GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Meeting Date	21st March 2019	Agenda Item	2c.
Report Title	Audit Committee		
Report Author	Hazel Lloyd, Head of Patient Experience, Risk & Legal Services		
Report Sponsor	Gareth Howells, Director of Nursing & Patient Experience Pam Wenger, Director of Governance		
Presented by	Gareth Howells, Director of Nursing & Patient Experience Pam Wenger, Director of Governance		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to provide: • the updated Health Board Risk Register (HBRR); • interim Risk Management Framework (supporting the organisation strategy) for April – September 2019 and; • the findings of the Internal Audit review of Risk Management and Assurance.		
Key Issues	• Executive Team have updated their risk entries in Datix for the Health Board Risk Register (HBRR) and two entries require approval for entry on the HBRR relating to Controlled Drugs and Ophthalmology; • The Executive Time out is being held in Q1 2019/20 to discuss the HBRR and whether the high rated risks recorded reflect the risks to the Health Board objectives. • Endorse the interim Risk Management Framework for ratification by the Board. • Internal Audit review on Risk Management and Assurance (ABM-1819-003) found that the level of assurance given to the effectiveness of the system of internal control in place to manage risks was Reasonable (Yellow).		
Specific Action Required *(please ✓ one only)*	**Information**	**Discussion**	**Assurance**	**Approval**
		✓		
Recommendations	The Audit Committee are asked to: • **DISCUSS** and **NOTE** the updated Health Board Risk Register and the risks assigned to the Board and its Committees; and • **ENDORSE** the Health Board Risk Register and the assignment of risks for submission to the Board in March 2019. • **ENDORSE** the interim Risk Management Framework to be submitted to the Board.		

UPDATE ON THE HEALTH BOARD RISK REGISTER (HBRR)

1. INTRODUCTION

The purpose of this report is to provide an update on:

- progress to update the Health Board Risk Register (HBRR);
- interim Risk Management Framework for endorsement and;
- the findings of the Internal Audit review of Risk Management and Assurance.

2. BACKGROUND

The Health Board Risk Register (HBRR) is intended to summarise the key 'live' extreme risks facing the Health Board and the actions being taken to mitigate them. It is also important to note that the Executives, as risk owners, are appropriately sighted and involved in the development of the corporate risk register, providing updates, including reports on mitigating actions.

All organisational risks will have a lead Executive Director and the risk assigned to either the Board, or as appropriate, a Committee of the Board to ensure appropriate review, scrutiny and where relevant updating. Each Director is responsible for the ownership of the risk(s) and the reporting of the actions in place to manage/control and/or mitigate the risks.

3. GOVERNANCE AND RISK

3.1 Progress in developing the Refreshed HBRR

Members of the Audit Committee will recall in Q3, 2018/19, the HBRR was revised and developed following updates and changes from the Executive Team. The revised HBRR is attached as **Appendix 1** for approval to be submitted to the Board in March 2019.

Two new entries are being worked through but are not ready to include in this report relating to:

- Controlled drugs and;
- Ophthalmology Services.

An additional further two entries are being considered relating to Health & Safety:

- Health & Safety Systems - this would be a new entry on Datix and would include reference to 9 notices being received from the Health & Safety Executive and;

- Violence & Aggression- (842) currently closed from a Health Board Risk Register perspective as it is being overseen by the Health & Safety Committee, although following a Health & Safety Executive notice being issued relating to V&A consideration is being given as to whether this should be escalated back to the HBRR.

3.2 Summary of Health Board Risks

As at 27th February 2019, there are 26 risks outlined on the HBRR which is presented as **Appendix 1** for review.

The 26 risks are categorised by rating against the Health Board's enabling values:

Enabling Objective	High (rated 16 -25)	Moderate (rated 9-15)
Best Value Outcomes from High Quality Care	9	5
Excellent Staff	3	0
Digitally Enabled Care	4	0
Partnerships for Improving Health and Wellbeing	0	1
Partnerships for Care	2	2
Total No of Risks	**18**	**8**

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Note – The total number of risks will feature a "+" or "-"in future to denote any new risks added or removed.

3.3 Highest scoring Risks

Presently the HBRR contains 5 risks which are risk rated at level 20:

- **Capacity within WODS (56)-** Insufficient capacity of Workforce and OD Function within ABMU to support and deliver the strategic and operational workforce agenda, plans and priorities of the Health Board.
- **Sustained Clinical Services (27) -** Inability to deliver sustainable clinical services due to lack of digital transformation.
- **Storage of Paper Records (36) -** Failure to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced
- **Discharge Information (45) -** If patients are discharged from hospital without the necessary discharge information this may have an impact on their care
- **Brexit (54) -** Failure to maintain services as a result of the potential no deal Brexit

The Executive Team have agreed to a workshop to consider the high risks facing the Health Board in delivering against the enabling objectives following discussions at the Senior Leadership Team on 6th March on the accuracy of the five high scoring risks.

4. INTERIM RISK MANAGEMENT FRAMEWORK

In light of the Bridgend Boundary changes and the work ongoing to update Risk Management processes, it is proposed that an Interim Risk Management Framework for Swansea Bay University Health Board be approved by the Board in March for 6 months. This will allow engagement with stakeholders through a Risk Management Workshop to be held in March and the results of which will inform a revised Risk Management Framework to be submitted to the Board in September 2019. Members

are requested to support this action. The proposed interim Risk Management Framework is attached as **Appendix 2.**

5. RISK MANAGEMENT WORKSHOP

The Risk Management Group on 26th March 2019 will now be used for a Risk Management Workshop. Members are requested to ensure appropriate representation at the Workshop from appropriate Directorates and Units. The Workshop will consider processes for escalation of risk and the organisation's risk appetite and tolerance and Internal Audit recommendations.

6. INTERNAL AUDIT REPORT

Internal Audit carried out a review of Risk Management and Assurance (ABM 1819003) and found that the level of Assurance given to the effectiveness of the system of internal control in place to manage risks was reasonable (yellow). A copy of the report can be obtained from Hazel Lloyd. An action plan has been developed in response to the recommendations made and these recommendations will be used to strengthen the internal systems of control.

7. FINANCIAL IMPLICATIONS

No financial implications in terms of carrying out the actions recommended by the Wales Audit Office (WAO).

8. RECOMMENDATION

The Senior Leadership Team are asked to:

- **DISCUSS** and **NOTE** the updated Health Board Risk Register and the risks assigned to the Board and its Committees;
- **ENDORSE** the Health Board Risk Register and the assignment of risks for submission to the Board in March 2019.

Governance and Assurance					
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships
					✓

Quality, Safety and Patient Experience
Ensuring the organisation has robust risk management arrangements in place that ensure organisational risks are captured, assessed and mitigating actions are taken, is a key requisite to ensuring the quality, safety & experience of patients receiving care and staff working in the UHB.
Financial Implications
The risks outlined within this report have resource implications which are being addressed by the respective Executive Director leads and taken into consideration as part of the Board's IMTP processes.
Legal Implications (including equality and diversity assessment)
It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks faced by the organisation, as failure to do so could have legal implications for the UHB.
Staffing Implications
Staff will be briefed on the changes through workshops and also meetings held with Executive Directors and Assistant Directors to support the changes required to meet the recommendations made by the Wales Audit Office.
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)
No implications for the Committee to be notified of.

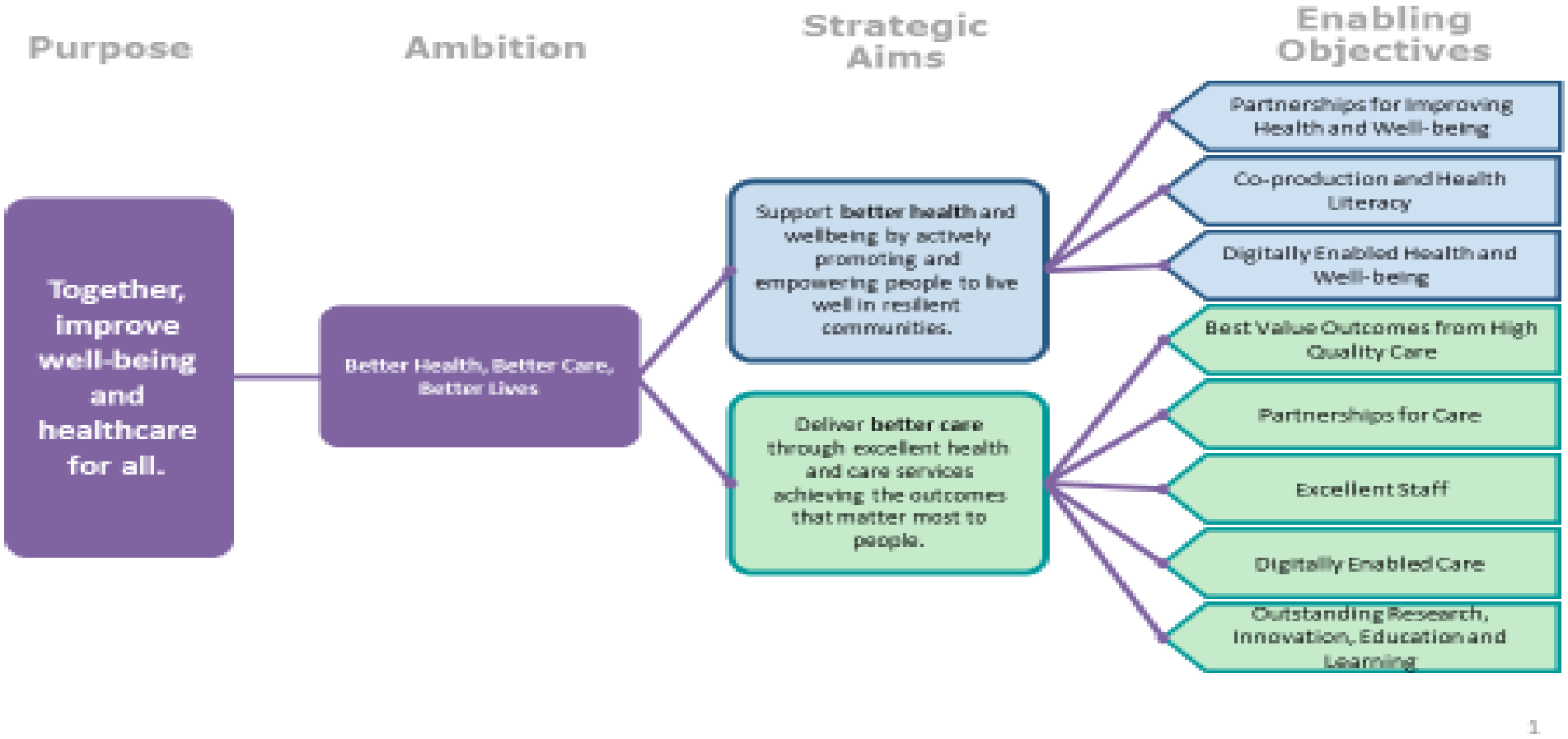
Report History	• Senior Leadership Team 7 November 2018 • Quarterly report to the Audit Committee 15 November 2019 and 24 January 2019 • Senior Leadership Team 6th March 2019
Appendices	• Appendix 1: ABMU Health Board Risk Register February 2019 • Appendix 2: Interim Risk Management Framework

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

HEALTH BOARD RISK REGISTER
FEBRUARY 2019

Aligning Risk with Abertawe Bro Morgannwg University Health Board (ABMUHB) Strategy

The Abertawe Bro Morgannwg University Health Board (ABMUHB) strategy is outlined in the figure below and all risks identified for inclusion on the Health Board Risk Register are mapped to our enabling objectives.



HEALTH BOARD RISK REGISTER
DASHBOARD OF ASSESSED RISKS – FEBRUARY 2019

Impact/Consequences						
5		**42:** Sustainable Services £20m Financial Control	**15:** Population Health Improvement	**56**: Capacity of Workforce function	
4				• **1**: Tier 1 Unscheduled Care Targets • **3:** Recruitment of Medical and Dental Staff • **49:** TAVI Service • **11:** Healthcare model for aging population • **16:** Referral to treatment times • **50**: Cancer Target Compliance • **51:** Compliance with Nurse Staffing Levels (Wales) Act 2016 • **43:** DOLS Authorisation and Compliance with Legislation • **44**: ED Information Systems • **48:** Child & Adolescence Mental Health Services • **52**: Engagement & Impact Assessment Requirements • **37**:Operational and strategic decisions are not data informed • **17:** Replacement of medical equipment	• **54:** No Deal Brexit • **45**: Discharge information • **27:** Sustainable Clinical Services for Digital Transformation • **36:** Electronic Patient Record
3			**55:** Bridgend Boundary Change	• **13**: Accommodation fit for purpose • **39**: IMTP	• **4:** Infection Control • **41:** Fire Safety Regulation Compliance • **53:** Compliance with Welsh Language Standards
2					
1					
C X L	**1**	**2**	**3**	**4**	**5**
	Likelihood				

Risk Register Dashboard

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
Best Value Outcomes from High Quality Care	1 (738)	**Tier 1 Targets** Failure to comply with Tier 1 target for Unscheduled Care which could impact on patient and family experience.	16	16	↑	↓	February 2019	Performance and Finance Committee
	4 (739)	**Infection Control Targets** Failure to achieve infection control targets set by Welsh Government	20	15	→	→	February 2019	Quality and Safety Committee, Infection Prevention and Control Committee
	11 (837)	**Ageing Population** Failure to provide an appropriate healthcare model for the aging population over the next 20 years.	16	16	→	→	February 2019	Quality and Safety Committee
	13 (841)	**Health & Safety Standards** Failure to meet the statutory health and safety requirements for our premises.	16	12	↓	→	February 2019	Health and Safety Committee
	16 (840)	**Patient Waiting Times** Failure to achieve compliance with waiting times there is a risk that patients may come to harm. Further, the health board will have financial resource clawed back to Welsh Government is the agreed target is not met.	16	16	→	→	February 2019	Performance & Finance Committee
	17 (838)	**Replacement of Equipment** An inability to replace key pieces of equipment could adversely affect capacity and patient well being	16	16	→	→	February 2019	Health and Safety Committee
	37 (1217)	**Information Led Decisions** Operational and strategic decisions are not data informed.	16	16	→	→	February 2019	Audit Committee/Informatics Programme Board

