Meeting Date	**28 November 2019**	**Agenda Item**	**2.4**
Report Title	**Health Board Risk Register**		
Report Author &	Hazel Lloyd, Head of Patient Experience, Risk & Legal Services		
Report Presented by	Pam Wenger, Director of Governance		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to provide the Board with an update on progress to revise the Health Board Risk Register (HBRR) and development of the Risk Management Policy.		

Key Issues	• Two Executive Team sessions on risk management were held in July and September 2019.
	
	• Executive Directors have updated their risk entries and following discussion of the full HBRR agreed that the highest risks facing the Health Board delivering against its objectives are rated 20 and relate to:
	
	  • Unscheduled Care
	  • Infection Control
	  • Trans-catheter Aortic Valve Implementation (TAVI)
	  • Ophthalmology Clinic Capacity
	  • Access and Planned Care
	  • Access to Cancer Services
	  • Screening for Fetal Growth Assessment in line with Gap-Grow (G&G)
	  • H&S Infrastructure
	  • Integrated Medium Term Plan (IMTP) Statutory Responsibility
	  • Financial Plan
	  • Sustainable Corporate Services
	  • Cardiotocography (CTG) Monitoring on Labour Wards
	
	• Risk Management Workshop was held in September with the aim of reviewing the Unit IMT Plans and their Unit risk registers to align the two processes. This work		

<table>
<tr><td></td><td colspan="4">is informing and supporting the Board Assurance Framework (BAF).

• The Audit Committee has received the complete HBRR and draft Risk Management Policy in November 2019.

• The HBRR entries have been aligned to the sub Committee of the Board and the sub Committees will receive quarterly reports from January 2020 onwards.</td></tr>
<tr><td rowspan="2">Specific Action Required
(please choose one only)</td><td>Information</td><td>Discussion</td><td>Assurance</td><td>Approval</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☒</td></tr>
<tr><td>Recommendations</td><td colspan="4">Members are asked to:
• NOTE the updated Health Board Risk Register and the risks assigned to the Board and its Committees; and
• APPROVE the Risk Management Policy noting this has been considered by the Audit Committee in November 2019 for ratification.</td></tr>
</table>

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); and
- development of the Risk Management Policy.

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 health board 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

Two Executive Team sessions on risk management were held in July and September 2019 following which updates and changes from the Executive Team were received. The revised HBRR is attached as **Appendix 1.**

3.2 Highest Scoring Risks on the HBRR

Following a review of the Health Board Risk Register and Executive updates received, the top risks facing the Health Board, in terms of delivering against our objectives, are identified based on a risk rating of 20 and above. Currently, there are twelve risks rated as 20 as detailed in **Table 1.**

Table 1

Ref	Risk Title	Risk Rating	Health Board Objective	Health & Care Standard	Executive Lead
1	Unscheduled care	20	Best Value Outcomes from High Quality Care	Timely Care	Chief Operating Officer
4	Infection Control	20	Best Value Outcomes from High Quality Care	Infection, Prevention, Control & Decontamination	Director of Nursing & Patient Experience
16	Access to Planned Care	20	Best Value Outcomes from High Quality Care	Timely Care	Chief Operating Officer
39	IMTP Statutory Responsibility	20	Demonstrating Value & Sustainability	Managing Risk	Director of Strategy
42	Financial Plan	20	Demonstrating Value & Sustainability	Managing Risk	Director of Finance
49	TAVI Service	20	Best Value Outcomes from High Quality Care	Timely Care	Medical Director
50	Access to Cancer Services	20	Best Value Outcomes from High Quality Care	Timely Care	Medical Director
58	Ophthalmology Clinic Capacity	20	Best Value Outcomes from High Quality Care	Timely Care	Chief Operating Officer
13	H&S Infrastructure	20	Demonstrating Value & Sustainability	Managing Risk & Promoting Health & Safety	Director of Nursing & Patient Experience
62	Sustainable Corporate Services	20	Demonstrating Value & Sustainability	Managing Risk	Chief Executive
63	Screening for Fetal Growth Assessment in line with Gap-Grow (G&G)	20	Best Value Outcomes from High Quality Care	Timely Care	Director of Nursing & Patient Experience
65	CTG Monitoring on Labour Wards	20	Best Value Outcomes from High Quality Care	Timely Care	Director of Nursing & Patient Experience

The remaining risks on the Health Board Risk Register are set out in **Table 2.**

Table 2

Ref	Risk Title	Risk Rating
3	Workforce/Recruitment of Medical & Dental Staff	16
45	Discharge Information	16
11	Healthcare Model for Aging Population	16
57	Non Compliance with Home Office Controlled Drug Licencing	16
43	The Deprivation of Liberty Safeguards (**DoLS**) Authorisation & Compliance with Legislation	16
48	Child & Adolescence Mental Health Service (CAHMS)	16
37	Information led Decisions	16
51	Compliance with Nurse Staffing Levels	16
61	Paediatric Dental GA Service - Parkway	16
53	Compliance with Welsh Language Standards	15
54	No Deal Brexit	15
60	Cyber Security	15
13	Environment of Premises	12
55	Bridgend Boundary Service Change	12
15	Population Health Improvement	15
27	Sustainable Clinical Services for Digital Transformation	12
36	Electronic Patient Record	12
44	Emergency Department Information Systems	12
52	Engagement & Impact Assessment Requirements	12

The total HBRR entries aligned to sub Committees of the Board are detailed in Table 3.

Table 3

Strategic Objective	Risk Reference	Description of risk identified	Scrutiny Committee
Best Value Outcomes from High Quality Care	1 (738)	**Unscheduled Care** Failure to comply with Tier 1 target for Unscheduled Care could impact on patient and family experience of care.	Quality and Safety Committee
	4 (739)	**Infection Control** Failure to achieve infection control targets set by Welsh Government could impact on patient and family experience of care.	Quality and Safety Committee
	11 (837)	**Ageing Population** Failure to provide an appropriate healthcare model for the ageing population over the next 20 years could impact on patient and family experience of care.	Quality and Safety Committee
	13 (814)	**Environment of HB Premises** Failure to meet statutory health and safety requirements.	Health and Safety Committee
	64 (2159)	**Health and Safety Infrastructure** Insufficient resource and capacity of the health, safety and fire function to maintain legislative and regulatory compliance.	Health and Safety Committee
	16 (840)	**Access to Planned Care** Failure to achieve compliance with waiting times, there is a risk that patients may come to harm. Also, financial risk not achieving targets.	Performance and Finance Committee
	37 (1217)	**Information Led Decisions** Operational and strategic decisions are not data informed.	Audit Committee
	39 (1297)	**Approved IMTP – Statutory Compliance** 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".	Performance and Finance Committee

	41 (1567)	**Fire Safety Compliance** Fire Safety notice received from the Fire Authority – MH&LD Unit. 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.re safety regulations.	Health and Safety Committee
	42 (1398)	**Financial Plan** If the Board is unable to successfully deliver a sustainable service and develop a balanced financial plan to support the Statutory Breakeven Financial Duty.	Performance and Finance Committee
	43 (1514)	**Deprivation of Liberties** 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.	Quality and Safety Committee
	48 (1563)	**CAMHS** Failure to sustain Child and Adolescent Mental Health Services (CAHMS).	Performance and Finance Committee
	49 (922)	**Trans-catheter Aortic Valve Implementation (TAVI)** Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)	Quality and Safety Committee
	63 (1605)	**Screening for Fetal Growth Assessment in line with Gap-Grow** Due to the scanning capacity there are significant challenges in achieving this standard.	Quality and Safety Committee
	50 (1761)	**Access to Cancer Services** Failure to sustain services as currently configured to meet cancer targets could impact on patient and family experience of care.	Performance and Finance Committee
	57 (1799)	**Controlled Drugs** Non-compliance with Home Office Controlled Drug Licensing requirements.	Audit Committee
Excellent Staff	3 (843)	**Workforce Recruitment** Failure to recruit medical & dental staff	Workforce and OD Committee
	51 (1759)	**Nurse Staffing (Wales) Act** Risk of Non Compliance with the Nurse Staffing (Wales) Act	Workforce and OD Committee,

	62 (2023)	**Sustainable Corporate Services** Health Board's Annual Plan and organisational strategy, and with the skills, capability, behaviours and tools to successfully deliver in support of the whole organisation, and to do so in a way which respects and promotes the health and well-being of our staff and their work-life balance.	Workforce and OD Committee
Digitally Enabled Care	27 (1035)	**Sustained Clinical Services** Inability to deliver sustainable clinical services due to lack of digital transformation.	Audit Committee
	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 if	Audit Committee
	45 (1565)	**Discharge Information** If patients are discharged from hospital without the necessary discharge information this may have an impact on their care	Audit Committee
	(2003)	**Cyber Security – High level risk** The level of cyber security incidents is at an unprecedented level and health is a known target.	Audit Committee
	65 (329)	**CTG Monitoring on Labour Wards** Risk associated with misinterpreting abnormal CTG readings in delivery rooms.	Quality and Safety Committee

Partnerships for Improving Health and Wellbeing	58 (146)	**Ophthalmology - Excellent Patient Outcomes** There is a failure to provide adequate clinic capacity to support follow-up patients within the Ophthalmology specialty.	Quality and Safety Committee
	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.	Quality and Safety Committee
	61 (1587)	**Paediatric Dental GA Service – Parkway** Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.	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	Performance & Finance Committee
	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.	Health Board (Welsh Language Group)
	54 (1724)	**Brexit** Failure to maintain services as a result of the potential no deal Brexit	Health Board (Emergency Preparedness Resilience and Response)
	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.	Performance and Finance Committee

The HBRR entries have been aligned to the sub Committee of the Board and the sub Committees, as identified in Table 3, will receive quarterly reports from January 2020 onwards.

4. Risk Management Policy

The Risk Management Policy has previously been reported, in draft, to the July and November Risk Management Group meetings and Audit Committee in November. Comments have been used to update the document and the main comments received are detailed in Table 4, together with the decision is relation to whether the change has been accepted or declined.

Table 4

Page/Section	Current	Proposed Change	Decision
Page 6, section 4.3	Refers to Directorate Risk Registers. Section refers to the Executive Directors responsibilities in the Scheme of Delegation within the Health Boards Standing Orders.	Clarity was requested in relation to Executive Directors responsibilities for specialty areas eg Health & Safety.	Not Accepted
Page 7, section 4.7	Refers to Unit Directors of Nursing & Patient Experience.	Remove reference to Patient Experience in the Unit Nurse Directors title.	Accepted
Page 7, section 4.7	No reference to the Unit Risk Registers linking to their Integrated Medium Term Plan.	Include reference to the requirement for Unit Risk Registers to be linked to the Integrated Medium Term Plan.	Accepted
Page 7, section 4.8	Ward/Departmental Managers to report risks identified from risk assessments into the Unit's risk register. Clarification sought in terms of the level of risk.	Ward/Departmental risks to be reported into the Unit's risk register when the risks are rated at 9 and above.	Accepted
Page 7, section 4.10	No reference to individual to identify training needs.	Employees to identify training needs.	Accepted
Page 9, section 5.2	Wales Internal Audit Standards	Public Sector Internal Audit Standards	Accepted
Page 9, section 5.4.2	Risk Management Scrutiny Panel role.	Panel role to be expanded to cover receiving themes across the Unit Risk Registers as well as escalated risks from the Units rated at 16 and above.	Accepted

Page/Section	Current	Proposed Change	Decision
Page 11, section 5.4.2.8	Director of Corporate Governance excluded for the list of Corporate Directorates.	Include the Director of Corporate Governance	Accepted
Page 12, section 6.1	Policy refers to risks rated at 16 and above, as a minimum, to be included on the risk management database (RL Datix) risk module.	Risks rated at risk rating 9 and above to be included on the risk management database, risk module.	Accepted
Page 15, Section 6.5.2	No mention of what happens when treatment of risks is out of control.	Section on escalation included – 6.5.5.	Accepted
Page 16, section 6.6	No reference to how risks also relevant to another Health Board can be transferred/reported to another Health Board as actioned for incidents.	Reference as to how risks relating to more than one Health Board can be communicated outside of the Health Board now included.	Accepted.
Page 17, section 8.	No referenced to training being included in Electronic Staff Record.	Reference to Electronic Staff Record now included.	Accepted

The amended Policy is attached as **Appendix 2** for ratification by the Board.

5. RECOMMENDATION

Members are asked to:

- **NOTE** the updated Health Board Risk Register and the risks assigned to the Board and its Committees; and
- **APPROVE** the Risk Management Policy noting this has been considered by the Audit Committee in November 2019 for ratification.

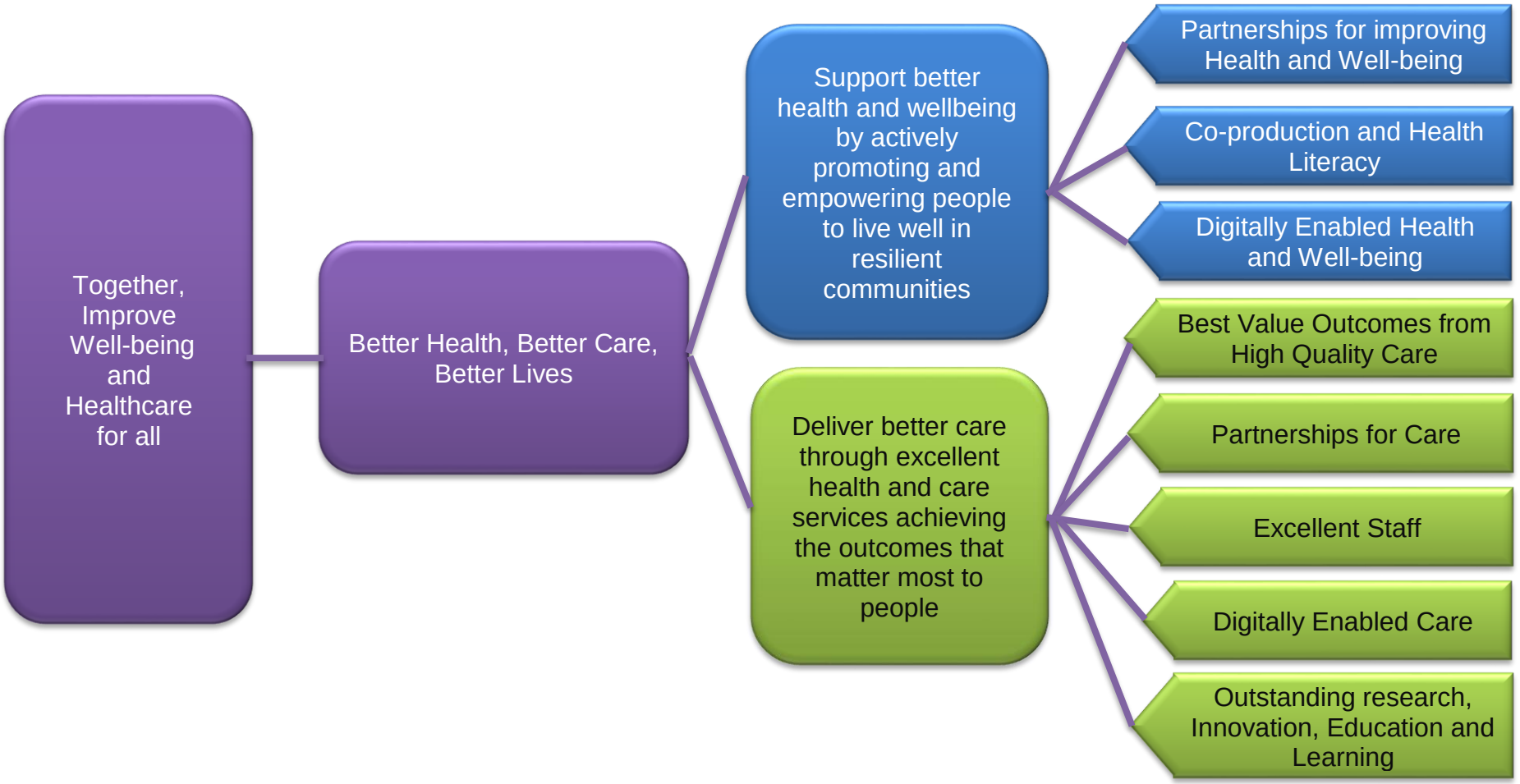
Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
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 bi monthly • Quarterly report to the Audit Committee
Appendices	• Appendix 1: Swansea Bay University Health Board Risk Register November 2019 • Appendix 2: Risk Management Policy

