



AGENDA ITEM

4.1

CTM BOARD

ORGANISATIONAL RISK REGISTER

Date of meeting	(30/01/20)
FOI Status	Open/Public
If closed please indicate reason	Choose an item.
Prepared by	Chris Darling, Head of Executive Business
Presented by	Georgina Galletly, Director of Governance / Board Secretary
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	FOR DISCUSSION

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	Date	Outcome
Received by the Health Board	18/12/2020	ENDORSED FOR APPROVAL
Reviewed at Management Board	16/01/2020	DISCUSSED

ACRONYMS	

1. SITUATION/BACKGROUND

- 1.1 The purpose of this report is for the University Health Board to review and discuss the organisational risk register and consider whether the assessed and recorded risks are appropriately assigned across the Committees of the Board. The Organisational Risk Register was last considered by the Management Board on 16 January 2020.
- 1.2 The Executive Team have made a commitment to reviewing the risks allocated individually following the Board Development session held on Risk Management in August 2019.

- 1.3 Changes have been made to the Committee arrangements where the scrutiny of the risk register and risk management will now be undertaken at the Audit and Risk Committee from the Quality and Safety Committee.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

- 2.1 Discussions between the Director of Corporate Governance and lead directors have started to comprehensively review the Organisational Risk Register with an aim for a new approach to be finalised as soon as possible.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Overall Analysis

39 extreme or high risks

Categories	Extreme (15-25)	High (8-12)
Setting the direction /performance and operational efficiency	7	4
Improve quality, safety and patient experience	11	1
Statutory compliance	7	3
Finance (including claims)	1	1
Workforce / Organisational Development / Innovation	1	
Business Continuity	1	2
Total risks	28	11

Score	How many
25	0
20	13
16	11
15	3
12	11
10	1

Removal of Risks

- 3.2 The following risks have been removed, following recommendation to do so in December 2019:
- Risk no 013 - Failure to Implement South Wales Plan outcomes
 - Risk no 42 - Failure to ensure successful implementation of the Welsh Governments decision to realign the Health Boundary, as it applies to the resident population of the Bridgend County Borough.
 - Risk no 46 - Poor quality unsafe services providing unsatisfactory patient experience which if not adequately addressed will continue to effect escalation status.

Additional Risks

- 3.3 The Lead Director has recommended that the following risks are added to the register:
- Not agreeing a sustainable model for emergency medicine and inpatient paediatrics (Risk number 050)
 - implementing a sustainable model for emergency medicine and inpatient paediatrics in a timely manner (Risk number 051)
 - Organisational reputation – lack of confidence in services and care provided by the organisation (Risk number 052)
 - New operating model leads to lack of clarity (Risk number 053)
- 3.4 The following risks have changed their risk scores during the past 3 months, on the recommendation of the Lead Director:
- Failure to continue to provide and sustain GP Out of Hours Services as currently configured (Risk number 030) – reduced from 20 to 12.
 - Reduction in medical training posts within various specialities and capacity to meet workload demands (Risk number 008) – reduced from 20 to 16.
 - Risk of information technology failures following national outage during 2018 and cyber security risk which could lead to loss of information or information governance issues (Risk number 044) – reduced from 15 to 10.
- 3.5 All areas have been updated since November 2019, or more recently, as indicated by the review date, this reflects the ongoing work to focus on management and mitigation of risk.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Aim to mitigate risks to patients and staff
Related Health and Care standard(s)	Governance, Leadership and Accountability
	All Health and Care Standards are included
Equality impact assessment completed	No (Include further detail below)
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.



Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Main Strategic Objective	To provide strong governance and assurance
Link to Main WBFG Act Objective	Service delivery will be innovative, reflect the principles of prudent health care and promote better value for users

5. RECOMMENDATION

- 5.1 The University Health Board is asked to **DISCUSS** and **REVIEW** the Organisational Risk Register.

Strategic Objective	Risk Ref	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
Setting the Direction and Performance and Operational Efficiency	028 DOF	Failure to ensure delivery of a viable balanced/break even 3 year integrated medium term plan.	20	20	↑	November 2019	Finance, Performance and Workforce
	015 DN	Reputational damage & potential legal challenge on the decision making on Funded Nursing Care (FNC).	20	12	↓	January 2020	Quality and Safety
	036 DPCMH	Primary Care Workforce - Recruitment and sustainability	20	16	→	November 2019	Primary, Community Population Health and Partnerships
	030 DPCMH	Failure to continue to provide and sustain GP Out of Hours Services as currently configured.	20	12	↓	January 2020	Primary, Community Population Health and Partnerships
	002 COO	Failure to achieve Referral to Treatment targets.	20	16	↑	January 2020	Finance, Performance & Workforce
	003 COO	Failure to achieve the 4 and 12 hour emergency (A&E) waiting times targets.	20	16	↓	January 2020	Finance, Performance & Workforce
	023 DN	Patients and/or relatives/carers do not receive timely responses to concerns raised, learning and improvement does not take place if there is failure to meet the timescale relating to responding to complaints	20	12	↓	January 2020	Quality and Safety
	050 MD	Not agreeing a sustainable model for emergency medicine and inpatient paediatrics across the CTMUHB footprint. (New Risk)	16	16		January 2020	Finance, Performance & Workforce
	051 MD	Implementing a sustainable model for emergency medicine and inpatient paediatrics across the CTMUHB footprint in a timely manner. (New Risk)	20	20		January 2020	Finance, Performance & Workforce

	052 DCG	Organisational Reputation: Lack of confidence in the services and care provided by the organization. (New Risk)	15	15		January 2020	Finance, Performance & Workforce
	053 WOD	New Operating Model: The new operating model leads to lack of clarity and/or lack of focus on delivering performance, quality and resources. (New Risk)	12	12		January 2020	Finance, Performance & Workforce

Risk Register Category – Business Objectives / Projects (11 risks)

The Trend column indicates whether the risk overall (from when first assessed), is increasing (↑), reducing (↓) or unchanged (→). The Controls column indicates whether assessed controls overall are improved (↑), reduced (↓) or unchanged (→) from when first assessed. Regardless of whether the risks rating has changed.

(Key: MD – Medical Director; ND – Nurse Director; COO – Chief Operating Officer; DPCMH – Director of Primary Community and Mental Health; DOF – Director of Finance; DCG – Director of Corporate Governance; DPP – Director of Planning and Partnerships; WOD – Workforce and Organisational Development Director; DPH – Director of Public Health; CEO – Chief Executive Officer; DoTH&HS – Director of Therapies and Health Sciences)

Risk Register Category - Impact on Safety (13 risks)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
To improve quality, safety and patient experience.	007 MD	Failure to recruit sufficient medical & dental staff.	20	20	⇒	January 2020	Quality and Safety
	034 MD	Increasing dependency on Agency Staff cover in Medical and Nursing areas, which has the potential to impact on continuity of care and patient safety and is actually impacting on the UHB financial position.	20	20	⇒	January 2020	Quality and Safety
	035 ND	Failure to recruit sufficient registered nursing and midwifery staff.	20	20	⇒	January 2020	Quality and Safety



Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
	008 MD	Reduction in medical training posts within various specialties & capacity to meet workload demands.	20	16	↓	January 2020	Quality and Safety
	027 COO	Lack of control and capacity to accommodate all hospital follow up outpatient appointments.	20	20	⇒	January 2020	Finance, Performance & Workforce
	032 COO	Sustainability of a safe & effective Ophthalmology Service.	20	16	↓	January 2020	Quality and Safety
	005 COO	Failure to sustain services as currently configured to meet cancer targets.	20	16	⇒	January 2020	Finance, Performance & Workforce
	033 DPCMH	Failure to sustain Child & Adolescent Mental Health Services across the Network	20	16	⇒	November 2019	Quality and Safety
	037 COO	Ensuring the development, approval and implementation of a Strategy for IM&T, that is clinically led and supports staff in care delivery	12	12	⇒	January 2020	ICT and IG
	043 DN	Under Reporting of Clinical Incidents in Maternity Services	20	20	⇒	January 2020	Quality and Safety
	047 (NEW) COO	Failure to treat patients in a timely manner resulting in potential avoidable harm	20	20	N/A	January 2020	Finance, Performance and Workforce
	049 (NEW) WOD	Insufficient skilled staff to deliver clinical services effectively due to poor retention of staff	20	20	new	January 2020	Finance, Performance & Workforce

Risk Register Category – Statutory Duty / Inspections (10)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
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Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
Statutory Compliance	017 DoTH&HS	Failure to meet Fire Safety Standards on ground and first floor PCH.	20	20	⇒	January 2020	Audit and Risk
	021 WOD	Enforcement action or litigation if an incident is linked to a lack of Core Mandatory Training	20	20	⇒	January 2020	Quality and Safety
	025 DoTH&HS	Failure to meet Fire Safety Standards across CTMUHB.	20	20	↑	January 2020	Audit and Risk
	018 DPP	Failure to achieve statutory and mandatory planned preventative maintenance (PPM) programme.	15	15	⇒	January 2020	Audit and Risk
	031 DN	Non-compliance with DoLS legislation and resulting authorisation breaches	16 (was 12)	12	↓	January 2020	Quality and Safety
	016 DPP	Failure to comply fully with the arrangements for managing Asbestos	16	12	⇒	January 2020	Audit and Risk
	039 COO	Failure to ensure sufficient storage capacity (or alternative solutions) are in place to safely store and secure patient records.	16	16	⇒	January 2020	Quality and Safety
	040 WOD	Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	15	15	⇒	January 2020	Quality and Safety
	041 COO	Failure to fully meet all the licensing requirements of the Human Tissue Authority in relation to Mortuary & Services for the Deceased.	16	12	↓	January 2020	Quality and Safety



Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
	048 DoTH&HS (NEW)	Failure to meet Fire Safety Standards in the Theatres, Princess of Wales Hospital.	20	20	New	January 2020	Audit and Risk

Risk Register Category – Finance / Including Claims (2)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
Financial Viability	011 DOF	Failure to achieve in year breakeven	15	20	↑	November 2019	Finance Performance and Workforce
	012 DPP	Failure to Deliver Major & Discretionary Capital programmes	12	12	⇒	January 2020	Capital Programme Board

Risk Register Category – Human Resources / Organisational Development / Staff Competency (1)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
Workforce Sustainability/ OD and Innovation	019 WOD	Failure to achieve the Management of Absence target.	20	20	⇒	January 2020	Finance, Performance & Workforce

Risk Register Category – Service / Business Interruption (3)

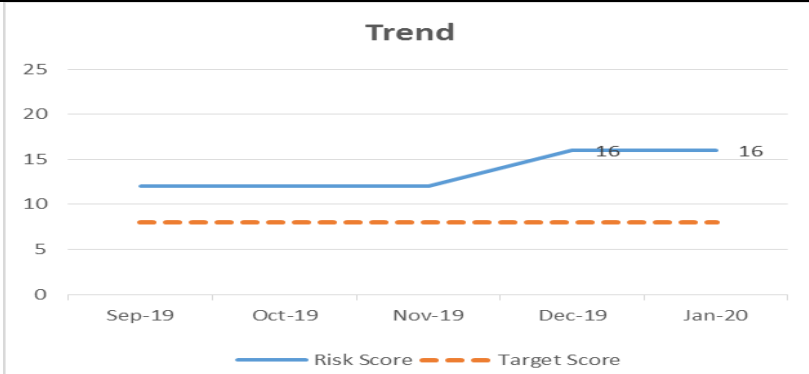
Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
Business Continuity	006 COO	Failure to appropriately manage Discharge Delays from Hospitals	20	12	↓	January 2020	Finance, Performance & Workforce



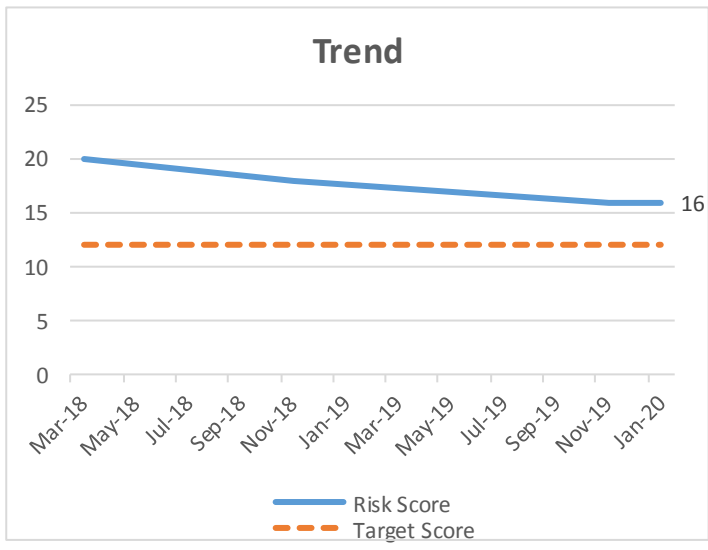
Business Continuity Information Technology Systems	044 COO	Risk of information technology failures following national outage during 2018 and cyber security risk which could lead to loss of information or information governance issues	15	10	↓	January 2020	Management Board Will be ICT/IG Committee
Business Continuity Brexit	045 DPH	Risk of interruption to service sustainability, provision and destabilising the Board's financial position as a result of Brexit.	16	16	⇒	November 2019	Management Board

HEALTH BOARD ORGANISATIONAL RISK REGISTER SUMMARY OF ASSESSED RISKS (TREND SINCE LAST REPORT) – January 2020

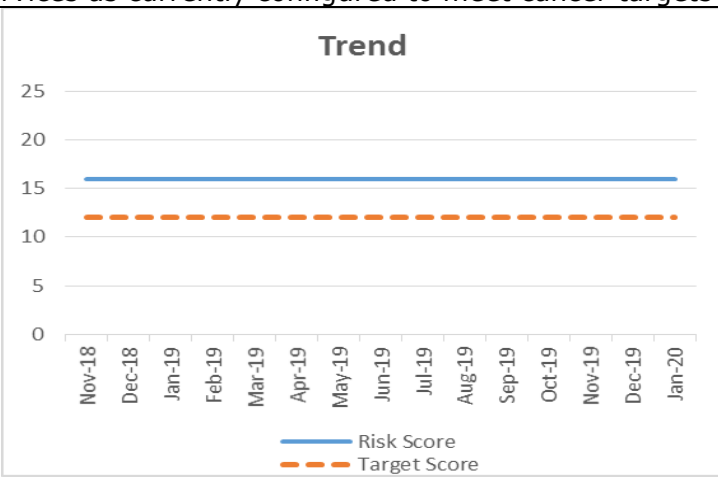
Impact/Consequence	Likelihood		Risk Description	Risk Details	Mitigation/Action
	1	2			
5		044 Loss of IT due to system outages ↓	052 (NEW) Organisational reputation	017 Failure to meet Fire Safety Standards on Ground & First Floor Prince Charles Hospital ↔ 011 Failure to achieve financial balance ↑ 007 Failure to recruit Medical & Dental Staff ↔ 043 Under reporting of clinical incidents in maternity services 047 (NEW) Failure to treat patients in a timely manner resulting in avoidable harm 048 (NEW) Failure to meet fire safety standards in the theatres at POW 025 Failure to meet Fire Safety standards across the UHB ↑	
4			037 Ensuring the development, approval and implementation of a Strategy for Digital Health, that is clinically led and supports staff in care delivery ↔ 016 Management of asbestos ↓ 012 Failure to deliver major and discretionary capital programmes ↔ 006 Discharge delays from acute hospitals ↔	032 Sustainability of safe & effective Ophthalmology Services ↓ 005 Failure to sustain services as currently configured to meet cancer targets ↓ 033 Sustaining CAMH Services ↔ 036 Primary Care workforce – recruitment & sustainability ↔ 015 Reputational damage & potential legal challenge (FNC) ↓ 021 Staff competency – compliance with statutory/mandatory training ↓ 041 Human Tissue Act compliance mortuary / deceased services 045 Brexit 003 Failure to achieve 4 & 12 hour Emergency access targets. ↔ 039 Ensuring Sufficient Health Records Storage 002 Failure to achieve RTT ↑ 023 Patients and/or relatives/carers do not receive timely responses to concerns raised, learning and improvement does not take place if there is failure to meet the timescale relating to responding to complaints ↑ 008 Reduction in medical training posts within various specialities & capacity to meet workload ↓ 050 (NEW) Not agreeing a sustainable model for emergency medicine and inpatient paed	028 Producing Viable balanced 3 year IMTP ↑ 034 Increasing dependency on agency staffing (medical & nursing) finance impact ↔ 035 Failure to recruit registered nursing and midwifery staff ↔ 027 Lack of control & capacity to accommodate Follow Up Outpatients ↔ 049 (NEW) Insufficient skilled staff to deliver clinical services effectively due to poor retention of staff 051 (NEW) Implementing a sustainable model for emergency medicine and inpatient paediatrics across the CTMUHB footprint in a timely manner
3				019 Failure to achieve the management of absence target ↑ 031 Non-compliance with DoLS legislation and resulting authorisation breaches ↓ 030 Continuing to provide GP Out of Hours Services as currently configured ↓ 053 (NEW) New operating model leads to lack of clarity	018 Failure to achieve statutory and mandatory planned preventative maintenance programme ↔ 040 Compliance with Welsh Language Standards
2					
1					
C x L	1	2	3	4	5

Objective: Setting the Direction & Performance & Operational Delivery		Director Lead: Chief Operating Officer	
Risk: Failure to achieve Referral to Treatment Times (0)		Assuring Committee: Finance, Performance & Workforce	
Date last reviewed: January 2020		Rationale for current score:	
<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 2 = 8</p> <p>Level of Control =50%</p> <p>Date added to risk register April 2013</p>		<p>The current score reflects current trajectories for year-end out turn. We have now completed our work with the Delivery Unit to identify additional patients (c.1750) for lists including neurophysiology, nephrology and specialised paediatrics and these are now fully absorbed into our plans for the remainder of the financial year.</p> <p>Rationale for target score: Effective D&C Plans with improved efficiency in flow, length of stay and assessment, and some improvement in theatre performance informs the target score.</p>	
		Controls (What are we currently doing about the risk?)	
<ul style="list-style-type: none"> • Directorate Demand & Capacity Plans in place (and being further developed) with regular RTT meetings in place. • Ongoing Flow Programme to address capacity issues. • Improved capacity for Day Surgery and 23:59 case load. • Monthly and Quarterly monitoring of trajectories, routinely discussed within CBMs. • Routine reporting into Finance, Performance & Workforce Committee • Surgical Assessment facilities now available on District General Hospital sites. • WG has released £7m against a £8.7m resource plan for restoring our trajectory. • Several workshops held to address HMRC tax and pension issues which have significantly eroded consultant sessional availability for ADH and WLI. • DU review of unreported waiting lists complete and all trajectories reworked to include patients from those lists – financial plans to achieve trajectories now in place. 		Mitigating actions (What more should we do?)	
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)	
Waiting list reductions; better response times from departments / compliance figures will improve.		F,P&W monitoring progress. Further work required in light of the establishment of CTMUHB. Working with the DU to analyse all waiting times.	