39 (1297)	**Approved IMTP** If the Health Board does not have an approved IMTP signed off by Welsh Government, primarily due to the inability to align performance and financial plans it will remain in escalation status, currently "targeted intervention".	16	12	↓	↑	February 2019	Health Board
41 (1567)	**Fire Safety of Cladding** Currently an uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations	15	15	→	→	February 2019	Health and Safety Committee
42 (1398)	**Financial Plan** If the Board is unable successfully to deliver a sustainable service and meet £20m financial control total then the performance, safety and quality of our provision will be at risk.	25	10	↓	↑	February 2019	Performance & Finance Committee
43 (1514)	**DoLS** If the Health Board is unable to complete timely completion of DoLS Authorisation then the Health Board will be in breach of legislation and claims may be received in this respect.	16	16	→	→	February 2019	Quality and Safety Committee/ Safeguarding Committee
48 (1563)	**CAMHS** Failure to sustain Child and Adolescent Mental Health Services (CAHMS).	16	16	→	→	February 2019	Performance & Finance Committee/ Health Board

	49 (922)	**Trans-catheter Aortic Valve Implementation (TAVI)** Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)	25	16	↓	↑	February 2019	Quality and Safety Committee
	50 (1761)	**Cancer Targets** Failure to sustain services as currently configured to meet cancer targets	20	16	↓	↑	February 2019	Performance & Finance Committee

Excellent Staff	3 (843)	**Recruitment** Failure to recruit medical & dental staff	20	16	↑	→	February 2019	Workforce & OD Committee
	51 (1759)	**Nurse Staffing (Wales) Act** Risk of Non Compliance with the Nurse Staffing (Wales) Act	16	16	→	→	February 2019	Quality and Safety Committee,
	56 (1796)	**Capacity within WODS** Insufficient capacity of Workforce and OD Function within ABMU to support and deliver the strategic and operational workforce agenda, plans and priorities of the Health Board.	20	20	→	→	February 2019	Workforce & OD Committee

Digitally Enabled Care	27 (1035)	**Sustained Clinical Services** Inability to deliver sustainable clinical services due to lack of digital transformation.	16	20	↑	→	February 2019	Quality and Safety Committee, Informatics Programme Board
	36 (1043)	**Storage of Paper Records** Failure to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced	20	20	→	→	February 2019	Quality and Safety Committee, Informatics Programme Board

	44 (1564)	**Emergency Department (ED) System** Current Emergency department (ED) systems are not fit for purpose.	20	16	↓	→	February 2019	Quality and Safety Committee
	45 (1565)	**Discharge Information** If patients are discharged from hospital without the necessary discharge information this may have an impact on their care	20	20	→	→	February 2019	Quality and Safety Committee/ Information Governance Board

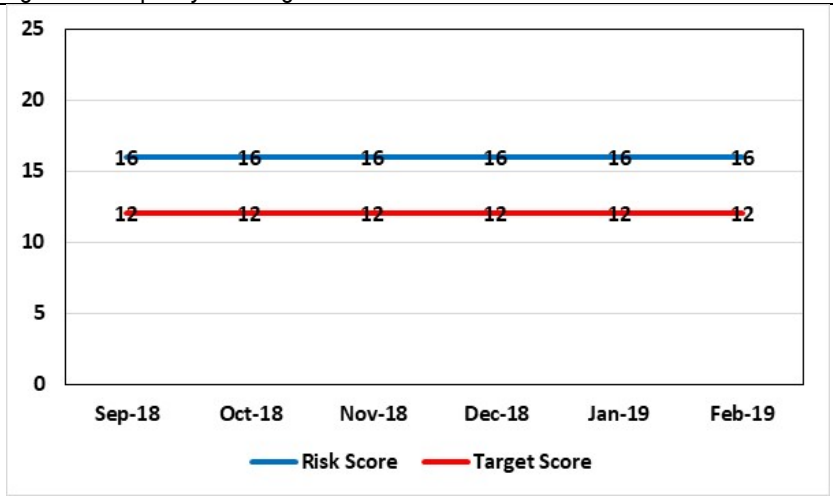
Partnerships for Improving Health and Wellbeing	15 (737)	**Population Health Targets** Failure to achieve population health improvement targets leading to an increase in preventable disease amongst the population resulting in increased morbidity impacting on operational and financial pressures.	15	15	→	→	February 2019	Quality and Safety Committee

Partnerships for Care	52 (1763)	**Statutory Compliance** The Health Board does not have sufficient resource in place to undertake engagement & impact assess in line with Statutory Duties	16	16	→	→	February 2019	Performance & Finance Committee/Health Board
	53 (1762)	**Welsh Language Standards** Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	15	15	→	→	February 2019	Health Board (Welsh Language Group)
	54 (1724)	**Brexit** Failure to maintain services as a result of the potential no deal Brexit	20	20	→	→	February 2019	Health Board/ EPPR Strategy Group

	55 (1764)	**Bridgend Boundary Change** Failure to ensure successful implementation of the Welsh Governments decision to realign the Health Boundary, as it applies to the resident population of the Bridgend County Borough.	15	15	➔	➔	February 2019	Joint Transition Board (JTB)

Risk Schedules

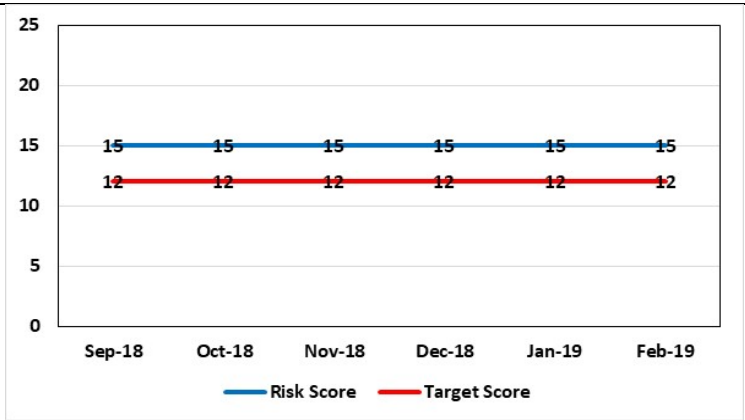
Datix ID Number: 738	HBR Ref Number: 1
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee
Risk: If we fail to comply with Tier 1 target - **Unscheduled Care** then this will have an impact on patient and family experience. Challenges with capacity /staffing across the Health and Social care sectors.	**Date last reviewed:** February 2019
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 4 =12	**Rationale for current score:** At the end of Q2 performance the Health Board did not achieve performance trajectories.
Level of Control = 50%	**Rationale for target score:**
Date added to the risk register 26.1.16	The service delivery units have been implementing models of care that reflect National priorities and there is evidence that these are starting to impact positively on patient flow, length of stay and demand management. Workforce capacity issues continue to be challenging in some key specialty areas.



Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	Lead	Deadline
• Programme management arrangements in place to improve Unscheduled Care performance. • Daily Health Board wide conference calls/ escalation process in place. • Regular reporting to Executive Team, Executive Board and Health Board/Quality and Safety Committee. • Increased reporting as a result of escalation to targeted intervention status. • Targeted unscheduled care investment to support changes to front door service models/ workforce redesign/ patient flow.	Bed utilisation audit being undertaken to support USC system redesign programme in NPT and Swansea.	Assistant Chief Operating Officer	January 2019
	Clinical services plan for USC is being finalised.	Assistant Chief Operating Officer	January 2019

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• Executive monitoring/support to achieve improvement plans on a weekly basis.	The need to deliver sustained service.
Current Risk Rating 4 x 4 = 16	Additional Comments

Datix ID Number: 739	HBR Ref Number: 4
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, Director of Nursing and Patient Experience **Assuring Committee:** Quality and Safety Committee, Infection Prevention and Control Committee
Risk: Failure to achieve **infection control** targets set by Welsh Government	**Date last reviewed:** February 2019

Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 3 x 5 = 15 Target: 3 x 4 =12		**Rationale for current score:** Currently under targeted intervention for rates of infection, achievement of targets are variable with monthly fluctuations
Level of Control = 40%		**Rationale for target score:**
Date added to the risk register January 2016		Once the infection control team is fully recruited to, ICNet is functioning to its full capability the infection control team will be able to support the clinical areas more and drive service improvements. In addition, a negative pressure isolation facility is being built into the new emergency department at Morriston hospital providing another facility to appropriately manage patients at the front door. Review and implementation of a robust clean of patient rooms following an infection will reduce the risk of cross infection. Plans are in place for initial training for this to commence January 2019.

Controls (What are we currently doing about the risk?)

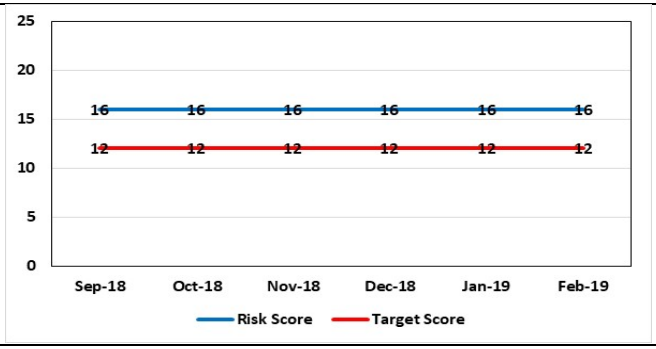
- Regular monitoring on infection rates
- Policies, procedures and guidelines in place
- Regular reporting through internal processes
- ICNet information management system for infections is in place
- Infection control team support the clinical teams for issues relating to infection control
- A permanent infection control doctor has been recruited
- Recruitment is ongoing and the decontamination lead and assistant director of nursing in infection control have been appointed
- Bug stop quality improvement programme
- Incident reporting

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Recruitment to ensure the team is fully established with the right skills and experience	Assistant Director Nursing Infection Control	April 2019
Ongoing infection control team involvement in site level estates projects to ensure appropriate isolation facilities are factored in from the outset	Senior Infection Control Nurse	December 2019
Review of reporting requirements to enable a focus on driving improvement and service delivery	Assistant Director Nursing Infection Control	March 2019
Review of extended properties, requirements for appropriate information and reporting capabilities within ICNet to streamline the process and reduce the burden on the infection control team enabling the focus on improvement	Head of Nursing Infection Prevention Control	March 2019

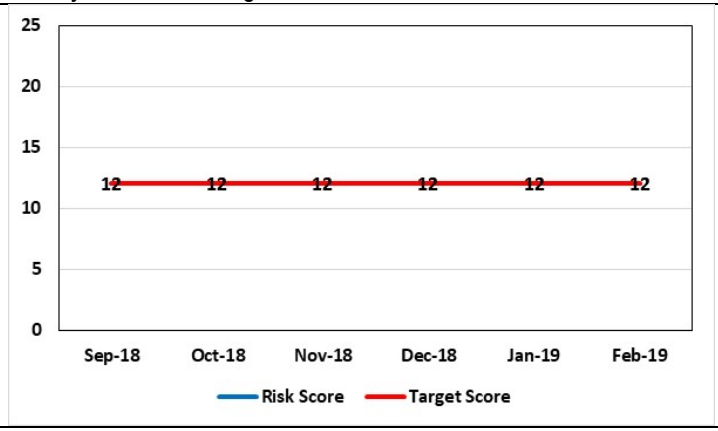
	HPV/UV cleaning post infection to be implemented	Senior Nurse Infection Prevention Control	April 2019
Assurances (How do we know if the things we are doing are having an impact?) • Ongoing monitoring of infection control rates and feedback provided to delivery units • Infection Control Committee monitors infection rates and identifies key actions to drive improvement • Sub groups to the infection control committee such as the decontamination group provide the assurances and operationally drive key areas of work.	Gaps in assurance (What additional assurances should we seek?) ICNet provides information linked with PAS relating to patients who have been inpatients since the connection was made therefore additional manual records are maintained by the infection control team creating additional work and some duplication.		
Current Risk Rating 3 x 5 = 15	Additional Comments		

Datix ID Number: 837	HBR Ref Number: 11
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, Director of Nursing and Patient Experience **Assuring Committee:** Quality and Safety Committee
Risk: If we fail to provide an appropriate **healthcare model for aging population** over next 20 years care resident population will see a 24% increase in people of a pensionable age and 15% increase in people of non-working age. Providing services to enable citizens to live independently at home is a major challenge.	**Date last reviewed:** February 2019
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 =16 Target: 4 x 3 = 12	**Rationale for current score:** New Service Module being developed
Level of Control = 70%	**Rationale for target score:**
Date added to the risk register January 2013	New models of care will reduce the risk to be at an acceptable level



Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	Lead	Deadline
• Twelve standards of care for older people in hospital have been developed jointly by clinical staff, patient groups and voluntary sector organisations. • The 'See It Say It' campaign was established to make it easier for staff, patients and visitors to raise concerns – anonymously if they wish – by phone, text or email • Introduction of the '15 Step Challenge' to improve the first impression patients and visitors get when they enter a ward	Move to a balanced service model with bed provision reducing over time, development of community OPMH Hubs, community development and essential infrastructure services such as support & stay, care home support, memory clinics and Day Services.	Chief Operating Officer	30.04.2019
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
Current Risk Rating 4 x 4 = 16	Additional Comments		

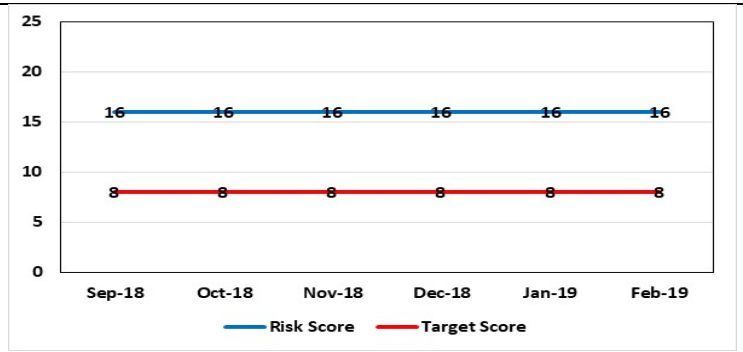
Datix ID Number: 841	HBR Ref Number: 13
Objective: Best Value Outcomes	**Director Lead:** Gareth Howells, Director of Nursing and Patient Experience **Assuring Committee**: Health and Safety Committee
Risk: Accommodation that does not meet statutory/health and safety requirements could have an adverse impact citizens, staff, financial and operational performance. This is a problem in the acute setting as well as across primary care in community clinics and surgeries.	**Date last reviewed:** February 2019

Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 =12 Target: 4 x 3 = 12		Rationale for current score: Lack of accommodation to meet statutory/health and safety requirements could have an adverse impact citizens, staff, financial and operational performance.
Level of Control = 90%		Rationale for target score:
Date added to the risk register April 2012		

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	Lead	Deadline
• Key areas where performance linked to health & safety/fire issues flagged through Health & Safety and Quality & Safety Committees and actions agreed to mitigate impacts. • Issues raised through site meetings held regarding service changes for all 4 acute hospital sites	Develop a strategy to improve primary and community services estate.	Asst Director Operations	30.04.2019
	Develop BJC's to improve the infrastructure of the 3 acute hospital sites (not including NPTH).	Asst Director Operations	30.04.2019

