AGENDA ITEM
2.8

CTM BOARD

ORGANISATIONAL RISK REGISTER

Date of meeting	28/05/2020
FOI Status	Open/Public
If closed please indicate reason	Not Applicable – Public Report
Prepared by	Chris Darling, Head of Executive Business
Presented by	Georgina Galletly, Director of Corporate Governance
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Received by the Health Board	26/03/2020	NOTED
Reviewed at Audit Committee	06/04/2020	DISCUSSED
Reviewed at Management Board	22/04/2020	DISCUSSED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The purpose of this report is for the Board to review 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 received by the Board on 26 March 2020 and the Audit Committee on the 6 April 2020, Management Board on 22 April 2020.

1.2 The Executive Team have made a commitment to reviewing the risks allocated individually following the Board Development session held on Risk Management in August 2019. Work to revise the risk management approach continues, but a number of milestones have been pushed back due to the focus on responding to COVID-19.

1.3 Changes have been made to the Committee arrangements where the scrutiny of the risk register and risk management will now be undertaken at the Audit and Risk Committee, moving from the Quality and Safety Committee. Changes in Executive portfolios have also changed where a number of risks sit.

1.4 Work is progressing to move all risks, including corporate risks onto Datix as per the Risk Management Strategy approved by the Audit and Risk Committee, however, due to the impact of COVID-19 and the need to respond moving to the new approach is taking place in a phased approach.

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

2.1 Discussions between the Director of Corporate Governance and lead directors have started to comprehensively review the Organisational Risk Register.

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

3.1 Overall Analysis

38 extreme or high risks

Categories	Extreme (15-25)	High (8-12)
Setting the direction /performance and operational efficiency	**10**	**2**
Improve quality, safety and patient experience	**11**	**1**
Statutory compliance	**7**	**3**
Finance (including claims)		**1**
Workforce / Organisational Development / Innovation	**2**	
Business Continuity	**1**	
Total risks	**31**	**7**

Score	How many
25	0
20	16
16	10
15	5

12	7
Below 12	0

Removal of Risks

3.2 **The following risks have been removed from the risk register following review by the Risk Owners and ratified by Management Board:**

- 053: New Operating Model: The new operating model leads to lack of clarity and/or lack of focus on delivering performance, quality and resources. Removed by Director of WOD.

- 011: Failure to achieve in year breakeven 2019/20 – Break even achieved for 2019/20, however note the new COVID-19 financial impact risk. Removed by Director of Finance.

- 012: Failure to appropriately manage Discharge Delays from Hospitals. All actions have been completed and the current DTOC position provides some assurance that this is currently not a high risk, although the situation will be monitored at ILG level going forward. Removed Director of Operations.

3.3 The following risk have been removed following review at the Audit and Risk and previous Management Board meetings:

- 015: Reputational damage & potential legal challenge on the decision making on Funded Nursing Care (FNC). Where the risk score has been reduced from 12 (Feb 2020) to 9 (March 2020).

- 017: Failure to meet Fire Safety Standards on ground and first floor PCH – to be removed (incorporated into Risk 025) and added to the Integrated Locality Group Risk Register.

- 048: Failure to meet Fire Safety Standards in the Theatres, Princess of Wales Hospital – To be removed (incorporated into risk 025) and added to the Integrated Locality Group Risk Register.

Changes to the Risk Score

3.4 **The following risks have changed their risk scores during the past 3 months, on the recommendation of the Risk Owner:**

- 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 – Reduced from 20 to 15, due to increased use of NHS Locums rather than agency leading to more consistent rostering. Changed by Medical Director.

- 030 Failure to continue to provide and sustain GP Out of Hours Services as currently configured – reduced from 20 to 12. Changed by Director of Operations.

Although risk 049 "Insufficient skilled staff to deliver clinical services effectively due to poor retention of staff" has not changed its risk score, it remains a score of 20, it should be noted the risk wording and description has changed to reflect the post COVID-19 re-setting context. Changed by the Director of Workforce and OD.

New Risks

3.5 **The following new risks have been added to the risk register over the past 3 months:**

3.6 A new risk 054: COVID-19 - *There is a risk that the contingency and business continuity plans do not manage the outbreak of COVID-19 as well as well as they could, failing to manage the pandemic appropriately.* Has been added to the risk register by the Director of Public Health.

3.7 A new risk 055: COVID19 Impact on business as usual – *There is a risk to the Health Board that the resources and focus going on managing the response to the outbreak of COVID-19 will lead to patient harm as a result of reduced service provision and capacity to respond to other areas of Health Board operations.* Has been added to the risk register by the Director of Corporate Governance / Director of Public Health.

3.8 A new risk 056: Financial impact of COVID-19 – There is a risk that the organisation's operational revenue costs of addressing the pandemic cannot be contained within available revenue funding resulting in an unplanned I&E deficit in 2020/21, and a parallel risk of unfunded additional capital costs. Added to the risk register by the Director of Finance.

3.9 A new risk 057: Staff Wellbeing: There is a risk of insufficient psychological and wellbeing support to staff during COVID-19. Added to the risk register by the Director of Workforce and OD.

3.10 It should be noted that in addition to the above four risks relating to COVID-19, there has been a Gold Command COVID-19 risk register maintained and updated each week, reviewed via the Command and Control structure. This register will cease when the Command structure is formally closed.

3.6 All areas have been updated since January 2020, or more recently, as indicated by the review date, this reflects the ongoing work to focus on management and mitigation of risk.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Aim to mitigate risks to patients and staff
Related Health and Care standard(s)	Governance, Leadership and Accountability
	All Health and Care Standards are included
Equality impact assessment completed	No (Include further detail below)
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Main Strategic Objective	To provide strong governance and assurance
Link to Main WBFG Act Objective	Service delivery will be innovative, reflect the principles of prudent health care and promote better value for users

5. RECOMMENDATION

5.1 The Board are asked to **NOTE** the risks that have been removed over the past 3 months.
5.2 **NOTE** the new risks added to the risk register over the past 3 months
5.3 **NOTE** the changes in risk scores over the past 3 months
5.4 **REVIEW** and **COMMENT** on the Organisational Risk Register.

Strategic Objective	Risk Ref	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
Setting the Direction and	028 DOF	Failure to ensure delivery of a viable balanced/break even 3 year	20	20	⇨	January 2020	Finance, Performance and Workforce
Setting the Direction and Performance and Operational Efficiency	036 DoO	Primary Care Workforce - Recruitment and sustainability	20	16	⇨	January 2020	Primary, Community Population Health and Partnerships
	030 DoO	Failure to continue to provide and sustain GP Out of Hours Services as currently configured.	20	12	⇩	February 2020	Primary, Community Population Health and Partnerships
	002 DoO	Failure to achieve Referral to Treatment targets.	20	16	⇩	January 2020	Finance, Performance & Workforce
	003 DoO	Failure to achieve the 4 and 12 hour emergency (A&E) waiting times targets.	20	16	⇩	January 2020	Finance, Performance & Workforce
	023 DN	Patients and/or relatives/carers do not receive timely responses to concerns raised, learning and	20	12	⇩	March 2020	Quality and Safety
	050 MD	Not agreeing a sustainable model for emergency medicine and inpatient paediatrics across the CTMUHB footprint.	16	16	⇨	May 2020	Finance, Performance & Workforce
	051 MD	Implementing a sustainable model for emergency medicine and inpatient paediatrics across the CTMUHB footprint in a timely manner.	20	20	⇨	May 2020	Finance, Performance & Workforce
	052 DCG	Organisational Reputation: Lack of confidence in the services and care provided by the organization.	15	15	⇨	May 2020	Finance, Performance & Workforce

	054 DPH	COVID-19 There is a risk that the contingency and business continuity plans do not manage the outbreak of COVID-19 as well as well as they could, failing to manage the pandemic appropriately.	20	20	⇨	May 2020	Primary, Community Population Health and Partnerships
	055 DPH	COVID-19 Impact on Health Board Business as Usual activity. There is a risk to the Health Board that the resources and focus going on managing the response to the outbreak of COVID-19 will lead to patient harm	20	20	⇨	May 2020	Primary, Community Population Health and Partnerships
	056 DoF	Financial Impact of COVID-19: There is a risk that the organisation's operational revenue costs of addressing the pandemic cannot be contained within available revenue funding resulting in an unplanned I&E deficit in 2020/21, and a parallel risk of unfunded	15	15	⇨	May 2020	Audit and Risk Committee

Risk Register Category – Business Objectives / Projects (12 risks)

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

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

Risk Register Category - Impact on Safety (12 risks)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
To improve quality, safety and patient experience.	007 MD	Failure to recruit sufficient medical & dental staff.	20	20	⇨	May 2020	Quality and Safety
	034 MD	Increasing dependency on Agency Staff cover in Medical and Nursing areas, which has the potential to impact on continuity of care and patient safety and is actually impacting on the UHB financial position.	20	15	⇩	May 2020	Quality and Safety
	035 ND	Failure to recruit sufficient registered nursing and midwifery staff.	20	20	⇨	March 2020	Quality and Safety
	008 MD	Reduction in medical training posts within various specialties & capacity to meet workload demands.	20	16	⇩	May 2020	Quality and Safety
	027 DoO	Lack of control and capacity to accommodate all hospital follow up outpatient appointments.	20	20	⇨	January 2020	Finance, Performance & Workforce
	032 DoO	Sustainability of a safe & effective Ophthalmology Service.	20	16	⇩	January 2020	Quality and Safety
	005 DoO	Failure to sustain services as currently configured to meet cancer targets.	20	16	⇩	January 2020	Finance, Performance & Workforce

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
	033 DoO	Failure to sustain Child & Adolescent Mental Health Services across the Network	20	16	⇩	January 2020	Quality and Safety
	037 DoPP	Ensuring the development, approval and implementation of a Strategy for IM&T, that is clinically led and supports staff in care delivery	12	12	⇨	January 2020	ICT and IG
	043 DN	Under Reporting of Clinical Incidents in Maternity Services	20	20	⇨	January 2020	Quality and Safety
	047 DoO	Failure to treat patients in a timely manner resulting in potential avoidable harm	20	20	⇨	January 2020	Finance, Performance and Workforce
	049 WOD	There is a risk that there is insufficient workforce to deliver against the emerging CTM Re-setting framework – balancing Covid and non Covid activity, due to staff recruitment, retention and sickness.	20	20	⇨	May 2020	Finance, Performance & Workforce

Risk Register Category – Statutory Duty / Inspections (10)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
Statutory Compliance	017 DoTH&HS	Failure to meet Fire Safety Standards on ground and first floor PCH.	20	20	⇨	January 2020	Audit and Risk
	021 WOD	Enforcement action or litigation if an incident is linked to a lack of Core Mandatory Training	20	20	⇨	May 2020	Quality and Safety
	025 DoTH&HS	Failure to meet Fire Safety Standards across CTMUHB.	20	20	⇨	January 2020	Audit and Risk

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
	018 DOF	Failure to achieve statutory and mandatory planned preventative maintenance (PPM) programme.	15	15	⇨	January 2020	Audit and Risk
	031 DN	Non-compliance with DoLS legislation and resulting authorisation breaches	16 (was 12)	12	⇩	March 2020	Quality and Safety
	016 DOF	Failure to comply fully with the arrangements for managing Asbestos	16	12	⇩	January 2020	Audit and Risk
	039 DoO	Failure to ensure sufficient storage capacity (or alternative solutions) are in place to safely store and secure patient records.	16	16	⇨	January 2020	Quality and Safety
	040 WOD	Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	15	15	⇨	May 2020	Quality and Safety
	041 DoO	Failure to fully meet all the licensing requirements of the Human Tissue Authority in relation to Mortuary & Services for the Deceased.	16	12	⇩	January 2020	Quality and Safety
	048 DoTH&HS	Failure to meet Fire Safety Standards in the Theatres, Princess of Wales Hospital.	20	20	⇨	January 2020	Audit and Risk

Risk Register Category – Finance / Including Claims (2)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
	012 DOF	Failure to Deliver Major & Discretionary Capital programmes	12	12	⇨	January 2020	Capital Programme Board

Risk Register Category – Human Resources / Organisational Development / Staff Competency (2)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
Workforce Sustainability/ OD and Innovation	019 WOD	Failure to achieve the Management of Absence target.	20	20	⇨	May 2020	Finance, Performance & Workforce
Workforce Sustainability/ OD and Innovation	057 WOD	Staff Wellbeing: There is a risk of insufficient psychological and wellbeing support to staff during COVID-19.	20	20	⇨	May 2020	TBC

Risk Register Category – Service / Business Interruption (2)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend (from last report)	Last Reviewed	Scrutiny Committee
Business Continuity Brexit	045 DPH	Risk of interruption to service sustainability, provision and destabilising the Board's financial position as a result of Brexit.	16	16	⇨	January 2020	Management Board