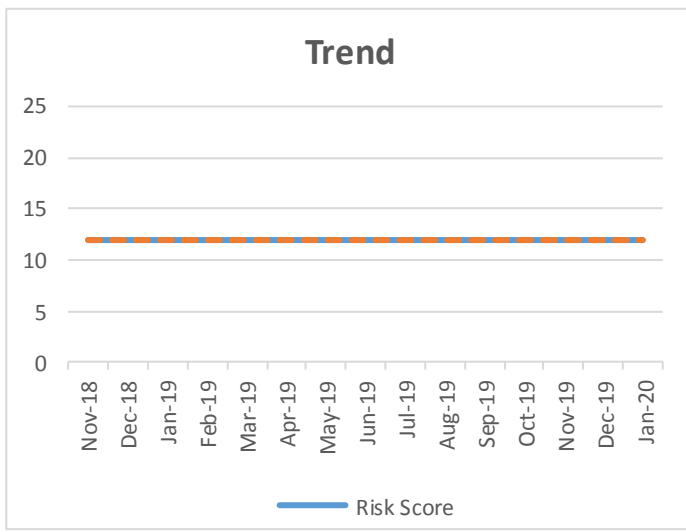
Current Risk Rating Current Risk Rating : 4 x 4 = 16	Additional Comments The plan last year (and this), was to sustain RTT position and deliver against the target without (or with limited) external outsourcing. However, this has not been possible and additional outsourcing in place.	Ref No. 002
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Objective: Setting the Direction & Performance & Operational Delivery		Director Lead: Chief Operating Officer																																								
Risk: Failure to achieve the 4 and 12 hour emergency (A&E) waiting times targets.		Assuring Committee: Finance, Performance & Workforce																																								
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 4 = 16 Target: 4 x 3 = 12		<p style="text-align: center;">Rationale for current score:</p> <p>The 4 hour 90% target is not currently being achieved. RGH performance has stabilised as medical workforce now back in balance; PCH and PoW have received detailed action plans from DU/CASC. Winter Plan now initiating with partners supportive.</p> <p style="text-align: center;">Rationale for target score:</p> <p>To meet the emergency access targets set by Welsh Government is dependent on the patient flow and therefore a target of 12 is challenging for the unscheduled care service (USC).</p>																																								
Level of Control =70%																																										
Date added to risk register April 2013																																										
<p>Trend</p>  <table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Mar-18</td><td>20</td><td>12</td></tr> <tr><td>May-18</td><td>19</td><td>12</td></tr> <tr><td>Jul-18</td><td>18</td><td>12</td></tr> <tr><td>Sep-18</td><td>17</td><td>12</td></tr> <tr><td>Nov-18</td><td>16</td><td>12</td></tr> <tr><td>Jan-19</td><td>16</td><td>12</td></tr> <tr><td>Mar-19</td><td>16</td><td>12</td></tr> <tr><td>May-19</td><td>16</td><td>12</td></tr> <tr><td>Jul-19</td><td>16</td><td>12</td></tr> <tr><td>Sep-19</td><td>16</td><td>12</td></tr> <tr><td>Nov-19</td><td>16</td><td>12</td></tr> <tr><td>Jan-20</td><td>16</td><td>12</td></tr> </tbody> </table>		Month	Risk Score	Target Score	Mar-18	20	12	May-18	19	12	Jul-18	18	12	Sep-18	17	12	Nov-18	16	12	Jan-19	16	12	Mar-19	16	12	May-19	16	12	Jul-19	16	12	Sep-19	16	12	Nov-19	16	12	Jan-20	16	12	Date last reviewed: January 2020	
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Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																								
<ul style="list-style-type: none"> Need to strengthen minors streams at DGH sites to sustain improved delivery of performance against the 4, 8 and 12 hour targets. Also variable practice across A&E departments. Consultant and middle grade gaps in RGH now filled. PCH DU report delivered and being enacted. PoW handover performance reviewed by DU & EASC/CASC team and being enacted. PoW/RGH/PCH provided full Safety and Dignity analysis to September QSR committee and Safety Briefing sitrep model and SAFER being rolled out across sites. Programme of improvement work with AM&ED, HR and Retinue teams to 		Action	Lead	Deadline																																						
		1) Clear discharge planning processes in place.	COO	Ongoing																																						
		2) Improvements in the patient flow and investments to support Winter planning.	Dep COO	Ongoing																																						
		3) Stay Well At Home (SW@H) Service introduced and evaluated (6 month). Transformation funding will initiate Jan/Feb 2020.	Dep COO	Ongoing																																						
		4) SW@H 2 developments and Enhanced Community Clusters being progressed through Transformation bid.	COO	Ongoing																																						

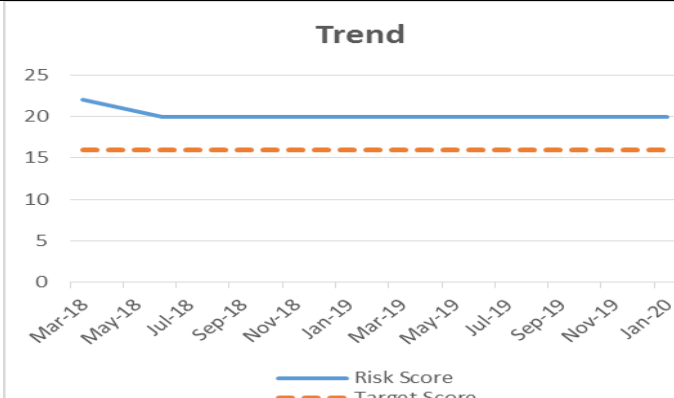
<p>improve medical booking and staffing to raise shift fill (ADH initiative has been successful).</p> <ul style="list-style-type: none"> • Winter Plan in train through directorate and partners (RPB). • Interim Site Management arrangements coming into place. • Systems model in development. 			
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
Monthly reporting of 4, 8 and 12 hour performance within the Integrated Performance Dashboard.	Risk management across sites in terms of Ambulance handover in PoW and safe management of corridor waits in PCH/RGH.		
Current Risk Rating	Additional Comments		Ref No.
Current Risk Rating : 4 x 4 = 16	Recruitment and retention of staff essential.		003

Objective: To improve quality, safety and patient experience		Director Lead: Chief Operating Officer																																																	
Risk: Failure to sustain services as currently configured to meet cancer targets		Assuring Committee: Finance, Performance & Workforce																																																	
Date last reviewed: January 2020																																																			
<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 3 = 12</p> <p style="background-color: #92d050; padding: 2px;">Level of Control =70%</p> <p>Date added to the risk register April 2014</p>	<p style="text-align: center;">Trend</p>  <table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Nov-18</td><td>16</td><td>12</td></tr> <tr><td>Dec-18</td><td>16</td><td>12</td></tr> <tr><td>Jan-19</td><td>16</td><td>12</td></tr> <tr><td>Feb-19</td><td>16</td><td>12</td></tr> <tr><td>Mar-19</td><td>16</td><td>12</td></tr> <tr><td>Apr-19</td><td>16</td><td>12</td></tr> <tr><td>May-19</td><td>16</td><td>12</td></tr> <tr><td>Jun-19</td><td>16</td><td>12</td></tr> <tr><td>Jul-19</td><td>16</td><td>12</td></tr> <tr><td>Aug-19</td><td>16</td><td>12</td></tr> <tr><td>Sep-19</td><td>16</td><td>12</td></tr> <tr><td>Oct-19</td><td>16</td><td>12</td></tr> <tr><td>Nov-19</td><td>16</td><td>12</td></tr> <tr><td>Dec-19</td><td>16</td><td>12</td></tr> <tr><td>Jan-20</td><td>16</td><td>12</td></tr> </tbody> </table>	Month	Risk Score	Target Score	Nov-18	16	12	Dec-18	16	12	Jan-19	16	12	Feb-19	16	12	Mar-19	16	12	Apr-19	16	12	May-19	16	12	Jun-19	16	12	Jul-19	16	12	Aug-19	16	12	Sep-19	16	12	Oct-19	16	12	Nov-19	16	12	Dec-19	16	12	Jan-20	16	12	<p>Rationale for current score: An overall reducing trend in current risk assessed score over last year. However target not consistently being met and focus on different delivery model for urology required. Regional provision of EBUS also an area being targeted for improved access.</p> <p>Rationale for target score: Target score reflects the challenge this area of work present the Board and where small numbers of patients regularly breaching impact on the potential to breach target.</p>	
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Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																																	
<ul style="list-style-type: none"> • Tight management processes to manage each individual case on the unscheduled care (USC) Pathway. • Initiatives to protect surgical capacity to support USC pathways have been put in place in RGH and PCH to protect core activity. • Prioritised pathway in place to fast track USC patients. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. • Overall Cancer target performance challenged by frailty of urology service 		Action	Lead	Deadline																																															
		Introduction of revised models for rapid diagnostic review / assessment in cancer pathways continuing to drive pick-up rate (15% from 3%)	COO / DPC&MH Med Dir	ongoing																																															
		Continue close monitoring of each patient on the USC pathways to ensure rapid flow of patients through the pathway.	COO / DPC&MH Med Dir	Ongoing																																															

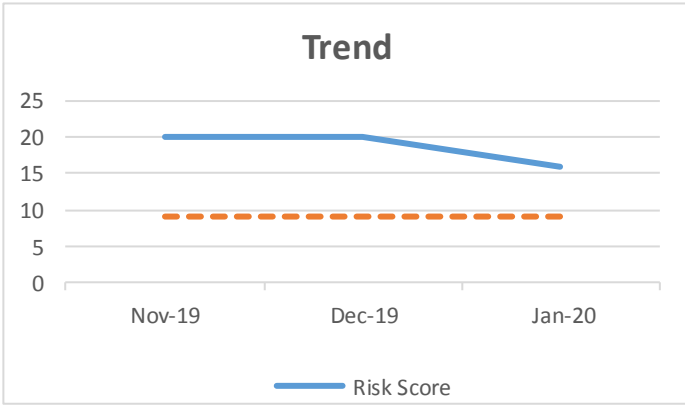
<p>with potential for regional service under review – connection with radiology an issue during late Summer. Regional access to EBUS through C&VUHB an issue.</p> <ul style="list-style-type: none"> Implementation of Single Cancer Pathway well underway with further work to do on underlying business case for sustained target delivery coming forward. 	<p>Some speciality challenges remain in Lung and Urology - action plans in place, along with monitoring. Also work underway on regional access to EBUS service.</p>	<p>COO / Med Dir</p>	<p>Ongoing</p>
<p>Assurances (How do we know if the things we are doing are having an impact?)</p>	<p>Gaps in assurance (What additional assurances should we seek?)</p>		
<p>General flattening of trajectory. Need to continue improvement actions and close monitoring. Early diagnosis pathway launched and impact being made. Urology and Radiology remain under constant review. Single Cancer Pathway being implemented.</p>	<p>The need to deliver sustained performance.</p>		
<p style="text-align: center;">Current Risk Rating 4 x 4 = 16</p>	<p style="text-align: center;">Additional Comments</p>		<p style="text-align: center;">Ref No. 005</p>

<p>Objective: Business Continuity</p>		<p>Director Lead: Chief Operating Officer Assuring Committee: Finance, Performance & Workforce</p>																																	
<p>Risk: Failure to appropriately manage Discharge Delays from Hospitals</p>		<p>Date last reviewed: January 2020</p>																																	
<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 4 x 3 = 12</p> <p style="background-color: #92d050; padding: 5px;">Level of Control =70%</p> <p>Date added to the risk register April 2013</p>	<p style="text-align: center;">Trend</p>  <table border="1"> <caption>Risk Score Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Nov-18</td><td>12</td></tr> <tr><td>Dec-18</td><td>12</td></tr> <tr><td>Jan-19</td><td>12</td></tr> <tr><td>Feb-19</td><td>12</td></tr> <tr><td>Mar-19</td><td>12</td></tr> <tr><td>Apr-19</td><td>12</td></tr> <tr><td>May-19</td><td>12</td></tr> <tr><td>Jun-19</td><td>12</td></tr> <tr><td>Jul-19</td><td>12</td></tr> <tr><td>Aug-19</td><td>12</td></tr> <tr><td>Sep-19</td><td>12</td></tr> <tr><td>Oct-19</td><td>12</td></tr> <tr><td>Nov-19</td><td>12</td></tr> <tr><td>Dec-19</td><td>12</td></tr> <tr><td>Jan-20</td><td>12</td></tr> </tbody> </table>	Month	Risk Score	Nov-18	12	Dec-18	12	Jan-19	12	Feb-19	12	Mar-19	12	Apr-19	12	May-19	12	Jun-19	12	Jul-19	12	Aug-19	12	Sep-19	12	Oct-19	12	Nov-19	12	Dec-19	12	Jan-20	12	<p>Rationale for current score: The current score reflects the overall improvement in reductions in DTOCs with a number of related initiatives established to reduce, in partnership with Local Authority colleagues.</p> <p>Rationale for target score: The target score reflects the requirement to reduce the numbers of patients delayed, whilst the impact can be significant for patients whose discharge is delayed, for them individually and for those awaiting admission.</p>	
Month	Risk Score																																		
Nov-18	12																																		
Dec-18	12																																		
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<p>Controls (What are we currently doing about the risk?)</p>		<p>Mitigating actions (What more should we do?)</p>																																	
<ul style="list-style-type: none"> Grouping of complex discharges; Implementation of Anticipated Date of Discharge (ADD), good performance sustained following focus on flow work. Working with Local Authority partners within the consortium to develop a 		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Ensure robust monitoring arrangements are maintained and actions in place to mitigate</td> <td>COO / DPC&MH</td> <td>Ongoing</td> </tr> </tbody> </table>	Action	Lead	Deadline	Ensure robust monitoring arrangements are maintained and actions in place to mitigate	COO / DPC&MH	Ongoing																											
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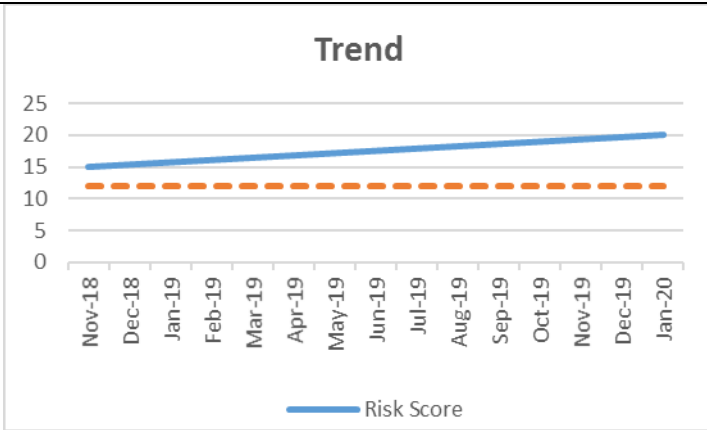
<ul style="list-style-type: none"> partnership response. General staff awareness being raised with regards the court ruling and its related impact. Deprivation of Liberties Safeguarding (DoLS) strengthened to support assessment and discharge. Prioritisation process in place for DoLS applications and training for all disciplines. Stranded Patient DU review suggests areas for improvement for PCH and PoW in particular – gives a positive review of RGH system balance across the integrated system. An increase in DTOC generally, mainly for the Bridgend locality based on access to rehabilitation support. 	flow barriers and escalate impact on flow		
	Maintain Flow improvement work and ensure all enablers (including planned benefits) to reduce dependency on hospital and appropriately support patients in their own communities are realised.	COO / DPC&MH	Ongoing
	Winter planning work also monitoring DTOC position Stranded Patient DU work reflects balanced RGH and PCH systems, with clear investment priorities for PoW at the back door.	COO / DPC&MH	Ongoing
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
The overall reduced trend in numbers, provides assurance that the improvement actions continue to have a positive effect.	As there is seasonal volatility in DTOCs, important still to monitor our position routinely.		
Current Risk Rating	Additional Comments		Ref No.
Current Risk Rating : 4 x 3 = 12	Maintain monitoring and joint working with Partners.		006

Objective: To improve quality, safety and patient experience		Director Lead: Medical Director																																								
Risk: Failure to recruit sufficient medical and dental staff		Assuring Committee: Management Board																																								
Date last reviewed: January 2020																																										
<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 4 = 16</p> <p>Level of Control = 50%</p> <p>Date added to the risk register August 2013</p>	<p>Trend</p>  <table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Mar-18</td><td>22</td><td>16</td></tr> <tr><td>May-18</td><td>20</td><td>16</td></tr> <tr><td>Jul-18</td><td>20</td><td>16</td></tr> <tr><td>Sep-18</td><td>20</td><td>16</td></tr> <tr><td>Nov-18</td><td>20</td><td>16</td></tr> <tr><td>Jan-19</td><td>20</td><td>16</td></tr> <tr><td>Mar-19</td><td>20</td><td>16</td></tr> <tr><td>May-19</td><td>20</td><td>16</td></tr> <tr><td>Jul-19</td><td>20</td><td>16</td></tr> <tr><td>Sep-19</td><td>20</td><td>16</td></tr> <tr><td>Nov-19</td><td>20</td><td>16</td></tr> <tr><td>Jan-20</td><td>20</td><td>16</td></tr> </tbody> </table>	Month	Risk Score	Target Score	Mar-18	22	16	May-18	20	16	Jul-18	20	16	Sep-18	20	16	Nov-18	20	16	Jan-19	20	16	Mar-19	20	16	May-19	20	16	Jul-19	20	16	Sep-19	20	16	Nov-19	20	16	Jan-20	20	16	<p>Rationale for current score: The agency costs for medical staff has risen annually and the lead in time to develop our own staff or provide different support by alternate practitioners etc takes time to implement.</p> <p>Rationale for target score: There are ongoing recruitment problems (reflecting a National problem). Changes led by the Wales Deanery have also featured in discussions around the South Wales Plan and the ability for Cwm Taf to continue services as configured on all sites.</p>	
Month	Risk Score	Target Score																																								
Mar-18	22	16																																								
May-18	20	16																																								
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Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																								
<ul style="list-style-type: none"> Linked with IMTP, modernise the workforce to support clinical service 		Action	Lead																																							
			Deadline																																							

<p>redesign and align the development of the clinical services strategy.</p> <ul style="list-style-type: none"> Continue to review and develop workforce plans, including role redesign to mitigate the requirements of the SWP implementation and reduce dependency on the reducing medical workforce. Continue to develop and implement new roles to support clinical practice. Recruit known clinicians to the UHB who have previously undertaken locum work. Resort to Agency cover, with strict vetting of CVs by the Directorates, with any concerns fed back to the Agency. Implement all Wales Agency Cap. Exploring joint appointments within Regional footprints (where appropriate). Consultants are supported by Nurse Practitioners/ Surgical Care Practitioner and Associate Specialists. Developing other supporting roles in the therapy and health science staff groups. 	Continue to Work with WG to maximise Train Work Live	Medical Director	Ongoing
	Maximise the lessons from the Rhondda Docs website and use of social media including the development of short videos of current medical staff aiming to recruit new colleagues – highlighting that Cwm Taf is a great place to work and live	Medical Director	Ongoing
	There are ongoing discussions between all HBs and the Deanery regarding the trainee rota. This is subject to ongoing review and separate risk assessments - Contingency plans in place for Paeds, developing plans for other key specialities.	Medical Director	Ongoing
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
Reduction of medical agency costs	Impact of locum workforce on safe standards for patient care		
Current Risk Rating	Additional Comments	Ref No. 007	
Current Risk Rating : 5 x 4 = 20	National problem being discussed at the highest level. Cwm Taf supported WG to launch Train, Work, Live.		

