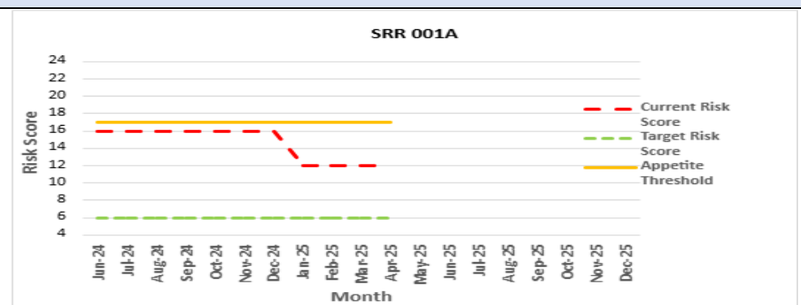
		Risk Description		Risk Score Matrix
				2 | 4 | 5 | 6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25
SRR 001	Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a)Due to an inability to recruit and retain staff across all disciplines and specialities.	
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff	
			c) Due to insufficient and ineffective leadership levels throughout the organisation.	
			d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	
	Director of Strategy, Planning and Partnerships.		e) Due to inadequate strategic plans which respond to population health and socio-economic needs	
			f) Due to unsustainable service models	
	Director of Finance and Procurement		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	
	Director of Strategy, Planning and Partnerships.		I) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	
SRR 002	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	
			b) Due to significant levels of backlog maintenance	
SRR 004	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a Major Incident	
			b) Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident.	
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems	
			b) Due to an adverse impact on service delivery in the implementation of new digital systems	
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future	
SRR 007	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	
			b) Due to the impact of fragile services across the regional and supra regional geography	
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	
SRR 010	Director of Allied Health Professions and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	
SRR 011	Director of Finance and Procurement	There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government (16% reduction by 2025 and a 34% reduction by 2030) . This is common to all Health Bodies across the country.	a) The effect of a failure to meet this target is on the wider environment due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected	

Key	
Current Score	●
Target Score	×
Appetite Threshold	◊
Current to target	◂ –

Assessment of adequacy of assurances	
	POSITIVE = Identified assurances are deemed robust in telling us that the controls in place are working effectively.
	REASONABLE = Identified assurances are deemed adequate in telling us that the controls in place are working effecively, however some gaps have been identified which need to be addressed.
	NEGATIVE = Identified assurances are deemed insufficent in telling us that the conrols in place are working effectively with substantial gaps identified which need to be addressed.

RISK THEME	PEOPLE				
LINK TO IMTP	**SECTION 4: ENABLER – WORKFORCE AND CULTURE**				
Strategic - SRR 001 A	**There is a risk The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to an inability to recruit and retain staff across all disciplines and specialties.**			**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Non-compliance with safe staffing principles and standards. • Increased Workload	**Organisation** • Operational Disruptions • Quality of Services • Reputational Damage • Financial strain – use of agency and bank staff	**Risk Appetite Threshold - Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	People & Culture Committee	**Likelihood**	**3** *(Possible)* x	**3** *(Possible)* x	
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**2** *(Minor)*	
Last Reviewed	01 April 2024	**Risk rating**	**= 12** ***(High)***	**= 6** ***(Moderate)***	
Next Review (Quarterly based on risk score)	01 July 2025				

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Monitoring Framework to support roll-out of the People Plan. • Workforce Dashboard to track activity – recruitment, turnover, sickness absence. • Supply and demand tracker (Nursing and HCSW). • People Plan tracker to support delivery of actions within the People Plan 2022-25. • Variable Pay Reduction Plan approved June 2022 and supported by the Programme Board. • Management of attendance through All Wales Management Attendance at Work Policy. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. • Nurse Staffing Levels (Wales) Act 201625b/25c. • Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. • Workforce planning supported by Compendium of new roles to support innovative workforce models. • Recruitment KPI's. • IMTP (Integrated Medium-Term Plan) Educational Commissioning. • Workforce Establishment controls national working group has been instigated. • Value and Sustainability Board. • Implementation of the Collective Agreement (Non-Pay Deal) 2022/24. • **Recruitment** • Engagement with national recruitment campaigns such as BAPIO, M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW (Health Education and Improvement Wales) for Junior Doctor. • Annual programme of Apprentice recruitment • Overseas Nursing (All Wales Recruitment programme) • Nursing Workforce Strategy agreed. • Streamlining and improving recruitment timescales through recruitment modernisation programme (started Oct 2022) • Partnerships with employability schemes and FE/HE to widen access. • Actively working with Local Authorities to promote joint recruitment activities via Gwent Workforce Board. • Working with partners to improve visibility and attraction	**Retention** • Development of career pathways (e.g., non-clinical to clinical). • NHS Wales Nurse Retention Plan quarterly updates being reviewed for submission 09 Sept 2024 ongoing reviews taking place. • HCSW retention plan developed in collaboration with Nursing focusing on areas of high turnover • Short project in progress with an MSc student to develop a retention dashboard, using a regression model to better understand and predict retention. Data analysis is underway with a 5 year past dataset shared. **Variable Pay Reduction** • Development of action plan based on WHC to support the reduction in bank and agency usage. **E- Systems** • Utilise benefits of roll out Safe Care staffing to support effective and efficient staff deployment within adult ward areas. • Roll out of medical rostering to predict junior doctor gaps and look for alternative ways to fill. • Ensure compliance increase in e-job planning to optimise current resources and identify any gaps in provision. • Review and analyse the electronic Bank & Agency data from Patchwork to identify areas with high usage, reasons for use and potentially convert to substantive roles. **Development of alternative and new roles** • Continued implementation of new roles such as Physician Associates, CAAPs, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP. • Establishment of Mental Health Workforce Planning through HEIW leadership of Mental Strategic Workforce Plan and allocation of workforce planning resources and training programme currently being delivered to Health Boards. • Updating of compendium of new roles and benchmarking is available via workforce planning intranet site and HEIW portal. • Looking to increase Assistant band 4 in Community/Mental Health and areas such as Cardiology Physiology • Continue to extend scope of Advanced Clinical Practitioners to undertake new procedures, reporting etc reducing medical capacity.

- DBS Policy in place with DBS risk assessment form
- Introduced centralised HCSW talent pools from September 2023.
- Future Nurse Academy introduced in January 2024.

Retention
- Retention lead appointed with programme action plan in place for the next two years.
- Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR.
- Week of events planned to support retention agenda in 2025. This will include a mixed method of online webinars, videos and retention materials.
- Internal Retention group has been established with a view to 1) interrogating data from multiple sources to fully understand the issues 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts.
- Changes in pension regulation and flexile retirement options from October 2023 and reduced break in service required following retire and return.
- Development of HCSW skills matrix and career framework has commenced.
- Talent management and succession planning framework and resources now live and available on SharePoint. Framework signed off by Executive Committee.
- Career conversations and succession planning resources designed; Talent management succession planning workshop dates available with spaces for 120 people (with monthly training sessions available). Sessions are nearly fully booked with 114/120 places booked**.** Further workshops planned until the end of the year.
- All Wales self-assessment retention tool completed and submitted to HEIW with assessment at organisational level for Nursing and Midwifery to provide a baseline.

Variable pay reduction
- Plan in place to monitor and review all agency, bank pay incentives supply and demand reporting to Value and Sustainability Board.

E- Systems
- Effective deployment of current staff - Programme Plan implemented to introduce Workforce Medical E-Systems to support effective deployment of medical staff. E-Locum Bank, E-Job Planning, E-Agency systems are all 'live' and rolled out within the Health Board.
- E-Rostering is planned to go live shortly following ESR interface testing and following increase in e-job planning compliance, provisionally scheduled for the end of July 2025.

Development of Alternative and New Roles
- Development of alternative and new roles.
- A Gwent Strategic Workforce Action plan has been developed through co-production with our partners across Gwent and now forms the basis of the Gwent Workforce Board programme of work and agenda. The Action plan has been developed around the 7 key principles of A Healthier Wales: Our Workforce Strategy for Health and Social Care.
- The NCN (Neighbourhood Care Networks) Workforce Planning programme commenced in Autumn 2023, with all initial workforce planning workshops with all 11 NCN areas completed. The programme is now moving into the next stage of the programme with a comprehensive workforce planning assessment of Blaenau Gwent as an initial project. Programme plan led by WOD developed in conjunction with NCN leads and Divisional Senior Management.

Training
- The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years. In the HEIW Education Training Plan 22/23 there were increases in - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2025 and beyond which are required to support turnover and existing vacancies in addition to external recruitment and internal training developmental programmes.
- The 2024/25 education training plan demonstrated very few increases on previous years for students graduating in 2027 and beyond. The draft 2025/26 education and training plan proposes further increases in Wales training numbers in all branches of Nursing, health care science, medical speciality training junior doctors, pharmacy and continued increase in HCSW investment and increased placements in adult nursing in General Practice.
- HEIW have increased Health Care Support Workforce Development funding and there have been further changes for accelerated training pathways in some areas so support entry graduate level qualifications. Improved HCSW funding has enabled clinical induction to be delivered in house from April 2024 to accelerate time to effectiveness and improve employee experience.
- RCN Connect Programme has been established in connection with HEIW and higher education providers to support candidates enter registered nursing training (12 supported so far this year, with 3 more to interview) – We don't get involved with regards to the interview process.
- Cadet Nursing programme in place – 16 candidates attended for the 2024 induction and work is ongoing to support all 16 to achieve accreditations. - 16 RCN cadets attending All Wales HCSW Clinical Skills Induction, currently 12 active.
- K102 bridging model now being offered to support HCSW pathways into registered nursing.
- Increasing consultant therapy and nurse practitioners.
- RCN introduction of Registered Nursing Associate role to help build the capacity of the nursing workforce – students to start from September 2025 with placements from September 2027.
- Development of new roles and career pathways to support hard to fill roles in Health Visiting.
- Re-design of the Health Board's work experience programme with 246 applicants since March 2024 and 75 placements confirmed

Training
- HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce, including Primary Care Academy
- Workforce planning training prospectus of local and online training launched September 2024
- Development opportunity being scoped for Business support staff.
- Suite of learning masterclasses launched with 5 topics now available to book, including influencing skills, setting up teams for success, giving feedback, having courageous conversations, having a meaningful PADR. 236 attendees in July 2024.
- Recruitment training for managers to streamline campaigns as much as possible to reduce time to hire.
- Development of training doctor fill rate dashboard to monitor and improve fill rate or to inform alternative recruitment strategies.
- A review and action plan underway to consider how to address instances where nurse streamlining preferences for specific posts exceed the number of vacancies available, to promote recruitment and retention.
- 31 staff enrolled on workforce planning online training modules level 1. 15 managers enrolled on level 2 training delivered locally March 2025. A capacity and capability workforce planning action plan are being developed to support 25/26 programme of activity.

