Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Meeting Date	21st February 2019	**Agenda Item**	6.2
Report Title	Health Board Risk Register (Q&S Risks)		
Report Author	Hazel Lloyd, Head of Patient Experience, Risk & Legal Services		
Report Sponsor	Cathy Dowling, Assistant Director of Nursing & Patient Experience		
Presented by	Gareth Howells, Director of Nursing & Patient Experience		
Freedom of Information	Open		
Purpose of the Report	This report provides an update on the work being undertaken to update the Health Board Risk Register		
Key Issues	• Health Board risks relating to Quality and Safety are attached as Appendix 1. • The Executive Team continue to review and develop the Health Board Risk Register. •		

Specific Action Required *(please ✓ one only)*	**Information**	**Discussion**	**Assurance**	**Approval**
	✓			

Recommendations	Members are asked to: • **NOTE** the contents of the report; • **NOTE** the Health Board risks relating to Quality and Safety and actions being taken to investigate the risk.

Strategic Risk Report

1. Introduction

The report provides an update on the work being undertaken to review and refresh the Health Board Risk Register ("HBRR") and the risk management processes in the organisation. The report also provides details of the Quality and Safety risks.

2. Background

The 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 for members to note that the Executive Directors, as risk owners, are appropriately sighted and involved in the development of the HBRR, 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

Refreshed Health Board Risk Register
The HBRR has been developed and updated following discussions with the Executive Team. The HBRR is attached as Appendix 1. The Senior Leadership Tem and Audit Committee have agreed that risks of the HBRR would be linked to the Board or a sub Committee of the Board for oversight and scrutiny. The current risks linked to the Quality and Safety Committee are detailed in Tale 1.

Table 1

ID	Risk
738	Infection Control
922	TAVI
837	Healthcare Models for Aging Population
737	Population Health Improvement
1035	Digital Transformation
1043	Electronic Record
1514	DoLS Management
1564	ED Electronic Systems
1565	Discharge Planning
1759	Nurse Staffing Levels

A full list of the Health Board risks linked to Committees, other than the Quality & Safety Committee, are set out in Table 2. Members are requested to consider whether they require oversight of any risks linked to another Committee as set out in Table 2.

ID	Risk
Quality & Safety Committee	
738	Infection Control
922	TAVI
837	Healthcare Models for Aging Population
737	Population Health Improvement
1035	Digital Transformation
1043	Electronic Record
1514	DoLS Management
1564	ED Electronic Systems
1565	Discharge Planning
1759	Nurse Staffing Levels
ID	**Risk**
Performance & Finance Committee	
738	Unscheduled Care Targets
840	Waiting Time Targets
1398	Sustainable Services
1563	CAHMS
1761	Cancer Targets
1763	Engagement & Equality Impact Assessments
ID	**Risk**
Workforce & OD Committee	
843	Recruitment of Medical & Dental Staff
1796	Capacity of W&OD Function
ID	**Risk**
Health & Safety Committee	
841	Accommodation requirements meeting H&S legislation
838	Equipment
1567	Cladding of High Rise Buildings
ID	**Risk**
Audit Committee	

1217	Operational Strategic Decisions to be data informed
ID	**Risk**
Joint Transition Board	
1764	Bridgend Boundary Changes
ID	**Risk**
Board	
1297	IMTP
1762	Welsh Language Standards
1724	BREXIT

4. **Financial Implications**

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

5. Recommendations

Members are asked to:

- **NOTE** the contents of the report and consider the risks to be reported on a quarterly basis to the Committee from the HBRR.

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

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

Report History	Last reported to December 2018 Quality and Safety Committee
Appendices	Appendix 1 HBRR

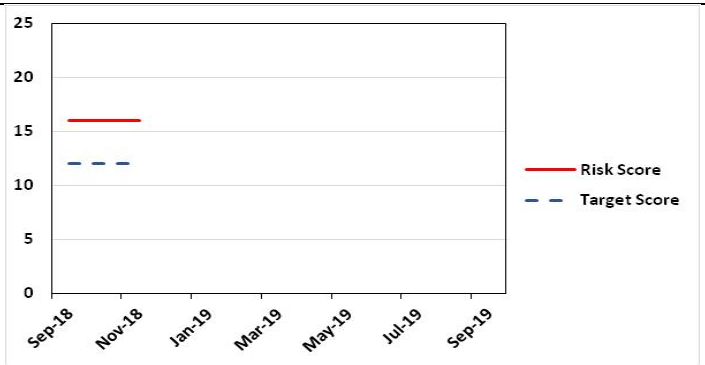
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

CORPORATE RISK REGISTER
JANUARY 2019

HEALTH BOARD CORPORATE RISK REGISTER
SUMMARY OF ASSESSED RISKS (OVERALL TREND) – JANUARY 2019

Impact/Consequences	5			737: Population Health Improvement		
	4				• 738: Unscheduled Care • 922: TAVI Service • 837: Healthcare model for aging population • 1761 Cancer Target Compliance • 1759: Compliance with Nurse Staffing Levels (Wales) Act 2016 • 1514: DOLS Authorisation and Compliance with Legislation • 1564: ED Information Systems • 1563: Child & Adolescence Mental Health Services • 1763: Engagement & Impact Assessment Requirements • 1217:Operational and strategic decisions are not data informed	• 1724: No Deal Brexit • 1565: Discharge information • 1035: Sustainable Clinical Services for Digital Transformation • 1043: Electronic Patient Record
	3			1764: Bridgend Boundary Change	• 739: Infection Control • 841: Accommodation fit for purpose • 838: Replacement of medical equipment • 1567: Fire Safety Regulation Compliance • 1762: Compliance with Welsh Language Standards • 1297: IMTP	
	2					
	1					
C X L		1	2	3	4	5
		Likelihood				

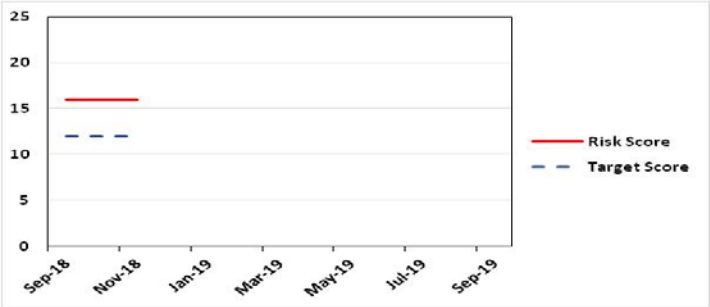
Datix ID Number :ID 738	CRR Ref Number:1
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee
Risk: If we fail to comply with Tier 1 target - **Unscheduled Care** then this will have an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

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
• 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.	**Action**	**Lead**	**Deadline**
	Bed utilisation audit being undertaken to support USC system redesign programme in NPT and Swansea.	Jan Thomas	January 2019
	Clinical services plan for USC is being finalised.	Jan Thomas	January 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 4x4 = 16	Additional Comments