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

Impact/Consequence	1	2	3	4	5
5			052 Organisational reputation ↔ 056 (NEW) Financial Impact of COVID-19	007 Failure to recruit Medical & Dental Staff ↔ 043 Under reporting of clinical incidents in maternity services ↔ 047 Failure to treat patients in a timely manner resulting in avoidable harm ↔ 025 Failure to meet Fire Safety standards across the UHB ↑ 021 Staff competency – compliance with statutory/mandatory training ↔	
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 ↔ 023 Patients and/or relatives/carers do not receive timely responses to concerns raised ↓	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 ↔ 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 ↓ 008 Reduction in medical training posts within various specialities & capacity to meet workload ↓ 050 Not agreeing a sustainable model for emergency medicine and inpatient paeds ↔	057 (NEW) Staff Wellbeing COVID-19 054 (NEW) COVID-19 055 (NEW) COVID-19 Impact on business as usual 028 Producing Viable balanced 3 year IMTP ↑ 035 Failure to recruit registered nursing sand midwifery taff ↔ 019 Failure to achieve the management of absence target ↔ 027 Lack of control & capacity to accommodate Follow Up Outpatients↔ 049 (NEW) Insufficient workforce to deliver CTM Re-setting framework 051 Implementing a sustainable model for emergency medicine and inpatient paediatrics across the CTMUHB footprint in a timely manner ↔
3				031 Non-compliance with DoLS legislation and resulting authorisation breaches ↓ 030 Continuing to provide GP Out of Hours Services as currently configured ↓	018 Failure to achieve statutory and mandatory planned preventative maintenance programme ↔ 0 40 Compliance with Welsh Language Standards ↔ 034 Increasing dependency on agency staffing (medical & nursing) finance impact ↓
2					
1					
C x L	1	2	3	4	5
	Likelihood				

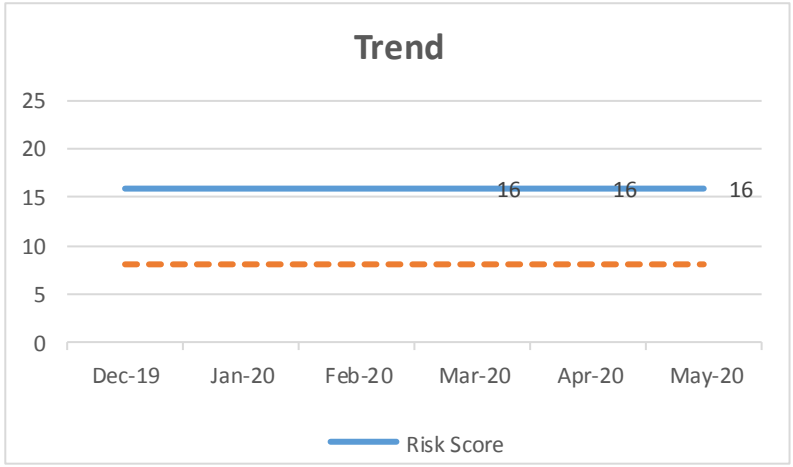
Objective: **Setting the Direction & Performance & Operational Delivery** | **Director Lead:** Director of Operations

	Assuring Committee: Finance, Performance & Workforce
Risk: Failure to achieve Referral to Treatment Times (0)	**Date last reviewed:** January 2020

Risk Rating
(consequence x likelihood):
Initial: 5 x 4 = 20
Current: 4 x 4 = 16
Target: 4 x 2 = 8

Level of Control
=50%

Date added to risk register
April 2013



Rationale for current score:
The current score reflects current trajectories for year-end out turn. We have now completed our work with the Delivery Unit to identify additional patients (c.1750) for lists including neurophysiology, nephrology and specialised paediatrics and these are now fully absorbed into our plans for the remainder of the financial year.

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.

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 District General Hospital sites.
- WG has released £7m against a £8.7m resource plan for restoring our trajectory.
- Several workshops held to address HMRC tax and pension issues which have significantly eroded consultant sessional availability for ADH and WLI.
- DU review of unreported waiting lists complete and all trajectories reworked to include patients from those lists – financial plans to achieve trajectories now in place.

Mitigating actions (What more should we do?)

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 4
• Develop, implement and monitor Directorate Demand & Capacity Plans. • Complete revision of delivery plans for all trajectories following DU report on unreported waiting lists. • Revise financial plan to deliver 0 36 weeks position.	Ops Directors	Ongoing quarterly

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

Waiting list reductions; better response times from departments / compliance figures will improve.

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

F,P&W monitoring progress. Further work required in light of the establishment of CTMUHB. Working with the DU to analyse all waiting times.

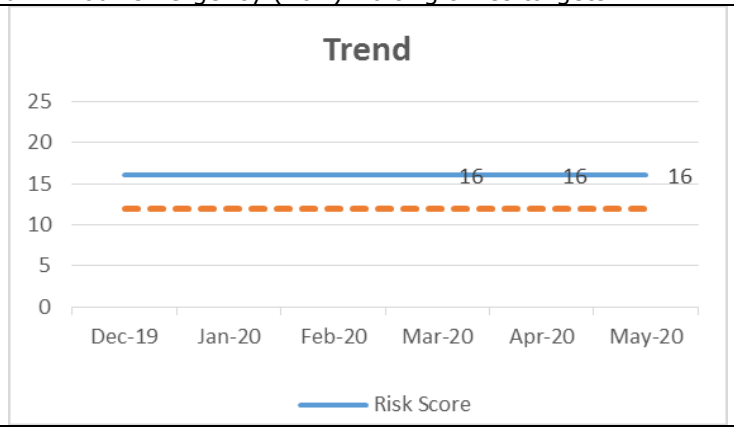
Current Risk Rating	Additional Comments	Ref No.
Current Risk Rating : 4 x 4 = 16	The plan last year (and this), was to sustain RTT position and deliver against the target without (or with limited) external outsourcing. However, this has not been possible and additional outsourcing in place.	**002**

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Director of Operations **Assuring Committee:** Finance, Performance & Workforce
Risk: Failure to achieve the 4 and 12 hour emergency (A&E) waiting times targets.	**Date last reviewed:** January 2020

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 has stabilised as medical workforce now back in balance; PCH and PoW have received detailed action plans from DU/CASC. Winter Plan now initiating with partners supportive.

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 DGH sites to sustain improved delivery of performance against the 4, 8 and 12 hour targets. Also variable practice across A&E departments.
- Consultant and middle grade gaps in RGH now filled.
- PCH DU report delivered and being enacted.
- PoW handover performance reviewed by DU & EASC/CASC team and being enacted.
- PoW/RGH/PCH provided full Safety and Dignity analysis to September QSR committee and Safety Briefing sitrep model and SAFER being rolled out across sites.
- Programme of improvement work with AM&ED, HR and Retinue teams to improve medical booking and staffing to raise shift fill (ADH initiative has been successful).
- Winter Plan in train through directorate and partners (RPB).
- Interim Site Management arrangements coming into place.
- Systems model in development.

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 Winter planning.	DepCOO	Ongoing
3) Stay Well At Home (SW@H) Service introduced and evaluated (6 month). Transformation funding will initiate Jan/Feb 2020.	Dep COO	Ongoing
4) SW@H 2 developments and Enhanced Community Clusters being progressed through Transformation bid.	COO	Ongoing

Assurances
(How do we know if the things we are doing are having an impact?)
Monthly reporting of 4, 8 and 12 hour performance within the Integrated Performance Dashboard.

Gaps in assurance
(What additional assurances should we seek?)
Risk management across sites in terms of Ambulance handover in PoW and safe management of corridor waits in PCH/RGH.

Current Risk Rating
Current Risk Rating : 4 x 4 = 16

Additional Comments
Recruitment and retention of staff essential.

Ref No. 003

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Director of Operations **Assuring Committee:** Finance, Performance & Workforce

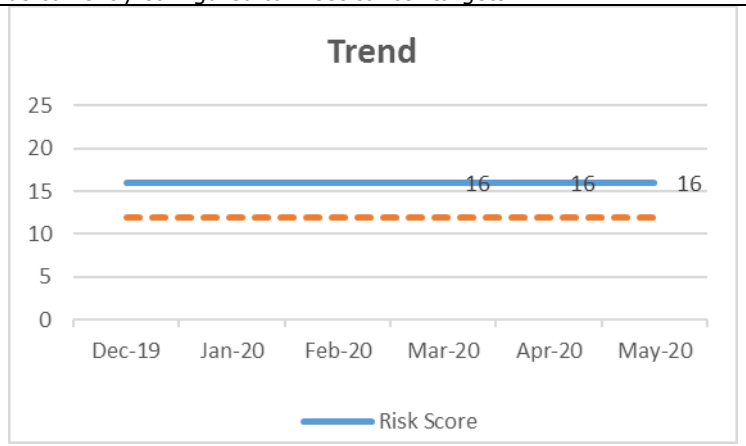
Risk: Failure to sustain services as currently configured to meet cancer targets

Date last reviewed: January 2020

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 over last year. However target not consistently being met and focus on different delivery model for urology required. Regional provision of EBUS also an area being targeted for improved access.

Rationale for target score:
Target score reflects the challenge this area of work present the Board and where small numbers of patients regularly breaching impact on the potential to breach target.

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

- Tight management processes to manage each individual case on the unscheduled care (USC) Pathway.
- Initiatives to protect surgical capacity to support USC pathways have been put in place in RGH and PCH to protect core activity.
- Prioritised pathway in place to fast track USC patients.
- Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies.
- Overall Cancer target performance challenged by frailty of urology service with potential for regional service under review – connection with radiology an issue during late Summer. Regional access to EBUS through C&VUHB an issue.
- Implementation of Single Cancer Pathway well underway with further work to do on underlying business case for sustained target delivery coming forward.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Introduction of revised models for rapid diagnostic review / assessment in cancer pathways continuing to drive pick-up rate (15% from 3%)	COO / DPC&MH Med Dir	ongoing
Continue close monitoring of each patient on the USC pathways to ensure rapid flow of patients through the pathway.	COO / DPC&MH Med Dir	Ongoing
Some speciality challenges remain in Lung and Urology - action plans in place, along with monitoring. Also work underway on regional access to EBUS service.	COO / Med Dir	Ongoing

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

General flattening of trajectory. Need to continue improvement actions and close monitoring. Early diagnosis pathway launched and impact being made. Urology and Radiology remain under constant review. Single Cancer Pathway being implemented.

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

The need to deliver sustained performance.

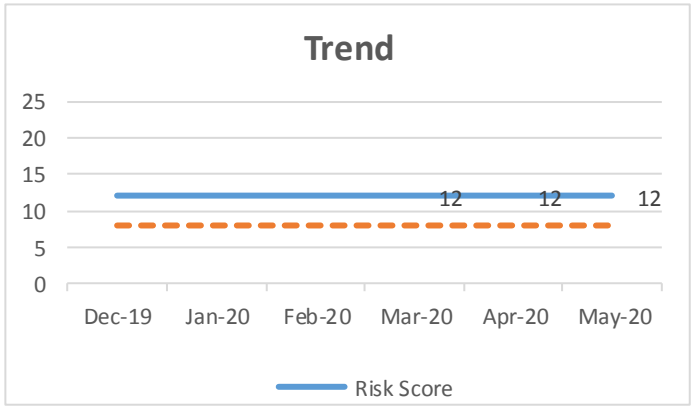
Current Risk Rating

Current Risk Rating : 4 x 4 = 20

Additional Comments

Ref No.
005

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

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 Programme Board in place to monitor development and delivery of the Board's Capital schemes. • Quarterly update reports are presented to Management Board and the Health Board meetings. • Whilst increased pressure as a consequence of capital slippage, plans in place to address.	Action	Lead	Deadline
	Capital Programme Board and Executive Capital Management Group in place	RT	Ongoing
	Work programme and review of bids on an ongoing basis.	RT	Ongoing
	Discretionary capital processes in place for allocation and slippage funding	RT	Ongoing

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Continue to work closely with Welsh Government. Elements of the Capital Programme feature routinely in the UHB's Internal Audit Plan	

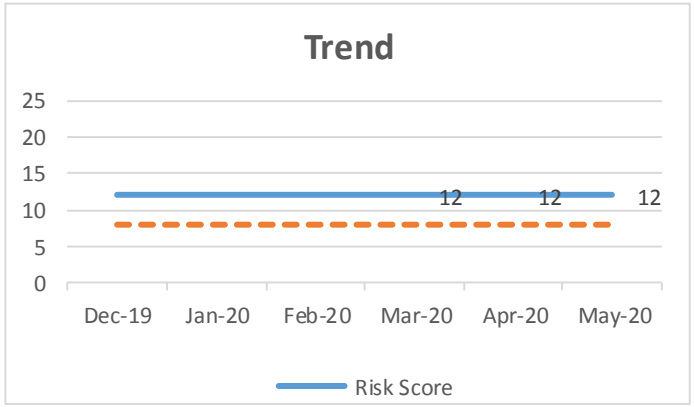
Current Risk Rating	**Additional Comments**	**Ref No. 012**
Current Risk Rating : 4 x 3 = 12		

Objective: **Statutory Compliance**	**Director Lead:** Director of Finance **Assuring Committee:** Audit and Risk Committee
Risk: Failure to comply fully with the arrangements for managing Asbestos	**Date last reviewed:** January 2020

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:
Asbestos data for former ABMUHB sites require inputting to the Micad Asbestos management database. This process is currently under review and will commence once the site floor plans have been upgraded for uploading into the Asbestos management database.

