

**PWYLLGOR ARCHWILIO A SICRWYDD RISG  
AUDIT AND RISK ASSURANCE COMMITTEE**

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	13 August 2024
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Risk Assurance Report
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Joanne Wilson, Director of Corporate Governance / Board Secretary
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Charlotte Wilmshurst, Assistant Director of Assurance and Risk Rachel Williams, Head of Assurance and Risk

**Pwrpas yr Adroddiad (dewiswch fel yn addas)**

**Purpose of the Report (select as appropriate)**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA  
SBAR REPORT**

**Sefyllfa / Situation**

The purpose of this report is to provide assurance to the Audit and Risk Assurance Committee (ARAC) on the effectiveness of the Risk Management Framework, and the implementation of the Risk Management Strategy.

**Cefndir / Background**

The Risk Assurance report was developed to address feedback received during the ARAC Self-Assessment 2021/22 process, where it was identified that the Committee required specific assurance on effectiveness of risk management in the Health Board. The Risk Assurance report was first presented to ARAC at its meeting in February 2023, and agreed that the report would be presented every 6 months. This report notes the developments made regarding risk management since February 2024.

**Asesiad / Assessment**

Since the previous report presented to ARAC, revised performance management arrangements have been implemented in order to help address the challenges which the Health Board is currently facing and its increased escalation status to Targeted Intervention status with Welsh Government (WG). Detail on the revised arrangements and underpinning processes are detailed within Appendix 1.

The attached report will aim to provide assurance by outlining the risk management activity that has taken place since the previous report presented to ARAC in February 2024, on the effectiveness of the Risk Management Framework and the implementation of the Risk Management Strategy.

The Risk Management Framework was approved by the Board in July 2022, and sets out the components that provide the foundation and organisational arrangements for supporting risk management processes in Hywel Dda UHB.

The revised Risk Management Strategy was approved by the Board in March 2024. It provides a supportive framework that ensures the integration of risk management into policy making, planning and decision-making processes, and sets the 3 proposed key risk management objectives for the next 18 months:

- Define the organisation’s risk appetite and tolerance statement;
- Support operational and corporate functions to strengthen their risk management arrangements; and
- Strengthen the assurance that the Board receives on risk management activities.

Due to the strengthened performance management arrangements in place, going forward, this report will provide ARAC with a high-level summary of each Directorate’s escalation status in relation to their risk management processes. It is proposed that the frequency of the Risk Assurance report being presented to the Committee is increased from the current bi-annual timeframes, to every other meeting.

### Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **TAKE ASSURANCE** on the rolling programme to collate updates from services in order to report progress to the Committee, including the revised performance management arrangements; and
- **TO DISCUSS AND DECIDE** on the proposal to amend the frequency of reporting of the Audit Tracker to every other meeting as a result of the implementation of the revised performance management arrangements.

### Amcanion: (rhaid cwblhau)

#### Objectives: (must be completed)

<p>Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:</p>	<p>2.4 The Committee’s principal duties encompass the following: 2.4.1 Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation’s activities, both clinical and non-clinical. 2.4.3 Work with the Quality, Safety and Experience Committee, the People Organisational Development and Culture Committee, Strategic Development and Operational Delivery Committee and Sustainable Resources Committee to ensure that governance and risks are part of an embedded assurance framework that is ‘fit for purpose’.</p>
<p>Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:</p>	<p>Included within the report</p>
<p>Parthau Ansawdd: Domains of Quality <a href="#">Quality and Engagement Act (sharepoint.com)</a></p>	<p>7. All apply</p>
<p>Galluogwyr Ansawdd:</p>	<p>6. All Apply</p>

Enablers of Quality: <a href="#">Quality and Engagement Act (sharepoint.com)</a>	
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: <a href="#">Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022</a>	10. Not Applicable

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	Datix Risk Module
Rhestr Termau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Governance/Board Secretary

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
<b>Ariannol / Gwerth am Arian: Financial / Service:</b>	No direct impacts from this report however late or non-reporting of risks could mean that the UHB is not addressing any gaps in control and exploiting opportunities to achieve value for money.
<b>Ansawdd / Gofal Claf: Quality / Patient Care:</b>	No direct impacts from this report however late or non-reporting of risks could mean that the UHB is not addressing any gaps in control in relation to patient quality and care.
<b>Gweithlu: Workforce:</b>	No direct impacts from this report however late or non-reporting of risks could mean that the UHB is not addressing any gaps in control in relation to workforce issues and risks.
<b>Risg: Risk:</b>	Risk implications are inherent within the report.
<b>Cyfreithiol: Legal:</b>	No direct impacts from this report however late or non-reporting of risks could mean that the UHB is less likely to defend itself in a legal challenge which could lead to larger fines/penalties and damage to reputation.

<b>Enw Da: Reputational:</b>	No direct impacts from this report however late or non-reporting of risks could mean that the UHB is less likely to defend itself in a legal challenge which could lead to larger fines/penalties and damage to reputation.
<b>Gyfrinachedd: Privacy:</b>	No direct impacts from this report
<b>Cydraddoldeb: Equality:</b>	No direct impacts from this report

## Purpose of the report

The purpose of the report is to provide assurance to the Audit and Risk Assurance Committee (ARAC) on the effectiveness of the [Risk Management Framework](#), as approved by Board in June 2022, and the implementation of the [Risk Management Strategy](#), as approved by Board in March 2024.

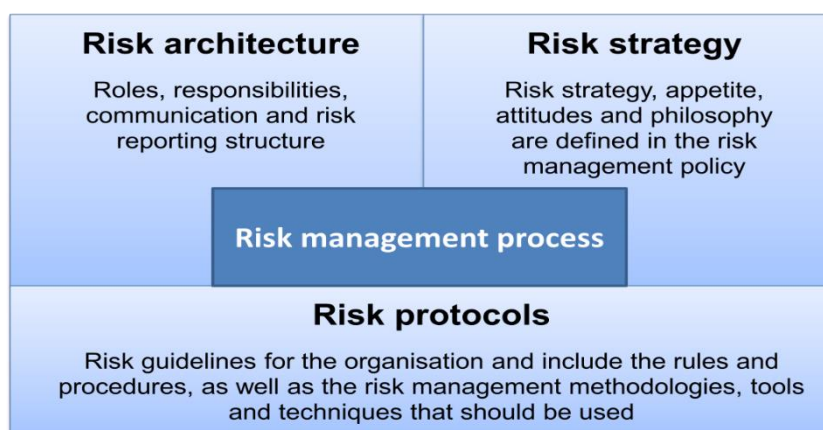
The overall aim of risk management is to:

- Ensure conformity with applicable rules, regulation and mandatory obligations;
- Provide assurance to the Board and the Audit and Risk Assurance Committee (ARAC) that risk management and internal control activities are proportionate, aligned, comprehensive, embedded and dynamic;
- Support decision-making through risk based information; and
- Provide effective and efficient strategy, operations and compliance activities.

The Health Board's Risk Management Strategy provides a supportive framework that ensures the integration of risk management into policy-making, planning and decision-making processes, and specifically:

- To improve the quality of service and protect patients, carers, staff and others who come in to contact with the Health Board;
- To create awareness through the Health Board about the importance of recognising and managing risk in a timely manner and providing staff with the appropriate knowledge, skills and support;
- To promote positive risk taking in the context of clinical care and in controlled circumstances;
- To provide a robust basis for strategic and operational planning through structured consideration of key risk elements;
- To enhance partnership working with stakeholders in the delivery of services;
- To improve compliance with relevant legislation and national best practice standards; and
- To enhance openness and transparency in decision-making and management.

The risk management framework is made up of the **risk architecture, strategy and protocols (RASP)**, which wraps round the Health Board's risk management process.



In order to provide the Committee with assurance that these goals are being met and that the risk management framework is effective, this report will outline the risk management activity that has taken place since the previous report as presented to ARAC in February 2024.

### **Revised Governance Arrangements**

A letter was sent in May 2024 (attached at Appendix 2) by the Chair of ARAC to the Executive Team to highlight concerns relating to overdue risks, also noting the limited assurance rating which was provided by Internal Audit for financial year 2023/24 in respect of the Health Board's arrangements to secure governance, risk management and internal control. Having up-to-date, relevant, and accurate risks enables the organisation to have an up-to-date risk profile which helps to better inform planning, decision-making the prioritisation of resources.

Since the previous report presented to ARAC in February 2024, revised performance management arrangements have been introduced in order to help address the challenges which the Health Board are currently facing, highlighted by the fact that the organisation is currently in Targeted Intervention status with Welsh Government (WG). Governance is one of the six domains which are assessed by WG in order to determine the Health Board's escalation status. To ensure that the Health Board can provide the best possible patient and staff experience, and to continue with necessary improvements, a new internal escalation framework has been introduced and implemented. Full detail on these arrangements can be found [later in the report](#).

Going forward, this report will aim to provide assurance to ARAC on the effectiveness of this process in respect to risk management, and will include detail on each Directorates' escalation status in line with the 3As assessment approach, and will complement the Audit Tracker paper. Data will be assessed as at the most recent month-end position to align with the escalation framework, and detail is noted within Appendix 3.

### **Risk Management Process**

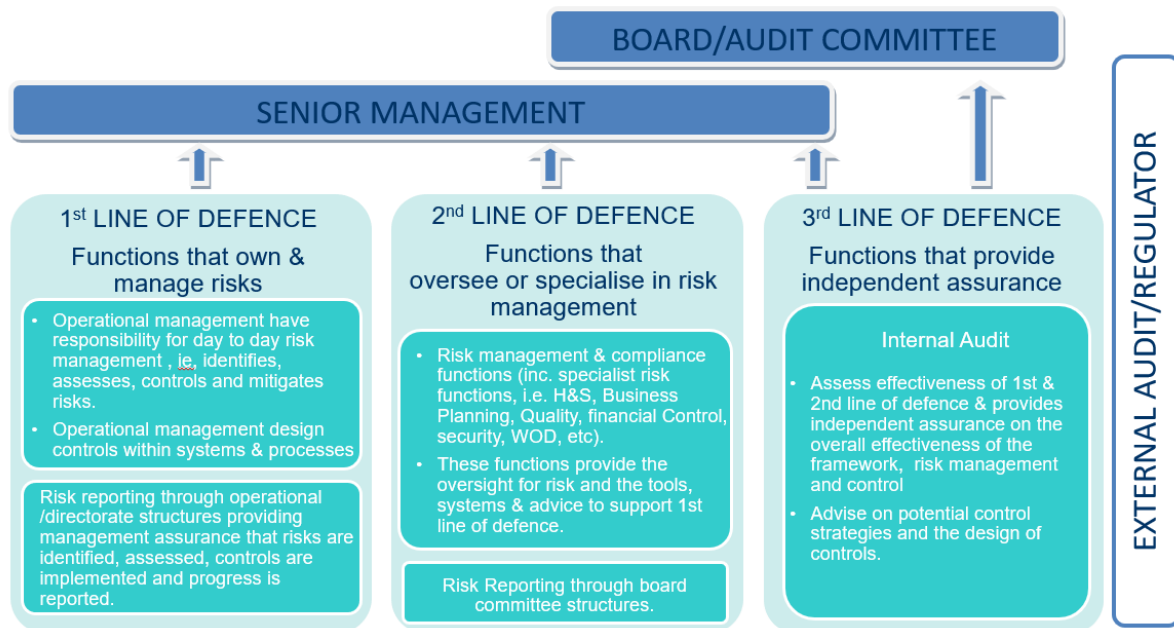
The Health Board's risk management process is recorded via the Datix Risk Module (Datix) and reported via risk register reports to both assurance and management meetings. Datix enables risks to be recorded at either Corporate, Directorate or Service level (definitions of which can be found in the [Risk Management Framework](#)), ensuring that risks are reported to, and scrutinised at, the most suitable forums.

