Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Corporate Risk Register

Contents

CRR REF: 25-01 - Timely Patient Access to Safe and Effective Care		
Director Lead: Chief Operating Officer		**Date Opened:** 21/08/2025
Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 05/03/2026
Date Last Reviewed: 30/04/2026	**Link to BAF**: BAF24-07	**Target Risk Date:** 30/06/2027

Risk Detail:
There is a risk that patients may not receive timely access to the care they need; for planned care this may lead to a delay in definite treatment, deterioration in health or harm occurring whilst waiting, poor patient experience, and poorer outcome. In the unscheduled care pathway, patients may experience harm whilst waiting for ambulances in the community, may have prolonged waits for specialist medical care, this could lead to patient harm and poor patient experience.
This may be caused by capacity and demand mismatch, lack of oversight of waiting lists, lack of validation, the need to transform services and service models and delays due to waiting for diagnostic tests in the unscheduled arena it may be caused by poor flow through the health and social system, poor discharge practices, lack of appropriate residential and nursing placement.
This may lead to extended waiting lists, patient harm due to delays, and reputational or regulatory consequences.

Mitigations/Controls in place

1. System Resilience Hub in place with hospital escalation protocols, daily and weekend plans, and winter/festive plans. Daily Hub + rapid review + weekly executive oversight panels
2. 6 week rapid improvement plan with clinical and operational executive oversight
3. Quality, professional and operational standards
4. Major change programmes for Urgent and Emergency Care (UEC) and planned care aligned to the Six Goals for UEC framework and national objectives (such as timely access to care and building community capacity). Governance structure completed, all workstreams now all aligned.
5. Winter Resilience Plan complete evaluation and lessons learnt.
6. Revised Access policy to ensure standardised practice across the Health Board
7. Single Integrated Clinical Assessment Triage (SICAT) and GP Out of Hours (OOHs) joint model providing 24/7 triage and advice
8. Same Day Emergency Care (SDEC) services established at all acute sites
9. Routine clinical prioritisation of patients by risk in line with Referral to Treatment guidance
10. Outsourcing of radiology reporting and insourcing of CT, MRI, ultrasound
11. Diagnostic Quality Management System accreditation system embedded
12. Welsh Government short-term Neurodevelopment funding to support longest waiters, agency staff, overtime

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 Fragility of UEC (Urgent Emergency Care) and specialist workforce posts, reliance on locums' temporary posts.	A UEC clinical lead has been appointed as part of the UEC programme team as well as other clinical leads specifically focusing on the priorities of the 6 goals plan within specific workstreams.	UEC Programme Director	Complete	Complete
	ED staffing business case for medical and nursing requirements including whole time equivalent and costings to be drafted for Executive Committee endorsement. Task & Finish group to be established to progress at pace with key leads including clinical, nursing, workforce and transformation and progress through HB governance. **Outcome:** A stable, sustainable UEC and frailty workforce with reduced reliance on locums, improved service continuity, and consistent delivery across all sites. **Metric:** Reduction in locum usage and vacancy rates in UEC and frailty posts, **Impact on risk:** Likelihood of risk will reduce as permanent posts are filled with further reduction expected as locum reliance decreases and workforce stability improves	Chief Operating Officer	Q1 2026/27 – 30/06/2026	Progressing

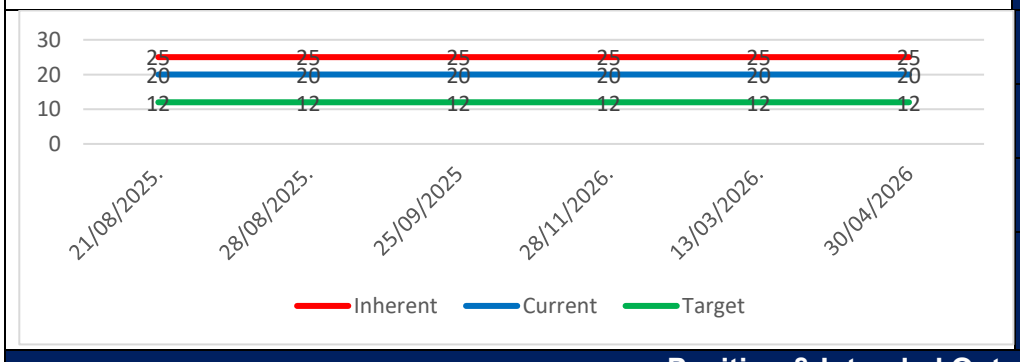
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G2 Fragility of social care provision causing delayed discharge and stranded patients	Implement reset 'sprint' fortnight 8-22 December focusing on improving number and timeliness of discharges, delivering 45-minute ambulance handover, and improve ED performance Second 'Sprint' undertaken 22 January – 4 February, supported by 3 diagnostics to target ongoing actions Action update: Further to competed actions, above, MADE events have been held on each site and further interventions have been identified including: >21-day length-of-stay reviews / 6As audits scheduled during March / April across all sites – findings will inform immediate and longer-term actions that strengthen	Chief Operating Officer	8/12/2025	Complete

	discharge processes and system-wide UEC flow – supported by external improvement and intensive support team.			
	Deliver December “Discharge Fortnight” - Intensive cross-sector focus to maximise discharge, unblock flow, reduce LOS, and significantly improve bed availability. Action update: Fortnightly regional realignment meetings in place with BCU / LA to maintain focus on discharges to support flow and patient outcomes	Chief Operating Officer	31/01/2026	Complete
G3 Need for demand and capacity modelling and specialty-level trajectories	Complete demand and capacity analysis across Planned Care to inform forward activity planning Demand & capacity (D&C) planning session held in April to review core demand and capacity planning across specialties within Q1 to confirm the position for 2026/27. A further session is scheduled in May with a specific focus on Cancer and Diagnostics to enable more detailed discussions on demand and capacity for 26/27. This will be supported by a ‘planned care sprint’ to improve booking of long waiters into core capacity and transfers of care to appropriate services **Outcome** Clear understanding of specialty level- demand and capacity, enabling improved activity planning, reduced long waits, and more efficient use of core capacity **Metric** Reduction in number of long waiting patients (aligned to IMTP trajectory) **Impact on Risk:** Likelihood decreases as clearer planning reduces backlog risk and improves ability to meet demand.	Chief Operating Officer	30/06/2026	Progressing (revised date from 31/03/2026)
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G4 Inadequate Neurodevelopment (ND) capacity to manage waiting list	Eradicate all >3 year waits by end March 2026. Ministerial priority. At the end of March 2026 there were 646 over three year waits due to the private provider being unable to complete their contract assessment numbers. These referrals have now been allocated to another private provider for completion by the end of Quarter 1, families and schools have been updated. Additionally there will be 2,358 C&YP that will have waited over 3 years in 26/27, WG have allocated £2m to BCUHB to address the >3 year waiters, however this will be insufficient with a shortfall of approximately 490 assessment. WG are to be informed of this residual gap and options to manage reviewed Confirmation of funding allocation (£2m) from WG re 26-27 for ND funding for assessments, was received in April. Approval from Exec Committee & PFIG subsequently confirmed in April for the continued use and extension of the private provider contract for children’s ND assessments to support delivery against WG expectations for 2026/27. **Outcome** The capacity gap has reduced significantly, supported by a 63% increase in assessment activity in 2025/26. This has been achieved through a prudent delivery approach alongside commissioning of independent providers. Allocated funding will support backlog reduction for waits exceeding 3 years in Q1 26/27, whilst also contributing to longer term service sustainability. **Metric** Ministerial milestone. Deliver and sustain no >3 year waits at the end of March.	Associate Directors Childrens	Qtr 1 2026/27 – 30/06/2026	Progressing

	Impact on Risk Failure to maintain increased assessment capacity and targeted backlog reduction may result in continued waits exceeding three years into 2026/27. This would lead to non-delivery of the ministerial milestone, prolonged delays for neurodevelopmental (ND) assessments, increased demand pressures on services, and potential deterioration in patient outcomes and experience			
G5 Outdated diagnostic IT systems causing inefficiencies in reporting and turnaround times with diagnostics.	• Strengthen and enhance monitoring of reportable diagnostics through implementation of upgraded systems including: - RISP (radiology) – completed RISP radiology system September 2025 completed. - LIMs 2.0 (pathology) – ongoing roll out to be completed by end Q3 • Ensure existing services have mechanisms in place to report urgent and unsuspected findings, including Welsh Clinical Portal (WCP). Enhanced / divisional monitoring of reportable diagnostics as a byproduct of planned care backlog recovery programmes. This will develop further with diagnostics division throughout 2026-27 to include UEC and urgent suspected cancer diagnostics Update Failure to act on Diagnostics Procedure to be presented at divisional meeting for discussion on the 10/10/2025 (NB: This action is delayed due to service focus on 8-week backlog reduction and supporting OPD programme. Proposed revise due date to Q1 2026-27) **Outcome:** improved oversight and strengthened reporting of findings / responsive actions **Metric:** reporting turnaround times maintained / improved, with outliers identified earlier for intervention **Impact on Risk:** overall reduction in likelihood of delayed diagnostic results to service users	Associate Director, North Wales Managed Clinical Services	30/06/2026 30/06/2026	Progressing
Gaps in Controls	• **Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G6 Variation in acute medicine, SDEC (Same Day Emergency Care), frailty pathways across sites, No standardised model yet Workforce recruitment impacted by non-recurrent (6 Goals) funding	• Complete pan BCUHB- baseline and gap analysis to inform a standardised frailty service model, develop unified Acute (front door) Frailty Services pathways aligned with SDEC and community services (Q2), Baseline and gap analysis completed • Finalise financial and workforce modelling required to deliver the national AFS model (Q1). **Outcome** A consistent, standardised frailty model across all acute sites, improving early assessment, flow, and access to same-day and community alternatives **Metric** Completion of baseline & gap analysis. Agreement of standardised AFS model for each site. Progress against recruitment to frailty workforce roles. **Impact of Risk** Risk reduces as variation decreases and standardised models strengthen service reliability and pathway consistency through pan BCU standardised approach.	UEC Programme Director	30/09/2026 30/06/2026	Progressing

G7 Consistent application of "Our Next Patient Please" flow model.	• Patient flow improvements: Implement “Our Next Patient Please” Move patients to wards ahead of predicted discharges; reduce ED congestion. Completed – Our next patient (forward waiting) is now BAU	Chief Operating Officer	31/01/2026	Completed
	• Develop draft Single Point of Access for alternative pathways & Primary Care redirection. Reduce unnecessary ED attendance; strengthen community pathways. **Outcome** Improved patient flow through earlier ward moves, reduced ED congestion, and strengthened use of alternative pathways and community services—leading to fewer unnecessary ED attendances and more efficient system-wide flow. **Metric** Reduction in ED congestion metrics (4 hour / 12 hour / time to triage / ambulance handover) • Reduction in LoS / POCD **Impact on Risk** Risk decreases as improved flow reduces system pressure, ED overcrowding, and delays in urgent and emergency care—lowering the likelihood and impact of service failure Action update: • Your Next Patient / Forward Waiting SOP developed • Accelerated Boarding in Extremis SOP developed	Chief Operating Officer	31/03/2027	Progressing

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G8 Health Board improvement goal for Colostrum Difficile Infection (CDI) reductions in 2025/2026 to reduce the number of cases within the Health Board.	Implementation of Health Board improvement goal for CDI (Colostrum Difficile Infection) reductions in 2025/2026 This action to reduce CDI is now based on the WHC Improvement Goals for 2025 – 2027. The Health Board has until March 2027 to reduce CDI by at least 25% against the 2024/2025 counts **Outcome** Reduced incidence of Clostridioides difficile infection across the Health Board through strengthened infection prevention-, antimicrobial stewardship, and system-wide adherence to improvement measures. **Metric** CDI incidence rate per 100,000 population **Impact on Risk** Risk decreases as CDI rates fall, demonstrating improved infection control and reduced harm as performance moves towards the 2025/26 reduction target.	Deputy Director of Nursing Infection Prevention and Decontaminatio n	31/03/2027	Progressing (revised date from 31/03/2026)



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	3	12
Risk Appetite	Quality <15		Not in Tolerance

Position & Intended Outcome for Risk

The number of Prevention of Future Death (PFD) / Regulation 28 Notices issued to BCUHB were: 23 in 2023-24; 7 in 2024-25; 3 in 2025-26 to date. In 2023 the Health Board was an outlier and 9 cases directly related to the impact of delays in the health and social care system on the timeliness of responses by the HB and Welsh Ambulance Service and ongoing work is required to resolve the underlining delays to treatment. The goal being to be in line with WG targets.
Intended Outcome:
By 2027, patients consistently receive timely, effective, and safe care, evidenced by:
- Reduction in long-wait patients (>104 weeks) and breaches of national access standards.

- Fewer harm events linked to delayed care.
- Improved quality metrics including length of stay, readmission rates, and patient-reported outcome measures (PROMs).
- Reduction in regulatory and legal cases associated with delayed access.
- A demonstrable shift in focus from access process metrics to sustained improvement in patient safety, experience, and outcomes.

CRR REF: 25-02 - Risk Title: Future Demand & Sustainable Workforce		
Director Lead: Executive Director of People and Organisational Development		**Date Opened:** 21/08/2025
Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 12/02/2026
Date Last Reviewed: 30/04/2026	**Link to BAF**:	**Target Risk Date:** 31/03/2027

Risk Detail:
There is a risk that the Health Board does not have an effective, coherent workforce plan and workforce supply, that is based upon an incorrect funded establishment.

This may be caused by the organisation not undertaking effective of demand and capacity planning, which may be compounded by high sickness rates and recruitment challenges.

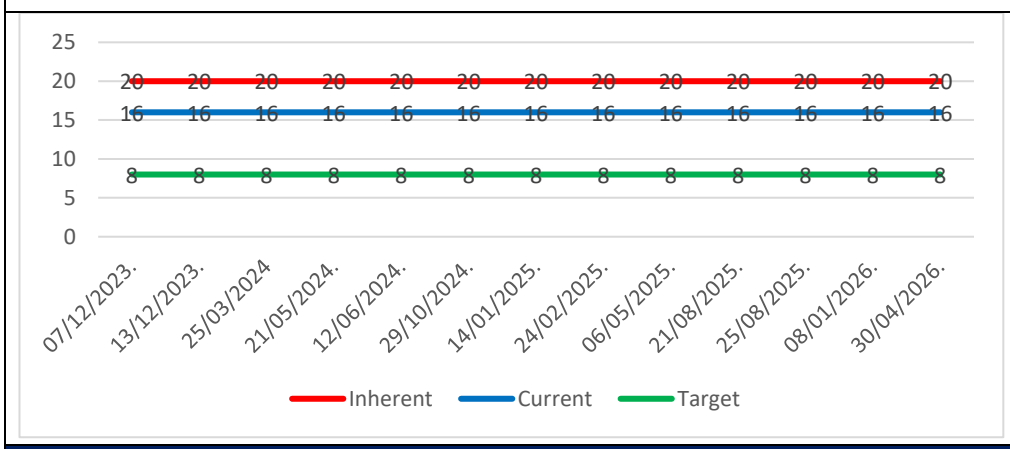
This may lead to staff burnout, reduced morale and retention and an inability to consistently deliver safe, high-quality care. This will likely place additional strain on services and impacting patient outcomes.