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

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

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

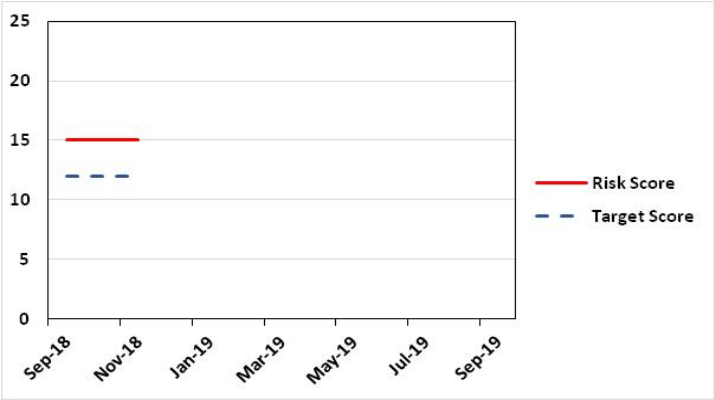
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• General situation monitored through W&OD Committee. • Communication with Deanery • Recruitment Campaigns • Integrated Medicine and Paediatrics short term workforce plans • Monitoring by Executive Teams and speciality based local workforce boards	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 4x4=16	Additional Comments

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

Risk Rating
(consequence x likelihood):
Initial: 5 x 5 = 20
Current: 3 x 5 = 15
Target: 3 x 2 = 12

Level of Control
= 40%

Date added to the risk register
January 2016



Rationale for current score:
Currently under targeted intervention for rates of infection, achievement of targets are variable with monthly fluctuations

Rationale for target score:

Once the infection control team is fully recruited to, ICNet is functioning to its full capability the infection control team will be able to support the clinical areas more and drive service improvements.
In addition, a negative pressure isolation facility is being built into the new emergency department at Morriston hospital providing another facility to appropriately manage patients at the front door. Review and implementation of a robust clean of patient rooms following an infection will reduce the risk of cross infection. Plans are in place for initial training for this to commence January 2019.

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

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

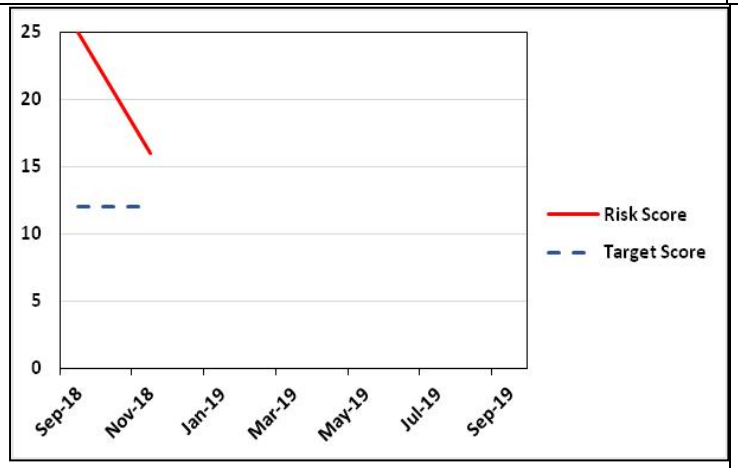
Mitigating actions (What more should we do?)

Action	Lead	Deadline
Recruitment to ensure the team is fully established with the right skills and experience	Lisa Hinton	April 2019
Ongoing infection control team involvement in site level estates projects to ensure appropriate isolation facilities are factored in from the outset	Joanne Walters	March 2019
Review of reporting requirements to enable a focus on driving improvement and service delivery	Lisa Hinton	March 2019
Review of extended properties, requirements for appropriate information and reporting capabilities within ICNet to streamline the process and reduce the burden on the infection control team enabling the focus on improvement	Delyth Davies	March 2019
HPV/UV cleaning post infection to be implemented	Sharon Williams	April 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 3 x 5 = 15	Additional Comments

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

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



Level of Control
= 50%

Date added to the risk register
19/07/2016

Rationale for current score:

Patients waiting in excess of 36 weeks for TAVI procedure as a result of lack of service infrastructure as well as increasing demand.

Mortality review undertaken which has indicated that patients have come to serious harm as a result of excessive waits.

Recovery plan commenced on 5th November and has begun to reduce number of patients waiting over 36 weeks however without sustainable service in place from early 2019, backlog will increase again.

Given reduction in number of patients waiting over 36 weeks since 5th November, risk score has reduced from 25 to 16.

Rationale for target score:

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

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

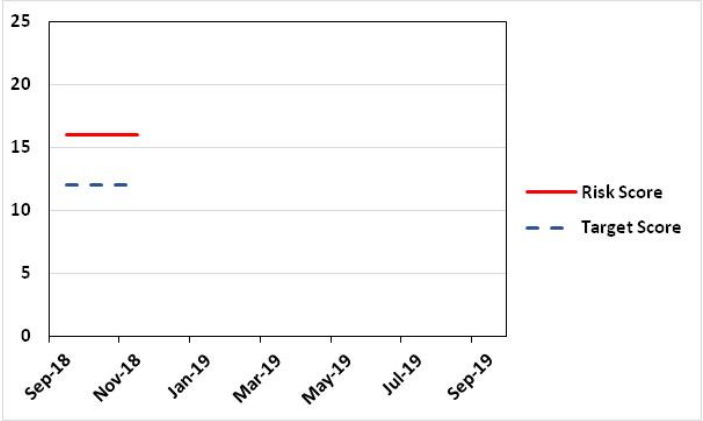
- TAVI Recovery Plan implemented with aim of reducing backlog of patients by end of financial year. Operational service meets weekly to oversee this plan.
- Plan is supported with Executive oversight at weekly TAVI OG meeting.
  TAVI has been prioritised for consideration in next year's WHSSC ICP however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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Clear backlog of patients awaiting TAVI by January 2019	Neil Miles	31/01/2019
Progress case to WHSSC for sustainable TAVI service resource to be included in 2019/20 ICP	Neil Miles/ Maxine Evans	18/10/2019
Establish HB support to 'bridge the gap' for	Neil	31/01/2019

	sustainable TAVI service between completion of recovery plan in February 2019 and possible receipt of WHSSC funding in April 2020.	Miles	
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		

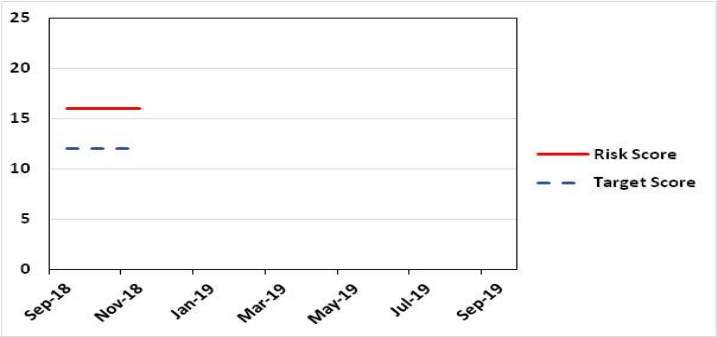
Datix ID Number :ID 837	CRR Ref Number: 11
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, Director of Nursing and Patient Experience **Assuring Committee:** Quality and Safety Committee
Risk: If we fail to provide an appropriate **healthcare model for aging population** 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:** January 2019

Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 =16 Target: 4 x 3 = 12		Rationale for current score: New Service Module being developed Rationale for target score: New models of care will reduce the risk to be at an acceptable level
Level of Control = 70%		
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	Move to a balanced service model with bed provision reducing over time, development of community OPMH Hubs, community development and essential infrastructure services such as support & stay, care home support, memory clinics and Day Services.	Chief Operating Officer	31/01/2019

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

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

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

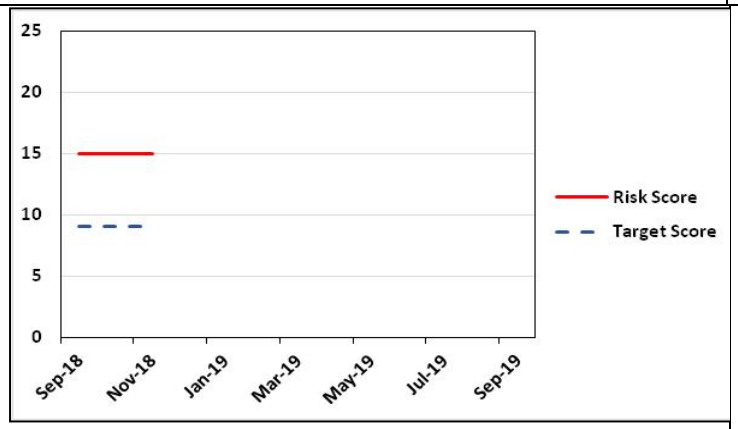
Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	Lead	Deadline
• Key areas where performance linked to health & safety/fire issues flagged through Health & Safety and Quality & Safety Committees and actions agreed to mitigate impacts.	Develop a strategy to improve primary and community services estate.	Des Keighan	30/04/2019
• Issues raised through site meetings held regarding service changes for all 4 acute hospital sites	Develop BJC's to improve the infrastructure of the 3 acute hospital sites (not including Neath Port Talbot).	Des Keighan	30/04/2019

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• The Cabinet Secretary for Health & Social Services has now set the initial pipeline of health and care centres to be delivered by 2020-21. • The following projects have been identified for your Health Board including: Penclawdd Health Centre - refurbishment/redevelopment proposal (£0.800m at 16-17 prices) Murton Community Clinic – refurbishment/redevelopment proposal (£0.400m at 16-17 prices) Bridgend Town Centre Primary Care Centre – new build development (£5.000m at 16-17 prices); and Swansea Wellness Centre – new build development (£10.000m at 16-17 prices).	

The figures above represent the funding ceiling identified for the schemes. All of the above projects have been identified within the capital pipeline, and we are In the stage of awaiting approval from the Welsh Government for each business cases applicable as soon as possible	
Current Risk Rating 4 x 3 = 12	Additional Comments

Datix ID Number : 737	CRR 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:** January 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
26/01/2016

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	Nina Williams	March 2019
Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report.	Nina Williams	March 2019
Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins	Nina Williams	March 2019

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

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

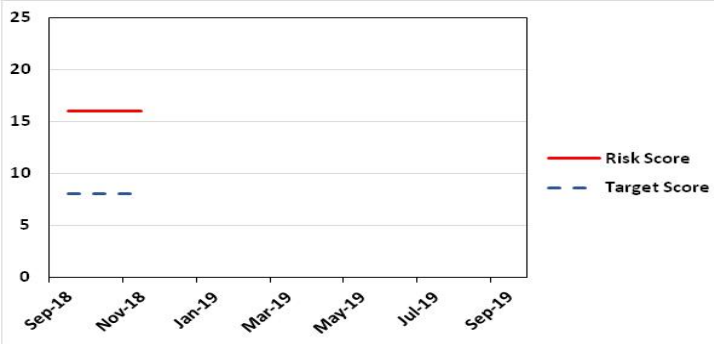
Gaps in assurance
(What additional assurances should we seek?)

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

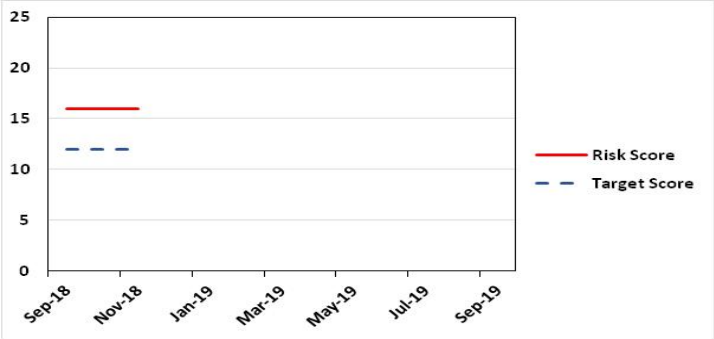
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 =16 Target: 4 x 2 = 8		Rationale for current score: Consequence is high given nature of the risk. Likelihood is being managed through the controls and actions set out.
Level of Control = 90%		Rationale for target score:
Date added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

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
• 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	Action	Lead	Deadline
	Escalation and scrutiny to Performance and finance Committee for off profile specialties	Darren Griffiths, Associate Director of Performance	Monthly
	Develop sustainability plans for specialties through the emerging Clinical Services Plan	Darren Griffiths, Associate Director of Performance	31/01/19
	Protect elective capacity during winter period to ensure elective capacity is maintained	Chris White, COO	All of Quarter 4

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

Current Risk Rating 4 x 4 = 16	Additional Comments

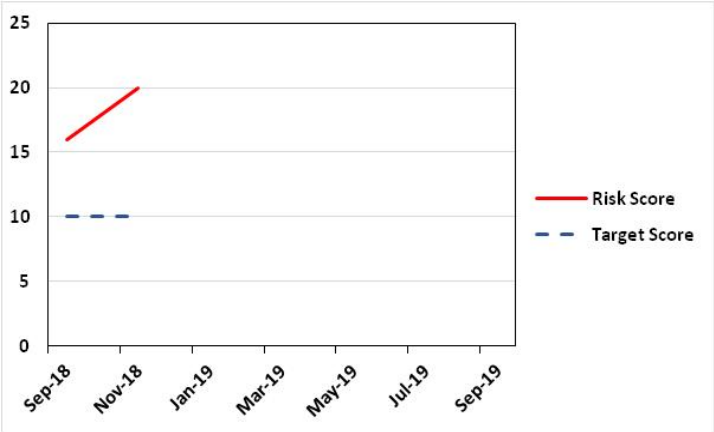
Datix ID Number :838	CRR Ref Number: 17
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Sian Harrop Griffiths, Director of Strategy **Assuring Committee:** Health and Safety Committee
Risk: If we are unable to replace key pieces of equipment could adversely affect capacity and patient well being	**Date last reviewed:** January 2019

Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 =16 Target: 4 x 3 = 12		Rationale for current score: Database being developed to support an ongoing equipment replacement programme.
Level of Control = 90%		Rationale for target score:
Date added to the risk register Jan 2013		