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• The Cabinet Secretary for Health & Social Services has now set the initial pipeline of health and care centres to be delivered by 2020-21. • The following projects have been identified for your Health Board including: Penclawdd Health Centre - refurbishment/redevelopment proposal (£0.800m at 16-17 prices) Murton Community Clinic – refurbishment/redevelopment proposal (£0.400m at 16-17 prices) Bridgend Town Centre Primary Care Centre – new build development (£5.000m at 16-17 prices); and Swansea Wellness Centre – new build development (£10.000m at 16-17 prices). The figures above represent the funding ceiling identified for the schemes. All of the above projects have been identified within the capital pipeline, and we are In the stage of awaiting approval from the Welsh Government for each business cases applicable as soon as possible	
Current Risk Rating 4 x 3 = 12	Additional Comments

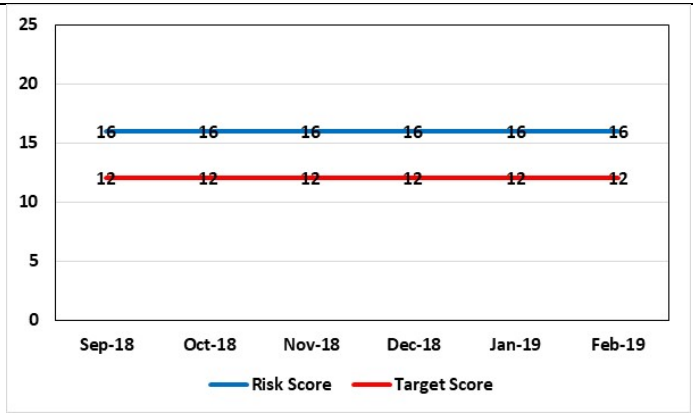
Datix ID Number: 840	HBR Ref Number: 16
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Performance & Finance Committee
Risk: If we fail to achieve compliance with waiting times there is a risk that patients may come to harm. Further, the health board will have financial resource clawed back to Welsh Government is the agreed target is not met.	**Date last reviewed:** February 2019

Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 =16 Target: 4 x 2 = 8		Rationale for current score: Consequence is high given nature of the risk. Likelihood is being managed through the controls and actions set out.
Level of Control = 90%		Rationale for target score:
Date added to the risk register January 2013		There is scope to reduce the likelihood score to reduce the Risk to an acceptable level

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	Lead	Deadline
• Weekly RTT meetings in place • Outsourcing additional capacity • NHS Wales Delivery Unit support provided in house and also support to the RTT meetings • Treat in Turn tools operationalised • Cohort tools operationalised • Support from Cwm Taf re backfill • Support from NPTH re additional orthopaedic waiting lists • Theatre group considering how to increase throughout through theatres • Additional staff training and recruitment (along with short term agency) to increase resilience of Morriston elective theatre	Escalation and scrutiny to Performance and finance Committee for off profile specialties	Associate Director Performance	Monthly
	Develop sustainability plans for specialties through the emerging Clinical Services Plan	Associate Director Performance	30.04.2019
	Protect elective capacity during winter period to ensure elective capacity is maintained	Chief Operating Officer	All of Quarter 4

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• Recover of specialties to profiled levels • Outsourcing volumes confirmed by providers • Increased Treat in Turn rates and cohort appointment • Reduction in overall waiting long waiting volumes	
Current Risk Rating 4 x 4 = 16	Additional Comments

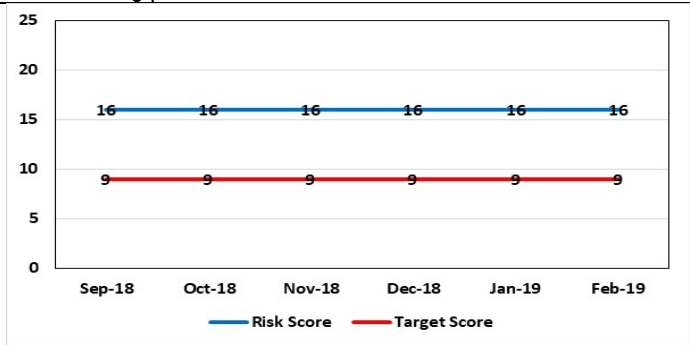
Datix ID Number: 838	HBR Ref Number: 17
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Sian Harrop Griffiths, Director of Strategy **Assuring Committee:** Health and Safety Committee
Risk: If we are unable to replace key pieces of equipment could adversely affect capacity and patient well being	**Date last reviewed:** February 2019
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 =16 Target: 4 x 3 = 12	**Rationale for current score:** Database being developed to support an ongoing equipment replacement programme.
Level of Control = 90%	**Rationale for target score:**
Date added to the risk register January 2013	



Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	Lead	Deadline
Equipment bids regularly reviewed and risk rating of the equipment bids considered. Proposal submitted to WG on use of discretionary capital slippage for medical equipment replacement in December 17.	Ensure that asset life information will be produced in the new single EBME system from 2011/12, is consistent with the Fixed Asset Register and will allow equipment replacement programmes to be planned for future years.	Director of Strategy	March 2019
	Ensure equipment replacement requirements are identified within all future capital new build/ refurbishment schemes	Director of Strategy	March 2020
	Database being developed to support an ongoing equipment replacement programme.	Director of Strategy	March 2019

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• Capital Prioritisation Group has been established to allocate discretionary capital in accordance with risk rating. All bids received for funding are risk assessed and verified by the Head of the Medical Equipment Management Service before being considered. When a business case is developed an allocation is included for equipment	
Current Risk Rating 4 x 4 = 16	Additional Comments

Datix ID Number: 1217	HBR Ref Number: 37
Objective: Best Value Outcomes from Quality Care	Director Lead: Chris White, Chief Operating Officer Assuring Committee: Audit Committee, Informatics Programme Board
Risk: Operational and strategic decisions are not data informed:- • Business intelligence and information already available is not utilized • Users are unable to access the information they require to make decisions at the right time • Gaps in information collection including patient outcome measures	Date last reviewed: February 2019

Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 3 =9		Rationale for current score: C – Opportunity cost of not acting on data could mean opportunities for improvement are missed, failures are not identified in a timely manner resulting in adverse national publicity and/or delays in care/increased length of stay. L - dashboard utilisation is lower than would be anticipated
Level of Control = 70%		Rationale for target score:
Date added to the risk register June 2016		C- will remain the same or increase due to increased reliance in information L- Investment in BI will lead to more information be available and used. The higher the use of information at operational level will lead to better quality data.

Controls (What are we currently doing about the risk?)

- The Health Board has continued to invest in the provision of Dashboards and we have doubled our licensing stock for both QlikSense and QlikView Business Intelligence Platforms in 2018/19.
- 17 dashboards in place including Mortality, Clinical Variation and Primary & Community Care Delivery Unit Dashboard and Ward Dashboard
- Safety Huddle implemented in Morriston is improving data quality and improving operational working
- Business Intelligent Information Manager appointed, who will take the lead for creating a Business Intelligence Strategy and Implementation Plan
- Investment and revised ways of working introduced within the coding department have achieved coding targets and data quality
- Flexible operational management of Coding Teams on a daily basis to cope with demand. Training programme in place for new coders.
- Short term funding secured at year end to support meeting tier 1 targets but does not resolve ongoing issues
- Information Dept. working with service leads in Planning and Finance to develop meaningful indicators also utilising dashboards to present information in a user friendly way

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Investment and implementation of system to record patient outcome measures	Interim Chief Information Officer	March 2019
Produce Business Intelligence Strategy and get signed off by the Board	Interim Chief Information Officer	Sept 2019
Produce BI strategy implementation plan outlining investment requirements in capacity and capability	Interim Chief Information Officer	December 2019

Assurances (How do we know if the things we are doing are having an impact?)

More evidence based and proactive decisions being made.

Dashboard technology; assist in developing indicators / triangulating information to identify issues

Gaps in assurance (What additional assurances should we seek?)

Culture of the organisation needs to change to focus on information and Business intelligence for operational rather than reporting purposes. Capability of operational staff to utilise the tools and capacity to act on the intelligence provided.

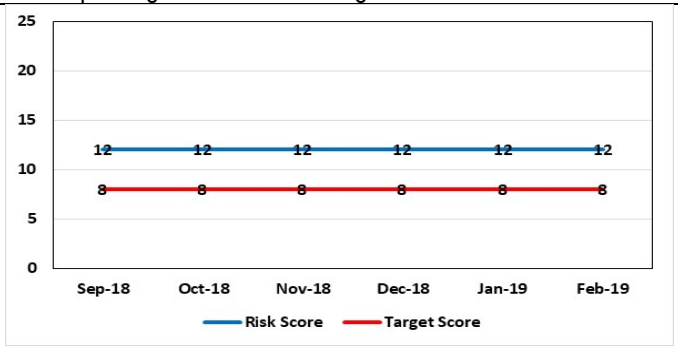
Current Risk Rating 4 x 4 = 16	Additional Comments

Datix ID Number: 1297	HBR Ref Number: 39
Objective: Demonstrating Value and Sustainability Risk in Brief: If the Health Board fails to have an approvable IMTP for 2018/19 then we will lose public confidence	**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee**: P&F Committee / Strategy, Planning and Commissioning Group Health Board
Risk: Operational and strategic decisions are not data informed:- Health Board does not have an IMTP signed off by WG, primarily due to the inability to align performance and financial plans. WG also advised that the Health Board needed to have a clear strategic direction by developing an Organisational Strategy and refreshing our Clinical Services Plan. In September 2016, the Health Board was escalated to 'targeted intervention' and having an approved IMTP is a key factor in improving our WG monitoring status.	**Date last reviewed:** February 2019

Risk Rating
(consequence x likelihood):
Initial: 4 x 4 = 16
Current: 4 x 3 = 12
Target: 4 x 2 = 8

Level of Control
= 70%

Date added to the risk register
Q4 2016/17



Rationale for current score:
Our Organisational Strategy was approved by the Board in November 2018
Our Clinical Services Plan has been developed and is at drafting stage for approval by the Board on 31st January 2019
We have planned on a medium-term basis and have a medium term delivery plan with one year performance and financial plan deliverables which will be assured at PFC in January for submission to the Board for approval in January 2019.
This Annual Plan includes a balanced financial plan.
We have agreed with Welsh Government that we will continue our detailed planning and submit an approvable IMTP in the Summer of 2019.
We will continue our work from January onwards on our detailed plans to submit an approvable IMTP in the Summer 2019.

Rationale for target score:
If the IMTP is approved in Summer 2019 it is likely our targeted intervention status will be improved when next reviewed and the risk can be closed.

Controls (What are we currently doing about the risk?)

- Medium term plan with one-year deliverables will be submitted to Board for approval in January – including a balanced financial plan
- Transformation Programme including programme approach will be established in February 2019
- Continuous planning through our Transformation Programme will work up detailed plans to submit an approvable IMTP in Summer 2019
- Executive Steering Group in place for development of medium term plan
- Plans will be assured by the P&F Committee before presentation to Board

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Complete implementation of RFID within Health Records	Interim Chief Information Officer	July 2019
Continue with roll out of digitisation of health record with a focus on Outpatients and Nursing documentation	Interim Chief Information Officer	March 2019
Continue with the roll out of WCP	Interim Chief Information Officer	March 2019

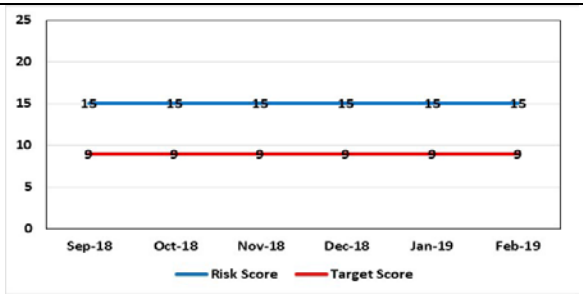
Assurances (How do we know if the things we are doing are having an impact?)

Gaps in assurance (What additional assurances should we seek?)

Current Risk Rating
4 x 3 = 12

Additional Comments

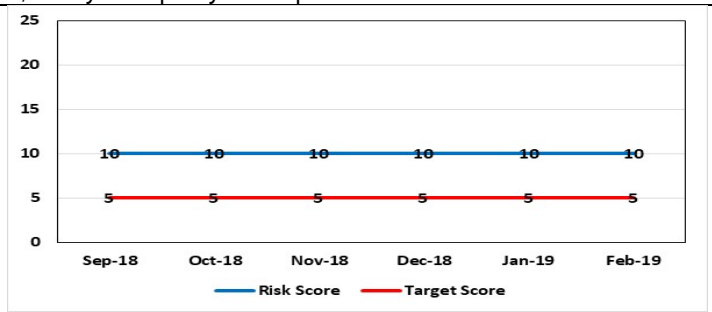
Datix ID Number: 1567	HBR Ref Number: 41
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, Director of Nursing and Patient Experience **Assuring Committee:** Health & Safety Committee
Risk: Currently an uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations.	**Date last reviewed:** February 2019

Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9		**Rationale for current score:** Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations
Level of Control = 50%		**Rationale for target score:**
Date added to the risk register 31/05/2018		Target Score should be lower

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
• Fire risk assessments. • Evacuation plans (vertical and horizontal). • Fire safety training. • Professional advice sought on compliance of panels. .	**Action**	**Lead**	**Deadline**
	Change in fire evacuation plans and alarm and detection cause and effect	Head of Health & Safety	31/01/2019
	Finalise Business Case for permanent remediation of the external wall cladding to comply with HTM 05-02 and Building Control Regulations Approved Document B	Assistant Director of Strategy & Workforce	31/01/2019
	Replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate	Assistant Director of Strategy & Workforce	31/01/2019

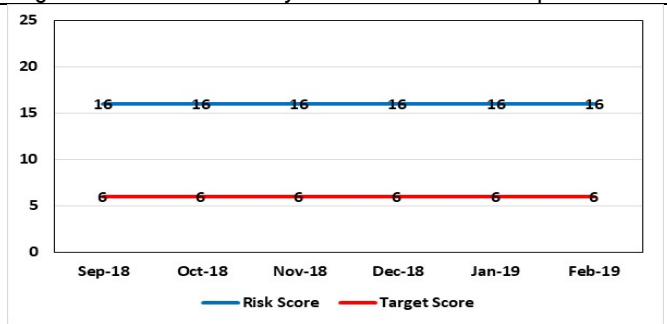
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?) Unclear if additional resources will be available
Current Risk Rating 5 x 3 = 15	**Additional Comments** Professional assessment of panel compliance being taken forward with NWSSP-SES, building control and WG colleagues.

