Health Board **12.7.18**	Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Title:	Corporate Risk and Assurance Framework
Author:	Mrs Justine Parry, Assistant Director of Information Governance and Assurance
Responsible Director:	Mrs Grace Lewis-Parry, Board Secretary
Public or In Committee	Public
Strategic Goals	*(Indicate how the subject matter of this paper supports the achievement of BCUHB's strategic goals –tick all that apply)*

1. Improve health and wellbeing for all and reduce health inequalities	√
2. Work in partnership to design and deliver more care closer to home	
3. Improve the safety and outcomes of care to match the NHS' best	
4. Respect individuals and maintain dignity in care	
5. Listen to and learn from the experiences of individuals	
6. Use resources wisely, transforming services through innovation and research	√
7. Support, train and develop our staff to excel.	

Approval / Scrutiny Route	Board Committees and Executive Management Group.
Purpose:	Attached is the latest iteration of the Betsi Cadwaladr University Health Board's (BCUHB) combined Corporate Risk and Assurance Framework which are presented for review and comment. The format remains the same as in previous submissions as a 'risk on a page' with the inclusion of the graph which plots any deviation to the initial, current and target risk scores. Text indicating the movement in the risk rating since last reviewed by the Board has been amended to make clear that this refers to the Current Risk Rating. The Health Board's Committees have undertaken a review of their assigned Corporate risk entries and following final review by the Audit Committee the Board are requested to note the following: • A number of Corporate Risk current risk ratings have been amended to reflect the improvement work to date and the increased controls. Where a change to the risk rating has taken

	place this will be indicated on the graph included with each record. • CRR04 Maternity Services recommended for de-escalation to Tier 2. Although this has been agreed in principle by the Audit Committee, it is recommended that any decision to de-escalate to Tier 2 is deferred until the commissioned organisational development work has been completed. • CRR08 Strategy Development. Recommended that this risk is de-escalated to Tier 2. • CRR11 Access and Delivery risk. It has been identified that this risk entry in its present format is too nebulous, covers many strands of service delivery and limits the ability of the Health Board to focus on and address key issues. Following extensive discussions, it is recommended that this risk is disaggregated to two key components – Planned Care and Unscheduled Care. These risks, 11a and 11b are included for consideration. • CRR16 Safeguarding. Risk description refreshed and improved to provide clarity around the key issues.
Significant issues and risks	As set out in the Corporate Risk and Assurance Framework attached.
Special Measures Improvement Framework Theme/ Expectation addressed by this paper	Governance Theme – To ensure an effective approach to the management of risk.
Equality Impact Assessment	Due to the nature of this report an Equality Impact Assessment is not required.
Recommendation/ Action required by the Board	The Board is asked to review the latest iteration of the corporate Risk and Assurance Framework and comment as appropriate.

Key to abbreviations within the attached report.

Strategic Goals

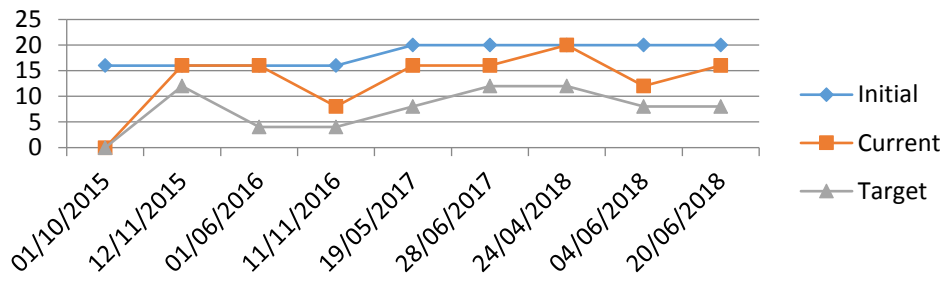
1) Improve health and wellbeing for all and reduce health inequalities.
2) Work in partnership to design and deliver more care closer to home.
3) Improve the safety and outcomes of care to match the NHS' best.
4) Respect individuals and maintain dignity in care.
5) Listen to and learn from experiences of individuals.
6) Support, train and develop our staff to excel.
7) Use resources wisely, transforming services through innovation and research.

Principal Risks

The Health Board has determined its principal risks to achieving its strategic goals as follows:-

Principal Risk 1: Failure to maintain the quality of patient services.
Principal Risk 2: Failure to maintain financial sustainability.
Principal Risk 3: Failure to manage operational performance.
Principal Risk 4: Failure to sustain an engaged and effective workforce.
Principal Risk 5: Failure to develop coherent strategic plans.
Principal Risk 6: Failure to deliver the benefits of strategic partnerships.
Principal Risk 7: Failure to engage with patients and reconnect with the wider public.
Principal Risk 8: Failure to reduce inequalities in health outcomes.
Principal Risk 9: Failure to embed effective leadership and governance arrangements.

CRR01	**Director Lead:** Executive Director of Public Health	**Date Opened:** 01/10/2015
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 20/06/2018
	Risk: Population Health	**Target Risk Date:** 31/03/2019
There is a risk that the Health Board fails to deliver Improvements in Population Health in North Wales. This is due to a failure to focus on prevention and early intervention. This could widen the gap in inequality of health outcomes.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in January 2018	**No Change** ⟺		

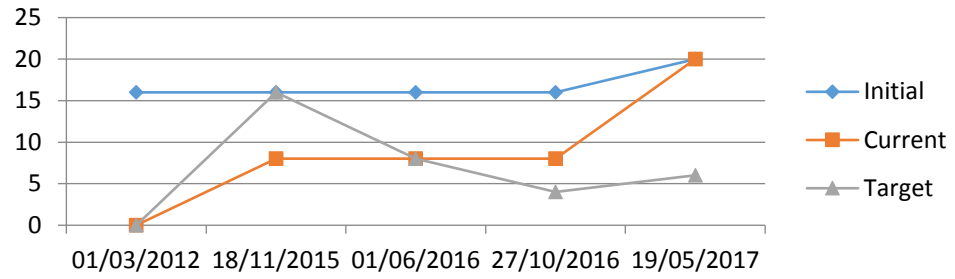
Controls in place	**Further action to achieve target risk score**
1. Population health intelligence updated on a continuing basis ensuring that information is available to support planning for and monitoring of health status. 2. Approved Population assessment to inform Social Services and Wellbeing Act developed in partnership, and now informing implementation of North Wales Regional Plan for 2018-2023. 3. Review of Board cycle of business completed to enable focus on population health issues. 4. Wellbeing Assessments completed and approved. 5. Wellbeing Objectives and Plans approved / to be approved in the 4 PSBs. 6. Strategic Partnerships in place providing opportunities for advocacy for improving population health with partners. 7. Approved HB Strategy Living Healthier, Staying Well confirms emphasis on improving population health through more focus on prevention. 8. Baseline Assessment informing LHSW completed, underpinned by	1. Further exploration and identification of new opportunities for Health Board to secure population health improvement through leadership role in strategic partnerships utilising new structures - Part 9 Board and Public Service Boards. March 2018 Update - Population health action is progressing through partnerships and PSBs. Further action will be needed with partners to progress specific actions in relation to strategic plans. June 2018 Update - Publication of "A Healthier Wales" and renewed expectation on the role Regional Partnership Boards to drive population health improvement and prevention should strengthen this area of work, but as yet timescales for this are not established. 2. Implementation of "Ein Dyfodol" programme a targeted Health Inequalities Programme in a small number of communities, alongside other Well North Wales activities. (By March 2019) March 2018 Update - No new funding was identified during 2017/18. Partnership discussions are underway to take forward initiatives in absence of funding for co-ordinated action.

WG Public Health Outcomes Framework. 9. Improved data on Primary care available to Area Teams and Contractors via PH Directorate website. 10. Organisational objectives have now been revised and redefined as our Wellbeing Objectives. 11. 2018/19 BCUHB Operational Plan aligned with key actions for improving health identified in Public Health Wales IMTP. 12. Mapping of community-based assets underway to highlight key community issues using Community Insight software. 13. DPH / Public Health Consultants attend all PSBs and Part 9 Board to advise and influence on prevention / early intervention agenda. 14. Delivery of Public Health Team workplan is aligned with operational Area Teams. 15. Public Service Boards Wellbeing Plans developed.	June 2018 Update - No further progress with funding continues to limit co-ordinated action. 3. 2018/19 Budget setting process to reflect increase in resources allocated to prevention and wellbeing ensuring provision of both universal and targeted interventions. (By April 2018) March 2018 Update - Limited funds have been identified for 2018/19. In-year funding will be explored during 2018/19. Strategic Business Case is in development to support opportunities which may arise. June 2018 - Strategic Business Case in development. Immediate operational pressures remain unresolved. 4. Establishment of Health Improvement, Health Inequalities (HIHI) Strategic Transformation Group to ensure that focus on prevention and early intervention as articulated in LHSW, is embedded within 2018/2021 IMTP. Update at December 17 - Transformation Group has now met and is overseeing the submission of IMTP templates. Update at March 2018 - HIHI Group has overseen the development of the 3 year and 1 year Operational Plan. Terms of Reference and membership have recently been reviewed to support transition of the Group to Health Inequalities and Improvement Transformation (HIIT) Group which will sit alongside other Transformation Groups. June 2018 Update - HIIT Group now established and reporting to SPPH Ctte. Group will oversee progress and reporting against Operational Plan commitments. 5. Interim PMO support for this programme is being explored. March 2018 Update - Temporary Programme Manager in post until July 2018 to support the agenda across the Health Board and ensure efficient and effective reporting of Operational Plan delivery. June 2018 Update - effectiveness of Programme Management support has been clearly demonstrated in terms of co-ordination of agreed actions. 6. Our Participation in Live Lab work with Office of Future Generations Commissioner and Public Health Wales will provide a new focus for prevention within the delivery of community services, and generate learning which can be shared across Wales.

