Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Corporate Risk Register

March 2026

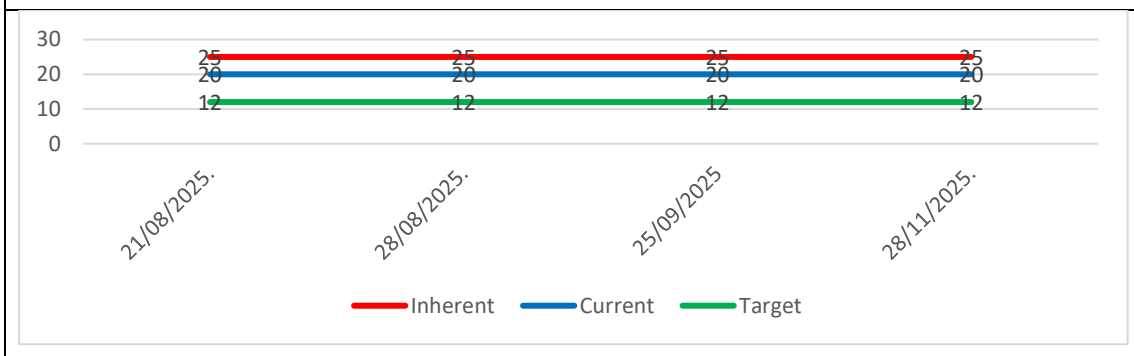
CRR 25-01	**Risk Title: Timely Patient Access to Safe and Effective Care**		**Date Opened:** 21/08/2025 *(version 2 refined from 2023)*
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 05/03/2026
Date Last Reviewed: 28/11/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**: BAF24-07	**Target Risk Date:** 30/06/2027

There is a risk that patients may not receive timely access to the care they need, which could lead to deterioration in health, poor patient experience, and poorer outcome.
This may be caused by lack of oversight of waiting lists, harm occurring on waiting lists, insufficient communication with clinicians, poor patient experience, and difficulties recruiting to specialist posts.
This may lead to extended waiting lists, patient harm due to delays, and reputational or regulatory consequences.

Mitigations/Controls in place	Additional Controls required
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	a. Fragility of UEC (Urgent Emergency Care) and specialist workforce posts, reliance on locums' temporary posts. b. Fragility of social care provision causing delayed discharge and stranded patients c. Need for demand and capacity modelling and specialty-level trajectories d. Inadequate Neurodevelopment capacity to manage waiting list e. Outdated diagnostic IT systems causing inefficiencies in reporting and turnaround times with diagnostics. f. Variation in acute medicine, SDEC (Same Day Emergency Care), frailty pathways across sites, No standardised model yet g. Consistent application of "Our Next Patient Please" flow model. h. Health Board improvement goal for Colostrum Difficile Infection (CDI) reductions in 2025/2026 to reduce the number of cases within the Health Board.

Actions	Action Owner	Due Date	Progression Analysis
b) Implement reset fortnight 8-22 December focusing on improving number and timeliness of discharges, delivering 45-minute ambulance handover, and improve ED performance Second winter Sprint 22 January – 4 February, supported by 3 diagnostics to target ongoing actions	Chief Operating Officer	08/12/2025	Complete
b) Complete demand and capacity analysis across Planned Care to inform forward activity planning As part of the planned care programme and major change programme. The Transformation improvement team have provided an allocation of project management and pathway re-design support to the planned care programme to be used flexibly across its delivery.	Programme Director, Planned Care	31/03/2026	Progressing
e) Update Failure to act on Diagnostics Procedure to be presented at divisional meeting for discussion on the 10/10/2025 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	Associate Director, North Wales Managed Clinical Services	30/06/2026	Progressing (revised date from 20/10/2025)
b) Deliver December “Discharge Fortnight” - Intensive cross-sector focus to maximise discharge, unblock flow, reduce LOS, and significantly improve bed availability.	Chief Operating Officer	31/01/2026	Complete
Issue Quality Standards (Clinical Execs) and Operational Standards (COO) Define practice expectations to standardise risk, quality, and operational performance. Issued and integrated into daily actions	Chief Operating Officer	31/01/2026	Complete
g) Patient flow improvements: Implement “Our Next Patient Please” Move patients to wards ahead of predicted discharges; reduce ED congestion. Develop draft Single Point of Access for alternative pathways & Primary Care redirection. Reduce unnecessary ED attendance; strengthen community pathways.	Chief Operating Officer	31/01/2026	Progressing

SOP finalised			
e Implementation of Health Board improvement goal for CDI (Colostrum Difficile Infection) reductions in 2025/2026	Deputy Director Of Nursing Infection Prevention and Decontamination	31/03/2026	Progressing
Planned care harms reviews on impact on patient safety and experience	Programme Director, Planned Care	TBC	Progressing
Review opportunities to redesign and reconfigure ED quadrant linked to capital programme development.	Chief Operating Officer	30/06/2026	Progressing
Winter plan developed with partners throughout Dec 2025	Chief Operating Officer	15/01/2026	Complete
Review opportunities to redesign and reconfigure ED quadrant linked to capital programme development	Chief Operating Officer	30/06/2026	Progressing



	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:

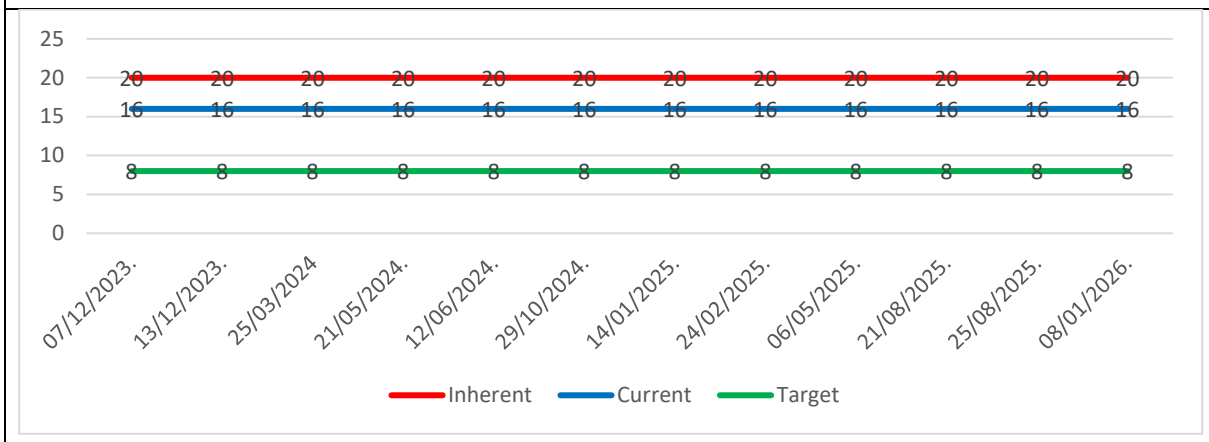
- Reduction in long-wait patients (>104 weeks) and breaches of national access standards.
- Fewer harm events linked to delayed care.
- Improved quality metrics including length of stay, readmission rates, and patient-reported outcome measures (PROMs).
- Reduction in regulatory and legal cases associated with delayed access.
- A demonstrable shift in focus from access process metrics to sustained improvement in patient safety, experience, and outcomes.