HEALTH BOARD RISK REGISTER
November 2019

Aligning Risk with Swansea Bay University Health Board (SBUHB) Strategy

The Swansea Bay University Health Board (SBUHB) 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 – November 2019

Impact/Consequences						
	5				**1:** Access to Unscheduled Care Service **4:** Infection Control **49:** TAVI Service **58:** Ophthalmology Clinic Capacity **16:** Access to Planned Care Services **50:** Access to Cancer Services **63:** Screening for Fetal Growth Assessment in line with Gap-Grow G&G) **65:** CTG Monitoring in Labour Wards	
	4				**3:** Workforce Recruitment of Medical and Dental Staff **11:** Healthcare Model for Aging Population **51:** Compliance with Nurse Staffing Levels (Wales) Act 2016 **43:** DOLS Authorisation and Compliance with Legislation **45**: Discharge information **48:** Child & Adolescence Mental Health Services **37**: Operational and strategic decisions are not data informed **57:** Non-compliance with Home Office Controlled Drug Licensing requirements **61:** Paediatric Dental GA Service - Parkway	**64:** H&S Infrastructure **39:** IMTP Statutory Responsibility **42:** Financial Plan **62:** Sustainable Corporate Services
	3				**13:** Environment of Health Board Premises **36:** Electronic Patient Record **27:** Sustainable Clinical Services for Digital Transformation **36:** Electronic Patient Record **41:** Fire Safety Regulation Compliance **52**: Engagement & Impact Assessment Requirements **55:** Bridgend Boundary Transition	**15:** Population Health Improvement **54:** No Deal Brexit **53:** Compliance with Welsh Language Standards **60:** Cyber Security
	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)	**Access to Unscheduled Care Service** Failure to comply with Tier 1 target for Unscheduled Care could impact on patient and family experience of care.	25	20	↓	↑	November 2019	Quality and Safety Committee
	4 (739)	**Infection Control** Failure to achieve infection control targets set by Welsh Government could impact on patient and family experience of care.	20	20	↑	→	November 2019	Quality and Safety Committee
	11 (837)	**Ageing Population** Failure to provide an appropriate healthcare model for the ageing population over the next 20 years.	16	16	→	→	November 2019	Quality and Safety Committee
	13 (814)	**Environment of HB Premises** Failure to meet statutory health and safety requirements.	16	12	→	→	November 2019	Health and Safety Committee
	64 (2159)	**Health and Safety Infrastructure** Insufficient resource and capacity of the health, safety and fire function to maintain legislative and regulatory compliance.	20	20	→	→	November 2019	Health and Safety Committee
	16 (840)	**Access to Planned Care** Failure to achieve compliance with waiting times, there is a risk that patients may come to harm. Also, financial risk not achieving targets.	16	20	↑	→	November 2019	Performance and Finance Committee
	37 (1217)	**Information Led Decisions** Operational and strategic decisions are not data informed.	16	16	→	→	November 2019	Audit Committee

39 (1297)	**Approved IMTP – Statutory Compliance** 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	20	↑	→	November 2019	Performance and Finance Committee
41 (1567)	**Fire Safety Compliance** Fire Safety notice received from the Fire Authority – MH&LD Unit. 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.re safety regulations.	15	15	↑	→	November 2019	Health and Safety Committee
42 (1398)	**Financial Plan** If the Board is unable to successfully deliver a sustainable service and develop a balanced financial plan to support the Statutory Breakeven Financial Duty.	12	20	↑	→	November 2019	Performance and 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	→	→	November 2019	Quality and Safety Committee
48 (1563)	**CAMHS** Failure to sustain Child and Adolescent Mental Health Services (CAHMS).	16	16	→	→	November 2019	Performance and Finance Committee

	49 (922)	**Trans-catheter Aortic Valve Implementation (TAVI)** Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)	25	20	↑	→	November 2019	Quality and Safety Committee
	63 (1605)	**Screening for Fetal Growth Assessment in line with Gap-Grow** Due to the scanning capacity there are significant challenges in achieving this standard.	20	20	→	→	November 2019	Quality and Safety Committee
	50 (1761)	**Access to Cancer Services** Failure to sustain services as currently configured to meet cancer targets could impact on patient and family experience of care.	25	20	↑	→	November 2019	Performance and Finance Committee
	57 (1799)	**Controlled Drugs** Non-compliance with Home Office Controlled Drug Licensing requirements.	20	16	↓	→	November 2019	Audit Committee
Excellent Staff	3 (843)	**Workforce Recruitment** Failure to recruit medical & dental staff	20	16	→	→	November 2019	Workforce and OD Committee
	51 (1759)	**Nurse Staffing (Wales) Act** Risk of Non Compliance with the Nurse Staffing (Wales) Act	16	16	→	→	November 2019	Workforce and OD Committee
	62 (2023)	**Sustainable Corporate Services** Health Board's Annual Plan and organisational strategy, and with the skills, capability, behaviours and tools to successfully deliver in support of the whole organisation, and to do so in a way which respects and promotes the health and well-being of our staff and their work-life balance.	20	20	→	→	November 2019	Workforce and OD Committee

Digitally Enabled Care	27 (1035)	**Sustained Clinical Services** Inability to deliver sustainable clinical services due to lack of digital transformation.	16	12	↓	↑	November 2019	Audit Committee
	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 if	20	12	↓	↑	November 2019	Audit 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	16	↓	→	November 2019	Audit Committee
	60 (2003)	**Cyber Security – High level risk** The level of cyber security incidents is at an unprecedented level and health is a known target.	15	15	→	→	November 2019	Audit Committee
	65 (329)	**CTG Monitoring on Labour Wards** Risk associated with misinterpreting abnormal CTG readings in delivery rooms.	20	20	→	→	November 2019	Information Governance Board
Partnerships for Improving Health and Wellbeing	58 (146)	**Ophthalmology - Excellent Patient Outcomes** There is a failure to provide adequate clinic capacity to support follow-up patients within the Ophthalmology specialty.	20	20	→	→	November 2019	Quality and Safety Committee

	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	→	→	November 2019	Quality and Safety Committee
	61 (1587)	**Paediatric Dental GA Service – Parkway** Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.	15	16	→	→	November 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	12	↓	↑	November 2019	Performance & Finance Committee
	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	→	→	November 2019	Health Board (Welsh Language Group)
	54 (1724)	**Brexit** Failure to maintain services as a result of the potential no deal Brexit	15	15	→	→	November 2019	Health Board (Emergency Preparedness Resilience and Response 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.	20	12	↓	↑	November 2019	Performance and Finance Committee

Risk Schedules

Datix ID Number: 738
Health & Care Standard: 5.1 Timely Care

HBR Ref Number: 1

Objective: Best Value Outcomes from High Quality Care

Director Lead: Chris White, Chief Operating Officer
Assuring Committee: Quality and Safety Committee

Risk: If we fail to comply with Tier 1 target – **Access to 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: November 2019

Risk Rating
(consequence x likelihood):
Initial: 4 x 4 = 16
Current: 5 x 4 = 20
Target: 3 x 4 =12

Rationale for current score:
At the end of Quarter performance the Health Board did not achieve performance trajectories.
Due to current pressures in MH A&E it was requested by the Q&S Forum that the risk score was upgraded.

Level of Control
= 50%

Rationale for target score:

Date added to the risk register
26.01.16

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?)

- 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.
- Weekly unscheduled care meeting implemented, led by COO and attended by Service Directors

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Bed utilisation audit being undertaken to support USC system redesign programme in NPT and Swansea.	Assistant Chief Operating Officer	30th November 2019
Clinical services plan for USC is being finalised.	Assistant Chief Operating Officer	30th November 2019
Breaking the Cycle implemented Board-wide for first two weeks of July to help address pressures	Chief Operating Officer	30th November 2019
Implement findings of Kendall Bluck report once supported by Executive Team	Chief Operating Officer	30th November 2019

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

- Executive monitoring/support to achieve improvement plans on a weekly basis.

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

Current Risk Rating
5 x 4 = 20

Additional Comments

Datix ID Number: 739 **Health & Care Standard: 2.4 Infection Prevention & Control & Decontamination**	**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
Risk: Failure to achieve **infection control** targets set by Welsh Government, increase risk to patients and increased costs associated with length of stays.	**Date last reviewed:** November 2019
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 4 = 20 Target: 4 x 3 =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.

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	Assist Dir Nursing Infection Control	13th December 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	29th December 2019
Review of reporting requirements to enable a focus on driving improvement and service delivery	Assist Dir Nursing Infection Control	13th December 2019
Review of environmental cleaning and decontamination	Senior Nurse Infection Prevention Control	13th December 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?)**

• 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.	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 **5 x 4 = 20**	**Additional Comments** Significant progress to date however trajectory not met overall. Work underway on recruitment to IPC, a work plan to improve practice and improved information available for reporting, oversite and also investigation. 13/06/19 Continue to make progress against annual IMTP profiles, however, incidence within the Health Board remains above that for the NHS in Wales. Recruitment to Matron IPC post on 03/06/19. Work in progress to improve incident reporting in relation to infections and pilot to commence on post infection review process. Appropriate environmental decontamination resource to be identified and staff trained in its appropriate use. Compliance with IPC standard precautions and ANTT training and competence needs to be improved. A review of cleaning of shared equipment such as beds, commodes is required to reduce risks of transmission. Increase in cleaning hours across the Units is required to meet national minimum standards. Dedicated protected decant facilities are required for each Unit to ensure appropriate cleaning. Sufficient isolation rooms required to manage patient's appropriately. Estate needs to be updated and maintained to reduce risks. IPCC resources required to support community and primary care. Increase numbers of Piis on the last two months. HB over trajectory on a number of the TI Tier 1 targets. Increased level of risk due to insufficient domestic hours at Singleton hospital and significant vacancies at Morrison, lack of decant facilities, over occupancy in bays.

Datix ID Number: 837 **Health & Care Standard: Staying Healthy 1.1 Health Promotion & Protection & Improvement**		**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:** November 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 Hospital to Home Service Module, Good Care at Home.
Level of Control = 70%		**Rationale for target score:** New models of care will reduce the risk to be at an acceptable level for timely discharges reducing lengthy harmful patient delays from hospital.
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**
• 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 • Close monitoring of the implementation plan via Health Board Clinical Redesign Group • Restructured Dementia Care Steering Group (July 2019) to review and monitor services for those living with Dementia within the Health Board population. • New models of working to commence as phased approach December 2019 – Hospital to Home essentially aims to increase the quality of patient care and patient experiences due to timely discharges from hospital through primarily a Reablement home-based home support using a Trusted Assessor model. Current hospital based assessment will shift to home based assessment which is strengths based and takes place when the person (patient) is not in crisis (in hospital). Jointly developed with Local Authority and Health.	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.	Corporate Head of Nursing	30th November 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 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**	**HBR Ref Number: 13**
Objective: Best Value Outcomes	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee**: Health and Safety Committee
Risk: Health & Safety Compliance – Environment of Premises. Risk relates to compliance in terms of appropriate accommodation in line with Health and Safety Regulations.	**Date last reviewed:** November 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:** HSE issued ten improvement notices. 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	Risk assessments of premises.

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

- 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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Develop a strategy to improve primary & community services estate.	Asst Director Operations	30th November 2019
Develop BJC's to improve the infrastructure of the 3 acute hospital sites (not including NPTH).	Asst Director Operations	30th November 2019

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

- 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

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

Current Risk Rating **4 x 3 = 12**	**Additional Comments**

Datix ID Number: 840 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 16**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee
Risk: Access and Planned Care. If we fail to achieve compliance **with waiting times** there is a risk that patients may come to harm. Further, the health board will face financial risk with Welsh Government if the agreed target is not met.		**Date last reviewed:** November 2019
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 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?)

- 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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
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	30th November 2019
Protect elective capacity during winter period to ensure elective capacity is maintained	Chief Operating Officer	30th November 2019

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

- 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

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

Current Risk Rating **5 x 4 = 20**	**Additional Comments**

Datix ID Number: 1217 **Health & Care Standard: Effective Care 3.1 Safer & Clinically Effective Care**	**HBR Ref Number: 37**
Objective: Best Value Outcomes from Quality Care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Audit Committee
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:** November 2019
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 4 = 16 Target: 4 x 2 = 8	**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?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• 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 mtg tier 1 targets, 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	Investment and implementation of system to record patient outcome measures	Assist Information Business Manager	31st March 2020
	Produce Business Intelligence Strategy and get signed off by the Board	Assist Information Business Manager	29th November 2019
	Produce BI strategy implementation plan outlining investment requirements in capacity and capability	Assist Information Business Manager	31st March 2020

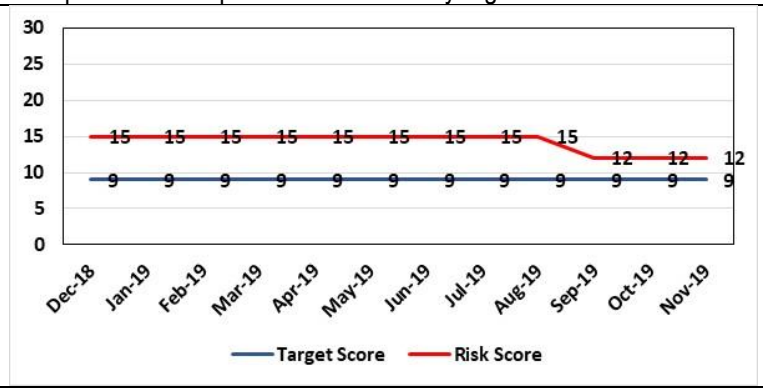
Assurances (How do we know if the things we are doing are having an impact?) More evidence based and proactive decisions being made. Dashboard technology; assist in developing indicators / triangulating information to identify issues	**Gaps in assurance (What additional assurances should we seek?)** 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	**Additional Comments**

4 x 4 = 16	PROMS currently being collected in Lung Cancer (Morriston) August 2019, Cataracts August 2019, Hip & Knee (Morriston) November 2018, and Breast Cancer June 2019 using PKB. Also Heart failure, April 2019, in one Community Clinic.

