Board/Committee report template

This template combines the former coversheet and report template. Authors should attempt to restrict reports to no more than four pages where possible. Any necessary supplementary information can be attached as appendices but the Board Members should be able to understand the key issues and make an informed decision from the report alone.

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 10th June 2021**
Cyhoeddus neu Breifat: Public or Private:	*Public*
Teitl yr Adroddiad Report Title:	Clinical Audit Forward Plan 2021/22
Cyfarwyddwr Cyfrifol: Responsible Director:	Prof A Guha Interim Executive Medical Director
Awdur yr Adroddiad Report Author:	Dr Melanie Maxwell Senior Associate Medical Director/Improvement Cymru Clinical Lead
Craffu blaenorol: Prior Scrutiny:	Clinical Effectiveness Group – April 2021
Atodiadau Appendices:	Draft Clinical Audit Plan- 2021/22

Argymhelliad / Recommendation:
The Committee is asked to approve the draft Clinical Audit Plan 2021/22 The Committee is also requested to note that this report is being presented to the Audit Committee before the QSE Committee.

Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	**x**	**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

Sefyllfa / Situation:
The Corporate Clinical Audit Annual plan for 2021/22 has not changed significantly between years due to the impact of the COVID-19 pandemic. Most audit activity was paused at national and local levels, and these are now gradually re-starting. There have been no additional Tier 1 requirements from Welsh Government.
Drive Cefndir / Background:
Clinical Audit is an important tool to provide assurance to the Board about the quality of services. It is an important mechanism to drive quality improvement and a vital part of our overall quality strategy, which is being developed. Audit measures compliance against evidence-based standards, targets or through benchmarking.

Tier 1 audits are those mandated nationally; in any year there may be data collection and/ or a report from the previous audit. The Clinical Audit lead for each Site or Area oversees the audit to ensure completeness.
Tier 2 audits are those considered necessary at a corporate level because of their risk profile or requirement to improve. They may be undertaken within the local services or through the clinical effectiveness department.

Clinical Audit has an annual planning cycle, although many audits are continuous across the year. There is quarterly reporting to QSE on progress against the plan, with an annual report at year end to the JAQS Committee.

Asesiad / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The clinical audit process will be embedded in the overall BCU strategy for quality and improvement. The ongoing process to develop the Quality Strategy [including the Clinical Effectiveness Strategy] will include the clinical audit strategy also going forward.

The draft plan includes the breadth of topics included in the Welsh Government's National Clinical Audit & Outcome Review Plan (NCAORP). The tier 2 audits have been chosen to reflect key risks and areas for improvement identified from the risk register, claims, regulatory compliance etc. Therefore, Tier 2 audits reflect the areas where improvement needs a focus and have been colour coded into themes.

Opsiynau a ystyriwyd / Options considered

Not required

Goblygiadau Ariannol / Financial Implications

The financial considerations are not included in this plan.
Implications are broad in terms of direct impact upon service delivery or a number of support departments such as Clinical Effectiveness, Medical Records or Clinical Informatics.
Clinical Audit enables the measurement of care delivery against evidence-based standards and facilitates optimum use of limited resources and identification of additional resource needs for improvement.
These will be identified within the context of each project.
Also, there is the indirect cost of support services that contribute to successful participation of the projects identified as priorities by each team. These support functions need to be resourced if clinicians are to be able to participate and focus upon improvement activity and will be discussed with the emerging Transformation function of BCUHB.

Dadansoddiad Risk / Risk Analysis

The Tier 1 element of the plan relates to mandatory projects prioritised by Welsh Government within the NCAORP.
Tier 2 includes some projects which are required for accreditation, regulation and licensing, alongwith management of risk, quality, safety, claims and patient experience.
Resources to support activity corporately has been reviewed and an option appraisal will be completed by the end of June for review by the Executive team. Risks have been mitigated by reducing the scope of activity of the corporate team for example introducing a digital solution to register tier 3 audits.
The Head of Clinical Effectiveness post is currently being advertised.
There is a risk of a lack of assurance for services where there is patchy or non-compliance with the plan. Actions to address this are predominantly with the secondary care HMT and include ensuring audit leadership is included within robust job planning, embedding audit reporting within the governance structures, whilst quarterly reporting will identify issues earlier for action.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

We are mandated to complete the national audit programme.

Asesiad Effaith / Impact Assessment

Not required

Reference:	Title of National Audit	East area Lead	Central Area Lead	West Area Lead	In year Data Submission	In year Report
NCAORP/2021/01	National Joint Registry	Mr Ian Wilson (Consultant Orthopaedic Surgeon)	Mr Madhusudhan Raghavendra & Mr Balasundaram Ramesh. (Consultant Orthopaedic Surgeon's)	Mr Koldo Azurza (Consultant Orthopaedic Surgeon)	Yes	Yes
NCAORP/2021/02	National Emergency Laparotomy Audit	Mr Duncan Stewart (Consultant Surgeon) / Dr Sianedd Elliott (Consultant Anaesthetist)	Mr Richard Morgan (Consultant Surgeon) / Dr Magdy Khater (Consultant Anaesthetist)	Dr Stephan Clements (Consultant Anaesthetist) / Mr Nik Adullah (Consultant Surgeon)	Yes	Yes
NCAORP/2021/03	Comparative audit of critical care unit adult patient outcomes (casemix) ICNARC	Dr Andy Campbell (Consultant Anaesthetist)	Dr Richard Pugh (Consultant Anaesthetist)	Dr Karen Mottart/ Dr. Alison Ingham, (Consultant Anaesthetists)	Yes	Yes
NCAORP/2021/04	Trauma Audit & Research Network (TARN)	Dr Ben Sasi (Anaesthetics Associate specialist)	Dr Tom O'Driscoll (Emergency Medicine Consultant)	Dr Leesa Parkinson / Dr Rio Talbot (Consultants: Emergency Department)	Yes	Yes
NCAORP/2021/05	National Diabetes Foot care Audit	Dr Anthony Dixon (Consultant Physician) & Nicola Joyce (Podiatrist)	Dr Aye Nyunt (Consultant Physician)	No Medical lead at present Jamie O'Malley (Diabetic Podiatrist)	Yes	No
NCAORP/2021/06	Diabetes Inpatient Audit (NaDia)	Dr Stephen Stanaway (Consultant Physician) / Cheryl Griffiths (Diabetes Specialist Nurse)	Dr Thomas Dacruz (Consultant Diabetes & Endocrinology) / Kirstin Clark (Diabetes Specialist Nurse)	Dr Muhammed Murtaza (Consultant Physician) / Ceri Roberts (Diabetes Specialist Nurse)	Yes	Yes
NCAORP/2021/07	Pregnancy in Diabetes Audit Programme	Dr Stuart Lee (Consultant Physician), Lynda Vergheese (Locum Physician) , Gill Davies (Diabetes Specialist Nurse), Rao Bondugulapati (Consultant Physician)	Dr Thomas Dacruz (Consultant Diabetes & Endocrinology), Miss Maggie Armstrong (O&G Consultant), Kirstin Clark (Diabetes Specialist Nurse)	Dr Leela Ramesh (Consultant Physician), Dr Noreen Haque (Registrar),Dr Tony Wilton (Consultant Physician), Ceri Roberts (Diabetes Specialist Nurse)	Yes	Yes
NCAORP/2021/08	National Core Diabetes Audit: (Primary / Secondary Care & Insulin Pump elements)	**Primary Care element**: Dr Gareth Bowdler (Area Medical Director) **Insulin Pump Element:** Dr Rao Bondugulapti (Consultant Physician)	**Primary Care element**: Dr Liz Bowen (Area Medical Director). **Insulin Pump element:** Julie Roberts (Lead Diabetes Specialist Nurse), Dr Minesh Shah (Associate Specialist)	**Primary Care element:** Dr Bethan Jones (Area Medical Director) **Insulin Pump element**: Dr Muhammed Murtaza (Consultant Physician)	Yes	Yes
NCAORP/2021/09	National Paediatric Diabetes Audit (NPDA)	Dr Kamal Weerasinghe (Consultant Paediatrician),	Dr Helen Moore (Consultant Paediatrician)	Dr Michael Cronin (Consultant Paediatrician)	Yes	Yes
NCAORP/2021/10	National Asthma & COPD Audit Programme (NACAP): Children and Young People Asthma	Dr Liz Richards (Locum Consultant)	Dr Lee Wisby (Consultant Paediatrician)	Dr Mair Parry (Consultant Paediatrician)	Yes	Yes
NCAORP/2021/11	NACAP: Adult Asthma	Erin Humphreys (Interim Deputy Head of Nursing)	Dr Daniel Menzies (Consultant Physician)	Dr Claire Kilduff (Consultant Physician)	Yes	Yes
NCAORP/2021/12	NACAP: COPD	Erin Humphreys (Interim Deputy Head of Nursing)	Dr Sarah Davies (Consultant Physician)	Dr Claire Kilduff (Consultant Physician)	Yes	Yes
NCAORP/2021/13	NACAP - Pulmonary Rehabilitation workstream	Michelle Owen (Clinical Specialist Physiotherapist / Pulmonary Rehab Coordinator)	Ann Ellis (Respiratory Occupational Therapist)	Tracy Redpath (Occupational Therapist) & Caerwyn Roberts (Physiotherapist)	Yes	Yes
NCAORP/2021/14	Renal Registry	Dr Stuart Robertson (Consultant Physician)	Dr Mick Kumwenda (Consultant Physician)	Dr Mahdi Jibani (Consultant Physician)	Yes	Yes
NCAORP/2021/15	National Early Inflamatory Arthritis Audit (NEIAA)	No lead at present Discussions taking place with Mark Garton, Sam Abraham & Randa 19.05.21	Dr Alessandro Ciapetti (Consultant)	Dr Yasmeen Ahmad (Consultant Physician)	Yes	Yes
NCAORP/2021/16	All Wales Audiology Audit	**Adult Rehabilitation:** Anna Powell, Head of Adult Rehabilitation (East)	**Adult Rehabilitation:** Suzanne Tyson, Head of Adult Rehabilitation (Central)	**Adult Rehabilitation:** Heidi Turner, Head of Adult Rehabilitation (West)	Adult Rehab and Paediatric Audits conducted by external visits preceded by a period of data collection. Adult Rehab audited 2019 (report awaiting sign off by Scientific Committee). Paediatric Audit of 2020 postponed - awaiting rescheduling.	Yes
NCAORP/2021/17	Stroke Audit (SSNAP)	Dr Walee Sayed (Consultant Physician)	Dr Krishnamurthy Ganeshram (Consultant Physician)	Dr Salah Elghenzai (Consultant Physician)	Yes	Yes
NCAORP/2021/18	Falls & Fragility Fractures Audit Programme: National Hip Fracture database	Mr Ian Starkes (Consultant Orthopaedic Surgeon)	Mr Amir Hanna (Consultant Orthopaedic Surgeon)	Mr Ashok Goel (Consultant Orthopaedic Surgeon)	Yes	Yes
NCAORP/2021/19	Falls & Fragility Fractures Audit Programme: In-patient Falls Audit	Erin Humphreys (Interim Deputy Head of Nursing)	Dr Geralt Owen (Consultant Physician)	Eleri Evans (Interim Head Of Nursing For Medicine - YG)	Yes	Yes
NCAORP2021/20	Falls & Fragility Fractures Audit Programme: Fracture Liaison Service	No FLS Service	No FLS service	Not participating	Yes	Yes
NCAORP/2021/21	National Dementia Audit	Dr Sam Abraham (Consultant Physician)	Dr Indrajit Chatterjee (Consultant Physician)	Dr Conor Martin (Consultant)	No	No
NCAORP/2021/22	National Audit of Breast Cancer in Older Patients (NABCOP)	Mr Tim Gate (Consultant Breast Surgeon)	Miss Mandana Pennick, (Consultant Breast Surgeon)	Mr Ilyas Khattak (Consultant Breast Surgeon)	Yes	Yes
NCAORP/2021/23	National Audit of Care at the End of Life (NACEL)	Mrs Geeta Kumar (Deputy Hospital Medical Director - Q&S)	Dr Tania Bugelli (Deputy Hospital Medical Director - Q&S)	Dr Karen Mottart (Hospital Medical Director - West)	Yes	Yes
NCAORP/2021/24	National Heart Failure Audit (NAHF)	Fiona Willcocks (Heart Failure Specialist Nurse)	Dr Mohammad Aldwaik (Consultant Cardiologist) / Andy Bennett (Heart Failure Specialist Nurse)	Dr Mark Payne (Consultant Cardiologist) / Nia Coster (Heart Failure Nurse)	Yes	Yes
NCAORP/2021/25	National Audit of Cardiac Rhythm Management (NACRM)	Dr Rajesh Thaman (Consultant Cardiologist)	Dr Mohammad Aldwaik (Consultant Cardiologist)	Dr Mark Payne (Consultant Cardiologist)	Yes	Yes
NCAORP/2021/26	National Audit of Percutaneous Coronary Intervention (NAPCI)	N/A	Dr Paul Das (Consultant Interventional Cardiologist)	N/A	Yes	Yes
NCAORP/2021/27	Myocardial Ischaemia National Audit Project (MINAP)	Dr Richard Cowell (Consultant Cardiologist)/ Lucy Trent (Nurse Practitioner)	Dr Paul Das (Consultant Interventional Cardiologist)	Dr Mark Payne (Consultant Cardiologist)	Yes	Yes
NCAORP/2021/28	National Vascular Registry Audit (inc. Carotid Endarterectomy Audit)	Mr Soroush Sohrabi (Clinical Director)	Mr Soroush Sohrabi (Clinical Director)	Mr Soroush Sohrabi (Clinical Director)	Yes	Yes
NCAORP/2021/29	National Audit of Cardiac Rehabilitation (NACR)	Jacqueline Cliff (Cardiac Rehabilitation Nurse Lead)	Catrin Warren (Cardiac Rehabilitation Physiotherapist)	Lisa Carson (Community Cardic Rehabilitation Nurse)/ Iorwerth Jones (Exercise Physiologist- Cardiac Rehab)	Yes	Yes
NCAORP/2021/30	National Lung Cancer Audit	Neil McAndrew (Consultant Physician)	Dr Sakkarai Ambalavanan (Consultant Physician)	Dr Ali Thahseen (Consultant Respiratory Physician)	Yes	Yes
NCAORP/2021/31	National Prostate Cancer Audit	Mr. Iqbal Shergill (Consultant Urologist)	Mr. Kingsley Ekwueme (Consultant Urologist)	Mr Kyriacos Alexandrou (Consultant Urologist)	Yes	Yes

NCAORP/2021/32	National Gastrointestinal Cancer Audit Programme	**Bowel:** Mr Micheal Thornton (Consultant Surgeon) **Oesophago-gastric:** Mr Andrew Baker (Consultant Surgeon) / Dr Thiriloganathan Mathialahan (Consultant Gastroenterologist)	**Bowel:** Mr Andrew Maw (Consultant Surgeon) **Oesophago-gastric:** Mr Richard Morgan (Consultant Surgeon)	**Bowel:** Dr Claire Fuller, (Consultant Oncologist) & Mr Anil Lala (Consultant Surgeon) **Oesophago-gastric:** Dr Jonathan Sutton (Consultant Gastroenterologist)	Yes	Yes
NCAORP/2021/33	National Neonatal Audit Programme (NNAP)	Dr Artur Abelian (Consultant Paediatrician)	Dr Geedi Farah (Consultant Paediatrician), Dr Mohammed Sakheer Kunnath (Consultant Paediatrician)	Dr Shakir Saeed (Consultant Paediatrician)	Yes	Yes
NCAORP/2021/34	National Maternity & Perinatal Audit (NMPA)	Maria Atkin (O & G General Manager & Business Lead)	Dr Niladri Sengupta (O&G Consultant)	Fiona Giraud (Director of Midwifery and Women's Services)	Yes	Yes
NCAORP/2021/35	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People.	Dr Praveen Jauhari (Consultant Paediatrician)	Dr Mohammed Sakheer Kunnath (Consultant Paediatrician)	Dr Kathryn Foster (Consultant Paediatrician)	Yes	Yes
NCAORP/2021/36	National Clinical Audit of Psychosis	No EIP service	No EIP service	Louise Rosenthal, EIP Service Manager	Yes	Yes
NCAORP/2021/42	National Covid-19 Audit	Dr Liz Brohan (Consultant Physician)	Dr Daniel Menzies (Consultant Physician)	Dr Claire Kilduff (Consultant Physician)	Yes	No

NCAORP projects not applicable to BCUHB: (due to commissioned services elsewhere):	
NCAORP/2021/37	National Adult Cardiac Surgery Audit
NCAORP/2021/38	National Congenital Heart Disease Audit
NCAORP/2021/39	Paediatric Intensive Care Audit (PICaNet)

Project Ref Number	Project Title	In/ext guidance	Corporate policy	External review	Reaudit/continuous	Risk Register	Claims Audit	Which BCUHB priority does this support?	Proposed Start Date	Proposed Finishing Date	Objectives being met: please include	Accountable Lead(s)	Responsible Corporate Group	In year Data Collection	In-year Report	Risk Assessment *(see key below)*
Acute/21/01	Ward Manager Weekly Audit			Y	Y	Y		Highly reliable clinical care	Across financial yr 21/22	Ongoing - no end date	This audit complements the ward accreditation framework by monitoring standards across a number of areas. The topics are patient safety, harm free care, medication safety, infection prevention, record keeping, nutrition and hydration, toileting and hygiene, patient experience, dementia care and learning disability care.Data is owned by wards for own quality improvements. The Ward Manager Weekly audits are reported to site Quality and Safety meetings and quarterly to the Secondary Care Patient Safety and Quality Group as part of the Secondary Care Governance structure.	Site Directors of Nursing - Lead Debra Hickman	Secondary Care Quality Group	Yes	Yes	Critical
Acute/21/02	IV Morphine (compliance against guidelines and record keeping)		Y		Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	Ensure Compliance with prescribing guidance	Lead Louise Howard Baker	Professional Advisory Group (PAG) / Safe Medication Steering Group	Yes	Yes	High
NEW Acute/21/03	Retrospective audit of compliance of completed DNACPR forms with All Wales DNACPR Policy in BCUHB		Y	Y	Y	Y		Highly reliable clinical care	Across financial yr 21/22	Mar-22	Ensuring compliance against All Wales DNACPR policy, which in turn will develop relevant pathways/standard operating procedures as appropriate. Improving documentation of DNACPR and communication with Primary Care	Dr Ben Thomas, Consultant Nephrologist, Renal	Secondary Care - Clinical Law and Ethics	Yes	Yes	High
BSQR/2021	Auditing compliance with the Blood Safety and Quality Regulations	Y		Y	Y			Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	These Regulations impose safety and quality requirements on human blood collection and storage. The requirements apply to blood transfusion services in England, Scotland, Wales and Northern Ireland. Many of the provisions of the Regulations also apply to hospital blood banks.	**Main Contact : Bernie Astbury**. Links for sites: Blood Bank Managers - Joe Leung (YG), Luke Hughes (YGC) and Tony Coates (WMH)	NWMCS Quality Committee	Yes	Yes	Critical
CORP/21/01	Record Keeping	Y	Y		Y			Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	Measure compliance with local policy to reduce patient harm	Site Medical Directors; Dr Steve Stanaway, Dr Emma Hosking, Dr Karen Mottart reporting to the Secondary Care Quality Committee and thereafter QSG	Secondary Care Quality Group/site CEG	Yes	Yes	Critical
CORP/21/02	Ward Accreditation Monthly Metrics	Y		Y	Y			Highly reliable clinical care. Reduce patient harms	Ongoing	Ongoing - no end date	This monitors standards across areas including the well led team, patient safety, harm free care, medication safety, infection prevention, record keeping, nutrition and hydration, toileting and hygiene, patient experience, dementia care and learning disability care. Data is owned by wards for own quality improvements. Again this complements to the ward accreditation framework.	Director of Nursing/by site	Senior Nursing Team	Yes	Yes	Critical
Corp/OMD/Consent/21/01	Informed Consent within Secondary Care – A Retrospective Re-audit of Consent review	Y	Y		Y	Y		Highly reliable clinical care. Reduce patient harms	Jan-22	Mar-22	Ensure compliance with the consent to examination or treatment processes to include completion of appropriate consent forms and compliance with the Welsh Language Regulations.	Site Medical Directors; Dr Steve Stanaway, Dr Emma Hosking, Dr Karen Mottart reporting to the Secondary Care Quality Committee and thereafter QSG	Consent and Capacity Strategic Working Group	Yes	Yes	Critical

HTA/HA/2021	Auditing compliance with the Human Tissue Act - Human application	Y		Y	Y			Highly reliable clinical care.	Across financial yr 21/22	Mar-22	Individual audits on a rolling schedule to monitor continual compliance	Chrissie Stringer (HTA / Jacie Quality Manager, Cancer Services) Trefor Roberts (Blood Science Site Manager, Pathology)	Pathology Management and Stem Cell Service	Yes	Yes	Critical
HTA/PM/2021	Auditing compliance with the Human Tissue Act - Post Mortem Sector	Y		Y	Y			Highly reliable clinical care.	Across financial yr 21/22	Mar-22	The HTA's remit is to ensure that post-mortem examinations are undertaken with appropriate consent or under the authority of the coroner and on suitable premises licensed for that purpose, which is a statutory requirement under the HT Act. It is also to ensure that post-mortem examination and the removal and retention of any organs or tissue samples, including those processed into wax blocks and microscope slides, comply with the requirements of the HT Act.	Dr Huyam Abdelsalam (Consultant Histopathologist)	North Wales Managed Clinical Services (NWMCS) Quality Committee	Yes	Yes	Critical
IP&C/21/01	Hand Hygiene audits	Y	Y	Y	Y			Quality and Safety. Reduction in healthcare associated infections	Across financial yr 21/22	Mar-22	Measuring complinace with the policy to support a reduction in healthcare associated infections	Andrea Ledgerton (cc Graham Yarlett)	Local IPG. Infection Prevention Strategic Group (IPSG)	Yes	Yes	High
IP&C/21/02	Decontamination Audits	Y	Y	Y	Y			Quality & Safety. Reduction in healthcare associated infections	Across financial yr 21/22	Mar-22	Compliance against policy to support a reduction in healthcare associated infections	Andrea Ledgerton (cc Graham Yarlett)	Exceptions to Strategic Decontamination Group then IPSG	Yes	Yes	Critical
ISO15189/2021	Annual audit calendar (minimum 12 audits per site/service) Auditing compliance with ISO 15189. Blood Science service on 3 sites, and Cellular Pathology service on one site.	Y	Y	Y	Y			Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	.ISO 15189 accreditation underpins confidence in the quality of medical laboratories through a process that verifies their integrity, impartiality and competence. Assessments under UKAS accreditation ensure labs meet the relevant requirements including the operation of a quality management system and the ability to demonstrate that specific activities are performed within the criteria set out in the relevant standard.	Bernadette Astbury (Head of Pathology Quality and Governance)	NWMCS Quality Committee	Yes	Yes	Critical
MedPhys/2021	Certification of the Medical Physics ISO9001:2015 compliant Quality Management System	Y	Y	Y	Y			Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Ongoing - no end date	Consistently provide products and services that meet our service users and applicable statutory and regulatory requirements	Mel Lewis, (Medical Physics Quality Lead)	NWMCS Quality Committee	Yes	Yes	Medium
MH&LD CEG/2021/01	Side effects of patients on long acting antipsychotic medication	Y			Y			Reduce patient harms. Quality and Safety.	Across financial yr 21/22	Ongoing - no end date	To monitor adherence to NICE standards and national comparisson and ensure safe and efficient medicine management. The results and reports are distributed to prescribers and discussed in CEG	Dr Premraj Muthuvelu	MH&LD CEG	Yes	Yes	High
MH&LD CEG/2021/02	Physical health monitoring	Y	Y	Y				Reduce patient harms. Quality and Safety.	Across financial yr 21/22	Ongoing - no end date	Improving physical healthcare for people with mental disorder by following RCPsych documentation to be reported back through CEG	Dr Premraj Muthuvelu	MH&LD CEG	Yes	Yes	High
MH&LD CEG/2021/03	Introduction of scale to monitor depression	Y						Highly reliable clinical care. Reduce patient harms. Quality and Safety.	Across financial yr 21/22	Ongoing - no end date	Using NICE guidelines standards to Monitor the efficacy of antidepressants	Dr Premraj Muthuvelu	MH&LD CEG	Yes	Yes	High
MH&LD CEG/2021/04	PPE within MH&LD	Y			Y			Reduce patients harm. Quality and Safety. Infection Prevention and control	Across financial yr 21/22	Mar-22	Adherence to donning and doffing and to share findings through presentations training posters, mnemonics .	Dr Alberto Salmoiraghi	MH&LD Clinical Effectiveness Group	Yes	Yes	High

NEW MH&LD CEG/2021/05	Transition Patient Audit Tool	Y	Y	Y	Y			Safe Value-based health care	Across financial yr 21/22	Ongoing - no end date	Establish uniform process for transition across BCUHB	Steve Riley - CAMHS Nurse consultant	Children Division	Yes	Yes	Medium
NICE21/01	Compliance with NICE Quality standards/Clinical pathways linked to NICE guidance	Y		Y	Y	Y		Safe Value-based health care	Across financial yr 21/22	Mar-22	Ensure Compliance - this will be a prorgamme of work	Directorate CD's/CG leads	BCUHB NICE Assurance Group	Yes	Yes	High
NEW NICE -NSF LTNC 2021/01	UK Parkinson's audit		Y	Y	Y			Highly reliable clinical care. Reduce Patient harms	Across financial yr 21/22	Mar-22	To review measurement of practice against evidence-based standards and patient feedback in a continuous cycle of improvement	Site Movement disorder clinical leads (Sam Abraham)	NeurologicalConditionsReview Board	Yes	Bi-annual	high
P&MM/21/01	Antimicrobial Point Prevalence Audit (Inpatients)	Y		Y	Y			Safe, Clean, Care. Keeping People Safe from Avoidable Harm	Across financial yr 21/22	Mar-22	Monitors antibiotic use across all sites	Charlotte Makanga (Consultant Antimicrobial Pharmacist) Co-Lead cc KMottart	Antimicrobial Steering Group	Yes	Yes	High
P&MM/21/02	Antibiotic Review Kit (ARK)/Start Smart then Focus audit via Public Health Wales tool	Y		Y	Y	Y		Safe, Clean, Care. Keeping People Safe from Avoidable Harm	Across financial yr 21/22	Mar-22	Monitor use of check list and forced stop to support appropraite antibiotic use	Charlotte Makanga (Consultant Antimicrobial Pharmacist) Co-Lead cc KMottart	Antimicrobial Steering Group	Yes	Yes	High
P&MM/21/03	All Wales Inpatient Medication Safety Audit	Y		Y	Y			Keeping People Safe from Avoidable Harm	Across financial yr 21/22	Mar-22	Monitoring compliance to enable safer prescribing	Assistant Directors of Pharmacy and Medicines Management (Susan Murphy, Bill Duffield, Louise Howard-Baker)	Safer Medicines Steering Group	Ongoing monthly audit	Ongoing monthly audit	High
P&MM/21/04	Safe and Secure Handling of Medicines in Clinical Areas	Y	Y	Y	Y			Keeping People Safe from Avoidable Harm	Across financial yr 21/22	Mar-22	Monitoring compliance to enable safer treatment	Judith Green Lead Governance Pharmacist - Policies, Pharmacy	Safer Medicines Steering Group	Ongoing	Yes	High
P&MM/21/05	Controlled Drugs: storage, handling and record keeping in pharmacies and clinical areas	Y	Y		Y			Keeping People Safe from Avoidable Harm	Across financial yr 21/22	Rolling 6 months	To audit compliance in relation to: Storage/Security/Record Keeping	Ass Directors of pharmacy and medicines management (Louise Howard-Baker, Bill Duffield, Sue Murphy)	Pharmacy Patient Safety Lead	Ongoing quarterly audit	Quarterly	Critical

P&MM/21/06	Compliance with the BCUHB Unlicensed Medicines Policy (MM42)	Y	Y		Y			Keeping People Safe from Avoidable Harm	Across financial yr 21/22	Mar-22	To audit compliance with MM42 regulations	Teena Grenier (Medicines Governance Lead Pharmacist)	Drug & Therapeutics Group	Yes	Yes	High	
Q&S21/01	Compliance with relevant LocSSIPso be carried out in each specialty (safety solutions)	Y		Y	Y	Y	Y	Quality and SafetyAvoid never events	Jan-22	Mar-22	Ensure Compliance with local guidance - this is a programme of audits	Directorate CD's/CG leads(KM,TB,GK)	Q&S site leads	Yes	Yes	High	
RES/21/01	2222 Audit	Y	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms. Quality and Safety	Across financial yr 21/22	Ongoing - no end date	monitoring if emergency call responses across all sites of BCUHB are in line with existing BCUHB Resuscitation Policy	Christopher Shirley (Professional Development Lead : Resuscitation) Sarah Bellis Hollway (Resuscitation Services Manager)	BCUHB Resuscitation Committee, & Rapid Response to Acute illness Learning Set (RRAILS), sepsis and Acute Kidney Injury (AKI) Steering Board	Yes	Yes	High	
Research 21/01	Audit and monitoring of hosted studies (for high and medium risk categorised studies) following Assess, Arrange, Confirm process	Y			Y			Highly reliable clinical care. Reduce patient harm	Across financial yr 21/22	Mar-22	To review study procedures and research documentation to determine whether the approved study protocol, Good Clinical Practice, BCUHB SOPs and Sponsor specific SOPS have been followed as appropriate for the study type.	Research Manager (also Lynne Grundy)	Research senior management team group	Yes	Yes	Low	
Research 21/02	Audit and monitoring of sponsored studies	Y			Y			Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	To review study procedures and research documentation to determine whether the approved study protocol, Good Clinical Practice, BCUHB SOPs and Sponsor specific SOPS have been followed as appropriate for the study type.	Research Manager (also Lynne Grundy)	Research senior management team group	Yes	Yes	Low	
Research 21/03	Research policies and Standard Operating Procedures (SOPS)	Y			Y			Reduce patient harms	Across financial yr 21/22	Mar-22	Review and compare practice against the standards and procedures as detailed in the Betsi suite of research SOPs and any applicable research policies.	Research Manager (also Lynne Grundy)	Research senior management team group	Yes	Yes	Low	
IRMER/PI/2021	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Patient Identification completed annually for each Radiology service	Y	Y	Y	Y			Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Helen Hughes (Head of Quality & Governance: Radiology)	NWMCS Quality Committee	Yes	Yes	Critical	
IRMER/PS/2021	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Pregnancy Status completed annually for each Radiology service	Y	Y	Y	Y			Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Helen Hughes (Head of Quality & Governance: Radiology)	NWMCS Quality Committee	Yes	Yes	Critical	
IRMER/RP/2021	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Recording of Practitioner completed annually for each Radiology service	Y	Y	Y	Y			Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Helen Hughes (Head of Quality & Governance: Radiology)	NWMCS Quality Committee	Yes	Yes	Critical	

IRMER/RPD/2021	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Recording of Patient Dose completed annually for each Radiology service	Y	Y	Y	Y			Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Helen Hughes (Head of Quality & Governance: Radiology)	NWMCS Quality Committee	Yes	Yes	Critical
IRR/2021	BCU Ionising Radiation Protection Regulations compliance audits (Minimum 2 a year performed by Head of Quality & Governace and Medical physics expert at any site or department in BCUHB where imaging takes place)	Y	Y	Y	Y			Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Helen Hughes (Head of Quality & Governance: Radiology)	Overarching Radiation Protection Committee	Yes	Yes	Critical
QSI/2021	Annual audit calendar (minimum 6 audits per site) Auditing compliance with Ionising Radiation (Medical Exposure) Regulations, Ionising Radiation Regulations, requirements for clinical audit and audits of the service as part of the requirements for Quality Standards in Imaging Accreditation	Y	Y	Y	Y			Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Helen Hughes (Head of Quality & Governance: Radiology)Chris Lloyd (OMFS)	NWMCS Quality Committee	Yes	Yes	Critical
NEW IR(ME)R CE 2021	Ionising Radiation(Medical Exposures) Regulation compliance audit - ensuring orthopaedics formally document clinical evalustion of lain film X-rays	Y	Y	Y	Y			Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Site Orthopaedic Clinical Director (cc HH)	Radiation Protection Committee	Yes	Yes	Critical

Risk classification criteria:	
Critical	Control weakness could have a significant impact on the system, function or process and achievement of organisational objectives in relation to compliance with laws and regulations or the efficient and effective use of resources.
High	Control weakness could have a significant impact on the system, function or process but does not have an impact on the achievement of organisational objectives (as above)
Medium	Control weakness has a low impact on the achievement of the key system, function or process or a low degree of risk associated with exposure.
Low	Control weakness has no impact on the achievement of the key system, function or process objectives; however, improved compliance would improve overall control.

