GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Corporate Risk Register

CORPORATE RISK REGISTER (AS AT END SEPTEMBER 2025)

1.0 PURPOSE

This report provides an update on the **Corporate Risk Register (CRR)** following a comprehensive review and refinement process.

1.1 Key Highlights

Two Executive Committee sessions were held on **16 July** and **20 August 2025** to review the CRR. It was agreed that the previous register of 26 risks should be consolidated into a more strategic format for Board oversight and committee governance.

Key Updates

- The revised CRR has been endorsed by Committees during their October cycles, with all requested refinements now incorporated.
- The **public CRR (Appendix 3)** now contains **nine strategic risks**, ensuring a sharper focus on organisational priorities.
- Operational risks have been de-escalated for management at Director level.
- Two sensitive risks remain restricted for private Committee and Board review due to their nature.

Risk Oversight

- The **Risk Scrutiny Group** continues its programme of deep dives on strategic risks.
    - September: CRR24-06 – *Value Delivery and Financial Sustainability*.
    - November: CRR25-09 – *Safe Environment* and CRR25-10 – *Health and Safety* (following postponement of the October session due to quoracy).

1.2 Changes in Score

Only 1 change in score has occurred for corporate risks within the past 12 months.

Within the Executive Committee Development Sessions held in July and August 2025, and the Audit Committee Development Session in November 2025, it was noted that actions within the Corporate Risk Register must demonstrably reduce the overall risk exposure and score, rather than solely describe ongoing activity.

- Action is therefore required by the Executive /Senior Responsible Officer (SRO) within the next six months to prioritise driving down risk scores through strengthened controls, enhanced accountability, and targeted interventions, particularly in areas such as financial sustainability, workforce resilience, estates safety, and regulatory compliance.

During this consolidation and review of the corporate risk register, the reduction of eight operational risks, on challenged services, have been identified as requiring enhanced oversight and scrutiny by the Chief Operating Officer, through inclusion and monitoring within the Operational Senior Leadership Team Meeting (OLT). The Corporate Risk Team will attend these meetings to monitor, ensuring that risk discussions are robust, actions are effective, and that clear evidence is available to demonstrate reduction in residual risk.
In addition, the Corporate Risk Team will undertake periodic risk maturity audit and reporting to the Risk Scrutiny Group, to provide assurance.

Risk Ref	Reduced Risks	Lead Exec Director	Previous Risk Score	Current Risk Score
CRR24-02	*Patient Safety*	Executive Direcor of Nursing	16	12

1.3 New Risks

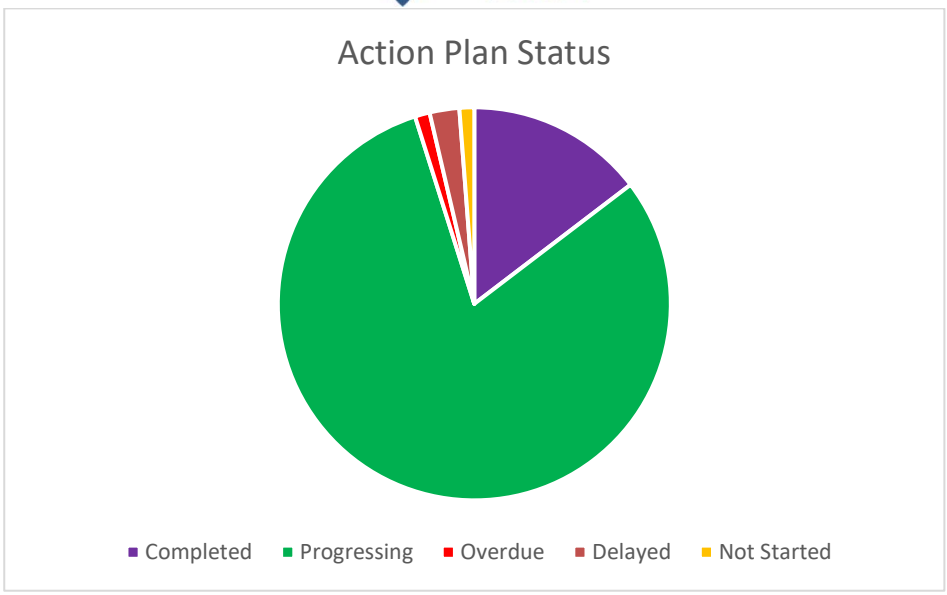
The risk(s) added to the Corporate Risk Register since the last update are:

Risk Ref	New Risks	Lead Exec Director	Current Risk Score (and IxL)
	2025: All 11 risks presented refined and consolidated		

1.4 Risks above Health Board 24/25 appetite

In 2024 the HB had eight risks reported to committee score **above** the tolerance range set in the appetite. Although some of these are now being managed operationally and remain above appetite. Ten corporate risks above tolerance are for the oversight of the Committees and Board.

1.5 Action Plan status of Corporate Risks



Of the 11 Corporate Risks, 82 actions have been developed to mitigate the risks 12 actions have been completed, 66 actions are progressing and on track, 1 action is overdue, 2 delayed actions (CRR25-03 Population Needs) rationale detailed within action update) and 1 action not started.

