Datix ID	Strategic Risk owner	Strategic Objective	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	Provide high quality, evidence based, and accessible 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. Update August 2021 - some progress reflected at COO's Performance Review Meetings with ILGs, however numbers remain high. Update October 2021 - given the continuing high numbers, the risk remains the same. Update November 2021 - 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.	Quality & Safety Committee	20	C4xL5	12 C4 x L3	↔	11.01.2021	05.11.2021	31.12.2021
4629	Executive Director of Finance & Procurement	Ensure sustainability in all that we do, economically, environmentally and socially.	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 21/11. 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 forecase recurrent deficit was increased to £50.9m in the month 7 finance report. Although Further work will continue on reccurring savings within the Health Board further discussion and actions are needed as part of the financial planning process for 2022-2023.	Planning, Performance & Finance Committee	20	C4 x L5	12 C4 x L3	↔	10.5.2021	18.11.2021	31.12.2021
4080	Executive Medical Director	Provide high quality, evidence based, and accessible 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 September 2021. 3. Reduce agency spend throughout CTMUHB – Update October 2021: This work is ongoing with the full roll out of the M&D Bank. 4. Launch of 'medical bank' to Bridgend ILG locality Autumn/ Winter 2020 –Revised Date September 2021. Update October 2021: The medical bank was rolled out in Bridgend ILG in July 2021 and is being rolled out in the other ILGs in October 2021.	Quality & Safety Committee People & Culture Committee	20	C5 x L4	15 (C5xL3)	↔	01.08.2013	07.10.2021	30.11.2021
3826 Linked to 4839 abd 4841 in Bridgend	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible 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 Target Score Rationale - the rationale for the consequence score reducing at the target level is that increased resources and staffing will support improved patient experience and care reducing the consequence rating. 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) ~~9~~ ~~(C3xL3)~~	↔	24.09.2019	28.10.2021	31.01.2022
4477	Executive Director of Nursing & Midwifery IPC - Decontamination	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is no dedicated operational lead for decontamination in CTMUHB	**If** there is no dedicated operational lead for decontamination in the Health Board. **Then:** compliance with best practice guidance/legislation will not be monitored. **Resulting in:**near misses/increased risk of infection/litigation risks.	The operational lead for decontamination role is undertaken by the Deputy Lead IPCN. The role is part time decontamination lead(0.5 WTE) and 0.5 WTE Deputy Lead IPC Nurse. The Health Board Decontamination Committee group meet quarterly. ILG decontamination meetings take place monthly. Annual audits are undertaken by Shared Services. AP(D) meetings have been set up by the assistant head of operational estates. Liaise with AE(D) and service group leads as required. The operational lead for decontamination/deputy lead IPCN participates in the all Wales decontamination meetings. Centralised decontamination facilities in RGH and PCH. A business case has been submitted to progress this forward in POW. External review of the decontamination infrastructure, governance systems and processes requested by Executive Nurse Director March 2021.	Working group to be set up to perform review. AE(D) Shared Services to form part of team. First meeting being set up to agree terms of reference/plan. Due Date: 30.06.2021 Update August 2021 - The review is ongoing. Draft paper including recommendations from working group to be presented at IPCC in September 2021. Update October 2021 - external review complete and report received. Managers response to be submitted to IPCC on the 10th November 2021.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	30/12/2020	07.10.2021	30.11.2021

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4632	Chief Operating Officer All Integrated Locality Groups	Provide high quality, evidence based, and accessible 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. Further update to be provided in the next review of this risk.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	05.07.2021	05.11.2021	31.12.2021
4253	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible 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.	Increased Staff observations in areas where risks have been identified. Any areas of the unit not being occupied by patients are to be kept locked to minimise risks. Use of therapeutic activities to keep patients occupied Patients not left alone / unattended in high risk areas Patients placed on observation levels according to their risk In Bridgend Locality there is a Ligature Action Plan in place and remedial work is underway, in addition to the above additional control measures include closing bathrooms and adding additional staff by night irrespective of patient observation levels, placing patients with a functional illness in bedrooms nearer to the nursing office. Remaining area for anti-ligature work is at Cefn Yr Afon site at Bridgend. Funding is approved and there is a programme of work which is due to commence June 21st 2021 after