Datix ID	Strategic Risk owner	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4491	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - 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. - A 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. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	The Health Board has established a Planned Care Board, with a full programme of work to address FUNB, demand and capacity and a recovery programme which will include cancer patients; The plans have timescales – which are being monitored, however it is likely that it will take time to reduce waiting times to acceptable levels in the post-covid-19 environment. The PCH Improvement Programme has significantly accelerated a number of mitigating actions designed to improve flow, reduce risk and improve the quality of care in the unscheduled care pathway. Updates on this are provided through the Quality & Safety Committee including specific actions and measures. There is also a PCH Improvement Board that meets monthly with the COO as the SRO. The Health Board is centralising the operational management and decision making around all elective services with the clear aim of increasing and protecting elective activity as we deal with the pressures of the Covid-19 pandemic and winter. This process commenced in late October 2021 and greater clarity will be provided in the next review. Update March 2022 - All of the existing controls and actions continue. An additional £26.1 million recovery fund has been allocated by Welsh Government to support the recovery programme within the Health Board. Work is currently underway as part of the IMTP 2022-2023 to develop the overarching Health Board Recovery Plan and this will focus on the following areas: Carry forward of existing capacity increase schemes in 2021-2022, Orthopaedics, Cancer , Regional Cataract Services, Implementation of the recommendations from the national endoscopy programme, Strengthened diagnostic and imaging services, Implementation of the Critical Care Plan and Stroke Pathway. The IMTP process will drive the development and prioritisation of these plans ahead of implementation in 2022-2023. Additionally as part of the IMTP Process we will be able to complete robust capacity and demand planning for all surgical specialities for the first time, this will allow us to fully understand our likely trajectory for recovery during 2022-2023 and beyond.	Quality & Safety Committee	20	C4xL5	12 C4 x L3	↔	11.01.2021	02.03.2022	31.05.2022
4629	Executive Director of Finance & Procurement	Sustaining Our Future	Financial Stability Risk	Failure to achieve or reduce the planned recurrent deficit of £33.9m at the end of 2021/22.	**IF**: The Health Board is not able to plan changes which enable current run rates of expenditure to align with the expected available funding for 2022/23. **Then**: The Health Board will not be able to develop a break-even financial plan for 2022/23 and deliver it . The context is that a key issue beyond 21/22 is the recurrent impact of the plan in 22/23 when it is likely that the non recurring funding for Covid in 21/22 will end or significantly reduce as well as non recurring Transformation funding ending. **Resulting in:** Potential deficit in 2022/23 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action.	2021/22 IMTP and financial plan submitted to WG at the end of June , including the Covid response, TTP, planned care and diagnostics, including prioritisation of planned changes within the available resources. Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Routine monitoring arrangements in place. Regular reporting of the forecast recurring position to Management Board and Planning, Performance & Finance Committee and Board.	Bottom up savings plans at the end of June are showing a gap of £8.2m against the £16.1m Recurring savings target for 21/22. Further develop the savings planning process identified by the COO and DoF for implementation in July onwards. Further discussions needed with Welsh Government to understand likely funding position for 22/23. Update August 2021 - No change this month. Further information is anticipated on the WG funding position for 21/22 in September 2021. Update as at November 2021: the forecast recurrent deficit was increased to £50.9m in the month 7 finance report. Although Further work will continue on recurring savings within the Health Board further discussion and actions are needed as part of the financial planning process for 2022-2023. Reviewed 6.01.2021 - No changes made to mitigating action or risk rating. Reviewed 4 March 22- Forecast recurrent deficit at the end of 21/22 is £44.5m. The forecast core plan deficit for 22/23 is currently £28.0m (excluding Exceptional items and ongoing covid response costs). An Accountable Officer Letter was sent to WG on 28 Feb confirming that we are not able to submit a balanced core plan for 22/23. Awaiting a response. No change to risk rating.	Planning, Performance & Finance Committee	20	C4 x L5	12 C4 x L3	↔	10.5.2021	04.03.2022	30.04.2022
4080	Executive Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Explore substantive appointments of staff undertaking locum work in CTMUHB • Feedback poor performance and concerns to agencies • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs	The response to Covid-19 has impacted the original timeframes for these actions due to the requirement to focus on clinical operational service delivery during the pandemic. Revised dates have been included below: 1. AMD and workforce to develop recruitment strategy - 31.3.2021 Update October 2021: The Health Board is in the process of introducing patchwork across Merthyr & Cynon ILG on 6th October and Rhondda Taf Ely on 20th October. This will give an indication of the gaps and the spend, allowing the ILG's to establish a medical recruitment strategy. 2. AMD and DMD to develop retention and engagement strategy - 31.3.2021 – Revised Date February 2022. 3. Reduce agency spend throughout CTMUHB – Update January 2022 - Patchwork rolled out across CTM. Data gathering currently. When sufficient data will have the discussions with HR and clinicians on a fair and appropriate rate card. 4) Task and Finish group to look into conversion of ADHs into permanent posts. 5) Task and Finish group Retire and return (emphasis on recruit new consultants (and therefore join on call) than R&R approach, use R&R on 1 year contracts and re-advertise	Quality & Safety Committee People & Culture Committee	20	C5 x L4	15 (C5xL3)	↔	01.08.2013	07.01.2022	31.03.2022
3826 Linked to 4839 and 4841 in Bridgend	Chief Operating Officer Bridgend Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Continue to implement actions identified in the control measures. Action plans are in the process of being reviewed so a timescale will follow once the review has been undertaken by the lead. Update June 2021 - Unscheduled Care Improvement Programme has now launched - Bridgend ILG is being provided with a Programme Manager to drive forward key projects, the key projects are yet to be launched. These projects will initially focus on the Emergency Department (ED) and Site Flow and measures will be identified that will allow us to track improvements in ED overcrowding. Timescale: Projects due to commence July 2021. . RCEM audit undertaken. Staffing remains ongoing issues- plans in place and frequently reviewed. ASCU staffing plan agreed at ILG level and ongoing. Surge trolleys in place to cope with additional capacity requirements. Building works progressing and phases complete. X references to ID4458 & ID3585 Update September 2021 - Health Board to engage with WAST colleagues to consider how transfers can be reduced. Meeting with the Chief Operating Officer's and WAST colleagues scheduled for the 10th September. Further update will be received in the October review of this risk. Estates walk around on the 27th September considered the environmental improvement plan which is dependent on the department being de-escalated (i.e. reduced demand into the department to release clinical areas) in order to commence work.	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	24.09.2019	28.10.2021	31.01.2022

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4632	Chief Operating Officer All Integrated Locality Groups	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Demand and capacity across the stroke pathway	**IF** there is continued high demand for stroke beds (currently located in Prince Charles Hospital (PCH) and Princess of Wales Hospital (POW)) **THEN:** patients may have a prolonged wait in getting to an appropriate stroke bed in PCH or POW **RESULTING in:** impact for patients in relation to a delay in appropriate treatment or therapy. Impact on the patient flow in the Royal Glamorgan Hospital. Limited therapy space due to the physical space within the ward at PCH and POW, limits the ability to appropriately carry out therapeutic treatment.	Stroke patients in RGH are managed by the medicine teams and referral to MDT as required but not specific to stroke rehabilitation. WAST alerted to the HB stroke pathway in CTMUHB regarding admissions to PCH or POW only. Stroke admission pathways have been reconfirmed with WAST to ensure patients are admitted to PCH to access specific stroke care.	Review of the CTM Stroke Pathway. Centrally led task and finish group, leadership from Executive Lead for Stroke. Update July 2021 – a short term draft paper has been developed and will be discussed at the Stroke Planning Group Meeting on Friday 09 July 2021, with the aim of making decisions about the way ahead. Work is underway on the long term plan – this will also be discussed at the meeting on 09 July. Deep dive in YCR with regards to stroke rehabilitation and length of stay – await findings Update August 2021 - Long term planning continues after very positive meeting in July 2021. Short term action plan will be developed by mid August 2021 for decision on actions to be taken by COO. Update September 2021 - for the short term plan, there is now a plan in advanced draft form which outlines actions with assigned officer leads. This will be discussed at the meeting on the 17th September 2021 and any additional progress will be reported in October 2021. Update October 2021 – at a meeting of the Board, Stroke Services were an agenda item and senior clinical staff were available to present and discuss – it was reported that colleagues were pleased to have had the opportunity to hear more and gain a wider understanding. At the Stroke Planning Meeting of 05 October the Short Term Plan was discussed again and it was agreed that the issues identified would be included in the IMTP. There will be a further meeting on 04 November 2021 and another update will be available then. Update November 2021 - Deputy Director of Therapies and Health Sciences has been identified as the designated lead for stroke and will be taking forward to the short term plan under the accountability of the COO and Executive Director of Therapies and Health Sciences. Update March 2022, the Deputy Director of Therapies and Health Sciences has worked closely with all stakeholders to develop the first draft of the Stroke Medium Term Improvement Plan Business Case this is currently for review with all Operational Teams and will be brought forward as part of the IMTP 2022-2023 process for sign off. We anticipate given the focus of the recovery fund specifically including stroke that this business case has a route for being supported. Confirmation will be received as part of the IMTP process in April 2022.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	05.07.2021	02.03.2022	31.05.2022
4253	Chief Operating Officer Bridgend Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ligature Points - Inpatient Services	**IF:** the Health Board fails to minimise ligature points as far as possible across identified sites. **Then:** the risk of patients using their surroundings as ligature points is increased. **Resulting In:** Potential harm to patients which could result in severe disability or death.	**Bridgend Locality:** The anti-ligature works has not yet been completed and signed off. There are snagging issues on ward 14 and remedial decoration. On PICU the bathrooms have not been started. All works have been chased by Senior Nurse to project lead for updates on completion. Actions identified for escalation if no update received regarding completion dates. The risk score remains unchanged at present. o Increased Staff observations in areas where risks have been identified. o Any areas of the unit not being occupied by patients are to be kept locked to minimise risks o The use of safe and supportive observations o Risk assessment process for patients and environment is in situ o Some ant-ligature work has been completed in some bedrooms which are used for patients assessed as being at higher risk.	~~**RTE Locality:**~~ ~~RTE Locality Update: Some environmental work has already been Undertaken- Anti-ligature doors to be installed to further reduce risk. Current score: 10. This risk therefore now only relates to Bridgend ILG~~. **Bridgend Locality:** o action plan developed with support from the head of nursing within the ILG. o Heath Board has approved additional staffing by night and to fund the outstanding capital anti ligature works. guidance issued to all staff on the implementation of local procedural guidelines. o Use of therapeutic activities to keep patients occupied Capital works remain ongoing and remain on programme to complete by July 2022	Quality & Safety Committee Health, Safety & Fire Committee	20	C5xL4	10 C5xL2	↔	17/08/2020	16.02.2022	30.04.2022
4688	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED), inability to appropriately triage	**IF:** The minors department is over capacity **Then:** there is no ability to appropriately triage and treat patients in a timely manner, neither is there visibility to observe patient acuity from a triage room as this is not co-located within the waiting area. **Resulting in:** Poor patient experience and unknown risk along with high levels of stress for staff.	Production of a flow chart for the management of patients to minors. Escalation cards. Re-direct the workforce to support the triage function. Additional doctor rostered to support the service	Emergency Department Improvement Programme established which includes the key enablers to improve the environment, template and patient flow through the Emergency Department. The programme is anticipated to take 12 months to complete. Emergency Department Improvement Plan being established to address risks in the short term as far as is reasonably practicable. Risk reviewed in December 2021 - no change to score and risk assessment at this time.	Quality & Safety Committee	20	C4xL5	12 C4 x L3	↔	11.06.2021	08.12.2021	07.03.2022
4071	Chief Operating Officer All Integrated Locality Groups Linked to RTE 4513	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	• Tight management processes to manage individual cases on the cancer Pathway. • Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. • Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk • Harm review process to identify patients with waits of over 104 days and potential pathway improvements. • Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. • All three ILGs are working to maximising access to ASA level 3+4 surgery on the acute sites. • HB working to ensure haematological SACT delivery capacity is maintained. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. • Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. • Alternative arrangements for MDT and clinics, utilising Virtual options - Cancer performance is monitored through the more rigours monthly performance review process. each ILG now reports actions against an agreed improvement trajectory.	Continue close monitoring of each patient on the pathway to ensure rapid flow of patients through the pathway. Active management of the diagnostic backlog (including endoscopy) and exploration of all options to reduce this. Comprehensive planning for repatriation of theatre and haematology services for when private provision is lost. This also needs to consider options for continuation during a potential second surge. These actions are ongoing and assigned to the EDO, DPC&MH and Medical Director. The Cancer Business Unit remain fully involved in the processes to improve care and that at present they are awaiting feedback from ILGs on their plans for restarting elective and other activity and their demand and capacity assumptions. There was a refocus on this risk post Covid-19 impact and there has been a consistently improving position from February to July. During July there was a slight deterioration which is being addressed and actioned. Each ILG has returned a Cancer Recovery Plan to facilitate monitoring by the COO. This remains ongoing with individual issues addressed as they arise. An Operating Framework has been developed with a tightened Performance Management framework which will be monitored by the COO. Update January 2022 - Maintaining cancer services during this challenging time is a priority for the Health Board. The Health Board has established enhanced monitoring processes which provides further assurance of the steps the Health Board has deployed and are putting into place to re-establish appropriate performance levels within the Suspected Cancer Pathway. The risk rating has been reviewed in light of these further mitigations and a rating of 20 is considered to still be appropriate. Update March 2022, the enhanced monitoring process continues with progress being made in all specialities. There is a lag between the increase in activity which is being evidenced and the impact on the Suspected Cancer Pathway (SCP) which results in overall performance still being depressed. Improvement activity in outpatients and diagnostics is in place and being closely monitored. There is an unmitigated risk within the breast cancer specialty where are RTE ILG continue to develop an improvement plan, however, it is worth highlighting the constrained nature of breast cancer capacity across Wales.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	02.03.2022	31.05.2022