	June 2018 Update - Live Lab work progressing slowly. Will inform development of community services in time.

Assurances	**Links to**		
1. Oversight by Public Service Boards and Local Authority Scrutiny Committees. 2. WG Review Meetings (JET). 3. Public Health Observatory reports and reviews. 4. WG Review and feedback on needs assessment.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 5 6 7	PR8	Strategic and Service Planning

CRR02	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 01/03/2012
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 19/06/2018
	Risk: Infection Prevention & Control	**Target Risk Date:** 29/03/2019
There is a risk that patients will suffer harm due to healthcare associated infection. This is due to the failure to put in place systems, processes and practices that prevent avoidable infection. The impact of this may increase morbidity and mortality, increase admissions and longer length of stay, increase treatment costs, reputational damage and loss of public confidence.		



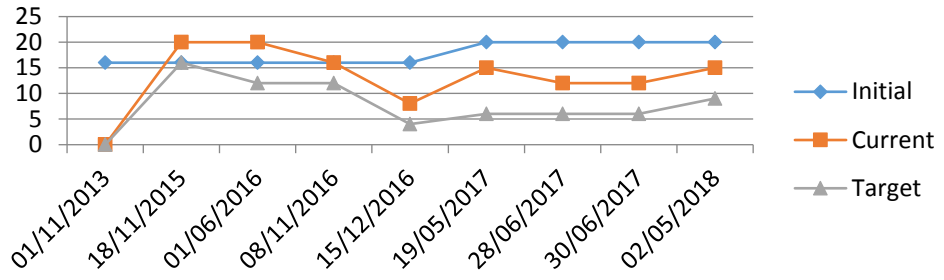
	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	3	2	6
Movement in Current Risk Rating since last presented to Board in January 2018	**No Change** ⇔		

Controls in place	**Further action to achieve target risk score**
1. Infection Prevention Sub-Group scrutinise objectives as part of the regular cycle of business, and reports to Quality, Safety & Experience Committee. 2. Surveillance systems and policy in place for key infections, with data now presented as part of electronic harms dashboard and IRIS. 3. Areas and Secondary Care sites have governance arrangements. 4. Site Management Team lead reviews of root-cause analysis on each site. 5. Continued progress on ANTT staff training, with increased focus now on medical staff. 6. External review performed August 2017; report on further actions presented to Board. 7. Safe Clean Care Programme (SCC) launched 29-01-18, with first 90-day plan completed to drive further improvement actions and behaviour change at pace. 8. Workshop held 5th June 2018 to develop 2nd 90-day plan with	1. Continue the implementation of a series of 90-day plans supported by PMO, to rapidly move forward on recommendations from 2017 external review. 2. Implement the other actions identified in the 2018-19 annual infection prevention programme, tied in to the SCC programme and series of 90-day plans. 3. Implement actions in response to Welsh Government Antimicrobial Delivery Plan, relevant Welsh Health Circulars and in response to multi-drug resistant organisms. 4. Continue to progress key actions from Duerden report 2016 in relation to Consultant Microbiologist staffing and capacity, Antimicrobial Stewardship, Estates and Facilities, Infection Prevention Team staffing to support Areas, Care bundle and pathway implementation. 5. Progress work on ward environment improvement, including work to standardise key elements of ward design, storage, signage, provision

focus on community hospitals as well as Secondary Care, and SCC programme embedded into 2018-19 annual programme.	of hand wash basins and bay doors. This is embedded within the 90-day plans. 6. Embed the work on Norovirus prevention, with a continued focus on Wrexham. 7. Review and progress work on influenza preparedness in preparation for winter 18-19. 8. Accelerate the work of the BCUHB E.Coli Collaborative as part of work to expand the focus on key infections to include gram-negative organisms.

Assurances	**Links to**		
1. Professor Duerden report 2016. 2. WG review of decontamination. 3. Demonstrable improvement in line with National Benchmarks. 4. CHC Bug watch visits. 5. HSE reviews. 6. Internal Audits of Governance Arrangements.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR1	Leadership

CRR03	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 01/11/2013
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 02/05/2018
	Risk: Continuing Health Care	**Target Risk Date:** 30/11/2018
There is a risk that the CHC Framework and process will not be fully adhered to. This is due to inconsistent application and service pressures including availability of suitable provision. This could lead to poor patient experience and outcomes and associated complaints and retrospective claims.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	3	5	15
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in January 2018	**Increased** ⇧		

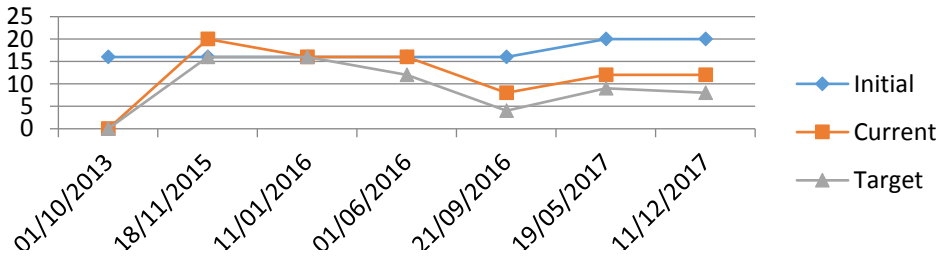
Controls in place	Further action to achieve target risk score
1. 2014 national CHC Framework. 2. Revised CHC structure in place including Practice Development Team. 3. All Wales Retrospective Claims process (Powys). 4. Joint LA & BCU CHC Regional Implementation Group. 5. BCUHB CHC Governance Framework agreed. 6. PMO Scheme for CHC with associated project management and reporting in place. 7. Annual WG self assessment. 8. North Wales care home market place community project. 9. Contracts and contract monitoring team in place. 10. Implemented Scheme of Delegation Process within Areas. 11. Implemented Skills and Knowledge Framework. 12. Recruited to Retrospective Team. 13. Implemented revised national retrospective claims procedure. 14. CHC rate revised.	1. Centralise CHC Governance and Strategic Commissioning Team. 2. Finalise and implement regional SOP. 3. Finalise and implement QAF. 4. Implement KPI's for CHC with Broadcare. 5. Monthly exception reporting. 6. Monthly CHC sub accountability meetings. 7. Develop CHC commissioning strategy. 8. Implement the Older persons Commissioner and Operation Jasmine action plans. 9. Roll out Bevan Exemplar care home support team. 10. Finalise and publish the Market position statement. 11. Finalise and implement joint quality monitoring tool across north Wales. 12. Implement patient and family feedback process. 13. Increase partnership working with the sector to include shared services.

15. CHC Contracts in place for all placements.	14. Develop training and workforce strategy.

Assurances	**Links to**		
1. Regular meetings with Regulators (CSSIW). 2.Inter-agency processes in place to review escalated concerns. 3. FNC Judicial Reviews of NHS Wales fee setting methodology implemented. 4. National reporting on CHC placements.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	2 3 4 5 6 7	PR1	Strategic and Service Planning

CRR04	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 01/10/2013
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 17/05/2018
	Risk: Maternity Services may become unsafe due to incomplete medical rotas	**Target Risk Date:** 31/12/2018

There is a risk that women will receive suboptimal care or delays in care provision. This may be caused by reduced clinic capacity and longer waits to be seen, due to minimal availability of doctors.
This could impact in the following ways; a negative effect on the quality and safety of patient care, the learning environment, public confidence and organisational reputation. The result of such impacts would be high litigation and low user satisfaction levels.