The Health Board has an escalation process in place to ensure that risks which require escalation or de-escalation are done via the appropriate approval process. This can also be found within the [Risk Management Framework](#).

### **Three Lines of Defence for Risk Management**

The Health Board operates within the widely accepted "Three Lines of Defence" model, which provides a simple and effective way to delegate and coordinate risk management roles and responsibilities within an organisation. To ensure the

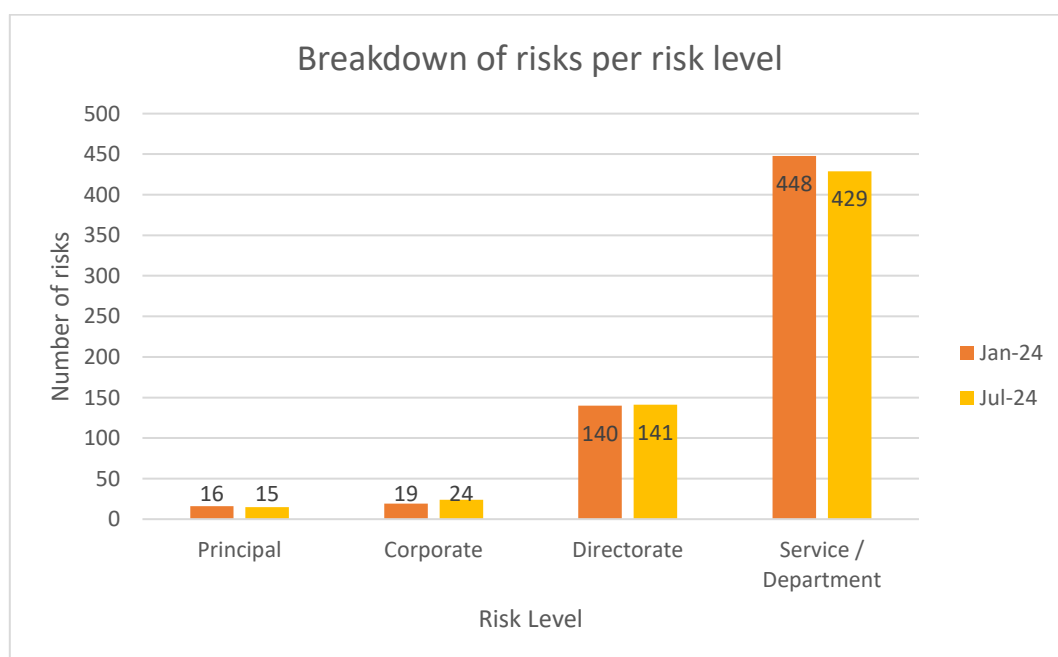
appropriate responsibility is allocated for the management, reporting and escalation of risk.



**Risk Management (1<sup>st</sup> line)**

The Health Board has 609 open risks on the Datix Risk Module as at 30 June 2024 (January 2024: 623), split as follows:

*Risks per Risk Levels*



Movements in risk since the previous report to ARAC are detailed in the table below:

Risk Level	Risks as at Jan 24	New risks *	Closed risks *	Risks as at Jul 24
Principal	16	0	1	15
Corporate	19	9	5	23
Directorate	140	32	30	142
Service / Department	448	71	90	429
<b>Total</b>	<b>623</b>	<b>112</b>	<b>126</b>	<b>609</b>

\*The numbers of new and closed risks include those which have been escalated or de-escalated since the previous report in line with the Health Board's escalation guidance. Detail of this movement is as follows:

- 1 risk de-escalated from Corporate to Directorate Level;
- 18 risks escalated to Directorate from Service Level; and
- 1 risk de-escalated from Directorate to Service Level.

The graph below highlights that the Health Board currently has 486 risks (80%) where their current risk scores are classified as either Extreme or High (January 2024: 501 (80%)), indicating that the organisation may be taking risks beyond its capacity.

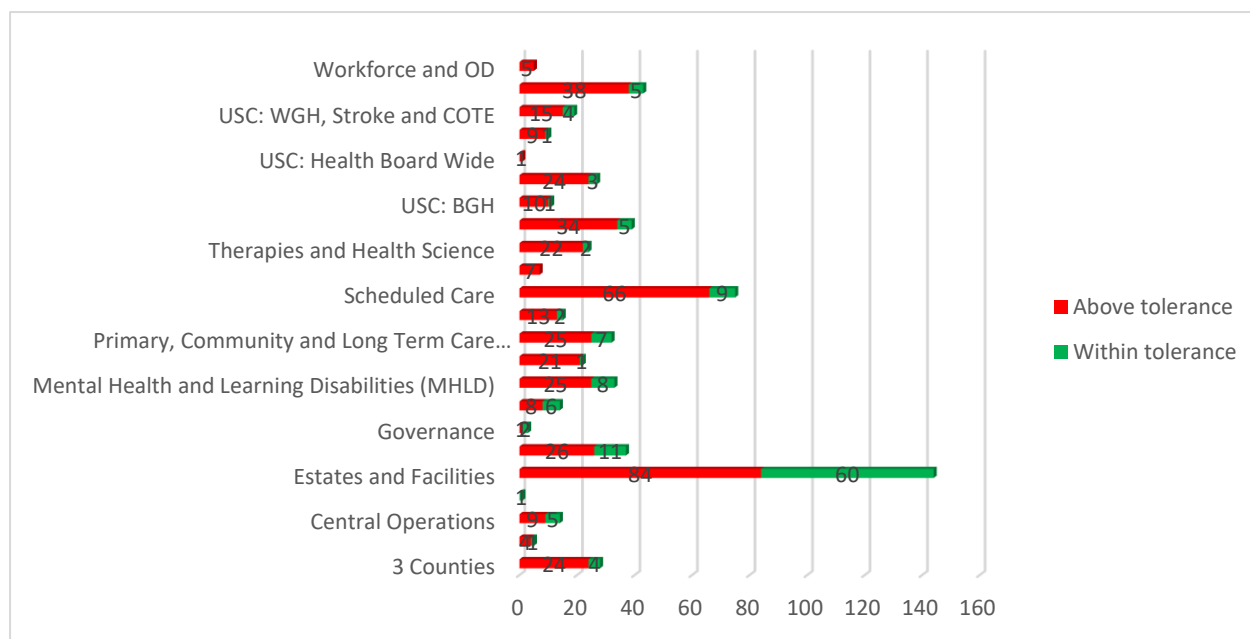


The definition of risk capacity is “the maximum level of risk to which the organisation should be exposed, having regard to financial and other resources”.

The graph below illustrates the number of risks assigned per Directorate, and highlights how many are within the current Board-accepted tolerance level (as discussed and agreed by the Board at its meeting on 27 September 2018), and how many are in excess of these thresholds. 471 of the 609 (77%) risks as at 30 June 2024 exceed Board tolerance thresholds (January 2024: 78%), further indicating that

the Health Board is carrying risk beyond its capacity. Following Board approval of risk appetite in January 2024, further work is being undertaken to review the Health Board's approach to its implementation, and its approach with regards risk tolerance.

### Risks per Service Area



Directorates across the Health Board are responsible for identifying risks that affect their services. However, risks are not always added to Datix in a timely manner however since the introduction of the internal escalation framework, there has been an improvement to reviewing risks within required timescales. There were 92 risks (16%) overdue for review as at 30 June 2024, which is a significant decrease and improvement from the 241 (39%) risks as identified in the report previously presented to ARAC.

For those risks noted as overdue, the majority have only recently lapsed (ie not been reviewed for 1-3 months), which may reflect the impact of current operational demands across the Health Board which have thus affected services' ability to update their risks within required timescales.

Whilst the recently implemented escalation framework has had a positive impact given the improved comparative figures to the previous report, further improvement is required as there were 285 actions from a total of 920 (31%) overdue as at 30 June 2024. The Assurance and Risk Team are working with service leads to ensure that risks are reviewed fully, appropriately and in a timely manner in order to reinforce the importance of reviewing and progressing risk actions. The timeliness of risk reviews, along with the progression of risk actions are key components in determining the levels awarded under the governance domain of the escalation framework. Appendix 3 details the performance of each Directorate as per escalation framework analysis undertaken at June month end.

### *Oversight of Risk (2nd Line)*

As part of the second line of defence, risk owners are able to assign multiple 'themes' to their risks, which allows the Health Board to share risk information on specific areas, such as health and safety, information governance and workforce with the relevant subject matter experts within the Health Board. This provides assurance that a holistic approach to risk management is undertaken, support and guidance can be offered to risk owners in the management of risk, and that areas of concern or trends can be identified. It also enables the Health Board to better identify and define its risk appetite, risk capacity and total risk exposure in relation to each risk, and to group similar risks or generic type of risk.

Each risk theme has assigned owners based on their subject matter expertise, who receive notifications when risks are added to the system, and are also provided with the relevant thematic risk register on a quarterly basis. Upon receipt, theme risk owners are required to review risks which have been assigned a theme to ensure that they have been correctly allocated, and review the risk, controls and planned actions from an expert perspective, and provide oversight and guidance to the relevant manager of any further controls that need to be undertaken to manage the risk to an acceptable level. The theme owner is also provided with a thematic risk register in order to identify trends, or risk clusters, and to consider whether there are gaps in controls in the Health Board's control framework, and to determine whether further action is required to prevent risks from materialising. Appendix 4 details the reporting of thematic risk registers since February 2024.