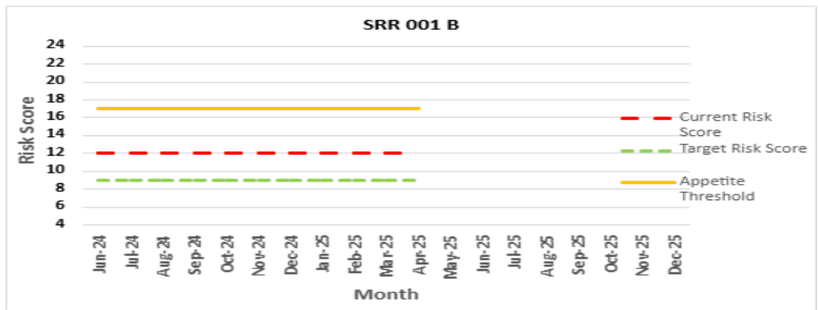
• Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx). Similar program for Directorate Managers (DMx) a 10-month leadership development program to support the capability of this key group commenced 23 April 2024 with cohort 2 launching June 2025. Nursing and Midwifery Academy for senior level nurses and midwifes, Leadership Development program (entry level) and Leading People (advanced Level) programmes fully booked. Core Leadership programme currently delivering to 200 staff per year. • Delivery of workforce planning training **Vacancy Numbers and establishment control** • Quarterly reporting of vacancy numbers to WG as of March 2025 was 629 WTE, an increase of 44 WTE since September 2024. • Development of ESR establishments commenced on a national basis in September 2023. Local delivery action plan has been developed and project workstream established and work commenced. National work programme proposal is also in development to assess digital solutions **Staff attendance** • Support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. • "Hot spot" areas identified and plans in place to support	

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*		**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*			
• Workforce reports to the Nurse Strategic Workforce Group. • Monthly sickness monitoring reports. • Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN. • Medical Staffing Co-ordinator review of medical rotas. • Cross site operational calls.	• Occupational Health and Wellbeing dashboards report KPIs. • Recruitment KPIs • Medical & Dental and Student Streamlining fill rate reports		
Level 2 Organisational *(Executed by risk management and compliance functions)*			
• Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 • Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. • Workforce and OD (Organisational Development) group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation. • Measurements of Wellbeing through the ABUHB	• (Aneurin Bevan University Health Board) Staff Survey • Routine Reporting against nurse staffing levels. • Variable Pay Programme Board reporting to Value and Sustainability Board	• Governance processes • risk management input (register, risk assessment)	
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
• Internal Audit Reviews 2023 -24 • Long Term Sickness Absence Management (Q4) • Flexible Working (Q4) • External quarterly vacancy reporting to WG • National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges. The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative.	• External reporting on Nursing Staffing Levels • National Acuity Audits (Nursing) • Workforce planning external audit action plan 2024	• Latest local survey saw a reduction in staff wellbeing	• Internal Audit Staff Culture Q3 2024/25

Assurance Rating (*Overall Assessment of controls and assurances) Guidance*

Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**POSITIVE**

RISK THEME	PEOPLE				
LINK TO IMTP	**SECTION 4: ENABLER – WORKFORCE AND CULTURE**				
Strategic - SRR 001 B	**There is a risk The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to a deterioration in, and a failure to improve, the well-being of staff.**			**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • High absence levels, with some sustained long periods • Non-compliance with safe staffing principles and standards	**Organisation** • Reputational damage to the health board as an employer • Work-related claims • Financial Implications	**Risk Appetite Threshold - Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	**3** *(Possible)* x	
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**3** *(Moderate)*	
Last Reviewed	01 April 2024	**Risk rating**	**= 12** ***(High)***	**= 9** ***(High)***	
Next Review (Quarterly based on risk score)	01 July 2025				

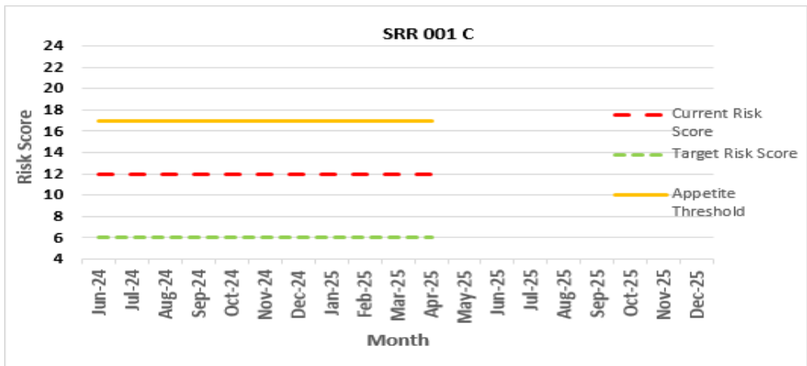


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
General • Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard. • Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity. • Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority. • Strategic Equality plan • Rest and Facilities charter – monitoring and compliance. • Staff related policies. • National Staff Survey and Health Board Employee Experience Survey • External Employee Assistance Programme • Speaking up Safely action plan • Race/LGBT groups. • Wellbeing resources • Staff diversity networks • Regular Schwartz rounds arranged across the Health Board • Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. • Close links with the Arts in Health programme • Chaplaincy service for staff • Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. • Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. • The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits	**General** • Increase wellbeing initiatives. • Identify, training and develop Respect and Resolution advocates (like Mental Health first aiders). • Work with Professional Nurse Advocates (PNA) to explore ways to offer high quality support to nursing colleagues. • Trained mediators so there is team and organisational resilience and network. • Scope, design and deliver a programme of research ‘Healthy Working Day’. • Enhanced our financial well-being offer. • Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. • Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. • The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits. The programme has now won six awards including two from NHS Wales. • Implementation of the Speaking up Safely process in line with the Welsh Government Framework. • We are planning a series of events to celebrate 10 Years of Schwartz Rounds within ABUHB. **Occupational Health.** • Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted. Current Demand and Capacity review underway with support from planning • Submission of response to All Wales KPI delivery and ongoing data analysis review in place. • Recently appointed 8a role to provide further clinical leadership and key priority for M1-3 is to undertake training needs analysis to develop OH team. Training needs analysis completed. Recently appointed Band 7 and Band 5 to stabilise nursing workforce currently advertising Band 6. Band 8a recently resigned and in the process of advertising for a replacement, • Support equality and diversity of workforce. • Review of staff diversity networks. • Review of National Staff survey s to understand variations within diverse workforce demographic profile.

• The Avoidable Employee Harm Programme model will be used to underpin our approach to the Speaking up Safely (SUS) initiative within ABUHB. • an externally commissioned SUS hotline will be piloted in September 2024. • An external Employee Assistance Programme (Vivup) has been commissioned for a further 12 months to offer additional psychosocial wellbeing support to staff, including a waiting list initiative. **Occupational Health** • Additional occupational health resources secured to reduce waiting times. • Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes. • Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. • Support equality and diversity of workforce. • A part time Disability Inclusion Officer has been seconded to the EDI Team and made permanent in December 2024. • Band 5 EDI Officer appointed and commenced in post at the end of March 2024. • Inclusive Leadership sessions embedded in the Leading People Programme from January 2024 onwards. • Reverse Mentorship Programme launched February 2024. **Other** • Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC • Reducing fatigue poster developed.	• Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. • Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing. **Staff Survey Action Plan** • Findings from the staff survey 24/25 indicate improvements with culture and diversity. • An ABUHB action plan is in development to address staff engagement, work related stress and to improve retention of staff.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Dashboard reporting • Reporting to monitor the rollout of the People Plan 22-25 • Reporting to monitor of demand on wellbeing services	• Understand if support is reaching all staff	• Meetings with Divisions ongoing to ensure all areas are aware of what's available.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• People and Culture Committee reports (People Plan 22-25) • Local wellbeing surveys • LNC – reporting of compliance of BMA Rest and • Facilities		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• National workforce surveys • Monitoring and compliance of BMA Rest and Facilities via NHS Employers • Staff Welfare Charter • Sickness Absence Audit 2023/24 – Outcome: Reasonable Assurance	• Latest local survey saw a reduction in staff wellbeing	• Internal Audit Staff Culture Q3 2024/25

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**POSITIVE**

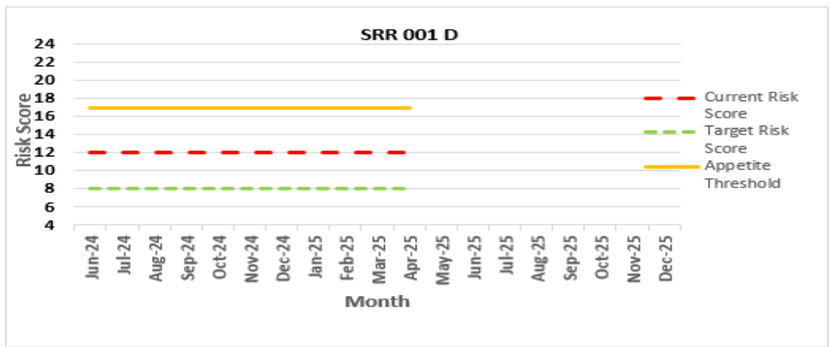
RISK THEME	**PEOPLE**					
LINK TO IMTP	**SECTION 4: ENABLER – WORKFORCE AND CULTURE**					
Strategic - SRR 001 C	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				**Publication Status**	**Public**
Threat *(As a result of)*	**Due to insufficient and ineffective leadership levels throughout the organisation**				**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings;	**Staff** • Adverse impacts on staff recruitment and retention	**Organisation** • Failure to deliver health board priorities, required improvements and achieve sustainability; • Poor levels of accountability and delivery; • Reputational damage to the health board as an employer;		**Risk Appetite Threshold - Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
					SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee / Group	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	**3** *(Possible)* x		
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**2** *(Minor)*		
Last Reviewed	01 April 2024	**Risk rating**	**= 12** ***(High)***	**= 6** ***(Moderate)***		
Next Review (Quarterly based on risk score)	01 July 2025					