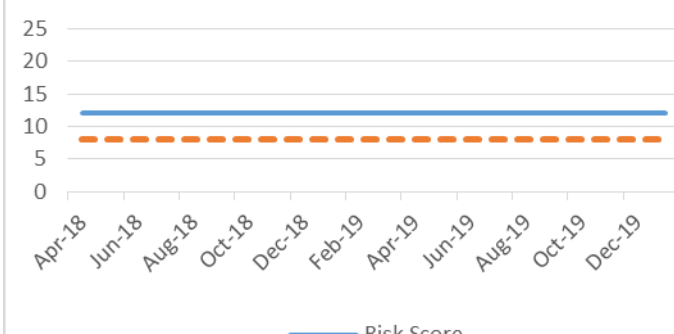
Objective: To improve quality, safety and patient experience		Director Lead: Medical Director Assuring Committee: Management Board, Quality Safety and Risk Committee													
Risk: Reduction in training posts within various specialties & capacity to meet workload demands.		Date last reviewed: January 2020													
<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 3 x 3 = 9</p> <p>Level of Control =60%</p> <p>Date added to the risk register August 2013</p>	<p style="text-align: center;">Trend</p>  <table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr> <td>Nov-19</td> <td>20</td> </tr> <tr> <td>Dec-19</td> <td>20</td> </tr> <tr> <td>Jan-20</td> <td>16</td> </tr> </tbody> </table>	Month	Risk Score	Nov-19	20	Dec-19	20	Jan-20	16	<p>Rationale for current score: Impact of insufficient trainees on the organisations ability to provide safe services remains challenging and problematic.</p> <p>Rationale for target score: A number of specialties rely on the training posts to ensure safe and effective services across the sites within Cwm Taf, reductions in trainee posts can significantly affect the organisations ability to provide services safely.</p>					
Month	Risk Score														
Nov-19	20														
Dec-19	20														
Jan-20	16														
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)													
<ul style="list-style-type: none"> Workforce Plan agreed by the Board as part of the 3 year IMTP The Postgraduate Dean has written to all Health Boards seeking plans to mitigate against predictable rota gaps. Continue to work with the Wales Deanery to ensure that the specific requirements for Cwm Taf to maintain safe services are understood and the impact assessed Ongoing meetings in place within the Region involving the Deanery. Exploration of joint appointments across the Region continue. Some appointment success e.g. Paediatrics that mitigated the risks associated with sustaining rotas. 		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Continue to develop alternative supporting roles by other professional staff</td> <td>Medical director</td> <td>Ongoing</td> </tr> <tr> <td>Undertake service change in line with agreed models within the South Wales Plan such as maternity services</td> <td>Chief operating officer</td> <td>Qtr 4. 2018/19</td> </tr> <tr> <td>Continue to work in partnership with other health boards to work across boundaries and develop safe and efficient services for the local populations</td> <td>Chief Executive</td> <td>Ongoing</td> </tr> </tbody> </table>		Action	Lead	Deadline	Continue to develop alternative supporting roles by other professional staff	Medical director	Ongoing	Undertake service change in line with agreed models within the South Wales Plan such as maternity services	Chief operating officer	Qtr 4. 2018/19	Continue to work in partnership with other health boards to work across boundaries and develop safe and efficient services for the local populations	Chief Executive	Ongoing
		Action	Lead	Deadline											
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Continue to work in partnership with other health boards to work across boundaries and develop safe and efficient services for the local populations	Chief Executive	Ongoing													
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)													
Able to provide safe and effective services		Regional solutions delivered at pace. Contingency plans in place.													
Current Risk Rating		Additional Comments													
Current Risk Rating : 4 x 4 = 16		Will require further review in light of establishment of the CTMUHB.													
		Ref No. 008													

Improvements in HEIW confidence – reduced immediate risk of losing Doctors.

Objective: Financial Viability		Director Lead: Director of Finance																																
Risk: Failure to achieve in year breakeven		Assuring Committee: Health Board (Finance, Performance and Workforce Committee)																																
		Date last reviewed: November 2019																																
<p>Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 4 = 20 Target: 4 x 3 =12</p> <p>Level of Control =60%</p> <p>Date added to risk register April 2013</p>	<p style="text-align: center;">Trend</p>  <table border="1"> <caption>Risk Score Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Nov-18</td><td>15</td></tr> <tr><td>Dec-18</td><td>15.5</td></tr> <tr><td>Jan-19</td><td>16</td></tr> <tr><td>Feb-19</td><td>16.5</td></tr> <tr><td>Mar-19</td><td>17</td></tr> <tr><td>Apr-19</td><td>17.5</td></tr> <tr><td>May-19</td><td>18</td></tr> <tr><td>Jun-19</td><td>18.5</td></tr> <tr><td>Jul-19</td><td>19</td></tr> <tr><td>Aug-19</td><td>19.5</td></tr> <tr><td>Sep-19</td><td>20</td></tr> <tr><td>Oct-19</td><td>20</td></tr> <tr><td>Nov-19</td><td>20</td></tr> <tr><td>Dec-19</td><td>20</td></tr> <tr><td>Jan-20</td><td>20</td></tr> </tbody> </table>	Month	Risk Score	Nov-18	15	Dec-18	15.5	Jan-19	16	Feb-19	16.5	Mar-19	17	Apr-19	17.5	May-19	18	Jun-19	18.5	Jul-19	19	Aug-19	19.5	Sep-19	20	Oct-19	20	Nov-19	20	Dec-19	20	Jan-20	20	<p>Rationale for current score: Breakeven forecast for 19/20 but significantly increased risk due to Bridgend arbitration outcome, level of overspending, projected WRP risk share cost and poor savings performance. In addition, potential £2m upfront costs from overseas nurse recruitment.</p> <p>Rationale for target score: Target risk is based on mitigating actions being successful</p>
		Month	Risk Score																															
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Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																
<ul style="list-style-type: none"> Developing a more project and programmatic approach to planning and delivery, with focus on pipeline schemes as well as schemes in delivery Specific review meetings involving DoF and DDoF and COO/DPMH have been in place with directorates. Escalated from November to meetings chaired by the CEO. Routine monitoring arrangements in place. Quarterly reports to Board; Monthly reports to Executive Board; Finance, Performance & Workforce Committee and routinely to Board. Separate report on efficiency savings to FP&W Cttee now put in place(i.e. separate to the finance report) Monitoring returns routinely submitted to Welsh Government and reported to FP&W Targets for in year improvement being set 		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Increased focus for improvement in directorate financial performance from escalation meetings chaired by CEO</td> <td>Chief Exec</td> <td>Ongoing</td> </tr> <tr> <td>Explore potential Invest to Save bid for overseas nurse recruitment</td> <td>DOF</td> <td>Nov/Dec</td> </tr> <tr> <td>Potential for TI bid to WG to fund some costs incurred by the Health Board at risk</td> <td>CEO</td> <td>Nov/Dec</td> </tr> </tbody> </table>		Action	Lead	Deadline	Increased focus for improvement in directorate financial performance from escalation meetings chaired by CEO	Chief Exec	Ongoing	Explore potential Invest to Save bid for overseas nurse recruitment	DOF	Nov/Dec	Potential for TI bid to WG to fund some costs incurred by the Health Board at risk	CEO	Nov/Dec																			
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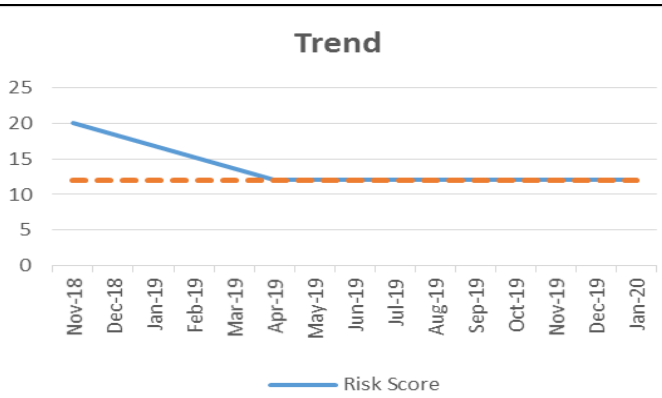
Strong scrutiny process within FP&W Committee. Escalation meetings	Lack of adequate improvement to date	
Current Risk Rating	Additional Comments	Ref No. 011
Current Risk Rating : 5 x 4 = 20	.	

Objective: Financial Viability	Director Lead: Director of Planning and Performance Assuring Committee: Finance, Performance and Workforce Committee / Capital Programme Board
Risk: Failure to Deliver Major & Discretionary Capital programmes	Date last reviewed: January 2020

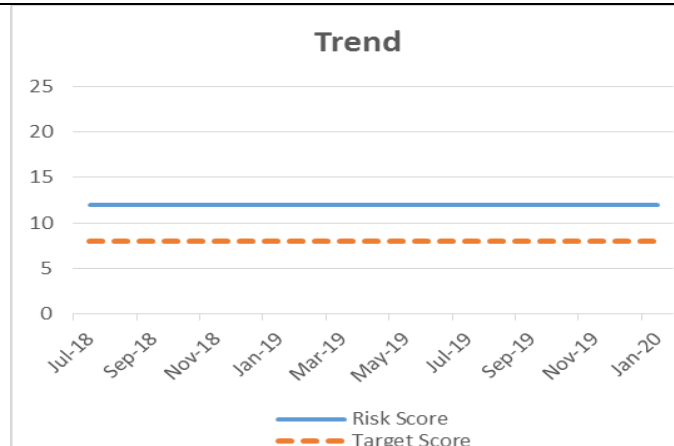
<p>Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 3 = 12 Target: 4 x 2 = 8</p> <p>Level of Control =50%</p> <p>Date added to the risk register April 2014</p>	<p>Trend</p>  <p>— Risk Score</p>	<p>Rationale for current score: Risks remain due to the size, value and complexity of the capital programme although discretionary capital managed (including slippage)</p> <p>Rationale for target score: Major capital programme will be in place for the foreseeable future and very large capital schemes underway – potential risks to the organisation in terms of finance and cost as well as reputational</p>
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Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
<ul style="list-style-type: none"> Prepare, review and submit regular monitoring returns to Welsh Government. Executive Capital Management Group to monitor the compliance with the actions agreed. Capital Programme Board in place to monitor development and delivery of the Board's Capital schemes. Quarterly update reports are presented to Management Board and the Health Board meetings. Whilst increased pressure as a consequence of capital slippage, plans in place to address. 	Action	Lead	Deadline
	Capital Programme Board and Executive Capital Management Group in place	RT	Ongoing
	Work programme and review of bids on an ongoing basis.	RT	Ongoing
	Discretionary capital processes in place for allocation and slippage funding	RT	Ongoing
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
Continue to work closely with Welsh Government. Elements of the Capital			

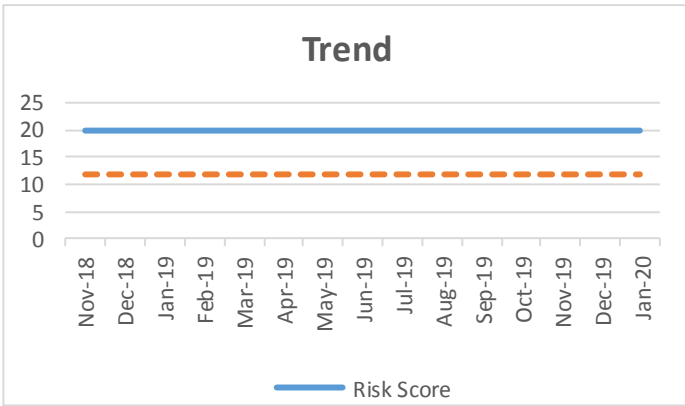
Programme feature routinely in the UHB's Internal Audit Plan		Ref No. 012
Current Risk Rating	Additional Comments	
Current Risk Rating : 4 x 3 = 12		

Objective: Setting the Direction & Performance & Operational Delivery		Director Lead: Director of Nursing, Midwifery and Patient Services Assuring Committee: Health Board																																	
Risk: Reputational damage and potential legal challenge on the decision making on funded nursing care (FNC).		Date last reviewed: January 2020																																	
<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 4 x 3 = 12</p> <p style="background-color: #92d050; padding: 2px;">Level of Control =70%</p> <p>Date added to the risk register November 2014</p>	<p>Trend</p>  <table border="1" style="display: none;"> <caption>Risk Score Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Nov-18</td><td>20</td></tr> <tr><td>Dec-18</td><td>18</td></tr> <tr><td>Jan-19</td><td>16</td></tr> <tr><td>Feb-19</td><td>14</td></tr> <tr><td>Mar-19</td><td>13</td></tr> <tr><td>Apr-19</td><td>12</td></tr> <tr><td>May-19</td><td>12</td></tr> <tr><td>Jun-19</td><td>12</td></tr> <tr><td>Jul-19</td><td>12</td></tr> <tr><td>Aug-19</td><td>12</td></tr> <tr><td>Sep-19</td><td>12</td></tr> <tr><td>Oct-19</td><td>12</td></tr> <tr><td>Nov-19</td><td>12</td></tr> <tr><td>Dec-19</td><td>12</td></tr> <tr><td>Jan-20</td><td>12</td></tr> </tbody> </table>	Month	Risk Score	Nov-18	20	Dec-18	18	Jan-19	16	Feb-19	14	Mar-19	13	Apr-19	12	May-19	12	Jun-19	12	Jul-19	12	Aug-19	12	Sep-19	12	Oct-19	12	Nov-19	12	Dec-19	12	Jan-20	12	<p>Rationale for current score: The risk rating has been maintained as although the Supreme Court of Appeal has made the ruling, the financial impact of this is still being worked through and potential for local challenge not fully mitigated.</p> <p>Rationale for target score: The score identifies the potential financial impact specifically on Cwm Taf Morgannwg.</p>	
Month	Risk Score																																		
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Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																	
<ul style="list-style-type: none"> Work in partnership with the sector, local authorities and WG to apply the outcome of the legal rulings. 		Action	Lead	Deadline																															
		Board approved rates last 2 years	DoF	Feb 2020																															
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)																																	
<ul style="list-style-type: none"> Utilise the newly revised Welsh Government policy to benchmark 		<ul style="list-style-type: none"> The establishment of a Health Board group to review, refresh and revise the implementation plan, to include medium and longer 																																	

	term financial implications	Ref No. 015
Current Risk Rating	Additional Comments	
Current Risk Rating : 4 x 3 = 12		

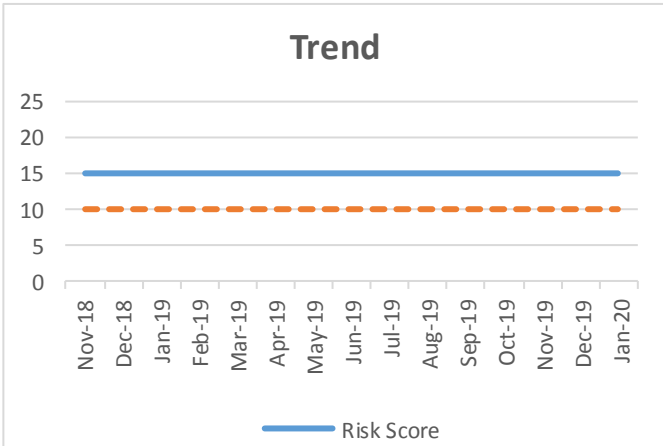
Objective: Statutory Compliance		Director Lead: Director of Planning and Performance		
Risk: Failure to comply fully with the arrangements for managing Asbestos		Assuring Committee: Audit and Risk Committee		
		Date last reviewed: January 2020		
<p>Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 = 12 Target: 4 x 2 = 8</p> <p style="background-color: #90ee90;">Level of Control =80%</p> <p>Date added to the risk register April 2012</p>	<p>Trend</p>  <p>— Risk Score - - - Target Score</p>	<p>Rationale for current score: Asbestos data for former ABMUHB sites require inputting to the Micad Asbestos management database. This process is currently under review and will commence once the site floor plans have been upgraded for uploading into the Asbestos management database.</p> <p>Rationale for target score: Potential risks could include Enforcement Action; Serious Ill Health/mortality; Personal Injury/Fatality Claim.</p>		
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)		
<ul style="list-style-type: none"> Approved updated Asbestos Management Plan which sets out clear guidance on the roles and responsibilities and operational procedures, in line with the asbestos regulations (CAR2012) and best practice. Competent Person and Asbestos Advisory Group in place reporting to the Capital and Estates Health Safety and Risk Group which reports to the Estates Governance Board and onwards through exception reports to the Quality Safety and Risk Committee Training Needs Analysis completed. Training programme has been developed to provide participants with an awareness of their responsibilities as defined by the plan. Internal Audit report noted that a programme of annual asbestos awareness training for UHB employees was evident, in line with the Regulations. 		Action	Lead	Deadline
		Implement Internal Audit report recommendations and action plan	Assistant Director of Estates	Complete
		We have recommended central monitoring of attendance at the annual asbestos awareness training to ensure full compliance	Assistant Director of Estates	Ongoing
		UHB staff do not undertake any direct work with asbestos (i.e. they are not involved in the removal, repair or disturbance of asbestos); all asbestos-related jobs are contracted to licensed contractors.	Assistant Director of Estates	Ongoing
Assurances		Gaps in assurance		

(How do we know if the things we are doing are having an impact?)	(What additional assurances should we seek?)
Periodical review of Asbestos Plan along with periodical internal audit review of its application.	Condition checks of all identified Asbestos materials are carried out annually by a trained in house Asbestos surveyor/analyst.
Current Risk Rating	Additional Comments
Current Risk Rating : 4 x 3 = 12	Will require further review in light of CTMUHB asbestos management plan and review of properties transferred.
	Ref No. 016

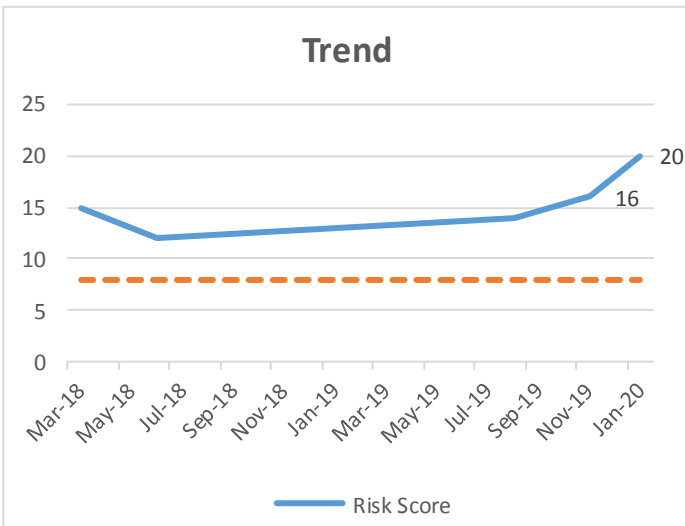
Objective: Statutory Compliance		Director Lead: Director of Therapies and Health Sciences																																	
Risk: Failure to meet Fire Safety Standards on ground and first floor PCH.		Assuring Committee: Audit and Risk Committee																																	
Date last reviewed: January 2020																																			
<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 3 = 12</p> <p style="background-color: #92d050;">Level of Control =60%</p> <p>Date added to the risk register October 2009</p>	<p style="text-align: center;">Trend</p>  <table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Nov-18</td><td>20</td></tr> <tr><td>Dec-18</td><td>20</td></tr> <tr><td>Jan-19</td><td>20</td></tr> <tr><td>Feb-19</td><td>20</td></tr> <tr><td>Mar-19</td><td>20</td></tr> <tr><td>Apr-19</td><td>20</td></tr> <tr><td>May-19</td><td>20</td></tr> <tr><td>Jun-19</td><td>20</td></tr> <tr><td>Jul-19</td><td>20</td></tr> <tr><td>Aug-19</td><td>20</td></tr> <tr><td>Sep-19</td><td>20</td></tr> <tr><td>Oct-19</td><td>20</td></tr> <tr><td>Nov-19</td><td>20</td></tr> <tr><td>Dec-19</td><td>20</td></tr> <tr><td>Jan-20</td><td>20</td></tr> </tbody> </table>	Month	Risk Score	Nov-18	20	Dec-18	20	Jan-19	20	Feb-19	20	Mar-19	20	Apr-19	20	May-19	20	Jun-19	20	Jul-19	20	Aug-19	20	Sep-19	20	Oct-19	20	Nov-19	20	Dec-19	20	Jan-20	20	<p style="text-align: center;">Rationale for current score:</p> <p>Ongoing and close working with South Wales Fire and Rescue Service (SWF&RS) and the UHB to maintain high awareness. Continuing to monitor the requirement for staff to undertake mandatory training which remains challenging</p> <p style="text-align: center;">Rationale for target score:</p> <p>Actions relating to Fire Safety across Ground and First Floor of Prince Charles Hospital as a key element of patient, staff and public safety management; this is a mandatory requirement for staff</p>	
Month	Risk Score																																		
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Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																	
<ul style="list-style-type: none"> Robust risk assessment processes in place to ensure the Board manages and mitigates identified risks; Implementation of Action Plans in response to proactive risk assessments. Alignment (where appropriate) of UHB risk assessment processes with those of Fire Service Constructive and positive working relationship in place with SWF&R Service and regular meetings between senior staff with at least Annual review meetings being led by CEO and Chief Fire Safety & Rescue Officer. Agreed Business Case for the refurbishment and redevelopment of the Ground and First Floor of Prince Charles Hospital with 6 year implementation. Agreed fire response and tactical plan with the Fire and Rescue Service. 		Action	Lead	Deadline																															
		Proactive management via Clinical / Corporate Business Meetings (CBMs) to ensure profile for fire safety remains high.	Director of Therapies and HS	Ongoing																															
		Regular inspections and dialogue with South Wales Fire & Rescue Service.	Head of Health, Safety & Fire	Ongoing																															
		Robust risk assessment processes in place and good compliance with staff training uptake to be sustained.	Head of Health, Safety & Fire	Ongoing																															