Since the previous risk assurance report presented in February 2024, the following developments have taken place in respect to risk themes:

- Work continues in relation to the theme of Fragile Services (added to Datix in January 2024). A report was presented to [Quality, Safety and Experience Committee in June 2024](#) detailing the overall approach to the identification and subsequent support of services deemed fragile, which noted the role in which risk management contributes. Since the initial methodology and approach was presented to QSEC in June 2023, further review of literature has been undertaken, considering work such as that of Rafa Bengoa relating to the reconfiguration of services, (which has been adopted in Northern Ireland), along with the requirements of the NHS Wales oversight and escalation framework where there is a requirement to demonstrate there is an effective process to recognise and respond to services that are at risk of becoming fragile. The Interim Director of Nursing, Quality and Patient Experience has established the Patient Safety Leadership Team as part of the Safer Care Collaborative, where the themed risk register is regularly scrutinised to support ongoing management and mitigation of the risks identified. It also facilitates a gap analysis, in identifying those services which may be considered as fragile who do not as yet have a corresponding risk on the risk register;
- Work continues with the Workforce Directorate to determine risk themes which will align to the six pillars, with the potential to supersede the current wide-ranging 'workforce' theme, to provide improved monitoring and reporting

arrangements. The Workforce theme is utilised by the Workforce and Organisational Development Directorate in order to provide analysis to the People, Organisational Development and Culture Committee.

### Independent Assurance (3<sup>rd</sup> line)

The third line of defence are those who provide independent assurance over the risk management arrangements in place, and where appropriate can advise on control strategies. Since the previous risk assurance report presented to ARAC, the following reviews relating to governance arrangements, which included a review of risk management processes, have been undertaken by external regulators and inspectorates:

- *Internal Audit – Head of Internal Audit Opinion:* The report was presented to ARAC at its meeting in June 2024, providing a **Limited Assurance** rating for the Health Board for the financial year 2023/24. While noting that in relation to Corporate Governance, Risk Management and Regulatory Compliance, substantial and reasonable assurances were provided on related reports issued in the year such as Board Oversight and Escalated Status Actions, the overall opinion noted that arrangements to secure governance, risk management and internal control for the areas reviewed provided limited assurance in terms of their design and application.
- *Audit Wales – Review of Operational Governance:* The report was presented to ARAC at its meeting in June 2024. The key focus of the report was on whether directorate level arrangements support the economic, efficient, and effective use of resources. Specifically, whether directorates have clear leadership and governance arrangements, are conducting business effectively and have good performance and risk management arrangements. It was found that while there are adequate systems of assurance at directorate level, supported by good performance information and risk management systems, there is inconsistent practice within directorates, with scope to strengthen and standardise performance and risk management arrangements within directorate teams. Recommendations raised in the report include:
  - the incorporation of risk management review process into routine business meetings held by operational teams; and
  - review risk management training within teams, and request refresher training where required from the corporate risk and assurance team.

### Risk Management Framework Risk Architecture

Risk architecture is the organisational arrangements for risk management which details the roles, responsibilities and the lines of communication for reporting on risk management.

## Committee and Reporting Structures

Effective risk management requires a reporting and review structure to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place. The Health Board's risk reporting structure is outlined in Appendix 2 of the [Risk Management Strategy](#).

### 1. The Board

The Board is responsible for oversight of the Health Board's principal risks, which are those that affect its ability to achieve its strategic objectives. The 6 strategic objectives are included within the Board Assurance Framework (BAF):

1. Putting people at the heart of everything we do	4. The best health and wellbeing for our communities
2. Working together to be the best we can be	5. Safe, sustainable, accessible, and kind care
3. Striving to deliver and develop excellent services	6. Sustainable use of resources

Principal risks are reported to the Board 3 times a year, with the last report provided in [July 2024](#) as part of the BAF Dashboard. The 15 principal risks were reviewed and updated following submission of the Health Board's 2023/24 Annual Plan at Executive Team in May 2024. The review reflected the priorities (the 2024/25 planning objectives) as agreed by the Board for the next year, as these are likely to have an impact on the Health Board's ability to implement its strategic objectives and manage its principal risks.

The table below summarises the changes to the Principal Risk Register (PRR) since the previous report presented to ARAC in February 2024:

Risk ref	Risk Title	Risk Score Jul-24	Status of risk	Date of change on PRR
1187	Strong enough reputation to attract partners to work with us	N/A	Closed – risk merged with 1188 - Effective leveraging within partnerships	05/06/24

The Board is also responsible for oversight of corporate risks, which are defined as significant risks that affect the Health Board's ability to deliver the healthcare services in the 'here and now'. Corporate risks are reported to the Board 3 times a year, with the last report provided in [May 2024](#). The Health Board has 23 corporate risks as at July 2024.

Revised Executive Team arrangements have been implemented since the previous report presented to ARAC, with risk now included as a standing agenda item on the formal Executive Team agenda on a monthly basis, which includes a review of the corporate and principal risk registers. The Executive Team is able to:

- approve new risks for addition to the register;
- escalate risks to corporate level;

- approve the closure of corporate risks; and
- de-escalate corporate risks to directorate level.

The table below summarises the changes to the Corporate Risk Register (CRR) since the previous report presented to ARAC in February 2024:

Risk ref	Risk Title	Risk Score Jul-24	Status of risk	Date of change on CRR
1328	Risk of harm to staff, patients and critical assets due to insufficient physical security measures	N/A	Closed	05/06/24
1642	Risk of Health Board not meeting statutory requirement to break even 23/24 due to significant deficit position	N/A	Closed	09/05/24
1657	Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 23/24 due to demand exceeding capacity	N/A	Closed	09/05/24
1699	Risk of loss of service capacity at WGH due to surveys and remedial work relating to RAAC	10	De-escalated	05/06/24
1810	Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS	15	New	20/02/24
1812	Risk of non-compliance with Medical Examiners (Wales) regulations to the failure to fully resource internal processes	16	New	27/02/24
1821	Risk to the welfare of Health Board staff due to current demands	9	New	07/03/24
1822	Risk to the welfare of senior management due to current demands	N/A	Opened and closed within reporting period	Added 07/03/24 Closed 03/07/24
1842	Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 24/25 due to demand exceeding capacity	15	New	09/05/24
1843	Risk that the cash consequences of the Health Board deficit cannot be covered due to significant deficit position	20	New	09/05/24
1859	Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	20	New	06/06/24

1860	Risk of harm to staff, patient, public and critical assets due to insufficient means to respond to V&A incidents	15	New	06/06/24
1861	Risk of harm to staff, patient, public and critical assets due to insufficient physical security measures and systems	16	New	06/06/24

All changes are included in risk reports to the Board and Committees.

## 2. Board Committees and Sub-Committees

Terms of References (TORs) are in place for each committee at the Health Board, which outline their responsibility to review and to seek assurance that risks aligned to Committees are being effectively managed across the Health Board and report any areas of significant concern. Committees receive corporate risk reports 3 times a year, which include the risks that are aligned to it, prior to them being reported to Board. Operational risks on Datix that are at Directorate level and above tolerance are also reported to the Board Committees 3 times a year. Risks are also reported to sub-committees, each of whom have delegated authorities from the parent committee, who received update reports at each meeting. Appendix 5 details recent risk reporting activity since February 2024.

## 3. Internal Escalation Framework Arrangements

The existing Directorate Improving Together (DIT) sessions have been strengthened to support an internal escalation framework for directorates, who will be assessed, on a monthly basis, against the following six domains to drive improvement in performance against several metrics:

- Quality;
- Governance;
- Workforce;
- Finance, Strategy and Planning;
- Fragile Services; and
- Performance and Outcomes.

One of the metrics under the Governance domain is how Directorates are managing risks in terms of the scale, significance, timeliness and quality, with levels awarded ranging between 1-3 to highlight progress being made:

Level	Definition
3	No assurance that the Directorate is managing their risks appropriately in terms of the scale, significance, timeliness and quality of response
2	Limited assurance that the Directorate is managing their risks appropriately in terms of the scale, significance, timeliness and quality of response
1	Reasonable assurance that there are no significant concerns within the Directorate

In addition to risk management, consideration is also given for each Directorate with the management of recommendations, implementation of Welsh Health Circulars and Ministerial Directions, compliance with Freedom of Information requests, and the management and review of policies and procedures.

This, in turn informs the wider escalation framework, where Directorates are assessed via the 3As assessment approach, and awarded an Alert, Advise or Assure status.

Escalation meetings are being held for Directorates where an Alert status has been awarded for three or more domains, chaired by the Director of Finance and report to the Targeted Intervention Working group. For those Directorates which are awarded a level 3 for Governance, but are not awarded an overall Alert status, meetings are set up between the Director of Corporate Governance and relevant service leads to discuss concerns, and determine next steps for de-escalation.

3A Status	Definition
<b>Alert</b>	There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.
<b>Advise</b>	There are areas of concern where assurance has been taken on actions in place but requires closed monitoring. An early warning of an emerging and potentially serious concern.
<b>Assure</b>	There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

The Assurance and Risk Team, via a business partnering approach, continue to support Directorates in providing technical risk advice, the ongoing monitoring and review of risks, and subsequent reporting of risks via local governance arrangements. The new arrangements came in to force in April 2024, two rounds of review and escalation have been undertaken as at the time of writing this report in July 2024. Detail on individual Directorates performance with regards risk management as part of the escalation framework is included in Appendix 3.

#### *4. Service and Directorate Level Monitoring Arrangements*

Risks are discussed by services and directorates via quality governance meetings for operational areas, or senior management meetings. These forums allow for the discussion of existing risks in detail by service leads and relevant Directors, and the identification of any new or emerging risks, with the frequency of these meetings varying dependant on the service either monthly or bi-monthly. Local governance arrangements are considered when awarding the escalation status for Governance. For operational services, corporate risks are also reported to the Director of Operations' monthly Operational Performance, Governance and Planning (OPGP) meetings.

In the absence of formal governance arrangements being in place in some areas, regular meetings with service leads are in place to review and update risks with the

relevant Assurance and Risk Officer, and is a process which works well. It is noted since the previous report to ARAC in February 2024, the Assurance and Risk Team now attend senior management meetings for the Finance, Digital and Strategy and Planning directorates.

### **Risk Management Strategy**

The [Risk Management Strategy](#) (the Strategy), approved by Board in March 2024, sets out the Health Board's risk management policy statement and objectives in respect of strengthening risk management for the next 18 months.

The Strategy aims to support a dynamic and systematic approach to risk management, and to ensure prompt and comprehensive identification, assessment and management of risks that threaten the delivery of its strategic objectives and day-to-day operations.

The Strategy contains the following three objectives for 2024, with progress against each objective detailed below:

#### *1. Define the Organisation's Risk Appetite and Tolerance Statement*

*We will further develop the Health Board's risk appetite by:*

- *Raising Board's awareness of risk appetite and its use through a Board Seminar regarding risk appetite;*
- *Developing risk appetite statements for each of the UHB's strategic objectives;*
- *Review the current risk tolerance levels;*
- *Reviewing the Risk Appetite Statement on an annual basis as part of the business planning process.*

In August 2023, Executive Risk Group (ERG) commenced work on refreshing its risk appetite to support the Health Board's recovery response. ERG considered the risk capability of the organisation to manage the level of risk which it is carrying. At its Board Seminar, held on 14 December 2023, the Board held a workshop to consider the risk appetite statement as developed by ERG, using the risk appetite matrix from the [Orange Book Risk Appetite Guidance Note](#), and subsequently approved by Board at its meeting in [January 2024](#).