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Talent and Succession Planning framework published • Monitoring Framework to support roll out of the People Plan – Focus on Talent and Succession Planning. • Monitoring Frameworks with HEIW • Lead appointed July 2023 on secondment funded by HEIW to create organisational talent management framework to enable to organisation to be deliberate and consistently attract, identify and develop talent for critical roles across ABUHB. • HEIW schemes • 1 x HEIW funded graduate managements trainee successfully appointed August 2023 following additional recruitment process. • Develop Leadership Capabilities • Leadership journey and programmes mapped, and 1 pager flyer designed and on intranet. Leadership development offer now available for entry level leaders and mangers, clinical directors, directorate managers (DMx), senior nurses and multi-disciplinary teams. • Learning masterclasses have been designed and developed for the organisation addressing ley themes such as giving feedback, developing team and having courageous conversations. • Leading People Programme (starting cohort 9 May 2025) • 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire council; our graduate joined the health board in March 2023 and is supporting the decarbonisation agenda.	Talent and Succession Planning • Pilot planned for Finance, Occupational Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy. Development leadership capabilities • Currently exploring leadership funding options with USW to maximise Governmental Grants and utilisation of the apprentice levy. • Continued commitment to NHS graduate schemes. • Continued bespoke development and support for senior management teams in clinical and non-clinical settings focusing on leadership, team dynamics and thriving. • Working with HEIW to inform a national development programme for managers • Engagement with the management competency framework which will be adopted in Wales (following implementation in NHS England).

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• WOD Divisional reporting • Evaluation of internal leadership programmes and regular review of our internal offer		
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Reporting to People and Culture Committee - progress against People Plan 22-25		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Internal Audit Review • Talent and Succession Board		

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**POSITIVE**

RISK THEME	**PEOPLE** **This risk score will be reviewed following the confirmation of the 25/26 pay scales, at which point the likelihood of industrial action may change.**				
LINK TO IMTP	**SECTION 4: ENABLER – WORKFORCE AND CULTURE**				
Strategic - SRR 001 D	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level**			**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Non-compliance with safe staffing principles and standards	**Organisation** • Litigation & Financial Penalties • Reputational damage to the health board and loss of public confidence	**Risk Appetite Threshold - Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	2 *(unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**4** *(Major)*	
Last Reviewed	01 April 2024	**Risk rating**	**= 12** ***(High)***	**= 8** ***(Moderate)***	
Next Review (Quarterly based on risk score)	01 July 2025				

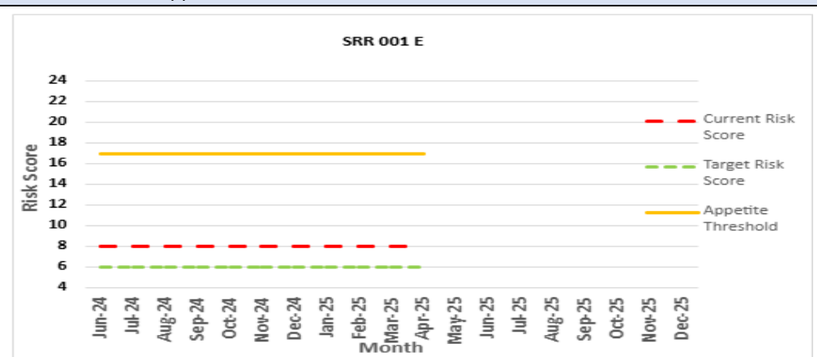


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• All Wales Industrial Action Planning Group • Local Health Board planning arrangements • Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and • CODE OF PRACTICE Industrial Action Ballots and Notice to Employers • Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture • Effective derogation processes including Christmas Day cover definition. • Local Negotiating Committee (LNC) • Services Business continuity plans in place. • Terms and conditions agreements in place for medical cover supported by NHS Wales Employer guidance. • Command and control structure and leads established. • Derogation test completed. • Executive and Senior Manager leads established links with national planning cells. • All Wales training sessions provide by legal and risk to support industrial action. • Reducing impact on patients - Support for early supported discharge prior to industrial action. • Picketing guidance supported and agreed.	• Agreement reached in England for Medical & Dental Staff – re-commencement of negotiations in Wales for Medical & Dental Staff. • Issue of WHC AFC non pay elements of collective agreement 2022-24. Response to WG on immediate assurance by end May 2024 • Review of rotas for junior doctor industrial action (minimum staffing levels based on safety assessment). • Communication plans- public, stakeholders and partners • Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer) and pay application. • Consideration of further additional national legal advice

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Local Staff re-deployments assessment • Divisional engagement and service planning arrangements in place • Local Negotiating Committee (LNC) • Trade Union Partnership meetings		Further industrial action
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Reporting to Executive team • Business Continuity groups • Command and control structure in place to be implemented as required.		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• All Wales IA group and Welsh Government planning group. • Debriefing session planned to reflect and capture learning for any potential future action		

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	**SERVICE DELIVERY**				
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**				
Strategic/ Corporate Risk SRR 001 E	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate strategic plans which respond to population health and socio-economic needs.**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Increased patient acuity levels • Worsening of health inequalities • Worsening of health outcomes	**Staff**	**Organisation** • Failure to train teams in multi-morbidity management • Failure to comply with the Wellbeing of Future Generations Act (Wales) • Reputational damage and loss of public confidence • Increased demand	**Risk Appetite Threshold – SCORE 17 AND BELOW** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Partnerships, Public Health and Planning Committee	**Likelihood**	**2** *(Unlikely)* x	**2** *(Unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	***4*** *(Major)*	**3** *(Moderate)*	
Last Reviewed	01 November 2024	**Risk rating**	***= 8 (Moderate)***	***= 6 (Moderate)***	
Next Review (Six monthly based on risk score)	01 May 2025				

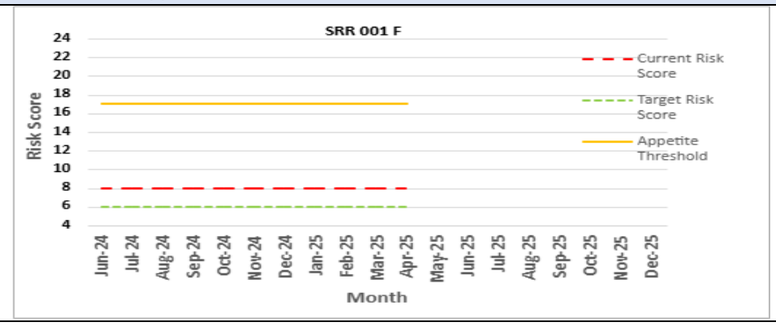


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Health Board IMTP and associated KPIs • Public Health Wales surveillance data • Qliksense – performance dashboard • Population Needs Assessment and Area Plan • Marmot Region Programme	• Area plan is being refreshed through the RPB • Marmot Region Implementation Plan • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Refresh organisational strategy with a central focus on population health and wellbeing. • Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Qliksense – performance information • SFN – performance information		• Effectiveness of the plans in delivering improvements
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• IMTP Delivery and Outcomes Reporting to Board • Marmot Region Programme • RPB reporting to Board and Population Health, Planning and Partnerships Committee • Regional Planning reporting to Population Health, Planning and Partnerships Committee • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Reviews 2023-24 • IMTP Planning (Q1) Outcome – Reasonable Assurance **Internal Audit Reviews 2024-25** • Internal Audit Partnership Arrangements – **Limited Assurance**	• Outcome of the Internal Audit Partnership Arrangements 2024/25 Plan – **LIMITED**	• Implementation of the recommendations of the Partnership Arrangements Audit

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	**SERVICE DELIVERY**				
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**				
Strategic Risk **SRR 001 F**	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to unsustainable Service Models**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Increased demand • Increased patient acuity levels • Worsening of health inequalities • Worsening of health outcomes	**Staff** N/A	**Organisation** • Failure to train teams in multi-morbidity management • Failure to comply with the Wellbeing of Future Generations Act (Wales) • Reputational damage and loss of public confidence	**Risk Appetite Threshold – SCORE 17 AND BELOW** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	**Likelihood**	**2** (Unlikely) x	**2** (Unlikely) x	
Initial Date of Assessment	01 June 2023	**Impact**	***4** (Major)*	**3** (Moderate)	
Last Reviewed	01 April 2024	**Risk rating**	**= 8** **(Moderate)**	***= 6*** ***(Moderate)***	
Next Review (Quarterly based on risk score)	01 May 2025				

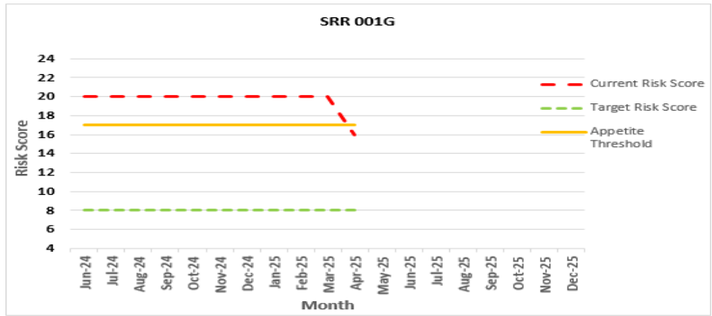


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• The Health Board IMPT and associated KPIs • Clinical Futures Transformation programmes. • Public Health Wales surveillance data – Covid, flu and other communicable diseases. • Qliksense – performance information. • Population needs assessment and area plan development by the RPB. • Southeast Wales Plan for fragile services.	• Area plan is being refreshed through the RPB. • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Review of enhanced local general hospital service models to ensure sustainable quality services. • Development of SEW plan for fragile. • Review of organisational strategy

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Public Health Wales surveillance data – COVID, flu and other communicable diseases. • Qliksense – performance information		• Evidence of individual arrangements in place to deliver service plans.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• IMTP delivery and outcomes reporting to Board. • RPB reporting to Board and Population Health, Planning and Partnerships Committee. • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee. • Regional Planning reporting to Population Health, Planning and Partnerships Committee.		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Reviews 2023-24 • IMTP planning Q1. Outcome – Reasonable Assurance. **Internal Audit Reviews 2024-25** • IMTP – Service Plans (Q2) – Outcome - Reasonable Assurance • Partnership Arrangements. Outcome – Limited Assurance	• Recommendations identified in the Limited and Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	• Implementation of the management responses to close off recommendations

