Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 3.6** **31 July 2019**

University Health Board Report
ORGANISATIONAL RISK REGISTER

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Purpose of the University Health Board Report	
The purpose of this report is for the Health Board Members 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 Health Board in January 2019 and by the Quality Safety and Risk Committee and Executive Board in June 2019. Changes made are identified in RED font.	
Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its strategic objectives, and the related organisational objectives outlined within the 3 Year Integrated Medium Term Plan 2018-2021, are being progressed. Aligned with the 'Quadruple Aim' described within 'A Healthier Wales' (Welsh Government, June 2018) these objectives are: • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board.
Supporting evidence	• There are a number of assessments that help inform the content of the organisational risk register. • The content of this report is informed by the University Health Board's (UHB) Risk Management Strategy.
Engagement – Who has been involved in this work?	
The information contained within this report has been developed following engagement with senior staff and Executive Directors.	

University Health Board Resolution to:							
APPROVE		**ENDORSE**	√	**DISCUSS**	√	**NOTE**	√
Recommendation	The Health Board is asked to: • **DISCUSS** and **NOTE** the update provided within this report and the risks assigned to the Board and its Committees and • **ENDORSE** the updated risk register and the assignment of risks.						
Summarise the Impact of the Health Board Report							
Equality and diversity	There are no identified equality & diversity implications.						
Legal implications	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks faced by the organisation, as failure to do so could have legal implications for the UHB.						
Population Health	No specific impact.						
Quality, Safety & Patient Experience	Ensuring the organisation has robust risk management arrangements in place that ensure organisational risks are captured, assessed and mitigating actions are taken, is a key requisite to ensuring the quality, safety & experience of patients receiving care and staff working in the						
Resources	The risks outlined within this report have resource implications which are being addressed by the respective Executive Director leads and taken into consideration as part of the Board's IMTP processes.						
Risks and Assurance	This report and the organisational risk register is an integral element of the Board's risk and assurance arrangements. It should be noted that this work continues to develop.						
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes but within a Governance Framework. This report focuses mainly on Governance & Accountability but also spans many of the 7 quality themes.						
Workforce	Failure to capture, assess and mitigate risks can impact adversely on the workforce.						
Freedom of Information status	Open						

ORGANISATIONAL RISK REGISTER

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is for the Health Board Members 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 Health Board in January 2019, and by the Quality, Safety and Risk Committee and the Executive Board in June 2019. Changes made are identified in RED font.

Members should **NOTE** that plans are in place for a session on risk appetite, risk management and the connection to the Board Assurance Framework at the Board Development session due to take place on 29 August 2019.

2. BACKGROUND / INTRODUCTION

Members will **NOTE** that in light of recent Welsh Government escalation decisions, made by the Minister, there is an urgent need for a Board Development session on risk appetite and the CTMUHB's risk register development in order to ensure the Board and its Committees are focusing on the right issues of its business. Arrangements for this have been discussed with the Chair of the Board and will need to be timetabled into the Board's business agenda. Clearly this will impact significantly on the revision of this document, not least in light of the matters discussed by the Board at its 30 May 2019 meeting.

The organisational risk register summarises the key 'live' extreme risks facing the Health Board and the actions being taken to mitigate them. The Health Board manages risk through its Directorate structures and in close alignment with the Board's 'approved' Assurance Framework. The Assurance Framework reports into the Audit Committee for periodical review, monitoring and scrutiny and also features (at least annually) on the agenda of the Board.

It is also important to **NOTE** that the Executives, as risk owners, are appropriately sighted and involved in the development of the organisational risk register, providing updates, including reports on mitigating actions. The organisational risk register is reviewed and where appropriate updated on a bi-monthly basis with input from the Executive lead as required.

All organisational risks have a lead Executive Director and the risk assigned to either the Board, or as appropriate, a Committee of the Board to ensure appropriate review, scrutiny and where relevant updating. Each Director is responsible for the ownership of the risk(s) and the reporting of the actions in place to manage/control and/or mitigate the risks.

The organisational Risk Register is reported quarterly to the Executive Board and routinely to the Quality, Safety & Risk Committee of the Board, for information and where appropriate, scrutiny of any assigned risks. Whilst this cover report summarizes the detail, the supporting appendices provide more detail.

3. ASSESSMENT OF GOVERNANCE AND RISK ISSUES

Overall analysis

The organisational risk register currently includes 37 Extreme / High risks which are categorised into the following groupings:

Categories / Risk Rating	Extreme (rated 15 -25)	High (rated 8-12)
Setting the direction and performance and operational efficiency	**5**	**3**
To improve quality, safety and patient experience	**10**	**1**
Statutory Compliance	**7**	**3**
Finance (including claims)	**1**	**1**
Workforce / Organisational Development / Innovation	**0**	**1**
Business continuity	**2**	**1**
Total Risks	**25 (-2)**	**10 (+2)**

High / Extreme Risks (Specifically those rated 20 and above)

In considering the robustness of a developing organisational risk register, Board Members need to consider whether the top recorded risks are those that Members of the Board can relate to and indeed evidence that they are informing the work of the Board and its Committees in delivering its related Strategy.

The **highest rated risks** outlined within the Organisation's risk register are:

- **Risk of poor quality unsafe services providing unsatisfactory patient experience and unable to de-escalate to meet the expectations and scrutiny of the Welsh Government and regulators leading to increased levels of escalation. This risk has been reworded as follows "Poor quality unsafe services providing unsatisfactory patient experience which if not adequately addressed will continue to effect escalation status."**
- **Failure to recruit sufficient numbers of medical & dental staff and its related impact on rotas and finance going forward (also aligned with South Wales Programme outcome)**
- **Reduction in medical staff training posts**
- **Failure to recruit sufficient numbers of registered nursing and midwifery staff**
- **Increasing dependency on agency staff to cover registered nursing, midwifery and medical staff gaps**
- **Fire Safety compliance and ongoing issues with Prince Charles Hospital site (Ground & First Floor)**
- **Lack of control and capacity to accommodate all hospital follow up outpatient appointments**
- **Failure to ensure delivery of a viable balanced/break even 3 year integrated medium term plan.**
- **Achieving financial break even on a recurring basis.**
- **Under Reporting of Clinical Incidents in Maternity Services.**
- **Failure to continue to provide GP out of hours services as currently configured.**

Of the categorised risks, these have been broken down as:

Score	How many
25	1
20	10
16	10
15	4
12	10

There are currently 35 Extreme / High risks, contained within the organisational risk register. In light of recent discussions at the May 2019 Board meeting, Members will note the need to consider further risk based issues that have the potential, if not managed and mitigated appropriately, to impact adversely on the quality and safety of the services we provide.

Risk Register Category – Business Objectives / Projects (8 risks)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
Setting the Direction and Performance and Operational Efficiency	028	Failure to ensure delivery of a viable balanced/break even 3 year integrated medium term plan.	20 (was 16)	20	⇧	⇨	July 2019	Health Board
	015	Reputational damage & potential legal challenge on the decision making on Funded Nursing Care (FNC).	20	12	⇩	⇨	July 2019	Health Board
	036	Primary Care Workforce - Recruitment and sustainability	20	16	⇨	⇨	July 2019	Primary & Community Care
	030	Failure to continue to provide and sustain GP Out of Hours Services as currently configured.	20	20	⇨	⇨	July 2019	Primary & Community Care
	002	Failure to achieve Referral to Treatment targets.	12	16 (was 12)	⇧	⇧	July 2019	Finance, Performance & Workforce
	003	Failure to achieve the 4 and 12 hour emergency (A&E) waiting times targets.	12	16	⇩	⇧	July 2019	Finance, Performance & Workforce
	013	Implementation of South Wales Programme outcomes.	12	12	⇨	⇨	July 2019	Health Board
	023	Failure to meet the timescale relating to issuing concerns (complaints) responses to patients and/or carers.	20	12	⇩	⇧	July 2019	Quality, Safety & Risk

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.

Risk Register Category - Impact on Safety (11 risks)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
To improve quality, safety and patient experience.	007	Failure to recruit sufficient medical & dental staff.	20	20	⇨	⇨	July 2019	Quality, Safety & Risk
	034	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	⇨	⇨	July 2019	Quality, Safety & Risk
	035	Failure to recruit sufficient registered nursing and midwifery staff.	20	20	⇨	⇨	July 2019	Quality, Safety & Risk
	008	Reduction in medical training posts within various specialties & capacity to meet workload demands.	20	20	⇨	⇨	July 2019	Quality, Safety & Risk
	027	Lack of control and capacity to accommodate all hospital follow up outpatient appointments.	20	20 (was 16)	⇨	⇧	July 2019	Finance, Performance & Workforce
	032	Sustainability of a safe & effective Ophthalmology Service.	20	16	⇩	⇨	July 2019	Quality, Safety & Risk
	005	Failure to sustain services as currently configured to meet cancer targets.	20	16	⇩	⇧	July 2019	Finance, Performance & Workforce
	033	Failure to sustain Child & Adolescent Mental Health Services across the Network	20	16	⇨	⇧	July 2019	Quality, Safety & Risk
	037	Ensuring the development, approval and implementation of a Strategy for IM&T, that is clinically led and supports staff in care delivery	12	12	⇨	⇧	July 2019	Health Board
	(043)	Under Reporting of Clinical Incidents in Maternity Services	20	20	⇨	⇨	July 2019	Quality, Safety & Risk

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
	(46)	Risk of poor quality unsafe services providing unsatisfactory patient experience and unable to de-escalate to meet the expectations and scrutiny of the Welsh Government and regulators leading to increased levels of escalation	25	25	N/A		July 2019	Health Board

Risk Register Category – Statutory Duty / Inspections (10)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
Statutory Compliance	017	Failure to meet Fire Safety Standards on ground and first floor PCH.	20	20	⇨	⇨	July 2019	Quality, Safety & Risk
	021	Failure to ensure all Staff obtain competency/ compliance with mandatory training requirements.	20	16	⇨	⇧	July 2019	Quality, Safety & Risk
	025	Failure to meet Fire Safety Standards across CTMUHB.	20	16	⇨	⇨	July 2019	Quality, Safety & Risk
	018	Failure to achieve statutory and mandatory planned preventative maintenance (PPM) programme.	15	15	⇨	⇨	July 2019	Quality, Safety & Risk
	031	Failure to appropriately apply Deprivation of Liberties Safeguards (DoLS) legislation following the West Cheshire court judgement.	16 (was 12)	12	⇩	⇧	July 2019	Quality, Safety & Risk
	016	Failure to comply fully with the arrangements for managing Asbestos	16	12	⇩	⇧	July 2019	Quality, Safety & Risk

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
	039	Failure to ensure sufficient storage capacity (or alternative solutions) are in place to safely store and secure patient records.	16	16	⇨	⇧	July 2019	Quality, Safety & Risk
	040	Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	15	15	⇨	⇨	July 2019	Quality, Safety & Risk
	041	Failure to fully meet all the licensing requirements of the Human Tissue Authority in relation to Mortuary & Services for the Deceased.	16	12	⇩	⇧	July 2019	Quality, Safety & Risk
	042	Failure to ensure successful implementation of the Welsh Government's decision to realign the Health Boundary, as it applies to the resident population of the Bridgend County Borough.	15	15	⇨	⇧	July 2019	Health Board (Joint Transition Board)

Risk Register Category – Finance / Including Claims (2)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
Financial Viability	011	Failure to achieve financial balance on a recurring basis and mitigate reliance on in year non recurring funding slippage.	15	20	⇧	⇨	July 2019	Health Board
	012	Failure to Deliver Major & Discretionary Capital programmes	12	12	⇨	⇨	July 2019	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	Controls	Last Reviewed	Scrutiny Committee
Workforce Sustainability/ OD and Innovation	019	Failure to achieve the Management of Absence target.	20	12	⇨	⇧	July 2019	Finance, Performance & Workforce

Risk Register Category – Service / Business Interruption (3)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
Business Continuity	006	Failure to appropriately manage Discharge Delays from Hospitals	20	12 (Was 16)	⇩	⇧	July 2019	Finance, Performance & Workforce
Business Continuity Information Technology Systems	044	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	15	⇨	⇨	July 2019	Executive Board
Business Continuity Brexit	045	Risk of interruption to service sustainability, provision and destabilising the Board's financial position as a result of Brexit.	16	16	⇨	⇨	July 2019	Executive Board

Quality, safety and patient experience
The Health Board's risk management arrangements are in place to ensure risks are assessed and mitigating actions taken to improve the quality, safety and experience of patients and where appropriate escalation arrangements are in place to inform the Board via its key Committees. Further work will be undertaken on the Board Assurance Framework in line with the Structured Assessment Recommendations.