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

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

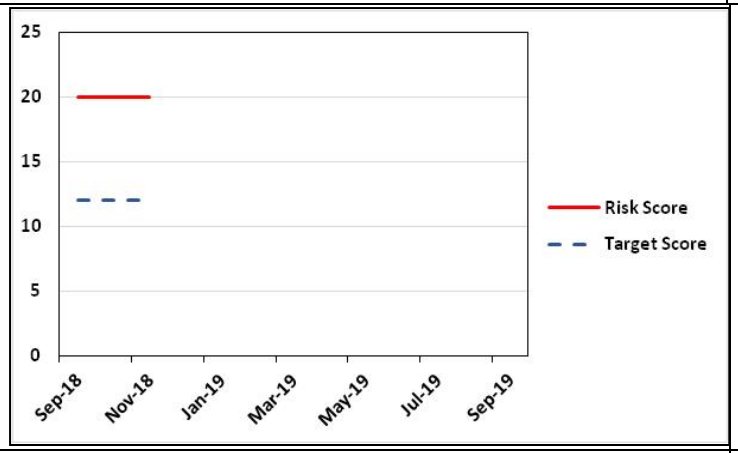
Datix ID Number: 1035	CRR Ref Number: 27
Objective: Digitally enabled care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Quality and Safety Committee, Informatics Programme Board
Risk: Inability to deliver sustainable clinical services due to lack of digital transformation.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

Risk Rating (consequence x likelihood):		Rationale for current score:
Initial: 4 x 4 = 16 Current: 4 x 5 = 20 Target: 5 x 2 = 10		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.
Level of Control =50%		Rationale for target score:
Date added to the risk register 2012		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?)		
• Digital strategy has been approved by the Health Board • Capital priority group for the HB considers digital risks for replacement technology which is fed	Action	Lead	Deadline
	Develop a new Strategic Outline Plan setting out the requirement to deliver the first phase of	Chief Operating	07/2019

into the annual discretionary capital plan • IBG process allows for investment requests in projects to be submitted to the HB for consideration and provides scrutiny to ensure Digital resources required are considered for all projects • Informatics prioritisation process has been introduced to ensure requests for digital solutions are considered in terms of alignment to the strategy objective, technical solutions and financial implications • 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	the Digital strategy	Officer	
	Work with finance and the Health Board leadership team to identify additional revenue streams	Chief Operating Officer	March 2019
	Ensure informatics prioritisation process is embedded into the ways of working so that resource implications of digital solutions are transparent and agreed at outset of projects	Chief Operating Officer	March 2019
	Ensure business cases requiring digital services include appropriate implementation and support costs	Chief Operating Officer	March 2019
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
• 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	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. Impact of boundary change on resources and capability to deliver digital services going forward could be significant.		
Current Risk Rating 4 x 5 = 20	Additional Comments This is further impacted by the boundary change which could have significant impact on resources and capability to deliver digital services going forward.		

Datix ID Number: 1043	CRR Ref Number: 36
Objective: Digitally Enabled Care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Quality and Safety Committee, Informatics Programme Board
Risk: Lack of a single electronic record means there is greater reliance on the provision of the paper record. If we fail to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards.	**Date last reviewed:** January 2019

Risk Rating (consequence x likelihood):		Rationale for current score:
Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 =12		C - Inability to find records for patients could delay care/increase length of stay over 15 days. Could also mean patients receive incorrect treatment L - we know this happens from incidents raised
Level of Control =70%		**Rationale for target score:**
Date added to the risk register June 2016		C - Inability to find records for patients could delay care/increase length of stay over 15 days. Could also mean patients receive incorrect treatment L – RFID and digitalisation of the health record will reduce the constraints of the current filing methodology and reduce the volume of paper being added to the record. Further digitalisation of the paper record will reduce the reliance of clinicians on the paper record.

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

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

Mitigating actions (What more should we do?)

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

Assurances	Gaps in assurance

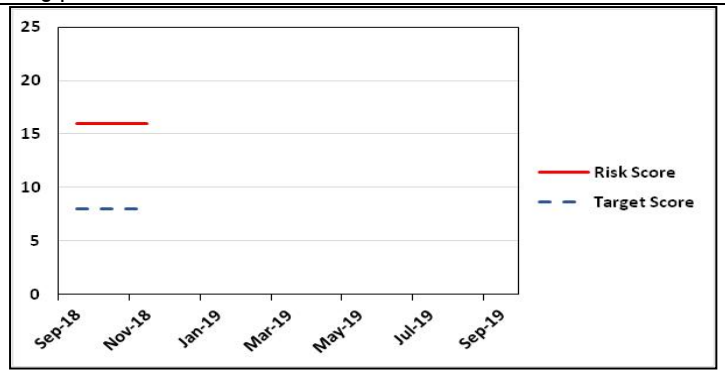
(How do we know if the things we are doing are having an impact?)	(What additional assurances should we seek?)
Preparation work for RFID has started to release space and increased destruction levels	Investment required supporting the delivery and operational costs of the Digital strategy. Reliance on NWIS for delivery of the solution for a fully electronic patient record Impact of the Infected Blood Enquiry on the Health Boards ability to destroy notes.
Current Risk Rating 4 x 5 = 20	Additional Comments

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

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

Level of Control
=70%

Date added to the risk register
Q2 2016/17



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

Rationale for target score:

C- will remain the same or increase due to increased reliance in information
L- Investment in BI will lead to more information be available and used. The higher the use of information at operational level will lead to better quality data.

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

- The Health Board has continued to invest in the provision of Dashboards and we have doubled our licensing stock for both QlikSense and QlikView Business Intelligence Platforms in 2018/19.
- 17 dashboards in place including Mortality, Clinical Variation and Primary & Community Care Delivery Unit Dashboard and Ward Dashboard
- Safety Huddle implemented in Morriston is improving data quality and improving operational working
- Business Intelligent Information Manager appointed, who will take the lead for creating a Business Intelligence Strategy and Implementation Plan
- Investment and revised ways of working introduced within the coding department have achieved coding targets and data quality

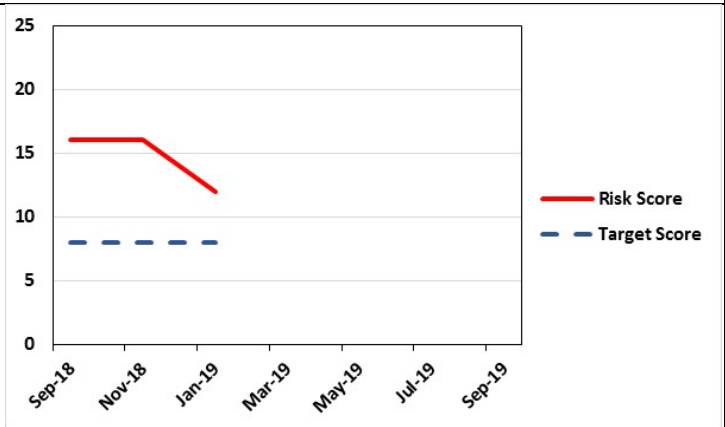
Mitigating actions (What more should we do?)