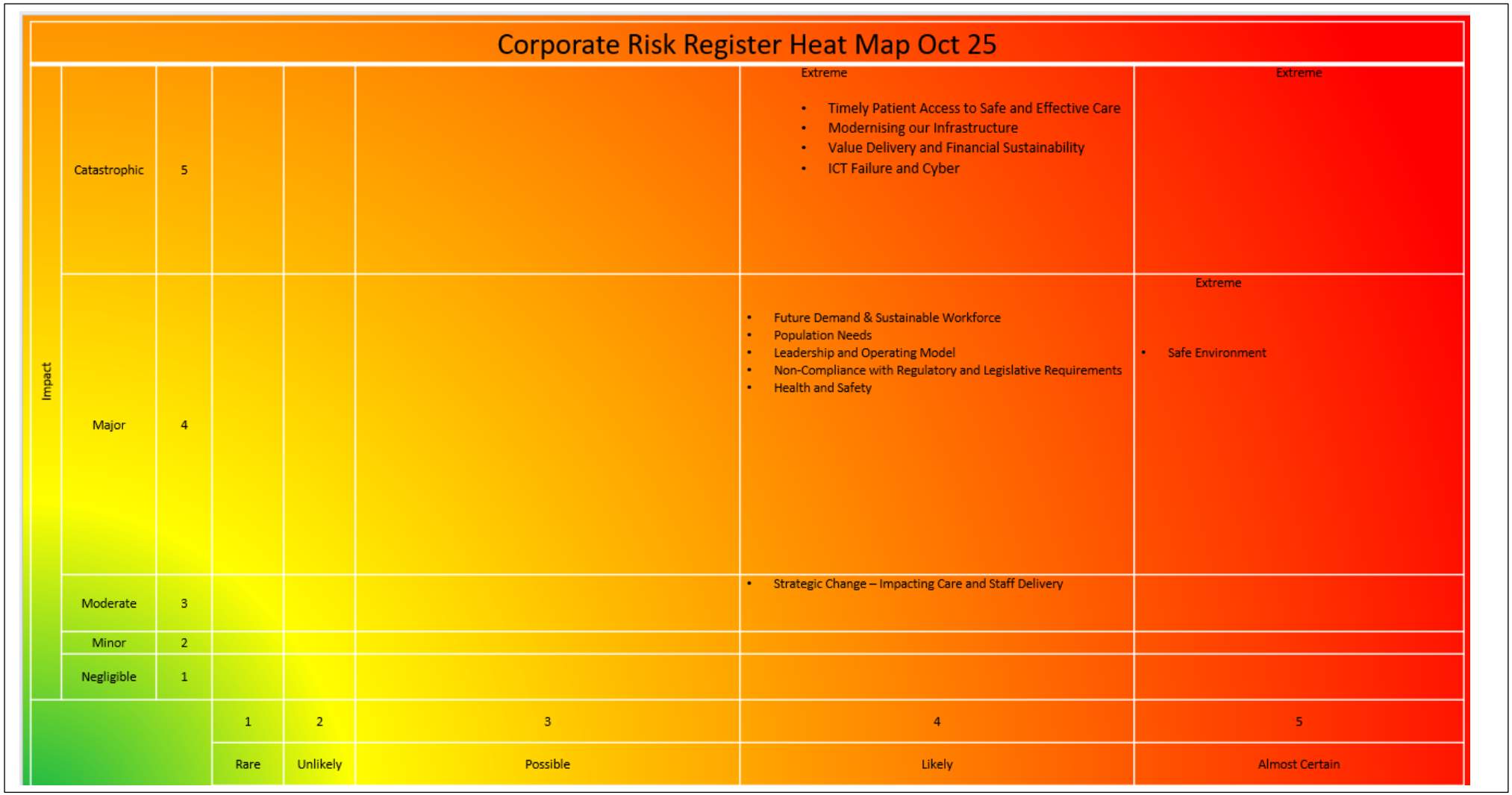
Next steps

1. Further scrutiny of all corporate risks by Executive Committee as per normal reporting cycle.

Appendix

1. Appendix 1 – Corporate Risk Register Heat Map September 2025.
2. Appendix 2 – Corporate Risk Register Dashboard September 2025.
3. Appendix 3 – Corporate Risk Register September 2025.

Appendix 1 – Corporate Risk Register Heat Map September 2025



Appendix 2 - Corporate Risk Register Dashboard September 2025

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type Appetite Level	Lead Board Committee	Action Progression			Risk Management Commentary
							Total	Completed	Delayed or Overdue	
COO	CRR25-01	Timely Patient Access to Safe and Effective Care	5x4 20	12	Quality (<15) Above Tolerance	Quality, Safety and Experience Committee	5	2	0	
EDoW	CRR25-02	Future Demand & Sustainable Workforce	4x4 16	8	Quality (<15) Above Tolerance	People & Culture Committee	8	1	0	
EDoPH	CRR25-03	Population Needs	4x4 16	12	Quality (<15) Above Tolerance	Planning, Population Health & Partnership Committee	13	0	2	
CDIO	CRR25-04	Modernising our Digital Infrastructure	5x4 20	12	Quality (<15) Above Tolerance	Planning, Population Health & Partnership Committee	9	1	0	*Removed from report, private
EDoTSP	CRR25-05	Strategic Change – Impacting Care and Staff Delivery	4x3 12	8	Quality (<15) In Tolerance	Planning, Population Health & Partnership Committee	6	0	0	

EDoF	CRR25-06	Value Delivery and Financial Sustainability	5x4 20	12	Financial (<15) Above Tolerance	Performance, Finance and Information Governance Committee	8	3	0	
EDoW	CRR25-07	Leadership and Operating Model	4x4 16	8	Quality (<15) Above Tolerance	People & Culture Committee	5	0	0	
DCG	CRR25-08	Non-Compliance with Regulatory and Legislative Requirements	4x4 16	8	Regulatory (<15) Above Tolerance	Quality, Safety and Experience Committee	8	1	0	
DoE	CRR25-09	Safe Environment	4x5 20	12	Regulatory (<15) Above Tolerance	Performance, Finance and Information Governance Committee	3	0	0	
DoE	CRR25-10	Health and Safety	4x4 16	8	Regulatory (<15) Above Tolerance	Performance, Finance and Information Governance Committee	8	0	1	
CDIO	CRR25-11	Cyber	5x4 20	15	Quality Above Tolerance	Planning, Population Health & Partnership Committee	9	4	2 (revised dates)	*Removed from report, private. Target score remains high.