completion of higher risk areas at POW Similarly within the RTE Locality, the ligature risk within the MH inpatient setting is minimised through environmental measures. Environmental security Broadly the anti-ligature work that effects the estate i.e. taking away high and low level structures that might be used as ligatures. Relational security Use of supportive observations on a sliding scale from. Informal and planned 1:1 where the person can use time to work through urges, address low mood anxiety up to a more intensive 1:1 observation when someone is considered high risk. Processes to manage security These will be mitigating processes, such as search polices or maintenance of a safe bedroom space by restricting the type of personal items allowed, or managing a necessary high risk area through maintaining locked doors. Capital work currently underway, estimated completion date July 2021.	**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:** Ligature Action Plan in place. Ligature remedial works underway - Completion of works anticipated July 21 . Update July 2021 - No Change. Update August 21: Structural work has progressed well. Ongoing programme to address ligature risks associated is progressing	Quality & Safety Committee Health, Safety & Fire Committee	20	C5xL4	10 C5xL2	↔	17/08/2020	07.06.2021	31.07.2021
4688	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED), inability to appropriately triage patients in the Minors area of ED, compounded by two current access points that are not co-located with neither incorporating 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.	Quality & Safety Committee	20	C4xL5	12 C4 x L3	↔	11.06.2021	11.06.2021	31.07.2021
3562	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department Overcrowding - within Majors, Minors, Clinical Assessment Unit and the GP Assessment Area at Prince Charles Hospital	**IF:** There is overcrowding as a result of capacity constraints within the emergency Department and Patients are waiting within corridors. **Then:** there is restricted ability to be responsive in emergency situations. There is an increased risk of an unsafe evacuation due to corridor space, personal accidents, breach in confidentiality and poor patient experience. **Resulting In:** Potential harm to patients, staff and visitors, poor patient experience, increase in incidents and complaints. Failure to comply with legislation if confidentiality is breached due to overcrowding in corridors. Impact on evacuation time and potential personal accidents. At times of high escalation it is challenging to clear the corridor of patients on trolleys	Escalation Plans / Cards established. Flow Manager in place Patient Safety Checklists undertaken. SOP for the Management of Patients in Corridors in place. Fire safety checks are to be carried out daily by the NIC to ensure all fire exits are accessible. When patients are nursed in the corridor due to lack of capacity, the emergency pressures escalation procedure is to be followed to de-escalate as quickly as possible.	Action to develop an escalation policy - Completed. Update October 2020: HB policy SoP approved by Management Board with regards to the care of patients in corridors. Completed. 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.	Quality & Safety Committee and the Health, Safety & Fire Sub Committee	20	C4xL5	12 C4 x L3	↔	22.05.2019	10/06/2021	31.07.2021
4071	Chief Operating Officer All Integrated Locality Groups Linked to RTE 4513	Provide high quality, evidence based, and accessible 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. Update September 2021 – The Health Board recognises that this risk has been on the Organisational Risk Register for a number of years and the position remains very challenging. 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 November 2021- this risk is currently being reviewed to ensure that the current scoring, control measures and mitigating actions accurately reflect the multiple factors and challenges impacting cancer services in the Health Board.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	1.9.2021	02.10.2021

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4664	Executive Director of Public Health - Interim Executive Lead responsible for ICT. Chief Information Officer	Provide high quality, evidence based, and accessible care.	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. **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.	The Health Board has purchased a Phishing tool which the ICT Department in co-operation with Information Governance and Counter Fraud are using to simulate Phishing attacks. This is to help educate staff and will be used to push the organisation to add the NHS Wales national cyber security awareness training as a mandatory core competency to all staff via ESR. The ICT Department are investigating ways to improve the security of backups to ensure that these are protected from potential ransomware attacks. The ICT Department are investigating ways to segregate the current configuration of the network infrastructure to ensure that critical clinical systems are better protected from cross infection. The ICT Department will be re-introduce Cisco FirePower which is an IDS/IPS networking software. The ICT Department will be reviewing the current local Cyber Incident Response Plan which will be escalated up to senior and board level management. The SIRO/cyber leads will be undertaking a programme of introducing the NCSC Board Level toolkit to provide knowledge of cyber to Board members. 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. No change as at November 2021 return. The actions above have a timeframe of the 6th December 2021.	Digital & Data Committee	20	C5 x L4	15 (C5xL3)	↔	26/05/2021	12/10/2021	06/12/2021