Datix ID Number: 1398	HBR Ref Number: 42
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Lynne Hamilton. Director of Finance **Assuring Committee:** Performance and Finance Committee
Risk: If the Board is unable successfully to deliver a sustainable service and meet £20m financial control total then the performance, safety and quality of our provision will be at risk.	**Date last reviewed:** February 2019
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 2 x 5 =10 Target: 1 x 5 = 5	**Rationale for current score:** Target set by WG. Improving likelihood due to enhanced controls and mitigating actions and opportunities.
Level of Control = 50%	**Rationale for target score:** Aim to increase confidence levels to deliver set target.
Date added to the risk register July 2017	



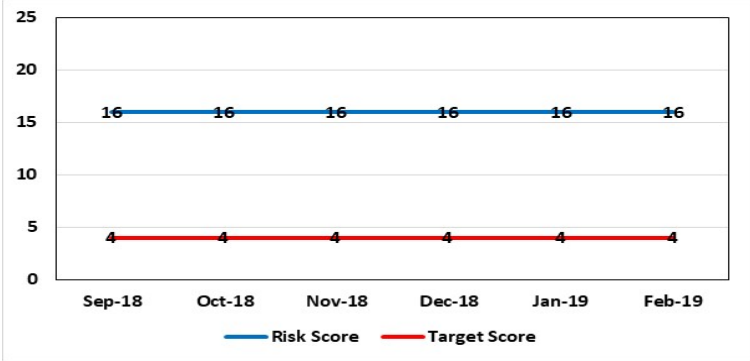
Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	Lead	Deadline
Monthly Performance, Quality and Finance Meeting • Medical agency caps • Spend Controls • QVC weekly panel • Investment & Benefits Group • Weekly FBP Meetings	Opportunities Schedule and Action Plan to deliver £20m deficit control in place, with steer and monitoring via Performance and Finance	Director of Finance	Monthly
Assurances **(How do we know if the things we are doing are having an impact?)** • Weekly pay and non-pay dashboard • Performance and Finance Committee and Board Financial Reporting • Savings plan confidence and delivery reporting	**Gaps in assurance** **(What additional assurances should we seek?)**		
Current Risk Rating 2 x 5 = 10	Additional Comments Recovery & Sustainability - detailed plan for all but 3 workstreams; plans in development urgently for remaining 3. Mitigating actions in place to counter balance these workstreams. • NWSSP providing schedule of contracts and SHOs for each. • QVC 1 - meetings taken place with clinical cabinet and MD.		

Datix ID Number: 1514	HBR Ref Number: 43
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, Director of Nursing & Patient Experience **Assuring Committee:** Quality & Safety Committee and Safeguarding Committee
Risk: If the Health Board is unable to complete timely completion of DoLS Authorisation then the Health Board will be in breach of legislation and claims may be received in this respect.	**Date last reviewed:** February 2019
Risk Rating (consequence x likelihood): Initial: 4 x 4 =16 Current: 4 x 4= 16 Target: 3 x 2 = 6	**Rationale for current score:** Although processes have been planned or implemented, the impact is yet to be measured over a longer term, and the challenges of managing a large backlog of breaches.
Level of Control = 40%	**Rationale for target score:** Consequences of DoLS breaches for the Health Board will not change. With controls in place, over time likelihood should decrease.
Date added to the risk register July 2017	



Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	Lead	Deadline
• Supervisory body signatories increased from 3 to 7 • BIA rota now implemented • 2 x substantive BIA posts and additional admin post advertised • DoLS database updated and DoLS dashboard devised to enable more accurate monitoring and reporting	Delivery of DOLS Action plan reviewed monthly	Head of Safeguarding	Monthly
Assurances (How do we know if the things we are doing are having an impact?) • Regular scrutiny at Safeguarding Committee and by DoLS Internal Audit; monitoring via DoLS Dashboard which is due to be rolled out imminently and will provide real-time accurate data.	Gaps in assurance (What additional assurances should we seek?)		
Current Risk Rating 4 x 4 = 16	Additional Comments		

Datix ID Number: 1563	HBR Ref Number: 48
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Sian Harrop Griffiths, Director of Strategy **Assuring Committee:** Performance & Finance Committee, Health Board
Risk: Failure to sustain Child and Adolescent Mental Health Services	**Date last reviewed:** February 2019
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 2 x 2 = 4	**Rationale for current score:** The specialist CAMHS Network is delivered by Cwm Taf University Health Board on behalf of ABMU. Cwm Taf have confirmed that they will not meet the 28 day target by the end of March 2018. This is as a result of pressures across the entire CAMHS network in relation to demand & capacity and recruitment & retention.
Level of Control = 50%	**Rationale for target score:**
Date added to the risk register 31/05/2018	If the IMTP is approved in Summer 2019 it is likely our targeted intervention status will be improved when next reviewed and the risk can be closed.

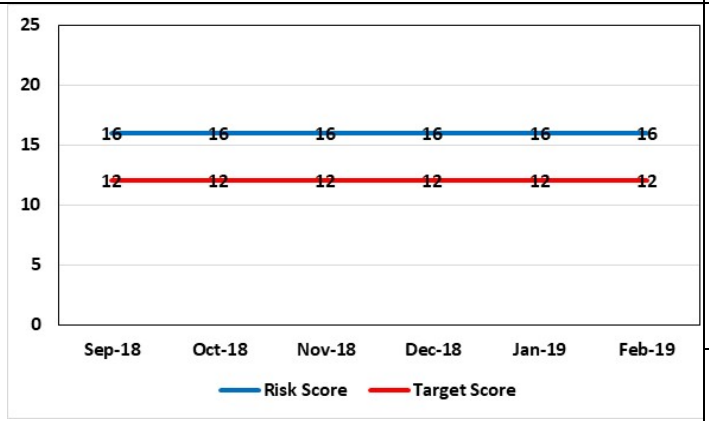


Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	Lead	Deadline
• Performance Scrutiny - is undertaken at monthly commissioning meetings between ABM & Cwm Taf University Health Boards. Improved governance -ensures that issues and concerns are discussed by all interested parties including local authorities to support the network identify local solutions.	Implementation of the Choice and Partnership Approach (CAPA) started on 1st November 2017 and being closely monitored	CAMHS network	31/03/2019
	Additional investment expected - from Welsh Government is supporting the delivery of Waiting List Initiative clinics to support the position.	CAMHS network	31/03/2019
	The Network is seeking to recruit agency staff to fill existing and upcoming vacancies to ensure that core capacity is maximised.	CAMHS network	31/03/2019

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
Current Risk Rating 4 x 4 = 16	Additional Comments The service is now in the 2nd cycle of CAPA with new job plans agreed from January, with updated demand & capacity mapping. WLI Clinics initiated at POW Hospital, Bridgend which enabled the 80% target to be achieved by end of end March. This was also achieved for NPT area. However Swansea had a significant backlog, which is starting to be addressed with waiting list initiatives from March 2018.

Datix ID Number: 922	HBR Ref Number: 49
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Richard Evans, Medical Director **Assuring Committee:** Quality & Safety Committee
Risk: Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)	**Date last reviewed:** February 2019

Risk Rating (consequence x likelihood):
Initial: 5 x 5 = 25
Current: 4 x 4 =16
Target: 3 x 4 = 12



Level of Control = 50%

Date added to the risk register July 2016

Rationale for current score:

- Patients waiting in excess of 36 weeks for TAVI procedure as a result of lack of service infrastructure as well as increasing demand.
- Mortality review undertaken which has indicated that patients have come to serious harm as a result of excessive waits.
- Recovery plan commenced on 5th November and has begun to reduce number of patients waiting over 36 weeks however without sustainable service in place from early 2019, backlog will increase again.
- Given reduction in number of patients waiting over 36 weeks since 5th November, risk score has reduced from 25 to 16.

Rationale for target score:
Recovery plan provides funded temporary capacity to reduce backlog of patients awaiting procedure. The service projects 0 patients waiting over 36 weeks by the end of December 2018. This will reduce risk of harm however risk of reoccurrence will remain until recurrent service infrastructure is established.

Controls (What are we currently doing about the risk?)

- TAVI Recovery Plan implemented with aim of reducing backlog of patients by end of financial year. Operational service meets weekly to oversee this plan.
- Plan is supported with Executive oversight at weekly TAVI OG meeting.
- TAVI has been prioritised for consideration in next year's WHSSC ICP however any funding allocation unlikely to be until Spring 2020. TAVI Executive OG Group therefore considering options to mitigate a further increase in TAVI backlog following completion of the recovery plan.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Clear backlog of patients awaiting TAVI by January 2019	Directorate Manager	31/01/2019
Progress case to WHSSC for sustainable TAVI service resource to be included in 2019/20 ICP	Directorate Manager	18/10/2019
Establish HB support to 'bridge the gap' for sustainable TAVI service between completion of recovery plan in February 2019 and possible receipt of WHSSC funding in April 2020.	Directorate Manager	31/01/2019

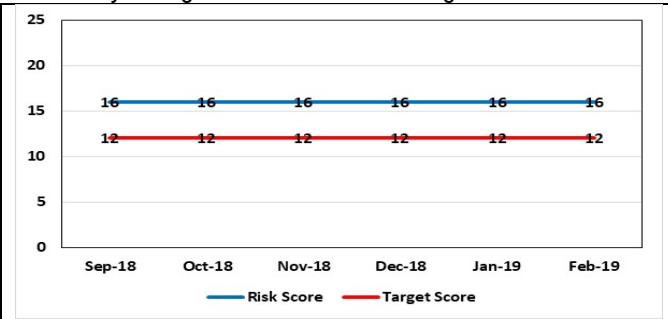
Assurances
(How do we know if the things we are doing are having an impact?)

Gaps in assurance
(What additional assurances should we seek?)

Current Risk Rating
4 x 4 = 16

Additional Comments

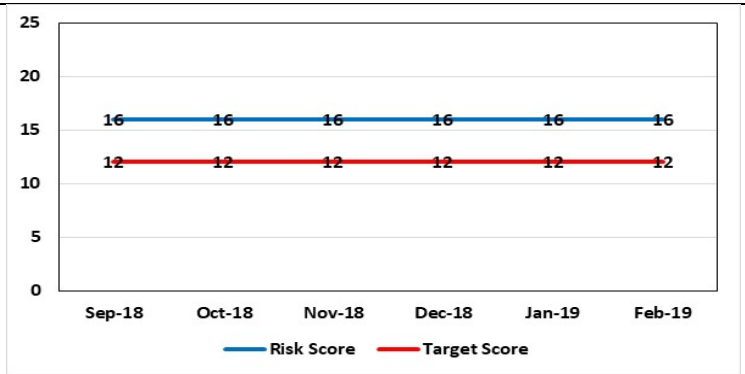
Datix ID Number: 1761	HBR Ref Number: 50
Objective: Best Value Outcomes from High Quality Care	Director Lead: Chris White, Chief Operating Officer Assuring Committee: Performance & Finance Committee
Risk: Failure to sustain services as currently configured to meet cancer targets	Date last reviewed: February 2019
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 4 = 16 Target: 4 x 3 = 12	Rationale for current score: An overall reducing trend in current risk assessed score. Whilst target not consistently being met, general improvement trajectory which needs to be sustained.
Level of Control = 70%	Rationale for target score:
Date added to the risk register April 2014	Target score reflects the challenge this area of work present the Board and where small numbers of patients impact on the potential to breach target



Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	Lead	Deadline
• Tight management processes to manage each individual case on the unscheduled care (USC) Pathway. • Initiatives to protect surgical capacity to support USC pathways have been put in place in RGH and PCH to protect core activity. • Prioritised pathway in place to fast track USC patients. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. • Overall Cancer target performance plateau at around 90% with ongoing monitoring of related actions in place at F,P&W Committee. • Small numbers of patients breaching which is impacting on sustained delivery of the 31 and 62 day target.	Introduction of revised models for rapid diagnostic review / assessment in cancer pathways being introduced.	COO / DPC&MH Med Director	January 2019
	Continue close monitoring of each patient on the USC pathways to ensure rapid flow of patients through the pathway.	COO / DPC&MH Med Director	January 2019
	Some speciality challenges remain in Lung and Urology - Action plans in place, along with monitoring.	COO / DPC&MH Med Director	January 2019

Assurances	Gaps in assurance
(How do we know if the things we are doing are having an impact?) General improvement (sustained) trajectory. Need to continue improvement actions and close monitoring. Early diagnosis pathway launched and impact being closely monitored.	(What additional assurances should we seek?) Clear current funding gap.
Current Risk Rating 4 x 4 = 16	Additional Comments The need to deliver sustained performance.

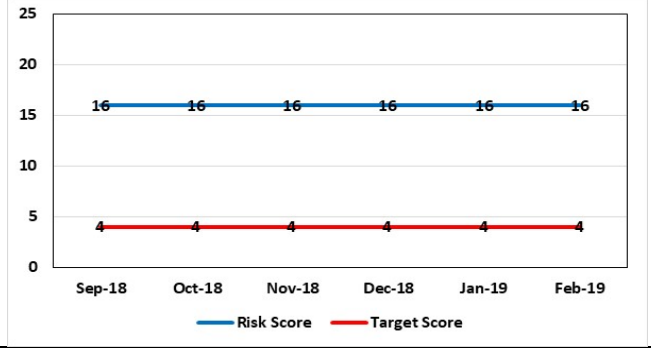
Datix ID Number: 843	HBR Ref Number: 3
Objective: Excellent Staff	Director Lead: Hazel Robinson, Director of Workforce and Operational Development Assuring Committee: Workforce & OD Committee
Risk: Failure to recruit medical & dental staff	Date last reviewed: February 2019

Risk Rating (consequence x likelihood):		Rationale for current score:
Initial: 5 x 4 = 20 Current: 4 x 4 =16 Target: 4 x 3 = 12		• National shortages of numbers in some areas can lead to: • Unable to recruit sufficient numbers of trainees to fulfil rotas on all sites • Unable to attract non training grades to complete rotas • Unable to fill Consultant grade posts in some specialties with adverse effects on patient safety and industrial relations. Unable to recruit sufficient registered nursing staff.
Level of Control = 70%		Rationale for target score:
Date added to the risk register April 2012		This remains a challenge and is also a national problem.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	Lead	Deadline
• Regular monitoring of recruitment position with reports to Executive Team and Board via Medical Director and Medical Workforce Board. • Specialty based local workforce boards established to monitor and control specific issues. The new HB Workforce & OD Committee will seek assurance of medical workforce plans to maintain services. • Engagement of the Deanery about recruitment position.	Medical training initiatives pursued in a number of specialties to ease junior doctor recruitment	Director W&OD.	March 2019
	The Medical Workforce Board continues to monitor recruitment and junior doctor's rotas.	Director W&OD.	March 2019
	Continue to recruit internationally.	Director W&OD.	March 2019

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• General situation monitored through W&OD Committee • Communication with Deanery • Recruitment campaigns • Integrated Medicine and Paediatrics short term workforce plans • Monitoring by Executive Teams and specialty based local workforce boards	
Current Risk Rating 4 x 4 = 16	Additional Comments

Datix ID Number: 1759	HBR Ref Number: 51
Objective: Excellent Staff	Director Lead: Gareth Howells, Director of Nursing Assuring Committee: Quality and Safety Committee, NMB
Risk: Non Compliance with Staffing Levels Act (2016)	Date last reviewed: February 2019

Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 4 x 1 = 4		Rationale for current score: • Section 25B places a duty on LHBs and NHS Trusts to calculate and take steps to maintain nurse staffing levels in specified settings, which are currently adult acute medical and surgical inpatient wards.timescale.
Level of Control = 80%		Rationale for target score: • The Health Board is ensuring we have the structures and processes in place to provide reassurance under the Act and are allocating resources accordingly. • Health Boards are duty bound to take all reasonable steps to maintain nurse staffing levels.
Date added to the risk register November 2018		

Controls (What are we currently doing about the risk?)