CRR 25-02	**Risk Title: Future Demand & Sustainable Workforce**		**Date Opened:** 21/08/2025 *(version 2 refined from 2023)*
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 12/02/2026
Date Last Reviewed: 08/01/2026	**Director Lead:** Executive Director of People and Organisational Development	**Link to BAF**:	**Target Risk Date:** 31/03/2027

There is a risk that the organisation will not have a sustainable workforce to meet future patient demand.
This may be caused by ongoing recruitment challenges (particularly in specialist roles), limited workforce planning to match future service needs, and increasing operational pressures across teams and departments.
This may lead to staff burnout, reduced morale and retention, and an inability to consistently deliver safe, high-quality care placing additional strain on services and impacting patient outcomes.

Mitigations/Controls in place	Additional Controls required
1. Strategic Recruitment Team supporting senior leadership, medical and dental consultant posts 2. Local IHC (Integrated Health Community) resourcing teams delivering recruitment activity against divisional priorities. 3. Recruiting Well / Joining Well programmes and recruitment campaigns. 4. Nurse Retention Lead and retention plan. 5. All-Wales Flexible Working policy implemented. 6. Speak Out Safely Multi-Disciplinary Team and Work in Confidence platform in place for staff concerns. 7. Workforce reviews underway in challenged specialties (ophthalmology, vascular, orthodontics, Neurodevelopment (ND), diagnostics).	a) Implement a system-wide Workforce Planning Framework that aligns health and social care workforce requirements with service demand and capacity modelling. b) Medical and Dental workforce engagement and management not fully effective. c) Fragile workforce pipelines in specialist services (ophthalmology, vascular, orthodontics, ND, diagnostics) (cross-theme). d) Retention measures not yet delivering consistent impact. e) Absence and sickness management requires stronger controls (linked to new Absence risk created Feb 2025).

Actions	Action Owner	Due Date	Progression Analysis
Deliver “Recruiting Well, Joining Well, Leaving Well” programme across staff journey Due to resource being allocated to the Foundations for the Future programme, the remaining workstreams within this action will continue to be worked on but the expected completion is delayed until later in 2025 a. The leaving well booklet b. Improving shortlisting timescales c. Advertising well in recruitment This action will be reviewed as part of a deep dive in January 2026	Head Of Policy, Practice & Compliance, Workforce & Organisational Development	31/03/2026	Progressing
Targeted management of sickness absence, linked to new Absence risk The 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	Head Of Policy, Practice & Compliance, Workforce & Organisational Development	31/03/2026	Progressing
Workforce modelling and specialty service plans for Ophthalmology, Vascular, ND and Orthodontics Workforce planning templates have been issued out to services and engagement is underway to support the completion. Vascular services are so far further along with this, having held an away day on 3rd September. There are challenges in service leads having time/capacity to work on their workforce plans	Associate Director Workforce Optimisation, Workforce & Organisational Development	31/03/2026	Progressing
Develop Vascular workforce strategy and Phase 2 Business Case	Vascular Network Manager, Vascular Services	31/03/2026	Progressing
Recruitment and workforce model development for Orthodontics Academy model	Chief Operating Officer	Ongoing	Progressing
ND workforce business case approval via Executive Team. 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	CAMHS Programme Management Business Lead	31/03/2026	Progressing (revised date from 31/12/2025)
Establish revised Radiology workforce model. Updated operational Diagnostic risk to be presented at divisional meeting to discuss on the 10/10/2025. This action is revised due to service focus on 8-week backlog reduction and supporting OPD programme. Proposed revise due date to Q1 2026-27	Associate Director, Diagnostics	30/06/2026	Progressing (revised date from 20/10/2025)



	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 Oct 2025;

Overall Vacancy rate of 8.2%, slight improvement from 8.8% since the April 25. Clinical staff groups such as Registered Nursing, and Professional Scientific and Technical are seeing positive reductions in vacancy FTE (Full time equivalent) over the last year, however, increases in Clinical Services, Admin and Clerical, Estates and Ancillary and Medical and Dental are causing the vacancy rate to remain fairly static.

Turnover stands at 7.7% and continues its downward trend from 10% in December 2022.

BCUHB continues to have the lowest reported sickness absence levels in Wales NHS, however, in August 2025 rolling sickness absence was 0.08% higher than during same period last year with Stress, anxiety and depression accounting for the largest proportion of absence.

CRR 25-03	**Risk Title: Population Needs**		**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: 24/12/2025	**Director Lead:** Executive Director of Public Health	**Link to BAF**: BAF24-06/07	**Target Risk Date:** 31/03/2028

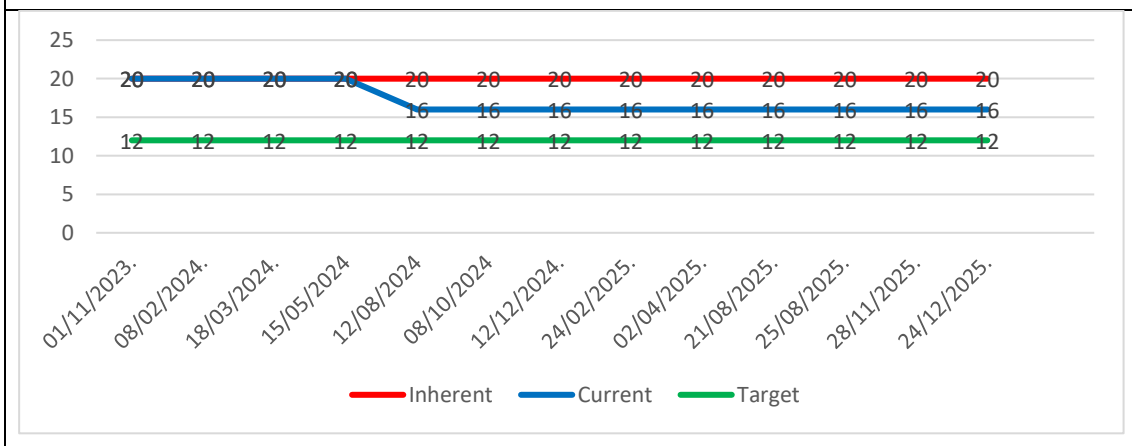
There is a risk that the organisation will fail to meet the health needs of the population and will not enable good health and wellbeing of the population.
This may be caused by a failure to take appropriate health prevention responses in areas such as immunisation, outbreak management and screening, 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	Additional Controls required
1. Recurrent funding secured for Healthy Weight / Healthy Wales programmes 2. Diabetes "Case for Change" a structured, evidence-based mechanism to identify service gaps 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 ND transformation programme funding to support longest waiters 8. National referral pathways in orthodontics and Dentist with Enhanced Skills / Tier 2 provision.	a. Limited system-wide prevention leadership and prevention not consistently prioritised b. Inconsistent commissioning approach across community and primary care services. c. 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 d. Diabetes Programme support to establish cross cutting delivery plan e. Insufficient digital integration for community and Neurodevelopment services f. Fragility of Neurodevelopment workforce and reliance on temporary funding g. Lack of restorative dentistry service and workforce pipeline h. Evidence to support the Health Inclusion offer.