4743	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible 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 No change as at November 2021 return.	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	Provide high quality, evidence based, and accessible 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. Reviewed 27.8.2021 - no change to mitigations, actions or scoring.	Quality & Safety Committee	20	C4 x L5	16 (C4xL4)	↔	1.7.2020	27.8.2021	01.12.2021
4149	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible 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	• Reported local and Network pressures across the CAHMS Network with variable problems dependant on the area of the network. • Updates provided to Management Board on developing service model to address reported issues and additional investment secured to increase capacity within the service and to address service pressures. Waiting list initiatives in place whilst staff recruitment is being progressed. • Service Model developed around Core CAHMS in Cwm Taf Morgannwg which includes agreement with General Paediatrics to take the lead on Neurodevelopmental Services and shared care protocols with Primary Care. • New investment impact being routinely monitored A number of service reviews in relation to Ty Llidiard undertaken and monitored via Q,S&R Committee - Regular WHSSC monitoring meetings to be held. Update July 2021 – Ty Llidiard WHSSC escalation level raised from 3 to 4. Risk description and control measures updated. Risk rating reviewed and consequence rating increased from a 4 to a 5.	Commissioning discussions taking place across the Network in relation to service pressures and funding. Implementation of the Choice and Partnership Approach (CAPA) and being closely monitored. Internal Enhanced Monitoring Action Plan being progressed and monitored on a fortnightly basis by Bridgend ILG. Single Point of Access being developed. Full demand and capacity plans being developed with some assumptions about additional CAMHS demand as a consequence of the pandemic. Update June 2021 - CSG and ILG continue to develop and progress business case proposals to improve service provision and access and recruitment / retention initiatives. Regular WHSSC monitoring meetings to be held. August 21 update: development of proposals to increase CAMHS SLT.Reviewing utilisation of psychology services across MH with potential to support ongoing requirements. Successful recruitment of 2 new staff and retention of 1 staff member . WOD and local partnerships developing guidance on appropriate remuneration for WLI. Trend analysis of complaints (2018 - 2021) completed . Theme of complaints are around the transition of CAMHS patients to adult MH and access. Improvement plans developed	Planning, Performance & Finance Committee & Quality & Safety Committee	20	C5 x L4	10 C5xL2	↔	01/01/2015	21.07.2021	31.8.2021
4721	Chief Operating Officer Rhondda Taf Ely Locality Group	Provide high quality, evidence based, and accessible 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. No change as at 21.09.2021	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	Provide high quality, evidence based, and accessible 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

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4103	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible 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
4841	Chief Operating Officer Bridgend Locality Group	Provide high quality, evidence based, and accessible 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
4479	Executive Director of Nursing & Midwifery Infection Control / Decontamination	Provide high quality, evidence based, and accessible 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. This risk has been reviewed and in view of aging equipment and failed weekly water testing results the risk has been increased from 12 (4x3) to 20 (4x5). This was reviewed and amended following discussions/agreement at Decontamination Committee and will be presented to IPCC committee in November.	Quality & Safety Committee	20	C4xL5	4 C4xL1	↔	30.12.2020	07.10.2021	30.11.2021
4893	Executive Director of Nursing & Midwifery Infection Control / Decontamination	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	ICNet is an integrated national system for infection surveillance and patient management	There are a significant number of patients who have duplicate records in ICNet as the system has not linked/merged patient demographics/identifiable information. **If:** patients' have duplicate records. **hen:** the IPC Nurses may miss laboratory results or see different laboratory records . **Resulting in:** mismanagement of the patient and potentially putting other patients/staff/visitors at risk of infection. This affects all HBs in Wales.	Patient records are being merged as they are identified on a daily basis. IPC Support including this in her daily work. IPC Nurses are aware of the merging issue with the system and have access to Welsh Clinical Portal to look for duplicate record. ICNet have investigated and resolved the all Wales issue identified but there are 1000's of duplicate records that need to be merged - ICNet are identifying a way to resolve this.	IPC Team to work with ICnet to determine number of records that require merging/ rectify issue. ICNet to merge duplicate records/ support HB to complete work. Timeframe: 23.12.2021	Quality & Safety Committee	20	C4xL5	8 C4xL2	Nerw Risk Escalated November 2021	01.11.2021	01.11.2021	23.12.2021