	RCA being carried out into the fire alarm in PCH pre-Christmas to assess the effectiveness of the response and take action where appropriate to improve and ensure compliance	Director of Therapies and HS	February 2020
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
Management and Staff awareness of the fire risks. Actively reducing the number of fire alarm activations through the implementation of risk reduction measures. Robust monitoring of the enforcement areas by the Hospital Fire Officer and Fire and Rescue Service. Reducing numbers of enforcement notices received.	Deliver the agreed business cases to complete the scheme. Fire enforcement action being progressed and routinely monitored.		
Current Risk Rating	Additional Comments	Ref No.	
Current Risk Rating : 5 x 4 = 20	Continuous progress needs to be demonstrated on improvement actions and related capital scheme (s)	017	

Objective: Statutory compliance	Director Lead: Director of Planning and Performance Assuring Committee: Finance, Performance and Workforce Committee
Risk: Failure to achieve statutory and mandatory planned preventative maintenance (PPM) programme.	Date last reviewed: January 2020

<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 15 Current: 5 x 3 = 15 Target: 5 x 2 = 10</p> <p>Level of Control =70%</p> <p>Date added to the risk register April 2014</p>	<p>Trend</p>  <table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Nov-18</td><td>15</td></tr> <tr><td>Dec-18</td><td>15</td></tr> <tr><td>Jan-19</td><td>15</td></tr> <tr><td>Feb-19</td><td>15</td></tr> <tr><td>Mar-19</td><td>15</td></tr> <tr><td>Apr-19</td><td>15</td></tr> <tr><td>May-19</td><td>15</td></tr> <tr><td>Jun-19</td><td>15</td></tr> <tr><td>Jul-19</td><td>15</td></tr> <tr><td>Aug-19</td><td>15</td></tr> <tr><td>Sep-19</td><td>15</td></tr> <tr><td>Oct-19</td><td>15</td></tr> <tr><td>Nov-19</td><td>15</td></tr> <tr><td>Dec-19</td><td>15</td></tr> <tr><td>Jan-20</td><td>15</td></tr> </tbody> </table>	Month	Risk Score	Nov-18	15	Dec-18	15	Jan-19	15	Feb-19	15	Mar-19	15	Apr-19	15	May-19	15	Jun-19	15	Jul-19	15	Aug-19	15	Sep-19	15	Oct-19	15	Nov-19	15	Dec-19	15	Jan-20	15	<p>Rationale for current score: Additional staff have been appointed to the Estates team; however, although improvements have been made additional work is required to ensure full compliance, this also now includes for the Bridgend locality.</p> <p>Rationale for target score: Reassurance was required in order that the statutory and mandatory planned preventative maintenance programme was well managed during time of increased vacancies in the estates department and also now with the transition of the Bridgend locality into the new CTM UHB.</p>
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Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
<ul style="list-style-type: none"> Estates Officers responsible for ensuring external contractors complete 	Action	Lead	Deadline

<p>PPM on time.</p> <ul style="list-style-type: none"> Two separate systems being used to plan, monitor and record work undertaken by external contractors within the new CTM UHB. Plan for these to be brought together into one system for 2020/2021 Development and implementation of staffing strategy for estates. PPM prioritised work of the estates department. Annual Estates Report considered by the Management Board and Health Board in September 2019, including PPM performance. Performance report also due to go to FPW Committee in November 2019. Whilst significant improvements noted, recognised that further work needed to ensure full compliance with Statutory PPM. 	Capital and estates governance group oversees the overall compliance	Assistant Director of Capital & Estates	Ongoing																
	Routine monitoring of progress, with use of CBM process to support also.	Director of Plan & Perf.	Ongoing quarterly																
	Presentation of Annual Report to Board & Management Board	Director of Plan & Perf.	Sept 2019																
	Review of Estates performance at least annually at Finance, Performance and Workforce Sub-Committee.	Director of Plan & Perf.	Annually – next Nov 2019																
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)																		
Overall levels of compliance have been improving in the former CT area although comparisons between former CT and Bridgend localities currently difficult with 2 different systems in use. Working to introduce one system in 2020/2021.																			
Current Risk Rating	Additional Comments		Ref No.																
Current Risk Rating : 5 x 3 = 15			018																
Objective: Workforce Sustainability/Organisational Development and Innovation	Director Lead: Director of Workforce & OD Assuring Committee: Finance, Performance & Workforce																		
Risk: Failure to achieve the Management of Absence target	Date last reviewed: January 2020																		
<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 2 = 8</p> <p>Level of Control =70%</p> <p>Date added to risk register April 2012</p>	<p>Trend</p>  <table border="1"> <caption>Risk Score Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Mar-18</td><td>15</td></tr> <tr><td>Jul-18</td><td>12</td></tr> <tr><td>Nov-18</td><td>14</td></tr> <tr><td>Mar-19</td><td>14</td></tr> <tr><td>Jul-19</td><td>15</td></tr> <tr><td>Nov-19</td><td>16</td></tr> <tr><td>Jan-20</td><td>20</td></tr> </tbody> </table>		Month	Risk Score	Mar-18	15	Jul-18	12	Nov-18	14	Mar-19	14	Jul-19	15	Nov-19	16	Jan-20	20	<p>Rationale for current score: Overall there is a small improvement in trend across the UHB and the overall risk score aligns to the improvement trajectory and strengthened controls in place.</p> <p>Rationale for target score: Failure to achieve the Management of Absence target (although greater risk is the impact absence is having on patient safety / care, workforce and associated cover costs) Target is 5%</p>
Month	Risk Score																		
Mar-18	15																		
Jul-18	12																		
Nov-18	14																		
Mar-19	14																		
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Nov-19	16																		
Jan-20	20																		

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
<p>We continue to monitor hot spot areas are being targeted to attend courses such as mindfulness and managing stress in the workplace. Attendance of the Managing Attendance at Work package. The percentage of all managers who have attended is 55%. We are currently recruiting a clinical psychologist to improve the service we provide employees with mental health illnesses. We have improved self-referral times for physiotherapy access. We are using dietetic expertise with OH using the FODMAP principles. We continue to run 8 week mindfulness course which has an evidence based outcome of improving employees return to work sooner than anticipated when absent from work due to stress and/or anxiety. We are working to break down the category of stress as the reason for absence so that work related stress can be highlighted and dealt with more effectively. This will allow for positive action to be taken to help reduce its impact on individuals.</p>	Action	Lead	Deadline
	Maintain existing controls and ensure consistent application by Line Managers of the All Wales Policy / Procedures.	JD All Directors	Ongoing with monitoring
	Regular review and assessment of sickness management to take place routinely at CBMs.	JD All Directors	Ongoing with monitoring
	Continue the business partner model to support directorates to proactively manage sickness absence.	JD	Ongoing
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
All HR teams carry out regular audits within their areas. We have now trained 55% of managers on the new policy and an online e-learning support will be launched shortly.	Need to maintain improvement actions and continue to reinforce the role of line management in consistently applying the Policy / Procedure.		
Current Risk Rating	Additional Comments		Ref No.
Current Risk Rating : 5 x 4 = 20			019

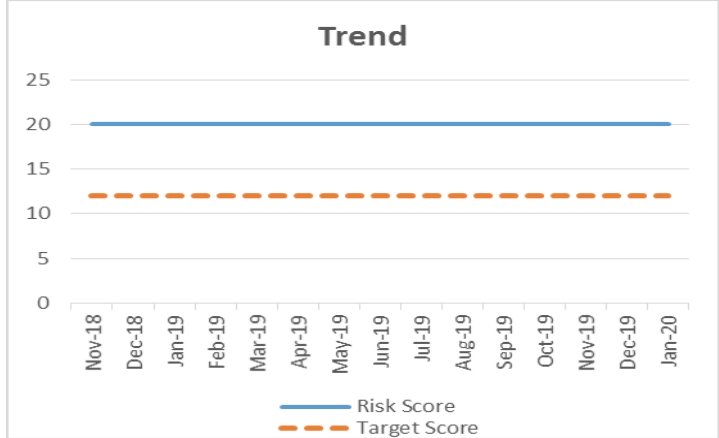
Objective: Statutory compliance (with Core Mandatory Training Requirements)	Director Lead: Director of Workforce and Organisational Development Assuring Committee: Quality and Safety Committee
Risk: Enforcement action or litigation if an incident is linked to a lack of Core Mandatory Training	Date last reviewed: January 2020



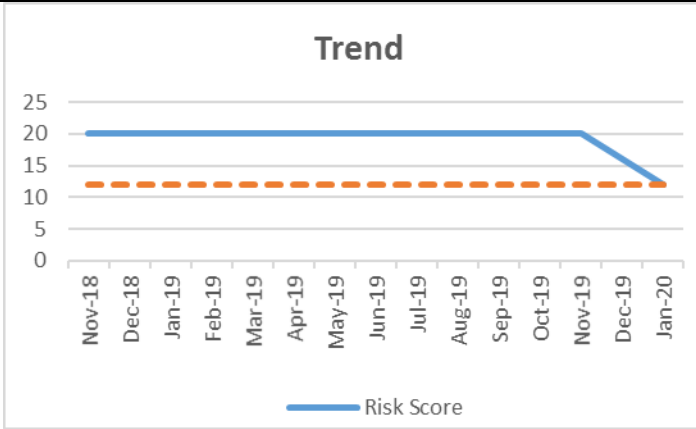
<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 3 x 3 =9</p> <p>Level of Control =70%</p> <p>Date added to the risk register June 2014</p>	<p style="text-align: center;">Trend</p> <table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>Nov-18</td><td>20</td><td>9</td></tr> <tr><td>Dec-18</td><td>20</td><td>9</td></tr> <tr><td>Jan-19</td><td>20</td><td>9</td></tr> <tr><td>Feb-19</td><td>20</td><td>9</td></tr> <tr><td>Mar-19</td><td>20</td><td>9</td></tr> <tr><td>Apr-19</td><td>20</td><td>9</td></tr> <tr><td>May-19</td><td>20</td><td>9</td></tr> <tr><td>Jun-19</td><td>20</td><td>9</td></tr> <tr><td>Jul-19</td><td>20</td><td>9</td></tr> <tr><td>Aug-19</td><td>20</td><td>9</td></tr> <tr><td>Sep-19</td><td>20</td><td>9</td></tr> <tr><td>Oct-19</td><td>20</td><td>9</td></tr> <tr><td>Nov-19</td><td>20</td><td>9</td></tr> <tr><td>Dec-19</td><td>20</td><td>9</td></tr> <tr><td>Jan-20</td><td>20</td><td>9</td></tr> </tbody> </table>	Month	Risk Score	Target	Nov-18	20	9	Dec-18	20	9	Jan-19	20	9	Feb-19	20	9	Mar-19	20	9	Apr-19	20	9	May-19	20	9	Jun-19	20	9	Jul-19	20	9	Aug-19	20	9	Sep-19	20	9	Oct-19	20	9	Nov-19	20	9	Dec-19	20	9	Jan-20	20	9	<p>Rationale for current score: Utilising ESR - staff, line managers and the UHB have a clear picture of what training is required and of current compliance level.</p> <p>Rationale for target score: Rationalised set training requirements and greater assurance that the UHB is offering enough training to meet the demand</p>
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<p>Controls (What are we currently doing about the risk?)</p> <ul style="list-style-type: none"> • Identification and uploading into ESR of all levels of core training, presenting a clear picture of training requirements to staff and the UHB • On-going work to rationalise set training requirements and ensure they match job roles • Production of on-going compliance reports covering all levels of training required • Making e-learning easier to identify and play utilising ESR auto-enrolment functionality. • Making face-to-face training easier to identify and book using ESR search functionality. • Provision of mandatory training days for clinical staff and Facilities staff and support sessions for all staff 	<p>Mitigating actions (What more should we do?)</p> <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Continue to improve compliance generally with Core Mandatory Training; ensure discussed routinely at Clinical/Corporate meetings</td> <td>Workforce Director</td> <td>Ongoing</td> </tr> <tr> <td>Development of demand -v- capacity plans to ensure enough face-to-face training is being delivered to meet the requirements of staff</td> <td>Workforce director</td> <td>Ongoing</td> </tr> <tr> <td>Making best use of the Electronic Staff Record – ensuring staff maintain mandatory requirements</td> <td>Workforce director</td> <td>Ongoing</td> </tr> <tr> <td>Audit exercise being carried out to allow compliance to be looked at.</td> <td>Workforce director</td> <td>Audit currently being undertaken</td> </tr> </tbody> </table>	Action	Lead	Deadline	Continue to improve compliance generally with Core Mandatory Training; ensure discussed routinely at Clinical/Corporate meetings	Workforce Director	Ongoing	Development of demand -v- capacity plans to ensure enough face-to-face training is being delivered to meet the requirements of staff	Workforce director	Ongoing	Making best use of the Electronic Staff Record – ensuring staff maintain mandatory requirements	Workforce director	Ongoing	Audit exercise being carried out to allow compliance to be looked at.	Workforce director	Audit currently being undertaken																																		
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Improved training compliance percentages – note overall improvement trajectory	Continue to maintain profile of performance and general improvement of the levels of compliance. Must address any gaps identified as a result of the demand-v-capacity analysis	
Current Risk Rating	Additional Comments	Ref No.
Current Risk Rating : 5 x 4 = 20		021


Objective: To improve quality, safety and patient experience		Director Lead: Chief Operating Officer Assuring Committee: Finance, Performance & Workforce; Quality & Safety																																																	
Risk: Lack of control and capacity to accommodate all hospital follow up outpatient appointments		Date last reviewed: January 2020																																																	
<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 3 = 12</p> <p>Level of Control =60%</p> <p>Date added to the risk register November 2014</p>	<p style="text-align: center;">Trend</p>  <table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Nov-18</td><td>20</td><td>12</td></tr> <tr><td>Dec-18</td><td>20</td><td>12</td></tr> <tr><td>Jan-19</td><td>20</td><td>12</td></tr> <tr><td>Feb-19</td><td>20</td><td>12</td></tr> <tr><td>Mar-19</td><td>20</td><td>12</td></tr> <tr><td>Apr-19</td><td>20</td><td>12</td></tr> <tr><td>May-19</td><td>20</td><td>12</td></tr> <tr><td>Jun-19</td><td>20</td><td>12</td></tr> <tr><td>Jul-19</td><td>20</td><td>12</td></tr> <tr><td>Aug-19</td><td>20</td><td>12</td></tr> <tr><td>Sep-19</td><td>20</td><td>12</td></tr> <tr><td>Oct-19</td><td>20</td><td>12</td></tr> <tr><td>Nov-19</td><td>20</td><td>12</td></tr> <tr><td>Dec-19</td><td>20</td><td>12</td></tr> <tr><td>Jan-20</td><td>20</td><td>12</td></tr> </tbody> </table>	Month	Risk Score	Target Score	Nov-18	20	12	Dec-18	20	12	Jan-19	20	12	Feb-19	20	12	Mar-19	20	12	Apr-19	20	12	May-19	20	12	Jun-19	20	12	Jul-19	20	12	Aug-19	20	12	Sep-19	20	12	Oct-19	20	12	Nov-19	20	12	Dec-19	20	12	Jan-20	20	12	<p>Rationale for current score: Follow up appointments not booked was previously increasing; concern raised by Board Members, discussed at Audit Committee, Finance Performance & Workforce Committee and Quality, Safety and Risk Committee. Improvement actions not previously reducing the large numbers of patients awaiting follow up clinic review.</p> <p>Rationale for target score: Agreed actions approved by Management Board, being implemented and routine monitoring in place, with regular reports to QSR and FPW Committees which is being aligned with the Performance Dashboard.</p>	
Month	Risk Score	Target Score																																																	
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<ul style="list-style-type: none"> Continued monitoring of progress at Quality Delivery Meetings with WG. Initial progress with reductions in all specialities. Exploring patient safety implications for some categories of follow ups not booked for consideration by the Management Board and at Q, S&R Committee where further audit related action is being undertaken. Continued improvement against trajectories in specialties. Surgery the first to achieve a 0 FUNB position. Outsourcing of 6, 500 Ophthalmology cases has now brought us to c.15k patients on the list, reducing to 13.5k. WG has asked us to put forward a financial bid for balancing the outpatients position to 0 – bid is in the order of £1.5m to deliver 0 position by March 2021. Harm review process now being piloted in Ophthalmology, with other specialties to follow. 		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>1) Scoping exercise undertaken – investment agreed at Exec Board, will require more</td> <td>COO / DPC&MH</td> <td>Ongoing</td> </tr> <tr> <td>2) Actions by speciality agreed, the outcome from which will help D&C planning.</td> <td>COO / DPC&MH</td> <td>Ongoing</td> </tr> <tr> <td>3) Service redesign proposals developed by speciality, to be implemented linked to D&C Plans.</td> <td>COO / DPC&MH</td> <td>In Progress</td> </tr> <tr> <td>4) Action plans with agreed timescales established, although insufficient capacity. Further resources now released and bid made to WG to achieve balance in outpatients.</td> <td>COO / DPC&MH</td> <td>Ongoing</td> </tr> </tbody> </table>		Action	Lead	Deadline	1) Scoping exercise undertaken – investment agreed at Exec Board, will require more	COO / DPC&MH	Ongoing	2) Actions by speciality agreed, the outcome from which will help D&C planning.	COO / DPC&MH	Ongoing	3) Service redesign proposals developed by speciality, to be implemented linked to D&C Plans.	COO / DPC&MH	In Progress	4) Action plans with agreed timescales established, although insufficient capacity. Further resources now released and bid made to WG to achieve balance in outpatients.	COO / DPC&MH	Ongoing																																	
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Assurances		Gaps in assurance																																																	
<p>Good progress still being made. Still further work needed to address and reduce volume and achieve balance. WAO review did not provide assurance of national progress, but CTM the best position in Wales achieved at 11/19. Current waiting FUNB at 13,700 patients, on track for 10,000 patients by year end as agreed at Board level.</p>		<p>Need to better understand any safety implications for follow ups not booked and patients waiting past clinic review dates. This is being provided through the piloting of the harm review process (proposal coming forward for additional resources in PC&S to implement). All instances of harm from delay are being fully reported to the QSR through exception reports and consolidated reports to QSR and FPW regularly. Best practice noted by national Outpatients Steering Group.</p>																																																	

