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|---|---|
| **Cyfarfod a dyddiad:**<br>**Meeting and date:** | Health Board<br>14th May 2020 |
| **Cyhoeddus neu Breifat:**<br>**Public or Private:** | Public |
| **Teitl yr Adroddiad**<br>**Report Title:** | Corporate Risk Register and Assurance Framework Report |
| **Cyfarwyddwr Cyfrifol:**<br>**Responsible Director:** | Mrs Gill Harris – Deputy Chief Executive/Executive Director of Nursing and Midwifery |
| **Awdur yr Adroddiad**<br>**Report Author:** | Mr Matthew Joyes, Associate Director of Patient Experience & Interim Associate Director of Quality Assurance.<br>Justine Parry, Associate Director of Information Governance & Risk.<br>Mr David Tita, Head of Risk Management |
| **Craffu blaenorol:**<br>**Prior Scrutiny:** | The full Corporate Risk and Assurance Framework (CRAF) is scrutinised by the Health Board twice per year and is published on the Board's external facing website. Individual risks are allocated to one of the Board's Committees for regular consideration and review. This report has been approved for submission to the Committee by the Deputy Chief Executive / Executive Director of Nursing and Midwifery. |
| **Atodiadau**<br>**Appendices:** | Appendix 1 – Details of Corporate Risk Register Report |

**Argymhelliad / Recommendation:**

The Board is hereby requested to:

1. Note, approve and ratify the Corporate Risk Register (CRR) and to gain assurance that risks articulated on it are appropriately and robustly managed in line with the Health Board`s risk management strategy and best practice.
2. To approve any changes to risks that have been requested by the various committees.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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|---|---|---|---|---|---|---|---|
| **Ar gyfer penderfyniad /cymeradwyaeth**<br>**For Decision/ Approval** | √ | **Ar gyfer Trafodaeth**<br>**For Discussion & Scrutiny** | √ | **Ar gyfer sicrwydd**<br>**For Assurance** | √ | **Er gwybodaeth**<br>**For Information** | |

**Sefyllfa / Situation:**

The emergence of Covid-19 as a `wicked issue` and the debilitating impact it is having on the Health Board`s resources, strategy, tactics and operations emphasises the strategic importance of embedding a risk-based, dynamic, proactive, structured and comprehensive approach to the identification, assessment, mitigation and management of risks across the organisation.

This paper presents risks on the Health Board`s CRR with the aim of highlighting the controls and further actions being implemented in mitigating and managing them including progress and any changes that have been made since the CRR was last presented to the Board. While this coversheet articulates the key highlights/progress and changes captured in each risks, appendix 1 presents details of each of the risks on the CRR.

The main thrust of this paper is to provide assurance to the Board that risks to the achievement of the Health Board`s objectives and priority areas as defined in its 3 Year Plan are being robustly, efficiently and effectively mitigated and managed in line with best practice and to expected standards.

**Cefndir / Background:**

Although the Health Board had undertaken a complete re-write of its risk management strategy which was due to be launched in April, 2020, the emerging, fluid, complicated and challenging situation now prevailing due to the Covid-19 outbreak has made it difficult for the launch to go ahead. The launch of our new Risk Management Strategy and Policy has thus been differed for the next six months until 1st October 2020 as this decision has been ratified by the Board. In order to ensure that risk management activities across the Health Board continue to be carried out in line with best practice, the current risk management strategy and its procedural documents has been extended until 30th September 2020.

This postpone has provided the opportunity for scarce resources to be channelled towards supporting the effective delivery of the Health Board`s Covid-19 strategic plan while ensuring that a dynamic risk-based approach is at its heart. On the other hand, the challenging context posed by Covid-19 does not only emphasise the need for a paradigm shift towards a more risk-based culture in which effective risk management is prioritised and put at the heart of all what we do but underlines the importance of innovation, agility and anticipation in continuously scanning the horizon for emerging risks while appropriately identifying, assessing, mitigating and managing them.

**Asesiad / Assessment & Analysis**

The QSE held on the 5th May 2020 and after reviewing and scrutinising their risks advised on the following two key aspects: -

- That CRAF be fully refreshed and updated especially in light of Covid-19.
- Risks which have been opened on it for many years be re-considered within the wider context of understanding why commensurate progress hasn`t been made in mitigating and reducing them to their target score despite the many controls in place.

In a similar light, the QSE meeting which held on 28th January 2020, reviewed, scrutinised, approved and recommended six new risks for inclusion onto the CRR. But following extensive discussions with Clinical Executive Directors during the Risk Management Group (RMG) on the 30th January 2020, members agreed to recommend four risks for consideration for the CRR. The RMG then de-escalated two of the risks and advised further updates were required, as these should be reviewed and managed as tier 2 risks linked to the existing Health and Safety corporate risk - CRR21. The QSE also agreed to the rewording of CRR03 which removed the Care Home element as this was risk assessed, de-escalated and will be mitigated and managed at tier 2 while the core components around CHC were upheld to constitute the updated CRR03.

The Digital and Information Governance Committee (DIGC) held on 13th February 2020 received, reviewed and scrutinised their risks on the CRR and noted and acknowledged the further updates being undertaken on their risks following discussions at the RMG. The committee also considered the accuracy of the scores as well as the effectiveness of the controls and actions as captured in each of their risks and approved the increase in the current score for CRR10b from 16 to 20 as advised by the RMG.

The Finance and Performance Committee (F&P) at its meeting held on the 23rd January 2020 recommended an increase in current score for CRR06 from 12 to 20 considering the current financial

position of the Health Board. The Committee further noted that a financial sustainability risk assessment will be undertaken and presented at their next meeting on 30th April 2020.

The Strategy, Partnership and Population Health Committee (SPPH) which was held on 5th March 2020, reviewed and scrutinised their risks on the CRR and declined a request for CRR14 to be recommended for de-escalation. Members also noted the ongoing work by the Public Health team around COVID-19 which aligns with the wider national PHW COVID response agenda.

In summary, following review, scrutiny and monitoring from the relevant committees, the following changes have been made to CRR since the last report was received by the Board: -

- **CRR01 Population Health.**
  Key progress: Members at the last SPPH noted that risk controls have been updated to include working with the Regional Partnership Board to ensure population prevention focus for Building a Healthier Wales (BAHW) funding across the North Wales Region. No change to current risk score however the Committee advised for control 11 "BCUHB Operational Plan aligned with key actions for improving health identified in Public Health Wales IMTP" to be deleted.
  **CRR02 Infection Prevention and Control.**
  Key progress: This risk was reviewed at the QSE and members noted that it remains largely the same with no change in score as was in the previous CRR report. Infection Prevention quality visits have commenced to replace the previous "audit programme". These visits encompass observation of clinical practices, support and advice, micro teaching, safe clean care updates, hand hygiene observations, screening and any other relevant support needed by the ward staff. Scrutiny of every avoidable infection and lessons learnt are regularly shared.
- **CRR03 Continuing Health Care.**
  Key progress: As per updates in the previous report, this risk has now been split into two distinct risks i.e. CHC and the Care Home strand. Both risks were reviewed at the last QSE and after much discussions, the committee was agreed that the updated version of CRR03 which focuses on CHC should replace the current CRR03 while the new risk around Care Homes should be de-escalated and managed as a tier 2.
- **CRR05 Learning from Patient Experience.**
  Key progress: This risk was reviewed at the QSE and members noted that it remains the same as in previous CRR report. Performance and accountability reviews include concerns monitoring as Patient Advice and Support Service has been initially established in Ysbyty Glan Clwyd. There has been no change to the current risk scoring and no change to this risk since the previous updates.
- **CRR06 Financial Stability.**
  Key progress: After some discussions regarding the inappropriate initial score rating, it was agreed that the initial score of this risk should be raised from 12 to 20. Further actions to mitigate this risk so as to achieve its target risk score were also discussed, agreed and have been incorporated which includes, continuously scrutinising recovery and savings delivery as the financial year elapses, potential additional escalatory grip as well as control measures. However, despite these additional actions and given the current financial position, it was recommended that current risk score be increased from 16 to 20.
- **CRR09 Primary Care Sustainability.**
  Key progress: Risk has been updated and controls strengthened. It was noted at the last SPPH that the controls in place for mitigating this risk have also been refreshed to take account of the current position and completion of sustainability Primary Care assessments for each of the

management practices. Development of a Primary Care Academic is proceeding as funding has been secured for the next three years.

- **CRR10a National Infrastructure and Products**.
  Key progress: This risk was reviewed at the DIGC on 13th February 2020 as members noted that it has been reviewed including its controls and further actions following feedback from the last AC and RMG. It was noted that future discussions regarding this risk will take place within the Executive Team for scrutiny alongside Area Directors.
- **CRR10b Informatics - Health Records**
  Key progress: Members of the DIGC noted that the updated change to the risk title had been actioned and it was proposed to increase the current score to 20. The Committee further debated and suggested the name change to being solely "health records". The Assistant Director of Information Governance and Risk clarified that the scoring would be updated to reflect the likelihood scoring. The Committee agreed with the updated score.
- **CRR10c Informatics infrastructure capacity, resource and demand.**
  Key progress: Members of the DIGC noted that controls had been updated to remove an action which was not a control, the target risk date had also been amended to reflect a realistic date to implement the further actions required to achieve the target risk score. Following an in-depth review of this risk at the RMG, it was noted that the further updates would be reflected.
- **CRR11a Unscheduled Care Access.**
  Key progress: Members of the F&P noted that the current score of this risk has been increased from 12 to 16 to reflect the current position of the Health Board. Risk controls have also been strengthened to include reporting arrangements and further actions identified and added to support the achievement of the target risk score.
- **CRR11b Planned Care Access.**
  Key progress: Members of the F&P noted that this risk has been updated alongside its controls and further actions. The target risk date was amended to take into account the implementation of further actions to support the achievement of the target risk score.
- **CRR12 Estates and Environment.**
  Key progress: members of the F&P recognised and noted that the current score of this risk has increased from 12 to 16 to reflect the current position of the Health Board. Risk controls had been strengthened to include reporting arrangements and further actions had been identified to support the achievement of the target risk score. Increase in score of risk was agreed.
- **CRR13 Mental Health Services.**
  Key progress: Risk was discussed at the QSE and it was noted it has been updated, controls and further actions had been refreshed and strengthened. Recommendation to reduce the score of this risk was declined at the last QSE.
- **CRR14 Staff Engagement**
  Key progress: The controls in place for reducing this risk have been strengthened and updated to include implementation of all the 2016 Engagement Strategy as initiatives within the strategy have been mainstreamed into ongoing organisational development. Mechanisms currently in place to measure staff engagement on regular basis via the BeProud organisational survey and NHS Wales Staff Survey were highlighted amongst others. A request to recommend this risk for de-escalation as it has met and sustained its target score was declined as the Committee was not convinced with the robustness of the evidence that was presented to them.
- **CRR15 Recruitment and Retention.**
  Key progress: Key controls have been strengthened and updated with further actions identified to support achieving the target risk score. There has been no change to the current risk scoring.
- **CRR16 Safeguarding.**

Key progress: This risk was reviewed at the QSE and it was noted that its controls have been strengthened to include business planning, a refreshed reporting framework and the introduction of a senior management tier in the safeguarding structure. It was also noted that further actions have also been updated to support achieving the target risk score. There has been no change to the current risk scoring.

- **CRR17 Development of Integrated Medium Term Plan.**
  Key progress: Whilst there were no further updates to this risk, members of the SPPH noted that an updated paper will be presented to the Board to which will include the next steps of the 3 Year Outlook for 2020/21. This risk would therefore be updated following further discussions at the Board and the SPPH appropriately notified. It was agreed that the score of this risk requires further review which will be done to align with the 2020/21 operational plan that is being finalised
- **CRR18 EU Exit - Transition Arrangements.**
  Key progress: This risk remains unchanged from the previous report as controls have been strengthened. Following exit from the EU on 31 Jan 2020 and progress of the Withdrawal Agreement Bill (WAB) through parliament, planning and preparations have now been stood down by WG until further notice. The national leadership Group will continue to meet on a monthly basis but SRO meetings have been stood down. Position will be reviewed by WG in July 2020 and response arrangements may be stood up if required, dependent on an evaluation of political situation.
- **CRR20 Security Risk**
  Key progress: Risk was reviewed at last QSE and scored agreed at 20 with the target score set at 10. A comprehensive action plan is being developed to further support and ensure the achievement of target score. It was noted that significant investment will be required in order to fully and timely mitigate this risk.
- **CRR21 Health & Safety Leadership and Management**
  Key progress: After some extensive discussion, review and scrutiny at the QSE, members agreed that the current score should of this risk stay at 20 as this is underpinned by evidence from the gap analysis. The target risk score was also agreed at 10. Progress on the implemenation of the H&S Gap Analysis will be aligned in informing and shaping future reviews and updates of this risk.
- **CRR22 Potential to compromise patient safety due to large backlog and lack of follow-up capacity**
  Key progress: Approved and recommended for inclusion onto the CRR. Updates have been included which comprise some information from Informatics following a paper that was done around resourcing a permanent validation team for the Health Board as the cost of independent or external validation is very high. This will be important in informing and shaping how this risk is mitigated and managed going forward.
- **CRR23 Asbestos Management and Control**
  Key progress: Discussed, approved and recommended for inclusion onto the CRR. Target score needs re-considering as it sits outside the Health Board's risk appetite.
- **CRR24 Contractor Management and Control**
  Key progress: Although the QSE recommended this risk for inclusion onto the CRR, members at the RMG requested for some further work to be done in strengthening the controls and further actions in place and for the title to be refreshed to focus on the potential risk and not the issue.
- **CRR25 Legionella Management and Control**.
  Key progress: Members at the RMG reviewed this risk and recommended that the current score should be changed to 16 to reflect the controls in place. Target score needs re-considering as it sits outside the Health Board's risk appetite.
- **CRR26 Non-Compliance of Fire Safety Systems**

Key progress: Members at the RMG reviewed these risks and requested for some further work to be done in strengthening its controls and further actions. Target score needs re-considering as it sits outside the Health Board's risk appetite.

The following two Covid-19 related risks were approved for inclusion onto the CRR following review and scrutiny at the last Board meeting.

- **CRR27– Risk to public health and safety arising from an outbreak of COVID-19 and demand outstripping organisational capacity.**
  Key Progress: The newly added risk focuses on highlighting the potential impact to public health and the safety of staff and patients which may result from the outbreak of Covid-19 as this could negatively affect the Health Board`s resources and operational capabilities in effectivley mitigating and managing this pandemic.
- **CRR28 - Risk of infection from COVID-19 to staff and patients as a result of inadequate supply, quality or usage of PPE.**
  Key Progress: This risk was discussed and approved at the last Board meeting as the shortage of PPE items, the challenge with sourcing the right PPE kits and ensuring that these are readily and sufficiently available to frontline staff has become a huge national conundrum. The need to effectively mitigate and manage this risk so as to protect the health, well-being and safety of both staff and patients was emphasised. This risk is regularly reviewed and monitored by the PPE Work-stream.

**NB: Details of the full CRR are captured in appendix 1.**

The Audit Committee are requested to note the following risks which had been de-escalated in the past.

- **CRR04** - **Maternity Services may become unsustainable due to difficulties recruiting into specific medical posts**: - was de-escalated in July 2019 following review by the Maternity SMT.
- **CRR08** - **Strategy Development**: - was de-escalated in July 2018 by the Board.
- **CRR19** - **Countess of Chester Hospital - Discontinued RTT for Patients in Wales**: - was de-escalated in June 2019 by the F&P Committee.
- **CRR14** - **Staff Engagement**: - de-escalated in January 2020 by the Audit Committee.

**Closed Risk:**
The following risk has been closed since the last CRR report was presented to the Board:

- CRR07 - Capital Systems on the 25$^{the}$ June 2019 by the F&P Committee.