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

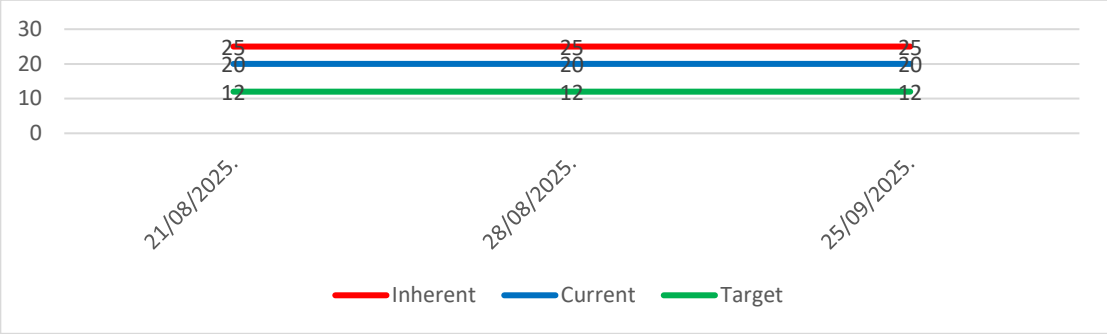
Appendix 3 – Corporate Risk Register October 2025

<table>
<tr><td rowspan="2">CRR 25-01</td><td colspan="2">Risk Title: Timely Patient Access to Safe and Effective Care</td><td>Date Opened: 21/08/2025
(version 2 refined from 2023)</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 06/11/2025</td></tr>
<tr><td>Date Last Reviewed: 25/09/2025</td><td>Director Lead: Chief Operating Officer</td><td>Link to BAF: BAF24-07</td><td>Target Risk Date: 30/06/2027</td></tr>
<tr><td colspan="4">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.</td></tr>
<tr><th colspan="2">Mitigations/Controls in place</th><th colspan="2">Additional Controls required</th></tr>
<tr><td colspan="2">1. System Resilience Hub in place with hospital full protocols and winter/festive plans
2. 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.
3. Winter Resilience Plan complete evaluation and lessons learnt.
4. Revised Access policy to ensure standardised practice across the Health Board
5. Single Integrated Clinical Assessment Triage (SICAT) and GP Out of Hours (OOHs) joint model providing 24/7 triage and advice</td><td colspan="2">a. Fragility of UEC 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.</td></tr>
</table>

6. Same Day Emergency Care (SDEC) services established at all acute sites 7. Routine clinical prioritisation of patients by risk in line with Referral to Treatment guidance 8. Outsourcing of radiology reporting and insourcing of CT, MRI, ultrasound 9. Diagnostic Quality Management System accreditation system embedded 10. Welsh Government short-term Neurodevelopment funding to support longest waiters, agency staff, overtime	

Actions	Action Owner	Due Date	Progression Analysis
a Complete recruitment of clinical leads and project management capacity to deliver sustainable specialty models. UEC clinical lead appointed to for 4 sessions a week commencing 1st October 2025 until March 2026.	Chief Operating Officer	30/03/2026	Progressing
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.	Danielle Edwards, Programme Director, Planned Care	31/03/2026	Progressing
d Implement new prudent ND assessment process to streamline and reduce wait times (ND Waiting List) Prudent assessment developed and agreed, to be rolled out across the teams from October 2025.Prudent assessment has been launched last week in September 2025	Louise Bell / Fiona Wright	31/07/2025	Completed
d Stratify ND waiting list to identify and prioritise high-risk children. Work undertaken to stratify the waiting list and identify high risk children. Stratification of Waiting Lists has taken place	Louise Bell / Fiona Wright	30/09/2025	Completed

e Update Failure to act on Diagnostics Procedure to be presented at divisional meeting for discussion on the 10/10/2025	David Fletcher, North Wales Managed Clinical Services	20/10/2025	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.

<table>
<tr><td rowspan="2">CRR 25-02</td><td colspan="2">Risk Title: Future Demand & Sustainable Workforce</td><td>Date Opened: 21/08/2025
(version 2 refined from 2023)</td></tr>
<tr><td colspan="2">Assuring Committee: People & Culture Committee</td><td>Date Last Committee Review: 16/10/2025</td></tr>
<tr><td>Date Last Reviewed:
25/08/2025</td><td>Director Lead:
Executive Director of People and Organisational Development</td><td>Link to BAF:</td><td>Target Risk Date: 31/03/2027</td></tr>
<tr><td colspan="4">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</td></tr>
</table>

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.