Use of resources
There is a significant risk to the service if robust risk based assessment arrangements are not in place. Good governance arrangements, including effective risk management help to ensure the effective use of resources. It is important to note that routinely as part of the Internal Audit and Assurance Annual Plan, 3 clinical and 1 corporate directorates undergo a governance review each year, which includes a review of its risk management arrangements. This is in addition to the organizational related audit reviews.

Compliance with Legislation
There may be an adverse effect on the organization if arrangements are not in place to manage and mitigate risks.

Performance
Assessment and monitoring of risks within the Health Board is undertaken within Directorates/Localities/Departments. The extreme / high organizational risks will be monitored by the Executive Team / Board and be reviewed and scrutinized by the Board and/or its Committees.

As a general rule the organisational risk register will be routinely reviewed by the Quality, Safety & Risk Committee and elements discussed at the Integrated Governance Committee, although all Committees of the Board have a role to play in ensuring risks assigned to a Board Committee are considered as part of its work. Risk management arrangements will also be a key element of internal audit work and key risks will help to inform the annual internal audit plan.

4. RECOMMENDATION

The Quality Safety and Risk Committee is asked to:

- **DISCUSS** and **NOTE** the update provided within this report and the risks assigned to the Board and its Committees; and

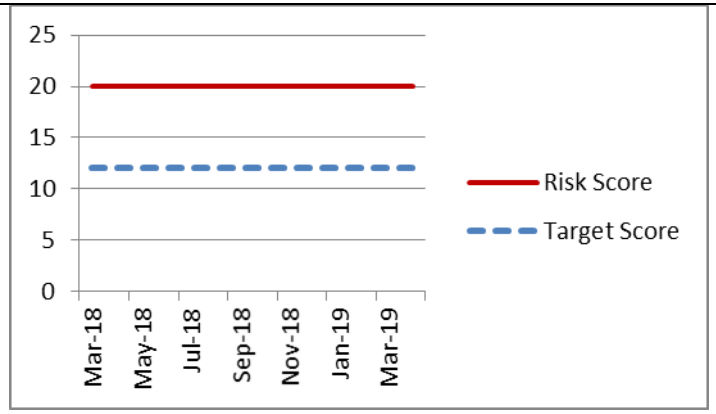
- **ENDORSE** the updated risk register and the assignment of risks.

Freedom of Information	Open

HEALTH BOARD ORGANISATIONAL RISK REGISTER
SUMMARY OF ASSESSED RISKS (OVERALL TREND) – JULY 2019

Impact/Consequence	1	2	3	4	5
5			042 Bridgend Boundary change 044 'New' Loss of IT due to system outages	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 Possible under reporting of clinical incidents in maternity services	046 Enhanced monitoring
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 ↔ 013 South Wales Plan outcomes ↔ 023 Deterioration in the timescale relating to issuing concerns (complaints) responses to patients and or carers ↔	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 ↔ 025 Failure to meet Fire Safety standards across the UHB ↔ 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 ↑	028 Producing Viable balanced 3 year IMTP ↑ 034 Increasing dependency on agency staffing (medical & nursing) finance impact↔ 035 Failure to recruit registered nursing sand midwifery taff ↔ 008 Reduction in medical training posts within various specialities & capacity to meet workload ↔ 027 Lack of control & capacity to accommodate Follow Up Outpatients↔ 030 Continuing to provide GP Out of Hours Services as currently configured ↔
3				019 Failure to achieve the management of absence target ↑ 031 Failure to appropriately apply DOLS legislation following West Cheshire court judgement ↓	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
	Likelihood				

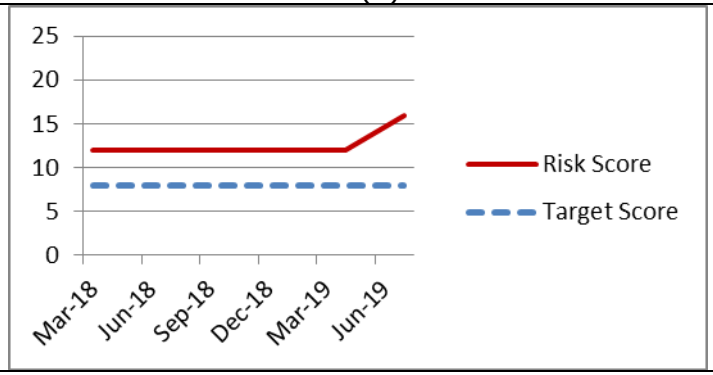
Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Director of Finance **Assuring Committee:** Health Board
Risk: Failure to ensure delivery of a viable balanced/break even 3 year integrated medium term plan.	**Date last reviewed:** July 2019

Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 3 =12		**Rationale for current score:** Approved IMTP last 5 years; Monthly monitoring arrangements in place. Breakeven forecast for 19/20 but increased risk due to poor savings performance and Bridgend transfer risks - and underlying recurring financial deficit now planned before taking account of these risks. Internal audit IMTP - reasonable assurance received. **Rationale for target score:** There are a number of uncertainties to support the creation and then delivery of a viable 3 year plan. These include uncertainty around resource allocation; cost pressures over a 3 year period; delivery of recurring savings; innovative solutions to developing and enabling delivery of a plan.
Level of Control =70%		
Date added to the risk register April 2013		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Starting refresh and update of saving delivery and monitoring arrangements • Health Board has sought(with SBUHB) WG arbitration on the Bridgend transfer funding arrangements • Routine monitoring arrangements in place. • Quarterly reports to Board; Monthly reports to Executive Board; Finance, Performance & Workforce Committee and routinely to Board. • Separate specific reporting on savings to FP&W going forward • Monitoring returns routinely submitted to Welsh Government and reported to FP&W.	Action	Lead	Deadline
	Strengthened planning process in place that continues to evolve and develop based on experience and learning.	Director of Planning	Ongoing
	Reporting and escalation arrangements for in year planning and delivery is being strengthened	Director of Finance	Ongoing
	WG arbitration on Bridgend transfer financing	Director of Finance	Outcome still awaited from WG

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Efficiency, Productivity and Value Board is in place for executive review and challenge, and its role being re-considered as part of refresh referred to above	Seeking earned autonomy with Welsh Government to use funding allocation more flexibly.

Current Risk Rating	**Additional Comments**	**Ref No. 028**
Current Risk Rating : 5 x 4 = 20	Approved IMTP status for 5 consecutive years up to and including 2018-21. Financial risks could be consolidated / merged - Bridgend position to be clarified	

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Chief Operating Officer **Assuring Committee:** Finance, Performance & Workforce
Risk: Failure to achieve Referral to Treatment Times (0)	**Date last reviewed:** July 2019
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 4 x 2 = 8 **Level of Control** =50% **Date added to risk register** April 2013	
	Rationale for current score: The current score reflects year end out turn and the significant progress made during 2018-19 to address the large volume of patients awaiting planned treatment. However, working with the Delivery Unit to identify additional patients for lists including neurophysiology, nephrology and specialised paediatrics. **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 of 8.

Controls (What are we currently doing about the risk?)

- 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 both District General Hospital sites.
- WG has released £7m against a £8.7m resource plan for restoring our trajectory.
- Several workshops held to address HNRC tax and pension issues which have significantly eroded consultant sessional availability for ADH and WLI.

Mitigating actions (What more should we do?)

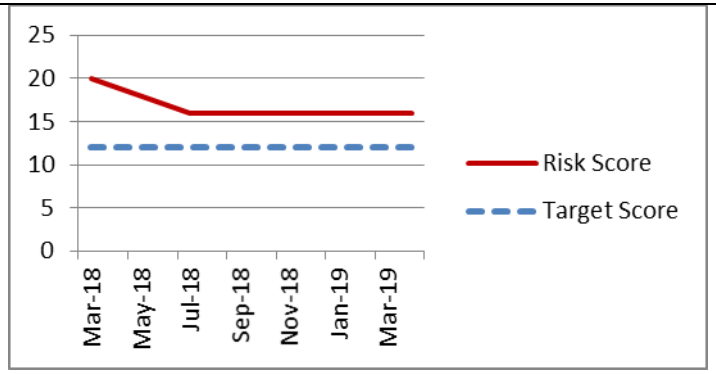
Action	Lead	Deadline
Continue delivery of the controls in place	Ops Directors	Ongoing
Ensure winter plans to address and respond to surge in demand are effective and support continued delivery of RTT	Ops Directors	Quarter 2
Develop, implement and monitor Directorate Demand & Capacity Plans	Ops Directors	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?)**
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	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 4 = 16	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 utilised.	**002**

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Chief Operating Officer **Assuring Committee:** Finance, Performance & Workforce
Risk: Failure to achieve the 4 and 12 hour emergency (A&E) waiting times targets.	**Date last reviewed:** July 2019

Risk Rating
(consequence x likelihood):
Initial: 4 x 5 = 20
Current: 4 x 4 = 16
Target: 4 x 3 = 12



Level of Control
=70%

Date added to risk register
April 2013

Rationale for current score:
The 4 hour 90% target is not currently being achieved. RGH performance is almost back to last year's high performance, PoW has 4&12 hour performance and handover challenges and PCH has 4&12 hour performance challenges.

However, concerns raised at PCH and working with the Delivery Unit for improvement

Rationale for target score:
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).

Controls (What are we currently doing about the risk?)

- Need to strengthen minors streams at both DGH sites to sustain improved delivery of performance against the 4, 8 and 12 hour targets. Also variable practice across both A&E departments. Additional minors physical capacity at RGH has impacted positively, with variable performance.
- Deterioration in PCH performance is being addressed by a DU supportive intervention – full analysis and options appraisal for improvement intiated.
- PoW handover performance receiving full review for EASC/CASC team.
- PoW/RGH/PCH providing full Safety and Dignity analysis to September QSR committee.
- Programme of improvement work with AM&ED, HR and Retinue teams to improve medical booking and staffing to raise shift fill.
- Consultant and middle grade gaps in RGH now filled or due to be filled with long term locum or substantive appointments.

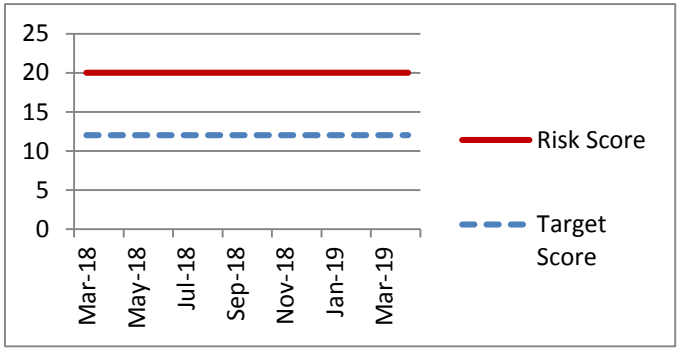
Mitigating actions (What more should we do?)