**New risks**

- There are no new risks for approval for inclusion onto the CRR.

After further discussion, extensive scrutiny and review, members at the RMG agreed that the following two risks should be de-escalated and managed at tier 2 as linked risks to CRR21 (Health & Safety Leadership and Management) that is already on the CRR.

- **Risk ID 3021** - Vibration Control
- **Risk ID 3022** – Electrocution at Work

| Current Risk Level | | Impact | | | | |
|---|---|---|---|---|---|---|
| | | Very Low - 1 | Low - 2 | Moderate - 3 | High - 4 | Very high - 5 |
| Likelihood | Very Likely - 5 | | | CRR03 | CRR10a<br>CRR11a<br>CRR11b<br>CRR17<br>CRR22<br>CRR26 | |
| | Likely - 4 | | | CRR05 | CRR01<br>CRR06<br>CRR09<br>CRR10b<br>CRR10c<br>CRR15<br>CRR16<br>CRR13<br>CRR12 | CRR20<br>CRR21<br>CRR23<br>CRR24<br>CRR25<br>CRR27 |
| | Possible - 3 | | | | CRR18<br>CRR28 | CRR02 |
| | Unlikely - 2 | | | | CRR14 | |
| | Rare - 1 | | | | | |

**Strategy Implications**
This CRR report is strategically important as it evidences, confirms and provides assurance to the Audit Committee that the Health Board is effectively and efficiently identifying, assessing, mitigating and managing high/extreme risk risks to the achievement of its Priority Areas and Objectives as defined in its 3 Year Plan in line with best practice and its risk management strategy.

**Financial Implications**
The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.

**Risk Analysis**
No risks have been identified from crafting this report as the risk of inaction is far greater than that of positive engagement with its content.

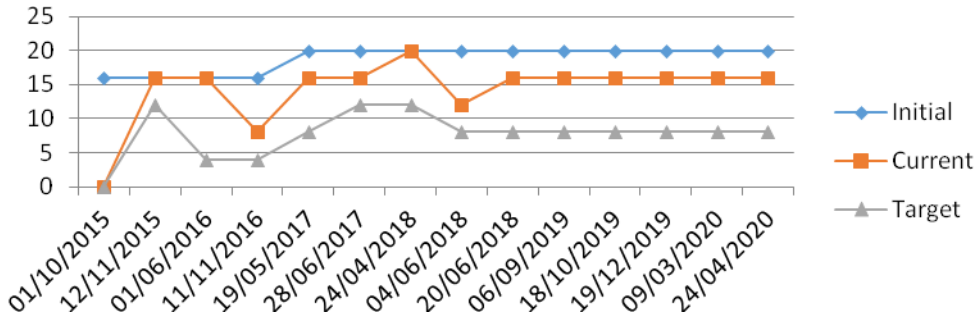
**Legal and Compliance**
This CRR report which will be periodically shared with the Board is intended to provide assurance.

**Impact Assessment**
Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

**Appendix 1: Details of the Corporate Risk Register**

| | | |
|---|---|---|
| CRR01 | **Director Lead:** Executive Director of Public Health | **Date Opened:** 1 October 2015 |
| | **Assuring Committee:** Strategy, Partnerships and Population Health Committee | **Date Last Reviewed:** 24 April 2020 |
| | **Risk:** Population Health | **Target Risk Date:** 31 March 2021 |

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 will lead to higher levels of non communicable diseases such as obesity, hypertension, coronary heart disease, stroke, diabetes, and some cancers. This will lead to an increase in demand on primary and secondary care, and increase levels of health inequalities between our most and least deprived communities.




| | 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 November 2019** | **No Change** ⟺ | | |

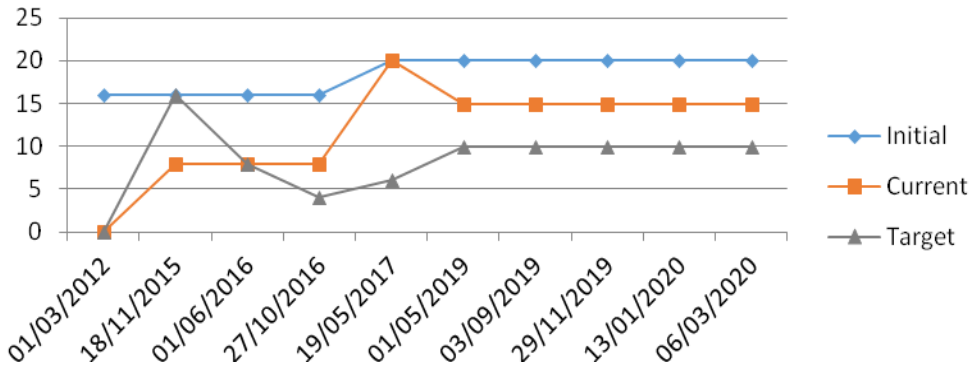
| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Population health intelligence updated on a continuing basis ensuring that information is available to support planning for and monitoring of health status.<br>2. Approved Population assessment to inform Social Services and Wellbeing Act developed in partnership, and now informing implementation of North Wales Regional Plan for 2018-2023.<br>3. Review of Board cycle of business completed to enable focus on population health issues. | 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 - Regional Partnership Board and Public Service Boards.<br>2. Health Improvement and Inequalities Transformation (HIIT) Group lead the development of relevant section of |

| | |
|---|---|
| 4. Wellbeing Assessments completed and approved.<br>5. Wellbeing Objectives and Plans approved / to be approved in the 4 PSBs.<br>6. Strategic Partnerships in place providing opportunities for advocacy for improving population health with partners.<br>7. Approved HB Strategy Living Healthier, Staying Well confirms emphasis on improving population health through more focus on prevention.<br>8. Baseline Assessment informing LHSW completed, underpinned by WG Public Health Outcomes Framework.<br>9. Improved data on Primary care available to Area Teams and Contractors via PH Directorate website.<br>10. Organisational objectives have now been revised and redefined as our Wellbeing Objectives.<br>11. DPH / Public Health Consultants attend all PSBs and Part 9 Board to advise and influence on prevention / early intervention agenda.<br>12. Delivery of Public Health Team workplan is aligned with operational Area Teams.<br>13. Public Service Boards Wellbeing Plans developed.<br>14. Health Improvement and Reducing Inequalities Group (HIRIG) established and working to ensure that population health and prevention initiatives are developed in Health Board Planning.<br>15. Continued engagement with the Live Lab work with Office of Future Generations Commissioner and Public Health Wales. Focusing on Healthy Weight in Pregnancy and Children.<br>16. BCUHB working with Regional Partnership Board to ensure population prevention focus for Building a Healthier Wales (BAHW) funding across the North Wales Region. | 2019/22 IMTP submission, and ensure co-ordination with other aspects of the Plan which are interdependent.<br>3. Identify substantive PMO support for this programme.<br>4. Participate in Live Lab work with Office of Future Generations Commissioner and Public Health Wales to provide a new focus for prevention within the delivery of community services, and generate learning which can be shared across Wales.<br>5. Review of all other public health risks underway which will inform the existing risk mitigation measures for this overarching risk.<br>6. Grant funding available for Prevention and Early Intervention from Welsh Government (Building a Healthier Wales) has been made available via Health Board and spend allocation over three years. |
| **Assurances** | **Links to** |

| | | | |
|---|---|---|---|
| 1. Oversight by Public Service Boards and Local Authority Scrutiny Committees.<br>2. WG Review Meetings (JET).<br>3. Public Health Observatory reports and reviews.<br>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:** 1 March 2012 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 6 March 2020 |
| | **Risk:** Infection Prevention & Control | **Target Risk Date:** 30 September 2020 |

There is a risk that patients will suffer harm due to healthcare associated infection. This may be caused by a failure to put in place systems, processes and practices that would 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 | 3 | 15 |
| Target Risk Score | 5 | 2 | 10 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⟺ | | |

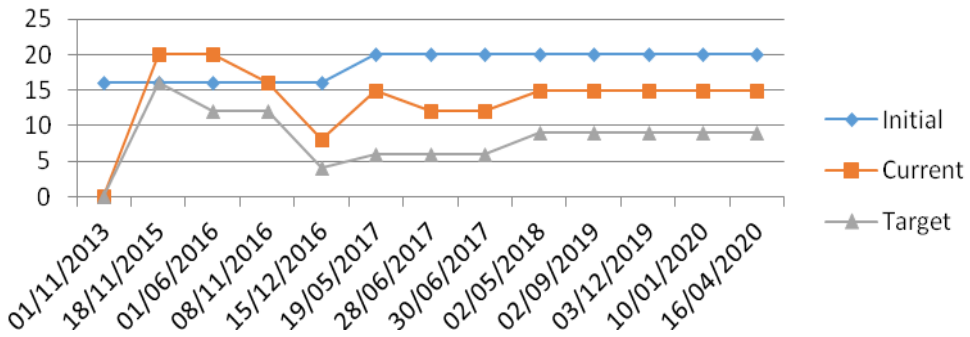
| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Infection Prevention Sub-Group scrutinise trajactories and performance through the regular cycle of business, quarterly and annual reports to Quality and Safety Group.<br>2. Surveillance systems and policies/SOPs in place for key infections, with data presented through the governance route to Board.<br>3. Areas and Secondary Care sites governance arrangements are in place. | 1. Continue the implementation of SCC and IP via annual work programmes.<br>2. Consider aligning SCC with IP Annual Work Prgramme.<br>3. Implement the other actions identified in the 2019-20 annual infection prevention programme.<br>4. Implement actions in response to Welsh Government Antimicrobial Delivery Plan, relevant Welsh Health Circulars and in response to multi-drug resistant organisms. Part of the ARK study and rollout. |

| | |
|---|---|
| 4. 6 weekly Executive-led scrutiny meetings to review infections and learning from each site in place.<br>5. Continued progress on ANTT staff training, with key trainers in place, increased focus on medical staff supported by MDs, competencies held by individuals managers.<br>6. External review performed August 2017; report on further actions presented to Board. Second review report received in August 2019 shows improvement, as does the internal audit on Safe Clean Care (SCC) assurance in June 2019.<br>7. SCC Programme launched 29-01-18.<br>8. CAUTI snapshot carried out in September 2019.<br>9. Deep dive considers every 6 organisms under WG scrutiny. | 5. Continue to progress key actions from Duerden and Jan Stevens reports 2016, 2017, 2019 in relation to Variation, Consultant Microbiologist staffing and capacity, Antimicrobial Stewardship, Estates and Facilities, policies and procedures and Safe Clean Care.<br>6. Scrutinise every avoidable infection and lessons learnt from these are shared formally from Post Infection Reviews and Deep Dives.<br>7. Continue work on influenza preparedness and response for Winter 19-20 and review Pandemic policy and procedures.<br>8. 12 Key action points carried out HB wide in November 2019 which showed a decrease in 5 of the 6 trajactories.<br>9. Educational event and Link practitioners in place December 2019.<br>10. Canula devices and documents approved for distribution.<br>11. Collaberative work with Continence, Tissue Viability and pharmacy to address unwarrented variation.<br>12. Improved visability across the HB from IP service.<br>13. Review of all IP policies and SOPs.<br>14. Development of IP team 2020.<br>15. Working alongside Tissue Viability, Pharmacy and Continence service in relation to HCAIs. |

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

| CRR03 | **Director Lead:** Director of Primary and Community Care | **Date Opened:** 1 November 2013 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 16 April 2020 |
| | **Risk:** Continuing Health Care | **Target Risk Date:** 31 March 2021 |

There is a risk that the CHC National Framework is not complied with. This is due to limited understanding of the framework and inconsistent application. This could lead to poor patient experience, outcomes and value for money.



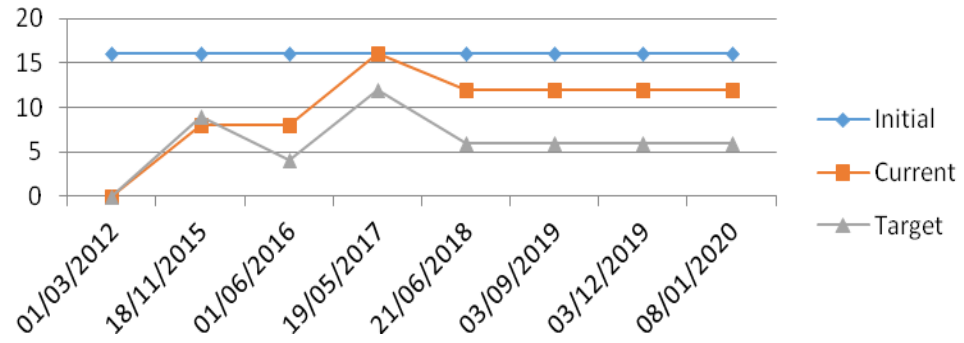

| | Impact | Likelihood | Score |
|---|---|---|---|
| Initial Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 3 | 5 | 15 |
| Target Risk Score | 3 | 3 | 9 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⟺ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. National CHC Framework. (2014).<br>2. Area and divisional CHC team with local accountability.<br>3. Revised BCUHB CHC Improvement Group and CHC operational Group Reporting and Governance Framework agreed.<br>4. Annual WG self assessment.<br>5. Contracts and contract monitoring team in place.<br>6. CHC Contracts in place for all placements.<br>7. Partnership established with the National Commisioning Collaborative Unit to oversee overarching strategy development improving quality, experience and value. | 1. Progress programme of CHC support with NCCU, to include focus on training and development, data and performance management, standard operating proceedures, stakeholder engagement and realignment of CHC within the Health Board.<br>2. Development of dashboard KPI's for CHC with Broadcare.<br>3. Monthly exception reporting.<br>4. Develop CHC commissioning strategy.<br>5. Develop and finalise the joint contracting process for providers in formal escalation. |
| **Assurances** | **Links to** |

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

| | | |
|---|---|---|
| CRR05 | **Director Lead:** Executive Director of Nursing and Midwifery | **Date Opened:** 1 March 2012 |
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 22nd April 2020 |
| | **Risk:** Potential inability to learn from patient safety and experience concerns | **Target Risk Date:** 31 December 2020 |

There is a risk that the Health Board does not listen and learn from patient safety and experience due to the untimely management, investigation and subsequent improvement actions from concerns (incidents, complaints, claims, inquests). This could lead to repeated failures in quality and safety of care, poor patient experience, loss of organisational memory and reputational damage to the Health Board.




| | Impact | Likelihood | Score |
|---|---|---|---|
| Initial Risk Rating | 4 | 4 | 16 |
| Current Risk Rating | 3 | 4 | 12 |
| Target Risk Score | 3 | 2 | 6 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⟺ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Processes in place to manage concerns (incidents, complaints, claims, inquests) in accordance with PTR Regulations.<br>2. Corporate and divisional meetings to manage processes and cascade learning including daily reviews within divisions, weekly reviews within divisions and a weekly pan Health Board Incident and Complaint Review Meeting.<br>3. Reporting to share learning and monitor performance at divisional and pan Health Board levels; including divisional quality and safety reports, divisional patient experience reports and a Health Board monthly and quarterly Patient Safety Report and quarterly Patient Experience Report. | 1. Concerns processes (incidents, complaints, claims, inquests) being fully reviewed following appointment of the new Assistant Director of Patient Safety and Experience – full process re-design will take place throughout 2020 in co-production with stakeholders, building on national best practice.<br>2. Patent Safety Alert process to be moved to the Patient Safety and Experience Department allowing for greater integration of data/insight and activity. |