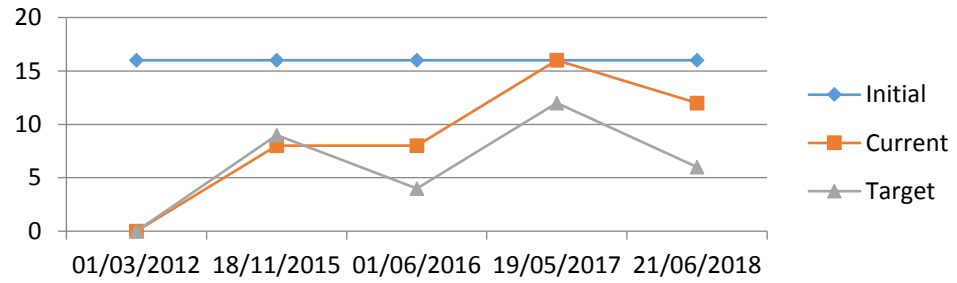


	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	3	12
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in January 2018	**No Change** ⟺		

Controls in place	**Further action to achieve target risk score**
1. Detailed monitoring arrangements and escalation procedures within service structures and to Board and Welsh Government on a monthly basis ongoing. 2. Revised service model introduced, with an aim to reduce locum Consultants and middle grade Drs. 3. Cultural and leadership work commissioned, phase 1 completed. 4. Continued use of locum staff where essential to maintain safe medical staffing numbers.	1. Maintain Women's Services as a separate clinical Directorate, to ensure robust management and scrutiny. 2. Work with Medical Staffing to develop a recruitment strategy and a new model for the service. 3. Improved culture and leadership to support sustainable services in North Wales. Commissioned OD work to be completed with effect by December 2018.

Assurances	**Links to**		
	Strategic Goals	**Principal Risks**	**Special Measures Theme**
1. NMC Reviews. 2. Royal College of Obstetrics and Gynaecology reports. 3. HIW Visits and reports. 4. Board and WG oversight as part of Special Measures.	1 3 4 6 7	PR1	Maternity Services

CRR05	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 01/03/2012
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 21/06/2018
	Risk: Learning From Patient Experiences	**Target Risk Date:** 31/10/2018
There is a risk that the Health Board does not listen and learn from patient experience due to the untimely management and investigation of concerns. This could lead to repeated failures in quality and safety of care.		



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	3	4	12
Target Risk Score	2	3	6
Movement in Current Risk Rating since last presented to Board in January 2018	**Decreased** ⇩		

Controls in place	**Further action to achieve target risk score**
1. Corporate concerns team embedded in operational management structures. 2. Performance and accountability reviews include concerns monitoring. 3. Weekly divisional PTR meetings being held. 4. Monthly reporting and monitoring of performance and learning to QSG. 5. Enhanced monitoring of claims with Welsh Risk Pool. 6. Ongoing programme of work in place as part of the IMPT to deliver improvement. 7. Patient Advice and Support Service established in YGC initially. 8. Minimum data sets provided monthly to all divisions regarding. Concerns. 9. Initial review (72hr) of serious incidents implemented. 10. Revised trajectories agreed as part of IMPT. 11. Significant reduction in total numbers of complaints open - focus on resolving complaints as OTS where possible.	1.Concerns management and investigation processes being reviewed with support of new ADQA with a particular emphasis on incident management. 2. Review and revision of corporate concerns management to enhance learning in the divisions and create capacity to support training and development for the divisions. 3. Manage performance in line with revised trajectories. 4. Weekly Incident Review Meeting to be implemented from July 12 lead by the ADQA.

12. Harm dashboard launched and being informed by Datix. 13. Weekly teleconference with corporate and divisions to monitor complaints. 14. Associate Director Quality Assurance in post. 15. Process commenced to manage historic incidents to closure and learning. 16. Additional support identified to manage overdue complaints and allow divisions to focus on new complaints raised.	

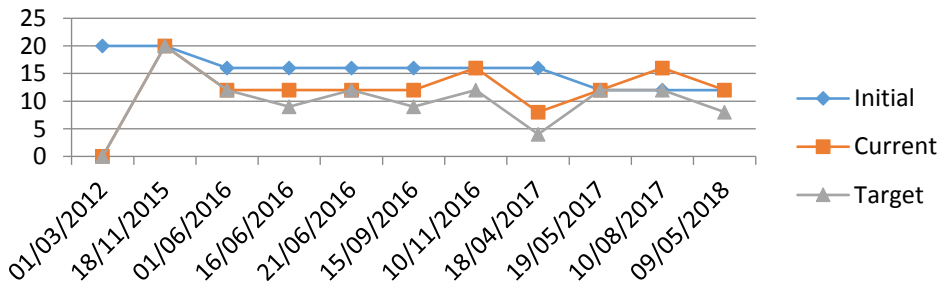
Assurances	**Links to**		
1. Welsh Risk Pool Reports. 2. Monthly review by Delivery Unit. 3. Public Service Ombudsman Annual Report, Section 16 and feedback from cases. 4. Regulation 28 Reports from the Coroner.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	3 4 5 6	PR7	Leadership

CRR06	**Director Lead:** Executive Director of Finance	**Date Opened:** 01/03/2012
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** 14/06/2018
	Risk: Financial Stability - Health Board Financial achievement of the control total agreed with Welsh Government	**Target Risk Date:** 29/03/2019

There is a risk that the Health Board will fail to achieve the deficit advised to Welsh Government.

This could be due to:
1. Cash releasing savings plans that are not fully identified and may not be fully delivered.
2. Cost pressures arising from the use of agency staff.
3. Continuing pressures within Mental Health & Learning Disability Division and Secondary Care Division.
4. Cost pressures arising from packages of care; and
5. Financial risks from the implementation of the new HRG 4+ tariff arrangements in England.
6. The use of non-recurrent measures may also contribute to a risk to the Health Board's longer term sustainability.

The impact of this could increase the deficit for the three-year period and the cumulative deficit to 31 March 2019 over the planned position of £35m



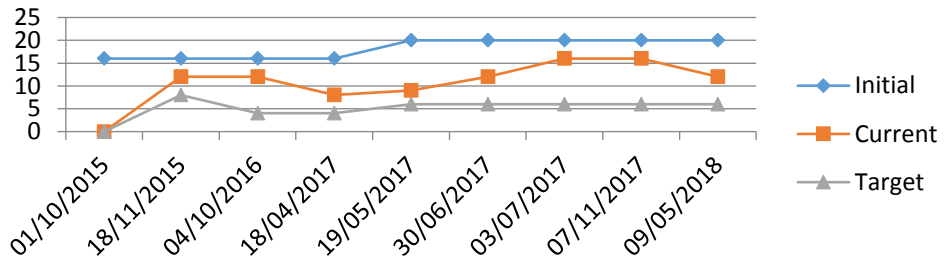
	Impact	Likelihood	Score
Initial Risk Rating	4	3	12
Current Risk Rating	4	3	12
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in January 2018	**Decreased** ⇩		

Controls in place	**Further action to achieve target risk score**
1. 2018/19 Interim Financial Plan, which has been approved by the Board and submitted to Welsh Government. 2. Scheme of Financial Delegation and Accountability Agreements in place. 3. Key skills framework developed for managers. 4. Performance and Accountability review meetings in place providing	1. A team is being appointed to support the Turnaround Director. 2. Review currently being undertaken to realign the Programme Management Office to provide improved support. 3. Accelerated rollout of SafeCare nurse e-rostering system will ensure greater controls in the use of Nurse Agency based on patient acuity and demand.

a focus on financial and operational delivery and performance. 5. Focused support provided by Finance in key areas of budget pressure. 6. Programme Management software is being used to track and monitor the delivery of savings. 7. Written assurance is sought on a regular basis from areas of significant overspend to identify recovery actions. 8. Open discussions are ongoing with Welsh Government to ensure that they fully understand the Health Board's financial position, and the key assumptions in the forecast position. 9. Information shared across divisions outlining benchmarking opportunities; opportunities identified from other organisations; and peer comparisons within the Health Board. 10. Strengthened financial reporting, including weekly cost driver intelligence dashboard; and monthly Day 6 Flash Reports. 11. A Turnaround Director is in post. 12. Turnaround framework in place supporting a number of work streams and reporting to the Executive Team, Finance & Performance Committee and the Board.	4. Further work is being undertaken to identify further opportunities to deliver recovery actions. 5. Mental Health and Secondary Care senior management teams in weekly escalation meetings with members of the executive team. 6. Individual Packages of Care (especially CHC) will be a continued area of focus or operational teams with actions prioritised over the coming weeks. 7. Reinforce of the controls to manage medical and nurse agency expenditure. 8. Implementation of the turnaround actions presented to the Board.