Action	Lead	Deadline
1) Clear discharge planning processes in place.	COO	Ongoing
2) Improvements in the patient flow and investments to support seasonal planning.	Dep COO	Ongoing
3) Stay Well At Home (SW@H) Service introduced and evaluated (6 month). Transformation funding not to follow.	Dep COO	Ongoing
4) SW@H 2 developments being progressed	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?)**
Monthly reporting of 4, 8 and 12 hour performance within the Integrated Performance Dashboard.	None identified although reliant on the recruitment and retention of appropriate workforce and general improvement in flow across USC.

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 4 = 16	Recruitment and retention of staff essential; closure of beds in the operational environment challenging when the numbers of patients continues to rise.	**003**

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Chief Operating Officer **Assuring Committee:** Finance, Performance & Workforce
Risk: Lack of control and capacity to accommodate all hospital follow up outpatient appointments	**Date last reviewed:** July 2019

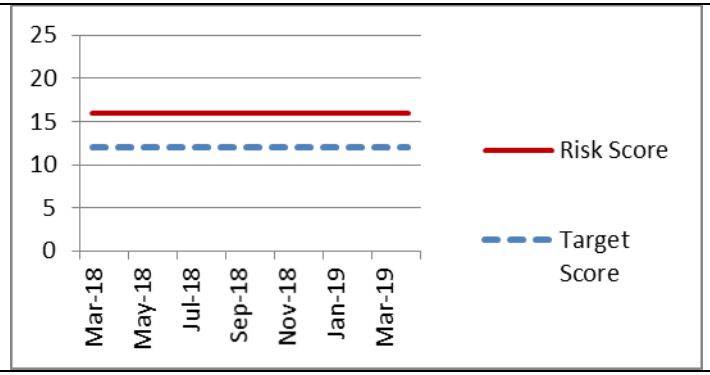
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current:5 x 4 = 20 Target: 4 x 3 = 12		**Rationale for current score:** Follow up appointments not booked increasing; concern raised by Board Members, discussed at Audit Committee, Finance Performance & Workforce Committee and Quality, Safety and Risk Committee. Improvement actions not reducing the large numbers of patients awaiting follow up clinic review. **Rationale for target score:** Agreed actions approved by Executive Board, being implemented and routine monitoring in place, with regular reports to Committees which is being aligned with the Performance Dashboard.
Level of Control =60%		
Date added to the risk register November 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Continued monitoring of progress at Quality Delivery Meetings with WG. Initial progress with reductions in some specialities but need to change the current operating model, with actions to address the validated position to be progressed at pace across directorates. • Exploring patient safety implications for some categories of follow ups not booked for consideration by the Executive 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.	Action	Lead	Deadline
	1) Scoping exercise undertaken – small 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

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Good progress made. Still further work needed to address and reduce volume. Further WAO review did not provide assurance of national progress, but CTM the best position in Wales achieved at 7/19.	Need to better understand any safety implications for follow ups not booked and patients waiting past clinic review dates.

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

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Chief Operating Officer **Assuring Committee:** Finance, Performance & Workforce
Risk: Failure to sustain services as currently configured to meet cancer targets	**Date last reviewed:** July 2019

Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 3 = 12 **Level of Control** =70% **Date added to the risk register** April 2014		**Rationale for current score:** An overall reducing trend in current risk assessed score. Whilst target not consistently being met, general improvement trajectory which needs to be sustained. **Rationale for target score:** Target score reflects the challenge this area of work present the Board and where small numbers of patients impact on the potential to breach target.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• 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 plateau at around 90% with ongoing monitoring of related actions in place at F,P&W Committee. • Small numbers of patients breaching which is impacting on sustained delivery of the 31 and 62 day target. • Under capacity in radiology led to 4 breaches in current cycle and C&V EBUS also had 4 breaches. Locum maternity cover in radiology now signed off to rectify slip in performance.	Action	Lead	Deadline
	Introduction of revised models for rapid diagnostic review / assessment in cancer pathways being introduced.	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
	Some speciality challenges remain in Lung and Urology - Action plans in place, along with monitoring.	COO / Med Dir	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?)**
General improvement (sustained) trajectory. Need to continue improvement actions and close monitoring. Early diagnosis pathway launched and impact being closely monitored. Urology and Radiology remain under constant review.	The need to deliver sustained performance.

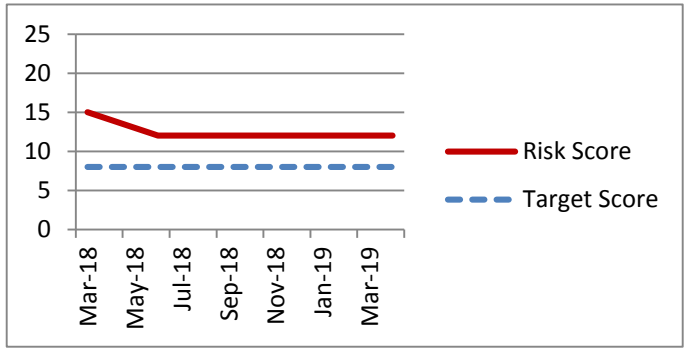
Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 4 = 16	Single Cancer Pathway will start to report in September.	**005**

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:** July 2019

Risk Rating
(consequence x likelihood):
Initial: 5 x 4 = 20
Current: 4 x 3 = 12
Target: 4 x 2 = 8

Level of Control
=80%

Date added to risk register
April 2012



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.

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%

Controls (What are we currently doing about the risk?)

The Workforce Team, through the business partner model are continuing to work proactively with Directorates to manage and reduce sickness absence rates. Regular training is also provided by the Team, including;

- Identification of hot spot areas and deep dives undertaken;
- Improving the processes around access and timeliness of Occ Health support (Joint consultant appointment with neighbouring Health Board);
- Sickness audits in place and routinely discussed at CBMs;
- Improving availability via ESR of real time data;
- Presentation (including deep dives) on position and actions made to Executive Board, WIPF and Finance, Performance & Workforce Committee;
- All Wales Sickness Policy adopted and being applied across the UHB.

Mitigating actions (What more should we do?)

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?)

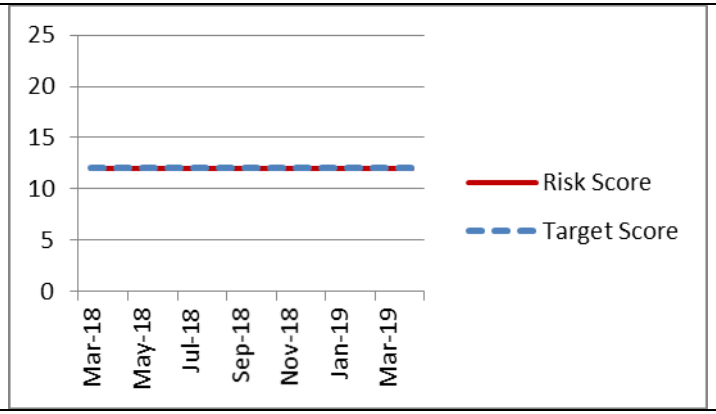
Some small reductions in overall sickness levels achieved. Need to continue to monitor improvement and sustain actions.

Gaps in assurance
(What additional assurances should we seek?)

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. 019
Current Risk Rating : 4 x 3 = 12		

Objective: **Business Continuity**	**Director Lead:** Chief Operating Officer **Assuring Committee:** Finance, Performance & Workforce
Risk: Failure to appropriately manage Discharge Delays from Hospitals	**Date last reviewed:** July 2019

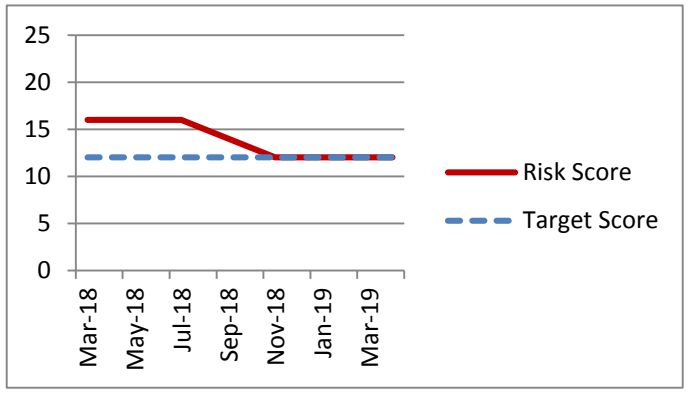
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 4 x 3 =12 **Level of Control** =70% **Date added to the risk register** April 2013		**Rationale for current score:** The current score reflects the overall improvement in reductions in DTOCs with a number of related initiatives established to reduce, in partnership with Local Authority colleagues. **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.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Grouping of complex discharges; Implementation of Anticipated Date of Discharge (ADD), significant improvements following focus on flow work. • Working with Local Authority partners within the consortium to develop a 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.	Action	Lead	Deadline
	Ensure robust monitoring arrangements are maintained and actions in place to mitigate flow barriers and escalate impact on flow	COO / DPC&MH	Ongoing
	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	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 are having a positive effect.	As there is seasonal volatility in DTOCs, important still to monitor our position routinely.

Current Risk Rating	**Additional Comments**	**Ref No. 006**
Current Risk Rating : 4 x 3 = 12	Maintain monitoring and joint working with Partners	

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:** July 2019

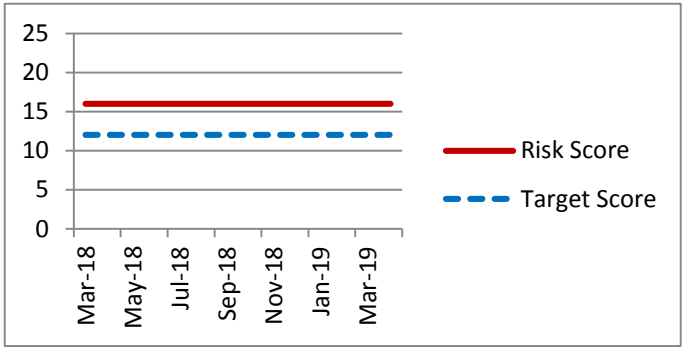
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 4 x 3 =12		**Rationale for current score:** The risk rating has been maintained as although the Supreme Court of Appeal has made the ruling, the impact of this is still being worked through and potential for further challenge not fully mitigated. **Rationale for target score:** The score identifies the potential reputational damage to the NHS as a consequence of a successful legal challenge on the decision making on Funded Nursing Care and the potential financial impact specifically on Cwm Taf.
Level of Control =70%		
Date added to the risk register November 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Contribute to the national outcomes framework. • National Procurement system to be established for continence pads. • Ongoing updates as required being provided to Board. • Note Legal advice procured across all Welsh HBs, to support NHS Wales in JR Process. It should be noted that the JR had initially been considered in February 2015 and the judge had ruled against the NHS. • A subsequent appeal was won by Health which resulted in Supreme Court Appeal which ruled that all parties need to renegotiate arrangements.	Action	Lead	Deadline
	Board approved rates last 2 years	-	Complete
	Further update to be considered by Boards following outcome of legal process.	DofN	Complete
	Outcome of Supreme Court Appeal ruling considered and acted upon.	DofN	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?)**
Continue to work in partnership with the sector, local authorities and WG to apply the outcome of the legal rulings.	