Audit Committee Cover Sheet

Cyfarfod a dyddiad: Meeting and date:	10th June, 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Updated Health Board Risk Management Strategy & Policy
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Deputy Chief Executive & Executive Director of Nursing and Midwifery.
Awdur yr Adroddiad Report Author:	David Tita, Head of Risk Management and Assurance. Justine Parry, Assistant Director of Information Governance & Risk.
Craffu blaenorol: Prior Scrutiny:	Executive Team (ET) on the 26th May 2021
Atodiadau Appendices:	**Appendix 1:** Updated Risk Management Strategy and Policy (including the revised Risk Management Appetite Framework) **Appendix 2:** Equality Impact Assessment (EQIA)

Argymhelliad / Recommendation:

The Audit Committee is requested to:

1) Approve the Health Board`s updated Risk Management Strategy and Policy;
2) Approve the proposed Risk Appetite for 2021/22;
3) Approve the revised risk appetite for use in exceptional circumstances, recognising the appropriate governance approval route from Gold Command.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	√	**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**Y**

Sefyllfa / Situation:

This report provides a summary of key changes that have been made to the attached updated Risk Management Strategy and Policy for the Health Board. The Health Board`s vision and strategic approach to risk management ensures that all staff including partners, contractors etc. who provide services with and/or on its behalf, place effective risk management at the heart of what they do.

Cefndir / Background:

The Health Board is committed to embedding a risk-based, agile, dynamic, enterprise-wide, integrated risk stratification and collaborative approach in effectively reducing and managing risks as it delivers its Annual Operational Plan for 2021/22 in a post-Covid-19 era. This will encourage staff to explore integrated, risk-based prioritisation and stratification tools in delivering more joined-up, patient focused personalised outcomes and effective allocation of resources.

The Health Board`s vision statement for risk management has been refreshed to reflect the new the direction of travel as it navigates through recovery in a post-Covid-19 era. The Equality Impact Assessment has also been updated as part of the process of updating the attached Risk Management Strategy and Policy.

Asesiad / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The following are the main changes included in the attached updated Risk Management Strategy and Policy.

Risk Appetite Framework:

- This updated strategy proposes a Risk Appetite Framework for the Health Board, which is split into three sections i.e. the one we are currently using, one that we are proposing for 2021/22 and one for use in exceptional circumstances.
- The proposed section in the Risk Appetite Framework for 2021/22 takes into consideration the current circumstances and the Health Board's requirement to recover from the COVID pandemic thus recognising the harm that could be caused to patients by long waiting lists for treatment.
- The proposed Risk Appetite Framework also includes a revised risk appetite for quick implementation with Gold Command approval should the Health Board find itself in exceptional circumstances in the future. This will support improved governance during future emergency situations.
- This Risk Appetite Framework stresses the importance for staff to embrace appropriate and informed risk exposure that aligns with the Health Board`s risk tolerance, risk capacity and risk capability.

Risk Mangement training and Learning from risks events:

- The focus in 2021/22 will be on developing staff capacity and capability in risk management as potential benefits will include improved outcomes for our patients, and greater efficiency of our core processes. The Health Board has embarked on a drive known as `Operation 1000 staff` which will see over 1000 staff across its services receive risk management training that is appropriate to their roles and responsibilities.
- This refreshed strategy recognises that learning from the experience from the past 12 months (pandemic and bomb threat) and also the benefits of learning from risks is important in continuously improving outcomes for our patients and the wider population of North Wales.

Focus on horizontal collaboration in managing Pan-BCU Risks, risk aggregation and joined-escalation:

- This updated strategy stresses the importance of horizontal collaboration in jointly identifying, assessing, reducing and managing shared risks or Pan-BCU risks. There is greater emphasis for Services, Departments, Divisions and Area Teams which share similar risks to frequently talk to each other through joined-up risk assessment meetings and work together in collaboratively reducing and managing risks and in considering risk aggregation and joined-escalation.
- As part of the focus on collaborative risk management, this updated strategy discourages silo risk management and strongly challenges the same services located across the three Sites (East, Central and West) to start considering and holding joined cross-site risk meetings to facilitate peer learning and better triangulation of risk-based intelligence in delivering greater outcomes to our patients. There are plans in the weeks ahead to run a pilot cross-site, by

organising joined risk meetings for Ophthalmology, ED and Endoscopy so they can discuss their risks, generate shared learning and consider risk aggregation and joined risk escalation where there is added value for doing so.

Clarification of the risk escalation and de-escalation process:

- The updated strategy has streamlined, simplified and clarified the Health Board`s risk escalation and de-escalation process. It also emphasises Health Board`s commitment to ensuring appropriate risk scrutiny and oversight within an open and transparent culture which is underpinned by Good Governance. The updated strategy states that risks are to be escalated in a dynamic and timely way and in real time via any of the followings standard approaches:-
  - ✓ The Governance route: through appropriate governance or Quality and Safety meetings.
  - ✓ Expedited escalation route through management.

Opsiynau a ystyriwyd / Options considered

No options have been considered to not updating the Health Board`s Risk Management Strategy and Policy.

Goblygiadau Ariannol / 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 thereby leading to enhanced quality, less waste and no claims.

Dadansoddiad Risk / Risk Analysis

An associated risk **(Potential inability to fully and timely implement the updated Risk Management Strategy - ID 3932)** has been identified, assessed and added onto the system and is being progressed to go `live`.

Risk currently scores `12` and has clearly identified the following controls which are in place:

1. Regular monitoring of progress with implementation of the updated Strategy and Annual Risk Management Improvement Plan.
2. Risk Management Training Programme in place and being delivered using various platforms and technologies.
3. Prioritisation of core aspects of the updated Strategy and Annual Risk Management Improvement Plan.

The following actions will be implemented to enable us to achieve the target risk score for this risk:-

1. Re-evaluation of the timescales for delivering the updated Strategy and Annual Risk Management Improvement Plan.
2. Consider the roll out of more forms of risk management training formats (e.g. eLearning, Video etc.).
3. Secure and deliver more training days and publicise these across the Health Board on the intranet.
4. Continue to populate the training and encourage staff to attend at a time suitable to them.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Updating the strategy complies with one of its stated expectation of an annual update and review. This updated strategy will need to be approved by the Audit Committee and ratified by the Board.

Asesiad Effaith / Impact Assessment

Due regard of any potential equality/quality and data governance issues have been factored into the updated Risk Management Strategy and Policy as part of the Equality Impact Assessment. This includes making the strategy available in other languages and formats.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Version 6.4 & Reference Number: RM01

Risk Management Strategy and Policy

Authors & Titles	David Tita: Head of Risk Management Justine Parry: Assistant Director of Information Governance & Risk.								
Responsible dept / director:	Risk Management Gill Harris: Deputy Chief Executive								
Approved by:	Audit Committee								
Date approved:									
Date activated (live):									
Documents to be read alongside this document:	Board Assurance Framework Health and Safety Policy (HS01) Risk Assessment Guidance (HS03) Concerns Policy and Procedure (PTR01 and PTR01A) Datix Risk Register – Procedure and User Guide (RM02)								
Date of next review:	July 2022								
Date EqIA completed:	Refreshed May 2021 (Original 2016)								
First operational:	1st October 2020								
Previously reviewed:	Dec 2015	Mar 2016	July 2016	July 2017	July 2018	Dec 2018	July 2018	Dec 2019	Apr 2021
Changes made yes/no:	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Contents: Page

PURPOSE	Vision Statement
To provide a framework and structure for the consistent management of both operational and strategic risks as drivers for better decision-making and the provision of high quality personalised patient-centred care and enhanced experience.	**BCU`s vision for risk management is underpinned by a dynamic, agile, proactive, integrated, Enterprise-wide strategic approach that is wrapped around the Principles of Good Governance. This emphasises the appropriate and timely management of risks in fostering the achievement of BCU`s objectives as defined in its Annual Operational Plan 2021-22. This Vision Statement sets out the Health Board`s strategic vision and ambition for risk management for 2021-22 and 2022-23 and underscores appropriate risk governance including the timely and dynamic escalation/de-escalation of risks. BCU will explore value-based, bottom-up, top-down and outcome-focused approaches in integrating risk management in better decision-making, priority/objective setting and in driving continuous improvements in patient care and safety.** **First Year – 2021/22: Training and capacity building in risk management (Operation 1000 staff); transition onto the new Datix platform i.e. Enterprise Risk Manager (dependent on WG) and system optimisation (i.e. migrate all actions from the Risk Management onto the Action Module by 31/03/2022). To pilot cross-site risk meetings in order to foster peer learning, joined/collaborative risk management and escalation and to continue to strengthen learning from risks.** **Second Year – 2022/23: The focus in 2022/23 will be on encouraging Services, Areas, Sites etc. to improve their governance footprint, learning from risks, rollout results of pilot and continue to refine cross-site risk meetings for similar services and delivery of further risk management training. The above objectives will be measured through the implementation of the Health Board`s Annual Health check and/or snapshot Audits.**

Our Strategic approach to Risk Management

1. Principles	2. Benefits	3. Realisation
Our approach to risk management is built on the following principles:	**Through our risk management approach, the following benefits will be realised:**	**Realisation of the principles and benefits will be achieved through:**
• It is dynamic, open, iterative; transparent, reacts to changes & consistently applied. • It triangulates information and intelligence in informing better decision making. • It is integrated into our processes and aligns with our objectives. • It engineers continuous improvements in patient care and organisational learning. • It is wrapped around the values of the Health Board. • It is underpinned by staff engagement and informed by innovation and best practice. • It will focus on continuous staff training and capacity building in risk management.	• Enhance organisational and system resilience via facilitating continuous improvement and innovation. • Strengthen governance to enable informed decision-making. • Promote a culture of proactive management of risks and opportunities • Improvements in patient care, safety, enhanced experience and flexibility to respond to pressure and challenges. • Help in embedding the values of the HB. • Stakeholder confidence, empowerment and trust.	• Strong risk-focussed leadership that ensures the effective operationalisation of BCU`s Risk Management Strategy. • Strong and transparent risk governance arrangements, including reporting and risk escalation. • Consistent application of the risk strategy and framework. • Clarity in communication of HB`s risk management approach and better staff engagement. • Staff development and continuous support in embedding ERM.

1. Introduction

BCU`s Risk Management Strategy and Policy provides a structured, comprehensive and coherent framework to support staff in identifying, assessing and managing risks arising from its business activities as the effective management of risks is an inherent part of its approach to continuous learning, improvement and Good Governance. The Health Board is committed to implementing and embedding a robust risk management framework that supports the timely and dynamic identification, assessment, mitigation and management of both clinical and non-clinical risks to the achievements of its operational and strategic objectives. Staff are encouraged to integrate risk management into key business/service planning, objective/priority setting, and better decision-making as well as in effectively managing risks in real time and in a dynamic way. BCU`s approach to risk management seeks to enhance strategic planning and prioritisation and strengthens its agility, capacity and capability to respond to emerging challenges and threats.

BCU`s Risk Management Strategy and Policy will draw inspiration from best practice, the AS/NZS ISO 31000:2018, policy and legislative instruments such as the National Health Service (Wales) Act 2006, the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999. This Strategy underscores the fact that risk management is everyone`s responsibility, a tool for improving productivity, ensuring business continuity and sustainability and achieving robust organisational planning and performance reporting. It identifies staff training and senior leadership engagement, clarity of roles and responsibilities, consistency, regular monitoring and review of risks including Good Governance, scrutiny, oversight and assurance as key drivers for embedding a positive risk-aware culture across the Health Board.

2. Statement of Intent

The Health Board is committed to implementing effective risk management across all its services through a comprehensive system of internal controls and compliance with this strategy and policy in order to minimise risks to its patients, staff, visitors, contractors and other stakeholders. The Health Board`s approach to risk management is proactive, integrated, enterprise-wide and is informed by an open and transparent culture in which staff feel empowered and confident to raise and discuss risks without fear. It thus seeks to engage staff across the entire organisation in exploring risk management as a tool for better decision-making and in achieving its objectives as articulated in its Annual Operational Plan 2021-22.

BCU`s approach to risk management will focus on developing local capacity and capability in risk management by delivering staff-focused risk management training within the context of `Operation 1000 staff` which will see at least 1000 staff trained in risk management in 2021/22. The Health Board will adopt an enterprise-wide approach to risk management by discouraging silo thinking and seeking to encourage a more joined-up, collaborative, system thinking and shared approach to risk management as a risk in one part of the organisation, if realised, could affect another part of the business. Training in risk management will enable staff to better integrate risk management into how they lead, organise, plan and deliver the Health Board`s core business activities while ensuring financial viability and sustainability. This revised Strategy and Policy will support the new “Duty of Quality” outlined within the Health and Social Care (Quality and Engagement) (Wales) Bill by requiring the Health Board to exercise its functions with a view to securing improvement in the quality of health services.

3. Definition of key concepts

This Risk Management Strategy and Policy is underpinned and informed by the following definitions: -

Enterprise risk management (ERM) is a process whereby an organisation plans, organises, leads and controls its activities in order to minimise the negative effects of any potential danger (risks) on its operations, business continuity and the achievement of its objectives. It is also an integrated and co-ordinated approach to mitigating and managing all risks faced by BCU.

Risk Management: The Charted Institute of Internal Auditors (CIIA) defines risk management as "the discipline that identifies, assesses, evaluates and takes actions to influence the likelihood of a risk event occurring or its impact if it does". The principles of risk management are; - proportionate, aligned, comprehensive, embedded and dynamic.

Risk: A risk is the uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's objectives and priority areas. It is measured in terms of likelihood (frequency or probability of the risk occurring) and consequence (impact or magnitude of the effect of the risk occurring).

Risk Assessment: This is the overall process of risk analysis and risk evaluation. This is achieved by comparing the individual risk against the Health Board's risk appetite. Risk assessment techniques include questionnaires and checklists, Workshops and brainstorming, and inspections and audits.

Assurance: This is a process to provide evidence that the controls in place are effective and working and that the Health Board is doing its best to appropriately reduce and manage risks to the achievement of its operational and strategic objectives. Levels of Assurance:

1. The first level of assurance comes from the department that performs the day to day activity, for example the data is available
2. The second level of assurance comes from other functions in the Health Board who have internally verified the data, for example quality, finance and H/R assurance
3. The third level of assurance comes from assurance provided from outside the Health Board, for example WG, HIW, HSE etc.

Controls: These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised. Impact could range from negative to positive. Some types of controls used in **reducing** risks include preventive, corrective, detective and directive controls.

Risk Mitigation: This refers to the process of reducing risk exposure and minimising its likelihood and/or lessening or making less severe its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity).

Actions: Actions are steps which the Health Board is required to implement to reduce the likelihood and/or consequence of a risk were it to be realised. Actions are also the things the

Health Board is doing or planning to do that will help us achieve the target risk score and thus reduce the risk to a tolerable and/or minimal level or even eliminate it altogether.

Distinguishing between a risk and an issue
A **risk** is an event that might occur and that could have an effect (usually negative) upon the organisation and/or its stakeholders. A risk is characterised by uncertainty.
An **issue** is something that has already happened or will definitely happen. An issue is a certainty.
e.g. If we are short staffed now or lack money to deliver a service, the shortage of staff or lack of money are issues (as these are already happening) and the risk will be the implications of staff shortage or the lack of money to the successful delivery of our operational and strategic objectives. The uncertainties these may cause is what will constitute the risks in both cases.

4. Objectives

The main objectives of this strategy and policy are:

- To provide an overarching framework including a clearly defined structure, consistency and standardisation and governance arrangements, roles and responsibilities for the effective risk management of both operational and strategic risks.
- To enable staff to understand our risk environment and to use the Health Board`s risk appetite framework to identify and assess risks which cannot be tolerated.
- To facilitate the use of risk management as a tool for better decision-making, driving continuous improvements and linking these to organisational planning and performance reporting including learning and fostering a blame-free and open culture.
- To enable the Health Board to identify and manage risks emanating from the well-being goals and ways of working included in the Well Being of Future Generations Act 2015. Overtime, to seek alignment with the risk management approaches used in our key partnership mechanisms e.g. Public Service Boards and the Regional Partnership Board (Social Services and Well Being Act).

5. Scope

Risk management is an intrinsic strand of good management at all levels across the Health Board and sits at the heart of its business continuity, patient safety and values. Staff are encouraged to continuously scan the horizon for emerging risks and to ensure such risks are appropriately identified, assessed, captured, reduced and managed in accordance with this strategy and policy as well as best practice.

This strategy and policy thus clearly defines the Health Board`s vision, approach, objectives, systems, processes and governance arrangements for risk management. It underscores the principles, best practice and emerging thinking which underpin and shape its overarching risk management culture. It is applicable to everyone involved in providing services for and on behalf of the Health Board including contractors, staff, Trade Unions etc.

6. The Board's Appetite for Risk

Risk appetite is defined as the amount and type of risk an organisation is able to take on in order to achieve its objectives and priority areas while risk capacity refers to the maximum

amount of risk that an organisation is able to take on. These are underpinned by the Health Board`s risk capability and the maturity of its risk management culture. The Health Board`s risk appetite for individual risks will thus be different depending on its current performance, strategic objectives and its level of risk maturity.

The Risk Appetite Statement sets out the amount and type of risks that the Health Board is able to take on in order to achieve its objectives and priority areas. The Board accepts that there is an element of risk in every activity it undertakes from the provision and commissioning of healthcare services and recognises that its risk appetite for any risk will change depending upon the individual risk and current performance. It also recognises that the transformation journey it has embarked on will involve taking on some transformation and project improvement risks which may sit outside its risk appetite. The Board is directly accountable for setting its risk appetite and risk culture. The Health Board has articulated its risk appetite statement to demonstrate the various range of often complex and complicated risks it may take on or accept in order to achieve its objectives and priority areas.

The Health Board`s Risk Appetite Framework aligns with its proactive, inclusive and enterprise-wide approach to risk management as well as its commitment to actively reduce, control and manage risks which could compromise the achievement of its objectives and priority areas. It is a live document, which will be regularly reviewed and monitored to ensure that any changes to the Health Board's strategy, objectives or capacity to manage risk is properly reflected. However, the Health Board realises that in some instances it may have to take on risks which sit outside its risk appetite in order to achieve its objectives and priority areas. It thus recognises that the decision to hold a risk outside the Health Board`s Risk Appetite Framework will need to be ratified by the Board. The Health Board`s Risk Appetite Framework stresses the importance for staff to embrace appropriate and informed risk exposure that is aligned with the Health Board`s risk tolerance, risk capacity and capability.

As outlined in appendix `A`, the Health Board`s updated Risk Appetite Framework for 2021/22 is split into three sections i.e. the one currently in use; the one being proposed for 2021/22 and then one for use in exceptional circumstances. The proposed section in the Risk Appetite Framework for 2021/22 takes into consideration the current circumstances and the Health Board's requirement to recover from the Covid-19 pandemic, thus recognising the harm that could be caused to patients by long waiting lists for treatment. It recognises that the use of risk-based approaches such as risk stratification in prioritising and allocating resources could be key determinants in enabling the Health Board to better tackle post-Covid-19 challenges and threats more efficiently and effectively. The section in the updated Risk Appetite Framework for use in exceptional circumstances also supports quick implementation with Gold Command approval should the Health Board find itself in exceptional circumstances in the future. This will also support improved governance during emergency situations. The Health Board`s Risk Appetite Framework will be widely communicated through mechanisms like trainings, drop-in sessions, Q&S/Governance meetings, newsletters, global emails and the weekly bulletins.

7. BCU`s Risk Management Process

The Health Board`s risk management process as shown in the following diagram is informed by the AS/NZS ISO 31000:2018 and the ERM model. BCU`S risk management process also

aligns with the process outlined in The Orange Book: Risk Management – Principles and Concepts (2020) which includes risk identification and assessment, risk treatment, risk monitoring and reporting. These emphasise the need to identify, assess, review, monitor and effectively reduce and manage risks to enable the achievement of organisational objectives. This strategy and policy is supported by a suite of procedural documents and guidance as full details on how to articulate controls and assurance can be found in the supporting **RM02 Risk Register Procedure and Guide.** BCU`s risk management process comprises five interrelated and complementary steps as outlined in the diagram below.

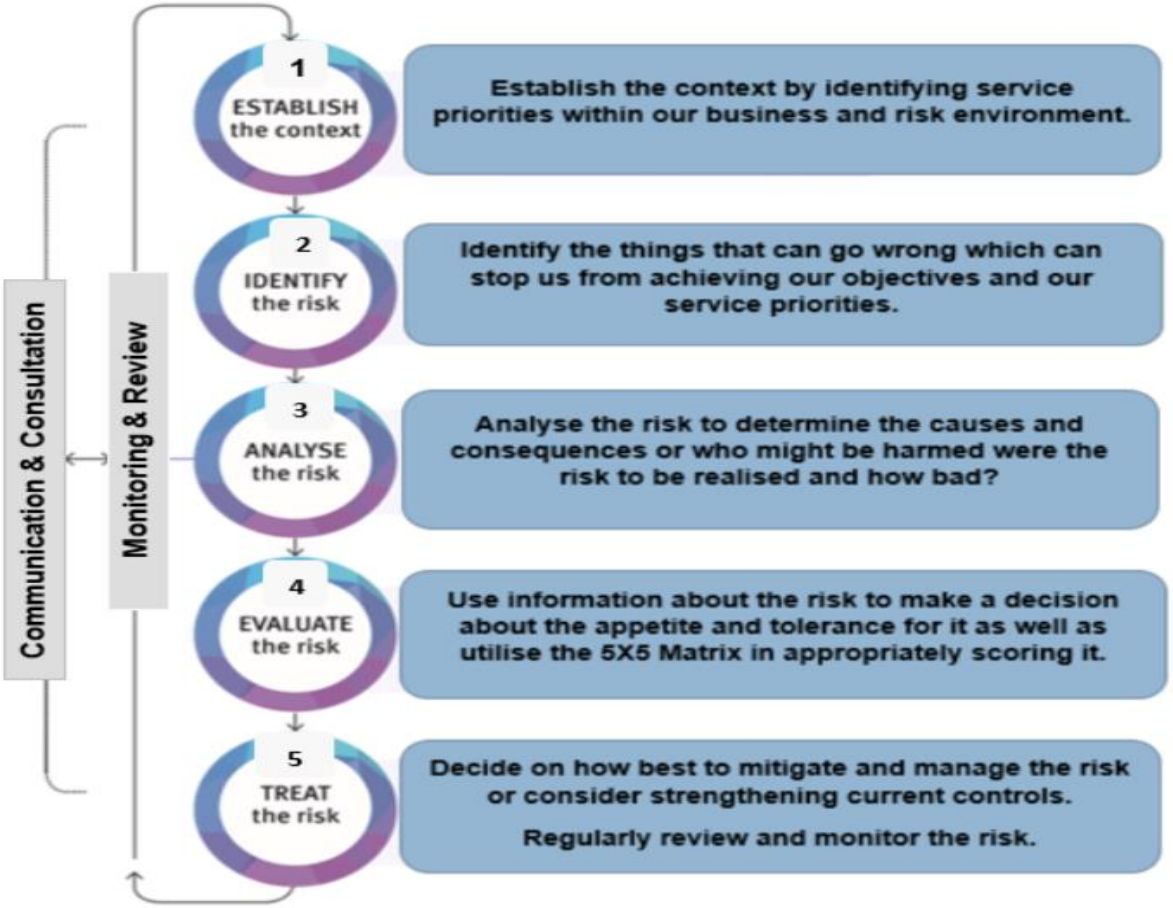

Figure 1 - BCU`s Risk Management Process.

Step 1: Establish the context

As the starting point for a robust risk assessment, it important to establish the context by clearly setting out the service objectives and priority areas in order to clearly identify risks which may negatively impact on their achievement.

Step 2: Risk Identification

The focus here is to identify the risk or what could go wrong. A risk can be proactively identified from incidents, complaints, claims, `near misses`, external and internal reports, clinical audits, external visits and Peer Reviews, new service development including service transformation etc. Staff should adhere to the Health Board`s structured approach for describing risks also

referred to `Cause and Effect Analysis` or the `Bow-Tie` model. This model clearly identifies the cause, the event and the effect.
It is helpful to frame the description of a risk in three parts by starting with these phrases:

- There is a risk of...if… (this relates to not achieving an objective as intended)
- This may be caused by…
- Could lead to an impact/effect on …

Risk description must be clear and concise with appropriate use of language e.g.

> "There is a risk that patients may not be discharged promptly from the Community Hospital.
> This may be caused by medications not being dispensed in a timely manner due to delays from pharmacy. This could lead to stress and anxiety, poor patient experience, delayed flow and reduced bed capacity."

Step 3: Risk Analysis
Determine the cause and effect and analyse what could happen, where, when, why and decide who might be harmed and how. Consider how the risk could negatively impact on say patient safety, the quality of clinical care, Workforce, Finance, patient experience for example and then decide what needs to be done.

Step 4: Risk Assessment/Evaluation
Evaluate, assess and quantify the risk by deciding on how bad (consequence) and how often (likelihood) if the risk were to be realised. The NPSA consequence and likelihood descriptors are a useful guide and the 5 x 5 grading matrix in assessing and scoring the risk. You can access the 5 X 5 Matrix by clicking on the link to the Guidance for Adding a new risk below and checking on pages 14 – 16. http://howis.wales.nhs.uk/sitesplus/861/page/71616

Step 5: Risk Treatment & Prioritisation
Once you have identified and assessed a risk, you will then need to record your findings, identify appropriate controls to reduce the risk and then identify further actions, which can be implemented to reduce the risk and decide who will lead on each of them. Design and implement an action plan and decide on how best to manage it.

Risk Review and Monitoring
Risk management is a dynamic and iterative process; hence, risk owners/leads will need to periodically review, re-assess and monitor their risks in line with the following timescales:-

- Risks scored 15 and above should be reviewed at least monthly
- Risks scored 9-12 should be reviewed at least bi-monthly
- Risks scored 1-8 should be reviewed at least quarterly.

NB: Please note that the above is just a guide and does not replace the timely, agile, dynamic and effective review and management of risks in real time.

8. Three Tier Risk Management Model

The Health Board utilises a three Tier risk management model, which specifies that risks on risk registers across the Health Board as held on Datix will be categorised and managed in line with the 3 tier model as depicted in **Figure 2** below.

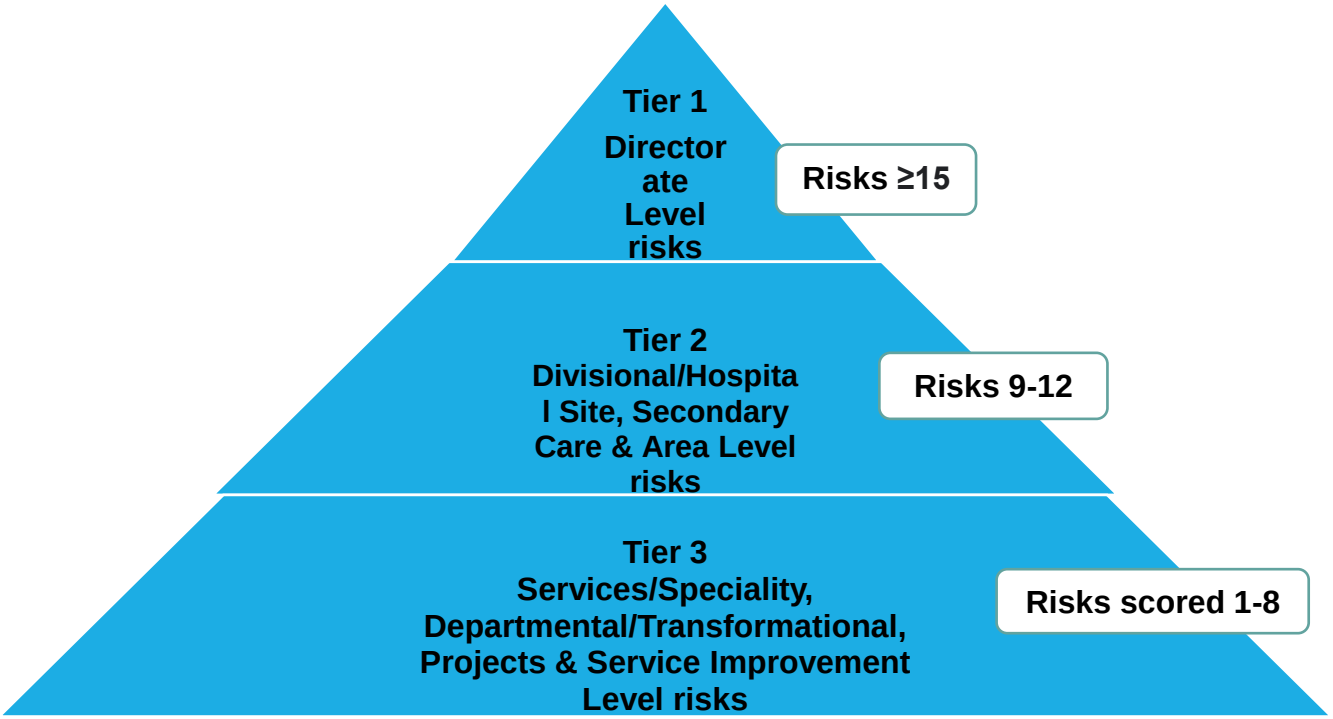

Figure 2 – Risk Management Tiers and oversight.