Current Risk Rating	Additional Comments	Ref No.
Current Risk Rating : 5 x 4 = 20	D&C plans not sufficient as yet – not enough capacity to completely balance the system; additional resources required; reporting to Committees.	027

Objective: Setting the Direction & Performance & Operational Delivery		Director Lead: Director of Primary, Community and Mental Health (DPCMH)																																
Risk: Failure to continue to provide GP out of hours services as currently configured		Assuring Committee: Primary, Community Population Health and Partnerships Committee																																
		Date last reviewed: January 2020																																
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		Month	Risk Score																															
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Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																
<ul style="list-style-type: none"> OOHs services reconfigured and number of centres reduced from 4 to 2 in order to sustain services. An evaluation update considered by the Board in July 2016, agreed to continue with the current service which is scrutinized and monitored by the Primary, Community Population Health and Partnerships Committee. There continues to be ongoing engagement and discussions with those practitioners currently supporting the revised model. There continues to be engagement with key stakeholders including the Community Health Council, GPs and patients. Further options are being considered in order to address ongoing sustainability issues with the current service configuration Peer review undertaken providing assurance of significant improvement 		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>The out of hours team continuing to work with GPs and other primary care staff, in a flexible way for the best shift fill rates.</td> <td>DPCMH</td> <td>Ongoing</td> </tr> <tr> <td>All Wales approach being progressed to mitigate variability of approaches across NHS Wales Health Boards</td> <td>Directors of W&OD/ Directors of PC&MH</td> <td>Ongoing</td> </tr> <tr> <td>Regular dialogue with OOHs service and Primary Care Clusters to ensure OOHs cover is strengthened and supported.</td> <td>DPCMH</td> <td>Ongoing</td> </tr> </tbody> </table>		Action	Lead	Deadline	The out of hours team continuing to work with GPs and other primary care staff, in a flexible way for the best shift fill rates.	DPCMH	Ongoing	All Wales approach being progressed to mitigate variability of approaches across NHS Wales Health Boards	Directors of W&OD/ Directors of PC&MH	Ongoing	Regular dialogue with OOHs service and Primary Care Clusters to ensure OOHs cover is strengthened and supported.	DPCMH	Ongoing																			
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<p>Assurances (How do we know if the things we are doing are having an impact?)</p> <p>Shift fill rates; patient experience surveys</p>		<p>Gaps in assurance (What additional assurances should we seek?)</p> <p>The current service model is not sustainable and alternative solutions are required.</p>																																

Current Risk Rating		Additional Comments	Ref No. 030																																	
Current Risk Rating : 4 x 3 = 12		Lack of an All Wales Approach results in HBs competing with each other on GP sessional pay rates.																																		
Objective: Statutory Compliance		Director Lead: Director of Nursing, Midwifery and Patient Care Assuring Committee: Quality and Safety Committee																																		
Risk: Non-compliance with DoLS legislation and resulting authorisation breaches		Date last reviewed: January 2020																																		
<p>Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 = 12 Target: 3 x 3 = 9</p> <p>Level of Control =60%</p> <p>Date added to the risk register October 2014</p>	<p style="text-align: center;">Trend</p>  <table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Apr-19</td><td>16</td><td>9</td></tr> <tr><td>May-19</td><td>14</td><td>9</td></tr> <tr><td>Jun-19</td><td>12</td><td>9</td></tr> <tr><td>Jul-19</td><td>12</td><td>9</td></tr> <tr><td>Aug-19</td><td>12</td><td>9</td></tr> <tr><td>Sep-19</td><td>12</td><td>9</td></tr> <tr><td>Oct-19</td><td>12</td><td>9</td></tr> <tr><td>Nov-19</td><td>12</td><td>9</td></tr> <tr><td>Dec-19</td><td>12</td><td>9</td></tr> <tr><td>Jan-20</td><td>12</td><td>9</td></tr> </tbody> </table>	Month	Risk Score	Target Score	Apr-19	16	9	May-19	14	9	Jun-19	12	9	Jul-19	12	9	Aug-19	12	9	Sep-19	12	9	Oct-19	12	9	Nov-19	12	9	Dec-19	12	9	Jan-20	12	9	<p>Rationale for current score: Boundary changes to include the Bridgend region has increased the demands on the DoLS service whilst new staff were recruited. In light of the demands of current legislation it is likely that full compliance cannot be achieved. The Liberty Protection Safeguards legislation provides for the repeal of DoLS and replacement with the Liberty Protection Safeguards (LPS). The UK government has not yet announced the date on which the legislation will come into force, possibly Spring 2020. For up to a year the DoLS system will run alongside the LPS.</p> <p>Rationale for target score: Whilst requirements have increased, mitigation has also been revised to manage increased risk, the UHB will need to be prepared for new legislation.</p>	
Month	Risk Score	Target Score																																		
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Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																		
<ul style="list-style-type: none"> Staff recruited to manage demand and mitigated by use of independent best interest assessors, a full time secondment transition post and nurse bank hours. Recruitment to all BIA posts complete on the 4/11/2019. Urgent authorisations are prioritised over standard authorisations. Monthly Safeguarding People training increased understanding of DoLS amongst UHB attendees. DoLS processes established and in place within the UHB but will be subject to change following enactment of the new legislation and statutory guidance. 		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>The Safeguarding Executive Group should establish a working group with multidisciplinary representation to consider the implications for the UHB on how the LPS scheme will have an impact on the current authorisation process for DoLS.</td> <td>Nurse Director</td> <td>Feb 2020</td> </tr> <tr> <td>Prioritisation process in place for DoLS applications and training for all disciplines in the Mental Capacity Act delivered on a monthly basis as part of a safeguarding people package.</td> <td>Nurse Director</td> <td>Complete</td> </tr> </tbody> </table>	Action	Lead	Deadline	The Safeguarding Executive Group should establish a working group with multidisciplinary representation to consider the implications for the UHB on how the LPS scheme will have an impact on the current authorisation process for DoLS.	Nurse Director	Feb 2020	Prioritisation process in place for DoLS applications and training for all disciplines in the Mental Capacity Act delivered on a monthly basis as part of a safeguarding people package.	Nurse Director	Complete																									
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Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)																																		
<ul style="list-style-type: none"> Audit of time taken to respond to requests Streamlining and target setting for the service following a review of quality, efficiency and effectiveness – more authorisations are taking place in a more timely manner. 		Staff compliance with training - uptake of level 1 & 2 DoLS & MCA training																																		

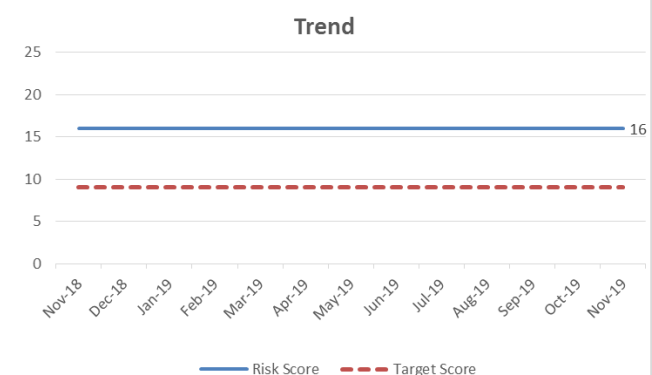
Current Risk Rating	Additional Comments	Ref No. 031
Current Risk Rating : 4 x 3 = 12		

Objective: To improve quality, safety and patient experience		Director Lead: Chief Operating Officer																																											
Risk: Sustainability of a safe & effective Ophthalmology Service.		Assuring Committee: Quality and Safety Committee																																											
Date last reviewed: January 2020																																													
<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 3 = 12</p> <p style="background-color: yellow;">Level of Control =60%</p> <p>Date added to the risk register April 2014</p>	<p>Trend</p>  <table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Nov-18</td><td>16</td><td>12</td></tr> <tr><td>Dec-18</td><td>16</td><td>12</td></tr> <tr><td>Jan-19</td><td>16</td><td>12</td></tr> <tr><td>Feb-19</td><td>16</td><td>12</td></tr> <tr><td>Mar-19</td><td>16</td><td>12</td></tr> <tr><td>Apr-19</td><td>16</td><td>12</td></tr> <tr><td>May-19</td><td>16</td><td>12</td></tr> <tr><td>Jun-19</td><td>16</td><td>12</td></tr> <tr><td>Jul-19</td><td>16</td><td>12</td></tr> <tr><td>Aug-19</td><td>16</td><td>12</td></tr> <tr><td>Sep-19</td><td>16</td><td>12</td></tr> <tr><td>Oct-19</td><td>16</td><td>12</td></tr> <tr><td>Nov-19</td><td>16</td><td>12</td></tr> </tbody> </table>	Month	Risk Score	Target Score	Nov-18	16	12	Dec-18	16	12	Jan-19	16	12	Feb-19	16	12	Mar-19	16	12	Apr-19	16	12	May-19	16	12	Jun-19	16	12	Jul-19	16	12	Aug-19	16	12	Sep-19	16	12	Oct-19	16	12	Nov-19	16	12	<p>Rationale for current score: Monitoring of the service continued, referral to treatment times remain challenging and the numbers of patients requiring a follow up appointment has significantly reduced with all potential harms from delay now under assessment.</p> <p>Rationale for target score: An action plan was developed for ophthalmology services to address service improvement requirements but included revising the staffing profile to ensure service sustainability.</p>	
Month	Risk Score	Target Score																																											
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Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																											
<ul style="list-style-type: none"> Action plan developed and ongoing monitoring – consolidated plan coming forward covering Eye Care Measure and ODTc DU reviews nationally. Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTcs, weekend clinics). Ongoing monitoring is in place with regards RTT impact of Ophthalmology. In line with other services, to meet the RTT requirement services are being outsourced- maintaining this level of performance will be challenging going forward. Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. Additional services to be provided in Community settings through ODTc (January 2020 start date). Intravitreal injection room x 2 established with nurse injectors trained. 		Action	Lead	Deadline																																									
		Follow up appointments not booked being closely monitored and outsourcing auctioned.	COO	Ongoing																																									
		Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues).	COO	Ongoing																																									
Reviewing UHB Action Plan in light of more recent WAO follow up review of progress.	COO	Ongoing																																											
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)																																											
Numbers of patients waiting for follow up appointments are reducing.		Work to be completed on harm review.																																											

Current Risk Rating	Additional Comments	Ref No. 032
Current Risk Rating : 4 x 4 = 16	Ongoing intensive review work is taking place to examine the safety of patients waiting for follow up appointments.	

Objective: To improve quality, safety and patient experience	Director Lead: Director of Primary, Community and Mental Health Assuring Committee: Management Board / Finance, Performance and Workforce Committee
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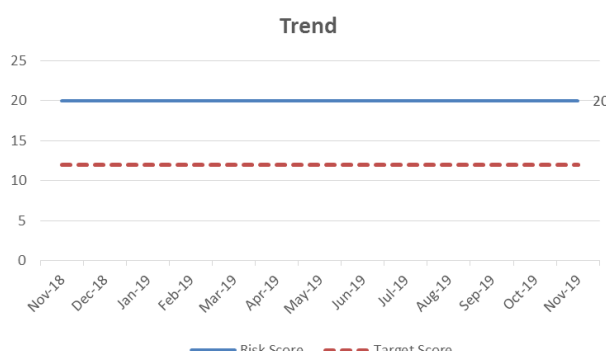
Risk: Failure to sustain Child and Adolescent Mental Health Services	Date last reviewed: November 2019
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<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 3 x 3 = 9</p> <p style="background-color: #92d050; padding: 2px;">Level of Control =70%</p> <p>Date added to the risk register January 2015</p>	<p>Trend</p>  <table border="1" style="display: none;"> <caption>Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Nov-18</td><td>16</td><td>9</td></tr> <tr><td>Dec-18</td><td>16</td><td>9</td></tr> <tr><td>Jan-19</td><td>16</td><td>9</td></tr> <tr><td>Feb-19</td><td>16</td><td>9</td></tr> <tr><td>Mar-19</td><td>16</td><td>9</td></tr> <tr><td>Apr-19</td><td>16</td><td>9</td></tr> <tr><td>May-19</td><td>16</td><td>9</td></tr> <tr><td>Jun-19</td><td>16</td><td>9</td></tr> <tr><td>Jul-19</td><td>16</td><td>9</td></tr> <tr><td>Aug-19</td><td>16</td><td>9</td></tr> <tr><td>Sep-19</td><td>16</td><td>9</td></tr> <tr><td>Oct-19</td><td>16</td><td>9</td></tr> <tr><td>Nov-19</td><td>16</td><td>9</td></tr> </tbody> </table>	Month	Risk Score	Target Score	Nov-18	16	9	Dec-18	16	9	Jan-19	16	9	Feb-19	16	9	Mar-19	16	9	Apr-19	16	9	May-19	16	9	Jun-19	16	9	Jul-19	16	9	Aug-19	16	9	Sep-19	16	9	Oct-19	16	9	Nov-19	16	9	<p>Rationale for current score: Difficulties remain in recruiting key staff and new model of care being implemented; waiting times for specialist CAMHS and the new neurodevelopmental service remains challenging.</p> <p>Rationale for target score: Increasing demands being placed on the Core CAHMS Services resulted in long waiting times and the service was experiencing difficulties in recruiting staff</p>
Month	Risk Score	Target Score																																										
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Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)
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<ul style="list-style-type: none"> Reported local and Network pressures across the CAHMS Network with variable problems dependant on the area of the network. Updates provided to Management Board on developing service model to address reported issues and additional investment secured to increase capacity within the service and to address service pressures. Waiting list initiatives in place whilst staff recruitment is being progressed. Service Model developed around Core CAHMS in Cwm Taf Morgannwg which includes agreement with General Paediatrics to take the lead on Neurodevelopmental Services and shared care protocols with Primary Care. New investment impact being routinely monitored 	Action	Lead	Deadline
	Performance scrutiny takes place at Finance, Performance and Workforce Committee quarterly. Included within Integrated Performance Dashboard monthly	DPCMH	Ongoing
	Commissioning discussions taking place across the Network in relation to service pressures and funding.	DPCMH	Ongoing
	Implementation of the Choice and Partnership Approach (CAPA) and being closely monitored.	DPCMH	Ongoing
	A number of service reviews in relation to Ty Llidiard undertaken and monitored via Q,S&R Committee.	DPCMH	Ongoing


Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
Reduction in waiting times; increased user satisfaction.	User satisfaction information – variability across network.


Current Risk Rating		Additional Comments		Ref No. 033								
Current Risk Rating : 4 x 4 = 16		Network service; varying levels of funding by commissioners; different waiting times in localities. Cardiff and Vale – reproviding services being worked through										
Objective: To improve quality, safety and patient experience		Director Lead: Medical and Nurse Directors										
Risk: Increasing dependency on Agency Staff cover in Medical and Nursing areas, which impacts on continuity of care and patient safety and the financial position.		Assuring Committee: Quality and Safety Committee										
Date last reviewed: January 2020												
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 5 = 20 Target: 4 x 3 = 12 Level of Control =60% Date added to the risk register June 2015	Trend 		Rationale for current score: The international evidence base identifies that there is increased clinical risk when the workforce is transient. Recruitment is a national and UK wide issue. Agency and bank costs are high, this resource could be better invested in developing substantive staff and investing in new models of care, realising 'A Healthier Wales'. Rationale for target score: Continued dependency on Agency Staff cover in Medical and Nursing areas, has the potential to impact on continuity of care and patient safety and will impact on the UHB financial position.									
	Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)									
	<ul style="list-style-type: none"> Recurring advertisements of posts in medical and nursing. Provision of induction packs for agency staff Proactive recruitment programme in place in areas where dependency on agency locum cover is increasing. Maintain strict vetting of CVs (Agency medical staff) by the Directorates, with any concerns fed back to the Agency. Wherever possible, use long term locum staff. For nursing, maximise opportunities to recruit graduate nurse students for each of the twice annual cohorts. Review all arrangements for payments to existing staff to make the best use of the resources available, maintain strong controls on the use of bank and agency staff, including stopping any off contract high agency shifts Adjust bed complement/configuration and skill mix to ensure safe staffing levels are maintained. 		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Maintain recruitment campaign</td> <td>WOD</td> <td>June 2020</td> </tr> <tr> <td>Redesign services wherever possible to embrace a healthier wales and therefore impact upon the workforce required to deliver services</td> <td>COO & DPCC MH</td> <td>March 2021</td> </tr> </tbody> </table>		Action	Lead	Deadline	Maintain recruitment campaign	WOD	June 2020	Redesign services wherever possible to embrace a healthier wales and therefore impact upon the workforce required to deliver services	COO & DPCC MH
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Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)										
<ul style="list-style-type: none"> Reduction in bank, locum and agency costs achieved where appropriate staffing levels have been secured (based on professional 		<ul style="list-style-type: none"> Absence of trends and themes in patient safety incidents attributed to agency staff 										

judgement)	<ul style="list-style-type: none"> Numbers of nursing and medial agency staff referred back to agency with concerns re practice Number and percentage of agency staff referred to professional regulator 	Ref No. 034
Current Risk Rating	Additional Comments	
Current Risk Rating : 4 x 5 = 20		

Objective: To improve quality, safety and patient experience		Director Lead: Director of Nursing, Midwifery and Patient Services		
Risk: Poor quality of care if there is failure to recruit and retain sufficient registered nursing and midwifery staff.		Assuring Committee: Executive Board, Quality and Safety Committee		
Date last reviewed: January 2020				
<p>Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 = 12</p> <p>Level of Control =60%</p> <p>Date added to risk register January 2016</p>	<p style="text-align: center;">Trend</p>  <p style="text-align: center;">— Risk Score - - - Target Score</p>			
		<p style="text-align: center;">Rationale for current score:</p> <p>National issue re recruitment, retention and retirement, increasing patient complexity, demand and acuity, increased use of bank and agency nursing,</p> <p style="text-align: center;">Rationale for target score:</p> <p>Realistic target given national challenge, expected extension of the Nurse Staffing Levels Act, increasing rates of unfilled bank and agency shifts</p>		
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)		
<ul style="list-style-type: none"> Proactive engagement with HEIW Scheduled, continuous recruitment activity overseen by WOD Targeted approach to areas of specific concern reported via finance, workforce and performance committee Close work with university partners to maximise routes into nursing Retire and return strategy to maintain skills and expertise Block booking of bank and agency staff to pre-empt and address shortfalls Risk management processes in clinical areas reviewed several times daily 		Action	Lead	
		Deadline		
		Continue recruitment campaign	Director of Nursing	March 2020
Workforce modernisation group identifying strategic direction for nursing workforce development including the development of CSW role	Director of Nursing	June 2020		
International recruitment plans developing	Director of Nursing	March 2020		
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)		
<ul style="list-style-type: none"> Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board Regular review by Birth Rate Plus, overseen by maternity Improvement 		<ul style="list-style-type: none"> Predicted medium to longer term trends and mean by which to address Achievement of workforce development plans as identified within IMTPs 		