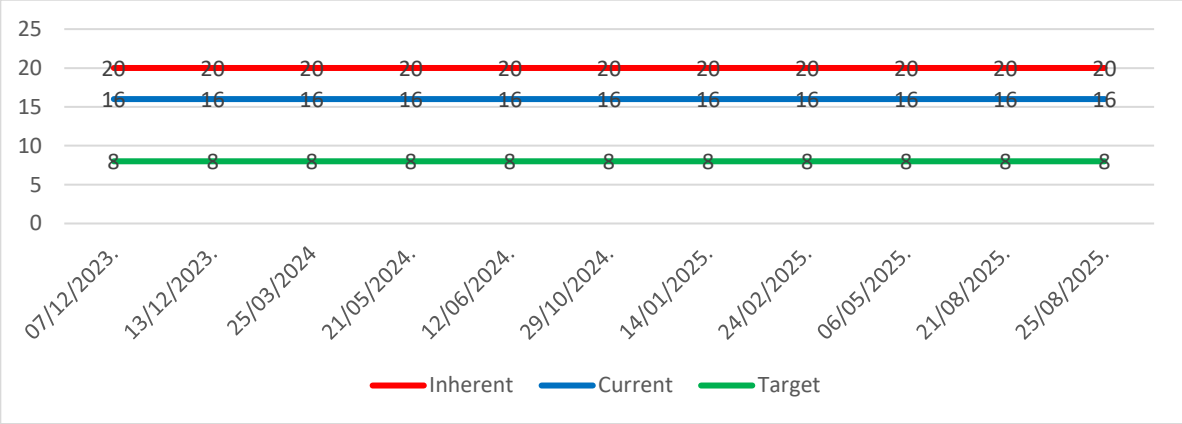
Mitigations/Controls in place	Additional Controls required
a) Strategic Recruitment Team supporting senior leadership, medical and dental consultant posts b) Local IHC resourcing teams delivering recruitment activity against divisional priorities. c) Recruiting Well / Joining Well programmes and recruitment campaigns. d) Nurse Retention Lead and retention plan. e) All-Wales Flexible Working policy implemented. f) Speak Out Safely Multi-Disciplinary Team and Work in Confidence platform in place for staff concerns. g) Workforce reviews underway in challenged specialties (ophthalmology, vascular, orthodontics, 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
Reintroduce Medical Staffing function within People Services The first stage of this is to recruit a new Band 7 Medical Staffing Policy and Practice specialist who will support key workstreams through the	Steven Gregg-Rowbury, Workforce & Organisational Development	30/06/2025	Completed

Value & Sustainability program and Medical Workforce Group. The individual starts in BCU on 1st October 2025. Any further implementation of a medical staffing resource will be dependent on the Foundations for the Future Program			
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	Steven Gregg-Rowbury, 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	Steven Gregg-Rowbury, 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	Nick Graham, Workforce & Organisational Development	31/03/2026	Progressing

September. There are challenges in service leads having time/capacity to work on their workforce plans			
Develop Vascular workforce strategy and Phase 2 Business Case	Jo Flannery, 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	Fiona Wright, C&YP	31/12/2025	Progressing
Establish revised Radiology workforce model. Updated operational Diagnostic risk to be presented at divisional meeting to discuss on the 10/10/2025.	David Fletcher, Diagnostics	20/10/2025	Progressing

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



Risk Appetite	Quality <15	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 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:** 06/11/2025
Date Last Reviewed: 25/08/2025	**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.

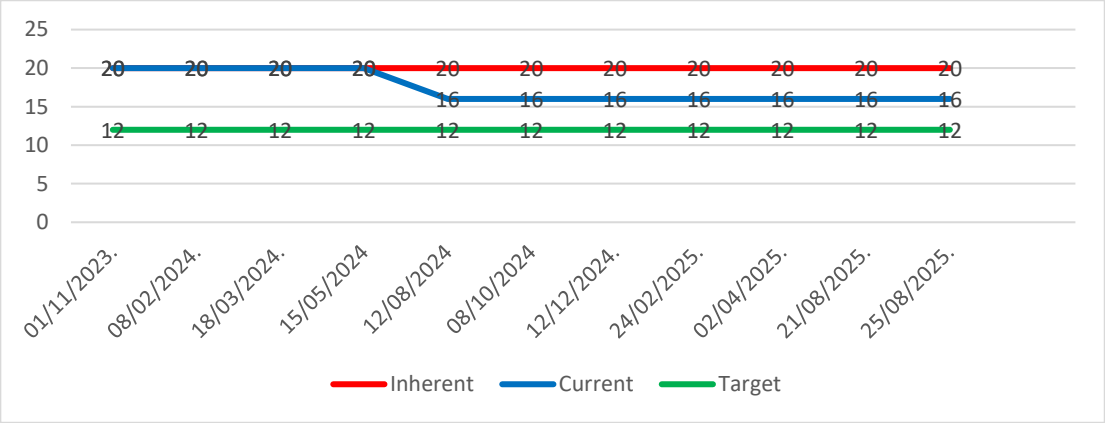
Mitigations/Controls in place	Additional Controls required
1. Recurrent funding secured for Healthy Weight / Healthy Wales programmes 2. Diabetes "Case for Change" a structured, evidence-based mechanism to identify service gaps 3. Healthcare Public Health programmes support the integration of population 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 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.

Actions	Action Owner	Due Date	Progression Analysis

Complete Population Needs Assessment which informs the development and focus of Health Board Strategy	Gwyneth Page, Public Health	31/03/2026	Progressing
Identify population health focused priorities for Health Board delivery	Gwyneth Page, 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 recruitment controls	Gwyneth Page, Public Health	31/03/2026	Delay
Develop a plan which addresses recommendations from the BCUHB Weight Management Service review	Gwyneth Page, 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	Sam Lauder, Public Health	31/03/2026	Progressing
Contribute to co-design Prevention Framework for North Wales as part of the Regional Partnership Board	Gwyneth Page, Public Health	31/03/2026	Progressing
Achieve the ministerial priority BCUHB Integrated Vaccination & Immunisation Service – Increase vaccination rates against targets	Gwyneth Page, 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	Gwyneth Page, 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) Delayed as clinical lead cover required and programme development	Gwyneth Page, Public Health	31/03/2026	Delay
Develop a Community and CHC Strategic Plan with Local Authorities (from CRR24-19)	Jane Trowman, CHC	31/03/2026	Progressing
Implement surge and escalation plans with Local Authority partners for community flow	Jane Trowman, CHC	Ongoing	Progressing
Management of CYP needs, ND workforce business case submitted to the Executive Team, decision on the case deferred pending a broader review of funding priorities	Fiona Wright, Child & Adolescent Health	31/12/2025	Progressing
Undertake a dental diagnostic deep dive to inform strategy	Rachael Page (amended from Gareth Evans)	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:** 06/11/2025
Date Last Reviewed: 01/10/2025	**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, and increased frustration or disengagement among staff tasked with delivering change.