***All risks must be managed in line with the three-tier risk management model. Hence,**

- Risks scored 1-8 must be managed at tier 3, will have the lowest potential to disrupt business operations or commissioning arrangements.
- Those scored at 9-12 after escalation and approval will be managed at tier 2, Divisional, Hospital Site, Secondary and Area Levels.
- Those scored 15 and above will need to be managed at tier 1 after the escalation process has been completed and the risk has been approved by a relevant committee. Tier 1 risks will have the greatest potential to negatively impact on or disrupt business operations/activities;

It is important to note that placing risks into tiers is for the purpose of governance and oversight. The responsibility for mitigating and managing risks on a daily basis resides with services or departments that escalated the risk. Effective risk management is built on empowering staff to own, manage and lead on their risks while translating any benefits into tangible patient-centred outcomes and positive patient experience.

All new risks added onto Datix must be held on Tier 3 under the status `Being Developed`. The status will only be changed to `Under Review` which alongside the status `Awaiting decision to close` denote our `live` risk register once the risk has been:-

- Appropriately completed and reviewed by the relevant manager and deemed satisfactory.
- Presented at the relevant Quality and Safety meeting and scrutinised in terms of its title, description, controls, further action and scores. However, in the case where there is an intention to escalate the risk, then it must be held under the status `Being Developed` until the outcome of the escalation is known and its status then changed accordingly.

- It is best practice to hold a governance footprint of a risk as it goes through its escalation process, ensuring that key decisions made in the process are adequately captured within the Datix system.

8.1 Corporate Risk Register (CRR)

The score of a risk is the main determinant for its escalation, hence,

- Risks scored ≥15 when approved as outlined above, recommended by the Executive Director, RMG, Executive Team (ET), and approved by the relevant Board Committee will be placed on Tier 1 and the CRR.

However, in exceptional circumstances, a risk which is linked to the development and delivery of the Health Board`s Annual Operational Plans and/or the achievement of one of its key deliverables/operational objectives may be escalated for consideration, approval and inclusion onto the CRR irrespective of its score. In some instances, risks may be de-escalated from the BAF for continuous management through the CRR. The CRR are Directorate level risks that encompass all significant/high level operational risks and in rare cases, those linked to the Annual Operational Plan or de-escalated from the BAF.

It is the responsibility of every risk owner; senior manager and Executive Director who owns risks on the CRR to ensure that updates/feedback from committees and the Board are captured on their related CRR risk on Datix.

8.2 Divisional, Secondary Care, Hospital Site Risk and Area Level Risks (Tier 2)

Divisional, Secondary Care, Area Teams and Hospital Directors are expected to ensure that there are appropriate processes, systems and governance arrangements in place to regularly review, scrutinise and effectively manage all tier 2 risks within their Areas, Divisions, Hospital Sites and Secondary Care. They will be required to periodically present their Divisional risk register reports and any assurance thereof at the Risk Management Group (RMG). The Cycle of Business for the Division, Hospital Site, Area and Secondary Care Q&S and Governance meetings should reflect how the Services and Departments under their remit periodically report their risks to them.

8.3 Service/Departmental, Transformational and Service Improvement Risk Management (Tier 3)

These are risks, which score 1-8 and should be regularly reviewed, scrutinised, approved, reduced and managed at the Service or Departmental levels while those which score above 8 should be escalated in accordance with guidance and the approval of either the relevant Q&S meeting and/or the triumvirate. No risks which score above 8 should be held on the `live` risk register at Tier 3. However, risks which score more than 8 which are being escalated will need to be held at Tier 3 under the status of `Being Developed` and can only be moved onto the `live` risk register after they have successfully gone through the entire escalation process. Tier 3 is therefore the entry point of all risks onto risk registers and Datix.

9. Source of Risks

Risks can be identified from the following sources as shown in figure 4 below. This list is not exhaustive, but can include:

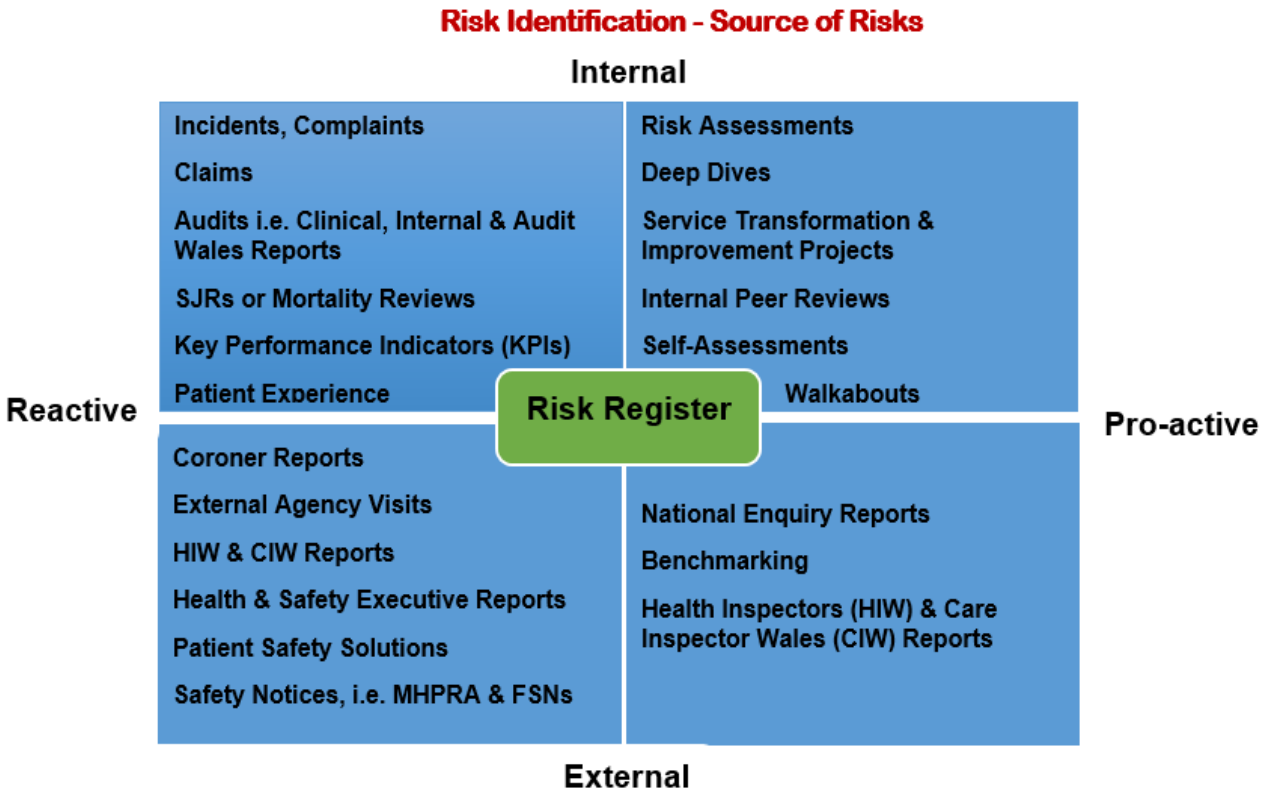

Figure 3 - Shows some examples of different source of risks.

10. BCU`s Enterprise Risk Management (ERM) Framework

BCU`s approach to risk management will be shaped, informed and underpinned by the ERM Model. This is important, as it will provide a framework through which BCU will seek to integrate effective and efficient risk management and governance into performance reporting, business continuity, organisational planning, priority setting and continuous improvements in patient care and journey. It will emphasise the need for open and transparent communication and consultation with all staff or key stakeholders at each stage of the risk management process to ensure engagement, shared understanding and awareness of the intelligence on controls in place.

ERM will provide a comprehensive approach to identifying, assessing, mitigating and managing risks to the delivery of high quality patient-centred outcomes or the achievements of the Health Board`s objectives in line with its Risk Appetite Framework. ERM enables more joined-up, system thinking, enterprise-wide, collaborative and organisational-wide approach to effective risk reduction and management as opposed to silo risk management. It will provide a platform for the Health Board to establish a clear view and understanding of its overall risk capacity while nurturing and embedding a positive risk-aware culture.

The following figure depicts BCU`s Enterprise risk management framework.

Figure 4 - BCU`s Enterprise Risk Management Framework

11. Optimising BCU`s Risk Management Escalation and De-escalation Process

Underpinning BCU`s risk management framework is the governance arrangement for escalating and de-escalating risks which staff are expected to adhere to. There are two ways through which risks can be identified, assessed and escalated i.e.-

i. A standard approach via regular governance and Q&S meetings and/or Triumvirate.
ii. An organisational discovery approach from the Board, Committees, Executive Team delivery and operational groups as they may identify risks from performance, quality and safety-related reports and request they be timely assessed and referred to the Risk Management Group to incorporate within the standard risk management process.

Risks can crystallise quickly hence, there is need to ensure risk escalation/de-escalation including risk aggregation take place in a dynamic, agile and timely way through either route.

11.1 The standard approach to risk escalation

Each Service, Department, Area, Site, Division or Directorate etc. within the Health Board is

expected to maintain a risk register on Datix and a local risk management procedural document which defines how risks are identified, assessed and managed within their unit. Services, frontline staff, their local governance meetings and triumvirate constitute the bedrock of BCU`s risk management arrangements. Datix is the sole repository for capturing risks which have been identified, assessed and added onto local risk registers that are being managed by the local Service, Department, Division, Area Team etc. Staff should not hold risks on paper-based systems or spreadsheets.

High level operational risks identified, assessed and added onto Datix by services and directorates should be escalated speedily via appropriate governance routes for consideration and approval so that such risks could be held at the right Tier and assigned the right profile, handler, manager and resources. There are two pathways for escalating or de-escalating risks:

- **Governance route**: through appropriate governance or Quality and Safety meetings.
- **Expedited escalation route**: Through the Service, Area and Directorate Triumvirate to the Divisional and/or Secondary Care SMT, the relevant Executive Director, RMG or its Chair`s action to the ET and then, to the appropriate Committee for approval.

However, there may be instances when escalation of risks can`t be implemented via the normal governance route because there is no meeting imminent. In such a situation, and in order to ensure that risk escalation is timely, agile and dynamic, escalation should be pursued via the expedited escalation route as described above. Escalation provides an opportunity for appropriate risk oversight and scrutiny and for raising the profile and visibility of the risk as well as requesting for support and resources. There must be sufficient clarity around the expectation from and rationale for escalating a risk. The next table shows BCU`s escalation and risk governance arrangements.

Tier	Risk Score	Category of risk	Level at which risk is managed	Approval Group or Committee	Escalation and De-escalation
Tier 1 Corporate Risk Register (CRR) **Directorate Level risks**	15-25	High to Very High	Executive Directors will lead on risks scored 15 and above, escalated and approved for inclusion onto the CRR although responsibility for managing and mitigating such risks on a daily basis will reside with original risk owners. **Reviewed monthly**	Board/ Committee	Appropriate Committee with the assigned risks on the CRR. Once reviewed, the Risk Management Group will have oversight of the entire CRR prior to authorisation by the Executive Team for Board or Committee approval

Figure 5a -The Health Board`s escalation and governance arrangements for risk management.

Tier	Risk Score	Category of risk	Level at which risk is managed	Approval Group or Committee	Escalation and De-escalation
Tier 2 **Divisional, Hospital Site, Secondary Care & Area Level risks**	9-12	Moderate	Managed at Divisional/Hospital Site, Secondary Care & Area level and led on by Directors with local ownership and input. **Reviewed bi-monthly**	Appropriate Divisional Governance meeting or Divisional Risk Meeting	Risks with a current score 9-12 will be managed under the leadership of a Director. Risks scoring above 12 are escalated to the Executive Team for consideration and approval as Tier 1 risks *CRR.
Tier 3 **Services, Specialities, Departmental, Transformational, Projects & Service Improvement Level risks**	4-8	Low to Very Low	Managed at local level Service, Speciality, Area/Directorate or Department including risks related to transformational, projects and Service Improvement. **Reviewed quarterly**	Service, Speciality, Area / Directorate or Department or relevant Group meeting or local governance meeting.	Risks with current score 1-8 are managed at local level with oversight from relevant local governance meetings. Those which score >8 will be escalated to the Divisional or Site governance meeting for consideration and escalation.
	1-3	Very Low			Risks escalated are still locally owned and managed.

Please note: This is a Continuation of Figure 5a above.

*The above timescales for reviewing risks are a minimum requirement and do not replace the dynamic, agile and timely review, mitigation, management and escalation of risks in real time.

11.2. From Silo to shared risk management and governance

The Health Board recognises that there will be instances where the effective management of a risk will require input from other colleagues and stakeholders who may not necessarily be part of the service in which the risk has been identified. For example, a service may identify a risk, which requires inputs from Informatics, Estates and Facilities, Safeguarding, Health & Safety etc. to effectively manage it. In such a situation, Services etc. should ensure that all key stakeholders who can contribute to the effective management of risks are involved in the discussions on how best to reduce and manage the risks. In other instances, such stakeholders like the Local Authority may be external; hence, there is need for shared agreement and clarity on roles and responsibilities in appropriately reducing and managing such risks.

11.3 Management of Pan-BCU Risks:

There are two types of Pan-BCU risks i.e. those that are owned by Pan-BCU Services like North Wales Managed Clinical Services (NWMCS) and those, which span-across more than one site i.e. East, Central and West. Whilst Pan-BCU risks like those owned by NWMCS will be reviewed and scrutinised by their governance arrangements, those, which span-across more than one Site should be managed collaboratively through joined risk meetings. It is thus important to establish cross-site meetings to bring together the same services that operate on the three regions around the table to discuss their risks, generate shared learning, agree on roles/responsibilities and how best to reduce and manage such risks or to consider risk aggregation and joined escalation. The aim here is to avoid the risk of silo management and escalation of risks and to create a platform for colleagues to start having meaningful risk-based conversations as the crystallisation of a risk in one service e.g. ED in the Central could impact on ED in the West or East and vice versa.

11.4. Appropriate Risk Reporting

Services, Departments and Divisions etc. should ensure that they regularly receive, review and scrutinise their risk registers at their governance or Q&S meetings. Risk registers should comprise of clear, high quality information on the controls and further actions in place, sources of assurance and reference where possible etc. High quality risk register reports that are reviewed and discussed at governance meetings constitute a good source of assurance. The Cycles of Business for governance meetings at Divisional, Hospital Site, Secondary Care and Area Levels should include assurance and oversight of risk management arrangements for Services and Departments within their remit . This should include presentation of risk registers for review and scrutiny of risks. Agendas and minutes from governance meetings should demonstrate governance footprint of risks that were reviewed and discussed as well as decisions, which were made.

12. Board Assurance Framework (BAF)

The BAF is a mechanism that should enable the Board to gain assurance that principal risks to the achievement of the Health Board`s strategic objectives have been identified, assessed and are properly managed in line with best practice. It is thus a robust tool, which the Board uses to reinforce strategic focus and better management of risks and in gaining assurance. The BAF also provides a structured framework for identifying and mapping the main sources of assurance across the Health Board and co-ordinating them to best effect. It thus provides a structure and process through which the Health Board can focus on those principal risks which could compromise the achievement of its strategic objectives as defined in its Clinical Strategy and Annual Operational Plan.

The Health Board`s BAF and CRR are symbiotically linked; inform, shape and feed-off each other as both toolkits are regularly updated, received and scrutinised by relevant committees and the Board as per their cycles of business. The BAF is thus the main tool that the Board uses in discharging its key responsibility of internal controls and gaining assurance that principal risks are managed in accordance with this Risk Management Strategy and Policy.

The next flowchart shows BCU`s escalation and de-escalation process:

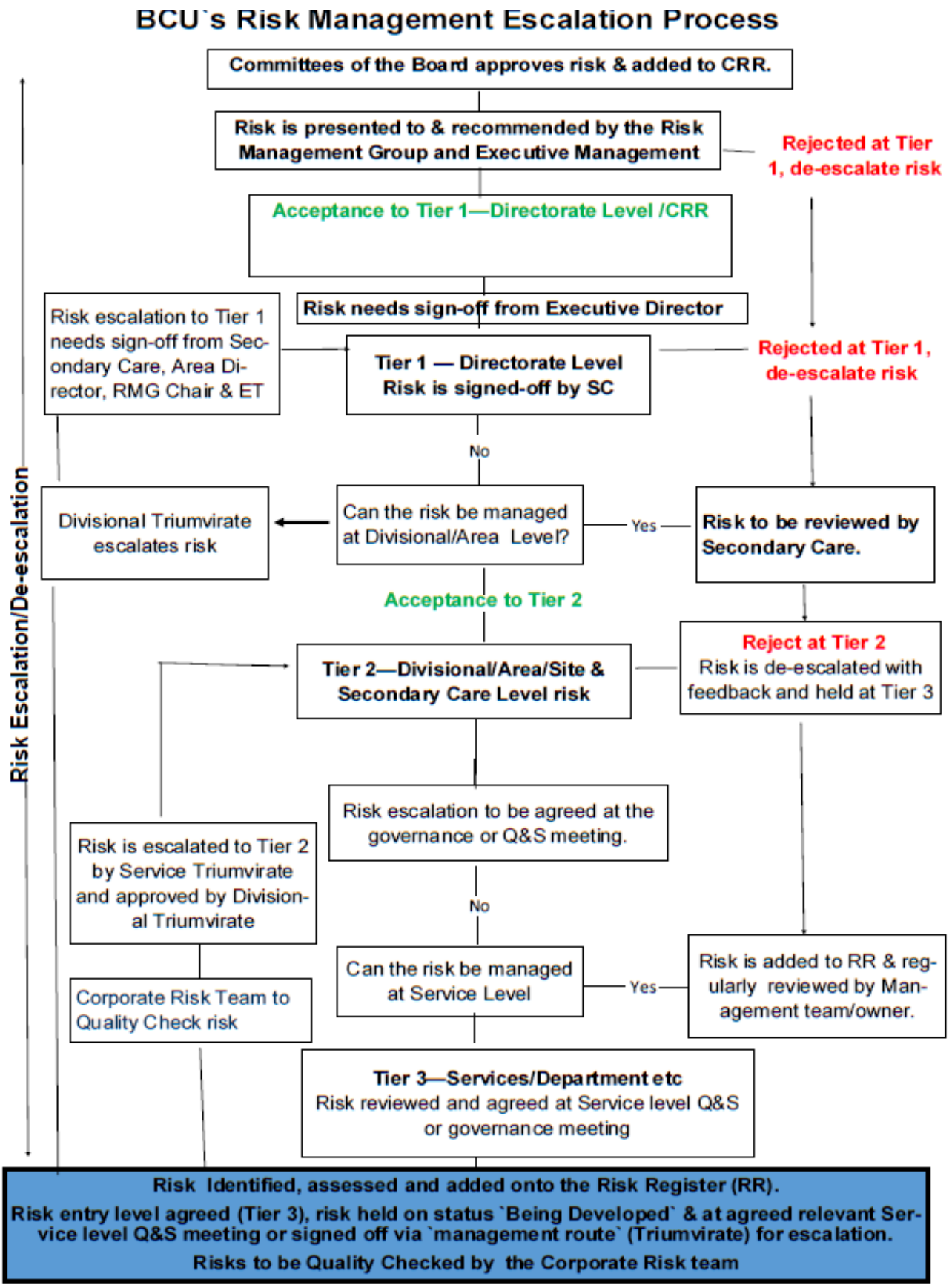

Figure 6 **- Escalation/De-escalation route**

13. Individual Roles and Responsibilities

The following section provides a synopsis of the roles and responsibilities of individuals, groups and committees in ensuring the timely and effective identification, assessment and management as well as review and scrutiny of risks across the Health Board: -

13.1 Chief Executive or Accountable officer

The Chief Executive has delegated responsibility from the Board to ensure that the Health Board has a robust risk management architecture; systems and processes in place to foster the effective mitigation and management of risks. The Chief Executive is accountable for the Board's risk management and governance arrangements and has executive responsibility for ensuring organisational compliance with the Health Board`s Risk Management Strategy and Policy. The Chief Executive has responsibility for communicating, implementing and monitoring the Health Board`s risk appetite as delegated by the Board and for ensuring that the Annual Governance Statement aligns with this risk management strategy and policy.

13.2 Deputy Chief Executive

The Deputy Chief Executive has been delegated responsibility from the Chief Executive to operationally deliver the Risk Management Strategy, develop the governance arrangements and strengthen the Health Board`s risk management systems and processes by:

- Embedding an effective risk management culture throughout the health board;
- Working closely with the Chair, Vice Chair, Chief Executive, Chair of the Audit Committee and Executive Directors to implement and maintain appropriate risk management and related processes;
- Developing and communicating the Board's risk awareness, appetite and tolerance;
- Leading and participating in risk management oversight at the highest level, covering all risks across the health board;
- Leading the development of, and Chair of the Risk Management Group;
- Working closely with the Chief Executive and Executive Directors to support the development and maintenance of the Corporate and Directorate level risk registers;
- Developing and implementing the health board's Risk Management Strategy and Policy.

The Deputy Chief Executive will discharge these responsibilities through the Interim Director Of Governance and/or Assistant Director of Information Governance and Risk and the Head of Risk Management.

13.3 Board Secretary

The Board Secretary provides advice and guidance to the Board on all aspects of governance and it is the Board's responsibility to approve the governance framework. The Board Secretary is responsible for designing, developing and maintaining the Health Board`s Board Assurance Framework (BAF).

13.4 Executive Directors

Executive Directors have overall responsibility for the operational management of risks within their directorates and are the named senior responsible officer for individual risks on the Corporate Risk Register. They are also responsible for the effective allocation of resources to timely reduce risks within their remit, while ensuring prompt escalation and de-escalation of

risks where appropriate. They shall also be responsible for ensuring that Senior Managers under their portfolio have effective risk management systems and processes in place in their Directorates, Areas, Hospital Sites, and Divisions to demonstrate robust identification, assessment, mitigation and management of all risks. They are responsible for ensuring that best practice in risk management and a positive risk-aware culture are fully embedded in their portfolio.

13.5 Independent Members (IMs)
Independent Members have an important role in risk management in seeking assurance on the robustness of processes and the effectiveness of controls through constructive, robust, positive and effective challenge to the Executive Directors and senior management. The role of Independent Members is not to manage individual risks but to understand and question risk on an informed and ongoing basis. IMs are expected to satisfy themselves that the Health Board`s risk management arrangements are effective, efficient and fit-for-purpose.

In addition, IMs chair Board Committees and in line with the relevant committee's terms of reference, should gain and provide assurance to the Board that risks within its remit are being managed effectively by the risk owners and report any areas of concern to the Board.

13.6 Clinical Executive Directors
The Executive Director of Nursing and Midwifery, Executive Medical Director, Executive Director of Therapies and Health Sciences and the Executive Director of Public Health have collective responsibility for clinical quality governance which includes patient safety, incident management and patient experience and will therefore have a responsibility to ensure that clinical risks are appropriately managed in line with this strategy. They are responsible in ensuring that significant clinical risks identified and assessed in their portfolios are brought to their attention in a timely manner and, if approved, escalated promptly and properly managed.

13.7 Senior Information Risk Officer
The Board will nominate an Executive Director as the Senior Information Risk Officer (SIRO) with delegated responsibility by the Chief Executive for ensuring that information risks are treated as a priority for business outcomes.

13.8 Senior Managers (including Directors)
Senior managers will take the lead on risk management within their divisions, sites and areas and set the example through visible and exemplary leadership. They are also responsible for the effective allocation of resources in managing, escalating and de-escalating operational and strategic risks within their remit.

13.9 All Staff
All staff including Trade Union colleagues and contractors are required to comply with this Risk Management Strategy and Policy, bring any issues of concern to the attention of their line manager and to appropriately reduce and manage risks to the best of their knowledge and ability. Controls and actions implemented in mitigating risks must be timely disseminated to all staff involved with the management of the risk were it to be realised. All staff are expected to share intelligence around any potential risks with contractors providing services within and on behalf of the Health Board.

14. Committee and Group Roles & Responsibilities

14.1 The Board

The Board have collective responsibility for the setting and ensuring delivery of strategic objectives and priority areas. Key strategic risks are identified and monitored by the Board. The Board is also accountable for setting the risk appetite of the Health Board and in providing scrutiny, oversight and constructive challenge while gaining assurance that the Health Board has robust systems and processes in place to ensure the effective management of risks, associated controls and assurances across its length and breadth. The UK Corporate Governance Code recommends that:

> 'the board should establish procedures to manage risk, oversee the internal control framework, and determine the nature and extent of the principal risks the company is willing to take in order to achieve its long-term strategic objectives'.

The Code recognises that as risks can emerge and crystallise rapidly, the risk management architecture in place should facilitate the timely, dynamic and agile escalation of principal risks to the attention of the Board in real time.

The Financial Reporting Council (2014) Guidance on Risk Management and Internal Controls states that, the board has ultimate responsibility for ensuring that appropriate risk management processes, systems, internal control, and risk-aware culture are embedded throughout the organisation. Hence, in the context of this Strategy and Policy, the Board will:

- Demonstrate its continuing commitment to risk management through the endorsement of this strategy;
- Ensure, through the Chief Executive that the responsibilities for risk management outlined in this strategy are communicated, understood and maintained;
- Take a lead role in "horizon scanning" for emerging threats/risks to the delivery of the health board's strategic objectives and priority areas and ensuring that controls put in place in response, manage risks to an acceptable level;
- Oversee and participate in the risk assurance process and ensure that appropriate structures are in place to implement effective risk management;
- Commit those financial, managerial, technological and educational resources necessary to adequately control identified risks;
- Ensure that lessons are learned and disseminated into practice from complaints, claims and incidents and other patient experience data;

Receive reports from the Committees of the Board in line with terms of reference and work plans of those committees.

14.2. Committees

The key responsibility of committees here are to-

- Provide scrutiny, oversight, approve and recommend risks for inclusion on the CRR.
- Approve new risks for escalation and inclusion onto the CRR and/or approve existing ones for de-escalation from the CRR once they have been appropriately reduced and managed to lower scores.

- Provide assurance to the Board that there are robust and effective arrangements in place to appropriately identify, assess, review, monitor and manage Tier 1 risks and those on the Corporate Risk Register (CRR) within their portfolio.
- Committees may through `horizon scanning` and a `top down approach` recommend that potential risks/threats from related reports e.g. Quality or Performance Reports be identified, assessed and captured on the risk register by the relevant Services or Divisions and escalated if applicable.
- Committees have responsibility for signing-off closed actions that were implemented to support in mitigating and managing risks to attain their target risk score.
- Committees should not be involved in the operational management of risks but should satisfy themselves that the Services and Divisions under their remit have robust risk management arrangements in place. They should also provide scrutiny and oversight, constructive challenge, gain assurance and hold Executive Directors to account for the effective management of risks under their portfolios.

Risks on the CRR are aligned to Committees for regularly review and scrutiny prior to the Board receiving the CRR. Committees here include:

- Quality, Safety and Experience Committee (QSE)
- Finance and Performance Committee (F&P)
- Strategy, Partnerships and Population Health Committee (SPPH)
- Digital and Information Governance Committee (DIGC)

14.3 Audit Committee

The Audit Committee is responsible on behalf of the Board for providing oversight and scrutiny of the CRR in order to assure the Board that there are robust processes and systems in place for appropriately mitigating and managing risks across the Health Board and especially those on the CRR. This involves reviewing how risks which could impact on the achievement of the Health Board`s objectives as defined in its Annual Operational Plan could be appropriately reduced and managed. The Audit Committee will also review and approve the Risk Management Strategy and Policy annually as required as part of the Health Board's Standing Orders in advance of ratification by the Board.

14.4 The Executive Team (ET):

The ET fulfil the following responsibilities:

- Receive, review and scrutinise the CRR and recommend any new risks that are being escalated to the attention of the relevant committee.
- Identify risks from other reports and instruct the relevant services to ensure such risks are appropriately assessed and captured on their risk registers and escalated if applicable.
- Gain assurance from the RMG that the CRR and BAF are robust, effective and fit for purpose.

14.5 The Risk Management Group

The Risk Management Group will maintain oversight of the risk management system and overall governance and reporting arrangements ensuring that they are fit for purpose and embedded across all areas of the Health Board in line with this Risk Management Strategy

and Policy. It is also responsible for the oversight and monitoring of risks at Directorate level (Tier 1) and providing scrutiny and oversight of the full Corporate Risk Register prior to review by the ET. As part of the Health Board governance arrangements, the Risk Management Group will report to the ET. The RMG will also perform the following functions:

- Review and scrutinise Divisional risk register reports including new risks for escalation and either recommend them to the ET or decline and provide feedback on changes that need to be made to strengthen the risk assessment prior to re-escalation if applicable.
- Challenge risks that are being presented for consideration and escalation.
- On behalf of the ET, the RMG will receive, review and scrutinise the CRR with focus on the risk entries, controls in place, new actions that have been added and old ones that have been completed, risk score etc. and make recommendations to the RMG.
- Identify risks from other reports and instruct the relevant services to ensure such risks are appropriately assessed and captured on their risk registers and escalated if applicable.
- Review and scrutinise risk management performance reports, audits, the updated Risk Management Strategy and its associated procedural documents as well as any other risk management related reports and advise accordingly.
- On behalf of the ET regularly review, challenge and scrutinise the Health Board`s risk management architecture, monitor its Risk Management Annual Improvement Plan and provide assurance to the ET.