Current Risk Rating	**Additional Comments**	**Ref No. 015**
Current Risk Rating : 4 x 3 = 12	Risk requires further review for removal from the Register.	

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Director of Primary, Community and Mental Health (DPCMH) **Assuring Committee:** Primary and Community Care Committee
Risk: Primary Care Workforce – recruitment and sustainability	**Date last reviewed:** July 2019

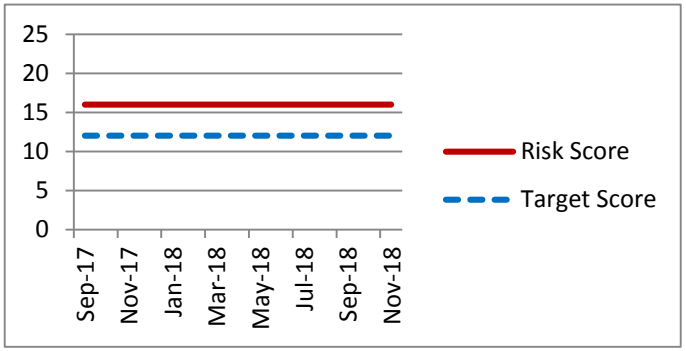
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 3 =12		**Rationale for current score:** An increasing number of practices across the UHB are advertising for GP sessions currently due to (and other staff groups) vacancies. **Rationale for target score:** Recruitment to Primary Care for GPs and some other professional groups across Cwm Taf UHB remains challenging (reflecting a National problem).
Level of Control =60%		
Date added to the risk register August 2016		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• 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 and Community Care 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 **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Recruitment and retention data.	

Current Risk Rating	**Additional Comments**	**Ref No. 036**
Current Risk Rating : 4 x 4 = 16	We are working closely with the Welsh Government on the recruitment of staff – Train, Work, Live campaign	

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Director of Primary, Community and Mental Health (DPCMH) **Assuring Committee:** Primary and Community Care Committee
Risk: Failure to continue to provide GP out of hours services as currently configured	**Date last reviewed:** July 2019

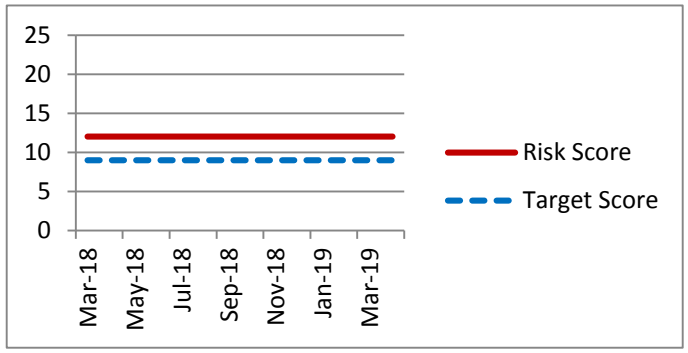
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 3 =12		**Rationale for current score:** The Out of Hours team is encouraging GPs to fill shifts. However, many sessions are filled via Locum Agency Doctors, which is expensive and flexible sessions are offered. However, the fill rate remains variable and is challenging to maintain services. The effect of the HMRC tax implications is now having an impact. **Rationale for target score:** There are ongoing and developing Primary Care recruitment problems (reflecting a National problem). It is becoming increasingly difficult to secure GP sessions for the GP Out of Hours Service and many sessions especially on the weekend remain unfilled putting additional demand on both existing A&E departments.
Level of Control =60%		
Date added to the risk register November 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	Lead	Deadline
• 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 and community Care 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	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 (2017/18)
	Regular dialogue with OOHs service and Primary Care Clusters to ensure OOHs cover is strengthened and supported.	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?)**
Shift fill rates; patient experience surveys	The current service model is not sustainable and alternative solutions are required.

Current Risk Rating	**Additional Comments**	**Ref No. 030**
Current Risk Rating : 5 x 4 = 20	Lack of an All Wales Approach results in HBs competing with each other on GP sessional pay rates.	

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Director of Planning and Performance **Assuring Committee:** Health Board
Risk: Failure to implement South Wales Plan outcomes.	**Date last reviewed:** July 2019

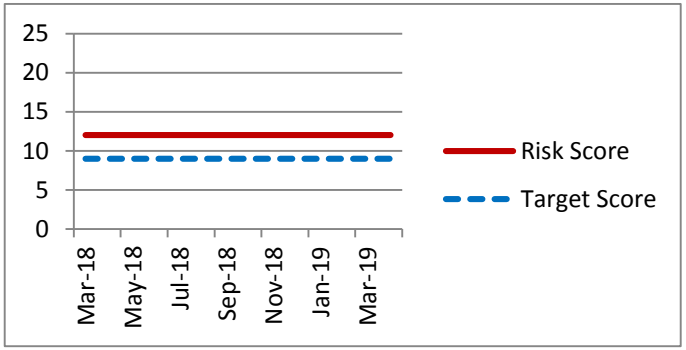
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 3 =12 Target: 3 x 3 =9		**Rationale for current score:** The issues around reciprocity and working with other health boards continues **Rationale for target score:** The Implications of implementing the South Wales Plan outcomes was a considerable challenge and posed risks to the organisation in terms of reputation and the changes required for service provision including location.
Level of Control =60%		
Date added to the risk register February 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Collaborative working arrangements in place, across Regions • Health Board involved and being kept updated. • Issues related to shared risks and interdependencies on others to deliver. • Diagnostic hub completed and opened. • Regional Planning & Delivery Forum established to oversee related work. • Obstetric service moved from RGH to PCH in March 2019. • Move of inpatient paediatric service from RGH to PCH– awaiting confirmation of date from the PON Board.	Action	Lead	Deadline
	Capital Scheme to be completed and implementation plan enacted	COO	Qtr 3 & 4 2018/19
	Awaiting confirmation date for the move of the inpatients paediatric date from RGH to PCH	COO	Qtr 2/3

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Planned capital work to support the change of service provision completed	

Current Risk Rating	**Additional Comments**	**Ref No. 013**
Current Risk Rating : 4 x 3 = 12	The Cabinet Secretary is seeking more pace in terms of working across boundaries with reciprocity at the centre	

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Director of Nursing, Midwifery and Patient Services **Assuring Committee:** Executive Board
Risk: Failure to meet the timescale relating to issuing concerns (complaints) responses to patients and or carers	**Date last reviewed:** July 2019

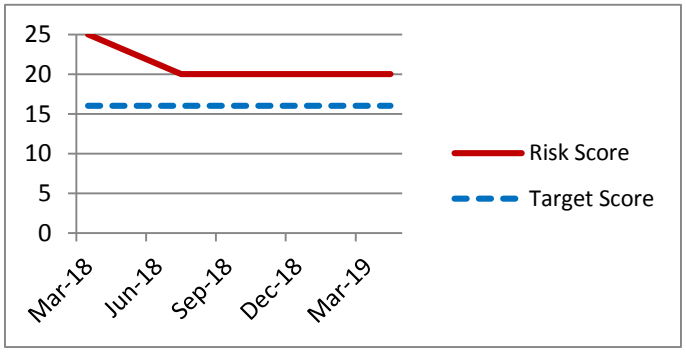
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 3 x 3 =9		**Rationale for current score:** Whilst position is slowly improving, there remains an ongoing capacity issue to meet the demand and expectations being placed. **Rationale for target score:** Putting Things Right provides the Welsh Government's guidance to the time that the NHS should respond to any concerns raised and following the publication of the Evans Report internal actions have been identified within Cwm Taf to meet the requirements.
Level of Control =60%		
Date added to the risk register April 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Actions have been taken to ensure a reduction in the backlog of outstanding concerns in delivering the action plan (internal response to the Evans report). • Actions are being taken, coordinated by the Director of Nursing, supported by other Executive Director colleagues, to ensure concerns responses for the less complex complaints are not unnecessarily delayed. • Whilst responses to complex complaints are known at the outset that these will be delayed, this is also communicated to those raising concerns; • Variable performance improvement to above 60% compliance, although sustaining this remains challenging.	Action	Lead	Deadline
	Progress continues to be monitored via the Concerns Scrutiny Panel and onwards to the Quality Safety and Risk Committee.	Nurse Director	Ongoing
	Improvement plans, developed with Directorates, following Internal Audit Limited Assurance review is making progress in some areas and whilst performance overall has improved slightly, more needs to be done for sustained improvement delivery.	Director of Nursing Lead Officers	Ongoing 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?)**
Improved performance in answering concerns within the timescales	Improved progression of responding to concerns within the timescale

Current Risk Rating	**Additional Comments**	**Ref No. 023**
Current Risk Rating : 4 x 3 = 12	Will require further review in light of establishment of CTMUHB.	

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Medical Director **Assuring Committee:** Executive Board / Executive Board
Risk: Failure to recruit sufficient medical and dental staff	**Date last reviewed:** July 2019

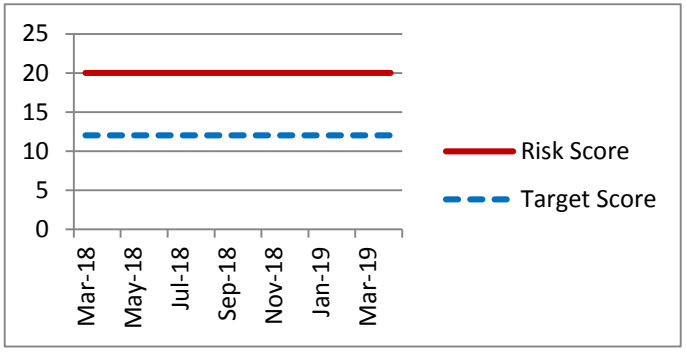
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 4 =16		**Rationale for current score:** The agency costs for medical staff has risen annually and the lead in time to develop our own staff or provide different support by alternate practitioners etc takes time to implement. **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.
Level of Control =50%		
Date added to the risk register August 2013		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Linked with IMTP, modernise the workforce to support clinical service redesign and align the development of the clinical services strategy. • 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.	Action	Lead	Deadline
	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 and Nurse Directors **Assuring Committee:** Quality, Safety & Risk Committee
Risk: 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.	**Date last reviewed:** July 2019

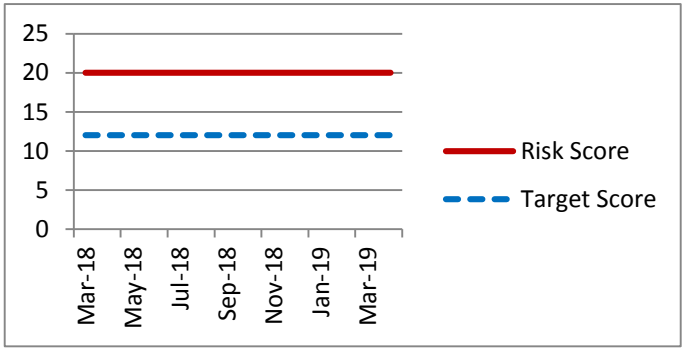
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 5 = 20 Target: 4 x 3 =12		**Rationale for current score:** The agency costs for medical and nursing staff has risen annually and the lead in time to develop our own staff or provide different support by alternate practitioners etc takes time to implement. Agency and bank costs are at their highest now. **Rationale for target score:** Increasing 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.
Level of Control =60%		
Date added to the risk register June 2015		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Ongoing advertisements of posts in medical and nursing. • 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.	Action	Lead	Deadline
	Continue with the campaigns to recruit medical and nursing staff – including using social media to have the widest impact across the UK and internationally.	Medical and Nurse Directors	Ongoing
	Continue to work with other HBs nationally to avoid increases in agency costs and influence the reduction of off contract spend	Medical and Nurse Directors	Ongoing
	Continue with strong controls in place to monitor all demand and approval for agency requests.	Medical and Nurse 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 in bank, locum and agency costs	