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	**FINANCIAL SUSTAINABILITY**			
LINK TO IMTP	**SECTION 4: ENABLER - FINANCE**			
Strategic - SRR 001 G	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the failure to deliver a sustainable financial position and longer-term financial plan.**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact *(Consequences of the threat)*	**Organisation** • Breach of statutory duty to breakeven over 3 years. • Instigation of NHS Wales Escalation & Intervention Arrangements. • Non–delivery of health board priorities, required improvements, and achieving longer-term sustainability. • Prioritisation and possible disinvestment in service delivery. • Reputational damage and loss of public confidence.			**Risk Appetite Threshold – Score 17 and Below** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.
Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	**4 (**Likely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	***4** (Major)*	**4** (Major)
Last Reviewed	01 May 2025	**Risk rating**	**= 16 (Extreme)**	***= 8*** **(Moderate)**
Next Review (Monthly based on risk score)	01 June 2025			



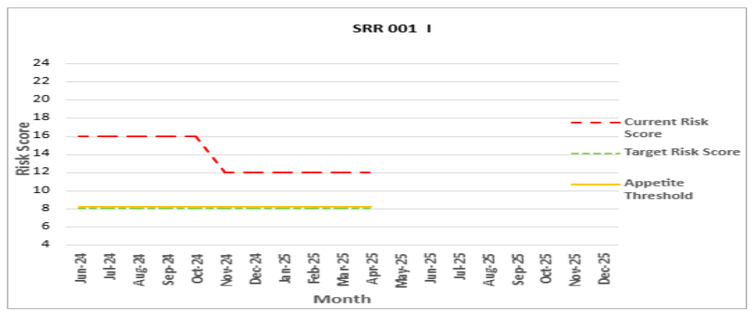
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• IMTP 25/26-27/28 • IMTP Delivery Framework • Sustainability Route Map revision • Accountability Framework • Performance Framework • 3-year route map to sustainable recovery developed and approved by Board July 24. • Scheme of Delegation • Standing Financial Instructions (SFIs) • Standing Orders (SOs) • Final budget delegation • Financial Control Procedure (FCP) Budgetary control • Financial Budget Intelligence (FBI) • Appropriately trained Finance Team (capacity & capability) • Budget holder training & other business training tools • Cost intervention procedures • 25/26 savings plans & opportunities. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. • Executive groups and structures established to deliver statutory duties. • Assessment of financial control environment within divisions and corporate teams. • Financial Escalation Meetings • Regular organisational Recovery plan meetings and briefings • Value & Sustainability Board established. • Revised accountability arrangements part of Executive governance.	• Revised V&SB approach for 2025/26 to help drive financial recovery, separating thematic and divisional scrutiny. • Service Redesign disaggregated as a V&SB theme • Review of programme structures to match V&SB thematic areas • Updated Route Map development • Focus on future opportunity development to deliver 3-year financial plan – through programmes under the VS&B structure.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Day 5 comprehensive financial performance review – DoF led. • Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance	None	• Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. • Development of detailed 3-year recovery plan.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established. • Financial assessment and review report to the Board and Finance & Performance Committee • Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position.	None	• 2025/26 – 27/28 IMTP plans focussed on 'living within' budget levels. • 2025/26 savings plan to be delivered. • Detailed delivery plans will be a constant development over next 3 years.
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit • Annual Report • 2025/26 Audit Reviews **External Audit Reports** • 2024 -25 – Annual Report • 2025/26 - Audit Reviews **Welsh Government** • Financial assessment and review reports to Welsh Government – monthly • Enhanced monitoring T.I. meetings with Welsh Government monthly • IMTP plan to WG end of March 2025	• Recommendations from audits	• Implement management actions to complete the recommendations from audit reports

Assurance Rating (*Overall Assessment of controls and assurances)* Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY		
LINK TO IMTP	SECTION 2: DRIVERS – PERFORMANCE EXPECTATIONS	SECTION 4: ENABLERS – WORKFORCE & CULTURE	
Strategic Risk **SRR 001 I**	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, sustainable services that meet the needs of the population.**	**Publication Status**	**Public**
Threat *(As a result of)*	**Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.**	**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	
Impact *(Consequences of the threat)*	**Patient** • Unintended Patient Harm. • Negative Public/Patient Experience.	**Staff** • Reduced Staff Morale leading to potential absence from work.	**Organisation** • Loss of patient/public trust and confidence. • Scrutiny from external organisations. • Adverse publicity. • Punitive Actions. • Financial implications.
			Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.
			SUMMARY The current risk level is **OUTSIDE** of target and the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Lead Director	Director of Strategy, Planning and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance and Performance Committee.	**Likelihood**	3 (Possible) x	**2** (Unlikely x
Initial Date of Assessment	19 April 2024.	**Impact**	***4** (Major)*	**4** (Major)
Last Reviewed	01 April 2025	**Risk rating**	**= 12** **(High)**	**= 8** **(Moderate)**
Next Review (Quarterly based on risk score)	01 July 2025			



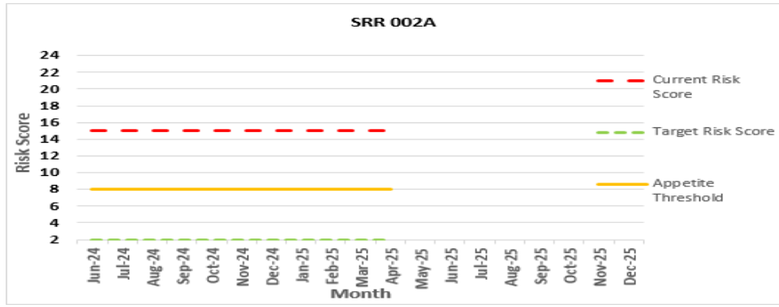
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Performance Management and Assurance Framework • Executive Accountability letters • Divisional Directors Accountability letters • Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions in place • Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reviewed post End of Year and proposed adjustments awaiting sign off • Reporting through to Finance and Performance Committee via Executives • Specific areas of focus are discussed at Value and Sustainability Board • System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. • External scrutiny via Welsh Government and NHS Executive • Capacity to run the performance framework and reporting requirements has been strengthened with the appointment of the Head of Systems Planning and Performance and analytical team who will fully be in place by January 2025 alongside the Business Partnering Support	• 6-month review of Performance Management and Assurance • Alignment of internal mechanisms to national escalation • Focussed agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach. • Standardised Divisional Assurance Templates (pre-populated) • Commission external reviews to support improvements where required. • Appropriate Business Partnering Support and analytical support • Realign capacity and/or redefine roles to provide explicit support

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• DMTs in place for all Divisions • Divisional oversight arrangements – monthly/fortnightly meetings • Divisional plans in place and focussed agendas • Cross Divisional meeting monthly – progress the wider system way of working. • System Leadership Team for awareness and updates	• 12-month Performance Management Framework review in the Autumn	• Outcome if the review will determine if further action is required
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Established reporting to the Executive Committee • Established reporting to the Finance and Performance and Patient, Quality and Safety • Committee • Established reporting to the Board • Routine reporting through the IQPD process	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Internal Audit 2024/25 Plan • Directorate Review - Mental Health and Learning Disabilities (Q2) • Divisional Governance Arrangements (Q2) • HIW Inspections • Llais for feedback	• Internal Audit 2024/25 Plan • Findings and recommendations from the Divisional Governance Arrangements (Q2) • Findings and recommendations from the Directorate Review - Mental Health and Learning Disabilities (Q2)	

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY				
LINK TO IMTP	SECTION 4: ENABLERS - ESTATES				
Strategic Risk **SRR 002 A**	**There is a risk that there will be significant failure of the Health Boards Estates.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.**			**Risk Appetite Level – MINIMUM** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	
Impact *(Consequences of the threat)*	**Patient** • Harm or injury to patients • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Harm or injury to staff	**Organisation** • Litigation & Financial Penalties • Loss of estate	**Risk Appetite Threshold –** Score 8 and below Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.	
				SUMMARY The current risk level is **OUTSIDE** of the target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold	

		Risk Exposure	Current Level	Target Level
Lead Director	Chief Operating Officer			
Monitoring Committee / Group	Partnerships, Public Health and Planning Committee	**Likelihood**	**3** (Possible) x	**1** (Rare) x
Initial Date of Assessment	01 June 2023	**Impact**	***5*** *(Catastrophic)*	**2** (Minor)
Last Reviewed	01 May 2025	**Risk rating**	**= 15** **(Extreme)**	**= 2** ***(Low)***
Next Review (Quarterly based on risk score)	01 June 2025			



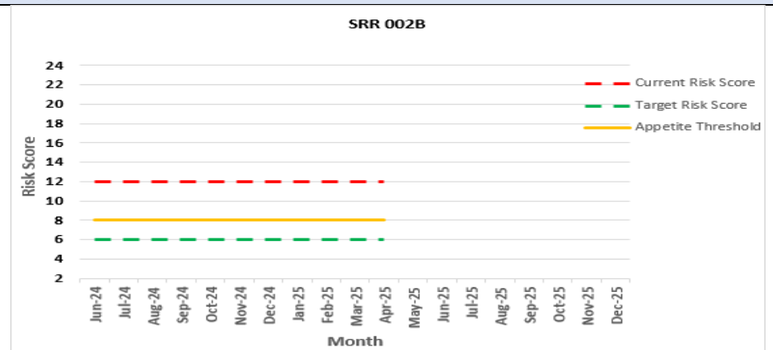
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Work to assess the risk has been undertaken with expert external surveyor advice. Repeat surveys undertaken on 6 monthly intervals (most recent June/July2024 with report detailing recommendations received in October 2024). Recent surveys completed over December and January and any recommended additional actions being scoped up in conjunction with external experts • Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance • Remediation work to areas of high-risk areas undertaken • Controlled access to roof areas • Implemented toolbox talks for awareness for estate teams and contractors to work in area where RAAC is present. • Ongoing engagement with expert surveyor • Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management • Risk assessments completed by the Health and Safety function in departments with props to manage any consequences of the presence of props. Note: H&S assessments are around the location of props not of RAAC itself and they flagged no issues or alterations • Links with NHS England and other Health Boards in Wales for shared learning. • Regular dialogue with Welsh Government and Shared Services Estates.	• Additional Surveys continue to take place with expert surveyors to inform the next steps relating to further remediation of the issues and monitor existing issues • Management Strategy and the Management Plan are completed and scheduled for approval at the March Health & Safety Committee meeting on 9th April.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Fortnightly checks in place for the props in place • Outcome of surveys continuing, and reinspection of conditions (a regular 6 monthly inspection) • Review of existing arrangements in place supported by external body	• Ongoing management of the issues.	N/A
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor • risks and issues associated with any remedial measures implemented. • Outcome of H&S risk assessment • Formal reporting to the Board/Committees in place • Formal update to the PPHPC in July and SOC being developed, led by Planning team for Q1 to Q2 2025/26	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Internal Audit 2024/25 Plan – report received as Reasonable Assurance (albeit Substantial Assurance on the process relating to surveys. Report submitted to Audit Committee November 2024. • Management Action Plan agreed following Internal Audit including the development of a Management Strategy. this document has been drafted and will be submitted to the ABUHB Health and Safety 'Committee' in March 2025 • Internal Audit also commented that the risk appetite needs to reflect the current position of monitoring and managing the RAAC pending SOC and FBC hence appetite of 15 should be considered by Board.	• Recommendations identified in the Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	• Repeat surveys have been completed and once the latest report from these surveys is received any necessary additional actions will be implements **Internal Audit 2024/25 Plan** • Implementation of the management responses to close off recommendations