4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible 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. Continuing with therapy business case as actions below. No other updates. No further updates as at November 2021.	Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	20.08.2021	03.11.2021	31.12.2021
4676	Executive Director for People (Executive Lead for Occupational Health)	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Absence of Perusssis (Whopping Cough) Vaccination Programme for Staff	**If:** There is an absence of the Pertussis vaccination for staff **Then:** Staff and patients are at risk of contracting whopping cough **Resulting In:** Failure to comply with the Welsh Government Directive, lack of confidence in the service	Head of Pharmacy ordered a supply of Repevax vaccines direct from the manufacturer on Monday 7th June, stock expecting to arrive week commencing 14th June. Able to commence clinics the same week. Further communication to be sent via relevant ILG to the priority groups highlighting offer of vaccine and benefits of receiving vaccine.	See Control Measures.	Quality & Safety Committee People & Culture Committee	16	C4xL4	8 C4xL2	↔	09.06.2021	02.08.2021	30.09.2021
4679	Executive Director for People (Executive Lead for Occupational Health)	Provide high quality, evidence based, and accessible 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	Quality & Safety Committee People & Culture Committee	16	C4xL4	8 C4xL2	↔	09.06.2021	02.08.2021	30.09.2021

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4677	Executive Director for People (Executive Lead for Occupational Health)	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Absence of Varicella (Chicken Pox) Vaccination Programme for Staff	**If**: there is an absence of the provision of varicella vaccination due to the absence of written instructions. **Then**: there will be a failure to comply with the IPC20-Varicella Zoster Policy. **Resulting in:** Staff not being protected against Varicella Zoster. presenting a risk to both staff and patients. Loss trust and confidence in the Health Board and service provision.	The staff fitness letter issued from Occupational Health (OH) to the appointing line manager after the OH health clearance has been processed highlights the immunisation status in relation to varicella (chicken pox).	Recall exercise required for staff recruited. Written instructions and competency document being drawn up week commencing 7th June. OH Manager contacting agencies for suitable nurse resources to run clinics. Recruit additional nursing staff to roll out the vaccination programme. Training programme to be established.	Quality & Safety Committee People & Culture Committee	16	C4xL4	8 C4xL2	↔	09.06.2021	27.07.2021	30.09.2021
4776	Executive Director of Nursing & Midwifery Infection Control / Decontamination	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Manual decontamination of Transoesophageal Echocardiogram (TOE) probes	**IF:** the current decontamination process (Tristel 3 Step) continues to be used in RTE and MC. **Then:** inadequate decontamination of the probes is possible resulting in transmission of infection/poor patient care. It is impossible to guarantee effective decontamination of the probes due to the human factor. **Resulting In:** variable techniques. The current manual process is not in line with WHTM guidance which recommends an automated/validated decontamination system. There is a Scope Vault available for decontamination of the probes in SSD, RTE and MC but due to issues with water ingress in the control panel, the Cardiology staff have lost confidence in this decontamination process and have reverted back to Tristel 3 Step.	Staff have received up to date Tristel 3 Step training. Risk assessment completed for the use of Tristel 3 Step. SOP in place for the use of Tristel 3 Step. Decontamination lead to complete assurance audits in the departments. Centralisation of TOE probes will be encouraged in the internal strategic decontamination review.	Encourage cardiopulmonary staff to continue transferring the TOE probes to SSD for decontamination in the Scope Vault. If UV decontamination systems are approved, decontamination areas will need to be refurbished in line with WHTM 01-06. Timescale: ~~2.09.2021~~ 30.11.2021	Quality & Safety Committee	16	C4xL4	4 (C4xL1)	↔	02.08.2021	07.10.2021	30.11.2021
4753	Chief Operating Officer Pharmacy & Medicines Management	Provide high quality, evidence based, and accessible 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.	Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	09.07.2021	05.10.2021	30.11.2021
3742	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based and accessible 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. Reviewed 21.09.2021 risk remains unchanged.	Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	19.07.2019	21.09.2021	06.12.2021