14.6 Divisional/Hospital Site/Area/Secondary Care etc. Risk Management Arrangements or Q&S Meeting

All Divisions/Hospital Sites/Area/Secondary Care etc. must have the necessary arrangements in place for good governance, quality, safety and effective risk management. Divisional Q&S or governance meetings are responsible for ensuring that there are effective systems and process in place across Services and Departments under their remit to ensure robust risk management and provide assurance that these are operating effectively. Q&S or governance must create the enabling environment for bottom-up risk reporting with Services and Departments under their remits routinely providing their risk register reports for review, scrutiny, assurance and oversight.

15. Risk Management Training

The Corporate Risk Team is committed to developing organisational capacity and capability in risk management as a driver for improving risk awareness, developing risk management skills in the local workforce and embedding best practice in risk management. Bespoke risk management training resources have been developed and tailored to suit staff in various roles and responsibilities. The Corporate Risk Team has launched an initiative to train 1000 staff across the Health Board in risk management for 2021/22, with various training slots advertised on the intranet and staff informed and encouraged to book. The plan is for all staff (including Board Members) in the next few years to receive training and/or refresher in risk management that is appropriate to their roles and responsibilities.

16. Equality Impact Assessment

The Health Board has undertaken an Equality Impact Assessment on the implementation of

this strategy and policy to ensure that it is inclusive and does not discriminate against any protected characteristics. The assessment has highlighted an equality impact concern regarding the availability of the documentation in a format to address any visual impairment disabilities. Positive action including support and the availability to transcribe the document will be provided to support individuals and the Health Board to positively meet its responsibilities under the equalities and human rights legislation.

17. Performance Measurement and Monitoring of Risk Management Culture

The Health Board will undertake regular Risk Management Self-assessments, annual internal audits, Snapshot Audits and/or an annual health check of its risk management culture using key performance indicators (KPIs) in measuring the effectiveness of risk management arrangements across its services. These will explore a sample of 20 risks randomly selected from each Directorate risk registers and 10 from the Corporate Risk Register in measuring the following KPIs.

17.1 Compliance: This will measure whether the Health Board is compliant with its own risk management strategy and policy by evaluating the following components: -

- % of risks which are in date and/or out of date;
- % of actions linked to Directorate risks which are out of date.

17.2 Maturity: This measure will focus on evaluating the completeness of risks on risk registers across the Health Board and will concentrate on the following aspects: - e.g.

- % of risks with all key dates completed;

17.3 Data Quality: This measure will focus on evaluating the accuracy of risk entries e.g. risk description, controls, actions and titles. It will consider: -

- % of risks with titles focusing on the risks and not issues.
- % of risks with appropriate descriptions

17.4 Risk Management Training: This metric will measure the number of staff who have attended the Health Board`s ongoing risk management trainings i.e. `Operation 1000 Staff`.

- % of staff who have attended the Health Board`s risk management trainings.

17.5 Appropriate risk escalation: This measure will seek to randomly identify some risks, which were escalated onto tiers 2 and 1 to ascertain if they were escalated in line with this Risk Management Strategy and Policy.

- % of risks escalated to tiers 2 and 1 that have governance footprint captured on agendas and minutes as defined by this Strategy.

18. Conclusion:

The use of ERM will thus provide a framework through staff across the Health Board to timely and proactively identify, assess, manage and reduce potential events or risks that may compromise the achievement of the organisation`s objectives and Priority Areas as outlined in its 3 Year Plan/IMTP. In conclusion, this risk management strategy and policy will foster standardisation, engagement, consistency and help embed ERM across all services within

BCU from `Ward to Board`.

19. References

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20. Acronyms:

No	Acronyms	Meaning
1	WG	Welsh Government
2	HIW	Health Inspectorate Wales
3	HSE	Health & Safety Executive
4	SC	Secondary Care
5	ET	Executive Team
6	ED	Emergency Department
7	RMG	Risk Management Group
8	Q&S	Quality & Safety
9	IMs	Independent Members
10	CRR	Corporate Risk Register
11	BAF	Board Assurance Framework
12	RR	Risk Register
13	KPIs	Key Performance Indicators

Appendix A – BCU`s Risk Appetite Framework – May 2021

The Health Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that it understands and is aware of the risks it is prepared to accept in pursuit of its aims, strategic objectives and priority areas.

The Health Board places fundamental importance on the delivery of its strategic objectives and priority areas and its relationships with its patients, the public and strategic partners in achieving delivery of its "*Living Healthier Staying Well*", Annual Operational Plan 2021/22.

The Health Board is not open to risks that materially impact on the quality or safety of services that we provide or commission; or risks that could result in us being non-compliant with UK law, healthcare legislation, or any of the applicable regulatory frameworks in which we operate.

The Health Board has the greatest appetite to pursue innovation and challenge current working practices and financial risk in terms of our willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

BCU`s Risk Appetite Framework

Risk Domains	Current Risk Appetite Framework 2020/21 Description of risk categories	Proposed Risk Appetite Framework 2021/22 Description of risk categories	Risk Appetite Framework during exceptional Circumstances e.g. Pandemic or loss of Acute Hospital Description of risk categories
Risk Appetite	**Category: Cautious (Low Score 1 - 6)**	**Risk Appetite Category: Cautious (Low Score 1 - 8)**	**Risk Appetite Category: Cautious (Low Score 1 - 8)**
Patient and Staff Safety	The Health Board consider the safety of patients and staff to be paramount and core to our ability to operate and carry out the day-to-day activities. We have a low appetite to risks that result in, or are the cause of incidents of avoidable harm to our patients or staff. This means we are not open to risks that could result in poor quality care or clinical risk assessment, non-compliance with standards of clinical or professional practice, unintended outcomes or poor clinical interventions. We will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual's competence to perform roles or tasks safely and, nor any incidents or	BCUHB places the safety of its patients and staff at the heart of everything it does. It has a cautious risk appetite for patient and staff safety risks that could result in harm or discomfort to patients and staff which may arise from the delivery of its core business activities. BCUHB recognises that during exceptional circumstances and in line with full clinical risk stratification, it will be prepared to accept a slightly higher threshold for patient and staff safety risks such as falls, delay referral to treatment, limited access to some operations, cancellation of appointments, etc. BCUHB will however not accept risks associated with underperformance, unprofessional conduct, Never Events	BCUHB places the safety of its patients and staff at the heart of everything it does. It has a cautious risk appetite for patient and staff safety risks that could result in harm or discomfort to patients and staff which may arise from the delivery of its core business activities. BCUHB recognises that during exceptional circumstances and in line with full clinical risk stratification, it will be prepared to accept a slightly higher threshold for patient and staff safety risks such as falls, delay referral to treatment, limited access to some operations, cancellation of appointments, etc. BCUHB will however not accept risks associated with underperformance, unprofessional conduct, Never Events (as

	circumstances which may compromise the safety of any staff member or group.	(as these shouldn`t occur in the first place), taking shortcuts, bullying, or an individual's competence to perform tasks safely and/or any incidents or undue circumstances which may compromise the safety patients and/or any staff member or group.	these shouldn`t occur in the first place), taking shortcuts, bullying, or an individual's competence to perform tasks safely and/or any incidents or undue circumstances which may compromise the safety patients and/or any staff member or group.
Quality and Patient Outcomes	The Health Board's ambition is to ensure that the health services it provides to individuals, patients and the population improve and achieve desired health outcomes and are informed by current professional and cutting-edge knowledge and best practice. The Health Board recognises that it`s quality risks will include those which relate to clinical effectiveness and patient experience amongst others. The provision of high quality services is of the utmost importance to the Health Board and for ensuring value for money in a challenging arena. We therefore have a cautious appetite to risks that impact adversely on quality of care and depending on the circumstances will accept some risks that could limit our ability to fulfil this activity.	**Risk Appetite Category: Moderate (Score 9 – 12)** BCUHB is committed to providing high quality healthcare services to patients and the entire population it serves with the view to delivering better outcomes and greater value for money that are informed by cutting-edge knowledge, best practice and professionalism. BCUHB has a moderate appetite for risks that could impact adversely on the quality of its healthcare services and patient-centred outcomes. It acknowledges that in exceptional circumstances, it will explore appropriate risk stratification and due diligence in deciding on the amount of risk associated with quality and patient outcomes it would be able to accept in pursuant of its operational and strategic objectives.	**Risk Appetite Category: Moderate (Score 9 – 12)** BCUHB is committed to providing high quality healthcare services to patients and the entire population it serves with the view to delivering better outcomes and greater value for money that are informed by cutting-edge knowledge, best practice and professionalism. BCUHB has a moderate appetite for risks that could impact adversely on the quality of its healthcare services and patient-centred outcomes. It acknowledges that in exceptional circumstances, it will explore appropriate risk stratification and due diligence in deciding on the amount of risk associated with quality and patient outcomes it would be able to accept in pursuant of its operational and strategic objectives.

Workforce and OD	The Health Board will continue to employ and retain staff that meet our high quality standards and provide on-going training to ensure all staff reach their full potential, always mindful of the professional and managerial capacity and capability of the Health Board. We will also actively promote staff well-being. In certain circumstances we will accept risks associated with the delivery of this activity, however the preference is for safe delivery options with a low degree of inherent risk. There might be occasions as part of a future strategy to meet changing needs that we seek to develop new staffing models, which in their development might require a greater level of risk.	**Risk Appetite Category: Moderate (Score 9 – 12)** BCUHB places emphasis on promoting staff safety and well-being as it recognises that a healthy staff is key to driving high productivity and ensuring the achievement of its core business objectives. BCUHB realises that during exceptional circumstances, its staff could however be stretched and put under enormous pressure as they support the delivery of its core operational and strategic objectives. It recognises that in pursue of its core objectives, it will have a moderate risk appetite for risks associated with Workforce and OD. This acceptance will be based on the understanding that such risks will be timely identified, assessed and appropriately reduced and managed.	**Risk Appetite Category: Moderate (Score 9 – 12)** BCUHB places emphasis on promoting staff safety and well-being as it recognises that a healthy staff is key to driving high productivity and ensuring the achievement of its core business objectives. BCUHB realises that during exceptional circumstances, its staff could however be stretched and put under enormous pressure as they support the delivery of its core operational and strategic objectives. It recognises that in pursue of its core objectives, it will have a moderate risk appetite for risks associated with Workforce and OD. This acceptance will be based on the understanding that such risks will be timely identified, assessed and appropriately reduced and managed.

Regulation and Compliance	The Health Board will continue to comply with all legislation relevant to us and will avoid risks that could result in the Health Board being non-compliant with UK law or healthcare legislation, or any of the applicable regulatory frameworks in which we operate.	**Risk Appetite Category: Moderate (Score 9 – 12)** BCUHB will have a moderate risk appetite for risks associated with regulation and compliance as it recognises that the regulatory and compliance landscape will be challenging and daunting during exceptional circumstances.	**Risk Appetite Category: Moderate (Score 9 – 12)** In order to foster a culture of high quality safe care across all its services, BCUHB is committed to ensuring compliance with regulatory, policy and legislative instruments and will greatly discourage and frown at non-compliance and/or staff taking shortcuts. BCUHB will have a moderate risk appetite for risks associated with regulation and compliance as it recognises that the regulatory and compliance landscape will be challenging and daunting during exceptional circumstances.
Risk Appetite	**Category: Moderate (Score 8 – 10)**	**Risk Appetite Category: Moderate (Score 8 – 10)**	**Risk Appetite Category: Moderate (Score 9 – 12)**
Reputation & Public Confidence	The Health Board will maintain high standards of conduct, ethics and professionalism at all times, espousing our Values and Behaviours, and will not accept risks or circumstances that could damage the public's confidence in the organisation. Our reputation for integrity and competence should not be compromised with the people of North	The Health Board will maintain high standards of conduct, ethics and professionalism at all times, espousing our Values and Behaviours, and will not accept risks or circumstances that could damage the public's confidence in the organisation. Our reputation for integrity and competence should not be compromised with the people of	BCUHB is committed to maintaining high standards of conduct, ethics and professionalism at all times as underpinned by its Values and Behaviours. It recognises that the mitigation and management of risks associated with reputation and public confidence could be exacerbated during exceptional circumstances. It will have a moderate risk appetite for reputation and public confidence risks that

	Wales, Partners, Stakeholders and Welsh Government. We have a moderate appetite for risks that may impact on the reputation of the health board when these arise as a result of the health board taking opportunities to improve the quality and safety of services, within the constraints of the regulatory environment.	North Wales, Partners, Stakeholders and Welsh Government. We have a moderate appetite for risks that may impact on the reputation of the health board when these arise as a result of the health board taking opportunities to improve the quality and safety of services, within the constraints of the regulatory environment.	can inhibit the achievement of its core business objectives. However, BCUHB won`t accept high risks associated with reputation and public confidence as these could lead to poor perception of its services and image, trigger adverse press and media coverage, reputational damage, financial penalties and loss of core business activities.
Partnership Working	The Health Board will continue to work with other organisations to ensure we are delivering the best possible service to our patients/service users and are willing to accept risks associated with this collaborative approach. Partnership working is a fertile ground for innovation in service delivery, new ways of delivering services and new service models. However, not where this compromises safety and quality of care for patients and service users. This is key to ensuring patients, carers and stakeholders receive seamless care from all agencies, especially with regard to legislation such as Social Care and Well Being Act and the Well Being of Future Generations Act, which will support the Health Boards commitment to improving	**Risk Appetite Category: Moderate (Score 9 – 12)** The Health Board will continue to work with other organisations to ensure we are delivering the best possible service to our patients/service users and are willing to accept risks associated with this collaborative approach. Partnership working is a fertile ground for innovation in service delivery, new ways of delivering services and new service models. However, not where this compromises safety and quality of care for patients and service users. This is key to ensuring patients, carers and stakeholders receive seamless care from all agencies, especially with regard to legislation such as Social Care and Well Being Act and the Well Being of	**Risk Appetite Category: Moderate (Score 9 – 12)** BCUHB recognises that in order to deliver high quality personalised transformational health services to its patients and the wider population, it is helpful to tap into the immense benefits which can accrue from working in collaboration both vertically and/or horizontally within and outside its boundaries with key stakeholders, agencies and partners as well as across organisational and professional divide. However, it will have a moderate risk appetite for all risks associated with partnership working which could inhibit the achievement of its operational and strategic objectives. This is key to ensuring patients, carers and stakeholders receive seamless care from all agencies, especially with regard to legislation such as Social Care and Well Being Act and

	population health and the general wellbeing of local people through the implementation of "Living Healthier Staying Well".	Future Generations Act, which will support the Health Boards commitment to improving population health and the general wellbeing of local people through the implementation of "Living Healthier Staying Well".	the Well Being of Future Generations Act, as these will support BCUHB`s commitment to improving population health and the general wellbeing of its local population through the implementation of "Living Healthier Staying Well".
Finance	The Health Board have been entrusted with public funds and must remain financially viable. We will make the best use of our resources for patients and staff. Risks associated with investment or increased expenditure will only be considered when linked to supporting innovation and strategic change. We will not accept risks that leave us open to fraud or breaches of our Standing Financial Instructions.	**Risk Appetite Category: Moderate (Score 9 – 12)** The Health Board have been entrusted with public funds and must remain financially viable. We will make the best use of our resources for patients and staff. Risks associated with investment or increased expenditure will only be considered when linked to supporting innovation and strategic change. We will not accept risks that leave us open to fraud or breaches of our Standing Financial Instructions.	**Risk Appetite Category: Open (High Score 15)** BCUHB acknowledges the exacerbating constraints and pressure during exceptional circumstances which could be exerted on its capacity and resources to effectively and efficiently reduce and manage finance risks to the delivery of its core business operations and objectives. It will therefore have an open risk appetite for risks associated with finance and will accept finance risks to the achievement of its core business objectives that are scored at 15. It won`t accept very high finance risks which could compromise the judicious, effective and efficient use of public funds placed at its disposal for the smooth delivery of its core business objectives.
Risk Appetite	**Category: Open (High Score 12 - 15)**	**Category: Open (High Score 12 - 15)**	**Risk Appetite Category: Open (High Score 15)**
Innovation &	The Health Board wishes to maximise opportunities for developing and growing our services by encouraging	The Health Board wishes to maximise opportunities for developing and growing our services by encouraging	BCUHB recognises that innovation and strategic change are critical drivers for the delivery of high quality patient-centred care

Strategic Change	entrepreneurial activity and by being creative and pro-active in seeking new initiatives, consistent with the strategic direction set out in the 3 Year outlook, Annual Plan, whilst respecting and abiding by our statutory obligations. We are willing to accept risks associated with innovation, research and development to enable the integration of care, development of new models of care and the use of technology to address changing demands. This will include new ways of working, trials and pilot programmes in the delivery of healthcare.	entrepreneurial activity and by being creative and pro-active in seeking new initiatives, consistent with the strategic direction set out in the 3 Year outlook, Annual Plan, whilst respecting and abiding by our statutory obligations. We are willing to accept risks associated with innovation, research and development to enable the integration of care, development of new models of care and the use of technology to address changing demands. This will include new ways of working, trials and pilot programmes in the delivery of healthcare.	and encourages staff to explore innovation, new technologies and cutting-edge approaches and models in delivering patient care. It will however, have an open risk appetite for innovation and strategic change risks and will accept related risks scored15 that are associated with innovation, research and development to enable better integration of care, development of new models of care and the use of technology to address changing demands.

This Statement will be regularly reviewed and modified so that any changes to BCUHB`s strategy, objectives, priority areas or our capacity to manage risk are properly reflected. It will be communicated throughout BCUHB in order to embed sound risk management and to ensure risks are properly identified and managed.

Appendix B: Guidance for completing the BAF Template

BAF Template Item		Please refer to the Risk Management Strategy and Policy for further detailed explanations
Risk Reference		Board Assurance Framework reference number, allocated by the Board Secretary
Risk Description		An uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's Priority. There are 3 main components to include when articulating the risk description (cause, event and effect):
		- There is a risk of / if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ……
Risk Ratings	Inherent	Without taking into consideration any controls which may be in place to manage this risk, what is the likelihood that this risk will be realised, and if it did, what would be the consequence
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place.
Risk Impact		The consequence (or how bad) if the risk were to be realised, in line with the NPSA Grading Matrix an impact of 1 is a Negligible (very low), with a 5 as Catastrophic (very high)
Risk Likelihood		The probability (frequency or how often) would this happen if the risk were to be realised. In line with the NPSA Grading Matrix a likelihood of 1 is this will probably never happen / recur, with a 5 being that it will undoubtedly happen, recur, possibly frequently
Score		Impact x Likelihood of the risk happening
Appetite	Definition	Is defined as the amount and type of risk the Health Board is willing to take on, pursue or retain in order to achieve its priorities.
	Low	Cautious with a preference for safe delivery options (Score 1 to 6)
	Moderate	Prepared to take on, pursue or retain some risks as a result of the Health Board taking opportunities to improve quality and safety of services (Score 8 to 10)
	High	Open or willing to take on, pursue or retain risks associated with innovation, research and development consistent with the Health Board's Priorities (Score 12-15)

Control	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise and ensure that care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management] A measure that maintains and/or modifies risk (ISO 31000:2018(en))
	Examples include, but are not limited to:	- People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklist in place and being implemented which ensures the delivery of an objective - Training in place, monitored and assurance reported - Compliance audits - Business Continuity plans in place, up to date, tested and effectively monitored - Contract Management in place, up to date and regularly monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood and/or lessening or making less severe its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity).
	Examples include, but are not limited to:	- Service or Pathway Redesign - Business Case Development - Staff Training - Risk Assessment - Evidential data sets - Taking out insurance
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the data is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified the data, for example quality, finance and H/R assurance
	3	The third level of assurance comes from assurance provided from outside the Health Board, for example WG, HIW, HSE etc.

Audit Committee 10th June 2021	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Chair's Report

Name of Group:	Risk Management Group (RMG)
Meeting date:	15th March and 12th April 2021
Name of Chair:	Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery
Responsible Director:	Simon Evans-Evans, Interim Governance Director
Summary of business discussed:	The Risk Management Group (RMG) met on the 15th March 2021 and the 12th April 2021. The Group was quorate on both occasions with good representation. This report summarises the activity of the Risk Management Group (RMG) and members noted: 1. The minutes from the meeting on the 15th March 2021 were approved as an accurate record. Please note the next meeting of the Risk Management Group is on the 15th June, where April's minutes will be presented for approval. 2. Scrutiny of the Risk Management Action Tracker took place during both meetings, with a revised format being introduced for the meeting in June to focus on outstanding items. The below action remained outstanding with an identified completion date: • Revised Risk Appetite Statement to be presented and discussed at the Board Workshop in April. 3. The Terms of Reference were approved by the Executive Team on the 11th February 2021. 4. The Cycle of Business was approved and has been shared with all Divisional Risk Leads to support the timely submission of cyclical Divisional Risk Reports. 5. The Risk Management Strategy and Policy was being revised and will be presented to the Executive Team in May 2021 for approval, with onward presentation to the Audit Committee in June 2021 for approval and then the Board in July 2021 for ratification. This will include the revised Risk Appetite Framework. The Group agreed to present a request for a short extension to the current arrangements whilst this revision was taking place. 6. The Risk Management Improvement Plan was presented, noting three actions remained outstanding from the original 25. These

	three actions would be transferred into the 2021/22 improvement plan. These were: i. Implementation of the new Datix Risk Module which has been delayed nationally; ii. Development of the Risk Management E-Learning package; iii. Activation of the Action Module in Datix for Tiers 2 and 3 risk levels. Achievement of the move from the five to three tiers was completed by the 31st March 2021. 7. A comprehensive review was undertaken on the Board Assurance Framework, including deep dive sessions targeted at the high level risks, these were BAF20-05 – Timely Access to Planned Care and BAF20-12 – Listening and Learning. The Schedule of BAF risks including 1-2-1 meetings with all risk leads was presented for assurance. Controls and Mitigations were checked and challenged, alongside a review of the scoring in line with the current Health Board's Risk Appetite Statement. Recommendations were proposed and will be presented to the Executive Team for agreement, this included: i. BAF20-01 – proposal to archive, with outstanding actions transferred to BAF20-02 for future management. Feedback has been provided to all individual Executive Directors and Lead Officers to ensure all risks are updated before the next submission to the Executive Team and appropriate Committees of the Board due from April to June 2021. Discussions on the template and reporting of the BAF and CRR also took place following feedback from the Committees and it was agreed to split the BAF report from the CRR whilst still maintaining a link between the levels of risk within the reports. 8. A comprehensive review was undertaken on all the Tier 1 Corporate Risks. Learning from the implementation of the BAF, 1-2-1 meetings with all the Corporate Risk Leads is now taking place to improve compliance with the Risk Management Strategy requirements. Controls and Mitigations were checked and challenged, alongside a review of the scoring in line with the current Health Board's Risk Appetite Statement. Feedback has been provided to all individual Executive Directors and Lead Officers to ensure all risks are updated before the next submission to the Executive Team and appropriate Committees of the Board due from April to June 2021.

	9. Four new risks were presented for escalation consideration, one was rejected requiring further work and the three below were to be presented to the Executive Team for agreement to escalate onto Tier 1: i. Risk ID1875 – National Infrastructure and Products; ii. Risk ID1976 – Nurse Staffing iii. Risk ID3659 - Cyber Security 10. Confirmation was provided that the COVID-19 High Level risks were continuing to be presented to the Executive Incident Management Team (EIMT), with the Risk Lead Officer in attendance at the Risk Management Group providing updates and assurance on the management of these risks. 11. Seven out of ten required Divisional Risk Reports were provided on time, noting the level of risk management maturity and compliance with the Risk Management Strategy and Policy within the Division. Three out of the seven have implemented their local RM04 – Local Risk Management Procedures, with the remaining four being supported by the Corporate Risk Team to finalise and implement their local procedures. The three reports not provided were: i. Office of the Medical Director ii. Secondary Care iii. Woman's – this had been completed but not approved by the Executive Director for presentation at the meeting. Moving forward, the RMG Chair has requested that each Divisional Risk Lead should be accompanied by the Hospital Managing Director, Nurse or Medical Directors (or equivalent posts) when presenting their Risk Reports. 12. A verbal update on the progress with the Once for Wales Integrated Risk Management Project was provided noting that the Complaints, Claims and Incident Module that was intended to go live from April 2021 has been delayed by the national programme team till July 2021, due to the impact from the pandemic. The Health Board will continue to ensure preparedness in light of this revised date. 13. An update on the Quality Governance Review Programme was provided, which detailed the bringing together of the differing governance functions across the Health Board to undertake quality surveillance and share information to highlight risks or concerns around services. The group will meet bi-monthly and work with the services to review the findings, and will follow

	already established escalation routes for any concerns identified.
Key assurances provided at this meeting:	• Progress with the implementation of the Risk Management Strategy and Policy and supporting documentation. • Progress with the implementation of the Board Assurance Framework. • Continued representation and presentation of Divisional Risk Management arrangements and escalation of risks. • Progress with the management of COVID-19 related risks and reporting arrangements. • Follow up of outstanding actions incorporated into future improvement plans.
Key risks including mitigating actions and milestones	Compliance with the Risk Management Strategy and Policy.
Issues to be referred to another Committee	None of note
Matters requiring escalation to the Board:	The ongoing impact of Covid-19 on Services/Directorates/Divisional resources and their ability to actively manage and review their risks.
Well-being of Future Generations Act Sustainable Development Principle	The work of the Risk Management Group will help to underpin the delivery of the sustainable development principles by: • Fully embedding Enterprise Risk Management to proactively manage risk to the delivery of the Health Board's planning and risk assessment processes. • Working collaboratively across Wales to deliver solutions with partners to improve planning and system delivery.
Planned business for the next meeting:	• Review of Corporate Risks. • Review of Board Assurance Framework. • Review of Extreme Covid-19 Risks. • Review and approve risks for escalation / de-escalation to the Executive Team. • Review of Divisional Risk Reports. • Update on Once for Wales Integrated Risk Management Project. • Review and approve the 2021/22 Risk Management Improvement Plan and future reporting requirements.
Date of next meeting:	15th June 2021

Cyfarfod a dyddiad: **Meeting and date:**	Audit Committee 10th June 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Corporate Risk Register Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Simon Evans-Evans, Interim Director of Governance
Awdur yr Adroddiad **Report Author:**	Justine Parry, Assistant Director: Information Governance and Risk
Craffu blaenorol: **Prior Scrutiny:**	Quality, Safety and Experience Committee Chair's Actions on the 2nd March 2021 Digital and Information Governance Committee on the 26th March 2021 Executive Team meetings on the 11th March 2021 and 2nd June 2021
Atodiadau **Appendices:**	Appendix 1 – Full Corporate Tier 1 Operational Risk Report

Argymhelliad / Recommendation:

The Committee is asked to:

1) Review and note the progress on the management of the Corporate Tier 1 Operational Risks.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**		**Ar gyfer Trafodaeth** **For Discussion**	✓	**Ar gyfer sicrwydd** **For Assurance**	✓	**Er gwybodaeth** **For Information**	

Y/N to indicate whether the Equality/SED duty is applicable

N

Sefyllfa / Situation:

The Corporate Risk Register (CRR) demonstrates how the Health Board is robustly mitigating and managing high rated risks to the achievement of its operational objectives.

The design of both the Board Assurance Framework (BAF) and CRR emphasises their distinctive roles in underpinning the effective management of both strategic and operational risks respectively, as well as underlining their symbiotic relationship as both mechanisms have been designed to inform and feed-off each other, the BAF is now be reported separately.

Each Corporate Risk has been reviewed and updated.

Cefndir / Background:

The implementation of the revised Risk Management Strategy underlines the Health Board's commitment to placing effective risk management at the heart of everything it does while embedding a risk-based approach into its core business processes, objective setting, strategy design and better decision making. This includes the evaluation, monitoring and review of progress, accountability and oversight of the Principal Risks and the high-level operational risks that could affect the achievement of the Health Board's agreed Priorities.

Teams reporting to the Lead Director (who is the Senior Responsible Officer for the risk) locally own and manage risks with support from the corporate risk team. The Risk Management Group has oversight of all risks and is scrutinised by the Executive Team who make the proposals for changes to the CRR to Board and Committees. Committees receive risk reports on a bi-monthly basis, with the full Corporate Risk Register presented twice yearly to the Board, with oversight of the risk management system and process remaining with the Audit Committee, who also receive an update twice a year.

The Corporate Risk Management Team continue to deliver the RM03 - Risk Management Training Plan for 2021/22 that commenced, in line with the plan in April. This training includes the management of risk in line with the Risk Management Strategy for managers and also practical training for developing, managing and reporting risks for risk handlers. Following the delivery of the training in April, feedback is being collated and will be used to influence further training from June 2021 onwards.

In addition to the above, the Corporate Risk Management Team also attend existing meetings and networks in place to deliver the training, for example: Junior Doctors meetings or Consultant's meetings.

A review of the current Corporate Risk Register Template presentation is underway and will be presented to the Risk Management Group on the 15th June 2021 for approval. This will see the inclusion of a new section to capture the specific progress from the previous presentation of the risk to the Committee from July 2021 onwards, similar to how this is captured within the Board Assurance Framework.

The current Tier 1 Corporate Risks are (full details of the risks and progress can be found in Appendix 1):

Risk Title	**Inherent risk rating**	**Current risk rating**	**Target risk rating**	**Movement***
CURRENT RISKS – Appendix 1				
CRR20-01 - Asbestos Management and Control	20	20	10	Unchanged
CRR20-02 - Contractor Management and Control	20	20	10	Unchanged
CRR20-03 – Legionella Management and Control	20	16	8	Decreased
CRR20-04 - Non-Compliance of Fire Safety Systems	20	20	8	Unchanged

CRR20-05 – Timely access to Care Homes	25	20	12	Unchanged
CRR20-06 – Informatics – Patient Records pan BCU	16	16	12	Unchanged
CRR20-07 - Informatics infrastructure capacity, resource and demand	20	16	12	Unchanged
CRR20-08 – Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	25	20	6	New Risk
CRR20-10 – GP Out of Hours IT System	De-escalated (please see below)			

*movement in the current risk score is measured from the last presentation to Board, and not necessarily reflective of the latest committee decisions.