Current Risk Rating	**Additional Comments**	**Ref No. 034**
Current Risk Rating : 4 x 5 = 20	Launched Nurse and Medical recruitment campaigns in Cwm Taf with Welsh Government	

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Director of Nursing, Midwifery and Patient Services **Assuring Committee:** Executive Board, Quality Safety and Risk Committee
Risk: Failure to recruit sufficient registered nursing and midwifery staff.	**Date last reviewed:** July 2019

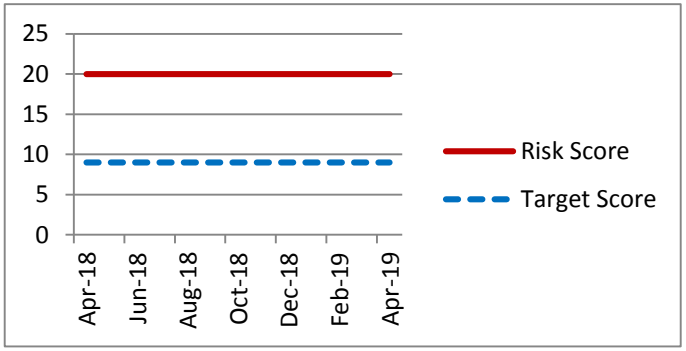
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 =12		**Rationale for current score:** The ability to recruit registered nursing and midwifery staff remains a considerable challenge (reflecting the national problem). Unable to achieve the Nurse Staffing Act (Wales) – identified areas non-compliant **Rationale for target score:** There are ongoing recruitment problems (reflecting a National problem) for nursing and midwifery which will impact on the patient experience and patient safety.
Level of Control =60%		
Date added to risk register January 2016		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Continuous advertisements for nursing and midwifery posts in Cwm Taf • Proactive recruitment programme in place in areas where dependency on agency locum cover is increasing. • Maximise opportunities to recruit graduate nurse students for each of the twice annual cohorts. • Review arrangements for nursing and midwifery enhanced hours payments, including the targeting of A4C overtime payments in areas where Agency staff usage is excessive or increasing. In addition, validation by Heads of Nursing of need for use of agency nurses, including not using off contract. • Adjust bed complement/configuration and skill mix to ensure Nurse staffing levels are recorded and reviewed. • Develop the health care support workers role to support registered nurses and ensure safe and effective care for patients in Cwm taf	Action	Lead	Deadline
	Continue with the nursing recruitment campaign making particular use of the social media aspect to influence potential staff across the UK and beyond	Director of Nursing	Ongoing
	Work nationally with other HBs and Trusts to agree strengthened Agency contract.	Director of Nursing	Ongoing
	Work nationally with other HBs and Trusts to address workforce plans and reduce dependency on agency staff.	Director of Nursing	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?)**
Increasing numbers of registered nursing and midwifery staff; retention levels improve	Actively monitor patient experience

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 5 = 20	Executive Board Report developed outlining resources required to fulfil compliance and impact of Nurse Staffing Act	**035**

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Medical Director **Assuring Committee:** Executive Board, Quality Safety and Risk Committee
Risk: Reduction in training posts within various specialties & capacity to meet workload demands.	**Date last reviewed:** July 2019

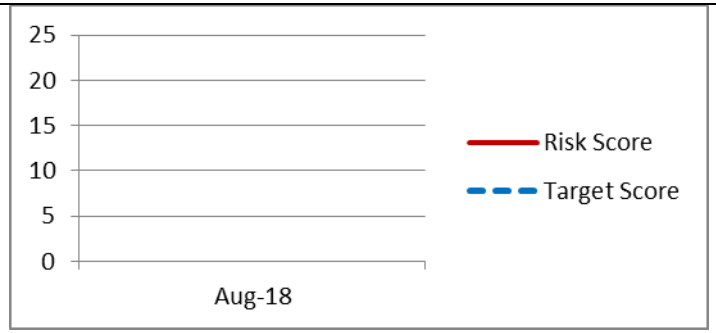
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 3 x 3 =9		**Rationale for current score:** Impact of insufficient trainees on the organisations ability to provide safe services remains challenging and problematic. **Rationale for target score:** A number of specialties 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.
Level of Control =60%		
Date added to the risk register August 2013		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• 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.	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

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**	**Ref No. 008**
Current Risk Rating : 5 x 4 = 20	Will require further review in light of establishment of the CTMUHB.	

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Chief Operating Officer **Assuring Committee:** Quality Safety and Risk Committee
Risk: Sustainability of a safe & effective Ophthalmology Service.	**Date last reviewed:** July 2019

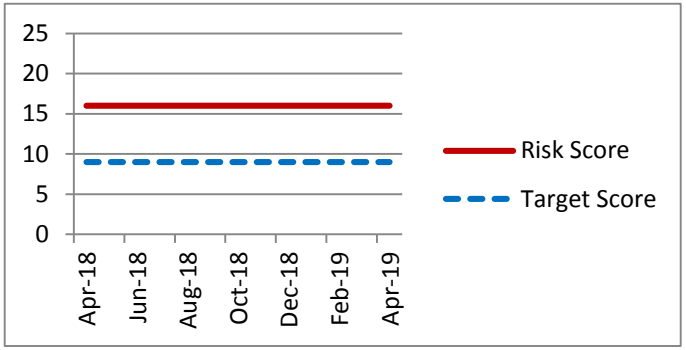
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 3 =12		**Rationale for current score:** Monitoring of the service continued, referral to treatment times remain challenging and the numbers of patients requiring a follow up appointment but have not yet been booked remains high **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.
Level of Control =60%		
Date added to the risk register April 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Action plan developed and ongoing monitoring • Staffing structure stabilised and absence reduced. • Ongoing monitoring is in place with regards RTT impact of Ophthalmology, this risk relates to quality and safety of patients affected. • 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). • Additional services provided in Community settings through ODTC (imminent start date).	Action	Lead	Deadline
	Follow up appointments not booked being closely monitored	COO	Ongoing
	Regular updates re follow up appointments not booked being monitored by Executive Board / QS&R (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	Still excess amount of FUNB patients and efficiency issues remain

Current Risk Rating	**Additional Comments**	**Ref No. 032**
Current Risk Rating : 4 x 4 = 16	Ongoing review work is taking place in targeted specialities, 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:** Executive Board / Finance, Performance and Workforce Committee
Risk: Failure to sustain Child and Adolescent Mental Health Services	**Date last reviewed:** July 2019

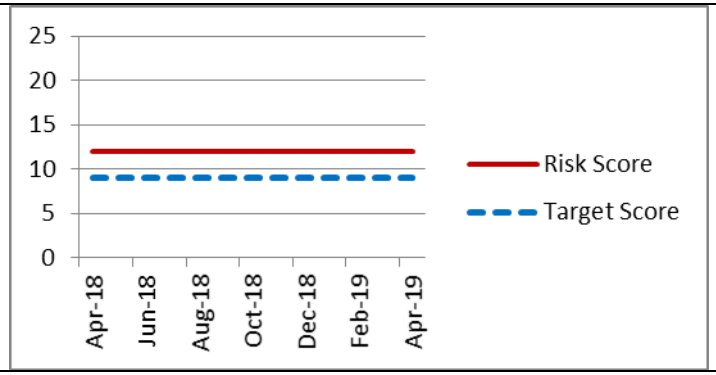
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 3 x 3 =9		**Rationale for current score:** Difficulties remain in recruiting key staff and new model of care being implemented; waiting times for specialist CAMHS and the new neurodevelopmental service remains challenging. **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
Level of Control =70%		
Date added to the risk register January 2015		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Reported local and Network pressures across the CAHMS Network with variable problems dependant on the area of the network. • Updates provided to Executive 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 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) started on 1st April 2017 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.**
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	**033**

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Director lead for ICT / COO **Assuring Committee:** Health Board
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:** July 2019

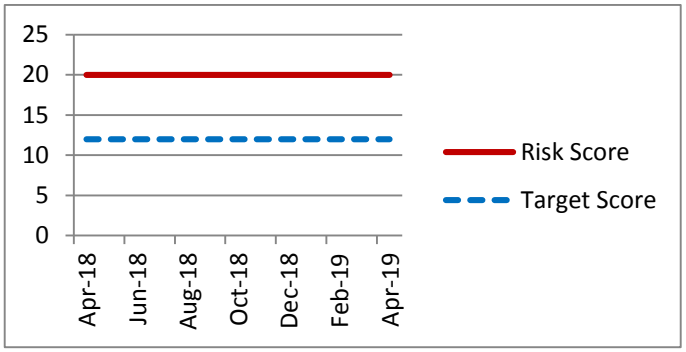
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 3 = 12 Target: 3 x 3 =9		**Rationale for current score:** Although work has continued behind the scenes, having an executive lead, supported by an Assistant Director is potentiating the actions identified and move forward on the action plans and strategic outline programme. **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.
Level of Control =50%		
Date added to the risk register December 2016		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• ICT Strategy developed with support from ATOS Consulting – being updated by Assistant Director and Digital Strategy Steering Group • Governance arrangements to oversee delivery of the Strategy agreed and will require review. • Align key elements of the Strategy and related SOP to the Board's IMTP. • Realignment of Executive lead and management structure and portfolio for ICT • Digital Strategy Steering Group well established and work programme linking national and local improvements well underway. • New Independent Member for ICT appointed and work on going to hold first ICT Committee meeting as soon as possible. • Work on Transformation programme initiating following successful funding bid.	Action	Lead	Deadline
	A major constraint/required action to delivery the strategy is additional capital and revenue investment supported by a business case which is clear on the non-financial and financial returns	COO	ongong
	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 Sept 2019	COO / 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?)**
• Monitor the timescales and milestones identified in the action plan. Strategy approved by the Health Board in May 2017	Group now established to take forward the actions agreed. Need to 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. New IM now in post	**037**

Objective: **Statutory Compliance**	**Director Lead:** Board Secretary/Director of Corporate Services and Governance **Assuring Committee:** Quality, Safety & Risk Committee / Capital Programme Board
Risk: Failure to meet Fire Safety Standards on ground and first floor PCH.	**Date last reviewed:** July 2019

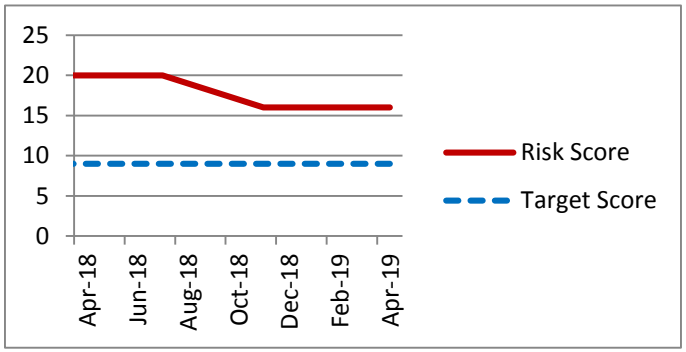
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 3 =12		**Rationale for current score:** Fire enforcement notice will remain until works are completed. Note there remains a 6 year programme of capital works in place. **Rationale for target score:** Fire enforcement notice related to the ground and first floor at Prince Charles hospital
Level of Control =60%		
Date added to the risk register October 2009		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Progress and extension of existing Fire Enforcement Notice from June 2014. • Discretionary capital scheme completed to address minimum requirements. OBC approved and FBC to deal with asbestos & fire issues to WG Dec 2014. Implementation of Action Plan. • Meetings held annually between CEO and SWF&R Chief Officer, agreed annual review of progress against requirements of the Enforcement Action. • Joint meeting has also taken place with Cwm Taf, WG & SWF&R to discuss related risks. • Both Cwm Taf and SWF&R Service have attended the Welsh Government June 2015 Capital Investment Board to discuss the FBC and related business case approach.	Action	Lead	Deadline
	Regular meetings being held with Fire Authority.	Board Secretary	Ongoing
	Ongoing discussions and engagement with WG Capital and the UHB to agree the plans to phase the related work.	Dir of Planning	Ongoing
	Revised options submitted to WG Capital Board late in 2015 / 16 and agreed, amended programme for delivery being progressed. Programme director appointed to ensure work progresses.	Dir of Planning	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?)**
Enforcement notice will only be lifted when work completed	Deliver the agreed business cases to complete the scheme.