Board	<ul style="list-style-type: none"> Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends 	<ul style="list-style-type: none"> Influencing national commissioning numbers
Current Risk Rating		Additional Comments
Current Risk Rating : 4 x 5 = 20		Ref No. 035

Objective: Setting the Direction & Performance & Operational Delivery		Director Lead: Director of Primary, Community and Mental Health (DPCMH)																																											
		Assuring Committee: Primary, Community Population Health and Partnerships																																											
Risk: Primary Care Workforce – recruitment and sustainability		Date last reviewed: November 2019																																											
<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 3 = 12</p> <p style="background-color: yellow;">Level of Control =60%</p> <p>Date added to the risk register August 2016</p>	<p style="text-align: center;">Trend</p>  <table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Nov-18</td><td>16</td><td>12</td></tr> <tr><td>Dec-18</td><td>16</td><td>12</td></tr> <tr><td>Jan-19</td><td>16</td><td>12</td></tr> <tr><td>Feb-19</td><td>16</td><td>12</td></tr> <tr><td>Mar-19</td><td>16</td><td>12</td></tr> <tr><td>Apr-19</td><td>16</td><td>12</td></tr> <tr><td>May-19</td><td>16</td><td>12</td></tr> <tr><td>Jun-19</td><td>16</td><td>12</td></tr> <tr><td>Jul-19</td><td>16</td><td>12</td></tr> <tr><td>Aug-19</td><td>16</td><td>12</td></tr> <tr><td>Sep-19</td><td>16</td><td>12</td></tr> <tr><td>Oct-19</td><td>16</td><td>12</td></tr> <tr><td>Nov-19</td><td>16</td><td>12</td></tr> </tbody> </table>	Month	Risk Score	Target Score	Nov-18	16	12	Dec-18	16	12	Jan-19	16	12	Feb-19	16	12	Mar-19	16	12	Apr-19	16	12	May-19	16	12	Jun-19	16	12	Jul-19	16	12	Aug-19	16	12	Sep-19	16	12	Oct-19	16	12	Nov-19	16	12	<p>Rationale for current score: An increasing number of practices across the UHB are advertising for GP sessions currently due to (and other staff groups) vacancies.</p> <p>Rationale for target score: Recruitment to Primary Care for GPs and some other professional groups across Cwm Taf UHB remains challenging (reflecting a National problem).</p>	
Month	Risk Score	Target Score																																											
Nov-18	16	12																																											
Dec-18	16	12																																											
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Nov-19	16	12																																											
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																											
<ul style="list-style-type: none"> Where possible the Primary Care Team is working with the practices to find solutions, which include practice mergers; considering where possible directly managing solutions and/or working to recruit on behalf of the practices. Primary, Community Population Health and Partnerships Committee in place to scrutinise delivery of the IMTP. Local and National recruitment campaigns progressed, with some reported success. 		Action	Lead	Deadline																																									
		Development of the Cluster arrangements maturing, working with Primary Care and localities to develop solutions;	DPCMH	Ongoing																																									
		The UHB has been successful following submission of bids against non-recurring Primary Care monies;	DPCMH	Complete																																									
		The Board has developed its Strategy for Primary Care aligned with its Integrated 3 Year Plan and National guidance. This includes milestones for addressing some of the related reported risks.	DPCMH	Ongoing milestones being monitored																																									
Assurances		Gaps in assurance																																											

(How do we know if the things we are doing are having an impact?)		(What additional assurances should we seek?)													
Recruitment and retention data.															
Current Risk Rating		Additional Comments													
Current Risk Rating : 4 x 4 = 16															
		Ref No. 036													
Objective: To improve quality, safety and patient experience		Director Lead: Director lead for ICT / Chief Operating Officer													
		Assuring Committee: Health Board (will be ICT/IG Committee)													
Risk: Ensuring the development, approval and implementation of a Strategy for IM&T, that is clinically led and supports staff in care delivery.		Date last reviewed: January 2020													
<p>Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 3 = 12 Target: 3 x 3 = 9</p> <p>Level of Control =50%</p> <p>Date added to the risk register December 2016</p>		<p>Trend</p>  <p>Rationale for current score: Although work has continued behind the scenes, having an executive lead, supported by an Assistant Director is potentiating the actions identified and move forward on the action plans and strategic outline programme.</p> <p>Rationale for target score: Developing an ICT Strategy that is clinically led and supports staff in care delivery is challenging in view of the current financial constraints although IM&T underpin all aspects of the patient pathway.</p>													
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)													
<ul style="list-style-type: none"> ICT Strategy developed with support from ATOS Consulting (May 2017). Governance arrangements to oversee delivery of the Strategy agreed in the form of new IG/ICT Committee. Digital Strategy Steering Group well established and work programme linking national and local improvements well underway. New Independent Member for ICT appointed. Major deliverables in the form of WEDs and notes digitisation now initiated and will deliver first quarter next year. Work on Transformation programme initiating following successful funding bid. 		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>A major constraint/required action to deliver the strategy is additional capital and revenue investment supported by a business case which is clear on the non-financial and financial returns.</td> <td>COO</td> <td>ongoing</td> </tr> <tr> <td>Implement the action plan developed with the Strategy; set up the group which will lead the work.</td> <td>COO</td> <td>Complete through DSSG</td> </tr> <tr> <td>Review and consider, the effectiveness of the related governance arrangements - new governance initiating end 2019</td> <td>Board Sec</td> <td>Complete</td> </tr> </tbody> </table>		Action	Lead	Deadline	A major constraint/required action to deliver the strategy is additional capital and revenue investment supported by a business case which is clear on the non-financial and financial returns.	COO	ongoing	Implement the action plan developed with the Strategy; set up the group which will lead the work.	COO	Complete through DSSG	Review and consider, the effectiveness of the related governance arrangements - new governance initiating end 2019	Board Sec	Complete
		Action	Lead	Deadline											
		A major constraint/required action to deliver the strategy is additional capital and revenue investment supported by a business case which is clear on the non-financial and financial returns.	COO	ongoing											
Implement the action plan developed with the Strategy; set up the group which will lead the work.	COO	Complete through DSSG													
Review and consider, the effectiveness of the related governance arrangements - new governance initiating end 2019	Board Sec	Complete													
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)													
<ul style="list-style-type: none"> Monitor the timescales and milestones identified in the action plan through 		Group now established to take forward the actions agreed. Need to													

DSSG.	consider effectiveness of related governance / scrutiny arrangements.	
Current Risk Rating	Additional Comments	Ref No.
Current Risk Rating : 4 x 3 = 12	New ICT Committee to be established, following comments and recommendations of WAO Structured Assessment. IM for ICT now in post.	037

Objective: Statutory Compliance	Director Lead: Chief Operating Officer Assuring Committee: Quality and Safety Committee / Management Board
Risk: Failure to ensure sufficient storage capacity (or alternative solutions) are in place to safely store and secure patient records.	Date last reviewed: January 2020


<p>Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 4 x 2 = 8</p> <p style="background-color: yellow;">Level of Control = 60%</p> <p>Date added to the risk register July 2018</p>	<p>Trend</p>  <table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Nov-18</td><td>16</td><td>8</td></tr> <tr><td>Dec-18</td><td>16</td><td>8</td></tr> <tr><td>Jan-19</td><td>16</td><td>8</td></tr> <tr><td>Feb-19</td><td>16</td><td>8</td></tr> <tr><td>Mar-19</td><td>16</td><td>8</td></tr> <tr><td>Apr-19</td><td>16</td><td>8</td></tr> <tr><td>May-19</td><td>16</td><td>8</td></tr> <tr><td>Jun-19</td><td>16</td><td>8</td></tr> <tr><td>Jul-19</td><td>16</td><td>8</td></tr> <tr><td>Aug-19</td><td>16</td><td>8</td></tr> <tr><td>Sep-19</td><td>16</td><td>8</td></tr> <tr><td>Oct-19</td><td>16</td><td>8</td></tr> <tr><td>Nov-19</td><td>16</td><td>8</td></tr> </tbody> </table>	Month	Risk Score	Target Score	Nov-18	16	8	Dec-18	16	8	Jan-19	16	8	Feb-19	16	8	Mar-19	16	8	Apr-19	16	8	May-19	16	8	Jun-19	16	8	Jul-19	16	8	Aug-19	16	8	Sep-19	16	8	Oct-19	16	8	Nov-19	16	8	<p>Rationale for current score: The effectiveness of the Williamstown Records Storages Hub is reliant on digitisation of health records. Now we have an agreed business case and investment, will be able to balance demand and capacity across the service.</p> <p>Rationale for target score: Delivering the Digitisation of health records, alongside the records hub will ensure a sustainable, safe & secure storage solution.</p>
Month	Risk Score	Target Score																																										
Nov-18	16	8																																										
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Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
<ul style="list-style-type: none"> Williamstown Hub is yet to reach full capacity. WG Invest to Save bid signed off June 2019. Digitisation of Records Business Case signed off and Civica will initiating project November 2019 covering old CT and PoW footprints. Requirement to stop disposing of records in line with the Infected Blood Inquiry; impact being closely monitored potentially to use a building leased by the Welsh Government to assist. Initiation of Document Management System, Clinical Portal interface and Eforms all follow as part of the project over the next year. 	Action	Lead	Deadline
	BJC for Digitisation approved via Management Board / Board as appropriate	COO	Approved
	Ensure Records management processes fully applied in Williamstown to maximise use of available physical capacity	COO	Ongoing
	Ensure no temporary storage solutions are agreed, without full consideration of the Executive.	COO	Ongoing

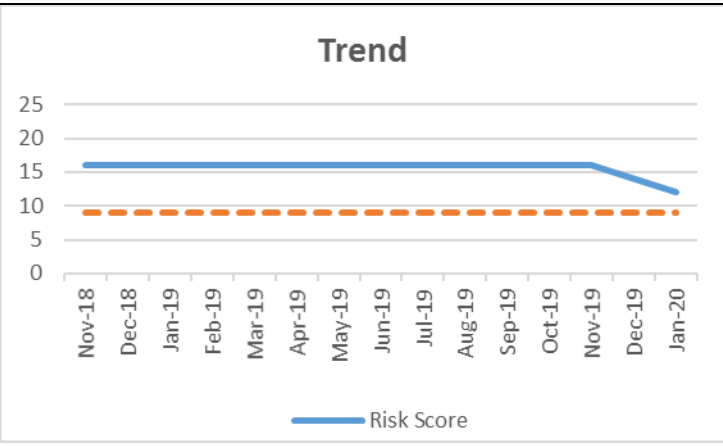
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
Compliance with regulations including H&S @ Work.	That the capacity at Williamstown is fully utilised and that records management processes are being applied in full, including culling etc.

Current Risk Rating	Additional Comments	Ref No. 039
Current Risk Rating : 4 x 4 = 16	Impact of Infected Blood Inquiry to be further considered; Management Board considered and supported phase 1 of work	

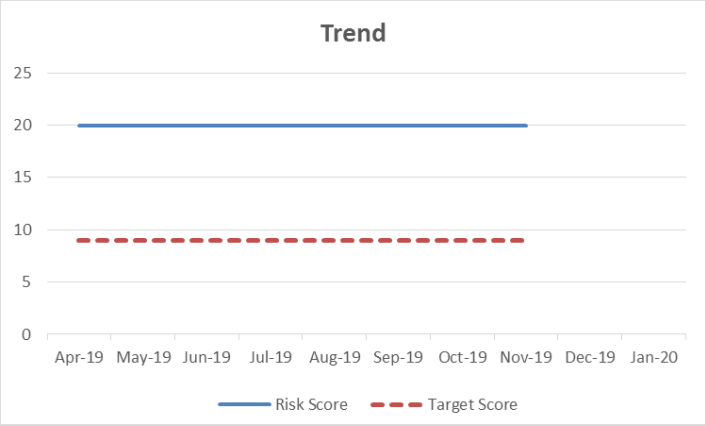
Objective: Statutory Compliance	Director Lead: Director of Workforce & OD Assuring Committee: Quality & Safety Committee
Risk: Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	Date last reviewed: January 2020

<p>Risk Rating (consequence x likelihood): Initial: 3 x 5 = 15 Current: 3 x 5 = 15 Target: 3 x 3 = 9</p> <p style="background-color: yellow;">Level of Control =60%</p> <p>Date added to the risk register July 2018</p>	<p>Trend</p>  <p>— Risk Score - - - Target Score</p>	<p style="text-align: center;">Rationale for current score:</p> <p>As a consequence of an internal assessment of the Standards and their impact on the UHB, it is recognised that the Health Board will not be fully compliant with all applicable Standards.</p> <p style="text-align: center;">Rationale for target score:</p> <p>Working through its related improvement plan the likelihood of non-compliance will reduce as awareness and staff training in response to the Standards, is raised.</p>
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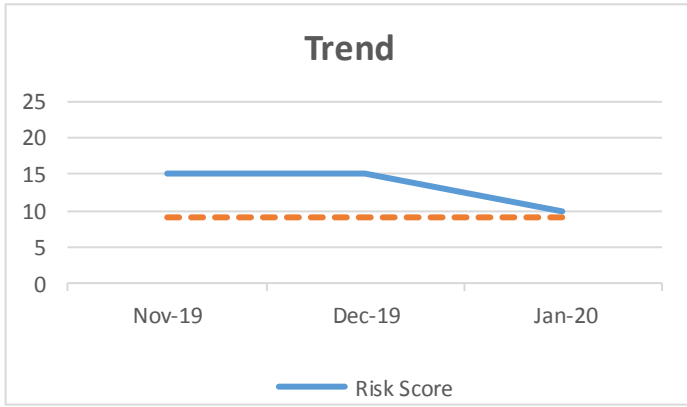
Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
<ul style="list-style-type: none"> The Welsh Language Unit has undertaken a self-assessment of the requirements of the Standards and how they apply to Cwm Taf Morgannwg Close constructive working relationships are in place with the Welsh Language Commissioner's Office Strong networks are in place amongst Welsh Language Officers across NHS Wales to inform learning and development of responses to the Standards. Regular reports to the Board to raise awareness Working Group set up to support managers Developing a new bilingual skills strategy Offering free Welsh courses for staff Carrying out Ward Audits to monitor progress with compliance Continue to review and act on the UHBs Self-Assessment findings and related improvement actions; ensure Board is fully sighted. Develop a 5 year plan outlining the extent to which the health board can 	Action	Lead	Deadline
	Continue to work with Directorates to develop action plans in response to the requirements of the Standards	DW&OD COO DPC&MH	Quarters 3 & 4
	Continue to develop the Welsh language skills of the workforce and implement a new bilingual skills strategy.	DW&OD	Quarters 3 & 4
	Publish a Primary Care Policy which takes into consideration the effects on the services for the Welsh speaking population	DPC&MH	Quarter 3
	Develop a process to ensure all new vacancies are advertised bilingually	DW&OD	Quarter 3 & 4

carry out consultations in Welsh and the actions taken to increase this																																			
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)																																	
Compliance with Statutory requirements outlined in Welsh Language Act and related Standards. Auditing and monitoring of compliance		<ul style="list-style-type: none"> Updated action plans from directorates to ensure all requirements are met across the HB 																																	
Current Risk Rating		Additional Comments																																	
Current Risk Rating : 3 x 5 = 15		The self-assessment has confirmed that the Health Board is not able to fully comply with all the Standards																																	
Objective: Statutory Compliance		Director Lead: Chief Operating Officer																																	
Risk: Failure to fully meet all the licensing requirements of the Human Tissue Authority (HTA) in relation to Mortuary & Services for the Deceased.		Assuring Committee: Quality & Safety Committee																																	
Date last reviewed: January 2020																																			
<p>Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 = 12 Target: 3 x 3 = 9</p> <p style="background-color: #92d050; padding: 2px;">Level of Control =70%</p> <p>Date added to the risk register July 2018</p>	<p style="text-align: center;">Trend</p>  <table border="1"> <caption>Risk Score Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Nov-18</td><td>16</td></tr> <tr><td>Dec-18</td><td>16</td></tr> <tr><td>Jan-19</td><td>16</td></tr> <tr><td>Feb-19</td><td>16</td></tr> <tr><td>Mar-19</td><td>16</td></tr> <tr><td>Apr-19</td><td>16</td></tr> <tr><td>May-19</td><td>16</td></tr> <tr><td>Jun-19</td><td>16</td></tr> <tr><td>Jul-19</td><td>16</td></tr> <tr><td>Aug-19</td><td>16</td></tr> <tr><td>Sep-19</td><td>16</td></tr> <tr><td>Oct-19</td><td>16</td></tr> <tr><td>Nov-19</td><td>16</td></tr> <tr><td>Dec-19</td><td>12</td></tr> <tr><td>Jan-20</td><td>12</td></tr> </tbody> </table>	Month	Risk Score	Nov-18	16	Dec-18	16	Jan-19	16	Feb-19	16	Mar-19	16	Apr-19	16	May-19	16	Jun-19	16	Jul-19	16	Aug-19	16	Sep-19	16	Oct-19	16	Nov-19	16	Dec-19	12	Jan-20	12	<p>Rationale for current score: Reflect the Directorate led baseline assessment and the findings of the HTA inspection in April 2018. Compliance now restored and focus is on sustainability of the service and bringing together CTM mortuary services under one HTA license.</p> <p>Rationale for target score: Likely rating once the issues identified are addressed and the corrective action & improvement plan is fully implemented.</p>	
Month	Risk Score																																		
Nov-18	16																																		
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Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																	
<ul style="list-style-type: none"> The Pathology Directorate undertook a baseline review which identified a number of areas for action in advance of the HTA inspection. The first line of defence (the Board's internal assurance) was not sufficiently strong enough to ensure related matters were raised and addressed in advance of the Licence Regulators informing the UHB when the statutory environment had changed and raised the standards required for compliance. The Pathology Directorate developed a comprehensive action plan in response to the HTA findings with Board agreed scrutiny & Monitoring arrangements in place via the Q,S&R Committee. Related controls are considered strong with regards knowing what the 		Action	Lead																																
		Deadline																																	
		Ensure the Directorate Corrective Action Plans are fully implemented	COO	Completed																															
Consider case for bringing CTM under one HTA license once SBUHB inspection cycle is complete and CAPAS compliant. Potential for future consolidation of coronial PM services to be considered as a service development if services can be brought together in the New Year.	COO	Ongoing through HTA Project Board and Care of the Deceased Project Board																																	

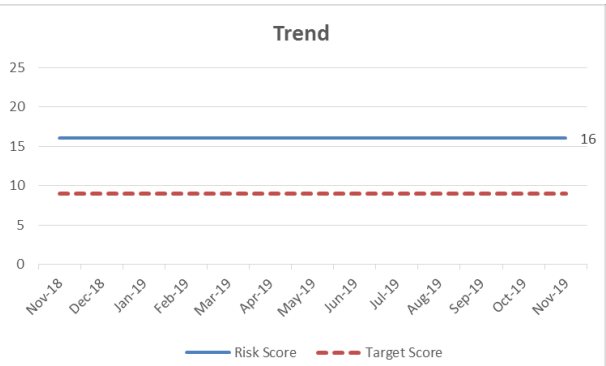
<p>related issues are and what actions need to be taken to achieve full compliance.</p> <ul style="list-style-type: none"> HTA signed off on all 32 CAPA plans on 10/7/2019; 0 HTARIs by 13/7/19. HTA published compliance notice in 8/2019. PoW HTA inspection took place 9/2019 and view on compliance expected before year end, with adoption of one license to follow. 	<p>Establish more robust monitoring arrangements, to ensure the Board's first line of assurance (defence) detects and informs corrective action plans.</p>	<p>COO</p>	<p>Ongoing through HTA Project Board and Care of the Deceased Project Board</p>
<p>Assurances (How do we know if the things we are doing are having an impact?)</p> <p>Compliance with Statutory requirements outlined in the Human Tissue Act and related Standards.</p>	<p>Gaps in assurance (What additional assurances should we seek?)</p> <p>PoW position to report once HTA inspection cycle and CAPAs completed.</p>		
<p>Current Risk Rating</p> <p>Current Risk Rating : 4 x 4 = 12</p>	<p>Additional Comments</p> <p>All 32 CAPA plans completed and submitted to the HTA. Compliance restored and sustained.</p>		<p>Ref No.</p> <p>041</p>