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4664	Executive Lead: Director for Digital. Chief Information Officer	Creating Health	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Ransomware Attack resulting in loss of critical services and possible extortion	**IF**: The Health Board suffers a major ransomware attack. **Then**: there could be potential data loss and subsequent loss of critical services. **Resulting in**: Catastrophic service loss to all clinical and business services impacting on population health management, patient care, business continuity, organisational relationships & substantial financial risk - culminating in a culture of mistrust of the Health Board and all things digital	**Key Controls**: 1. Email filters from both Microsoft and the National email relay which scan for malicious and suspicious email types and their attachments. 2. National Checkpoint firewalls that monitor for and block suspicious network traffic, including those from known malicious geographical areas. 3. National SIEM that monitors and logs suspicious external incoming traffic. As well as monitoring local network traffic for each NHS Wales organisations. 4. Local Firewalls at each of the Health Board's geographical areas that only allows inbound trusted network traffic. 5. Anti-malware software installed on all Health Board computing devices which includes ransomware behavioural intelligence. 6. Blocking and monitoring of Internet traffic. 7. Locally systems that monitor the local network for suspicious traffic. 8. A monthly patching regime to ensure that all operating systems are up to date. 9. Regular backups of critical information and device configuration which is stored off site as part of DR/BC planning. 10. Cyber Incident response plan developed and being iteratively developed **Gaps in Controls**: 1. Current National SIEM has presented many issues in terms of access to the Health Board for identifying issues and addressing false positives. 2. The Health Board is currently not addressing the need for the national Cyber Security training to become part of mandatory training to all staff. 3. A regular co-ordinated approach to providing Phishing campaigns as part of staff awareness to indicators of compromise. 4. A process where the Health Board can monitor where staff have read important information/cyber security policies. 5. The current network Intrusion Detection/Intrusion Protection system (IDS/IPS) is no longer licensed under the new generation firewall infrastructure. 6. No assurance processes in place for UHB to determine & manage vulnerabilities presented by third party suppliers and other NHS Wales organisations 7. Insufficient skills and capacity within the UHB (not just within digital)	CTMUHB is amalgamating the issues arising from the Cyber Essentials plus, the NIS-D assessment and the NCSC board framework in a single plan. Elements of this need to be taken forward at the UHB level, others nationally. - Timeframe: Quarterly updates The ICT Department are investigating ways to improve the security of backups to ensure that these are protected from potential ransomware attacks. Timeframe - 21.02.2022 The ICT Department are investigating ways to segregate the current configuration of the network infrastructure to ensure that critical systems are better protected from cross infection. Timeframe - 21.02.2022 The ICT Department will re-appraise a case to re-introduce Cisco FirePower which is an IDS/IPS networking software. Timeframe -1.4.2022 The ICT Department will be reviewing and further testing the developing Cyber Incident Response Plan . Timeframe - 1.02.2022 Medical Engineering and the ICT team to develop a programme for assessing risks presented by medical devices and possible mitigations. Timeframe - 21.04.2022 The organisation is recruiting a Director of Digital Services who will be a member of the Board. This position will enhance the complexities and needs of both service delivery and information/cyber risks. Completed - Commenced December 2021.	Digital & Data Committee	20	C5 x L4	15 (C5xL3)	↔	26/05/2021	31.12.2021	21.01.2022
4743	Chief Operating Officer Bridgend Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure of appropriate security measures / Safety Fencing	**If:** there is a failure in security measures. **Then:** there is an increased likelihood of patients having unrestricted and inappropriate access on the site. **Resulting In:** absconding events and possible harm to the patient or members of the public	The risk of absconding, and self harm/ suicidal ideation for Mental Health and CAMHS patients is risk assessed on admission and reviewed regularly thereafter. Works programme to review and renew physical barriers such as door locks and restricted window access to limit unauthorised ingress and egress from Mental Health and CAMHS units are in situ. High risk patients are escorted when outside the units Absconding patient policy in place Some fencing is in place in the areas concerned, however, it is aged and fails to provide an adequate barrier.	Funding Bid for approx. £385K has been submitted by Estates	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	05.07.2021	20/10/2021	30/09/2021
4203	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group Merthyr Cynon Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Unable to provide Surgical Services	**If:** Surgical services cannot meet demand and patients are not treated in targeted timeframes (RTT) **Then:** Patients will not receive surgery and subsequent treatments **Resulting In:** Harm to patients, poor prognosis, reduced treatment options, poor quality of life, risk of claims, increased demand on wider health and social care services including emergency care, staff burnout. Since March 2020 COVID 19 Pandemic has resulted in Surgery being ceased for Urgent and Routine listed patients.	Restart plans including Waiting List Initiative to increase capacity. Limited ring-fenced funding for recovery plans. Outsourcing Some pathway innovations Ongoing validation of waiting lists. M&C ILG Risk 3958 closed as merged with this risk.	Restarting elective surgery and further outsourcing to private sector. Discuss reconfiguration of acute site to enable more surgical capacity.	Quality & Safety Committee	20	C4 x L5	16 (C4xL4)	↔	1.7.2020	27.8.2021	01.12.2021
4721	Chief Operating Officer Rhondda Taf Ely Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Shift of the boundary for attendances at the ED.	IF: the current boundary change to redirect emergency cases from the lower Cynon Valley to the Royal Glamorgan Hospital is not reviewed: THEN: patients will continue to be admitted to a hospital further from their home RESULTING IN: increased pressure on the medical teams to manage an increased patient cohort, lack on continuity of care with follow up arrangements closer to home	Boundary change currently subject to review to understand the impact across CTM.	Boundary change currently subject to review to understand the impact across CTM.	Quality & Safety Committee	20	C4xL5	12 (C4xL3)	↔	28/06/2021	21.09.2021	08.11.2021
4722	Chief Operating Officer Rhondda Taf Ely Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Senior Medical Workforce Shortfall	**If** the gaps in the senior medical workforce in RTE are not addressed (2wte vacancy OP, 1wte LTS, 1wte Non clinical duties plus paternity leave and isolation). **Then** routine work such as clinics will be cancelled, clinical decision making will be delayed and emergency escalation compromised along with the ability of the service to discharge the powers of the Mental Health Act. It is also possible that the training of junior doctors will be negatively affected. **Resulting in** poor quality and unsafe patient care, increasing concerns, risk of litigation, compromise of the UHB's reputation and removal of UHB from Psychiatry training programme.	Regular meetings with interim CSGD and Consultants to plan cover arrangements and support on weekly basis. All staff being offered additional hours. Locum consultant covering all Rhondda Mental Health Act work. ANP's covering appropriate PCMHSS AND CMHT clinics.	Increase capacity of consultant teams by planned cancelation non-urgent work. This would need to be approved by ILG and Board due to unintended consequences of wider system. Recruitment - Vacancies out to advert for locum and substantive contracts. Exploring options for overseas recruitment.	Quality & Safety Committee	20	C4xL5	6 (2x3)	↔	28.06.2021	1.9.2021	26.10.2021
4103	Chief Operating Officer Bridgend Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**IF**: The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring 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 x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. 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). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	Action plan developed and on going monitoring - consolidated plan coming forward covering Eye Care. The service has transitioned to Bridgend ILG and Bridgend ILG has engaged in potential national solutions to address FUNB. Update June 2021 - Position paper submitted to Management Board and Quality & Safety Committee .The ILG is in the final stages of Quality Assuring the submission of data to the Royal College of Ophthalmologists in readiness for the external review that has been commissioned. Update July 2021 Evidence submitted for Royal College review. Update August/ September 2021: New Quality and Performance Improvement Manager now in post to lead on improvements, a new pan-CTM Clinical Lead post that is currently being recruited to will support this. Update paper presented to PPF Committee in August setting out the range of actions being taken to improve the position, further update to be taken to October meeting. Further feedback from Royal College awaited.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	07.09.2021	31.10.2021

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4841	Chief Operating Officer Bridgend Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of Mental Health Services in CTM	**If:** a bespoke admission for a young person at Ty Llidiard continues beyond a short-term period of two weeks **Then:** Male staff from across CTM adult mental health services will be required. **Resulting in:** depleted and fragile adult mental health services	1. Attempt to rapidly assess and treat young person to alleviate risks and potentially reduce staffing demand 2. Collaborative planning across adult mental health services and CAMHS to build a staffing model that considers all risks 3. Secure additional staffing from other sources	Working with WHSSC to seek alternative placement. Timeframes in discussion WHSSC and will be confirmed. Consideration of external commissioning of adult mental health inpatient provision to mitigate against reduced staff levels underway.	Quality & Safety Committee	20	C4xL5	16 (C4xL4)	↔	27.09.2021	11.10.2021	31.10.2021
4217	Executive Director of Nursing & Midwifery Infection Control	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No IPC resource for primary care	**If** there is no dedicated IPC resource for primary care. **Then:** the IPC team is unable to provide an integrated whole system approach for infection prevention and control. **Resulting In:** non compliance with the reduction expectations set by WG. A significant proportion of gram negative bacteraemia, S.aureus bacteraemia and C.Difficile infections are classified as community acquired infections.	Liaise with specialist services in primary care e.g.. bowel and bladder service IPC team investigate all preventable community acquired S.aureus and gram negative bacteraemia and share any learning with the IPC huddles arranged in primary care to look at community acquired. Update August 2021: the IPC team is working collaboratively with the bowel and bladder service to investigate all preventable urinary catheter associated bacteraemia. Any learning points/ actions is being shared with community teams. Work in progress to start/reintroduce RCAs/IPC huddles for community acquired C.Difficile cases	A business case for additional resources for an IPC team for primary care to be developed. Due Date: 31.08.2021 07/10/2021 - Lead IPC Nurse is a member of an All Wales task and finish group looking at the IPC workforce across Wales. Report to IPCC once national work complete - Due to complete in December 2021. SBAR to be presented to IPCC. 15/12/2021 - Risk peer reviewed and score increased from 16 (4x4) to 20 (4x5) February Update: Outcome of the IPCC National Work awaited. Deputy Director of Nursing undertaking a review of the IPC provision within the Health Board to provide capacity to the primary care function - deadline 31.3.2022	Quality & Safety Committee	20	C4 x L5	8 (C4xL2)	↔	16/07/2020	17.2.2022	01.04.2022
4652	Chief Operating Officer Executive Director of Therapies & Health Sciences Merthyr & Cynon Locality - Host of Therapies Services within the Health Board	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Therapies provision to increased numbers of stroke patients in PCH, POW, YCR and community/out patients	**If:** Current increase in numbers of stroke patients across these sites continues, then the ability of OT SLT Physio and Dietetics to respond and provide a quality service to these patients will reduce and not be sustainable without additional resource. **Then**: this will impact on quality of care, patient flow, safe discharges and staff wellbeing. **Resulting In**: Reduced quality of patient care, poorer patient outcomes, issues with patient flow and negative impact on staff well-being.	Additional hours offered to staff, but limited pool to draw from; seeking locum cover at financial risk, but lack of availability due to national workforce shortages.	Scoping of short and medium term solutions via Stroke Planning Group, currently meeting monthly to review whole HB stroke pathway . Review end of September 2021. Please also see risk 4632 in relation to the stroke pathway. 01.10.2021 issue continue to be highlighted via Stroke Planning and Delivery groups and Therapies assurance meetings. 24.12.2021 situation remains a risk especially with lack of capacity in PCH so number of patients in RGH not receiving required stroke service input. Also therapy rooms in PCH and POW units not available as yet. Risk score reviewed and increased to 20 (4 x 5), to reflect current capacity issues, with a number of patients not able to access specialist stroke intervention due to admission at RGH. Update March 2022 - short term goals have progressed: work to complete ring-fenced therapy rehabilitation space is complete at PCH and almost complete at POW.	Quality & Safety Committee	20 ↑ 16	C4 x L5	12 (C4xL3)	↔	21.05.2021	04.03.2022	21.05.2022
4866	Chief Operating Officer Executive Director of Therapies & Health Sciences Merthyr & Cynon Locality - Host of Therapies Services within the Health Board	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of dedicated dietetic provision to Upper GI Oncology patients across CTMUHB.	**IF:** there is no funding identified to support the recruitment of specialist dedicated upper GI oncology dietitians **THEN:** The health board is not able to provide a clinical service in line with local, national and international guidelines or clinical standards for this patient group **Resulting in**: Lack of specialist nutrition intervention impacting on patient safety, poorer treatment outcomes, increased hospital admissions, increased length of stay and poorer quality of life.	Identification of virtual support from existing clinical teams. Collaboration with the clinical teams and across each ILG to identify and provide initial first line advice.	Business case Presented at Macmillan panel and funding for dedicated Upper GI dietetic posts was agreed for 2 years from Macmillan with cost pressure sitting in therapies Awaiting completion of contractual agreement to progress with recruitment, so gaps remain in workforce but progressing at pace. Update 25/2/22, funding agreed with Macmillan, recruitment is in progress.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	13.10.2021	25.02.2022	04.05.2022
4699	Director of Corporate Governance Information Governance Function	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Failure to deliver a robust and sustainable Information Governance Function	**If:** the Health Board fails to adequately resource the Information Governance Function following an increase in activity and demand since the boundary change and new operating model. **Then:** the health and wellbeing of staff along with the ability to comply with legislation and service delivery will be impacted. **Resulting in:** an impact on the workforce (poor morale, health and wellbeing, retention), Impact on Service Delivery e.g. delays in approving Data Sharing Agreements, Data Protection Impact Assessments, Subject Access Requests and FOI requests. Compliance with Legislation such as the Data Protection Act, FOI Act and GDPR Regulations could also be impacted.	Context: The IG Team (1 WTE and 2 PTE) have experienced the following increase in activity: 1. 300% increase in FOI requests and a 500% increase in complexity (number of questions asked per FOI request); 2. 600% increase in Data Protection Impact Assessments to be undertaken; and 3. 225% increase in the number of Information Sharing Agreements being handled . Work programme prioritised to focus on the "must do's": - Urgent Data Sharing Agreements - Responding to FOI's from the Public - Responding to Subject Access Requests - Responding to IG activity that relates to the safety of the public, responding to queries from external agencies such as Police investigations etc. - Significant incident investigations and concerns. -ICO activity and audit	Benchmarking with other organisations in Wales undertaken. Business case for additional IG resource completed. Funding sources being explored by the Executive Lead and Assistant Director of Governance & Risk - Timeframe: 31.03.2022. The control measures and risk prioritisation exercise undertaken by the IG Team is captured and detailed in this risk assessment and linked to Risk ID 5004. Alternative ways of working have been explored with no sustainable solution identified. The fundamental risk treatment option to manage this risk, given the significant increase in activity in this area is an increase in resource. In this regard, an increase in resource has been included in the IMTP for 2022/2023. If funding is not available then the Health Board will need to consider its risk treatment in terms of Tolerating/Accepting the risks facing the organisation.	Digital & Data Committee	20 ↑ 16	C4xL5	8 C4xL2	↑ Risk Increased from a 16 to a 20 in February 2022	18.06.2021	20.01.2021	30.04.2022
4149	Chief Operating Officer Bridgend Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain Child and Adolescent Mental Health Services	**If:** The Health Board continues to face challenges in the CAMHS Service **Then:** there could be an impact in maintaining a quality service **Resulting in:** recruitment challenges, long waiting times and impact to the implementation of the new model of care. Loss of trust and confidence in the services provided by the Health Board. 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	o Reported local and Network pressures across the CAHMS Network with variable problems dependent on the area of the network. o 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. o 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. o New investment impact being routinely monitored internally via the SMT and via monitoring meetings with the ILG o There has been progress with being able to recruit to vacancies with a number of new appointments made. For CTM UHB, the majority of vacancies have been recruited into. The Swansea Bay locality has had more challenges in recruiting skilled staff and there has been plans in place to recruit to developmental posts to attract more interest and invest in staff training and development. More recently the team have managed to recruit into a number of posts (9 to date) with start dates in the next couple of months and interviews scheduled for HCSW and Band 5 practitioners in next month	o Monthly commissioning meeting discussions taking place across the Network in relation to service pressures and funding. Further discussions with commissioners expected by April 22 regarding service provision o Implementation of the Choice and Partnership Approach (CAPA) with a new service model introduced ensuring the service aligns itself with All Wales Mental Health Measure. All referrals accepted to CAMHS will now receive a Part 1 Mental Health Assessment to determine the level of support required. Performance is being reported and monitored via monthly performance meetings o A number of service reviews in relation to Ty Llidiard undertaken and monitored via Q,S&R Committee. Additional nursing leadership implemented and progress on required action plans and proposed staffing model. Business case being drafted for additional investment to support staffing model by start of March 22. Workshops scheduled with WHSSC to review service specification and gap analysis. First workshop to take place on 15th Feb 22 o Community CAMHS in both CTM UHB and Swansea Bay UHB are carrying out WLI via the planned care recovery (PCR) scheme. The additional clinics and dedicated team for assessment and single point of access have helped to reduce waiting times in CTM UHB to approx. 8 weeks but proposal to continue the PCR additional clinics after April 22 to reduce waiting times and improve compliance. The waiting times in Swansea Bay UHB are much longer (average wait is 10 weeks as of Feb 22 but longest wait is 32 weeks). Further work is planned by end of March 22 on capacity and demand and the implementation of a new service model to aim to meet demand. Proposal to continue with the planned care recovery schemes post April-22 to address the backlog.	Planning, Performance & Finance Committee & Quality & Safety Committee	16 ↓ 20	C4xL4	8 C4xL2	↔	01/01/2015	16.02.2022	30.04.2022