Current Risk Rating	**Additional Comments**	**Ref No. 017**
Current Risk Rating : 5 x 4 = 20	(Current notice extended on an annual basis subject to confirmation and evidence of ongoing improvement towards full compliance - recent positive review meeting)	

Objective: **Statutory compliance**	**Director Lead:** Director of Workforce and Organisational Development **Assuring Committee:** Quality Safety and Risk Committee
Risk: Staff Competency/ Compliance with mandatory training requirements.	**Date last reviewed:** July 2019

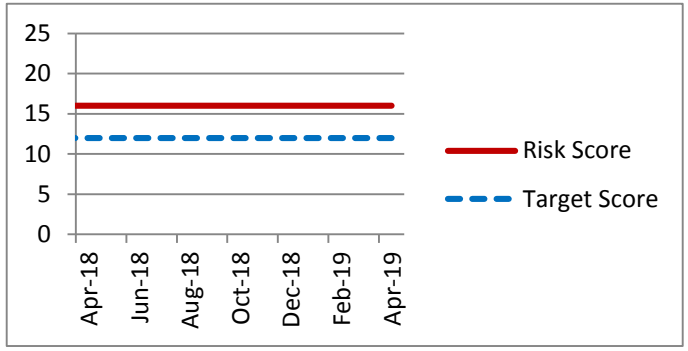
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 3 x 3 =9 **Level of Control** =70% **Date added to the risk register** June 2014		**Rationale for current score:** Although additional opportunities for staff to undertake moving and handling training uptake continues to fluctuate; increasing numbers of compliance with mandatory training but needs to be constantly attended, remains challenging. **Rationale for target score:** Backlog of training for bank health care support worker staff identified in July 2014; fixed term resource to resolve training backlog agreed but delayed due to recruitment.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Risk assess requirements and review delivery options; move to competency based assessment rather than mandatory updates where appropriate • Implementation of UK Core Skills Training Framework (CSTF), general improvement in compliance levels overall (against 10 Core Skills) • CSTF Task & Finish Group established Chaired by DW&OD and includes Director of Nursing and Board Secretary; • Significant investment in Moving and Handling equipment from year end discretionary capital progressed. • Ongoing monitoring of actions through Executive Board and Committee • HSE re-visits and audits resulted in enforcement notice on Moving & Handling being lifted but significant work still needed to maintain progress made.	Action	Lead	Deadline
	Compliance generally with Core Skills Training Framework improving; discussed routinely at Clinical/Corporate meetings	Workforce Director	Ongoing
	Specific action plans in place to address moving and handling training, particularly for bank staff – although ceased and fixed term support ended – prioritised to address in IMTP.	Board secretary	Ongoing
	Making best use of the Electronic Staff Record – ensuring staff maintain mandatory requirements	Workforce 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?)**
Improved training compliance percentages – note overall improvement trajectory	Continue to maintain profile of performance and general improvement of the levels of compliance. Must address solution for M&H.

Current Risk Rating	**Additional Comments**	**Ref No. 021**
Current Risk Rating : 4 x 4 = 16	Additional impact of Bridgend Boundary change being identified	

Objective: **Statutory compliance**	**Director Lead:** Board Secretary/Director of Corporate Services and Governance **Assuring Committee:** Executive Board
Risk: Failure to meet Fire Safety Standards across the UHB.	**Date last reviewed:** July 2019

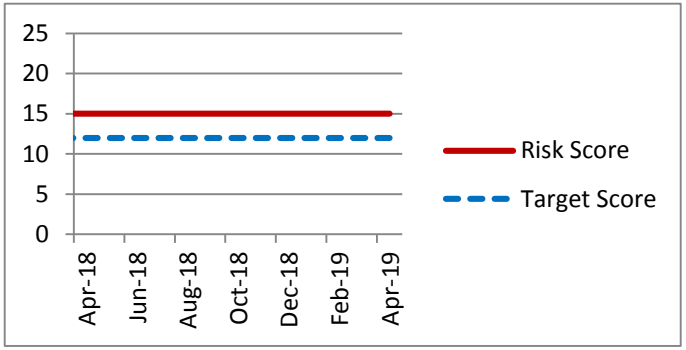
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 3 =12		**Rationale for current score:** Ongoing and close working with South Wales Fire and Rescue Service (SWF&RS) and the UHB to maintain high awareness. Continuing to monitor the requirement for staff to undertake mandatory training which remains challenging Fire enforcement notice and issues within systems and controls identified at Princess of Wales **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
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?)**		
• 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.	Board Secretary	Ongoing
	Regular inspections and dialogue with South Wales Fire & Rescue Service.	Board Secretary	Ongoing
	Robust risk assessment processes in place and good compliance with staff training uptake to be sustained.	Head of Fire Safety	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?)**
Reducing numbers of enforcement notices received.	Fire enforcement actions being progressed and routinely monitored.

Current Risk Rating	**Additional Comments**	**Ref No. 025**
Current Risk Rating : 4 x 4 = 16	Continuous progress needs to be demonstrated on improvement actions and related capital scheme (s)	

Objective: **Statutory compliance**	**Director Lead:** Director of Planning and Performance **Assuring Committee:** Executive Board
Risk: Failure to achieve statutory and mandatory planned preventative maintenance (PPM) programme.	**Date last reviewed:** July 2019

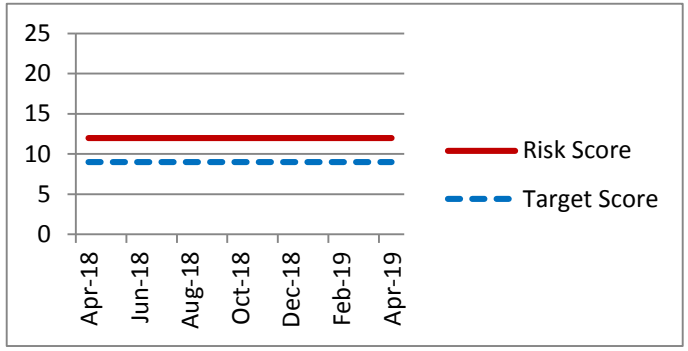
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 15 Current: 5 x 3 = 15 Target: 5 x 2 =10		**Rationale for current score:** Additional staff have been appointed to the Estates team; however, although improvements have been made additional work is required to ensure full compliance. **Rationale 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.
Level of Control =70%		
Date added to the risk register April 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• All vacancies now filled; workforce plan developed. • Estates Officers responsible for ensuring external contractors complete PPM on time. • TABS (Computer-Aided Facilities Management) is being used to plan, monitor and record work undertaken by external contractors. • Development and implementation of staffing strategy for estates. • PPM prioritised work of the estates department. • Annual Estates Report considered by the Executive Board and Health Board – next report due shortly for 2018/2019. • Whilst significant improvements noted, recognised that further work needed to ensure full compliance with Statutory PPM.	Action	Lead	Deadline
	Capital and estates governance group oversees the overall compliance	Assistant Director of 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 & Executive Board	Director of Plan & Perf.	July 2019
	Review of Estates performance at least annually at Finance, Performance and Workforce Sub-Committee.	Director of Plan & Perf.	Annually

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 improving	

Current Risk Rating	**Additional Comments**	**Ref No. 018**
Current Risk Rating : 5 x 3 = 15	Will require further review in light of new CTMUHB estate responsibilities.	

Objective: **Statutory Compliance**	**Director Lead:** Director of Nursing, Midwifery and Patient Services **Assuring Committee:** Executive Board
Risk: Failure to appropriately apply Deprivation of Liberties Safeguards (DoLS) legislation following the West Cheshire court judgement.	**Date last reviewed:** July 2019

Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 = 12 Target: 3 x 3 =9		**Rationale for current score:** Whilst Best Interests Assessors (BIA) are in place, these are insufficient to address the increased demand, resulting in a back log accumulating. Internal Audit Report gave a limited assurance rating on the management of Deprivation of Liberties Safeguards in March 2017. **Rationale for target score:** UHB requirements increased (along with other Public Bodies) as a consequence of the recent court judgement.
Level of Control =60%		
Date added to the risk register October 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• January 2015 Executive Board approved to develop a DoLS team. The new UHB DoLs team set up, to include co-ordinator post and dedicated Best Interest Assessor time. • Internal Audit report on DoLS to Audit Committee (April 2016) provided limited assurance in relation to the backlog in assessment required. Action Plan in place to address and recent additional investment to help address some of the actions and mitigate the risks provided. • DoLS processes established and in place.	Action	Lead	Deadline
	Internal Audit Report recommendations progressed.	Nurse Director	Complete
	Prioritisation process in place for DoLs applications and training for all disciplines in the Mental Capacity Act ongoing.	Nurse Director	Complete
	General staff awareness being raised with regards the requirements of the legislation.	Nurse 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?)**
Time taken to respond to requests reducing. Full delivery of Action Plan required.	Are staff generally understanding the requirements of the legislation

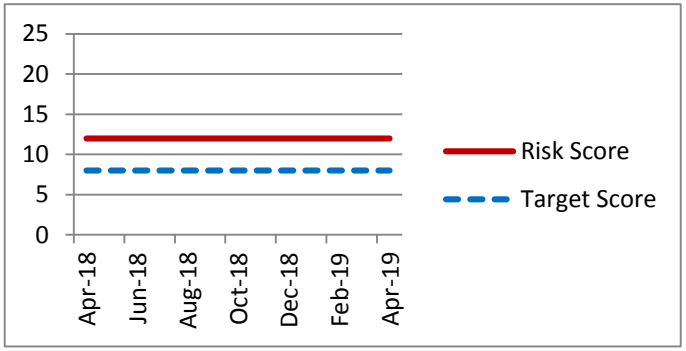
Current Risk Rating	**Additional Comments**	**Ref No. 031**
Current Risk Rating : 4 x 3 = 12	Internal Audit review of two previous Limited Assurance reports provided Substantial assurance (Sept 17). Review for considersation of removal of the Risk Register.	

Objective: **Statutory Compliance**	**Director Lead:** Director of Planning and Performance **Assuring Committee:** Executive Board
Risk: Failure to comply fully with the arrangements for managing Asbestos	**Date last reviewed:** July 2019

Risk Rating
(consequence x likelihood):
Initial: 4 x 4 =16
Current: 4 x 3 = 12
Target: 4 x 2 = 8

Level of Control
=80%

Date added to the risk register
April 2012



Rationale for current score:
The Asbestos Register was being transferred to an in-house system and was available in hard copy only; reasonable assurance on IA report but some actions to be completed.

Rationale for target score:
There was an All Wales focus on asbestos management with audit to be undertaken. Potential risks could include Enforcement Action; Serious Ill Health/mortality; Personal Injury/Fatality Claim.

Controls (What are we currently doing about the risk?)

- 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 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.

Mitigating actions (What more should we do?)