An implementation plan was developed and presented to the Executive Team in March 2024, detailing proposals as to how risk appetite will be cascaded to Directorate and Service leads across the Health Board, and risk management training as provided by the Assurance and Risk team updated as required. This informs an objective as included in the refreshed Risk Management Strategy, [detailed later in this report](#). Work is ongoing to develop the integrated impact assessment (IIA) process in order to incorporate risk appetite, including what threshold or trigger point would be required in order to instigate this process. Consideration is also being given to the creation of a Task and Finish group, now that the escalation framework has been implemented, in order to develop processes which identify, measure and report on risks outside of the Health Board's appetite, with support from colleagues across the wider Health Board.

## 2. Support Operational and Corporate Functions to strengthen their Risk Management Arrangements

*Through our Business Partnering relationship, we will support operational risk management by:*

- *Utilising information provided and discussed at Directorate quality and business meetings to help services identify, assess and manage risks and improve outcomes;*
- *Enhancing the knowledge of staff in risk management across the Health Board through training on risk assessment and risk management, and the systems used to capture this process;*
- *Embedding the revised risk management framework and using a consistent language of risk management including concepts such as controls, mitigations, escalation, assurance, risk appetite and risk tolerance;*
- *Implement the new Once for Wales Concerns Management system when it has been developed and is ready to be rolled out;*
- *Linking risks on the risk management module;*
- *Providing practical support to services in the escalation and acceptance of risk; and*
- *Supporting corporate and operational directorates with risk review meetings.*

The Assurance and Risk team is currently comprised of:

- Assistant Director of Assurance and Risk (ADAR);
- Head of Assurance and Risk (HAR);
- 2 x Assurance and Risk Officers (ARO); and
- 1 x Assurance and Risk Administrator (ARA).

The team operates within a business-partnering approach to support operational and corporate teams meet their obligations in respect of risk management, with each Directorate assigned a dedicated Assurance and Risk Officer (ARO). The ADAR, HAR and 2 AROs are accredited members of the Institute of Risk Management (IRM), having successfully completed the IRM Certificate in Enterprise Risk Management. 1 ARO is currently studying towards accreditation with the IRM, supported by the Annex 21 framework adopted by the Health Board.

AROs support the Health Board by preparing risk reports and risk registers for the relevant directorate or service governance meetings, and attend meetings in order to facilitate and support discussions on risk identification, assessment and treatment in order to improve outcomes. These forums are also utilised to confirm if risks as noted on the risk registers are at the correct level, and to support the escalation or de-escalation of risks in line with Health Board guidance where required.

AROs provide training to operational managers and risk leads across the Health Board on using the Datix Risk Management System, and technical risk assessment and risk management training where appropriate. In undertaking their role, AROs provide general support to services in the regular risk management and review process, continually embedding the principles of the revised Risk Management

Framework, to ensure a consistent approach is adopted across the Health Board to risk management, and risk language. Risk Management Training is also included within the Manager's Passport Programme in place within the Health Board. Work continues to improve the understanding of risk tolerance across the Health Board, and will link with the implementation strategy for the embedding of the revised risk appetite statement. Since the previous report to ARAC, the [Risk Assessment Procedure](#) has been reviewed and updated, endorsed by the Committee in June 2024 and approved by Board in July 2024.

The Head of Assurance and Risk has been supporting the work relating to understanding what constitutes service fragility within the Health Board. At its meeting on 5 May 2023, the Executive Risk Group commissioned work to agree:

- A clear definition of what is meant by fragility (in the context of services);
- A clear definition of what constitutes a single point of failure;
- What criteria/triggers would be used to enable the organisation to identify that a service is classified as fragile; and
- How the prioritisation of these would be weighted to determine the level of risk.

The Assurance and Risk team continue to regularly review and update the content of its Sharepoint site, which is accessible to all staff across the Health Board, in order to further support the enhancement of knowledge of risk management and ensure consistency in the use of risk terminology. Staff can access the site via the [following link](#), and are able to access a suite of risk management documents such as policies, procedures and templates, along with the ability to book risk management training sessions.

Members of the Assurance and Risk team continue to support services in the linking of risks, particularly when they may be owned by another service or directorate to which they may not have sight of. This encourages a holistic approach to risk management, and AROs are able to share examples of best practice where necessary in the aim to further improve the managing and mitigation of risk.

Performance dashboards, which include data from the Datix Risk Module, allow staff across the organisation to view all risks, thus increasing the visibility and awareness of risks facing the Health Boards. The [risk-specific dashboard](#) is updated twice a month, and risk data in the [Health Board wide dashboard](#) is refreshed on a monthly basis and provides a snapshot of the risk landscape, with recent developments highlighting risks which are overdue for review, and risks with overdue actions which underpin the newly implemented internal escalation framework.

The date of implementation of the new Once for Wales Concerns Management system has been extended to 30 November 2027 following recent contract discussions. This allows the Health Board to continue using the existing Datix Risk Module system, and enables all Health Boards across Wales to observe the outcomes from the pilot roll-out of the system at Powys Teaching Health Board, and inform ongoing system developments. The ADAR is a member of the All-Wales group and is involved with the project planning of the upgrading process.

### *3. Strengthen the Assurance that the Board receives on Risk Management Activities*

*We will do this by:*

- Undertaking an assessment against a recognised standard and develop a plan to enable the Health Board to continue to strengthen its risk management arrangements, culture, and attitude to risk;*
- Developing a Risk Assurance Report for the Audit and Risk Assurance Committee, who can provide onward assurance to the Board in risk management activities and delivery of the agreed risk management objectives within this strategy; and*
- Continuing to report both Corporate and Directorate level risks to Board Committees, who can provide onward assurance to the Board on the management of risk within the Health Board.*

A risk maturity self-assessment was undertaken during quarter 3 of 2023/24, in accordance with the Orange Book, which is a recognised risk management standard for the public sector, and going forward will be undertaken on an annual basis. Detail of the assessment was presented to ARAC in February 2024, the outcomes of which informed the Risk Management Strategy as approved by Board in [March 2024](#). A further self-assessment will be undertaken during Q3/4 of 2024/25, building on the lessons learned from the assessment undertaken in 2023/24, with collaboration with services and directorates across the Health Board in order to obtain a holistic response from the organisation.

The Risk Assurance Report aims to provide assurance to the Board that the risk management framework is effective and outline the risk management activities that are being undertaken, and where any gaps are identified, these will be addressed and implemented. It will also provide assurance that the objectives outlined in the Risk Management Strategy are being progressed. The Assurance and Risk Team continue to provide risk reports to Board and its sub-committees in line with agreed workplans.



Gofynnwch am/Please ask for: Emily Price  
Rhif Ffôn /Telephone: 01267239644  
Dyddiad/Date: 14.05.2024

Swyddfeydd Corfforaethol, Adeilad Ystwyth  
Hafan Derwen, Parc Dewi Sant, Heol Ffynnon Job  
Caerfyrddin, Sir Gaerfyrddin, SA31 3BB

Corporate Offices, Ystwyth Building  
Hafan Derwen, St Davids Park, Job's Well Road,  
Carmarthen, Carmarthenshire, SA31 3BB

Dear Colleagues

## Re: Overdue Risks and Audit Recommendations

I am writing following concerns raised at the last two Audit and Risk Assurance Committee meetings in relation to the number of risks that are overdue for review. These concerns also apply to an increasing number of audit recommendations which have exceeded their target implementation dates with many now citing unknown.

The need to write to you has also been reiterated by this year's Head of Internal Audit Opinion which has provided a limited assurance rating in respect of our arrangements to secure governance, risk management and internal control. It is therefore more important than ever that we work together to reduce the Health Board's risk exposure through strong risk management and audit tracking.

The Risk Assurance Report to ARAC in February 2024 reported that there were 241 (39%) risks overdue for review (this was an increase from the 157 (26%) risks identified as overdue for review in August 2023). Having up-to-date, relevant, and accurate risks enable organisations to reduce harm, minimise loss and limit damage, and also enables organisations to have an up-to-date risk profile which helps to better inform planning, decision-making and prioritisation of resources.

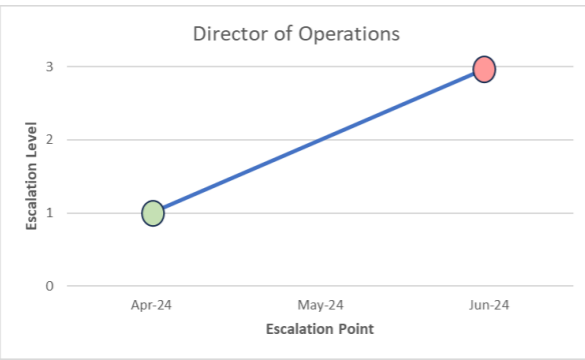
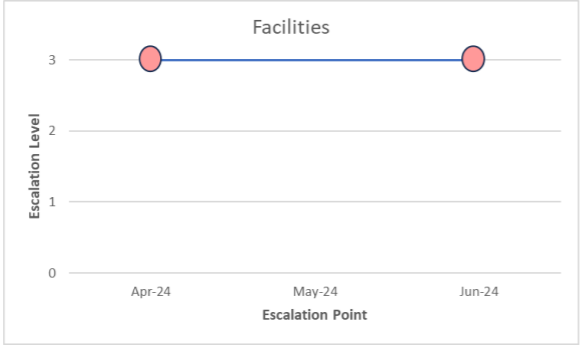
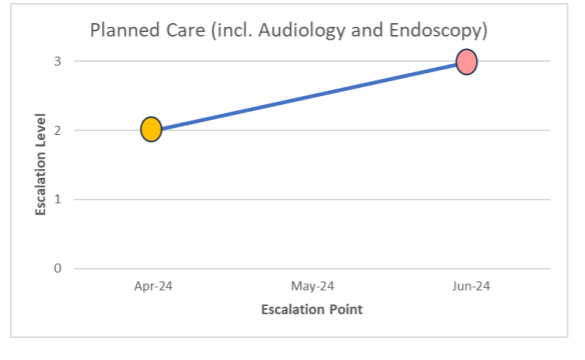
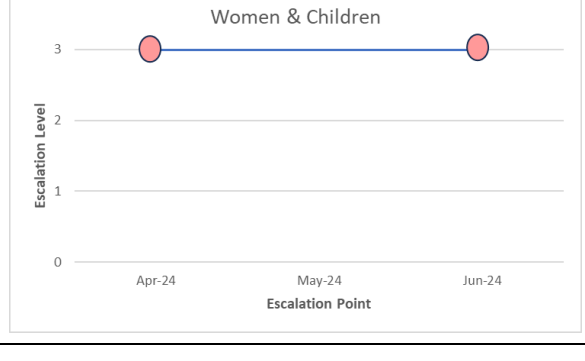
Whilst winter is always a challenging time for health organisations, it is extremely disappointing that this has not improved as we move into Summer. At present, there are now 280 (45%) risks overdue for review and I would urge you to ask your teams to review their risks more regularly particularly given the scrutiny the Health Board is currently subject to. By taking a proactive approach to risk and risk management, we can make better strategic decisions, reduce operational disruption, reduce financial loss and improve stakeholder confidence. I also ask that the same approach is applied to outstanding audit recommendations. Can I please ask that this work is completed over the next two months as the Committee is expecting an improvement in both areas by the August 2024 Audit and Risk Assurance Committee meeting.