9. Prevention, Population Health & Early Intervention Executive Delivery Group provides oversight of delivery.	

Actions	Action Owner	Due Date	Progression Analysis
Complete Population Needs Assessment which informs the development and focus of Health Board Strategy. Data to support the Strategic Intent has been provided	Head of Public Health Assurance & Development, Public Health	31/03/2026	Progressing
Identify population health focused priorities for Health Board delivery Data to support the Strategic Intent has been provided alongside a number of evidence reviews. Programme plans within the Public Health Directorate include identification of need across a range of services, programmes and within the population.	Head of Public Health Assurance & Development, Public Health	31/03/2026	Progressing
Development of Population Health Management data and intelligence to ensure that Health Board is intelligence-led Delayed due to financial approval for spend against new posts. Recent agreement for posts to commence in 26/27.	Head of Public Health Assurance & Development, Public Health	31/03/2026	Delay
Develop a plan which addresses recommendations from the BCUHB Weight Management Service review Report received outlining recommendations, which will inform 26/27-28/29 IMTP plans.	Head of Public Health Assurance & Development, Public Health	31/03/2027	Progressing
Communicable disease outbreak management plan is embedded within services with an agreed schedule of simulation events and schedule of review by the Board The plan is available however it is recognised that the risk now lies within preparedness for communicable disease likelihood and severity. The associated risk descriptor has been updated to reflect this. The gaps around preparedness lie with communications, knowledge and application of existing plans and procedures.	Assistant Director of Health Protection, Public Health	31/03/2026	Progressing
Contribute to co-design Wellbeing, Prevention & Anchor Framework for North Wales as part of the Regional Partnership Board The Regional Partnership Board and BCUHB have develop a set of 7 key mission statements as the basis of the Framework.	Head of Public Health Assurance & Development, Public Health	31/03/2026	Progressing
Achieve the ministerial priority BCUHB Integrated Vaccination & Immunisation Service – Increase vaccination rates against targets	Head of Public Health Assurance & Development, Public Health	31/03/2026	Progressing
Implement plan to target resources for the most vulnerable groups (e.g. – those experiencing homelessness, Gypsy, Roma and Traveller communities) which will contribute to reducing inequalities in healthy life expectancy This work supports the development of the Health Board Health Inclusion Offer which will support access to health in key groups.	Head of Public Health Assurance & Development, Public Health	31/03/2026	Progressing
Establish Diabetes Change Programme providing programme management, milestones and delivery plan – in order to meet the Ministerial priorities (increasing the % receiving all 8 NICE Care processes) There is a risk to delivery of the Q3 and Q4 Diabetes objectives, related to system resources available. This is being mitigated through alignment with other Health Board key programmes of work to support efficient use of resources, but may result in changes to timelines for delivery. There are plans currently being implemented to progress the programme and these will extend into 26/27.	Head of Public Health Assurance & Development, Public Health	31/03/2026	Delay
Develop a Community and CHC Strategic Plan with Local Authorities.	Acting Assistant Director Care Homes Support & CHC Commissioning	31/03/2026	Progressing
Implement surge and escalation plans with Local Authority partners for community flow	Acting Assistant Director Care Homes Support & CHC Commissioning	31/03/2026	Progressing

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	CAMHS Programme Management Business Lead, Child & Adolescent Health	31/03/2026	Progressing (revised date from 31/12/2025)
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.	Assistant Director Of Primary Care	31/03/2026	Progressing



	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 25-05	**Risk Title: Strategic Change – Impacting Care and Staff Delivery**		**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: 31/12//2025	**Director Lead:** Executive Director of Transformation and Strategic Planning	**Link to BAF**: BAF24-02	**Target Risk Date:** 31/03/2026

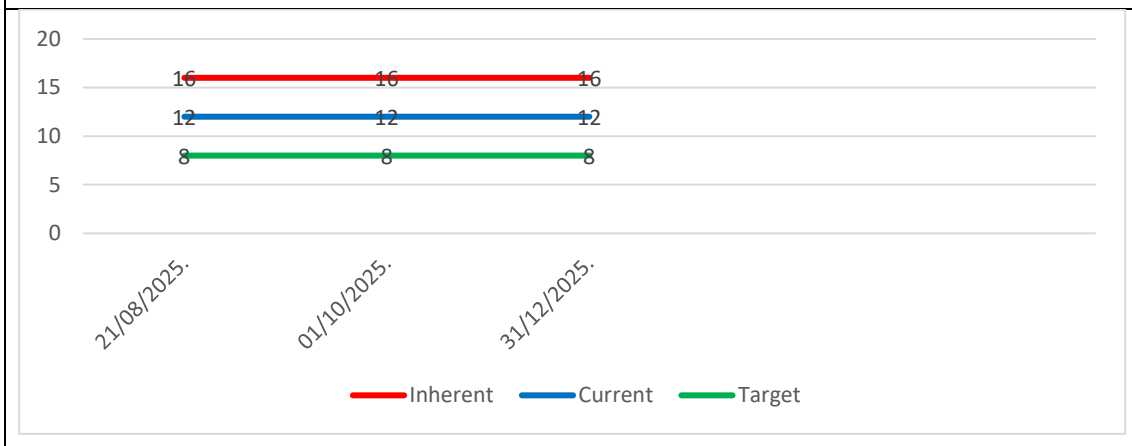
There is a risk that patients may not benefit from planned improvements in care, access, and outcomes if the HB does not effectively implement or develop its strategic change programmes.
This may be caused by a lack of momentum in delivering change, unclear or underdeveloped clinical strategy, competing 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	Additional Controls required
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;	a. Completion of the strategy development work, moving into the execution phase. b. Organisational approach to change management to be developed and implemented.

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.	