Action	Lead	Deadline
Produce Business Intelligence Strategy and get signed off by the Board	Matt John, Interim Chief Information Officer	09/2019
Produce BI strategy implementation plan outlining investment requirements in capacity and capability	Matt John, Interim Chief Information Officer	12/2019
Investment and implementation of system to record patient outcome measures	Matt John, Interim Chief Information Officer	March 2019

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)	
More evidence based and proactive decisions being made.	Culture of the organisation needs to change to focus on information and Business intelligence for operational rather than reporting purposes. Capability of operational staff to utilise the tools and capacity to act on the intelligence provided.	
Current Risk Rating 4 x 4 = 16	Additional Comments	

Datix ID Number :1297	CRR Ref Number: 39
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Health Board
Risk: If the 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:** January 2019

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



Level of Control
= 70%

Date added to the risk register
Quarter 4 2016/2017

Rationale for current score:

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

We will continue our work from January onwards on our detailed plans to submit an approvable IMTP in the Summer 2019.

Rationale for target score:

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

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

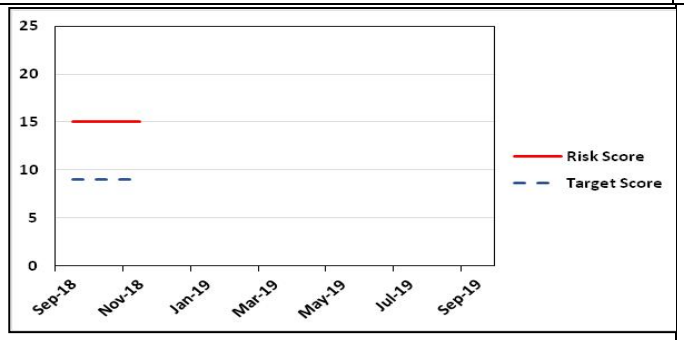
- Organisational Strategy approved by the Board in November 2018
- Clinical Services Plan developed through a highly engaged process and will be submitted to the Board for approval in January 2019
- Medium term plan with one-year deliverables will be submitted to Board for approval in January – including a balanced financial plan
- Transformation Programme including programme approach will be established in February 2019
- Continuous planning through our Transformation Programme will work up detailed plans to submit an approvable IMTP in Summer 2019

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Develop an annual plan for approval for the health board	Director of Strategy	January 2019

• Executive Steering Group in place for development of medium term plan • Plans will be assured by the P&F Committee before presentation to Board			
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
• Development of all 3 Plans considered by Executive Team and assured by PFC before submission 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 3 = 12	Additional Comments		

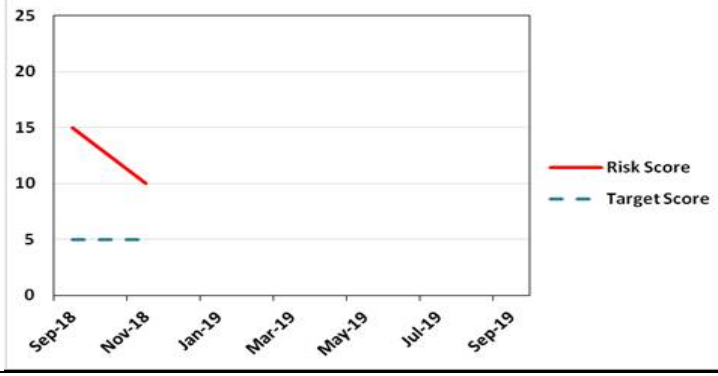
Datix ID Number: 1567	CRR Ref Number: 41
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, Director of Nursing and Patient Experience **Assuring Committee:** Health & Safety Committee
Risk: Currently an uncertain position in regard to the appropriateness of the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

Risk Rating (consequence x likelihood):		Rationale for current score:
Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9		Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations
Level of Control = 50%		Rationale for target score: Target Score should be lower
Date added to the risk register 31.05.18		

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

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

Datix ID Number : 1398	CRR Ref Number: 42
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Lynne Hamilton. Director of Finance **Assuring Committee:** Performance and Finance Committee
Risk: If the Board is unable successfully to deliver a sustainable service and meet £20m financial control total then the performance, safety and quality of our provision will be at risk.	**Date last reviewed:** January 2019

Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 2 =10 Target: 5 x 1 = 5		Rationale for current score: Target set by WG. Improving likelihood due to enhanced controls and mitigating actions and opportunities.
Level of Control = 50%		Rationale for target score: Aim to increase confidence levels to deliver set target.
Date added to the risk register July 2017		

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
• Monthly Performance, Quality and Finance Meeting • Medical agency caps • Spend Controls • QVC weekly panel • Investment & Benefits Group • Weekly FBP Meetings	Action	Lead	Deadline
	Opportunities Schedule and Action Plan to deliver £20m deficit control in place, with steer and monitoring via Performance and Finance	Director of Finance	Monthly

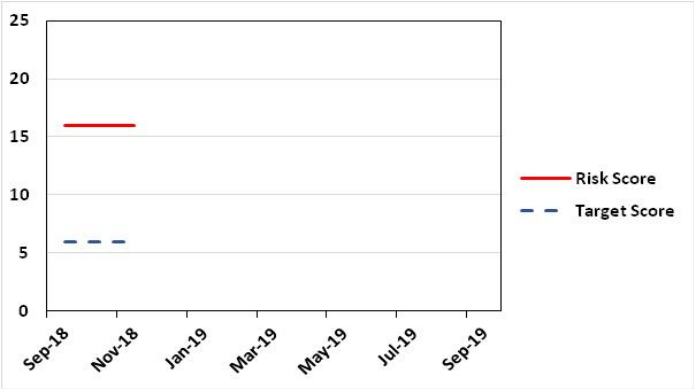
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• Weekly pay and non-pay dashboard • Performance and Finance Committee and Board Financial Reporting • Savings plan confidence and delivery reporting	
Current Risk Rating 5 x 2 = 10	Additional Comments • Recovery & Sustainability - detailed plan for all but 3 workstreams; plans in development urgently for remaining 3. Mitigating actions in place to counter balance these workstreams. • NWSSP providing schedule of contracts and SHOs for each. • QVC 1 - meetings taken place with clinical cabinet and MD.

Datix ID Number: 1514	CRR Ref Number: 43
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, Director of Nursing & Patient Experience **Assuring Committee:** Quality & Safety Committee and Safeguarding Committee
Risk: If the Health Board is unable to complete timely completion of DoLS Authorisation then the Health Board will be in breach of legislation and claims may be received in this respect.	**Date last reviewed:** January 2019

Risk Rating
(consequence x likelihood):
Initial: 4 x 4 =16
Current: 4 x 4= 16
Target: 3 x2 = 6

Level of Control
= 40%

Date added to the risk register



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?)

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Delivery of DOLS Action plan reviewed monthly	Head of Safeguarding	Monthly

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

Regular scrutiny at Safeguarding Committee and by DoLS Internal Audit; monitoring via DoLS Dashboard which is due to be rolled out imminently and will provide real-time accurate data.