Thank you for your co-operation.

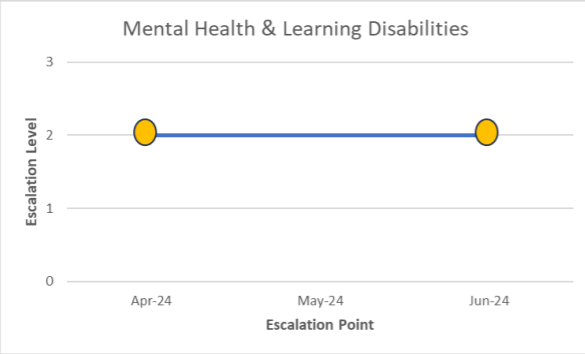
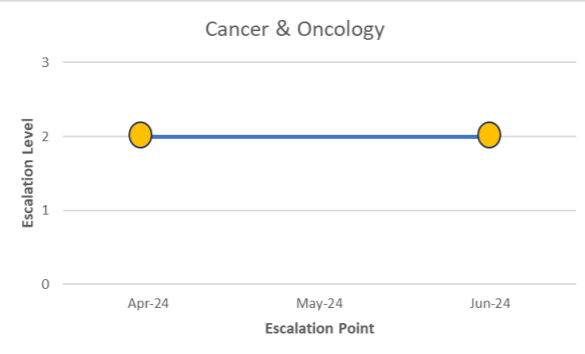
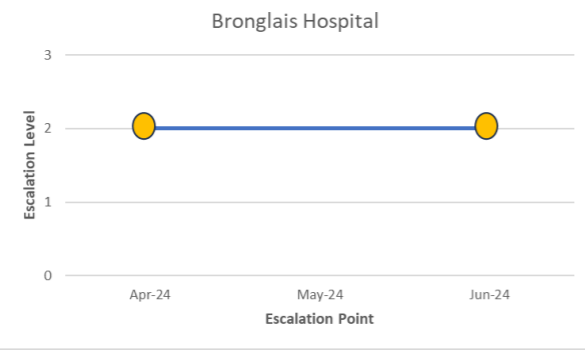
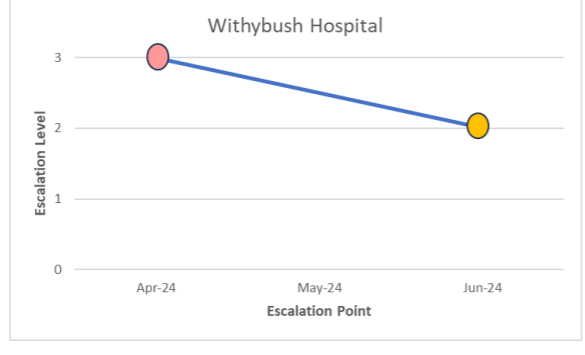
Rhodri Evans  
Chair of Audit and Risk Assurance Committee

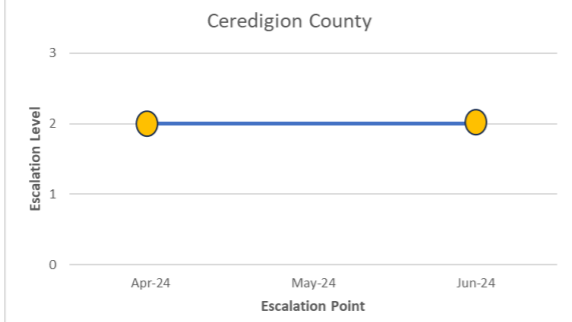
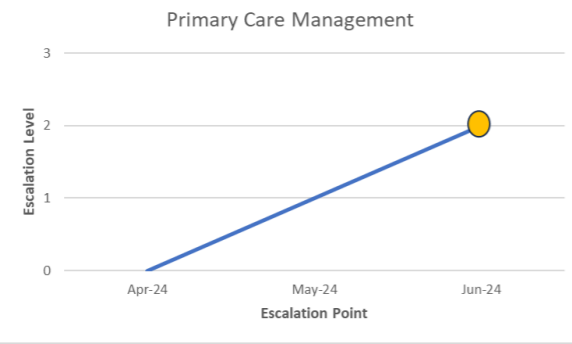
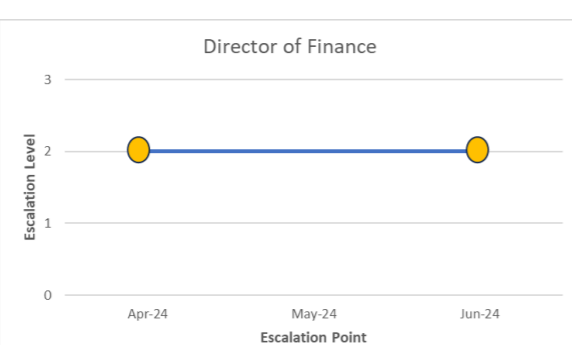
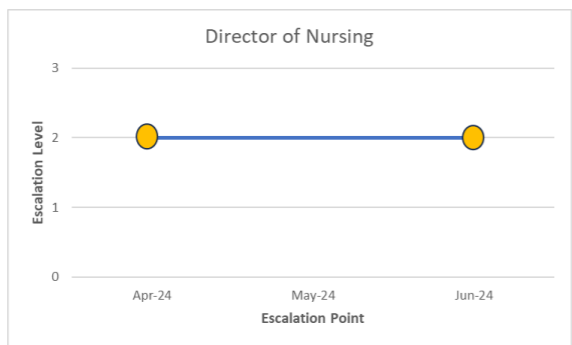
CC Chair  
Audit and Risk Assurance Committee Members

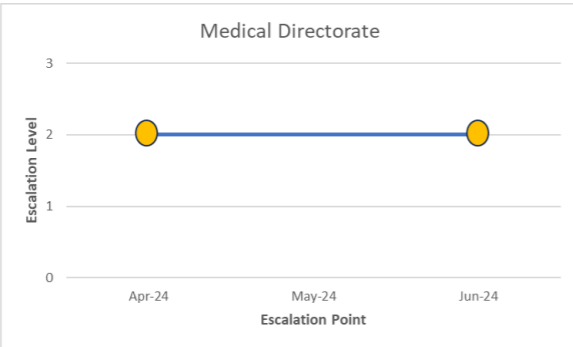
**Level 3 Services with No Assurance at July 2024**

Service	Trend – June 2024	Reason for escalation status (Risk)	Minimum requirement for de-escalation (Risk)
<p>Director of Operations <i>(including Central Operations, Acute Service, and USC: Health Board wide)</i></p>		<p>15 risks, 7 (47%) of which are overdue for review, 1 overdue by more than a month. 44% of actions on risk actions plans are noted as being overdue.</p> <p>The Head of Assurance and Risk attends the monthly Acute Leadership Group (ALG) meeting to present risks aligned to the service. Whilst there are currently no formal governance meetings in place for Central Operations, the Head of Assurance and Risk is liaising with the Business and Governance Manager within the Directorate to determine what meetings could be instigated so that the Assurance and Risk Team are able to attend and present the position of their risks.</p>	<p>Ensure at least 90% of risks are reviewed within risk review timescales and at least 90% of risk actions are reviewed and have revised completion dates.</p> <p><i>Meeting scheduled on 19 August 2023 with Director of Corporate Governance.</i></p>
<p>Facilities</p>		<p>144 risks, 6 (4%) of which are overdue for review, none overdue by more than a month. 38% of actions on risk actions plans are noted as being overdue. 144 risks operational and corporate risks on Datix, which represents 24% of all risks on the Health Board's risk register.</p> <p>Whilst there are monthly meetings in place within the Directorate to review risks, there are currently no formal governance arrangements in place. Along with the Directorate's performance in relation to the implementation of their recommendations (which is detailed in the Audit Tracker paper being presented to ARAC in August 2024), they were awarded a Level 3 in the Escalation Framework as at June month end.</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates.</p>
<p>Planned Care</p>		<p>75 risks (representing 12.5% of all the Health Board's current risks), 64 (45%) of which are overdue for review (34), of which 6 are overdue by greater than one month. 78% of actions on risk actions plans are noted as being overdue.</p> <p>Whilst there is good engagement with service leads, and bi-monthly meetings in place within the Directorate which the Assurance and Risk Team attend to present the position of the risk register, many risk actions remain out of date. Quarterly face to face meetings are being scheduled between the Directorate and the Assurance and Risk team to review risks (along with recommendations and Welsh Health Circulars), the first of which took place in July 2024.</p>	<p>Ensure at least 90% of risks are reviewed within risk review timescales and at least 90% of risk actions are reviewed and have revised completion dates.</p>
<p>Women &amp; Children</p>		<p>Whilst all 43 risks were reviewed within required timescales, 20% of actions noted as being overdue. However, concerns remain in relation to the performance in managing recommendations raised (which is detailed in the Audit Tracker paper being presented to ARAC in August 2024), along with timely review of policies, the Directorate were awarded a Level 3 in the Escalation Framework as at June month-end.</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates.</p>

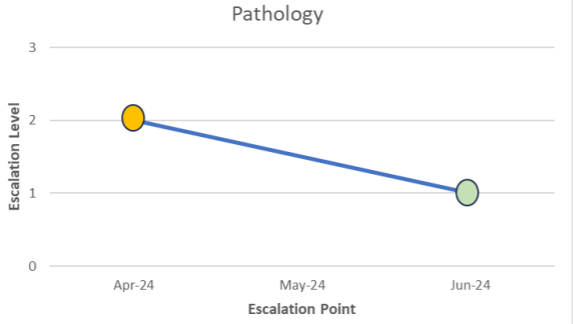
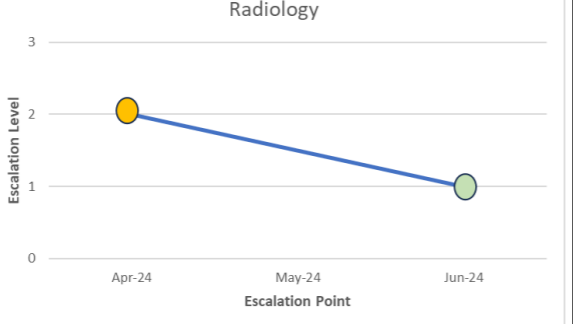
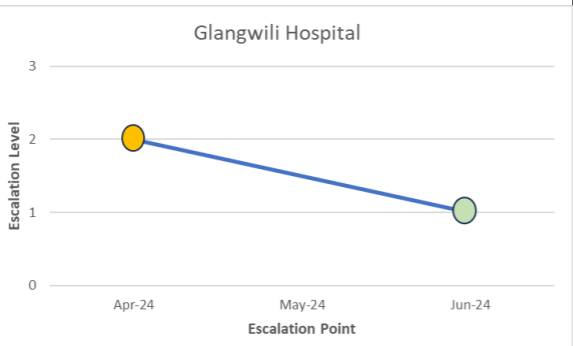
**Level 2 - Services with Limited Assurance at July 2024**