Mitigations/Controls in place

1. A new workforce planning framework has been agreed
2. A Healthy Workforce group is in place overseeing a comprehensive range of actions to improve sickness rates and employee wellbeing
3. The Foundations for the Future (FFTF) Board is in place to oversee the development of the future workforce model
4. The Board has approved the three-year culture change programme
5. A Value & Sustainability programme is in place, overseeing a range of initiatives to improve productivity and financial efficiencies
6. A recently introduce Medical & Dental policy advisory service is in place
7. Work around retention initiatives has seen a reduction in avoidable turnover

Gaps in Controls/	Action	Action Owner	Due Date	Progression Analysis
G1 Implement a system-wide Workforce Planning service with reportable workforce plans across key services	Adoption of the workforce planning framework, based on the results of the demand and capacity review in conjunction with the clinical services plan	Chief Operating Officer, Executive Medical Director and Executive Director of Transformation and Improvement	31/03/2027	Will commence fully once D&C has been completed
G2 Demand and Capacity (D&C) forecasting	Full demand and capacity review that will identify true gaps in the workforce model	Finance and Performance	31/03/2027	Progressing
G3 An establishment review is required following D&C review	Undertake establishment reviews based on the outputs of the Demand & Capacity review	Finance and Performance	31/03/2027	Will commence fully once D&C has been completed
G4 An agreed operating model for the Health Board through the FFTF programme	Consultation and Implementation of the new operating model leadership structure. The first phase is Band 8c +	Senior Associate Director of People & Organisational Development(OD)	31/03/2027	Progressing
G5 Clinical Service plan that outlines workforce requirements	Engagement sessions are being held in May 26, a draft outline plan has been shared.	Executive Medical Director (Kamela Williams, support in Planning)	01/04/2027	Progressing
G6 M&D leadership and engagement is not fully effective	Strengthen the governance arrangements for the Medical Workforce Group, to report into the new Executive Delivery Group for People & OD	Senior Associate Director of People & OD	30/09/2026	Progressing
	To scope and put forward proposals for a wider Medical Staffing function in the People Service directorate	Senior Associate Director of People & OD	31/03/2027	Progressing
G7 M&D Job Planning policy	To approve and publish the new Job Planning procedure and meet the target of achieving 90% of M&D Job Plans being in place.	Executive Medical Director	31/03/2027	Progressing
G8 More effective workforce pipelines in fragile services	Within the overarching OD plan, Values Based Recruitment (VBR), values based induction and transition are being	Exec Director People & Organisational Development(POD)	31/03/2027	Progressing

	introduced as part of the new Health Board values implementation			
G9 Absence and sickness management to deliver on ministerial targets and enabling actions	Targeted management of sickness absence. A Healthy Workforce group is in place and is overseeing the action plan to target reducing sickness absence rates, in line with the Welsh Government requirements by March 2026. A range of actions are being worked on through this group, which are expected to be delivered by the end of 2026/27	Deputy Director, People & Organisational Development	31/03/2027	Progressing
	A sickness deep dive paper was tabled at December 2025 People & Culture Committee which incorporates a series of initiatives that will help reduce sickness absence rates. The planned delivery for these is March 2027	Deputy Director, People & Organisational Development	31/03/2027	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	Not in Tolerance	

Position & Intended Outcome for Risk

KPIs to that inform our risk in this area as at February 2026;
Overall Vacancy rate of 8.1%; Target 8%. M&D, Add Clin Services, Healthcare Sciences, E&F and A&C above target
Turnover stands at 7.1% and continues its downward trend from 7.9% this time last year.
Sickness rates currently 6.08%; Target 4.2%
Time to Hire currently 77 days; target 71 days

CRR REF: 25-03 - Risk Title: Population Needs

Director Lead: Executive Director of Public Health		**Date Opened:** 21/08/2025 *(version 2 refined from 2023)*
Assuring Committee: Planning, Population Health & Partnership Committee		**Date Last Committee Review:** 05/03/2026
Date Last Reviewed: 29/06/2026	**Link to BAF**: BAF24-06/07	**Target Risk Date:** 31/03/2028

Risk Detail:
There is a risk that the organisation will fail to meet the health needs of the population and will not enable good health and wellbeing of the population.
This may be caused by a failure to embed appropriate health prevention responses including areas such as immunisation, outbreak management and screening, failure to deliver interventions that improve people's health, increasing pressures in primary care, rising demand for chronic condition management, and insufficient capacity in children's, dental, and mental health services.
This may lead to unmet health needs, preventable and communicable diseases, poorer health outcomes and widening inequalities for the North Wales population.

Mitigations/Controls in place

1. Recurrent funding secured for Healthy Weight / Healthy Wales programmes
2. Diabetes Programme established
3. Healthcare Public Health programmes support the integration of population health approaches within patient pathways
4. Approved Communicable Disease Plan in place with supporting procedures in place for some communicable diseases.
5. Primary Care Board and subgroups (dental, community pharmacy, optometry, GMS) provide cluster-level governance.
6. CHC (Community Health Council) teams and community escalation frameworks in place
7. Welsh Government Neurodevelopment transformation programme funding to support longest waiters
8. National referral pathways in orthodontics and Dentist with Enhanced Skills / Tier 2 provision.
9. Prevention, Population Health & Early Intervention Executive Delivery Group provides oversight of delivery.
10. The IMTP and National Planning Guidance 26/27 outline the requirement for health board focus on the development of population health intelligence and the submitted health board plan responds to this – Strategic Intent 1
11. Development of the Health Board Strategy, Clinical Services Plan and major programmes such as Community by Design and Foundations for the Future provide opportunity to integrate Prevention and Population Health into plans and are informed by identified population heath priorities.
12. Regional Wellbeing, Prevention and Anchor Framework agreed by Health Board and Partners
13. Improvement on uptake against National Immunisation Framework achieved 25/26.

14. Health Needs Assessment and a scoping/insight review completed to understand the health needs and experiences of inclusion health groups (including Homelessness, Sex Workers and Asylum Seekers and Refuges).
15. Homelessness Insights paper prepared with recommendations to the Health Board for the upcoming duty to Ask, Act, and Cooperate within the Homelessness and Social Housing Bill (Welsh Government, 2026)
16. A community outreach offer designed to improve access to prevention and early intervention services for inclusion health groups.
17. Evaluation framework designed to measure the impact of the primary care continuity of care pathway for prison leavers.
18. Identification of unauthorised Encampments across North Wales and their proximity to GP practices, to increase access to primary care provision for Gypsy, Roma and Traveller people.
19. Health Equity Checklist to support the Health Board's strategic planning by ensuring that services are deigned and delivered in ways that address health inequalities.
20. Inclusion of Prevention and population health priorities are implicit in Strategic intent priorities 2,3 and 4 and the Corporate Risk has been updated to reflect gaps in controls which are addressed through integrated deliverables throughout the Health Board Annual Delivery Plan.

Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Limited system-wide prevention leadership and prevention not consistently prioritised	Weight Management Steering Group to develop a plan which addresses recommendations from the BCUHB Weight Management Service review **Outcome:** Improved organisational oversight of provision to support weight management and improvement of population healthy weight priorities **Metric:** Access to services and success rates **Expected Impact on Risk Score Reduction:** Services reflect the needs of the population with a prevention and health improvement focus. **Action Update:** 29/4/26 Report received outlining recommendations, which will inform 26/27-28/29 IMTP plans. next steps in terms of the plan have been incorporated into the Draft delivery plan which supports the IMTP 26.27. Identify variation across North Wales in service delivery. **26/6/26** – (links to Annual Delivery Plan 1A.2) Programme Group established, reporting progress against Annual Delivery Plan. Awaiting outcomes of national work in relation to digital weight management offer which will support progress, however we continue to move forward with level 2 and level 3 digital offers locally.	IHC Director – Weight Management Services	31/03/2026	Progressing
Gaps in Controls	**Actions**	**Action Owner**	**Due Date**	**Progression Analysis**
The plan in place for the management of communicable disease outbreaks (in and out-of-hours) within BCUHB requires testing / simulation and socialising to ensure effectiveness	Health Board can demonstrate robust plans are in place and tested for Communicable disease outbreak management across its services and functions. **Outcome:** Improved preparedness for the identification and management of communicable disease threats. **Metric:** The Health Board response to communicable disease threats, the existence of plans and pathways for the management of communicable disease threats, the numbers of staff trained in preparedness measures (including HCID PPE training, and FFP3 face fit testing), the existence and delivery of health board simulation exercises. The evaluation of data on disease incidence and infection rates within BCUHB settings. **Expected Impact on Risk Score Reduction:** Strengthened preparedness within the Health Board for the identification and management of communicable disease threats. **Action Update:**	Assistant Director Of Health Protection, Public Health	30/09/2026	Progressing

	29/04/2026 (links to Annual Delivery Plan 1D) - The Strategic Communicable Disease Preparedness Group continues to meet with an agreed ToR however attendance is poor and the group remains un-quorate despite being in existence for 12 months. No response following submission of a paper to QSE in March 2026. HCID PPE trolleys are available in each of the 3 IHC hospitals but training in the use of the HCID PPE ensemble remains low with 22 staff trained across the Health Board (including 2 trainers). There is only 1 staff member trained in the West IHC where engagement appears particularly poor. Independent GP practices continue to lack fit testing for FFP3 masks, continuing the additional risk that GP practices will refer patients with suspected communicable diseases to secondary care. The revised pathway for Rabies Post-Exposure Prophylaxis remains un-approved despite being submitted for approval in Dec/Jan. There has been no progress on a national level to review GP contracts to include health protection medicines. BCUHB areas of weakness identified by recent cases and incidents include the ability (or lack of) to provide post-exposure vaccination to the contacts of Hepatitis A cases, or Invasive Meningococcal Disease cases. These were brought to the attention of the Chief Executive during a corporate directorate review on the 24th April 2026 where is was agreed that further executive level discussion was required. A successful HCID/pandemic preparedness exercise took place on the 15th April and was represented by a number of services from across the Health Board and Welsh Government and Public Health Wales. The findings from the event will help develop the Health Boards pandemic plan and encourage IHCs to re-instate their HCID preparedness meetings (IHC East met on 28th April 2026). **29/6/26 –** As a result of two high profile health protection incidents (Andes Hantavirus outbreak on board the MV Hondius, and an outbreak of Ebola in the Democratic Republic of Congo and Uganda), a number of activities have taken place since early May to improve preparedness measures for communicable diseases (with a focus on High Consequence Infectious Diseases in particular). Activities included the convening of a BCUHB IMT (Initially for Andes Hantavirus, and subsequently HCIDs), the development of plans and pathways within YGC for managing symptomatic contacts of Andes Hantavirus, improving the numbers of staff trained in the HCID PPE ensemble. The consideration of paediatrics, maternity and MHLD into HCID planning and preparedness. Whilst each of the 3 IHCs are at different stages in their preparedness, the international focus on HCID has resulted in improved focus on this particular issue. However, despite the increased interest and attention, attendance at the Strategic Communicable Disease Preparedness group remains poor, and the group is likely to be disbanded and incorporated into the Strategic Infection Prevention Group (this is yet to be approved).			

	The plans and pathways for HCID will be tested with a 'mystery shopper' exercise in July. An education session on HCID was provided to medical staff in YGC with teams links to East and West. The Rabies Post Exposure Prophylaxis pathway has been approved and has been used successfully. A response to a case of Hepatitis A in a primary school class room assistant resulted in approximately 90 contacts within the setting (children and teachers) requiring Hep A vaccine. The response was successful and will be used to develop a vaccination outbreak response pathway for BCUHB. Welsh Government have made contact with BCUHB following the simulation exercise that took place on the 15th April. Welsh Gov want to incorporate a short overview of this exercise in a national evaluation of Exercise Pegasus in Wales			

Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Inconsistent commissioning approach across community and primary care services.	Develop a Community and CHC Strategic Plan with Local Authorities. **Legacy item 24/25 CRR Framework - This does not form control for this Corporate Risk**	Acting Assistant Director Care Homes Support & CHC Commissioning	31/03/2026	Progressing
	Implement surge and escalation plans with Local Authority partners for community flow **Legacy item 24/25 CRR Framework - This does not form control for this Corporate Risk**	Acting Assistant Director Care Homes Support & CHC Commissioning	31/03/2026	Progressing
Fragility of Neurodevelopment workforce and reliance on temporary funding	Management of CYP (Children and Young People) needs, ND workforce business case submitted to the Executive Team, decision on the case deferred pending a broader review of funding priorities - No approval received in relation to business case submitted, focus for this financial year is on utilising additional non-recurrent funding received from WG to reduce longest waiters Two private providers commissioned for ND assessments over 3 years, one provider delivering as per contract, the other provider is in breach of contract in relation to the assessments completed, as such there will be approximately 700 over 3-year waiters at the end of March. Awaiting communication from WG re 26-27 ND funding for assessments, plan is to continue use of one provider, all procurement and contract arrangements are in place. A briefing update has been shared with WG colleagues. **Legacy item 24/25 CRR Framework - This does not form control for this Corporate Risk - this is a service level issue**	CAMHS Programme Management Business Lead, Child & Adolescent Health	31/03/2026	Progressing (revised date from 31/12/2025)

Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Lack of restorative dentistry service and workforce pipeline	Undertake a dental diagnostic deep dive to inform strategy - In 2025 a review of the primary care dental service was undertaken to look at the current challenges in both General Dental Services (GDS) and the Community Dental Service (CDS). Key issues were identified in areas including leadership, performance, process, finance and people management. Progress within the service is now being monitored at a senior level via the IPEDG group, and a senior clinical review of the service is being planned for earlier 2026. **Legacy item 24/25, 25/26 CRR Framework - This does not form control for this Corporate Risk - this is a service level issue* - Restorative Dentistry service is not part of this risk.*	Assistant Director Of Primary Care (Dental)	31/03/2026	Progressing
Develop and improve system-wide prevention through consistent prioritisation and integration with a **focus on health improvement**	1) Progress **Strategic Intent Priority 1 deliverables 'Focus on Health and Wellbeing'** Workstream **1A – Preventative Approaches to health & wellbeing** **Outcome:** Healthier communities with fewer people smoking, more people with healthy weight and in better physical and mental health. Greater preventative focus across the life course. **Metric:** • Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks. • % Improvement in Breastfeeding rates at birth and at 10 days • Increase the proportion of children in Wales who are a healthy weight by halting the rise, and contributing to a year-on-year decrease in the levels of overweight and of obesity as measured and reported through the National Child Measurement Programme, focusing on those most disadvantaged. • Level 2 Adult weight service – increase activity rates • Tiny Tums – increase number of settings who achieve Tiny Tums award • Increase family programmes via schools – Come and Cook **Expected Impact on Risk Score:** Most care delivery in the NHS now relates to long-term conditions the majority of which have significant preventable factors. Preventable health measures should consider all stages across the life course – from pre-conception and into older age. This can reduce the likelihood and severity of chronic illness, reducing flow towards acute settings **25/6/26** – 1A.3 - Grant funding confirmation for Prevention and Early years, Whole Schools Approach and Healthy Weight Healthy Wales received into the health board. Agreements and plans in place – focus on weight, smoking, breastfeeding and early years.	Consutant in Public Health (Health Improvement Programme)	31/03/2027	Progressing