Actions	Action Owner	Due Date	Progression Analysis
Complete Strategic Intent for North Wales with partners, presenting to Health Board for approval The statements of strategic intent were co-created, tested and refined with partners. They were reviewed by PPHP on the 14th January and subsequently approved by the Board on the 29th January.	Head of Health Strategy and Planning, Transformation & Strategic Planning	31/01/2026	Completed
Complete the diagnosis phased of the Health Board's 10 Year Strategy, including an implementation plan for the remaining programme of work Now referred to as the discovery phase. A range of engagement activity has taken place to date including sessions with the Board, sub committees and partners as well as specific Strategy Development events. Further work is required to gather the more quantitative pieces of evidence which are required to develop the output of this work - a case for change document and to develop the implementation plan	Head of Health Strategy and Planning, Transformation & Strategic Planning	31/03/2026	Progressing
Complete preparations for phase 2 of the Clinical Services Planning (CSP) work, including an implementation plan Work has commenced and actions identified which will need to be developed into a work plan for the remainder of the financial year – actions include: - Establish initial Clinical Reference Group - Develop, test and finalise CSP methodology - Identify first tranche of CSP services - Raise awareness with staff, leveraging the opportunities presented by Foundations for the Future - Produce overarching case for change which will underpin the CSP Phase 2 work.	Head of Health Strategy and Planning, Transformation & Strategic Planning	31/03/2026	Progressing
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.	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	31/12/2025	Complete

Mobilise the Challenged Services oversight group that will report into the SP&SC Group This 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.	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	31/12/2025	Complete
Organisational approach to change developed as one of the enabling products within Foundations for The Future programme Work is progressing and on track. A core group is in place to drive forward the work with discovery work complete and commencement of design work. A paper outlining the approach has been socialised at the Strategy Workstream in December with further discussion scheduled as part of a deep dive during January.	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	31/03/2026	Progressing



	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

CRR25-06	**Risk Title: Value Delivery and Financial Sustainability**		**Date Opened:** 21/08/2025 *(version 2 refined from 01/04/2024)*
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 24/02/2026
Date Last Reviewed: 22/12/2025	**Director Lead:** Executive Director of Finance	**Link to BAF**: BAF24-03	**Target Risk Date:** 31/03/2026

There is a risk that the Health Board is unable to secure current non-recurrent (one off) allocations in future financial years, these allocations conditional on attainment of financial plans. If this reosurce is not secured then services will be required to deliver within a reduced envelop of funds and as a consequence patients may experience patient harm, reduced access to high-quality, timely and innovative care. The objective is to achieve long-term financial sustainability or maximise value from its spending.
The key risks centre upon cost overruns from out of area referrals for mental health patients and patient flow out of the Hospital resulting in cost exposure from requiring additional capacity areas to remain open and additional costs within Emergency Care front of house, combined with an inability to deliver savings plans, reduced investment in transformation.

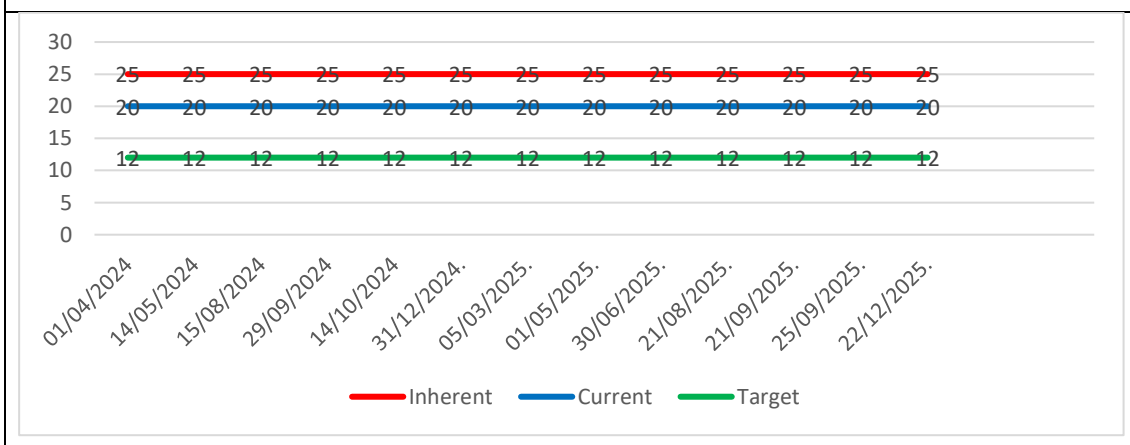
Mitigations/Controls in place	Additional Controls required
1. Core Savings targets for IHCs, Non-IHC Directorate and Corporate functions have been issued and performance to be challenged at Integrated Performance Executive Delivery Group – chaired by the Chief Executive. 2. Value and Sustainability programme approach to 2025/26 savings has been endorsed by the Executive and Board. Executive Leads have been assigned and a flow chart issued setting out the governance process for sharing of costed savings opportunities and Divisional delivery. 3. 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 4. Continuation of the Enhanced Establishment Control Group (executive approval before advertising) to review all requests for A&C posts and all Band 7+ posts, moratorium on requests for Permanent recruitment to Band 8B and above where potentially affected by Foundations for the Future but excluding any clinical posts and minimising interim staff appointments. 5. Expansion of EEC (Enhanced Establishment Control) to be utilised for acting up and any increase in hours to be managed through the Enhanced Establishment Control process. 6. Cease use of agency in line with Ministerial Actions by end of September 2025 with the exceptionality of sign off by Executive Director of Nursing for all Agency nursing requests which are deemed clinically necessary beyond 31	a. Prior year and current year financial performance material deterioration and therefore additional actions are required to control the run rate and reduce the deficit to a balanced position. These have been previously endorsed for implementation through the Integrated Performance – Executive Delivery Group. b. Health Board delegation to Executive to produce a recovery plan, Health Board working group formed to provide Board oversight with Performance, Finance and Information Governance Committee to mitigate against the year-to-date deficit and risk to attainment of target break even whilst assessing impact on patient safety and quality c. Performance is reported and scrutinised through the IP-EDG monthly meetings where officers are held to account for delivery. A 1.5% cost benefit and savings ask delivery is required as a minimum

October. This exceptionality for nursing requests is for all areas excluding Mental Health. Mental Health to be included from December 2025.

7. Non-Pay – all discretionary, non-clinical expenditure directed to the office of the Executive Director of Finance for scrutiny prior to approval
8. Internal scrutiny by central finance teams, of the Divisional financial assumptions, overspends and forecasts.
9. Financial reporting throughout the Health Board and to Welsh Government monthly via the Monthly Monitoring Return.
10. Early identification of emerging issues through horizon scanning and trends in run rate and alerting Operational Management to changes to regularity requirements.
11. Monitoring the adequacy and effectiveness of internal control, accuracy and completeness of financial reporting and forecast, compliance with laws and timely remediation of deficiencies through conformance reporting to Audit Committee and reporting through local finance reports to services
12. Review of SORD September 2025 to provide clarity with aim of authority moving towards earned autonomy
13. Health Board receiving a report on need for additional financial oversight, delegating Executive to develop a recovery plan building on the measures deployed and key asks of officers from the Integrated performance executive Delivery Group. A representation of the Health Board to support development of the recovery plan and Performance, Finance and Information Governance Committee to provide Health Board oversight

d. Gaps in delivery of savings targets mandated to be met on a recurrent basis
e. Escalation meetings where improvements are not realised will continue to be held with leadership teams by the Chief Executive. In these forums support is offered to improve performance and trajectories supported for improvement.
f. Prioritisation exercise involving £42m transformation funding received on a conditionally recurrently basis to the end of 2025/26 completed for clinical schemes, with requirement to disinvest / identify alternative funding streams prior to new developments being funded.
g. Consideration of additional strengthening of enhanced establishment controls and vacancy freeze for non-patient facing roles and continued reduction in variable staffing costs