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|---|---|
| 4. Harm Dashboards available for local clinical leaders to identify opportunities for learning and improvement.<br>5. Pan Health Board quality improvement collaborative programmes commenced based on identified risks including a Falls Collaborative, Sepsis Collaborative and a Healthcare Acquired Pressure Ulcer (HAPU) Collaborative.<br>5. Patient Safety and Experience Department in place to develop and manage processes and systems and offer advice and assurance – supported by divisional governance teams and linked to the BCU Quality Improvement Hub.<br>6. New Patient Advice and Liaison Service (PALS) fully resourced and launched in 2019.<br>7. Learning from Event (LfE) Reports prepared for all claims and redress cases.<br>8. The Head of Patient Safety is part of, and chairs, the All-Wales Redress Case Review Group enabling learning from across the country to be identified. The Patient Safety and Experience Department is represented at, and fully engaged in, each All-Wales concerns related network.<br>9. Training programme in place to support continued learning, delivered by the Patient Safety and Experience Department.<br>10. Patient Safety Alerts process in place to cascade learning across the Health Board.<br>11. Quality and Safety Group in place to oversee patient safety and to cascade learning from patient safety issues, and a Patient Experience Group in place to undertake the same for patient experience (divisions provide reports to both groups).<br>12 Joint protocol in place between Health Boards and Welsh Ambulance Service Trust to undertake joint investigations when appropriate.<br>13. Mortality review process in place to support learning from deaths. | 3. Development of a Patient Safety and Experience Learning Library on the intranet to further promote learning.<br>4. Development of a Patient Safety and Experience Bulletin to further promote learning.<br>5. Review and update of training and development with a particular emphasis on developing and embedding human factors and systems thinking.<br>6. Implementation of new "Once for Wales" RLDatix concerns management system to aid learning across the Health Board and Wales.<br>7. Review of the weekly incident and complaint review meeting and development into a weekly Patient Safety Summit.<br>8. Structure review within the Patient Safety and Experience Department to improve the focus and profile of patient safety and to integrate complaints with patient experience/PALS.<br>9. Enhancement of the mortality review process to implement the new national Medical Examiner programme.<br>10. Workshop to be held with the Community Health Council to develop partnership working. |

| | | | |
|---|---|---|---|
| 14. Site audits by the Community Health Council (CHC) received through a single point of contact within the Health Board.<br>15. Inspections by Health Inspectorate Wales (HIW) received and coordinated through a single point of contact within the Health Board along with regular meetings with the HIW relationship manager. | | | |
| **Assurances** | **Links to** | | |
| 1. Welsh Risk Pool Reports.<br>2. Monthly review by Delivery Unit.<br>3. Public Service Ombudsman Annual Report, Section 16 and feedback from cases.<br>4. Regulation 28 Reports from the Coroner. | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| | 3 4 5 6 | PR9 PR7 PR1 | Leadership |

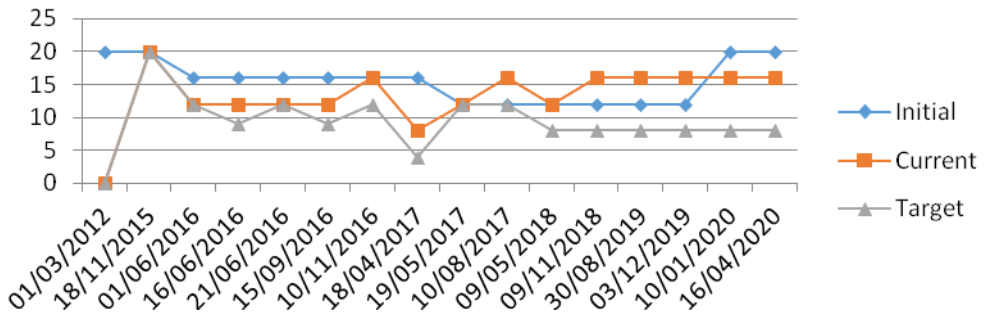
| CRR06 | **Director Lead:** Executive Director of Finance | **Date Opened:** 1 March 2012 |
|---|---|---|
| | **Assuring Committee:** Finance and Performance Committee | **Date Last Reviewed:** 16 April 2020 |
| | **Risk:** Financial Stability - Health Board Financial achievement of the control total agreed with Welsh Government | **Target Risk Date:** 31 December 2020 |

There is a risk that the Health Board will fail to achieve the deficit that meets the control total set by Welsh Government.

This is due to:
1. Savings plans that are not fully identified and may not be fully delivered.
2. Expenditure exceeding plan in both pay and non-pay areas.
3. The use of non-recurrent measures to support the in-year position risking the Health Board's longer term sustainability and continued failure to achive its financial duty.
4. Failure to identify and progress transformational schemes that will position the Health Board for the longer-term.

The impact of this could increase the in-year deficit to 31 March 2020 and fail to progress towards the Control Total of £25m, and impact on the ability of the Health Board to improve its financial position in out-years.

The Health Board will remain in Special Measures until the financial position improves and will fail to attract necessary investment.




| | 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 November 2019** | **No Change** ⇔ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Appointment of Recovery Director and establishment of a multi-faceted Recovery Programme, including recovery challenge meetings across all | 1. Further work to identify and convert recovery opportunities, including ongoing review by |

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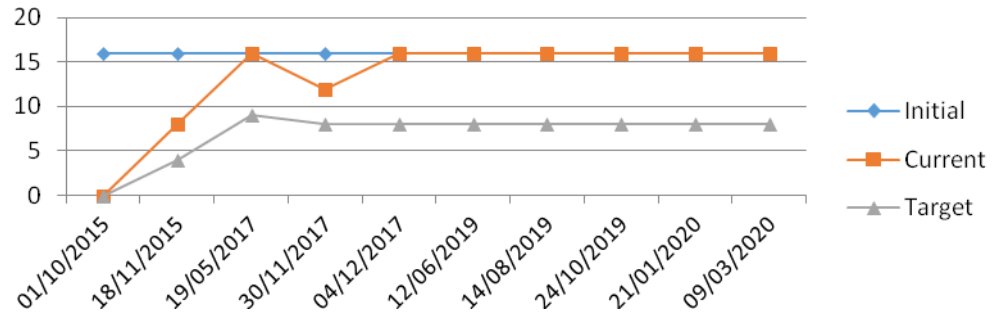
| business areas and improvement themes, deployment of detailed grip and control, and active management if savings opportunity pipeline.<br>2. Scheme of Financial Delegation and Accountability Agreements in place covering all devolved budgets.<br>3. Additional stretch targets issued across all business areas.<br>4. Dedicated Chief Finance Officer embedded in the management team of each Division (and hospital/area team).<br>5. Focused additional recovery support provided by PwC and Finance in key areas of budgetary pressure.<br>6. Programme Management software used to track and monitor the delivery of savings.<br>7. Reporting through Financial Recovery Group and Finance and Performance Committee. | Improvement Groups of the All Wales Efficiency Framework for further opportunities.<br>2. Ongoing communications to continuously embed financial goals across the organisation and all devolved budget areas including Better Care, Spending Well initiative.<br>3. Potential F&P Committee requesting attendance of divisions with recovery shortfalls to seek assurances regarding further progress.<br>4. Improved Financial Recovery Reporting to support oversight and decision-making.<br>5. Recovery and savings delivery are under continuous and progressive scrutiny as the financial year elapses.<br>6. Executives are discussing and agreeing potential additional escalatory grip and control measures. |

| **Assurances** | **Links to** | | |
|---|---|---|---|
| | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| 1. Monthly financial position reported to the F&P Committee and Board.<br>2. Finance Delivery Unit (FDU) view at the WG Special Measures meeting. | 7 | PR2 | SM4 SM1 |

| CRR09 | **Director Lead:** Director of Primary and Community Care | **Date Opened:** 1 October 2015 |
|---|---|---|
| | **Assuring Committee:** Strategy, Partnerships and Population Health Committee | **Date Last Reviewed:** 09 March 2020 |
| | **Risk:** Primary Care Sustainability | **Target Risk Date:** 31 March 2021 |

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 November 2019** | **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 January 2020.<br>2. Each Area has developed a regular practice review process to prioritise support.<br>3. Area Teams have developed support infrastructure to those practices experiencing significant challenges/pressures in terms of sustainability.<br>4. National Sustainability assessment process allows practices to request support from the Health Board. | 1. Evaluation and integration of new service models into primary care to ascertain their success.<br>2. New governance models of primary care need to be assessed to identify their reliability and assurance.<br>3. Care closer to home strategy to be evaluated. |

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| 5. Clinical advice available from Area Medical Directors and Cluster leads to provide support and development advice to practices.<br>6. Salaried GPs employed by Areas, working in managed practices and also GMS practices in difficulty. Further GPs employed since August 2019.<br>7. Agreement to employ clinical leads in managed practices to provide leadership and oversight. Clinical lead appointed for Blaenau Ffestiniog, Criccieth/Porthmadog, Cambria/Longford other practices progressing recruitment at present.<br>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.<br>9. Schemes for retaining and recruiting staff e.g. Outstanding GP scheme and the GP with experience scheme in place.<br>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.<br>11. Developing new models of delivery of care within GP practices.<br>12. Primary care funding is supporting the way that services are delivered within community and primary care setting to take pressure off GPs.<br>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 2019/20 continuing into 20/21.<br>14. Cluster plans and funded schemes are focusing on areas such as pathways and supporting the way that care is delivered at local level.<br>15. ANPs focusing activity within Care/Nursing homes to improve patient care and reduce demand on GP visits.<br>16. Running 24/7 DN service to reduce out of hours call out and unnecessary ED admissions.<br>17. Navigators working within GP practices signposting patients to the right healthcare.<br>18. Workflow optimisation training available to practices.<br>19. Intermediate care funded schemes supporting primary care. | 4. Establish primary care academy and further develop primary care training, including mentorship.<br>5. Recruit to GP schemes being adopted by Clusters and supported by new project manager for recruitment and retention.<br>6. Primary care workforce plan to be developed and fully implemented.<br>7. Further engagement with primary care and partner organisations.<br>8. Demand management scheme – establishing ways to release GP capacity and shift services out of hospital settings – new roles, new models, and new services.<br>9. Work with Deanery to increase the number of GP training places in N Wales.<br>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. |

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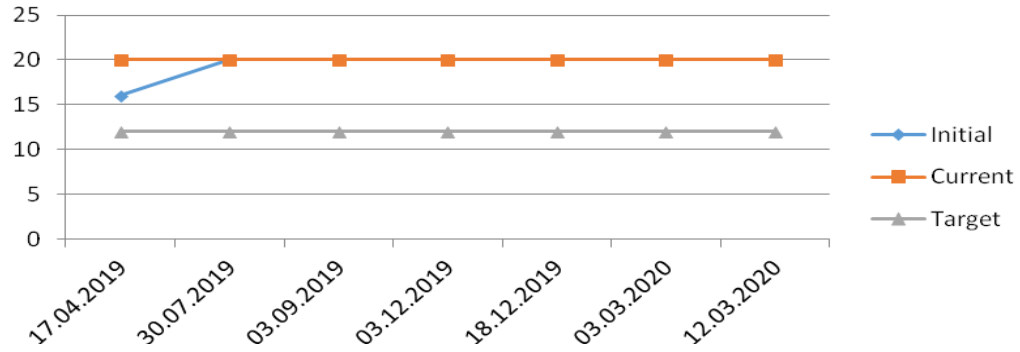
| 20. 16 BCUHB managed practices in place that are providing opportunities to trial new models of working and develop new areas of clinical care.<br>21. BCUHB has approved a 'Care Closer to Home' strategy that provides a vision of the way that care will be provided within community and primary care setting in the future. A CCtH transformation board has been established to oversee progress, with the first meeting held on 20 July 2018.<br>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.<br>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.<br>24. Premises issues being addressed with a number of practices, including approval to assign some premises head leases from partners to BCUHB.<br>25. Programme for recruiting and training practice nurses funded by PC funds in place with 6 nurses being recruited per annum.<br>26. Director of Primary and Community Health Services appointed and in post.<br>27. Plans to progress CCtH built into IMTP 2019-20, identified leads for progressing 4 themes (CRTS, Clusters, Health and Worksforce/service model) Centres.<br>28. Project to establish a Primary & Community Care Academy in place to deliver a sustainable, fit for purpose workforce within primary and community services through the allocation resources and drvelopment of new models. Project Manager appointed August 2019 and additional pacesetter proposal funding secured.<br>29. Changes to GP contract include partnership premium to support and encourage GPs becoming partners going forward. | 11. Accelerated role out of advanced practice training.<br>12. Promote practice mergers and federating.<br>13. Project to establish a Primary & Community Care Academy in place to deliver a sustainable, fit for purpose workforce within primary and community services through the allocation resources and development of new models.<br>14. Further development of clusters/localities with partners to strengthen primary/community/social care.<br>15. Accelerate estates improvements to ensure fit for purpose buildings for care in community settings. |

| **Assurances** | **Links to** | | |
|---|---|---|---|
| | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| 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. | 1 2 3 4 5 6 7 | PR6 | Primary Care |

| CRR10a | **Director Lead:** Executive Medical Director | **Date Opened:** 28 March 2019 |
|---|---|---|
| | **Assuring Committee:** Digital and Information Governance Committee | **Date Last Reviewed:** 12 March 2020 |
| | **Risk:** National Infrastructure and Products | **Target Risk Date:** 28 December 2020 |

There is a risk that the national infrastructure, technical architecture and products are not fit for purpose and do not allow the organisation to deliver benefits when planned. This may be caused by
a) a one size fits all approach.
b) products which are not delivered as specified (e.g. time, functionality and quality).
c) the approach of the National Programme to mandate/design systems rather than standards.
d) poor resilience and a "lack of focus on routine maintenance".
e) Supplier capacity leading to commitment or delivery delays.
f) Historic pricing models that are difficult to influence / may not be equitable.
This could result in negative impacts in several key areas including:- Patient outcomes. An inability to support the strategic direction of the Health Board. Delays to delivery of transformational change. Inefficient work flows, poor system usage. Increased costs as we maintain multiple systems / pay inequitable prices. Delays with the delivery of cost saving schemes.