	1A.6 – Health Improvement offer is under development which considers where opportunities lie to implement changes and improvements to delivery and health outcomes within the health board. 1A.9 – 15 organisations across North Wales are now engaged with the Healthy Travel Charter 1A.10 – Organisational campaign planned to improve uptake of 'Make Every Conversation Count' training			
Gaps in Controls	2) **Actions**	**Action Owner**	**Due Date**	**Progression Analysis**
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on **Healthcare Public Health including disease prevention and managing health outcomes**	2) Progress **Strategic Intent Priority 1 'Focus on Health and Wellbeing'** Workstream **1B** – **Proactive strategies for disease prevention, frailty & falls** **Outcome:** More proactive care of frail people, reducing falls and the need for healthcare services. Increased screening services for cancer improving early identification and management. Fewer complications linked to diabetes due to improved monitoring and management. Health Board can demonstrate a clear prevention and health inequalities focus in its major strategic plans and services. **Metric:** • Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes. • Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within last 15 months. • Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within last 15 months. • National screening targets. **Expected Impact on Risk Score:** Falls and frailty are a significant driver of demand across primary and acute NHS Services and is expected to increase. Applying data and evidence through population health management will allow the organisation to target action within identified population groups towards where there is a strong likelihood of a health risk occurring, develop tailored interventions to prevent or reduce the impact of health risks which would contribute to preventing further deterioration, and optimise how the early stages of disease is detected. Intervening in the early stages of disease can prevent the disease from progressing, allows people to self-manage their health, improves health outcomes, prevents the individual developing other health conditions and ensures that people can continue to live their lives fully within their families and communities. **26/06/26 –** 1B.1 – Population Management post advertised – this is a senior post with focus on development population health intelligence which will inform service and organisational planning. 1B.5 – Diabetes programme structure to support place based approaches for Diabetes are being established with initial practice level work being	Consutant in Public Health (Health Care Public Health & Population Health Management Programmes)	31/03/2027	Progressing

	initiated. Initial work underway to understand challenges and opportunities at a cluster and GP level 1B.6 – Diabetes 8 Care processes - Work underway to establish access to GP level data and to establish offer to practices that have the lowest levels of uptake.			
Gaps in Controls	**Actions**	**Action Owner**	**Due Date**	**Progression Analysis**
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on **reducing health inequalities**	3) Progress the **Strategic Intent Priority 1 'Focus on Health and Wellbeing'** Workstream **1C** – **Health Inequalities** **Outcome:** Reduced risk factors linked to the wider determinants of health such as environmental, social and economic factors. Improved equity of access between most and least deprived areas in relation to vaccinations, screening and diabetes care. All services and strategic plans should have metrics that enable them to assess the potential health inequalities in delivery. **Metric:** • Reduce inequity in the uptake in the most and least deprived areas in preventing ill-health especially in relation to vaccination, screening and Diabetes prevention and care. • National screening uptake targets - reduction in variation, increase in uptake from inclusion groups • Vaccination targets - reduction in variation, increase in uptake from inclusion groups • Diabetes 8 Care Processes – reduction in variation, increase in uptake from inclusion groups **Expected Impact on Risk Score:** Inequalities will continue to widen if we do not embed population health approaches in pathways and service plans that can enable the organisation to target resources proportionate to need. Through understanding the needs of communities, the Health Board can better enable provision of care in the right way, in the right place, and at the right time. The Health Board cannot reduce health inequalities alone. Many factors which impact on health and wellbeing require commitment and coordinated action across public sector organisations, enabled through the organisation's role and opportunity as an Anchor institute. Together, the right social, economic and environmental conditions can be created that allow health and wellbeing to flourish. **26/6/26 -** 1C.2 – Vaccine Equity Plan in draft and 1C.4 engagement plan for primary care partners drafted 1C.3 – Screening inequalities data sourced and reviewed to inform Screening Equity Plan 1C.6 – Anchor Charter – systems engagement events have taken place and findings alongside 'Missions' for focus presented to Regional Partnership Board 1C.7 - Homelessness insights implementation plan developed. Community prevention outreach offer developed for the Traveller community.	Consultant in Pubic Health (Health Inequalties Programme)	31/03/2027	Progressing

Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on **health protection**	4) Progress the **Strategic Intent Priority 1 'Focus on Health and Wellbeing'** Workstream **1D** – **Health Protection** **Outcome:** More people in the population are protected from increased uptake of vaccinations with a particular focus on vulnerable groups. People are protected against existing, new and emerging health hazards. Communicable outbreak plan developed and tested, providing assurance to the Health Board and partners. **Metric:** • *Percentage uptake of the following targeted measures:* • Children who are up to date with all routine scheduled vaccinations by age 5. • Children receiving the Human Papillomavirus (HPV) vaccination by the age of 15. • Influenza vaccination amongst adults aged 65 years and over Applicable during: 01.09.2026 - 31.03.2027. • Respiratory Syncytial Virus (RSV) vaccination for those turning 75 years old. • Influenza <65 at risk • Influenza - Staff • MenACWY Cml (Y10) **Expected Impact on Risk Score:** Health Protection focuses on preventing harm before it happens and keeps communities safe from communicable and other notifiable illness that could affect large numbers of the population at scale. Risk of infectious diseases include Flu, Measles, and M-Pox, with disease outbreaks having a significant impact on closed settings such as care homes and schools. Health Protection includes the management of vaccine preventable disease risks such as measles, outbreak control planning, and training and education in settings to support Infection Prevention Control (IPC). **26/06/26 –** 1D.1 School Immunisation Programme : The e-consent app is on track to be introduced for the School based Flu immunisation programme for winter 2026-2027. RSV older adult programme : Reflecting on lower uptake within this cohort and an expansion to the eligibility , the integrated vaccination service and primary care partners have adopted a cohort specific co-administrated focus for the Covid-19 Spring programme to optimise delivery alongside improving RSV uptake rates 1D.5 – increased sampling and new vaccination pathways established 1D.6 - Annual residential Care Homes IP&C reviews have commenced.	Assistant Director Health Protection / Deputy Director Vaccs & Imms	31/03/2027	Progressing

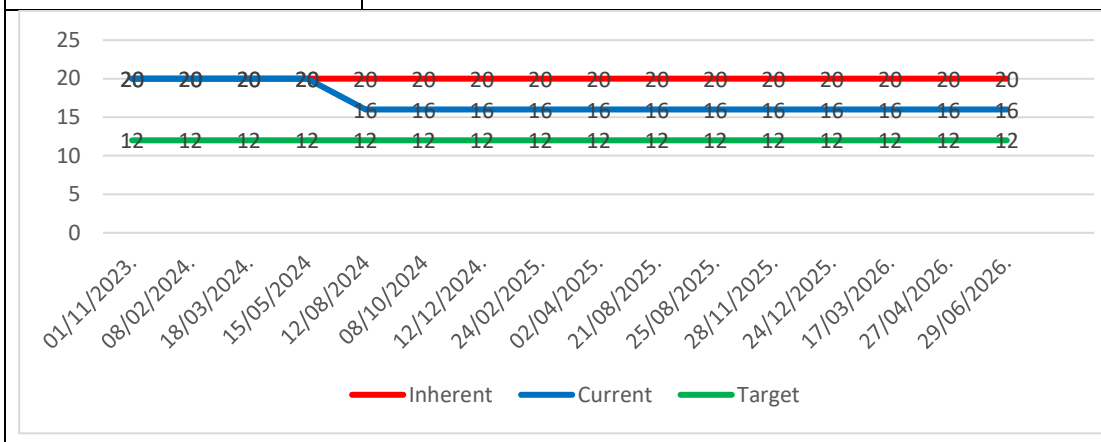
Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Develop and improve system-wide prevention through consistent prioritisation and integration with a **focus on Primary and Community Care**	5) Progress against the **Strategic Intent Priority 2 - Enhanced Co-ordination of Care** deliverables which will directly contribute to improving population health and keeping people well for longer. **This includes focused deliverables:** - *Development of Health and Wellbeing Hubs* - *Primary Care contracting inc Dental* - *Progression of Community by Design* - *Delivery of Frailty and falls prevention models* - *Delivery of Weight Management and smoking cessation services* - *Diabetes management* - *Health and wellbeing of Children & Young People* **Outcome:** More co-ordinated care in the community for people with long term conditions. Better access to community based preventative care. **Metrics:** • Percentage of population (adult) receiving NHS dental care over a 24-month period - General Dental Services (GDS) • Percentage of population (child) receiving NHS dental care over a 12-month period - General Dental Services (GDS) • Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes. • Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within last 15 months. • Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within last 15 months. • Percentage of individuals identified via the Audit Plus Frailty Tool (or its replacement) to receive proactive care in line with their agreed care plans. • Number of staff undertaking MECC **Expected impact on Risk Score:** A well-functioning Primary Care system is essential to improving population health outcomes, supporting the shift towards prevention and early intervention, and delivering a more sustainable, prudent healthcare model for the future. Community-based services are essential to improving outcomes through prevention, early intervention, and supported self-management. Providing care within local communities makes services more accessible, improves user experience, and helps reduce inequity by removing practical, geographical, and socioeconomic barriers to care-based services which is essential to improving outcomes through prevention, early intervention, and supported self-management. Health and Wellbeing Hubs bring together physical health, mental health, social care and community wellbeing services in one accessible location, creating a “no wrong door” approach that enables earlier intervention, smoother referrals and more holistic care. By embedding prevention and public	AD Primary & Community Care	31/03/2027	Progressing

	health activity within local communities, they help address the wider determinants of health, promote independence and reduce avoidable demand on acute services. **26/6/26 -** 2A.7 – development of plans in relation to use of the Adult Plus Frailty tool 2B – Community by Design is progressing as expected through the 'Discovery' phase 2C – Health & Wellbeing hubs programme continues to make progress against plans for implementation – different stages for different hubs			
Gaps in Controls	**Actions**	**Action Owner**	**Due Date**	**Progression Analysis**
Develop and improve system-wide prevention through consistent prioritisation and integration with a **focus on secondary care, clinical pathways and specialist services**	6) Progress against the **Strategic Intent Priority 3 - Improve Access, outcomes and experience for all** deliverables which will directly contribute to improving population health and keeping people well for longer. **This includes deliverables which focus on:** – *BCU community falls response resource* – *Providing falls prevention training across Care Homes* – *BCU MHLD physical health policy in line with national developments.* – *Reducing inequality and variation in access to services and pathways* – *Digitally delivered specialist All-Wales gambling harm and treatment service* – *CAMHS Early Help systems and processes* – *Healthy Child Wales 2 Programme* – *Childhood diabetes – prevention and management* – *Women's Health - prevention and early intervention, including preconception health and earlier identification of women's health conditions* – *Support the National Lung Screening Programme and other National screening programmes including reducing of variation* – *Support staff to complete MECC training* **Outcomes:** People who fall in the community are treated outside of acute hospitals where they are more likely to de-condition. Patients are directed to the most appropriate service, freeing up resources such as ambulances and emergency departments. . A modern, people-centred healthcare system A clear long-term vision and strategy for our clinical services across North Wales, and an organisational structure that enables its delivery. Improved quality of maternity services including reduced perinatal mortality rates. Improved waiting times for people of all ages with Mental Health, Learning Disabilities and Neurodevelopment. More people supported with substance misuse. **Metrics:** • Reduce avoidable ambulance conveyances and ED admissions from Care Homes through providing falls lifting equipment and level one falls prevention training to be delivered to 30 Care Homes across North Wales.	ADs / Programme Leads – UEC, Planned Care, C&YP CAMHS, MH & LD, Womens	31/03/2027	Progressing

	• Reduce avoidable ambulance conveyances and ED admissions from the community by developing a proposal to use Six Goals Programme funding to increase Community Resource Teams (CRT) capacity, focused on mobilising Band 3 therapy support staff as a dedicated pan BCU community falls response resource. • Reduce Health Inequalities for people with learning disabilities by increasing the uptake of the annual health checks and public health screening initiatives across services. • Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol) • Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment • National screening targets • Childhood Measurement Programme participants • Percentage of C&YP waiting less than 26 weeks to start neurodevelopment assessment • Number of staff undertaking MECC **Expected impact on risk score:** Earlier diagnosis leading to better health outcomes. Prevention of deterioration and ill health or worsening conditions which impact on health and wellbeing. Reducing the gap in health outcomes for people with mental health and learning disabilities, supported by a focus on prevention, early intervention and reducing health inequalities. An integrated, responsive system where people receive the right care, in the right place, at the right time. Reduction in health inequalities and variation within clinical pathways of care. **26/06/26 –** 3A – Falls prevention training and Falls lifting equipment delivery plan finalised for Care homes 3D.6 reduce inequalities for LD patients - Patient-facing support focusing on facilitating the uptake and delivery of health checks for patients, particularly those in hard-to-reach locations, through our Health Liaison Team and ‘Lab in a Bag’ initiatives. 3F.8 - Development of a strategic plan for children with a learning disability, and reduce inequalities for consultation - on track following meeting with Childrens CCAG 3F.2 - gap analysis of the requirements to fully implement the Healthy Child Wales 2 Programme 3G.6 local delivery of the NHS Wales Women’s Health Plan across North Wales - Confirmed funding allocation both locally and nationally to expand on the Women's Health Hub as detailed within the National Women's Health plan 2025-2035			

Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Develop and improve system-wide prevention through consistent prioritisation and integration with a **focus on system-wide approaches, Enabling services, strategy and pan BCU delivery**	10)Progress against the **Strategic Intent Priority 4 - Create a modern people centred healthcare system** deliverables which will directly contribute to improving population health and keeping people well for longer. **This includes deliverables which focus on:** - *Population health management* - *Development of key plans and strategies* - *Embedding prevention as a core component and enabler of major programmes* - *Develop organisational understanding of population health needs and priorities* - *Develop collaborative partnership working which tackles wider factors which impact on population health and wellbeing such as employment and environment.* - *Funding models which support movement of services towards primary and community settings* **Outcomes:** Improved and more resilient systems, data and insights to support better day to day delivery of safe services and their improvement. More research and innovation projects and collaboration with education partners to provide improved health care for the future. Improved value for money services ensuring that precious resources are spent to deliver maximum benefit to the population. Better experience and outcomes for the population. **Metrics:** • Develop the measures of success in relation to both population and patient outcomes as well as the strategy development process. • Planning maturity matrix self-assessment scores (Population Needs Assessment is part of this) • Develop the measures of success in relation to both population and patient outcomes as well as the CSP process for those areas selected in the first tranche of the CSP. • High Value High Impact pathway analysis • Increase proportionate spend on Primary and Community Services **Expected Impact on risk score:** The Health Board can evidence informed decision making based on population health management data and intelligence. The Health Board can demonstrate response to population need and the impact on service delivery and resourcing. **26/6/26 –** 4B – Development of Strategy continues through Discovery phase, considers prevention and population health. 4D.12 – Facilitate transformation through targeted activity - Early milestones relates use of data to inform a regional Warm Homes initiative in collaboration with local government and progressing recruitment to newly developed Population Health Management Team roles 4K – quantify current spend on primary and community services re strategic move to proportionately increasing investment into primary and community care - database is being is being	AD Planning / DDAT, Transformation, Estates, Finance, VBH	31/03/2027	Progressing

	developed to enable clear identification of Primary and Community cost centres and spend			



	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	Not in Tolerance	

Position & Intended Outcome for 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 REF: 25-05 - Risk Title: Strategic Change – Impacting Care and Staff Delivery		
Director Lead: Executive Director of Transformation and Strategic Planning		**Date Opened:** 21/08/2025 *(version 2 refined from 2023)*
Assuring Committee: Planning, Population Health & Partnership Committee		**Date Last Committee Review:** 05/03/2026
Date Last Reviewed: 05/05/2026	**Link to BAF**: BAF24-02	**Target Risk Date:** 26/11/2026

Risk Detail:

There is a risk that patients may not benefit from planned improvements in care, access, and outcomes if the HB does not effectively implement or develop its strategic change programmes.