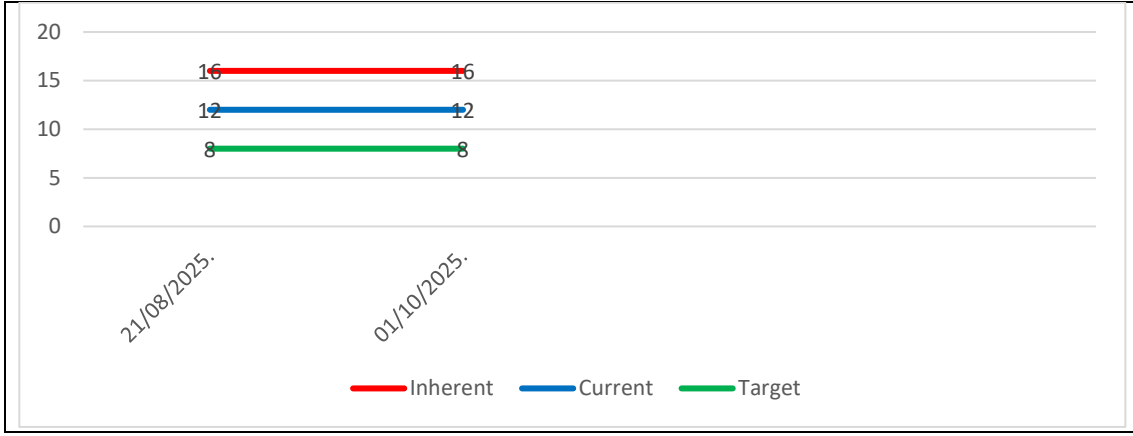
Mitigations/Controls in place	Additional Controls required
1. Scrutiny and oversight of strategy development work by the Strategic Planning and Service Change Group (SP&SC Group a sub-group of the Executive Committee), Planning Population Health and Partnerships (PPHP) Board Committee and the Health 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; Llandudno Planned Care hub; Improving safety,	a. Completion of the strategy development work, moving into the execution phase. b. Continued development of the portfolio management and reporting approach for all priority change programmes, including monthly monitoring of high risks across all priority programmes. c. Mobilisation of the Challenged Services oversight group that will report into the SP&SC Group. d. Organisational approach to change management to be developed and implemented.

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.	

Actions	Action Owner	Due Date	Progression Analysis
Complete Strategic Intent for North Wales with partners, presenting to Health Board for approval	Kamala Williams, Transformation	31/01/2026	Progressing

	& Strategic Planning		
Complete the diagnosis phased of the Health Board's 10 Year Strategy, including an implementation plan for the remaining programme of work	Kamala Williams, Transformation & Strategic Planning	31/03/2026	Progressing
Complete preparations for phase 2 of the Clinical Services Planning work, including an implementation plan	Kamala Williams, 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.	Geraint Parry, Transformation & Strategic Planning	31/12/2025	Progressing
Mobilise the Challenged Services oversight group that will report into the SP&SC Group	Geraint Parry, Transformation & Strategic Planning	31/12/2025	Progressing
Organisational approach to change developed as one of the enabling products within Foundations For The Future programme	Geraint Parry, 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:** 22/10/2025
Date Last Reviewed: 25/09/2025	**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 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.

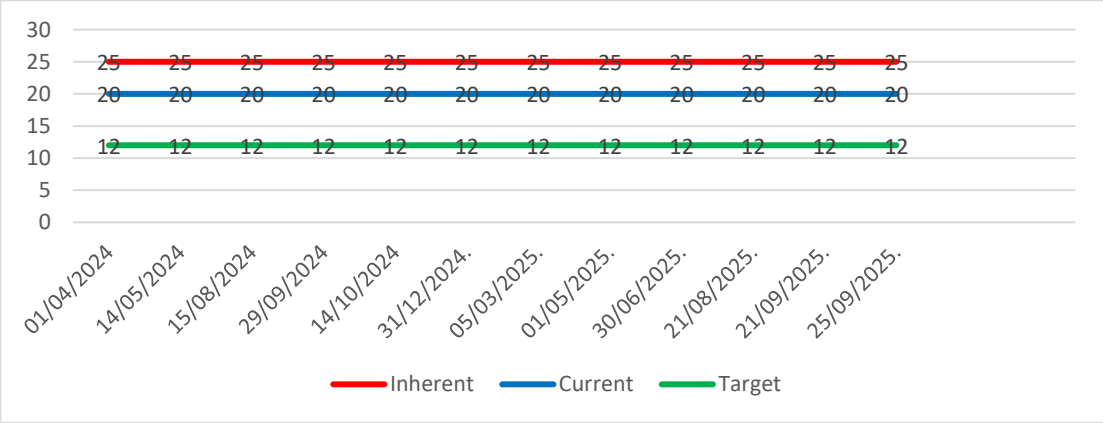
Mitigations/Controls in place	Additional Controls required
1. Core Savings targets for IHCs, Non-IHC Directorate and Corporate functions have been issued and performance to be challenged at Integrated Performance Executive Delivery Group – chaired by the Chief Executive. 2. Value and Sustainability programme 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	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

potentially affected by Foundations for the Future but excluding any clinical posts and minimising interim staff appointments. 5. Expansion of EEC 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 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-catalogue, non-clinical expenditure directed to the office of the Executive Director of Finance for scrutiny prior to approval 8. Internal scrutiny by Central Finance Team, of the Divisional financial assumptions, overspends and forecasts. 9. Financial reporting throughout the Health Board and to Welsh Government on a monthly basis, 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. Reviewing of SORD in place in September 2025 which was implemented in October 23 with a view to providing clarity of authority moving towards earned autonomy	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% cost benefit and savings ask delivery is required as a minimum d. Gaps in delivery of savings targets are to be 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. Ongoing prioritisation exercise involving £42m transformation funding received on a conditionally recurrently basis to the end of 2025/26