The Health board has put the following controls in place:-

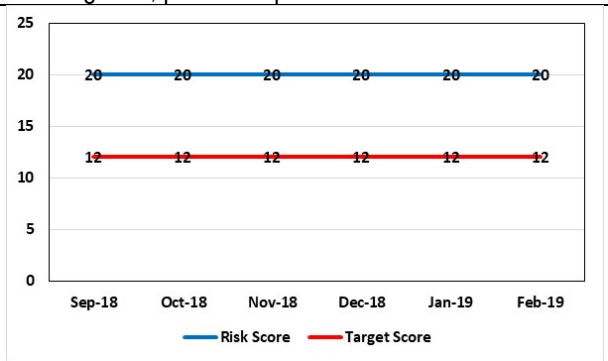
- Confirmed the designated person
- Represented the All-Wales Nurse Staffing Group and its sub groups
- Contributed with the work undertaken at an all-Wales level on Acuity levels of care.
- Undertaken a formal review across all acute Service Delivery Units for calculating and reporting nurse staffing requirements to ensure a Health Board wide consistent approach is adopted.
- Presented a Health Board position status paper to both Board & Executive team outlining the preparedness for the Nurse Staffing Act (Wales).
- Conducted a review of workforce planning procedures, for 2018 to 2021, which includes; Health Board recruitment events, retention, workforce Planning & redesign, training and development.
- Developed a monthly Health Board Multidisciplinary Nurse Staffing Act Task & Finish Group, chaired by the Interim Deputy Director of Nursing & Patient Experience, which reports to Nursing and Midwifery Board and Workforce & Organisational Development Committee.
- Provided acuity feedback sessions to all Service Delivery Units included in the June audit.
- Formally launched the Nurse Staffing (Wales) Act Guidance.
- Raised the issue regarding Information Technology barriers around the capture of data required for the Act on an All- Wales and Health Board basis.
- Circulated the Welsh Levels of Care and Operational Handbook to Service Delivery Unit Leads.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
The Ward Sister / Charge Nurse and Senior Nurse should continuously assess the situation and keep the designated person formally appraised.	Director of Nursing & Patient Experience	31/03/2019
The responsibility for decisions relating to the maintenance of the nurse staffing level rests with the Health Board should be based on evidence provided by and the professional opinions of the Executive Directors with the portfolios of Nursing, Finance, Workforce, and Operations.	Director of Nursing & Patient Experience	31/03/2019
Health Board should agree the operating framework for these decisions to include actions to be taken, and by whom.	Director of Nursing & Patient Experience	31/03/2019

• Confirmed the 32 acute medical & surgical clinical areas that fall within the Act. These areas have been agreed using the criteria set out in the Operational Handbook. • A Rigorous data approval process has been put in place to ensure accuracy of the 6 monthly acuity data prior to sign off. There has also been a number of workshops organised across the organisation to ensure a consistent approach to data collection and there is national work on solutions for electronic capture of acuity data.			
Assurances (How do we know if the things we are doing are having an impact?) • Ongoing robust recruitment and retention plans in place to reduce vacancies in key clinical areas, which is in line with the Health Board recruitment plan. • Accurate reporting of Acuity data and governance around sign off. • Agreed establishments to funded. • Implementation of E-Rostering to enable accurate reporting of Compliance • Implement all Wales Templates, which are visible and signed within the agreed 32 ward areas, informing patients of planned roster. • At least Yearly Board reports outlining compliance and any key risks.	Gaps in assurance (What additional assurances should we seek?)		
Current Risk Rating 4 x 4 = 16	Additional Comments		

Datix ID Number: 1796	HBR Ref Number: 56
Objective: Excellent Staff	Director Lead: Hazel Robinson, Director of Workforce and Operational Development Assuring Committee: Finance, Performance & Workforce
Risk: Insufficient capacity of Workforce and OD Function within ABMU to support and deliver the strategic and operational workforce agenda, plans and priorities of the Health Board	Date last reviewed: February 2019

Risk Rating (consequence x likelihood):		Rationale for current score:
Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 = 12		• Since the establishment of the Health Board in 2009 there has been a significant reduction in the workforce and OD staffing levels. The current capacity of the team and the team's ability to provide appropriate, high quality and timely advice on both operational and strategic issues is a significant area of professional concern. Current resourcing levels have been benchmarked with other Health Boards. Output anticipated by the end of November 2018
Level of Control = 30%		Rationale for target score: • Target score reflects requirement to resource the workforce and OD function to be able to meet the operational and Strategic priorities of the Health Board. Failure to do this will negatively impact of financial, service, performance and quality outcomes.
Date added to the risk register November 2018		

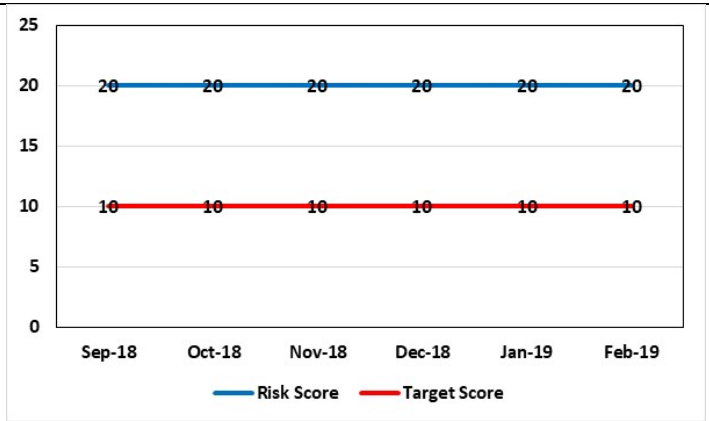
Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	Lead	Deadline
Director of Workforce and OD reported risk stocktake to W&OD Committee. A Workforce and OD risk register has been generated as a consequence. Reported at Corporate Performance review with CEO. Reported to Audit Committee. Further update on risk and progress against these reports to W&ODC in November 2018.	Review of resourcing to take into account Boundary Change	Director of W&OD	April 2019
General situation monitored through W&OD Committee.	Gaps in assurance (What additional assurances should we seek?)		
Current Risk Rating 4 x 5 = 20	Additional Comments Utilise temporary funded capacity to meet immediate areas of risk. Continue to raise resourcing issue at corporate level and through committee governance arrangements. Run at risk. • Actions Complete: Risk Stock Take reported to W&OD Committee, Audit Committee and Corporate Performance Review. • Update on progress and improvement against key risk areas provided to W&ODC • Development of W&OD Risk Register.		

Datix ID Number: 1035	HBR Ref Number: 27
Objective: Digitally enabled care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Quality and Safety Committee, Informatics Programme Board
Risk: Inability to deliver sustainable clinical services due to lack of digital transformation. There are insufficient resources to: • invest in the delivery of the ABMU Digital strategy, • support the growth in utilisation of existing and new digital solutions • replace existing technology infrastructure and the end of its useful life.	**Date last reviewed:** February 2019

Risk Rating
(consequence x likelihood):
Initial: 4 x 4 = 16
Current: 5 x 4 = 20
Target: 5 x 2 =10

Level of Control
= 50%

Date added to the risk register
2012



Rationale for current score:
C – reliance on digital ways of working has increased. Loss of IT service has a greater impact on ability to provide clinical care. Lack of investment in new digital solutions to make services more effective will mean clinical service provision will become unsustainable.
L- There has been an increase in the number of devices in circulation by 3000 (39%) over the last 4 years (2015-2018) without an increase in IT support capacity. HB are currently only able to replace devices that are over 7 years old. Call volumes and wait times have increased over the last 4 years. Key IT maintenance work is not being completed in a timely fashion. Investment required in Informatics to deliver the Digital strategy is greater than the funding currently available. Informatics budget is estimated to be 0.73% of the HB budget - well below the recommended 4%. Resources available to provide digital services could be reduced because of the boundary change.

Rationale for target score:
C – of failure will increase as the reliance and proliferation of the use of digital solutions increases.
L – investment will mean the support mechanisms, rate of failure and ability to deliver solutions that meet the needs of users will improve sustainable digital services. There will however always be an inherent risk of failure of IT solutions.

Controls (What are we currently doing about the risk?)

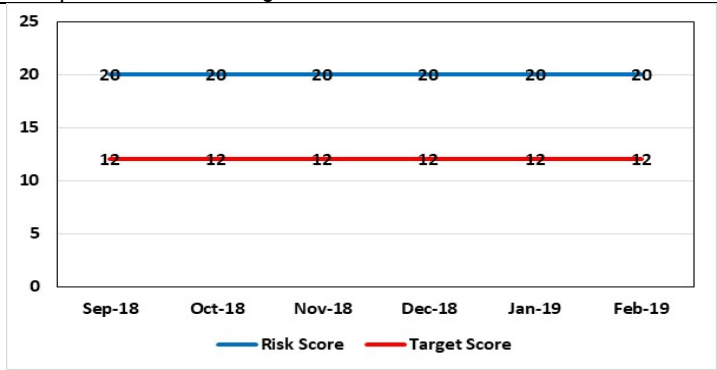
- Digital strategy has been approved by the Health Board
- Capital priority group for the HB considers digital risks for replacement technology which is fed into the annual discretionary capital plan
- IBG process allows for investment requests in projects to be submitted to the HB for consideration and provides scrutiny to ensure Digital resources required are considered for all projects
- Informatics prioritisation process has been introduced to ensure requests for digital solutions are considered in terms of alignment to the strategy objective, technical solutions and financial implications

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Develop a new Strategic Outline Plan setting out the requirement to deliver the first phase of the Digital strategy	Chief Operating Officer	February 2019
Work with finance and the Health Board leadership team to identify additional revenue streams	Chief Operating Officer	March 2019
Ensure informatics prioritisation process is embedded into the ways of working so that resource implications of digital solutions are transparent and agreed at outset of projects	Chief Operating Officer	March 2019

• HB has invested £900k recurrently in the project staffing resources to facilitate the delivery of the Informatics Strategic Outline Plan • Working closely with WG to identify funding streams to support investment in digital including the approval of the Informatics Strategic Outline Plan	Ensure business cases requiring digital services include appropriate implementation and support costs	Chief Operating Officer	March 2019
Assurances (How do we know if the things we are doing are having an impact?) • Progress has been made in securing capital investment both internally and externally for new developments • IBG and CPG processes are in place and ensuring highest technology replacement risks are being addressed • There are 22 active projects in place and being delivered	Gaps in assurance (What additional assurances should we seek?) Lack of certainty over future funding streams makes planning and implementation difficult/less effective Revenue model for support unclear given the financial pressures of the organisation.		
Current Risk Rating 5 x 4 = 20	Additional Comments This is further impacted by the boundary change which could have significant impact on resources and capability to deliver digital services going forward.		

Datix ID Number: 1043	HBR Ref Number: 36
Objective: Digitally enabled care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Quality and Safety Committee, Informatics Programme Board
Risk: Lack of a single electronic record means there is greater reliance on the provision of the paper record. If we fail to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards.	**Date last reviewed:** February 2019
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 =12	**Rationale for current score:** C - Inability to find records for patients could delay care/increase length of stay over 15 days. Could also mean patients receive incorrect treatment L - we know this happens from incidents raised
Level of Control = 70%	**Rationale for target score:**
Date added to the risk register June 2016	C - Inability to find records for patients could delay care/increase length of stay over 15 days. Could also mean patients receive incorrect treatment L – RFID and digitalisation of the health record will reduce the constraints of the current filing methodology and reduce the volume of paper being added to the record. Further digitalisation of the paper record will reduce the reliance of clinicians on the paper record.



Controls (What are we currently doing about the risk?)

Temporary retention and destruction plans are in place.
Alternative storage arrangements are being identified and utilised where appropriate.
Ward protocols and audits have been rolled out across sites.
RFID project now approved. Implementation process has started and will change the way records are filed and release storage capacity.
Roll out plan for WCP is in place and being enacted as outlined in the SOP

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Complete implementation of RFID within Health Records	Interim Chief Information Officer	July 2019
Continue with the roll out of WCP	Interim Chief Information Officer	March 2019
Continue with roll out of digitisation of health record with a focus on Outpatients and Nursing documentation	Interim Chief Information Officer	March 2019

Assurances
(How do we know if the things we are doing are having an impact?)

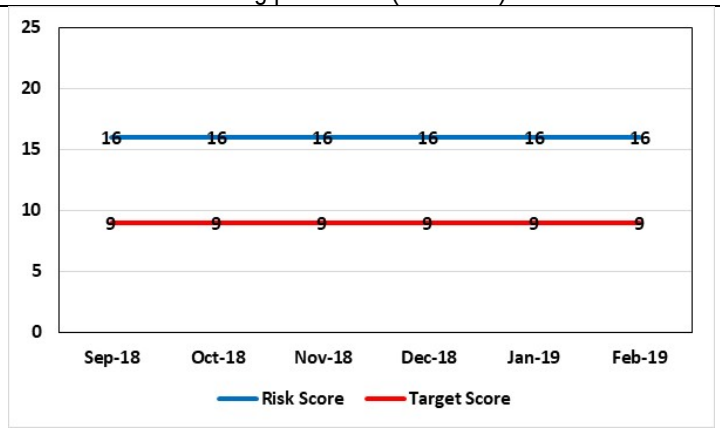
- Preparation work for RFID has started to release space and increased destruction levels

Gaps in assurance
(What additional assurances should we seek?)
Investment required supporting the delivery and operational costs of the Digital strategy.
Reliance on NWIS for delivery of the solution for a fully electronic patient record
Impact of the Infected Blood Enquiry on the Health Boards ability to destroy notes.