This may be caused by a lack of momentum in delivering change, unclear or underdeveloped clinical strategy, competing ministerial priorities, and inconsistent transformation efforts across clinical services.

This may lead to inefficiencies, missed opportunities to modernise care, continued misalignment between service delivery and patient needs, patient harm from long waiting times, delays, and backlog reviews, and increased frustration or disengagement among staff tasked with delivering change.

Mitigations/Controls in place

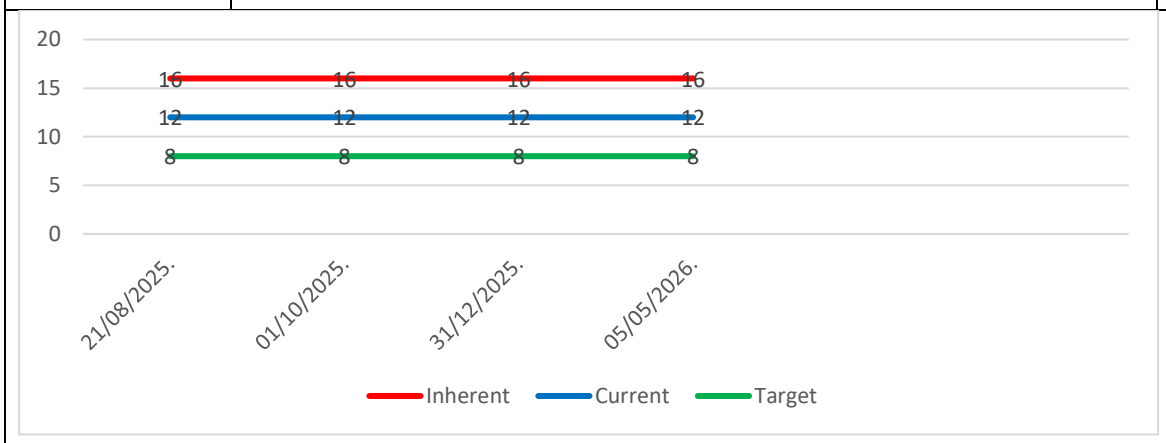
1. Scrutiny and oversight of strategy development work by the Strategic Planning and Service Change Group (SP&SC Group a sub-group of the Executive Committee), Planning Population Health and Partnerships (PPHP) Board Committee and the Health Board to ensure robust governance arrangements and timely escalation; which are important for enabling foundations for successful delivery of strategic change and co-production of the 1) Strategic Intent for North Wales with partners, 2) 10 Year Strategy for the Health Board, 3) Clinical Services Plan
2. Priority change programmes in place for the organisation 1) Major Change Programmes (Planned Care; Urgent and Emergency Care; Value and Sustainability; and Foundations For The Future), 2) Key Programmes (grouped into: Mental Health; Llandudno Planned Care hub; Improving safety, efficiency and effectiveness through digitisation; Diagnostics improvement; and Health and Well-being Hubs), 3) Challenged Services (Dermatology, Ophthalmology, Vascular, Urology, Oncology, Plastics, Orthopaedics, Orthodontics).
3. Change programmes controls in place and monitored by the Transformation and Improvement team to ensure they are run consistently and best practice project, programme and portfolio management is applied. As well as providing an objective and independent assessment of progress and areas of risk.
4. Oversight and scrutiny of the Major Change Programmes tracking progress, risks, and dependencies by the Executive Committee, relevant Board Committee and Health Board. The Key Programmes reports into SP&SC Group, PPHP and Health Board.
5. The Challenged Services report into SP&SC Group for review and oversight, Quality, Safety and Experience Committee (QSE) and Health Board.
6. External oversight and scrutiny is provided by Welsh Government via IQPD and JET as well as quarterly Challenged Services review meetings.
7. Terms of References for all groups with clear routes to escalation.
8. Legal and policy compliance including adherence to Welsh Government (WG) service change guidance.
9. Continued development of the portfolio management and reporting approach for all priority change programmes, including monthly monitoring of high risks across all priority programmes.
10. Mobilisation of the Challenged Services oversight group that will report into the SP&SC Group.

Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
G1 Completion of the strategy development work, moving into the	Complete Strategic Intent for North Wales with partners, presenting to Health Board for approval **Expected Impact on Risk Score Reduction:** Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual	Head of Health Strategy and Planning, Transformati on &	31/01/2026	Completed

execution phase.	actions alone will not affect the score. **Action Update: COMPLETED.** Four Strategic Intent Statements were co-created, tested and refined with key partners. They were reviewed by PPHP on the 14th of January and subsequently approved by the Board on the 29th of January. Following Board approval, the Statements were used to provide the strategic planning framework for the 2026/29 three-year plan replacing the previous five Strategic Priorities.	Strategic Planning		
G2 Organisational approach to change management to be developed and implemented.	Organisational approach to change developed as one of the enabling products within Foundations for The Future programme **Expected Impact on Risk Score Reduction:** Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. **Action Update:** Further work has been scheduled into 26/27 as part of the service level plan, to ensure full engagement in this work. Successful sessions have been held with the Executive team and the Stakeholder Reference Group. A discovery phase report is being finalised for presentation to the Strategic Planning and Service Change group on the 4th June, and a time-limited group of key stakeholders is forming around the design elements. This will lead to an organisational change framework which is scheduled for completion in Q3.	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	26/11/2026	Progressing (revised date from 31/03/2026

Gaps in Controls/	Action	Action Owner	Due Date	Progression Analysis
G3	Complete the diagnosis phased of the Health Board's 10 Year Strategy, including an implementation plan for the remaining programme of work **Expected Impact on Risk Score Reduction:** Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. **Action Update:** Due to competing pressures with the strategic intent and capacity constraints this work has rolled into 26/27 and will complete before the end of Q1. This will include endorsement through governance and be supplemented by a detailed and time-bound implementation plan for the delivery phase of the 10yr Strategy.	Head of Health Strategy and Planning, Transformation & Strategic Planning	30/06/2026	Progressing (revised date from 31/03/2026
G4	Complete preparations for phase 2 of the Clinical Services Planning (CSP) work, including an implementation plan **Expected Impact on Risk Score Reduction:** Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. **Action Update:** A CSP engagement event with senior clinical leaders is taking place on the 5th May. Preparatory work underway, with initial CSP engagement event scheduled for 5th May. This event is one of the final steps in the preparation phase which is now expected to complete by the end of Q1. The day is designed to build a shared purpose and initiate the development of a new CSP for BCUHB. The CSP has now been adopted as a major change programme during 26/27 and a fully programme plan will be put in place.	Head of Health Strategy and Planning, Transformation & Strategic Planning	30/06/2026	Progressing (revised date from 31/03/2026
G5	Implement changes to portfolio management and reporting based on feedback on early iterations of reporting across all the priority programme areas, including monthly monitoring of high risks across all priority programmes.Work is now complete and will continue to evolve as part of business as usual. Iterative changes have been made and the reporting has been very well received by Board Members for both Key Programmes and Challenged Services, with Board members stating that they feel more assured. Highlight reports in place for each programme/service in scope with summarised reporting through the Strategic Planning and Service Change Group and onwards to PPHP and Board. **Expected Impact on Risk Score Reduction:** Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. **Action Update:** No further update in this period as now complete.	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	31/12/2025	Complete

G6	Mobilise the Challenged Services oversight group that will report into the SP&SC GroupThis is complete. The first meeting was held on the 28th November with the next meeting scheduled for the 26th January, with the group developing plans for the regionalisation of services and transitioning into broader Clinical Services Plan work. **Expected Impact on Risk Score Reduction:** Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. **Action Update:** No further update in this period as now complete.	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	31/12/2025	Complete



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	3	12
Target Risk Score	4	2	8
Risk Appetite	Quality <15		In Tolerance

Position & Intended Outcome for Risk

CRR REF: 25-06 Risk Title: Delivery of the 2026/27 Financial Plan and Financial Sustainability		
Director Lead: Executive Director of Finance		**Date Opened:** 01/04/2026
Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:**
Date Last Reviewed: 06/07/2026	**Link to BAF:** BAF24-03 / financial sustainability	**Target Risk Date:** 31/03/2027

There is a risk that the Health Board will be unable to deliver the 2026/27 financial plan and to demonstrate a credible route to longer-term financial sustainability. The plan is set within a zero-investment framework and includes a planned deficit of £43.0m, a recurrent savings requirement of £46.0m and significant reliance on delivery of savings, grip and control, and receipt/retention of anticipated Welsh Government allocations.

This may be caused by inflation and unavoidable cost pressures exceeding the 1.11% allocation uplift; recurrent impacts from 2025/26 cost pressures; growth and price pressures in commissioned services, prescribing, secondary care drugs and CHC; unfunded national pressures including Welsh Risk Pool, digital/Microsoft licensing and additional NWJCC contributions; pressures in Out of Area Mental Health placements and escalated capacity; and insufficiently mature savings and disinvestment plans.

This may lead to failure to achieve the planned deficit trajectory and key financial duty, loss or non-retention of conditionally recurrent strategic funding, reduced ability to fund essential services and transformation priorities, further escalation and scrutiny, and increased risk to safe, timely and high-quality care.

Mitigations/Controls in place

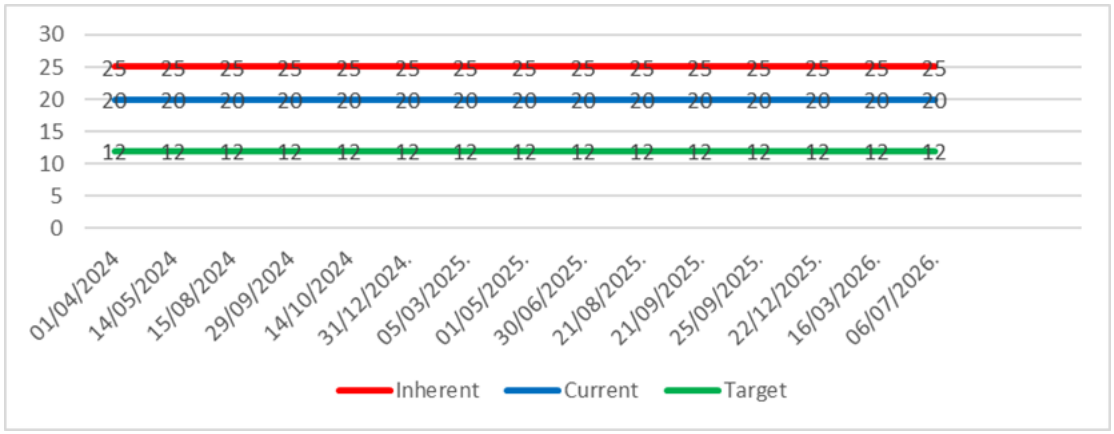
- Monthly financial reporting to Welsh Government through the Monthly Monitoring Return and internal Health Board reporting, including forecast outturn, risks and opportunities.
- Performance, Finance and Information Governance Committee oversight, with financial and performance information shared routinely.
- Executive and divisional governance over targeted investment allocations, including Performance and Transformation, Planned Care, Value-Based Healthcare, Further Faster and other specific Welsh Government allocations.
- Continuation of 2025/26 Grip and Control measures into 2026/27, including additional non-pay expenditure controls for non-clinical categories, scrutiny of Travel Bureau requests and Stores orders, procurement review of pending Oracle requisitions and cancellation where not critically urgent.
- Pay controls and added oversight over non-clinical external recruitment and clinical posts prior to recruitment, with scrutiny of temporary workforce use through Clinical Executive leadership.
- Value and Sustainability thematic savings model across Clinical Value, Workforce, Continuing Healthcare, Medicines Management and Non-Pay & Procurement.
- Savings identification and monitoring through the Green/Amber/Red pipeline, with Welsh Government action point deadlines for schemes to meet required classification by 30 June 2026 and conversion requirements by 30 September 2026.
- Continued scrutiny of agency, locum and variable pay, including delivery against the Cabinet Secretary enabler target of a 30% agency cost reduction.
- Ongoing review of reserves, central budgets, virements and forecast categorisation to improve transparency of cost pressures, mitigations and underlying deficit.
- 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.

- Accountability Agreements to be 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
- Integrated Performance and Accountability Framework 2026-29 adopted by Board on 28 May 2026
- Escalation meetings in place with key budgets holders and Chief Executive for July 2026 for those services / divisions that have not underwritten their savings targets at the end of June 2026.