4106	Executive Director of Nursing and Midwifery	Provide high quality, evidence based, and accessible 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; TofR 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	Provide high quality, evidence based, and accessible 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.	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. 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 31.5.2021. The operational Nursing Act Group to reconvene. Completed as reconvened in April 2021 - included as a control measure. Await review of Birth Rate Plus Compliant Tool by WG - Timescale - WG led so await WG timescales - No further update at this time. Risk currently being reviewed as at August 2021 and an update will be provided in the next iteration of the Organisational Risk Register.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	~~9~~ 12 (C4xL3)	↔	01/01/2016	04.05.2021	30.09.2021

Datix ID	Strategic Risk owner	Strategic Objective	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
4458	Chief Operating Officer All Integrated Locality Groups	Provide high quality, evidence based, and accessible 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.	Live Flow Information Dashboard being scoped - Target Date: 31.3.2021 Unscheduled Care Board focus on SDEC/AEC, D2RA - Contact ahead 111 - Target Date: Contact Ahead: March 2021, 111: January 2021. March 2021 - the 111 system commenced in RTE and M&C Locality in November 2020 - will commence in Bridgend Locality shortly. The Unscheduled Care Improvement Programme will be launched in April 2021. A focus of this forum will be on the improvement of the urgent care pathway through the Health Board with the primary benefits being the reduction/eradication of Ambulance Handover Delays. 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. Review in August 2021. 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.	Quality & Safety Committee Planning, Performance & Finance Committee	16	C4 x L4	12 (C4 x L3)	↔	04/12/2020	4.08.2021	30.09.2021
4706	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based and accessible 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
4152	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible 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. No change as at November 2021 return.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	04.10.2021	31.12.2021
4478	Executive Director of Nursing & Midwifery IPC - Decontamination	Provide high quality, evidence based, and accessible 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.	Assistant Medical Director for QSCE has been tasked to progress the requirements of WHC 2020 15 - Laryngoscope Handles. Update August 2021: - Princess of Wales is compliant with Welsh Health Circular. - Rhondda Taf Ely purchased additional laryngoscope handles (Proact) for decontamination/sterilisation in an accredited Sterile Service department. SOP to be checked by the operational lead for decontamination. Risk assessment to be completed for the McGrath handles. - Merthyr Cynon need to purchase additional laryngoscope handles. Risk assessment to be completed for the McGrath handles. 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.	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	↔	30/12/2020	07.10.2021	30.11.2021
4217	Executive Director of Nursing & Midwifery Infection Control	Provide high quality, evidence based, and accessible 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. SBAR to be presented to IPCC.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	16/07/2020	07.10.2021	30.11.2021
4476	Executive Director of Nursing & Midwifery IPC - Decontamination	Provide high quality, evidence based, and accessible 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	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.	Naso-endoscopes should be processed using a validated and automated process in line with WHTM 01-06. Working group to be established to discuss options available to decontaminate naso-endoscopes. SBAR (options appraisal) to be developed and shared with Exec team Evidence of SOPS for manual process to be shared at local decontamination meetings Update August 2021 - Working group has been set up with all relevant personnel. The group will work on developing a business case for the centralisation of nasoendoscopes in an accredited Sterile Service Department -Timeframe for action 30.11.2021. Update 7th October 2021 - work ongoing to develop a business case.	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	↔	30/12/2020	07.10.2021	30.11.2021

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4148	Executive Director of Nursing & Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non-compliance with DoLS legislation and resulting authorisation breaches	**IF:** due to current capacity the Health Board fails to fully comply with the DoLS legislation. **Then:** the Health Board may have to operate outside the current legislative process. (a change in legislation is coming which will hopefully improve lawfulness) **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.	