Current Risk Rating
4 x 5 = 20

Additional Comments

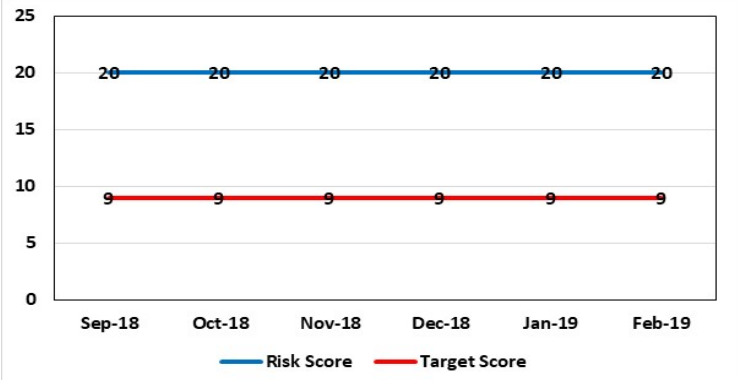
Datix ID Number: 1564	HBR Ref Number: 44
Objective: Digitally enabled care	Director Lead: Chris White, Chief Operating Officer Assuring Committee: Quality and Safety Committee
Risk: Current ED systems are not fit for purpose: • There is an increased risk of system (Accent) failure (PoWH and NPT) • Do not support effective and efficient working processes (Morriston)	Date last reviewed: February 2019

Risk Rating (consequence x likelihood): Initial: 5 x 4 =20 Current: 4 x 4 =16 Target: 3 x 3 = 9		Rationale for current score: • C – Reduced due to mitigating actions/controls taken to reduce impact of system failure in PoW. Inability to meet A&E targets and ambulances queuing at entrance could have adverse national publicity. Part of targeted intervention monitoring – loss of confidence in Health Board • L - WEDS has been delayed and the current systems do not meet the requirements of users to aid the improvement of operational services. System in Pow and NPT is still unstable and unsupported
Level of Control = 60%		Rationale for target score:
Date added to the risk register May 2018		• C – moving to a stable supported solution will reduce the impact of failure but the impact of the system not meeting all operational requirements will remain. • L – of system failure will reduce once a stable supported solution is in place. The National system has been evaluated as meeting operational requirements as part of procurement process, however requirements will change over time.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	Lead	Deadline
• WPAS has been implemented in Morriston as an interim solution but does not provide all the additional functionality required. • Archive solution developed for Accent to allow access to historic data in case of failure • WEDs programme is still being progressed by NWIS	Implement WPAS ED module in NPT and POW	Chief Operating Officer	March 2019
	Implement alternative ED system across the Health Board.	Chief Operating Officer	March 2020

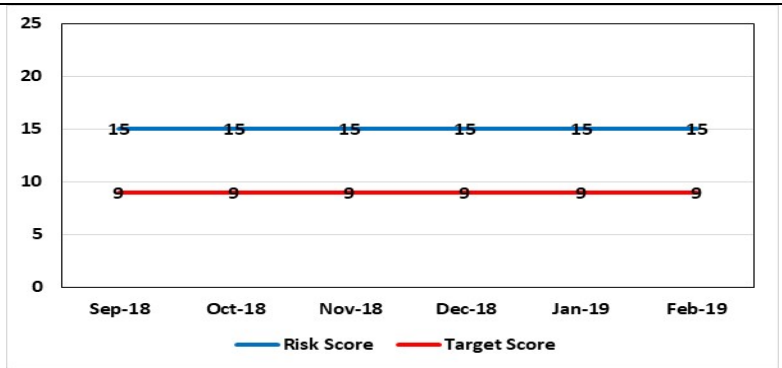
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• Replacement of Accent will increase stability of system. Archive solution has been tested.	National solution currently being tested so no assurances at this stage the solution will be suitable or on implementation timescales
Current Risk Rating 4 x 4 = 16	Additional Comments

Datix ID Number: 1565	HBR Ref Number: 45
Objective: Digitally enabled care	**Director Lead**: Richard Evans, Medical Director **Assuring Committee**: Quality and Safety Committee, Information Governance Board
Risk: If patients are discharged from hospital without the necessary discharge information this may have an impact on their care	**Date last reviewed:** February 2019

Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 3 x 3 = 9		Rationale for current score: • Despite the provision of an electronic discharge summary available across the Health Board to support the processing of discharge summaries within agreed targets, compliance with the targets, on average, remains low. GPs are therefore not always provided with the information required to provide continued care on discharge of the patient.
Level of Control = 50%		Rationale for target score:
Date added to the risk register May 2018		

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	Lead	Deadline
• Executive directive issued to all SDUs to improve compliance. • Medical Director in Morriston SDU leading "no discharge summary, no discharge" initiative with training support being provided by Informatics to improve performance. • E-learning package now available to support training requirements. • Performance Dashboard available to provide ""live"" view of EToC status Informatics to improve performance. • E-learning package now available to support training requirements. • Performance Dashboard available to provide ""live"" view of EToC status"	All SDUs to focus on improved performance - actions plans required from each SDU to demonstrate how compliance will be achieved	Medical Director	31/12/2018
	Implementation of WCP will include the MTED module which will allow extra project support to facilitate improved compliance	Medical Director	31/12/2018
	Informatics to improve performance	Medical Director	31/12/2018
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
Current Risk Rating 5 x 4 = 20	Additional Comments The most recent HB "completed & sent" performance was 60% (August 2017) compared with 48% a year ago.• In August 2017 the best performing hospital is NPTH (83%), this is reduced by the poor performance on wards not directly managed by NPT. Medical Wards regularly achieve 99%• August 2016 v August 2017 Delivery Unit comparisons demonstrate substantial improvement in Morriston, POW & Singleton• Morriston is coming to the end of a 6-month improvement programme which is bearing fruit, performance was 46% in March when it started.		

Datix ID Number: 737	HBR Ref Number: 15
Objective: Partnerships for Improving Health and Wellbeing	**Director Lead:** Sandra Husbands, Director of Public Health **Assuring Committee:** Quality and Safety Committee
Risk: If we fail to achieve population health improvement targets leading to an increase in preventable disease amongst the population resulting in increased morbidity impacting on operational and financial pressures.	**Date last reviewed:** February 2019

Risk Rating (consequence x likelihood):		Rationale for current score:
Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9		If we fail to prevent a serious outbreak by effectively achieving herd immunity in the population through immunisation and vaccination programmes, or to effectively manage an outbreak by disrupting the spread, this will result in serious harm to individual, maybe death, and pressure on health services, disruption to flow, business continuity and reputational damage to the health board and public health team.
Level of Control = 60%		Rationale for target score:
Date added to the risk register 26.1.16		Manage preventable disease

Controls (What are we currently doing about the risk?)

- Public Health Strategy and work plan
- Internal Audit Management Plan
- Strategic Immunisation Group
- MMR Task & Finish group
- Childhood Imms Group;
- Primary Care Influenza Group
- Support from PHW Health Protection

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Deliver immunisation awareness training for pre-school settings to promote key vaccination messages	Consultant Public Health Medicine	March 2019
Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report.	Consultant Public Health Medicine	March 2019
Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins	Consultant Public Health Medicine	March 2019

Assurances
(How do we know if the things we are doing are having an impact?)

- School imms target is over 70%, we are the 2nd highest in Wales. All other childhood imms targets below trajectory.

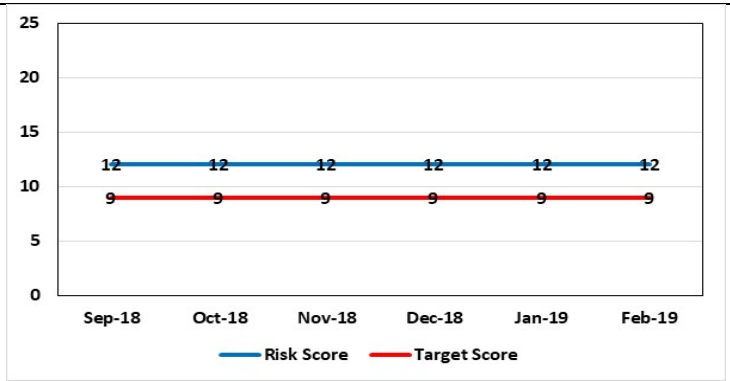
Gaps in assurance
(What additional assurances should we seek?)
The need to deliver sustained service.

Current Risk Rating
5 x 5 = 15

Additional Comments
Scrutiny by internal audit, raise awareness, encourage uptake, target population. Co-production work with the public.

Datix ID Number: 1763	HBR Ref Number: 52
Objective: Partnerships for Care – Effective Governance	**Director Lead:** Director of Strategy **Assuring Committee:** P&F Committee Health Board
Risk: The Health Board does not have sufficient resource in place to undertake engagement & impact assessment in line with Stat Duties	**Date last reviewed:** January 2019

Risk Rating
(consequence x likelihood):
Initial: 4 x 4 = 16
Current: 4 x 3 = 12
Target: 4 x 2 = 8



Rationale for current score:

- Engagement – a temporary post has been released for a Head of Engagement & an appointment made.
- Postholder started on 7.1.19 but there is no agreement yet for permanent resourcing.
- Impact Assessment – there is no dedicated resource and policies / processes are out of date. A paper has been drafted that recommends processes based on best practice for Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) and preparation for Health Impact Assessment (HIA), as well as preferred option for appointing a full time temporary Impact Assessment Manager.
- The paper was received by the Executive Team in January 2019 and the recruitment paperwork is being prepared.

Level of Control
= 50%

Date added to the risk register
November 2018

Rationale for target score:

- Both of these areas need to have adequate resourcing and robust processes / policies in place for the organisation to make robust plans, engage public confidence and meet our statutory and public duties.

Controls (What are we currently doing about the risk?)

- Engagement – a temporary post has been released for a Head of Engagement and the postholder has been in post since 7.1.19. There is no agreement yet for permanent resourcing. Robust processes are, however, in place as agreed with the CHC and based on best practice guidance.
- Impact Assessment – a proposal to appoint a temporary Integrated Impact Assessment Manager was received by the Executive Team in January 2019 and the recruitment paperwork is being prepared.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Agree resource for the Head of Engagement and Impact Assessment Manager	DoS / DoHR	31/03/2019
Robust policies and processes to be in place for Impact Assessment	DoTransformation / DoS (TBC)	31/03/2019

Assurances (How do we know if the things we are doing are having an impact?)

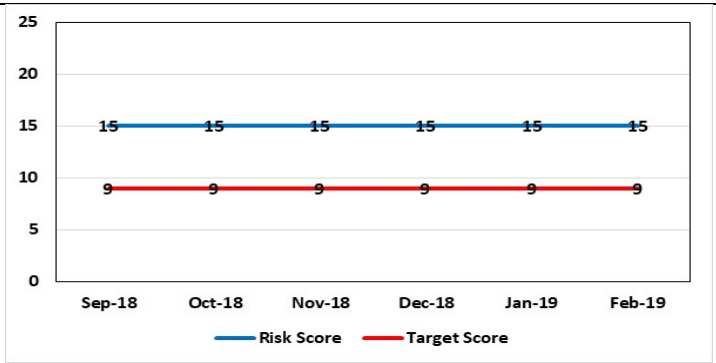
- A Stage 1 EIA has been prepared for the Clinical Services Plan and Annual Plan to inform the Board to approve the Plans
- A QIA process for the Financial Plan is in place and was assured by the joint meeting of the PFC and Q&S Committee on 22nd January for the plans to be submitted to Board for approval

Gaps in assurance
(What additional assurances should we seek?)
Permanent additional resources not yet available

Current Risk Rating
4 x 3 = 12

Additional Comments

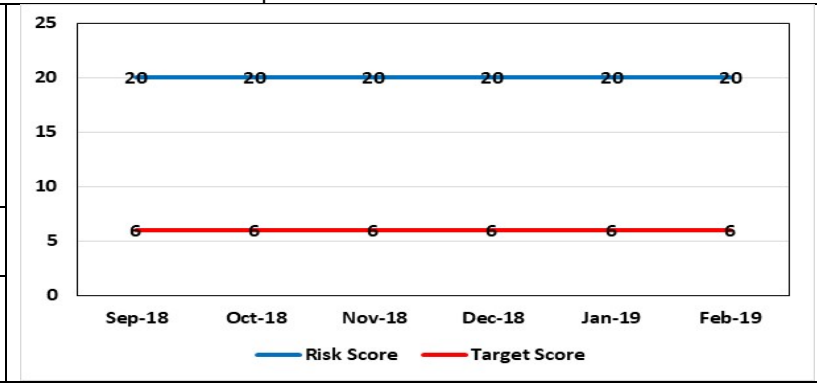
Datix ID Number: 1762	HBR Ref Number: 53
Objective: Partnerships for Care	Director Lead: Pam Wenger, Director of Corporate Governance Assuring Committee: Health Board (Welsh Language Group)
Risk: Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	Date last reviewed: February 2019
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9	Rationale for current score: As a consequence of an internal assessment of the Standards and their impact on the UHB, it is recognised that the Health Board will not be fully compliant with all applicable Standards.
Level of Control = 60%	Rationale for target score:
Date added to the risk register November 2018	Working through its related improvement plan the likelihood of noncompliance will reduce as awareness and staff training in response to the Standards, is raised.



Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
• The Welsh Language Officer has undertaken a self-assessment of the requirements of the Standards and how they apply to Cwm Taf. • Close constructive working relationships are in place with the Welsh Language Commissioner's Office. • Strong networks are in place amongst Welsh Language Officers across NHS Wales to inform learning and development of responses to the Standards. • Establishment of Welsh Language Delivery Group agreed at Executive Board February 2019. • Outline implementation plan developed, further work required in next 3 – 6 months.	Action	Lead	Deadline
	To develop an implementation plan including the identification of resources to deliver the Welsh Language Standards	Director of Governance	March 2019
	Ensure the Board is fully sighted on the UHB's position through regular reporting to the Health Board	Director of Governance	March 2019

Assurances (How do we know if the things we are doing are having an impact?) Compliance with Statutory requirements outlined in Welsh Language Act and related Standards.	Gaps in assurance (What additional assurances should we seek?) The self-assessment has confirmed that the Health Board is not able to fully comply with all the Standards and that the Health Board will need to take a risk management approach to the delivery of the standards.
Current Risk Rating 5 x 3 = 15	Additional Comments

Datix ID Number: 1724	HBR Ref Number: 54
Objective: Partnerships for Care	Director Lead: Sian Harrop Griffiths, Director of Strategy Assuring Committee: Health Board/EPRR Strategy Group
Risk: Failure to maintain services as a result of the potential no deal Brexit	Date last reviewed: February 2019

Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 3 x 2 = 6		Rationale for current score: The initial risk assessment is based on the fact that significant work needs to take place to understand the risks in terms of the Health Board's ability to maintain services as business as usual
Level of Control = 70%		Rationale for target score: By undertaking the actions highlighted it is anticipated that the arrangements put in place will ensure business as usual in light of a no deal Brexit.
Date added to the risk register November 2018		

Controls (What are we currently doing about the risk?)