Datix ID Number: 1297 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**	**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 and breach legislation.	**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee**: Performance and Finance 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:** November 2019
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 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 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 when ready. We have continued the work from January onwards on our detailed plans to submit an approvable IMTP when ready.
	Rationale for target score: If the IMTP is approved 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**
• Organisational Strategy approved by the Board in November 2018 • Clinical Services Plan approved by the Board in January 2019 • Annual Plan submitted to Board and approved in January for submission to Welsh Government, accepted as a draft • Good feedback received on the document. • Due to the complexities of the Bridgend transfer, the CEOs of CTM and SB UHBs have formally asked WG for support to resolve the issues and formal arbitration process was initiated by WG. • The results of the arbitration is now received as is the outcome of the Due Diligence Review. • The Transformation Programme to deliver the Organisational Strategy and CSP including programme approach was established in April 2019 • Continuous planning through our CSP Programme and IMTP process will work up detailed plans to develop an integrated three year plan in line with the national timescales. • The new Operating Model and Delivery Support Team will contribute to delivery of the financial plan. • A decision will be made as to the ability to submit a balanced IMTP in November.	Sign off of Annual Plan 2019/20 by Board – will be submitted in Oct 2019	Director of Strategy	30th November 2019
	IMTP development for 2020 -23 to test approvability with Performance Finance Committee.	Director of Strategy and Director of Finance	30th November 2019
	Draft Plan to Board in November	Director of Strategy	30th November 2019
	Final plan to be submitted to Board for approval for submission to WG.	Director of Strategy	January 2020
Additional Comments	**Gaps in assurance (What additional assurances should we seek?)**		

IMTP Executive Steering Group in place for development of the integrated medium term plan. Integrated Planning Group in place to co-ordinate Transformation and planning activities and approaches • Performance and Finance Plans are be assured by the P&F Committee before presentation to Board •Through monthly IMTP briefings, TI meetings and bi-annual JET meeting with WG – planning approach and emerging plans discussed and WG fully supportive of the direction of travel.	EIA in development for PFC assurance QIAs in development for joint PFC/Q&S assurance
Current Risk Rating **4 x 5 = 20**	

Datix ID Number: 1567 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**	**HBR Ref Number: 41**
Objective: Best Value Outcomes	**Director Lead:** Gareth Howells, Director of Nursing and Patient Experience **Assuring Committee:** Health and Safety Committee
Risk: Fire Regulation Compliance – one improvement notice received relating to MH&LD Unit. 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:** November 2019
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 3 = 12 Target: 3 x 3 = 9 **Level of Control** = 50% **Date added to the risk register** 31/05/2018	
	Rationale for current score: Improvement notice in relation to MH&LD Unit. 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 **Rationale for target score:** 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	31st December 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	31st December 2019
	Replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate	Assistant Director of Strategy & Workforce	31st December 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 **4 x 3 = 12**	**Additional Comments** Professional assessment of panel compliance being taken forward with NWSSP-SES, building control and WG colleagues. W/c 26/8/19 Cladding being removed from East and West end of main block. Escape route on west end redirected with approval of Fire and Rescue Service922

Datix ID Number: 1398 **Health & Care Standard: Staff Resources 7.1 Workforce**		**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: Financial Plan - The Board is unable successfully to deliver sustainable services and develop a **balanced financial plan** to support the Statutory Breakeven Financial Duty.		**Date last reviewed:** November 2019
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 4 = 20 Target: 2 x 3 = 6		**Rationale for current score:** In 19/20 the Health Board has developed a balanced financial plan to support the Statutory Breakeven Financial Duty. However a number of risks have been identified which may result in the breakeven duty not being met in this financial year. Ability to deliver required level of savings; Cost pressures in excess of plan emerge are unable to be managed; Impact of diseconomies of scale following the Bridgend Boundary Change are unable to be mitigated in full during 2019/20; Delivery risks considered too high by Welsh Government and the additional funding support provided in recognition of operational and financial performance improvement is withdrawn; Target set by WG. Improving likelihood due to enhanced controls and mitigating actions and opportunities, led by delivery support team and support by KPMG.
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		

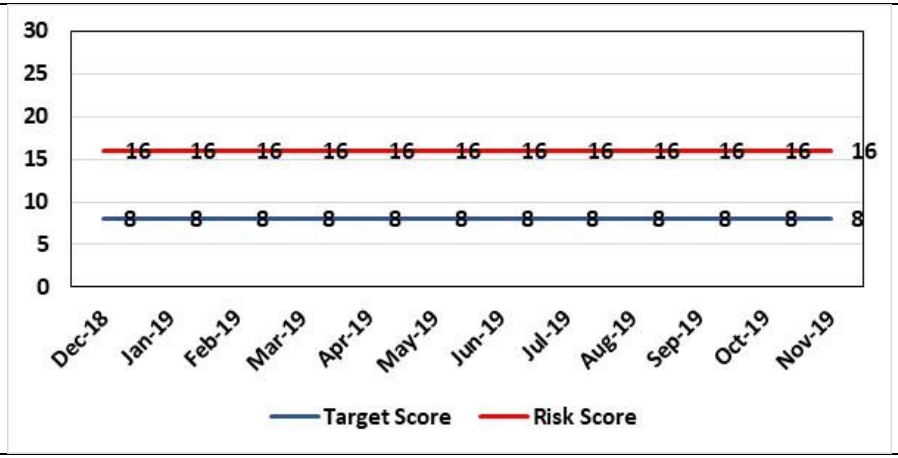
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
The Health Board has established a multi-professional Delivery Support Team (DST) to focus on: • Grip & control • Driving up confidence in existing savings plan • 2019/20 – Further actions • Financial Sustainability	Monitor risk through Performance and Finance Committee	Director of Finance	Monthly Review
The Health Board has a number of established financial control measures including authorisation hierarchies, QVC panels and vacancy control panel.	Monitor risk and agree action through Financial Management Group	Director of Finance	Monthly Review
These controls are being enhanced through the High Value Opportunity work streams, and Financial Recovery Actions which are monitored and support by the Delivery Support Team.			

From October KPMG external support commission by WG in support of the Health Board's 19/20 Financial Plan delivery and IMTP preparation will be working alongside the DST and the Finance team to support driving up confidence and the development of a strong pipeline of opportunities			
Assurances **(How do we know if the things we are doing are having an impact?)** The Health Board financial performance is reviewed and monitored through : • Unit and cross-system financial recovery meetings (Weekly) • Financial Management Group (chaired by CEO) • Performance and Finance Committee	**Gaps in assurance** **(What additional assurances should we seek?)** Accountability letters to be issued following Annual Plan approved by Board.		
Current Risk Rating **4 x 5 = 20**	**Additional Comments**		

Datix ID Number: 1514 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**	**HBR Ref Number: 43**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, Director of Nursing & Patient Experience **Assuring Committee:** Quality and Safety 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:** November 2019
Risk Rating (consequence x likelihood): Initial: 4 x 4 =16 Current: 4 x 4= 16 Target: 3 x 2 = 6 **Level of Control** = 40% **Date added to the risk register** July 2017		**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. **Rationale for target score:** Consequences of DoLS breaches for the Health Board will not change. With controls in place, over time likelihood should decrease.

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 • Process in place within P&C Unit for management of authorisations and identifications of breaches in timescales. The Corporate Safeguarding Team is monitoring this. • 31.07.19 2 WTE BIA's and a Band 4 Administrator have been appointed since April 2019. These individuals are managed by the Interim Head of Long Term Care, primary & Community Service Delivery Unit	Delivery of DOLS Action plan reviewed monthly	Head of Safeguarding	Monthly Review

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• 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.	
Current Risk Rating **4 x 4 = 16**	**Additional Comments**

Datix ID Number: 1563 **Health & Care Standard: Safe Care 5.1 Access**	**HBR Ref Number: 48**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Sian Harrop Griffiths, Director of Strategy **Assuring Committee:** Performance and Finance Committee, Health Board
Risk: Failure to sustain Child and Adolescent Mental Health Services	**Date last reviewed:** November 2019
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 4 x 2 = 8 **Level of Control** = 50% **Date added to the risk register** 31/05/2018		**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. **Rationale for target score:**

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• 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. • New Service Model agreed and being established by Summer 2019 which should give further stability to service.	**Action**	**Lead**	**Deadline**
	Implementation of the Choice and Partnership Approach (CAPA) started on 1st November 2017 and being closely monitored	CAMHS network	30th November 2019
	Additional investment expected - from Welsh Government is supporting the delivery of Waiting List Initiative clinics to support the position.	CAMHS network	30th November 2019
	The Network is seeking to recruit agency staff to fill existing and upcoming vacancies to ensure that core capacity is maximised.	CAMHS network	30th November 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. Primary & specialist CAMHS services are delivered by Cwm Taf University Health Board on behalf of ABMU (although this will only be for Swansea & NPT from 1/4/19). Cwm Taf achieved the non-urgent 28 day target for specialist CAMHS by the end of March 2019. Their ability to sustain this performance is dependent on consistency and availability of staff which due to the small numbers in the various CAMHS teams can affect achievement of waiting times significantly.

Datix ID Number: 922 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 49**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Richard Evans, Medical Director **Assuring Committee:** Quality and Safety Committee
Risk: Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)	**Date last reviewed:** November 2019
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 4 x 5 =20 Target: 3 x 4 = 12 **Level of Control** = 50% **Date added to the risk register** July 2016		**Rationale for current score:** • External review undertaken by Royal College of Physicians which will likely indicate that patients have come to serious harm as a result of excessive waits. • Remains significant reputational risk to the Health Board **Rationale for target score:** External review by the Royal College of Physicians will provide a view on improvement required immediately and for sustainability.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• TAVI Recovery Plan implemented and backlog has been cleared.. • Plan is supported with Executive oversight at fortnightly TAVI OG meeting. • TAVI has been prioritised in next year's WHSSC ICP for 2020/21. The UHB has commissioned the Royal College of Physicians to undertake a review of the service. Final report awaited, but anticipated that this will indicate that patients have come to serious harm	Commission external review of the service by the Royal College of Physicians (Awaiting report)	Directorate Manager	30th November 2019

Assurances **(How do we know if the things we are doing are having an impact?)** Reduction in waiting times for TAVI. Appointment to key posts (medical & nursing).	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **4 x 5 = 20**	**Additional Comments** No patients now waiting > 36 weeks. Service awaiting outcome of RCP invited service review Business case for WHSSC funding has been agreed. There is considerable reputational risk to the organisation on the outcome of the Royal College of Physicians review.

Datix ID Number: 1761 **Health & Care Standard: Timely Care 5.1 Access**		**HBR Ref Number: 50**
Objective: Best Value Outcomes from High Quality Care		**Director Lead**: Chris White, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee
Risk: Access to Cancer Services - Failure to sustain services as currently configured to meet cancer targets		**Date last reviewed:** November 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:** 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	30th November 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	30th November 2019
	Some speciality challenges remain in Lung and Urology - Action plans in place, along with monitoring.	COO / DPC&MH Med Director	30th November 2019

Assurances **(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.	**Gaps in assurance** **(What additional assurances should we seek?)** Clear current funding gap.
Current Risk Rating **4 x 5 = 20**	**Additional Comments** The need to deliver sustained performance.

Datix ID Number: 1799 **Health & Care Standard: Controlled Drug 2.6 Medicines Management**		**CRR Ref Number: 57**
Objective: Best Value Outcomes of High Quality Care		**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee**: Audit Committee
Risk: Non-compliance with Home Office Controlled Drug Licensing requirements		**Date last reviewed:** November 2019
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** The Health Board has limited assurance regarding whether or not it is compliant with Home Office Controlled Drug Licensing requirements at the present time, nor does it currently have processes in place to ensure any future service change complies. Risk: That the Health Board is operating in breach of the law by managing controlled drugs without an appropriate Home Office Controlled Drug License. Legal advice provided to the Health Board has indicated that failure to comply with the Home Office Controlled Drug licensing requirements could result in criminal and civil action, both against responsible individuals and the Health Board as a public body. Work has commenced to fully understand the licensing situation along with the drafting of a detailed policy that will ensure compliance going forward. Risk: That the Health Board is maintaining unnecessary Home Office Controlled Drug Licenses. Each Home Office Controlled Drug license costs around £3k plus additional administrative set-up and maintenance costs. Health Board wide scrutiny is required to ensure no unnecessary licenses are held (one such example has recently been discovered).
Level of Control = 40%		**Rationale for target score:**
Date added to the risk register January 2019		Once the new policy is complete and has been checked for legal compliance to the Home Office regulations there will be a training session held with all clinical areas supported at Executive level. The work currently underway includes checking areas of concern for compliance with the regulations.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**

Legal advice received and principles upon which to decide whether a Home Office Controlled Drug License would be required have been drafted. This forms the basis of a detailed policy that is currently in draft form. This will be sent for legal ratification to ensure compliance to the Home Office regulations. The Home Office have been advised work is currently being completed as a matter of urgency. Areas of specific concern regarding license compliance are being visited to enable an accurate assessment. Additionally work is underway to develop a governance framework to ensure responsibility for management and use of controlled drugs is fully understood within the delivery units. The framework will enable both the Controlled Drug Accountable Officer and the Health Board Medical Director to discharge their individual accountabilities. The Executive Medical Director, the Executive Director of Nursing and the Chief Pharmacist/CDAO are fully involved and supportive of any potential changes for delivery units. .	Training session to be held for all clinical areas. All delivery units will be required to identify a responsible manager and ensure compliance with both the CD Licensing Policy and the new framework for management and use of controlled drugs.	Clinical Director of Medicines Management (Pending internal corporate governance review of controlled drugs governance in new organization)	December 2019 (Pending policy development and sign off in conjunction with Home Office)
Assurances **(How do we know if the things we are doing are having an impact?)** • To date the HB has received legal advice. Pending policy development, the principles contained within the legal advice are referred to when issues are raised in order to provide consistency in arrangements.	**Gaps in assurance** **(What additional assurances should we seek?)** The Health Board will develop a license compliance register, this is expected to be maintained by the Corporate Governance Team thus ensuring there is sufficient segregation of duty.		
Current Risk Rating **4 x 4 = 16**	**Additional Comments** The Home Office are aware that the Health Board have sought independent legal advice regarding the situations where a Home Office Controlled Drug license is required. Advice received to date from the Home Office regarding particular scenarios of Controlled Drug management by the Health Board has differed from the independent legal advice received. The Home Office are currently awaiting the Health Board policy on this matter so that they can review our position. Once completed the policy outlining the Health Board position on Controlled Drug licensing will be shared with both Welsh government and all other Health Boards in Wales as the Swansea Bay UHB position is likely to be used by the Home Office as a precedent.		

Datix ID Number: 843
Health & Care Standard: Staff & Resources 7.1 Workforce

HBR Ref Number: 3

Objective: Excellent Staff

Director Lead: Hazel Robinson, Director of Workforce and Operational Development
Assuring Committee: Workforce and OD Committee

Risk: Workforce recruitment of medical & dental staff

Date last reviewed: November 2019

Risk Rating
(consequence x likelihood):
Initial: 5 x 4 = 20
Current: 4 x 4 =16
Target: 4 x 3 = 12

Rationale for current score:

- 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?)