• Training and DOLs Process impacted by Covid-19 pandemic due to not being able to undertake face to face capacity assessments. Staff recruited to manage demand e.g. independent best interest assessors, a full time secondment transition post and nurse bank hours. As a matter of routine the HB remain in the position that it is encouraging urgent authorisations by the managing authorities and undertaking virtual capacity assessments with standard authorisations and reviews. • Virtual DoLS processes established and in place within the HB during Covid19, this is subject to regular review and monitoring. Urgent authorisations are prioritised over standard authorisation Although this process is effective in terms of identifying patients deprived of their liberty, it is not a lawful process and does not comply with legislation. The HB is therefore at greater risk of breaching the legislation and the rights of those who lack capacity are potentially compromised. • Monthly Safeguarding People training for Covid 19 - there has been a pause in training as a result of the second wave of the pandemic as patient facing activity takes precedence. Training restrictions have also impacted upon the numbers of authorisations requested and alternative ways of delivering Level 3 DoLS & MCA awareness has been developed via TEAMS and will commence in April 2021. • DoLS legislation will subject to change following enactment of the new legislation and statutory guidance. Whilst requirements have increased, mitigation has also been revised to manage increased risk, the HB will need to be prepared for new legislation. Further conversations with our 3 local authorities have been undertaken to recommence a CTM regional understanding and preparation for the changes in legislation, supported by the Safeguarding Board. • Audits are undertaken on time to respond to requests. Virtual capacity and best interest assessments involve family, patient representatives and those who care for the patient. Streamlining and target setting implemented which has led to more authorisations taking place in a more timely manner. • Authorisation breaches are required to be reported on Datix. • The DoLS team maintain an accessible level of virtual support and advice to wards, have supported the development of a consent form for Covid testing for those who lack capacity and the nursing workforce are strong advocates for the rights of individuals who lack capacity. A member of the DoLS teams has been allocated as a link for each ILG. • Audit of the service continues and a business scorecard will be produced on for each ILG Q&S bi-monthly and on an organisational wide perspective on a quarterly basis for review by the CTMUHB Safeguarding Executive Group and the CTM Safeguarding Adult Quality Assurance Group. Quality Assurance Group.	The Health Board has transitioned back to face to face capacity assessments, following a return of staff from re-deployment. Funding has been received from Welsh Government to support the improvement of the Health Boards compliance with DoLS legislation. This funding will support the Health Board to improve capacity for authorisation and prepare for the new Liberty Protection Safeguards. A review will be undertaken in June 2021. June 2021 - Review with DoLS team with a plan to develop Court of Protection Training, Communications in preparation for LPS, Increasing Health Board Signatories, performance management to reduce breach, use of WG grant to develop eLearning for greater HB MCA/Best Interests awareness. There is a further risk in relation to the observance of the new Liberty Protection Safeguards Legislation (LPS). There will be no Supervisory Body to undertake the assessments themselves. The assessments will be undertaken at ward level as part of the ordinary care planning. Therefore if the ward level assessments are deficient the DOL will not be authorised and there is a risk of allowing the patient to leave and risk them coming to harm for which the Health Board could be liable in damages; or unlawfully depriving patients of their liberty until such time as they get the correct evidence in place – this could also attract damages and potentially awards of costs if appealed to court. Therefore the Health Board needs to ensure it is acting lawfully is to ensure that there is sufficient time, resources and training for those making ward level decisions for people who lack capacity to ensure they are working in compliance with the MCA from the outset. Legal & Risk colleagues are reporting a more aggressive trend from those representing patients and a growing appetite for costs and damages related to poorly managed deprivation of liberty. A LPS co-ordinator role has been submitted for transformation monies to support implementation. A bid was submitted for transformation monies to support the new legislation however, this was not approved. The New Code of Practice publication is further delayed due to the impact of COVID19 therefore no change to this risk for the September review. Update November 2021 - An improvement in risk controls is anticipated for January 21.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01/10/2014	05.11.2021	31.12.2021
4116	~~Director of Corporate Governance~~ Chief Executive Communications	Provide high quality, evidence based, and accessible care.	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 date as possible.	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	16	C4 x L4	8 (C4xL2)	↔	01.07.2019	12.10.2021	30.11.2021