Rationale for target score:
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 Capital and Estates Health Safety and Risk Group which reports to the Estates Governance Board and onwards through exception reports to the Quality Safety and Risk Committee
- Training Needs Analysis completed.
- Training programme has been developed to provide participants with an awareness of their responsibilities as defined by the plan.
- Internal Audit report noted that a programme of annual asbestos awareness training for UHB employees was evident, in line with the Regulations.

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?)

Condition checks of all identified Asbestos materials are carried out annually by a trained in house Asbestos surveyor/analyst.

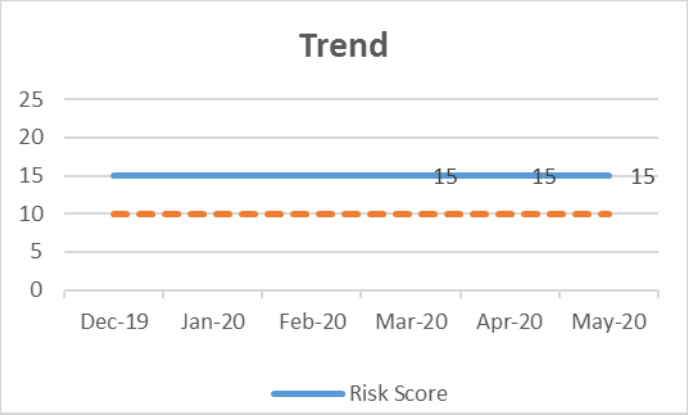
Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 3 = 12	Will require further review in light of CTMUHB asbestos management plan and review of properties transferred.	**016**

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

Risk Rating
(consequence x likelihood):
Initial: 5 x 4 = 15
Current: 5 x 3 = 15
Target: 5 x 2 =10

Level of Control
=70%

Date added to the risk register
April 2014



Rationale for current score:
Additional staff have been appointed to the Estates team; however, although improvements have been made additional work is required to ensure full compliance, this also now includes for the Bridgend locality.

Rationale for target score:
Reassurance was required in order that the statutory and mandatory planned preventative maintenance programme was well managed during time of increased vacancies in the estates department and also now with the transition of the Bridgend locality into the new CTM UHB.

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

- Estates Officers responsible for ensuring external contractors complete PPM on time.
- Two separate systems being used to plan, monitor and record work undertaken by external contractors within the new CTM UHB. Plan for these to be brought together into one system for 2020/2021
- Development and implementation of staffing strategy for estates.
- PPM prioritised work of the estates department.
- Annual Estates Report considered by the Management Board and Health Board in September 2019, including PPM performance. Performance report also due to go to FPW Committee in November 2019.
- Whilst significant improvements noted, recognised that further work needed to ensure full compliance with Statutory PPM.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Capital and estates governance group oversees the overall compliance	Assistant Director of Capital & Estates	Ongoing
Routine monitoring of progress, with use of CBM process to support also.	Director of Plan & Perf.	Ongoing quarterly
Presentation of Annual Report to Board & Management Board	Director of Plan & Perf.	Sept 2019
Review of Estates performance at least annually at Finance, Performance and Workforce Sub-Committee.	Director of Plan & Perf.	Annually – next Nov 2019

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

Overall levels of compliance have been improving in the former CT area although comparisons between former CT and Bridgend localities currently difficult with 2 different systems in use. Working to introduce one system in 2020/2021.

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

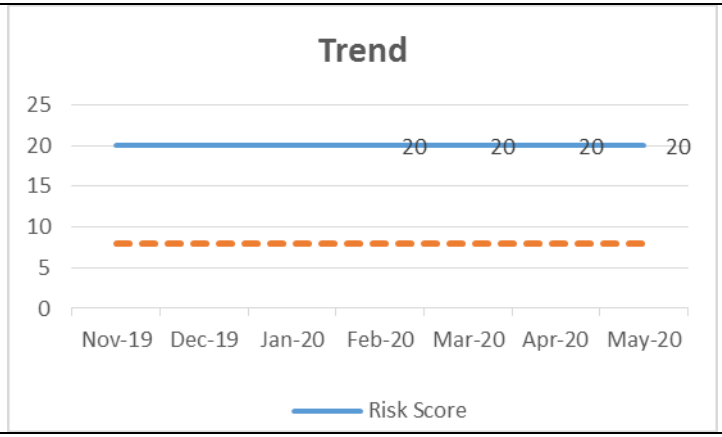
Current Risk Rating	Additional Comments	Ref No.
Current Risk Rating : 5 x 3 = 15		**018**

Objective: **Workforce Sustainability/Organisational Development and Innovation**	**Director Lead:** Director of Workforce & OD **Assuring Committee:** Finance, Performance & Workforce
Risk: Failure to achieve the Management of Absence target	**Date last reviewed:** May 2020

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

Level of Control
=70%

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?)

We continue to monitor hot spot areas are being targeted to attend courses such as mindfulness and managing stress in the workplace.
Attendance of the Managing Attendance at Work package. The percentage of all managers who have attended is 55%.
We are currently recruiting a clinical psychologist to improve the service we provide employees with mental health illnesses.
We have improved self-referral times for physiotherapy access.
We are using dietetic expertise with OH using the FODMAP principles.
We continue to run 8 week mindfulness course which has an evidence based outcome of improving employees return to work sooner than anticipated when absent from work due to stress and/or anxiety.
We are working to break down the category of stress as the reason for absence so that work related stress can be highlighted and dealt with more effectively. This will allow for positive action to be taken to help reduce its impact on individuals.

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
Roll out COVID-19 test and trace for staff	Director of WOD/PH	June 2020
Roll out of health roster to improve data quality and capture	Director of WOD	June – July 2020

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

All HR teams carry out regular audits within their areas. We have now trained 55% of managers on the new policy and an online e-learning support will be launched shortly.

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

Current Risk Rating : 5 x 4 = 20

Additional Comments

Monitoring COVID-19 impact on sickness levels.

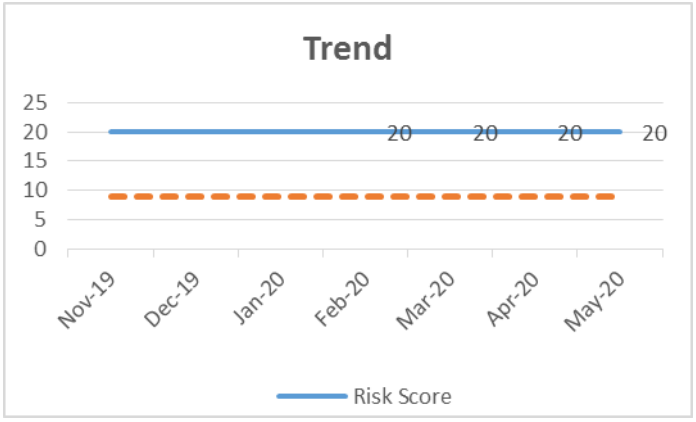
Ref No. 019

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

Risk Rating
(consequence x likelihood):
Initial: 5 x 4 = 20
Current: 5 x 4 = 20
Target: 3 x 3 =9

Level of Control
=70%

Date added to the risk register
June 2014



Rationale for current score:
Utilising ESR - staff, line managers and the UHB have a clear picture of what training is required and of current compliance level.

Rationale for target score:
Rationalised set training requirements and greater assurance that the UHB is offering enough training to meet the demand

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

- Identification and uploading into ESR of all levels of core training, presenting a clear picture of training requirements to staff and the UHB
- On-going work to rationalise set training requirements and ensure they match job roles
- Production of on-going compliance reports covering all levels of training required
- Making e-learning easier to identify and play utilising ESR auto-enrolment functionality.
- Making face-to-face training easier to identify and book using ESR search functionality.
- Provision of mandatory training days for clinical staff and Facilities staff and support sessions for all staff

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Continue to improve compliance generally with Core Mandatory Training; ensure discussed routinely at Clinical/Corporate meetings	Workforce Director	Ongoing
Development of demand –v- capacity plans to ensure enough face-to-face training is being delivered to meet the requirements of staff	Workforce director	Ongoing
Making best use of the Electronic Staff Record – ensuring staff maintain mandatory requirements	Workforce director	Ongoing
Audit exercise being carried out to allow compliance to be looked at.	Workforce director	Audit on hold during COVID-19. Recommence June 2020

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Improved training compliance percentages – note overall improvement trajectory	Continue to maintain profile of performance and general improvement of the levels of compliance. Must address any gaps identified as a result of the demand-v-capacity analysis

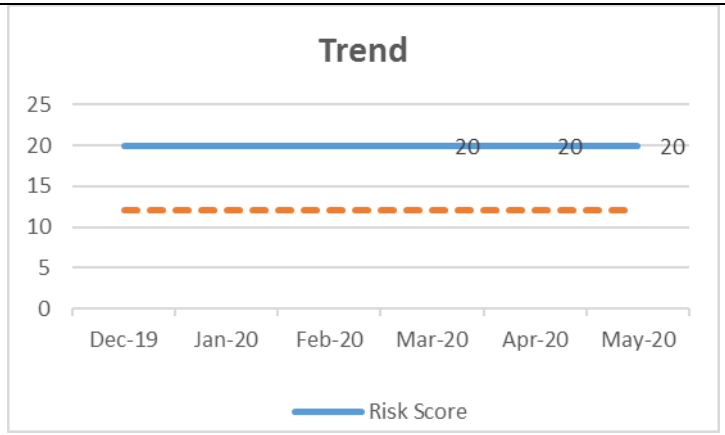
Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 5 x 4 = 20		**021**

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Director of Operations **Assuring Committee:** Finance, Performance & Workforce; Quality & Safety
Risk: Lack of control and capacity to accommodate all hospital follow up outpatient appointments	**Date last reviewed:** January 2020

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

Level of Control
=60%

Date added to the risk register
November 2014



Rationale for current score:
Follow up appointments not booked was previously increasing; concern raised by Board Members, discussed at Audit Committee, Finance Performance & Workforce Committee and Quality, Safety and Risk Committee. Improvement actions not previously reducing the large numbers of patients awaiting follow up clinic review.

Rationale for target score:
Agreed actions approved by Management Board, being implemented and routine monitoring in place, with regular reports to QSR and FPW Committees which is being aligned with the Performance Dashboard.

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

- Continued monitoring of progress at Quality Delivery Meetings with WG. Initial progress with reductions in all specialities.
- Exploring patient safety implications for some categories of follow ups not booked for consideration by the Management Board and at Q,S&R Committee where further audit related action is being undertaken.
- Continued improvement against trajectories in specialties. Surgery the first to achieve a 0 FUNB position.
- Outsourcing of 6, 500 Ophthalmology cases has now brought us to c.15k patients on the list, reducing to 13.5k.
- WG has asked us to put forward a financial bid for balancing the outpatients position to 0 – bid is in the order of £1.5m to deliver 0 position by March 2021.
- Harm review process now being piloted in Ophthalmology, with other specialties to follow.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
1) Scoping exercise undertaken – investment agreed at Exec Board, will require more	COO / DPC&MH	Ongoing
2) Actions by speciality agreed, the outcome from which will help D&C planning.	COO / DPC&MH	Ongoing
3) Service redesign proposals developed by speciality, to be implemented linked to D&C Plans.	COO / DPC&MH	In Progress
4) Action plans with agreed timescales established, although insufficient capacity. Further resources now released and bid made to WG to achieve balance in outpatients.	COO / DPC&MH	Ongoing

Assurances

Good progress still being made. Still further work needed to address and reduce volume and achieve balance. WAO review did not provide assurance of national progress, but CTM the best position in Wales achieved at 11/19. Current waiting FUNB at 13,700 patients, on track for 10,000 patients by year end as agreed at Board level.

Gaps in assurance

Need to better understand any safety implications for follow ups not booked and patients waiting past clinic review dates. This is being provided through the piloting of the harm review process (proposal coming forward for additional resources in PC&S to implement). All instances of harm from delay are being fully reported to the QSR through exception reports and consolidated reports to QSR and FPW regularly. Best practice noted by national Outpatients Steering Group.

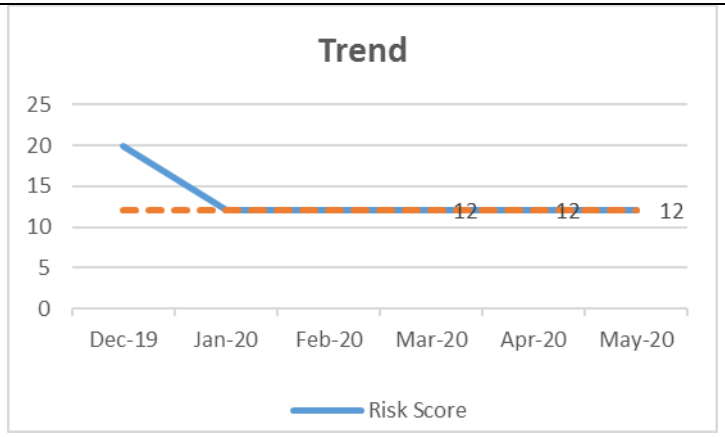
Current Risk Rating	Additional Comments	Ref No.
Current Risk Rating : 5 x 4 = 20	D&C plans not sufficient as yet – not enough capacity to completely balance the system; additional resources required; reporting to Committees.	**027**

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Director of Primary, Community and Mental Health (DPCMH) **Assuring Committee:** Primary, Community Population Health and Partnerships Committee
Risk: Failure to continue to provide GP out of hours services as currently configured	**Date last reviewed:** February 2020

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

Level of Control
=60%

Date added to the risk register
November 2014



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.