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*

Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY				
LINK TO IMTP	SECTION 4: ENABLERS - ESTATES				
Strategic Risk **SRR 002 B**	**There is a risk that there will be significant failure of the Health Boards Estates**.			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to significant levels of backlog maintenance and structural impairment.**			**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	
Impact *(Consequences of the threat)*	**Patient** • Harm or injury to patients. • Adverse impacts on the delivery of care to patients across acute and non-acute settings.	**Staff** • Harm or injury to staff.	**Organisation** • Non-compliance with health and safety legislation. • Litigation and financial penalties. • Loss of estate	**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.	
				SUMMARY The current risk level is **OUTSIDE** of the target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Partnerships, Health Protection & Planning Committee	**Likelihood**	**3** (Possible) x	**3** (Possible) x	
Initial Date of Assessment	01 June 2023	**Impact**	***4*** *(Major)*	**2** (Minor)	
Last Reviewed	01 May 2025	**Risk rating**	**= 12** **(High)**	**= 6** **(Moderate)**	
Next Review (Quarterly based on risk score)	01 August 2025				

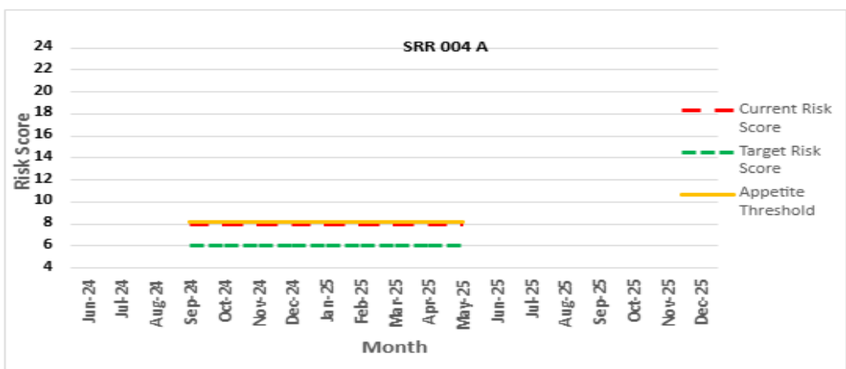


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Health Board Estates Rationalisation Strategy • Health Board Estates Strategy • Health Board policies and procedures related to the maintenance of Health Board estate. • 6 Facet survey completed in 2019. • Divisional Risk Register • Multiple policies and SOPs published and communicated to staff. • A robust internal training programme in place covering all aspects of estate management including food hygiene. • Improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) • Asbestos reinspection programme (over the next 3 years) • Additional capital allocation to Estates and Facilities for backlog maintenance reduction of £500k from discretionary allocation • HB-wide groups on compliance (such as Ventilation and water) are widened in membership to ensure clinical services are active participants • A clear approach to compliance monitoring and escalation of AE reports has been implemented	• Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. • A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. • Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. • Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance. • Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM. • Drive clinical service engagement in compliance meetings where engagement is low. • Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible. • Continuation of the additional £500k backlog maintenance allocation by the Board to the Estates and Facilities Division in 2025/26 • Informed by the risk assessment processes of the Estates and Facilities Division, the Health Board has secured significant investment in estate during 2025/26 and 2026/27 from the All Wales Targeted Estates Fund (TEF)

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Divisional reporting of Statutory and Mandatory training of staff • Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance. • Outcome of the Asbestos reinspection programme	• If the revised approach for monitoring and escalation of AE reports is effective in reducing the level of a deterioration.	• Performance reporting
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group • Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Reviews 2023- 24 • Estates Assurance - Estate Condition. Audit completed and been shared with Audit Committee and • Finance and Performance Committee Internal Audit Plan 2024-25 • Estates Assurance – Energy Management (Q2) Outcome = Reasonable Assurance. Reported to the • November ARA • Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes. • Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level	• Recommendations identified in the Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	**Internal Audit 2024/25 Plan** • Implementation of the management responses to close off recommendations

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	**COMPLIANCE AND SAFETY**				
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**				
Strategic Risk SRR 004 A	**There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a business continuity incident or critical incident**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a major incident.**			**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.	
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings • Harm or injury to patients	**Staff** • Inability to respond to a major incident to meet needs of those affected • Harm or injury to staff	**Organisation** • Health Board breaches statutory duties under the Civil Contingencies Act 2004 • Litigation & Financial Penalties • Reputational damage and loss of public confidence	**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	**Likelihood**	**2** (Unlikely) x	**2** (Unlikely) x	
Initial Date of Assessment	01 June 2023	**Impact**	***4*** *(Major)*	**3** (Moderate)	
Last Reviewed	01 April 2025	**Risk rating**	**= 8 (Moderate)**	**= 6 *(Moderate)***	
Next Review (Quarterly based on risk score)	01 July 2025				

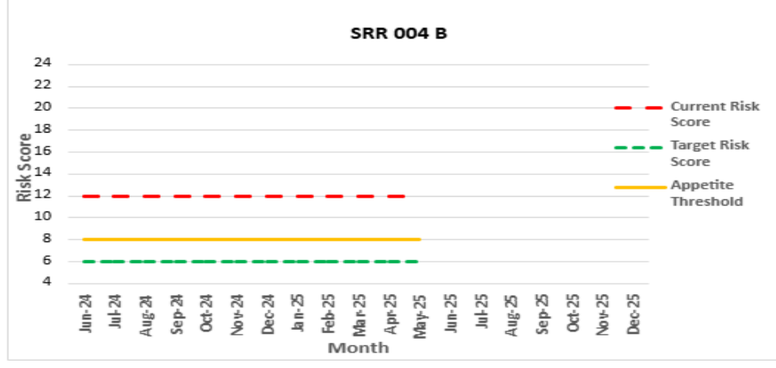


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Local/Divisional action cards are in place in key areas • Training undertaken service-specific relating to local response. • Major incident exercise 'Euclid' undertaken 20 June 24. Approx. 100 participants and external observers, demonstrated that the Health Board was able to successfully respond to an incident. As a result of the exercise action cards refreshed and renewed with teams to incorporate learning • Internal strategic on call training • Executive Team attending 2-day strategic training. • Loggist training is provided and accessed regularly • New all Wales logbooks are in place for use • Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) • Joint Planning and Training with LRF and across Wales. • Ongoing Participation in exercises UK, Wales, LRF and HB. • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP) • Continuing to work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner • LRF Pandemic Solaris undertaken	• Continue to deliver training programmes to support staff preparedness to response to an incident. • Additional 'local' team and intra team exercises to take place for areas to practice and embed their response to a major incident together • Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational. • BCPs in place across all services • National pandemic exercise Pegasus Autumn 2025 • Development of a pan plan to support pandemic pathways (HCIDs e.g., MPOX)

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Departmental debrief following an incident to inform learning and enhance controls. • Training records • Plans and action cards in place and up to date • Debrief with key stakeholders following an incident to inform learning and enhance controls.	None	N/A
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Review(s) • Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response - **Reasonable Assurance** • Outcome and feedback from national exercises	None	N/A

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY				
LINK TO IMTP	SECTION 3: SYSTEM CHANGE				
Strategic Risk **SRR 004 B**	**There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident**			**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.	
Impact *(Consequences of the threat)*	**Patient** • Harm or injury to patients • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Staff absence (injury, wellbeing) • Harm or injury to staff	**Organisation** • Operational flow if services fail to prepare BCPs against the 5 key themes • Loss of infrastructure; • Financial implications due to staff absence • Health Board breaches statutory duties under the Civil Contingencies Act 2004; • Litigation & Financial Penalties; • Reputational damage and loss of public confidence	**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	**Likelihood**	**3** (Likely) x	**2** (Unlikely) x	
Initial Date of Assessment	01 June 2023	**Impact**	***4*** *(Major)*	**3** (Moderate)	
Last Reviewed	01 February 2025	**Risk rating**	**= 12** **(High)**	**= 6** **(Moderate)**	
Next Review (Quarterly based on risk score)	01 May 2025				