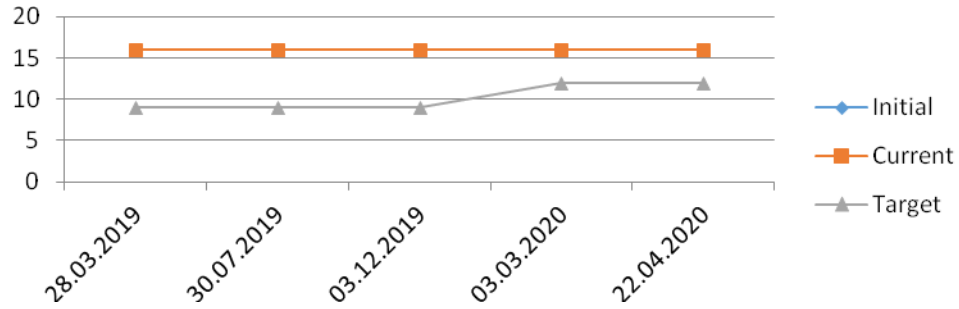

| | Impact | Likelihood | Score |
|---|---|---|---|
| Initial Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 5 | 20 |
| Target Risk Score | 4 | 3 | 12 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⟺ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Scrutiny of NWIS by DIGC.<br>2. Project Governance. | 1. Viable SLA.<br>2. Development and approval of local Digital Record.<br>3. Implementation of recommendation's (by NWIS) from Architecture and Governance Reviews. |

| Assurances | Links to | | |
|---|---|---|---|
| 1. Public Accounts Committee Review of NWIS.<br>2. Assurance Reports from Informatics to DIGC / EMG.<br>3. WAO - review.<br>4. National Architecture and Informatics Governance Reviews. | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| | 7 | PR6 | Not Applicable |

| CRR10b | **Director Lead:** Executive Medical Director | **Date Opened:** 28 March 2019 |
|---|---|---|
| | **Assuring Committee:** Digital and Information Governance Committee | **Date Last Reviewed:** 22 April 2020 |
| | **Risk:** Informatics - Patient Records pan BCU | **Target Risk Date:** 1 April 2022 |

There is a risk that patient information is not available when and where required. This may be caused by a lack of suitable storage space, uncertain retention periods, and the logistical challenges with sharing and maintaining standards associated with the paper record. This could result in substandard care, patient harm and an inability to meet our legislative duties.




| | 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 November 2019** | **No Change** ⇔ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Corporate and Health Records Management policies and procedures are in place pan-BCUHB.<br><br>2. iFIT RFID casenote tracking software and asset register in place to govern the management and movement of patient records.<br><br>3. Escalation via appropriate committee reporting. | 1. Enable actions to meet the regulatory recommendations from the ICO, HASCAS/Ockenden and Internal Audit reports. UPDATE MARCH 2020 - Last ICO review was positive with good feedback on the progress to date. A full review of all outstanding regulatory recommendations across all regulators is planned for Q1 of 2020/21.<br>2. (Project) Development of a local Digital Health Records system to digitise the 'acute general' patient record. UPDATE MARCH 2020 - The OJEU tender is closed and the evaluation findings will be ready to present to the DHR Steering Group for ratification of the preferred supplier on 6th March. The work on the FBC will commence next week and the project remains on track to present to the F&P Committee end of April and then the Health Board in May. |

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| 4. Key performance indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group). | 3. (Project) Improve the assurance of Results Management (stop printing results). UPDATE MARCH 2020 - The project is making good progress under the SRO of the Secondary Care Medical Director. Requirements in the WCP to action record (enable stopping printing) are planned for release v3.12 expected end July/August. Work is underway in partnership with NWIS to increase ETR (test requesting in WCP) by Sept 2020, with a new e-test requesting form being developed for Cytology/Histology. The NDR national project remains sighted as a priority to enabling access to our results data locally to feed an assurance report of results not viewed/actioned.<br>4. (Project) Digitise the clinic letters for outpatients through implementation of Digital Dictation, and as appropriate Speech Recognition software. UPDATE MARCH 2020 - The options appraisal was undertaken to appraise the subsequent ITT responses against the incumbent supplier, to evaluate the best approach for BCUHB and its patients, demonstrating value for money and minimising recurring revenue costs. The findings from the options appraisal concluded that the incumbent supplier is the preferred choice in both technical and commercial elements, with the best chance of mitigating the migration off the PIMS to WPAS at greater pace. Progress is with Procurement to advise on the extended contract. In the meantime the preparation for the upgrades to the product in use by the pilot users is underway.<br>5. (Project) Digitise nursing documentation through engaging in the WNCR - Adults National Nursing systems. UPDATE MARCH 2020 - The WNCR product has been through UAT and with all showstoppers addressed, enters pilot on one live ward 02/03/20 for 4 weeks. There are a number of enhancements to be addressed which will be reviewed again by NWIS alongside any pilot findings. A local business case will need to be written to consider the evaluation and any future roll out.<br>6. (Project) Baseline the; storage, processes, management arrangements and standards compliance, and present the recommendations and funding requirements to work towards PAN-BCUHB Patient Records Compliance with legislation and standards in patient records management across all casenote types. UPDATE MARCH 2020 - The Project Manager post funding has been secured and interviews planned for March. Records standards will be assessed pan-BCU against the new IG Toolkit to inform the ensuing recommendations. |

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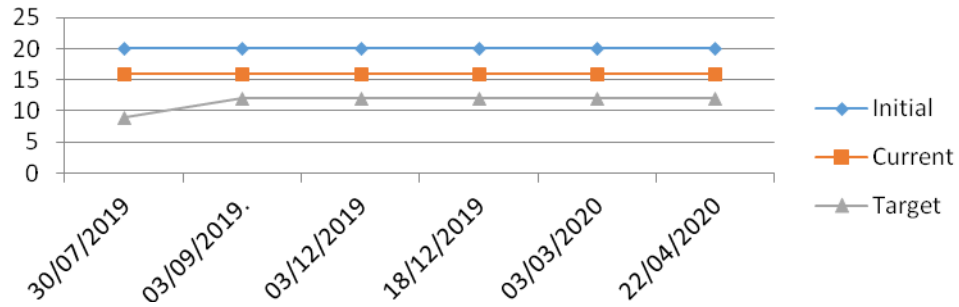
| | 7. Engage with the Estates Rationalisation Programme to secure the future of 'fit for purpose' file libraries for legacy paper records. UPDATE MARCH 2020 - In order to ensure the YGC File Library development is fit for purpose and value for money in the wider context of evolving estates and Service plans, a full review of need is being undertaken across all schemes and Service growth demands, with an update due at the next meeting of the YGC File Library Programme Board in April. |

| **Assurances** | **Links to** | | |
|---|---|---|---|
| 1.Chairs reports from Patient Record Group.<br>2.ICO Audit.<br>3.HASCAS Audit. | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| | 7 | PR1 | Not Applicable |

| CRR10c | **Director Lead:** Executive Medical Director | **Date Opened:** 28 March 2019 |
|---|---|---|
| | **Assuring Committee:** Digital and Information Governance Committee | **Date Last Reviewed:** 22 April 2020 |
| | **Risk:** Informatics infrastructure capacity, resource and demand. | **Target Risk Date:** 15 December 2021 |

There is a risk that digital services within the Health Board are not fit for purpose. This may be due to:
(a) A lack of capacity and resource to deliver services / guide the organisation.
(b) Increasing demand (internally from users e.g. for devices/ training and externally from the public, government and regulators e.g. growing need for digital services).
(c) the moving pace of technology.
This could lead to failures in clinical and management systems, and a failure to support the delivery of the Health boards strategy / plans impacting negatively on patient safety/outcomes. It may also pose a greater risk to the Health board of infrastructure failures and 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 November 2019** | **No Change** ⇔ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Governance structures in place to approve and monitor plans. Monitoring of approved plans for 2019 2020 (Capital, IMTP and Operational. Approved and established process for reviewing requests for services.<br>2. Integrated planning process and agreed timescales with BCU and third party suppliers.<br>3. Key performance metrics to monitor service delivery and increasing demand. | 1. Develop associated business cases and secure funding for resource required based upon risks and opportunities e.g. Digital Health Record.<br>2. Review workforce plans and establish future proof informatics/digital capab<br>ility and capacity. |

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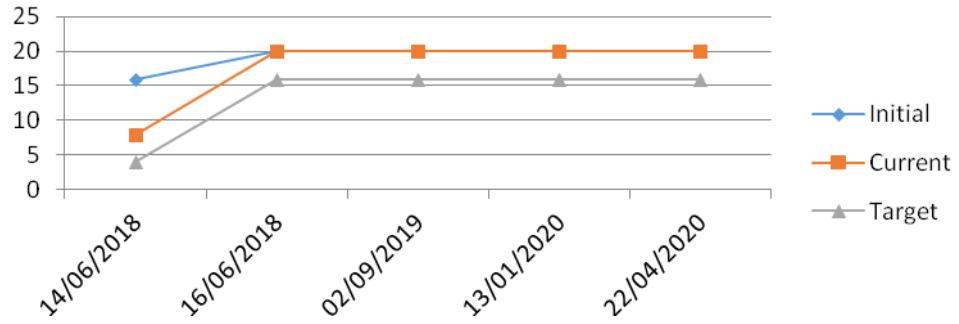
| 4. Risk based approach to decision making e.g. Local hosting v's National hosting for WPAS etc. | 3. Review governance arrangements e.g. DTG whose remit includes review of resource conflicts has not been replaced (April 2020). |

| **Assurances** | **Links to** | | |
|---|---|---|---|
| 1. Annual Internal Audit Plan. 2. WAO reviews and reports e.g. structured assessments and data quality. 3. Scrutiny of Clinical Data Quality by CHKS. 4. Auditor General Report - Informatics Systems in NHS Wales. 5. Regular reporting to DIGC (for Governance). | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| | 2 3 4 5 6 7 | PR6 PR5 PR2 | Not Applicable |

| | | |
|---|---|---|
| CRR11a | **Director Lead:** Executive Director of Nursing and Midwifery | **Date Opened:** 14 June 2018 |
| | **Assuring Committee:** Finance and Performance Committee | **Date Last Reviewed:** 22 April 2020 |
| | **Risk:** Unscheduled Care Access | **Target Risk Date:** 31 December 2020 |

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.
This could lead to an impact/effect on patient experience and outcomes, organisational 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 | 2 | 8 |

**Movement in Current Risk Rating since last presented to Board in November 2019**

**No Change** ⟺

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Multi-agency Unscheduled Care (USC) Transformation Board refreshed to USC improvement group, chaired by the Executive Director of Nursing.<br>2. Continued cycles of improvement with 3 specific work streams: Demand, Flow and Discharge.<br>3. Program manager appointed to oversee production and implementation of action plans.<br>4. Daily National Conference Calls with WG to address daily position. | 1. 3 EC managers substantively recruited and engaged with building better care plans (was previously 90 day improvement plan).<br>2. Building better care plan consisting of 3 streams of work:<br>a. Demand - SICAT established and demonstrating reduction in transfers to ED (~30% of calls - assumption that ALL calls previously would have resulted in transfer).<br>b. Flow - Multiple substreams including: |

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| 5. Daily Safety Huddles in place on 3 acute sites.<br>6. Daily BCU system calls to support flow between divisions.<br>7. Daily Board rounds on acute sites to support continuity of care and early discharge planning.<br>8. Weekly MDT stranded patient review meetings to identify reasons for lack of progress to facilitate more complex discharges across the Health Economies.<br>9. Development of USC dashboard with live and daily performance information to support decision making.<br>10. Weekly teleconference with DU to report performance and concerns and track improvement plans.<br>11. Sitrep reporting 3 times a day including SAPhTE for ED risk assessment.<br>12. Mental Health support located within site Police Control.<br>13. Frequent attenders WEDFANs group regularly review vulnerable patients who frequently access services to support implementation of care plans.<br>14. Escalation process and structure in place to provide 24/7 escalation from site management through bronze, silver and gold.<br>15. Development of internal clinical standards to highlight best practice and support teams to consider ways of working to achieve standards.<br>16. Discharge information provided to patients on admission via new discharge leaflet.<br>17. Use of SHINE tool to ensure that patient safety is monitored and intentional rounding complete for all patients including those waiting for offload from ambulances.<br>18. EDQDF early adopter site with focus on improving KPI's, patient feedback and experience and staff feedback and | -ambulance handover - WMH lost improved with consistent reduction in time taken for handover.<br>-proactive triage - promoting use of alternative resources and early decision-making to reduce time in ED (Overall average time in ED is reducing).<br>-early senior decision-making - recognition of senior medical staffing issues especially at WMH - requiring workforce and roster review.<br>-escalation and capacity management review - test of 'grip and control' at YGC site de-escalated from sitrep 4 to 2 without associated reduction in overall time in ED - further work on-going to review process and pilot at other sites.<br>-implementation of SAFER - ongoing - small increase in numbers of earlier discharges.<br>-stranded & super-stranded patient review - to launch across sites.<br>-review of acute assessment/ambulatory models with pilots to be launched later this month at YGC & WMH.<br>-review of specialty reviews for inpatients - to enable earlier discharge.<br>-review of imaging pathways to support early outpatient scans and avoid longer inpatient stay.<br>c. discharge planning - work continues to reduce delays in transfers of care and decision-making. Letter shared re. patient choice and working with staff to encourage proactive discussions with families and patients.<br>3. Review of site escalation and management to support site responsibility during normal working hours. |

| | |
|---|---|
| experience as key pieces of work within this programme and specific work to improve ambulance handover.<br>19. Active engagement in Every Day Counts programme to support key pathways of discharge.<br>20. Remodelling of urgent care processes in place across all 3 sites. | 4. Associate Director for unscheduled care replaced with programme manager with additional interim support at area level to oversee progress against building better care plan.<br>5. Engagement with National ED Quality & delivery framework.<br>6. Workforce review - supported by Kendall Bluck. |

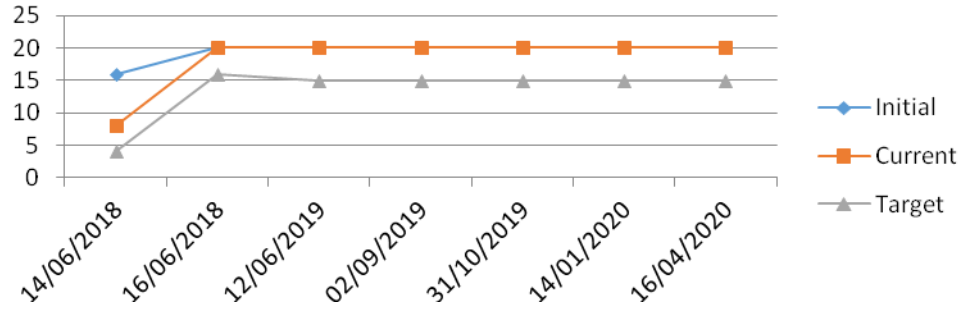
| **Assurances** | **Links to** | | |
|---|---|---|---|
| | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| 1. Seasonal Plan. 2. RTT Plan. 3. Twice Yearly JET meetings with WG. 4. Monthly meetings with Delivery Unit. 5. National Patient Flow Collaborative. 6. OOHs review (both 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. | 1 2 3 6 7 | PR3 | Leadership |

| | | |
|---|---|---|
| CRR11b | **Director Lead:** Executive Director of Nursing and Midwifery | **Date Opened:** 14 June 2018 |
| | **Assuring Committee:** Finance and Performance Committee | **Date Last Reviewed:** 16 April 2020 |
| | **Risk:** Planned Care Access | **Target Risk Date:** 31 July 2021 |

There is a risk that the BCUHB is not able to provide access to planned care in accordance with the national standards. This may result in not being able to meet the timely clinical needs and expectations of patients. BCUHB will need to provide assurance to partner organisations on the management of clinical safety and treatment of the backlog.

This is caused by capacity shortfalls or mismatch between allocation of available capacity and demand including booking of patients in chronological order following clinical urgency, a lack of effective utilisation of resources, conflicting pressures (management of Unscheduled Care pressures and elective delivery), equipment failure and availability of suitable facilities, workforce issues.

This could lead to adverse outcomes for patients, prolonged waiting periods, an inability to meet national targets (RTT, diagnostics, cancer, clinically due review time, and impact on the financial stability and the reputation of the Health Board.