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

- OOHs services reconfigured and number of centres reduced from 4 to 2 in order to sustain services. An evaluation update considered by the Board in July 2016, agreed to continue with the current service which is scrutinized and monitored by the Primary, Community Population Health and Partnerships Committee.
- There continues to be ongoing engagement and discussions with those practitioners currently supporting the revised model.
- There continues to be engagement with key stakeholders including the Community Health Council, GPs and patients.
- Further options are being considered in order to address ongoing sustainability issues with the current service configuration
- Peer review undertaken provding assurance of significant improvement

Mitigating actions (What more should we do?)

Action	Lead	Deadline
The out of hours team continuing to work with GPs and other primary care staff, in a flexible way for the best shift fill rates.	DPCMH	Ongoing
All Wales approach being progressed to mitigate variability of approaches across NHS Wales Health Boards	Directors of W&OD/ Directors of PC&MH	Ongoing
Regular dialogue with OOHs service and Primary Care Clusters to ensure OOHs cover is strengthened and supported.	DPCMH	Ongoing

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

Shift fill rates; patient experience surveys

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

The current service model is not sustainable and alternative solutions are required.

Current Risk Rating

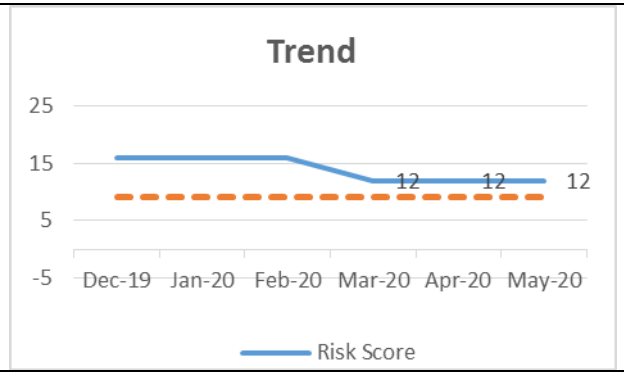
Current Risk Rating : 4 x 3 = 12

Additional Comments

Lack of an All Wales Approach results in HBs competing with each other on GP sessional pay rates.

Ref No. 030

Objective: **Statutory Compliance**	**Director Lead:** Director of Nursing, Midwifery and Patient Care **Assuring Committee:** Quality and Safety Committee
Risk: Non-compliance with DoLS legislation and resulting authorisation breaches	**Date last reviewed:** March 2020

Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 = 12 Target: 3 x 3 =9		**Rationale for current score:** Boundary changes to include the Bridgend region has increased the demands on the DoLS service whilst new staff were recruited. In light of the demands of current legislation it is likely that full compliance cannot be achieved. The Liberty Protection Safeguards legislation provides for the repeal of DoLS and replacement with the Liberty Protection Safeguards (LPS). The UK government has not yet announced the date on which the legislation will come into force, possibly Spring 2020. For up to a year the DoLS system will run alongside the LPS. **Rationale for target score:** Whilst requirements have increased, mitigation has also been revised to manage increased risk, the UHB will need to be prepared for new legislation.
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?)**		
• Staff recruited to manage demand and mitigated by use of independent best interest assessors, a full time secondment transition post and nurse bank hours. Recruitment to all BIA posts complete on the 4/11/2019. • Urgent authorisations are prioritised over standard authorisations. • Monthly Safeguarding People training increased understanding of DoLS amongst UHB attendees. • DoLS processes established and in place within the UHB but will be subject to change following enactment of the new legislation and statutory guidance.	Action	Lead	Deadline
	The Safeguarding Executive Group should establish a working group with multidisciplinary representation to consider the implications for the UHB on how the LPS scheme will have an impact on the current authorisation process for DoLS.	Nurse Director	Feb 2020
	Prioritisation process in place for DoLs applications and training for all disciplines in the Mental Capacity Act delivered on a monthly basis as part of a safeguarding people package.	Nurse Director	Complete

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• Audit of time taken to respond to requests • Streamlining and target setting for the service following a review of quality, efficiency and effectiveness – more authorisations are taking place in a more timely manner.	Staff compliance with training - uptake of level 1 & 2 DoLS & MCA training

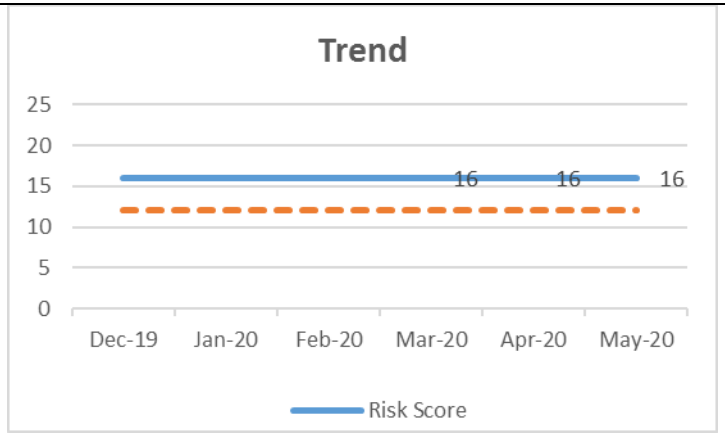
Current Risk Rating	**Additional Comments**	**Ref No. 031**
Current Risk Rating : 4 x 3 = 12		

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Director of Operations **Assuring Committee:** Quality and Safety Committee
Risk: Sustainability of a safe & effective Ophthalmology Service.	**Date last reviewed:** January 2020

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

Level of Control
=60%

Date added to the risk register
April 2014



Rationale for current score:
Monitoring of the service continued, referral to treatment times remain challenging and the numbers of patients requiring a follow up appointment has significantly reduced with all potential harms from delay now under assessment.

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.

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

- Action plan developed and ongoing monitoring – consolidated plan coming forward covering Eye Care Measure and ODTC DU reviews nationally.
- Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTCs, weekend clinics).
- Ongoing monitoring is in place with regards RTT impact of Ophthalmology.
- In line with other services, to meet the RTT requirement services are being outsourced- maintaining this level of performance will be challenging going forward.
- Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms.
- Additional services to be provided in Community settings through ODTC (January 2020 start date).
- Intravitreal injection room x 2 established with nurse injectors trained.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Follow up appointments not booked being closely monitored and outsourcing actioned.	COO	Ongoing
Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues).	COO	Ongoing
Reviewing UHB Action Plan in light of more recent WAO follow up review of progress.	COO	Ongoing

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Numbers of patients waiting for follow up appointments are reducing.	Work to be completed on harm review.

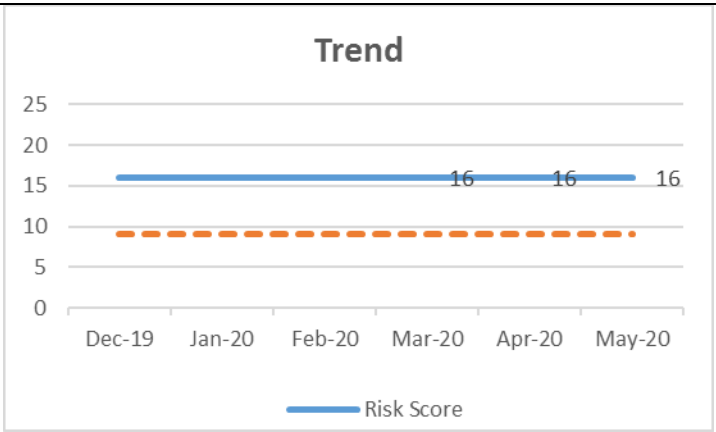
Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 4 = 16	Ongoing intensive review work is taking place to examine the safety of patients waiting for follow up appointments.	**032**

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Director of Primary, Community and Mental Health **Assuring Committee:** Management Board / Finance, Performance and Workforce Committee
Risk: Failure to sustain Child and Adolescent Mental Health Services	**Date last reviewed:** November 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
January 2015



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

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

- Reported local and Network pressures across the CAHMS Network with variable problems dependant on the area of the network.
- Updates provided to Management Board on developing service model to address reported issues and additional investment secured to increase capacity within the service and to address service pressures. Waiting list initiatives in place whilst staff recruitment is being progressed.
- Service Model developed around Core CAHMS in Cwm Taf Morgannwg which includes agreement with General Paediatrics to take the lead on Neurodevelopmental Services and shared care protocols with Primary Care.
- New investment impact being routinely monitored

Mitigating actions (What more should we do?)

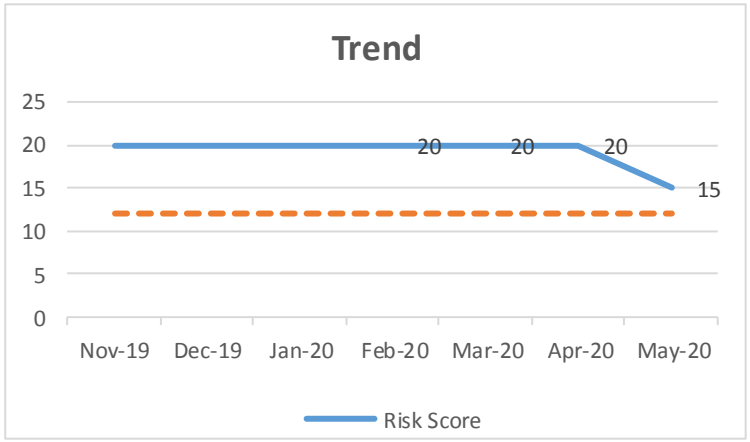
Action	Lead	Deadline
Performance scrutiny takes place at Finance, Performance and Workforce Committee quarterly. Included within Integrated Performance Dashboard monthly	DPCMH	Ongoing
Commissioning discussions taking place across the Network in relation to service pressures and funding.	DPCMH	Ongoing
Implementation of the Choice and Partnership Approach (CAPA) and being closely monitored.	DPCMH	Ongoing
A number of service reviews in relation to Ty Llidiard undertaken and monitored via Q,S&R Committee.	DPCMH	Ongoing

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

Ref No. 033

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Medical and Nurse Directors

	Assuring Committee: Quality and Safety Committee
Risk: Increasing dependency on Agency Staff cover in Medical and Nursing areas, which impacts on continuity of care and patient safety and the financial position.	**Date last reviewed:** May 2020

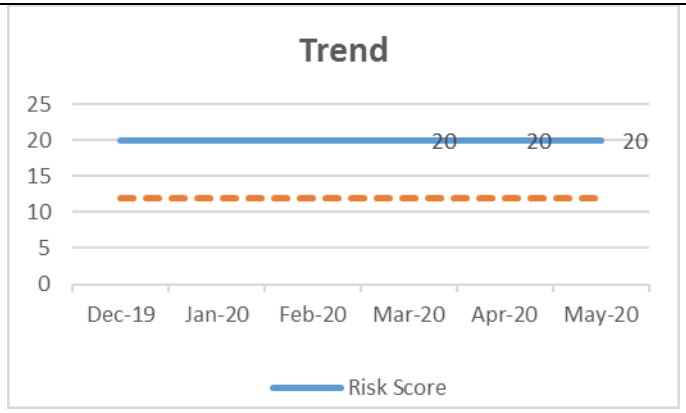
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 3 = 15 Target: 4 x 3 =12		**Rationale for current score:** The international evidence base identifies that there is increased clinical risk when the workforce is transient. Recruitment is a national and UK wide issue. Agency and bank costs are high, this resource could be better invested in developing substantive staff and investing in new models of care, realising 'A Healthier Wales'. **Rationale for target score:** Continued dependency on Agency Staff cover in Medical and Nursing areas, has the potential to impact on continuity of care and patient safety and will impact on the UHB financial position.
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?)**		
• Recurring advertisements of posts in medical and nursing. • Provision of induction packs for agency staff • Proactive recruitment programme in place in areas where dependency on agency locum cover is increasing. • Maintain strict vetting of CVs (Agency medical staff) by the Directorates, with any concerns fed back to the Agency. • Wherever possible, use long term locum staff. • For nursing, maximise opportunities to recruit graduate nurse students for each of the twice annual cohorts. • Review all arrangements for payments to existing staff to make the best use of the resources available, maintain strong controls on the use of bank and agency staff, including stopping any off contract high agency shifts • Adjust bed complement/configuration and skill mix to ensure safe staffing levels are maintained. • Increased use of NHS Locums rather than agency leading to more consistent rostering – May 2020	Action	Lead	Deadline
	Maintain recruitment campaign	WOD	June 2020
	Redesign services wherever possible to embrace a healthier wales and therefore impact upon the workforce required to deliver services	COO & DPCCMH	March 2021