- 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.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Medical training initiatives pursued in a number of specialties to ease junior doctor recruitment	Director W&OD.	December 2019
The Medical Workforce Board continues to monitor recruitment and junior doctor's rotas.	Director W&OD.	May 2020
Continue to recruit internationally.	Director W&OD.	May 2020

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

- 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

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

Current Risk Rating
4 x 4 = 16

Additional Comments
In development despite some work going on with Medacs permanent recruitment arm and participation in BAPIO. A rolling programme of recruitment underway. Participating in the November 2019 BAPIO recruitment round.

Datix ID Number: 1759 **Health & Care Standard: Staff & Resources 7.1 Workforce**	**HBR Ref Number: 51**
Objective: Excellent Staff	**Director Lead:** Gareth Howells, Director of Nursing **Assuring Committee:** Workforce and OD Committee
Risk: Non Compliance with Nurse Staffing Levels Act (2016)	**Date last reviewed:** November 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:** • 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?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
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. • 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	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	30th November 2019
	The Board should ensure a system is in place that allows the recording, review and reporting of every occasion when the number of nurses deployed varies from the planned roster.	Director of Nursing & Patient Experience	30th November 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	30th November 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	30th November 2019

organisation to ensure a consistent approach to data collection and there is national work on solutions for electronic capture of acuity data. • The NSA Steering group continues to meet on a monthly basis. • Risks are presented at each meeting • Scrutiny panels are held for each SDU following the submission of acuity templates. • Impact assessment work is being undertaken to prepare for further roll out of the Act.			
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. • In line with the Boundary changes there are now 29 reportable wards which excludes POW. • E-rostering has been rolled out in Singleton and Morriston is in the process of being rolled out. Scrutiny panels are in place. • Following the investment already provided to the funded establishments. The overall risks have reduced as outlined above. • The quality and accuracy of the Acuity data has improved.	**Gaps in assurance** **(What additional assurances should we seek?)**		
Current Risk Rating **4 x 4 = 16**	**Additional Comments**		

Datix ID Number: 2023
Health & Care Standard: Staff Resources 7.1 Workforce

HBR Ref Number: 62

Objective: Excellent Staff

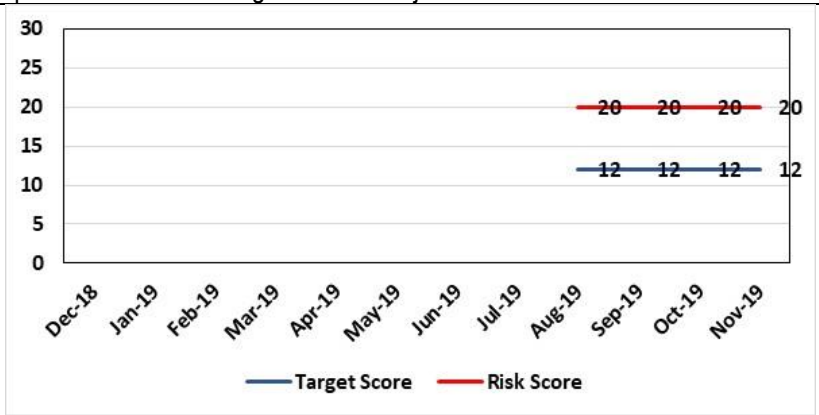
Risk: Sustainable Corporate Services aligned to the Health Board's Annual Plan and organisational strategy, and with the skills, capability, behaviours and tools to successfully deliver in support of the whole organisation, and to do so in a way which respects and promotes the health and well-being of our staff and their work-life balance.

Director Lead: Tracy Myhill, CEO
Assuring Committee: Workforce and OD Committee

Risk: Failure to deliver corporate services and organisational objectives due to insufficient staff.

Date last reviewed: November 2019

Risk Rating
(consequence x likelihood):
Initial: 4 x 5 = 20
Current: 4 x 5 = 20
Target: 4 x 3 = 12



Level of Control
= 50%

Date added to the risk register
August 2019

Rationale for current score:
Constraints, stress and resourcing of corporate services post Bridgend Boundary Change and in light of the change agenda in the Health Board. Current resourcing levels have been benchmarked with other Health Boards, in some areas.
The Finance department has been under considerable pressure due to the work required to support the Health Board's Targeted Intervention status and the Bridgend boundary change.

Rationale for target score: Sustainable services will always encounter turnover and need to develop skill set and capabilities.
Target score reflects requirement to resource 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.
Failure to do this will negatively impact of financial, service, performance and quality outcomes.

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

- Designing and Developing new Operating model for the Health Board
- Designing and Developing HB HQ and Corporate structures
- Reviewing Directorate requirements
- Vacancy Panel to support prioritisation

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Mitigating actions (What more should we do?)

Action	Lead	Deadline
Review Structures	Chief Executive	31st December 2019
Agree new operating model	Chief Executive	31st December 2019
Review of resourcing to take into account Boundary Change	Director of W&OD	31st December 2019

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

- Decisions late summer / early autumn on corporate services structures, operating model and resourcing.

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.

Datix ID Number: 1035 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 27**
Objective: Digitally enabled care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Audit Committee
Risk: Digital Transformation 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:** November 2019
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 = 12 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?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• 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	Develop a new Strategic Outline Plan setting out the requirement to deliver the first phase of the Digital strategy. Three year plan to be developed in line with the Health Boards IMTP Planning process.	Assistant Informatics Business Manager	6th December 2019
	Work with finance and the Health Board leadership team to identify additional revenue	Assistant Informatics	31st March 2020

<table>
<tr><td rowspan="3">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
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</td><td>streams. 2019/ 2020 Capital plan approved. 200K revenue increase agreed to reflect growth in IT service provision</td><td>Business Manager</td><td></td></tr>
<tr><td>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.</td><td>Assistant Informatics Business Manager</td><td>31st March 2020</td></tr>
<tr><td>Ensure business cases requiring digital services include appropriate implementation and support costs.</td><td>Assistant Informatics Business Manager</td><td>31st March 2020</td></tr>
<tr><td colspan="2">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
Digital enablement is a cornerstone of the organization strategy. Two of the strategies, 8 areas, of focus are digital enablement.
WG have announced (Oct 19) £50m investment into Digital Transformation in 19/20. The HB are awaiting final confirmation of its allocation which is indicated to be £1,390k capital and £1,060k revenue. Whilst this is under what was requested it will be utilised against priority requirements for the HB.</td><td colspan="2">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.</td></tr>
<tr><td>Current Risk Rating
4 x 3 = 12</td><td colspan="3">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.
Internal processes have been established to ensure that all informatics costs are included in Business cases developed by Informatics. Representation from Informatics at IBG and the Scrutiny Panel.</td></tr>
</table>

Datix ID Number: 1043 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 36**
Objective: Digitally enabled care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Audit Committee
Risk: Paper Record Storage: 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:** October 2019
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 3= 12 Target: 3 x 3 =9	**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
All records must be documented and risk assessed in the Information Asset Register (IAR)
Develop a case for improved storage solution both for paper and digitally.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Complete implementation of RFID within Health Records	Interim Chief Information Officer	29th November 2019
Continue with the roll out of WCP	Interim Chief Information Officer	30th April 2020
Continue with roll out of digitisation of health record with a focus on Outpatients and Nursing documentation	Interim Chief Information Officer	31st December 2019
Develop case for improved storage solution for acute paper record.	Head of Health Records & Clinical Coding	31st December 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 3 = 12**	**Additional Comments** All records must be documented and risk assessed in the Information Asset Register (IAR). This will mean that the risk can be quantified and understood. **Action - All SDU and corporate leads** Health Records Department will work with HB colleagues to develop a case for improved storage solution both for paper and digitally. In regard to the plans for the HB wide storage work, given the delay with the implementation of RFID, the timescales have been moved back slightly. Timescales for this work is as followed (based on current allocation of resources / no additional support. A dedicated project resource would get this done quicker) o Scoping and requirements gathering exercise by October 19 o Options developed – Q4 2019-20 o Business case - Q1 2020-21 o Implementation Q3/4 2020-21

Datix ID Number: 1565 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 45**
Objective: Digitally enabled care	**Director Lead**: Richard Evans, Medical Director **Assuring Committee**: Audit Committee
Risk: If patients are discharged from hospital without the necessary discharge information this may have an impact on their care	**Date last reviewed:** November 2019
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 3 x 3 = 9 **Level of Control** = 50% **Date added to the risk register** May 2018		**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. • The implementation of MTED across surgical wards has been delayed by NWIS due to a delay in the release of WCP probably until April 2020. **Rationale for target score:**

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

- 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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Escalation report to be submitted with objective of attempting to obtain earlier release.	Medical Director	30th November 2019
Implementation of WCP will include the MTED module which will allow extra project support to facilitate improved compliance	Medical Director	29th November 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 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. MTeD went live on 10 wards (medicine) at Morriston Hospital on 20 May 2019. The delivery unit have also mandated that alongside MTeD, they are implementing a no discharge summary, no discharge policy with an escalation procedure for when patients are discharged without one. Implementation across remaining wards is scheduled for later in the year when we are able to send surgical data with the discharge summary/operation note directly to GPs.

Datix ID Number: 146 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**CRR Ref Number: 58**
Objective: Excellent Patient Outcomes	**Director Lead**: Chris White. Chief Operating Officer **Assuring Committee**: Quality and Safety Committee
Risk: There is a failure to provide adequate clinic capacity to support follow-up patients within the **Ophthalmology** specialty. The consequence of this failure is a delay in patients with chronic eye conditions accessing ongoing secondary care monitoring of diagnosed conditions with the potential risk of permanently impairing eyesight.	**Date last reviewed:** November 2019
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 4 x 5 = 20 Target: 4 x 1 = 4	**Rationale for current score:** Sustainable plans underway - short term measures in process of being implemented. Serious incidents being reported to WG. Gold Command exec-led oversight established November 2018. Risk rating increased to 25 January 2019 as instructed by Gold Command. LJ advised change risk score to 16, 03/04/2019 as Probable x Major.
Level of Control = 40%	**Rationale for target score:**
Date added to the risk register December 2014	

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• All patients are categorised by condition in order to quantify issue. Second glaucoma consultant appointed November 2018. • Additional accommodation secured to increase capacity; implementation plan under development. Welsh government funding secured for 2019/20 to employ additional activity and deliver some services in a community setting. Virtual clinics established. • Service Manager for Ophthalmology providing regular updates via Planned Care Programme	Strawberry Place ODTC clinics planned to commence in April 2019	Service Group Manager Surgical Specialties	20th December 2019
	Further additional Glaucoma practitioner and Visual Field Technician posts are to be advertised and recruited to in increase Glaucoma capacity further as part of an OPDTC Outreach Community Clinic in Strawberry Place GP Surgery	Service Group Manager Surgical Specialties	20th December 2019
	Vacant Orthoptist post within AMD filled, start date TBC.	Service Group Manager Surgical Specialties	20th December 2019
	Several posts out for recruitment	Service Group Manager Surgical Specialties	20th December 2019
	An overall Sustainability Plan to be delivered	Service Group Manager Surgical Specialties	1st April 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?)
• A Welsh Government pilot programme was implemented in June 2014. The purpose of the HES project is to use clinic capacity to assess, review and treat patients within clinical priority rather than prioritising new patients based on their waiting time. A Project Management Lead was in post to deliver on the HES objectives.	Extended waiting times for patients requiring routine clinical intervention, but these are still listed as per RTT guidance.
Current Risk Rating **4 x 5 = 20**	**Additional Comments** Additional Glaucoma practitioner (temporary for 12 months) commenced in post 11/06/2018. 2nd Glaucoma Consultant started 05/11/2018. Accommodation in Corridor 3 reconfigured 08/02/2019. Further work needed on accommodation and additional rooms required. Ongoing discussions continue with Singleton Unit so that space can be created to house a co-located Ophthalmology Department Middle grade doctor to commence in post April 2019. Monthly tracker of glaucoma backlog patients indicates reduction of over 800 patients to end of January 2019. Diabetic Retinopathy Virtual Review clinics are to be increased via a WG funded successful bid.

Datix ID Number: 737 **Health & Care Standard: Staying Healthy 1.1 Health Promotion**	**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:** November 2019
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9 **Level of Control** = 60% **Date added to the risk register** 26.01.16		**Rationale for current score:** 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. **Rationale for target score:** 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	30th April 2020
Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report.	Consultant Public Health Medicine	30th April 2020
Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins	Consultant Public Health Medicine	30th April 2020

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 3 = 15

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

Datix ID Number: 1763 **Health & Care Standard: Staff & Resources 7.1 Workforce**	**HBR Ref Number: 52**
Objective: Partnerships for Care – Effective Governance	**Director Lead:** Sian Harrop Griffiths, Director of Strategy **Assuring Committee:** Performance and Finance Committee
Risk: The Health Board does not have sufficient resource in place to undertake engagement & impact assessment in line with strategic service change	**Date last reviewed:** November 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:
-

Level of Control
= 50%

Rationale for target score:
- All 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.

Date added to the risk register
November 2018

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

- Engagement – a temporary post was created for a Head of Engagement for 6 months. The impact of this post was evaluated and will be used to inform the structures change (Operating model). In the meantime the Band 5 has been backfilled to support engagement activities. Robust processes are, however, in place as agreed with the CHC and based on best practice guidance.
- Impact Assessment - A JD has been drafted. The post has now been put forward as part of the CSP support package. Will be taken forward as part of the review of Executive portfolios regarding Equalities.
- Commissioning - two temporary posts are in place until the end of 2019/20 to support the disaggregation programme relating to Bridgend. Will be considered by the Joint Executive Group as part of the resource assessment for the ongoing legacy of the Bridgend transfer.
- Planning - 2 temporary unfunded posts in place (Partnerships Manager and Older people's Programme Manager). Executive Team agreed to fund these, as well as appoint an Acute Care Planning Manager. Core department resources have been aligned to the needs of the CSP and a range of additional posts have been put forward in the resource assessment for the Transformation Portfolio.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Agreement of dedicated resource to support Engagement activity – through structure reviews	Director of Transformation	31st December 2019
Conclude work on Exec Equalities portfolios	WoD	31st December 2019
Appoint to agreed Planning posts	Director of Strategy	31st December 2019
Review commissioning requirements through JEG	Director of Strategy	30th November 2019

Assurances (How do we know if the things we are doing are having an impact?)
Temporary backfill resource for engagement.