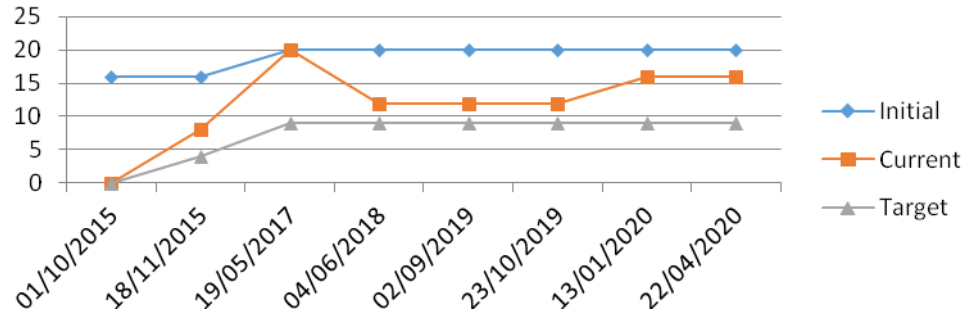

| | Impact | Likelihood | Score |
|---|---|---|---|
| Initial Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 5 | 20 |
| Target Risk Score | 4 | 2 | 8 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⟺ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Weekly PTL and Daily waiting times information in place for RTT, diagnostics and Cancer.<br>2. Performance team and trackers in Cancer utilising escalation processes with operational teams. | 1. Developing Capacity plan for 2020/21 ongoing, which includes outpatients follow up, non-planned care, diagnostics and Endoscopy. |

<table>
<tr><td>3. Demand and Capacity plan agreed per specialty and site confirming extent of sustainable service gap.<br>4. Weekly Access meeting extended to include RTT, Diagnostics and Cancer.<br>5. Interim Planned Care leadership in place responsible for leadership across the HB providing oversight of RTT.<br>6. Leadership in place responsible Cancer, Endoscopy and Diagnostics remedial action plans.<br>7. Weekly Performance management meetings at Hospital and Area Level.<br>8. Weekly outsourcing meeting in place.<br>9. Elective patient pathway and outpatient improvement cells in place with clear targets for efficiency improvement.<br>10. Engaged with National Planned Care, National Outpatient and Cancer Implementation Groups.<br>11. Single Cancer Pathway demand and capacity submission completed and shadow reporting to monthly to WG.<br>12. Elective and Seasonal plan assumes only daycase and urgent/cancer surgery is scheduled for winter 2019/20 to support unscheduled care capacity (except at Abergele).<br>13. Implemented additional eye care resource to undertake measure reporting and activity.<br>14. Insourcing and outsourcing of Endoscopy being undertaken till March 2021.<br>15. Additional contracts in place to maintain non-obstetric Ultrasound 8 week waits till March 2021.<br>16. Programme of work in place to reduce follow up backlog monitored via QSE.</td><td colspan="3">2. Sustainable service plans for 5 specialties are being further developed for 2020/21 including feedback from the national planned care programme (Orthopedics, Ophthalmology, Urology, Maxio facial and General Surgery).<br>3. Review Endoscopy management and governance structure.<br>4. Matrix working and responsibilities of clinical and operational leaders to be confirmed to strengthen governance.<br>5. Enhanced governance structure and responsibilities are being put in place for 2020/21.<br>6. Outpatient Programme Group established and commencing in February 2020.</td></tr>
<tr><td>Assurances</td><td colspan="3">Links to</td></tr>
<tr><td rowspan="2">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.</td><td>Strategic Goals</td><td>Principal Risks</td><td>Special Measures Theme</td></tr>
<tr><td>1 2 3 6 7</td><td>PR3</td><td>Leadership</td></tr>
</table>

| CRR12 | **Director Lead:** Executive Director of Planning and Performance | **Date Opened:** 1 October 2015 |
|---|---|---|
| | **Assuring Committee:** Finance and Performance Committee | **Date Last Reviewed:** 22 April 2020 |
| | **Risk:** Estates and Environment | **Target Risk Date:** 30 April 2023 |

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.



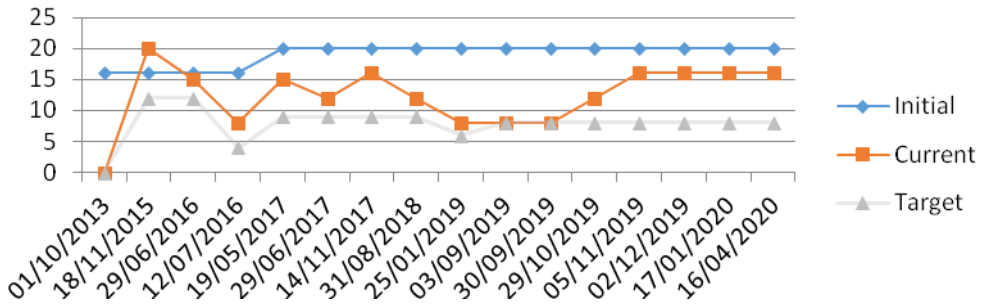

| | Impact | Likelihood | Score |
|---|---|---|---|
| Initial Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 4 | 16 |
| Target Risk Score | 3 | 3 | 9 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **Increased** ⇧ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Three Year Outlook 2020-2023 and 2020-21 Annual Plan - Living Healthier Staying Well in place and reporting to the Board and Committees.<br>2. Three Year Outlook 2020-2023 and 2020-21 Annual Plan - Living Healthier Staying Well - Sec 5.4 High Quality Estates and work programme priorities 2020-2023 in place and reporting to the Finance and Performance (F&P) Committee, Board and other appropriate Committees.<br>3. Estates Strategy - 3 yr (2019 - 2022)in place and reporting to F&P Committee.<br>4. Annual Estates Performance Reporting (EFPMS) to QSG and QSE.<br>5. Annual Capital Investment Programme 2019-20 Disc and All-Wales Projects ongoing with reporting to F&P Committee and the Board. | 1. Annually agreed programme of estates rationalisation and selective demolition (2019-20).<br>2. Annually agreed programme of Disc and All-Wales capital investment across the Estate.<br>3. Development of Estates Compliance PBC and SOC for Ysbyty Wrexham Maelor, Ystyty Gwynedd and Ysbyty Glam Clwyd Hospitals.<br>4. Undertake six facets condition survey of the Estates for Acute and Community premises to inform capital investment plans (2020/23). |

<table>
<tr><td colspan="2">6. 2020-2023 - Annual Plan Work Programmes Deliverables for High Quality Estates (Investment schemes listed within plan)in place and reporting to appropriate Committees and the Board.<br>7. Estates Health and Safety Compliance Audit and Action Plans 2019-20 in place and reporting to SOH&SG, QSE and the Board.<br>8. Estates Improvement Group (EIG) established based on Health Economy Groups processing Estate rationalisation and disposals, capital investment, corporate accommodation and review of Leased premises. Reporting to the Finance Recovery Group (which reports to Executive Team), F&P and the Board.</td><td colspan="3">5. Implement MICAD Property Management IT System to manage estate data and drawings. (2020-2023).<br>6. Implement actions required following Estates Health and Safety Compliance Audit (2019/20) including assessing additional revenue investment required for 2020-21 budget setting process.<br>7. Update Estates and Facilities Tier 5-4-3 risk registers to reflect current status of Estates and Facilities risks and mitigation required.</td></tr>
<tr><td>Assurances</td><td colspan="3">Links to</td></tr>
<tr><td rowspan="2">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).</td><td>Strategic Goals</td><td>Principal Risks</td><td>Special Measures Theme</td></tr>
<tr><td>1 2 3 4 5 7</td><td>PR5</td><td>Strategic and Service Planning</td></tr>
</table>

| CRR13 | **Director Lead:** Director of Mental Health and Learning Disabilities | **Date Opened:** 1 October 2013 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 16 April 2020 |
| | **Risk:** Mental Health Services | **Target Risk Date:** 31 March 2020 |

There is a risk that patients receive inappropriate care within Mental Health Services due to failings in leadership and governance within the Division which could result in poor quality outcomes for patients.




Between August 2018 and October 2019 a reduction in score was unauthorised, this has been reverted to correct score.

| | 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 November 2019** | **No Change** ⇔ |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Board assurance provided at all levels of MHLD governance framework – local, divisional and directors, MHLD presents weekly at Corporate complaints and concerns meeting, monthly at QSG, bi monthly to QSE, Board as required/requested and F&P.<br>2. More focussed monitoring on progress at Board level agreed and implemented.<br>3. Achieved and implemented renewed focus and escalation arrangements for dealing with operational issues: weekly operations meeting in each area, daily safety huddles, weekly leadership review, MHLD QSG and MHLD F&P.<br>4. Governance Framework developed and fully embedded – review of committee names being undertaken to ensure consistency with BCUHB framework. | 1. Review of Tier 7 & 8 in leadership structure underway.<br>2. Improve the use of patient experience and real time feedback intelligence to inform service improvements.<br>3. Further embed learning culture across the division. |

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| 5. Recommendations from Internal Audit Review (2019) implemented.<br>6. Mental Health Strategy approved by the Board and now in implementation phase with areas sustaining strategy change and new developments evidenced with new initiatives that are being modelled across MH services as good practice.<br>7. Senior Management and Clinical Leadership is no longer a holding structure but implemented with a permanent structure of leadership established, including to Tier 5 & 6.<br>8. External reviews and visits including positive HIW inspections detailed to QSE and Board.<br>9. MHLD provides Quality and Performance assurance to Executive accountability meetings in two forms of scrutiny<br>i) Divisional presentation and<br>ii) with each area health economy and is not in escalation as a result of current progress.<br>10. Monitoring continues via SMIF.<br>11. Implementation of HASCAS investigation and wider governance review including completion of HASCAS recommendation specific to MHLD has been successfully achieved. This is monitored through corporate governance processes and QSE Committee.<br>12. Ward accreditation embedded.<br>13. Improved scrutiny at local and divisional level in relation to PTR has resulted in improved KPIs across all of PTR. MHLD is the only division to have 0 complaints overdue. This is monitored via QSEEL.<br>14. Implementation of Listening Leads and BE PROUD OD Programme across the division with full engagement at Director level. | 4. Systematic implementation of Quality Improvement Methodology across the division at all levels.<br>5. Implementation of actions following skill mix review on inpatients wards to inform our future staffing levels linked to the All Wales Staffing Principles.<br>6. Delivery Unit have undertaken demand and capacity review with the Community Mental Health Teams, which will inform BCUHB and Local Authority future plans for staffing.<br>7. Additional actions to address Sickness across MHLD includes the development of Wellness strategy developed for MHLD – wellness, work and you! |

| **Assurances** | **Links to** | | |
|---|---|---|---|
| | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| 1. Board and WG oversight as part of Special Measures.<br>2. External reviews and investigations commissioned (Ockenden and HASCAS).<br>3. HIW Reviews.<br>4. Internal objective accreditation.<br>5. External Accreditation. | 1 2 3 4 5 6 7 | PR1 | Mental Health |

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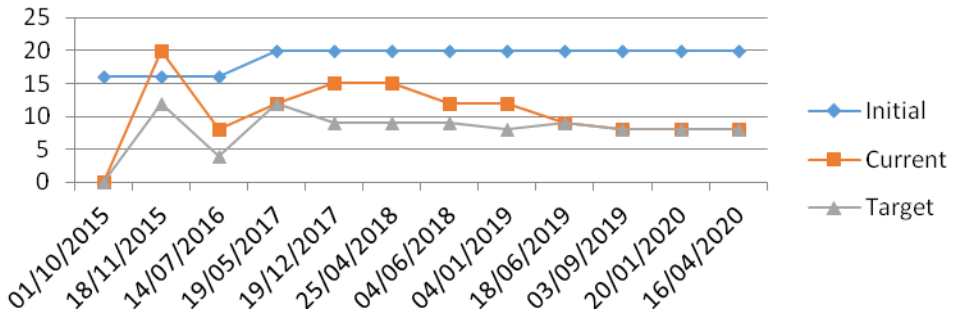
|---|---|---|---|
| 6. Delivery Unit oversight of CTP.<br>7. Caniad coproduction and objective day to day review of services.<br>8. Enhanced WG support has now concluded following intense scrutiny and input due to assurances provided by MHLD, including PAC report as submitted evidence. | | | |

| CRR14 | **Director Lead:** Executive Director of Workforce and Organisational Development | **Date Opened:** 1 October 2015 |
|---|---|---|
| | **Assuring Committee:** Strategy, Partnerships and Population Health Committee | **Date Last Reviewed:** 16 April 2020 |
| | **Risk:** Staff Engagement | **Target Risk Date:** 31 December 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 | 4 | 2 | 8 |
| Target Risk Score | 4 | 2 | 8 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⟺ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. All the requirements of the Engagement Strategy 2016 have been met. All the initiatives within the strategy have been mainstreamed into ongoing organisational development work.<br>2. Workforce & Organisational Development Strategy 2019-22 in place.<br>3. Workforce Objectives 2019-20 to meet the Workforce Strategy in place and monitored through the Annual Plan Progress Monitoring mechanism.<br>4. Mechanism in place to measure staff engagement on a regular basis via the BeProud organisational survey.<br>5. Mechanism in place to measure team level staff engagement through the BeProud Pioneer programme. | 1. Implement HEIW talent management framework to retain and develop staff at Tiers 1-3.<br>2. Develop Workforce Objectives 2020-21 to continue to meet the Workforce Strategy.<br>3. Implement Pay Progression Policy to drive improvements in PADR. |

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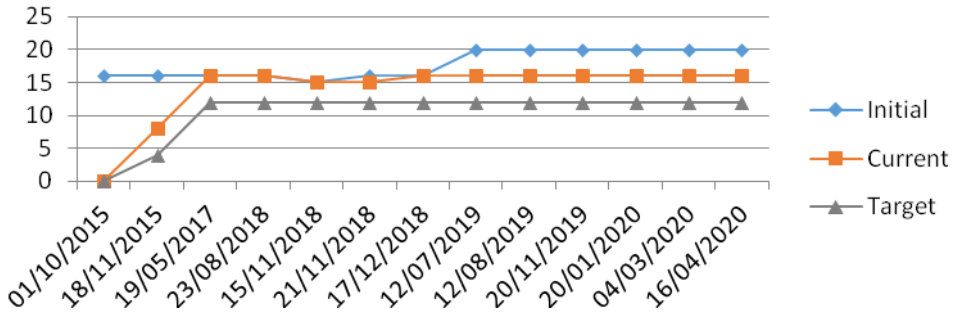
| 6. NHS Wales Staff Survey Organisational Improvement Plan and Divisional Improvement Plans monitored through the Workforce Improvement Group.<br>7. Retention Improvement plan in place.<br>8. PADR Improvement plan in place. | |

| **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:** 1 October 2015 |
|---|---|---|
| | **Assuring Committee:** Strategy, Partnerships and Population Health Committee | **Date Last Reviewed:** 16 April 2020 |
| | **Risk:** Recruitment and Retention | **Target Risk Date:** 31 December 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 | 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 November 2019** | **No Change** ⇔ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Embedded Medical & Dental (M&D) recruitment panel that oversees the fast tracking of medical vacancies from authorisation to offer accepted. This is having a positive effect on M&D vacancy rates and time to hire (TTH) .<br>2. This also includes fast tracking the EC posts for hard to fill vacancies, reports submitted to the Board.<br>3. WOD currently reviewing options to increase admin support for M&D recruitment by placing adverts on Trac on behalf of the lead recruiters. This is anticipated to further reduce TTH KPIs by ensuring adverts are ready to go live as soon as EC has been approved.<br>4. Promotion of the employment brand "Train Work Live North Wales" through digital media and marketing through key publications such as RCN careers brochures, BMJ on line and hard copy. | 1. Improve digital media marketing via social media the train work live north wales brand now has its own facebook.<br>2. Identification of recruitment co-ordinators in each secondary care high vacancy areas. Continue with student recruitment and promotion of nurse vacancies to Manchester, Chester and Staffordshire Universities.<br>3. Contribution to Medical Training Initiatives (MTI) Bapio Scheme.<br>4. Source recruitment marketing funding to support further digital marketing. Further work on |

| | |
|---|---|
| The Tender for international nursing recruitment is nearing completion; bidder presentations took place in February with anticipated contract award in March. First cohort of Nurses could be arriving in July 2020 with planned numbers of circa 25 per month.<br>5.New calendar of recruitment events being organised for 2020. This will include planning and attendance at local and national job fairs for nurses in particular.<br>6.Deeper analysis of the time to hire showing more specifically where the hot-spots and delays are in the process, leading to improvements.<br>Implemented a new process to review all posts to ensure that the BCUHB is compliant with the Welsh Language Standards - work led by the Workforce Information Systems Manager, compliance of existing process reported to the Welsh Language Forum on a quarterly basis, and will be included in Annual Report for Welsh Language.<br>7. Identification of top 10 priority areas for nurse recruitment is in place, the team are focusing on adverts out versus vacancies and then using enabling techniques to improve the time to hire.<br>Streamlined process for internal vacancies in place, which also allows a focus to be placed on these.<br>8. Recruitment lead for BCUHB working with Corporate Nursing on a number of recruitment pipelines such as fast track of HCA band 4 to adult nurse course at Bangor University (2 year course will provide 12 nurses in 2020).<br>Positive changes to bursary system on degree nursing courses at Welsh Universities will commit graduates to 2 years working in the Welsh NHS.<br>9. A focus on retention with appraisal compliance and mandatory training monitored.<br>10. National KPI's Time to Hire focus on recruitment timescales monitoring both within BCUHB and NWSSP.<br>11.TRAC system in place which ensures standardised processes, this is monitored through the Workforce Monthly Reports including time to hire which enables Managers, HR and the Board to understand on a monthly basis where | recruitment pipelines such as trainees, graduates return to practice, cadet scheme and overseas candidates.<br>5. Finalise and implement the all Wales approach to Student Streamlining Process which will ensure that the HB complies with the national agreed process and manage the Bursary Schemes in conjunction with NWSSP.<br>6. Finalise tendering process for an international recruitment campaign to bring 200+ RN into BCU form overseas, this is due to complete in March 2021.<br>7. Implement a new process to embed Welsh Language Standards as part of the Establishment Control process. This will be achieved by reviewing the Portal, the aim is to enable the HB to report on all posts and triangulate data back to appointees in the HB.<br>8. Work is currently underway to review the Exit Questionnaire process to encourage further feedback on our leavers.<br>9. Further work to develop our retention strategy being led by the Head of OD.<br>10. Implement a return to practice campaign later in 2019 - although challenges raised in November 2018 to Bangor University on lack of places for BCU RTP nurses. Corporate Nursing taking forward. |