Assurances	**Links to**		
Monthly finanical position reported to F&P Committee and Board.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	7	PR2	Not Applicable

CRR07	**Director Lead:** Executive Director of Strategy	**Date Opened:** 01/10/2015
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** 09/05/2018
	Risk: Capital Systems	**Target Risk Date:** 03/09/2018
There is a risk that the Board fails to appropriately manage capital expenditure due to failures in implementing appropriate controls and governance systems. This could negatively impact on service delivery, financial resources and the reputation of the organisation.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	3	12
Target Risk Score	3	2	6
Movement in Current Risk Rating since last presented to Board in January 2018	**Decreased** ⇩		

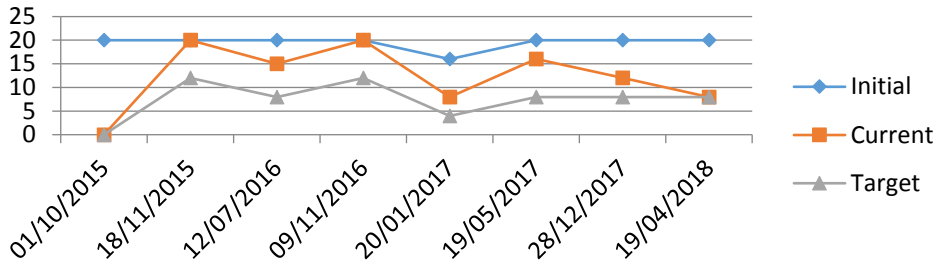
Controls in place	**Further action to achieve target risk score**
1. Management actions arising from the Capita review and response to capital internal audit review in progress including: a. Revised capital structure and decision making processes. b. Revised capital manual adopted. c. Revised Capital Development Team established and all post recruited. 2. Project Governance Frameworks in place for all major schemes. 3. Capital Programme Management Team meeting monthly. 4. Review of revised capital procedures by Specialist Capital Audit. 5. Revisions and addendum to Capital Procedures Manual in place. 6. Revised financial reporting framework adopted for major schemes. 7. Capital reporting to F&P Committee further enhanced including monthly exception reports for major capital schemes. 8. External review of cost reporting completed. 9. Stage 4 Gateway review completed for SuRNICC providing amber/green assurance. 10. Forward programme agreed for reporting benefits realisation to	1. Full implementation of all outstanding audit findings together with recommendations of Deloitte review. 2. Internal Audit to undertake targeted review of amended cost reports and control documents to gain further assurance. 3. Audit plan for 2018/19 to be reviewed to provide targeted scrutiny, assessment and assurance. 4. Risk assessed programme of Gateway reviews for major schemes to be progressed.

F+P committee. 11. Management action plans developed in response to Deloitte review and confirmed through Audit Committee.	

Assurances	**Links to**		
1. WG oversight of Capital Governance Arrangements. 2. Monthly progress reports to WG as part of All Wales Capital Scheme. 3. Evidence of compliance of all actions arising from Audit Reports (Including Capita Review).	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	3 7	PR2	Leadership

CRR08	**Director Lead:** Executive Director of Strategy	**Date Opened:** 01/10/2015
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 20/04/2018
	Risk: Strategy Development	**Target Risk Date:** 01/03/2018

There is a risk that the Health Board cannot develop a holistic strategy for well-being, health and healthcare and consequently may not be able to deliver safe and sustainable services to the population of North Wales in the medium to longer term. This could lead to an inability to address and improve health and healthcare services.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	2	8
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in January 2018	**Decreased** ⇩		

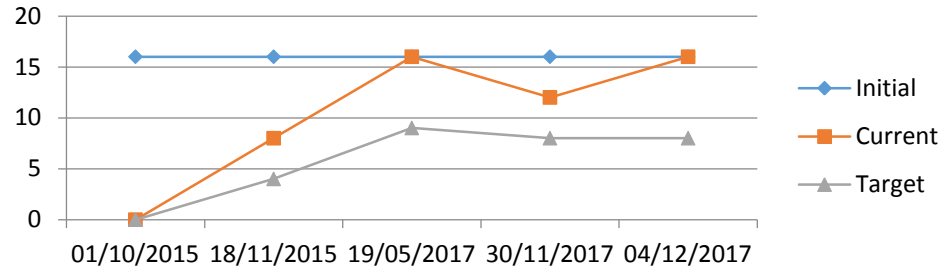
Controls in place	**Further action to achieve target risk score**
1. There was a detailed risk and issue log for the LHSW strategy programme reviewed on a fortnightly basis by the core team. Any risks or issues requiring escalation are raised with the Programme Executive Group which meets on a monthly basis. 2. The governance route through PEG and onward to SPPH was approved by Board. Regular updates have been presented to PEG and SPPH. 3. Approach to developing a strategy (Living Healthier, Staying Well) approved by SPPH and Board on 21 July 16. During 2017 there has been continuous engagement with a wide range of groups to support the development programme. 4. Primary Care Strategy framework, Maternity, paediatrics and neonatal framework and Mental Health Strategic framework document published Nov 2016. 5. Mental Health Strategy published in April 2017 and being taken forward through Together for Mental Health Partnership Board. 6. Board development session July and September debated emerging	No further action - target score achieved. It is proposed by SPPH Committee that this risk be closed, subject to Board agreement in July 2018.

priorities and informed next stages of development. Timelines reviewed and revised in light of Board development discussions. 7. Strategy development programme now in phase 5 - prioritise, consult, review and refine. 8. October 2017 - Board agreement to future engagement to test the principles, direction and draft priorities. 9. Broad engagement commenced Autumn 2017; comprehensive programme of face to face meetings with staff, partner organisations, community groups and members of the public using community facing version of the proposed priorities document. 10. Regular updates to Board advisory committees throughout the strategy development process (LPF, HPF, SRG). 11. Links with IMTP process established; development of strategy priority areas through the transformation groups is underway. 12. Additional PEG meeting arranged to address issues arising from engagement period, and ensure PEG input to final stages of development. 13. Analysis of feedback from engagement period informed final strategy document. 14. Review and revision of draft priority areas in light of engagement feedback and development of final draft strategy document. Feedback from OFG Commissioner also used to shape the final draft narrative. 15. Draft strategy submitted to Board and approved on 1 March 2018. 16. An end of programme report was signed off by SPPH Committee on 12 April 2018. This includes the approach to ongoing work streams, lessons learned and risks which will inform the next phases of strategic implementation. Recommended to close this risk,and develop a risk log/logs as appropriate related to implementation.	

Assurances	**Links to**		
1. Board and WG oversight as part of Special Measures. 2. Oversight of strategy development through the SPPH Committee. 3. Regular presentation to advisory forums - LPF, HPF, SRG 4. Joint Services Planning Committee of Community Health Council.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR5	Strategic and Service Planning

CRR09	**Director Lead:** Executive Director of Public Health	**Date Opened:** 01/10/2015
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 04/07/2018
	Risk: Primary Care Sustainability	**Target Risk Date:** 29/03/2019

There is a risk that the Health Board may be unable to meet its statutory responsibilities to provide a primary care service to the population of North Wales. This may be due to the significant number of GPs who are able to retire within the next 5 years and the supply of GPs in training may not meet the demand created by the turnover. This could lead to delayed access for some patients to the appropriate primary care service.



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in January 2018	**No Change** ⟺		

Controls in place	**Further action to achieve target risk score**
1.5 Domain Sustainability risk assessment metric developed by PCUS used pan-BCUHB and by Areas to RAG rate and identify highest risk requiring support. Last assessment undertaken April 2018. 2. Each Area has developed a regular practice review process to prioritise support. 3. Area Teams have developed support infrastructure to those practices experiencing significant challenges/pressures in terms of sustainability. 4. National Sustainability assessment process allows practices to request support from the Health Board. 5. Clinical advice available from Area Medical Directors and Cluster leads to provide support and development advice to practices. 6. Salaried GPs employed by Areas, working in managed practices and also GMS practices in difficulty. 7. Agreement to employ clinical leads in managed practices to provide leadership and oversight.	1. Evaluation and integration of new service models into primary care to ascertain their success. 2. New governance models of primary care need to be assessed to identify their reliability and assurance. 3. Care closer to home strategy to be evaluated. 4. Establish primary care academy and further develop primary care training, including mentorship. 5. Recruit to GP schemes being adopted by Clusters and supported by new project manager for recruitment and retention. 6. Primary care workforce plan to be developed and fully implemented. 7. Further engagement with primary care and partner organisations. 8. Demand management scheme – establishing ways to release GP capacity and shift services out of hospital settings – new roles, new models, and new services. 9. Work with Deanery to increase the number of GP training places in N Wales.