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 achieved where appropriate staffing levels have been secured (based on professional judgement)	• Absence of trends and themes in patient safety incidents attributed to agency staff • Numbers of nursing and medial agency staff referred back to agency with concerns re practice • Number and percentage of agency staff referred to professional regulator

Current Risk Rating	**Additional Comments**	**Ref No. 034**
Current Risk Rating : 3 x 5 = 15		

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Director of Nursing, Midwifery and Patient Services **Assuring Committee:** Executive Board, Quality Sand Safety Committee
Risk: Poor quality of care if there is failure to recruit and retain sufficient registered nursing and midwifery staff.	**Date last reviewed:** March 2020

Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 =12		**Rationale for current score:** National issue re recruitment, retention and retirement, increasing patient complexity, demand and acuity, increased use of bank and agency nursing, **Rationale for target score:** Realistic target given national challenge, expected extension of the Nurse Staffing Levels Act, increasing rates of unfilled bank and agency shifts
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?)**		
• Proactive engagement with HEIW • Scheduled, continuous recruitment activity overseen by WOD • Targeted approach to areas of specific concern reported via finance, workforce and performance committee • Close work with university partners to maximise routes into nursing • Retire and return strategy to maintain skills and expertise • Block booking of bank and agency staff to pre-empt and address shortfalls • Risk management processes in clinical areas reviewed several times daily	Action	Lead	Deadline
	Continue recruitment campaign	Director of Nursing	March 2020
	Workforce modernisation group identifying strategic direction for nursing workforce development including the development of CSW role	Director of Nursing	June 2020
	International recruitment plans developing	Director of Nursing	March 2020

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board • Regular review by Birth Rate Plus, overseen by maternity Improvement Board • Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends	• Predicted medium to longer term trends and mean by which to address • Achievement of workforce development plans as identified within IMTPs • Influencing national commissioning numbers

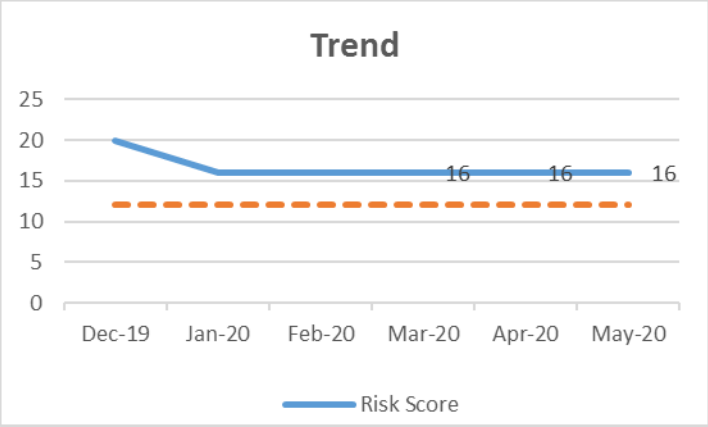
Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 5 = 20		**035**

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

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

Level of Control
=60%

Date added to the risk register
August 2016



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).

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

- Where possible the Primary Care Team is working with the practices to find solutions, which include practice mergers; considering where possible directly managing solutions and/or working to recruit on behalf of the practices.
- Primary, Community Population Health and Partnerships Committee in place to scrutinise delivery of the IMTP.
- Local and National recruitment campaigns progressed, with some reported success.

Mitigating actions (What more should we do?)

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

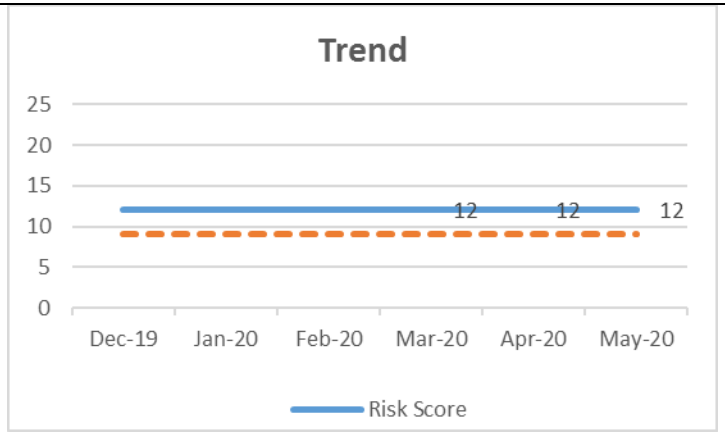
Assurances
(How do we know if the things we are doing are having an impact?)

Recruitment and retention data.

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

Current Risk Rating	Additional Comments	Ref No.
Current Risk Rating : 4 x 4 = 16		**036**

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Director of Planning and Performance **Assuring Committee:** Health Board (will be ICT/IG Committee)
Risk: Ensuring the development, approval and implementation of a Strategy for IM&T, that is clinically led and supports staff in care delivery.	**Date last reviewed:** January 2020

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 (May 2017). • Governance arrangements to oversee delivery of the Strategy agreed in the form of new IG/ICT Committee. • Digital Strategy Steering Group well established and work programme linking national and local improvements well underway. • New Independent Member for ICT appointed. • Major deliverables in the form of WEDs and notes digitisation now initiated and will deliver first quarter next year. • Work on Transformation programme initiating following successful funding bid.	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	ongoing
	Implement the action plan developed with the Strategy; set up the group which will lead the work.	COO	Complete through DSSG
	Review and consider, the effectiveness of the related governance arrangements – new governance initiating end 2019	Board Sec	Complete

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• Monitor the timescales and milestones identified in the action plan through DSSG.	Group now established to take forward the actions agreed. Need to consider effectiveness of related governance / scrutiny arrangements.

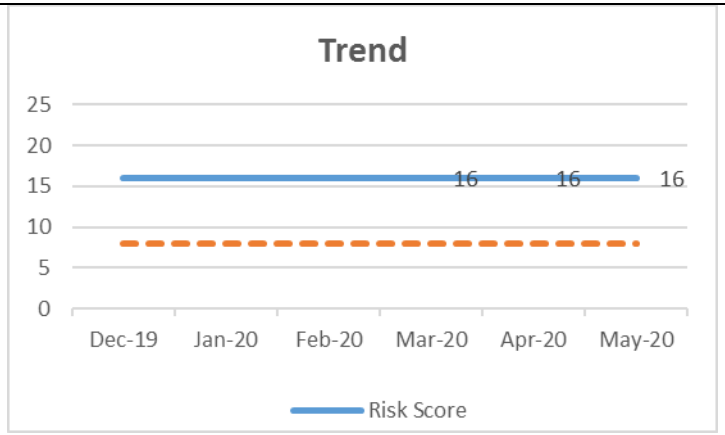
Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 3 = 12	New ICT Committee to be established, following comments and recommendations of WAO Structured Assessment. IM for ICT now in post.	**037**

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

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

Level of Control
=60%

Date added to the risk register
July 2018



Rationale for current score:
The effectiveness of the Williamstown Records Storages Hub is reliant on digitisation of health records. Now we have an agreed business case and investment, will be able to balance demand and capacity across the service.

Rationale for target score:
Delivering the Digitisation of health records, alongside the records hub will ensure a sustainable, safe & secure storage solution.

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

- Williamstown Hub is yet to reach full capacity.
- WG Invest to Save bid signed off June 2019.
- Digitisation of Records Business Case signed off and Civica will initiating project November 2019 covering old CT and PoW footprints.
- Requirement to stop disposing of records in line with the Infected Blood Inquiry; impact being closely monitored potentially to use a building leased by the Welsh Government to assist.
- Initiation of Document Management System, Clinical Portal interface and Eforms all follow as part of the project over the next year.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
BJC for Digitisation approved via Management Board / Board as appropriate	COO	Approved
Ensure Records management processes fully applied in Williamstown to maximise use of available physical capacity	COO	Ongoing
Ensure no temporary storage solutions are agreed, without full consideration of the Executive.	COO	Ongoing

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

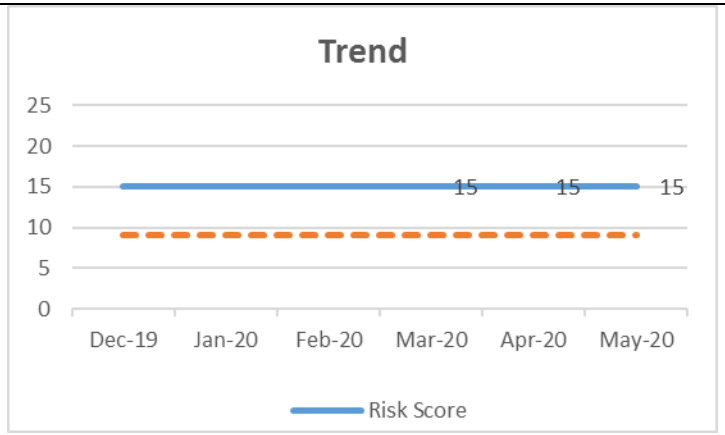
Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 4 = 16	Impact of Infected Blood Inquiry to be further considered; Management Board considered and supported phase 1 of work	**039**

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

Risk Rating
(consequence x likelihood):
Initial: 3 x 5 = 15
Current: 3 x 5 = 15
Target: 3 x 3 = 9

Level of Control
=60%

Date added to the risk register
July 2018



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.

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

- The Welsh Language Unit has undertaken a self-assessment of the requirements of the Standards and how they apply to Cwm Taf Morgannwg
- Close constructive working relationships are in place with the Welsh Language Commissioner's Office
- Strong networks are in place amongst Welsh Language Officers across NHS Wales to inform learning and development of responses to the Standards.
- Regular reports to the Board to raise awareness
- Working Group set up to support managers
- Developing a new bilingual skills strategy
- Offering free Welsh courses for staff
- Carrying out Ward Audits to monitor progress with compliance
- Continue to review and act on the UHBs Self-Assessment findings and related improvement actions; ensure Board is fully sighted.
- Develop a 5 year plan outlining the extent to which the health board can carry out consultations in Welsh and the actions taken to increase this

Mitigating actions (What more should we do?)

Action	Lead	Deadline
All actions on hold/light touch during COVID-19, re-starting June 2020.		
Continue to work with Directorates to develop action plans in response to the requirements of the Standards	DW&OD COO DPC&MH	June 2020
Continue to develop the Welsh language skills of the workforce and implement a new bilingual skills strategy.	DW&OD	June 2020
Publish a Primary Care Policy which takes into consideration the effects on the services for the Welsh speaking population	DPC&MH	June 2020
Develop a process to ensure all new vacancies are advertised bilingually	DW&OD	June 2020

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

Compliance with Statutory requirements outlined in Welsh Language Act and related Standards.
Auditing and monitoring of compliance

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

- Updated action plans from directorates to ensure all requirements are met across the HB

Current Risk Rating

Current Risk Rating : 3 x 5 = 15

Additional Comments

The self-assessment has confirmed that the Health Board is not able to fully comply with all the Standards

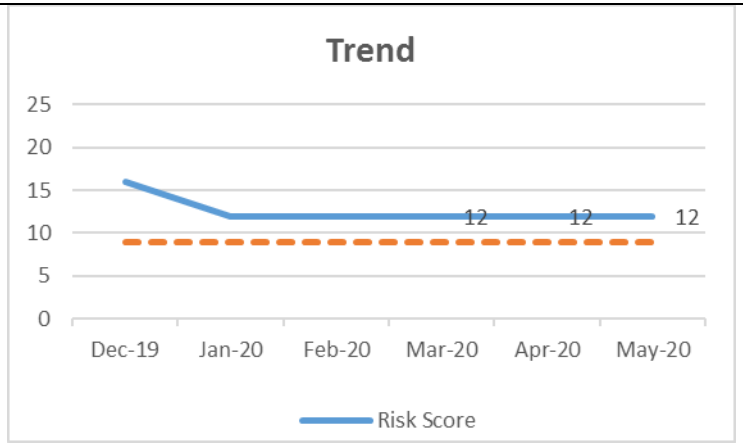
Ref No. 040

Objective: **Statutory Compliance**	**Director Lead:** Director of Operations **Assuring Committee:** Quality & Safety Committee
Risk: Failure to fully meet all the licensing requirements of the Human Tissue Authority (HTA) in relation to Mortuary & Services for the Deceased.	**Date last reviewed:** January 2020

Risk Rating
(consequence x likelihood):
Initial: 4 x 4 = 16
Current: 4 x 3 = 12
Target: 3 x 3 = 9

Level of Control
=70%

Date added to the risk register
July 2018



Rationale for current score:
Reflect the Directorate led baseline assessment and the findings of the HTA inspection in April 2018. Compliance now restored and focus is on sustainability of the service and bringing together CTM mortuary services under one HTA license.

Rationale for target score:
Likely rating once the issues identified are addressed and the corrective action & improvement plan is fully implemented.

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

- The Pathology Directorate undertook a baseline review which identified a number of areas for action in advance of the HTA inspection.
- The first line of defence (the Board's internal assurance) was not sufficiently strong enough to ensure related matters were raised and addressed in advance of the Licence Regulators informing the UHB when the statutory environment had changed and raised the standards required for compliance.
- The Pathology Directorate developed a comprehensive action plan in response to the HTA findings with Board agreed scrutiny & Monitoring arrangements in place via the Q,S&R Committee.
- Related controls are considered strong with regards knowing what the 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; 0 HTARIs by 13/7/19.
- HTA published compliance notice in 8/2019.
- PoW HTA inspection took place 9/2019 and view on compliance expected before year end, with adoption of one license to follow.