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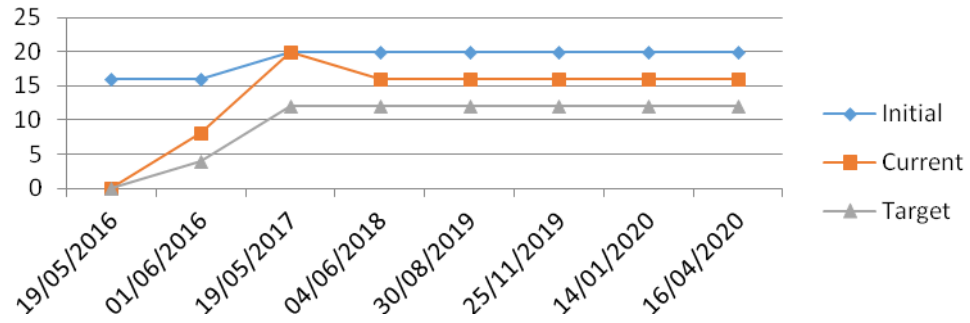
|---|---|
| the recruitment difficulties are. Summary of monthly dashboard reported to F&P Committee Quarterly.<br>12.Implementation and promotion of flexible working: part time working, job share, compressed hours, annualised hours, flexi, career breaks, personalised annual leave etc.<br>13. Staff benefits such as cycle to work schemes and other non-pay benefits in place.<br>14. HR and Recruitment Team continue to promote best practice through times of organisational change, redeployment and secondments and through flexible working arrangements.<br>15. An 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.<br>16. BCU HB contributes to the All-Wales Recruitment campaigns - 'train, work, live' brand. BCU Recruitment Team now has the SPOC which is promoted nationally and locally. Student nurse recruitment is the most successful pipeline and BCU have worked with WG/SSP to introduce a more robust method of recruiting our nurse graduates resulting in 130 nurses joining in September 2019 and a further 75 planned to join in March 2020.Resource implications | |

| **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 May 2016 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 16 April 2020 |
| | **Risk:** A Failure To Discharge Statutory and Legislative Safeguarding Responsibilties | **Target Risk Date:** 31 March 2020 |

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 to 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 BCUHB has a duty of care.




| | 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 November 2019** | **No Change** ⟺ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. A cycle of Business Planning meetings have been implemented within the Nursing and Midwifery Directorate which scrutinises and reviews Level 1 and 2 Risks and is attended by the Associate Director of Safeguarding.<br>2. A refreshed Safeguarding Reporting Framework has been implemented which sets out clear lines of accountability and is underpinned by a Cycle of Business. | 1. The third and final phase of the review of all Safeguarding JDs will be submitted to A4C January 2020.<br>2. Vacant posts continue to be progressed through the establishment control approval process to maintain a fully funded Safeguarding Team.<br>3. Further structural activity is planned to ensure business continuity and stability within the Corporate Safeguarding Team. This includes the provision of a 7 day on call, flexible working service. This was incorporated into the Structure Report at QSG 10th January 2020. |

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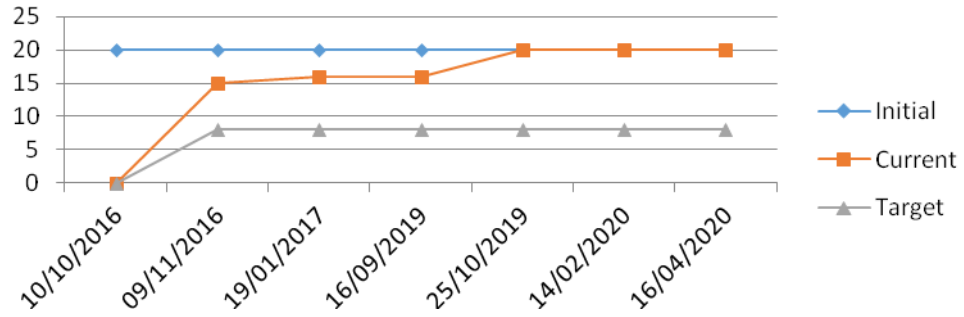
|---|---|
| 3. A standardised data report on key areas including Adult at Risk, Child at Risk and DoLS is submitted to Safeguarding Forums in order that data is scrutinised and risks identified.<br>4.Risk Management has been embedded into the processes of the Reporting Framework by being included as a standing item on the Safeguarding Governance and Performance and Safeguarding Forum[s] Agendas. Issues of Significance reports require risks to be identified and reported on in terms of mitigating action.<br>5. The new Senior Management tier has been appointed to within the Safeguarding Structure. This will strengthen strategic oversight in key areas.<br>6. A paper has been presented to QSG on the 10.1.20, in line with HASCAS / DO recommendation Numbers 8 and 6 and 11 and 9. This is relating to the review and effectiveness of the Safeguarding structure and progress report relating to the DoLS 2017-2018 action plan. Key controls have been implemented by increasing the number of DoLS Signatories, development of a Signatories Governance Framework and Specialist training. Bespoke DoLS Training and reporting of compliance and activity at Safeguarding Forums in accordance with the Safeguarding Reporting Framework has been put in place. See Risk 2548.<br>7. Bespoke training continues to be delivered to key high priority areas with responsibilities for 16/17 yr olds who may be / or experience a deprivation of their liberty as a result of a Supreme Court Judgement 26.9.19. | 4. In line with the HASCAS Recommendation / DO Recommendation 8, 6, 11 and 9. A Business Case is to be presented to the Finance and performance Group.<br>5. The legal framework and organisational accountability for Deprivation of Liberty Safeguards [DoLS] continues to place increased demands upon the organisation. In addition DoLS will be replaced by the Liberty Protection Safeguards [LPS] in 2020/2021 and will have a greater impact upon activity. The recent Supreme Court Judgement relating to 16/17 yr olds, came into force on the 26.9.19. A National Task and Finish Group and a BCU implementation group is to be convened to support the review and identify the impact the new legislation will have on organisations.<br>6. The programme of work to support the implementation of the Supreme Court Judgement and the increased activity is to be driven by a Task & Finish Group as agreed by QSG and completed by 31.3.20 (see Risk 2548.<br>7. A review of the DoLS structure and service provision is a priority activity for 2019-20 and a key requirement from HASCAS. An options paper which sets out options for the DoLS Team will be presented to QSG in January 2020. See Risk 2548.<br>8. The appointment of a Named Doctor, Adult at Risk remains outstanding however positive discussions have taken place with the Office of the Executive Medical Director. The business case to be presented at Finance and Performance Group is to include the financial requirements to support the appointment of a Named Doctor Adult at Risk and additional clinical support.<br>9. Fully engage with the Corporate Safeguarding Governance Audit and Deprivation of Liberty Safeguarding [DoLS] Audit, conducted by the NHS Wales Shared Services Partnership Audit and Assurance Service. Engage with any actions identified. |

| 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 Planning and Performance | **Date Opened:** 10 October 2016 |
|---|---|---|
| | **Assuring Committee:** Strategy, Partnerships and Population Health Committee | **Date Last Reviewed:** 16 April 2020 |
| | **Risk:** Development of IMTP (Integrated Medium Term Plan) | **Target Risk Date:** 31 December 2020 |

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 | 5 | 20 |
| Target Risk Score | 4 | 2 | 8 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⟺ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. The timetable to develop the 2019/22 IMTP was discussed and agreed by SPPH Committee on 9th August 2018.<br>2. The Health Board approved approach for developing the 2019/22 IMTP on 6th September 2018.<br>3. Unscheduled Care - 90 day plan launched and measures and trajectories agreed for inclusion in the AOP for 2018/19.<br>4. Transformation fund proposals developed with RPB partners Proposals for Community Services, children, mental health and learning disabilities submitted to Welsh Government.<br>5. Workplan established to develop 2019/22 IMTP with 3 CEO sponsored workshops held on 4th October, 8th November and 13th December 2018. | 1. Revised Plan to SPPH Committee on 5th March 2020.<br>2. On 12th March, there will be a full board workshop. The intention is to make the focus of the day the plan, and associated aspects.<br>3. Final version of the plan to the executive team on 18th March 2020.<br>4. Plan presented to Board on 26th March 2020. |

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| 6. Care closer to home service transformation plan and approach reviewed and re-profiled under the leadership of the Director of Primary and Community Services.<br>7. Board resolved to develop a 3 year plan for 2019/22 and WG notified.<br>8. Board received draft 2019/22 3 year plan in January 2019.<br>9. Planned care delivery group established in January 2019. Work programme under development including; RTT, diagnostics, cancer and outpatient plans, infrastructure/support, Strategic/tactical change - Acute hospital care programme schemes, Policy/national programmes - National delivery plans, Enablers - PMO turnaround schemes with a focus short term productivity and efficiency improvements and processes i.e. transactional rather than transformational.<br>10. Feedback from WG received around ensuring a clear work programme for 2019/20 to deliver improvements in RTT and Unscheduled care.<br>11. Three Year outlook and 2019/20 Annual plan presented to Board in March 2019. Plan approved with further work identified and agreed around elective care in the specialties set out on page 40 of the paper.<br>12. The Board received an updated plan in July 2019 and recommended that further work be undertaken led by F&P Committee to scrutinise underpinning planning profiles, specifically RTT, (including diagnostics), unscheduled care alongside the financial plan for 2019/20.<br>13. Completed profiles at BCU level and submitted to F&P Committee on 22nd August 2019.<br>14. Site and speciality core activity profiles developed.<br>15. Draft 2020/23 Cluster plans developed to feed into health economy plans.<br>16. Key deliverables for 2020/23 developed in September 2019.<br>17. Health economy planning arrangements established to support development of 2020/23 plan with linked support from corporate planning team.<br>18. 2020/23 Planning principles and timetable prepared and presented to EMG, F&P and SPPH Committees. Identified plan development actions to be implemented September - December. | |

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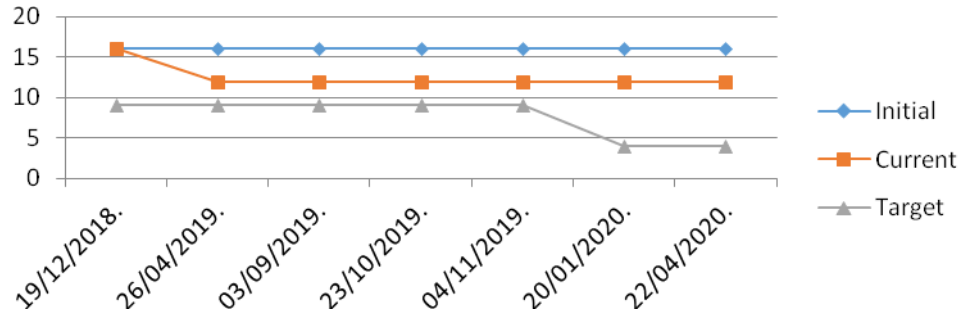
| 19. Plan updates provided to SPPH Committee meetings and workshops from October. Following our financial review, our aim is to develop a refreshed Three Year Outlook for 2020/23 alongside a Work Programme for 2020/21 in the context of our statutory duty to produce a three-year IMTP.<br>20. Draft health economy plans for 2020/23 developed in November 2019 for initial review by Improvement Groups.<br>21. F&P Committee received on 19th December 2019 the draft Three Year Outlook and Annual Plan for 2020/21 (v.0.02)together with draft 2020/21 Work Programme incorporating North Wales wide actions and specific health Economy Actions.<br>22. Draft 2020/23 plan presented to Board in committee in January 2020. Principles to further inform strategy and plan development identified. The annual plan guidance for 2020/21 provided by WG was presented together with our local assessment of progress and where further work is required and the route map and timetable to complete the outstanding work, specifically around Planned Care and our Financial Plan. | |

| **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 |

| CRR18 | **Director Lead:** Executive Director of Planning and Performance | **Date Opened:** 19 December 2018 |
|---|---|---|
| | **Assuring Committee:** Strategy, Partnerships and Population Health Committee | **Date Last Reviewed:** 22 April 2020 |
| | **Risk:** EU Exit - Transition Arrangements | **Target Risk Date:** 31 December 2020 |

There is a risk that the Health Board (HB) will fail to maintain a safe and effective healthcare service. This may be caused by a lack of clarity and understanding at UK level in respect of the impact of withdrawal from the European Union (EU), and a subsequent failure by the HB to develop robust withdrawal contingency plans. This could lead to a disruption of service delivery and thereby adversely impact on outcomes for patients in terms of safety and access to services.




| | Impact | Likelihood | Score |
|---|---|---|---|
| Initial Risk Rating | 4 | 4 | 16 |
| Current Risk Rating | 4 | 3 | 12 |
| Target Risk Score | 4 | 1 | 4 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⟺ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. BCUHB Task & Finish Group established, currently paused.<br>2. Potential risks and issues identified for no deal Brexit, will be further updated as implementation period progresses.<br>3. Participation with regional and national co-ordinating groups will re-commence as required.<br>4. Engagement with Executive Team will continue as required to ensure cascade of any necessary actions.<br>5. Update briefings will continue to staff via Bulletin, and webpages will be updated, as the situation develops.<br>6. Lower level risks entered onto Datix and linked to CRR18 will be updated as required. | Following extension to date of exit to 31 Jan 2020 and progress of the Withdrawal Agreement Bill through parliament, planning and preparations have been stood down by WG until further notice. The national leadership Group will continue to meet on a monthly basis but SRO meetings have been stood down.<br><br>Position will be reviewed by WG in July 2020 and response arrangements may be stood up if required, dependent on evaluation of political situation; however, currently the risk of leaving on 31 January 2020 without the passing of the WAB is significantly reduced. |

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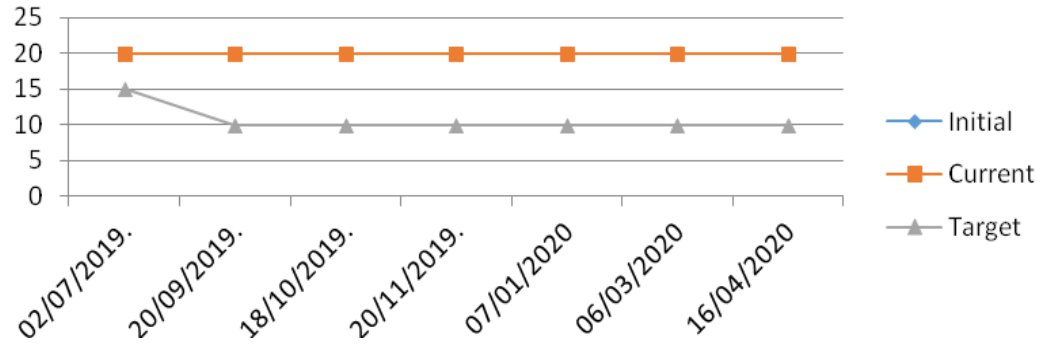
| Assurances | Links to | | |
|---|---|---|---|
| 1. Reporting to Executive Team and SPPH Committee<br>2. WAO audit of preparedness<br>3. WG oversight through national work streams | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| | 1 2 3 4 5 6 7 | PR1 | Not Applicable |

| CRR20 | **Director Lead:** Executive Director of Workforce and Organisational Development | **Date Opened:** 2 July 2019 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 16 April 2020 |
| | **Risk:** Security Risk | **Target Risk Date:** 1 November 2020 |

There is a risk the Health Board fails to ensure that a suitable systems are in place to protect staff, patients and stakeholders from security, violence and aggression incidents arising out of our work activity. This is due to lack of formal arrangements in place to protect premises and people in relation to CCTV, Security Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed.