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 **Health & Care Standard: Staff & Resources 7.1 Workforce**	**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:** November 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:** Working through its related improvement plan the likelihood of noncompliance will reduce as awareness and staff training in response to the Standards, is raised.
Date added to the risk register November 2018		

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 new Welsh Language Standards and how they apply to Swansea Bay University Health Board. A Welsh Language Standards Implementation plan has been devised to focus on strengthening and developing compliance in key areas. • Close constructive working relationships are in place with the Welsh Language Commissioner's Office • Strong networks are in place with the NHS Wales Welsh Language Officers network to share good practice, inform learning and to develop Business intelligence. • The Welsh Language Delivery group has been set to integrate Welsh language into the business and share responsibility for compliance and learning – first meeting 14 May 2019. • Proactive communication and marketing activity is being undertaken across the Health Board to raise awareness of Welsh language compliance, customer service standards and training opportunities. Working with NHS Wales Shared Services (NWSSP) to achieve compliance for workforce and recruitment standards.	**Action**	**Lead**	**Deadline**
	To Welsh Language Delivery Group meet quarterly and ensure the group comprises of appropriate representation from across all sectors of the organisation.	Director of Corporate Governance	30th December 2019
	Ensure the Board is fully sighted on the UHB's position through regular reporting to the Health Board. Update reports issued to the Executive Team and Board	Director of Corporate Governance	31st December 2019

Assurances (How do we know if the things we are doing are having an impact?) 1. Compliance with Statutory requirements outlined in Welsh Language Act and related Standards. 2. Monitoring through the WLD group 3. Meetings with the Welsh Language Commissioner.	**Gaps in assurance** **(What additional assurances should we seek?)** ESR Welsh language competency information needs to be improved and targeted actions are being undertaken to increase compliance.
Current Risk Rating **5 x 3 = 15**	**Additional Comments** The self-assessment has confirmed that the Health Board is not able to fully comply with all the Standards by May 2019 and that the Health Board will need to take a risk management approach to the delivery of the standards.

Datix ID Number: 1724 **Health & Care Standard: Safe Care 2.1 Managing Risk & Health & Safety**		**HBR Ref Number: 54**
Objective: Partnerships for Care		**Director Lead:** Sian Harrop Griffiths, Director of Strategy **Assuring Committee:** Health Board (Emergency Preparedness Resilience and Response Group)
Risk: Failure to maintain services as a result of the potential no deal Brexit		**Date last reviewed:** November 2019
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 3 = 15 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.
  - Assessing command and control requirements
  - Work programme monitored via EPRR Strategy Group
  - All services to complete business continuity plans
  - all services to identify high risks related to Brexit on risk register
  - Engagement in health national groups

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.	Head of Emergency Preparedness, Resilience & Response	30th November 2019
To carry out risk assessments	Head of Emergency Preparedness, Resilience & Response	30th November 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?)
• Work programme in place and monitored via EPRR Strategy Group • All services to complete business continuity plans	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 **3 x 5 = 15**	**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.

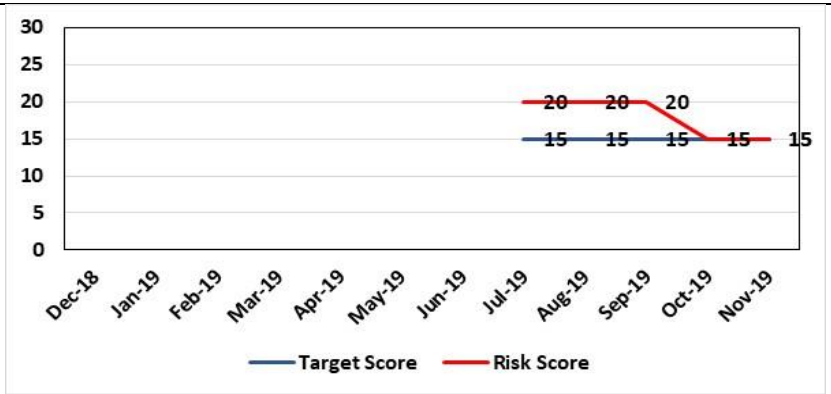
Datix ID Number: 1764 **Health & Care Standard: Safe Care 2.1 Managing Risk & Health & Safety**	**HBR Ref Number: 55**
Objective: Partnerships for Care	**Director Lead:** Sian Harrop Griffiths, Director of Strategy **Assuring Committee:** Joint Transition Board, Health Board
Risk: Failure to manage the residual risks arising from the Welsh Governments decision to realign the Health Boundary, as it applies to the resident population of the Bridgend County Borough.	**Date last reviewed:** November 2019
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 3 = 12 Target: 3 x 3 = 9	**Rationale for current score:** • The risk score has reduced from red 20 to red 16 which reflects that the Bridgend Boundary change took effect 1 April 2019 and that there are ongoing arrangements being put in place to manage the residual risks arising from the transfer. • The score has reduced to red 16, however it is important to recognise that financial discussions are ongoing with Welsh Government. • Outcome from arbitration and due diligence still unknown
Level of Control = 70%	**Rationale for target score:** • The Bridgend Boundary change took effect 1 April 2019 and there are ongoing arrangements being put in place to manage Service Level Agreement's (SLA's) and Long Term Agreements (LTA's) for service delivery.
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**
• Responsibility for the provision of health and care services for the Bridgend County Borough Council (BCBC) area transferred to Cwm Taf Morgannwg UHB on the 1 April 2019, this included the transfer of assets, services and resources. • A Joint Handover statement was approved by the Joint Transition Board on the 23 April 2019 and captures the business of the University Health Boards (UHBs), identifying key achievements, developments and investments, as well as highlighting any outstanding areas of work, risks and considerations which will need to be taken into account by Cwm Taf Morgannwg UHB and Swansea Bay UHB going forward. • A Memorandum of Understanding (MOU) has been devised which outlines joint agreements and stipulates what Service Level Agreements (SLAs) and Long Term Agreements (LTAs) are in place for cross border working. • A Quality and Patient Safety legacy document has been devised outlining the outstanding risks and the residual work required post April 2019. (can be accessed from the Joint Handover statement) • The cost pressures of the transfer are being discussed with Welsh Government	**Phase 2 – Service Transformation Plan** **Finance** Further discussion to take place with Welsh Government around to cost neutrality and financial stability. **Commissioning –** joint meeting set up to monitor memorandums of understanding and SLAs	Director of Transformation	31st January 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?)
• Performance is reviewed at monthly meetings with Cwm Taf Morgannwg UHB and progress is monitored by the Director of Transformation. • Executive leadership for boundary change will be transferring to director of strategy that the relationship with CTMHB is largely a service planning and commissioning one.	

Current Risk Rating 4 x 3 = 12	Additional Comments The last Joint Transition Programme group meeting was held in April 2019, all supporting work streams will disband thereafter. The ongoing work to manage the residual issues will need to be included on top of routine duties and responsibilities

Datix ID Number: 2003 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 60**
Objective: **Digitally Enabled Care**	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Audit Committee
Risk: Cyber Security - high level risk • The level of cyber security incidents is at an unprecedented level and health is a known target. The health board has increased digital services (users, devices and systems) and therefore the impact of a cyber security attack is much higher than in previous years. The introduction of the Network and Information Systems Directive (NISD) in May 2018 means that large fines can be issued to organisations that are not compliant with the Directive. A report from the department of health following the Wannacry incident in May 2017 stated that attack cost the NHS (England) £92m as 19,000 appointments were cancelled and this was before the NISD came into effect. The largest risk to the organisation is on user awareness and unsupported software (old versions which are no longer patched for security vulnerabilities) and devices not managed by the ICT department e.g. medical devices.	**Date last reviewed:** November 2019
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 3 = 20 Target: 5 x 3 = 15	**Rationale for current score: C and L** The level of cyber security incidents is at an unprecedented level and health is a known target. The health board has increased digital services (users, devices and systems) and therefore the impact of a cyber security attack is much higher than in previous years.
Level of Control	**Rationale for target score:**
Date added to the risk register July 2019	C- will remain the same or increase due to increased reliance in information L- The overall likelihood score would increase to (20) if the funding of the 8A and 2 x Band 6 are not recruited .



Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
The ICT department only has one ICT security manager and agreement is in place to recruit a Band 8A Cyber Security manager to provide strategic direction and develop action plans to address the risks highlighted in the Stratia Report as well as ensuring the Health Board complies with NISD. There are also 2 x band 6 WTE positions agreed pending release of funding to build the team which are required to act on information provided by the national security tools.	Recruit Band 6 operational cyber security staff x2	Head of ICT Systems	31st January 2020
The national security tools will highlight vulnerabilities and provide warnings when potential attacks are occurring. Swansea Bay will adopt these tools in financial year 2019/20.	Implement National Cyber Security Tools	Cyber Security Manager	31st March 2020
The NHS in Wales is protected by a firewall by NHS Wales Informatics Service (NWIS). Swansea Bay UHB has advanced firewall protection to protect the network from potential cyber- attacks.	Rollout Cyber Security Training Module	IT Security Manager	30th November 2019

All emails coming into NHS Wales are scanned using the national email filter. Whilst malicious emails come into the health board on a daily basis, the number are vastly reduced using the email filter and NWIS issue warnings to users affected when the contents are discovered (same day). Users are warned to delete emails and if opened, contact ICT service desk for investigation. A patching regime has been in place around 18 months which ensures desktops, laptops and servers are protected against any known security vulnerabilities. Anti-virus is in place to protect against known viruses with intelligent scanning on potential viruses not yet discovered. Access to the internet is controlled through a smart filtering solution which restricts access to potentially vulnerable content. Work is ongoing in order to replace out of date systems, this is a huge task given the number of clinical and administrative systems in place across the health board. The creation of the service management board will help in terms of getting stakeholder agreement and engagement. Capital funding has also been available to address this. A Cyber Security training module has been developed and available in the Electronic Staff Record training to ensure staff are fully aware of the risk of cyber security and are vigilant in recognising malicious activity e.g. malicious email. This needs to be adopted as mandatory training.			
Assurances (How do we know if the things we are doing are having an impact?) This will be developed following the appointment of the Cyber Security Manager. In the meantime, the follow up Stratia report has confirmed a major improvement in terms of Microsoft Security patching and SBU are compliant with standards agreed. The Cyber Assurance Framework (compliance with NISD) has been submitted to the Operational Security Service Management Board and plan will be developed nationally to address areas of non-compliance.	**Gaps in assurance (What additional assurances should we seek?)**		
Current Risk Rating **5 x 3 = 15**	**Additional Comments** Band 8a Cyber Security Manager appointed October 2019		

Datix ID Number: 1587 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 61**
Objective: Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.		**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Strategy Planning and Commissioning Committee
Risk: Paediatric dental GA/Sedation services provided under contract from Parkway Clinic, Swansea. Risk to patient safety with no immediate access to crash team/ICU facilities in Parkway Clinic. Sustainability issue within Parkway Clinic due to reduced commissioning. Financial risk to Parkway in reduction of remuneration received.		**Date last reviewed:** November 2019
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** There is no immediate access to crash team/ICU facilities in in Parkway Clinic – the client group are undergoing G/A/sedation. Paediatric GA/Sedation services provided under contract from Parkway Clinic, Swansea continue due to lack of capacity for these patients to be accommodated in Secondary Care
Level of Control =		**Rationale for target score:**
Date added to the risk register 4th July 2018		Relocation of the paediatric GA service [provided by Parkway Clinic] to a hospital site being treated as a priority

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Consultant Anaesthetist present for every General Anaesthetic clinic. • Assurance Documentation supplied by Parkway Clinic including confirmation of arrangements in place with WAST and Morriston Hospital for transfer and treatment of patients • New care pathway implemented - no direct referrals to provider for GA. • Multi -drug sedation ceased from Sep 2018 in line with WHC 2018 009 • Revised SLA/Service Specification • HIW Inspection Visit Documentation provided to HB • All extended GA cases require approval from paediatric specialist prior to treatment	**Action**	**Lead**	**Deadline**
	Theatre review to facilitate paediatric dental general anaesthetics delivered from MHSDU.	UDD/HOPC	December 2020
	Transfer of services from Parkway.	UDD/HOPC	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?)**
• 1.RMC collate referral and treatment outcome data for review by Paediatric Specialist • 2. Regular clinical meeting arranged with Parkway to discuss individual cases/concerns • 3.Regular clinical/ management meeting for CDS/primary care management team to discuss service pathway /concerns/issues arising • 4. Roll out of new pathway to encompass urgent referrals	ToR for the task and finish group should continue to include consideration of the pressures on the POW special care dental GA list and this service is considered alongside any plans for the Parkway contract.
Current Risk Rating **4 X 4 = 16**	**Additional Comments** 4th July 2019 – discussed in Risk Management Committee

Datix ID Number: 1605 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 63**
Objective: Screening for Fetal Growth Assessment in line with Gap-Grow (G&G)	**Director Lead**: Gareth Howells, Director of Nursing and Patient Experience **Assuring Committee:** Quality and Safety Committee
Risk: There is evidence a growth restricted/small for gestational age fetus (SGA), has an increased risk of intra-uterine death before or during the intrapartum period. Identification and appropriate management for SGA in pregnancy should lead to improved outcomes. GAP & Grow standards were implemented to contribute to the reduction of stillbirth rates in wales. Obstetric USS scan appointments are at capacity leading to delays in obtaining required appointments. In addition the guidance from Gap & Grow is for women requiring serial scanning with a risk factor for a growth restricted baby must have 3 weekly scans from 28 to 40 week gestation. Due to the scanning capacity there are significant challenges in achieving this standard.	**Date last reviewed:** November 2019 **Rationale for current score:** CSFM's leading on audit reviewing records of all women where SGA not identified in antenatal period. Scanning capacity under increasing pressure. Meeting arranged with radiology management to discuss introduction of midwife sonographer third trimester scanning. Staff to be informed to submit Datix incident where scan not available in line with standards.
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 5 = 20 Target: 3 x 4 = 12 **Level of Control** = 60% **Date added to the risk register** 1st August 2018		**Rationale for target score:** Compliance with Gap & Grow requirements.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
All staff have received training on Gap & Grow and detection of small for gestational babies. Obstetric scanning capacity across the HB is being reviewed and compliance with criteria for scanning is being monitored. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening and complying with Gap & grow recommendations.	Adherence to Gap/Grow Standards	Deputy Head of Midwifery	31st December 2019

Assurances **(How do we know if the things we are doing are having an impact?)** Audit of compliance with guidance being undertaken, detection rates of babies born below the 10th centile is being monitored via datix and audited by the service. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening and complying with Gap & grow recommendations.	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **4 X 5 = 20**	**Additional Comments**

Datix ID Number: 2159 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 64**
Objective: Best Value Outcomes		**Director Lead:** Gareth Howells, Director of Nursing and Patient Experience **Assuring Committee:** Health and Safety Committee
Risk: Insufficient resource and capacity of the Health, safety and fire function within SBUHB to maintain legislative and regulatory compliance for the workforce and for the sites across SBUHB. .		**Date last reviewed:** November 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:** The Health Board are in receipt of 10 Health & Safety Executive (HSE) improvement notices concerning health and safety management, violence and aggression and manual handling, limited assurance internal audit reports for water safety management and COSHH, and a fire enforcement notice for one of our sites. Fire risk assessment frequencies are not being kept up to date. Statutory/mandatory training provision and recording will not be sustainable. Unable to support units sufficiently for H&S, case management (V&A), fire and training or to conduct audits/inspections. Potential for litigation, with implications of financial and reputational consequences for not meeting legislative requirements.
Level of Control = 70%		**Rationale for target score:**
Date added to the risk register September 2019		Additional resources and updated/refreshed/new systems will enable the Health Board to demonstrate that suitable resources are in place to undertake the roles and responsibilities of the department, and to undertake suitable and sufficient training, provide corporate overview/audit to ensure practices are being employed in the workplace. Risk assessments are being undertaken within required frequencies and periodic audits are taking place to support the various units and departments.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
HSE Improvement working group set up to address the HSE recommendations and meets fortnightly to monitor the improvement action plan. Interim posts of Assistant Director of Health and Safety and Interim Head of Compliance employed on secondment to support strengthening and developing the H&S function Health and Safety Operational Group meets quarterly and reports to the Health and Safety Committee. Water safety management action plan in place. COSHH procedure reviewed and updated. Fire risk assessments are being undertaken at priority sites (patient areas) to address recommendations of the MAWWFRS. Fire training in place and fire wardens in place.	HSE re-inspection planned 16 & 17 September	Assistant Director of H&S	31st December 2019
	Health and safety department structure to be reviewed and produce proposals	Assistant Director of H&S	31st December 2019
	Health and safety structure review to be presented to the H&S Committee	Assistant Director of H&S	31st December 2019

The Health & Safety executive (HSE) inspection took place 16, 17, 18 & 20 September 2019, 7 out of the 10 original HSE inspection notices were complied with, 3 were given extensions for completion before December 2019. Inspection visit for the electric shock incident on 10 October 2019 - the HSE issued two new improvement notices relating to the low voltage electrical system given a date of compliance 6 December 2019, and competent persons to assist in statutory provisions for supervisory or managerial positions to manage electrical safety given a date of compliance 31 January 2020. HSE routine site inspection to visit Singleton Hospital 30 October 2019 as a follow up to new consents issued under the Ionising Radiation Regulation 2017 resulted in a breach notice, date for compliance end November 2019.			
Assurances **(How do we know if the things we are doing are having an impact?)** Monitoring through the H&S committee to receive assurance and or identify gaps for key compliance and adherence to applicable legislation. HSE Improvement working group monitor compliance against the HSE improvement notices and report to the H&S operational group and H&S committee. Site visits/audits to identify compliance and gaps in compliances.	**Gaps in assurance** **(What additional assurances should we seek?)**		
Current Risk Rating **4 X 5 = 20**	**Additional Comments** Long term plans to be developed to understand the health and safety resource requirements for SBUHB.		