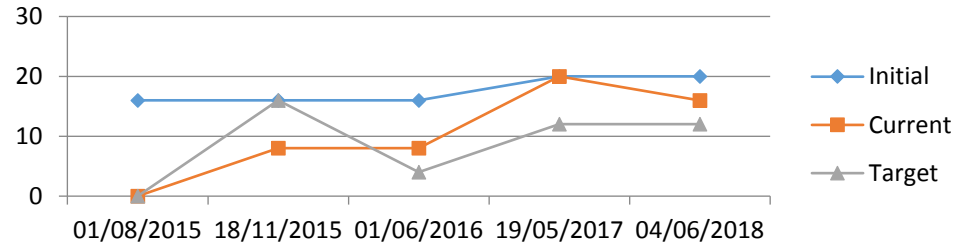
8. Recruitment and retention plan to recruit new GPs into North Wales under development. Project Management for recruitment and retention appointed. Attendance at recruitment fairs and other conferences being co-ordinated to promote careers and share current vacancies in North Wales. 9. Schemes for retaining and recruiting staff e.g. Outstanding GP scheme and the GP with experience scheme in place. 10. Developed Multi-Disciplinary Teams within GP practices eg physiotherapists, ANPs, audiologist, pharmacists and this team takes on patients that were previously seen by the PG. 11. Developing new models of delivery of care within GP practices. 12. Primary care funding is supporting the way that services are delivered within community and primary care setting to take pressure off GPs. 13. Emerging schemes that will further support the way that services are delivered from Primary care eg Occupational therapy, advanced practice paramedics and GP sustainability and innovation unit have been allocated funding from Primary Care Investment funds in 2018/19. 14. Cluster plans and funded schemes are focusing on areas such as pathways and supporting the way that care is delivered at local level. 15. ANPs focusing activity within Care/Nursing homes to improve patient care and reduce demand on GP visits. 16. Running 24/7 DN service to reduce out of hours call out and unnecessary ED admissions. 17.Navigators working within GP practices signposting patients to the right healthcare. 18. Workflow optimisation training available to practices. 19. Intermediate care funded schemes supporting primary care. 20. 12 BCUHB managed practices in place that are providing opportunities to trial new models of working and develop new areas of clinical care. 21. BCUHB has approved a 'Care Closer to Home' strategy that provides a vision of the way that care will be provided within community and primary care setting in the future. A CCtH	10. Lobby WG for review of national DDRB pay scales and recommendations to increase the rates to better reflect the different roles of salaried GPs. 11. Accelerated role out of advanced practice training. 12. Promote practice mergers and federating.

transformation board is being established to oversee progress, with the first meeting on 20 July 2018. 22.Care closer to home themes set out in annual operational plan. Priority for cluster development, service model, workforce development, digital healthcare and technology and estates. 23. Governance and accountability of managed practices group in place; performance indicators established, project management work books published, governance framework for nurses and pharmacists agreed. 24. Premises issues being addressed with a number of practices, including approval to assign some premises head leases from partners to BCUHB. 25. Recruiting and training practice nurses.	

Assurances	**Links to**		
1. Oversight by Board and WG as part of Special Measures. 2. CHC visits to Primary Care. 3. GP council Wales Reviews. 4. Progress reporting to Community Health Council Joint Services Planning Committee.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR6	Primary Care

CRR10	**Director Lead:** Executive Medical Director	**Date Opened:** 01/08/2015
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** 03/05/2018
	Risk: Informatics	**Target Risk Date:** 31/12/2019

There is a risk that the Informatics infrastructure is not fit for purpose. This may be due to:
(a) A lack of capacity and resource.
(b) Increasing demand.
(c) Reliance on the NHS Wales Informatics service.
This could lead to failures in clinical and management information systems, impacting negatively on patient safety/outcomes, and greater risk of cyber-attack.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Movement in Current Risk Rating since last presented to Board in January 2018	**Decreased** ⇩		

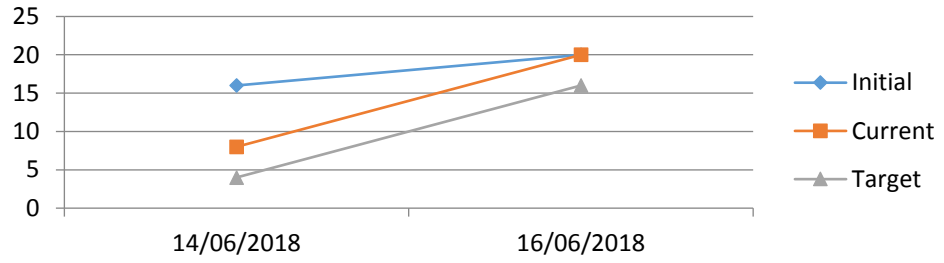
Controls in place	**Further action to achieve target risk score**
1. Governance structures in place to approve plans and approved plans for 2018 (Capital, IMTP and Operational). 2. Integrated planning process and agreed timescales from third party suppliers including NWIS Note: evidence of slippage past agreed dates is suggested to be a trend for NWIS. 3. Forward programme of business case development. 4. Local innovation to address operational risk (e.g. SBRI, ETTF). 5. Programme management approach to the implementation of Systems including Gateway review process where required. 6. Detective control and processes e.g. Performance Monitoring, reporting and escalation structures in place. 7. Governance structure for Informatics to review requests for work and prioritise.	1. Refine and agree the Strategic Outline Plan for Informatics - Quarter 3 2018. 2. Agreed Strategic direction for the Electronic Patient Record SOC date TBC. 3. Develop associated business cases for resource required for SOP and SOC and to address failing infrastructure e.g. Central File Library. (Qtr 3 BC Central File Library, Tele health and Digital Dictation QTR 2/3 2018). 4. Engagement with National Teams at multiple levels and escalation of issues via processes re requirements for:- a. A more user friendly better performing Welsh Clinical Portal. b. Delivery of a single Radiology System (TBC Qtr 2/3 2018 2019). c. Rapid development of the Welsh Care Record Service.

8. Draft Informatics Strategic Outline Plan detailing the "investment requirements for technology and digitally enabled service change" produced to support local and national planning.	5. Secured additional Capital and revenue budget going forward. 6. Review of funding models for services which are unsustainable and provision of options for future models. Ongoing.

Assurances	**Links to**		
1. National system implementation oversight by NMIB chaired by the Cabinet Secretary. 2. Annual Internal Audit Plan. 3. WAO reviews and reports e.g. Structured assessments and data quality. 4. Scrutiny of Clinical Data Quality by CHKS. 5. Auditor General Report - Informatics Systems in NHS Wales.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	2 3 4 5 6 7	PR6 PR5 PR2	Strategic and Service Planning

CRR11a	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 14/06/ 2018
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** 16/06/2018
	Risk: Unscheduled Care Access	**Target Risk Date:** 30/09/2018

There is a risk that systematic harm may be caused to patients needing access to unscheduled care services due to failures to be able to respond to demand in accordance with expected national targets.
This may be caused by mismatches between resources available across the unscheduled care system to demands placed on the system for prolonged periods of time or inappropriate allocation of resources available to meet the demand.
Could lead to an impact/effect on patient experience and outcomes, organizational reputation, delivery of national targets and recognised standards of care.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	4	16
Movement in Current Risk Rating since last presented to Board in - NA	First review by Board of newly developed risk to part replace CRR11 Access & Delivery		

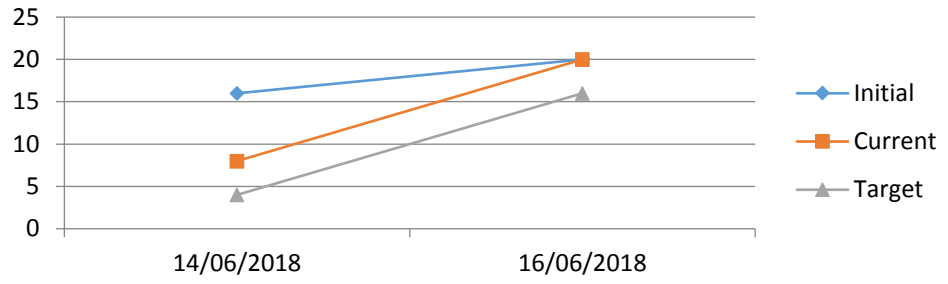
Controls in place	**Further action to achieve target risk score**
1. Multi-agency Unscheduled Care Transformation Board Cared by the Executive Director of Nursing. 2. Daily Conference Calls with WG in place to address daily position. 3. Daily Safety Huddles in place on 3 acute sites. 4. Pan BCU calls in place to manage flow between divisions. 5. Daily Board rounds in place to support continuity of care and early discharge planning. 6. Weekly review meetings with LA partners to support discharge. 7. PWC employed to improve 4 hour performance and assist in system planning. 8. Live and daily performance information to support decision making. 9. 3 times daily escalation status reviews. 10. SAPHTE scoring for assessment of ED departmental patient safety.	1. Recruitment of 3 Emergency Quarter managers by July 2018. 2. Development of USC plan by July 2018 supported by PWC design workshop outcomes. 3. Development of Seasonal Plan 2018/19 by Sept 2018. 4. Embedding of SAFER in all sites and wards by August 2018. 5. Roll out of command and control, reverse queuing and floor. management principles from the PWC work in YGC to Wxm and YG during July and August 2018. 6. Review and re-allocation of escalation capacity by August 2018. 7. 10-by-10 ie 10 patients to discharge lounge by 10am daily. 8. Discharge to Assess to be implemented Summer 2018. 9. Review outcomes of WAST pathway audits end of June 2018.

11. MH support in Police Control. 12. Frequent attenders WEDFANs group regularly review vulnerable patients who frequently access services. 13. Escalation process and structure in place to provide 24/7. escalation from site management through bronze, silver and gold 14. Escalation capacity in place.	