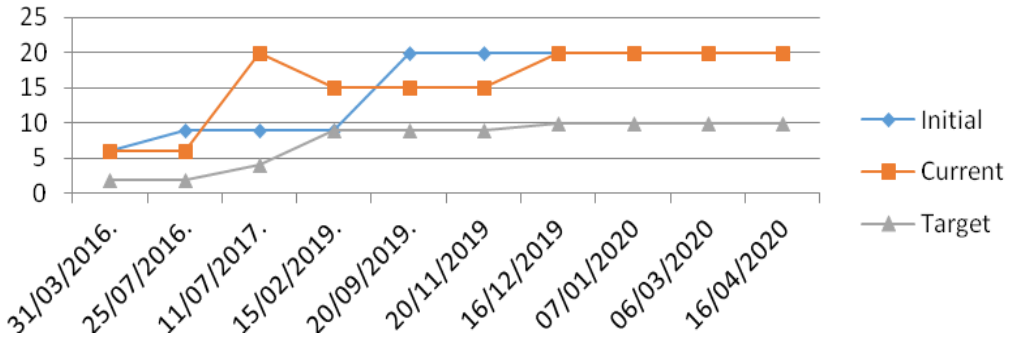

| | Impact | Likelihood | Score |
|---|---|---|---|
| Initial Risk Rating | 5 | 4 | 20 |
| Current Risk Rating | 5 | 4 | 20 |
| Target Risk Score | 5 | 2 | 10 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⇔ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1) There is a system in place for a contractor (Samsun) to manage the physical/people aspects of Security for the organisation.<br>2) A V&A Case manager is in place to support individuals who have been exposed to violence and aggression incidents.<br>3) An external contractor is supporting the Head of H&S to review all aspects of Security across the Board. | A systematic approach is required to both physical and people aspects of the risks identified. This includes:<br>1. A complete review of CCTV and recording systems.<br>2. Finalise and implement the CCTV Policy.<br>3. Clear lines of communication with the contractor, review of the contract in relation to key holding responsibilities and reporting on activities to be implemented.<br>4. Responsibilities of Security roles within BCUHB to be clearly defined. |

| | | | |
|---|---|---|---|
| 4) An external Police Support Officer is in place part time to support the organisation and staff. | 5. Lone worker procedures and risk assessments further established.<br>6. Reducing numbers of violence incidents to staff through clear markers and systems for monitoring violent patients.<br>7. Comprehensive review of Security on gaps in system which was provided to the Strategic OHS group. | | |
| **Assurances** | **Links to** | | |
| 1. Health and Safety Leads Group<br>2. Strategic Occupational Health and Safety Group<br>3. QSE | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| | 3 | | SM4 SM1 |

| CRR21 | **Director Lead:** Executive Director of Workforce and Organisational Development | **Date Opened:** 31 March 2016 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 16 April 2020 |
| | **Risk:** Health & Safety Leadership and Management | **Target Risk Date:** 1 November 2020 |

There is a risk that the Health Board fails to achieve compliance with Health and Safety Legislation due to insufficient leadership and general management. This could have a negative impact on patient and staff safety, including organisational reputation and prosecution.



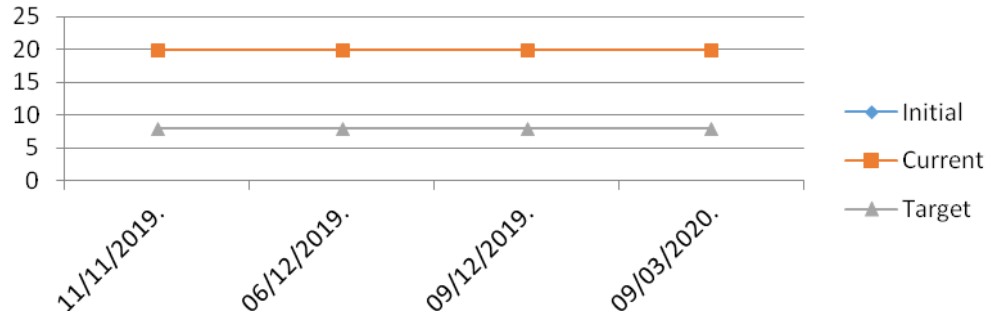

| | Impact | Likelihood | Score |
|---|---|---|---|
| Initial Risk Rating | 5 | 4 | 20 |
| Current Risk Rating | 5 | 4 | 20 |
| Target Risk Score | 5 | 2 | 10 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⇔ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Health and Safety risk assessment systems are in place in some service areas to protect staff, patients and others from hazards.<br>2. Health and Safety Management arrangements further developed.<br>3. Strategic Health and Safety Group in place meeting regularly (3 times in 3 months).<br>4. Risk Assessments and safe systems of work in place.<br>5. Mandatory Training in place.<br>6. Clinical and Corporate Health and Safety Teams established. | 1. Undertaken gap analysis of 31 pieces of legislation. Completed within specified time frame (117 inspections in 7 weeks).<br>2. Action plan developed based on non compliance with legislation.<br>3. Develop a programme of intervention and training through TNA Review.<br>4. Identified RIDDOR reports and scrutiny of process, looking at improved RCA system.<br>5. 12 Month action plan developed and 3 year strategy, that is owned by Divisions and Senior Leaders. |

<table>
<tr><td colspan="2">7. Corporate Health and Safety Team established.<br>8. Programme of Annual Self-Assessment Audits.<br>9. Gap analysis in place.<br>10. Health and Safety Walkabouts.<br>11. Health and Safety Report to QSE and Board.<br>12. Health and Safety Improvement Project Plan.</td><td colspan="3">6. Further develop individual risk register for items of none. compliance identified through gap analysis 8-10 specific items.<br>7. Review Divisional governance arrangements so that they marry with H&S governance system and reporting to Strategic OHS Group.<br>8. Implement findings of internal audit review of process of inspection and governance.</td></tr>
<tr><td colspan="2">Assurances</td><td colspan="3">Links to</td></tr>
<tr><td colspan="2" rowspan="2">1. Health and Safety Leads Group<br>2. The Strategic Occupational Health and Safety Group<br>3. QSE</td><td>Strategic Goals</td><td>Principal Risks</td><td>Special Measures Theme</td></tr>
<tr><td>1 2 3</td><td></td><td>SM4 SM1</td></tr>
</table>

| CRR22 | **Director Lead:** Executive Director of Nursing and Midwifery | **Date Opened:** 11 November 2019 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 09 March 2020 |
| | **Risk:** Potential to compromise patient safety due to large backlog and lack of follow-up capacity. | **Target Risk Date:** 31 December 2020 |

The is a risk that patient safety and experience may be comprised due to the Health Board's lack of follow-up capacity especially in outpatients specialities within Secondary across all three sites. This could lead to claims, poor patient experience, harm, reputational damage and deterioration in patient conditions who might have missed their 100% follow-up target.




| | Impact | Likelihood | Score |
|---|---|---|---|
| Initial Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 5 | 20 |
| Target Risk Score | 4 | 2 | 8 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⟺ | | |

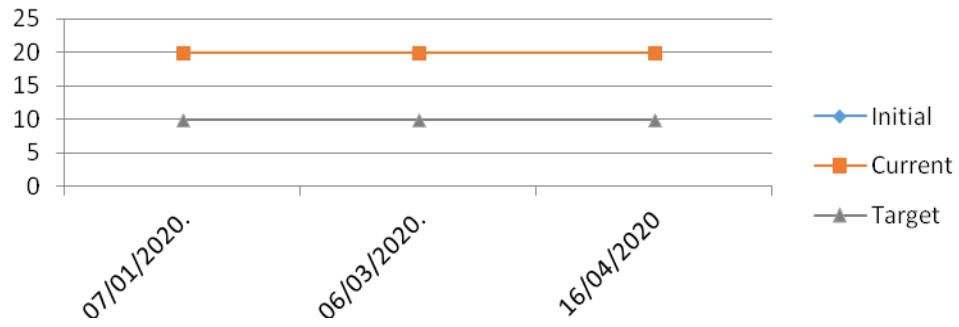
| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Ophthalmology and Cancer services have been validated and patients who might have come to harm due to missing their follow-up have been prioritised and seen in clinics.<br>2. Monitoring of follow-up numbers at weekly meetings.<br>3. Tendering completed for an external company to validate all follow-ups in OPD.<br>4. Close links with all services to ensure appropriate care planning for patients are in place. | The current reported number of backlog patients who have exceeded their follow up time by a 100% stands at 57,187 as of the end of December, of which 6,332 are booked and 50,855 are un-booked.<br>1. Continue the work to date outlined in the previous action plan following the best practice methodology but support with the best practice methodology outlined above.<br>2. Focus on the highest risk specialities for the immediate implementation of harm reviews with agreed trajectories for reduction by:<br>- Urology<br>- Cardiology<br>- General surgery<br>- Ophthalmology |

| | |
|---|---|
| 5. Strong clinical engagement and project management support established.<br>6. Prioritisation of patients at clinical risk and harm reviews being undertaken for all patients who have missed their 100% follow-up. | 3. Work on the trajectory of 15% reduction of the backlog by March 2020 and monitor these on a weekly basis through the local PTL meeting.<br>4. Establish a process that will allow the Health Board to contact all patients who are over 52 weeks and currently un-booked to establish if they still require an appointment in the larger specialties.<br>5. Review any new patient breaching 52 weeks or over 100% beyond their follow-up appointment will have a harm review to prevent growth of the backlog.<br>6. Agree monitoring and governance arrangements.<br>7. Discussion on resourcing a sustained in-house validation team ongoing as procuring indepndent validation is expensive. |

| **Assurances** | **Links to** | | |
|---|---|---|---|
| 1. Monitoring and governance arrangements for this risk in place.<br>2. Review of Ophthalmology and Cancer patients now completed.<br>3. Risk is now regularly reviewed at QSE with potential of adding onto the CRR. | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| | 2 3 4 5 7 | NA | Strategic and Service Planning |

| CRR23 | **Director Lead:** Executive Director of Workforce and Organisational Development | **Date Opened:** 7 January 2020 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 16 April 2020 |
| | **Risk:** Asbestos Management and Control | **Target Risk Date:** 2 November 2020 |

There is a significant risk that BCUHB is none compliant with the Asbestos at Work Regulations 2012. This is due to the evidence that not all surveys have been completed and re-surveys are a copy of previous years surveys. There are actions outstanding in some areas from surveys. This may lead to the risk of contractors, staff and others being exposed to asbestos, resulting in death from mesothelioma or long term ill health conditions, claims, HSE enforcement action including fines, prosecution and reputation damage to BCUHB.




| | Impact | Likelihood | Score |
|---|---|---|---|
| Initial Risk Rating | 5 | 4 | 20 |
| Current Risk Rating | 5 | 4 | 20 |
| Target Risk Score | 5 | 2 | 10 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⟺ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Asbestos Policy in place and partially implemented due to lack of complete asbestos registers on all sites.<br>2. A number of surveys undertaken, quality not determined.<br>3. Asbestos management plan in place.<br>4. Asbestos register available on some sites, generally held centrally. | 1. Undertaking a re-survey of 10-15 premises to determine if the original surveys are valid. This is problematic as finances are not available for this work, increasing the risk of exposure to staff and contractors.<br>2. Update and review the Asbestos Policy and Management Plan.<br>3. Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.<br>4. Ensure priority assessments are undertaken and highest risk escalated. |

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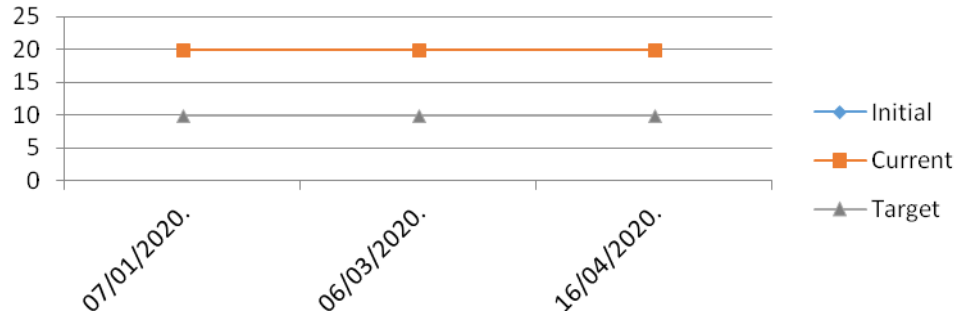
| 5. Targeted surveys were capital work is planned or decommissioning work undertaken.<br>6. Training for operatives in Estates.<br>7. Air monitoring undertaken in some premises where there is limited clarity on asbestos condition. | 5. Evaluate how contractors are provided with information and instruction on asbestos within their work environment. Ensure work is monitored.<br>6. Ensure all asbestos surveys are available at all sites and there is a lead allocated for premises.<br>7. Annual asbestos surveys to be tracked and monitor for actions providing positive assurance of actions taken to mitigate risks.<br>8. Update intranet pages and raise awareness with staff who may be affected by asbestos.<br>9. QR Code identification to be provided on all areas of work with identified asbestos signage in non public areas.<br>10. Lack complete asbestos registers on all sites picked up in H&S Gap Analysis Action Plan. |

| **Assurances** | **Links to** | | |
|---|---|---|---|
| | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| 1. Health and Safety Leads Group<br>2. Strategic Occupational Health and Safety Group<br>3. QSE | 1 2 3 | | SM4 SM1 |

| CRR24 | **Director Lead:** Executive Director of Workforce and Organisational Development | **Date Opened:** 7 January 2020 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 16 April 2020 |
| | **Risk:** Contractor Management and Control | **Target Risk Date:** 1 December 2020 |

There is a risk that BCUHB fails to achieve compliance with Health and Safety Legislation due to lack of control of contractors on sites. This may lead to exposure to substances hazardous to health, non compliance with permit to work systems and result in injury, death, loss including prosecution, fines and reputation damage.




| | Impact | Likelihood | Score |
|---|---|---|---|
| Initial Risk Rating | 5 | 4 | 20 |
| Current Risk Rating | 5 | 4 | 20 |
| Target Risk Score | 5 | 2 | 10 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⟺ | | |