Actions	Action Owner	Due Date	Progression Analysis
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	Director of Finance (DoF)	30/11/2025	Progressing

Health Board to support development of the recovery plan and Performance, Finance and Information Governance Committee to provide Health Board oversight			
The Integrated Performance – Executive Delivery Group (IP-EDG) endorsed implementation of expenditure controls within the areas and directorates (from November 2024) as a measure to cease the run rate deterioration above plan and recover the year to deficit, to attain the forecast control total deficit for the financial year as agreed with Welsh Government. These measures were expanded to cover controls over expenditure discretionary expenditure (non-patient related) in January 2025 within IP-EDG. In 2025/26, a further target 1% reduction of total spend has been provided to services in September 2025 with a view to reduce the year to date overspend and mitigate any further movement of the financial position. The total target is c£20m. Action completed: As at Month 6 reporting the risk to attaining breakeven was reported at £40m.In November 2025 following discussion at Finance Oversight Group (FOG) it was agreed that the total spend reduction target be increased to 1.5% equating to c£30m alongside an acceptance that services and corporate directorates achieve the full amount of their own savings target. An assessment of the additional savings and mitigation submitted by 7th November will be presented to the next FOG meeting for assessment against the presented risks to breakeven.	DoF	31/10/2025	Complete
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.	DoF	31/03/2026	Progressing
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) / DoF	Monthly	Progressing
Strengthen application of SORD decision-making framework across all directorates /Decision Making Framework to be developed and shared with stakeholders (completed). Decision Making Framework to be progressed to January 2026 Board (progressing).	DoF / Director of	31/10/2025	Complete

	Corporate Governance		
Programme of work initiated to review how the Health Board spends its money, visibility of IHC performance and national benchmarks to ensure value outcomes (Patient Related Outcome Measures) are developed to support Allocative Efficiency moving forwards (cost / activity / outcomes)	DoF	30/09/2025	Complete / Ongoing
Examine and explain clinical variation with a view to benchmarking opportunities internally initially with a view to ensuring financial sustainability	DoF	30/09/2025	Complete / Ongoing
Directorate teams to review medical devices capital replacement plans. Directorate teams are linking with Capital to update their replacement plans.	Susan Brierley-Hobson, Therapies & Health Science	15/12/2025	Progressing



	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:** 16/10/2025
Date Last Reviewed: 25/08/2025	**Director Lead:** Executive Director of People and Organisational Development	**Link to BAF**: BAF25-04	**Target Risk Date:** 31/03/2027

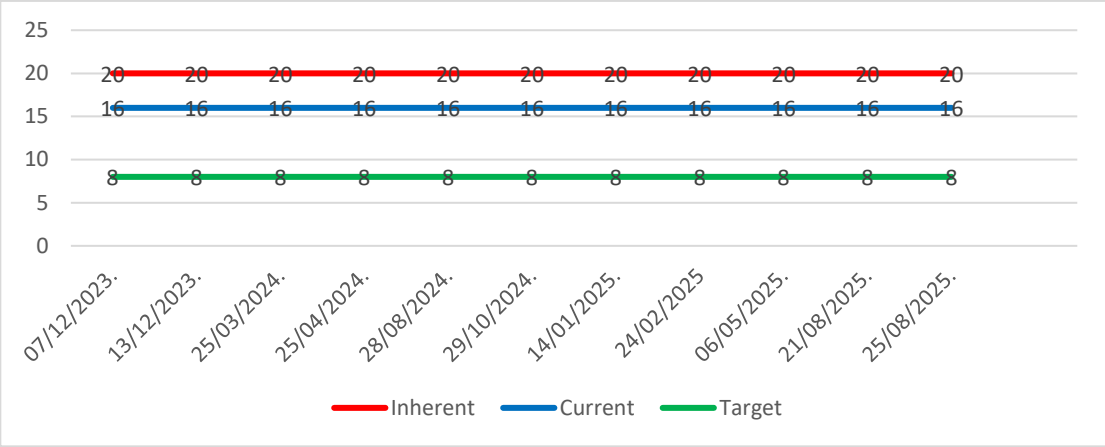
There is a risk that patients may experience delays, reduced quality of care, or fragmented services if the organisation does not have an operational model to deliver its strategic objectives
This may be caused by fragile management structures, workforce shortages, leadership capabilities and competence 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
a) Strategic Recruitment team for senior leadership, medical and dental consultant posts b) Local IHC resourcing teams driving recruitment priorities c) Recruiting Well and Joining Well programmes d) All-Wales Flexible Working policy implemented e) Speak Out Safely MDT and Work in Confidence platform for staff to raise concerns	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

f) Organisational Culture Change Plan and Behaviours Framework approved by Board g) Integrated Leadership Development Framework (ILDF) with measurement metrics h) Increased nurse retention i) Clear top-down commitment reinforced leadership culture that prioritises staff wellbeing, inclusion, and psychological safety (Pledge signed) j) 60% senior staff trained in leadership through conferences and masterclasses				
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		Katie Sargent - Corporate Office	31/03/2026	Progressing

engagement and experience-related improvements which will include mechanisms for both improving engagement and measuring engagement such as Pulse surveys			
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.	Rebecca Testa Workforce & Organisational Development	31/03/2026	Progressing
Roll out Compassionate Leadership resources and embed into development programmes	Director of People and Organisational Development	Ongoing	Progressing
Deliver Culture Change Plan with Comms and Engagement rollout The synthesis report has been submitted to the Executive Committee (EC) and pulls together the findings from the Discovery phase of the Culture & Leadership Programme and staff feedback from other sources including the NHS Wales Staff Survey 2024 and the Foundations for the Future programme engagement work. This report includes a series of proposals for the EC to agree that will form the work program to improve culture and leadership in the organisation,	Nia Thomas Workforce & Organisational Development	31/12/2025	Progressing
Quarterly Culture, Leadership & Engagement Plans finalised and monitored	Nia Thomas Workforce & Organisational Development	Ongoing	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 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:** 06/11/2025
Date Last Reviewed: 01/10/2025	**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.