Please note:

a) Following agreement at the QSE on the 2nd March 2021, the below risk was rejected for escalation and has been returned to the Executive Director of Nursing and Midwifery for review and management at the Tier 2 level:

   - **Risk ID3638 - Patient Care could be compromised due to no clinical lead for Diabetes Speciality**

b) Following agreement at the DIGC on the 26th March 2021, the below risk has been de-escalated and is now being actively managed by the Executive Director of Primary and Community Care at the Tier 2 level:

   - **CRR20-10 – GP Out of Hours IT System**.

During the Executive Team meeting on the 12th May 2021 and the 2nd June 2021, it was agreed to escalate the following operational risks onto the Corporate Tier 1 Risk Register and these are subject to formal approval from the QSE and DIGC in June 2021:

- **Risk Reference 1925 - Potential harm to patients arising from delays in patient IVT treatment**
- **Risk Reference 1875 – National Infrastructure and Products** (re-opened risk)
- **Risk Reference 3659 – Cyber Security**

Below is a heat map representation of the current corporate risk scores:

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5				CRR20-04	
	Likely - 4				CRR20-03 CRR20-06 CRR20-07	CRR20-01 CRR20-02 CRR20-08
	Possible - 3					CRR20-05
	Unlikely - 2					
	Rare - 1					

Asesiad / Assessment & Analysis

Strategy Implications
The implementation of the Risk Management Strategy and Policy aligns with the Health Board`s strategy to embed effective risk management in fostering its culture of safety, learning to prevent recurrence and continuous improvements in patient, quality and enhanced experience.

Options considered
Continuing with the Corporate Risk Register.

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
See the individual risks for details of the related risk implications.

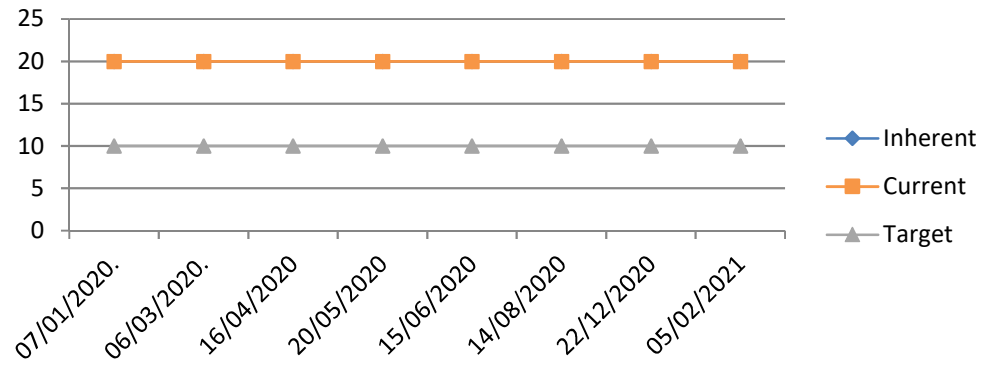
Legal and Compliance
There are no legal and compliance issues associated with the delivery of the Risk Management Strategy and Policy.

Impact Assessment
No specific or separate EqIA has been done for this report, as a full EqIA has been completed in relation to the Risk Management Strategy and Policy to which CRR reports are aligned.

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

Appendix 4 – QSE Corporate Risk Register Report

CRR20-01	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 5 February 2021
	Risk: Asbestos Management and Control	**Date of Committee Review:** 15 January 2021
		Target Risk Date: 31 March 2022
There is a significant risk that BCUHB is non-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, and may result 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
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level)*	5	2	10
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
1. Asbestos Policy in place (refer to further action 12242). 2. A number of surveys undertaken (refer to further action 12241). 3. Asbestos management plan in place. 4. Asbestos register available (refer to further action 12250). 5. Targeted surveys where capital work is planned or decommissioning work undertaken. 6. Training for operatives in Estates. 7. Air monitoring undertaken in premises where there is limited clarity on asbestos condition (refer to further action 15032).	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

Links to	
Strategic Priorities	**Principal Risks**

Effective use of our resources Safe, secure & healthy environment for our people	BAF20-15 BAF20-20

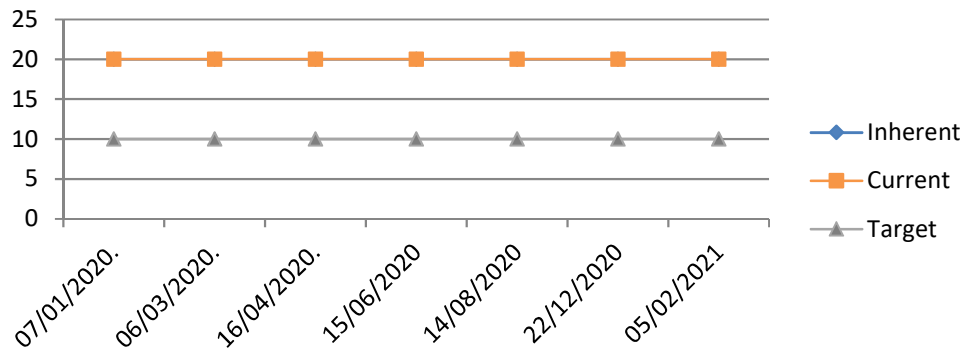
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12241	Undertaking a re-survey of 10-15 premises to determine if the original Asbestos surveys are valid. This is problematic as finances are not available for this work, increasing the risk of exposure to staff and contractors.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Re-survey of existing asbestos surveys, sample 10 – complete and assurance provided that surveys are robust. Resampling will be included with the updated management plan as an ongoing compliance work stream.	On Track
	12242	Update, review and implement the Asbestos Policy and Management Plan across the whole Health Board.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Partially completed - Updated Policy and Management Plan included on the agenda SOH&SG (02-02-2021). Policy partially implemented due to lack of complete asbestos registers on all sites.	On Track
	12243	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.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Asbestos Registers and data storage – current data hosted on Client Server, work has commenced to commission MICAD as a Health Board wide property management system. The system will include an asbestos management portal.	On Track

	12244	Ensure priority assessments are undertaken and highest risk escalated.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/2021 - Priority assessments and risk reviews – Actions complete and removal / management plan in place.	Complete
	12245	Evaluate how contractors are provided with information and instruction on asbestos within their work environment. Ensure work is monitored.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/2021 - Contractor management and control – actions complete with updated permit to work system and contractor control framework.	Complete
	12246	Ensure all asbestos surveys are available at all sites and there is a lead allocated for premises.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Asbestos surveys – all site have access to site-specific registers (hard copy). Following the roll out of the asbestos management modal within MICAD, all sites will have access to digital register.	On Track
	12247	Annual asbestos surveys to be tracked and monitor for actions providing positive assurance of actions taken to mitigate risks.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/2021 - Annual re-inspections – Asbestos Management Group providing oversight and governance with escalation to SOH&SG. Appointed Independent Asbestos Consultants.	Complete
	12248	Update intranet pages and raise awareness with staff who may be affected by asbestos.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Update Internet Pages and staff awareness – Intranet updated and working with Corporate Health and Safety on staff awareness.	On Track

	12249	QR Code identification to be provided on all areas of work with identified asbestos signage in non public areas.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	QR Codes to identify the location of asbestos – Updated asbestos management plan address identification.	On Track
	12250	Lack of completed asbestos registers on all sites picked up in H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/2021 - Corporate Health and Gap analysis – Action plan updated and progress against actions recorded and included within escalation report to SOH&SG.	Complete
	15032	Air Monitoring in all premises where there is limited clarity on asbestos condition.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Improve safety and ongoing compliance with the Regulations.	On Track

CRR20-02	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 5 February 2021
	Risk: Contractor Management and Control	**Date of Committee Review:** 15 January 2021
		Target Risk Date: 30 September 2022

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
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *select low, moderate or high level)*	5	2	10
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
1. Control of contractors procedure in place (refer to further action 12260). 2. Induction process being delivered to new contractors. 3. Permit to work paper systems in place across the Health Board.	1.Health and Safety Leads Group. 2.Strategic Occupational Health and Safety Group. 3.Quality, Safety and Experience Committee.

Links to	
Strategic Priorities	**Principal Risks**
Safe, secure & healthy environment for our people	BAF20-15

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12251	Identify current guidance documents and ensure they are fit for purpose.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021	The Control of Contractors Guidance Document is currently being reviewed and updated.	On Track
	12252	Identify service Lead on each site to take responsibility for Contractors and H&S Management within H&S Policy).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	On Track
	12253	Draft and implement a Control of Contractors Policy that all adhere to including IT and other services who work on BCUHB premises.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021	The Control of Contractors Policy Document is currently being drafted.	On Track
	12254	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	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance for contractor's appointment criteria. The process and	On Track

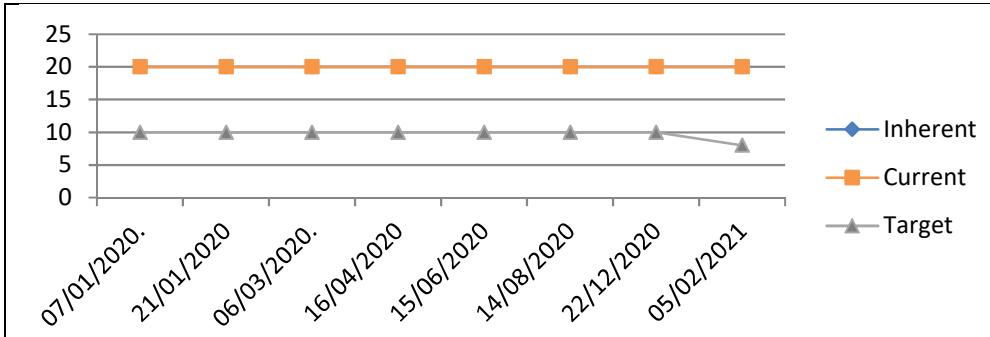
		externally checked prior to coming top site.			system will be a Health Board wide management system.	
	12255	Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc. Is the current system fit for purpose and robust?	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.	On Track
	12256	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.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.	On Track
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor	On Track

					management across the Health Board.	
	12258	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.).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	On Track
	12259	Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A Permit to Work system will be adopted as part of implementation of SHE software.	On Track
	12260	Standardise the implementation of contractor management procedure picked up in H&S Gap Analysis Action Plan across the Health Board.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas	On Track

					outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	
	12552	Develop a process so that the Induction process is completed by all current contractors and new ones as they are appointed.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for addition staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	On Track
	12553	Evaluation of standing orders and assessment under Construction Design and Management Regulations.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021	The Control of Contractors Guidance Document is currently being reviewed and updated.	On Track

CRR20-03	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 5 February 2021
	Risk: Legionella Management and Control.	**Date of Committee Review:** 15 January 2021
		Target Risk Date: 30 September 2022

There is a significant risk that 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 to death, ill health conditions in those who are particularly susceptible to such risks, and a breach of relevant Health & Safety Legislation.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite – *low level)*	4	2	8
Movement in Current Risk Rating Since last presented to the Board in January 2021	Decreased		

Controls in place	**Assurances**
1. Legionella and Water Safety Policy in place (refer to further action 12270). 2. Risk assessment undertaken by clear water. 3. High risk engineering work completed in line with clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonis. 6. Authorising Engineer water safety in place who provides annual report. 7. Annual Review of the H&S Self Assessments undertaken by the Corporate H&S Team.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Experience Committee.

Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources Safe, secure & healthy environment for our people	BAF20-15 BAF20-20

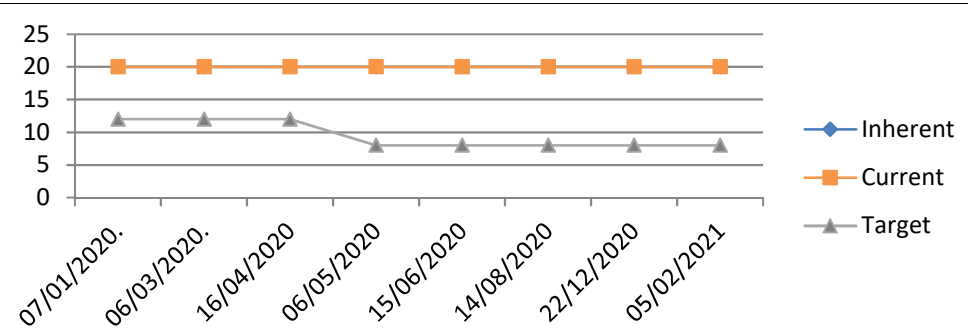
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12262	Ensure that engineering schematics are in place for all departments and kept up to date under Estates control. Implement MiCAD/database system to ensure all schematics are up to date and deadlegs easily identified.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	MiCAD (IT) system being rolled out on a phased basis and work has commenced on polylining site drawings (digital site drawings) for migration to MiCAD. Schematic drawings for all sites for water safety being reviewed as part of the new Water Safety Maintenance Contract, which has been approved by the Health Board in January 2021.	On Track
	12263	Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	All water outlets within managed departments have outlets run as part of the cleaning schedule undertaken by domestic services. Deadlegs are removed on identification and assessment of risk.	On Track
	12264	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.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A policy for the Management of Safe Water Systems in place to ensure water safety compliance. A programme of flushing of little use outlets in place for un-occupied areas and recorded by Operational Estates for each site.	On Track
	12265	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).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Pseudomonas and Legionella sample testing carried out within augmented care areas, exception reports are presented at the Water Safety Group in an excel format. All	On Track

					water testing across BCUHB is undertaken by Operational Estates through Public Health Wales.	
	12266	Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Escalation and notification process is contained within Policy for the Management of Safe Water Systems (Appendix B).	On Track
	12267	Awareness and training programme in place to ensure all staff aware. Departmental Induction Checklist.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A training and development structure for Operational Estates is being reviewed as part of new Water Safety Contract, which has just been approved by the Health Board.	On Track
	12268	BCUHB Policy and Procedure in place and ratified, along with any department-level templates for SOPs and check sheets.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A policy for water safety management is currently in place – A consultant has been appointed to review current procedural documents for each area with the objective to develop one policy document.	On Track
	12269	Clinical and Microbiology support required to ensure that the assurance provided by the Water Safety Group that the Policy is being effectively implemented across all sites.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	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. The Water Safety Groups reports issues of significance and assurance to the Infection Prevention Sub-Group (IPSG) and Strategic Occupational Health and Safety Group (SOH&SG).	On Track

	12270	Improve consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Independent Consultant appointed to review the current procedural documents for each area with the objective to develop one policy document.	On Track

CRR20-04	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 5 February 2021
	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 15 January 2021
		Target Risk Date: 30 September 2022

There is a risk that the Health Board 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 and lack of relevant operational Risks Assessments. This may lead to a major Fire, breach in Legislation and ultimately prosecution against BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score (Risk Appetite – *low level)*	4	2	8
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
1. Fire risk assessments in place (refer to further action 15036). 2. Evacuation routes Identified and evaluation drills established and implemented. 3. Fire Safety Policy established and implemented. 4. Fire Engineer regularly monitor Fire Safety Systems. 5. Fire Safety Mandatory Training and Awareness session regularly delivered to BCUH Staff. 6. Fire Warden Mandatory Training established and being delivered to Nominated Fire Warden.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

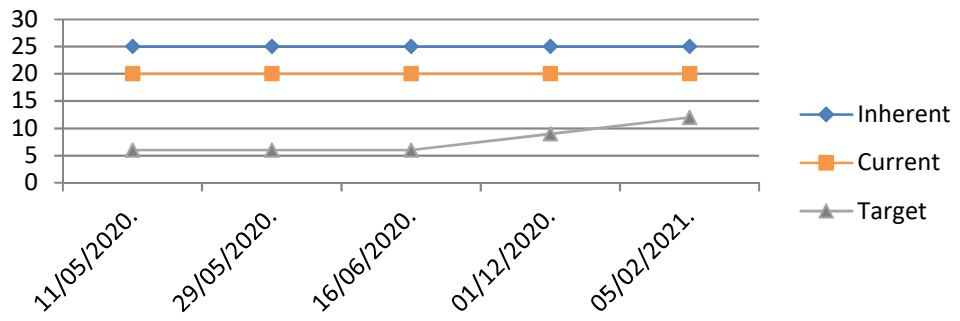
Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources Safe, secure & healthy environment for our people	BAF20-15 BAF20-20

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12273	Review Internal Audit Fire findings and ensure all actions are taken.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Governance actions completed and operational elements are captured within the gap analysis areas below.	On Track
	12274	Identify how actions identified in the site FRA are escalated to senior staff and effectively implemented.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Complete with escalation through Hospital Management Teams, Area Terms and MH&LD management teams with site responsible persons.	On Track
	12275	Identify how site specific fire information and training is conducted and recorded.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Database located within the fire safety files, managed and updated by the fire safety trainer.	On Track
	12276	Consider how bariatric evacuation training is undertaken and define current plans for evacuation and how this is achieved.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Work in progress. To be included in site specific manual and training developed with Manual Handling team.	On Track
	12279	AlbaMat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Albac mat training is undertaken as part of the induction programme for clinical staff and as part of the refresher-training programme delivered by the Manual Handling team.	On Track

	12554	Commission independent shared services audits.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Independent, Shared Services (Specialist Estates Services) audits commissioned on an annual basis to ensure the appropriate fire safety measures, process and procedures are in place within Acute and Community hospital sites.	On Track
	12555	Information from unwanted fire alarms and actual fires to be collated and reviewed as part of the fire risk assessment process.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Unwanted Fire signals (Uwfs) and fire safety data collated within an All-Wales management system and annual report collated and published. Details shared with the SOH&SG and escalated to QSE as necessary. Information reviewed as part of the annual Fire Risk Assessment process and appropriate action taken.	On Track
	15036	Ensure Fire Risk Assessments in place for all service areas across the Health Board.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Improve safety and compliance with the Order.	On Track

CRR20-05	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 11 May 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 5 February 2021
	Risk: Timely access to care homes	**Date of Committee Review:** 15th January 2021
		Target Risk Date: 30 June 2021

There is a risk that there will be a delay in residents accessing placements in care homes and other communal facilities. This is caused by the need to protect these vulnerable communities from the transmission of the virus during the pandemic. This could lead to individual harm, debilitation and delay in hospital discharges impacting on wider capacity and patient flow.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level)*	4	3	12
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
1. Multi-agency care home cell established as part of the emergency planning arrangements. 2. PPE distribution system operational including identification and support for residents with aerosol generating procedures. 3. Testing for residents and staff in place aligned with national guidance. 4. Unified "One contact a day" data gathering from care homes established with 6 Local Authorities. 5. Systems for Access to specialist advice via Public Health Wales and the Environmental Health Teams in place to manage isolation and outbreaks. 6. Personalised care and support plans promoted led by specialist palliative care team. 7. New arrangements in place for the timely provision of pharmacy and medication support at the end of life. 8. Remote consulting offered by general practice. 9. Home first bureaus established by the 3 area teams to facilitate sensitive and collaborative decision making on hospital discharge, transfer between care homes and admissions from home. 10. Regular formal communication channels with care homes at a local level and across BCU.	1. Oversight via the Care Home Cell which includes representatives from Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). 2. Oversight via Gold and Silver Strategic Emergency Planning. 3. Oversight as part of the Local Resilience Forum via SCG.

Links to	
Strategic Priorities	**Principal Risks**
Continuing to provide care under 'essential' services & safe stepping up planned care	BAF20-04

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14936	Establish separate discharge cell to ensure system wide leadership and action to implement the revised step up step down hospital discharge requirements.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14937	Develop a BCU wide approach to primary care support and intervention, including GPOOH.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will improve communication and support direct admission to care homes.	On Track
	14938	Develop electronic daily reporting metrics that are robust and analysed at an organisational level.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14939	Complete and implement a North Wales care home escalation and support tool that complements national work programmes.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track

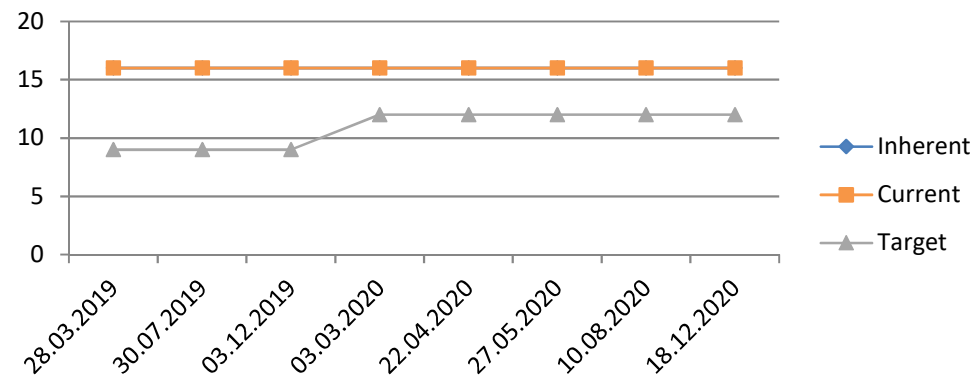
	14940	Ensure that all new national guidance on testing for care home staff and residents is widely communicated and implemented.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Ongoing weekly reviews will ensure that regular guidance is shared and implemented to reduce the risk likelihood of the risk re-occurring.	On Track
	14941	Embed the new ways of working in all home first bureau.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14942	Develop communication with care homes at a local level and across North Wales.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14943	Work with Welsh Government and Health Boards across Wales to deliver a revised financial support package for care homes.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This action support access to care homes.	On Track
	14944	Adopt care home DES for primary care.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	On Track
	14945	Increase the frequency for multiagency care home cell to weekly to support issues management.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will improve communication and support direct admission to care homes.	On Track

	14946	Update the 2020 care home monitoring levels and escalation framework.	Kathryn Titchen, Commissioning Manager CHC	30/04/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	On Track
	14947	Development of proactive risk triggers to support quality monitoring with a primary focus on infection prevent and control issues once an outbreak/ a single case declared and identifying at risk homes for proactive intervention coordinated across Health and social care limited resources.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	On Track
	14948	Diversion of CHC priorities from routine reviews to crisis care home support maintaining D2RA and crisis step up assessments facilitating flow.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14949	Development of resources support capacity and demand for care homes and enclosed settings to support prioritisation of support.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14951	Increase MDT Care Home group to weekly for issue resolution for period of enhanced second covid wave pressures.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14952	Implementation of reactive support to in crisis care homes and application of learning of covid issues to support HB working with LA's to have a proactive early identification of IPC at risk issues	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	On Track

		to reduce the risk of wider spread care home infection outbreak.				
	14954	Working with developing national guidance to support proactive, supportive development of provider resilience through provider business continuity prompt, challenge and support.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	On Track

CRR20-06	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 28 March 2019
	Assuring Committee: Digital and Information Governance Committee	**Date Last Reviewed:** 21 December 2020
	Risk: Informatics - Patient Records pan BCU	**Date of Committee Review:** 19 June 2020
		Target Risk Date: 30 September 2024

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
Inherent Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite – low level)	3	3	12
Movement in Current Risk Rating Since last presented to the Board in January 2021	*unchanged*		

Controls in place	**Assurances**
1. Corporate and Health Records Management policies and procedures are in place pan-BCUHB. 2. iFIT RFID casenote tracking software and asset register in place to govern the management and movement of patient records. 3. Escalation via appropriate committee reporting. 4. Key performance indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group).	1.Chairs reports from Patient Record Group. 2.ICO Audit. 3.HASCAS Audit.

Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources	BAF20-18 BAF20-28

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status

Actions being implemented to achieve target risk score	12422	Enable actions to meet the regulatory recommendations from the ICO, HASCAS/Ockenden and Internal Audit reports.	Mrs Danielle Edwards, Head of Digital Records	31/03/2021	21.12.20 (DE) - UPDATE Dec 2020 - many of the recommendations are being addressed either via the 'ATHR Project' or the 'Baseline of Standards Project'. A full gap analysis will be undertaken in Q4 to catch any recommendations not already covered.	On Track
	12423	Development of a local Digital Health Records system	Mrs Danielle Edwards, Head of Digital Records	30/09/2024	21.12.20 (DE) - UPDATE Dec 2020 - Following approval from the Health Board in July and subsequently approval to award contract from the WG following the Ministerial Brief in September, the contract has now been awarded to Civica for their Cito product. The Project Board is established with the Executive Medical Director as SRO, along with a Clinical Task & Finish Sub Group - both of which have met and are engaged in Phase 0 - Pre-Project Start (planning). Outline Project Plan anticipated for the January Project Board meeting.	On Track
	12424	Improve the assurance of Results Management	Mrs Danielle Edwards, Head of Digital Records	30/09/2021	21.12.2020 (DE) - UPDATE Dec 2020 - Main updates: (WS1) - WCP 3.11.3 is due to be available for user UAT in January which will support the ability to sign of results electronically. Email baseline audit is returning information	On Track

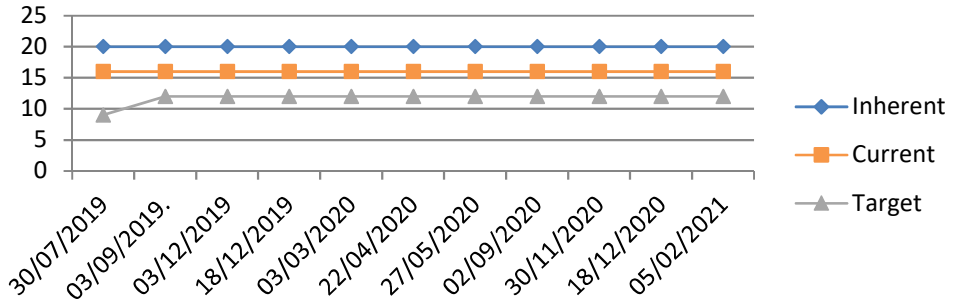
					pan-BCU on current processes used across Departments. SBAR being prepared due to inability to secure resources corporately to fully baseline and prepare the organisation for a full roll out. Overall WS1 remains on track for September 2021 but with resource risks. (WS4) - It has been agreed that BCU will remain on 3 instances of Radis which means the upgrade can now progress.	
	12425	Digitise the clinic letters for outpatients	Mrs Danielle Edwards, Head of Digital Records	30/04/2021	21.12.20 (DE) - UPDATE Dec 2020 - This project is now commencing in line with expectations, with roll out underway in West. Engagement sessions have been held and were well received; integration to PiMs held some challenges but is due to complete by end December; roll out to Cancer Services planned for w/c 11/01, followed by a sustained and ambitious roll out across all Service aiming for completion by the end of February.	On Track
	12426	Digitise nursing documentation through engaging in the WNCR	Mrs Danielle Edwards, Head of Digital Records	31/01/2021	15/02/21 - The Nursing Lead working on the Business Case is still being repurposed to support IPC Covid Response; work has commenced with	Delay

					progress made on case when available.	
	12428	Baseline the; storage, processes, management arrangements and standards compliance	Mrs Danielle Edwards, Head of Digital Records	31/03/2021	21.12.20 (DE) - UPDATE Dec 2020 - This project is now well underway under the lead of the Deputy Head of Patient Records & Digital Integration Department. There are currently 12 tasks to be completed within the Project, with good progress made in the 1st reporting period. Progress is being reported into the Patient Records Group (via a highlight report) then up to the Information Governance Group (via the Chair's Assurance Report), and to the DIGC as part of the overall summary progress from Informatics.	On Track
	12429	Engage with the Estates Rationalisation Programme to secure the future of 'fit for purpose' file libraries for legacy paper records.	Mrs Danielle Edwards, Head of Digital Records	30/04/2021	21.12.20 (DE) - UPDATE Dec 2020 - Meeting with SRO and planning lead was held this month with outcome that, due to the delay in the Mental Health scheme and the pressures of Covid within all Departments, work to evaluate the Ablett for Health Records use will hold until April. The Health Records Site Manager reported that risks associate with the portacabin Library are	On Track

					being managed and the delay is within tolerance.	

CRR20-07	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 28 March 2019
	Assuring Committee: Digital and Information Governance Committee	**Date Last Reviewed:** 05 February 2021
	Risk: Informatics infrastructure capacity, resource and demand	**Date of Committee Review:** 19 June 2020
		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
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite – moderate level)	4	3	12
Movement in Current Risk Rating Since last presented to the Board in January 2021	*unchanged*		

Controls in place	**Assurances**
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. 2. Integrated planning process and agreed timescales with BCU and third party suppliers. 3. Key performance metrics to monitor service delivery and increasing demand. 4. Risk based approach to decision making e.g. Local hosting v's National hosting for WPAS etc. 5. National Infrastructure Review (Independent Welsh Government Review undertaken by Channel 13).	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).

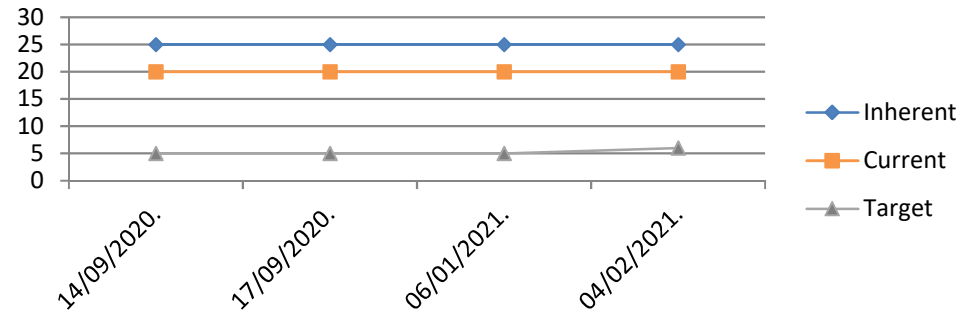
Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources	BAF20-18 BAF20-20 BAF20-28

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12378	Develop associated business cases and secure funding for resource required based upon risks and opportunities e.g. Digital Health Record.	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	31/01/2021	5/2/21 - action closed and more detailed BC actions have and will be added	Closed
	12379	Review workforce plans and establish future proof informatics/digital capability and capacity.	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	30/09/2021	29/10/20 (AW) - Informatics will be developing a Workforce Planning Strategy that will take into account the services capability and capacity.	On Track
	12380	Review governance arrangements e.g. DTG whose remit includes review of resource conflicts has not been replaced (April 2020).	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	30/06/2021	04/02/2021 - This needs to be undertaken once the Digital Strategy has been approved. April 21.	On Track
	13182	To develop a Digital Strategy	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	31/03/2021	This high level digital strategy will set the strategic direction and support the prioritisation of work which will support and make the case for capacity and resources. It will also influence the governance and mapping to clinical services requirements.	On Track

CRR20-08	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 14 September 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 4 February 2021
	Risk: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	**Date of Committee Review:** New Risk for Escalation
		Target Risk Date: 28 February 2022

There is a risk that patients may come to harm of permanent vision loss. This may be caused by reduced capacity resulting from Covid-19 and increase in waiting times for clinic review as clinics have been cancelled.