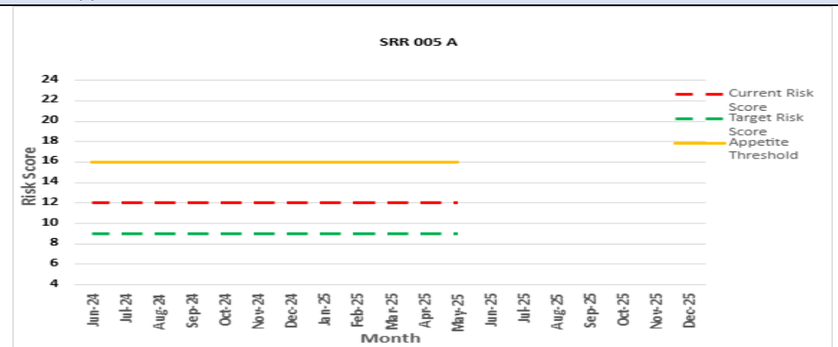


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• BC Policy • BC Response Guidance • BC Template • BC Exercise • BC debrief learning. • HB and LRF Plans. • 3C (Command/Control, Communication) structure in place to respond to incidents. • 1-2-1 graining with Divisional BC leads and BC plan workshops for services • EPRR Group Established. • Repository on intranet for BC plans to be added to by areas for audit, maintenance, and review of interdependencies. • Awareness raising of the requirement for BC across the Health Board through various training programmes • Infectious Diseases • Joint plan with PH in response to infectious diseases and public health incidence response overall • Internal strategic on call training • Executive Team attending 2-day strategic training. • Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) • Joint Planning and Training with LRF and across Wales. • Ongoing Participation in exercises UK, Wales, LRF and HB. • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update • knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint • decision model and the principles of joint working (JESIP).	• Ongoing support to develop business continuity plans. • Developing a Health Board service BC supporting plan – to provide a generic response framework if they have no specific plans in place • Continued engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the • organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. • Develop further training programmes to support staff preparedness to response to an incident. • Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational. • Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. • Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages. (As this is not fully implemented, it is still being worked through thus would make it additional control until in place) • Each Division to identify on their risk register outstanding business continuity planning for their areas.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Departmental debrief following an incident to inform learning and enhance controls. • Training records • Plans and action cards in place and up to date • Debrief with key stakeholders following an incident to inform learning and enhance controls.	None	N/A
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Review(s) Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response – **Reasonable Assurance** • Outcome and feedback from national exercise	None	N/A

Assurance Rating (*Overall Assessment of controls and assurances)* Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

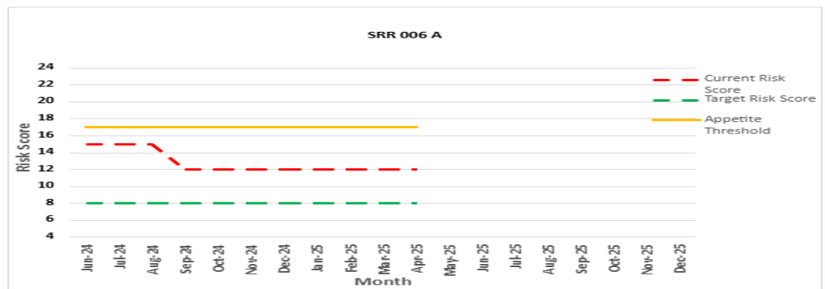
RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	SECTION 3: SYSTEM CHANGE				
Strategic Risk **SRR 005 A**	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate arrangements to support system-wide patient flow**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Avoidable deaths and significant harm. • Delayed discharges from acute and non-acute settings resulting. in deteriorating patients. • Delays in releasing ambulances from hospital sites back into the community.	**Staff** • Increased workload • Fatigue & burnout	**Organisation** • Litigation & Financial Penalties • Reputational damage and loss of public confidence	**Risk Appetite Threshold – OPEN SCORE 17 AND BELOW** Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is **OUTSIDE** of target level but WITHIN appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Chief Operating Officer	Risk Exposure	**Current Level**	**Target Level**	
Monitoring Committee / Group	Patient Quality, Safety and Outcomes Committee	**Likelihood**	**3** (Possible) x	3 (Possible) x	
Initial Date of Assessment	01 June 2023	**Impact**	***4*** *(Major)*	3 (Moderate)	
Last Reviewed	01 February 2025	**Risk rating**	**= 12** **(High)**	***= 9*** ***(High)***	
Next Review (Quarterly based on risk score)	01 May 2025				



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Escalation Policy. • Performance and Accountability Framework • Operational Framework • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Enhanced monitoring in place for U&EC • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. • Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. • Planned care recovery meetings with the NHS execs. • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. • WG – IQPD meetings to review areas of focus	• New developments and pathways coming online into FY25/26 • New expanded transfer lounge o New ED extension and reconfiguration • Additional ED consultants coming onboard • Safety Flow agenda delivering wider developments and improvements

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• The Escalation Framework has been enacted and ineffective in mitigating threats and impact to services. • Performance report against measures/metrics	• Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. • The impact of the Performance and Accountability framework in improving patient flow	• Close monitoring and reporting of the frameworks in practice to support learning and improvements.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Divisional Assurance reviews. • Performance against measures/metrics reported to the Executive Committee	• Effectiveness of the Operational Framework	• Operational framework coming into place in November / December 2024 and will be tested as part of a deep dive exercise.
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Reviews • Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. • External inspections/visits. -	None	N/A

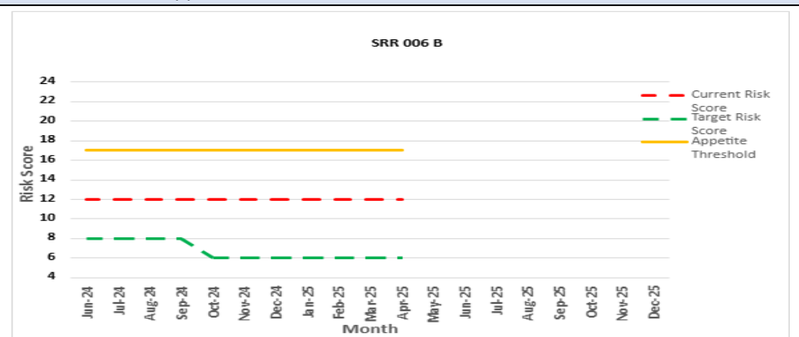
Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

RISK THEME	**SERVICE DELIVERY**				
LINK TO IMTP	**SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY**				
Strategic Risk **SRR 006 A**	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the full or partial failure of existing digital infrastructure and systems.**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or Injury to Patients.	**Staff** • Unintended harm or injury to staff	**Organisation** • Data Breaches • Litigation and Financial Penalties. • Reputational damage and loss of public confidence.	**Risk Appetite Threshold – Score 17 and Below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is **OUTSIDE** of target level but WITHIN appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x	
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	4 (Major)	
Last Reviewed	01 April 2025	**Risk rating**	**= 12** **(High)**	***= 8*** ***(Moderate)***	
Next Review (Quarterly based on risk score)	01 July 2025				

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Remedial Action Plan revised and updated to capture further recommendations against NIS CAF assessment in Jan 2024. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. • Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained. • New Information Governance and Cyber Security governance and assurance processes reviewed and implemented. • Governance group terms of reference agreed. Meetings started in November 2023. • Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff • Scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. • Working with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber, and the Teams review compliance levels against policy. Results are captured within the monthly Cyber Report. • Implement the recommendations from Templar report: • Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. • Battle tested OUR cyber incident response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan. • Working with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The least important service impacting Version 1 is being managed through ICT Departmental risk management process. · Risk impact reduced as recent loss of power at key sites, incorporating our data Centre allowed is to failover in a seamless fashion from one DC to the other with no service impact. · • Maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails. · • Begun the roll out simulated phishing campaigns. The initial phishing has been tested on the ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. • ·Introduced scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023.	• Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. • A recent cyber incident at several London Hospitals presented an opportunity for ABUHB to battle test its cyber response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan. • Updated audit from Cyber Resilience Unit to be undertake in Q2 2025. • Internal Audit review on Shadow IT scheduled for 2025/2026. • Improvements in mandatory training compliance for Information Governance and Cyber Security.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*		**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*			
• Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Single directorate risk registers now in place.		• None	• N/A
Level 2 Organisational *(Executed by risk management and compliance functions)*			
• Regular reporting on progress to the Finance & Performance Committee on the cyber security action plan. • Annual Senior Information Risk Owner report.		• None	• N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
• Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. • Oversight from NHS Wales Cyber Resilience Unit.	Internal Audit 2024/25	• None	• N/A

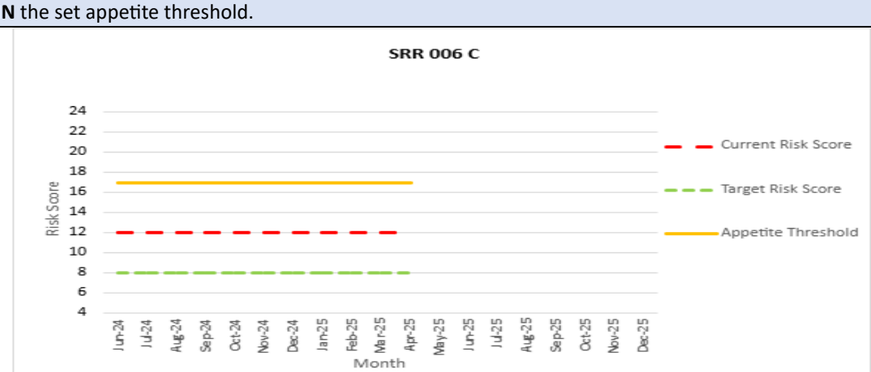
Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	**SERVICE DELIVERY**				
LINK TO IMTP	**SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY**				
Strategic Risk **SRR 006 B**	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to an adverse impact on service delivery in the implementation of new digital systems.**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or Injury to Patients. • Adverse impacts on delivery of care to patients across acute and non-acute settings.	**Staff** • Unintended harm or injury to staff	**Organisation** • Data Breaches • Litigation and Financial Penalties. • Reputational damage and loss of public confidence.	**Risk Appetite Threshold – Score 17 and Below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x	
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	3 (Moderate)	
Last Reviewed	01 April 2025	**Risk rating**	**= 12** **(High)**	***= 6*** ***(Moderate)***	
Next Review (Quarterly based on risk score)	01 July 2025				

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services. • Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. • Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages. • Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services. • Business change team in place to support services in improvement of clinical and administrative processes. • Benefits team in place who identify, track, and ensure any benefits are realised which will ultimately improve service delivery. • Projects support backfilling of clinical time where required. • Assurance activities included in project framework including clinical safety, information governance, health records and cyber security. • An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects. • Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements. • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation. • Aggregated view of digital Lessons Learned available, and lessons are reviewed during project initiation for best chance of success. • Formal divisional engagement meetings in place monthly to discuss new programmes of work and provide update on critical programmes/projects	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee. • Terms of reference developed, and meeting will be put in place during Q2 2025. • Digital benefits Board development session planned for 2025. • Digital transformation development programme to be provided to the Board in 2025/2026.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
○ Project Boards meet monthly and report into the bi-monthly Digital Portfolio Progress Group (DPPG) ○ Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. ○ Risk management approach and escalation processes in place in line with the Health Board's Risk Framework	• Escalation of risks and issues done on an Ad hoc basis to Director of Digital and Executive Committee in the absence of DDaT Sub-committee.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular Reporting to the Finance & Performance Committee	• None	• Not Applicable
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2023/24 • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance **Internal Audit 2024/25** • Implementation of the Welsh Intensive Care System – future of programme to be decided	• Recommendations identified through audit work	• Recommendations identified through audit work