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 The Month 2 position is adverse to plan, with an in-month deficit of £5.6m, £2.0m adverse to profile, a year-to-date deficit of £10.9m and cumulative savings shortfall of £5.0m.	Maintain enhanced monthly financial recovery and run-rate review through Executive, IP-EDG and PFIG Committee oversight. **Outcome** In-month deficit and year-to-date adverse variance are contained and brought back towards the profiled planned deficit trajectory. **Metric** In-month variance to plan; cumulative deficit to plan; run-rate movement by division. **Impact on Risk** Reduces likelihood of further deterioration and supports delivery of the £43.0m planned deficit.	Executive Director of Finance / Chief Executive Officer	Monthly to 31/03/2027	Progressing
G2 The plan relies on retention of conditionally recurrent strategic Welsh Government funding; loss of this funding is identified as an £82.0m risk and would materially worsen the underlying position.	Maintain evidence against conditions attached to strategic funding and ensure clear escalation where delivery or de-escalation requirements are at risk. **Outcome** Conditions for retention are explicitly tracked and risks escalated early. **Metric** Condition tracker RAG; evidence of delivery; value of funding at risk. **Impact on Risk** Protects critical income and reduces exposure to a significantly larger underlying deficit.	Executive Director of Finance / Executive Team	Monthly to 31/03/2027	Progressing
G3 Savings plans are not yet sufficiently mature to bridge the full requirement: £13.3m Green schemes were identified at Month 2 against a £46.0m target, with £31.9m Red schemes and pipeline opportunities still to be converted.	Accelerate conversion of pipeline and Red/Amber schemes to Green, with recurring/non-recurring split and delivery confidence reviewed monthly. **Outcome** A greater proportion of the £46.0m savings requirement becomes assured and deliverable. **Metric** Green schemes £m and % of target; recurring savings £m; YTD delivery against profile; pipeline conversion rate. **Impact on Risk** Reduces risk of unachieved savings and reliance on non-recurrent mitigations.	Executive Director of Finance / Value & Sustainability Leads / Divisional CFOs	30/09/2026 and monthly thereafter	Progressing
G4 Unplanned cost pressures are being reported and offset by unplanned spend reductions after virements, indicating volatility and complexity in interpreting run-rate, recurrent impact and genuine mitigations.	Strengthen monitoring return reconciliation and recurrent/non-recurrent classification, with monthly CFO check-and-challenge on cost pressures, spend reductions and virements. **Outcome** Improved clarity of the underlying position and fewer late adjustments. **Metric** Reconciliation issues resolved; value of items moved to correct category; forecast accuracy.	Executive Director of Finance / Central Finance / Divisional CFOs	Monthly to 31/03/2027	Progressing

	Impact on Risk Improves financial grip and enables earlier corrective action.			
G5 Inflationary and cost pressures exceed available allocation uplift, particularly CHC, Prescribing, Secondary Care Drugs, commissioned services, NWJCC/cross-border contracts, Welsh Risk Pool and digital pressures.	Maintain targeted pressure reviews and confirm mitigations/disinvestment proposals for high-risk categories, supported by benchmarking and contract scrutiny. **Outcome** Material pressures are quantified, mitigated and escalated through the financial governance route. **Metric** Pressure value by category; mitigation value identified; residual forecast variance. **Impact on Risk** Reduces likelihood that unavoidable pressures destabilise the plan.	Executive Director of Finance / Central Finance / Divisional CFOs	Monthly to 31/03/2027	Progressing
G6 Grip and Control measures may not deliver sufficient recurrent impact or may not be fully captured in the financial plan.	Quantify the impact of continued Grip and Control measures across non-pay, procurement, pay and temporary workforce, and report delivery through monthly returns. **Outcome** Savings and run-rate reductions attributable to Grip and Control are evidenced and sustained. **Metric** Value of requisitions cancelled/approved; non-pay reduction; recruitment controls impact; temporary workforce spend trend. **Impact on Risk** Supports run-rate containment and reduces reliance on unidentified mitigations.	Executive Director of Finance / Executive Directors / Procurement and Workforce Leads	Monthly to 31/03/2027	Progressing
G7 Agency and variable pay remain material risks, with Month 2 agency spend of £2.6m and variable pay of £8.5m, and 2026/27 variable pay forecast increasing from Month 1.	Maintain executive scrutiny of agency, locum, bank and overtime, including action plans against the 30% agency reduction enabler and temporary workforce controls. **Outcome** Agency and variable pay are reduced where clinically safe and affordable. **Metric** Agency spend £m/% of pay; variable pay forecast; delivery against 30% reduction target. **Impact on Risk** Reduces pay overspend and supports workforce affordability.	Executive Director of Finance / Executive Director of Workforce / Clinical Executive Leads	Monthly to 31/03/2027	Progressing
G8 Conditionally funded performance and transformation schemes are forecast to spend £42.0m in full, creating a need for strong benefits tracking and clear disinvestment/alternative funding where relevant.	Track programme spend, benefits and recurrent consequences for Performance and Transformation, Planned Care, Value-Based Healthcare and Further Faster allocations. **Outcome** Strategic funding supports agreed priorities without creating unfunded recurrent commitments. **Metric** Spend vs forecast; benefits delivery; recurrent consequence assessment completed. **Impact on Risk** Protects affordability and value for money while supporting transformation.	Director of Transformation / Executive Director of Finance / Programme SROs	Quarterly to 31/03/2027	Progressing
G9 Forecast assumptions depend on full receipt of anticipated income,	Continue monthly confirmation of RRL assumptions and anticipated allocations with Welsh Government, including pay	Executive Director of Finance /	Monthly to 31/03/2027	Progressing

including pay award funding and other RRL assumptions; misalignment with Welsh Government allocations would increase forecast risk.	award estimates and working balances support. **Outcome** Income assumptions are validated, and any funding gaps are escalated early. **Metric** Confirmed vs anticipated RRL; value of unconfirmed allocations; pay award estimate variance. **Impact on Risk** Reduces risk of unidentified income shortfalls affecting forecast outturn.	Deputy Director of Finance		
G11 Risks and opportunities identifies total quantified risks and no / low quantified opportunities	Maintain monthly risk and opportunity review to ensure risks are reflected in forecast where clear and evidenced. **Outcome** The forecast position remains aligned to the risk register and MMR Table A2. **Metric** Quantified risks/opportunities £m; movements since prior month; forecast inclusion status. **Impact on Risk** Improves transparency and supports early mitigation or escalation.	Executive Director of Finance / Central Finance	Monthly to 31/03/2027	Progressing



	Impact	Likelihood	Progressing
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	3	12
Risk Appetite	Financial/VfM <15		Not in Tolerance

Position & Intended Outcome for Risk

At Month 2, the Health Board is reporting material financial sustainability risk for 2026/27. The plan is not balanced and is forecasting delivery of the planned £43.0m deficit, supported by receipt of anticipated income, retention of conditionally recurrent strategic funding and delivery of a £46.0m savings requirement. The year-to-date position is already adverse to plan, with savings delivery below profile.

The intended outcome is to contain the run-rate, strengthen the recurrent savings pipeline, improve confidence in forecast assumptions and demonstrate clear evidence that savings, grip and control, disinvestment and value-based opportunities can reduce the forecast risk over the year. The target risk score remains outside the Financial/VfM appetite until there is sufficient assurance that recurrent savings are deliverable, conditional funding is secure and the forecast deficit is aligned with a credible route to financial balance.

CRR REF: 25-07 Risk Title: Leadership and Operating Model		
Director Lead: Executive Director of People and Organisational Development		**Date Opened:** 21/08/2025
Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 12/02/2026
Date Last Reviewed: 30/04/2026	**Link to BAF**: 25-04	**Target Risk Date:** 31/03/2027

Risk Detail:

There is a risk that the Health Board does not deliver high quality patient care aligned to operational plans, or not meeting HB targets or adhering to legislative requirements.

This may be caused by not building and maintaining an effective culture and leadership environment, or developing the necessary skills and knowledge of our leaders.

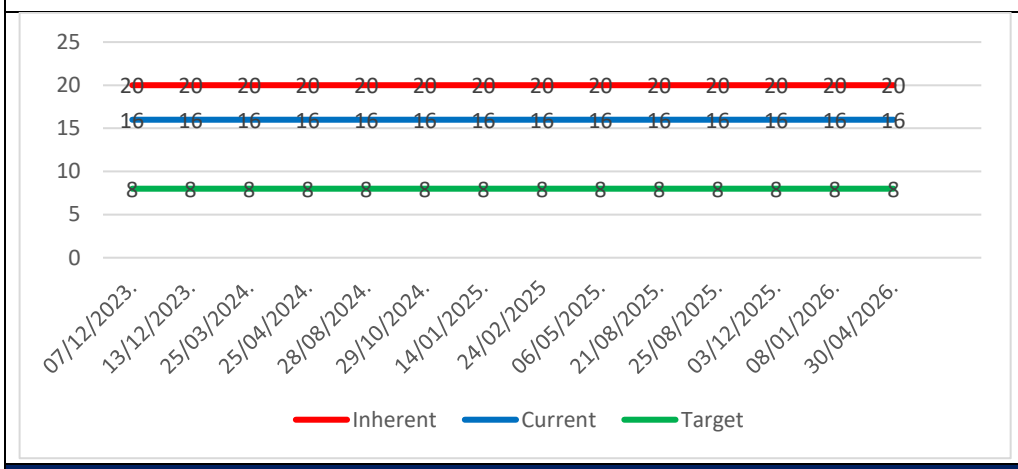
This may lead to poor organisational culture and behaviours which in turn will lead to low staff morale, poor patient care and inefficient services for the population of North Wales.

Mitigations/Controls in place

1. Speak Out Safely Multi Disciplinary Team (MDT) and Work in Confidence platform for staff to raise concerns
2. Organisational Culture Change Plan and Behaviours Framework approved by Board and is being deployed
3. Integrated Leadership Development Framework (ILDF) in place
4. Improved nurse retention results over the last 2 years
5. Clear top-down commitment to reinforce leadership culture that prioritises staff wellbeing, inclusion, and psychological safety (Pledge signed)
6. Increased uptake on the 2025/26 staff survey
7. 60% of senior staff trained in leadership through conferences and masterclasses
8. New all Wales Flexible Working policy in place – monitored at the People and Culture Committee
9. Organisational Development (OD) plans are in place in 2026/27 to support recruiting well and joining well, for example Values Based Recruitment and Corporate induction

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 - Leadership development pathways not fully integrated	Further embed ILDF and measure effectiveness HEIW will release a Management Competency Framework due to be launched April 2026. This will be used to inform the mid-level management ILDF leadership courses / resources design. There has been a delay in HEIW launch of Management Competency Framework Mid level pilot to commence in May 26 this has been delayed due to financial restrictions on training. Evaluation of programmes completed for Q1 & Q2 with Q3 & Q4 due May 26. People Managers forum evaluation underway for first 12 month roll out	Head of Organisational Development Workforce & Organisational Development	30/09/2026	Progressing
G2 Outdated PADR process and system in place	A new values and behaviours based PADR system will be deployed in 2026. It is expected this programme will show results within the first year following the launch	Head of Organisational Development, People & OD	30/09/2027	Progressing
G3 Leadership taking on board and acting on staff survey results	Assess and agree the actions based on the 2025 staff survey results. The preliminary results are in. The next phase is for each service to confirm the localised actions in place to address the necessary actions in their areas	Head of Employee Engagement and Experience - Corporate Office	31/12/2026	Progressing
	A paper detailing the key findings from the NHS Wales Staff Survey 2025 and suggested next steps in response to feedback (including areas of focussed action) will go to the Board in May 2026. Directors received the results for their areas of responsibility in early March to inform discussions and action and teams across the organisation have access to HEIW'S survey dashboard to review performance and identify improvement opportunities. Briefings have also been held through established forums including local People and Culture Committees.	Head of Employee Engagement and Experience – Corporate Office	30/06/2026	Progressing
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G4 Capacity in delivering planned programmes of work alongside FFtF without any additional resource in OD, this may impact on the timelines for delivery	Review and prioritise workload in the OD function in 2026/27 to accommodate FFtF	Deputy Director, People & OD	30/09/2026	Progressing
G5 Fully implemented culture change programme that will demonstrate improved KPIs	Implement Employee Engagement Plan with suite of indicators The actions underway listed below are part of the 2025-26 plan for culture and engagement. The 2025 staff survey result will be used to assess the impact these actions have had. It is expected the result will be available in early 2026. • Embedded new engagement listening approach including staff stories being shared at People and Culture Committee, Local Partnership Forum and more widely to support organisational understanding and learning. • Refreshed reward and recognition activity to introduce monthly recognition awards 'Seren Betsi' with Executive involvement, improved annual staff achievement awards event. A new approach to recognise 25 & 40 years service will be ratified in the April 2026 P&CC	Head of Employee Engagement and Experience - Corporate Office	31/12/2026	Progressing

	• Staff survey champions will be trained to support local monitoring and reporting			
	Deliver Culture Change Plan with Comms and Engagement rollout. P&CC received an update on the plan in February 2026 and it was agreed a revised plan would be submitted back to P&CC in June 2026	Head of Organisational Development,	30/06/2026	Progressing
	Quarterly Culture, Leadership & Engagement Plans finalised and monitored P&CC received an update on the plan in February 2026 and it was agreed a revised plan would be submitted back to P&CC in June 2026	Head of Organisational Development, Workforce & Organisational Development	30/06/2026	Progressing
G6 Regular culture performance reporting at IHC/Directorate level	Introduce culture reporting at IHC level. A new dashboard to be deployed in Q1 26/27 to track Y1 performance against corporate and divisional target	Deputy Director, People & OD	30/09/26	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		Not in Tolerance

Position & Intended Outcome for Risk

The general feeling is culture and engagement had improved with the recent workstreams, however, the FFtF change programme is expected to impact this and will test organisational resilience
KPIs to that inform our risk in this area as at February 2026;
Staff retention 91.4% compared to 90.7% last year.
PADR compliance 80%, compared to 78.95% last year
The number of Grievance cases is 5 compared to 13 this time last year
The percentage of stress & anxiety absences remains high at 1.8% which is over 1.2% this time last year
The trend of speak out safely cases have remains static, but shows a 40% decrease from this time last year

CRR REF: 25-08 Risk Title: Non-Compliance with Regulatory and Legislative Requirements		
Director Lead: Director of Corporate Governance		**Date Opened:** 21/08/2025
Assuring Committee: Audit Committee		**Date Last Committee Review:** 06/11/2025
Date Last Reviewed: 16/07/2026	**Link to BAF**: BAF24-01	**Target Risk Date:** 31/03/2027

Risk Detail:
There is a risk that the Health Board may fail to comply with regulatory and legislative requirements, which could directly or indirectly impact the safety, quality, and accessibility of patient care.
This may be caused by inefficiencies in managing regulatory complexities and changes at pace, ineffective relationship management with regulators and statutory bodies, inadequate monitoring and reporting of actions and progress, including escalation, and insufficient operational assurance.
This may lead to enforcement action, impact patient safety, financial penalties, impact on workforce, and loss of public and stakeholder confidence.