This may negatively impact on patients negatively through untreated proliferative diabetic retinopathy, untreated glaucoma, untreated age related macular degeneration prolonged suffering and may result in falls from impaired vision due to cataract secondary to prolonged surgical l capacity during the pandemic. This could negatively also impact on patient safety and experience, the quality of care, finance through claims, and the reputation of the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level)*	3	2	6
Movement in Current Risk Rating Since last presented to the Board in January 2021	*unchanged*		

Controls in place	**Assurances**
1. Proliferative diabetic retinopathy – Pan BCUHB pathway about to be implemented to get optometry review of the backlog. 2. Reviewing list of patients affected to get fast-track or book those who may deteriorate to clinics. 3. Cataract - All cataracts have been stratified in order of visual impairment in order to deal with the most clinically pressing cases first. A plan is in progress to share patients across all three units in North Wales to ensure equity of access. 4. Increase capacity in existing clinics.	Risk is regularly reviewed at local Quality and Safety meetings.

Links to	
Strategic Priorities	**Principal Risks**
Continuing to provide care under 'essential' services & safe stepping up planned care	BAF20-03 BAF20-05

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14907	Age related macular degeneration – A business case (central area only) is awaiting approval to increase staffing and treatment capacity.	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	This action will enable the service to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise.	On track
	14908	A second business case (Pan BCUHB) has been submitted for a retinal camera to enable virtual clinic working and increase capacity.	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	This action will enable the service to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise.	On track

Cyfarfod a dyddiad: **Meeting and date:**	Audit Committee 10 June 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Board Assurance Framework (BAF)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Louise Brereton, Board Secretary
Awdur yr Adroddiad **Report Author:**	Dawn Sharp, Assistant Director: Deputy Board Secretary
Craffu blaenorol: **Prior Scrutiny:**	Executive Team meeting on 2 June 2021
Atodiadau **Appendices:**	Appendix 1 – BAF Report Appendix 2 – Re-mapping of BAF risks to revised Annual Plan 2021-22 Appendix 3 - Key field guidance/definition of assurance levels

Argymhelliad / Recommendation:

That the Committee:-

(1) note the progress on the Principal Risks as set out in the Board Assurance Framework (BAF); and
(2) note the remapping of BAF risks to the revised Annual Plan 2021-22

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**		**Ar gyfer Trafodaeth** **For Discussion**	✓	**Ar gyfer sicrwydd** **For Assurance**		**Er gwybodaeth** **For Information**	

Y/N to indicate whether the Equality/SED duty is applicable

N

Sefyllfa / Situation:

The revised Risk Management Strategy and Policy was implemented on the 1st October 2020, and on the 21st January 2021, the Board approved the implementation of the revised Board Assurance Framework (BAF) template reporting arrangements.

This new design captures the work undertaken by the Board on the identification of its Priority Areas to support the effective management of the agreed Principal Risks that could affect the achievement of its agreed Priorities. This has led to streamlining and re-design of the Corporate Risk Register (CRR), which more effectively demonstrates how the Health Board is robustly mitigating and managing high rated risks to the achievement of its operational objectives.

Each BAF risk has since been reviewed and updated.

Appendix 1 highlights the Board Assurance Framework Risks. Members are reminded that this is a live document with reviews taking place with relevant leads on an ongoing basis. The data included within this cut of the BAF includes updates up to and including 28 May 2021.

Appendix 2 Re-mapping of BAF risks to revised Annual Plan 2021-22

Appendix 3 Key field guidance/definition of assurance levels.

Cefndir / Background:

The design of both the new BAF and CRR emphasises their distinctive roles in underpinning the effective management of both strategic and operational risks respectively, as well as underlining their symbiotic relationship as both mechanisms have been designed to inform and feed-off each other. This includes the evaluation, monitoring and review of progress, accountability and oversight of the Principal Risks and also the high level operational risks which could affect the achievement of the Health Board's agreed Priorities. These are being monitored by regular review with respective leads and oversight by the Risk Management Group and Executive Team.

Board Assurance Framework

Oversight and co-ordination of the BAF has transferred to the Office of the Board Secretary from the Corporate Risk Management Team, with the risk management system and process continuing to be managed by the Corporate Risk Team.

It is worth emphasising that ownership of the BAF rests with the Board with individual Executives being responsible for the management of their respective risks, not the Board Secretary. Engagement with risk leads continues to progress well and work continues to refine and further develop the BAF to ensure it becomes a tool to ensure strategic risks are visible to the Board and Committees.

The Board has updated its strategic priorities as set out within the 2021-22 Annual Plan. Due to the revised strategic priorities, some principal risks do not lend themselves to direct mapping, and have subsequently been mapped to an 'enabler'. The remapped BAF risks were shared with Members of the Audit Committee at a workshop held on 25th May.

The BAF is a 'live' document which continues to evolve, and has progressed with the engagement and support of the full Board. This serves well going forward as the Health Board progresses and refreshes *'Byw'n iach, Aros yn iach/Living Healthier, Staying Well'* and all underpinning strategies. With this refresh there will need to be greater focus and consideration of strategic risks in the BAF as the Health Board looks to the future in delivering its strategies. A revision of the BAF will then need to take place to link to the strategic objectives as defined in the refreshed strategy with any operational BAF risks being managed as part of the Corporate Risk Register going forward. Consideration is being given to the potential input/engagement from the Good Governance Institute.

It is important that the Risk Management Group becomes the main driver to review the risks and ensure moderation in terms of scoring and proportionality of the risks, and being able to facilitate deep dives. With this in mind a re-alignment of reporting cycles is underway.

Key progress on the BAF risks is reflected within the relevant BAF risk sheet attached.

Asesiad / Assessment & Analysis

Strategy Implications
The implementation of the Board Assurance Framework and the revised Risk Management Strategy and Policy aligns with the Health Board`s strategy to embed effective risk management in fostering its culture of safety, learning to prevent recurrence and continuous improvements in patient, quality and enhanced experience.

Options considered
Not applicable.

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.

Due to the improved and increased reporting frequency arrangements, the management of the BAF is resource intensive and so additional resources may be required.

Risk Analysis
See the individual risks for details of the related risk implications.

Legal and Compliance
There are no legal and compliance issues associated with the delivery of the Board Assurance Framework or the Risk Management Strategy and Policy.

Impact Assessment
No specific or separate EqIA has been done for this report, as a full EqIA has been completed in relation to the new Risk Management Strategy and Policy to which the BAF and CRR reports are aligned.
Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

Board Assurance Framework 2020/21

Strategic Priority 1: Safe Unscheduled Care

Risk Reference: BAF20-01		Risk Rating	Impact		Likelihood		Score		Appetite	
Surge Plan / Winter Plan										
There is a risk that the Health Board may not be able to deliver the winter plan due to the appropriate availability of capacity and capability of its resources and external collaboration. This could negatively impact on the quality of planned patient care services and the reputation of the organisation.		Inherent Risk	5		5		25		Low 1 - 6	
		Current Risk	4	↔	3	↓	12	↓		
		Target Risk	4		3		12			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
BCUHB Winter Resilience plan approved by Board underpinned by Local Health Community plans which includes acute surge plans for increased capacity.	2	Programme of check and challenge meetings in completed to review and prioritise winter schemes including prioritisation of the workforce elements. Schemes prioritised based on most impact, most achievable. Schemes closely linked to agreed funding streams are in progress.	2	Identify improvement and project support for delivery of some of the schemes. Improvement trajectories developed and incorporated into the Winter/Q3/4 plan. Identify recruitment requirements and related workforce processes - Workforce requirements identified as part of the check and challenge process. Some posts have been recruited to in order to progress, however process of recruitment still remains outstanding due to the funding structures of the posts i.e. non recurring and short period of a maximum 6 months which is proving to be difficult to attract staff. Fully implement across NWales the following to require maximising impact Same Day Emergency Care (SDEC) - currently in place in YG and YGC but further work required in East. SDEC is part of USC continuous improvement programme. D2R&A - in progress; Phone First - 111 - on track to implement by June 2021 Primary Care Urgent Treatment Centres.Implemented in East and Centre - ongoing work in West.	Complete Complete Complete 30 September 2021 30 June 2021 30 June 2021
Established surge plans in place to manage Covid-19 demand which are regularly reported to Finance and Performance (F&P) Committee.	2	i) Intelligence cells in place, regularly tracking against Swansea University modelling work and now reporting into the Executive Incident Management Team (EIMT) and reviewed weekly. ii) Ysbyty Enfys Deeside opened (4/11) to accept up to 30 recovering Covid positive patients. on 9.1.21 admission criteria reviewed and amended along with increased capacity to 45 patients in response to the projected demand identified through the modelling. Amendments approved by EMIT, CAG.	2	Finalisation of nursing workforce capacity to staff the current model (up to 30 patients) and any expansion of future model at Ysbyty Enfys Deeside. Ysbyty Enfys in patient factility now closed. Post implementation review of the suitability of the acute to community pathways is underway, including staffing model and patient cohort to ensure fit for purpose.	Completed 30 June 2021
Critical Care Surge plans in place and enacted, monitored through the BCUHB Critical Care Group, reported to EIMT, and the National Critical Care Network.	3	Surge plans for each site with an overarching total BCUHB capacity, transfer pathway established which safely allows patients to be transferred across the Health Board to the best possible capacity where a site becomes overwhelmed. BCUHB continue to link into the National Transfer and Mutual Aid Arrangements, coordinated by the National Critical Care Network. Commissioned a dedicated critical care transfer vehhicle from WAST to support the timely transfer of patients when required	3		

Review comments since last report: It is recommended that this risk be archived as it was in relation to the winter plan which has now been delivered. Continuous improvement actions linked to the unscheduled care improvement plan (e.g. SDEC and community pathways) have been transferred to BAF Risk 20-02 - Emergency Care Review Recommendations, which is to be retitled Safe and Effective Management of Unscheduled Care as proposed by the Risk Management Group.

Executive Lead:	**Board / Committee:**	**Review Date:**
Mark Wilkinson, Executive Director of Planning and Performance	Finance and Performance Committee	**7 April 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 1: Safe Unscheduled Care

Risk Reference: BAF20-02		Risk Rating	Impact		Likelihood		Score		Appetite
Safe and Effective Management of Unscheduled Care (formerly titled Emergency Care Review Recommendations)									
There is a risk that the Health Board may not be able to deliver safe and effective care due to being unable to commit support processes. This could negatively impact on the quality of patient care provided.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	4	↔	4	↓	16	↓	
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Unscheduled Care Improvement Group in place to oversee the improvement programme of work and monitor performance which provides regular reports to the Finance & Performance.	2	1) Ysbyty Glan Clwyd (YGC) improvement plans in place and approved by Executive Team for ambulance handover and flow including EDQDF. 2) Emergency Department (ED) dashboard established which monitors performance. 3) Established Tactical Control Centres in place. 4) Standardised SITREP / escalation reports submitted 3 x day. 5) Primary Care Urgent Treatment (PCUT) Centre established in East	2	1) Roll out of YGC improvement plan to other sites as appropriate. National support agreed. 2) Identify improvement and project support for delivery of the objectives. 3) In line with Welsh Government (WG) directive, implement Phone First programme that will ensure patients are seen by the right person, in the right place, first time. 4) In line with the agreed standards implement a uniform model for patient access to and from EDs. 5)Fully implement across NWales the following to require maximising impact Same Day Emergency Care (SDEC) - currently in place in YG and YGC but further work required in East. SDEC is part of USC continuous improvement programme. 6) D2R&A (discharge to rehabilitate and assess) - in progress; 7)111 - on track to implement by June 2021 and PCUT to be established in Centre and West.	30 June 2021 30 June 2021 30 June 2021 30 June 2021 30 September 2021 31 December 2021 30 June 2021
Annual Plan in place and agreed by the Board, with monthly monitoring and review through the Unscheduled Care (USC) Improvement Group.	2	Monthly USC Improvement Group meetings Chaired by the Chief Operating Officer.	1	1) USC scoping review to be undertaken to develop strategic blueprint solution for unscheduled care. 2) Implement recommendations of Kendal Bluck Emergency Department workforce review related to unscheduled care.	Complete 30 April 2021
Interim COO / Interim Director of USC overseeing the Annual plan in respect of USC and variance to the plan with regular reporting to the Finance and Performance Committee.	2	Bi-monthly report to Finance & Performance Committee to provide assurance on unscheduled care strategic developments.	2	Establish permanent substantive posts currently covered on an interim basis, providing continuity and sustained leadership for unscheduled care.	30 June 2021

Review comments since last report: Key controls, gaps and mitigations updated to reflect the current position and agreement of annual plan. Elements of outstanding action from BAF risk 20-01 regarding the Winter Plan now incorporated above. Risk title also amended to Safe and Effective Management of Unscheduled Care as proposed by the Risk Management Group. Current risk score reduced to reflect progress against the USC plans. Actions reviewed in terms of which would have the most material impact on the risk - it is considered that it is the collective impact of the actions that will mitigate the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	**7 April 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 2: Essential Services and Planned Care

Risk Reference: BAF20-03		Risk Rating	Impact		Likelihood		Score		Appetite
Sustainable Key Health Services									
There is a risk that the Health Board may not be able to deliver sustainable key population health services to the wider population of North Wales due to demand exceeding capacity.		Inherent Risk	5	↑	4	↔	20	↑	**Low 1 - 6**
		Current Risk	5	↑	3	↔	15	↑	
		Target Risk	5	↑	2	↔	10	↑	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Health Improvement & Reducing Inequalities Group (HIRIG) provide strategic direction and monitors delivery of the Population Health Services. HIRIG reports to Executive Team.	2	Health Board commitment to establishing priority services including: Programme management and recruitment to posts.	2	1) Fully integrated the Smoking Cessation service. 2) Implement a Tier 3 Childrens Obesity service. 3) Implement a Healthy Weight pathway T1-3. 4) Implement and delivery the Immunisation Strategy. 5) Implement and deliver the Infant feeding strategy. 6) Implement and deliver a suite of Building a Healthier North Wales projects.	30 June 2021 31 August 2021 31 March 2022 31 March 2023 31 March 2023 31 December 2022
Strategy, Partnership and Population Health Committee have oversight via standard reports by exception on progress.	2	Contribution to national delivery programmes and the Public Health Outcomes Framework with monitoring of key indicators in place.	2	Embed BCUHB North Wales population health priorities within its operational and strategic plans.	1 April 2022
Welsh Government have oversight of Smoking Cessation, Building a Healthier Wales, Infant Feeding, Healthy Weight Healthy Wales, Immunisation programmes and provide an element of funding.	3	HIRIG provide reports nationally regarding expenditure and performance.	3	Standardised reporting and meet submission requirements once national reporting requirements determined.	30 September 2021
The Executive Director of Public Health provides consistency to the regional strategic approach for North Wales in the form of expertise and prioritisation and through leadership of the Local Public Health Team.	2	Regional evidence based priorities are developed to meet the needs of the population in North Wales and deliver the greatest impact.	3	1) Embed Public Health Outcomes approach into local planning through Local partners and Health Board. 2) The Recovery Co-ordination Group (RCG) is focussing on Public Health actions as part of the recovery plan for North Wales.	31 March 2022 31 March 2022

Review comments since last report: The risk description has been modified to remove the words 'diminishing capacity' and to reflect the current status on demand levels. The scoring - including inherent, current and target risk scores have been revised to reflect the significant impact on health effects. Actions reviewed, all dates still appropriate. Additional action added in respect of the recovery focus across North Wales and the establishment of the Recovery Co-ordination Group. Action in relation to embedding Public Health Outcomes - wording amended to reflect approach rather than Framework. Population Health is dependent of system wide commitment and actions and therefore the action in realtion to embeding Public Health Outcomes and the approach will have the most material impact on the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Executive Director of Public Health	Strategy, Partnership and Population Health Committee	**17 May 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 2: Essential Services and Planned Care

Risk Reference: BAF20-04		Risk Rating	Impact		Likelihood		Score		Appetite
Primary Care Sustainable Health Services									
There is a risk that the Health Board will be unable to ensure timely access to Primary Care (GMS) Services for the population due to growing demand and complexity, an ageing workforce and a shift of more services out of hospital. As a gateway to health care, this could result in an deterioration in the population health, impacting on other health & care services and the wellbeing of the primary care workforce.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Each Area Team reviews GP practice sustainability and provides bespoke support to individual practices.	1	Regular review of 5 domains matrix. Escalation tool implemented and monitored by the Primary Care Panel, chaired by the Executive Director of Primary and Community Care, with reports provided to Quality, Safety and Experience Committee.	2	Delivery of Quality Assurance Visiting Programme across all contractors, in-depth review/visits which will be supportive for practices where concerns are identified.	31 March 2023
Delivery of All Wales Primary Care Model in place (including innovation and new ways of working), which is monitored by the Strategic Programme for Primary Care.	3	1)Review of current workforce profiles. 2)Delivery of milestones set by the national strategic programme. Contribution and leadership in the national priorities. 3)Increase in the number of GP Trainees in north Wales. (WG Statement in December 2020 stated that GP places would remain at current levels with the ability to over recruit if needed).	2	1) Primary Care Strategy for north wales embedded in the clinical strategy of BCUHB. 2) Further development of primary care workforce plans, with a further consideration of the impact of the pandemic on assumed GP retirements.	31 March 2022 30 July 2021
Provision of alternative services to increase capacity in GP practices in place.	1	Development of Urgent Primary Care Centre (UPCCs) pathfinders. Delivery of digital solutions (accelerated in response to C-19) Commissioning of community pharmacy enhanced services.	1	Full roll out of UPCCs (subject to national evaluation & pathways) (presentation made to Welsh Government on 19 May 2021 to secure ongoing funding for the pathfinders).	31 March 2022
Primary & Community Care Academy (PACCA) in place with further development and roll out planned.	2	Academy work plan 2019/22 in place, monitored by the Strategic Leadership Group for the Academy and as part of the performance monitoring of the Health Board's Operational Plan which feeds through to the Strategy, Partnership and Population Health Committee.	2	1) Increase in Academy outputs to have a greater impact on primary care workforce modernisation & capacity. Business case to be presented for consideration. 2) Strengthen coordination and implementation of work placements for training, mentorship and formal internship.	30 September 2021 31 March 2022
The Health Board has committed to work in partnership to develop proposal for a Medical School at the Univeristy of Bangor	1	Review progress in the development of a Medical School with Bangor University with the first commitment being delivery of medical degrees in partnership with Cardiff University (see below).	1	1) Development of a business case	31 July 2021
Delivery of Medical Degrees at Bangor University in partnership with Cardiff University	1	Cardiff University in partnership with Bangor University have 21 students undertaking their medical degree in north Wales. Students spend 12 months in Primary Care as part of their 4 year course	1	1) Ensure sufficient capacity with Primary Care for medical students	01 September 2021
The Health Board continues to work in partnership with local HE providers to secure funding for and delivery of courses and programmes of education to attract and retain the workforce in north Wales	1	The development of the North Wales Dental Academy in partnership with HEIW, WG and Bangor University will provide an essential resource and training environment for the dental practitioners include Dental Hygienists and Dentists.	1	1) Establish Dental Training Unit in Bangor (currently being advertised)	01 April 2022
Cluster working/Health & Social care Localities in place with further development planned, with oversight by Area Teams, Regional Partnership Board Leadership Group and Integrated Care Boards (partnerships).	2	GP clusters have increased maturity throughout Covid-19 with practices working closely together with oversight by the Area Directors.	1	1) Development of broader cluster membership with the further integration with locality services. 2) Establish Cluster Transformation Board to lead the further development of clusters and promote/facilitate innovation and transformation.	30 September 2021

Review comments since last report: Update since the last submission - The following action is now show as a mitigation :-Increase in the number of GP Trainees in north Wales. (WG Statement in December 2020 stated that GP places would remain at current levels with the ability to over recruit if needed. Dental Training Unit contract is currently being advertised - Continuation & roll out of UPCCs prioritised for funding in draft Annual Plan was made to Welsh Government on 19 May 2021 to secure ongoing funding as part of the national programme. It is considered that the following actions will have the most material impact on the risk - Primary Care Strategy for North Wales to be embedded in the clinical strategy of BCUHB; further development of primary care workforce plans, with further consideration of the impact of the pandemic on assumed GP retirements; establishment of the Dental Training Unit in Bangor (currently being advertised); increase in Academy outputs to have a greater impact on primary care workforce modernisation & capacity.

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary and Community Services	Strategy, Partnership and Population Health Committee	**20 May 2021**

Linked to Operational Corporate Risks:
CRR20-05 Timely Access to Care Homes

Board Assurance Framework 2020/21

Strategic Priority 2: Essential Services and Planned Care

Risk Reference: BAF20-05		Risk Rating	Impact		Likelihood		Score		Appetite
Timely Access to Planned Care									
There is a risk that the Health Board may be unable to deliver timely access to Planned Care due a mismatch between demand and capacity and Covid-19, which could result in a significant backlog and potential clinical deterioration in some patient conditions.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	5	↔	25	↔	
		Target Risk	5		3		15		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Manual validation being conducted across all three sites on a daily and end of month basis.	2	Revised Monthly meetings to focus solely on planned care performance chaired by the Interim Director of Performance, aligns to Finance and Performance Committee. Introduction of further validation staff in Q3/4 non recurring complete.	2	1)Scoping of Artificial Intelligence approach to validation requires IT infrastructure and engagement of Informatics to ensure the inclusion of the scheme within the Informatics Business Plan. 2)Validation staff being recruited on a fixed term basis to continue with validation work. 3)Subject matter expert reviewing validation exercises for planned care.	31 July 2021
Implemented risk stratification system and process for stage 4 patients providing clinical priority with regular monitoring by local Primary targeting list (PTL) and access group.	1	1)Ensure the waiting list size is continually validated and patients appropriately communicated with. 2)Waiting list initiatives introduced in Q3/4, Business case for Insourcing to support long waiting patients approved via Single Tender Waiver.	1	1) Introduce a system that allows patients to "opt in" for treatment. allowing a communication strategy to support the Q1/Q2 plan. 2) Introduce risk stratification for stages 1-3 (outpatients and diagnostics). Work currently ongoing with Welsh Government. 3) Sites and areas are completing backlog clearance plans to ensure the pre-Covid backlog is cleared by March 2022.	20 June 2021 31 July 2021 31 May 2021
Head of Planned Care overseeing the plan and variance to the plan with monthly reporting to the Chief Operating Officer and bi-monthly reporting to the Finance and Performance Committee.	2	Bi-monthly report to Finance and Performance Committee to provide assurance on planned care strategic and tactical developments.	2	Introduce substantive post into the organisation, currently covered on an interim solution. Thus providing continuity and sustained leadership for planned care. Shortlisted candidates, interviews mid May.	31 July 2021
Once for North Wales approach introduced to standardise and ensure consistent delivery of general surgery, orthopaedics, Ophthalmology (Stage 4), Urology and Endoscopy to reduce health inequalities.	2	1)Weekly operational group with Divisional general Managers (DGM's) to ensure operational co-ordination of the once for north wales approach. 2)Scoping of new strategic model of care known as the diagnostic and treatment centre approach for planned care. Strategic outline case to be presented to Board and Welsh Government. 3) Insourcing for ophthamology introduced in February. 4) Over 52 week recovery plan for the 2019/20 end of March co-hort as first phase agreed.	1	1) Introduction of insourcing into the organisation to undertake activity that supports P2-3 activity and over 52 week waiters, therefore reducing the overall waiting times 2) Agree a strategy for planned care over the next 3 years that will improve the business process and reduce long waiting patients. 3) Review of Opthamology Business Case in light of Welsh Government Strategy re Cataract Centres. 4) Additional internal activity above core is being mobilised via recovery plan. 5) Business case being developed for orthopaedic modular ward and theatre on each site. 6) Outsourcing of orthopaedic activity is currently being investigated with the Independent Sector.	31 July 2021 31 May 2021 20 June 2021 31 July 2021 20 June 2021 20 June 2021

Review comments since last report: Mitigations and Gaps/Actions updated to reflect current developments including extension to some timelines.Further actions added which include:- additional internal activity above core being mobilised via recovery plan; business case being developed for orthopaedic modular ward and theatre on each site; outsourcing of orthopaedic activity being investigated with the Independent Sector; and capacity planning undertaken to understand the clearance times for the over 52 week backlogs. It is estimated to be approximately 3-4 years to clear this activity, orthopaedics being the most significant driver for this length of time. These are the reasons for retaining the current scoring. It is considered that the following actions will have the most material impact on the risk:- Review of Ophthamology Business Case in light of Welsh Government Strategy re Cataract Centres; Additional internal activity above core is being mobilised via recovery plan; Business case being developed for orthopaedic modular ward and theatre on each site; and Outsourcing of orthopaedic activity is currently being investigated with the Independent Sector.

Executive Lead:	**Board / Committee:**	**Review Date:**
Mark Wilkinson, Executive Director of Planning and Performance	Finance and Performance Committee and Quality, Safety and Experience Committee	**7 May 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 3: Mental Health Services

Risk Reference: BAF20-07		Risk Rating	Impact		Likelihood		Score		Appetite
Effective Stakeholder Relationships									
There is a risk that our relationships (internal and external) are ineffective. This could be caused by a lack of engagement, poorer communication, a lack of a co-productive approach, lack of direction, shared purpose and culture or insufficient service and organisational development. This could lead to a lack of trust, poor morale, high staff turnover, reduced stakeholder credibility plus reduced staff and public confidence, and an impact on services.		Inherent Risk	3		4		12		Moderate 8 - 10
		Current Risk	3	↔	3	↔	9	↔	
		Target Risk	2		2		4		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Together for Mental Health (T4MH) Strategy implemented with key stakeholders which sets out the direction of travel for Mental Health and Learning Disabilities services.	2	T4MH Partnership Board which oversees implementation of the strategy and includes key partners.	2	1) First meeting held on 22nd January where a number of actions were agreed which consist of a review of the TOR of the T4MHPB, and a refresh of the MH Strategy. To deliver this a number of task and finish groups are being established. 2) Population needs assessment to be undertaken across North Wales which will influence the MH Strategy.	31 May 2021 30 September 2021
Deputy Director attendance at Regional Leadership group with regular feedback into the MHLD Division to ensure two-way communication and engagement.	2	Consistent and regular communication with senior Local Authority partners in relation to service redesign. Feedback to Senior Leadership Team on key issues	2	Ensuring appropriate cover to ensure relevant and appropriate attendance at Regional Leadership Group.	30 April 2021
Divisional CAG meetings whereby senior clinicians and managers discuss and agree service model across the division.	2	Recommendations from meetings presented to BCU Clinical Advisory Group and presented for sign off via Divisional Finance and Performance meeting.	2	To present update of service model to BCU CAG and then to Regional Leadership Group.	30 September 2021
In line with Divisional Wellness, Work and Us Strategy, oversight of all vacancies and sickness overseen by Divisional Workforce Group to ensure any identified demand and capacity pressures.	1	The MHLD division has introduced a workforce group which oversees key actions and identifies and escalates risks to Divisional Directors.	1		
Regular and concise communication with all staff groups across the division.	1	Fortnightly divisional staff engagement newsletter which highlights significant issues/service changes and celebrates staff achievements which reduces the risk of breakdown in communication. This is now embedded practice within the Division.	1	Ensure newly formed meeting with Staff Side to discuss key operational and strategic staffing issues continues.	30 September 2021
Service users, carers and the public to have the opportunity to be involved in the development, planning, design and delivery of the services.	2	Divisional Patient and Carer Engagement Group re-introduced in order to listen better and use feedback from consultation and engagement to make mental health and learning disability services more relevant to service users and carers' needs. We are reviewing the CANIAD contract to ensure integrated working.	2	1) To ensure the review of the CANIAD contract is discussed with the North Wales Leadership group for the joint review. Currently out to procurement for independent review of the CANIAD contract. 2) Address potential gap in advocacy contract arrangements.	31 October 2021 31 May 2021
Closer and regular working with North Wales CHC to ensure the population of North Wales have the opportunity to feedback on their experiences of local services and to contribute to the future design.	3	Safe space events started in December 2020 have been set up with CHC to engage with North Wales population to seek views/experiences of MHLD services. Deputy Director & Director of Nursing are attending the CHC AGM.	3	MHLD Division to agree process for sharing feedback from events with staff groups. An action plan is being developed following the Safe Space events facilitated by the CHC.	30 June 2021

Review comments since last report: Key actions updated including timeframes to reflect the overall progress being made in the Division in relation to Partnerships. In terms of which actions will hae the most material impact on the risk it is considered that the T4MH Partnership Board actions and the action relating to closer working with the CHC will have the greatest impact.