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

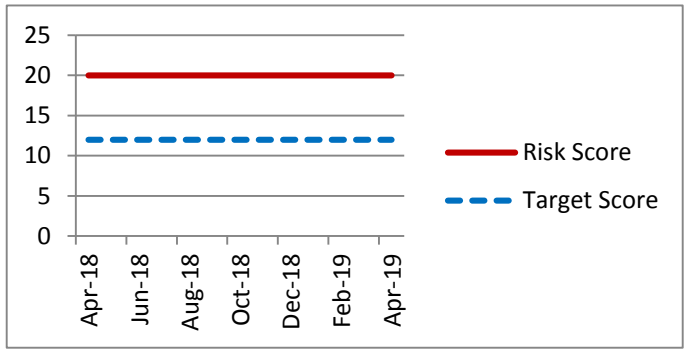
Assurances
(How do we know if the things we are doing are having an impact?)

Periodical review of Asbestos Plan along with periodical internal audit review of its application.

Gaps in assurance
(What additional assurances should we seek?)

Current Risk Rating	Additional Comments	Ref No.
Current Risk Rating : 4 x 3 = 12	Will require further review in light of CTMUHB asbestos management plan and review of properties transferred.	**016**

Objective: **Financial Viability**	**Director Lead:** Director of Finance **Assuring Committee:** Health Board
Risk: Failure to achieve financial balance on a recurring basis.	**Date last reviewed:** July 2019

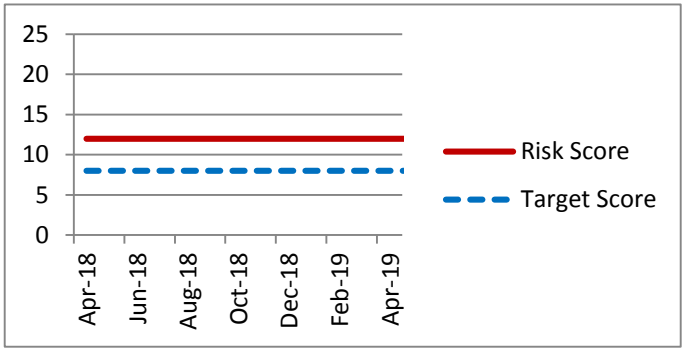
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 4 = 20 Target: 4 x 3 =12 **Level of Control** =60% **Date added to risk register** April 2013		**Rationale for current score:** Recurring underlying deficit – Health Board breaks even through non recurrent slippage (meeting 3 year financial duty) **Rationale for target score:** Target risk is based on sustained delivery of underlying recurring savings target

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Monthly monitoring and review by Welsh Government; • Clinical Business Meetings established • Three Year Integrated Medium Term Plan approved by the Board and approved by Welsh Government for third successive year. Three year planning process introduced by Welsh Government supports more medium term planning and service re-design approach; • Risks are managed by Directorate Action Plans and monitored through the Executive Programme Board and onto the Executive Board; • Integrated service planning which includes and requires significant service re-design • Additional non recurring resource allocated, is not addressing the underlying recurring deficit.	Action	Lead	Deadline
	Efficiency Productivity and Value Board established and first meeting held; Terms of Reference now finalised.	Chief Exec	Ongoing
	Two weekly information required by each directorate and preparation of quarterly position against their specific actions	DOF	Ongoing
	Significant internal risks being managed and external risks have been raised with WG Routine monitoring arrangements in place to track the financial delivery and impact of the IMTP.	DOF	Each month's finance report

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Strong scrutiny process within FP&W Committee	Focus required on recurring savings plans and their delivery.

Current Risk Rating	**Additional Comments**	**Ref No. 011**
Current Risk Rating : 5 x 4 = 20	Over reliance on in year non-recurring slippage to deliver savings plans. Needs further review across CTMUHB. Potential opportunity to merge risks or identify Bridgend financial position separately	

Objective: **Financial Viability**	**Director Lead:** Director of Planning and Performance **Assuring Committee:** Capital Programme Board
Risk: Failure to Deliver Major & Discretionary Capital programmes	**Date last reviewed:** July 2019

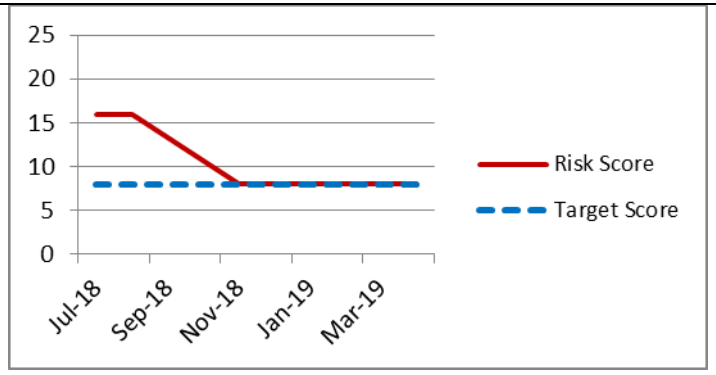
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 3 = 12 Target: 4 x 2 =8		**Rationale for current score:** Risks remain due to the size, value and complexity of the capital programme although discretionary capital managed (including slippage) **Rationale for target score:** Major 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
Level of Control =50%		
Date added to the risk register April 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Prepare, review and submit regular monitoring returns to Welsh Government. • Executive Capital Management Group to monitor the compliance with the actions agreed. • Capital Board in place to monitor development and delivery of the Board's Capital schemes. • Quarterly update reports are presented to Executive 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	

Current Risk Rating	**Additional Comments**	**Ref No. 012**
Current Risk Rating : 4 x 3 = 12	PCH GFF Project - internal audit report received a limited assurance, although good progress with improvement actions is being reported through to Audit Committee.	

Objective: **Statutory Compliance**	**Director Lead:** Chief Operating Officer **Assuring Committee:** Quality, Safety & Risk Committee / Executive Board
Risk: Failure to ensure sufficient storage capacity (or alternative solutions) are in place to safely store and secure patient records.	**Date last reviewed:** July 2019

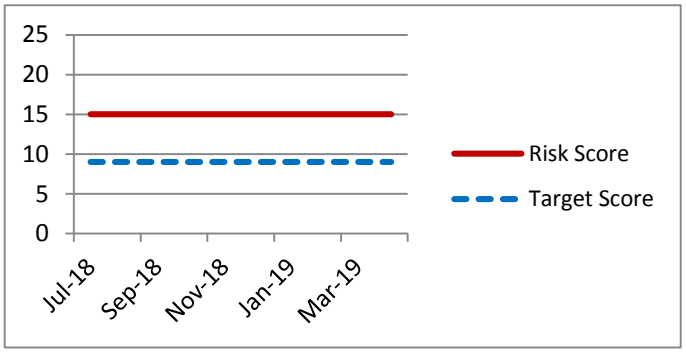
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** The effectiveness of the Williamstown Records Storages Hub is reliant on digitisation of health records. In the absence of an agreed business case and investment, it's likely that records storage will once again start to be undertaken across multiple sites, increasing risks to staff and patient safety. **Rationale for target score:** Delivering the Digitisation of health records, alongside the records hub will ensure a sustainable, safe & secure storage solution.
Level of Control =60%		
Date added to the risk register July 2018		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Williamstown Hub is yet to reach full capacity • Digitisation of Records Business Case signed off (December 2018) and Civica will initiate contract in November 2019 covering old CT and PoW footprints. • WG Invest to Save bid signed off June 2019. • 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.	Action	Lead	Deadline
	BJC for Digitisation to be considered and approved via Executive 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.**
Current Risk Rating : 4 x 4 = 16	Impact of Infected Blood Inquiry to be further considered; Executive Board considered and supported phase 1 of work	**039**

Objective: **Statutory Compliance**	**Director Lead:** Director of Workforce & OD **Assuring Committee:** Quality, Safety & Risk Committee / Equality & Welsh Language Forum
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:** July 2019

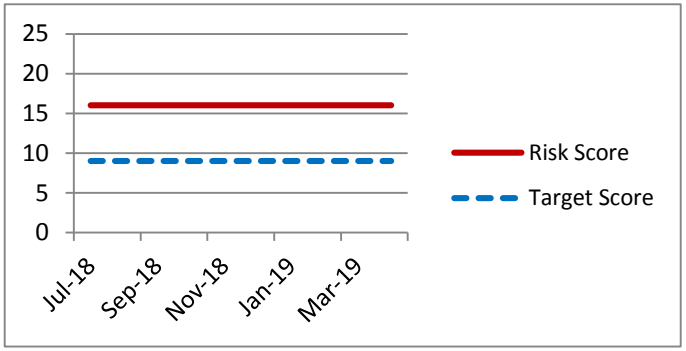
Risk Rating (consequence x likelihood): Initial: 3 x 5 = 15 Current: 3 x 5 = 15 Target: 3 x 3 = 9		**Rationale for current score:** As a consequence of an internal assessment of the Standards and their impact on the UHB, it is recognised that the Health Board will not be fully compliant with all applicable Standards. **Rationale for target score:** 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.
Level of Control =60%		
Date added to the risk register July 2018		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• The Welsh Language Unit has undertaken a self-assessment of the requirements of the Standards and how they apply to Cwm Taf • 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 • Support group set up to assist managers	Action	Lead	Deadline
	Continue to review and act on the UHBs Self-Assessment findings and related improvement actions.	DW&OD	Ongoing
	Ensure the Board is fully sighted on the UHB's position	DW&OD	Quarter 3
	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

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.	

Current Risk Rating	**Additional Comments**	**Ref No. 040**
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 and this will inform its response to the Commissioner in seeking further time to implement those Standards considered more challenging.	

Objective: **Statutory Compliance**	**Director Lead:** Chief Operating Officer **Assuring Committee:** Quality, Safety & Risk Committee
Risk: Failure to fully meet all the licensing requirements of the Human Tissue Authority in relation to Mortuary & Services for the Deceased.	**Date last reviewed:** July 2019

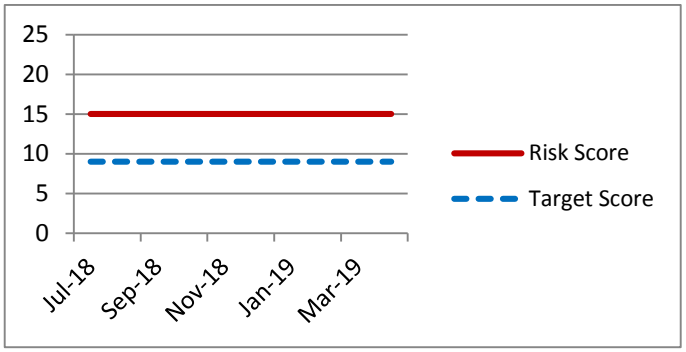
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 3 = 9		**Rationale for current score:** Reflect the Directorate led baseline assessment and the findings of the HTA inspection in April 2018. **Rationale for target score:** Likely rating once the issues identified are addressed and the corrective action & improvement plan is fully implemented.
Level of Control =70%		
Date added to the risk register July 2018		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• The Pathology Directorate has undertaken a baseline review which identified a number of areas for action in advance of the HTA inspection • The Pathology Directorate has 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 related issues are and what actions need to be taken to achieve full compliance. • HTA signed off on all 32 CAPA plans on 10/7/2019 and 0 HTARIs achieved by 13/7/19. • 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.	Action	Lead	Deadline
	Ensure the Directorate Corrective Action Plans are fully implemented	COO	Completed
	Establish more robust monitoring arrangements, to ensure the Board's first line of assurance (defence) detects and informs corrective action plans.	COO	Ongoing through HTA Project Board and Care of the Deceased Project Board

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 the Human Tissue Act and related Standards.	