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4922	Director of Corporate Governance Information Governance Function	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Covid-19 Inquiry Preparedness - Information Management	If: the Health Board fails to ensure that it is a position of preparedness to respond to the Covid-19 Inquiry in terms of information and decision making. Then: the Health Board may not be able to provide evidence as to decisions made "What happened" "What we did", "Why we did it" and "What we have learned from it". Resulting in: Impact on trust and confidence in the Health Board - There is a huge public interest in any inquiry and as a responsible public body the Health Board is committed to ensure that it is as open and as transparent as possible. Risk to quality and safety of patient care through limited lessons being learned for the future from the pandemic response. Inability to respond robustly to any potential Judicial Reviews in relation to decisions taken in response to the pandemic.	Covid-19 Information Manager - Fixed Term position for 3 years commencing 29.11.2021 who will act as the Archivist for the Health Board. As the Health Board is likely to be a Core Participant within the Inquiry, the Health Board has instructed legal representation. HB is linked with National co-ordination group fronted by L&RS to ensure shared learning in preparation for the Inquiry. Established a group to respond to any inquiry requests and support preparedness - Covid 19 Pandemic Inquiry Working Group - first met in January 2022. Formal instructions on legal representation to include WHLS Solicitor, Queens Counsel and Junior Barrister.	Covid - 19 Information Manager will develop a detailed action plan to support the Health Boards preparedness for a Covid-19 Inquiry. Timeframe 31st March 2022. Regular updates to be provided to the Board/Q&S Committee on preparedness for the Inquiry. Update being received at the March Quality & Safety Committee.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	23.11.2021	23.11.2021	30.04.2022
4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.	**If** the therapy services (physiotherapy, speech and language therapy, dietetics, occupational therapy) continue to not be at the recommended staffing levels according to national level requirements (GPICs), **Then:** the critical service will be unable to meet the need of patients requiring therapy, **Resulting in:** significant negative impact on patient outcomes, ability to recover from critical illness and length of stay in critical care unit and consequently in hospital longer than needed.	Currently staff stretch to cover and prioritise patient need as much as possible. During winter pressures have tried in the past to recruit locums but availability still remains an issue for some services and not sustainable. Sighted within HB Critical Care Board as significant gap and within peer review response. Update 16-9-21 Continuing with therapy business case as actions below. No other updates	Completed comprehensive business case detailing recommendations for staffing, gaps, impact and consequences of gaps Next steps require consideration for prioritising of funding for gaps in therapy posts in critical care within ILGs to decrease risk RTE critical care short-term planning business case, identified RGH therapies workforce requirement, however these would need to be recruited to recurrently, as unable to recruit to fixed term tenure. Update January 2022 - Business case completed, no investment yet identified to fund the posts. Gaps in service provision continue to be highlighted via Datix incident reporting. No change to mitigation or risk rating.	Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	20.08.2021	07.01.2022	26.03.2022
4679	Executive Director for People (Executive Lead for Occupational Health)	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Absence of a TB vaccination programme for staff	**If:** the Health Board is not providing TB vaccination to staff **Then**: Staff and patients are at risk of contracting TB **Resulting in**: Failure to comply with the Department of Health and Social Care guidance and lack of confidence in the service	The 'fitness letter' issued by Occupational Health to the appointing line manager following an employee health clearance highlights vaccination status. Screening for latent TB for new entrants and offering T spot testing to assess positive or negative.	Action plan collated-To clarify current screening process in relation to local and National guidance via specialist respiratory nurses prior to administering BCG. OH Senior screening nurse to compile written instructions and staff information leaflet. Training requested via the respiratory team. Meeting to discuss training needs set for 9th June 2021 Update January 2022 - Training of OHN to deliver BCG vaccinations remains outstanding due to difficulty resourcing training within CTMUHB. Alternative training has now been resourced via CAV UHB Respiratory Team and dates for training to be agreed. Continuing to risk assess TB status as part of Pre-employment clearance process. Update March 2022 - Ongoing difficulties accessing BCG training in CTM and CAV UHB. OH currently exploring alternative training options in order to introduce BCG vaccinations. TB assessment as part of pre employment Health Questionnaire screening process ongoing.	Quality & Safety Committee People & Culture Committee	16	C4xL4	8 C4xL2	↔	09.06.2021	07.03.2022	29.04.2022
4753	~~Chief Operating Officer~~ Executive Medical Director Pharmacy & Medicines Management	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Maternity : Lack of pharmacy clinical service, medicines governance and medicines safety	**IF:** the Health Board fails to resource pharmacist time for maternity services in all acute sites **Then:** the Health Board will be unable to support maternity services with development of medicines procedures, audit of and training on medicines procedures and processes, scrutiny and intervention on medicines prescribing, support patients with their medicines and breast feeding concerns. **Resulting in:** medicines related incidents and harm continuing with little or no learning actions put in place, limited governance for medicines use, minimal training for new staff, no pro-active medicines safety initiatives. This risk has been highlighted by the delivery unit and they have indicated it should be prioritized.	Very limited support for maternity from pharmacy provided on an ad hoc basis when urgent issues arise or incidents. Medicines Management Training. Local Audit.	Business case for Pharmacy resource to be considered by Obstetrics and Gynaecology directorate and considered as part of the maternity improvement plan and to be prioritised for funding. Review date: 10.09.2021 Funding identified for a maternity and neonate lead pharmacist, recruitment underway with interview planned for early November. The risk score remains until recruitment finalised and appointment made. Update February 2022 - Service being delivered as Pharmacist appointed as funding initially agreed, funding from within ILG and Neonatal budget. Funding planned to be transferred into Medicines management staff budget and therefore risk remains until this final step has been completed.	Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	09.07.2021	11.02.2022	30.04.2022
3742	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of 16-18 Year Olds	**If**: Children aged 16-18 years are cared for in an adult acute setting. **Then:** there is a concern that the care provided will not meet the required paediatric standards. **Resulting in**: Inappropriate care and an inappropriate setting.	Cases are managed on an individual basis dependent upon the needs of the child. Ongoing discussion with the medicine specialties and the paediatric teams about the most appropriate setting for each individual. Discussion underway with the CSGs across CTM to understand the support required and the action plan will be updated accordingly, identifying any corporate level support as required.	Discussion with CSG's to understand the support required is underway and the action will be updated accordingly, identifying any corporate level support as required.	Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	19.07.2019	21.09.2021	06.12.2021
4940	Executive Director of Nursing Patient, Care and Safety.	Improving Care	Quality, Complaints & Audit	Delay to full automated Implementation of Civica	**If:** the Information team are not be able to complete the necessary data extraction requirements, **Then:** there will be a delay to the roll out of the automated survey process within the Civica system, **Resulting in:** a lack of service user feedback and opportunity to areas of improvement as well a good practice.	Update February 2022: The automated element of Civica has been implemented for the 4 phased maternity survey. This sends an SMS text message to women at four key points of their labour pathway. This actively pushes the survey out and improves engagement in feedback mechanisms. The aim is to send an SMS text containing a survey link to all patients/service users following their contact with the Health Board. The Health Board launched the electronic ""Have your Say"" and Generic Patient Experience Survey on the 13.02.22. Posters containing QR codes are displayed on notice boards in our hospital sites, KHHP and Dewi Sant. In addition links are available on our internal and external webpages, along promotion on available social media channels. A small card (like a business card) containing a QR code has been developed which will displayed in main thoroughfares such as Emergency Departments, Outpatients and community settings. Their will be made available to staff that are providing services in patients' homes. Exploration is taking place as to how the posters/cards can be promoted within he wider non-health board community settings. From the 28.02.22, within the Bridgend and Merthyr & Cynon Localities, the PALS team will be actively engaging with patients/ service users to promote the completion of the ""have your say"" cards and generic survey. This is through paper copies being available in areas, which are collated and uploaded on to the system on a monthly basis. Along side this, within Merthyr & Cynon PALS Officers will be present with Emergency Department at PCH and outpatients at YCC to capture feedback via iPADS. A number of other surveys are active or being developed which will be implemented in the same format at the current time.	Information Team support is required to fully implement the Civica Service User Feedback System. Implementation of the Civica System. Information Team to identify resources required to undertaken actions required to support the implementation of the Civica system. Undertaking any recruitment processes and escalating where demand can not be met. Deadline 31.3.2022 Whilst the overall consequence and likelihood of the risk is not extremely high, the SMS component remains high as currently there is no target date for full implementation of the automated element of Civica which would increase real time response rates. Reactive feedback continues be received and reported on via complaints, claims and compliments.	Quality & Safety Committee	16 ↓ 20	C4 x L4	12 (C4xL3)	↓ Decreased from a 20 in February 2022	09.12.2021	28.02.2022	31.03.2022

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4479	Executive Director of Nursing & Midwifery Infection Control / Decontamination	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No Centralised decontamination facility in Princess of Wales Hospital (POWH)	**If:** there is no centralised decontamination facility in POWH **Then:** there are a number of areas undertaking their own decontamination via automated/manual systems. **Resulting In:** possible mismanagement of the decontamination processes/near misses/increased risk of infection/litigation risks and non compliance with national guidance/best practice documents. The hospital site is at risk of losing their JAG accreditation in Endoscopy if plans to centralise decontamination is not progressed. There is no dirty - clean flow for procedure room 2 in endoscopy. There is some decontamination equipment in HSDU that needs replacement. The decontamination equipment in Urology is at the end of it's life and there are regular service disruptions due to failed weekly water testing results.	Monthly audits undertaken in all decontamination facilities in POWH by the lead endoscopy decontamination officer and results shared at local decontamination meetings. AP(D)support available on site. Monthly ILG decontamination meetings take place where all concerns are escalated to the HB Decontamination Committee meeting. SOPs is place Water testing carried out as per WHTM guidance Maintenance programme in place for decontamination equipment 07/10/2021 - In view of aging Urology washer disinfectors, urology service managers to liaise with APDs to initiate/ agree a service contract for maintenance and servicing of equipment with an external.	Centralised Decontamination Facility at POWH - 02/08/21 - SOC approved by WG and design team appointed. Project team group and working group to be set up - Timeframe 30.09.2021. Each area that decontaminates scopes/intra cavity probes(outside CSSD)has developed SOPs detailing the decontamination process. Evidence of SOPs to be shared at decontamination meeting in POWH. Lead IPCN to ask Operational Lead for Decontamination to action. 02/08/21 - Operational lead for Decontamination has requested assurance from the lead endoscopy decontamination officer in POW. Timeframe 30.11.2021. 15.12.2021 - risk peer reviewed and agreed that the risk remains as a 20. Development of a business case to create a single centralised decontamination facility on the POWH site has commenced with Welsh Government Funding support. Business case expected to be completed by Spring 2022. Availability of WG funding to create the unit remains a risk. Update February 2022 - Final design to be signed off by all parties. To await WG monies for centralised decontamination facility. Deadline: 1.6.2022. Risk peer reviewed and agreed that the risk should be reduced to a 16 (4x4). Availability of WG funding to create the facility remains a risk. Target rating reduced to a risk of 1x1 as the centralised decontamination facility will have a direct impact on the consequence.	Quality & Safety Committee	16 ↓ 20	C4xL4	2 C1xL1	↓ Decreased from a 20 in February 2022	30.12.2020	01.03.2022	01.06.2022
4106	Executive Director of Nursing and Midwifery	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Increasing dependency on agency staff cover which impacts on continuity of care, patient safety	**IF:** The Health Board increasingly depends on agency staff cover **Then:** the Health Board's ability to provide stability and consistency in relation to high quality care could be impacted. **Resulting in**: disruption to the continuity, stability of care and team communication. Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover.	Recurring advertisements of posts in and nursing continue with targeted proactive recruitment employed in areas of high agency/locum use. Provision of induction packs for agency staff Agency nursing staff are paid via an All wales contract agreement, any off framework agency requests must be authorised by an Executive Director prior to booking (system of audit trail in place). Fixed Term Contracts being offered to all existing HCSW and RN currently on the Nurse Bank. Redesign services wherever possible to embrace a healthier Wales and therefore impact upon the workforce required to deliver services. Overtime incentives offered to workforce in response to Covid-19 pandemic. As of July 2021 - the overseas recruitment campaign has ceased pending further scoping exercises by Workforce and Organisational Development. Bi-Annual Nursing Staffing Levels Wales Act - Acuity Audit to be undertaken in June 2021 to report to Board in October 2021. Completed: This has been completed and received by the Board.	Deputy Exec DON is currently reviewing the nurse rostering policy in conjunction with the workforce team in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's . Established a new nursing workforce taskforce. Consultation with Local Partnership Forum undertaken and amendments to the policy have been made as appropriate, the policy will be seeking approval at the Quality & Safety Committee in May 2021- Timescale 31.5.2021. Update November 2021: The Revised policy which was based on SBUHB's current policy (in terms of content / KPI's etc. was taken to Local Partnership forum where it was identified further amendments were requested, these were made in terms of making the clear distinction between the current break times in some areas of POW and that of the rest of CTMUHB. The policy is currently with an ILG Nurse Director who has kindly offered to make the policy more "user friendly" Timescale: 31st December 2021 All Wales "Safer Care Module" on e-roster system due to be received in due course. WG led so await WG timescales. No Change as at 4.5.2021. Update November 2021 - No update from WG as of November 2021 Nursing & Midwifery Strategic Workforce Group, Chaired by the Deputy Director of Nursing to recommence in April 2021. The Workforce Group did not meet in April 2021 as planned due to the need to revise membership in line with ILG structure, however, bi-monthly nursing workforce operational task force meetings have been held chaired by the Deputy Director of Nursing since February 2021. the Strategic workforce group is scheduled to meet on the 11th May 2021. November 2021 update: Bi monthly workforce meetings have been stood down and the ILG's are establishing their own workforce meetings. The Nursing and Midwifery Strategic Workforce Group met in May 2021; ToR amended and membership agreed. Next meeting scheduled for December 2021 .	Quality & Safety Committee People & Culture Committee	16	C4 x L4	12 (C4xL3)	↔	01/06/2015	05.11.2021	31.12.2021
4157	Executive Director of Nursing and Midwifery	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of high quality patient care due to the difficulty in recruiting and retaining sufficient numbers of registered nurses and midwives	**IF:** the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage **Then:** the Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff. **Resulting in**: Disruption to the continuity and stability of care and team communication Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover.	• Proactive engagement with HEIW continues. • Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues. • Targeted approach to areas of specific concern reported via finance, workforce and performance committee • Close work with university partners to maximise routes into nursing • Block booking of bank and agency staff to pre-empt and address shortfalls • dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act. • Deputy Exec DON is currently reviewing the nurse rostering policy in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's • Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board • Regular review by Birth Rate Plus compliant, overseen by maternity Improvement Board • Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends. successful overseas RN recruitment. - There is an operational Nursing Act Group that reconvened from April 2021. Impact assessment signed off from a Mental Health Nursing perspective in relation to an extension to the Nurse Staffing Act 2016.	Established recruitment campaign - which is monitored at the Nursing Workforce Strategic Group - group due to meet/recommence in April 2021.The Nursing and Midwifery Strategic Workforce Group did not meet in April 2021 as planned due to the need to revise membership in line with ILG structure, however, bi-monthly nursing workforce operational task force meetings have been held chaired by the Deputy Director of Nursing since February 2021. the Strategic workforce group is scheduled to meet on the 11th May 2021. This action has been overtaken by the Nursing Productivity Programme. Revised nurse rostering policy currently being taken through the relevant approval process - Timescale 31.3.2021.Consultation with Local Partnership Forum undertaken and amendments to the policy have been made as appropriate, the policy will be seeking approval at the Quality & Safety Committee in May 2021- Timescale 31.5.2021Complete and currently with WF&OD to finalise through to Approval. Await review of Birth Rate Plus Compliant Tool by WG - Timescale - WG led so await WG timescales - No further update at this time. Remains the same as at Februany 2022. Impact assessment relating to Health Visiting provision with regards to compliance of the draft principles of the Nurse Staffing Act 2016 to be completed by the end of March 2022. Ward Assurance Pilot Tool tested within PCH and to be rolled out across the other two Acute Hospitals by the end of April 2022.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	12 (C4xL3)	↔	01/01/2016	02.03.2022	30.04.2022
4458	Chief Operating Officer All Integrated Locality Groups	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches.)	**If:** the Health Board fails to deliver against the Emergency Department Metrics **Then:** The Health Boards ability to provide safe high quality care will be reduced. Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. **Resulting In:** A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls. Compromised safety of patients, potential avoidable harm due to waiting time delays. Potential of harm to patients in delays waiting for treatment.	Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protections Schemes Implemented within ILG's. Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	The Unscheduled Care Improvement Board will monitor progress on the programme on a monthly basis. Given the decrease in compliance for 12 and 4 hour waits, it is impossible to outline progress at this point. It is anticipated that the work of the Urgent Care Improvement Group will be able to report some improvement in the coming months. BILG update: RCEM audit undertaken. Staffing remains ongoing issues- plans in place and frequently reviewed. ASCU staffing plan agreed at ILG level and ongoing. Surge trolleys in place to cope with additional capacity requirements. Building works progressing and phases complete. X references to ID3826 & ID3585. Update March 2022, significant work continues to be underway in this area. A Local system reset (perfect fortnight) commenced on the 2nd March 2022 with the aim of being a system wide learning event to establish an improved grip across the patient pathway and a set of improvement projects that can be deployed. Further update to be provided at the completion of the event. Within M&C ILG the PCH Improvement Programme continues to deliver improvement with the feedback from the second unannounced Health Inspectorate Wales Visit in January 2022 providing clear evidence of significant improvement in patient safety and experience. Overwhelming demand activity continues to provide challenging operational context, this is being addressed through joint working with Improvement Cymru and an external provider to deploy a real time flow management process with the specific objective of improving the pace of the patient along the pathway.	Quality & Safety Committee Planning, Performance & Finance Committee	16	C4 x L4	12 (C4 x L3)	↔	04/12/2020	02.03.2022	30.04.2022
4706	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure of appropriate security measures in mental health services.	**If:** there is a failure in security measures. **Then:** there is an increased likelihood of patients leaving the ward without the knowledge of staff **Resulting In:** absconding events and possible harm to the patient or members of the public	The following control measures are in place: - Signs are placed on doors to ensure staff check the doors lock behind them. - Patients are on appropriate levels of observations - Problems are escalated to estates as they arise	There has been a proposal that Estates undertake environmental checks accompanied by leads within the respective Mental Health Clinical Service Groups to work together to review onsite security systems in mental health services. Timeframe 30.11.2021.	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	↔	22.06.2021	28.10.2021	31.12.2021