Actions	Action Owner	Due Date	Progression Analysis
B Health Board receiving a report on need for additional financial oversight, delegating Executive to develop a recovery plan building on the measures deployed and key asks of officers from the Integrated performance executive Delivery Group. A representation of the Health Board to support development of the recovery plan and Performance, Finance and Information Governance Committee to provide Health Board oversight	Director of Finance (DoF)	30/11/2025	Complete
C Enhanced 'Check and Challenge' discussions with Chief Finance Officers, on a monthly basis, to ensure the forecast expenditure is robust. Escalation of Out of Area Mental Health Placements, through the Chief Executive Officer. Maintain increased controls.	Director of Finance	31/03/2026	Progressing
B Continued oversight and holding to account via the Integrated Performance Executive Delivery Group, and holding to account against expenditure control reductions identified for the remainder of the financial year.	Chief Executive Officer (CEO) / Director of Finance	Monthly	Progressing
Directorate teams to review medical devices capital replacement plans. The medical devices capital programme has been agreed for 2026-27 via the Medical Devices Capital Group. Refinements to the process will be made in line with progress with Foundations for the Future, which will determine the appropriate governance processes. Proposal to close the action	Assistant Director of Ahps and Health Science, Therapies & Health Science	31/03/2026	Complete



	Impact	Likelihood	Score
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

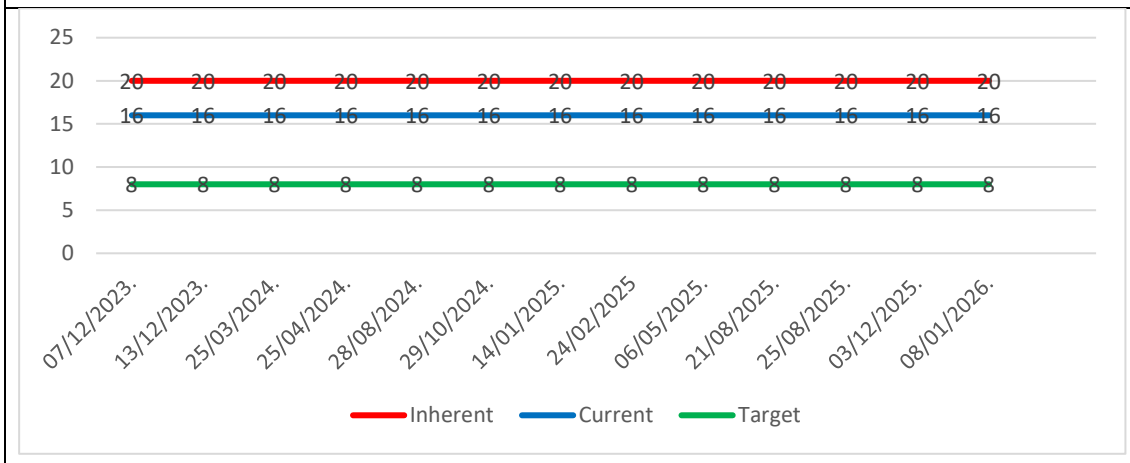
CRR25-07	**Risk Title: Leadership and Operating Model**		**Date Opened:** 21/08/2025 *(version 2 refined from 2023)*
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 12/02/2026
Date Last Reviewed: 08/01/2026	**Director Lead:** Executive Director of People and Organisational Development	**Link to BAF**: BAF25-04	**Target Risk Date:** 31/03/2027

There is a risk that patients may experience delays, reduced quality of care, or fragmented services if the organisation does not have an operational model to deliver its strategic objectives
This may be caused by fragile management structures, workforce shortages, leadership capabilities and competence and rising demand in high-need areas.
This may lead to diminished organisational resilience, reduced capability to deliver foundations for the future, low staff morale, and risks to safe, high-quality care.

Mitigations/Controls in place	Additional Controls required
1. Strategic Recruitment team for senior leadership, medical and dental consultant posts 2. Local IHC resourcing teams driving recruitment priorities 3. Recruiting Well and Joining Well programmes 4. All-Wales Flexible Working policy implemented 5. Speak Out Safely MDT and Work in Confidence platform for staff to raise concerns 6. Organisational Culture Change Plan and Behaviours Framework approved by Board 7. Integrated Leadership Development Framework (ILDF) with measurement metrics 8. Increased nurse retention 9. Clear top-down commitment reinforced leadership culture that prioritises staff wellbeing, inclusion, and psychological safety (Pledge signed) 10. 60% senior staff trained in leadership through conferences and masterclasses	a) Need for further embedding of workforce planning function b) Leadership development pathways not fully integrated c) Engagement and operational effectiveness with Medical and Dental workforce inconsistent d) Absence management requires stronger controls Compassionate leadership adoption requires measurable indicators across organisation e) Monitor any harm that arises to patient and service users due to the operating model changes.

Actions	Action Owner	Due Date	Progression Analysis
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 (26.9.25) and currently reviewing approach to the celebration of long serving colleagues while holding ceremonies for those who have reached 25 years service in October 2025 • Involved local teams and introduced new local responsibility for actions in response to the 2024 NHS Wales Staff Survey to prepare the ground for the 2025 survey (goes live 6.10.25) • As of August 2025, two members of staff joined the team, bringing additional capacity to proceed with work to further develop and deliver employee engagement and experience-related improvements which will include mechanisms for both improving engagement and measuring engagement such as Pulse surveys	Head of Employee Engagement and Experience - Corporate Office	31/03/2026	Progressing
Further embed ILDF and measure effectiveness HEIW will release a Management Competency Framework due to be launched September 25. This will be used to inform the mid-level management ILDF leadership courses / resources design.	Head of Organisational Development Workforce & Organisational Development	31/03/2026	Progressing
Roll out Compassionate Leadership resources and embed into development programmes	Director of People and Organisational Development	31/03/2027	Progressing
Deliver Culture Change Plan with Comms and Engagement rollout The synthesis report was submitted to EC then P&CC and then board on 27th November. The report was accepted and endorsed at Board. The next step is to provide a more detailed improvement plan and submit to P&CC for approval. This is expected to have been submitted by 31st March 26.	Information Manager, Workforce and Organisational Development	31/03/2026	Progressing (revised date from 31/12/2025)
Quarterly Culture, Leadership & Engagement Plans finalised and monitored The-2025/26 plan was in operation and overseen by ODSG. This will be superseded by the 3 year improvement plan noted above	Information Manager, Workforce and	31/03/2027	Progressing

	Organisational Development	



	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 April 2025;
Staff retention is 90.6% In April 2025 compared to 90.2% last year.
PADR compliance showed improvement increasing to 9.6%

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

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

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

CRR 25-08	**Risk Title: Non-Compliance with Regulatory and Legislative Requirements**		**Date Opened:** 21/08/2025 *(version 2 refined from 2023)*
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 05/03/2026
Date Last Reviewed: 18/12/2025	**Director Lead:** Director of Corporate Governance	**Link to BAF**: BAF24-01	**Target Risk Date:** 30/06/2027