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 4 = 16	All 32 CAPA plans completed and submitted to the HTA. Will also need to consider Bridgend site.	**041**

Objective: **Statutory Compliance**	**Director Lead:** Chief Executive Officer **Assuring Committee:** The Health Board ~~/ Joint Transition Board~~
Risk: 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.	**Date last reviewed:** July 2019

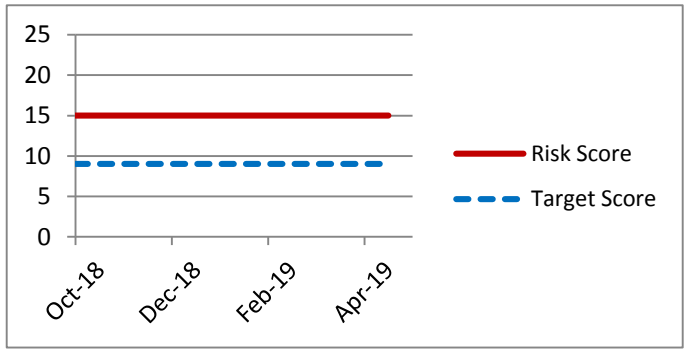
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9		**Rationale for current score:** Reflect the Directorate led baseline assessment and the findings of the HTA inspection in April 2018. **Rationale for target score:** Likely rating once the issues identified are addressed and the corrective action & improvement plan is fully implemented.
Level of Control =70%		
Date added to the risk register July 2018		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Joint Transition Board in place across CTUHB and ABMU HB • Programme Management Arrangements in place • Programme Director / Team appointed • Agreed work streams established along with related reported arrangements • Internal Audit involvement being agreed • External Audit (critical Friend observer status) on Transition Board • Strong Partnership arrangements already established, which are a strong platform to deliver the revised legislative programme / change.	Action	Lead	Deadline
	Ensure delivery of the Programme's agreed milestones	CEO Prog Dir	April 2019
	That established work streams deliver on their key products and routinely provide exception reports into Programme Structure	CEO Prog Dir Dep CEO	Ongoing
	Ensure partners remain involved and updated on related progress and play their part where appropriate to deliver the requirements of the change.	CEO Prog Dir	April 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?)**
Compliance with the revised legislative changes proposed as a consequence of the Bridgend Boundary change.	Delivery of the Programme within the proposed timescales, which all recognise is extremely tight / challenging.

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 5 x 3 = 15	Joint Transition Board Programme to be formally closed at May 2019 Board.	**042**

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Director of Nursing, Midwifery and Patient Services **Assuring Committee:** Health Board
Risk: Under reporting of clinical incidents in maternity services	**Date last reviewed:** July 2019

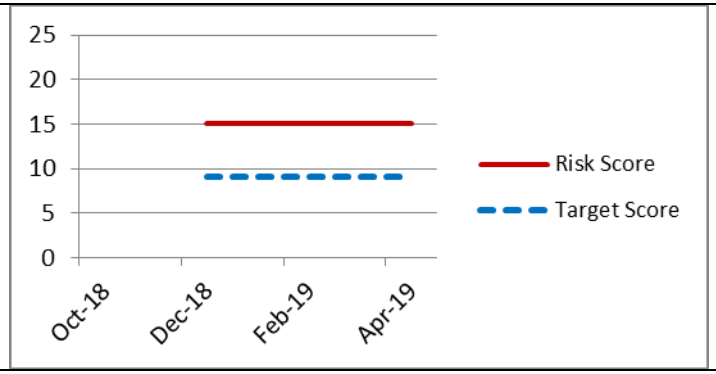
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 =20 Target: 3 x 3 = 9		**Rationale for current score:** Reflect the findings of the directorate review on incident reporting **Rationale for target score:** Likely rating once the issues identified are addressed and the corrective action & improvement plan is fully implemented.
Level of Control 50%		
Date added to the risk register September 2018		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Significant piece of work being undertaken to review the possible under reporting of clinical incidents, • Processes have been developed within maternity to flag whether an incident should have been reported and that consideration would need to be given as to how to ensure that all clinical incidents were being reported, • Guidance being issued for staff as to what is needed to be reported as an incident • Working with the Welsh Government's RCOG and RCM review of Cwm Taf maternity services. • Ensuring the actions in response to the publication of the RCOG & RCM Report is fully implemented.	Action	Lead	Deadline
	Work is progressing to get MDT's to review data. External review planned for early October, weekly rhythm to drive action plan. This will provide assurance to Executive Board. CMO/CNO discussion on assurance,	Director of Nursing, Midwifery and Patient Services	Jan 2019
	The Director of Nursing, Midwifery and Patient Services will chair 3 weekly meetings and additional monthly meetings will be chaired by Denise Llewelyn until January 2019		Jan 2019
	Take immediate action on initial findings of the RCOG / RCM review		Feb 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?)**
Greater awareness on incident reporting, increase in incidents reported and increased patient satisfaction.	Greater monitoring of incidents reported through monthly meetings with key staff and analysis of incident reports.

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 5 x 4= 20	Health Board now in Special Measures for its Maternity Services. Regular reports to the Health Board and to Quality Safety and Risk Committee (Standard agenda item)	**043**

Objective: **Service / Business Interruption**	**Director Lead:** Chief Operating Officer / Board Secretary **Assuring Committee:** Executive Board
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:** July 2019

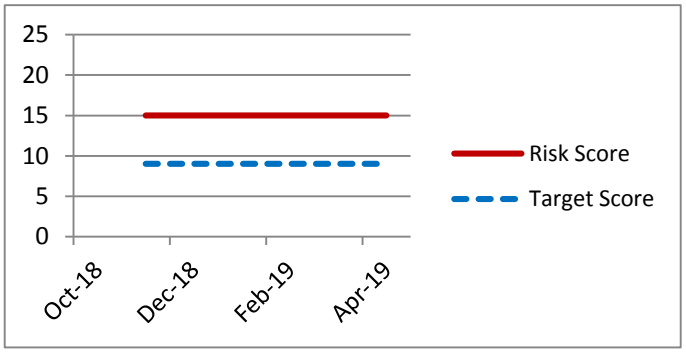
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9		**Rationale for current score:** System failures during 2019 but service continuity plans in place and services were maintained **Rationale for target score:** New risk identified and at best impact could be severe and likelihood appears moderate. Much is outside of the control of the UHB although all systems have business continuity plans
Level of Control = 50%		
Date added to the risk register December 2018		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• 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 recent data centre outage. • Ongoing improvements of local system resilience through DSSG.	Action	Lead	Deadline
	Work nationally with NWIS and other HBs and Trusts to share business continuity plans.	Board Sec COO	March 2019
	Continue with strong controls in place to ensure "business as usual" through robust business continuity plans	Board Sec COO	Ongoing
	Working with other HBs and Welsh NHS Confederation learn lessons from other organisations	Board Sec COO	April 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?)**
The Health Board is providing services "business as usual" with no interruption to service sustainability and provision of patient care.	Undertake a business continuity exercise to test existing business continuity plans to identify any gaps in resilience.

Current Risk Rating **Current Risk Rating: 5x3 =15**	**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:** Chief Executive Officer **Assuring Committee:** Executive Board
Risk: Risk of interruption to service sustainability, provision and destabilising the Board's financial position as a result of Brexit.	**Date last reviewed:** July 2019

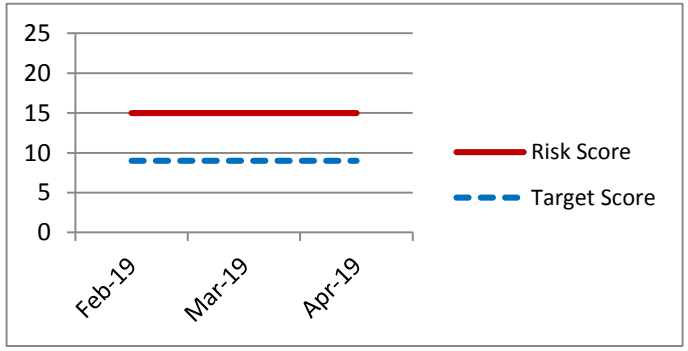
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 3 = 9		**Rationale for current score:** Whilst Brexit negotiations continue the Health Board must prepare for every eventuality based on a thorough risk assessment on the impact of Brexit on the Health Board. **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.
Level of Control = 50%		
Date added to the risk register November 2018		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Carry out gap analysis/risk assessment on Brexit • Complete the Wales Audit Office (WAO) call for evidence self-assessment • Respond to WG as requested to inform of plans • 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 • Emergency Planning, Preparedness & Response (EPPR) for the sites transferring to CTUHB from ABMU managed by the Governance work stream of the project. • Small number of staff within CTUHB potentially need to apply for settled status through the EU Settlement Scheme. • Establish internal Brexit group • Assessment of potential risks to the flow of personal data following Brexit	Action	Lead	Deadline
	Work nationally with Welsh Government, Local Resilience Forums and other HBs and Trusts to share business continuity plans.	Board Sec CCM	March 2019
	Continue with strong controls in place to ensure "business as usual" through robust business continuity plans	Board Sec CCM	Ongoing
	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	Board Sec CCM	April 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?)**
The Health Board is providing services "business as usual" with no interruption to service sustainability and provision of patient care.	Undertake a business continuity exercise to test existing business continuity plans to identify any gaps in resilience.

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating: 4x4 =16	Whilst Brexit negotiations continue the Health Board will work with other organisations to identify risk	**045**

Objective: To **improve the quality, safety and patient experience**	**Director Lead:** Chief Executive Officer **Assuring Committee:** Health Board
Risk: Poor quality unsafe services providing unsatisfactory patient experience which if not adequately addressed will continue to effect escalation status.	**Date last reviewed:** July 2019

Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 5 = 25 Target: 3 x 3 = 9		**Rationale for current score:** Enhanced monitoring by Welsh Government (WG) and regulators - Plan developed to comply with the 7 areas for improvement including requirements of: SI reporting; Healthcare Inspectorate Wales reporting; Nurse Staffing (Wales) Act; Radiation protection (IR(ME)R); Human Tissue Authority; Structured Assessment (WAO); Maternity Services and RCOG/RCM Review **Rationale for target score:** Return to routine monitoring and able to maintain WG and regulators confidence in the systems, processes, actions and behaviours within the Health Board where the consequences and likelihood is mitigated and managed
Level of Control = 25%		
Date added to the risk register February 2019		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Board discussion with the Director General • Chair, CEO and Vice Chair to meet with regulators to discuss assurance requirements • Working with the WG officials and regulators to fully comply with requirements • Developing more inclusive relationships with external bodies • Identifying lead directors and actions for completion with timescales • Clarifying key actions to be taken and increase the pace • Clarifying the governance route for actions and sign off	Action	Lead	Deadline
	Develop plans in response to areas of concern.	CEO	Ongoing
	Monitor key actions and progress at Exec Catch up meetings weekly and onwards to Board and Committees	CEO	Ongoing
	Seek assistance from the WG and Regulators and work with other external bodies to learn lessons and improve services in Cwm Taf	CEO	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?)**
Regular liaison with WG and Regulators for feedback; key improvements made to actions required at pace – leading to improved quality safety and patient experience and staff satisfactionf	Work with the OD team to develop Cwm Taf as an open and transparent organisation where learning is at the centre; develop a better understanding of the culture and behaviours required to develop more robust processes and receive and disseminate lessons learned

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating: 5 x 5 = 25	Aim to return to Level 1 – Routine Monitoring as soon as practicably possible	**046**