Datix ID	Strategic Risk owner	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4152	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	**If:** there is a backlog of imaging and reduced capacity **Then:** waiting lists will continue to increase. **Resulting in** delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Currently looking at plans for capacity for the whole service - unlikely to see much change in the near future. Locums to support CT service CT vans on site RGH/PCH MRI running at higher capacity Ultrasound concerning 3.2.21 Whilst mobile scanner presence allowed us to reduce the backlog (CT/MRI) routine imaging has since been stopped and has not been reinstated, which will in a build up of back log.	Increased capacity required for current referrals to address backlog, particularly in CT/MRI /Ultrasound. Require funding and procurement of mobile scanners in the longer term. Actions: Staffing Resource, Capacity and Demand Planning and business case.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	04.10.2021	31.12.2021
4148	Executive Director of Nursing & Midwifery	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non-compliance with Deprivation of Liberty Safeguards (DoLS)legislation and resulting authorisation breaches	**IF:** the Health Board fails to adequately resource the DoLS Team to address the backlog of authorisations and adequately manage a timely and effective response to new authorisations. ~~due to current capacity the Health Board fails to fully comply with the DoLS legislation~~ **Then:** the Health Board will be unlawfully depriving patients of their liberties and failing to comply with the DoLs legislation ~~the Health Board may have to operate outside the current legislative process.~~ **Resulting in**: the rights, legal protection and best interests of patients who lack capacity potentially being compromised. Potential reputational damage and financial loss as a result of any challenge by the ombudsman or litigation.	During February 2022 review of this risk the control measures have been revisited and streamlined. - Prioritisation assessment is being undertaken on the urgent authorisations. - Hybrid approach to the management of authorisations which includes the ability to offer a virtual format if necessary, although face to face is the preferred mechanism. - As at February 2022, the DoLS Team have now returned to full establishment which will support the resilience within the function. - A temporary Best Interests Assessor has now commenced with the Health Board whose role will be to focus on reducing the backlog. - A temporary Practice Educator has also been appointed whose role will be to prepare the Health Board for the Liberty Protection Safeguards and ensure that all staff are trained in the Mental Capacity Act. - From February 2022, the DoLs Training has been revised and is running virtually on a monthly basis. - Audits are undertaken by the DoLS Team to look at compliance across the Locality Groups with the support of AMaT. - Capacity issues are also being supported by addition resources sourced through CTM Staff Bank.	During February 2022 review of this risk the Mitigation Actions have been revisited and streamlined. - In February 2022, the Health Board has received confirmation that the Welsh Government will be offering funding to address backlogs in authorisations, to provide training in the MCA and prepare the implementation of the Liberty Protection Safeguards. It is anticipated that the Health Board will need to apply for the funding by the start of the new financial year and in preparation the Health Board has already planned its approach in the form of an SBAR. Timelines: a response to the application is anticipated by the 30th April 2022. - The implementation of the change in legislation with regards the Liberty Protection Safeguards will improve the Health Boards compliance however the date of implementation is still awaited. - The DoLs Team are meeting with leads within the Locality Groups to work with CSGs to progress the action plan in order to enhance the awareness of the MCA, the risks associated with DoLs authorisations and timely review required and reporting compliance. Timeframe: Due to commence March 2022.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01/10/2014	01.03.2022	30.04.2022
3585	Chief Operating Officer. Bridgend Integrated Locality Group	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Princess of Wales Emergency Department Hygiene Facilities	**If:** the toilet and shower facilities are not increased within the Emergency Department. **Then:** at times of increased exit block the facilities are insufficient for the needs of the patients in the department. **Resulting In:** Poor patient experience, complaints and further concerns raised from the Community Health Council have repeatedly flagged this issue on visits to the department.	There are additional toilet facilities in the radiology department that mobile patients can be directed to however staff do whatever they can within the constraints that they have.	Additional facilities being explored as part of departmental capital works. There is a capital plan for improvement works in ED. The improvements will be – 1. NIV cubicle 2. Creation of a second patient toilet 3. Improvement to HDU area 4. Relocation of Plaster Room 5. Creation of 2 paediatric bays with adjoining paediatric waiting room 6. Redesign of waiting room and reception desk Prior to the Covid pandemic, improvements 2-6 were planned, but the creation of an NIV cubicle has taken priority. The plans are in the process of being signed off for all areas but there is no confirmed start date yet. There was / is potential for delays in sourcing materials by contractors and we need to consider the need to keep contractors as safe as possible from any Covid contact. Patient numbers are now increasing daily but we are restricting visitors and relatives attending with patients (unless required as carers etc). We have also developed a remote waiting room for patients who can safely wait in their cars. This will help to mitigate the footfall in the department when the capital work commences. June 21 Update - Capital works for NIV room still ongoing and therefore no progress yet with the rest of the capital build. NIV room to be handed back mid June and patient toilet will be the next priority for completion Update August 2021 - No Change.RCEM audit undertaken. Staffing remains ongoing issues- plans in place and frequently reviewed. ASCU staffing plan agreed at ILG level and ongoing. Surge trolleys in place to cope with additional capacity requirements. Building works progressing and some phases complete. X references to ID4458 & ID3826 Update: Awaiting update from Capital team to confirm start date for next phase of works. Patient toilet is the next priority.	Quality & Safety Committee	16	C4 x L4	1	↔	31.05.2019	28.09.2021	31.01.2022
4337	Executive Lead: Director for Digital. Bridgend Integrated Locality Group	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Integrated IT Systems	**If:** The Health board is unable to deliver vital clinical information services to the Bridgend locality affecting many clinical systems that are not compatible with Cwm Taf University Morgannwg Systems. **Then:** The Health board will be unable to deliver safe, high quality care to patients without vital clinical information available. **Resulting In:** Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan.	**Key Controls** 1. SBUHB Service Level Agreement 2. Bridgend disaggregation and the one-CTM aggregation plan 3. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. 4. Band 7 Senior Server manager being appointed specifically to work with SBU on the transference of infrastructure and services within Princess of Wales (POW) to CTMUHB. **Gaps in Control** The business case for integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. SBUHB have no process in place to incorporate the needs of Bridgend users in their developments.	Progress in line with the existing plans which were agreed on the primary basis of their need to be affordable, has been made over 2020/21 with a number of new systems, such as pharmacy management introduced as pan-CTM products. However there is still considerable work required to create a unified digital infrastructure for CTM = around the clinical systems and the remainder of the ICT SLA. The business case details a funding requirement of £8 million. This was discussed at the Digital cell with WG in February 2021 and a further funding request has been submitted to WG at their request, along with complimentary proposals from Digital Healthcare Wales (DHCW) for which CTM has worked with them on. Timeframe - Mid June 2021 when DPIF Funding is announced. Update October 2021 - In the absence of WG support to provide the necessary infrastructure to safely and effectively enable the boundary change the UHB took the decision, informed by a business case appraisal, to make best endeavours, using the opportunities provided to lead to integration. In addition nearly all efficiencies made by the digital and informatics team are being put to resourcing the aggregation programme. Phase 1 of which, which includes the integration of non PAS interfaced clinical systems, the helpdesk and Wi-Fi and mobilisation is nearing completion. Phase 2 is presently being planned, with the business case still awaiting agreement from the Welsh Minister for Health. Meetings have been ongoing with a Band 7 Senior Server manager being appointed specifically to work with Swansea Bay UHB on the transference of infrastructure and services within Princess of Wales (POW) to CTMUHB. No change to mitigation or risk rating. Review date extended to 25.3.2022.	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	31.12.2021	25.03.2022
2987	Chief Operating Officer Merthyr & Cynon Integrated Locality Group Executive Director for People (Executive Lead for Health & Safety and Fire.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire enforcement order is in place for the ground and first floor PCH due to inadequate fire compartments to prevent spread of fire, smoke and noxious gasses	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Fire Enforcement Order. An action plan and target dates for the 1st and ground floor areas at PCH is available and is subject to available finance for completion. Phase 1b of the wider programme has progressed to the point that the UHB has now achieved remediation for physical fire issues identified in the FEN in the majority of the new Pharmacy, Dining Room and Kitchen areas at PCH which opened in January 2021. This has tackled the higher risk for fire areas of the old kitchens and improved the fire stopping below ITU as well as reducing the overall volume of area remaining in the FEN to be remediated (remediated c2000m2 of c18000m2). In addition the UHB secured Welsh Government approval in October 2020 for the Phase 2 FBC, in the sum of £220m, which will see progressive improvement of the majority of the remaining G&FF areas to be remediated for fire over the next 5 and a half years. As a reminder these works are progressive due to the need to balance them against maintaining service delivery as best as we are able and are intended to be supplemented (to run concurrently with final years of the Phase 2) by a final Phase 3 business case intended to address the final physical accommodation areas included within the FEN. Ongoing maintenance of fire systems. Increased knowledge on site of the fire issues, fire training, Initial works carried out on areas as part of the scheme already.	Ground and first floor major project approved by WG to address the fire notification on PCH. In progress with completion due 2026 / 27. Annual reviews as to remediation progress are held with SWF&RS and the Health Board is required to evidence continued progression in the shortest timescale. If satisfied SWF&RS issue an annual extension letter against the FEN. The current extension runs to the 31/07/22. The Phase 2 programme has now reached a point where an additional c 3500m2 of FEN accommodation has been handed to the contractor (End of Jan 2022) as the next section to be remediated, having now decanted these areas to alternate fire compliant accommodation. An extension of a further 12 months has been granted by the Fire Service and will now expire on 31/07/2022.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	6	↔	29.11.2017	16.02.2022	31.07.2022
4294	Chief Operating Officer Merthyr & Cynon Integrated Locality Group Rhondda Taf Ely Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long waiting times and large backlog of patients awaiting Cardiac Echo	**IF:** The health Board is unable to meet the demands for patients awaiting Echo scans for both follow up surveillance **Then:** The RTT WG target will not be met and waits may be 26weeks **Resulting in:** Potential risk to patients from delays in identifying and treating disease and progression of disease	Forms were verified and triaged by Cardiology team. Patients prioritised in relation to clinical need and rated between urgent and routine. I/P room identified away from main department to increase outpatient capacity and to prevent cross infection risks to outpatient services for both staff (inc returning shielders)and patients Clinically urgent completed and move to routine. New forms triaged as received. Overall loss of capacity post Covid circa 56 / month due to test time changes. (+ currently 1.0 wte lts further 120/month. Will submit SBAR to highlight capacity deficit and cost solutions. Updated SBAR awaiting finance review will upload once completed review again in 3 months awaiting ILG feedback	See Control Measures As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Quality & Safety Committee	16	C4 x L4	6	↔	14.09.2020	26.10.2021	31.01.2022