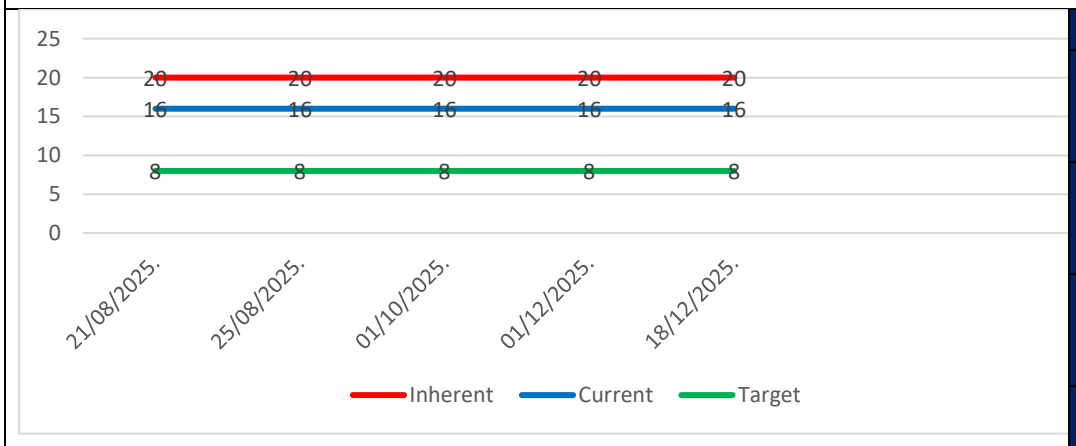
There is a risk that the organisation may fail to comply with regulatory and legislative requirements, which could directly or indirectly impact the safety, quality, and accessibility of patient care.
This may be caused by inefficiencies in managing regulatory complexities, insufficient policy management, managing changes in legislation at pace, insufficient operational assurance across estates, health and safety, and medical devices, and failure to deliver climate/net zero requirements.
This may lead to enforcement action, financial penalties, and loss of public and stakeholder confidence.

Mitigations/Controls in place	Additional Controls required
1. Training, induction and mandatory requirements for staff for highlights legislation and compliance. 2. Monitoring of regulations and legislation by various groups exist 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) 3. Various External peer review programmes e.g. Finance, Counter Fraud, Pharmacy, Imaging and Pathology reporting areas of non-compliance with legislation. 4. Regulatory compliance around Health Inspectorate Wales and Care Inspectorate Wales reported to QSE, and to Audit Committee (via the Statutory Compliance Report)	a) Improved escalation routes, governance, oversight and monitoring of non-compliance. Governance and regulatory Executive Delivery Group (EDG) group to be in place to ensure HB wide oversight of all regulatory activity and inspections (not just clinical) and tracking non-compliance with a clear route for escalation of non-compliance to the EDG and route of escalation. b) Creation of an electronic system to capture all legislative and regulatory requirements, to capture information in relation to accountability and responsibility for the different elements, to enable the sharing of information, monitoring of progress and production of monitoring reports as necessary c) The Quality Management system is yet to be fully embedded and will highlight external peer reviews which cite any areas of non-compliance for better oversight by the EDG. d) Lack of consistent medical device training and local governance e) Inadequate workforce capacity in Pharmacy aseptic units; >80% capacity utilisation

	f) Quality assurance and regulatory compliance gaps in Pharmacy services g) Net zero / climate compliance delivery plan not embedded (consolidated) h) Core Emergency Preparedness policies, templates, and guidance documents are still under review, such as the Business Continuity Operational Response Framework.

Actions	Action Owner	Due Date	Progression Analysis
A) Governance and regulatory EDG to be set up to oversee non-compliance (strategic actions from this to be added here going forward) The Executive Committee has agreed the formation of a governance and regulatory group, and work to make the necessary arrangements will continue during February 2026 once TOR (Terms of Reference) and membership approved.	Head of Statutory Compliance and Inquiries	31/03/2026	Progressing (revised date from 01/12/2025)
B) Creation of an electronic system to capture legislative and regulatory information and requirements. On Track: procurement of system underway. System design will take place Jan-Feb, contract awarded and then can be piloted Aug 2026 before being rolled out in Nov 2026.	Head of Statutory Compliance and Inquiries	01/11/2026	Progressing
D) Complete audit of medical devices readiness of services. Post-market surveillance audit completed August; three services who make or modify devices need support to ensure compliance. Meetings scheduled with those services, Head of Clinical Engineering and ADAHPS in September / October to facilitate next steps. The audit was circulated widely across the Health Board, prioritising services/pathways most likely to make or modify devices. As there may be other services who fit these criteria, the engagement team have supported ongoing communication into the organisation for awareness. National benchmark audit completed June 2025. Benchmark summary received August 2025. Head of Clinical Engineering working with services to progress improvements. The National audit remains live so we can update as required. Audit completed by end Q2 2025, with report submitted to Executive Committee Q3 2025.	Assistant Director of Ahps and Health Science, Therapies & Health Science	31/03/2026	Complete
A) Review local medical devices groups governance & membership. A proposal was written re these groups being reformed in April 2025. EDAHPHS (Executive Director of Allied Health Professions & Health Science) and COO (Chief Operating Officer) in discussion re way forward. Action on track.	Assistant Director of Ahps and Health Science, Therapies & Health Science	16/03/2026	Progressing
E) In order for compliance in pharmacy (aseptic production, QA and regulatory staff) Workforce Expansion is required. Regarding outstanding posts to be recruited to. YMW band 3 to 4 uplifts, still progressing, one post to be appointed to in Jan 2026, due to another member of the team resigning (they were eligible for the band 4) the 2nd post will need to be advertised again as a staff development role. YG will appoint to the band 3 position in Jan 2025. YGC band 7 post – no change in position from November 2025 update. All other posts recruited to.	Chief Pharmacist, Corporate Office	31/01/2026	Progressing (revised date from 30/11/2025)
A) Prevent Fraud legislation. Compliance task and finish group to be set up with risk leads appointed to ensure compliance across the HB. Areas of non-compliance or not progressing in a timely manner to be monitored by Finance and EDG. Service currently working at 50% capacity currently due to long term sickness within the team. Some progress made in that risks have been identified and reviewed by Counter Fraud but no risk owner allocated in order for the first task finish meeting to take place.	Head of Local Counter Fraud, Finance	31/03/2026	Progressing (revised date from 31/12/2025)
Review and update business continuity plans for Pharmacy Technical Services. The Cancer Division have set up a working group to develop and implement a demand and capacity SACT Dashboard, multi-disciplinary group meeting monthly. Pharmacy Technical Services business continuity/contingency plans have been reviewed and updated and includes actions to be taken in the event of service failure whether that be a planned or unplanned event.	Chief Pharmacist, Corporate Office	31/12/2025	Complete
h) A number of Business Continuity Plans (BCP) have been identified as in place however scoping is required to identify all outstanding BCPs (possibility of over 100 BCP, however scoping is required to determine). Continue support is required	Deputy Head of Emergency Preparedness	31/03/2026	Complete