Assurances	**Links to**		
1. Seasonal Plan. 2. RTT Plan. 3. Twice Yearly JET meetings with WG. 4. Monthly meetings with Delivery Unit. 5. National Patient Flow Collaborative. 6. OOHs review (both National and Internal Audit). 7. Subject specific internal audit reviews. 8. Orthopaedic Plan development. 9.Transformation groups reporting. 10. WPAS implementation group reporting and daily tracking.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 6 7	PR3	Leadership

CRR11b	**Director Lead:** Executive Medical Director	**Date Opened:** 14/06/2018
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** 16/06/2018
	Risk: Planned Care Access	**Target Risk Date:** 30/09/2018

There is a risk that the BCUHB fails to provide access to planned care in accordance with the needs and expections of its stakeholders.
This may be caused by capacity shortfalls or mismatch beween allocation of available capacity and demand, a failure to utilise resources effectively, conflicting pressures (management of USC pressures and elective delivery), equipment failure and availablity of suitable facilities, workforce issues.
This could lead to adverse outcomes for patients, prolonged waiting periods, a failure to meet national targets (RTT, dignostics, cancer, clinically due review time), and impact on the financial stablity and the reputation of the Health Board.



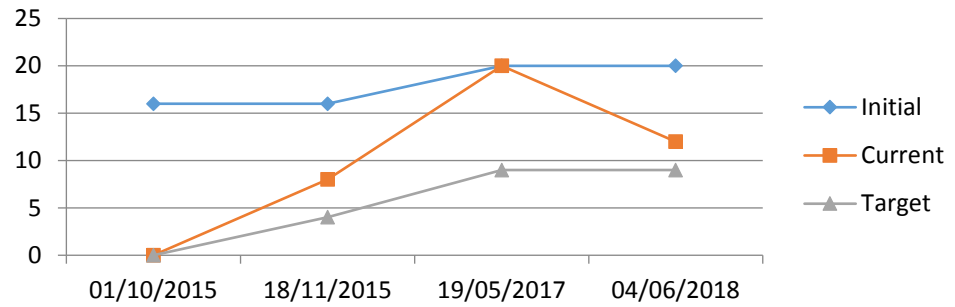
	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	5	16
Movement in Current Risk Rating since last presented to Board in - NA	First review by Board of newly developed risk to part replace CRR11 Access & Delivery		

Controls in place	**Further action to achieve target risk score**
1. Daily waiting times information in place for RTT,diagnostics,and Cancer. 2. Performance team and trackers in Cancer utilising escalation processes with operational teams. 3. Activity plan agreed per specialty and site. 4. Twice weekly Access meeting managing activity v plan, booked v capacity, cohort waiting list progress and treat in turn. 5. Weekly diagnostic and OPD meeting established 16.6.18. 6. Weekly outsourcing meeting in place. 7. Elective patient pathway and outpatient improvement cells in place with clear targets for efficiency improvement. 8. Engaged with National Planned Care, National Outpatient and Cancer Implementation Groups.	1. Planned care operational plan to be signed off. 2. Resource for RTT and Diagnostics 2018-19 to be confirmed. 3. Pan BCU service line management to be implemented with initial recruitment to the specialties of : Orthopaedics, Ophthalmology and Urology. 4. Sustainable service plans for these 3 specialties to be further developed and implemented. 5. Learning from Single Cancer Pathway shadow working to be shared and used to inform Cabinet Secretary decision making - this will impact on diagnostic capacity and demands on cancer tracking. 6. Learning and application of change management in respect of the Eye Care measures to inform sustainable plan. 7. Follow up efficiency measures for the 4 specialties from the national

9. Elective and Seasonal plan assumes only daycase surgery is scheduled for January 2019 to protect unscheduled care capacity.	planned care programme to be implemented. 8. Governance structure for OPD to be finalised. 9. Matrix working and responsibilities of clinical and operational leaders to be confirmed to strengthen governance.

Assurances	**Links to**		
1. Seasonal Plan. 2. RTT Plan. 3. Twice Yearly JET meetings with WG. 4. Monthly meetings with Delivery Unit. 5. National Patient Flow Collaborative. 6. OOHs review (both National and Internal Audit). 7. Subject specific internal audit reviews. 8. Orthopaedic Plan development. 9.Transformation groups reporting. 10. WPAS implementation group reporting and daily tracking.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 6 7	PR3	Leadership

CRR12	**Director Lead:** Executive Director of Finance	**Date Opened:** 01/10/2015
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** 20/06/2018
	Risk: Estates and Environment	**Target Risk Date:** 01/04/2022
There is a risk that the Health Board fails to provide a safe and compliant built environment. This may be due to insufficient financial investment and estates rationalisation. This could result in avoidable harm to patient, staff, public, reputational damage and litigation.		



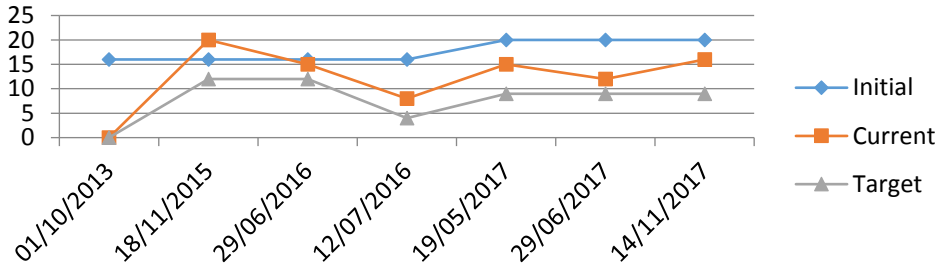
	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	3	12
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in January 2018	**Decreased** ⇩		

Controls in place	**Further action to achieve target risk score**
1. Clear Board direction on future service model (2018/19). 2. Operational Risk Registers in place defining high risk priorities for capital and revenue investment. 3. Risk assessed schedules for implementation of agreed priorities. 4. Estates maintenance strategy in place for the delivery of capital and investment objectives. 5. Input data into All Wales Estates Facilities Performance Management System (EFPMS) Portal to assess overall estate performance. 6. Risk based estates rationalisation programme. 7. Redevelopment plan for Ysbyty Glan Clwyd (Asbestos Management Controls). 8. Project Director appointed for development of Ysbyty Wrexham Maelor. 9. Stock Condition Survey of Primary Care Estate premises completed. 10. Operational Estates and Facilities Management annually agreed	1. Estates Strategy to deliver mitigation and reduce risk (Sept 2018). 2. Strategic capital investment/development plans Wrexham Maelor (Sept 2018). 3. Ongoing programme of estates rationalisation and selective demolition (2019). 4. Develop new service models for non strategic estate (Sept 2018). 5. Estates Strategy based on current assessment of backlog maintenance (Sept 2018). 6. Stock Condition Survey of Acute and Community premises to interim capital investment plans (Sept 2018). 7. Options appraisal on Future Service Model for Residential Estates (Sept 2018). 8. Options appraisal on future Service Delivery model for North Wales Laundry Services. (Sept 2018).

Discretionary capital funding.	

Assurances	**Links to**		
1. Independent authorising engineer appointments. 2. Internal Audit Programme. 3. HSE Statutory Reviews and Reports. 4. EFPMS Portal Data used by WG for Annual All Wales Report. 5. Local Authority Trading Standing. 6. Food Safety Assessment. 7. Annual Reports (HSE, Fire, V&A and sustainability).	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 7	PR5	Strategic and Service Planning

CRR13	**Director Lead:** Director of Mental Health and Learning Disabilities	**Date Opened:** 01/10/2013
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 22/06/2018
	Risk: Mental Health Services	**Target Risk Date:** 28/06/2019
There is a risk that patients receive inappropriate care within Mental Health Services due to failings in leadership and governance at all levels within the Division which could result in poor quality outcomes for patients.		

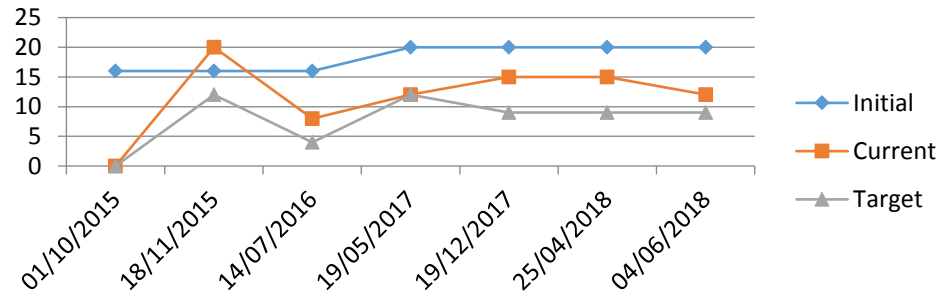


	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in January 2018	**No Change** ⟺		

Controls in place	**Further action to achieve target risk score**
1. Improvement plan in place and subject to ongoing review. 2. Enhanced monitoring in progress at Board level. 3. Renewed focus and escalation arrangements for dealing with operational issues. 4. Governance Framework developed and implemented within mental health. 5. Mental Health Strategy approved by the Board. 6. Senior Management and Clinical Leadership holding structure in place. 7. Older Person's Mental Health action plans in place. 8. Weekly PTR meeting in place. 9. Revised interim leadership, management and governance arrangements in place November 2017.	1. Ongoing implementation of performance and accountability reviews across the division. 2. Continue to improve internal divisional communication systems. 3. Contribute to HASCAS investigation and wider governance review. 4. Undertake review of demand, capacity and skill mix. 5. Ongoing review of staffing levels. 6. Consultation on permanent structure to be completed. 7. Embed revised arrangements for safeguarding, and dynamic risk assessment. 8. Standardise operational procedures for acute inpatient care.