Datix ID	Strategic Risk owner	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
3008	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk of injury due unavailability of opportunities to train and maintain compliance with Manual handling training.	**If:** There is a lack of manual handling training there is the risk of potential injury to a member of staff or injury to the patient. **Then:** There are a number of clinicians who have not had the opportunity to meet the requirements for manual handling training. **Resulting In:** Potential harm being caused to both staff and patients.	1. Staff are aware of the risks associated with manual handling. 2. All staff have been informed to consider the ergonomics of the environment that this activity is being undertaken. 3.Appropriate equipment is available in the clinical areas or on request from the MH team e.g. pat slides, slide sheets, hoists. 4. Manual Handling risk assessments are incorporated into the admission bundles 5. The training group are planning training for clinical staff with the manual handling department - current position that this can not be supported 7. Ask other HB`s their MH requirements SBUHB online training package to be shared. 8. Directorate will Seek out any opportunities for online updating to support current practice 9. E-learning module has been sourced for all staff to complete on line update for manual handling.	Organisational plan for compliance training. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates. As at March 2022, the Head of Quality & Safety in the ILG is meeting with the CSG to support a review of this risk. Meeting arranged for the 10th March 2022.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	01.05.2017	01.12.2020	31.03.2022
3654	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Gynaecology Cancer Service	**If:** Demand continues to exceed the agreed manageable caseload in Gynaecology services across the Health Board. **Then**: there will be a delay in the pathway requiring multiple consultations on site and reliance on an individual Practioner. **Resulting in**: Delay in patient pathways, poor experience, unsustainable demand on the workforce and Gynae Rapid access service development is slow progression. Risk description reframed into the if, then, resulting in format.	Hysteroscopy service business case is being updated - Increased cancer tracking - Review of pathways and service - tracking of results G17Scrub training in place and a rolling programme organised with main theatres Covid Health Board Guidelines in place.	Action: Agreed COVID pathways. Service to re-submit gynaecology 'one stop' Service. Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Quality & Safety Committee	16	C4 x L4	9 (C3xL3)	↔	18.06.2019	12.05.2021	11.06.2021
3133	Chief Operating Officer Facilities	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Due to capacity issues to deal with Covid-19 staff not attending medical gas safety training and courses being rescheduled.	**If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	Monthly reporting template of Medical Device Training Compliance to be constructed and presented to COO and ILG Director leads to inform current take up of courses and improve take up of courses including Medical Gas Training. If happy continue using template on a monthly basis. Completed. Reporting template has been agreed and is now in place. Action: Use reporting template to monitor attendance. Timescale: 31/03/2022. COMPLETE Quarterly reports in place for all med device training sent to Corporate Services for dissemination to ILG management, places offered, places attended/competency assessments etc. Current med gas training attendance is 12% in latest Feb 2022 report. Based on this update the risk rating remains unchanged until the attendance for Medical Gas Training is being consistently achieved. As a high risk the risk will be reviewed in 3 months.	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	11.02.2022	31.05.2022
4500 Linked to 4483.	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of high patient care due to the difficult in recruiting sufficient numbers of registered therapists and health scientists.	**If:** the Health Board fails to recruit and retain a sufficient number of therapists and health scientists due to increasing numbers of vacancies and shortages of professional staff. **Then:** the Health Board's ability to provide certain services may be compromised. **Resulting in:** increased waiting times for diagnosis and treatment, missed opportunities to diagnose at an earlier stage, potential for poorer outcomes for patients.	Links via the Director Therapies to HEIW for planning. Proactive recruitment for difficult to fill posts. Use of Agency/Locum staff where available. Director of Therapies & Health Sciences have supported participation in streamlining to appoint AHP summer 2021 graduates to band 5 vacancies. This is the first time AHPs have recruited in this way and it is too soon to ascertain whether this will impact positively on staff retention.	Continue with active recruitment wherever possible. Ensure workforce plans included and supported in the Integrated Medium Term Plan (IMTP). Utilise 'novel' staffing approaches where indicated. Update January 2022 - Opportunities to enhance workforce via planned care funding 22-23 has the potential to increase workforce. Current focus lies in workforce education commissioning.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	8 (C4xL2)	↔	21.12.2020	07.01.2022	15.03.2022.
816	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Follow up capacity and clinic cancellations (FUNB)	**If:** The Health Board is unable to control and meet the capacity and demand to accommodate all hospital follow up outpatient appointments. **Then:** the Health Board's ability to provide high quality care may be reduced. **Resulting in**: Potential avoidable harm to patients who are not reviewed in a timely manner.	Clinical Service Group (CSG) plan in place to address the FUNB position across all specialties as part of the restart programme. Additional funding requirements identified. Regular meetings in place to monitor the position.	Harm review processes being implemented. Further discussions underway with Assistant Director of Nursing. Update September 2021: Colleagues within the Health Board are aware that this issue has been on the risk register for some time and significant progress was made prior to Covid-19 across the organisation, unfortunately this progress has been impacted upon by pandemic restrictions. The Health Board is now aiming to use WG Outpatient funding to run administrative validation on the lists to help support the position, and this is currently with ILGs to explore around uptake for overtime. The See on Symptom (SOS) and Patient Initiated Follow Up (PIFU) project is underway, however, it will take some time before any impact of that work is seen because of the time it will take to go speciality by speciality to implement the changes needed. This is a longer term transformation as part of the Outpatient Strategy.	Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	18/11/2013	16.9.2021	31.03.2022
2787	Executive Director for People Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Absence of a robust Health Surveillance Programme for employees.	**If:** there is no monitoring in place for staff who work in areas of the organisation where known health risks could develop e.g. Hand, Arm Vibration (HAVs), noise, skin conditions such as contact dermatitis, respiratory etc. **Then:** then this means that the organisation may not be able to identify the areas and departments within the organisation that require Health Surveillance intervention. Should a reportable incident occur CTMUHB will be liable to criminal repercussions by the HSE **Resulting in:** it not being possible to develop a robust HS programme for the organisation without this baseline intervention as required by the Health & Safety Executive (HSE). Criminal Actions by the HSE.	OH linking with H&S to re-establish the skin surveillance programme. Plan to submit a briefing to execs in relation to the associated risks due to the absence of a health surveillance programme.	Plan to submit a briefing to execs in relation to the associated risks due to the absence of a health surveillance programme.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	8 C4xL2	↔	26.06.2017	07.01.2022	31.03.2022
1133	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; **Then:** the Health Board will be unable to deliver safe, high quality services for the local population; **Resulting in:** compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce.	ED sustainable workforce plan developed and being implemented (May 2021). Reviewed no change as at 7th September 2021. Reviewed 21.09.2021 - remains working progress.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4 x L4	12 (C4xL3)	↔	20.02.2014	7.9.2021	13.12.2021

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4339	Director of Corporate Governance Information Governance Function	Improving Care	Legal / Regulatory	Failure to complete a timely and robust Data Protection Impact Assessment (DPIA)	**If:** the organisation fails to complete a timely DPIA for processing activities associated with new projects and systems. **Then:** there is a risk that the organisation will not identify and/or minimize the data protection risks of a project and undertake the necessary consultation with the Information Commissioners Office (ICO). **Resulting in:** non compliance with the General Data Protection Regulations, Information Governance breaches leading to complaints, incidents and impact on the reputation of the Health Board. Enforcement action/investigation by the ICO. Potential risk that Health Board officers may decide to proceed at risk on projects, sharing agreements where a DPIA cannot be provided in the timescales required.	Context: 600% increase in Data Protection Impact Assessment in the last 12-18 months. Information Governance Team providing specialist expert advice and support to teams across the organisation. Information Governance training as part of the Statutory and Mandatory training compliance captures the DPIA requirements. Information Governance Policy for the Health Board. Data Privacy Impact Assessment Procedure for the Health Board - updated to clearly indicate timescales for responding and the key stages in the DPIA process. This will allow risks and mitigations to be identified at the earliest opportunity. Information Governance included within a "Good Governance" slot on the Welcome Day Induction Programme.	Continue to raise awareness through training and induction. Monthly IG Awareness Sessions to be reinstated from March 2022. Identify IG Champions through TNA to increase capacity within Health Board and reduce reliance on central team. Likelihood of risk occurring has increased from a 4 to a 5 in January 2022 in light of the continuing increase in demand for the completion of DPIA's which is resulting in a backlog which will likely incur delays.	Digital & Data Committee	16	C4 x L4	8 C4xL2	New risk escalated to Organisational Risk Register in February 2022	19.10.2020	20.01.2022	31.03.2022
4282	Chief Operating Officer Facilities	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Risks associated with the transfer to the new Planet FM System	**If:** the Health Board transfers over to the new Planet FM system **Then:** the TAB system will no longer be supported for Support Services, Laundry Services etc **Resulting In**: Business Continuity / Service Delivery not being available leading to service and financial loss. Potential for system to crash with no support available to rectify. No reporting system being available.	The Health Board is still using the TAB system until suitable alternative is found. Additional control measure in place of reverting to spreadsheets being used with manual entry, with additional staff put in post. Option to transfer services over to Planet FM through a phased approach has been looked at but unfortunately this is no longer feasible. Depending on if feasible there may be costs associated with licences, training etc. with new system. This has been included within the 'Support Services Forward Work Plan' to identify a solution in place of TAB system. Following review of this risk, the Technical Services Team have agreed that the risk now needs to be increased following confirmation that Tabs will no longer be supported on an IT server from July 2021, so there will be no system in place. Five demonstrations of alternative systems have been undertaken, however they have not been suitable for the Facilities Services. Other systems continue to be looked at by the Technical Services Team. Based on this update the likelihood of the risk remains at 4, giving a high rating (from 12 to 16). The risk will be reviewed in 3 months or following any mitigating actions being undertaken.	Action: Alternative system for Technical Services and the Laundry Service to be sourced. Timescale: 31/03/2022. Alternative systems continue to be reviewed. Tabs upgrade still appears to be the best option so far and could further expand to support other disciplines in the future; examples are accommodation and Shuttle bus bookings. This version also supports full audit tools and history transfer (if required). This is a web based version with live IT support from TABS and does not need CTM ICT infrastructure. However Server maintenance and support is necessary. Based on this update the high rating of 4 x 4 = 16 remains. The risk will be reviewed in 3 months or following any mitigating actions and / or implementation of above options being undertaken. Review Date: 31/05/2022	Digital & Data Committee	16	C4xL4	4 C4xL1	↔	19/02/2020	11.02.2022	31.05.2022
4356	Executive Director for People Health, Safety & Fire Function	Improving Care	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Overdue/Out of date fire risk assessments due to resource issues and the amount required to be undertaken	**If:** Fire Risk Assessments are not completed and reviewed in a timely manner. **Then:** Significant findings on the FRA may have changed which could compromise the safety of patients, staff, visitors/contractors and building fabric. **Resulting in**: Increased risk of fire/harm, enforcement action by Enforcing Authority i.e. Notification of Deficiences (IN01) which will further escalate to Enforcement Notices (EN01) if no remedial action is taken.	There are FRA's in place however a substantial number have not been reviewed by the review date. Fire safety advisors are reviewing FRA's in areas where it is safe to do so (Covid restrictions are in place in many areas). A concentrated effort will be necessary to reduce the number of overdue FRA's. An initial 12 months funding has been secured to appoint a Fire Officer.	It is recommended that additional fire safety resources are provided to support the work of the fire officers to undertake FRA reviews. As referred to in Risk ID:4315, 2 x Band 5 additional fire safety trainers to be appointed. Agreement on additional fire safety training resource (Risk ID 4315) will create additional time for the Fire Officers to undertake this activity - Due by date 31.03.2021. Update June 2021: Recruitment has focussed on an appointment of a Fire Officer who will be able to undertake the Fire Risk Assessment reviews as well as undertake training as required. No specific Fire Safety Trainees are considered to be required at this time. Fire Officer post currently being advertised. Review - July 2021. Update July 2021 - Recruitment to Fire Officer post underway and pending a successful shortlisting exercise interviews are planned for circa mid July. Despite the appointment of an additional fire officer in 2021, this risk is likely to increase in the first part of 2022 due to the retirement and loss of 2 other fire officers (Specifically in Merthyr Cynon ILG area) To try and mitigate this risk, fire officer property allocations have been reassigned and only high risk FRA (patient sleeping areas) will be the main focus of the Team until the 2 fire officer vacancies are appointed. Appointment of 2 vacant Fire Officer Posts - deadline 31.03.2022	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	26.10.2020	01.03.2022	31.03.2022
4906	Director of Corporate Governance Putting Things Right / Legal Cases	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to provide evidence of learning from events (Incidents and Complaints)	**If:** The Health Board is unable to produce evidence of learning from events. **Then:** the Health Board will be unable to recoup any costs from Welsh Risk Pool for personal injury or clinical negligence claims made against the Health Board. **Resulting in**: Risk to quality and patient safety with potential for further claims as learning and improvement will not have taken place. Financial impact to the Health Board	Controls are in place and include: * Monitored and reported through the weekly Executive Quality & Safety meeting. * Regular engagement and meetings with the Executive team to assist in gathering of learning.	The Health Board are developing a Learning Framework to ensure Learning is captured and shared across the organisation. The Health Board are developing an action plan in response to the Welsh Risk Pool review. Action plan has been developed and will be submitted to the Quality & Safety Committee in January 2022 which includes a specific action in respect of compilation and assurance of learning from events. New SOP and 'how to' guide developed for completion of LFERs and shared with ILGs with immediate implementation (Feb 2022).	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	06.01.2022	31.03.2022
4907	Director of Corporate Governance Putting Things Right / Legal Cases	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively	**If**: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, Duty of Candour, FUNB Ophthalmology Redress/Claim cases **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the establishment of a dedicated Redress Team within the existing work force. The Health Board are reviewing the Covid funding in respect of the recruitment Covid19 specific Redress Handlers. A Redress panel will be established to effectively manage cases through the PTR process. Meetings with ILGs to be established in respect of complaint responses to ensure legal aspects have been reviewed and validated. Update January 2022: The Health Board submitted a funding request in December 2021 for two Claims Handlers to support the management of Covid-19 cases. A response is currently awaited.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	06.01.2022	31.03.2022

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4908	Director of Corporate Governance Putting Things Right / Legal Cases	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Legal cases efficiently and effectively	**If:** The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in**: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager	The Health Board is delivering an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads The Health Board are reviewing the Covid funding in respect of the recruitment Covid19 specific Redress Handlers. Meetings with ILGs to be established in respect of complaint responses to ensure legal aspects have been reviewed and validated. Update January 2022 - the funding request outlined in Datix Risk ID: 4907 would provide some mitigation to this risk if funding is secured. A response is currently awaited.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	06.01.2022	31.03.2022
4873	Chief Operating Officer Rhondda Taf Ely Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	The Implementation of the TRAK 2016 LIMS within Blood Transfusion	**If** The implementation of the blood transfusion Trak 2016 project is delayed (deadline 31st December 2021). **Then:** The departments current LIMS (Telepath) will be unsupported by the supplier (current contract ends December 31st 2021) **Resulting in:** The department and the health board being exposed to risk in terms of a) increased errors in relation to patient blood management. b) governance - the MHRA can issue a cease and desist order, closing the transfusion department.	The Trak 2016 implementation project is progressing within the department with as much resource as possible diverted to the project but a number of facets of the project are subject to external bodies (e.g. DHCW; Haemonetics; Intersystem)and unknown variables (e.g. anything that may be found via testing and validation). A large amount of risk will be mitigated by the negotiation of a short term extension of the current LIMS provider (Telepath).	Implement the L2016 Trak LIMS solution for blood transfusion. The implementation of the blood transfusion Trak 2016 project has a deadline of the 31st of December 2021. In order to mitigate the risk around any possible slippage of this project, it is recommended that a short term extension to the current contract is negotiated. Update 16.12.2021 - Reviewed - Telepath contract extension has been agreed, and is currently progressing through the health board approval process.	Quality & Safety Committee	16	C4 x L4	6 C3xL2	↔	18.10.2021	16.12.2021	31.12.2021
3267	Chief Operating Officer Primary Care	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Out of Hours - Contingency Plan for Business Continuity Communications Hub Ty Elai	**If:** There is no ability to divert calls for services delivered from the Ty Elai Communications Hub (111, GP Out of Hours, Dental ,District Nursing, Safe Haven, 111 First). **Then:** In the event Ty Elai should become inaccessible due to adverse weather there is a likelihood of interruption to services. **Resulting In:** Potential delays, impact on service to patients and their experience received. Staff impact.	Some home working is possible for access to the Patient Administration system Adastra. However, there is currently no means to transfer telephone calls from Ty Elai. Communications colleagues from both Ty Elai and RCT CBC have been consulted on this issue and have arrived at the same determination.	Explore the possibility of relocation to a health board owned site. Options Appraisal to take to board and to discuss with co-location partners. Relocation would ensure IT systems and telephony are easily transferable to another area within the HB in the event of a major incident. This would then be able to be managed internally with no need for Local Authority input. Preliminary meeting with capital and ICT have been undertaken Options Appraisal is being undertaken. A building has identified and a awaiting a decision around space. Building has been identified as a possible location. Awaiting blueprints to see if space is suitable for requirements. Timeframe: 31.3.2022	Quality & Safety Committee	16	C4 x L4	6 (C2xL3)	↔	16.07.2018	11.01.2022	31.03.2022
5017	Chief Operating Officer Merthyr Cynon Locality Group	Improving Care	Statutory duty / Inspections	Implementation of the Additional Learning Needs (ALN) Act	The implementation of the new ALN bill in September 2021 was assumed to be cost neutral with no additional workforce time allocated. The new system involves a change in the way the child health admin team have been requested to work, new format to the reports written by paediatric staff, a different balance to the information requested, a new approach to ensuring that health needs are met within the educational setting and an increase in the requests for paediatric input into person centred planning meetings of children and young people. The provision of information to the local authority is a statutory duty, along with a record of compliance. If: Relevant Staff have lack of education on the new ALN Act Then: Failure to Monitor Resulting in: Reports not being completed within statutory time frame with the risk of inappropriate information being provided for which health board could be financially responsible.	Champion identified within community child health to be involved in implementation group and disseminate information to wider team. However, there is no additional resource available to support with the time required to undertake this role	1. Education of broader paediatric team, 2. dedicated time identified in job plan for ALN champion, 3. Appropriate admin & IT support. I have added to the datix. Is this adequate?	Quality & Safety Committee	16	C4 x L4	4 (C2 x L2)	New risk escalated February 2022	06.02.2022	06.02.2022	06.05.2022
5031	Executive Nurse Director Clinical Education	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Clinical Education & Training Accommodation	If: There continues to be a limited availability of dedicated clinical education and training accommodation required for face to face training activity. Then: the Health Boards ability to provide high quality essential clinical skills training would be reduced. Resulting in: a risk that clinical staff are not up-to-date with their skills training and therefore potentially not able to offer the most up-to-date evidence based care to patients.	Temporary alternative arrangements continue to be sourced however they are short term and do not provide for continuity and sustainability of training provision. Examples of training impacted include resuscitation and clinical skills training, health care support worker training, nurse education including clinical skills. Assessment of required training has been undertaken for delivery in another format has been considered and is in place.eg move to virtual/ online. However it is necessary to continue to deliver some training face to face	Investigate existing estate for alternative training accommodation. Alternative training accommodation needs to be sought for each of the 3 localities. YGT is currently being utilised for staff based within RTE and MC localities. This is currently a temporary arrangement. Timeframe 30.03.2022.	Quality & Safety Committee	15	C3xL5	6 C2xL3	New Risk Escalated February 2022 Superseded Datix Risk ID 3899	24.02.2022	24.02.2022	08.04.2022