Mitigations/Controls in place

1. Internal and external audit reviews identifying and reporting areas of non-compliance with legislation and regulation.
2. Report on progress on some regulatory compliance submitted to the Regulatory Assurance Group, Executive Quality and Delivery Group, and Quality, Safety and Experience Committee via the Integrated Quality Report.
3. An update on progress on some regulatory compliance from the Integrated Quality Report also included in the Statutory Compliance Report to Executive Committee and Audit Committee.
4. Monitoring of regulations and legislation by various groups, such as:
   - Medical Devices Governance & Assurance Group oversees procurement, selection, risk management and safety communication
   - Estates and Health & Safety Committee oversee areas of non-compliance and tracking of action plans.
   - Pharmacy Technical Services and monitoring of compliance in relation to Controlled Drugs. Regulatory Assurance Group for some clinical regulations. (Oversight and gap analysis of all groups required and reflected in the action plan/gaps in controls)

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 The Health Board currently lacks a complete and consolidated picture of its regulatory and statutory relationships, leading to limited visibility over roles, responsibilities, and engagement practices.	**Capture current relationship management practices and arrangements around Health Board regulators and statutory bodies** Complete a structured mapping exercise of all regulators and statutory bodies across the Health Board to identify lead Executive Team member, operational lead, and current relationship with these bodies 16/07/2027 – The latest version of the Regulatory Relationship Management Matrix was presented to the inaugural meeting of the Governance and Regulatory Executive Delivery Group on 7 July 2026. Executive Team members have been asked to review the information contained within the Matrix and provide any comments, amendments or additional information as required. Initial discussions indicated that the Matrix is largely comprehensive and captures the majority of known regulatory, statutory, professional and oversight body relationships. The Group agreed to use the Matrix as the primary mechanism for oversight of external regulatory and professional body relationships. A programme of rolling review will be established, with the Group identifying priority regulators and bodies for detailed discussion at future meetings to ensure appropriate governance, assurance and relationship management arrangements are in place. As the Matrix has been developed, presented to the Group and adopted as a tool to support ongoing oversight and monitoring, it is recommended that this action be closed, with future review and maintenance of the Matrix being undertaken through the Governance and Regulatory Executive Delivery Group.	Head of Statutory Compliance and Inquiries	31/07/2026	Completed

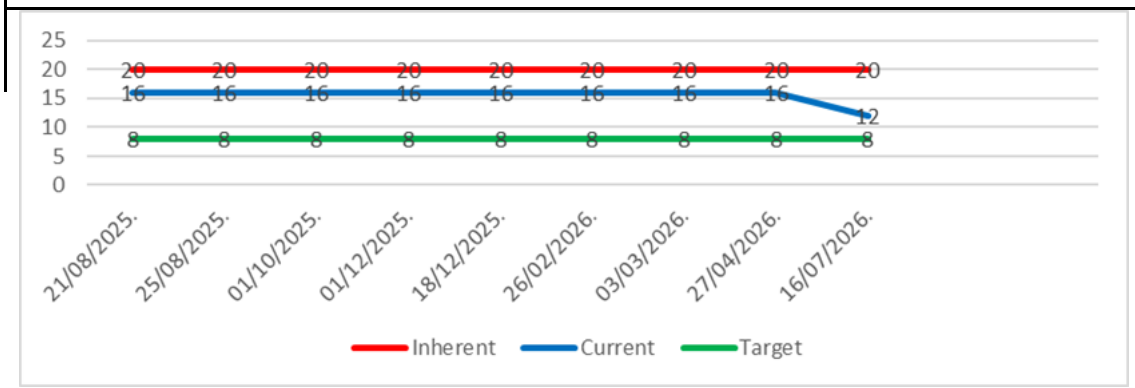
	Outcome • A clear, consolidated view of how the Health Board currently manages relationships with regulators and statutory bodies • A baseline understanding that supports improved coordination, compliance, and strategic engagement • Clarity, visibility, and baseline understanding. **Metric** • Confirmation from each Executive Team member that details of all regulators and statutory bodies under their portfolio have been captured **Impact on Risk** • Increased visibility of current relationship management practices with its regulators and statutory bodies across the Health Board • Increased visibility of the current reporting and monitoring practices relating to regulator and statutory body information across the Health Board • Increased visibility of roles and responsibilities relating to regulators and statutory bodies.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G2 There is no fully reliable or validated register of regulatory relationships and statutory obligations, creating uncertainty around ownership, assurance, and compliance oversight	**Review of regulatory and statutory body relationship management, reporting and monitoring arrangements** 16/07/2027 – The Regulatory Relationship Management Matrix was presented to the inaugural meeting of the Governance and Regulatory Executive Delivery Group on 7 July 2026. The Group noted that, whilst the Matrix contains a significant amount of information relating to regulatory, statutory, professional and oversight bodies, some sections remain incomplete. In many cases, this reflects the absence of formal processes or arrangements rather than missing information. As such, the Matrix will remain a live document and will continue to be reviewed and updated as governance arrangements mature and additional information becomes available. The Group agreed that the Matrix will be used to inform its programme of work, with regulators and other external bodies being identified for focused review and discussion at future meetings. This will form part of the Group's routine cycle of business and will support ongoing oversight, assurance and the continual development of relationship management arrangements across the Health Board. Review the Relationship Management Matrix. **Outcome** • A strengthened, authoritative information set that can be used confidently by the Board, Executive Team Members, and operational teams • Identification of strengths, gaps, inconsistencies, and duplication in governance practices	Head of Statutory Compliance and Inquiries	28/08/2026	Progressing

	• An assessment of whether the existing information is sufficient to support assurance, compliance oversight, and regulatory engagement • A foundation for designing a more consistent, risk-aligned regulatory engagement framework **Metric** • Completeness — proportion of regulators/statutory bodies for which full information exists • Clarity of ownership — proportion of entries with clearly assigned responsible officers or teams. **Impact on Risk** When the information is complete and reliable: • Regulatory risk decreases because the Health Board has a clear, accurate understanding of all obligations and expectations • Ability to identify gaps in the improvements required to strengthen our processes • A verified, up-to-date record of all regulatory relationships and obligations, with inaccuracies corrected and gaps identified.			

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G3 There is no formalised executive-led forum providing consistent oversight, coordination, and escalation of governance, statutory compliance, and regulatory issue	**Executive Governance and Regulatory Group** Formalise a multi-disciplinary Governance and Regulatory Group to provide routine scrutiny, coordination, and escalation. 16/07/2027 – The first meeting of the Governance and Regulatory Executive Delivery Group was held on 7 July 2026 and was well attended by Executive and senior colleagues. Constructive discussions took place regarding the future direction, priorities and governance arrangements for the Group. In response to feedback received, the duration of future meetings has been increased to allow sufficient time for discussion and oversight. Meetings have also been scheduled for the remainder of 2026/27. The Group's Terms of Reference were reviewed and discussed at the inaugural meeting, with feedback incorporated into a revised draft. The updated Terms of Reference will be presented for further consideration at the next meeting. At the next meeting on 15 September 2026, the Chair will present a forward workplan and standing agenda items for future meetings. Due to this, the due date for this action has been extended. **Outcome** A formalised, multi-disciplinary Executive Led Group to ensure consistent oversight, aligned decision-making, and timely escalation across governance, statutory compliance, and organisational assurance domains **Metric**	Head of Statutory Compliance and Inquiries	15/09/2026	Progressing

	• Group established with agreed terms of reference • Clear, defined and documented reporting and escalation processes • Attendance and representation across disciplines. **Impact on Risk** Formalising this Group will have a material positive impact on organisational risk exposure, the key improvements include: • Clearer escalation routes ensure strategic risks receive timely executive attention • More coordinated oversight supports consistent compliance across operational divisions • Improved accountability reduces drift, variability, and unmanaged exposures • Systematic monitoring ensuring the Health Board maintains compliance with statutory duties and regulatory frameworks • Provides clearer lines of sight for Board Committees			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G4 The Health Board lacks a centralised system to record, monitor, and assure compliance with legislative and regulatory requirements, resulting in fragmented and inconsistent oversight.	**Compliance Management System** Implement a centralised compliance management system to capture and enable the monitoring of Health Board-wide legislative and regulatory requirements 16/07/2026 - Work continues on the scope within DDaT to include the IT security, infrastructure and integration requirements. Once this has been finalised, the procurement process can commence. **Outcome** Implementation of a centralised electronic system provides a single source of information for all legislative, statutory, and regulatory requirements, linked directly to named accountabilities and real-time assurance. **Metric** • System procured • System live by agreed date **Impact on Risk** Implementation of the system will have a significant positive effect on reducing organisational risk in multiple categories. • Ensures the organisation maintains a live, accurate register of all legislative and regulatory duties • Strengthens evidence trails for external inspections (for example Health Inspectorate Wales, Audit Wales, Health and Safety Executive) • Clear ownership of responsibilities reduces operational ambiguity and the risk of requirements being missed • Real-time visibility enables early escalation of compliance risks before becoming significant failures • Moves the Health Board from reactive to proactive compliance management • Reduces inconsistencies across directorates, improving confidence in assurance processes	Head of Statutory Compliance and Inquiries	31/03/2027	Progressing

	• Supports Board Committees by providing reliable, validated, accessible assurance information
	• Demonstrates to regulators and external stakeholders a systematic, robust approach to compliance
	  • Automated reporting reduces human error, version-control issues, and information gaps
	  • Ensures a clear audit trail for decisions, updates, accountability, and evidence.			



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	3	12
Target Risk Score	4	2	8
Risk Appetite	Regulatory/Compliance <15		In Tolerance

Position & Intended Outcome for Risk

Governance and regulatory EDG to be set up to oversee compliance, and to track non-compliance to ensure risks are mitigated, reporting areas of non-compliance to the Executive Committee. This risk has been developed into a more strategic risk, which will encompass overarching compliance to statutory requirements across the Health Board.

CRR REF: 25-09: Risk Title: Safe Environment

Director Lead: Director of Environment and Estates		**Date Opened:** 04/01/2024
Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 24/02/2026
Date Last Reviewed: 22/06/2026	**Link to BAF**: BAF24-03	**Target Risk Date:** 31/03/2030

Risk Detail:

There is a risk that patients may be exposed to unsafe, uncomfortable, or unsuitable care environments if the organisation's estates and infrastructure are not maintained to appropriate standards.

This may be caused by ageing estate, backlog maintenance, and gaps in fire safety, health and safety compliance, and alignment with the estate's strategy.

This may lead to safety incidents, non-compliance with statutory duties, and barriers to service modernisation.

Mitigations/Controls in place

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 £17m for 25/26 approved by Welsh Government with an allocation of approximately £3.45m 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 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 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 align 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. Review of Reinforced Autoclaved Aerated Concrete (RAAC) completed by the Health Board's approved structural engineers – Curtins and a report will be presented at the Strategic Occupational Health and Safety Group

14. 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

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 6-facet surveys 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.	**Facet Survey** Undertake actions to deliver a facet survey across the Health Board over the next 2 years. Due to financial constraints within the Health Board a review of the facet survey programme is being undertaken to confirm which facets are a priority for the Health Board. **Facet 1** - Physical Condition Survey (Fabric and M&E) **Facet 2** - Statutory Requirements (Risk Based Methodology for Establishing and Managing Backlog) **Facet 3** – Space Utilisation (Scope to be finalised) **Outcome** Deliver a phased, prioritised partial Facet Survey Programme across the Health Board over the next 2 years, ensuring a comprehensive understanding of estate condition, statutory compliance, space utilisation and backlog risk. Due to financial constraints, conduct a review to determine which facets are critical to informing investment decisions, focusing initially on Facet 1 (Physical Condition: Fabric & M&E) and Facet 2 (Statutory Requirements / Risk-Based Backlog). The outcome is to produce accurate, site-wide data that underpins capital planning, operational risk management, and strategic estate development. **Metric** **Programme Scope & Completion -** Completion of Facet 1 and Facet 2 surveys for all major acute, community, and mental health sites within 3 years. **Data Quality & Integration -** Survey data validated and uploaded into estates asset management systems (e.g., MICAD and future CAFM plans). Buildings or zones with complete, up-to-date backlog and condition profiles **Backlog & Statutory Risk Assessment -** Reduction in "unknown" condition/risk items within asset registers (target: elimination). Development of a risk-based statutory compliance backlog for Facet 2. **Alignment With Capital Plans -** Capital bids or business cases supported by validated facet data. Use of Facet 1 and 2 outputs to prioritise high-risk backlog items in annual capital allocation. **Alignment with developing clinical service plans** – to ensure optimum utilisation of the retained Estate and disposal opportunities for lease hold properties and redundant or obsolete Estate **Impact on Risk** Delivering this programme will: **Reduce strategic and financial risk** by ensuring investment decisions are based on validated, prioritised, and risk-driven estate data rather than assumptions or incomplete surveys. **Mitigate statutory non-compliance** through a clear understanding of high-risk areas within Facet 2, enabling timely intervention and reducing exposure to regulatory enforcement. **Lower operational risk** by identifying critical M&E, structural, and fabric issues early, preventing service disruption, safety incidents, or unplanned ward/department closures.	Head Of Operational Estates	31/03/2028 (Subject to funding)	Progressing Due date extended from 31/03/2027 to 31/03/2028

	Improve organisational assurance, giving the Board confidence that estate condition, backlog maintenance, and statutory risks are transparently understood and being managed in a structured, evidence-based manner. **Strengthen long-term planning**, ensuring the estate strategy, clinical strategies, and capital programme are all informed by a consistent, Health Board-wide dataset. **Reduce reputational risk**, demonstrating responsible stewardship of the estate and a proactive approach to addressing backlog and compliance issues before they compromise patient care.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G2 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.	**Develop ToR** Develop a standardised Terms of Reference to be considered and endorsed by Capital Investment Group **Outcome** A standardised, comprehensive, and governance-compliant Terms of Reference (ToR) is developed and endorsed by the Capital Investment Group. This ensures consistent governance, clarity of responsibilities, improved decision-making, and strengthened assurance for capital planning, prioritisation, and delivery across the Health Board. **Metric** **Development & Approval** • Revised ToR to be drafted and aligned with SFI and SoRD • ToR reviewed by required stakeholders (Capital Planning, Finance, Clinical, Estates). • ToR formally endorsed by the Capital Investment Group. **Quality & Governance Compliance** • Alignment with HB governance framework and Welsh Government capital governance. • Evidence of clear roles, responsibilities, delegated authority, and reporting lines within the ToR. **Implementation** • ToR published and communicated to all relevant stakeholders within agreed timescale. **Impact on Risk** **Governance Risk Reduction** • Reduces ambiguity around decision-making, leading to robust capital approval process • Ensures consistent application of governance standards across capital schemes. • Strengthens audit trail and assurance for internal/external scrutiny (WG, Audit Wales). **Strategic & Operational Risk Reduction** • Ensures that roles, responsibilities, and authority for capital decisions are clearly defined, minimising project delays or misaligned decisions.	Director of Environment and Estates	31/09/2026	Progressing Due date extended from 31/03/2026 to 30/09/2026 to reflect Foundations for the future structure, and review of capital processes.