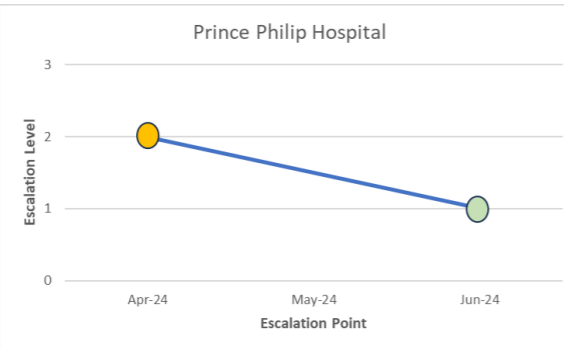
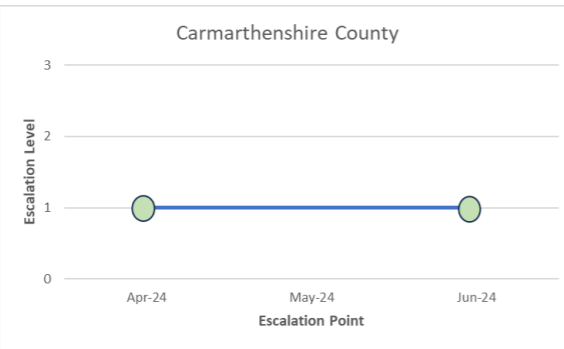
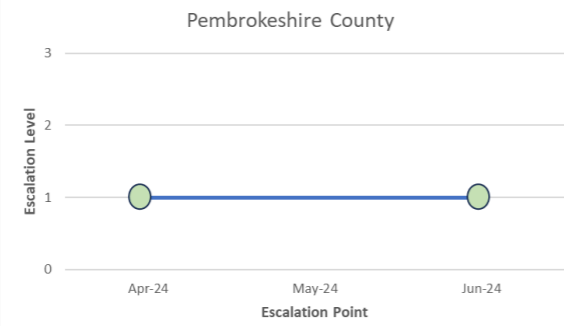
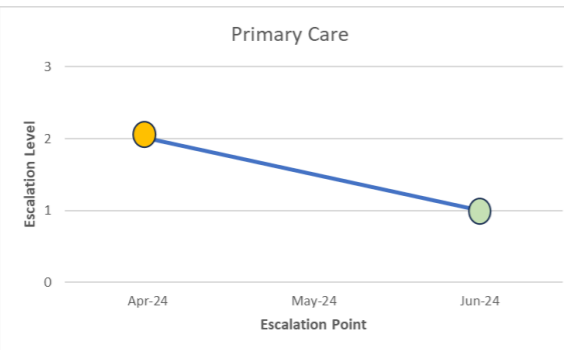
Service	Trend – June 2024	Reason for escalation status (Risk)	Minimum requirement for de-escalation (Risk)
Mental Health & Learning Disabilities	 <p>Mental Health &amp; Learning Disabilities</p> <p>Escalation Level: 2 (Apr-24), 2 (May-24), 2 (Jun-24)</p>	<p>There are timely reviews of risks with the Directorate, with only 1 risk (3%) overdue for review at the point of data extraction for the Escalation Framework. 20% of actions on risk actions plans are noted as being overdue. A level 2 has been awarded to the Directorate as June month-end due to their performance in relation to the management and implementation of recommendations, which is detailed in the Audit Tracker paper being presented to ARAC in August 2024.</p> <p>The Directorate have monthly meetings in place (QSE and BPPAG) which is attended by the Assurance and Risk Team, with risk and assurance a standing agenda item for these meetings.</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation.</p>
Cancer and Oncology	 <p>Cancer &amp; Oncology</p> <p>Escalation Level: 2 (Apr-24), 2 (May-24), 2 (Jun-24)</p>	<p>All 5 risks on the Directorate's risk register were reviewed in required timescales, however 86% of actions on associated risk plans are overdue.</p> <p>Whilst there a bi-monthly meetings in place within the Directorate, whereby the Assurance and Risk Team are invited to attend in order to present service leads with an updated position on their risk register, all meetings scheduled for 2024 to date have been stood down as a result of staffing pressures.</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation.</p>
Bronglais Hospital	 <p>Bronglais Hospital</p> <p>Escalation Level: 2 (Apr-24), 2 (May-24), 2 (Jun-24)</p>	<p>The Directorate have 11 risks, 1 of which was overdue at the point of data extraction. However, 39% of actions on risk actions plans are noted as being overdue.</p> <p>Monthly governance meetings are in place for the site, with attendance from the Assurance and Risk Team. Summary positions are also reported for the site at the monthly Acute Leadership Group (ALG) meetings. Whilst there has been a positive trend in relation to the site's risk management processes, they were awarded a Level 2 as part of the Escalation Framework as at June month-end due to performance in relation to the management of recommendations aligned to the service, which are detailed in the Audit Tracker paper being presented to ARAC in August 2024.</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation.</p>
Withybush Hospital <i>(including Stroke and Care of the Elderly)</i>	 <p>Withybush Hospital</p> <p>Escalation Level: 3 (Apr-24), 2 (Jun-24)</p>	<p>The site has 19 risks, all of which were reviewed within required timescales as at June month-end, however it was noted that 38% of risk actions noted were overdue. An improved trend was noted in relation to the prior round of Escalation Framework data, reflecting in a reduced escalation status being awarded at June month-end.</p> <p>Bi-monthly governance meetings are in place for the site, with attendance from the Assurance and Risk Team. Summary positions are also reported for the site at the monthly Acute Leadership Group (ALG) meetings.</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation.</p>

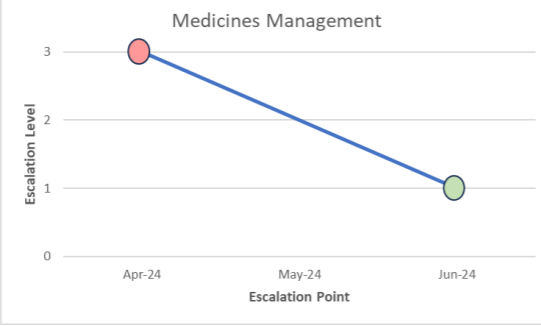
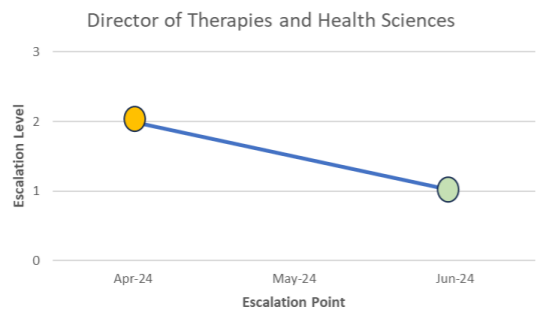
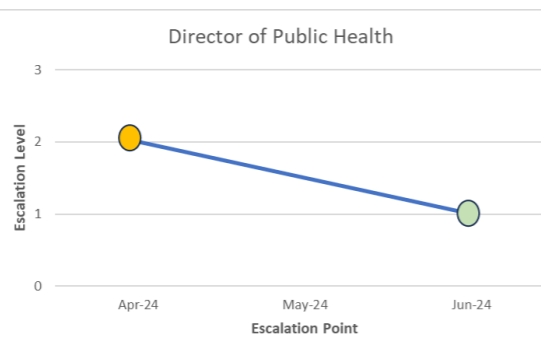

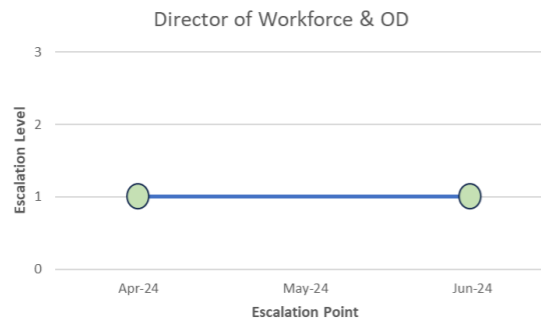
Service	Trend – June 2024	Reason for escalation status (Risk)	Minimum requirement for de-escalation (Risk)
<p>Ceredigion County <i>(including Palliative Care)</i></p>	 <p>The chart shows the Escalation Level for Ceredigion County. The y-axis is labeled 'Escalation Level' and ranges from 0 to 3. The x-axis is labeled 'Escalation Point' and shows months Apr-24, May-24, and Jun-24. A horizontal blue line is drawn at level 2, with yellow circular markers at each data point, indicating a consistent level of 2 across all three months.</p>	<p>The Directorate have 10 risks, all of which were reviewed within required timescales as at June month-end. However, it is noted that 43% of actions were overdue.</p> <p>Monthly governance meetings are in place for the county, with attendance from the Assurance and Risk Team.</p> <p>Whilst a positive picture can be noted for the risk management processes undertaken by the county, the Directorate were awarded a Level 2 in the Escalation Framework process as at June month-end due to outstanding recommendations assigned, and discussed in detail in the Audit Tracker paper being presented to ARAC in August 2024.</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation.</p>
<p>Primary Care Management <i>(including Long Term Care and Chronic Conditions)</i></p>	 <p>The chart shows the Escalation Level for Primary Care Management. The y-axis is labeled 'Escalation Level' and ranges from 0 to 3. The x-axis is labeled 'Escalation Point' and shows months Apr-24, May-24, and Jun-24. A blue line starts at level 0 in Apr-24, rises to level 1 in May-24, and reaches level 2 in Jun-24, with yellow circular markers at each data point.</p>	<p>The Directorate had 2 risks, both of which were overdue for review at the point of escalation as at June month-end. It was also noted that 80% of risk actions were being overdue. Clarification was sought during the escalation process in terms of the alignment of relevant Primary Care services to the category of Primary Care Management, the explanation for which justifies the increased escalated position in comparison to the escalation point.</p>	<p>Ensure at least 90% of risks are reviewed within risk review timescales and at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation.</p>
<p>Director of Finance <i>(including Finance, Digital and Performance)</i></p>	 <p>The chart shows the Escalation Level for the Director of Finance. The y-axis is labeled 'Escalation Level' and ranges from 0 to 3. The x-axis is labeled 'Escalation Point' and shows months Apr-24, May-24, and Jun-24. A horizontal blue line is drawn at level 2, with yellow circular markers at each data point, indicating a consistent level of 2 across all three months.</p>	<p>The Directorate has 37 risks, 8 of which were overdue for review at June month-end position relating to the Digital service. In addition, 44% of risk actions aligned to the Digital service were noted as being overdue. Both the Finance and Performance directorates had up-to-date risks on their respective risk registers.</p> <p>Papers are regularly submitted to the Directorate of Finance's Finance, Digital and Performance meeting (attended by senior leadership from the three directorates), and further supplemented by in-depth discussions on the risk register positions at the monthly Finance Senior Management Team monthly meeting, with attendance from the Assurance and Risk Team. Arrangements have also commenced in July 2024 with the Digital Senior Leadership team whereby the Assurance and Risk Officer attends bi-monthly meetings to review the Directorate's risk register.</p>	<p>Concerns relate to Digital Service only and the following action to be taken to avoid increased escalation:</p> <p>Ensure at least 90% of risks are reviewed within risk review timescales and at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation.</p>
<p>Director of Nursing, Quality and Patient Experience</p>	 <p>The chart shows the Escalation Level for the Director of Nursing. The y-axis is labeled 'Escalation Level' and ranges from 0 to 3. The x-axis is labeled 'Escalation Point' and shows months Apr-24, May-24, and Jun-24. A horizontal blue line is drawn at level 2, with yellow circular markers at each data point, indicating a consistent level of 2 across all three months.</p>	<p>The Directorate has 22 risks, 20 of which were reviewed within required timescales as at June month end, with the two noted as overdue for review only recently lapsed. 24% of risk actions were noted as being overdue. Monthly governance meetings are in place, with representation from the Assurance and Risk team.</p> <p>Whilst a positive picture can be noted for the risk management processes undertaken by the Directorate, they were awarded a Level 2 in the Escalation Framework process as at June month-end due to the difficulty in progressing and implementing Welsh Health Circulars assigned (details of which can be found in the Quality Assurance report presented to QSEC in August 2024), and concerns around policies being out of date review (noting that they are currently pending extension).</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation.</p>