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

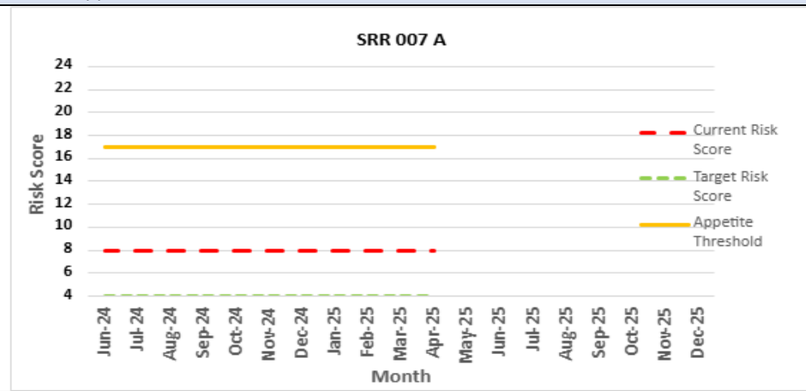
RISK THEME	SERVICE DELIVERY					
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY					
Strategic Risk **SRR 006 C**	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**				**Publication Status**	**Public**
Threat *(As a result of)*	**Due to failure to develop digital solutions that are sustainable and fir for the future.**				**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or injury to patients. • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Unintended harm or injury to staff.	**Organisation** • Data breaches • Litigation & Financial Penalties • Reputational damage and loss of public confidence		**Risk Appetite Threshold – Score 17 and Below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
					SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	**3** (Possible) x	**2** (Unlikely) x		
Initial Date of Assessment	01 June 2023	**Impact**	***4** (Major)*	**4** (Major)		
Last Reviewed	01 April 2025	**Risk rating**	**= 12** **(High)**	***= 8*** ***(Moderate)***		
Next Review (Quarterly based on risk score)	01 July 2025					

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
○ New Digital Service Request process in place which provides governance in several key areas: ○ Automation of request process via 'Seren' the ICT Portal ○ Information Governance – ensuring new services have appropriate controls to keep patient information safe. ○ Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. ○ Patient Safety – ensuring services do not introduce any patient safety risks. ○ Records – ensuring new systems comply with the requirements of records management. ○ Strong business analysis function in operation which ensures the "as-is" and "to-be" process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. ○ Business change function which ensures implemented systems are effective and deliver the benefits required. ○ Formal framework in place for the adoption of new digital services and best practice guidance followed. ○ Annual planning processes include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process ○ New Digital Request processes include fortnightly senior leadership scrutiny of requests, ○ New prioritisation framework & tool Monthly/quarterly Operational delivery aligned to ITIL standards ○ Annual operational plan completed and aligned with IMTP ○ Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities for Urgent Care, MH & LD, CSS, Division of Surgery & PCCS in place ○ Software Development uses an agile product management methodology using DevOps software for managing its backlog, delivery plan and sprints.	• Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities to be arranged for Division of Medicine, • Portfolio optimisation to ensure the resources of the service are aligned to key priorities • New Digital Request quarterly reporting to DDAT sub-committee • New governance structures to be put in place further to directorate restructuring • Development of product management approach to delivery of core software applications and extending use of agile processes to ICT • Development of digital strategies including Electronic Health & Care Record

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Quarterly reporting to DDAT sub-committee	• If the NDSR process delivers anticipated improvements • The outcome of the EDRMS audit	• Monitor the performance of the NDSR process • Audit into the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular Reporting to the Finance & Performance Committee	• None	• Not Applicable
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2023/24 • LINC Programme– **Outcome Reasonable assurance** • Network Infrastructure (VPN) - **Outcome Reasonable assurance** **Internal Audit 2024/25** • Electronic document and records management solution - planned for Q4	• Recommendations identified through audit work	• Regular Reporting to the Finance & Performance Committee

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	**TRANSFORMATION AND PARTNERSHIP WORKING**			
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**		**SECTION 4: ENABLERS - REGIONAL PLANS**	
Strategic Risk: SRR 007A	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.**		**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unmet patient need resulting in harm	**Staff** N/A	**Organisation** • Ineffective use of combined resource Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence	**Risk Appetite Threshold – SCORE 17 AND BELOW** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.
Lead Director	Director of Strategy, Planning, and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	**2** (Unlikely) x	**2** (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	**4** (Major)	**2** (Minor)
Last Reviewed	01 October 2024	**Risk rating**	**= 8 (Moderate)**	***= 4 (Moderate)***
Next Review (Six Months based on risk score)	01 April 2025			



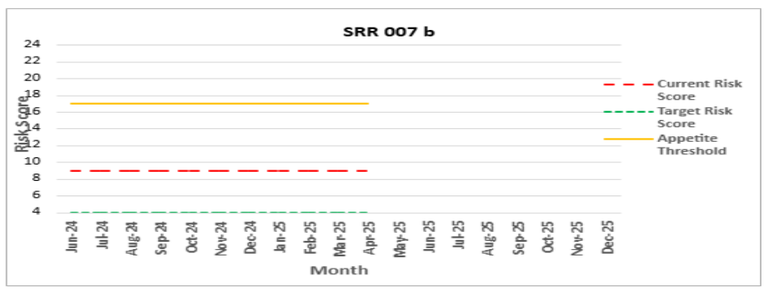
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including: • The Gwent Public Services Board (Gwent PSB) brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. • The Gwent Regional Partnership Board As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care, and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place. • In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. • Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams	• Governance review of Regional Partnership Board undertaken in August 2023. • Renewed Strategy for strategic partnership Capital in place and revised governance processes. • New Long-Term Strategy for Health Board to focus on Partnership approach.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• PMO reporting to the Director of Strategy, Planning and Partnerships. • Regional Leadership Group Reporting	• Systematic reporting of outcomes • Systematic evaluation of schemes • Governance of financial control arrangements	• Implementation plan to be developed following RPB governance review. • Health Board strategy development approach to focus on partnership approach
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board.	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Plan 2024/25 • RPB Governance Review (Q4) – **Outcome = Limited Assurance.** Reported to ARAC September 2024 • Partnership Arrangements Review (Q1) Deferred	• Recommendations identified in the Limited Assurance RPB Governance Revie	• Implementation of the management responses to close off recommendations

Assurance Rating (*Overall Assessment of controls and assurances) Guidance*

Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	**TRANSFORMATION AND PARTNERSHIP WORKING**				
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**			**SECTION 4: ENABLERS – REGIONAL PLANS**	
Strategic/ Corporate Risk SRR 007 B	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the impact of fragile services across the regional and supra regional geography**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unmet patient need resulting in harm • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** N/A	**Organisation** • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence • Ineffective use of combined resources • • Delayed decision making	**Risk Appetite Threshold – SCORE 17 AND BELOW** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Director of Strategy Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	**Likelihood**	**3** (Possible) x	**2** (Unlikely) x	
Initial Date of Assessment	04 January 2024	**Impact**	***3*** *(Moderate)*	**2** (Minor)	
Last Reviewed	01 April 2025	**Risk rating**	**= 9 (High)**	***= 4 (Low)***	
Next Review (xx based on risk score)	01 July 2025				

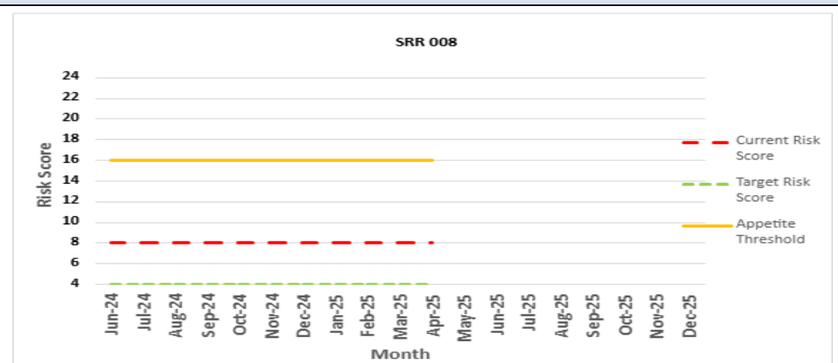


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• A robust Southeast Wales regional planning infrastructure has been established with clear governance mechanisms in place with attendance from CEO, DoP and COO. • The Regional Portfolio Delivery Board brings the participating health boards together to review all regional service projects, to assess progress against agreed timelines and to agree additional measures / escalations in the event of identified issues and risks. This Board then reports to an Oversight Board with Chief Executive membership. • Four workstreams are established (Orthopaedics, Ophthalmology, Diagnostics and Cancer) and the UHB is well represented and engaged on all. • Where appropriate workstreams are underpinned by a Memorandum of Understanding between the participating health board, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. • The south east Wales health boards agreed revised joint priorities and working arrangements for regional planning in 2024, following a review workshop attended by Chief Executives. Workstreams are underpinned by a Memorandum of Understanding between the participating health boards, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. • When service issues span regions, arrangements are set up on a bespoke basis, for example the Vascular Project Board and the Interventional Radiology (IR) project. • In addition to these arrangements, the Health Board has a range of informal planning networks and communication channels, with an ongoing commitment to communication, sharing best practice and advising of anticipated service issues and risks.	Additional direction and guidance have been received from Welsh Government, placing greater emphasis on the role of regional planning to achieve sustainable longer-term positions for a range of services where fragilities currently exist. The principal actions are:- • Requirement to develop a portfolio of documents to inform and drive the forthcoming development of a regional diagnostic and treatment centre at Llantrisant Health Park (LHP). These will include a clear outline strategy, comprehensive demand & capacity modelling for proposed LHP services, future development opportunities and programme governance arrangements • Direction for the participating health boards to establish a Joint Regional Committee in quarter 3 of 2025/26, to exercise the facilitation and oversight of regional planning and drive effective collaboration and regional working. The health boards are progressing the above on a collaborative basis. There remains an absolute commitment to delivering on the existing regional programmes of work, and following 're-baselining' work during 2024/25, there is a continued regional consensus on objectives, outcomes, and planning assumptions.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Service Divisions reporting to the Chief Operational Officer	• Alignment and effectiveness of partners to deliver integrated services	
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board. • Regular touchpoint meetings of all key players to review progress and issues arising		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