	• Enhances reliability of capital programme delivery through improved oversight. **Compliance & Regulatory Risk Reduction** • Reduces likelihood of non-compliance with Welsh Government capital governance requirements. • Supports consistent, well-governed business case progression.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G3 Ensure that the Health Board has an Estates rationalisation programme in place that will support the capital prioritisation programme and reduce backlog maintenance.	**Estates Rationalisation Programme** Undertake action to deliver a Health Board Estates Rationalisation Programme. Estates Rationalisation Programme being developed and in draft format. The Draft will be submitted to a multi-disciplinary group for initial comment, with a final version to be ratified by Capital Investment Group. Health Board Rationalisation Programme to be presented to CIG on 12th September 2024. 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. **Outcome** Deliver a comprehensive Health Board–wide Estates Rationalisation Programme that identifies, prioritises, and progresses opportunities for estate disposal, consolidation, and optimisation, utilising information received from the HB Clinical Plans and Estates Condition Survey. This includes producing a fully developed Estates Rationalisation Plan—currently in draft—to be reviewed by a multidisciplinary group and ratified by the Capital Investment Group (CIG), with formal presentation scheduled for September 2026. The programme will be updated to incorporate approved disposals within financial year. **Metric:** **Programme Development & Governance -** Draft Rationalisation Programme completed and submitted to the multidisciplinary review group. Final Estates Rationalisation Plan to be approved by the Board. **Delivery of Approved Disposals** - Number and value (£) of estate disposals completed. Progress planned disposal opportunities for 2026–2030. **Estate Consolidation & Space Efficiency** - Total reduction in estate footprint through rationalisation. Under-utilised space to be identified and addressed through disposal, consolidation, or repurposing. **Financial Impact** - Revenue savings delivered through reduction of lease, utility, security, and maintenance costs (year-on-year increase). Capital receipts generated from disposal of surplus estate (reported annually). **Impact on Risk** Delivering the Estates Rationalisation Programme will: **Reduce financial risk** - Lowering the cost of maintaining under-utilised, poor-condition, or non-compliant estate assets, and by generating capital receipts that can be reinvested in priority clinical infrastructure.	Head Of Operational Estates	30/03/2028	Progressing Due date extended from 31/03/2026 to 30/03/2028. Aligned with Facet Survey Programme

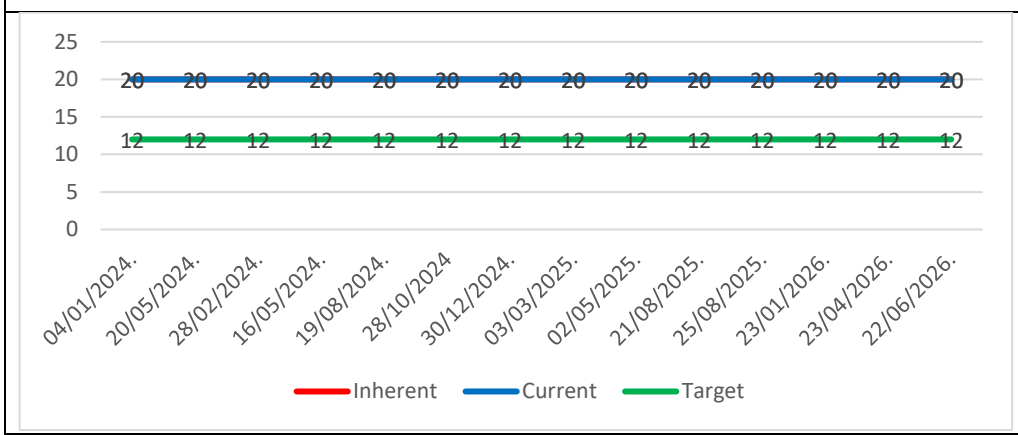
	Mitigate operational risk, ensuring that estate resources are focused on the most functional, safe, and strategically aligned sites, reducing exposure to failures in aged or inefficient buildings. **Lower compliance and statutory risk** by enabling the Health Board to phase out high-risk assets where the investment required to achieve compliance is disproportionate to clinical benefit. **Improve organisational assurance**, Demonstrating to CIG, the Board, and regulators that the estate is being actively and responsibly managed through structured, risk-based rationalisation. **Reduce reputational risk**, as proactive rationalisation demonstrates efficiency, and commitment to improving the quality and sustainability of the estate.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G4 Internal Audit review of Fire Safety – Agreed Management Action Plan being implemented and being managed through the Fire Safety Management Group	**Non-Compliance with Fire Safety** Ensure the HB is fully compliant with Fire Safety Infrastructure on all sites (acute and Community) YG - Health Board submitted a PBC to address the Fire Safety and Infrastructure compliance issues on the Ysbyty Gwynedd site through the Welsh Government Infrastructure Board. In response to Programme Business Case Welsh Government have asked the Health Board to identify within the Programme Business Case those elements that relate to Fire safety only. Wrexham Maelor - Health Board submitted a PBC to address the infrastructure compliance issues on the Ysbyty Maelor site (Wrexham Resilience Programme) through the Welsh Government Infrastructure Board. In response to Programme Business Case, Welsh Government have asked the Health Board to identify high risk priority improvement projects **Outcome** Achieve full statutory compliance with fire safety legislation across the Health Board estate by implementing all required actions identified in the Fire Safety Audit/Firecode compliance assessment. This includes ensuring fire precautions, compartmentation, detection and alarm systems, evacuation procedures, maintenance regimes, training, and governance arrangements fully meet regulatory and NHS Firecode standards to protect life, property, and continuity of clinical services. **Metric** **Fire Audit Action Completion Rate -** Fire safety audit actions completed within agreed timescales **WHTM 05 Compliance Level -** Measured compliance against HTM 05-01/02/03 requirements, including structural fire precautions, fire alarm and suppression systems, and management arrangements (target: full compliance or approved derogations). **Fire Safety Training Compliance -** staff completing mandatory fire safety training and evacuation drills. **Number of Fire Incidents & Unwanted Fire Signals (UWFS) -** Reduction in fire incidents and UWFS across the estate (target: continual reduction and compliance with national UWFS targets). **Impact on Risk**	Head Of Operational Estates	31/03/2030	Progressing

	Significantly reduce risk to life - by ensuring effective fire detection, containment, and evacuation arrangements for patients, staff, and visitors. **Mitigate legal and regulatory risk**, - ensuring compliance with the Regulatory Reform (Fire Safety) Order 2005 and NHS Firecode, preventing enforcement notices, prosecutions, or reputational harm. **Improve estate resilience**, - reducing the likelihood of fire-related service disruption, ward closures, or damage to critical clinical infrastructure. **Strengthen organisational assurance**, - providing the Board with confidence that fire safety across the estate is being effectively managed, monitored, and continuously improved.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G5 Timely progression of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase and Ysbyty Gwynedd PBC	**PBC Developments** Ensure the HB has a strategic plan of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase and Ysbyty Gwynedd PBC **Outcome** A comprehensive, Board-approved strategic pipeline of major capital schemes is produced, ensuring that critical Estates Safety, infrastructure resilience, and service continuity risks across Wrexham Maelor and Ysbyty Gwynedd are clearly defined, prioritised, and supported by robust, compliant PBCs. This enables the HB to progress to SOC and subsequent business case stages with confidence, in alignment with WG capital requirements and timelines. **Metric** **PBC Development & Approval** • Review of Wrexham Maelor Continuity Plan PBC within agreed timeline. • Review of Ysbyty Gwynedd PBC within agreed timeline. **Strategic Alignment & Quality** • Compliance with WG Capital Guidance and Five-Case Model requirements. • Number of key risks and constraints captured and mitigations identified in PBCs. **Impact on Risk** **Estates Safety Risk Reduction** • High-risk backlog maintenance reduced through planned major capital interventions. • Clear identification and prioritisation of statutory and infrastructure compliance issues (e.g. fire safety, electrical resilience, water systems). • Enables proactive replacement of life-expired critical infrastructure (HV/LV, ventilation, medical gases, roofs, drainage etc.). **Service Continuity & Resilience** • Reduced risk of unplanned service outages at Wrexham Maelor and Ysbyty Gwynedd. • Improved resilience for essential acute and emergency services.	Director of Environment and Estates	30/09/2026	Progressing Due date extended from 31/03/2026 to 30/09/2026 to reflect Foundations for the future structure

	• Lower likelihood of business continuity incidents due to infrastructure failure. **Strategic & Financial Risk Reduction** • Reduces risk of WG capital bids failing due to incomplete or misaligned business cases. **Governance & Assurance** • Improved transparency and auditability through structured PBC documentation. • Ensures HB meets statutory obligations for safe, sustainable estate provision.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G6 Assurance around the progress made with the BCUHB Estates Strategy and the lack of clarity around the BCUHB Clinical Strategy.	**BCUHB Estates Strategy** Progress with delivering an updated Estates Strategy by engagement with stakeholders across BCUHB and identifying a number of common themes around strategic ambitions for the estate that aligns with the Health Board's Clinical Strategy. **Outcome** Deliver meaningful progress on the Health Board's Estates Strategy by actively engaging with key stakeholders across BCUHB to identify shared priorities, establish common themes, and ensure that estates planning aligns directly with the Health Board's Clinical Strategy. This includes producing a clear, evidence-based strategic direction for the estate that supports clinical service transformation, improves functionality and resilience, and informs future investment decisions. **Metric** **Stakeholder Engagement Completion -**Divisions, Clinical Boards, and Corporate Departments engaged as part of the Estates Strategy programme **Themes & Strategic Priorities Identified -** Number of common themes captured and validated across stakeholder groups (e.g., capacity, clinical adjacencies, digital enablement, estate condition, sustainability). **Alignment with Clinical Strategy** - Evidence of mapped alignment between Estates Strategy themes and the Health Board's Clinical Strategy goals (target: full alignment across all major programmes). **Strategic Output Deliver -** Completion of key strategy documents (e.g., Strategic Outline Programme, Estate Development Priorities Schedule, site-specific masterplans) within agreed timescales **Incorporation Into Planning & Capital Process -** strategic priorities formally integrated into capital plans, business cases, or service transformation programmes. **Impact on Risk** **Reduce strategic misalignment risk**, ensuring estate development directly supports the Clinical Strategy rather than evolving in isolation. **Mitigate investment and Financial risk (Capital and Revenue)** by providing a clear, prioritised plan that supports informed capital decision-making and reduces the likelihood of unsuccessful business cases or inefficient expenditure.	Director of Environment and Estates	30/09/2026	Progressing Revised date from 31/03/2026

	Lower operational and service delivery risk by identifying estate constraints early and planning improvements that enhance flow, capacity, and resilience across clinical environments. **Improve organisational assurance**, demonstrating that the Estates Directorate is actively engaging service leaders and shaping a modern, fit-for-purpose estate that supports safe, effective care. **Reduce reputational and regulatory risk**, ensuring that estate challenges—condition, compliance, functional suitability, sustainability—are addressed through a transparent and collaboratively developed long-term plan. **Strengthen future readiness**, ensuring the estate is aligned to changing service models, population health needs, digital transformation, and sustainability commitments.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G8 NWSSP Authorising Engineer – Water – Audit on water safety undertaken and agreed action developed to improve compliance which are reported at the Water Safety Group	**Legionella Management and Control** Ensure the Health Board is compliant with its statutory duty to manage water systems across the estate by addressing all fundings reported as part of the AE audit of water systems and operational management **Outcome** Achieve full statutory compliance in the management and control of Legionella across the Health Board estate by implementing all required actions identified in the Authorising Engineer (Water) audit. This includes ensuring safe operation, monitoring, testing, maintenance, and governance of water systems to minimise the risk of Legionella proliferation and protect patients, staff, and visitors. **Metric:** **AE (Water) Audit Action Completion Rate -** Audit actions completed within the agreed timeframe (target: 100%). **Compliance score against ACoP L8**, - WHTM 04-01 Part B, and internal Water Safety Plan standards (target: full compliance or approved derogations in place). **Legionella and Pseudomonas Sampling Compliance -** Routine water sampling and microbiological monitoring completed on schedule. **Impact on Risk** **Reduce the risk of Legionella growth**, lowering the likelihood of Legionnaires' disease outbreaks, safeguarding vulnerable patient groups and clinical operations. **Mitigate statutory non-compliance**, reducing exposure to enforcement action from regulators (HSE), legal claims, and reputational damage. **Improve system reliability**, ensuring cold and hot water systems remain within safe operating parameters. **Strengthen organisational assurance** through robust water safety governance, clear maintenance regimes, and evidence-based compliance reporting. **Reduce operational disruptions**, preventing ward closures, service interruptions, and emergency remedial works due to water safety failures.	Head Of Operational Estates	30/09/2026	Progressing Revised date from 31/03/2026
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G9 NWSSP Authorising Engineer – Electrical– Audit on Electrical	**Electrical and Mechanical Infrastructure on the Wrexham Maelor Hospital Site** Ensure the Health Board is compliant with its statutory duty to manage electrical systems across the estate by	Head Of Operational Estates	31/03/2028	Progressing

Systems undertaken and agreed action developed to improve compliance which are reported at the Electrical Safety Group	addressing all fundings reported as part of the AE audit of electrical systems and operational management **Outcome** Achieve full statutory compliance for electrical systems across the Wrexham Maelor Hospital site by implementing all required actions arising from the Authorising Engineer (AE) electrical audit. This includes ensuring safe operation, maintenance, resilience, and governance of electrical infrastructure, thereby supporting continuity of clinical services and reducing risk to patients, staff, and the organisation. **Metric** **Statutory Compliance -** Measured improvement against HTM 06-01 / BS 7671 compliance requirements (target: full compliance or approved derogations in place). **Risk Reduction Achievement -** Reduction in high- and medium-risk items recorded on the electrical risk register (target: 0 high risks, 50% reduction in medium risks within 12 months). **Unplanned Outage Incidents -** Year-on-year reduction in electrical infrastructure failures or unplanned interruptions impacting clinical services (target: continual reduction). **Impact on Risk** **Significantly reduce risks associated with electrical system failure**, including power loss to critical clinical areas, unsafe equipment operation, or potential electrical fires. **Mitigate organisational statutory non-compliance risk**, preventing enforcement action, regulatory escalation, or reputational harm. **Improve resilience of electrical infrastructure**, reducing vulnerability during peak clinical load, emergency events, or equipment failure. **Lower health and safety risks** to patients, staff, and contractors through improved control of isolation, testing, and operational procedures. **Strengthen assurance to the Board**, demonstrating that the Estates function is effectively managing safety-critical infrastructure in line with HTMs, legislation, and AE recommendations.			