Assurances	Links to		
1. Board and WG oversight as part of Special Measures. 2. External reviews and investigations commissioned (Ockenden and HASCAS). 3. HIW Reviews. 4. External Accreditation (AIMS). 5. Delivery Unit oversight of CTP.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR1	Mental Health

CRR14	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 01/10/2015
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 25/04/2018
	Risk: Staff Engagement	**Target Risk Date:** 31/03/2020
There is a risk that the Health Board does not maintain a culture which promotes excellence and engagement of staff in order to transform services. This may be caused by a disconnect between stated values and actual behaviours. This could lead to poor quality services, damage to the organisations reputation, long term sustainability and low levels of workforce satisfaction and well being.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	3	4	12
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in January 2018	**Decreased** ⇩		

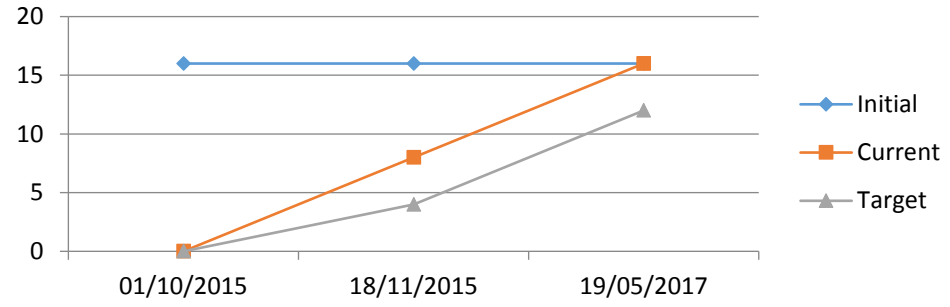
Controls in place	Further action to achieve target risk score
DIALOGUE 1. Proud to Lead - Leadership Framework. 2. Range of engagement processes established: -3D Model-Discover, Debate, Deliver -Listening Leads -Staff Engagement Ambassadors -"Proud Of" Groups established in each DGH and some Community Hospitals. This was formally launched in Q4 17/18 -Staff Reward and Recognition Schemes such as Seren Betsi Star, Staff Achievement Awards and Long Service Awards 3. Range of opportunities for public engagement - Link to cross reference Public Engagement Risk. 4. Staff Engagement Group (SEG), comprising IMs, Trade Union representatives and senior managers, established to provide oversight and direction to engagement activities.	1. Cultural Assessment Tool "Go Engage" implementation plan to be developed in Q1 18/19. 2. 3D Listening methodology - Delivery plan to increase activity to be developed in Q1 18/19. 3. Senior Leadership Development - Analysis and programme design to be completed in Q1/2 18/19. Aim to launch programme in Q3 18/19. 4. Staff Survey 2016 feedback in the form of "You Said-We Did" to be launched in Q1 18/19. 5. Staff Survey 2018 Implementation plan and Communications plan to be developed in Q1 18/19. Survey will be live in Jun/Jul 2018. 6. Organisational Development Metrics Dashboard in development, first draft due for completion Q2 18/19. 7. Organisational Development Celebration Event to be held in Q3 18/19 showcasing key OD achievements across BCUHB. 8. An advanced Coaching Skills training programme for Medical Staff

5. Business cases developed in September 2016 to support: •Photo boards •Listening Leads •Chief Executive Recognition Awards - Seren Betsi Star 6. Trade Union partnership arrangements: Local Partnership Forum/Local Negotiating Committee in place. VALUES & BEHAVIOURS 7. Defined purpose and values. 8. Proud to Lead – Leadership Behaviours Framework 9. "Hello my name is" / “Helo fy enw l ydy” re- launched August 17 10. Raising Concerns Procedure and Safe Haven Scheme in place with task and finish group oversight. 11. Workforce policies and procedures in place including Dignity at Work. 12. Operational and clinical policies. 13. BCU Code of conduct. 14. Professional codes of conduct. 15. Leadership Development Programmes in place including Generation 2015 programme. 16. Speak out safely campaign. 17. Being Open Policy. 18. Staff Engagement Strategy approved by the Board in August 2016. 19. Launch of revised PADR documentation including Leadership Behaviours. 20. Cultural Assessment Tool "Go Engage" identified, and procured. Implementation due to commence Q1 18/19. 21. 3D Listening Methodology - All fixed term posts have now been appointed to. Model has been developed, case-studies in the form of "You Said - We Did" are collated for each project area. 22. Senior Leadership development programme for Bands 8a and above and Medical colleagues is in development. Training needs analysis for this group has been completed Q4 17/18. External support has been procured to support this programme. 23. Staff Survey 2016, action plan was approved by the Board in May	and Senior Leaders is in development, to be launched Q2 18.19.

2017. All Divisions, Areas Corporate Directorates, developed their own Action Plans. 24. Staff Engagement Strategy Delivery plan (Phase 2) was ratified by the SEG in September 2017. 25. Launch of values Based Recruitment resources and guidance were launched in Q3 17/18. 26. BCUHB Best, Facebook and Twitter launched Q4 17/18. 27. BCUHB are part of the All Wales Public Services Coaching Network. In-house coaching programmes have been established and are currently available. 28. Partnerships established with Local Further Education Providers to deliver a programme of Essential Skills for Staff. 29. Senior Leadership Master Classes have been established for 2018/19. 30. Staff Engagement resource tool kit developed and available on the Intranet.	

Assurances	**Links to**		
1. Board and WG monitoring as part special measures. 2. Staff survey benchmarked across Wales. 3.Corporate Health Award. 4. Implmentation of I Want Great Care.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR9	Engagement

CRR15	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 01/10/2015
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 24/04/2018
	Risk: Recruitment and Retention	**Target Risk Date:** 31/01/2020
There is a risk that the Health Board will have difficulty recruiting and retaining high quality staff in certain areas. This may be due to UK shortages for certain staff groups and the rurality of certain areas of the health board. This could lead to poor patient experience and outcomes , low morale and well being and attendance of staff.		



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Movement in Current Risk Rating since last presented to Board in January 2018	**No Change** ⇔		

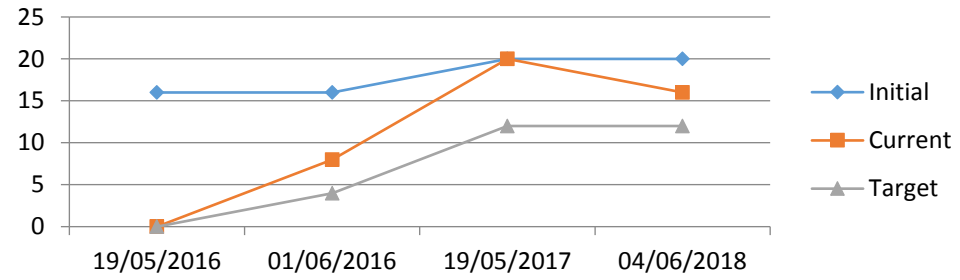
Controls in place	**Further action to achieve target risk score**
Workforce Planning 1. Workforce Plans included as part of annual plan. 2. Corporate Recruitment group in place Professional /occupation Sub group in place Volume recruitment days via geographical areas Local Workforce Teams are in place. 3. MEDACS managed service in place to secure effective processes for employing Locums. 4. Step into Work Programmes. POLICIES 5. Workforce policies and procedures in place and in use. 6. Service Level Agreement for recruitment services with NHS Wales Shared Services Partnership (NWSSP) with regular performance reviews.	1. Promotion of the new employment brand and web site Train Work live north Wales. 2. Contributing to All-Wales Recruitment campaigns - 'train, work, live' brand. 3. BCU is promoted Nationally and locally through recruitment days, job fairs conferences and wider use of digital media. 4. Following up contacts from presence at conferences / recruitment fairs. 5. All Wales Single Point of Contact(SPOC) for recruitment activity and local professional SPOC to be established. 6.Creation of attraction recruitment and retention strategy. 7. Continuing to engage WG colleagues in discussions on terms of salaried GP contracts. 8. Engage with Physicians Associate programme in conjunction with Bangor University.