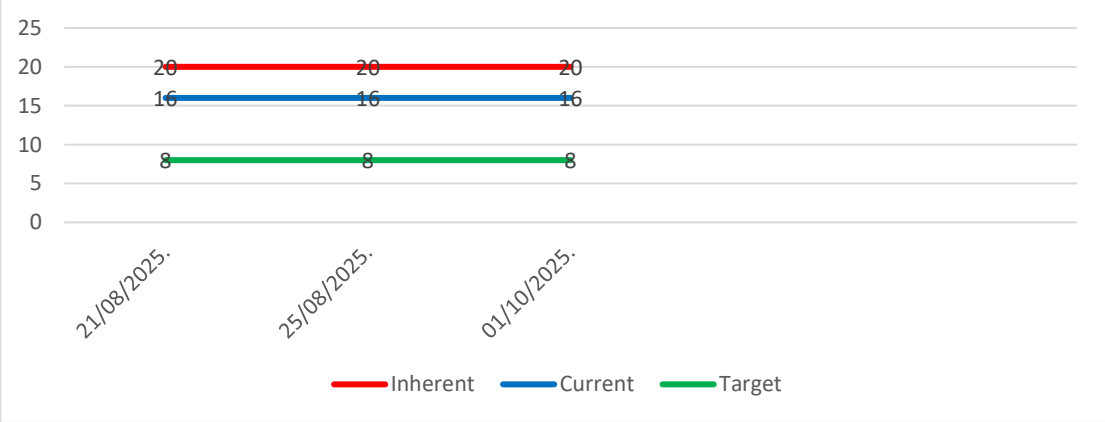
Mitigations/Controls in place	Additional Controls required
1. Training, induction and mandatory requirements for staff for highlights legislation and compliance. 2. Monitoring of regulations and legislation by various groups exist such as: Medical Devices Governance & Assurance Group oversees procurement, selection, risk management and safety communication Estates and Health & Safety Committee oversee areas of non-compliance and tracking of action plans.	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

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)	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)	Glesni Driver, Corporate Office	01/12/2025	Progressing
B)Creation of an electronic system to capture legislative and regulatory information and requirements. Not started due to resource constraints anticipated start date Q1 25/26.	Glesni Driver, Corporate Office	01/11/2026	Not Started

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.	Susan Brierley-Hobson, Therapies & Health Science	16/12/2025	Progressing
A)Review local medical devices groups governance & membership. A proposal was written re these groups being reformed in April 2025. EDAHPHS Teresa Owen and COO Tehmeena Ajmal in discussion re way forward.	Susan Brierley-Hobson, Therapies & Health Science	16/03/2026	Progressing
E)In order for compliance in pharmacy (aseptic production, QA and regulatory staff) Workforce Expansion is required. The delay in initial progress has been due to annual leave in July and August, responding to external audit findings and responding to out of specification environmental monitoring results. Work has restarted but completion will be delayed until end of Nov 2025.	Lois Lloyd , Corporate Office	31/11/2025	Progressing
E) Strengthen pharmacy QMS and regulatory compliance roles	Lois Lloyd , Corporate Office	31/05/2025	Completed
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.	Danielle Timmins, Finance	31/12/2025	Progressing
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.	Lois Lloyd, Corporate Office	31/12/2025	Progressing

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 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.	Sharon Scott	31/03/2026	Progressing
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.	Sharon Scott	31/12/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	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:** 22/10/2025.
Date Last Reviewed: 25/08/2025	**Director Lead:** Director of Environment and Estates	**Link to BAF**: BAF 24-03	**Target Risk Date:** 31/03/2027

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

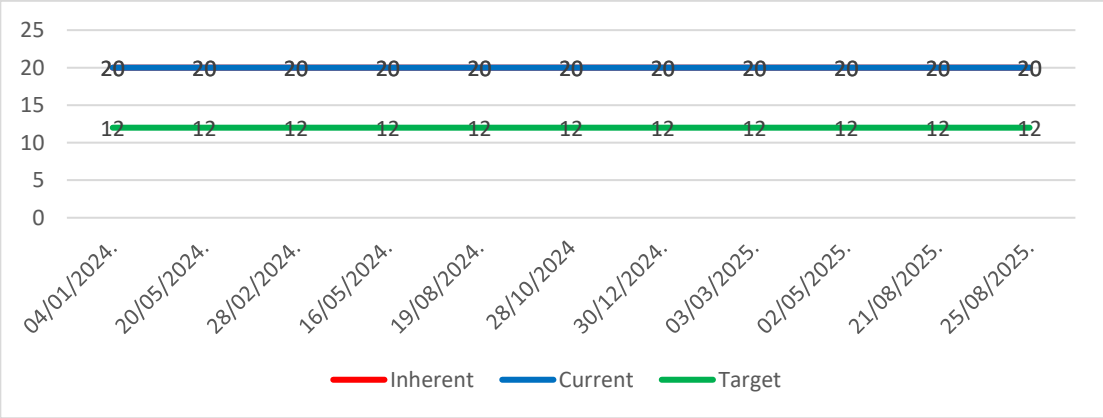
Mitigations/Controls in place	Additional Controls required
1. Estates Strategy developed and approved by the Health Board in January 2023. 2. Internal Governance for capital allocation in place within the Health Board. 3. Business Cases to Welsh Government to resolve major infrastructure issues in line 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.	a) 6 facet survey to be undertaken to obtain an updated report of the condition of the Estate' this will inform the risk status by site, which will be assessed against the controls currently in place. Additional mitigation or strengthening of controls will also be considered. b) 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.

