to capacity, service failure and regulatory compliance will be escalated appropriately to ensure the

7. Limited outsourcing of products scoped and implemented to reduced demand.	recruitment process is as efficient as possible and the vacancies will be prioritised. e. Current contingency plans are inadequate (Business Continuity) to address immediate regulatory non-conformances and meet increasing demand which leads to failure to deliver services. The contingency plans will be reviewed to ensure they are fit for purpose.

Actions	**Due Date**	**Progression Analysis**
C: Outsourcing: Scale up existing outsourcing of selected injectable medicines to reduce capacity stress. This includes procurement of individual patient doses of injectable systemic anti-cancer treatment and batch produced special licensed aseptic products and over-labelled/pre-packaged medicines. Develop KPIs and workload statistics to demonstrate the increase, maximise efficiency, economy of scale and monitor performance and report into Pharmacy IHC senior management meetings.	30/08/ 2025	Progressing
A & D: Workforce Expansion: Recruit and onboard additional staff through a phased plan over three years, targeting critical gaps in production, quality assurance, and regulatory roles. Timeline: Initiate recruitment in Q1 2025/26; Completion date October 2025	30/10/2025	Progressing
E: Governance Improvements: Review and update contingency (business continuity plans) for technical services across BCU to ensure they are fit for purpose. This will be included together with capacity, key equipment status, service demand and risk of service failure in technical services Quality meetings as standard agenda items on a monthly basis. Monthly KPI reports for the service and any issues concerning risk to service delivery will be escalated through the Directors of Pharmacy. Any immediate risks will be escalated appropriately. Timeline: Immediate changes to Quality meeting agenda and include in monthly reviews starting June 2025.	30/06/2025	progressing
B: Regulatory Compliance Investment: Strengthen quality management systems and address gaps identified during audits and escalate if any concerns with achieving compliance	30/05/ 2025	Complete



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Risk Appetite	Open		<16

Rationale for Corporate Risk

BCUHB) three pharmacy aseptic units based at each district general hospital have been operating above capacity, exacerbated by pandemic recovery demands. This has created a high-risk environment for regulatory compliance and patient safety. Year-on-year activity increases by 10%. Re-prioritisation of resources has led to reduced services for adult/children's wards and batch manufacturing lines. Output constrained by staffing and resource limitations. Products produced facilitate maintaining hospital patient flow via quicker discharge in high turnover areas (note circa 100% increase in activity over Winter 2023/24).