for the IHCs/ Womens and MH/LD to obtain denominators for accurate reporting, monitoring and compliance rates. The scoping exercise to identify all required BCPs will be completed by March 2026. We have now received a denominator number from IHC Centre (46). We are now working with individual services offering supporting workshops to review/amend and create BCPs, this is across all 6 areas. 3 IHCs, Womens, MH/LD and Corporate. Complete	Resilience & Response		
h) Business Continuity dashboard has been established, a RAG system has been introduced and a % compliance indicator, to be a control once uptake and communicated out. BCP Dashboard in place and reporting monthly by email to leads and CCAG group members. Complete	Deputy Head of Emergency Preparedness Resilience & Response	31/12/2025	Complete
Ensure the Wholesale Distribution Authorisation (WDA(H) is upheld to enable the lawful procurement, storage, and supply of medicinal products to organisations outside the Health Board's legal entity The Wholesale Distribution Authorisation (WDA(H)) remains compliant and upheld following the MHRA inspection in November 2025. The inspection has been formally closed with a low site risk rating and a 3–5 year inspection cycle. The MHRA-approved action plan is largely complete, with the Quality Management System strengthened through monthly QMS meetings, formal governance arrangements and standardised agendas. Remaining actions are progressing and are primarily dependent on external factors or sequencing (including an SLA with Mountain Rescue, delivery of calibrated data loggers to enable temperature mapping, and completion of governance training), with revised timescales extending into early 2026 where appropriate. Overall, regulatory assurance is strong and outstanding actions are focused on resilience and embedding good practice rather than addressing compliance concerns.	MSO/ Lead Governance Pharmacist - Policies	31/03/2026	Progressing
New approach for Health and Safety Management System being developed aligned to NHS Employers Health and Safety Standards, to include Violence Prevention and Reduction Standards. In-house security service model not being pursued. 22/01/2025: Extension of current Security SLA and Technical specification awaiting sign off.	Head of Health, Safety and Security	31/03/2026	Progressing (revised date from 31/12/2025)
Review Integrated Performance Framework and finalise the redesign of reporting structures/timings to enhance transparency. Due to be updated ahead of March 2026 Board	Director of Performance	31/03/2026	Progressing
Reviewing current systems to have a more effective way of tracking and reporting audit recommendations. Corporate Governance (policies/tracking) /Risk Management and System to be approved for procurement 22/12/25, new software in place by 30/04/25 but piloted end of 2026 which will support automated tracking. This will not be embedded until 2026-2027	Head of Statutory Compliance and Inquiries	30/09/2026	Progressing
Executive Team recruitment ongoing with some progress made on appointments. Director of People and OD in progress with interim arrangements in place	Interim Executive Director of People Services and Organisational Development	31/03/2026	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

Governance and regulatory EDG to be set up to oversee non-compliance and all operational aspects. This risk to be

	developed to be more strategic following the group and to report areas of non-compliance to the Executive Committee. Compliance to be tracked and risks mitigated.

CRR 25-09	**Risk Title: Safe Environment**		**Date Opened:** 04/01/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 24/02/2026.
Date Last Reviewed: 23/01/2026	**Director Lead:** Director of Environment and Estates	**Link to BAF**: BAF 24-03	**Target Risk Date:** 31/03/2030

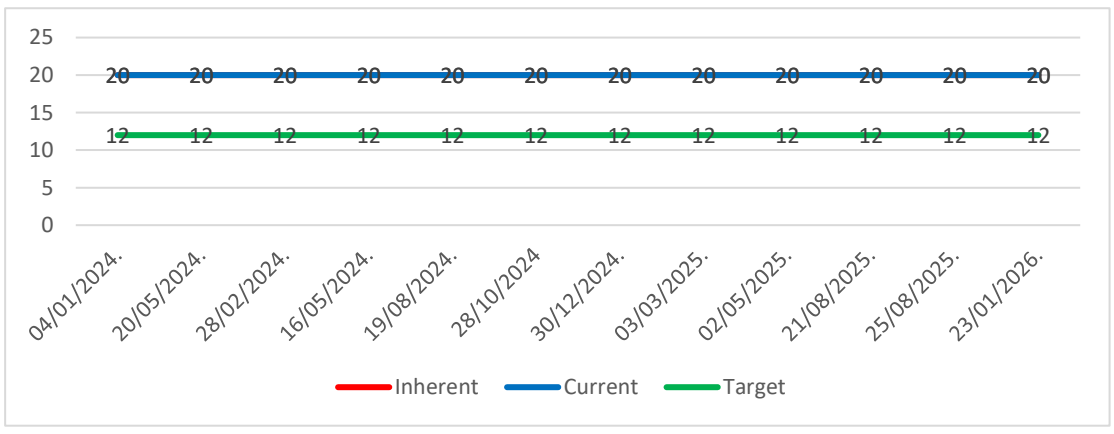
There is a risk that patients may be exposed to unsafe, uncomfortable, or unsuitable care environments if the organisation's estates and infrastructure are not maintained to appropriate standards.
This may be caused by ageing estate, backlog maintenance, and gaps in fire safety, health and safety compliance, 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	Additional Controls required
1. Estates Strategy developed and approved by the Health Board in January 2023. 2. Internal Governance for capital allocation in place within the Health Board. 3. Business Cases to Welsh Government to resolve major infrastructure issues in line with the Estates Strategy 4. Priority bids against Welsh Government Estates Funding Advisory Board (EFAB) for the allocation and prioritisation of funding in relation to infrastructure funding, decarbonisation, fire and Mental Health and Learning Disability. 5. Discretionary Capital Allocation of £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 aligns with the capital prioritisation form that we will submit to Welsh Government. 12. Updated agreed protocol for use of Annual Discretionary Slippage in place for developing Business Justification Cases (BJC) for essential estates works and discretionary capital schemes that could be aligned with in-year additional Capital Funding provided by WG. 13. 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,	a) 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. b) 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. c) Ensure that the Health Board has an Estates rationalisation programme in place that will support the capital prioritisation programme and reduce backlog maintenance. d) Internal Audit review of Fire Safety – Agreed Management Action Plan being implemented and being managed through the Fire Safety Management Group e) Timely progression of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase and Ysbyty Gwynedd PBC f) Assurance around the progress made with the BCUHB Estates Strategy and the lack of clarity around the BCUHB Clinical Strategy. g) Internal Audit review of Asbestos Management – Agreed Management Action Plan developed and managed through the Asbestos Management Group h) NWSSP Authorising Engineer – Water – Audit on water safety undertaken and agreed action developed to improve compliance which are reported at the Water Safety Group i) NWSSP Authorising Engineer – Electrical– Audit on Electrical Systems undertaken and agreed action developed to improve compliance which are reported at the Electrical Safety Group

Infrastructure, Decarbonisation, Mental Health, Infection Prevention Control and Decontamination	