Datix ID Number: 329 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 65**
Objective: Digitally enabled Care	**Director Lead**: Gareth Howells, Director of Nursing and Patient Experience **Assuring Committee:** Information Governance Board
Risk: Risk associated with misinterpreting abnormal cardiotocography readings in the delivery room. A central monitoring station would enable multi-disciplinary viewing and discussion of the readings to take place, and reduce the risk of a concerning CTG trace going unidentified. Provisionally scored C4 (irrecoverable injury) x L3= 12. The central monitoring system has a facility to archive the CTG recordings: currently these tracings are only available as a paper copy, which can be lost from the maternity records. There is also a concern that the paper tracings fade over time which makes defending claims very difficult.	**Date last reviewed:** November 2019 **Rationale for current score:** Meeting with K2, IT, finance, procurement and midwifery team on 30/09/2019. system viewed and IT needs identified. Final costing to be assessed prior to resubmission to IBG in Oct or November 2019.
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 5 = 20 Target: 4 x 2 = 8 **Level of Control** = 50% **Date added to the risk register** 31st December 2011	
	Rationale for target score:

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
Current controls include all staff undertaking RCOG CTG training and competency assessment. Protocol in place for an hourly "fresh eyes" on 'intrapartum CTG's' and jump call procedures. CTG prompting stickers have been implemented to correctly categorise CTG recordings. Central monitoring is also expected to strengthen the HB's position in defending claims. K2 fetal monitoring system has been identified as the best option for a central monitoring system.	Business case prepared for Central monitoring system to store CTG recordings of fetal heart rate in electronic format.	Deputy Head of Midwifery	20th December 2019
	Identified need for midwife for fetal surveillance training and support to improve knowledge through increased support and training in the clinical areas as well as support for the formal training programme within SBUHB.	Deputy Head of Midwifery	30th November 2019

Assurances **(How do we know if the things we are doing are having an impact?)** All Wales Fetal Surveillance Standards for 6hrs Fetal Surveillance Training per year	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **4 X 5 = 20**	**Additional Comments** Submission to IGB in January 2019. CTG envelopes placed in every set of records for safe storage of CTG.

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

Risk Management Policy

This document may be made available in alternative formats and other languages, on request, as is reasonably practicable to do so.

Caring for each other, working together and always improving.

Policy Owner: ***Risk Management Group***

Approved by: ***Audit Committee***

Issue Date: ***…….. 2019***

Review Date: ***…….. 2022***

Contents

Appendices

1. Risk Management Policy Statement

Swansea Bay University Health Board (SBUHB) 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 SBUHB policies and have a personal responsibility for patients' safety as well as their own and colleagues health and safety. SBUHB 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 SBUHB aims to ensure:

- the risk management process is robust, integral to the day to day operation of the organisation, consistent and supports the achievements of SBUHB'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;
- a safe, high quality service is provided 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 SBUHB, 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. Aim of the Policy

The policy aims to set out a framework for consistent management of risk within the Health Board and support the achievement of the risk management objectives:

- Embed risk management at all levels of the organisation using a consistent framework;
- Create a culture which supports risk management;
- Provide the tools to support risk management;
- Provide the training to support risk management;
- Embed the Health Board's risk appetite in decision making.

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. SBUHB recognises that Risk Management is an integral part of good management practice and if successful will lead to:

- 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 SBUHB 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

SBUHB 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.

3. Significant Risks

The significant risks facing SBUHB are the risks linked to achieving the Health Board's objectives and the operational risks which have been escalated, in line with the risk management process, by Service Delivery Units. The organisational objectives are referred to in the Health Board's Annual Plan/ Integrated Medium Term Plan for 2019-2022 (IMTP). The objectives are:

- Together improve wellbeing and healthcare for all;
- Better health, better care, better lives;
- Support better health and wellbeing by actively promoting and empowering people to live well in resilient communities;

- Deliver better care through excellent health and care services achieving the outcomes that matter to people;
- Partnerships for improving health and wellbeing;
- Co-production and health literacy;
- Digitally enabled health and wellbeing;
- Best value outcomes from high quality care;
- Partnerships for care;
- Excellent staff
- Digitally enabled care;
- Outstanding research, innovation, education and learning.

The organisational priorities are monitored by the Board and Board Committees through assurance and exception reports. The Executive Team will use the IMTP as the basis for performance monitoring of Units and Corporate Directorate priorities. Quarterly performance meetings will be held, aligned to the *IMTP* with the Units to monitor performance against the priorities and other Key Indicators.

4. Risk Management Roles and Responsibility

4.1 Chief Executive

As Accountable Officer the Chief Executive has responsibility for ensuring that the Health Board meets all its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of governance. This responsibility encompasses the elements of financial control, organisational control, quality, health & safety and risk management.

Each year the Chief Executive sets out the risk management arrangements and issues within the Health Board within the Annual Governance Statement which forms part of the Annual Accounts and is scrutinised by the Audit Committee.

The Medical Director and Director of Nursing and Patient Experience are responsible for Quality and Safety, ensuring robust systems are in place. They are supported to drive forward the patient safety agenda through their Assistant Directors who have roles in quality and safety, safeguarding, infection control and education, all supporting patient safety.

4.2 Director of Governance

The Director of Governance has specific responsibilities for Risk Management and will support the Chief Executive by providing competent advice and support in the development of effective systems and arrangements to help facilitate the management of risk, this will include arranging to:

- Produce and regularly review the Risk Management Strategy and Risk Management Policy;
- Draft the Risk Management section of the Annual Plan/ IMTP;
- Ensure key risks are co-ordinated and reported to the Executive Board, Board Committees and Health Board;
- Produce the Annual Governance Statement

In undertaking this role the Director of Governance is supported by the Head of Patient Experience, Risk and Legal Services.

4.3 Executive Directors

Each Executive Director is responsible for managing risk within their area of responsibility. This means they will:

- Ensure staff are appropriately trained in risk assessment and management.
- Ensure there are mechanisms in place for identifying, managing and alerting the Board to significant risks within their areas of responsibility through regular, timely and accurate reports to the Senior Leadership Team/Executive Team, relevant Board Committees and the Board.
- Ensure there are mechanisms in place to learn lessons from any incidents or untoward occurrences and that corrective action is taken where required.
- Ensure their Directorate Risk Register is regularly received and updated in Datix and risks requiring escalation are escalated to the Risk Assurance Team for consideration for inclusion on the Health Board Risk Register.
- Ensure compliance with Health Board policies, legislation and regulations and professional standards for their functions.

A schedule setting out key areas of responsibility of individual Directors is set out in detail in the Scheme of Delegation appended to Standing Orders and are supplemented by individual job descriptions.

4.4 Head of Patient Experience, Risk & Legal Services

The Head of Patient Experience, Risk & Legal Services acts on behalf of the Director of Governance to achieve high standards of risk management for the Health Board, including the ongoing review and development of the Risk Management Policy. Responsibilities include continuing development of a proactive risk management culture and practice throughout the organisation; actively promoting and ensuring good risk management practices, an open, just and fair culture and the achievement of national risk management standards.

4.5 Head of Health & Safety

The Head of Health and Safety, supported by the Health & Safety Department, are responsible for policy development and implementation. Providing professional advice in respect of health and safety management. Ensuring the Health Boards risk management methodology is applied to Health and Safety issues.

4.6 Specialist Advisors

There are a number of specialist advisers within the Health Board who provide advice on specific areas of risk management. These include: Safeguarding, Fire; Health & Safety; Infection Prevention & Control; Information Governance; Medical Devices; Radiation Protection; Resuscitation and Security Management etc.

4.7 Operational Risk Management Arrangements

The Unit Directors (Service Director, Director of Nursing and the Medical Director have devolved responsibilities for risk and are responsible for ensuring that:

- Staff are aware of the Risk Management Policy, are aware of their responsibilities, understand the extent to which they are empowered to take risk, and are appropriately trained in risk assessment and risk management;
- Adopt an open and fair culture;
- Hazards, incidents and risk are identified using a consistent approach to ensure that a learning approach results in continuous improvement;
- Risks are managed and high unresolved risks reported to the appropriate Executive Director;
- Appropriate governance arrangements are established to manage risks, ensure action is taken and lessons learned;
- Staff are released to attend mandatory/statutory training;
- Staff receive regular PDR's/Appraisals;
- Risk registers are regularly revised and used as a tool to proactively manage risks and;
- Unit Risk Registers to be linked to the Integrated Medium Term Plan.

4.8 Ward / Departmental Managers

- Promotes an open and fair culture for staff to report incidents;
- Promptly investigates incidents and supports staff through the process;
- Completes or ensures risk assessments are completed and, as a minimum, reviewed on an annual basis;
- Reports risks identified from risk assessments, rated 9 and above, into the Unit's risk register and;
- Monitor staff attendance at mandatory/statutory training.

4.9 Independent Contractors

The Primary and Community Care Unit is responsible for working with independent contractors and ensuring appropriate risk management arrangements and systems are in place to effectively manage risk. This is carried out through the review of the governance self assessments for each profession.

4.10 All Employees

Everyone working in SBUHB has a responsibility to continuously improve patient safety, minimise risk and to ensure they: -

- Comply with policies, procedures, protocols and guidelines;
- Complete risk assessment and report hazards and incidents;
- Inform their manager of risks which they have identified;
- Ensure that there is an open and fair culture in their work place and;
- Identify training needs.

5. Risk Management Reporting Structure

Appendix 1 attached is the reporting arrangements and Committee Structure and details SBUHB's structural arrangements for the risk management process. The remainder of this section sets out the roles and responsibilities of the component parts of this structure and its relationship to the risk management process.

5.1 Health Board

The SBUHB Board shall, in relation to risk management: -

- Critically review and, when content, endorse the Risk Management Policy and associated Policies/procedures/methodologies;
- Deliberate annual reports and annual assurance statements;
- Consider where lessons may be learned from clinical/non-clinical incidents to foster continuous improvement;
- Consider any legal claims in accordance with the Health Board's Standing Orders and Financial Instructions;
- Consider where lessons may be learned from significant complaints, "no harm incidents" and other incidents to foster continuous improvement;

The Health Board will receive regular progress reports on the implementation of Risk Management through the Audit Committee.

Each Executive Director will ensure their Directorate risk register is up to date and risks are regularly considered for inclusion on the Health Board Risk Register and is then used to formulate the Annual Plan/IMTP and appended to the Plan. The Plan would then be approved by the Executive Board, Audit Committee and Board. Alongside this, key principal risks will be highlighted through all main plans e.g. for service change proposals and in key reports to the Board, its Committees and the Executive Board as a key element to decision making through the Board Assurance Framework.

The Health Board will appropriately delegate its responsibilities and functions in accordance with the arrangements set out in this document and Standing Orders. The Health Board is responsible for the system of internal control, including risk management. The Audit Committee will provide assurance that risk management systems are in place and functioning properly to minimise risk.

5.2 Audit Committee

The Audit Committee provides ***advice*** and ***assurance*** to the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Health Boards assurance framework - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Health Boards objectives, in accordance with the standards of good governance determined for the NHS in Wales.

This Committee is accountable for reviewing the Corporate Risk Register and receiving and recommending approval of the Risk Management Policy to the Board.

Internal Audit

Internal Audit will, through a programme of work based on risk, provide SBUHB with independent assurance of the adequacy of the systems of internal control across a range of financial and business areas in accordance with the Public Sector Internal Audit Standards.

5.4 Quality & Safety Committee

The Quality & Safety Committee is responsible for monitoring the implementation of Quality and Safety across the organisation including the integration of quality activities. The Terms of Reference of this Committee are set out in the Standing Orders approved by the Health Board and available on the Intranet. The Committee will receive and review the risks in the HBRR relating to quality and safety.

5.4.1 Risk Management Group

The Group reviews the Risk Management Policy and is responsible for overseeing the operational management of risk ensuring local systems and processes are in place and are operating effectively to ensure appropriate reporting and escalation. This is a Management Group which reports to the Audit Committee and Senior Leadership Team on a quarterly basis as follows:

5.4.2 Risk Management Scrutiny Panel

The Panel will meet on a monthly basis and will oversee the escalation of all risks and ensure the risk management process is followed. On a monthly basis Units and Corporate Directorate are requested to escalate risks for consideration for entry on the HBRR, a trigger of risks rated 16 and above is used for escalation where the controls are not adequate and or the actions are outside of the Units/Corporate Directorate's control. In addition risks can be escalated in terms of themes of risks across the organisation or sensitive risks which need to be escalated to the Risk Management Group/Senior Leadership Team and sub Committees of the Board. The Risk Scrutiny Panel will oversee the escalation and reporting of these risks.

5.4.2.1 NHS Redress

The NHS Redress legislation received Royal Assent in July 2008 and came into force in NHS Wales in April 2011. The Measure is intended to ensure that patients can seek Redress by means of treatment, support and compensation, if appropriate, for lower-value clinical negligence claims without the need to instigate legal action through the Courts.

Regulations setting out the detail of the new arrangements have been developed in close consultation with the NHS, patient groups and Community Health Councils and the *Putting Things Right* Project. The previous Incident, Complaints and Claims policies and procedures have been reviewed in line with the Regulations and changes made to produce an integrated Putting Things Right Policy and Procedure.

5.4.2.2 Incidents

Incidents will be managed and reported in accordance with the SBUHB's Putting Things Right Policy & Procedure. Incidents are analysed for trends and to ensure action is taken and a Root Cause Analysis Investigation of serious incidents. Guidance on Root Cause Analysis is contained within the Putting Things Right Policy as an appendix document.