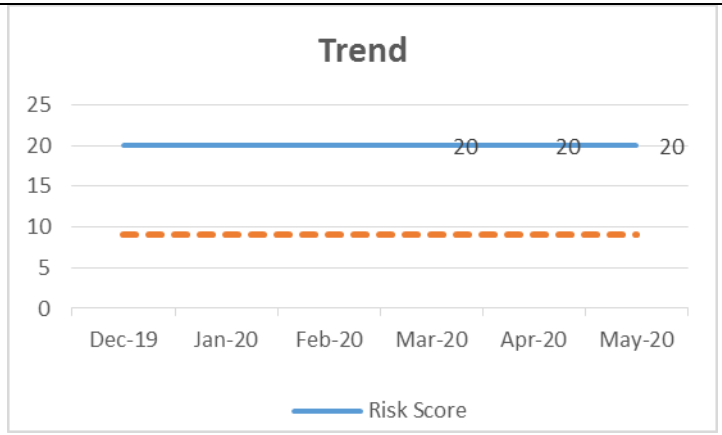
Mitigating actions (What more should we do?)

Action	Lead	Deadline
Ensure the Directorate Corrective Action Plans are fully implemented	COO	Completed
Consider case for bringing CTM under one HTA license once SBUHB inspection cycle is complete and CAPAs compliant. Potential for future consolidation of coronial PM services to be considered as a service development if services can be brought together in the New Year.	COO	Ongoing through HTA Project Board and Care of the Deceased Project Board
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.	PoW position to report once HTA inspection cycle and CAPAs completed.

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 4 = 12	All 32 CAPA plans completed and submitted to the HTA. Compliance restored and sustained.	**041**

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:** January 2020

Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 =20 Target: 3 x 3 = 9		**Rationale for current score:** Delivery Unit's Report: Intervention into Cwm Taf Morgannwg University Health Board systems and processes for reporting, management and review of patient safety incidents & Concerns, (September, 2019) joint review of maternity services by the Royal College of Obstetrics and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) March 2019 Targeted intervention status with maternity services specifically being placed into special measures. **Rationale for target score:** Likely rating once organisational structures are in place values and behaviours framework established and the issues identified are addressed and the corrective action & improvement plan is fully implemented.
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?)**		
• Implementation of the Quality & Patient Safety Governance Framework • Implementation of the Maternity Improvement Board • Implementation of the improvement plan developed in response to the Delivery Unit review • Full implementation of the outcomes of the Delivery Unit's supportive intervention	Action	Lead	Deadline
	Data generation and analysis is accurate, intelligent and sued to inform performance and outcome	Medical Director	April 2020

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• Additional scrutiny applied by Welsh Government and the Independent Maternity Oversight Panel • Regular reporting to Quality & Risk Committee and Board • Regular engagement with external stakeholders e.g. the public, County Borough Councils, Community Health Councils • Audit of directorate and service governance arrangements	• Benchmarking with comparative providers

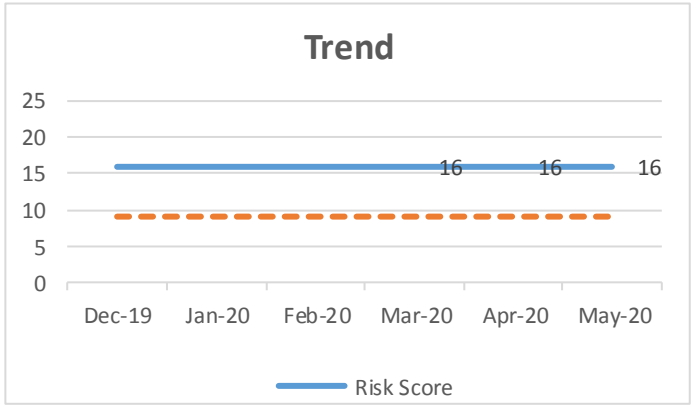
Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 5 x 4= 20		**043**

Objective: **Service / Business Interruption**	**Director Lead:** Director of Public Health **Assuring Committee:** Management Board
Risk: Risk of interruption to service sustainability, provision and destabilising the Board's financial position as a result of Brexit.	**Date last reviewed:** January 2020

Risk Rating
(consequence x likelihood):
Initial: 4 x 4 = 16
Current: 4 x 4 = 16
Target: 3 x 3 = 9

Level of Control
= 50%

Date added to the risk register
November 2018



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.

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

- Gap analysis/risk assessment on Brexit completed
- Completed the Wales Audit Office (WAO) self-assessment
- Regular updates provided to WG as required
- Directorate Business Continuity plans being updated – particularly in Medicines Management; Facilities (food); ICT; Workforce; Estates; R&D
- Regular dialogue with Welsh Government and working with the Welsh NHS Confederation – active on SRO and Health Securities groups
- Emergency Planning, Preparedness & Response (EPPR) for the CTM sites
- Workforce actively pursuing the gap analysis.
- Assessment of potential risks to the flow of personal data following Brexit
- Active with NWSSP to provide detail on product lines and non stock items
- Taking part in Operation Yellowhammer reporting (with WG)
- Undertaken a number of business continuity exercises to test existing business continuity plans to identify any gaps in resilience.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Work nationally with Welsh Government, Local Resilience Forums and other HBs and Trusts to share business continuity plans.	Board Sec CCM	Ongoing
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	ongoing

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

The Health Board is providing services "business as usual" with no interruption to service sustainability and provision of patient care.

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

All directorates to confirm business continuity plans updated

Current Risk Rating

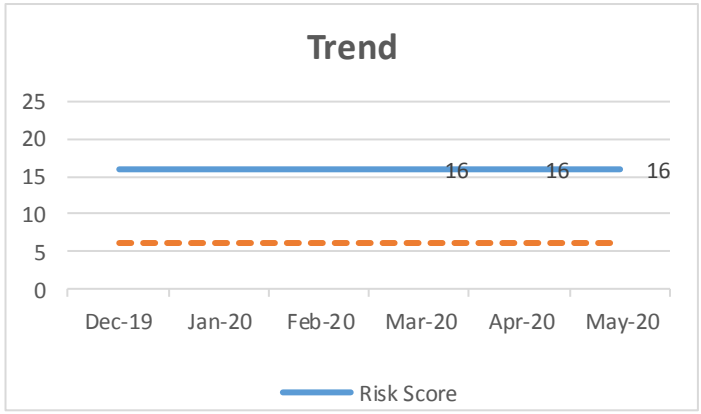
Current Risk Rating: 4x4 =16

Additional Comments

Whilst Brexit negotiations continue the Health Board will work with other organisations to identify risk

Ref No. 045

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead: Medical Director** **Assuring Committee:** Finance, Performance and Workforce Committee.
Risk: Not agreeing a sustainable model for emergency medicine and inpatient paediatrics across the CTMUHB footprint. **Impact**: Unable to deliver safe high quality emergency medicine and inpatient paediatrics services across the CTM footprint.	**Date last reviewed:** May 2020

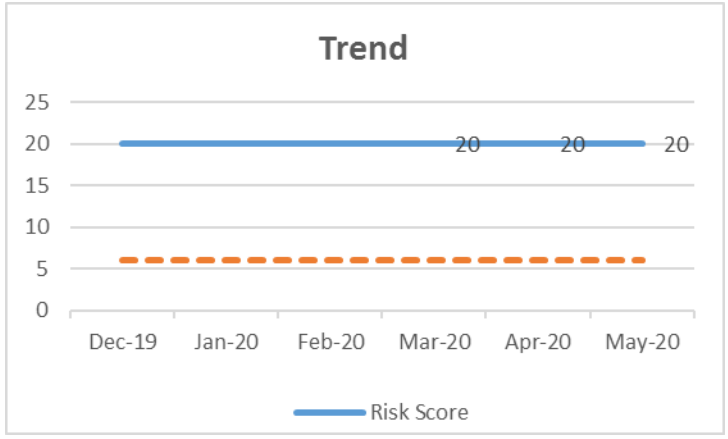
Risk Rating		**Rationale for current score:** • Recent workforce pressures (RGH ED) and paediatrics • Safety concerns identified by PoW consultants at RGH • South Wales Programme paused due COVID work, although recruitment initiatives continue. Risk unchanged **Rationale for target score:** • Ensure CTM communities are provided with the highest quality sustainable services.
(consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 2 = 6		
Level of Control =TBC%		
Date added to risk register		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Project Board establish to work up the options and manage the risks • Modelling work, informed by that done by the SWP, being undertaken to establish a number of options, and to assess patient flow implications	Action	Lead	Deadline
	Engage with staff and staff representatives on the options.	NL	Jan – Sept 20
	Engage with the CHC, and wider external stakeholders on the options.	NL	Jan – Sept 20
	Clinical reference groups (CRGs) are being established to assist with the work of the project and facilitate appropriate clinical engagement.	NL	Jan – Mar 20
	SWP work paused during COVID-19, but recruitment drive continues	NL	March – June 20

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
CHC and stakeholder support.	

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 4 = 16	The previous SW Programme implementation risk was removed from the risk register (December 19)	**050**

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead: Medical Director** **Assuring Committee:** Finance, Performance and Workforce Committee.
Risk: Implementing a sustainable model for emergency medicine and inpatient paediatrics across the CTMUHB footprint in a timely manner. **Impact**: Unable to deliver safe high quality emergency medicine and inpatient paediatrics services across the CTM footprint.	**Date last reviewed:** May 2020

Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 3 x 2 = 6		**Rationale for current score:** • Recent workforce pressures (RGH ED) and paediatrics • Safety concerns identified by PoW consultants at RGH • South Wales Programme paused due COVID work, although recruitment initiatives continue. Risk unchanged **Rationale for target score:** • Ensure CTM communities are provided with the highest quality sustainable services.
Level of Control =TBC%		
Date added to risk register		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Project Board establish to work up the options and manage the risks • Modelling work, informed by that done by the SWP, being undertaken to establish a number of options, and to assess patient flow implications	Action	Lead	Deadline
	Engage with staff and staff representatives on the options.	NL	Jan – Sept 20
	Engage with the CHC, and wider external stakeholders on the options.	NL	Jan – Sept 20
	Clinical reference groups (CRGs) are being established to assist with the work of the project and facilitate appropriate clinical engagement.	NL	Jan – Mar 20
	SWP work paused during COVID-19, but recruitment drive continues	NL	March – June 20

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Escalation levels.	

Current Risk Rating	**Additional Comments**	**Ref No.**

Current Risk Rating : 4 x 4 = 20	The previous SW Programme implementation risk was removed from the risk register (December 19)	051

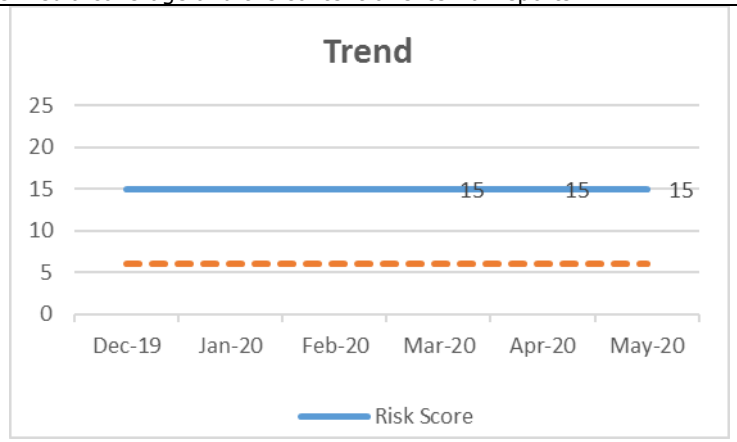
Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead: Director of Corporate Governance** **Assuring Committee:** Finance, Performance & Workforce
Risk: Risk: Organisational Reputation: Lack of confidence in the services and care provided by the organization. **Impact**: Reputational damage, loss of confidence, patients seeking services from elsewhere, increased external scrutiny. Staff disengaged due to negative media coverage and the content of external reports.	**Date last reviewed:** May 2020

Risk Rating

(consequence x likelihood):
Initial: 5 x 3 = 15
Current: 5 x 3 = 15
Target: 3 x 2 = 6

Level of Control
=TBC%

Date added to risk register



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

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

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

- Rebuild trust and confidence programme under Targeted Intervention Improvement Programme underway.
- Improved staff engagement and involvement, new approaches to partnership engagement and involvement.
- Ensure balanced news stories are regularly reported and communicated.
- Additional capacity bid included in TI investment bid under the TI programme to WG.
- Additional capacity bid included in TI investment bid under the SW Programme.