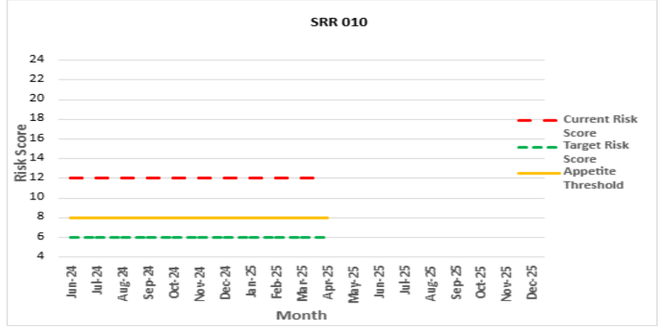
RISK THEME	**TRANSFORMATION AND PARTNERSHIP WORKING**				
LINK TO IMTP	**SECTION 4: ENABLER - QUALITY**				
Strategic Risk SRR 008	**There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unmet patient needs resulting in patient harm. • Ineffective use of combined resources • Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** N/A	**Organisation** • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence	**Risk Appetite Threshold – OPEN SCORE 17 and Below** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.	
				SUMMARY The current risk level is **OUTSIDE** of target but **WITHIN** the appetite threshold. Target level is **WITHIN** the set appetite threshold.	
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	**2** (Unlikely) x	**2** (Unlikely) x	
Initial Date of Assessment	01 June 2023	**Impact**	***4** (Major)*	**2** (Minor)	
Last Reviewed	01 January 2025	**Risk rating**	**= 8 (Moderate)**	***= 4 (Low)***	
Next Review (Six monthly based on risk score)	01 July 2025				



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys and National surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX • Oversight of Medical Examiner reports to determine patient experience actions • Public Engagement- Big Conversation Bereavement held 20th March 2024 • People Participation Panel ED in Progress • Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams.	• Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. • PCCT staff training to support Civica data entry and retrieval. • Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. • Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to QPSOG • Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. SMS provision to be implemented in Feb 2025 across ED and all MIU's. • National directives around new national surveys that need to be managed additional to internal roll out programme. • Volunteer feedback to be reviewed to identify themes. • Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. • Patient Experience and Involvement Team undertaking Culturally Competent Accreditation, receiving a silver distinction award in Oct 2024 • Immediate feedback and escalation to clinical teams following PALS queries and concerns • Civica patient feedback in in the process of being rolled out across all – all divisional leaders receive reports for their live areas monthly.	• Currently there is no SMS provision to increase the number of surveys. • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards. • • CIVICA team have the ability to pull and view feedback that has been left by patients/family. The listening and learning from the feedback to be shared by each department/directorate/division i.e., / 'you said, we did' / quality improvement projects.	• SMS provision for patient experience feedback will be launching in ED and all MIU's in February 2025. • PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Need to have discussions with facilities around rooms. • Patient experience KPI's and common themes by department/directorate/division need to be identified and pulled from the civica system left on surveys feedback. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation. • Development of a ABUHB bereavement survey has been built within CIVICA and tested. Launch date likely early 2025.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee • Implemented PALS DATIX Module	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Bi-monthly LLais Reports • HIW inspections • Advocacy reports	None	N/A

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable**

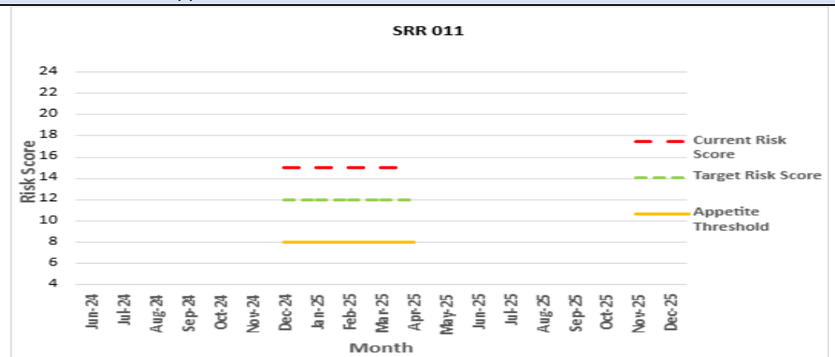
RISK THEME	COMPLINCE AND SAFETY				
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE & CULTURE				
Strategic Risk **SRR 010 A**	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.**			**Risk Appetite Level – MINIMAL** Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below.	
Impact *(Consequences of the threat)*	**Patient** • Unintended physical harm to patients • Psychological trauma	**Staff** • Unintended physical harm to staff • Psychological trauma • Increased levels of staff sickness	**Organisation** • Punitive actions from the Health and Safety Executive (HSE) • Loss of estates due to unsafe environments • Financial implications • Adverse publicity • Reputational damage.	**Risk Appetite Threshold – SCORE OF 8 or Below** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.	
				SUMMARY The current risk level is **OUTSIDE** of target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Allied Health Professions and Health Science	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x	
Initial Date of Assessment	01 December 2023	**Impact**	*4 (Major)*	3 (Moderate)	
Last Reviewed	01 February 2025	**Risk rating**	**= 12** **(High)**	**= 6** **(Moderate)**	
Next Review (Quarterly based on risk score)	01 May 2025				

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established. • Board Training /development (Completed 24 April 2024) • Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. • Established Health and Safety Governance and reporting arrangements (Health and Safety Committee)	• Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System • Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) • Consultation and communication with the workforce regarding compliance with the Act • New ways of working with Divisions to ensure accountability for health and safety is recognised. • Implement key performance indicators to monitor health and safety compliance. • Health and Safety Policies and Procedures being reviewed. • Onboard further Manual Handling trainers across the organisation to improve compliance. • Scope for training non-Health Board staff • Learning from events to be documented and communicated to the organisation. • Establishment of a Thematic Risk Register

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Health and Safety compliance data extracted from ESR and Datix and reported • Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act •	• Implementation of a health and safety performance report • Compliance on completion of risk assessments and mitigating actions	• Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Established monitoring of H&S at the Executive Committee • Corporate H&S report risk and assurance to the Health and Safety Committee • Established monitoring of H&S at the PQSO Committee	• Thematic Risk Register	• Development of a thematic risk register to be discussed at the Health and Safety Committee
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2024/25 Plan • Health and Safety Internal Audit – TBR • Performance reviews at All Wales Health and Safety Management Steering Group • South Wales Fire & Rescue Service fire safety audit programme. Health and Safety Executive reviews/inspections.	None	N/A

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	**SECTION 4: ENABLER – GREEN HEALTH**				
Strategic Risk SRR 011	**There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government (16% reduction by 2025 and a 34% reduction by 2030)** *This is common to all Health Bodies across the country.*			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected.** *(The effect of a failure to meet this target is on the wider environment.)*			**Risk Appetite Level – OPEN:** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure	
Impact *(Consequences of the threat)*	**Organisation** • Failure to meet the target set on Welsh Health bodies for reducing carbon output • Non–delivery of health board priority in this regard, required improvements, and achieving longer-term sustainability for the Health Board and nationally. • Reputational damage and loss of public confidence. • Opportunity cost of reduced energy costs			**Risk Appetite Threshold – SCORE 17 AND BELOW.** Risk driven by the likelihood of the HB missing this target with some cause for optimism regarding making some progress towards reducing carbon emissions in some areas such as ReFit and changes in clinical practice. The impact locally is relatively small.	
				SUMMARY The current risk level is **OUTSIDE** of target level and WITHIN the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	5 (Almost Certain) x	**4** (Likely) x	
Initial Date of Assessment	30 October 2024	**Impact**	***3*** *(Moderate)*	***3*** *(Moderate)*	
Last Reviewed	01 April 2025	**Risk rating**	**= 15 (Extreme)**	***= 12 (Moderate)***	
Next Review (Monthly based on risk score)	01 May 2025				



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Quarterly review of projects and workstreams at the Decarbonisation Programme Board • The project structure has 5 key workstreams each with a Health Board Lead covering clinical, communications, resources, • waste and facilities and estates • Regular reporting of financial data available • Significant work already with the ReFit programme and Investment Grade Proposal (IGP) which aims to secure funding for • projects of £7.4m, to reduce carbon emissions by 995 tonnes Co2 with a 10-year payback on investment. • Refreshed Decarbonisation Action Plans for 2024-25. The DAPs are integrated with other sustainability plans and were approved at the Decarbonisation Project Board in July 24. • Annual net zero return submitted to Welsh Government • Regular reporting of success stories in this area communicated across the Health Board (e.g., “Gloves R off”) • Decarbonisation Action Plans reported annually Executive lead and publicised on the green health website • SUS Qi training • Met office training • Carbon literacy training HEIW • 4 modules on carbon reduction and net zero ESR • Spread & Scale academy training sessions	• Project structure regularly reviewed should action be needed. • Controls will be implemented further as part of the ReFit programme when it progresses following approval of the Investment Grade Proposal.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Regular meetings of the subgroups to discuss position, monitor and new ideas • Bi-annual ISO14001 audit to be undertaken in October 2024. Estates operational meetings	• Detailed level metrics and measures are limited due to data capture equipment.	• All opportunities for funding will be optimised • Training opportunities will be maximised.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Six monthly updates to the Board • Executive Committee (Clinical Futures Board) updates – Quarterly • Six monthly updates to the Finance & Performance Committee Decarbonisation Programme Board – Quarterly reporting	• None	• The annual reporting to Welsh Government via the net zero return is the main source of information for carbon output by the Health Board. However, it provides a relatively simplistic picture of output of total tonnes per carbon and so its value is limited. • Funding is the greatest limitation on achieving targets. All opportunities for funding will be optimised • Training opportunities will be maximised.
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Report in July 24. • Received "limited assurance" but not because of controls – the issues were largely around funding limitations. **External Audit Reports 2023 -24**Periodic reports from Audit Wales – considered by the Audit and Risk Assurance committee	• Funding for a comprehensive ABUHB decarbonisation strategy is not available.	• As above - REFIT invest to Save capital opportunities being progressed.

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable** - adequate evidence that the controls in place are working effectively.	**Positive** - robust evidence that the controls in place are working effectively.	**NEGATIVE**