- All services to identify high risks related to Brexit on risk register Engagement in health national groups
- Welsh Government is working with NWSSP procurement to commission a review of devices and consumables supply chain in Wales to complement the work already completed at UK level.
- Welsh Government has put in place national communication and co-ordination arrangements, including:
  - A Brexit Ministerial Stakeholder Advisory Forum made up of senior leaders from across the sector, and led by the Cabinet Secretary for Health and Social Services and the Minister for Children, Older People and Social Care;
  - An EU Transition Leadership Group, chaired by WG focusing on ensuring operational readiness arrangements for both health and social services in Wales (terms of reference attached);
  - Regular meetings of NHS emergency planners, chaired by Welsh Government, as part of established resilience arrangements;
  - A 4 Nations public health group addressing public health associated risks and health security concerns, and a joint Welsh Government – Public Health Wales working group considering specific Welsh issues;
  - Working in partnership with the Welsh NHS Confederation to ensure ongoing flexible and effective communication and engagement between us and other stakeholders in the health and care system; and
  - Regular updates on Brexit to the monthly NHS Wales Executive Board meetings.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
To review and rehearse promptly the existing business continuity and resilience/contingency arrangements, and to do so working with your local and regional partners, including through your local resilience forums.	Director of Strategy	01/04/ 2019
To carry out risk assessments	Director of Strategy	01/04/2019

Assurances (How do we know if the things we are doing are having an impact?)

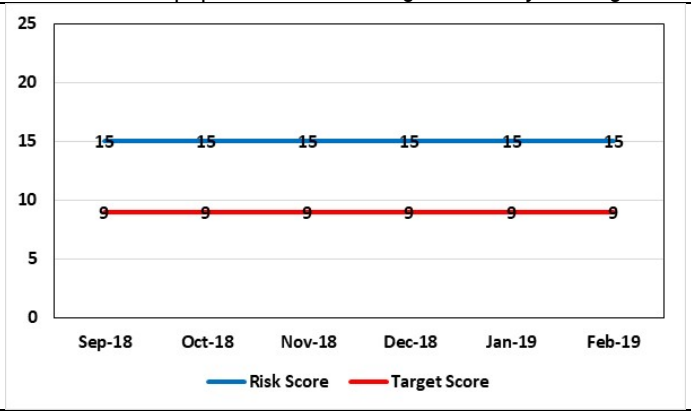
- Work programme in place and monitored via EPRR Strategy Group
- All services to complete business continuity plans

Gaps in assurance (What additional assurances should we seek?)

To understand from the review what arrangements need to be in place to minimise the risks in relation to a potential no deal Brexit.

Current Risk Rating 4 x 5 = 20	Additional Comments There is an obligation to maintain critical services and business as usual in an emergency and this includes Brexit and consequently there is the potential for disruption in commercial and public services and therefore supplies, services, transport, fuel, border issues, EU national issues, immigration, critical infrastructure, energy and command resilience etc.

Datix ID Number: 1764	HBR Ref Number: 55
Objective: Partnerships for Care	**Director Lead:** Director of Transformation **Assuring Committee:** Joint Transition Programme
Risk: Failure to ensure successful implementation of the Welsh Governments decision to realign the Health Boundary, as it applies to the resident population of the Bridgend County Borough.	**Date last reviewed:** January 2019

Risk Rating (consequence x likelihood): Initial: 3 x 5 = 15 Current: 3 x 5 = 15 Target: 3 x 3 = 9		Rationale for current score: • The current score reflects the programme arrangements in place and that there is a programme structure and critical path to achieve the 1 April 2019 timescale.
Level of Control = 70%		Rationale for target score: • As the critical milestones are achieved the target score reflects assurances required to deliver the programme within the timescales set.
Date added to the risk register November 2018		

Controls (What are we currently doing about the risk?)

- Joint Transition Board in place across ABMU HB and CTUHB
- Programme Management Arrangements in place
- Programme Director / Team appointed
- Agreed work streams established along with related reported arrangements
- Internal Audit involvement being agreed
- External Audit (critical Friend observer status) on Transition Board
- Strong Partnership arrangements already established which are a strong platform to deliver the revised legislative programme / change. .

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Ensure delivery of the Programme's agreed milestones	Director of Transformation	April 2019
That established work streams deliver on their key products and routinely provide exception reports into Programme Structure	Director of Transformation	April 2019
Ensure partners remain involved and updated on related progress and play their part where appropriate to deliver the requirements of the change.	Director of Transformation	April 2019

Assurances (How do we know if the things we are doing are having an impact?)

- Compliance with the revised legislative changes proposed as a consequence of the Bridgend Boundary change.

Gaps in assurance
(What additional assurances should we seek?)

Current Risk Rating 3 x 5 = 15	Additional Comments

Risk Score Calculation

For each risk identified, the LIKELIHOOD & CONSEQUENCE mechanism will be utilised. Essentially this examines each of the risks and attempts to assess the likelihood of the event occurring (PROBABLILITY) and the effect it could have on the Health Board (IMPACT). This process ensures that the Health Board will be focusing on those risks which require immediate attention rather than spending time on areas which are, relatively, a lower priority.

Risk Matrix	LIKELIHOOD (*)				
CONSEQUENCE (**)	1 - Rare	2 - Unlikely	3 - Possible	4 - Probable	5 - Expected
1 - Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 - Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25

INSERT NEW HEALTH BOARD LOGO

Risk Management Framework

Author: ***Patient Feedback Team***

Policy Owner: ***Risk Management Department***

Approved by: ***Health Board***

Issue Date: ***April 2019***

Review Date: *September 2019*

Policy ID:

This policy has been screened for relevance to equality. No potential negative impact has been identified so a full impact assessment is not required

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1. Risk Management Statement

Swansea Bay University Health Board ("Health Board") is committed to providing safe and effective, high quality healthcare. We mandate a culture and environment, which minimises and actively seeks to reduce risk and promotes the health, safety and well-being of patients, staff, visitors and the general public.

The Health Board recognises that all health service activity carries risks including harm to patients which need to be managed through a systematic framework. This will ensure that risks to patient and staff safety and the organisations objectives are identified, assessed, eliminated or minimised so far as is reasonably practicable. The aim being to minimise the chance of the risk being realised, although where this has not been possible then we will review, learn and share the learning to minimise the likelihood of reoccurrences in an open and fair culture.

All staff have a responsibility for promoting risk management, adhering to Health Board policies and have a personal responsibility for patients' safety as well as their own and colleagues health and safety. The Health Board encourages staff to take ownership of their responsibilities through a two-way communication process, with appropriate training and support, to identify and manage risk. To support the development of good risk management practice in the organisation we aim to ensure:

- the risk management process is robust, integral to the day to day operation of the organisation, consistent and supports the achievements of the Health Board's objectives;
- we have a safe environment for patients, staff and visitors through the identification of hazards and the management of risks;
- there is an open and fair culture and staff can highlight and discuss risks openly;
- risk management is linked to clinical audit to prioritise risk based audits and risks identified following audit are risk assessed and managed;
- the level of risk appetite is clear and tolerance is defined to support innovation at an agreed level of risk;
- we provide a safe, high quality service promoting continuous improvement;
- awareness of risk management is raised through education/training and guidance to ensure awareness and effective management of potential hazards/risks and how they can be minimised;
- there is a culture of learning from everything we do to improve safety in the Health Board, compliance with legislation and continuous improvement by using the Health & Care Standards in Wales as a framework;
- roles, responsibility and accountability for risk management is clear and well documented within policies, procedures and Job Descriptions;

Ensuring robust risk management systems are in place will enable the organisation to:

- be proactive rather than reactive;
- identify and treat risks within the organisation;
- improve identification of opportunities and threats;
- comply with legislation and regulations.

…… ……

Signed: **Chief Executive** **Date**

2. Introduction

Risk Management is a process based upon good governance practice and is an integral part of the Health Board's approach to ensure it achieves its objectives and protects patients, service users, staff, and the public and other stakeholders against all kinds of risks. Organisations encounter risk every day as objectives are pursued and in conducting appropriate oversight, both management and Board must deal with the fundamental question of how much risk is acceptable in pursuit of those objectives.

Good risk management awareness and practice at all levels is considered a critical success factor for the Health Board as managing risk is inherent in everything that we do: treating patients, determining service priorities, managing projects, purchasing new medical equipment, taking decisions about future strategies, or even deciding where it is appropriate not to take any action at all. This document sets out the Board's strategy regarding Risk Management confirming the accountability and structural arrangements. The Health Board recognises that success will depend upon the commitment of staff at all levels, and the development of a culture of openness within a learning environment will be an important factor.

3. Scope

This strategy applies to all employees of the Health Board and those seconded to work in the organisation. There will be an active lead from managers at all levels to ensure that risk management is a fundamental part of the total approach to health and social care governance, service delivery and corporate governance.

Independent contractors are not explicitly included within these responsibilities, the Health Board supports the adoption of this strategy and related policies/procedures, or similar, by independent contractors as good employment and professional practice.

4. Risk Management in Swansea Bay University Health Board

Risk Management is having in place a corporate and systematic process for evaluating and addressing the impact of risk in a cost effective way and having staff with the appropriate skills to identify and assess the potential for risk to arise.

A risk management system should consider the full range of the organisations' activities and responsibilities and constantly check that various good management disciplines are in place. The Health Board will therefore regularly seek assurance that the following disciplines are in place:

- Well defined strategies & policies are put into practice in all relevant parts of the organisation and are regularly reviewed;
- High quality services are delivered efficiently and effectively;
- Performance is regularly and rigorously monitored with effective measures implemented to tackle poor performance;
- Compliance with legislation and regulations;
- Information used by the Health Board is relevant, accurate, reliable and timely;
- Financial resources are safeguarded by being managed efficiently and effectively;
- Human and other resources are appropriately managed and safeguarded.

The Health Board's risk management system will also support the compilation of both the Annual Governance Statement and the Annual Quality Statement.
Risk Management is an iterative process consisting of well defined steps which, taken in sequence, support better decision making by contributing a greater insight into risks and their impacts. It is also a dynamic process and as such will require different groups and individuals to be involved in the process at different times. The Health Board recognises that Risk Management is an integral part of good management practice.

The Health Board will therefore integrate risk management into the day to day management and business plans aligned to its corporate objectives and not practiced as a separate programme. This is a key concept in risk management becoming the business of everyone in the organisation.

The risk management system will ensure that:

- Objectives are clear and understood across the organisation;
- Risks to the achievement of objectives are identified;
- Effective controls, understood by those expected to apply them, are in place to mitigate the risk;
- The operation of controls is monitored by management with any gaps being rectified;
- Accountability for the effective operation of controls;
- Assurances are reviewed and acted on.

ABMU will achieve the above by:

- Effective objective setting;
- Effective learning and responsive management action, with dissemination of lessons learnt;
- Effective employee engagement &provision of training and advice to managers and staff;
- Effective liaison with enforcing authorities, regulators and assessors;
- Effective Committee structures with appropriate reporting arrangements;
- Formulation of appropriate policies and procedures ;
- Investigation of concerns and implementation of remedial actions;
- Systematic identification & control of risks.

5. Partners/Stakeholders

An environment where services and projects are increasingly being delivered through partner organisations puts a premium on successful risk management. The Health Board recognises that good risk management is integral to delivering successful partnerships.

The Health Board recognises that although delivering services through partners can bring significant benefits and innovation, it has less direct control than if delivering them alone. It is also recognised that partnerships can lead to a high level of uncertainty and that there are risks around failing to align agendas and ineffective communication.

The diversity of different cultures in partnerships requires an understanding of the diverse perceptive on risk and the arrangements for managing them. Separate statutory responsibilities and separate lines of accountability (e.g. as with Local Authorities) have

to be managed. The terms of any agreements between such partners may be less explicit than in a typical contract with very little explicit agreement of risk management responsibilities. The Health Board therefore endeavour to ensure that any such contracts/agreements, some of which may be with long term partners, should at an early stage in negotiation, agree on ownership of action to address risks and have clarity on what risks have been transferred. Taking these steps will reduce the possibility of unhelpful behaviour should a risk materialise.

Clarity as to where partner's objectives overlap and can therefore be aligned to address a common goal with common risks as opposed to where they are fully independent. A common understanding of the objectives of the partnership should assist in reaching a common understanding of the risks and how they can be managed and clarity of who is responsible for and manages which risks is also essential. Such arrangements should be incorporated into partnership agreements.

The Health Board will also develop its partnership arrangements to include clear agreements on what information is provided and by whom, for monitoring purposes.

6. Projects and Strategic Policy Decisions

Programme or Project Risk(s) relate to risk(s) relating to a Programme or Project which may impact on the delivery of the project. A project may be defined as the process of carrying out work to achieve a clear objective, usually bringing about a change, and will normally have a set of characteristics:

Agreed, well defined documented set of objectives and end products;

- A start and end point which brings about change;
- A definition which sets out what is included and excluded from the project;
- A plan which takes account of timescales, costs and quality;
- A defined set of tasks – which will often be interrelated and can be grouped into phases or work areas;
- An agreed set of staff and resources- who should have an agreed dedicated level of time to carry out the tasks;
- Access to a wider community of interested parties;
- A well defined plan, with constraints issues and risks communicated and managed;
- A prescribed set of benefits and outcomes which can be measured – before and after the project, leading to a successful conclusion on time to budget and meeting expectations.

All discrete/significant projects or strategic policy decisions, within the Health Board must be risk assessed using the agreed risk management procedure. Each Project Manager within the Health Board must undertake risk assessments of their designated projects at the beginning of the project with each project required to have a separate risk register.

The management of the project's risk register must be a standing agenda item at all Project Board (or equivalent) meetings, where risks must be reviewed and updated as appropriate.

Any changes identified and agreed by the project team must then be reported to the appropriate overarching Committee/Executive Lead with responsibility for reviewing the

project. One overarching risk which covers the whole programme or project will then be added to the relevant risk register and escalated to a Corporate Executive Director Risk Register and if appropriate to the Health Board Risk Register.

Where ABMU is involved in projects which are managed through third parties who utilise a different project methodology, a clear protocol will be established which identifies how risks held in the project format or system will be escalated to the risk register. There may be projects that require formal project methodology which is fully documented within a Project Initiation Document, detailing all project risks which are known and are included in any associated Business Case. A formal project approach using or based upon a recognised project methodology will reduce the associated risks within a project.