Actions	Action Owner	Due Date	Progression Analysis
a.) 6-Facet Survey Undertake actions to deliver a 6-facet survey across the Health Board over the next 5 years. Due to financial constraints within the Health Board a review of the 6-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** - Functional Suitability Review **Facet 4 -** Environmental Management Audit **Facet 5** - Space Utilisation **Facet 6 -** Quality of the Environment	Head Of Operational Estates	31/03/2027	Progressing
b.) Develop ToR Develop a standardised Terms of Reference to be considered and endorsed by Capital Investment Group	Director of Environment and Estates	31/03/2026	Progressing
c.) 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.	Head of Operational Estates	31/03/2026	Progressing
d.) 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	Head of Operational Estates	31/03/2030	Progressing
e.) 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	Director of Environment and Estates	31/03/2026	Progressing
f.) BCUHB Estates Strategy Progress with delivering on the 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.	Director of Environment and Estates	31/03/2026	Progressing
g.) Pan BCUHB Asbestos Management and Control Ensure the Health Board is fully compliant with its duty to manage asbestos by addressing all findings listed within the internal audit review	Head of Operational Estates	31/03/2026	Progressing
h.) 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	Head of Operational Estates	31/03/2026	Progressing
i.) 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 addressing all fundings reported as part of the AE audit of electrical systems and operational management	Head of Operational Estates	31/03/2028	Progressing
	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 was £348.4m. Cost to achieve physical condition B is c. £213m. Cost to achieve condition B for fire and safety statutory compliance is c. £136m. Total risk adjusted backlog is c. £240m. The majority (73%) of backlog relates to the 3 acute hospitals. Backlog for MH&LD, Community and Local Hospitals, and Community Facilities each comprise c.10% of total backlog.

The estate is facing significant risks and challenges and severe limitations on expected future funding. The current estate is not sustainable or viable in the long term and will not support the implementation of key BCUHB strategies and is a significant risk to the Board.

To aid with supporting a Capital Programme the Health Board will commence with a programme to deliver a 6 facet survey for the Estates, these surveys will commence in 2024 focussing on Acute sites and then community hospitals with a target to complete within 2 years. This will be a significant part of the estates portfolio and backlog maintenance cost. As sites are completed the cost associated with backlog maintenance will be identified and capital funding requested. The end date is dependant of how much capital investment is provided to the Health Board from Welsh Government. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government.

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

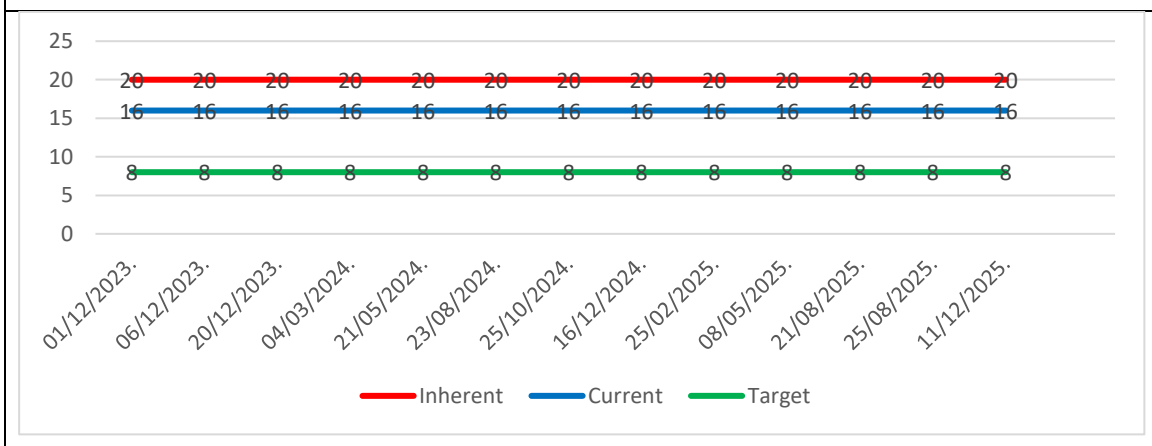
CRR 25-10	**Risk Title: Health and Safety**		**Date Opened:** 21/08/2025
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 24/02/2026
Date Last Reviewed: 11/12/2025	**Director Lead:** Director of Environment and Estates	**Link to BAF**: BAF24-03	**Target Risk Date:** 31/03/2026

There is a risk that the organisation will not maintain a safe environment for staff and patients in line with health and safety legislation. This may be caused by inadequate oversight of health and safety risks, gaps in estates and equipment compliance, and insufficient resources to address safety priorities.
This may lead to patient and staff harm, enforcement action, reputational damage, and increased legal claims

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

Actions	Action Owner	Due Date	Progression Analysis
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 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.	Head of Health, Safety and Security	31/12/2025	Complete
In-house security service model not being pursued. 22/01/2025: Extension of current Security SLA (Service level agreement) and Technical specification awaiting sign off. Extension to due date requested. Tender delayed due to governance timetable and hampered by Christmas break, and legal obligations under TUPE, which means 4-week consultation and 12-week notice period cannot commence until after 26/03/2025.Secure sign-off for SLA extension, publish tender documentation, complete TUPE consultation (4 weeks) and notice period (12 weeks), and award the new contract. Dependencies include governance approval and TUPE legal obligations; timelines adjusted to accommodate these requirements. Ensures continuity of security services and compliance with legal and governance obligations while transitioning to a new provider. Obtain SLA extension sign-off by 14/01/2026, award new contract by 01/08/2026.	Director of Estates	01/08/2026	Progressing (revised date from 31/03/2026)
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	31/12/2025	Complete
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, and a completed 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. Address audit	Director of Estates	30/09/2026	Progressing (revised date from 31/12/2025)

recommendations, ensures adequate resourcing, and supports delivery of Health & Safety objectives across BCUHB. Complete the resource review and business case by September 2026, following confirmation of Foundations for the Future outcomes.			
The BCUHB business model aligned to the All-Wales NHS Manual Handling Passport Scheme 2020 to be reviewed. Following meeting with DDoNs (Deputy Director of Nursing) and Service Leads, further meetings scheduled to discuss bespoke service requirements. Complete a gap analysis and produce a revised business model document that addresses bespoke service requirements, with sign-off from all relevant stakeholders. Initial meetings with DDoNs and Service Leads have taken place; further meetings are scheduled to gather detailed requirements and ensure feasibility. Supports compliance with national standards and improves consistency in manual handling training and practice across BCUHB. Finalise and approve the revised business model by August 2026, following stakeholder engagement and review.	Director of Estates	31/08/2026	Progressing (revised date from 31/07/2025)
Implement an Electronic Document Management System (EDMS) across BCUHB to centralise health and safety compliance reporting and risk management documentation. Ensure 100% of health and safety risk assessments, compliance reports, and key documentation are uploaded and accessible through the EDMS within 12 months of go-live. Risk Management software is already approved; project team and resources will be allocated by Head of Health, Safety and Security for the health and safety element to support implementation. Improves transparency of health and safety risks, enhances visibility, and reduces non-compliance by enabling easy access and sharing of documentation. Complete EDMS implementation and staff training by **December 2026**, with full operational use from **January 2027**.	Director of Estates	01/01/2027	Progressing



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

Position & Intended Outcome for Risk

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