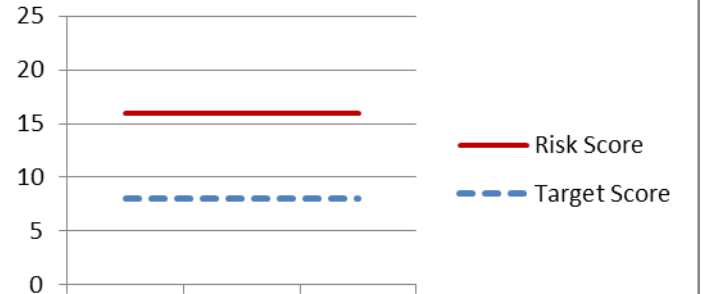
<p>Objective: To improve quality, safety and patient experience</p>		<p>Director Lead: Director of Nursing, Midwifery and Patient Services Assuring Committee: Health Board</p>							
<p>Risk: Under reporting of clinical incidents in maternity services</p>		<p>Date last reviewed: January 2020</p>							
<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 3 x 3 = 9</p>	<p>Trend</p> 		<p>Rationale for current score: Delivery Unit's Report: Intervention into Cwm Taf Morgannwg University Health Board systems and processes for reporting, management and review of patient safety incidents & Concerns, (September, 2019)</p> <p>joint review of maternity services by the Royal College of Obstetrics and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) March 2019</p> <p>Targeted intervention status with maternity services specifically being placed into special measures.</p>						
<p>Level of Control 50%</p>	<p>Rationale for target score: Likely rating once organisational structures are in place values and behaviours framework established and the issues identified are addressed and the corrective action & improvement plan is fully implemented.</p>								
<p>Date added to the risk register September 2018</p>		<p>Mitigating actions (What more should we do?)</p> <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Data generation and analysis is accurate, intelligent and used to inform performance and outcome</td> <td>Medical Director</td> <td>April 2020</td> </tr> </tbody> </table>		Action	Lead	Deadline	Data generation and analysis is accurate, intelligent and used to inform performance and outcome	Medical Director	April 2020
Action	Lead	Deadline							
Data generation and analysis is accurate, intelligent and used to inform performance and outcome	Medical Director	April 2020							
<p>Controls (What are we currently doing about the risk?)</p> <ul style="list-style-type: none"> Implementation of the Quality & Patient Safety Governance Framework Implementation of the Maternity Improvement Board Implementation of the improvement plan developed in response to the Delivery Unit review 									

<ul style="list-style-type: none"> Full implementation of the outcomes of the Delivery Unit's supportive intervention 		
Assurances (How do we know if the things we are doing are having an impact?) <ul style="list-style-type: none"> Additional scrutiny applied by Welsh Government and the Independent Maternity Oversight Panel Regular reporting to Quality & Risk Committee and Board Regular engagement with external stakeholders e.g. the public, County Borough Councils, Community Health Councils Audit of directorate and service governance arrangements 	Gaps in assurance (What additional assurances should we seek?) <ul style="list-style-type: none"> Benchmarking with comparative providers 	
Current Risk Rating Current Risk Rating : 5 x 4 = 20	Additional Comments	Ref No. 043

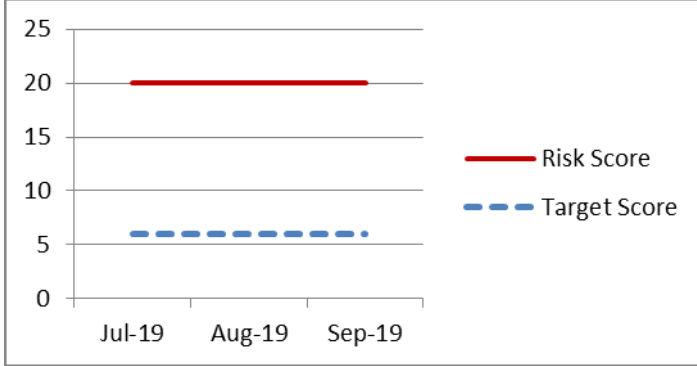
Objective: Service / Business Interruption		Director Lead: Chief Operating Officer / Director of Governance Assuring Committee: Management Board (will be ICT/IG Committee)										
Risk: Risk of information technology failures following national outages during 2018 and cyber security risk which could lead to loss of information or information governance issues		Date last reviewed: January 2020										
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 2 = 10 Target: 3 x 3 = 9		Rationale for current score: System failures during 2019 but service continuity plans in place and services were maintained. Cyber Security issues identified within Audit reports										
Level of Control = 50%		Rationale for target score: New risk identified and at best impact could be severe and likelihood appears moderate. Much is outside of the control of the UHB although all systems have business continuity plans										
Date added to the risk register December 2018												
Controls (What are we currently doing about the risk?) <ul style="list-style-type: none"> Carry out gap analysis/risk assessment on IT systems. Business continuity plans updated. Working with NWIS to gain assurance on the major national systems. Representations made to National Informatics Management Board on data centre outage. 		Mitigating actions (What more should we do?) <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Work nationally with NWIS and other HBs and Trusts at the operational security management board.</td> <td>COO Dir of Governance</td> <td>ongoing</td> </tr> <tr> <td>Continue with strong controls in place to ensure "business as usual" through robust</td> <td>COO Dir of</td> <td>Ongoing</td> </tr> </tbody> </table>		Action	Lead	Deadline	Work nationally with NWIS and other HBs and Trusts at the operational security management board.	COO Dir of Governance	ongoing	Continue with strong controls in place to ensure "business as usual" through robust	COO Dir of	Ongoing
Action	Lead	Deadline										
Work nationally with NWIS and other HBs and Trusts at the operational security management board.	COO Dir of Governance	ongoing										
Continue with strong controls in place to ensure "business as usual" through robust	COO Dir of	Ongoing										

<ul style="list-style-type: none"> Ongoing improvements of local system resilience through Digital Health Strategy Steering Group (DHSSG). Cyber team has been expanded from one to three members of staff, an addition fourth member will be joining the team in early January 2020. The Cyber team now has both the national monitoring and scanning tools to be pro-active regarding detection of possible cyber breaches. From Monday 6th January the Cyber Security team will contain 4 members of staff. The new Cyber team will be responsible for the implementation of standard security governance and guidance such as the National Cyber Security Centre's (NCSC) Cyber Essentials plus certification and the Network & Information Systems (NIS) Regulations 2018. 	business continuity plans	Governance	
	Set up monthly Cyber Security and IT Governance Group to report into DHSSG – develop action plan to respond to NWIS review recommendations	COO Dir of Governance	June 2020
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
The Health Board is providing services “business as usual” with no interruption to service sustainability and provision of patient care.	Work towards Cyber Security essentials plus certificate		
Current Risk Rating Current Risk Rating: 5x2 = 10	Additional Comments Recent issues with national outages – working with staff at CTM to respond to the impact on services to report to NWIS		Ref No. 044

Objective: Service / Business Interruption		Director Lead: Director of Public Health																																											
Risk: Risk of interruption to service sustainability, provision and destabilising the Board's financial position as a result of Brexit.		Assuring Committee: Management Board																																											
		Date last reviewed: November 2019																																											
<p>Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 3 = 9</p> <p style="background-color: red; color: white; text-align: center;">Level of Control = 50%</p> <p>Date added to the risk register November 2018</p>	<p style="text-align: center;">Trend</p>  <table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Nov-18</td><td>16</td><td>9</td></tr> <tr><td>Dec-18</td><td>16</td><td>9</td></tr> <tr><td>Jan-19</td><td>16</td><td>9</td></tr> <tr><td>Feb-19</td><td>16</td><td>9</td></tr> <tr><td>Mar-19</td><td>16</td><td>9</td></tr> <tr><td>Apr-19</td><td>16</td><td>9</td></tr> <tr><td>May-19</td><td>16</td><td>9</td></tr> <tr><td>Jun-19</td><td>16</td><td>9</td></tr> <tr><td>Jul-19</td><td>16</td><td>9</td></tr> <tr><td>Aug-19</td><td>16</td><td>9</td></tr> <tr><td>Sep-19</td><td>16</td><td>9</td></tr> <tr><td>Oct-19</td><td>16</td><td>9</td></tr> <tr><td>Nov-19</td><td>16</td><td>9</td></tr> </tbody> </table>	Month	Risk Score	Target Score	Nov-18	16	9	Dec-18	16	9	Jan-19	16	9	Feb-19	16	9	Mar-19	16	9	Apr-19	16	9	May-19	16	9	Jun-19	16	9	Jul-19	16	9	Aug-19	16	9	Sep-19	16	9	Oct-19	16	9	Nov-19	16	9	<p>Rationale for current score: Whilst Brexit negotiations continue the Health Board must prepare for every eventuality based on a thorough risk assessment on the impact of Brexit on the Health Board.</p> <p>Rationale for target score: Whilst Brexit negotiations continue the Health Board must prepare for every eventuality based on a thorough risk assessment on the impact of Brexit on the Health Board.</p>	
Month	Risk Score	Target Score																																											
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Nov-19	16	9																																											
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																											
<ul style="list-style-type: none"> Gap analysis/risk assessment on Brexit completed 		Action	Lead	Deadline																																									

<ul style="list-style-type: none"> Completed the Wales Audit Office (WAO) self-assessment Regular updates provided to WG as required Directorate Business Continuity plans being updated – particularly in Medicines Management; Facilities (food); ICT; Workforce; Estates; R&D Regular dialogue with Welsh Government and working with the Welsh NHS Confederation – active on SRO and Health Securities groups Emergency Planning, Preparedness & Response (EPPR) for the CTM sites Workforce actively pursuing the gap analysis. Assessment of potential risks to the flow of personal data following Brexit Active with NWSSP to provide detail on product lines and non stock items Taking part in Operation Yellowhammer reporting (with WG) Undertaken a number of business continuity exercises to test existing business continuity plans to identify any gaps in resilience. 	<p>Work nationally with Welsh Government, Local Resilience Forums and other HBs and Trusts to share business continuity plans.</p>	<p>Board Sec CCM</p>	<p>Ongoing</p>
<p>Continue with strong controls in place to ensure “business as usual” through robust business continuity plans</p>	<p>Board Sec CCM</p>	<p>Ongoing</p>	
<p>Working with other HBs and Welsh NHS Confederation learn lessons from other organisations and provide information on SharePoint to allow opportunities for staff across the HB to identify and areas of concern</p>	<p>Board Sec CCM</p>	<p>ongoing</p>	
<p>Assurances (How do we know if the things we are doing are having an impact?)</p>	<p>Gaps in assurance (What additional assurances should we seek?)</p>		
<p>The Health Board is providing services “business as usual” with no interruption to service sustainability and provision of patient care.</p>	<p>All directorates to confirm business continuity plans updated</p>		
<p>Current Risk Rating</p>	<p>Additional Comments</p>		<p>Ref No.</p>
<p>Current Risk Rating: 4x4 = 16</p>	<p>Whilst Brexit negotiations continue the Health Board will work with other organisations to identify risk</p>		<p>045</p>
<p>Objective: Setting the Direction & Performance & Operational Delivery</p>		<p>Director Lead: Medical Director Assuring Committee: Finance, Performance and Workforce Committee.</p>	
<p>Risk: Not agreeing a sustainable model for emergency medicine and inpatient paediatrics across the CTMUHB footprint. Impact: Unable to deliver safe high quality emergency medicine and inpatient paediatrics services across the CTM footprint.</p>		<p>Date last reviewed: January 2020</p>	
<p>Risk Rating</p> <p>(consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 2 = 6</p>			<p>Rationale for current score:</p> <ul style="list-style-type: none"> Recent workforce pressures (RGH ED) and paediatrics Safety concerns identified by PoW consultants at RGH <p>Rationale for target score:</p> <ul style="list-style-type: none"> Ensure CTM communities are provided with the highest quality sustainable services.
<p>Level of Control =TBC%</p>			
<p>Date added to risk</p>			

register			
Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
<ul style="list-style-type: none"> Project Board establish to work up the options and manage the risks Modelling work, informed by that done by the SWP, being undertaken to establish a number of options, and to assess patient flow implications 	Action	Lead	Deadline
	Engage with staff and staff representatives on the options.	NL	Jan – Sept 20
	Engage with the CHC, and wider external stakeholders on the options.	NL	Jan – Sept 20
	Clinical reference groups (CRGs) are being established to assist with the work of the project and facilitate appropriate clinical engagement.	NL	Jan – Mar 20
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
CHC and stakeholder support.			
Current Risk Rating	Additional Comments		Ref No.
Current Risk Rating : 4 x 4 = 16	The previous SW Programme implementation risk was removed from the risk register (December 19)		050

Objective: Setting the Direction & Performance & Operational Delivery		Director Lead: Medical Director
		Assuring Committee: Finance, Performance and Workforce Committee.
Risk: Implementing a sustainable model for emergency medicine and inpatient paediatrics across the CTMUHB footprint in a timely manner.		Date last reviewed: January 2020
Impact: Unable to deliver safe high quality emergency medicine and inpatient paediatrics services across the CTM footprint.		
<p>Risk Rating</p> <p>(consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 3 x 2 = 6</p> <p>Level of Control =TBC%</p> <p>Date added to risk</p>	 <p>— Risk Score - - - Target Score</p>	<p>Rationale for current score:</p> <ul style="list-style-type: none"> Recent workforce pressures (RGH ED) and paediatrics Safety concerns identified by PoW consultants at RGH <p>Rationale for target score:</p> <ul style="list-style-type: none"> Ensure CTM communities are provided with the highest quality sustainable services.

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Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
Escalation levels.			
Current Risk Rating	Additional Comments		Ref No.
Current Risk Rating : 4 x 4 = 20	The previous SW Programme implementation risk was removed from the risk register (December 19)		051

Objective: Setting the Direction & Performance & Operational Delivery

Director Lead: Director of Corporate Governance
Assuring Committee: Finance, Performance & Workforce

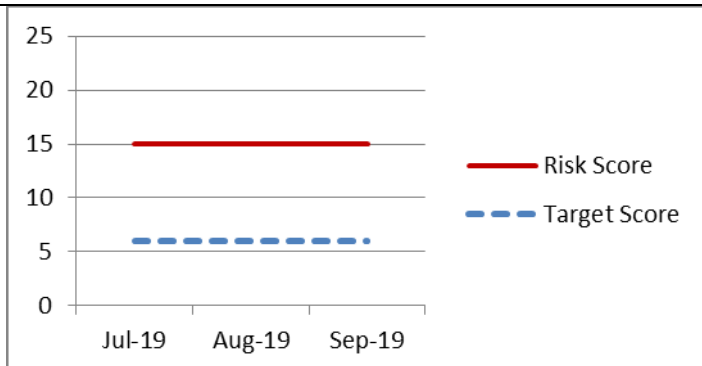
Risk: Organisational Reputation: Lack of confidence in the services and e provided by the organization.

Date last reviewed: January 2020

Impact: Reputational damage, loss of confidence, patients seeking services n elsewhere, increased external scrutiny.
ff disengaged due to negative media coverage and the content of external orts.

Risk Rating

(consequence x likelihood):
Initial: 5 x 3 = 15
Current: 5 x 3 = 15
Target: 3 x 2 = 6
Level of Control
=TBC%



Rationale for current score: 15
Adverse media, external reviews and reports, stakeholder relationships. Further media coverage likely over the next few months.

Rationale for target score: 6
The HB is working to improve the engagement and involvement of key stakeholders, to include the media, which it is hoped will help what and how things are reported.

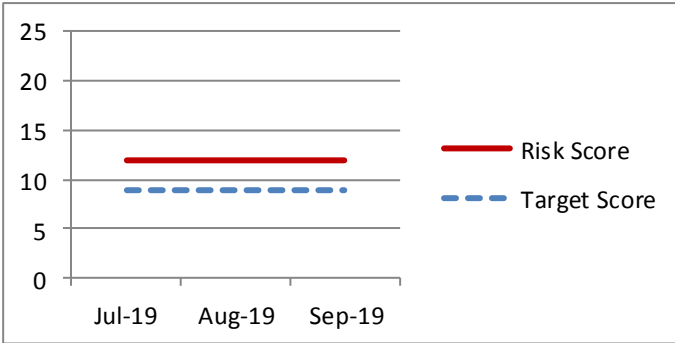
Rate added to risk register			
Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
<p>Rebuild trust and confidence programme under Targeted Intervention Improvement Programme underway. Improved staff engagement and involvement, new approaches to partnership engagement and involvement. Ensure balanced news stories are regularly reported and communicated. Additional capacity bid included in TI investment bid under the TI programme to WG. Additional capacity bid included in TI investment bid under the SW Programme.</p>	Action	Lead	Deadline
	Objective assessment against the TI maturity matrix and action as a result of the assessment.	Head of Comms	End of Feb 20
	A programme of public and patient engagement and involvement, Let's Talk programme, developing Values and Behaviours with staff and patients. Open door policy.	Head of Comms	June 20
	Relationship building with the media.	Head of Comms	April 20
	Focused on increased transparency and partnership working with stakeholders.	Head of Comms	Jan 20 – Jan 21
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
<p>Progress against the TI maturity matrix categories. Media coverage. Number of external reviews and actions to address recommendations in external reviews. Escalation status of CTMUHB.</p>			
Current Risk Rating Current Risk Rating : 5 x 3 = 15	Additional Comments		Ref No. 052



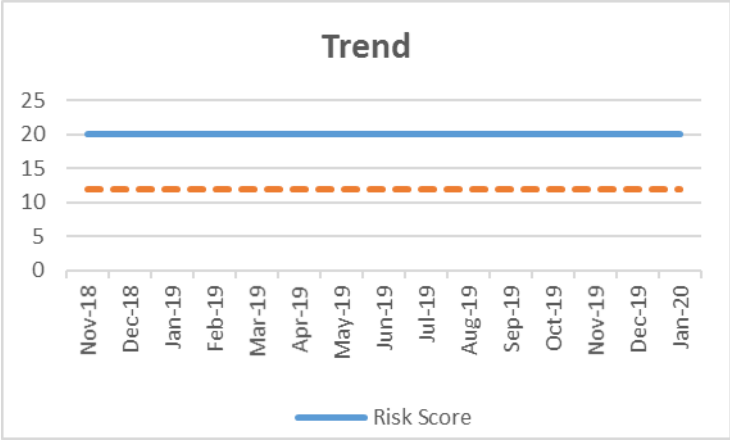
Objective: Setting the Direction & Performance & Operational Delivery

Director Lead: Director of Workforce and OD

Assuring Committee: Finance, Performance and Workforce Committee.