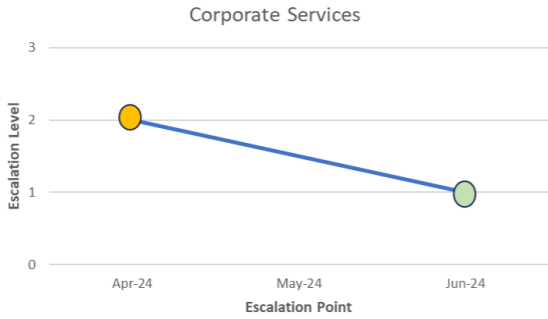
Service	Trend – June 2024	Reason for escalation status (Risk)	Minimum requirement for de-escalation (Risk)
Medical Directorate		<p>The Directorate has 14 risks, 13 of which were reviewed within required timescales as at June month-end, with the overdue risk having only recently lapsed. 24% of risk actions noted as being overdue. There are monthly Medical Directorate Business and Governance meetings, with representation from the Assurance and Risk team.</p> <p>Whilst a positive picture can be noted for the risk management processes undertaken by the Directorate, they were awarded a Level 2 in the Escalation Framework process as at June month-end due to outstanding recommendations assigned, and is discussed in detail in the Audit Tracker paper being presented to ARAC in August 2024.</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation.</p>

**Level 1 - Services with Reasonable Assurance as at July 2024**

Service	Trend – June 2024	Reason for escalation status (Risk)	Minimum requirement to remain de-escalated (Risk)
Pathology		<p>An improved position was noted for the Directorate as at June month-end in comparison to the initial round of data for the Escalation Framework process, with all 27 risks assigned reviewed within required timescales, and 6% of actions noted as being overdue. The Directorate have bi-monthly governance meetings in place, with attendance from the Assurance and Risk team.</p>	<p>N/A – an improved performance noted since initial point of escalation.</p>
Radiology		<p>An improved position was noted for the Directorate as at June moth-end in comparison to the initial round of data for the Escalation Framework process, with all 12 risks reviewed within required timescales. It was noted that 17% of risk actions are overdue. The Directorate have bi-monthly governance meetings in place, with attendance from the Assurance and Risk team.</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation. An improved performance noted since initial point of escalation.</p>
Glangwili Hospital <i>(including Cardiology, Gastroenterology and Renal)</i>		<p>An improved position was noted for the site as at June moth-end in comparison to the initial round of data for the Escalation Framework process, with all 27 risks reviewed within required timescales. It was noted that 25% of risk actions are overdue. The site has bi-monthly governance meetings in place, with attendance from the Assurance and Risk team.</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation.</p>

Service	Trend – June 2024	Reason for escalation status (Risk)	Minimum requirement to remain de-escalated (Risk)
<p>Prince Philip Hospital <i>(including Diabetes and Respiratory)</i></p>	 <p>The chart shows the Escalation Level for Prince Philip Hospital from April 2024 to June 2024. The y-axis represents the Escalation Level from 0 to 3. The x-axis shows the months Apr-24, May-24, and Jun-24. A blue line connects a yellow dot at level 2 in April and a green dot at level 1 in June. The label 'Escalation Point' is centered below the x-axis.</p>	<p>An improved position was noted for the site as at June moth-end in comparison to the initial round of data for the Escalation Framework process, with all 10 risks reviewed within required timescales. It was noted that 19% of risk actions are overdue. The site has bi-monthly governance meetings in place, with attendance from the Assurance and Risk team.</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation.</p>
<p>Carmarthenshire County</p>	 <p>The chart shows the Escalation Level for Carmarthenshire County from April 2024 to June 2024. The y-axis represents the Escalation Level from 0 to 3. The x-axis shows the months Apr-24, May-24, and Jun-24. A blue line connects a green dot at level 1 in April and another green dot at level 1 in June. The label 'Escalation Point' is centered below the x-axis.</p>	<p>The county had 10 risks as at June month-end, all of which were reviewed within required timescales. However, it was noted that 45% of risk actions noted were overdue. Monthly governance meetings are in place for the county, with attendance from the Assurance and Risk Team.</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation.</p>
<p>Pembrokeshire County</p>	 <p>The chart shows the Escalation Level for Pembrokeshire County from April 2024 to June 2024. The y-axis represents the Escalation Level from 0 to 3. The x-axis shows the months Apr-24, May-24, and Jun-24. A blue line connects a green dot at level 1 in April and another green dot at level 1 in June. The label 'Escalation Point' is centered below the x-axis.</p>	<p>The county had 8 risks as at June month-end, 7 of which were reviewed within required timescale, with the overdue risk having only recently lapsed. 18% of risk actions were noted as being overdue. Monthly governance meetings are in place for the county, with attendance from the Assurance and Risk Team.</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation.</p>
<p>Primary Care</p>	 <p>The chart shows the Escalation Level for Primary Care from April 2024 to June 2024. The y-axis represents the Escalation Level from 0 to 3. The x-axis shows the months Apr-24, May-24, and Jun-24. A blue line connects a yellow dot at level 2 in April and a green dot at level 1 in June. The label 'Escalation Point' is centered below the x-axis.</p>	<p>An improved position was noted for the Directorate as at June moth-end in comparison to the initial round of data for the Escalation Framework process, with all 20 risks reviewed within required timescales. 14% of risk actions were noted as being overdue. Monthly governance meetings are in place, with representation from the Assurance and Risk team. Quarterly governance meetings are in place with the Directorate, further supplemented by governance meetings for each service within Primary Care. Arrangements are currently being discussed between the Directorate and the Assurance and Risk team to confirm the most relevant forum for attendance going forward from a risk perspective, with a meeting scheduled for 26 July 2024 to finalise.</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation.</p>

Service	Trend – June 2024	Reason for escalation status (Risk)	Minimum requirement to remain de-escalated (Risk)
Medicines Management	 <p>Medicines Management</p>	<p>A significantly improved position was noted for the Directorate as at June moth-end in comparison to the initial round of data for the Escalation Framework process, having previously been awarded a Level 3 status due to the number of risks being overdue. As at June month-end, all 10 risks had been reviewed within required timescales, with 11% of risk actions noted as being overdue.</p> <p>The Assurance and Risk team have previously attended the Directorate’s Medicines Management Operational Group (MMOG) to present updates on risk registers, however discussions are currently ongoing so that the team attend the Senior Pharmacy Leadership (SPL) business meetings on a bi-monthly basis going forward.</p>	<p>N/A – an improved performance noted since initial point of escalation.</p>
Director of Therapies and Health Sciences	 <p>Director of Therapies and Health Sciences</p>	<p>An improved position was noted for the Directorate as at June moth-end in comparison to the initial round of data for the Escalation Framework process, with 22 of the 24 risks assigned reviewed within required timescales, noting that the two overdue risks had only recently lapsed. 31% of risk actions were noted as being overdue. The Directorate have monthly governance meeting, with every other meeting dedicated risk, with representation from the Assurance and Risk team.</p>	<p>Ensure at least 90% of risk actions are reviewed and have revised completion dates to avoid increased escalation.</p>
Director of Public Health	 <p>Director of Public Health</p>	<p>An improved position was noted for the Directorate as at June moth-end in comparison to the initial round of data for the Escalation Framework process, with all 15 risks reviewed within required timescales, and only 2% of risk actions noted as being overdue. The Directorate have bi-monthly quality meeting, which has representation from the Assurance and Risk team.</p>	<p>N/A – an improved performance noted since initial point of escalation.</p>
Director of Strategy and Planning	 <p>Director of Strategy and Planning</p>	<p>An improved position was noted for the Directorate as at June moth-end in comparison to the initial round of data for the Escalation Framework process, with all 7 risks reviewed within required timescales, and only 3% of actioned noted as being overdue. The Assurance and Risk team attend the Directorate’s Senior Management Team, a process which commenced in July 2024.</p>	<p>N/A – an improved performance noted since initial point of escalation.</p>
Director of Workforce & OD	 <p>Director of Workforce &amp; OD</p>	<p>The Directorate as at June month-end had 3 corporate and 2 principal risks, which are regularly reviewed via Executive Team in addition to risk leads. The Directorate do not have any operational risks.</p>	<p>N/A</p>