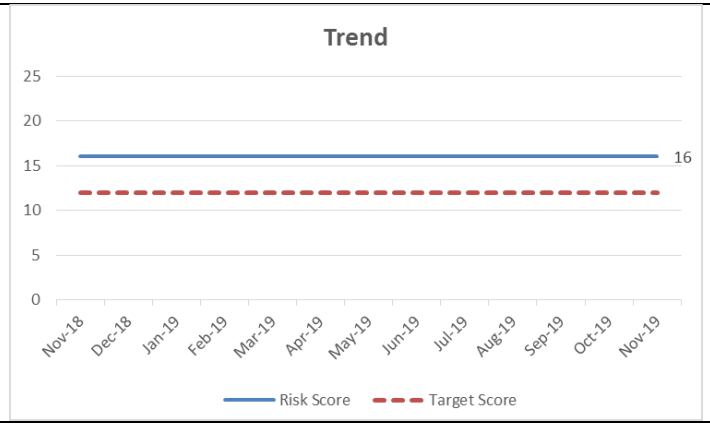
Mitigating actions (What more should we do?)

Action	Lead	Deadline
Objective assessment against the TI maturity matrix and action as a result of the assessment, to include COVID-19 evidence of progress.	Head of Comms	June 20
A programme of public and patient engagement and involvement, Let's Talk programme, developing Values and + with staff and patients. Open door policy.	Head of Comms	June 20
Relationship building with the media.	Head of Comms	April 20
Focused on increased transparency and partnership working with stakeholders.	Head of Comms	Jan 20 – Jan 21

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Progress against the TI maturity matrix categories.	

Media coverage. Number of external reviews and actions to address recommendations in external reviews. WG escalation status of CTMUHB.		
Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 5 x 3 = 15		**052**

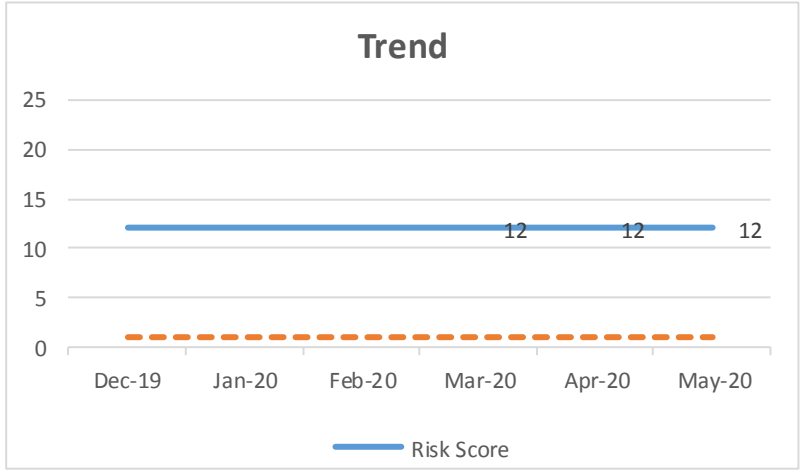
Objective: **Statutory compliance**	**Director Lead:** Director of Therapies and Health Sciences **Assuring Committee:** Management Board / Audit and Risk
Risk: Failure to meet Fire Safety Standards across the UHB.	**Date last reviewed:** January 2020

Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 3 =12 **Level of Control** =70% **Date added to the risk register** October 2009		**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

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 • RCA being carried out into the fire alarm in PCH pre Christmas to assess the effectinvess of the response and take action where appriate to improve and ensure compliance – Feb 20	Action	Lead	Deadline
	Pro active management via Clinical / Corporate Business Meetings (CBMs) to ensure profile for fire safety remains high.	COO /DPCMH	Ongoing
	Regular inspections and dialogue with South Wales Fire & Rescue Service.	Head of Fire Safety	Ongoing
	Robust risk assessment processes in place and good compliance with staff training uptake to be sustained.	Head of Fire Safety	Ongoing

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

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Director of Nursing, Midwifery and Patient Care **Assuring Committee:** Quality and Safety Committee
Risk: Patients and/or relatives/carers do not receive timely responses to concerns raised resulting in learning and improvement which is delayed	**Date last reviewed:** March 2019

Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 3 x 4 = 12 Target: 1 x 1 = 1		**Rationale for current score:** Increasing numbers of complaints received following the organisation's escalation status, and the Bridgend Boundary change, differing management models within DGH sites, reduced directorate capacity in areas that have greater patient flow volumes and therefore more complaints, reduced corporate capacity. Risk score decreased to moderate (3 – formal complaints and repeated failure to meet standards) x 4 (happens 10 – 50% of the time) = 12 **Rationale for target score:** Putting Things Right identifies the Welsh Government's requirement in relation to response times, proactively supporting shared learning and quality improvement
Level of Control =		
Date added to the risk register April 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Implementation of the Quality & Patient Safety Governance Framework • Organisational structures are being agreed which will help ensure right resource right place right time to reduce and manage appropriately complaints, including establishing governance resource within service delivery units • Values and behaviors work will support outcome focused care • supportive intervention from the Delivery Unit supporting redesign of complaints management • relocation of the concerns team into District General Hospitals • Preservation of the governance resource within the princess of Wales Hospital	Action	Lead	Deadline
	Develop the quality governance operating model within the new operating structure	Executive Nurse Director	June 2020
	Ensure access to education, training and learning	Executive Nurse Director	June 2020

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• Views of the Community Health Council • Weekly monitoring in the executive patient safety meetings • Regular reporting to the Quality Assurance sub group, Quality & Safety Committee and Board • External scrutiny from Welsh Government	• Results of post complaint response survey

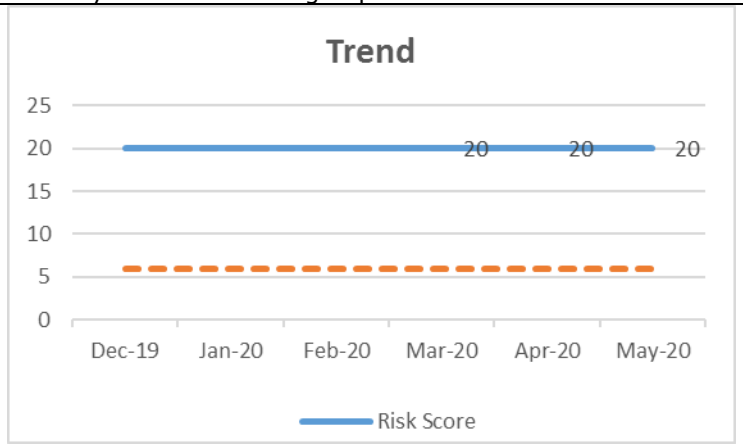
Current Risk Rating **3 x 4 = 12**	**Additional Comments**	**Ref No.** **023**

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Director of Operations **Assuring Committee:** Finance, Performance & Workforce Quality and Safety Committees
Risk: Failure to treat patients in a timely manner resulting in potential avoidable harm	**Date last reviewed:** January 2019

Risk Rating
(consequence x likelihood):
Initial: 5 x 4 = 20
Current: 5 x 4 = 20
Target: 3 x 2 = 6

Level of Control
= 50%

Date added to risk register
July 2019



Rationale for current score:
The level of clinical risk is being scoped
The current score reflects the issue identified as a result of the discovery of unreported waiting lists. A number of sub-specialty waiting list codes were discovered to be unreported and therefore unsighted. UHB staff have worked in conjunction with Delivery Unit staff to identify all lists that should be reported and therefore develop plans to ensure these patients are treated as a matter of urgency.
As these lists are confirmed additional work is being undertaken with the patient care and safety team to ensure any avoidable harm is reported and acted upon accordingly. Immediate safe systems of work been implemented to ensure no other sub specialties can be entered onto the unreported lists.

Rationale for target score:
The need to ensure safe timely patient care, eradicate such lists and ensure appropriate reporting supports the target score of 6.

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

- Speciality specific plans are in place to ensure patients requiring clinical review are assessed
- All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly.
- Immediate process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months
- All unreported lists that appear to require reporting have been added to the RTT reported lists
- All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Ensure service plans provide enough capacity for timely assessment		
Continue delivery of the controls in place	Ops Directors	Ongoing
Annual check of all waiting lists should be undertaken to ensure robustness of processes	Ops Directors	Quarter 2
Develop Demand & Capacity Plans for all areas that were not previously reported	Ops Directors	Ongoing quarterly

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

- Regular reporting and scrutiny at directorate CBMs and board sub committees?
- Share learning across all areas who may need to review their own practice?

All appropriate waiting lists will be reported and will be dealt with in line with RTT waiting times criteria.

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

F,P&W monitoring progress.
Working with the DU to analyse all waiting times

Current Risk Rating

5 x 4 = 20

Additional Comments

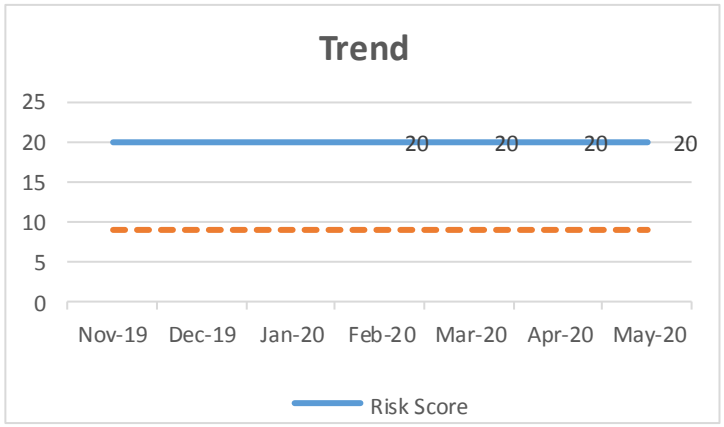
Ref No. NEW 047

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Director of Workforce and Organisational Development **Assuring Committee:** Finance, Performance and Workforce Committee
Risk: There is a risk that there is insufficient workforce to deliver against the emerging CTM Re-setting framework – balancing Covid and non Covid activity, due to staff recruitment, retention and sickness.	**Date last reviewed:** May 2020

Risk Rating
(consequence x likelihood):
Initial: 4 x 5 = 20
Current: 4 x 5 = 20
Target: 3 x 3 = 9

Level of Control
=50%

Date added to risk register
November 2019



Rationale for current score:
Impact of retaining sufficient staff will affect the organisations ability to provide safe services to respond to COVID and non COVID services, particularly in Nursing.

Rationale for target score:

Some degree of staff turnover is inevitable

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

- Overseas recruitment project aiming to secure 200 Nurses – intial nurses receruited, but circa 80 not able to recruit due to flight restrictions linked to COVID-19.
- Introduction of exit questionnaire and exit interview process. Returns scrutinised by HR Teams for any concerns to be taken forward. Metrics run on return rates and included in WOD metrics report submitted to FPW.
- Turnover rates reported on Workforce Metrics Report at FPW.
- Ensure all staff are supported and developed through effective personal development reviews and career planning.
- In process of reviewing Leadership and Management offering.
- Attendance at recent trip to India as part of All Wales BAPIO/MTI initiative for medical staff. Allocation of doctors to CTM due by end of November 2019.
- Launched Let's Talk Culture – a major new project involving as many staff and patients as possible sharing their views about how we build our new organisation and co-creating our culture, values and behaviours.
- Harassment, Bullying and Abuse (HBA) steering group has been set up to create a positive workplace culture and tackle bullying & harassment.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Ensure our workforce planning processes clearly identify the roles required for the future, based on the re-setting post covid-19 framework.	Director of WOD	June – July 2020
Improve flexible working opportunities.	Director of WOD	Ongoing
Identify common themes and trends from exit questionnaires and develop specific action plans.	Director of WOD	Ongoing
Increase staff testing (COVID-19) capability and track and trace.	Director of WOD/PH	June – July 2020
Re-commence international recruitment, when able to (post Covid-19).	Director of WOD	Sept – March 2020/21

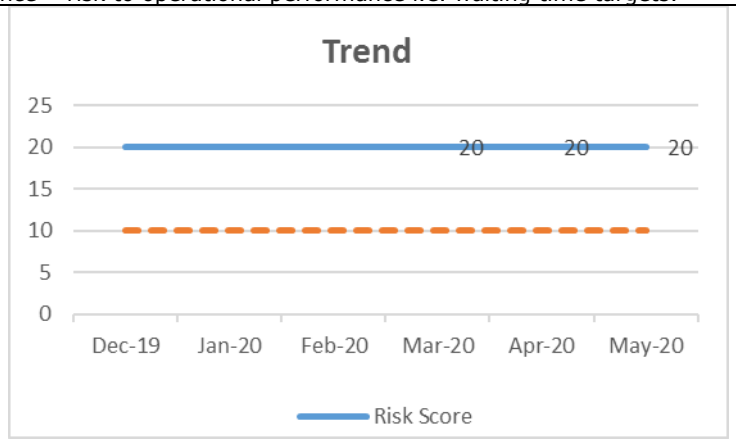
Assurances
(How do we know if the things we are doing are having an impact?)