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.	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

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 15. Assurance around the Capital Prioritisation Plans that it is aligned with both the Estates strategy and the Clinical strategy. This forms part of the T.O.R of the Capital Investment Group	

Actions	Action Owner	Due Date	Progression Analysis
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.	Arwel Hughes, Estates	31/03/2026	Progressing

Undertake actions to deliver a 6 facet survey across the Health Board over the next 5 years. The 6 Facet survey contract is currently being procured through the SBS framework via mini-competition, the contract is due to be awarded by January 2025. A Phase 1 approach for the Acute Hospitals, is expected to be completed by 30/09/26. The completion of the full survey has been brought forward from the original 5 year time frame to a 2 year programme. A review of the 6 facet survey programme has been undertaken with support from Director of Environment and Estates and a plan has been agreed to utilise Ysbyty Gwynedd as a pilot site to conduct a 6-facet survey, it is anticipated that the pilot will be completed by 31st March 2026	Arwel Hughes, Estates	31/03/2027	Progressing
Develop a standardised Terms of Reference to be considered and endorsed by Capital Investment Group. New Terms of Reference for IHC Capital Groups will be reviewed as part of the Foundation for the Future Programme.	Arwel Hughes, Estates	31/03/2026	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.

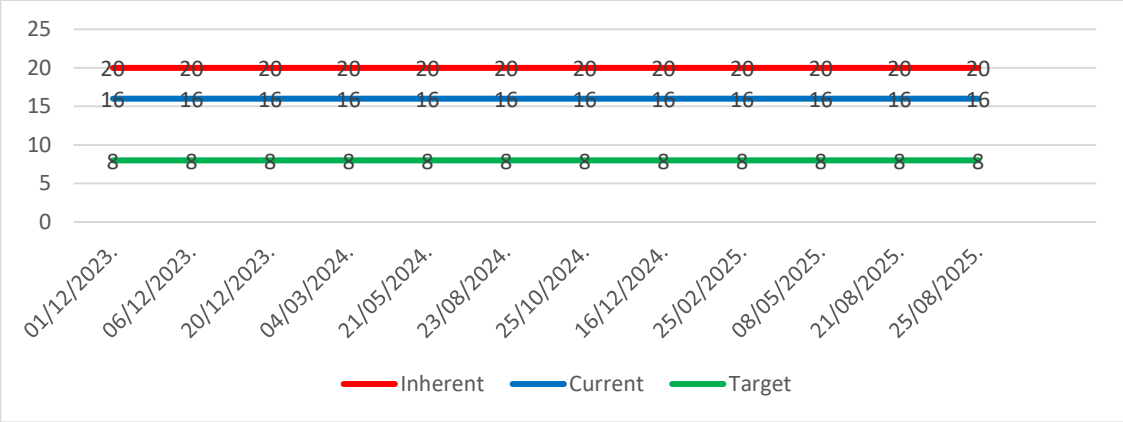
CRR 25-10	**Risk Title: Health and Safety**		**Date Opened:** 21/08/2025
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 22/10/2025
Date Last Reviewed: 25/08/2025	**Director Lead:** Director of Environment and Estates	**Link to BAF**: BAF24-03	**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. Three-year Occupational Health, Safety and Security strategy. 2. Health and Safety Policies report into the Strategic Occupational Health & Safety Group (SOSHG). 3. Health and Safety eLearning and short courses in place. 4. Gap Analysis has been reviewed. Strategy and plan to March 2026. 5. Health and Safety Policies and Procedures are on BetsiNet. 6. Programme of Health and Safety Reviews are in place. 7. Programme of Health and Safety Self-Assessments are in place for completion twice yearly. 8. Health and Safety presentation delivered to Board members in February 2025, to raise awareness of requirements.	a) NHS Employer Health and Safety Standards are being developed b) A review of resources required following the internal audit. c) BCUHB Executive Team and Board of Directors to complete health and safety training. d) The business model aligned to the NHS Manual Handling Passport Scheme to be reviewed e) Investment in training venues is required for manual handling training delivery. f) Senior Leaders to nominate staff to support with Divisional delivery of manual handling refresher training. g) Review of health and safety policies within the next 12-24 months.

	h) A Health and Safety Risk Assessment and Management Framework needs developing. i) A pan BCUHB Health, Safety and Security Training Needs Analysis is required. j) Utilise the Violence Prevention and Reduction Standards to provide a framework for a safer environment. k) Intranet pages for Health, Safety and Security Services require development.

Actions	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.	Lynne Bushell, Workforce & Organisational Development	31/12/2025	Progressing
In-house security service model not being pursued. 22/01/2025: Extension of current Security SLA and Technical specification awaiting sign off. Existing security SLA being extended to the 31/03/2026 to allow for a formal tender process.	Director of Estates	31/03/2026	Progressing (revised date from 31/07/2025)
A process to monitor and review department self-assessments is under development and will be issued in readiness for the April Self-Assessment Cycle.	Director of Estates	31/12/2025	Progressing
A review of resources within the Health, Safety and Security Service is required following the internal audit findings.22/01/2025: Structure reviewed and remodelled. A business case to be developed.	Director of Estates	31/12/2025	Progressing
The BCUHB business model aligned to the All-Wales NHS Manual Handling Passport Scheme 2020 to be reviewed. Following meeting with DDoNs and Service Leads, further meetings scheduled to discuss bespoke service requirements. Work is progressing, with current target date not being met due to lack of engagement with some services. Those	Director of Estates	31/07/2025	Overdue

services that have engaged work will commence to update ESR with the agreed changes.			
An electronic document management system (EDMS) for reporting of health and safety compliance and risk management pan BCUHB. Risk Management software approved. Implementation 2026 which will improve transparency of all H&S risks and reduce non-compliance around visibility and sharing of key documentation.	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.