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3638	~~Chief Operating Officer~~ Executive Medical Director Pharmacy & Medicines Management	Inspiring People	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Pharmacy & Medicines Management - Training & Development Infrastructure	**IF:** the planned HEIW led changes to the education and training of pharmacists and pharmacy technicians with increased numbers of trainees across both primary and acute care are fully implemented **Then:** the there will be insufficient capacity within the medicines management team to provide the required training, supervision and management of the planned trainees. **Resulting in:** a lack of appropriately qualified pharmacy professionals to meet future service demands in all sectors and particularly in hard to recruit to ILGs such as Merthyr where we have established a "grow our own" model. This can impact the primary care sustainability MDT model. Also a reduction in reputation of a HB that has a very high level of % qualifying and a reduction in future applicants. Current capacity is overstretched and a robust education, training and development infrastructure is needed to meet these demands for specialist & advanced practitioners in primary and secondary care.	SBAR submitted to CBM in March 18 to increase training capacity in order to meet the demand. Included in IMTP and prioritised as number one priority. A bid was included as part of the primary care pacesetter for education and development in primary care academic hubs and was successful. This element of the ed/tr will be implemented in 2018 for 3 years with evaluation. The secondary care elements were not supported in the IMTP prioritisation process and so this still leaves significant risks. SBAR needed to describe the impact of the new technicians training qualification. Funding approved for primary care lead pharmacist - commenced in post April 2019. Included a new case in 2019/20 IMTP as high priority. SBAR for Nov CBM on new technician training requirements. Progress and evaluate primary care pacesetter plan to increase training infrastructure to inform business case to continue funding and scale up.	Update June 2021: HEIW have agreed training support grants for trainers to support pre-registration foundation posts which mitigates the risk for this group of staff. However this funding is only temporary and not guaranteed beyond 2022-23, which presents a potential risk around recruitment of suitable staff. The post-registration foundation programme has been deferred until 2022 which buys some time for health boards to explore solution to the significant financial shortfall that will arise form the lack of on going funding for these posts. Update July 2021 - No further update to that recorded in June 2021. Review 30.09.2021. Update November 2021 - as reported to the Quality & Safety Committee: Discussion with HEIW have resulted in a delay to the financial changes until 2024, which will allow the service related impact to be better transitioned into the planning cycle. Update February 2022 - Risk remains as funding for the posts will be significantly reduced from 2023 onwards as HEIW will reduce from 50% to 20% funding. The shortfall in funding between establishment and post costs remains the risk. The funding resource is being captured in the IMTP submission for 22-23 in preparedness for the impact in 2023-4. Funding gap is approximately £90k pa. This equates to 2 posts. Decision of funding is required by March 2022 to allow for recruitment process in 2023.	People & Culture Committee	15	C3 x L5	6 (C3xL2)	↔	02.01.2018	11.02.2022	30.04.2022
3698	Chief Operating Officer Bridgend Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting List for Autism Diagnostic Observation Schedule (ADOS) assessments and Attention Deficit Hyperactivity Disorder (ADHD) medicals over 1 year.	**If:** there are delays in diagnosing children with ADHD and Autism. **Then:** this results in a delay in management including appropriate school placements **Resulting in:** potential harm to patients, poor patient experience, dignity, staff morale. Complaints.	* The team have reviewed their clinical practice in line with the rest of CTM e.g. no longer undertaking ADOS for all children * Discussions underway re: repatriating service from Swansea Bay and investing funding into enhanced local service in Bridgend * New Consultant starting June 2020 with 3 sessions to support community paeds	Vacant sessions to be recruited to - Additional staff appointed who could undertake assessments would ensure this activity was managed in a timely manner.	Quality & Safety Committee	15	C3 x L5	4	↔	02.07.2019	04.11.2021	31.12.2021
4672	Executive Lead: Director for Digital. Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	~~Absence of coded structured data & inability to improve our delivery of the national clinical coding targets and standards (target is 95% completeness within month coded, and 98% on a rolling 3 month period)~~ Access to a complete and coded medical record.	**IF:** The Health Board is not able to record information accurately and reliably & does not address the 25000 backlog of uncoded FCEs **Then:** the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete **Resulting in:** Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc.	**Operational controls:** Coding key performance indicators covering productivity, demand and backlog robustly monitored Digitised Patient Notes programme board monitors scanning times, adherence of contractor to terms and quality of staff in maintaining a record DHCW annual coding quality audit. Coding Improvement and transformation plan established incorporating additional trained coding capacity, coding at source, use of data captured in other systems and e-forms implemented. Natural language programming resource deployed and outputs of programme being validated. Tactical - EPR programme with deployment of snomed-CT onotology server, WCP & E-forms etc. **Tactical controls:** Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme . **Gaps in controls** Scanning time of outpatient activity to digitise the record is at 8 days cf maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor Insufficient resource available to address coding backlog Digital solutions not yet using snomed-CT/ structurally coded data Information and Technical Standards Clinical audit	o Work is ongoing to improve the quality of clinical data held within Clinical Systems. o Data quality improvements efforts are ongoing in collaboration with colleagues from the relevant clinical areas and the Software Development team (MITS data fields are being updated/amended and TOMs OPCS codes are being refreshed to the latest version). – OPCS: Classification of Interventions and Procedures Code - there is no fixed completion date as this is dependent on the pace of improvement. The plan is to review progress quarterly. o MediCode 360 Go Live scheduled for completion by the end of February 2022 (this provides automated template coding capabilities, medical history assurance, live data quality checks and data quality analytics). o Work is underway to develop mechanisms to batch feed data from MITs, TOMs, McKesson Cardiology, Medilogik Endoscopy Management System (EMS) and MediSoft Ophthalmology into MediCode 360 ARC (automated template coding module) back end. Proposal for an interim target operating model will be completed by the end of February 2022. Funding approved to procure contract clinical coders to support the delivery of national clinical coding targets. Risk Rating remains unchanged at this current time and this decision is based on the wider risk profile not just the mitigation that is being put into place to address the coding of our consultant engagement.	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	05.03.2022	30.04.2022
4671	Executive Lead: Director for Digital. Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	NHS Computer Network Infrastructure unable to meet demand	**IF**: The Health Board suffers regular local and/or national network issues and/or outages to clinical and critical business systems. **Then**: there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated. **Resulting in**: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: Loss of information integrity and accessibility as multiple copies of clinical records. Threat of malware being introduced on to the network from unmanaged data, systems and software. Possible breaches to the GDPR, safeguarding and information governance risks. Mistrust by staff of the ICT systems and services they are using	There are various Service Management boards from ADIs, service delivery and infrastructure management which have representatives from each NHS Wales organisation and departments. These meet regularly with a governance structure to escalate any service delivery and security incidents and risks. SLAs are in place between DHCW and NHS Wales organisations and incidents are escalated up via the national Service Point Service Management system. The Health Board has the Risk Audit Governance & Cyber Security Board which meets monthly to discuss and take action on service delivery incidents. Local and National Infrastructure reviews are presently underway. CTMUHB has a large digital infrastructure refresh and expansion programme which is well funded with local and national support and is close to completing the infrastructure review. Operational weekly meetings take place to manage and learn from all new and ongoing major incidents. National infrastructure review is close to completing and making recommendations. Gaps in controls: Approach to cloud is variable across Wales, this presents numerous risks ranging from Information Governance and privacy to workforce (minimal skills available) and finance (revenue based and a lot more expensive)	Infrastructure and comms actions plans were agreed 24 months ago and are being delivered as funding and staffing are available (recognising priorities changed during Covid). The Health Board to develop a robust incident management process. This is to ensure that regular outages of national systems and infrastructure are escalated to the appropriate governance structures to address such issues locally and nationally. Update October 2021 - Progress has been made with the firewall replacement completed at PCH increasing bandwidth to 3GB and 10 GB by May 2022, RGH is planned for mid-October 2021. Enhanced WIFI has been made available on all sites. Server back ups have been optimised to reduce the overloading and DHCW are half way through their infrastructure and application initiatives which will also improve service availability and responsiveness. Weekly meetings are now taking place to discuss and update all new and ongoing major incidents. As at March 2022 - no change to risk score or mitigation.	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	26/05/2021	05.03.2022	30.04.2022
4512	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of patients with mental health needs on the acute wards.	**If:** there is a consistent number of patients with mental health needs who are being cared for on the acute wards without RMN support or there are delays in discharge an appropriate EMI setting; **Then:** patients who have been sectioned and / or are under medication review may remain on wards where specialist mental health therapy and input is not possible; **Resulting in:** incidents of staff and patients assaults may occur; poor patient experience; increased supervision needed.	MHL team contacted for each patient who required support; 1:1 patient supervision where required; Ward manager and senior nurse undertake regular patient reviews; Regular meetings with the mental health CSG in place.	Regular meetings with the mental health CSG in place, number of working groups established and working well.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	30/12/2020	17.8.2021	15.11.2021
3993	Chief Operating Officer Bridgend Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2021. Need to plan for drop in theatres to mitigate work commencing	Need building work to be undertaken to ensure safety. Operating theatres will need to close for this to occur. Fire enforcement notice has been extended to December 2023 by South Wales Fire and Rescue Service, work is ongoing with the construction supply chain partner to complete detailed design, obtain planning permission, a costed programme and submit a business case to Welsh Government by Spring 2022.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31/01/2020	07.01.2022	31.03.2022

Datix ID	Strategic Risk owner	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
3337 Linked to RTE Risk 4813 and M&C 4817.	Chief Operating Officer Director of Primary Care and Mental Health Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	1. Process in place for clinical teams to access information via local authority and health board teams. 2. Clinical teams will only use historical information as part of their current risk assessment and if this is not available they will judge the risk accordingly. 3. Merthyr and Cynon and Bridgend CGS leads have confirmed that WCCIS is on their CSG risk register and their updates have been provided within this this section, therefore aligned. 4. WCCIS Programme Board establishment for CTM will be finalised by the 30th June 2021, Merthyr and Cynon CGS Lead will Chair this group. The Chair of this group will report to the Senior Responsible Officer. The Task and Finish Groups to be established and aligned to this Programme board Programme will be established by the 31st July 2021. 5. Local Authority have recently developed reports for Mental Health which identifies practitioner caseloads, admissions and discharges and care plan for compliance. 6. Community Drug and Alcohol Team in Bridgend have now moved over to WCCIS, early implementation learning continues to take place. 7. WCCIS Regional Working Group now has a representative from the Health Board to maintain pace of delivery for WCCIS mental health rollout. 8. Project manager has been recruited, preemployment checks in place. This role will develop and lead on the implementation plan.	1. Deployment order to be in place for all existing WCCIS mental health staff users – Next step of this process is to seek Executive sign which is being progressed by the Director of Primary Care and Mental Health. 2. WCCIS Regional Working Group to have a representative from the UHB to maintain pace of delivery for WCCIS mental health rollout - COMPLETE. 3.CTM to set up a Project Board in partnership to start preparing for implementation of WCCIS - Currently working with CSG on priority of services for roll out, implementation plan will then be created 4. Project manager has been recruited too, pre-employment checks in place, develop and lead on the implementation plan - COMPLETE. 5. In mid January 22 there is a meeting with ICT colleagues scheduled to discuss current workforce capacity as this is having an impact on some of the programme deliverables. 6. A Business Case has been developed which identifies additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. Deadline - 30.06.2022	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	21.02.2022	18.04.2022
4590	~~Chief Operating Officer~~ Executive Medical Director Pharmacy & Medicines Management	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Critical Care Pharmacist Resource	**If:** additional resource is not identified to increase the critical care clinical pharmacy service **Then:** there is a risk that insufficient support can be provided to meet national standards and there would be lack of capacity to support future surges in demand, such as Covid. **Resulting In:** an increasing risk to patient safety, increased workload for critical care nursing and medical staff and lack of appropriate support for digital developments such as e-prescribing	SBAR included in Medicines management and advised to include in ACT directorate IMTPs. Meetings to discuss potential funding arranged with ACT leads. Baseline level of service (0.2wte) pharmacist time per site. A small pool of CC trained pharmacists are providing clinical services to acute wards which would be impacted if they are redeployed to support ITU, resulting in risk to patient safety and flow on acute wards.	June 21: Current situation included in planning review of CTMUHB ICU services Aim is to secure funding for 1WTE 8a specialist pharmacist for each critical care in RGH, POW and PCH and also supporting technician resources Update November 2021 as reported to the Quality & Safety Committee: Discussions are ongoing with ILGs so that pharmacy resource costs are included in any new business cases e.g. PACU and progress can be made to meeting the standards. Update February 2022: Discussion are ongoing with ILG's and submission for funding was made in Medicines Management in IMTP Feb 2022.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	05.04.2021	23.02.2022	30.04.2022
4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer Director of Primary Care and Mental Health Services Rhondda Taf Ely Locality	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Capital anti-lig scheme in Bridgend is due to be completed by the end of July 2021, this is reflected in BCB CGS risk register. SRU/Pinewood – ligature work has been completed, awaiting a final report from Pinewood and will then be taken off the register Annual revisiting of all patient ligature risks progress Statement of needs via capital process for any ligature risks assessed as needing resolution. The capital Anti Ligature scheme is nearing competition. With Ward 14 close to sign off with just snagging and making good left to be completed. The mitigating environment and staffing measures put in place last year are still in place. Anecdotally it is reported that the ward feels safer by night, the challenge for the ward team is to now use QI methodology to make a case for continuing with these staffing levels after the capital work is complete. No incidents involving suspended ligatures have been reported since these measures were implemented. This is reflected in BCB CGS risk register. Capital works remain ongoing and remain on programme to complete by July 2022.	1. Discussions to commence with Welsh Government in relation to the impatient environment. 2. A strategic case to be prepared and submitted to Welsh Government (No 1 & 2 above) Complete. Strategic Outline Document submitted and agreement to commence a Strategic Outline Business Case received. WCCIS in BCBILG (CDAT team), is managed by western bay and hosted by the city and county of Swansea. CTM WCCIS MH Programme Board is picking up this query as part of their work, further updates will be given). 3. If the strategic case conversation is supported by Welsh Government, develop a strategic outline business case. timescales March 22 4. if the strategic outline business case is accepted, progress to the development of a full business case." Reviewed February 2022 with no change to current score or mitigation.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	21.02.2022	18.04.2022
4772	Chief Operating Officer Facilities	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Replacement of press software on the 13 & 10 stage CBW presses	**If:** The 10 & 13 stage Lavatec presses have old software control systems, and are both vulnerable to failure. Following a fault developing and a recent maintenance call out it was identified that the 10 stage press is working intermittently caused by a software problem. **Then**: If the 10 Stage press control system fails the consequence of not purchasing the software replacement would result in the laundry service being unable to produce to full capacity and reduced to around 55%. If the Stage 10 press control system software fails then it could also impact on the Stage 13 press. The consequence of both presses failing and not purchasing the software replacement would result in the laundry service being unable to process any laundry which will result in all CTMUHB laundry being outsourced to commercial laundries. The costs will be significantly higher than those incurred in-house. **Resulting In:** •Potential of service failure due to existing system. •Potential of CTM sites being without bedding and linen at existing volumes and turnaround times. •Potential increased costs resulting from having to outsource laundry processing to commercial laundries in the event of equipment failure.	The All - Wales Laundry review continues, and at the current time, it is likely that services will be provided from CTM laundry until at least 2024. After this time, the equipment could be moved and rehoused elsewhere to continue to support CTM and the All-Wales Laundry agenda. Previous IMTP submissions have included as a priority £375K for a replacement automated sorting and roll cage washer/dryer system at the laundry. The software that controls system for the CBW forms an integral part of the current press. Benefits of equipment being replaced: •Reduced risk of service failure and therefore improved confidence in continued production. •Easier to diagnose and put right any mechanical defects. The consequence of not purchasing the replacement software would result in the laundry service being unable to process laundry at full capacity. This would mean that there is a real risk of CTM sites being without the ability to process adequate quantities of common user items such as sheets and pillowcases and other items used for income generation projects. If the 10 Stage press control system fails the consequence of not purchasing the software replacement would result in the laundry service being unable to produce to full capacity and reduced to around 55%. This would mean that there is a real risk of CTM sites being without the ability to process adequate quantities of common user items such as sheets and pillowcases and other items used for income generation projects. Additional costs would be incurred for laundry to be provided through commercial services which would immediately present a financial cost pressure risk due to the high price of external commercial laundry processing.	SON to be submitted and if successful replacement software purchased and installed. Timescale: 31/03/2022. SON approved and funding provided, awaiting installation. Update from Deputy Linen Services Manager that order has been raised to replace. The press tank for the 13 stage has now been replaced with software to the 10 & 13 presses on course for being updated by end of March 22 Based on this update the risk is a high risk and will be reviewed in 3 months time or once the software has been installed. Review Date: 31/05/2022	Quality & Safety Committee Planning, Performance & Finance Committee	15	15 (C5xL3)	5 (C5xL1)	↔	27.07.2021	11.02.2022	31.05.2022
4888	Executive Director for People	Creating Health	Statutory duty / Inspections	Insufficient resource in the Welsh Language Team	**If:** the resources of the Welsh Language Team remains as it is, the Health Board will not be able to fully meet its legislative duties set out in Compliance notice (no7) issued by the Welsh Commissioner in November 2018. **Then:** the team will not be able to effectively monitor compliance, there will be a reduction in staff and community engagement and cultural activities and the demand for translation will continue to exceed capacity. **Resulting in:** Significant use of expensive external translation agencies, non-compliance in many areas of the health board (including hosted bodies) and a high risk of investigations, financial penalties and reputational damage.	*Translation team prioritise patient related work. *Careful management of compliance monitoring and translation for Primary Care (work with Dental completed) *Ongoing programme of translation of the Health Board website and Social Media. (Member of team attends Communication team meetings) *Use of external translation agencies for large pieces of work e.g. Annual Reports.	Low level of resources in the Welsh Language Team impacts the Health Board's ability to meet the Welsh Language Standards. Develop a business case setting out the additional resources required within the Welsh Language Team to enable the Health Board to implement the actions set out in the Welsh Language Commissioners compliance notice. The business case needs to be reviewed/approved by the People and Culture Committee and appropriate Executive Forum. The business case needs to be incorporated into the IMTP for 2022/2023. A business will be submitted to the People and Culture Committee following a discussion with the Assistant Director. (NOV 21). Timeframe for completion: 31.03.2022. Risk Reviewed March 2022 - and the above mitigation remains.	People & Culture Committee	15	C3 x L5	12 (C3xL4)	↔	28.10.2021	04.03.2022	31.03.2022
4732	Chief Operating Officer Merthyr Cynon Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of orthogeriatricain as NICE guidance and KPI1 NHFD	IF: If we do not have this specialist service THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality. RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too.	The already stretched on call medical team are contacted for ad hoc advice. There is no COTE service and no specialist advice available	Recommendation: Employ a frailty team at each site to care for this complex group of patients. This may have cost benefits such as reduced length of stay, reduced complications and reduced complaints. Timeframe: 31.01.2022	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	30.06.2021	08.12.2021	03.10.2022