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

Current Risk Rating
4 x 4 =16

Additional Comments

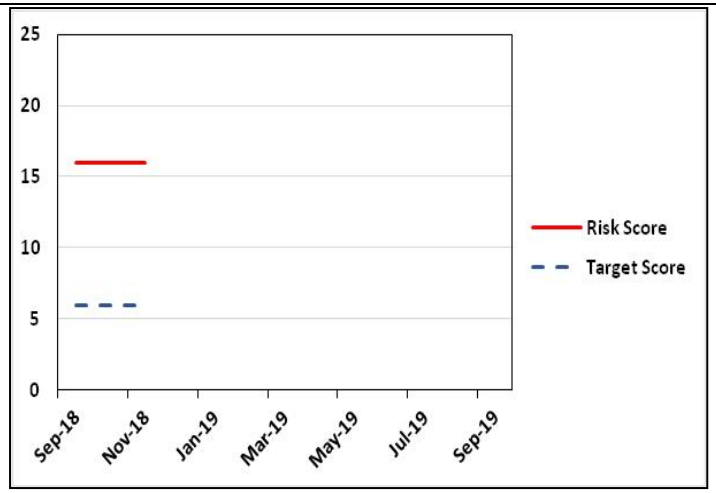
026 DoLS Follow Up Final action plan

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

Risk Rating
(consequence x likelihood):
Initial: 5 x 4 =20
Current: 4 x 4 =16
Target: 3 x 2 = 6

Level of Control
=60%

Date added to the risk register
May 2018



Rationale for current score:
C – Reduced due to mitigating actions/controls taken to reduce impact of system failure in PoW. Inability to meet A&E targets and ambulances queuing at entrance could have adverse national publicity. Part of targeted intervention monitoring – loss of confidence in Health Board
L - WEDS has been delayed and the current systems do not meet the requirements of users to aid the improvement of operational services. System in Pow and NPT is still unstable and unsupported

Rationale for target score:
C – moving to a stable supported solution will reduce the impact of failure but the impact of the system not meeting all operational requirements will remain.
L – of system failure will reduce once a stable supported solution is in place. The National system has been evaluated as meeting operational requirements as part of procurement process, however requirements will change over time.

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

- WPAS has been implemented in Morriston as an interim solution but does not provide all the additional functionality required.
- Archive solution developed for Accent to allow access to historic data in case of failure
- WEDs programme is still being progressed by NWIS

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Implement WPAS ED module in NPT and POW	Chief Operating Officer	March 19
Implement alternative ED system across the Health Board.	Chief operating Officer	March 20

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

Replacement of Accent will increase stability of system. Archive solution has been tested.

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

National solution currently being tested so no assurances at this stage the solution will be suitable or on implementation timescales

Current Risk Rating
4 x 4 = 16

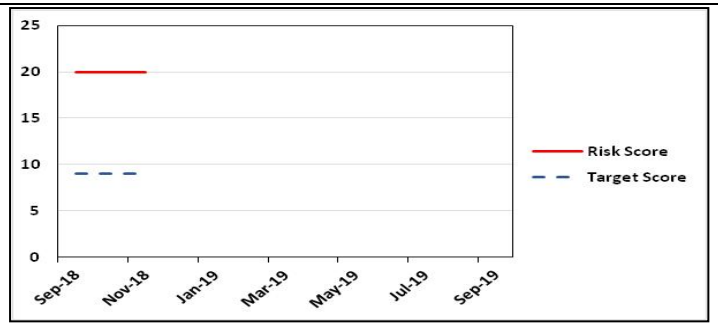
Additional Comments

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

Risk Rating
(consequence x likelihood):
Initial: 5 x 4 = 20
Current: 5 x 4 = 20
Target: 3 x 3 = 9

Level of Control
=50%

Date added to the risk register
31/05/2018



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.

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

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
All SDUs to focus on improved performance - actions plans required from each SDU to demonstrate how compliance will be achieved	Medical Director	31/12/2018
Implementation of WCP will include the MTED module which will allow extra project support to facilitate improved compliance	Medical Director	31/12/2018
Informatics to improve performance	Medical Director	31/12/2018

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

Current Risk Rating
5 x 4 = 20

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

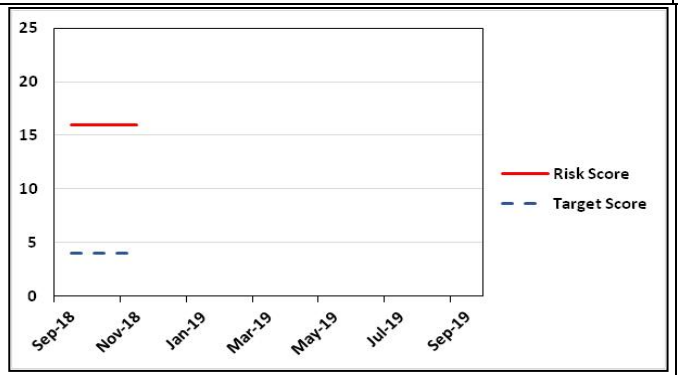
Additional Comments
The most recent HB "completed & sent" performance was 60% (August 2017) compared with 48% a year ago.• In August 2017 the best performing hospital is NPTH (83%), this is reduced by the poor performance on wards not directly managed by NPT. Medical Wards regularly achieve 99%• August 2016 v August 2017 Delivery Unit comparisons demonstrate substantial improvement in Morriston, POW & Singleton• Morriston is coming to the end of a 6-month improvement programme which is bearing fruit, performance was 46% in March when it started.

Datix ID Number :1563	CRR Ref Number: 48
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Sian Harrop Griffiths, Director of Strategy **Assuring Committee:** Performance & Finance Committee, Health Board
Risk: Failure to sustain Child and Adolescent Mental Health Services	**Date last reviewed:** January 2019

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

Level of Control
= 50%

Date added to the risk register
31.5.18



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.	Action	Lead	Deadline
	Implementation of the Choice and Partnership Approach (CAPA) started on 1st November 2017 and being closely monitored	CAMHS network	31/03/19
	Additional investment expected - from Welsh Government is supporting the delivery of Waiting List Initiative clinics to support the position.	CAMHS network	31/03/19
	The Network is seeking to recruit agency staff to fill existing and upcoming vacancies to ensure that core capacity is maximised.	CAMHS network	31/03/19

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)

Current Risk Rating 4 x 4 =16	Additional Comments The service is now in the 2nd cycle of CAPA with new job plans agreed from January, with updated demand & capacity mapping. WLI Clinics initiated at POW Hospital, Bridgend which enabled the 80% target to be achieved by end of end March. This was also achieved for NPT area. However Swansea had a significant backlog, which is starting to be addressed with waiting list initiatives from March 2018.