Service	Trend – June 2024	Reason for escalation status (Risk)	Minimum requirement to remain de-escalated (Risk)								
<p>Corporate Services <i>(including Governance and CEO Directorate)</i></p>	 <p>The chart shows the Escalation Level for Corporate Services from April 2024 to June 2024. The y-axis represents the Escalation Level (0 to 3), and the x-axis represents the Escalation Point (Apr-24, May-24, Jun-24). The level starts at 2 in April 2024 and decreases to 1 in June 2024. An escalation point is indicated at May 2024.</p> <table border="1"> <caption>Corporate Services Escalation Level Trend</caption> <thead> <tr> <th>Month</th> <th>Escalation Level</th> </tr> </thead> <tbody> <tr> <td>Apr-24</td> <td>2</td> </tr> <tr> <td>May-24</td> <td>1.5</td> </tr> <tr> <td>Jun-24</td> <td>1</td> </tr> </tbody> </table>	Month	Escalation Level	Apr-24	2	May-24	1.5	Jun-24	1	<p>The Directorate as at June month-end had 4 risks assigned, reviewed within timescales. The Governance directorate have monthly Senior Management Team meeting in place, with detail provided by the Assurance and Risk team to provide an update on the position of the risk register.</p>	<p>N/A</p>
Month	Escalation Level										
Apr-24	2										
May-24	1.5										
Jun-24	1										

## Reporting of Themed Risk Registers

Risk Theme	Number of risks – July 2024	Theme owner	Month themed risk register sent to theme owner	Forum which theme reported to, and date last reported
Accommodation / Property	9	Head of Property Performance	June 2024	Health and Safety Committee
Business Continuity / Service Disruption	143	Emergency Planning Officer	June 2024	Managed outside of Committee as agreed with the Chair of the Operational Quality Safety and Experience Sub-Committee due to risks being included within individual Directorate exception reports presented to the Sub-Committee
Capital - Estates	109	Head of Facilities Information & Capital Management	July 2024	Capital Sub Committee* <i>Local Management Arrangements: Central Compliance and Assurance Audit Meeting, July 2024</i>
Capital – Equipment	33	Deputy Director of Operations	July 2024	Capital Sub Committee*
Capital – Digital	13	Digital Director	July 2024	Capital Sub Committee*
Consent and Mental Capacity	1	Head of Consent and Mental Capacity	April 2024	Managed outside of Committee as agreed with the Chair of the Operational Quality Safety and Experience Sub-Committee due to risks being included within individual Directorate exception reports presented to the Sub-Committee
Cyber Security	10	Cyber Security Senior Specialist	July 2024	Information Governance Sub Committee

Risk Theme	Number of risks – July 2024	Theme owner	Month themed risk register sent to theme owner	Forum which theme reported to, and date last reported
Deprivation of Liberty Safeguards (DOLS)	1	Deprivation of Liberty Safeguards Coordinator	April 2024	Managed outside of Committee as agreed with the Chair of the Operational Quality Safety and Experience Sub-Committee due to risks being included within individual Directorate exception reports presented to the Sub-Committee
Digital Transformation	15	Head of Digital Innovation and Transformation	July 2024	Sustainable Resources Committee
Estates	124	Head of Estates Risk and Compliance	July 2024	Health and Safety Committee  <i>Local Management Arrangements: Central Compliance and Assurance Audit Meeting, July 2024</i>
Finance	64	Assistant Director of Finance	July 2024	Sustainable Resources Committee
Fire	16	Head of Fire Safety	July 2024	Health and Safety Committee  <i>Local Management Arrangements: Fire Safety Group, July 2024</i>
Fragile Services	217	Fragile Services Working Group	April 2024	Managed outside of Committee as agreed with the Chair of the Operational Quality Safety and Experience Sub-Committee due to risks being included within individual Directorate exception reports presented to the Sub-Committee

<b>Risk Theme</b>	<b>Number of risks – July 2024</b>	<b>Theme owner</b>	<b>Month themed risk register sent to theme owner</b>	<b>Forum which theme reported to, and date last reported</b>
Fraud	0	Local Counter Fraud Specialist	No risks assigned	Audit and Risk Assurance Committee
Health and Safety	100	Head of Health, Safety and Security	April 2024	Health & Safety Committee
Information and Communication Technology	35	Head of Digital Business and Engagement	June 2024	Information Governance Sub Committee
Infection Control	29	Senior Nurse, Infection Prevention	April 2024	Managed outside of Committee as agreed with the Chair of the Operational Quality Safety and Experience Sub-Committee due to risks being included within individual Directorate exception reports presented to the Sub-Committee
Information and Data Capture	23	Head of Information Services	June 2024	Information Governance Sub Committee
Information Governance	24	Head of Information Governance	June 2024	Information Governance Sub Committee
Medical Devices	32	Assistant Director of Therapies and Health Sciences	July 2024	Medical Devices Group  Managed outside of Committee as agreed with the Chair of the Operational Quality Safety and Experience Sub-Committee due to risks being included within individual Directorate exception reports presented to the Sub-Committee

Risk Theme	Number of risks – July 2024	Theme owner	Month themed risk register sent to theme owner	Forum which theme reported to, and date last reported
Medication	22	Clinical Pharmacy Lead for Patient Services	April 2024	Managed outside of Committee as agreed with the Chair of the Operational Quality Safety and Experience Sub-Committee due to risks being included within individual Directorate exception reports presented to the Sub-Committee
Natural Environment	8	Head of Facilities Information and Capital Management	April 2024	Health and Safety Committee
NICE/National Guidance	31	Head of Effective Clinical Practice and Quality Improvement	July 2024	Clinical Standards and Guidelines Group, June 2023  Managed outside of Committee as agreed with the Chair of the Operational Quality Safety and Experience Sub-Committee due to risks being included within individual Directorate exception reports presented to the Sub-Committee
Patient Safety	262	Head of Quality and Governance	November 2023	Managed outside of Committee as agreed with the Chair of the Operational Quality Safety and Experience Sub-Committee due to risks being included within individual Directorate exception reports presented to the Sub-Committee

<b>Risk Theme</b>	<b>Number of risks – July 2024</b>	<b>Theme owner</b>	<b>Month themed risk register sent to theme owner</b>	<b>Forum which theme reported to, and date last reported</b>
Quality	186	Head of Quality and Governance	November 2023	Managed outside of Committee as agreed with the Chair of the Operational Quality Safety and Experience Sub-Committee due to risks being included within individual Directorate exception reports presented to the Sub-Committee
Reputation	147	Communications Director	January 2023	Managed outside of Committee as agreed with the Director of Communications
Safeguarding	30	Head of Safeguarding	April 2024	Managed outside of Committee as agreed with the Chair of the Operational Quality Safety and Experience Sub-Committee due to risks being included within individual Directorate exception reports presented to the Sub-Committee
Security	17	Head of Health, Safety and Security	April 2024	Health and Safety Committee
Workforce	185	Assistant Director of Workforce and Organisational Development	April 2024	People, Organisational Development and Culture Committee

\* The Terms of Reference of the Capital Sub Committee (CSC) were amended in March 2023, and approved by Strategic Development and Operational Delivery Committee (SDODC) in April 2023 agreed that the risk reporting arrangements to CSC changed. Themed risk registers are shared with the capital leads for Digital, Equipment and Estates for them to inform their prioritisation for capital funding.

**Reporting of Corporate Risks January - July 2024**

<b>Committee</b>	<b>Risk Reporting frequency</b>	<b>Reports presented</b>	<b>Number of risks reported</b>	<b>Matters arising from last meeting</b>
Charitable Funds Committee (CFC)	Every other meeting	No risks currently assigned to CFC	N/A	N/A
Health and Safety Committee (HSC)	Every other meeting	January 2024	4	No specific actions raised.
		May 2024	4	No specific actions raised.
People, Organisational Development and Culture Committee (PODCC)	Every other meeting	April 2024	3	No specific actions raised. Discussions were held on the addition of two staff welfare risks being reported for the first time to the Committee.
Quality, Safety and Experience Committee (QSEC)	Every other meeting	April 2024	11	Action raised to revise the risk relating to the aseptic unit, requesting Chars action for inclusion of the revised risk in the QSEC update report to Board in May 2024 as a result of discussions at Committee requesting clarification on mitigating actions.
<b>Committee</b>	<b>Risk Reporting frequency</b>	<b>Reports presented</b>	<b>Number of risks reported</b>	<b>Matters arising from last meeting</b>
Strategic Development and Operational Delivery Committee (SDODC)	Every other meeting	April 2024	4	No specific actions raised. Discussion held at the Committee in relation to the corporate risk relating to the Single Cancer Pathway, with the impact of reputational challenge and escalation by Welsh Government if progress is not satisfactory.
Sustainable Resources Committee (SRC)	Every meeting	February 2024	3	No specific actions raised.
		April 2024	3	Committee noted that the risk relating to the Health Board's ability to meet the statutory requirement to break even was being redrafted for financial year 2024/25,

*Note: Risks relating to Cyber Security are*

<i>presented and discussed via in-committee due to the sensitive nature of the risks</i>		June 2024	3	awaiting formal ratification at Executive Team in May 2024.  Action raised to confirm whether the corporate risk in relation to records management has been de-escalated.
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**Reporting of Operational Risks January - July 2024**

<b>Committee</b>	<b>Risk Reporting frequency</b>	<b>Reports presented</b>	<b>Number of risks reported</b>	<b>Matters arising from last meeting</b>
Charitable Funds Committee (CFC)	Every other meeting	No risks currently assigned to CFC	N/A	N/A
Health and Safety Committee (HSC)	Every other meeting	January 2024  July 2024	4  7	No specific actions raised.  Actions raised for risk leads to update relevant risk controls and actions for clarification as requested at Committee.
People, Organisation-al Development and Culture Committee (PODCC)	Every other meeting	N/A	0	No operational risks were assigned to the committee during this reporting timeframe. Detailed analysis is provided to PODCC on work undertaken by the Workforce and OD Directorate on Workforce themed risks via the Workforce Plan update.
<b>Committee</b>	<b>Risk Reporting frequency</b>	<b>Reports presented</b>	<b>Number of risks reported</b>	<b>Matters arising from last meeting</b>
Strategic Development and Operational Delivery Committee (SDODC)	Every other meeting	February 2024  June 2024	4  3	No specific actions raised.  No specific actions raised.

Sustainable Resources Committee (SRC)	Every meeting	February 2024	16	Actions raised for the Director of Finance to discuss with the Director of Corporate Governance as to how risks feed into the Escalation Framework, and to circulate to committee members an example of a pack which feeds into the Directorate Improving Together Sessions.
		April 2024	14	No specific actions raised.

\* Operational risks are discussed via the Operational Quality, Safety and Experience Committee (OQSEC) at every other meeting, with updates provided to QSEC via the sub-committee report

#### **Reporting of Risks to sub-committees January – July 2024**

Sub-Committee	Parent Committee	Risk Reporting frequency	Reports presented	Number of risks reported
Information Governance Sub Committee (IGSC)	SRC	Every other meeting	April 2024	2
Operational Quality, Safety and Experience Sub Committee (OQSESC)  <i>Directorate exception reports presented at each meeting detail the status of their risk registers</i>	QSEC	N/A	N/A	N/A – all risks are reported via Directorate Exception Reports presented by service leads at each meeting.
Research and Innovation Sub Committee (RISC)	PODCC	Every other meeting	September 2023	8