Reduction of turnover rates
Reduction in use of agency and bank staff

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

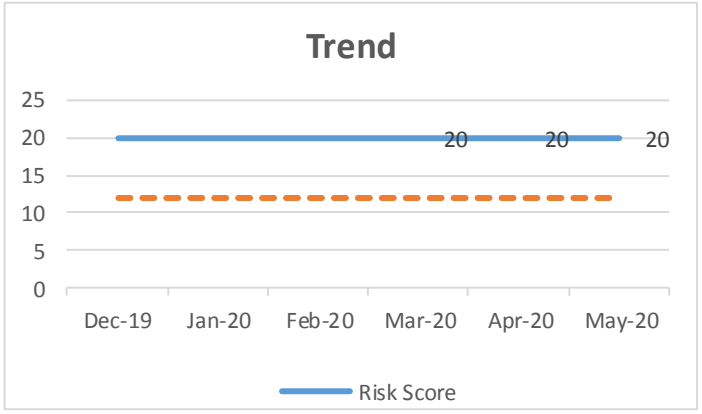
Current Risk Rating	Additional Comments	Ref No.
Current Risk Rating : 4 x 5 = 20		**049 NEW**

Objective: **Setting the Direction & Performance & Operational Delivery** **Risk: COVID-19 business continuity plans**	**Director Lead: Director of Public Health** **Assuring Committee: Primary, Community, Population Health & Partnerships Committee**
Background: COVID-19 is caused by a contagious newly identified virus. There are no therapeutics and vaccines available and there is presumably no pre-existing immunity in the population. Symptoms of COVID-19 range from no symptoms (asymptomatic) to severe pneumonia and can lead to death. **Risk:** There is a risk that the contingency and business continuity plans do not manage the outbreak of COVID-19 as well as well as they could, failing to manage the pandemic appropriately. **Impact**: Resulting in the Health Board not mounting an appropriate response to the pandemic, impacting on: *Patient safety* – patients at increased risk of infection. *Population* – excess mortality over and above what would be expected under normal circumstances *Staff* – exposed to psychological stressful conditions i.e. fearful of working environment and their personal safety. *Quality* – care may be effected due to the increased focus of dealing with COVID 19, and the need to expedite discharges etc. *Resources* – incurring costs in order to response to COVID-19. *Operational performance* – risk to operational performance i.e. waiting time targets.	**Date last reviewed: May 2020**

Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 3 = 15 Target: 5 x 2 = 10 **Level of Control** =TBC% **13.03.20**		**Initial Risk Score: 4x5 = 20** Before business continuity and contingency arrangements put in place. **Rationale for target score: 2x5 = 10** Business continuity established, with Gold, Silver, Bronze Command structure in place from 09/03/20. Aiming to reduce the likelihood down to 'unlikely'.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Planning preparedness, contingency structures across gold, silver, and bronze.	Action	Lead	Deadline

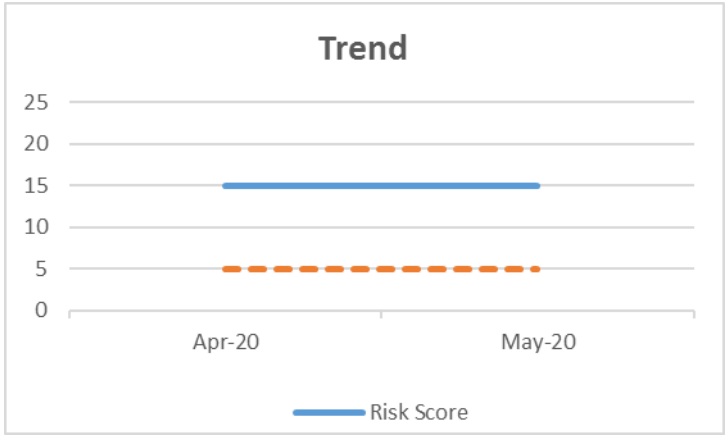
• Staff, partner and public communication to reinforce behavioural messages – wash hands, etc • Cancellation of non-essential meetings and activities • Re-directing planning, and operational resources to respond to COVID-19 • Staff training – fit testing for personal protective equipment and stock control, systematic deployment of PPE informed by completed pathways • Implement national advice on behavioural interventions to delay spread •	• Imlement Testing Strategy	DoPH	May-June 2020
	• Continue to promote lockdown and social distancing messages to the CTM communities •	DoPH	May – June 2020
	• Work to understand potential impact of 2nd, 3rd peak	DoPH	May – Oct 2020
	• Electives cancelled to prevent risk of capacity to manage COVID-19 impact.	DoPH	
Assurances **(How do we know if the things we are doing are having an impact?)** Monitoring 3 strategic objectives CTM dashboard with daily numbers and impact of COVID-19. Routine performance discussions through bronze, silver and gold. Monitoring the numbers and deaths on a daily basis, and deaths to go through the mortality review process.	**Gaps in assurance** **(What additional assurances should we seek?)** Partner engagement and wider community implications e.g. planning for residential and care sector, getting the balance with communication.		
Current Risk Rating	**Additional Comments**		**Ref No.**
Current Risk Rating : 5 x 4 = 20			**054**

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead: Director of Public Health** **Assuring Committee: Primary, Community, Population Health & Partnerships Committee**
Background: COVID-19 is caused by a contagious newly identified virus. There are no therapeutics and vaccines available and there is presumably no pre-existing immunity in the population. Symptoms of COVID-19 range from no symptoms (asymptomatic) to severe pneumonia and can lead to death. **Risk:** There is a risk to the Health Board that the resources and focus going on managing the response to the outbreak of COVID-19 will lead to patient harm as a result of reduced service provision and capacity to respond to other areas of Health Board operations. **Impact**: Patients have poor experience and potential harm as a result of the Health Board's focus on COVID-19, and operating in business continuity mode. Potential impact on life, quality of life, increase in claims and complaints and negatively impact on reputation and the trust and confidence in the services of the Health Board.	**Date last reviewed: May 2020**
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 3 = 12 **Level of Control** =TBC% **23.03.20**	
	Rationale for current score: 5x4 = 20 Business continuity established, with Gold, Silver, Bronze Command structure in place from 09/03/20. The level of business as usual activity being stepped down, means there is a risk of patient harm, which might have been avoided were we operating in an environment where these services in place. **Rationale for target score: 4x3 = 12** Aiming to reduce consequence score to 3 and likelihood to 4 during the COVID-19 response period. To be done by Quality Impact Assessing (QIA) all major decisions and risk assessing situations which could have implications for patients and patient harm.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Planning preparedness, contingency structures across Gold, Silver, and Bronze. • Critical services operating. • Governance process in place for financial and non-financial decision making to support Gold, Silver and Bronze decision-making, all predicated on Quality Impact Assessments. • Quality & Safety Committee one of only 2 committees continuing throughout COVID-19 to ensure scrutiny and assurance on behalf of the Board. • Indicators of quality and patient safety for all services continue to be closely	Action	Lead	Deadline
	• QIA all decisions that are likely to have patient quality, safety and experience impact.	DoPH	23.03.20
	• Implemeting re-setting to new normal framework.		May – August 2020

monitored throughout COVID-19. • Processes and guidance in place to ensure clarity on areas such as safeguarding and child protection. • Essential Services list reviewed and submission to WG given. • Working to WG guidance on essential services provision.		DoPH	
Assurances **(How do we know if the things we are doing are having an impact?)** The QIA process for service changes relating to COVID-19 management will include an assessment of related impact on any existing service delivery. Monitoring deaths via the mortality review process. Monitoring incidents, complaints and feedback through social media. Monitoring Core quality and safety metrics.	**Gaps in assurance** **(What additional assurances should we seek?)** Unknown harms.		
Current Risk Rating	**Additional Comments**		**Ref No.**
Current Risk Rating : 5 x 4 = 20			**055**

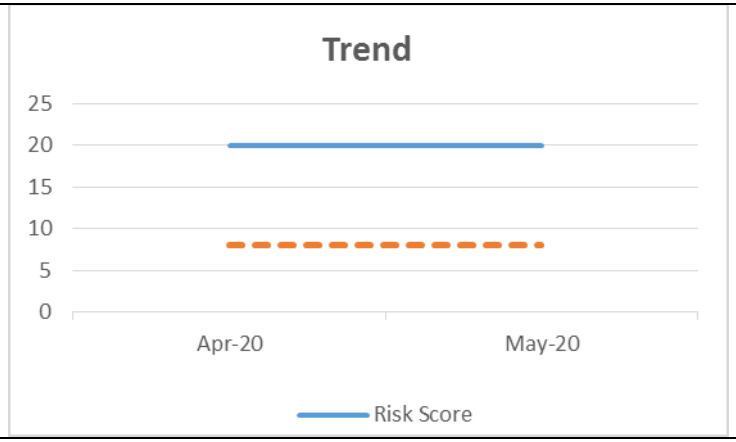
Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead: Director of Finance** **Assuring Committee: Audit and Risk Committee**
Background: COVID-19 is caused by a contagious newly identified virus. There are no therapeutics and vaccines available and there is presumably no pre-existing immunity in the population. No pre-agreed budget for managing COVID-19 was agreed/approved by WG. All spend has been approved via the CTMUHB Command and Control Structure and associated Scheme of Delegation. **Risk:** Financial Impact of COVID-19: There is a risk that the organisation's operational revenue costs of addressing the pandemic cannot be contained within available revenue funding resulting in an unplanned I&E deficit in 2020/21, and a parallel risk of unfunded additional capital costs resulting in the Capital Resource Limit being exceeded in 2020/21. There is also a risk to the recurrent financial position which is then taken into 2021/22. This risk may apply even if 2020/21 costs are funding by Welsh Government, if that funding is non-recurrent. **Impact**: Unplanned I&E deficit in 2020/21	**Date last reviewed: May 2020**

Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 5 x 1 = 5 **Level of Control** =TBC% **05.05.20**		**Rationale for current score: 5x3 = 15** Business continuity established, with Gold, Silver, Bronze Command structure in place from 09/03/20. The level of funding for COVID-19 is currently unknown. **Rationale for target score: 5x1 = 5** Aiming to reduce likelihood score so that the risk of not being able to fund the COVID-19 response is very unlikely.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• 01.05.20 Updated: • • Modelling of anticipated patient flows, and the resultant capacity requirements, workforce requirements and revenue and capital costs • • Financial modelling and forecasting is co-ordinated with planning and projecting of service impacts	Action	Lead	Deadline
	Exploring internal sources of funding further (from slippage or re-direction of targeted WG funding including partnership funding)	DoF	May 20

• • Financial reporting to Welsh Government on projected and actual revenue and capital costs to inform central and local scrutiny, feedback and decision-making; • • Seeking feedback from WG on funding availability (both revenue allocations and Capital Resource) • Ensuring all Covid-19 related expenditure is properly required and authorised within the scheme of delegation, and value for money is properly considered. • • Oversight arrangements in place at Silver and Gold	Scrutiny and assurance on planning and mitigation through PPF Committee and Health Board	DoF	19.05.20
	Continuing to seek WG feedback on WG funding for Covid revenue costs and capital costs.	DoF	Ongoing (as at May 20)
Assurances **(How do we know if the things we are doing are having an impact?)** • PPF Committee Feedback • Gold Command Decision making audit	**Gaps in assurance** **(What additional assurances should we seek?)** WG feedback		
Current Risk Rating	**Additional Comments**		**Ref No.**
Current Risk Rating : 5 x 3 = 15			**056**

Objective: Human Resources / Organisational Development / Staff Competency	**Director Lead: Director of WOD** **Assuring Committee: TBC**
Background: COVID-19 is caused by a contagious newly identified virus. There are no therapeutics and vaccines available and there is presumably no pre-existing immunity in the population. No pre-agreed budget for managing COVID-19 was agreed/approved by WG. All spend has been approved via the CTMUHB Command and Control Structure and associated Scheme of Delegation. **Risk:** Staff Wellbeing: There is a risk of insufficient psychological and wellbeing support to staff. **Impact**: potentially leading to more staff absence, and / or adverse staff mental wellbeing impact.	**Date last reviewed: May 2020**

Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 2 = 8 **Level of Control** =TBC% **15.05.20**		**Rationale for current score: 4x5 = 20** Staff wellbeing impact from working in a COVID-19 environment is likely to have a psychological impact, this risk has been informed by other Engish NHS Trusts expeience who were circa 2 weeks ahead of CTM in dealing with COVID-19. **Rationale for target score: 4x2 = 8** Aiming to reduce likelihood score based on significant investment in psychological and wellbeing support for staff.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• 13.05.20 Updated: • Daily staff communications - staff Q&A sessions onsite, daily electronic communication 20.03.20 • Wobble rooms established in PoW • Lessons being learnt from Kings College London 31.03.20 • PPE guidance issued 02.04.20 • Access to well-being resources available on Sharepoint 03.04.20 • Well-being blog 03.04.20 • Literature giving links to available wellbeing sites and phone numbers so that staff can access more support 03.04.20. • Wobble rooms to be rolled out across all sites. • Looking to commission well-being support service • Advert has gone out (30.03.20) across our social media channels for a range of talking therapies input, including psychology and counselling.	Action	Lead	Deadline
	Baseline survey being carried out.	DoWOD	May - June 20

• Baseline survey being undertaken to understand impact. • Oversight arrangements in place at Silver and Gold			
Assurances **(How do we know if the things we are doing are having an impact?)** • Number of staff absent due to mental wellbeing impact of covid. Psychological support available for staff.	**Gaps in assurance** **(What additional assurances should we seek?)** WG feedback		
Current Risk Rating	**Additional Comments**		**Ref No.**
Current Risk Rating : 4 x 4 = 20			**057**