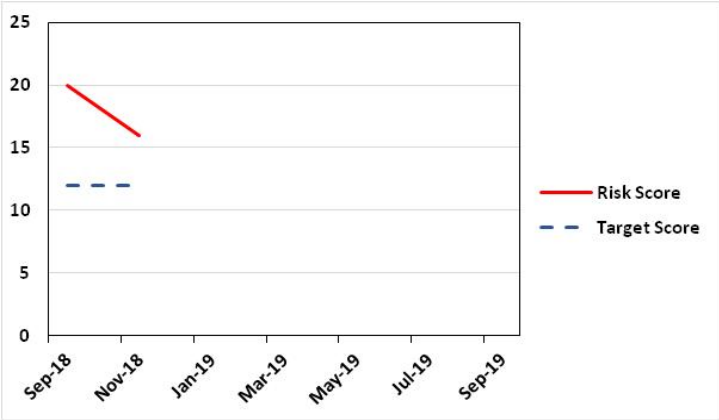
Datix ID Number: 1761	CRR Ref Number: 50
Objective: Best Value Outcomes from High Quality Care	**Director Lead**: Chris White, Chief Operating Officer **Assuring Committee:** Performance & Finance Committee
Risk: Failure to sustain services as currently configured to meet cancer targets	**Date last reviewed:** January 2019

Risk Rating

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

Level of Control
= 70%

Date added to the risk register
April 2014



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.

Rationale for target score:

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?)

- 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.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Introduction of revised models for rapid diagnostic review / assessment in cancer pathways being introduced.	COO / DPC&MH Med Dir	January 2019
Continue close monitoring of each patient on the USC pathways to ensure rapid flow of patients through the pathway.	COO / DPC&MH Med Dir	January 2019
Some speciality challenges remain in Lung and Urology - Action plans in place, along with monitoring.	COO / Med Dir	January 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 3 = 12

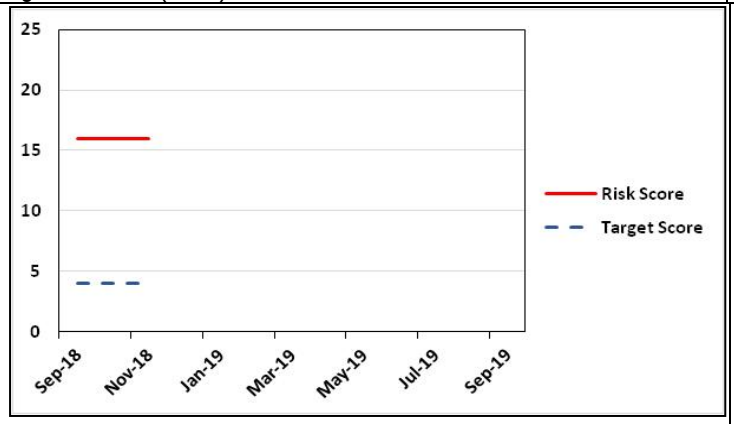
Additional Comments
The need to deliver sustained performance.

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

Risk Rating
(consequence x likelihood):
Initial: 4 x 4 = 16
Current: 4 x 4 = 16
Target: 1 x 4 = 4

Level of Control
= 80%

Date added to the risk register
November 2018



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.

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.

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

The Health Board has put the following controls in place;

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

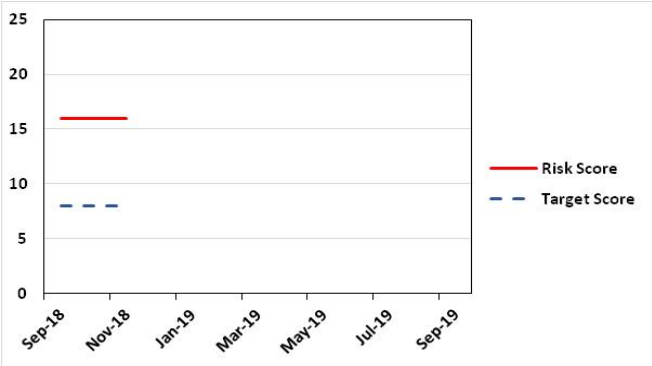
Mitigating actions (What more should we do?)

Action	Lead	Deadline
The Ward Sister / Charge Nurse and Senior Nurse should continuously assess the situation and keep the designated person formally appraised.	Director of Nursing & PE	31/01/19
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 & PE	31/01/19
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 & PE	31/01/19
Health Board should agree the operating framework for these decisions to include actions to be taken, and by whom.	Director of Nursing & PE	31/01/19

•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 organisation to ensure a consistent approach to data collection and there is national work on solutions for electronic capture of acuity data.			
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
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. •Implement mobile devises to be used within adult acute medical and surgical wards included within the Act in readiness for the June Adult Acuity Audit. •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.			
Current Risk Rating 4 x 4 = 16	Additional Comments		

Datix ID Number: 1763	CRR Ref Number: 52
Objective: Partnerships for Care	**Director Lead:** Sian Harrop Griffiths, Director of Strategy **Assuring Committee:** Performance & Finance Committee, Health Board
Risk: Through the Service Remodelling Workstream of the R&S programme in 2017/18 it was identified that the Health Board does not have sufficient resource in place to undertake robust engagement and impact assessment in line with our statutory and public duties. There is a risk of judicial review if public engagement is not carried out in line with public sector guidance and/or impact assessments are not carried out in line with our statutory duty and best practice. The Health Board has a statutory duty to carry out Equality Impact Assessments and will have a similar duty for Health Impact assessments from Autumn 2019. Quality Impact Assessments of service change and cost improvement schemes are also best practice following the Mid-Staffordshire Inquiry.	**Date last reviewed:** January 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
19.11.18

Rationale for current score:

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

Rationale for target score:

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

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

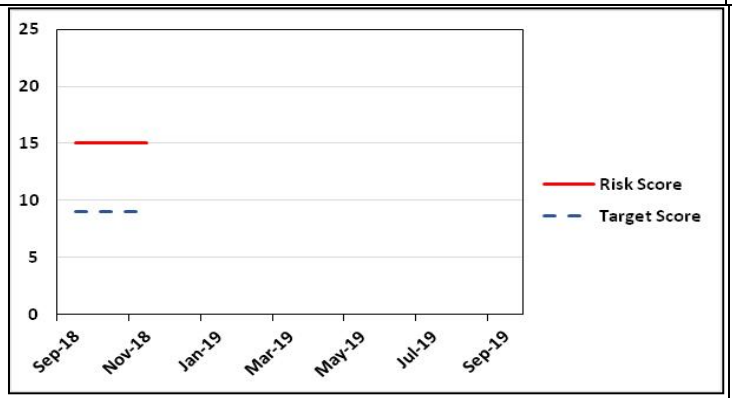
Engagement – a temporary post has been released for a Head of Engagement & an appointment made and postholder will be in post on 7.1.19. yet in post. There is no agreement yet for permanent resourcing. Robust processes are, however, in place as agreed with the CHC and based on best practice guidance.
•Impact Assessment – there is no dedicated resource and policies / processes are out of date. Processes using our existing resources for the IMTP / CSP and external advice from WG are in progress. The paper is to be discussed by Executive Team in January 2019.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Agreement for permanent resource for the Head of Engagement post.	Director of Strategy and Director of Transformation	April 2019
Robust policies and processes to be in place for Impact Assessment and engagement going forward.	Director of Strategy and Director of Transformation	April 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?)
• EIA and QIAs are being undertaken for the Clinical Services Plan and Annual Plan • The EIA and QIAs will be assured by the joint meeting of the PFC and Q&S Committee in January for the plans to be submitted to Board for approval	Permanent additional resources not yet available
Current Risk Rating 4 x 4 = 16	Additional Comments .