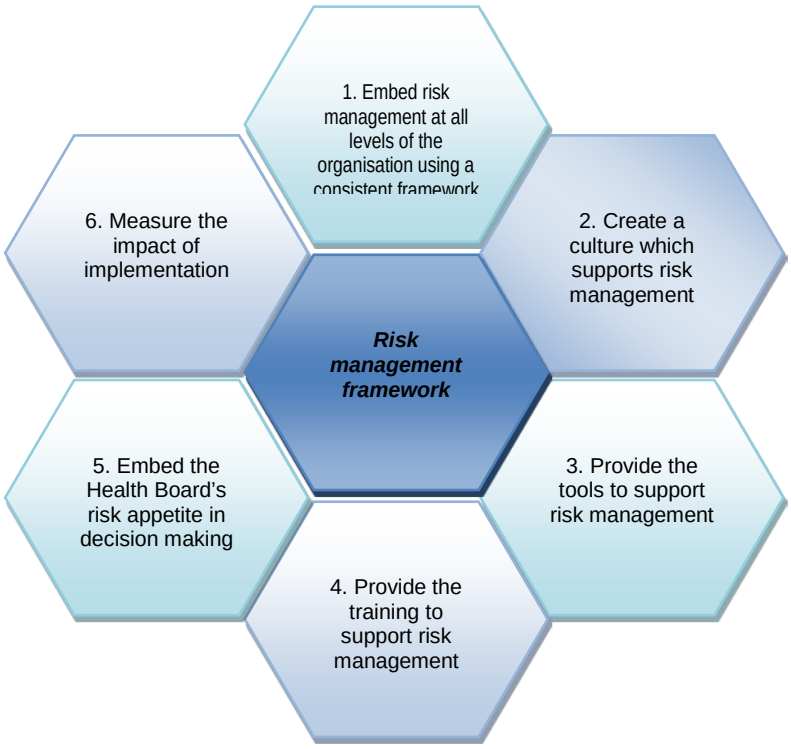
7. Framework Objectives

The aim of this framework is therefore to strengthen the existing risk management framework, embed risk management at a local level and ensuring appropriate escalation of risks through the organisation to the Board, supported by training and tools. It is based on the principles of a risk-based approach to managing an enterprise, integrating concepts of governance, assurance, and strategic planning. The aim being to embed risk management in the day to day running of an organisation and to understand the broad spectrum of risks facing the organisation to ensure they are appropriately managed.

The key aims of this framework are to achieve greater local level ownership of risk, enhanced clarity regarding roles and responsibilities for risk management and strengthened governance arrangements to support the current framework.

The risk management framework has six key objectives which are detailed in diagram 1:

Diagram 1:



The overall vision of the strategy is:-

'*To continually improve the maturity of the risk management framework that supports the Board in its oversight and Management of risks to the achievement of Health Board objectives*'

The strategy is supported by an implementation plan, with objectives to support the achievement of the aims of the strategy. Both strategy and implementation plan will be reviewed each year. Implementation of the strategy will be monitored by the Executive Team and Audit Committee.

The implementation will be in two main phases:

- Design and developing capacity – between April 2019 and September 2019
- Implementation – commencing from October 2019

7.1 Objective 1: Embed risk management at all levels of the organisation

One of the key aims of this strategy will be to ensure greater local ownership of risks. To achieve this, we will introduce risk registers at a more local level within the Service Delivery Units, at Service Group and Specialty level, supported by clear criteria and timeframes for escalation of risks.

To support this greater local ownership of risks, the roles and responsibilities for risk identification, assessment, management and monitoring will be clarified to ensure clear escalation of risks between the different levels of the organisation, from 'ward to Board' with effective scrutiny and challenge.

7.2 Objective 2: Create a culture which supports risk management

Risk culture is a term describing the values, beliefs, knowledge and understanding about risk shared throughout the Health Board and is shaped by the underlying values, beliefs and attitudes of individuals, which are partly inherent but are also influenced by the prevailing culture in the organisation. The culture of the organisation will influence the way it manages risk. Setting the right culture is not achievable without visible support from the highest level within the organisation, which is why overall accountability and responsibility for risk management lies with the Chief Executive & the Board.

The Health Board aims to develop a culture where risk management is viewed positively and seen as an opportunity for learning. As a learning organisation, we are committed to promoting a fair and positive approach seeking to learn from experience rather than highlighting individual's actions. It is acknowledged that exceptional cases may arise where there is clear evidence of wilful or gross neglect that contravenes the policies and procedures of the organisation and/or professional codes of conduct, or where there is repeated evidence of poor performance despite intervention/support, in which case appropriate action will follow. Problems with risk culture are often blamed for organisational difficulties and an effective risk culture is one that enables and rewards individuals. A good risk culture will facilitate the better management of risk and will underpin the Health Board's ability to work within its risk appetite.

A key component of an effective and mature risk management framework is having a culture of knowledge and understanding of risk management, and leadership. This means that roles and responsibilities need to be clearly defined so that risk management is 'owned' by appropriate members of staff and that staff are encouraged to be more risk aware by promoting openness and supporting them to manage risks locally where

possible. It also means visible and effective leadership from the Board in ensuring effective systems and processes for the management and escalation of risks.

As well as structure, a mature risk management framework requires risk management to be at the heart of Board level discussion. To enhance the maturity of existing conversations at Board level, one of the aims of this strategy is to create a clear link between assurance, risk management, corporate governance and regulation. Using an agreed risk appetite matrix, the Board can set out a framework within which all risk should be considered, linking objectives, business planning and risk appetite. This will also help to develop an approach that engenders risk forecasting.

7.3. Objective 3: Provide the tools to support risk management

For a risk management system to work effectively it is important that the language used to describe risks is the same throughout the organisation and that risk registers are consistent in format. Standardisation of the platform for risk registers also provides an efficient mechanism for escalation and de-escalation. All operational risks rated 16 and above have been entered on the Datix Risk module and the aim will be to ensure that all risk registers used within the organisation use the Datix Risk module, to provide a single, integrated platform for risk registers.

A standardised format of registers will also be applied across the organisation. The Health Board risk register acts as an assurance tool for the Board as well as a management tool for the management of risks that have come from either 'top-down' from risk assessment of strategic objectives, or 'bottom-up' from aggregation or escalation of risks from Service Delivery Units or Corporate Directorate risk registers.

7. 4. Objective 4: Provide the training to support risk management

In order to develop the requisite culture for risk management and to ensure successful implementation of this strategy, there needs to be a structured, organisation-wide training programme for staff.

Risk management training will be reviewed and developed to provide training at three levels:

Level 1 – will provide a basic introduction to the concepts of hazards and risks, provided as an e-learning package and available on the following link: http://broiis1/elearning/log/login.asp.Training is a requirement at induction and is also encouraged for all members of staff to ensure a basic awareness of risk management.

Level 2 – will provide training to Ward Managers, Department Managers and Service Managers and will aim to support them in understanding how to mitigate, manage and escalate risk, controls and action planning.

Level 3 – aimed at Directors, Executive Directors and Non Officer Members.

As well as including training in the Health Board's risk management processes, we will use the organisation-wide programme to help to embed a consistent language of risk management, including concepts such as controls, mitigations, assurances, residual risk and proximity. This will enhance the quality of conversation and consistency of approach.

We will therefore review the existing training programme and training materials to ensure appropriate knowledge and skills in risk management at different levels of the organisation.

7.5. Objective 5: Embed the Health Board's risk appetite and tolerance in decision making

Risk appetite is the degree of risk exposure, or potential adverse impact from an event, that the Health Board is willing to accept in pursuit of its objectives. H M Treasury has defined risk appetite as "The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time" and the guidance indicates that if no formal statement on its risk appetite is made by an organisation, control problems will be experienced.

No organisation, whether in the private, public or third sector can achieve its objectives without taking a risk. The question for the decision-makers is how much risk do they need to or are prepared to take?

The UK Corporate Governance Code states that "the Board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic decisions". As well as meeting the requirements imposed by corporate governance standards, organisations are increasingly being asked to express clearly the extent of their willingness to take risk to meet their strategic objectives.

Risk appetite, correctly defined, approached and implemented, should be a fundamental business concept that makes a difference to how organisations are run.

The strategy aims to develop an approach to risk appetite that is practical and pragmatic, and that makes a difference to the quality of decision-making, so that decision-makers understand the risks in any proposal and the degree of risk to which they are permitted to expose the organisation while encouraging enterprise and innovation.

The Board recognises the importance of a robust and consistent approach to determining risk appetite in order to ensure:

 The Health Board's collective appetite for risk and the reasons for it are widely known to avoid erratic or inopportune risk taking, or an overly cautious approach which may stifle growth and development;

 Managers throughout the organisation know the levels of risks that are legitimate for them to take, as well as appropriate opportunities when they arise, in order to ensure service improvements and patient outcomes are not adversely affected.

The Health Board uses the following principles/definitions, to be applied to the key business drivers in **Table 1** below, in determining risk appetite:

Table 1

Assessment	Description of potential effect
Very High Risk Appetite 5	The Health Board **accepts risks that are likely** to result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / service users.
Upper threshold	
High Risk Appetite 4	The Health Board **is willing to accept risks that may result** in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / service users.
Moderate Risk Appetite 3	The Health Board **is willing to accept some risks in certain circumstances that may** result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / service users.
Low Risk Appetite 2	The Health Board **aspires to avoid (except in very exceptional circumstances) risks that may** result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / service users.
Zero Risk Appetite	The Health Board **aspires to avoid risks under any circumstances that may** result in reputation damage, financial loss or exposure, major breakdown in services, information

Setting a risk appetite is only a worthwhile exercise if the organisation is able to manage the risk to the level at which it is set. Taking the above factors into account, the Health Board's overarching risk appetite, outlines its approach to risk in relation to four key areas of the business: quality, finances, performance and reputation.

The Health Board has considered ten key areas, linked to the strategic aims of the organisation, and the risk appetite for each is detailed in **Table 2**

Table 2

Key Business Drivers/ Strategic Aim	Risk Appetite	Description
Patient Safety	2 - low	We will continue to hold the safety of people who use services in the highest regard and, at all times, act to avoid risk and uncertainty. Only in exceptional circumstances would the Board have an appetite to make a decision that may jeopardise it. This key value driver directly supports our core objective to improve the safety of our

		services to patients. The preference is for ultra-safe delivery options with a low degree of inherent risk.
Quality	2/3 – low/ moderate	We will continue to provide high quality services ensuring value for money in a competitive arena and, depending on the circumstances will accept some risks that could limit our ability to fulfil this objective. This key value driver directly supports our core objective to improve the experience of people using our services, and that of their carers" and relatives, by providing personalised and responsive services The preference is for safe delivery options that have a low degree of inherent risk and may have only limited reward potential.
Workforce/OD/ Staffing	2 - low	We will continue to employ and retain staff that meet the high quality standards of the organisation and provide on-going training to ensure all staff reach their full potential, always mindful of the professional and managerial capacity and capability of the organisation and staff well-being. In certain circumstances we will accept risks associated with the delivery of this aim. The preference is for ultra-safe delivery options with low degree of inherent risk and only for limited potential.
Finance	2 - low	We will strive to deliver our services within the available income as laid out in the financial plan and will not accept risks that if realised might cause us to exceed the financial plan. This key value driver directly supports our value to maximise our use of resources and deliver cost effectiveness.
Public confidence/ Reputation	3 - moderate	We will continue to maintain high standards of conduct and care delivery and will only accept risks in certain circumstances that if realised could cause loss of public confidence / reputational damage to the organisation.
Compliance with Legislation	1/2 - zero/low	We will continue to comply with all legislation relevant to the organisation. Avoidance of risk and uncertainty is a key objective, with a preference for ultra-safe delivery options to mitigate risks that if realised could result in non-compliance with legislation.
Environment & Estates	3 - moderate	We are willing to accept some risks in the pursuit of estates development and rationalisation but with preference for safe delivery options for both staff and patients. We will continue to encourage a culture of sustainability to fulfil our environmental duties taking account of the impact of future environmental changes on our organisational ways of working.
Service/Business Interruption	2 - low	We will avoid, except in very exceptional circumstances, any risks that may cause disruption or compromise operational areas.
Partnership working	4 - high	We will continue to work with other organisations to ensure we are delivering the best possible service to our patients/service users and are willing to accept risks associated with this collaborative approach. This will include the ways in which the behaviour of the organisation or any of its partners affects each other. This key value driver directly supports our core objectives to strengthen and deepen our partnerships to ensure patients, carers and stakeholders receive seamless service.
Maximise innovation and the use of technology	4 - high	We will continue to encourage a culture of innovation within the organisation and are willing to accept risks associated with this approach. This will include risks associated with the capacity to deal with the pace/scale of technological change, or the ability to use technology to address changing demands. This key value driver directly supports our value to foster innovation.

Risk Tolerance

Whilst risk appetite is about the pursuit of risk, tolerance is about what the organisation is allowed to deal with. In the vast majority of cases, the appetite will be smaller than the risk tolerance, which can be expressed in terms of absolutes, e.g. “the Health Board will not perform certain types of surgical operations”.

Risk tolerance differs from risk appetite in that it is:

- Derived from risk appetite;
- Looks at risk at a granular level (e.g. on specific risk, at a transactional level);
- Measured in the form of limits (financial risks) and thresholds (non-financial risks);
- Assists in day to day/operational decision making.

7.6. Objective 6: Measure the impact of implementation

There is a need to measure the impact of the strategy, to measure its effectiveness in developing the maturity of the Health Board’s risk management framework. Therefore the strategy will be reviewed together with the implementation plan on an annual basis and an annual risk maturity assessment, using an adapted version of the HM Treasury Risk Management Assessment Framework.

This tool provides a flexible tool to assist in evaluating performance and progress in developing and maintaining effective risk management capability and assessing the impact on delivering effective risk handling and required/planned outcomes. It tests the framework in the following seven areas:

Capabilities

1. **Leadership:** do senior management and Clinical leaders support and promote risk management?
2. Are **people** equipped and supported to manage risk well?
3. Is there a clear risk **strategy** and risk **policies**?
4. Are there effective arrangements for managing risks with **partners**
5. Do the organization’s **processes** incorporate effective risk management?

Risk Handling

6. Are **risks handled well**?

Outcomes

7. Does risk management contribute to **achieving outcomes**?

8. Equality Impact Assessment

As part of its development, the Strategy was screened to determine whether it should be subject to an equality impact assessment. No potential negative impacts were identified on particular groups of people protected under the Equality Act 2010. It was concluded that a full equality impact assessment was not needed.

9. References

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