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	3	4	12
Risk Appetite	Regulatory/Compliance <15	Not in Tolerance	

Position & Intended Outcome for Risk

Current Risk score of 20 aims to be reduced to a 12 by April 2035 as a part of a wider Estates strategy.
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 were £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 partial facet survey for the Estates, these surveys will commence in 2026 focussing on Acute sites and then community hospitals with a target to complete within 2

years. This will be a significant part of the estate's 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 align 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 2026. 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. Both sites are currently being disposed of with Ruthin HC awaiting completion of contract.
Internal Audit review of Asbestos Management has been completed which reported Substantial Assurance, due to this outcome action G7 'Internal Audit review of Asbestos Management – Agreed Management Action Plan developed and managed through the Asbestos Management Group' has been completed.
Estates Rationalisation programme being reviewed to identify any quick wins that can deliver financial savings quicker.

CRR REF: 25-10: Risk Title: Health and Safety		
Director Lead: Director of Environment and Estates (DoE&E)		**Date Opened:** 21/08/2025
Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 24/02/2026
Date Last Reviewed: 30/04/2026	**Link to BAF**: BAF24-03	**Target Risk Date:** 31/03/2027

Risk Detail:
There is a risk that the organisation may fail to maintain a safe environment for staff, patients, service users and visitors in line with health and safety legislation.
This may be caused by
- Inadequate governance, leadership oversight or assurance of health and safety arrangements.
- Insufficient resources (financial, staffing or time) allocated to health and safety management.
- Poor compliance with statutory inspections, maintenance schedules or risk assessments.
- Lack of staff competence, training or awareness of health and safety responsibilities.
- Failure to learn from incidents, near misses or external safety alerts.
- Ageing estate, infrastructure failures or unsafe plant and equipment.
- Inconsistent application of policies and procedures across sites or services.

This may lead to
- Injury, ill-health or fatalities involving staff, patients or visitors.
- Increased incidents, near misses and reportable accidents (RIDDOR).
- Regulatory enforcement action (e.g. HSE or CQC notices, prosecutions or fines).
- Civil claims, increased insurance costs and reputational damage.
- Reduced staff morale, increased sickness absence and staff turnover.
- Service disruption, ward closures or loss of public confidence.
- Failure to meet statutory duties and corporate objectives.

Mitigations/Controls in place

Governance and Leadership (Links to ACR1)
- HS01 Health and Safety Policy approved and reviewed at Board level
- Director of Environment and Estates Designated Executive Lead for Health and Safety
- Health and Safety Committee (Strategic Occupational Safety and Health Group) with staff side representation, which escalates up to People and Culture Committee.

Health and Safety Risk Management (Links to ACR2)
- Annual gap analysis using the NHS Employer Health and Safety Standards used to assess compliance against current health and safety legislation and standards
- HS03 General Risk Assessment Procedure
- Local Health and Safety File
- Routine workplace risk assessments (e.g. slips and trips, manual handling, COSHH, etc.)
- Incident reporting systems and investigation processes

Training and Competence (Links to ACR3)
- Mandatory health and safety training for all staff
- Accredited Health and Safety Training courses (e.g. NEBOSH)
- In-house taught Health and Safety Training courses (e.g. Risk Assessment, COSHH, RIDDOR)
- Health and Safety webpages on BetsiNet

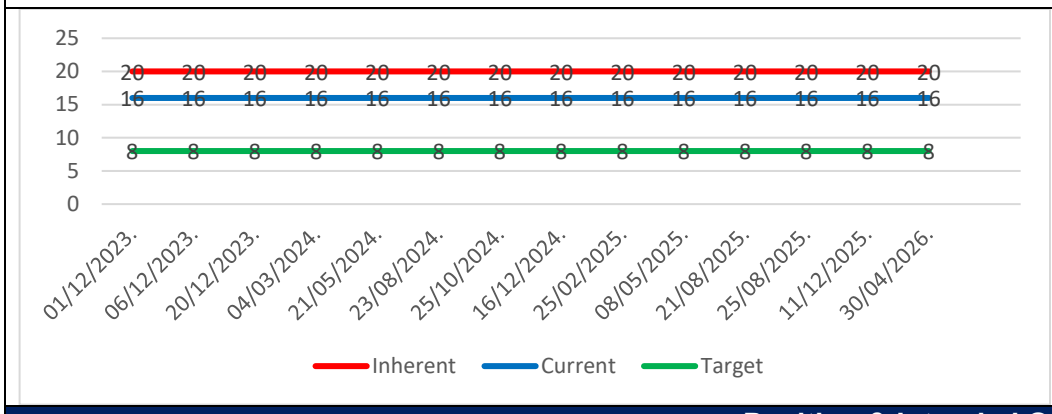
Monitoring and Assurance (Links to ACR4&5)
- Proactive: Scheduled health and safety reviews/audits that incorporate workplace inspection
- Reactive: Ad hoc visits in response to incidents

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
ACR1: Governance and Leadership (PLAN)				
ACR1a A review of resources required following the internal audit	A review of resources within the Health, Safety and Security Service is required following the internal audit findings. Produce a documented resource review paper and proposed structure for Leadership consideration. Complete a business case if necessary ready for approval. Initial structure review and remodelling completed; progress dependent on the outcome of the Foundations for the Future program, which will inform final decisions. Addresses audit recommendations to ensure adequate resourcing and supports delivery of Health and Safety objectives across BCUHB. Complete the resource review and business	DoE&E	31/03/2027	Progressing

	case by September 2026, following confirmation of Foundations for the Future outcomes. **Outcome** An appropriately resourced Health, Safety and Security Service that meets internal audit recommendations and supports statutory compliance across BCUHB. **Metric** • Resource review paper and proposed structure completed by September 2026. • Business case (if required) completed and submitted for approval by November 2026. • Final structure aligned with outcomes of the Foundations for the Future programme. **Impact on Risk** Completing the review and securing the required resources will reduce the likelihood of non-compliance, improve assurance, and strengthen organisational safety governance.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
ACR1b A review of the Terms of Reference, Cycle of Business and Escalation and De-escalation Routes	Undertake a comprehensive review and update of the Terms of Reference, Cycle of Business, and escalation and de-escalation routes to ensure clarity of roles, responsibilities, decision-making authority and timely escalation of health and safety risks. **Outcome** Clear, consistent and well-understood governance arrangements that support effective oversight, assurance and timely management of health and safety risks at all levels of the organisation. **Metric** • Revised Terms of Reference, Cycle of Business and escalation framework formally approved • Evidence of dissemination and staff awareness • Auditable compliance with escalation timescales and reporting routes • Reduction in delayed or inappropriate escalations identified through reviews or audits **Impact on Risk** Improves governance and assurance, reducing the likelihood of unmanaged or unrecognised health and safety risks, and lowering the overall risk of failing to maintain a safe environment for staff and patients.	DoE&E	31/03/2027	Progressing
ACR2: Health and Safety Risk Management (DO)				
ACR2a Review of HS03 General Risk Assessment Procedure	Undertake a review and update of the HS03 General Risk Assessment Procedure to ensure it remains current, legally compliant, clearly articulated and consistently applied across all services and sites. **Outcome** A robust, clear and standardised risk assessment procedure that supports effective identification, evaluation and control of health and safety risks and promotes consistent practice across the organisation. **Metric** • HS03 procedure formally reviewed, updated and approved • Evidence of implementation and dissemination to managers and staff • Increased compliance identified through audits and assurance reports • Improved quality and consistency of risk assessments reviewed **Impact on Risk** Reduces the likelihood of poorly identified or inadequately controlled hazards, strengthening organisational compliance with health and safety legislation and lowering the overall risk of harm to staff and patients.	Head of Health, Safety and Security	31/03/2027	To commence
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
ACR2b Implement an Electronic Document Management System (EDMS) across BCUHB to centralise health and safety compliance reporting and house risk management documentation, to support a health and safety management framework	Source or develop and implement a digital technology solution to support the health and safety risk management framework, enabling consistent recording, monitoring, escalation and assurance of risks, actions and controls across the organisation. **Outcome** A single, reliable and transparent system that improves the visibility, consistency and timeliness of health and safety risk management, supporting informed decision-making and effective organisational assurance. **Metric** • Technology solution procured/developed and fully implemented • Percentage of services using the system for health and safety risk management • Improved completeness, timeliness and quality of risk and action data • Reduction in manual processes and duplicated reporting	Head of Health, Safety and Security	31/03/27	To commence

	Impact on Risk Strengthens risk identification, monitoring and escalation, reducing the likelihood of unmanaged or poorly controlled health and safety risks and improving the organisation's ability to maintain a safe environment for staff and patients.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
ACR2c Reviewing and updating the Health and Safety Risk Assessment Training Course	Review, update and re-launch the Health and Safety Risk Assessment Training Course to ensure it reflects current legislation, organisational procedures and best practice, and is accessible to all staff with health and safety responsibilities. **Outcome** Improved staff knowledge, competence and confidence in completing suitable and sufficient health and safety risk assessments, leading to more consistent and effective risk control across the organisation. **Metric** • Updated training course approved and implemented • Percentage of relevant staff completing the updated training • Improved quality of risk assessments identified through audit and review • Reduction in errors, omissions or repeat findings linked to risk assessments **Impact on Risk** Reduces the likelihood of hazards being poorly identified or inadequately controlled by improving workforce competence, thereby lowering the overall risk of harm to staff and patients and improving compliance with health and safety legislation.	Head of Health, Safety and Security	31/03/2027	To commence
ACR3: Training and Competence (DO)				
G3a A pan BCUHB Health, Safety and Security Training Needs Analysis is required.	Health, Safety and Security Training Needs Analysis under development. **Outcome** A comprehensive, pan-BCUHB Health, Safety and Security Training Needs Analysis that clearly identifies statutory, mandatory, role-specific and risk-based training requirements across the organisation. The completed TNA will provide a clear framework for training provision, resource planning and compliance monitoring, ensuring consistent and appropriate training delivery across all services. **Metric** • Approval of the TNA by relevant governance groups (e.g., SOSHG and Executive Committee). • Identification of training gaps and development of an implementation or delivery plan. • Measurable improvements in training compliance rates across Health, Safety and Security subjects. • Reduction in variation of training requirements or delivery between Divisions. **Impact on Risk** A robust, organisation-wide TNA reduces the risk of non-compliance with statutory and mandatory training requirements, improves clarity for managers and staff, and supports safer practice across the organisation.	Head of Health, Safety and Security	31/12/2026	Progressing
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G3b BCUHB Executive Team and Board of Directors to complete health and safety training.	NEBOSH HSE Certificate in Health and Safety Leadership Excellence 1-day accredited course. **Outcome** Executive Team and Board members will have the required level of Health and Safety knowledge and assurance to fulfil their statutory duties, demonstrate effective organisational oversight, and meet internal audit expectations. **Metric** • Agreement of the proposal by the Director of Estates and Director of Governance. • Approval and scheduling of the training programme. • 100% completion of the required Health and Safety training by Executive Team and Board members within the agreed timeframe. **Impact on Risk** Completing Health and Safety training for Executive and Board members will enhance understanding at senior levels reduces risks relating to poor decision-making, inadequate oversight, regulatory non-compliance, and potential enforcement action.	DoE&E	31/03/2027	Progressing

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G3c Intranet pages for Health, Safety and Security Services require development.	**Outcome** A comprehensive, accessible and up-to-date Health, Safety and Security intranet site aligned to the NHS Employer Health and Safety Standards that provides staff with clear guidance, policies, procedures, training information and support resources. The developed intranet pages will improve organisational visibility, enhance staff access to essential information, and support consistent practice across BCUHB. **Metrics** • Increased staff access and usage (measured via intranet analytics, where available). • Reduction in staff queries related to information that is now accessible online. **Impact of Risk** Improved access to accurate and current Health, Safety and Security information reduces the likelihood of procedural errors, non-compliance, and inconsistent practice. Clear guidance supports safer working environments, reduces the risk of incidents, strengthens organisational assurance, and improves staff confidence in accessing essential safety information.	Head of Health, Safety and Security	31/03/27	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Regulatory/Compliance <15	Not in Tolerance	

Position & Intended Outcome for Risk

There is an inherent risk that the failure of health and 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 implemented on 31/03/2025, with Health and Safety moving from Workforce Directorate to a new role of Director of Environment, reporting directly to CEO (Chief Executive Officer).

Additional Controls required	Action	Action Owner	Due Date	Progression Analysis
ACR1: Governance and Leadership (PLAN)				
ACR1c Determine the Organisations H&S policy/Plan for implementation: Review of health and safety policies within the next 12-24 months.	Policy tracker presented to SOSHG quarterly and updates specific to Policies provided to Executive Policy Oversight Group, with further oversight by Policy and Compliance Team. **Outcome** A fully reviewed, up-to-date, and compliant suite of Health and Safety policies that reflect current legislation, national guidance, internal audit expectations, and organisational requirements. The policy tracker provides structured oversight and assurance to SOSHG, ensuring visibility of progress and governance throughout the review cycle. **Metric** • Regular updates of the policy tracker and presentation to SOSHG. • Reduction in overdue policies or those requiring exception reporting. **Impact on Risk** Timely review and updating of health and safety policies reduces the likelihood of non-compliance with statutory requirements, inconsistent practice across the organisation, and potential legal or regulatory challenge. Up-to-date policies strengthen governance, provide clarity for staff, and ensure that safe systems of work are based on current, accurate guidance.	DoE&E	28/04/27	Complete
ACR2: Health and Safety Risk Management (DO)				
ACR2a A Health and Safety Management Framework needs developing.	Develop a Health Board Health and Safety Management Framework. The introduction of the NHS Employer's Health and Safety Standards will provide an indication of Health & Safety performance and be a mechanism to monitor the Health Board Health & Safety management framework and will be used to formulate strategy moving forwards. Key service objectives will be monitored going forward. Standards and guidance are available; resources and stakeholder engagement will be secured through the Health & Safety governance structure. Supports	Head of Health, Safety & Security	31/12/25	Complete

	compliance, improves governance, and provides a structured mechanism for monitoring and continuous improvement of health and safety performance. Framework to be developed, approved, and implemented by April 2025 with first performance report issued by June 2025.This is complete. The standards are in use and the Health and Safety Team are completing the second Cohort of the self-assessment exercise that this action is built around. Paper went to Executive Committee 12/11/2025 and People and Culture Committee 04/12/2025.			
ACR4&5: Governance and Leadership (PLAN)				
ARCR4&5 A Health and Safety Management Framework needs developing.	A process to monitor and review department self-assessments is under development and will be issued in readiness for the April Self-Assessment Cycle. Complete see action point 1 above and the paper that went to EC (Executive Committee) and P&CC (People & Culture Committee)	Director of Estates	31/12/25	Complete