Datix ID	Strategic Risk owner	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4923	Chief Operating Officer Merthyr Cynon Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Increase in infection on ITU	IF: The ILG do not progress with Capital Works in order that Critical Care can return to a unit that is fit for purpose. THEN : The current ITU originally designed to temporary House ITU through Covid is not conducive to deliver safe, effective and dignified care Issue are many - bed spacing too close unable to distance patient due to the demand for ITU beds - no room for the equipment required to nurse an ITU patient - lack of storage on the area current storage held on a different floor and in metal containers outside - use of agency staff is over 50% on some shifts having worked in multiple areas before coming to work on our ITU - short staffed nursing 2-1 on a ventilator which is working against current GPIC guidelines, nurse are looking after multiple patient cross contamination is a higher risk for those patients nursed 2.1 - DTOC patients ready for discharged held in ITU this increases risk e.g. they request use of commodes by bedside, they move around the unit near other patients RESULTING IN: Increased risk of infection transmission, poor care delivery-not dignified. Not meeting WG guidance re bed spacing for Critical Care and Covid. Has a negative impact on staff morale, recruitment and retention.	Increased cleaning on the unit environmental audits hand hygiene audits 3x week bare below elbow audits 3 x week enhanced rate of pay to encourage own staff to work to reduce the agency usage. Await move back to previous ITU area Risk reviewed 8/12/21	See Control Measures.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	24.11.2021	8.12.2021	14.02.2022
2808	Chief Operating Officer Merthyr Cynon Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	The service is operating as efficiently as possible e.g. enhanced roles for SLT/CNS/Pharmacist. Pathways have been reviewed e.g. ADOS's limited to only those cases where clinically necessary. Clinical Lead role created to support this (as below). Non-recurrent investment of the below posts have been given for 12 months, but Clinical Service Group has highlighted the requirement for these posts to be made permanent. *1.0 wte Psychiatrist (clinical lead role) *Uplift from 8a to 8b 0.6 wte Pharmacist *1.0 wte Band 3 admin *0.6 wte Band 3 HCSW Additional clinics are currently being held on weekends to address longest waiters. (WLI has been carried out in the service since 6 months of the service being set up) Meetings with National Lead for Values Based and Prudent Health Care arranged to look at modelling of the service. Bids have been submitted through successive IMTPs and previously against new WG funding sources for the ND service. Within Bridgend the Directorate is reviewing the feasibility of repatriating the SLA from Swansea Bay so that a local service can be developed	Seeking confirmation that non-recurrent funding is made permanent for fixed term posts - timeframe 31.3.2022. Consideration required for further investment in the service to allow us to meet the demands on the service and reach the Welsh Government target of 80% of assessments being seen within 26 weeks. This will also reduce the need for WLI every year. Further investment in the service following D&C review - Timeframe - 31.03.2022.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	06.01.2022	30.04.2022
4833	Chief Operating Officer Executive Director of Therapies & Health Sciences Merthyr & Cynon Locality - Host of Therapies Services within the Health Board	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of high quality physiotherapy and rehabilitation to in-patients on all sites across the Health Board.	IF: The level of physiotherapy staffing remains significantly below normal operating levels. THEN: The health boards ability to provide essential physiotherapy interventions will be compromised. RESULTING IN: Poorer clinical outcomes, missed opportunities to discharge patients and support patient flow and have a negative impact on moral and staff wellbeing	1. All posts advertised as soon as possible (some recruitment challenges at band 6) 2. Robust use of clinical prioritisation tools to support clinical decision-making 3. Exploring availability of agency staff 4. Regular links by head and assistant head with clinical leads and staff on the ground to re-evaluate regularly and support difficult decision-making.	Communicated the staffing challenges to the Head of community nursing and the YCC senior nurse. They are aware of the pressures on the staff and will support them in their clinical prioritisation. Locum secured for 1 month tenure (national shortage, limits pool available), but risk has not reduced due to increased demand to provide physio cover at YYS and to ABUHB planned care recovery outsourced orthopaedics. Update March 2022 - Staff availability remains challenging, flexing of staff according to clinical prioritisation continues. No change to risk rating.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	20.09.2021	2.03.2022	21.05.2022
4920	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Capacity within the ED/ Medical/ Rehabilitation and Orthopaedic Inpatient Occupational Therapy Service within Princess of Wales	**If:** clinical capacity remains significantly reduced due to staff sickness and vacancies **Then:** clinical service delivery will be negatively compromised. **Resulting in:** increased length of stay, potential clinical incidents, poor clinical outcomes for patients, and increase in complaints. It will impact on staff wellbeing within the team and increase incidence of staff sickness.	Regular team meetings to support prioritisation and wellbeing. Updating AHP lead in Bridgend ILG on potential impact.	Recruitment of locum. Additional hours offered, resulting in part- time staff working additional hours. Redeployment of staff according to clinical priority, utilising a therapies version of daily "safe to start" with AHP Clinical Director, where staffing is monitored daily	Quality & Safety Committee	15	C3 x L5	12 (C3xL4)	New Risk escalated to the Organisational Risk Register March 2022	27.11.2021	2.2.2022	31.3.2022
5040	Executive Lead: Director of Digital Chief Information Officer (SIRO)	Creating Health	Operational: • Core Business • Business Objectives • Projects Including systems and processes, Service /business interruption	Digital Healthcare Wales (DHCW interdependencies	**IF:** The Health Board can not integrate new applications into its digital architecture in a timely fashion **Then:** there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend aggregation and the deployment of the new Emergency Department system) not being delivered **Resulting in:** delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: 1. Loss of information integrity and accessibility as multiple copies of clinical records. 2. Failure and delay of digital system deployments (e.g. WEDS) 3. Possible breaches to the GDPR, safeguarding and information governance risks. 4. Mistrust by staff of the ICT systems and services they are using 5. Money being wasted	A Myrddin strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome SLAs are in place between DHCW and NHS Wales organisations, however their futility has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months Gaps in controls: WG have agreed some funding for the PAS element, however the DHCW IMTP continues to be a top down decision process rather than one being based on HB (user / customer) needs - driven in part by demand overwhelming their capacity (much of which is either covid born or results from the significant overrun in establishing a minimum viable product to replace CanISC) and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying vacancies in critical areas with no capacity to cover the work from within. As a consequence programme to digitise the Emergency Department processes and records has been suspended.	National Data Resource Programme has accelerated plan to open up the architecture, with API management procured for all of Wales. National Funding received from WG for PAS integration work to create a second team supporting data migration. CTMUHB appointment process has commenced	Digital & Data Committee	15	C3xL5	9 C3xL3	New Risk escalated to the Organisational Risk Register March 2022	07.02.2022	05.03.2022	01.04.2022

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
4116	Chief Executive Comms	Creating Health	Adverse publicity/ reputation	Organisational Reputation - Lack of confidence in the services and care provided by the organisation.	**IF:** the Health Board does not effectively engage with its stakeholders, communities and staff to demonstrate listening and learning from external reviews and more recently the Health Boards response to Covid-19 **Then:** Trust and confidence in the services of the Health Board will be negatively impacted. **Resulting in:** negative media coverage, lack or credibility with our communities and staff, ineffective communication, loss of commitment, deteriorating morale, increase in staff turnover and recruitment.	Rebuild trust and confidence programme under Targeted Intervention Improvement Programme underway. Maintaining public confidence in the Health Boards response to the Covid-19 Pandemic through regular and robust communication and messaging through the Health Board's communication channels. Improved staff engagement and involvement, new approaches to partnership engagement and involvement. 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. Ensure balanced news stories are regularly reported and communicated. Relationships with the media have been strengthened. Partnership working with Channel 4 and proactive engagement with other media outlets - resulting in positive working relationships and fair media coverage. 'In Committee' meetings have been significantly reduced. TTP Communications work stream focussed on provision of accurate and timely information to the Public. Live streaming of the Board meetings now in place to improve transparency and involvement. New Health Board Values and Behaviours were officially launched in October 2020, World Values Day, following the Let's Talk staff engagement programme. The launch was further complemented by a peer recognition 'wall of thanks' campaign throughout Oct/Nov/Dec and a Staff Gratitude Event in December which recognised all CTM staff for their contributions throughout 2020 pandemic year. High visibility, communications and engagement from CEO office internally with staff and externally with key stakeholders since Sept 2020. Media have been given increased access to interviews and filming, most recently in ED at all three acute sites for BBC Wales, ITV and C4. Stakeholder database reviewed in May 2021 to ensure it is as up to	Stakeholder engagement survey planned for August 2020 -Stakeholder engagement survey delayed due to Covid-19 outbreaks in autumn but re-scheduled for spring 2021. Update June 2021 - Stakeholder database has undergone a significant review to ensure that it is as up to date as possible in readiness for the survey. Currently exploring the procurement of a company to undertake the survey independently from the Health Board. Anticipated that the survey will be live by the end of summer 2021 - Review Date: 31.8.2021. Update Oct 2021 – This work has been interrupted by the staff vacancies and re-structure work being implemented. Stakeholder database continues to be developed and is now used actively for comms campaign and engagement purposes. This database now gives a solid foundation of stakeholders to target in the survey. Suppliers have been identified and currently at tender whilst funding is being confirmed. Anticipated that the survey will be live in November 2021	Quality & Safety Committee	12 ↓ 16	C4xL3 ~~C4 x L4~~	Following review of this risk on the 9.2.2022, the likelihood has been reduced from a 4 to a 3, de-escalating this risk from the Organisational Risk Register. It is considered that the above improvement activity outlined below supports the reduction in the risk scoring. Whilst the operational pressures caused by the Omicron wave and organisational focus on ramping up the vaccination campaigns set back the survey work during the winter months, the actual work ongoing in stakeholder relations management continues and is reflecting positively. -The Health Board has strengthened its approach to engaging with partners ensuring that views are sought and communication/updates are given in a timely and trusted way. -Conversations with trusted partners and stakeholders have moved on to a pro-active space, actively looking at joint issues with our local authority partners; -The Health Board continues to build and be more effective in partnership working, including the focussed work on strengthening our stakeholder database understanding more about who are stakeholders are, and have taken a systematic approach to developing connections with community based partners in the third sector, local authorities, public health organisations, housing associations and academia. -A blueprint for stakeholder engagement is being developed through our organisational and clinical strategy work currently underway and our Covid related programmes have also done some great work taking this approach by developing a more engaging approach to campaigns within the Comms & Engagement Team -There has been alignment of the Health Boards topics/themes across both internal engagement and external engagement platforms in order to provide greater traction across all audiences so we will now see consistent topic updates and engagement at Stakeholder Reference Group, and Community Health Council. -Building on the connections between partner organisations, which become so essential during COVID, the Health Board is now working with our partners when it comes to communications relating to the population health agenda as evidenced in news items. - Focus groups have been hosted by partner organisation to provide intelligence and insights on specific issues such as vaccination attitudes for example. - Engagement sessions with third sector partners are underway looking at our new strategy.
4684	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department Environment at Prince Charles Hospital	**If:** there is no change to the template for the environment of the Emergency Department at Prince Charles Hospital to improve the areas for Major, Minors, Fractures and GP Assessment. **Then:** there will continue to be challenges to the safety of patients and the management of patient flow through the appropriate departments/areas. **Resulting in:** Potential delays for patients in accessing the right treatment in a timely and efficient manner. Poor Patient experience. The environment does not allow for the EPIC model of consultant oversight which will impact clinical oversight	Caring for patients in corridors SOP established and followed. Flow Manager in place. Additional staff are rostered into the functions above core establishment to support staffing levels. Escalation Plans and Cards established. Surge Capacity Plan in place.	Emergency Department Improvement plans being formalised / developed. Update 28/01/2022 Pathways have been redesigned to reduce overcrowding and reduce the risk of cross infection. There have been some challenges in terms of flow and levels of demand at times but PCH now has a small surgical assessment unit, completed first phase of changes to the revised Gynae pathway and continue to work on the paediatric pathways. These options improve flow of some speciality patients from the department when it is safe to do so	Quality & Safety Committee & Health, Safety & Fire Sub Committee	12 ↓ 16	C4xL3	Risk Rating reduced from a 16 to a 12. Pathways have been redesigned to reduce overcrowding and reduce the risk of cross infection
4478	Executive Director of Nursing & Midwifery IPC - Decontamination	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Inappropriate decontamination process in place for laryngoscope handles in RTE & MC	**If:** the current decontamination process for laryngoscope handles continue **Then** staff are not following manufacturer instructions/Welsh Government guidance. **Resulting in:** possible infection transmission/poor patient care/litigation risks. A Welsh Health Circular was distributed in September 2020 outlining that laryngoscope handles must either be single use or decontaminated/sterilised in between use following manufacturer instructions via an accredited Sterile Service Department.	A wipe system is being used to decontaminate handles following use. Risk assessment completed to continue using the current process due to the additional funding required to comply with the WHC. Sheaths used to minimise contamination to the handle which is changed following use.	Update 07/10/2021 - In RGH, the Proact laryngoscope handles are decontaminated/sterilised in a centralised decontamination facility in line with WHC requirement. Risk remains until PCH have adopted the same process. *McGrath - risk assessment/ SOP completed by anaesthetic department (agreed at Decontamination committee). Staff will decontaminate handles with Clinell Universal wipes and document this on the theatre system. Progress being made to achieve sterilisation in SSD. Score currently remains the same. 1/11/2021 - Awaiting a go live date for PCH to decontaminate Proact handles in SSD. 17/02/2022 - additional handles have	Quality & Safety Committee	8	C4 x L4	Risk rating reduced from a 16 to an 8. Additional handeles have been purchased.