7. Compliance with pre-employment checks. 8. Changes to bursary system on degree nursing courses at Welsh Universities will commit graduates to 2 years working in the Welsh NHS. SYSTEMS / PRACTICE 9. Range of communication systems in place - Cross reference to Staff Engagement Risk. 10. Appraisal compliance and mandatory training monitored. 11. National KPi's Time to Hire focus on Recruitment timescales monitoring both within BCU and NWSSP. 12. TRAC system in place which ensures standardised processes. 13. E-rostering system in place to ensure effective rostering. 14. BCU employment brand launched which supports the new recruitment web site to promote North Wales and recruitment 'train, work, live' North Wales. 15. Promotion of flexible working: part time working, job share, compressed hours, annualised hours, flexi, career breaks etc. 16. Staff benefits such as child care vouchers, cycle to work schemes and other non-pay benefits. 17. Continue to promote best practice through times of organisational change, redeployment and secondments and through flexible working arrangements. 18. Agency cap for medical and dental staff in place, with tight controls in place to reduce agency expenditure. National reporting is conducted monthly, which will be reviewed regularly.	9.Promoting return to practice for all professions via advertising strategy and Introduction of taster days e.g. Nurse/therapists. 10. If appropriate continue with International nurse recruitment. 11. Expanding successful Nurse Cadet programme, utilising modern apprenticeship programme, in west to centre and east areas. 12. Exploring expansion of Level 4 Assistant Practitioner Programme in place with college Llandrillo Menai, with a number progressing to registered nurse training. 13. Further links being developed with Manchester , Chester and Staffordshire Universities. 14. Identify the recruitment challenges within each professional group and create recruitment activity action plans as appropriate. 15. Continuing to contribute to Cavendish coalition and NHS employers on potential impact of BREXIT negotiations. 16. Contribution to Medical Training Initiatives (MTI) Bapio Scheme. 17. Exit interviews procedure to be developed and approved – to be rolled out across the organisation. 18. Celebrate local achievements through 'Proud of Campaign' building on existing staff awards and celebration of success. 19. Seeking staff input to the way the health board runs through Listening Leads, Staff Ambassadors and 3D engagement activity. 20. Developing strategy for older workers reflecting the outputs from the Working longer Group.

Assurances	**Links to**		
1. Staff surveys. 2. WG reporting (e.g. sickness absence and long term disciplinary cases). 3. NMC Royal College and Deanery Reviews and Reports. 4. Review of NWSSP recruitment timescales	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR4	Leadership

CRR16	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 19/05/2016
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14/06/2018
	Risk: Safeguarding	**Target Risk Date:** 31/12/2018

There is a risk that the Health Board does not discharge its statutory and moral duties in respect of Safeguarding. This may be caused by a failure develop and implement suitable and sufficient safeguarding arrangements, develop an engaged and educated workforce and provide sufficient resources to manage the undertaking. This could impact on those persons at risk of harm to whom the BCUHB owes a duty of care.



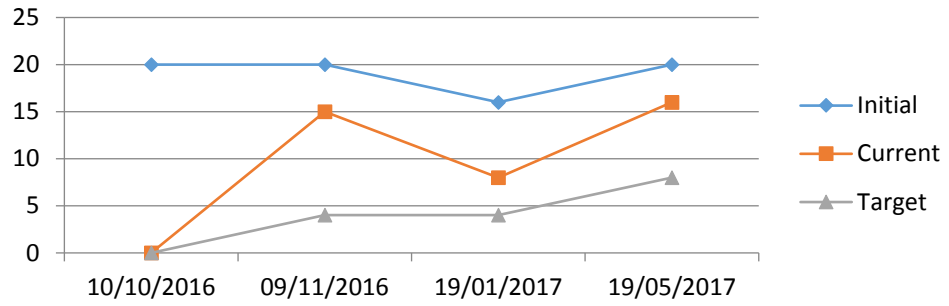
	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Movement in Current Risk Rating since last presented to Board in January 2018	**Decreased** ⇩		

Controls in place	**Further action to achieve target risk score**
1. The substantive post holder and senior management team have returned their substantive posts Jan 2018. 2. The Safeguarding Annual Report 2017- 2018 highlighted significant activities and engagement, with a detailed action plan to reduce risk and improve Governance and Accountability arrangements. 3.A review of the safeguarding risk register has been completed by the Safeguarding Leadership Team; a review of risks and options for mitigation will report through to the Safeguarding Sub Committee on a quarterly basis. 4. Regular meetings/briefings between Executive Lead and /or her Deputy and the Associate Director to ensure risks are known and to ensure safety of safeguarding systems and processes. 5. Recent recognition of the return of enhanced relationships and true engagement with statutory partners with consistent membership at key Safeguarding Board Meetings. 6. Strengthened governance has been progressed including a new	1. Service reconfiguration was completed and signed off on the 11/10/17. JDs are under review and will be finalised 11th June. There is an urgency by which the vacant posts are filled due to retirement and required appointment and training of BIAs. 2. Development of the HUB is in progress. 3. Safeguarding Committee minutes are reported to QSE in line with organisational reporting. 4. The revised Reporting Framework will be formally agreed on 19th June 2018. 5.The programme of works relating to the governance, Reporting Framework and accountability of Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act is monitored through the annual report action plan. 6. Work has commenced with IM&T to develop and build databases, with an identified priority schedule for implementation. 7. Engagement has been made with GP OOH service provision and

approach for progressing recommendations of APR/CPR's which see health recommendations from an individual review being owned by a Lead Director. 7. The Safeguarding Reporting Framework has been reviewed and updated, revised TOR/Scope with the re-establishment of a Regional Policy and Procedure Forum and Regional Safeguarding Training Forum to improve compliance. This will also ensure commissioned services are compliant with updated Policies and Procedures. 8. We have aligned mental health and LD safeguarding and dementia within the safeguarding structure. 9. Full alignment has been achieved with Information Management & Technology (IM&T) supported with a Safeguarding financial resource to develop recording, pathways, reports, alerts and the triangulation of data to enhance the identification of risk throughout the organisation. 10. Engagement has commenced to identify activities, omissions and reduce risks relating to safeguarding activities and access to children, ensuring safe escalation in GP OOH services, with consideration given to cross border services (COCH). 11. HASCAS Report and Recommendations. Full engagement with internal activities and the Regional Safeguarding Adult Board to implement recommendations and ensure learning from the findings.	services within COCH relating to all NW Children/adults relating to the safeguarding agenda. 8.A formal request has been made to NWSAB to include the membership of Director of Nursing MHLD, Regional Commissioning Lead CHC and when in post Named Dr Safeguarding Adults.

Assurances	**Links to**		
1.Strengthened Governance and Reporting arrangements. 2.Enhanced engagement with partner agencies. 3.Safe and effective data collection and triangulation of organisational data to identify risk. 4. Improved compliance against recognised omissions relating to the review and development of Safeguarding policies and Training materials. 5. Regional Safeguarding Boards.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	3 7	PR9	Governance

CRR17	**Director Lead:** Executive Director of Strategy	**Date Opened:** 10/10/2016
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 21/06/2018
	Risk: Development of IMTP (Integrated Medium Term Plan)	**Target Risk Date:** 29/03/2019
There is a risk that the Health Board cannot deliver safe and sustainable services to the population of North Wales which may be because there is not an agreed plan for the next 3 years. This could lead to an inability to address and improve health and healthcare services.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in January 2018	**No Change** ⇔		

Controls in place	**Further action to achieve target risk score**
1. Revised operational plan for 2017/18 submitted to WG on 10th April. 2. Board approved Annual Operational Plan in May. 3. Performance Review and accountability meetings for operational Divisions being used to monitor progress against delivery of Annual Operational Plan. 4. Timeline for developing 3 Year Integrated Medium Term Plan for 2018-21 developed and agreed including alignment of 3 year plan and strategy timeline. 5. Reporting and risk assessment against quarterly delivery of the Annual Operational Plan key deliverables through SPPH, linked to JET review. 6. Population needs assessment completed to inform 2018/21 IMTP. 7. Review of 2017/18 planning process undertaken with lessons for 2018/21 identified. 8. IMTP development programme and actions agreed by SPPH on 27th July.	1. Work on-going to develop annual operational plan for approval by Board in July 2018. 2. Plan and timetable to develop IMTP for 2019/22 to be developed for approval by SPPH Committee in July 2018.

9.Planning Guidance and Planning and Commissioning Intentions for 2018/21 issued - linked to strategy priorities. 10. Board considered outputs from Strategy work in October for a further phase of engagement to 15th December. Outputs to feature in the IMTP. 11. November/December 2017 - Divisional priorities identified and draft plans developed to underpin the IMTP. 12. December 2017 - Draft delivery priorities and themes reported to the SPPH Committee in December on behalf of the Board. January 2018 - SPPH workshop scheduled for 12th January to review priorities and the core content of the plan. 13. Draft plan submitted to WG in January 2018. 14. WG feedback received and Board resolved to develop a 3 year plan for 2018/21. 15. Board endorsed 3 year plan in March and submitted to WG. This has not been presented as an approvable IMTP. Board agreed the development of an annual operational plan for 2018/19.	

Assurances	**Links to**		
1. Board and WG oversight as part of Special Measures. 2. Oversight of plan development through the SPPH Committee. 3. All Wales peer review system in place. 4. Joint Services Planning Committee of Community Health Council.5. Regular links to advisory for a - LPF, SRG, HPF.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7 8	PR5	Strategic and Service Planning