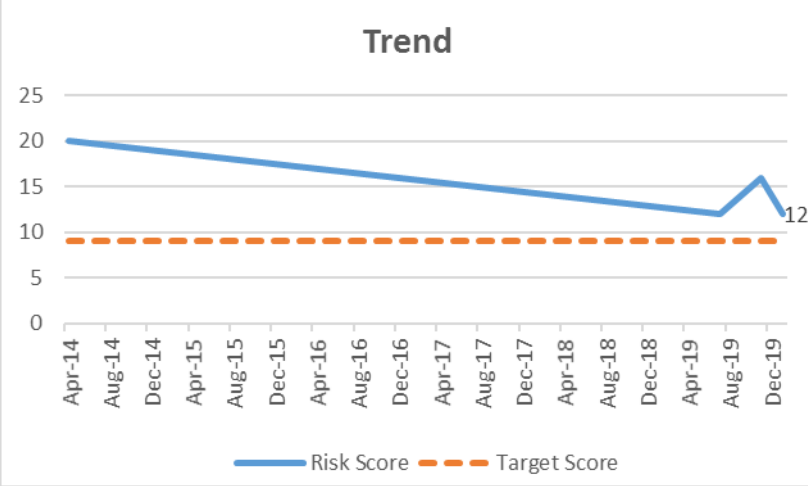
<p>Risk: New Operating Model: The new operating model leads to lack of clarity and/or lack of focus on delivering performance, quality and resources. The new model doesn't deliver the additional community benefits of a population health focus to improve community wellbeing' and better service integration for the people we serve.</p> <p>Impact: Staff and stakeholders become unclear on the systems and processes as CTM transitions from the current operating model to the new operating model.</p>		<p>Date last reviewed: January 2020</p>																
<p>Risk Rating</p> <p>(consequence x likelihood): Initial: 3 x 4 = 12 Current: 2 x 4 = 12 Target: 3 x 3 = 9</p>		<p>Rationale for current score:</p> <ul style="list-style-type: none"> Major change in how things will operate, may lead to some confusion during the transition phase. Ability to get everything in place for the 1st April when the new operating model is implemented. <p>Rationale for target score:</p> <ul style="list-style-type: none"> Try to minimise the likelihood of not having clarity from the 1st April, but focusing on achieving the agreed milestones and clear communication. 																
<p>Level of Control =TBC%</p>	<p>Date added to risk register</p>																	
<p>Controls (What are we currently doing about the risk?)</p> <ul style="list-style-type: none"> Programme Director in place to drive the new operating model. Executive team regularly review the project plan and required actions to deliver the operating model. Regular communication and engagement with staff and stakeholders on the move to the new operating model. Recruitment to senior leadership posts underway(January 2020) 		<p>Mitigating actions (What more should we do?)</p> <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>New Governance systems and processes to be developed reflecting the new operating model</td> <td>GG</td> <td>Jan – Mar 20</td> </tr> <tr> <td>New performance management framework to be developed</td> <td>RT</td> <td>Jan – Mar 20</td> </tr> <tr> <td>Leadership programme to be introduced for staff.</td> <td>HD</td> <td>Jan – Mar 20</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Action	Lead	Deadline	New Governance systems and processes to be developed reflecting the new operating model	GG	Jan – Mar 20	New performance management framework to be developed	RT	Jan – Mar 20	Leadership programme to be introduced for staff.	HD	Jan – Mar 20			
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New performance management framework to be developed	RT	Jan – Mar 20																
Leadership programme to be introduced for staff.	HD	Jan – Mar 20																
<p>Assurances (How do we know if the things we are doing are having an impact?)</p> <p>Progress against project plan, staff engagement and feedback, successful recruitment into leadership roles.</p>		<p>Gaps in assurance (What additional assurances should we seek?)</p> <p>Audits on effective systems and processes e.g. risk escalation.</p>																

Current Risk Rating	Additional Comments	Ref No.
Current Risk Rating : 3 x 4 = 12		053

Objective: Statutory compliance		Director Lead: Director of Therapies and Health Sciences																																	
Risk: Failure to meet Fire Safety Standards across the UHB.		Assuring Committee: Management Board / Audit and Risk																																	
Date last reviewed: January 2020																																			
<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 3 = 12</p>	<p>Trend</p>  <table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Nov-18</td><td>20</td></tr> <tr><td>Dec-18</td><td>20</td></tr> <tr><td>Jan-19</td><td>20</td></tr> <tr><td>Feb-19</td><td>20</td></tr> <tr><td>Mar-19</td><td>20</td></tr> <tr><td>Apr-19</td><td>20</td></tr> <tr><td>May-19</td><td>20</td></tr> <tr><td>Jun-19</td><td>20</td></tr> <tr><td>Jul-19</td><td>20</td></tr> <tr><td>Aug-19</td><td>20</td></tr> <tr><td>Sep-19</td><td>20</td></tr> <tr><td>Oct-19</td><td>20</td></tr> <tr><td>Nov-19</td><td>20</td></tr> <tr><td>Dec-19</td><td>20</td></tr> <tr><td>Jan-20</td><td>20</td></tr> </tbody> </table>	Month	Risk Score	Nov-18	20	Dec-18	20	Jan-19	20	Feb-19	20	Mar-19	20	Apr-19	20	May-19	20	Jun-19	20	Jul-19	20	Aug-19	20	Sep-19	20	Oct-19	20	Nov-19	20	Dec-19	20	Jan-20	20	<p>Rationale for current score: Ongoing and close working with South Wales Fire and Rescue Service (SWF&RS) and the UHB to maintain high awareness. Continuing to monitor the requirement for staff to undertake mandatory training which remains challenging Fire enforcement notice and issues within systems and controls identified at Princess of Wales</p> <p>Rationale for target score: Actions relating to Fire Safety across the UHB as a key element of patient, staff and public safety management; this is a mandatory requirement for staff</p>	
Month	Risk Score																																		
Nov-18	20																																		
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Level of Control =70%																																			
Date added to the risk register October 2009																																			
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																	
<ul style="list-style-type: none"> Robust risk assessment processes in place to ensure the Board manages and mitigates identified risks; Implementation of Action Plans in response to pro active risk assessments. Alignment (where appropriate) of UHB risk assessment processes with those of Fire Service Constructive and positive working relationship in place with SWF&R Service and regular meetings between senior staff with at least Annual review meetings being led by CEO and Chief Fire Safety & Rescue Officer. Other enforcement actions taken for example ICU at Royal Glamorgan Hospital, but plan in place to address and agreed with SWF&R service. Ongoing work at the POW site – identification of key issues and mitigation 		Action	Lead	Deadline																															
		Pro active management via Clinical / Corporate Business Meetings (CBMs) to ensure profile for fire safety remains high.	COO /DPCMH	Ongoing																															
		Regular inspections and dialogue with South Wales Fire & Rescue Service.	Head of Fire Safety	Ongoing																															
		Robust risk assessment processes in place and good compliance with staff training uptake to be sustained.	Head of Fire Safety	Ongoing																															
		RCA being carried out into the fire alarm in PCH pre Christmas to assess the effectiveness of the response and take action where appropriate to improve and ensure	Director of Therapies and HS	February 2020																															

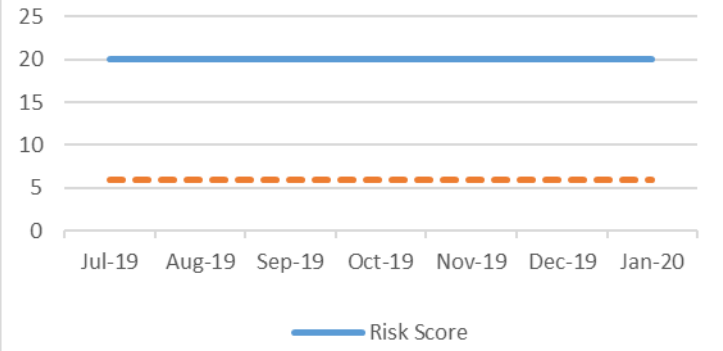
	compliance		
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
Reducing numbers of enforcement notices received.	Fire enforcement actions being progressed and routinely monitored.		
Current Risk Rating: 4 x 4 = 20	Additional Comments		Ref No. 025

Objective: Setting the Direction & Performance & Operational Delivery	Director Lead: Director of Nursing, Midwifery and Patient Care Assuring Committee: Quality and Safety Committee
Risk: Patients and/or relatives/carers do not receive timely responses to concerns raised, learning and improvement does not take place if there is failure to meet the timescale relating to responding to complaints	Date last reviewed: January 2019

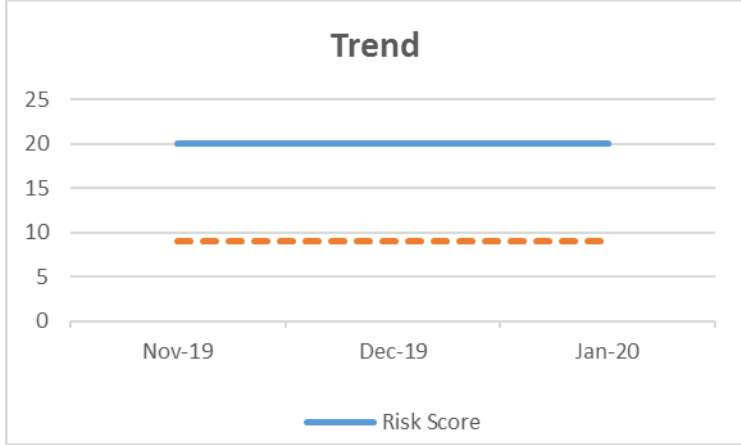
<p>Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 3 x 3 = 9</p> <p>Level of Control =</p> <p>Date added to the risk register April 2014</p>	<p>Trend</p>  <table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Date</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Apr-14</td><td>20</td><td>9</td></tr> <tr><td>Aug-14</td><td>19</td><td>9</td></tr> <tr><td>Dec-14</td><td>18</td><td>9</td></tr> <tr><td>Apr-15</td><td>17</td><td>9</td></tr> <tr><td>Aug-15</td><td>16</td><td>9</td></tr> <tr><td>Dec-15</td><td>15</td><td>9</td></tr> <tr><td>Apr-16</td><td>14</td><td>9</td></tr> <tr><td>Aug-16</td><td>13</td><td>9</td></tr> <tr><td>Dec-16</td><td>12</td><td>9</td></tr> <tr><td>Apr-17</td><td>11</td><td>9</td></tr> <tr><td>Aug-17</td><td>10</td><td>9</td></tr> <tr><td>Dec-17</td><td>9</td><td>9</td></tr> <tr><td>Apr-18</td><td>8</td><td>9</td></tr> <tr><td>Aug-18</td><td>7</td><td>9</td></tr> <tr><td>Dec-18</td><td>6</td><td>9</td></tr> <tr><td>Apr-19</td><td>5</td><td>9</td></tr> <tr><td>Aug-19</td><td>15</td><td>9</td></tr> <tr><td>Dec-19</td><td>12</td><td>9</td></tr> </tbody> </table>	Date	Risk Score	Target Score	Apr-14	20	9	Aug-14	19	9	Dec-14	18	9	Apr-15	17	9	Aug-15	16	9	Dec-15	15	9	Apr-16	14	9	Aug-16	13	9	Dec-16	12	9	Apr-17	11	9	Aug-17	10	9	Dec-17	9	9	Apr-18	8	9	Aug-18	7	9	Dec-18	6	9	Apr-19	5	9	Aug-19	15	9	Dec-19	12	9	<p>Rationale for current score: Increasing numbers of complaints received following the organisation's escalation status, and the Bridgend Boundary change, differing management models within DGH sites, reduced directorate capacity in areas that have greater patient flow volumes and therefore more complaints, reduced corporate capacity.</p> <p>Rationale for target score: Putting Things Right identifies the Welsh Government's requirement in relation to response times, proactively supporting shared learning and quality improvement</p>
Date	Risk Score	Target Score																																																									
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Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
<ul style="list-style-type: none"> Implementation of the Quality & Patient Safety Governance Framework Organisational structures are being agreed which will help ensure right resource right place right time to reduce and manage appropriately complaints, including establishing governance resource within service delivery units Values and behaviors work will support outcome focused care supportive intervention from the Delivery Unit supporting redesign of complaints management relocation of the concerns team into District General Hospitals Preservation of the governance resource within the princess of Wales Hospital 	Action	Lead	Deadline
	Develop the quality governance operating model within the new operating structure	Executive Nurse Director	June 2020
	Ensure access to education, training and learning	Executive Nurse Director	June 2020


Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)	
<ul style="list-style-type: none"> Views of the Community Health Council Weekly monitoring in the executive patient safety meetings Regular reporting to the Quality Assurance sub group, Quality & Safety Committee and Board External scrutiny from Welsh Government 	<ul style="list-style-type: none"> Results of post complaint response survey 	
Current Risk Rating 3 x 4 = 12	Additional Comments	Ref No. 023

Objective: Setting the Direction & Performance & Operational Delivery		Director Lead: Chief Operating Officer Assuring Committee: Finance, Performance & Workforce Quality and Safety Committees		
Risk: Failure to treat patients in a timely manner resulting in potential avoidable harm		Date last reviewed: January 2019		
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 3 x 2 = 6	<div style="text-align: center;"> <p>Trend</p>  <p>— Risk Score</p> </div>	Rationale for current score: The level of clinical risk is being scoped The current score reflects the issue identified as a result of the discovery of unreported waiting lists. A number of sub-specialty waiting list codes were discovered to be unreported and therefore unsighted. UHB staff have worked in conjunction with Delivery Unit staff to identify all lists that should be reported and therefore develop plans to ensure these patients are treated as a matter of urgency. As these lists are confirmed additional work is being undertaken with the patient care and safety team to ensure any avoidable harm is reported and acted upon accordingly. Immediate safe systems of work been implemented to ensure no other sub specialties can be entered onto the unreported lists. Rationale for target score: The need to ensure safe timely patient care, eradicate such lists and ensure appropriate reporting supports the target score of 6.		
Level of Control = 50%		Date added to risk register July 2019		
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)		
<ul style="list-style-type: none"> Speciality specific plans are in place to ensure patients requiring clinical review are assessed All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. Immediate process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months All unreported lists that appear to require reporting have been added to the RTT reported lists All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) 		Action	Lead	Deadline
		Ensure service plans provide enough capacity for timely assessment		
		Continue delivery of the controls in place	Ops Directors	Ongoing
		Annual check of all waiting lists should be	Ops	Quarter 2

are being reviewed and will be visible and monitored going forward.	undertaken to ensure robustness of processes	Directors	
	Develop Demand & Capacity Plans for all areas that were not previously reported	Ops Directors	Ongoing quarterly
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
<ul style="list-style-type: none"> Regular reporting and scrutiny at directorate CBMs and board sub committees? Share learning across all areas who may need to review their own practice? All appropriate waiting lists will be reported and will be dealt with in line with RTT waiting times criteria.	F,P&W monitoring progress. Working with the DU to analyse all waiting times		
Current Risk Rating	Additional Comments		Ref No.
5 x 4 = 20			NEW 047

Objective: To improve quality, safety and patient experience		Director Lead: Director of Workforce and Organisational Development		
Risk: Insufficient skilled staff to deliver clinical services effectively due to poor retention of staff		Assuring Committee: Finance, Performance and Workforce Committee		
Date last reviewed: November 2019				
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 3 x 3 = 9 Level of Control =50% Date added to risk register November 2019	Trend 	Rationale for current score: Impact of retaining sufficient staff will affect the organisations ability to provide safe services, particularly in Nursing. Rationale for target score: Some degree of staff turnover is inevitable		
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)		
<ul style="list-style-type: none"> Overseas recruitment project aiming to secure 200 Nurses over 12 months. Introduction of exit questionnaire and exit interview process. Returns scrutinised by HR Teams for any concerns to be taken forward. Metrics run on return rates and included in WOD metrics report submitted to FPW. 		Action	Lead	Deadline
		Ensure our workforce planning processes clearly identify the roles required for the future.	Director of WOD	Ongoing

<ul style="list-style-type: none"> Turnover rates reported on Workforce Metrics Report at FPW. Ensure all staff are supported and developed through effective personal development reviews and career planning. In process of reviewing Leadership and Management offering. Attendance at recent trip to India as part of All Wales BAPIO/MTI initiative for medical staff. Allocation of doctors to CTM due by end of November 2019. Launched Let's Talk Culture – a major new project involving as many staff and patients as possible sharing their views about how we build our new organisation and co-creating our culture, values and behaviours. Harassment, Bullying and Abuse (HBA) steering group has been set up to create a positive workplace culture and tackle bullying & harassment. 	Improve flexible working opportunities.	Director of WOD	Ongoing
	Identify common themes and trends from exit questionnaires and develop specific action plans.	Director of WOD	Ongoing
	Further conversations in relation to additional overseas initiatives and the engagement of agencies to recruit to substantive/ fixed terms posts for one off finder fee with meetings taking place in the next 2 months.	Director of WOD with other directors	Ongoing
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
Reduction of turnover rates Reduction in use of agency and bank staff			
Current Risk Rating	Additional Comments		Ref No. 049 NEW
Current Risk Rating : 4 x 5 = 20			

Objective: Statutory compliance		Director Lead: Director of Therapies and Health Science Assuring Committee: Management Board		
Risk: Failure to meet Fire Safety Standards in the Theatres, Princess of Wales Hospital.		Date last reviewed: November 2019		
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 3 = 12		Rationale for current score: Ongoing and close working with South Wales Fire and Rescue Service (SWF&RS) and the UHB to maintain high awareness. Continuing to monitor the requirement for staff to undertake mandatory training which remains challenging		
Level of Control =70%		Rationale for target score: Actions relating to Fire Safety in Theatres in the Princess of Wales Hospital as a key element of patient, staff and public safety management; this is a mandatory requirement for staff		
Date added to risk register November 2019				
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)		
<ul style="list-style-type: none"> Robust risk assessment processes in place to ensure the Board manages and mitigates identified risks; Implementation of Action Plans in response to proactive risk assessments. 		Action	Lead	Deadline
		Proactive management via Clinical / Corporate Business Meetings (CBMs) to	Head of Health,	Ongoing

<ul style="list-style-type: none"> Alignment (where appropriate) of UHB risk assessment processes with those of Fire Service Constructive and positive working relationship in place with SWF&R Service and regular meetings between senior staff. Development of a draft Business Case to provide the additional fire safety measures to comply with current fire safety standards. Monthly MDT Fire Enforcement Meetings taking place on site 	<p>ensure profile for fire safety remains high. Local MDT Fire Enforcement meeting monthly.</p>	Safety & Fire	
	<p>Regular inspections and dialogue with South Wales Fire & Rescue Service.</p>	Head of Health, Safety & Fire	Ongoing
	<p>Robust risk assessment processes in place and good compliance with staff training uptake to be sustained.</p>	Head of Health, Safety & Fire	Ongoing
<p>Assurances (How do we know if the things we are doing are having an impact?)</p> <p>Management and Staff awareness of the fire risks. Actively reducing the number of fire alarm activations through the implementation of risk reduction measures. Robust monitoring of the enforcement areas by the Hospital Fire Officer and Fire and Rescue Service</p>	<p>Gaps in assurance (What additional assurances should we seek?)</p> <p>Fire enforcement action being progressed and routinely monitored. Fire enforcement notice and issues within systems and controls identified at Princess of Wales.</p>		
<p>Current Risk Rating</p> <p>5 x 4 = 20</p>		<p>Additional Comments</p>	
		<p>Ref No. NEW 048</p>	