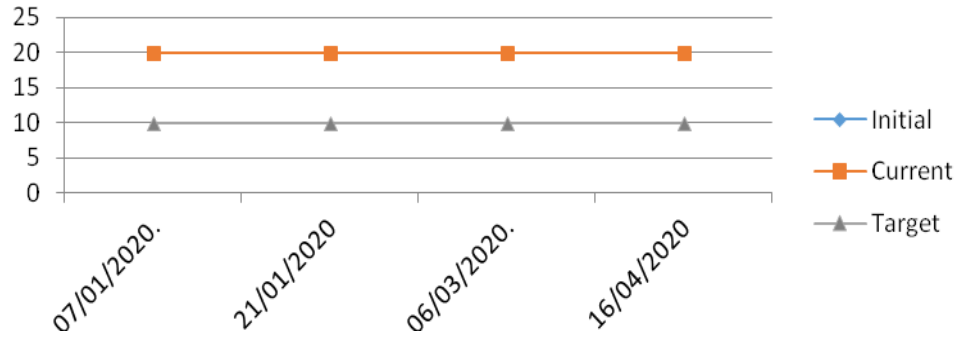
| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Control of contractors procedure in place and partially implemented due to lack of consistency and standardisation.<br>2. Evaluation of standing orders and assessment under Construction Design and Management Regulations.<br>3. Induction provided to some contractors but not all. Not all come through operational Estates such as IT.<br>4. There are a number of permit to work paper systems in place. | 1. Identify current guidance documents and ensure they are fit for purpose.<br>2. Identify service Lead on each site to take responsibility for Contractors and H&S Management within H&S Policy).<br>3. Draft and implement a Control of Contractors Policy that all adhere to including IT and other services who work on BCUHB premises.<br>4. Identify current tender process & evaluation of contractors, particularly for smaller contracts consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum H&S are implemented and externally checked prior to coming top site.<br>5. Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc. Is the current system fit for purpose and robust? |

| | |
|---|---|
| | 6. Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE data base.<br>7. Identify level of Local Induction and who carry it out and to what standard.<br>8. Identify responsible person to review RA's and signs off Method Statements (RAMS), skills, knowledge and understanding to be competent to assess documents (Pathology, Radiology, IT etc.).<br>9. Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis.<br>10. Lack of consistency and standisation in implementation of contractor management procedure picked up in H&S Gap Analysis Action Plan. |

| **Assurances** | **Links to** | | |
|---|---|---|---|
| 1.Health and Safety Leads Group<br>2.Strategic Occupational Health and Safety Group<br>3.QSE | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| | 1 2 3 | | SM4 SM1 |

| CRR25 | **Director Lead:** Executive Director of Workforce and Organisational Development | **Date Opened:** 7 January 2020 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 16 April 2020 |
| | **Risk:** Legionella Management and Control. | **Target Risk Date:** 30 November 2020 |

There is a significant risk that the BCUHB is non-compliant with COSHH Legislation (L8 Legionella Management Guidelines). This is caused by a lack of formal processes and systems to minimise the risk to staff, patients, visitors and General Public, from water-borne pathogens (such as Pseudomonas). This may ultimately lead death, ill health conditions in those who are particularly susceptible to such risks, and a breach of relevant Health & Safety Legislation.




| | Impact | Likelihood | Score |
|---|---|---|---|
| Initial Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 5 | 4 | 20 |
| Target Risk Score | 5 | 2 | 10 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⟺ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Legionella and Water Safety Policy in place and being partially impemented due to lack of consistency and standardisation.<br>2. Risk assessment undertaken by clear water.<br>3. High risk engineering work completed in line with clearwater risk assessment.<br>4. Bi-Annual risk assessment undertaken by clear water. | 1. Update Corporate H&S Review template and H&S Self Assessment Template to ensure that actions are completed by all wards and Departments to ensure systems are in place.<br>2. Ensure that engineering schematics are in place for all departments and kept up to date under Estates control. Implement MiCAD/database system to ensure all schematics are up to date and deadlegs easily identified.<br>3. Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed. |

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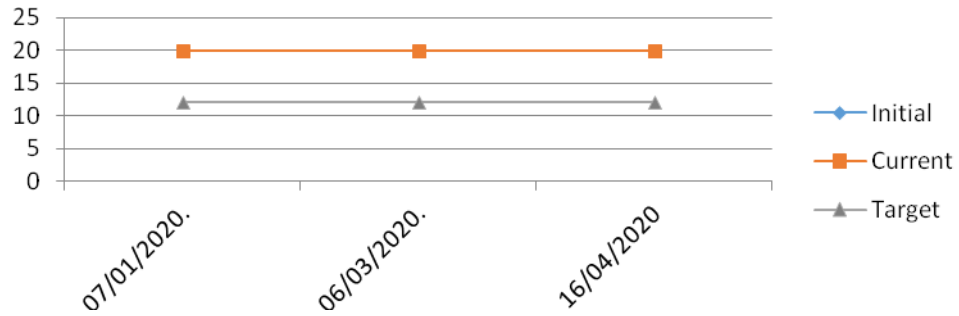
|---|---|
| 5. Water samples taken and evaluated for legionella and pseudomonis.<br>6. Authorising Engineer water safety in place who provides annual report. | 4. Departments to have a flushing and testing regime in place, defined in a Standard Operating Procedure, with designated responsibilities and recording mechanism Ward Manager or site responsible person.<br>5. Water quality testing results and flushing to be logged on single system and shared with or accessible by departments/services - potential for dashboard/logging system (Public Health Wales).<br>6. Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting.<br>7. Awareness and training programme in place to ensure all staff aware? Departmental Induction Checklist.<br>8. BCUHB Policy and Procedure in place and ratified, along with any department-level templates for SOPs and check sheets.<br>9. Water Safety Group provides assurance that the Policy is being effectively implemented across all sites, this requires appropriate clinical and microbiology support to be effective.<br>10. Lack of consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the H&S Gap Analysis Action Plan. |

| **Assurances** | **Links to** | | |
|---|---|---|---|
| | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| 1. Health and Safety Leads Group<br>2. Strategic Occupational Health and Safety Group<br>3. QSE | 1 2 3 | | SM4 SM1 |

| CRR26 | **Director Lead:** Executive Director of Workforce and Organisational Development | **Date Opened:** 7 January 2020 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 16 April 2020 |
| | **Risk:** Non-Compliance of Fire Safety Systems | **Target Risk Date:** 1 November 2020 |

There is a risk that the Health Board's is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005). This is caused by a lack of robust Fire Safety Governance in many service areas /infrastructure (such as compartmentation), a significant back-log of incomplete maintenance risks, lack of relevant operational Risks Assessments. This may lead to major Fire, breach in Legislation and ultimately prosecution against BCUHB.




| | Impact | Likelihood | Score |
|---|---|---|---|
| Initial Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 5 | 20 |
| Target Risk Score | 4 | 2 | 8 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⟺ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Fire risk assessments in place in a number of service areas.<br>2. A number of areas have evacuations.<br>3. There is a fire safety group established.<br>4. There is a fire Policy in place.<br>5. The Fire Authority regularly inspect BCUHB premises and provide reports on their findings which have action plans in place.<br>6. Appointed fire engineer in place who oversees fire safety system in place.<br>7. Commission independent shared services audits. | 1. BCUHB required to comply with all elements of the Fire Safety Order 2005.<br>2. Review Internal Audit Fire findings and ensure all actions are taken.<br>3. Identify how actions identified in the site FRA are escalated to senior staff and effectively implemented.<br>4. Identify how site specific fire information and training is conducted and recorded.<br>5. Consider how bariatric evacuation training - is undertaken define current plans for evacuation and how this is achieved? |

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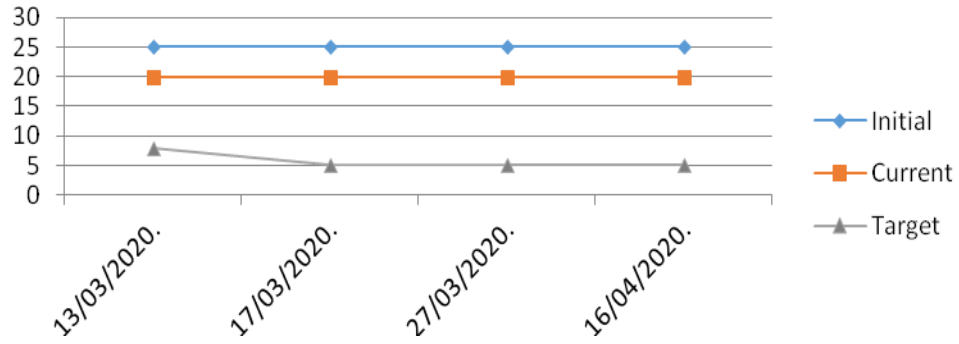
|---|---|
| 8. Information from unwanted fire alarms and actual fires is collated and reviewed as part of the fire risk assessment process. | 6. How is evacuation training delivered / monitored?<br>7. How is fire safety advice provided to contractors, define when this happens?<br>8. AlbaMat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved.<br>9. Ensure actions from the fire authority findings are escalated and actions completed reporting back to the Strategic OHS Group. |

| **Assurances** | **Links to** | | |
|---|---|---|---|
| 1. Health and Safety Leads Group<br>2. Strategic Occupational Health and Safety Group<br>3. QSE | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| | 1 2 3 | | SM4 SM1 |

| CRR27 | **Director Lead:** Executive Director of Nursing and Midwifery | **Date Opened:** 13 March 2020 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee<br>Strategic, Partnership and Population Health Committee | **Date Last Reviewed:** 16 April 2020 |
| | **Risk:** Risk to public health and safety arising from an outbreak of COVID-19 and demand outstripping organisational capacity | **Target Risk Date:** 31 December 2020 |

There is a risk to public health and safety from an outbreak of coronavirus (COVID-19) and this may impact on the ability of the Health Board to respond to this, arising from increased unscheduled demand on healthcare resources (including specialist resources and equipment) and a reduction in available resource to meet that demand such as workforce shortages arising from staff who are unwell or self-isolating.




| | Impact | Likelihood | Score |
|---|---|---|---|
| Initial Risk Rating | 5 | 5 | 25 |
| Current Risk Rating | 5 | 4 | 20 |
| Target Risk Score | 5 | 1 | 5 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⟺ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| Preventative controls:<br>1 - Health Emergency Control Centre (HECC) activated 7 days per week supported by local control centres<br>2 – Specialist work streams in place reporting to incident control team including clinical group<br>3 – Emergency plans and business continuity plans<br>4 – Access to specialist public health, clinical, operational and governance advice | 1 - Ongoing real time management via Health Emergency Control Centre (HECC), local control centres and work streams - each work stream as a PRAID log to track and management actions<br>2 – Establishment of a recovery group and recovery plan |

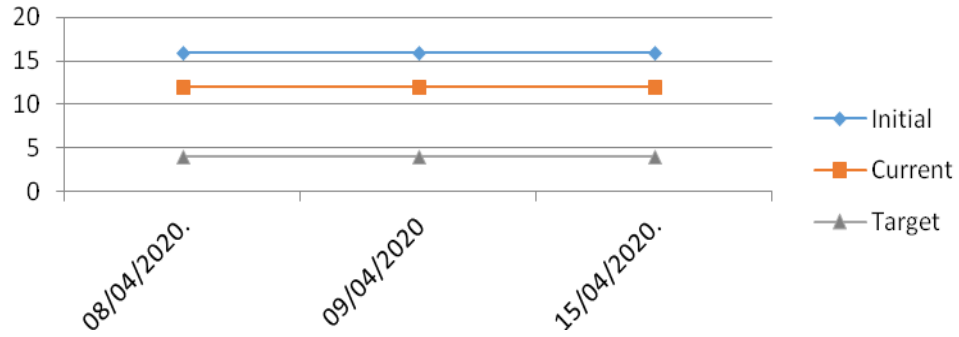
| | |
|---|---|
| 5 – Coordinated communication links with Welsh Government and Public Health Wales<br>6 – Public health messages including on social media and posters in hospitals<br>7 – Infection control measures in line with national guidance<br>8 – National guidance reviewed and cascaded - daily staff bulletin<br>9 – Advice for staff issued by Workforce and Organisational Development<br><br>Response controls:<br>1 - Health Emergency Control Centre (HECC) activated 7 days per week (extending hours as necessary) supported by local control centres<br>2 – Specialist work streams in place reporting to incident control team including clinical group<br>3 – Emergency plans and business continuity plans<br>4 – Access to specialist public health, clinical, operational and governance advice<br>5 – Coordinated communication links with Welsh Government and Public Health Wales<br>6 – Infection control measures in line with national guidance<br>7 – National guidance reviewed and cascaded - daily staff bulletin<br>8 – Self isolation measures for staff in line with national guidance<br>9 – Agreement to utilise temporary staffing off framework<br>10 – Non-essential activities stood-down i.e. corporate meetings<br>11 – Cancelling clinically appropriate non-urgent and elective activity<br>12 - Development of additional capacity and field hospitals<br>13 - Staff testing in line with national guidelines<br>14 - Additional staffing through retired staff returning and volunteers<br>15 - Public donations being coordinated through Awyr Las and checked for infection control and health and safety standards<br>16 – Multi agency co-ordination through SCG and TCG and Military Liaison Officer<br>17 - Establishment of daily PPE Taskforce led by Executive Director of Nursing and Midwifery/Deputy CEO | |

| | |
|---|---|
| 18 – Staff wellbeing support through BCU Staff Wellbeing & Support Service and national Health for Health Professionals Wales (HHPW)<br><br>Recovery controls:<br>1 – Establishment of a recovery group and recovery plan | |

| **Assurances** | **Links to** | | |
|---|---|---|---|
| 1. Command and contol structures (see COVID-19 Command Structure Framework) | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| | 1 2 3 4 5 6 7 | PR7 PR1 PR3 PR8 PR4 | Not Applicable |

| CRR28 | **Director Lead:** Executive Director of Nursing and Midwifery | **Date Opened:** 8 April 2020 |
|---|---|---|
| | **Assuring Committee:** Quality and Safety Group | **Date Last Reviewed:** 15 April 2020 |
| | **Risk:** Risk of infection from COVID-19 to staff and patients as a result of inadequate supply, quality or usage of PPE | **Target Risk Date:** 31 December 2020 |

There is a risk to patients and staff arising from the shortage of PPE supply (as a result of increased demand globally), the quality of PPE being less than needed (as a result of utilising alternative supply chains and manufacturers) and incorrect use by staff. It is also recognised that staff have anxieties about these issues and this may impact on their wellbeing, confidence and resilience.




| | Impact | Likelihood | Score |
|---|---|---|---|
| Initial Risk Rating | 4 | 4 | 16 |
| Current Risk Rating | 4 | 3 | 12 |
| Target Risk Score | 4 | 1 | 4 |
| **Movement in Current Risk Rating since last presented to Board in November 2019** | **No Change** ⇔ | | |

| **Controls in place** | **Further action to achieve target risk score** |
|---|---|
| 1. Daily PPE Taskforce led by Executive Director of Nursing and Midwifery<br>2. Daily PPE Stock Report to HECC Silver and Gold Command<br>3. PPE guidance to staff issued in line with national guidance from Public Health Wales<br>4. PPE guidance detailed in daily staff COVID bulletin<br>4. Expert advice to senior leaders and clinical leaders available from infection control team<br>5. Dedicated PPE email account for staff queries and concerns<br>6. Face fit testing programme in place | 1. Modelling tool to be developed detailing PPE requirements against future predicated demand<br>2. Flow of communication in regards to PPE to be simplified<br>3. Development of an SOP for ordering, storage, distribution and monitoring of PPE<br>4. Telephone line to be established for staff to raise concerns |

| | |
|---|---|
| 7. Donations of PPE received via Awyr Las and checked against infection control and health and safety standards | |

| **Assurances** | **Links to** | | |
|---|---|---|---|
| 1. Command and control structures (see COVID-19 Command Structure Framework)<br>2. PPE Taskforce (daily meeting led by Executive Director of Nursing and Midwifery / Deputy CEO)<br>3. Daily PPE Stock Report to HECC Silver and Gold Command<br>4. Regular review of risk by PPE Taskforce and governance meetings | **Strategic Goals** | **Principal Risks** | **Special Measures Theme** |
| | 3 5 6 | PR9 PR1 PR4 | Not Applicable |