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Executive Director of Public Health	Strategy, Partnership and Population Health Committee	**31 March 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 3: Mental Health Services

Risk Reference: BAF20-08		Risk Rating	Impact		Likelihood		Score		Appetite
Safe and Effective Mental Health Service Delivery									
There is a risk to the safe and effective delivery of MHLD services. This could be due to unwarranted variation and inefficiencies. This could lead to poorer and inconsistent outcomes, poorer use of resources, failure to learn from events or inequity of access.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	3		3		9		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Mental Health and Learning Disabilities Divisional Governance Structure is in place and aligned to corporate governance requirements, providing consistent approach across the Division.	1	1) Key divisional roles in governance and safety are in the process of aligning to corporate reporting from the 1.11.20. 2) Formal reporting and financial transfer of budget complete to ensure the alignment of governance and associated roles to BCUHB corporate.	2		
Partnership and assurance structures are in place. These are: Together for Mental Health Partnership Board (T4MHPB), Local Authority Scrutiny meetings, Local Implementation Teams (LIT), North Wales Adult Safeguarding Board is in place and the division is in attendance. All meetings are formerly minuted and reported with membership regularly reviewed according to their Terms of Reference. The East Local Implementation Team has been re-established; work is ongoing to re-establish in the other Areas. There has been a review of the Terms of Reference of the T4MHPB)	1	Partnership working and reporting assures flow of information and raising of any concerns over delivery or equity. North Wales Community Health Council have held a number of formal stakeholder listening events for the division and a report from the CHC has now been received. The Director of Mental Health meets formally with the 6 local authority directors.	1	1) The T4MH Partnership Board is now meeting regularly (last met on 9 April 2021). Interim Deputy Director leading this key partnership agenda.	30 June 2021
The Mental Health Learning Disabilities Divisions Senior Leadership Team in place with regular cycle of business meetings. This is a control for the delivery of safe and effective services. Regular reports are presented to the appropriate governance body.	1	1)The Mental Health Learning Disability Division has an agreed management structure (2019). It provides timely reports to the agreed Committees of the Board and the Executive Team and is held to account by them for delivery of a safe and effective Mental Health and Learning Disability Service. 2) Divisional triumvirate in place (albeit interim cover is currently in place through to September 2021). The division has created 2 additional Deputy Directors in post reporting to the Director of Mental health to fill operating gaps in partnership and strategy development.	2	Work is ongoing to address interim roles in the management structure. There is a "Head of Psychology" role currently vacant in the Senior Leadership Team, action is in place to fill this role.	30 June 2021

Review comments since last report: Controls, mitigations and actions updated. Ensuring the effective working of the T4MHPB will have the most material impact on this risk.

Executive Lead:	**Board / Committee:**	**Review Date:14 April 2021**
Teresa Owen, Executive Director of Public Health	Quality, Safety and Experience Committee	

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 3: Mental Health Services

Risk Reference: BAF20-09		Risk Rating	Impact		Likelihood		Score		Appetite
Mental Health Leadership Model									
There is a risk that the leadership model is ineffective and unstable. This may be caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	3	↔	15	↔	
		Target Risk	4		2		8		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Interim Senior Leaders in place and working within division. This is alongside other key posts; Interim Director of Nursing and Interim Deputy Directors x2. Each lead specific programmes and will further support and develop leadership, governance and management.	1	Interim Leadership changes are regularly reviewed by the Executive Director to ensure the model is effective in discharging it's roles and responsibilities.	2	Stabilise Senior Management with substantive posts. Sustainability needs to reviewed as a matter of priority to ensure continuity.	30 June 2021
Strategy approved and regular updates reported via Targetted Intervention to Welsh Government.	2	All key actions will be further developed and underpins the required work to have a well developed, fully integrated, Integrated Medium Term Plan (IMTP), which will further strengthen and support an effective model. Oversight will be via the Clinical Advisory Group (CAG).	2	Review Mental Health Structure to ensure fit for purpose and reflects new clinical pathways. There is on-going work to agree plan for 21/22	30 June 2021
		Engagement has been re-established through the Pathway Development Groups (e.g. Rehab / OPMH) with regular and consistent attendance with Regional Partners and stakeholders via North Wales leadership groups.	2	Implement the Mental Health Strategy in a consistent manner across the Health Board.	1 December 2021
		Pathway groups are clinically led and partners working to deliver the strategy, patients groups are members of those groups. All pathway groups report via the Division Clinical Advisory Group.	2	Evaluate regional management and pathway structure approach to delivery of strategy via a pilot and report findings to the Executive Team.	1 December 2021
		Business Case developed with additional funding from Welsh Government secured. Scrutiny of financial governance monitored by Head of Finance.	1		
Business Continuity Plan including essential service sustainability in place, with engagement from the Corporate Business Continuity Team.	2	Business Continuity Plans are updated within the Area with final scrutiny and approval at the Divisional monthly Finance and Performance Meeting.	1	Finalise all 4 service areas draft Business Continuity Plans for implementation.	30 June 2021
Divisional Quality, Safety and Experience Group meeting monthly, chaired by the Interim Director of Nursing to oversee Divisional governance arrangements and reporting, with oversight at the QSE Board Committee.	1			Division is actively working to ensure that the Divisions Governance Structure more accurately reflect and is coherent with BCUHB's governance structure.	30 June 2021

Review comments since last report: Actions reviewed and updated to reflect the current position with target dates amended. Action were reviewed and it is considered that the stability of the leadership team will have the most material impact on the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Executive Director of Public Health	Quality, Safety and Experience Committee	**14 April 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 3: Mental Health Services

Risk Reference: BAF20-10		**Risk Rating**	**Impact**		**Likelihood**		**Score**		**Appetite**
Mental Health Service Delivery During Pandemic Management									
There is a risk to the safe and effective delivery of MHLD services. This could be due to the consequences of the COVID-19 pandemic. This could lead to changing type and level of demand across the region, a lack of appropriate staff and resources, poorer outcomes for our population.		Inherent Risk	4		4		16		Low 1 - 6
		Current Risk	3	↔	3	↔	9	↔	
		Target Risk	3		2		6		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
MH&LD Covid19 Lead has been identified, and reports into the Divisional Governance meetings, Covid19 Divisional meetings and Covid19 Corporate meetings. Weekly Establishment Control meetings. Monthly operational accountability meetings.	1	1) MH&LD Covid19 Winter Plan discussed and agreed in both the Divisional and Corporate Clinical Advisory Group (CAG). 2) MH&LD Operational Covid19 Winter Plan fully implemented. (All patient transfers now progressed back to localities, although direct admission to Bryn Hesketh are being worked through due to outstanding estates works)	2		
MH&LD Covid19 Winter Plan approved in both the Divisional Covid19 CAG meeting 3.11.20, and Corporate CAG meeting 6.11.20. Gaps in recruitment have been assessed and recruitment plan established as part of ESR.	1	MH&LD Engagement and Communication Plan in place to ensure effective and efficient communication across the MHLD Division and also to all key stakeholders, both external and internal. This includes sharing the MH&LD Covid19 Winter plan. Monthly reporting against ESR and the divisional actions to scruitinise them through Senior Leadership Team.	2	Recruitment to vacancies identified as part of each area agreed establishment plan to be progressed.	30 August 2021
Wellness, Work and Us Strategy launched in October 2020, to ensure staff are supported. Approved by the MH&LD Divisional Directors within the Divisional Business meeting September 2020.	1	1) Engagement sessions held across the MH&LD Division regarding the Wellness, Work and Us Strategies. Reviewed Year One priorities aligned to Covid19, ongoing implementation. 2)Approval by Corporate Business Continuity Lead for quality checking, and final sign of by the Divisional SLT at the appropriate Governance meeting of Business Continuity Plans and MH&LD Covid19 Action Cards. (East Business Continuity plan received Divisional sign off)	1		
Business Impact Analysis, Business Continuity Plans and MH&LD Covid19 Action Cards implemented November 2020.	1	1) Support being delivered by Corporate Business Continuity Lead to quality check the MH&LD Business Continuity Plans. 2)Revisit and assess gaps in recruitment processes to support additional staff requirements. 3)Heddfan Establishment review undertaken and discussed in Gold Command meeting, 5.2.21	2	Having assessed the gaps in the recruitment processes it has been agreed that a full establishment review should be undertaken to clarify future needs and resource requirements.	30 September 2021
MH&LD Divisional PPE Task and Finish Group in place, reporting into MH&LD Divisional daily SITREP call, MH&LD Covid19 Briefing meeting and Corporate PPE Task and Finish Group.	2	1) Monitoring and reviewing PPE availability, MH&LD Divisional plan developed and monitored to ensure all staff are appropriately FIT testing as part of key mitigation, feeds into Corporate PPE Task and Finish Group. Also reports to the Corporate FIT testing Steering Group. 2) Process to ensure continuous mapping of staff to enable redeployment decisions.	2		
Clinical Patient Pathway, approved by Clinical Advisory Group, monitored and reviewed by the MH&LD Clinical Pathway Group and changes made aligned to the Covid19 Winter Plan.	1	MH&LD SITREPS completed daily, with oversight by Covid MH&LD Lead. MH&LD SITREPS sent daily to Executive Nurse Director. Staffing pressures reviewed in daily SITREPS and Divisional Safety Huddle, any issue escalated to Corporate Staff Redeployment meeting.	1		
Covid 19 Training in place with compliance monitored and reviewed through Workforce Work stream.	2	MH&LD Covid19 Senior Leadership Team briefing meeting in place, currently meeting twice weekly, but flexible and responsive to need, which reports into the Corporate Covid19 meetings.	2		
MH&LD Divisional Workforce meeting, currently meeting fortnightly to review workforce plan, reports into MH&LD Covid19 briefing meeting and the Divisional Governance meetings.	1	1) MH&LD Covid-19 Command Structure SOP developed 21st December 2020. 2) MH&LD Covid-19 Command Structure SOP operationalised	1		
Attend Anywhere in operation across the MH&LD Division to provide a virtual consultation platform to allow the continuation of appropriate services, approved by the Divisional Clinical Advisory Group and is part of the MH&LD Winter Plan.	1	Divisional prioritisation of IT equipment requirements completed and forwarded to IT.	1	To source and procure additional IT equipment, primarily laptops, to increase the roll out of Attend Anywhere across the MH&LD Division. All Priority 1 laptops delivered across the MH&LD Division, priority 2 laptops delivery roll out planned ongoing.	31 July 2021

Review comments since last report: A number of completed actions have transferred across to mitigations and action dates reviewed and updated. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that it is the collective impact of the actions that will mitigate the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Acting Chief Executive / Executive Director of Public Health	Quality, Safety and Experience Committee	1 April 2021

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-11		Risk Rating	Impact		Likelihood		Score		Appetite
Infection Prevention and Control									
There is a risk that Health Board may not be able to deliver appropriate care to patients and they may 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.		Inherent Risk	5		5		25		Low
		Current Risk	5	↔	4	↔	20	↔	1 - 6
		Target Risk	5		3		15		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
New leadership in place with revised governance arrangements supporting Infection Prevention.	2	Business case approved and recruitment commenced to increase IPC team/resource. Risk register monitored and escalated via IPSG and Patient Safety & Quality Group. Safe, clean care harm free programme commenced.	2	1) Analysis to be undertaken to ensure that there is the right leadership in place across Directorates/Divisions/Teams who understand infection prevention and the appropriate escalation arrangments in place across the Health Board. 2) Finalise recruitment to increase IPC Team resource. 3) To develop the leadership to influence culture and behaviours to ensure that infection prevention becomes habit. This is an integral part of the safe, clean care harm free programme. 4) IT solution and information leadership required to ensure that the right data is captured which can then be tranformed into intelligence, so that people delivering care can see that they are delivering safe practice (real time system).	31 December 2021 30 September 2021 31 December 2021 31 December 2021
Infection Prevention Sub Group in place providing regular oversight and gaining assurance that the key controls are in place and effective, reporting into Quality, Safety and Experience Committee.	2	Monitoring of performance and risk in place by Public Health Wales and Welsh Government.	3	1) Identify decamp facilities on all clinical sites to ensure an effective deep cleaning programme (Hydrogen Peroxide Vapour {HPV}) 2) To build or purchase more isolation facilities to ensure all infected patients can be isolated within two hours.	31 October 2021
Major Outbreak policy (IPO5) currently in place for managing Covid 19 infections.	2	Work, policy and risk register review programmes in place. Microbiology and Antimicrobial stewardship activity overseen by Infection Prevention Sub Group (IPSG), Audit Committee/ Patient Safety & Quality Group and Quality and Safety Executive.	2	Strengthening of effective reporting arrangements through outbreak control groups and IPSG.	30 September 2021

Review comments since last report: Additional actions identified including decamp facilities, isolation facilities, IT solution and information solutions. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that the action to build or purchase more isolation facilities would have the most material impact on this risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	**1 April 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-12		Risk Rating	Impact		Likelihood		Score		Appetite
Listening and Learning									
There is a risk that adverse events occur, or re-occur, in the organisation due to: 1) Lack of a clear and easy mechanism for patients or staff to raise incidents or complaints, 2) lack of a clear, effective and transparent mechanism for reviewing, addressing, sharing learning and feedback from reviews/investigations, 3) lack of trust and confidence in the systems and process. These adverse events could result in avoidable harm to patients or staff, disruption to clinical and support services, avoidable costs and loss of public and stakeholder confidence.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Incident reporting and investigation procedure, systems and processes in place - includes lessons learning learned being shared and actions tracked with reporting to Patient Safety and Quality Group (PSQ) and Quality, Safety and Experience Committee (QSE).	2	Training programme implemented for staff involved in investigations and sharing of learning.	2	Implementation of new procedures and processes for incidents, complaints, claims, redress, safety alerts and inquests - new processes will focus on learning and improvement, with improved use of technology. This will address aspects 1, 2 and 3 of the risk.	30 September 2021
Complaint reporting and investigation procedure, systems and processes in place - includes lessons learned being shared and actions tracked and fed back to patients, families and carers with reporting to PSQ and QSE.	2	Use of the Datix concerns management system to track events, investigations and actions with reporting to PSQ and QSE.	2	Implementation of the new Datix IQ Cloud system for incidents, complaints, redress, claims and mortality reviews - new system will improve the quality of information (including across Wales) and the ability to triangulate information better. This will address aspects 1, 2 and 3 of the risk.	30 June 2021
Safety alerts procedure, systems and processes (both national and local alerts) - includes actions being tracked and WG Compliance Returns completed with reporting to PSQ and QSE.	3	Reporting on patient safety and patient and carer experience to local, divisional and Health Board groups and committees.	2	Implementation of a new skills pathway and passport for those involved in investigations and sharing of learning. This will address aspects 2 and 3 of the risk.	31 May 2021
Claims and redress investigation procedure, systems and processes - includes completion of Welsh Risk Pool (WRP) Learning from Events Reports evidencing learning which are reviewed by the WRP Committee with reporting to PSQ and QSE.	3	Dashboards and information available at local, divisional and Health Board level to provide oversight of quality and safety indicators.	2	Implementation of a new digital learning library to bring together the access, cascade, and sharing of lessons learned. This will address aspects 2 and 3 of the risk.	30 September 2021
Learning from deaths procedure, systems and processes including mortality reviews, inquest coordination and interaction with Medical Examiners in place with reporting to CEG and QSE.	2			Implementation of safety culture initiatives including development of a human factors community of practice, embedding of just culture principles into processes, embedding of Safety II considerations, learning from excellence reporting, annual safety culture survey, and safety culture promotion initiatives. This will address aspects 1, 2 and 3 of the risk.	31 March 2022
Local and organisation-wide safety culture and quality improvement initiatives based on identified themes, trends and areas of concern with reporting to PSQ and QSE.	2			Implementation of a new Quality Strategy (developed with patients, partners and staff) containing organisational improvement priorities and enabling measures aligned to the organisational strategy. This will address aspects 2 and 3 of the risk.	31 March 2022
				Implementation of an organisation-wide integrated Quality Dashboard. This will address aspects 2 and 3 of the risk.	20 May 2021
				Implementation of a new Speak out Safely process for staff to raise concerns. This will address aspects 1, 2 and 3 of the risk.	30 June 2021

Review comments since last report: Target action dates reviewed and updated, acknowledging impact of Covid on some action deadline dates. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that it is the collective impact of the actions that will mitigate the risk. An addition action has been added regarding the Speak our Safely work. Actions have been mapped to the three elements of the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	**19 April 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-13		Risk Rating	Impact		Likelihood		Score		Appetite
Culture - Staff Engagement									
There is a risk that the Health Board loses the engagement and empowerment of its workforce as a result of staff not feeling that it is safe and/or worthwhile highlighting concerns due to: Lack of clear mechanisms for raising concerns at any and every level, lack of a clear, effective and transparent mechanism for listening, reviewing, addressing, sharing learning and feedback, lack of trust and confidence regarding the reception of and impact of raising concerns, lack of support and guidance for all parties involved. This could lead to an impact on the organisation being able to learn from experience or improve services, which could result in poor staff morale, leading to poor outcomes impacting on the delivery of safe and sustainable services and the reputation of the Health Board.		Inherent Risk	4		5		20		Low 1 - 6
		Current Risk	4	↔	4	↔	16	↔	
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Key Policies: 1.Raising Concerns Policy 2.Safehaven Guidance	2	Revised new Speak Out Safely process agreed by Renumeration and Terms of Service Committee 1st February 2021. Implementation Plan in place, key elements being: 1. External platform commissioned - Work in Confidence - to replace Safe Haven to enable staff to engage in, dependent on preference, anonymous and/or two way dialogue with Speak Out Safely Guardian and/or members of wider Multi-disciplinary Team. 2. Job outline for first Speak Out Safely Guardian in draft, who will report directly to CEO, with an independent board member also being identified to support and scrutinise Guardian role and new Multi-Disciplinary Team being established which will review concerns raised, agree actions required; and monitor themes to identify learning; 3. Role of Speak Out Safely Champions being refreshed and network of champions being created 4. Communications and promotion strategy under development with support of corporate communications; 5. WP4a policy to be revised to reflect the transition to the new process	1	1. Launch of Work in Confidence platform by early May 2021; 2. Through expressions of interest, appoint first Speak Out Safely Guardian by early May; 3. First meeting of MDT to take place by mid May; 4. Initial meeting with Speak Out Safely Champions by end of April 2021. 5 Commence communications and promotions strategy during April in advance of 'go live' for Work in Confidence and appointment of Speak Out Safely Guardian. 6. WP4a policy revised and agreed by end of May 2021	31 May 2021
3. Dignity At Work Policy 4. Grievance Policy	2	Assessment of cases upon submission to determine most appropriate process undertaken. Case management review takes place monthly. Thematic review in place at operational level.	1	1. Dignity at Work Policy under review at All Wales level. 2. Triangulation of themes to be included within the reporting outlined in Raising concerns review. 3. Simplified Guidance to be developed for managers and staff to follow to promote early resolution. 4. Current training to be reviewed to align to revised approach.	30 September 2021
5.Performance & Development Review Policy	2	Monthly analysis and reporting at operational level undertaken (as well as strategic level) to enable managers to identify areas with low compliance with PADR. Staff Engagement, Organisational Development and HR Teams work with challenged areas to support and improve in terms of engagement/feedback/recognition/development.	2	1. Identify improvements to the process and documentation to support specific areas/teams. 2. Develop a programme for "Dip testing" of quality of PADRS against key metrics/feedback. 3. Utilise the survey function of the system implemented for Speak out safely to support identification of examples of outstanding/good and requires improvement. 4. Build "role contribution" into Strategic OD programme specification. 5. Review feedback from NHS Staff Survey and update divisional improvement plans.	30 September 2021

Review comments since last report: New Speak Out Safely process being implemented with aim of full implementation of all actions by end of May 2021. It is considered that the collective impact of the actions for Raising Concerns will mitigate the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	15 April 2021

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-14		Risk Rating	Impact		Likelihood		Score		Appetite
Security Services									
There is a risk that the Health Board does not provide effective security services across the organisation. 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. This could lead to a breach in the Health Board's statutory security duties.		Inherent Risk	5		4		20		Low 1 - 6
		Current Risk	5	↔	4	↑	20	↑	
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
1)There is Security provision at the three main hospital sites with 24/7 Security staff present. The Field Hospitals have adequate external security contract in place and reviewed to support the change of use of the sites until the end of June 2021 to ensure appropriate to needs of staff, landlord and patients. The external contractor is responsible for Patient Safety & Visitors and Estates Building Management. This has been increased to support Covid safe environments. 2) New Security Contractor appointed from 1.4.21 who will undertake enhanced DBS assessments of all security staff on the DGH sites.	1	Staff Training is in place in certain service areas. Risk Assessments on some areas looking at physical security. V&A Case Manager to support staff when taking criminal action against assailant. Additional Bank staff employed to support Covid vaccination centre work and security review.	2	1) A review of Security was undertaken in August 2019 and identified a number of shortfalls in the systems management and staffing of the current security provision for BCUHB. BCUHB requires copies of Security Industry Authority licences. Limited capacity within the H&S Team to implement safe system of work. Clarity on roles required to describe an effectively managed security contract and safe systems of work in areas such as lone working, restraint training, lockdown and CCTV. Resources to facilitate and support V&A Security are looking at being secured, with recruitment of Bank/Agency staff until permanent post agreed. 2) Business case under further review to identify gold standard approach. 3) Ligature assessments require additional support to ensure safe systems of working are in place in all service areas.	30 June 2021 30 June 2021 30 June 2021
There is a Security Group established to review workstreams. Specific restraint training is provided in specific areas such as mental health. General Violence and Aggression (V&A) training is provided by the Manual Handling Team.	1	Data capture and reporting systems for V&A. A V&A Case Manager is in post to support staff when criminal action is taken. The Obligatory Response to Crime has had a combined training event with North Wales Police.	1	The lack of Policies staffing and structures poses a significant risk to staff, patients and visitors from V&A cases and security related activity. To control the risks a full review of Security services including, training particularly in restraint and restrictive practices is required. To ensure appropriate care, this particular aspect is delivered by competent staff. A full Security review was undertaken in September 2019 and previous reviews in 2017 by Professor Lepping and to date none of the recommendations have been implemented due to lack of appropriate resourcing. There is a lack of compliance with the NHS Wales Security Management Framework (NHS in Wales 2005) and Obligatory Response to Violence etc. The Manual Handling Team require competency training in order to be able to deliver appropriate V&A training.	30 September 2021
There are some up to date maintained CCTV systems in place. Staff in some areas have had training on use and licencing requirements. IG aware of issues in relation to data and management of CCTV.	1	There is a system for gathering data when an incident occurs if the equipment is working effectively. A task and finish group has been established to review the current systems with a view to working up a scheme to centralise the CCTV system and improve current compliance.	2	There is a lack of a structured approach to CCTV management and control. The systems are different in many service areas. A central Policy is being developed but requires significant investment to centrally control all systems. This is likely to result in a breach of the Data Protection Act if not appropriately managed. There is often limited maintenance on CCTV systems. A full review of all systems is required. Estates have committed to upgrate CCTV systems in a number of premises.	30 September 2021

Review comments since last report: Scoring reviewed and remains static. Target action dates in relation to line one have been updated to June 2021 from May 2021.
Reference also made to an action regarding Estates, who have committed to upgrade CCTV systems in a number of premises. Additional the refence in the 'Control' column to the Field Hospitals has been updated to reflect an extension of the requirement to maintain premises during de-commissioning.
- It is considered that the following actions will have the most material impact on the risk: Support for the case for investment and change to improve capacity and quality of the security service and management and Implementation of the gap analysis findings.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	**26 May 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-15		Risk Rating	Impact		Likelihood		Score		Appetite
Health and Safety									
There is a risk that the Health Board fails in its statutory duty to provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation that could result in avoidable harm or loss.		Inherent Risk	5		4		20		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Health and Safety Leadership and Management Training Programme in place across the Health Board, with regular monitoring reported to Strategic H&S group.	1	Competence in training in service areas has been reviewed. Plan in place through business case to establish robust Safety Competence and leadership training programme. There is a three year strategy that requires implementing to support the Strategic Objectives of BCUHB.	2	1)The gap analysis of 31 pieces of legislation,117 site specific inspections including Acute, Mental Health Community Services GP and Wrexham HMP. Identified significant areas of none compliance. The OHS team continues to have significant support from our trade union partners. Further evaluation of H&S systems has been led by Internal Audit. A clear plan and framework for action to firstly identify hazards and place suitable controls in place has been developed. Covid support has significantly effected the delivery of the action plan. 2) IOSH Managing Safely and Leading Safely Modules for Senior Leadership to be implemented subject to business case approval.	30 September 2021 31 October 2021
Policies and Sub groups have been established including Asbestos, Water Safety, Fire Electrical Safety etc. to monitor and report into the Strategic Occupational Health & Safety Group and escalate via Quarterly Reports to QSE.	1	Clearly identified objectives for the Annual plan to achieve and transfer of risk ownership for a number of high level risks to E/F as duty holder for asbestos, legionella, contractor management and control, Electricity and Fire.	1	1) Clearly identified issues escalated to Board via business case to be reviewed. Gaps in Fire safety for a number of premises including YG working with North Wales Fire and Rescue service on action plans. (Welsh Government are likely to be providing additional support post 'Grenville' to support the new Fire Bill.) Close working relationship with HSE to ensure key risks and information required is provided in a timely manner. HSE are scrutinising work activity in many areas, likely to Audit BCUHB for Asbestos and Violence at work shortly. 2)Actions arising from the Legonella review to be implemented.	30 September 2021 31 October 2021
Lessons Learnt analysis from COVID reported to Executive Team, Through Covid Group and with action to progressed to appropriate Executives. Clear strategy from Board to deal with PPE and suitable control measures to minimise risk of transmission of Covid through risk assessment, safe distancing advice, FAQ's, ICT Audits, guidance and standard operating procedures.	2	RIDDOR reporting in place with robust timeline and tracking through outbreak groups of Datix 72 hour reviews a total of 820 RIDDOR investigations undertaken since April 2020. PPE steering group has weekly meetings and a 'triple A' assurance report is provided to QSG and key issues escalated via QSE. Over 200 site safety visits undertaken by the H&S Team to review Covid safe environments. Action cards in place to ensure movement of staff effectively managed during outbreak.	3	HSE have identified gaps in COSHH Regulations specifically fit testing which requires fit2fit training programme to be in place. Improvement Notice from HSE against BCUHB provided on 24th October was lifted at the beginning of April. There has been significant investment with fit testing equipment with further plans in place to continue fit testing on new masks. There will be a requirement to release fit testers and staff to comply with legal compliance required within all service areas. Full time fit testing staff are required as the current arrangement is predicated on temporary staffing.	30 September 2021
Executive Team understand the range and types of risks identified through Annual Report and Gap analysis. Gaps in safety including areas of inefficiency to be addressed. Internal Audit have reviewed structure of meetings and Governance procedures.	1	Strategic OHS Group established to monitor performance and workshop with OD support has looked at leadership styles and developing a positive culture with partners from finance, procurement, Estates and Facilities and Occupational Health.	2	Robust action plan with clear objectives for Team difficult to deal with all elements of legislative compliance with limited capacity. Action: Recommending specialist support to review key areas of risk and attendance at operational groups to further understand significant risks.	30 September 2021

Review comments since last report: Actions updated to reference IOSH Managing Safely and Leading Safely Modules for Senior Leadership to be implemented **subject to a business case** and that Welsh Government are likely to be providing additional support post 'Grenville' to support the new Fire Bill. It is considered that the action that will have the most material impact on the risk is the Competence and leadership training programme including IOSH Managing Safely and Leading Safely Modules for Senior Leadership and it is anticipated that the necessary funding will therefore be made available.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	26 May 2021

Linked to Operational Corporate Risks:

CRR20-01 - Asbestos Management and Control
CRR20-02 - Contractor Management and Control
CRR20-03 - Legionella Management and Control
CRR20-04 - Non-Compliance of Fire Safety Systems

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-16		Risk Rating	Impact		Likelihood		Score		Appetite
Pandemic Exposure									
There is risk that patients, staff or visitors are exposed to COVID-19 due to inadequate/inappropriate resources, lack of compliance with prevention/protection measures across all settings, lack of understanding, skills, ownership of responsibilities, lack of systems and/or capacity and/or capability to identify, analyse, adapt, address immediate themes arising from intelligence both internal and external in a dynamic way. This could impact or effect avoidable harm caused to our patients, staff, visitors, increase in demand/length of stay/risk to other patients, reduction in availability of staff to support the delivery of safe care and services. This could led to prosecution for breach of statutory/legal duty and reputational damage to trust and confidence.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	5		3		15		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
PPE monitoring and management in place with regular reporting to the Patient Safety and Quality Group and reporting through to Quality, Safety and Experience Committee.	1	PPE steering group (PPESG) and reporting into Infection Prevention Sub Group, Patient Safety & Quality Group with governance structure in place. In addition the formation of the Safe Clean Care Harm Free Group which now reports to Quality,Safety and Experience Committee.	2	Continuous supply is not secure, training availability limited due to staffing resource in PPE and IPC teams. BCUHB to approve second admission screen.	30 September 2021
Fit testing in place to prevent avoidable infection. This is monitored via IPSG and OH&SG.	1	Fit testing programme, Accreditation training and business case in place to increase assurance monitored by PPESG.	2	Establish a routine programme to ensure continuous review of dynamic plan for fit testing with plan being kept under review by IPSG	30 April 2021
Review of all buildings has taken place against new regulations in relation to what the clinical environment should look like with regard to infection prevention, with a schedule of improvements identified.	1	Ventilation and Environmental groups reporting into Infection Prevention Sub Group and Patient Safety & Quality Group with governance structure in place. Implementation of segregation and screening to clinical areas.	1	1) Review and risk assess the improvement plans in order to address the environmental considerations necessary to meet new guidance in relation to the built environment. Some buildings are a risk due to infrastructure (dialysis and community hospitals). Improvement plans in place via Planning and Estates. 2) To build or purchase more isolation facilities to ensure all infected patients can be isolated within two hours.	30 September 2021 31 December 2021

Review comments since last report: Controls and actions updated to include revised governance structure including establishment of the Safe Clean Care Harm Free Steering Group and reference to the purchase of more isolation facilities. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that the purchase/building of more isolation facilities will have the most material impact on this risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	**1 April 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF20-17		Risk Rating	Impact		Likelihood		Score		Appetite	
Value Based Improvement Programme										
There is a risk that the Health Board does not understand or use its resources effectively and efficiently due to a lack of implementing an appropriately resourced value based improvement programme. This could impact on the quality of outcomes for the services it delivers.		Inherent Risk	4		4		16		Moderate 8 - 10	
		Current Risk	4	↔	3	↔	12	↔		
		Target Risk	4		2		8			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Finance & Performance (F&P) Committee oversight via standard reporting of opportunities and savings delivered.	2	Contribution to national benchmarking programmes, providing detailed analysis of service areas and opportunities.	3	The June refresh of the Annual Plan will provide further clarification regarding the way in which the VBHC Improvement Programme supports the Health Board's transformational approach.	31 July 2021
F&P Committee oversight of benchmarking data & follow up work e.g. Mental Health.	2	Drivers of the Deficit analysis and external benchmarking data used to inform Annual Plan and to identify priorities for tackling efficiency opportunities, linked to service transformation.	1	Staff recruitment to be aligned with Annual Plan and broader transformation programme approach. Job descriptions drafted; banding and recrtuiment prep to be concluded in June.	30 June 2021
Lessons Learnt analysis from COVID reported to Executive Team, with action to mainstream innovation and value opportunities. Reporting of progress to delivering opportunities to F&P Committee.	2	National efficiency framework analysis to identify opportunities and cascade to Improvement Groups and Divisions.	1	Planning and business case approach to be reviewed to capture VBHC principles. Work ongoing to finalise , adopting learning from other Health Board approaches	30 June 2021
Clinical Effectiveness Group re-established with oversight of Value Based Healthcare within its brief.	1	1) Executive leadership confirmed as for Medical Director and Finance Director - endorsed by the F&P Committee. 2) Initial priorities agreed.	2	Initial priorities identified e.g. lymphodema and orthopaedic services, with projects being established along with reporting arrangements.	30 June 2021
Executive Team reviewing the opportunities analysis produced for Improvement Groups to identify potential areas of inefficiency to be addressed.	2	Finance Delivery Unit of Welsh Government have designed a maturity matrix for VBHC which can be used to guide and inform the programme of work.	2	Steering group to be established to drive the programme of work, supported by the VBHC structure. Progress reports to be provided to the Clinical Effectiveness Group. Initial group established; the approach to be aligned with the overall transformation approach as part of the Annual Plan refresh.	31 July 2021
		Direct support secured from the National VBHC Team to support the Health Board in developing and implementating the programme.	2	Initial data capture and reporting systems for VBHC to be developed. Data capture in place for initial projects. Future system requirements under review as part of the national programme	Complete 30 September 2021
		The Draft Plan for 2021/22 confirmed that VBHC is part of the Board's overall transformation approach	2	Programme reporting established to Finance and Performance Committee	31 July 2021
		Resources have been secured from the strategic support allocation to resource the VBHC Team	2	Utilise the FDU maturity matrix approach to prioritise actions and subsequently undertake a formal assessment of progress.	30 September 2021

Review comments since last report: Actions completed in April have moved to mitigations. Status of actions has been reviewed to reflect work undertaken since the last update in April. Job descriptions for team roles have been drafted, linked to the resource available. Data collection in initial projects has started, with consideration of future system needs progressing as part of a national review. The following actions are considered those that will have the most material impact on the risk:- 1) Further clarity within the Plan refresh as to how the VBHC programme supports the Board's transformation approach; 2) Recruitment of the VBHC team, aligned to the broader transformation resource; 3) Clarity on longer term systems solutions to support VBHC; and 4) utilise the FDU maturity matrix approach to prioritise actions and subsequently undertake a formal assessment of progress.