3585	Chief Operating Officer. Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible 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 Director of Public Health - Interim Executive Lead for ICT Bridgend Integrated Locality Group	Ensure sustainability in all that we do, economically, environmentally and socially.	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** SBUHB Service Level Agreement Bridgend disaggregation and the one-CTM aggregation plan Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. **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 wifi and mobilisation is nearing completion. Phase 2 is presently being planned, with the business case still awaiting agreement from the Welsh Minister for Health.	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	15.10.2021	19.11.2021

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4684	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible 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 across all areas and silo working.	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.	~~Phase 2 of the PCH Development Plans include the Emergency Department template.~~ Removed October 2021 as this area is not within the scope of Phase 2. Emergency Department Improvement plans being formalised / developed.	Quality & Safety Committee & Health, Safety & Fire Sub Committee	16	C4 x L4	8 (C4xL2)	↔	10.06.2021	10.06.2021	31.07.2021
4686	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Management of Controlled Drugs within the Theatres Department at Prince Charles Hospital	**If:** dedicated Pharmacy support to manage controlled drugs within the Theatres department at Prince Charles hospital is not improved. **Then:** there is a risk to medicines management and compliance with the requirements to manage controlled drugs **Resulting in:** Medicines not being stored and controlled appropriately within required standards.	Controlled Drugs are locked when not in use. Review of the Medi Well System undertaken. New equipment ordered to improve storage solutions within Theatres.	Task and Finish Group to be established to look at the flow and realign the environment - further update in July 2021. Theatres improvement plan developed. Swipe card system to be extended for 24hrs a day. Request for dedicated pharmacy support made.	Quality & Safety Committee & Health, Safety & Fire Sub Committee	16	C4 x L4	8 (C4xL2)	↔	10.06.2021	10.06.2021	31.07.2021
4685	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Patient Flow within the Theatres Department at Prince Charles Hospital	**If:** we fail to alter the patient flow (in and out) of the Theatres department. **Then:** there is an increased waiting time for patients waiting to enter theatres and potential harm to staff and patients exiting theatres. **Resulting in:** failure to comply with the appropriate theatre standards, inefficiencies, delays for staff and patients, possible cross-contamination.	Maintaining the safety of patients is paramount at all times to ensure the inefficiencies and problems with flow do not impact upon patient safety, however, this control measure does in itself then present a delay for patients waiting as the current flow is not efficient.	Task and Finish Group to be established to look at the flow and realign the environment - further update in July 2021. Theatres improvement plan developed.	Quality & Safety Committee & Health, Safety & Fire Sub Committee	16	C4 x L4	8 (C4xL2)	↔	10.06.2021	10.06.2021	31.07.2021
2987	Chief Operating Officer Merthyr & Cynon Integrated Locality Group Executive Director for People (Executive Lead for Health & Safety and Fire.	Provide high quality, evidence based, and accessible 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.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	6	↔	29.11.2017	27.10.2021	07.02.2022
4294	Chief Operating Officer Merthyr & Cynon Integrated Locality Group Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible 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 Its 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
3008	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible 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.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	01.05.2017	01.12.2020	31.3.2021
3654	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible 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

Datix ID	Strategic Risk owner	Strategic Objective	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
3133	Chief Operating Officer Facilities	Provide high quality, evidence based, and accessible 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.	Action: 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. Timescale: 30/11/2021. Based on this update the risk rating remains unchanged until the required reporting template is in place and attendance for Medical Gas Training is being consistently achieved. Update October 2021: No change in this position. Update November 201 - No Change in this position. IPC team providing additional training in an attempt to improve compliance	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	3.9.2021	30.11.2021
4500 Linked to 4483.	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible 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. The review of the graduate approach to the Band 5 Vacancies will be on a 6-9 month timeline as the graduates are not due to commence until late summer. At June 2021 - no change to the above update. Latest review 15.9.21 Narrative: appointment to graduate band 5 workforce via streamlining is on schedule. Gaps remain in higher banded roles, especially when attempting to recruit to short-term funded schemes. Ongoing exploration of opportunities to enhance the HCSW workforce, both uni-professionally and multi-professional roles. No change as at November 2021	Quality & Safety Committee People & Culture Committee	16	C4 x L4	8 (C4xL2)	↔	21.12.2020	15.9.2021	5.12.2021