4476	Executive Director of Nursing & Midwifery IPC - Decontamination	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Manual decontamination of nasoendoscopes in RTE & MC	**If** the current decontamination process (Tristel 3 Step)continues to be used in RTE & MC. **Then:** inadequate decontamination of the scopes is possible resulting in transmission of infection/poor patient care. It is impossible to guarantee effective decontamination of the scopes every time due to the human factor. **Resulting In:** in variable techniques. The current manual process is not in line with WHTM guidance which recommends an automated system Risk 4776 has closed and merged with this risk.	A risk assessment to be completed for the use of Tristel 3 step by the ENT service group in RGH, YCR and PCH. SOPs in place for users Decontamination lead to complete assurance audits in the departments. Staff in the ENT department to undertake annual training by the representatives for Tristel 3 Step. Centralisation of nasoendoscopes will be encompassed in the internal strategic decontamination review. Update February 2022- Following a decontamination incident in ENT POW, datix number - W182841, the decontamination process has reverted back to a wipes system. The UV decontamination machine has caused UV scaling damage on the nasoendoscopes. External investigations are being carried out by the manufacturers. The risk has been extended to cover all three ILG's.	Decontamination of naso-endoscopes - Set up a working group to discuss options available to decontaminate naso-endoscopes. Decontamination of transoesophogeal probes - move to an automated validated process. Meetings required to discuss automated validated options for decontamination. Timeframe 2.05.2022. Risk rating reviewed and likelihood score reduced from a 4 to a 2.	Quality & Safety Committee	8	C1 xL1	Risk rating reviewed and likelihood score reduced from a 4 to a 2. Target rating reduced to a risk of 1x1 as decontaminating the endoscopes in a CSD will have a direct impact on the consequence
4789	Executive Director of Nursing & Midwifery Maternity Services Merthyr & Cynon Locality Group Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Number of overdue Serious Incidents awaiting completion	**If:** The Health Board fails to provide sufficient capacity and skills to clear the backlog of low or no harm SI cases relating to Maternity and Neonatal Services **Then**: learning and improvement may not be progressed and there will be further delays in completion & sign off of RCA's **Resulting in:** the delay in feedback to women and their families, staff and action to learn and improve. Lack of Trust and confidence in the maternity and neonatal services. Reputational Health Board damage	All SI's have been risk stratified. Dedicated central team resource established. Weekly meetings established between representatives from the DUQST, Corporate Cwm Taf Morgannwg central and Maternity and Neonatal, the meetings enhanced team working and communication across all levels. There is now shared ownership of the Open Cases and a culture of working together to address the required areas for action and improvement. IMSOP Panel Maternity and Neonatal Improvement Board provide monitoring, oversight and scrutiny. SI Toolkit. Twice monthly panel to review /QA and close as appropriate. Risk merged 25/08/21 with 4661	Weekly meetings established between representatives from the DUQST, Corporate Cwm Taf Morgannwg central and Maternity and Neonatal, the meetings enhanced team working and communication across all levels. There is now shared ownership of the Open Cases and a culture of working together to address the required areas for action and improvement.	Quality & Safety Committee	10 ↓ 15	10 C5xL2	This work has been led by the central team and as of the 4/2/22 the review of the historical SI's from maternity and neonatal services has been completed. There are no further cases to be presented to the Assurance and Closure panels. Any comments/amendments required by the DU will be managed centrally with clinical colleagues and resubmitted as required no later than the end of March 22: Investigation outcomes will now be shared with women and their families and PTR implications will need to be considered via PTR panels which will need to be led by maternity/neonatal services, supported by the corporate team. There is a TOR and one panel has been held in order to determine PTR for these cases. A successful showcase event has been held on 29th November 2021 for stakeholders to demonstrate the progress and learning of this process. A paper will be provided to March Q&SC to update on the DU recommendations. The risk scoring has been reduced to 10 (meeting the target risk score) however, at this point the risk cannot be closed due to amendments/comments from the DU awaited which will be actioned and completed by 31st March 2022 as required. This risk will be monitored through to closure by the Patient Care and Safety Team.

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Closure Rationale
3072	~~Chief Operating Officer~~ Executive Medical Director Pharmacy & Medicines Management	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Temperatures in medicines storage room on the wards in Prince Charles Hospital not fit for purpose.	**If** there is no control of the temperatures in all the medicines storage rooms on the wards in Prince Charles Hospital. The medicines storage room have pipes in ducts which give off significant heat year round and increased issues in the summer months. **Then:** medicines are being kept above the required temperatures as stated in their specifications of storage as part of their license from MHRA. **Resulting in:** medicines stored at a higher temperature than their specifications which could result in them being less active or denatured and affect patient outcomes.	Some wards are placing small fans in rooms but this does not reduce the temperature. alternative rooms for storage have been discussed but unable to progress due to other ward priorities A SON for air conditioning for each ward will be progressed by medicines management on behalf of ILG	A SON for air conditioning for each ward will be progressed by medicines management on behalf of ILG, however, due to COVID-19 this will be considered in 21-22. Update as at November 2021 as reported to Quality & Safety Committee: Discussions with estates are required to get advice on options other than air–conditioning which would not be aligned to our sustainability agenda, this is being progressed	Quality & Safety Committee	Closed	Closed	Closed as target score met. The temperatures within the areas are now within specification. They will remain under review but this risk can be marked as resolved.
3161	~~Chief Operating Officer~~ Executive Medical Director Pharmacy & Medicines Management	Improving Care	Legal / Regulatory	Lack of Wholesaler Dealers Authorisation	**If:** the Health Board fails to provide the significant time and resource to secure a Wholesaler Dealer's Authorisation and a Home Office Licence **Then:** it would be unable to sell or supply medicines outside the organisation **Resulting In:** Non-compliance with criminal law and Medicines HealthCare Regulatory Agency Regulations. The ability to respond to the Covid-19 Vaccine requirements and protecting population health.	WDA working group established to progress training, governance and infrastructure requirements to submit to MHRA in August 21, a case will be submitted to Vaccine Board.	Business case being progressed. July 21 case submitted to COVID Vaccine Board. Business case supported at vaccine Board and escalated to Executives who supported the business case, awaiting final confirmation of capital funding to progress fridge capacity within required timescales for vaccine booster roll out. progressing training and recruitment of staff. progressing installation of large fridge area, but delays so alternative temp fridge storage now planned in interim. Update November 2021 as reported to the Quality & Safety Committee: This plan is on target, the Licence application will be submitted to the MHRA in November 21 with expected MHRA inspection to follow.	Quality & Safety Committee	Closed	Closed	Closed as target score met. The licence application has been submitted and the MHRA inspection visit undertaken with no significant concerns that would impact the licence application. Therefore, receipt of the licence is expected in due course.
4693	Chief Operating Officer Facilities	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Electrocardiogram (ECG) carts not connecting to hospital network	**If:** The GE ECG carts use DHCP to obtain an IP address from the network so that they can connect to the SBUHB MUSE system and download ECGs. If they are not able to connect to the hospital network then they cannot identify patient demographics from the wrist band using the online ADT functionality. **Then:** This is causing a backlog of tests not being stored centrally and only held locally on the machines. The machines are only capable of storing 200 tests before overwriting historic tests on a first in first out principle. **Resulting In:** the Health Board having no method of recording what tests have been deleted and failed to store on the MUSE server. In addition to this ICT (SBUHB) have looked at the situation and informed us that the wireless connectivity for these machines are running out of IP addresses depending on the number of wireless devices also live on the network at the time. This makes the connection of machines to the network random and unsustainable for the service. This could result in service / business interruption and delays.	There are no control measures that can be put into action currently. Situation is being escalated to SBUHB ICT. The Health Board can only rely on paper copies of the ECGs being kept in the patient notes. There is no mitigation options for digital review and storage of ECGs with GE MUSE System. Based on this update the risk has been scored as a high risk (Consequence 3 x Likelihood 5 = 15) and will be reviewed in 3 months time or when mitigating actions have been implemented.	Action: ICT (SBUHB) to review potential solutions with Clinical Engineering to address the wireless connectivity for these machines and the running out of IP addresses. Timescale: 31/03/2022. There is an on-going issue with the corporate Wi-Fi in Princess of Wales Hospital where devices are taking up all the IP addresses available due to an issue with the free Wi-Fi. This initially caused some of the carts to fail in successfully obtaining IP addresses. Whilst SBU colleagues are looking into the issues relating to the free Wi-Fi, a workaround is in place where a daily manual intervention from ICT staff keeps the services running until a permanent solution is in place. A further issue was identified with a number of carts not transmitting data into MUSE. Upon investigation this was due to internal departmental processes not being followed. Training has been provided and the Cardiology department have confirmed that all carts are now transmitting in to MUSE.	Digital & Data Committee	Closed	Closed	It is suggested that this risk will close as the mitigation undertaken has reduced the likelihood of the risk being realised.
4768	Chief Operating Officer Facilities	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Replacement of press tank on the 13 stage CBW Press	**If**: The press tank on the 13 stage CBW press was not replaced. **Then:** Would result in the laundry service being unable to produce to full capacity and reduced to around 44%. In addition to this, without this piece of equipment additional costs would be incurred for laundry to be provided through commercial services which would immediately present a financial cost pressure risk due to the high price of external commercial laundry processing. Also patient and staff safety could be compromised. **Resulting In:** •Potential of service failure due to existing system. •Potential of CTM sites being without bedding and linen at existing volumes and turnaround times. •Potential increased costs resulting from having to outsource laundry processing to commercial laundries in the event of equipment failure.	The All - Wales Laundry review continues, and at the current time, it is likely that services will be provided from CTM laundry until at least 2024. After this time, the equipment could be moved and rehoused elsewhere to continue to support CTM and the All-Wales Laundry agenda. Previous IMTP submissions have included as a priority £375K for a replacement automated sorting and roll cage washer/dryer system at the laundry. The press tank for the CBW forms an integral part of the current press. Benefits of equipment being replaced: •Reduced risk of service failure and therefore improved confidence in continued production. •Easier to diagnose and put right any mechanical defects. The consequence of not purchasing the replacement tank would result in the laundry service being unable to produce to full capacity and reduced to around 44%. In addition to this, without this piece of equipment additional costs would be incurred for laundry to be provided through commercial services which would immediately present a financial cost pressure risk due to the high price of external commercial laundry processing.	SON to be submitted and if successful replacement equipment purchased and installed. Timescale: 31/03/2022 – Complete. SON approved and funding provided, awaiting installation. Update from Deputy Linen Services Manager that order has been raised to replace. The press tank for the 13 stage has now been replaced. Based on this update the risk has been mitigated to target low risk rating (5 x 1 = 5) and agreed to archive risk. Risk Archived / Closed: 09/02/2022	Quality & Safety Committee Planning, Performance & Finance Committee	Closed	Closed	The press tank for the 13 stage has now been replaced. Based on this update the risk has been mitigated to target low risk rating (5 x 1 = 5) and agreed to archive risk. Risk Archived / Closed: 09/02/2022

3899	Executive Director of Nursing & Midwifery	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Clinical staff resuscitation training compliance	**IF:** there continues to be poor compliance with resuscitation training in relation to clinical staff. **Then:** the Health Board's ability to provide high quality and safe care would be reduced. **Resulting in:** a risk that clinical staff are not up-to-date with their resuscitation training and therefore potentially not able to offer the most up-to-date evidence based care to patients requiring resus. There is a secondary risk that if ESR records are not accurate there is no clear organisational picture which of our staff are resus trained and who are not, presenting a particular risk for rota planning.	ESR record is being reviewed and data checked for accuracy - doctors records need updating as currently ESR not routinely used by Medical staff. New models of training with robust demand and capacity training planning in place need to be identified. This will need to have appropriate resus officer training capacity. An internal restructure has now taken place to ensure a more robust management line. Resus dept. is now managed by the Senior Nurse Clinical Education. 2 x band 7 resuscitation practitioner posts successfully recruited to and both in post end of May 2020. Covid re-emergence in September / October will have a further impact on training availability & compliance levels. Staff availability for training also impacted. All training taking place is compliant with social distancing / PPE requirements for COVID. High turnover/ retirement / long term sickness/ redeployment due to Covid of qualified Resuscitation staff recently have all impacted on capacity to deliver training. Key appointments have now been made, redeployed staff are returning and recruitment to current vacancies in is place. Resuscitation Training Standards agreed at June CTMUHB RADAR meeting. Resus Team now fully staffed with redeployed staff now returned.	Risk reviewed by RADAR committee in November 2021: Progress was noted in trajectory of training compliance and that ESR has now been populated with new training standards. Expected go live in December 2021 so a clearer picture of compliance against new standards will be available in 2022. However it was agreed that risk should remain at current score due to the following factors: 1) there is still a higher than normal demand for resus training due to the covid vaccination programme, where capacity for training remains static. 2) Lack of permanent suitable training accommodation remains an issue with current arrangements at YGT and YS only temporary. 3) DNA training rates remain high potentially due to clinical pressures at ward level. This has been escalated to Exec Director of Nursing. 4) Pressures due to Covid mean that we are asking some staff to work outside their normal areas and so there is an additional training need.	People & Culture Committee	Closed	Closed	Robust review of risk undertaken in February 2022 and this risk has been superseded by new risk ID 5031 - Clinical Education & Training Accommodation, which is considered to more appropriately reflect the risk held by Clinical Education.