Executive Lead:	**Board / Committee:**	**Review Date: 26 May 2021**
Sue Hill, Executive Finance Director	Finance and Performance Committee	

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF20-18		Risk Rating	Impact		Likelihood		Score		Appetite
Digital Estate and Assets									
There is a risk that Informatics cannot implement digital solutions due to available resource not keeping step with an organisational wish to become more digitally focused. This could impact on the safety of our patients, service efficiency and the reputation of the Health Board, the ability to recruit and retain staff or impact on compliance with legislation resulting in significant financial penalties.		Inherent Risk	4		5		20		Moderate to High 8 - 15
		Current Risk	4	↔	5	↔	20	↔	
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Monthly budget reviews take place with finance. Finance attendance at Informatics Senior Management Team (SMT) on a monthly basis as part of the Cycle of Business.	1	Contribution to national informatics programmes through representation both informatics and clinical i.e. Virtual Consultations, Digital Services for Patients and the Public Programme.	3	1) Development of a Digital Strategy - approved by the Board on 20 May 2021. 2) Formal launch of Digital Strategy	Complete 1 September 2021
Quarterly review of Operational Plan at SMT with Digital and Information Governance Committee (DIGC) oversight of the delivery of the Informatics Operational Plan and budget on a quarterly basis.	2	Review of required business cases through the Business Case Review Group and to the Finance & Performance Committee (F&P) Committee for approval.	2	Implementation of the Digital Strategy Year 1 to 2.	1 March 2022
Capital and Revenue Programmes are in place and are reported through the DIGC on a quarterly basis.	2	Resource risks are identified and go through the escalation process as documented in the Risk Management Strategy. This governance includes SMT, DIGC and Risk Management Group.	2	Established resource structure submitted, together with revenue and capital requirements for 21/22 - decision taken by ET not to fund cost presssure for additional capacity. Accordingly a review of the current projects is being undertaken which will be presented in due course to the Executive Team.	30 June 2021
		Programmes and Projects are managed using agreed standard methodologies (Tailored Prince2) and have governance structures.	1	Development of an established resource structure and revenue and capital requirements in line with the strategy delivery from 22/23.	1 December 2021
		Regular meetings with Digital Health Care Wales in place to discuss local and national priorities and challenges.	3	Development a Management of Portfolio approach so that all digital solution change initiatives are well governed, controlled and prioritised. Implementation of the Management of Portfolio Approach.	31 October 2021
				Meeting with Digital Health Care Wales has taken place to discuss the BCUHB Priorities and Risks and plan currently in development to take account of the challenges.	30 June 2021

Review comments since last report: Actions updated to reflect approval of the Digital Strategy by the Board, with additional action added re formal launch of the Strategy. Date in relation to the Management of Portfolio approach amended to align with the proposed Governance Structure Review implemention. Mitigations updated to reference regular meetings with DHCW together with extensions to action timeframes. Implemention of the Digital Strategy together with the resources to deliver it will be the actions that have the most material impact on the risk. Resource structure had been developed however decision taken not to fund cost pressures for additional capacity which will necessitate a review of existing resources against current projects.

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary and Community Services	Digital and Information Governance Committee	21 May 2021

Linked to Operational Corporate Risks:

CRR20-06 - Informatics - Patient Records pan BCUHB

CRR20-07 - Informatics infrastructure capacity, resource and demand

Board Assurance Framework 2020/21

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF20-20		Risk Rating	Impact		Likelihood		Score		Appetite
Estates and Assets Development									
There is a risk that the Health Board does not systematically review and capitalise on the opportunity to develop its estates and assets due to changes in working practices (for example agile working) which could impact on recruitment, financial balance and the reputation of the Health Board.		Inherent Risk	3		4		12		Moderate 8 - 10
		Current Risk	3	↔	3	↔	9	↔	
		Target Risk	3		2		6		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Estates Strategy, monitored by Capital Investment Group with oversight at Finance and Performance, and Strategy Partnerships and Population Health Committees and Health Board.	2	Disposal or acquisition of assets are signed off by the Board and Welsh Government in line with the BCUHB Scheme of Reservation and Delegation (SoRD).	3	Health Board through the Workforce Strategy to agree the standards for workforce accommodation and changes in working practices through modern ways of working - Stronger Together.	31 March 2022
Workforce Strategy monitored by the Health Board.	2	Business Case process in place with oversight by the Executive Team, Capital Investment Group, Finance and Performance Committee and onto Welsh Government.	3	Financial Planning to be agreed and secured to support the change in working practices and a digitally enabled workforce.	31 March 2022
		Collaboration on public sector assets/corporate hubs, and regional working across North Wales.	3	Additional Resources for Asset Management function have been identified through the Health and Safety Business Case to be approved by Finance and Performance Committee.	31 March 2022
				Health Board agreed Estate rationalisation programme over three years 2021 to 2023. 2021-22 overview through Finance and Performance Committee and oversite through the Capital Investment Group.	01 June 2021
				Opportunities to progress corporate accommodation hubs in partnership with North Wales Regional Public Service Providers and Local Authorities.	31 March 2022
				Update Estates Strategy to reflect demands for flexible accommodation hubs and review current and future needs for Office accommodation.	01 September 2021
				The Health Board is progressing a Programme Business Case (PBC) to address fire safety and infrastructure compliance for Ysbyty Gwynedd (YG). This PBC will be submitted to the Health Board for approval and progression to Welsh Government for funding approval. The scope of the PBC will address all risks for YG which are listed within the Corporate Risk Register.	20 May 2021
				Development of enabling plans i.e. Finance, Workforce, Digital Strategy together with a refresh of Living Healthier, Staying Well	01 September 2021

Review comments since last report: Updates to actions and review dates with extension to the action in relation to the Estates Strategy and the inclusion of the refresh of Living Healthier, Staying Well. All of the actions collectively have a contributory effect on the impact of the risk and its mitigation. It is not possible at this stage to identify one particualr action in isolation due to a number of strategic enablers being progressed currently, e.g. Living Healthier, Staying Well; Digital and Workforce Strategies which will be relfected through an updated Estates Strategy. The current scores will be revisited in September 2021 based upon actions within the themes identified once approved.

Executive Lead:	**Board / Committee:**	**Review Date:**
Mark Wilkinson, Executive Director of Planning and Performance	Finance and Performance Committee	**13 May 2021**

Linked to Operational Corporate Risks:
CRR20-07 Informatics infrastructure capacity, resource and demand.

Board Assurance Framework 2020/21

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF20-21		Risk Rating	Impact		Likelihood		Score		Appetite
Workforce Optimisation									
There is a risk that the Health Board cannot attract or retain sufficient staff (core and flexible) to resource delivery of the strategic priorities due to a lack of integrated workforce planning, safe deployment systems and insufficient support for recruitment and on boarding. This could impact on the Board's ability to deliver safe and sustainable services.		Inherent Risk	4		5		20		Low 1 - 6
		Current Risk	4	↔	4	↔	16	↔	
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Establishment Control Policy and system in place. Pipeline reports produced monthly for review and action by managers across the organisation. Roster management Policy. Recruitment Policy. Safe Employment Policy.	2	1. Review of Vacancy control process underway to establish a system for proleptic/proactive recruitment against key staff groups/roles. 2. Review of delivery group structure underway to ensure regional over view and leadership of planning, recruitment and retention.	2	G. Workforce planning undertaken at a local/team level and requires a once for North Wales approach. G. Workforce planning skills, capacity and guidance insufficient for step change in approach and effectiveness. A. Development of a clear Wokforce Planning Process and Policy underway. A. Workforce Service Review programme commissioned. G. Previous structure for planning and recruitment dispersed across secondary care sites, area teams, MHLD. Once for North Wales approach required. A. Revised delivery group structure developed subject to further refinement and approval. G.Use of technology requires review and improvement A.Scope for review of systems and usage to be drafted.	30 April 2021
Workforce plans for each of the core priority programmes: 1. Existing USC delivery. 2. Existing Planned Care Delivery. 3. Existing TTP delivery. 4. USC Surge Plan. 5. Planned Care Recivery Plan. 6. TTP reslience plan. 7. COVID Vaccination Plan.	1	1. Review and development of a clear Workforce planning process. 2. Workforce Service Review programme commissioned.	1	G. Workforce planning undertaken at a local/team level and requires a once for North Wales approach. G. Workforce planning skills, capacity and guidance insufficient for step change in approach and effectiveness. A. Development of a clear Wokforce Planning Process and Policy underway. A. Workforce Service Review programme commissioned.	30 April 2021
Temporary Staffing Policy. Medical Bank Protocol.	1	1. Temporary Staffing Solutions Plan under development.	1	G. Temporary bank primarily established to support Nursing and Health Care Support. A. Medical Bank established with contract with MEDACs in place for 2020/22. A. Plan to establish BCU Temporary Staffing Solutions under development. Service to cover all staff groups and include "ready to work" pipeline.	30 June 2021

Review comments since last report: Reviewed and suggest aligning future reporting to Finance and Performance Committee. Actions reviewed in terms of which would have the most material impact on the risk. At this stage, it is considered that it is the collective impact of the actions that will mitigate the risk. This will be reviewed and updated by end of April.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Finance and Performance Committee	**23 March 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority: Essential Services and Planned Care

Risk Reference: BAF20-25		Risk Rating	Impact		Likelihood		Score		Appetite
Impact of COVID-19									
There is a risk that the ongoing Covid-19 pandemic will lead to the HB being overwhelmed and unable to respond to Covid healthcare needs and/or carry out its core functions due to the spread and impact of Covid-19 in North Wales. This could lead to reduced staff numbers available for work, increased demand on services (including acute, community, mental health and primary care), and suspension of planned services. This could negatively affect patient safety and quality of care, patient outcomes; delivery of the mass vaccination programme and TTP; and the Health Board's ability to deliver its plans and corporate priorities.		Inherent Risk	5		4		20		Low 1 - 6
		Current Risk	4	↔	3	↔	12	↔	
		Target Risk	4		2		8		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Divisional operational management teams' Covid response arrangements are in place and meeting regularly. Any issues requiring escalation are reported into Executive Team or the Executive Incident Management Team (EIMT) as appropriate. EIMT is now phasing down (now meeting fortnightly) as business as usual returns.	2	Contingency and escalation plans are in place and operational measures taken to support the response to Covid-19 including amended care pathways; provision of PPE; remote or prioritised assessment pathways; prioritisation of treatment; escalation plans and surge capacity. De-escalation and decommissioning plans are being implemented. Surge plans/winter resilience plans are being tracked against modelling predictions. Revised modelling is being used to inform capacity and re-escalation plans.	2	1) Updating of business continuity and escalation plans. 2) Decomission Ysbytai Enfys in Bangor and Llandudno. 3) Deeside to be retained as local vaccination centre and for surge capacity.	30 June 2021 31 July 2021 31 March 2022
Covid-19 response programmes established to plan and deliver specific targeted response including Test, Trace and Protect programme; Vaccination Delivery Programme; PPE group; Operational Delivery Group for outbreak management; Ysbyty Enfys Assurance Group now stood down but reporting continues through EIMT for significant decisions.	2	1)Detailed programme plans in place for each programme area; performance indicators identified to enable monitoring and evaluation; governance structures in place to enable oversight and decision-making. 2) Strengthening of reporting processes into and from EIMT and/or Executive Team in place. 3) Establishment of clear regularised reporting structures around established workstreams.	2	1) Updating of programme plans and development of new plans in response to new Welsh Government guidance as it arises. 2) Prevention and response plan to be refreshed with partners.	31 July 2021 30 June 2021
Clinical Pathways Group established to scrutinise clinical response to the pandemic and approve amended pathways and reporting into the Clinical Effectiveness Sub-Group.	2	1) Clinical approval for service delivery proposals; approved pathways published on the BCU intranet; reporting to Executive Team and EIMT. 2) Programme and links into ET/EIMT reviewed.	2		
Coronavirus Co-ordination Unit established to support programme reporting and strategic co-ordination, working closely with the Business Intelligence Unit (BIU) and Covid Intelligence Hub to ensure timely and accurate analysis of data and modelling of trajectories.	2	Covid dashboards to facilitate up to date review of performance; weekly reporting to executive team and IMs; monitoring of reporting to WG including SitReps, outbreak reporting, unscheduled care and hoc reports. Dashboard now consistently linked for BIU users. Mechanisms in place for ongoing surveillance, analysis and modelling after current pandemic peak.	2	1) Ensure readiness for further escalation as required in the event of further waves of Covid pandemic.	30 September 2021
Executive Incident Management Team has been established and is meeting as required (frequecy dropped since original inception), with formal reporting to the Board as appropriate.	2	Recording of actions and decisions via daily updates to logs; regular briefing to IMs via Board briefings; escalation of matters requiring Board approval.	2	Ongoing work to ensure all records captured and indexed.	30 September 2021
North Wales LRF Strategic Co-ordinating Group has stood down. Recovery Co-ordinating Group remains in place and is continuing surveillance and managing recovery. SCG will be reconvened as and when required.	3	Risk assessment, escalation of sub-regional and regional issues, whole system response; and reporting to WG on an escalation basis.Mechanisms in place through RCG for ongoing collaborative arrangements for monitoring transition into recovery.	3	1) Prevention response plan to set out remobilisation.	30 June 2021

Review comments since last report: Control, mitigations and action together with timeframes updated to reflect the current position of the pandemic. Current risk score reviewed but remains unchanged in light of the potential risks posed by the Variants of Concern. It is considered that the collective impact of the actions listed will mitigate the risk. Executive Lead transferred to Gill Harris from Chris Stockport.

Executive Lead:	**Board / Committee:**	**Review Date: 28 May 2021**
Gill Harris, Deputy Chief Executive and Executive Director of Nursing and Midwifery	Quality, Safety and Patient Experience Committee	

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF20-26		Risk Rating	Impact		Likelihood		Score		Appetite
Development of Annual Operational Plan 2021/22									
There is a risk the Health Board fails to deliver a plan to Welsh Government and remains in breach of its statutory duties whether due to inability to deliver financial balance or to present a plan that delivers key performance targets. This impacts on reputation, and reduces freedom to act.		Inherent Risk	3		3		9		**Low 1 - 6**
		Current Risk	3	↔	2	↑	6	↑	
		Target Risk	3		1		3		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Executive led planning process in place responsible for meeting the Welsh Government requirements for the development / implementation of an operational plan for 2021/22	2	1) Strong corporate, clinical, managerial and partnership engagement / collaboration with established and coordinated communication links including Welsh Government, Public Health Wales, and key internal and external stakeholders, e.g.: Executive led Planning Workstream, Stakeholder Reference Group, Regional Partnership Board. 2) Clear accountability across the organisation - agreed programmes with designated Executive lead, programme lead	2	1) Review of 2021-22 Planning Process to ensure robust arrangements are in place going forward. 2) Development of a 2022-23 plan by December 2021 3) In view of the draft nature of the plan it is expected that the plan will be refreshed during the year. 4) Residual financial gap to be addressed. 5) Plan refresh to Board in July, following Finance and Performance consideration in June. This will reflect the feedback from WG and the further new recovery fund resources which have been introduced across NHS Wales.	30 June 2021 31 December 2021 30 June 2021 30 June 2021 15 July 2021
Planning cycle established with outline BCUHB Planning schedule/overall approach for 2021/2022 plan led by Assistant Director, Corporate Planning and reporting into the Executive Team and the Strategy, Partnership and Population Health Committee.	2	1) Developed Cluster Plans to influence the Primary Care Recovery Plans. 2) Planning arrangements established to support development of a high level plan with identified support from Corporate Teams. 3) Programme Groups led by designated programme lead with input from Divisional Teams with direct reporting to the Planning Workstream. 3) Planning and Performance, workforce, financial and informatics functions supporting oversight of plan development 4) Plan supported by F&P on 25.3.21 for submission to Board on 30.3.21	2		
BCUHB Annual Planning cycle in place that responds to national NHS Wales annual planning timetable and requirements.	2	Welsh Government annual planning framework issued. Communications Team support to the plan to improve the engagement.	2		

Review comments since last report: Actions, timelines and scoring previous updated to reflect that the Plan was supported by Finance and Performance Committee and was approved by the Health Board for submission to Welsh Government (WG) on 30 March 2021. Correspondence from WG on 11 March 2021 acknowledges the considerable uncertainty hindering firm planning commitments across NHS Wales and the draft Plan is being refreshed to take into account the recovery fund resources which has now been made available and to tackle the residual financial gap, with a view to being presented to the Board in July, following Finance and Performance consideration in June. Taking into account the discussion at the last SPPH Committee meeting, together with the above factors, the scoring of this risk has been revised, and increased from 3 to 6. Agreement of the refreshed plan by the Board will have the most material impact on the risk.

Executive Lead:	**Board / Committee:**	**Review Date: 14 May 2021**
Mark Wilkinson, Executive Director of Planning and Performance	Strategy Partnerships and Population Health Committee	

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority: 5 Effective Use of Resources

Risk Reference: BAF 20-27		**Risk Rating**	**Impact**		**Likelihood**		**Score**		**Appetite**
Delivery of a Planned Annual Budget									
There is a risk the Health Board spends in excess of its planned annual budget. Any financial deterioration against the financial plan may result in the Health Board breaching its statutory duties. This could affect the provision of healthcare across North Wales, potentially leading to Welsh Government intervention and reputational damage, impacting on the Health Board's ability to remain sustainable.		Inherent Risk	5		4		20		Moderate 8-10
		Current Risk	5		3		15		
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Board led annual operational plan, developed and approved in conjunction with Welsh Government, setting out the Health Board's key priorities	2	1. Focused financial modelling and forecasting to deliver efficiency and achieve set Welsh Government targets. 2. A structured programme to demonstrate engagement with all stakeholders to agree a realistic and achievable savings plan 3. Financial and business partnering strategy, offering clear and reliable leadership from senior management team 4. Savings Opportunities and Benchmarking shared with Budget Holders 5. Strategic Support agreed with WG to support transformational change programme to be agreed with Board in March 2021 6. Finance led analytical review of the underlying deficit and cost pressures by Division to establish how much real new money is available to cover pay and inflation 7. Finance led evaluation of the recurrent Forecast Outturn; compare with recurrent budget including the impact of COVID-19 on our spend 8. The Health Board has submitted a draft plan with a £28m financial risk as agreed by the Board.		1. Consistent approach to be adopted across Divisions, in line with best practice, from April '21 2. Finance Team stategy includes as a key outcome to develop our approach to business partnering, to maximise the finance functions contribution to divisional management teams 3. Co-produce 2021/24 Planning principles, timetable and key deliverables with ET, EMG and SPPH Committees. 4. An action plan to address the deficit is being formulated as part of the refresh Plan as at Q1 5. Plans to deliver savings against the agreed Plan need to be finalised.	Complete 31 May 2021 31 May 2021 30 June 2021 30 June 2021
Oversight of financial position and controls through Health Board Committees. Scrutiny through reporting to Welsh Government and the annual statutory Audit	2	1. Formal finance meetings and communication between senior colleagues in the Health Board and Welsh Government 2. Oversight arrangements in place through the Finance & Performance Committee and the Board. 3. Annual assurance of financial position by Audit Wales. 4. Annual financial programmes monitored through the Finance and Performance Committee. 5. Finance report format revised to provide clearer position on financial position and risks. Consistent reporting across all Divisions from April '21. 6. Evaluation in relation to finance capacity and capability to support Divisions in delivering timely financial plans that link to activity and workforce impacts has been undertaken. Gap analysis has been undertaken in conjunction with Divisions to assess what skills they need from finance, to ensure the structure of the team meets the needs of the senior managers		1. Embed ownership of savings by Divisional managers supported by finance. 2. Review consistency of content and format of individual Divisional finance reports.	30 June 2021 30 June 2021

Review comments since last report: Actions to achieve target risk score together with timelines reviewed and updated with a number of actions having been completed and now shown as key mitigations. It is considered that the action plan to address the deficit will have the most material impact on the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Executive Director of Finance, Sue Hill	Finance and Performance Committee	**13 May 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF20-28		Risk Rating	Impact		Likelihood		Score		Appetite
Estates and Assets									
There is a risk that the Health Board fails to provide a safe and compliant built environment, equipment and digital landscape due to limitations in capital funding. This could impact on the Health Board's ability to implement safe and sustainable services through an appropriate refresh programme, could result in avoidable harm to patient, staff, public, reputational damage and litigation.		Inherent Risk	5		4		20		Moderate 8 - 10
		Current Risk	5		3		15		
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Estates Strategy in place and approved by the Board in January 2019 with updates provided to the Strategy, Partnership and Population Health Committee.	2	Development for business case for key projects identified in key strategies.	1	Secure WG funding to support Business Cases (short and long term).	31 March 2022
Annual Capital Programme in place and approved by the Finance and Performance Committee with regular reports provided to the committee.	2	Capital Investment Group with representation from all divisions with monthly updates to the Executive Team in place.	2	Rationalisation of the Health Board Estate.	31 March 2022
		Capital Programme based on priorities as identified by divisions, Core Areas (Estates, Informatics and medical devices) feeding into the Capital Investment Group and onward to the Finance and Performance Committee.	2	Review undertaken and work is ongoing to secure capacity to deliver all the projects.	30 September 2021
		Selection criteria signed off by the Executive Team which links back to risk, service continuity, service transformation and sustainability.	2	Development of Digital Strategy (due to be presented to the Board on 20 May 2021)	30 June 2021
		1) Project Teams in place to deliver the business case and projects. 2) 3 year Capital Programme agreed with Executive Team and approved by F&P Committee on 25 March 2021.	1		

Review comments since last report: Actions reviewed and updated to reference approved capital programme which is now shown as a mitigation. It is considered that the action in relation to securing WG funding to support Business Cases (short and long term) will have the most material impact on the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Mark Wilkinson, Executive Director of Planning and Performance	Finance and Performance Committee	**17 May 2021**

Linked to Operational Corporate Risks:
CRR20-06 - Informatics - Patient Records pan BCU
CRR20-07 - Informatics infrastructure capacity, resource and demand

Appendix 2 – Remapping BAF Risks to Annual Plan

- Remapping of BAF risks to the revised strategic priorities and enablers as set out within the Draft Annual Plan for 2021-22: -
  - **Priorities**
    - 1 Covid19 response
    - 2 Strengthen our wellbeing focus
    - 3 Primary and community care
    - 4 Recovering access to timely planned care pathways
    - 5 Improved USC pathways
    - 6 Integration and improvement of MH Services
  - **Key enablers:-**
    - Making effective and sustainable use of resources
    - Transformation for improvement
    - Effective alignment of our people

Remapped BAF Risks

New BAF Ref.	New priority alignment	20-21 Plan Priority	Previous BAF Ref.	Title
N/A Archived	5 Improved USC Pathways	1 Safe USC	20-01	Surge/ Winter Plan
21-01	**5 Improved USC Pathways**	**1 Safe USC**	**20-02**	**Safe and Effective Management of Unscheduled Care (formerly titled Emergency Care Review Recommendations)**
21-02	2 Strengthen our wellbeing focus	2 Essential Services and Planned Care	20-03	Sustainable Key Health Services
21-03	3 Primary and Community Care	2 Essential Services and Planned Care	20-04	Primary Care Sustainable Health Services
21-04	**4 Recovering access to timely planned care pathways**	**2 Essential Services and Planned Care**	**20-05**	**Timely Access to Planned Care**

Remapped BAF Risks continued

New BAF Ref.	New priority alignment	20-21 Plan Priority	BAF Ref.	Title
21-05	**6 Integration and Improvement of MH Services**	**3 Mental Health Services**	**20-07**	**Effective Stakeholder Relationships**
21-06	6 Integration and Improvement of MH Services	3 Mental Health Services	20-08	Safe and Effective Mental Health Delivery
21-07	6 Integration and Improvement of MH Services	3 Mental Health Services	20-09	Mental Health Leadership Model
21-08	6 Integration and Improvement of MH Services	3 Mental Health Services	20-10	Mental Health Service Delivery During Pandemic Management
21-09	**2 Strengthen our wellbeing focus**	**4 Safe and Secure Environment**	**20-11**	**Infection Prevention and Control**
21-10	**2 Strengthen our Wellbeing focus**	**4 Safe and Secure Environment**	**20-12**	**Listening and Learning**

Remapped BAF Risks continued

New BAF Ref.	New priority alignment	20-21 Plan Priority	Prev. BAF Ref.	Title
21-11	**2 Strengthen our wellbeing focus**	**4 Safe and Secure Environment**	**20-13**	**Culture – Staff Engagement**
21-12	**2 Strengthen our wellbeing focus**	**4 Safe and Secure Environment**	**20-14**	**Security Services**
21-13	2 Strengthen our wellbeing focus	4 Safe and Secure Environment	20-15	Health and Safety
21-14	**1 Covid 19 response**	**4 Safe and Secure Environment**	**20-16**	**Pandemic Exposure**
21-15	**NB aligned to key enabler – Making effective and sustainable use of resources**	**5 Effective Use of Resources**	**20-17**	**Value Based Improvement Programme**
21-16	**NB aligned to key enabler – Transformation for Improvement**	**5 Effective Use of Resources**	**20-18**	**Digital Estate and Assets**

Remapped BAF Risks continued

New BAF Ref.	New priority alignment	20-21 Plan Priority	BAF Ref.	Title
21-17	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-20	Estates and Assets Development
21-18	NB aligned to key enabler – Effective alignment of our people	5 Effective Use of Resources	20-21	Workforce Optimisation
21-19	1 Covid 19 response	2 Essential Services and Planned Care	20-25	Impact of COVID-19
21-20	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-26	Development of Annual Operational Plan 2021-22
21-21	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-27	Delivery of a Planned Annual Budget
21-22	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-28	Estates and Assets

Board Assurance Framework Key field guidance/ definitions of assurance levels

BAF Template Item		Please refer to the Risk Management Strategy and Policy for further detailed explanations
Risk Reference		Board Assurance Framework reference number, allocated by the Board Secretary
Risk Description		An uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's Priority. There are 3 main components to include when articulating the risk description (cause, event and effect):
		- There is a risk of / if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ……
Risk Ratings	Inherent	Without taking into consideration any controls which may be in place to manage this risk, what is the likelihood that this risk will be realised, and if it did, what would be the consequence
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place.
Risk Impact		The consequence (or how bad) if the risk were to be realised, in line with the NPSA Grading Matrix an impact of 1 is a Negligible (very low), with a 5 as Catastrophic (very high)
Risk Likelihood		The probability (frequency or how often) would this happen if the risk were to be realised. In line with the NPSA Grading Matrix a likelihood of 1 is this will probably never happen / recur, with a 5 being that it will undoubtedly happen, recur, possibly frequently
Score		Impact x Likelihood of the risk happening
Appetite	Definition	Is defined as the amount and type of risk the Health Board is willing to take on, pursue or retain in order to achieve its priorities.
	Low	Cautious with a preference for safe delivery options (Score 1 to 6)
	Moderate	Prepared to take on, pursue or retain some risks as a result of the Health Board taking opportunities to improve quality and safety of services (Score 8 to 10)
	High	Open or willing to take on, pursue or retain risks associated with innovation, research and development consistent with the Health Board's Priorities (Score 12-15)

Board Assurance Framework Key field guidance/ definitions of assurance levels

Control	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise and ensure that care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management] A measure that maintains and/or modifies risk (ISO 31000:2018(en))
	Examples include, but are not limited to:	- People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklist in place and being implemented which ensures the delivery of an objective - Training in place, monitored and assurance reported - Compliance audits - Business Continuity plans in place, up to date, tested and effectively monitored - Contract Management in place, up to date and regularly monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood and/or lessening or making less severe its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity).
	Examples include, but are not limited to:	- Service or Pathway Redesign - Business Case Development - Staff Training - Risk Assessment - Evidential data sets - Taking out insurance
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the data is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified the data, for example quality, finance and H/R assurance
	3	The third level of assurance comes from assurance provided from outside the Health Board, for example WG, HIW, HSE etc.