Incident Reporting is not part of the SBUHB's disciplinary process. However, examples of situations where disciplinary action may be necessary are as follows:

- Criminal Activity (eg theft, assault and fraud)
- Professional misconduct
- Acts of gross misconduct (eg treating patients under the influence of alcohol)
- Malicious activity (eg malicious reporting of untrue allegations against a colleague)
- Repeated unreported errors or violations of procedures

5.4.2.3 Complaints

Complaints are managed in accordance with the Health Board's Putting Things Right Policy and procedure. Each complaint received is risk assessed in terms of the severity of the complaint and likelihood of the circumstances re occurring. The Patient Feedback Team grade complaints and support Units to investigate their complaints. In addition, analyses of serious complaints are presented to the Quality and Safety Forum for inclusion in the relevant Risk Register as appropriate. Action plans produced to reduce the risk of the complaint reoccurring are reviewed and monitored by the Forum, with lessons learned from investigations shared throughout the Health Board.

5.4.2.4 Claims

Claims are managed in accordance with the Claims Policy & Procedure. Claims management and trend analysis are reviewed by the Quality and Safety Forum. Lessons learned, where identified, are disseminated throughout SBUHB via the Quality and Safety Forum.

5.4.2.5 Health & Safety Committee

The Health & Safety Committee is chaired by a Non Officer Member and is supported by the Health & Safety Team. The Committee is a sub Committee of the Board.

The Head of Health & Safety is a member of the Quality and Safety Assurance Group ensuring there are strong links between quality assurance and health & safety agendas within the Health Board.

5.4.2.6 Health Board Specialist Groups

In addition to the above there are a number of specialist groups/committees (e.g. Infection Control & Prevention Committee, Medical Devices Group) in the Health Board which have specific responsibility for managing the risk associated to the specialty. These management

Groups and Committees either report directly to a sub committee of the Board or to the Quality & Safety Assurance Group.

5.4.2.7 Unit Governance Forums

The Chief Operating Officer reports directly to the Chief Executive and is responsible for the following Units:

- Mental Health and Learning Disabilities
- Morriston Hospital
- Neath Port Talbot Hospital
- Primary Care and Community Services
- Singleton Hospital

Each Unit has a Unit Board, which is ultimately responsible for Risk Management, specifically operational risks. The Unit Boards will ensure that risk management issues, which cannot be managed or are high level risks (16 and above), which may impact on strategic objectives, are escalated to the Risk Assurance Team for review and if appropriate advice sought from appropriate expertise in the Health Board and then escalated to an Executive Director lead who will consider the risk and whether to add to their Directorate risk register or recommend inclusion on the Health Board Risk Register to the Senior Leadership Team.

5.4.2.8 Corporate Directorates

There are nine Corporate Directorates:

- Chief Operating Officer
- Director of Governance
- Medical Director
- Director of Nursing and Patient Experience
- Director of Finance
- Director of Workforce & OD
- Director of Strategy
- Director of Public Health
- Director of Transformation

Each Executive Directorate is responsible for ensuring any risk management issue identified as a high risk is reported to the Senior Leadership Team and linked into the planning process, capital planning programme by identifying risks against the Board Objectives within the Annual Plan/IMTP.

6. Risk Management Process

This section of the document sets out an approach to the assessment of risk and the development of an integrated framework for risk management for the Health Board. When considering risk management it is important to understand the Health Board's risk appetite and

risk tolerance to specific risks as these will change, as they are not single fixed concepts, and will vary over time, and current influential factors at a strategic, tactical and operational level.

Risk appetite is about the pursuit of risk and risk tolerance is about what the Health Board will allow management levels within the organisation to deal with. Both risk appetite and risk tolerance are inextricably linked to performance over time.

The Health Board's Board is explicitly responsible for determining the nature and extent of the significant risks the organisation is willing to take to achieve strategic objectives.

6.1. Methodology

The methodology for identifying risk used within Health Board is the Australian/New Zealand model AS/NZ; Guidance upon acceptable risk is addressed within this methodology to assist managers to make informed decisions as to the extent of the risk and the application of appropriate action thereafter.

For each issue/risk identified the LIKELIHOOD & CONSEQUENCE mechanism will be utilised. Essentially this examines each of the issues and attempts to assess the likelihood of the event occurring (PROBABILITY) 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. The prioritising of risk using this mechanism is detailed in **Appendix 2.**

The Health Board uses the risk module of Datix to record and monitor all risks. Ideally all risks should be recorded on Datix and as a minimum all risks rated 9 and above must be reported in the risk management database. The Health Board Risk Register can be accessed through the Health Boards intranet and internet and is updated, as a minimum, on a quarterly basis.

6.2 Establish the context

Establish the strategic, organisational and risk management context in which the rest of the process will take place. Criteria against which risk will be evaluated should be established and the structure of the analysis defined.

The context can include the financial, operational, competitive, political (public perceptions/image), social, client, cultural and legal aspects of the Health Board's functions. Within these areas it is critical to identify the internal and external stakeholders/partners which may include any of the following: Welsh Government, patients, staff and contractors. Once the stakeholders/partners have been identified it is important to consider their objectives, take into account their perceptions, and establish communication policies with these parties. It is also important to consider these issues when considering relationships inside and outside the NHS the behaviour of the "partners" and the organisation and how this will affect any risks identified.

6. 3 Risk Identification

Risk identification can be undertaken on an individual basis or as part of a multidisciplinary team and can be reactive or proactive and linked to strategic objectives, underpinning the

assurance framework, or operational services we provide. Details of how to identify risks are provided within the Easy Read Guide for how to complete a Risk Assessment which supports the implementation of the Risk Management Policy and Risk Management Framework.

6.3.1 Strategic Risk and IMTP Plan (associated with the achievement of aims and objectives of the HB).

The IMTP Plan sets out the organisational objectives for 2019-2022 the achievement of these objectives will ensure the Health Board effectively manages key organisational risks. This will be a "top down" approach, undertaken collectively by the members of the Executive Board. The risk of not achieving the objective and the risks to that objective will be highlighted, as appropriate, to the Health Board, Stakeholders and partners.

6.3.2 Operational Risk (associated with the direct delivery of services by the organisation area i.e. risks arising from operational activities).

This will be a "bottom up" approach undertaken by the staff within individual Units overseen by the Management Boards. Where "operational" issues raise questions over the strategic objectives of the Health Board, these will be considered in detail by the Unit's Governance Groups.

6.3.3 Patient/Health & Safety Management

Patient and Health & Safety assessment involves identifying the significant risk areas in Units, prioritising them and deciding what action to take. Significant patient/Health & Safety risks are classified as those:

- that could lead to death, disability or severe distress to patients/staff/visitors;
- that are less serious but could occur more frequently or affect large numbers of patients/staff/visitors should also be included
- that could impact on the finances or reputation of the Health Board.

6.4. Analyse/Evaluate risks

Determine the existing controls and analyse risks in terms of consequence and likelihood in the context of those controls. The analysis should consider the range of potential consequences and how likely those consequences are to occur. This enables risk to be ranked so as to identify management priorities. If the levels of risk established are low, then risks may fall into an acceptable category and treatment may not be required. Consideration should be given to the balance between potential benefits and adverse outcomes of managing these risks.

The risk mapping exercise will be based around an analysis of the likelihood of the risk materialising and its impact should it materialise. Whilst there are quite complex models available, a simple model has been adopted and it is important to recognise that discussion of the risks is essential to determine within the risk description what the actual risk level is at the time of identification and review. In addition the description should set out the consequences of not taking the actions identified to support and inform management decisions and the IMTP process.

6.4.1. Acceptable Risk: Risk Score of 1 – 4 (Green)

Realistically it is never possible to eliminate all risks, and there will be a range of risks identified within the Health Board that would require us to go beyond 'reasonable action', if any, required to eliminate or reduce them, i.e. the cost in time or resources required to reduce the risks would outweigh the potential for harm. These risks would be considered 'acceptable' by the Health Board. Examples are frequent, low consequence events such as minor property loss or damage, injuries requiring first aid only, or potentially serious events that are unlikely to occur and for which reasonable preventative measures are already in place.

6.4.2. Manageable Risk: Risk Score of 5 – 9 (Yellow)

The risk can be realistically reduced, within a reasonable time scale, through cost effective measures through the purchase of new equipment and or training. Examples are manual handling injury, malicious damage, and injury to staff or patients. Action would normally be the responsibility of the Unit.

6.4.3 Moderate Risk: Risk Score 10 – 15 (Amber)

The risk will need to be reduced within 6 months, given that it is a moderate risk, action would normally be the responsibility of the Units.

6.4.4 High Risk: Risk Score of 16 – 25 (Red)

Significant risks are where the consequences of the event could seriously impact on the organisation and threaten its objectives. As examples accidental death, major fire, and major disruption of services. This category might include risks that are individually manageable but cumulatively serious, such as a series of similar injuries. Risks identified as being serious should be reported to the relevant Executive Director and to the monthly performance review meeting.

6.5. Risk Management and Control

For identified risks, the organisation will agree a programme of actions to manage and control the risks. This will take into account value for money, quality of service delivery, quality and reliability of the evidence to support the identified risk and the impact upon the organisation, stakeholders and partners. Consideration will be given to how to develop and implement specific cost-effective strategies to increase benefits and reduce potential costs. The SBUHB will use the following approaches to risk control:

6.5.1 Risk Appetite and Tolerance

The Chief Executive and the Board encourage the taking of controlled risks, the grasping of new opportunities and the use of innovative approaches to further the interests of the organisation and achieve its objectives, provided the resultant exposures are understood and acceptable.

When deciding if a risk should be tolerated it is necessary to consider a number of factors, e.g. legislation, clinical governance, patient experience, requirements of commissioners and the appetite for these risks. Risk appetite and tolerance considers what risks the Health Board is

prepared to take in pursuit of achieving its objectives. This document sets out levels of risks and within these levels there is a management structure which supports decision making in terms of risk appetite and tolerance. Risks rated up to 15 can be managed including determining the risk appetite and tolerance within Units. Risks rated 16 and above will need to be considered at Executive level in terms of the risk appetite and tolerance levels. Each risk must be considered individually to determine the level of risk appetite and tolerance.

Organisational policies and written control documents define where there are mandatory processes and procedures, e.g. the Equality and Human Rights Policy etc. Non-compliance with prescribed policies and procedures constitutes an unacceptable risk and possibly a contravention of legislation.

Some risks are tolerable provided the prescribed organisational process is followed, e.g. expenditure proposals, staff recruitment, and designated responsibilities/ authorities are adhered to.

Managers may take risk management decisions on the basis of their delegated financial authority and the devolved responsibilities set out in the Scheme Delegation within the Standing Orders.

6.5.2 Treat the Risk

Treat by taking action to contain the risk to an acceptable level using internal controls which include:

- Reactive controls – these controls are designed to identify occasions of undesirable outcomes having been achieved – after the event so only appropriate when it is possible to accept the loss or damage incurred e.g. post implementation reviews to detect lessons to be learnt from projects for application in future work.
- Proactive controls – designed to ensure a particular outcome is achieved or to ensure an undesirable event is avoided e.g. health and safety guidelines etc.
- Preventative controls – limit the possibility of an undesirable event being realised e.g. separation of duties etc
- Corrective controls – to correct undesirable outcomes which have been realised – provide a route of recourse to achieve some recovery against loss or damage e.g. design contract terms to allow recovery of overpayment.

6.5.3 Terminate the Risk

Terminate – decision not to take the risk. This might be where the level of risk outweighs the possible benefits, and the risk is terminated by not doing something or doing something differently thereby removing the risk (where it is feasible to do so).

6.5.4 Transfer the Risk

Transfer – decision is made to transfer the risk to others, e.g., through insurance, contracting out the provision of service or paying a third party to take it on. Overall accountability for the risk may still remain with the Health Board and therefore assurance would still need to be gained

in this area. In addition, many areas of business and reputational risk cannot be transferred at all.

Action plans will be developed to set out the steps required to manage each risk and will include the approach chosen to control the risk as detailed above. Where additional resources are required to effectively manage a risk, this will be linked into the Health Board's business planning process.

6.5.5 Escalation of Risks

On a monthly basis Units and Corporate Directorate are requested to escalate risks for consideration for entry on the HBRR, a trigger of risks rated 16 and above is used for escalation where the controls are not adequate and or the actions are outside of the Units/Corporate Directorate's control. In addition risks can be escalated in terms of themes of risks across the organisation or sensitive risks which need to be escalated to the Risk Management Group/Senior Leadership Team and sub Committees of the Board. The Risk Scrutiny Panel will oversee the escalation and reporting of these risks.

6.6 Communicate and Consult

Communicate and consult with internal and external stakeholders and partners as appropriate at each stage of the risk management process and concerning the process as a whole. The frequency of the communication will vary depending upon the severity of the risk and should be discussed and agreed with the stakeholders and partners. This process will be led by the person nominated as the lead to manage the risk and for communication with external stakeholders this will be the appointed Executive Director lead for the risk.

Effective internal and external communication is important to ensure that those responsible for implementing risk management, and those with a vested interest understand the basis on which decisions are made and why particular actions are required. Internal stakeholders can include any managers which the risk identified may impact on their service or staff. External stakeholders will vary depending on the type of risk and the risk lead for the Unit will need to consider which external stakeholders will need to be notified. All significant risks will be reported to the Welsh Government through the weekly brief from organisations and quarterly performance review meetings.

There will be occasions when a risk is shared with another Health organisation for example in the instance of Service Level agreements for the delivery of services across organisations. In this case the Risk & Assurance Team can share these risks with the relevant health organisations through the risk management database on the request from Units.

7. Risk Register

Once the risk has been identified and analysed the next stage is to ensure the risk is recorded in Datix Web Risk Register Module which will form the Unit's Risk Register. The principal tool that the organisation will use for managing the risk assessment systems and processes will be the Health Board's Risk Register, template attached as **Appendix 3**. The Health Board's Risk Register can be described as

“a log of all the risks that may threaten the success of the Health Board in achieving its declared aims and objectives.”

Identifying and logging the risk will ensure that the Units are aware of the risk and, following consideration of any existing controls in place, whether other options exist to further reduce or eliminate the risk.

An Action Plan will be approved and monitored by the Unit Boards setting out action to be taken and priorities within their Units. The Head of Patient Experience, Risk and Legal Services will coordinate the Health Board Risk Register and produce a SBUHB Risk Register Report and action plan, for risks with a risk rating of 16 and above. The Executive Team will oversee and approve the Health Board Risk Register which will then be reported to the Audit Committee.

Risk Registers will continue to be developed to include risks identified from:

- Legislation and regulations;
- National and local targets
- Deficiencies with various Healthcare Standards;
- Findings from department specific and organisational wide hazard reports and risk assessments;
- Underlying "root" causes of incidents complaints and claims;
- Underlying causes related to poor trends identified from key performance indicators;
- Actions to reduce risks which could not be or were not implemented for various reasons, such as resource limitations; and
- Any other source of information that could be considered to be threat to patient, staff, visitors, environmental safety or the organisations wellbeing.