Datix ID Number:1762	CRR 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:** January 2019

Risk Rating (consequence x likelihood):		Rationale for current score:
Initial: 3 x 5 = 15 Current: 3 x 5 = 15 Target: 9 x 3 = 9		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 Standards and how they apply to Cwm Taf • Close constructive working relationships are in place with the Welsh Language Commissioner's Office • Strong networks are in place amongst Welsh Language Officers across NHS Wales to inform learning and development of responses to the Standards.	Action	Lead	Deadline
	To develop an implementation plan including the identification of resources to deliver the Welsh Language Standards	Director of Governance	January 2019
	Ensure the Board is fully sighted on the UHB's position through regular reporting to the Health Board	Director of Governance	January 2019
	To review the terms of reference for the Welsh Language Group and ensure appropriate representation across the organisation	Director of Governance	January 2019

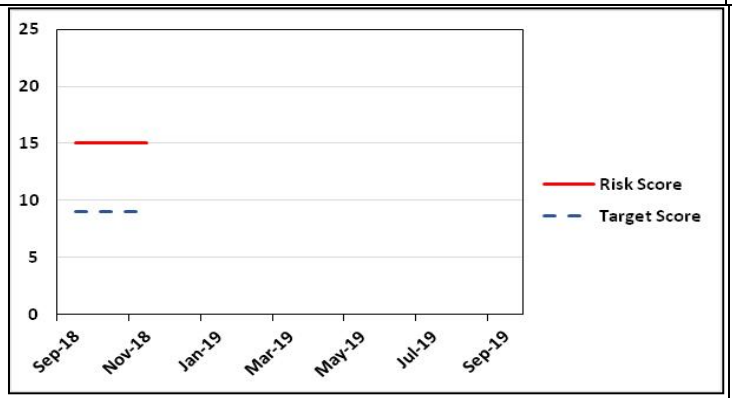
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
Compliance with Statutory requirements outlined in Welsh Language Act and related Standards	The self-assessment has confirmed that the Health Board is not able to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

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

Risk Rating
(consequence x likelihood):
Initial: 3 x 5 = 15
Current: 3 x 5 = 15
Target: 9 x 3 = 9

Level of Control
=70%

Date added to the risk register
November 2018



Rationale for current score:
The current score reflects the programme arrangements in place and that there is a programme structure and critical path to achieve the 1 April 2019 timescale.

Rationale for target score:
As the critical milestones are achieved the target score reflects assurances required to deliver the programme within the timescales set.

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

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

Mitigating actions (What more should we do?)

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

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

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

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

Current Risk Rating
3 x 5 = 15

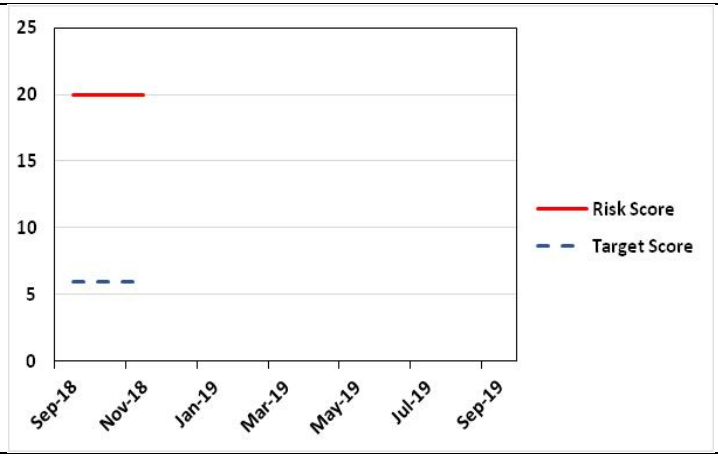
Additional Comments

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

Risk Rating
(consequence x likelihood):
Initial: 4 x 5 = 20
Current: 4 x 5 = 20
Target: 2 x 3 = 6

Level of Control
=70%

Date added to the risk register
November 2018



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

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.

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;

Mitigating actions (What more should we do?)

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

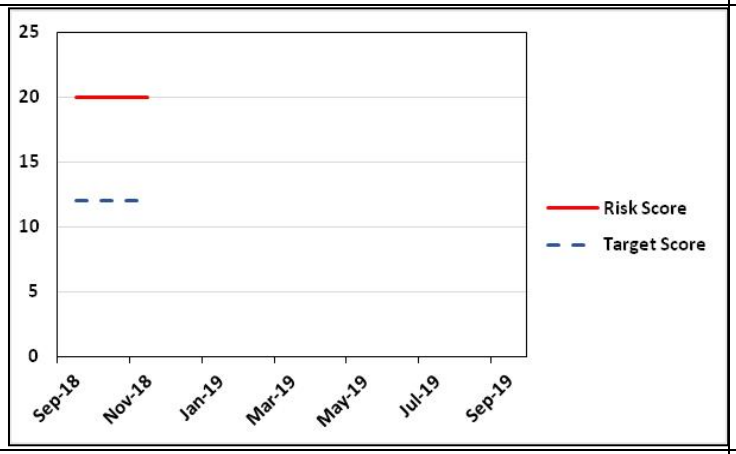
➢ A 4 Nations public health group addressing public health associated risks and health security concerns, and a joint Welsh Government – Public Health Wales working group considering specific Welsh issues; ➢ Working in partnership with the Welsh NHS Confederation to ensure ongoing flexible and effective 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.			
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 4 x 5 = 20	Additional Comments There is an obligation to maintain critical services and business as usual in an emergency and this includes Brexit and consequently there is the potential for disruption in commercial and public services and therefore supplies, services, transport, fuel, border issues, EU national issues, immigration, critical infrastructure, energy and command resilience etc.		

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

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

Level of Control
=30%

Date added to the risk register
November 2018



Rationale for current score:
Since the establishment of the Health Board in 2009 there has been a significant reduction in the workforce and OD staffing levels. The current capacity of the team and the team's ability to provide appropriate, high quality and timely advice on both operational and strategic issues is a significant area of professional concern. Current resourcing levels have been benchmarked with other Health Boards. Output anticipated by the end of November 2018

Rationale for target score:
Target score reflects requirement to resource the workforce and OD function to be able to meet the operational and Strategic priorities of the Health Board. Failure to do this will negatively impact of financial, service, performance and quality outcomes.

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

.
Director of Workforce and OD reported risk stocktake to W&OD Committee. A Workforce and OD risk register has been generated as a consequence. Reported at Corporate Performance review with CEO. Reported to Audit Committee.

Further update on risk and progress against these reports to W&ODC in November 2018.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Review of resourcing to take into account Boundary Change.	Director W&OD.	April 2019

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

General situation monitored through W&OD Committee.

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

Current Risk Rating
5 x 4 = 20

Additional Comments
Utilise temporary funded capacity to meet immediate areas of risk. Continue to raise resourcing issue at corporate level and through committee governance arrangements. Run at risk.

- Actions Complete: Risk Stock Take reported to W&OD Committee, Audit Committee and Corporate Performance Review.
- Update on progress and improvement against key risk areas provided to W&ODC

	• Development of W&OD Risk Register.