8. Risk Management Training

The Risk Management Policy will be supported by training to ensure staff are trained in the assessment and management of risks and promote an open and fair culture focusing on learning and sharing lessons. Ward/Department Managers will be primarily responsible for managing risk and a minimum of 2 members of staff, including the Manager, will be trained. These staff will be expected to oversee the risk assessments carried out in their area of work and be responsible to cascade this training to their staff with particular reference to:

- General principles and objectives of risk management;
- Role of staff in the risk management process;
- Reporting systems and the importance of following them;
- Risk register and;
- Risk identification and assessment.

All training provided to staff (of whatever grade) is to be recorded centrally using the Electronic Staff Record and training will be provided every three years. Managers can book their staff onto the training earlier if a training need is identified through an individual’s personal development review.

9. Glossary

Risk Appetite
The amount of risk that an organisation is willing to seek or accept in the pursuit of its long term objectives.

Risk Tolerance
The boundaries of risk taking outside of which the organisation is not prepared to venture in the pursuit of its long term objectives.

Risk Universe
The full range of risks which could impact, either positively or negatively, on the ability of the organisation to achieve its long term objectives.

Risk analysis
Systematic use of information to identify opportunities and threats and to estimate the likelihood of occurrence and severity of the impact

Risk assessment
The approach and process used to prioritise and determine the likelihood of risks occurring and their potential impact on the achievement of objectives.

Risk identification
Determination of what could pose a risk; the process to describe and list sources of risks (opportunities and threats).

Risk Management
The process of identifying and assessing risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress. This provides a disciplined environment for proactive decision making.

Risk & assurance framework
As an integral aspect of planning and performance management, sets the context within which risks are managed in terms of how they will be identified, analysed, controlled, monitored and reviewed.

Risk management matrix
Tool to assess the overall risk rating using a 5x5 matrix based on the impact of the risk and the likelihood of the risk being realised.

Risk owner
An individual who is in a position to ensure a risk is managed and controlled.

Risk rating
The overall score given to a risk based on an assessment of both its likelihood of being realised and its potential impact, measured on a scale of 1 (lowest) to 25 (highest).

Significant risk

Those risks assessed to have an overall rating of 16 or above (using risk management matrix).

Strategic risk
Risk concerned with where the organisation wants to go, how it plans to get there and how it can ensure success.

Terminate
Remove the risk by termination or doing things differently.

Tolerate
Continue with a risk as it is at a reasonable level but monitor regularly.

Transfer
Transfer the risk to a third party such as insurance.

Treat
Control the risk by taking contingent or containment action e.g. security checks etc.

11. References

1. Building the Assurance Framework: *A Practical Guide for NHS Boards* (Department of Health, Gatelog Ref 1054, March 2003)

3. BS ISO 31000 Risk management – Principles and guidelines on implementation (British Standards Institute, DPC/30182164 DC, May 2008)

5. Identifying risk, taking action: Monitor's approach to service performance in NHS foundation trusts (Monitor, IRREP 02/03,)

6. Audit Committee Handbook June 2012

7. Leading health and safety at work – Leadership actions for Directors and Board Members (Institute of Directors and Health and Safety Executive, INDG417, 09/09)

8. Risk Assessment Framework: a tool for departments (HM Treasury, ISBN 978-1-84532-625-8, July 2009)

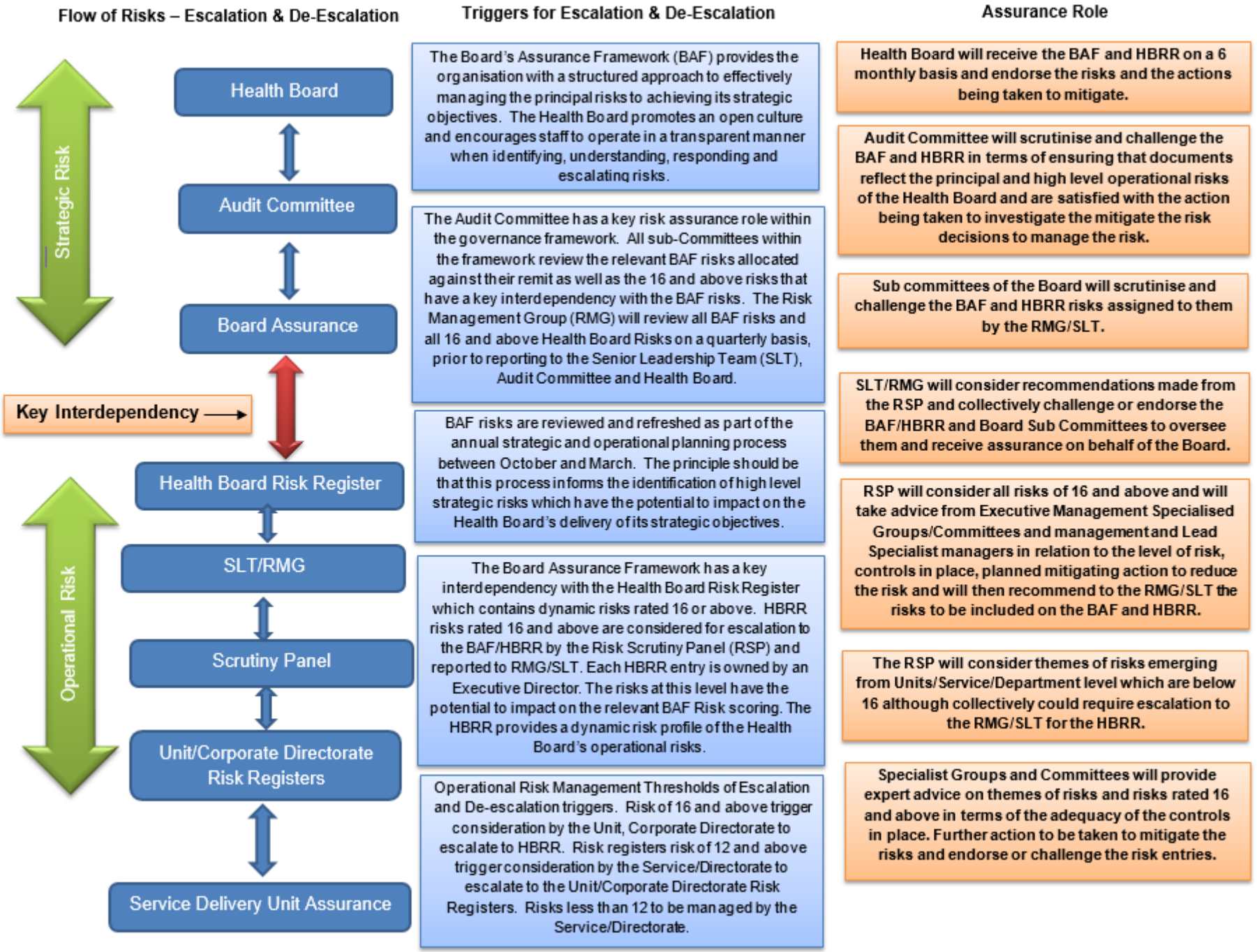
9. Risk Essentials – A Risk Management Framework (Welsh Government, Version 2, October 2006)

10. Risk Management in the NHS (NHS Management Executive, December 1993)

11. The Orange Book: Management of Risk – Principles and Concepts (HM Treasury, ISBN 1-84532-044-1-1, October 2004)

12. Your Risk & Assurance Framework: A structured approach – (Welsh Government, December 2009)

Appendix 1


Flow of Risks – Escalation & De-Escalation
Triggers for Escalation & De-Escalation
Assurance Role
Strategic Risk
Health Board
Audit Committee
Board Assurance
Key Interdependency
Health Board Risk Register
SLT/RMG
Scrutiny Panel
Unit/Corporate Directorate Risk Registers
Service Delivery Unit Assurance
Operational Risk
The Board's Assurance Framework (BAF) provides the organisation with a structured approach to effectively managing the principal risks to achieving its strategic objectives. The Health Board promotes an open culture and encourages staff to operate in a transparent manner when identifying, understanding, responding and escalating risks.
The Audit Committee has a key risk assurance role within the governance framework. All sub-Committees within the framework review the relevant BAF risks allocated against their remit as well as the 16 and above risks that have a key interdependency with the BAF risks. The Risk Management Group (RMG) will review all BAF risks and all 16 and above Health Board Risks on a quarterly basis, prior to reporting to the Senior Leadership Team (SLT), Audit Committee and Health Board.
BAF risks are reviewed and refreshed as part of the annual strategic and operational planning process between October and March. The principle should be that this process informs the identification of high level strategic risks which have the potential to impact on the Health Board's delivery of its strategic objectives.
The Board Assurance Framework has a key interdependency with the Health Board Risk Register which contains dynamic risks rated 16 or above. HBRR risks rated 16 and above are considered for escalation to the BAF/HBRR by the Risk Scrutiny Panel (RSP) and reported to RMG/SLT. Each HBRR entry is owned by an Executive Director. The risks at this level have the potential to impact on the relevant BAF Risk scoring. The HBRR provides a dynamic risk profile of the Health Board's operational risks.
Operational Risk Management Thresholds of Escalation and De-escalation triggers. Risk of 16 and above trigger consideration by the Unit, Corporate Directorate to escalate to HBRR. Risk registers risk of 12 and above trigger consideration by the Service/Directorate to escalate to the Unit/Corporate Directorate Risk Registers. Risks less than 12 to be managed by the Service/Directorate.
Health Board will receive the BAF and HBRR on a 6 monthly basis and endorse the risks and the actions being taken to mitigate.
Audit Committee will scrutinise and challenge the BAF and HBRR in terms of ensuring that documents reflect the principal and high level operational risks of the Health Board and are satisfied with the action being taken to investigate the mitigate the risk decisions to manage the risk.
Sub committees of the Board will scrutinise and challenge the BAF and HBRR risks assigned to them by the RMG/SLT.
SLT/RMG will consider recommendations made from the RSP and collectively challenge or endorse the BAF/HBRR and Board Sub Committees to oversee them and receive assurance on behalf of the Board.
RSP will consider all risks of 16 and above and will take advice from Executive Management Specialised Groups/Committees and management and Lead Specialist managers in relation to the level of risk, controls in place, planned mitigating action to reduce the risk and will then recommend to the RMG/SLT the risks to be included on the BAF and HBRR.
The RSP will consider themes of risks emerging from Units/Service/Department level which are below 16 although collectively could require escalation to the RMG/SLT for the HBRR.
Specialist Groups and Committees will provide expert advice on themes of risks and risks rated 16 and above in terms of the adequacy of the controls in place. Further action to be taken to mitigate the risks and endorse or challenge the risk entries.

Appendix 2

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 (PROBABILITY) 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.

LIKELIHOOD (*)					
LIKELIHOOD SCORE	1	2	3	4	5
DESCRIPTOR	RARE	UNLIKELY	POSSIBLE	PROBABLE	EXPECTED
Frequency: How often might it/ does it happen?	Not expected to occur for 10 years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability: Will it happen or not?	Less than 0.1% chance	0.1 - 1% chance	1 - 10% chance	10 - 50% chance	Greater than 50% chance

CONSEQUENCE (**) - Severity of Harm					
LIKELIHOOD SCORE	1	2	3	4	5
DOMAINS	NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
Patient Safety	Minimal injury requiring no/minimal intervention or treatment. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Increase in length of hospital stay for 1-3 days. Category 2 pressure ulcer.	Moderate injury requiring professional intervention. Increase in length of stay by 4-15 days. Category 3 pressure ulcer. An event which impacts on a small number of patients.	Major injury leading to long-term incapacity/ disability. Fall requiring surgical intervention. Category 4 pressure ulcer. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of people.
Health and Safety	No obvious injury. No time off work.	An injury sustained at work requiring time off or reduced duties up to 7 days.	RIDDOR Reportable 7 Days or more off due to work related injury or reduced duties. Any Reportable Occupational Disease.	RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. (Formally classified as major injuries).	RIDDOR Reportable. Incident leading to death. An event which impacts on a large number of staff.
Governance and Assurance	Peripheral element of treatment or service suboptimal. Informal inquiry.	Overall treatment or serivce suboptimal. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance rating if unresolved.	Treatment or service has significantly reduced effectiveness. Formal complaint. Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.	Non-compliance with national standards with significant risk to patients if unresoved. Multiple complaints/ independent review. Low performance rating. Critical report.	Totally unacceptable level or quality of treatment/ service. Gross failure of patient safety if findings not acted on. Inquest/ombudsman/ inquiry. Gross failure to meet national standards.
Workforce and Organisational Development	Lower than expected staffing level that temporarily reduces service quality for 1 day or less.	Lower than expected staffing level that temporarily reduces service quality for 1 day or more.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level or skill mix (1 - 5 days). Low staff morale. Poor staff attendance for mandatory/key training.	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or skill mix (5 days or more). Loss of key staff. Very low staff morale.	Non-delivery of key objective/service due to lack of staff. Ongoing unsafe staffing levels or skill mix. Loss of several key staff. No staff attending mandatory training/ key training on an ongoing basis.
Compliance with Legislation and Statutory/Regulatory Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	Single breach in statutory duty. Challenging external recommendations/ improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices/ Critical report. Low performance rating.	Multiple breaches in statutory duty or prosecution. Complete systems change required. Zero performance rating. Severely critical report.
Information Governance	There is absolute certainty that no adverse effect can arise from the breach	A minor adverse effect must be selected where there is no absolute certainty. A minor adverse effect may be the cancellation of a procedure but does not involve additional suffering. It may also include possible inconvenience to those who need the data to do their job.	An adverse effect may be release of confidential information into the public domain leading to embarrassment ot it prevents someone from doing their job such as a cancelled procedure that has the potential of prolonging suffering but does no lead to a decline in health.	There has been reported suffering and decline in health arising from the breach or there has been some financial detriment occurred. Loss of bank details leading to loss of funds. There is a loss of employment.	A person dies or suffers a catastrophic occurrence.
Sustainable Services	Insignificant cost increase/ shcedule slippage. Loss/interruption of service >1 hour	<5% over project budget. Minor schedule slippage <1 month. Loss/interruption of service >8 hours.	5-10% over project budget. Schedule slippage <2 months. Loss/interruption of service >1 day	10-25% over project budget. Schedule slippage <3 months. Loss/interruption of service >1 week	>25% over project budget. Schedule slippage >3 months. Key objectives not met. Permanent loss of service or facility
Financial Management	Small loss.	Loss of 0.1 - 0.25% of budget*	Loss of 0.25 - 0.5% of budget*	Loss of 0.5 - 1.0% of budget* Uncertain delivery of key objective.	Loss of >1% of budget* Non-delivery of key objective.
Environment, Estates and Infrastructure	Minimal or no impact.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic impact on environment.
Medical Devices, Equipment and Supplies	Minimal injury requiring no/minimal intervention or treatment. Negligible disruption to a clinical service.	Minor injury or illness, requiring minor intervention. Minor short term disruption to a clinical service.	Moderate injury requiring professional intervention. Re-scheduling of a clinical service.	Major injury leading to long-term incapacity/ disability. Cancellation of a clinical service.	Incident leading to death or permanent irreversible health effects. Cessation or closure of a clinical service.

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

Appendix 3

Risk Register Template

Risk Ref	Strategic Aim	Date of Entry	Unit	Type of Risk/ Specific Risk	Current Context	Controls in Place	Consequence	Likelihood	Current Risk Rate	Action Plan	Action Lead	Board/ Committee	Progress