816	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible 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
3656	Executive Director For People. Health & Safety	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Health Surveillance	**If:** There is an absence of a robust Health Surveillance (HS) Scoping Report. **Then:** The Organisation will not be able to identify the areas and department within the organisation that require Health Surveillance Intervention. **Resulting In:** The Health Board not being able to develop a HS Programme for the organisation as required by the Health & Safety Executive (HSE). Employees working in specific areas/conditions without the relevant health surveillance.	Directors and line managers responsible for own areas and should have own Health & Safety measures such as risk assessments, safe systems of work in place however this does not address any Health Surveillance needs of CTM employees.	Scoping report being looked at by senior H&S lead. Require scoping report to inform the development of a robust Health Surveillance programme. Skin assessments under the remit of ward/dept managers. OH manager linking with senior nurses to incorporate audit of assessments within nursing remit. Continued collaborative working will be required between OH, H&S, Workforce, trade unions and line managers to implement the programme. No change as at November 2021.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	18.06.2019	20.09.2021	31.12.2021
1133	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible 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
4699	Director of Corporate Governance Information Governance Function	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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 and Compliance with Legislation	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 developed to seek funding.and will shortly be presented to the Executive Team for consideration following receipt of new risk. Review: 31.10.2021	Digital & Data Committee	16	C4xL4	8 C4xL2	↔	18.06.2021	24.8.2021	31.10.2021

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4282	Chief Operating Officer Facilities	Provide high quality, evidence based, and accessible care.	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.	Update October 2021: Action: Alternative system for Technical Services and the Laundry Service to be sourced. Amended Timescale: 31/03/2022. Update November 2021: Alternative systems continue to be looked at. Tabs upgrade 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 (DW 28/10/2021).	Digital & Data Committee	16	C4xL4	4 C4xL1	↔	19/02/2020	07.10.2021	31.12.2021
4356	Executive Director for People Health, Safety & Fire Function	Provide high quality, evidence based, and accessible 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 Office.	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 Trainers 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. Update November 2021 - Fire Officer post appointed on a fixed term contract. Review of risk underway.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	26.10.2020	01.11.2021	31.01.2022
4906	Director of Corporate Governance Putting Things Right / Legal Cases	Provide high quality, evidence based, and accessible 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.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	New Risk Escalated November 2021	02.11.2021	02.11.2021	31.01.2022
4907	Director of Corporate Governance Putting Things Right / Legal Cases	Provide high quality, evidence based, and accessible 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.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	New Risk Escalated November 2021	02.11.2021	02.11.2021	31.01.2022
4908	Director of Corporate Governance Putting Things Right / Legal Cases	Provide high quality, evidence based, and accessible 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 are developing 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.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	New Risk Escalated November 2021	02.11.2021	02.11.2021	31.01.2022
4873	Chief Operating Officer Rhondda Taf Ely Locality Group	Provide high quality, evidence based, and accessible 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.	Quality & Safety Committee	16	C4 x L4	6 C3xL2	New Risk Escalated to Org RR November 2021	18.10.2021	18.10.2021	15.11.2021

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3899	Executive Director of Nursing & Midwifery	Provide high quality, evidence based, and accessible 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.	At the December 2020 meeting the RADAR Committee received an update on the Resuscitation Training Compliance Risk and were advised that the compliance position has deteriorated further during 2020 due to Covid pressures. Training was cancelled in the first wave and release of staff for training has also impacted through the second wave. The Committee has agreed a number of actions to be presented at the March 2021 meeting: • Review of agreed training standards against which compliance is measured. • Review of training formats to include e-learning options. • Review resus departments demand and capacity for training. Update September 2021: Training accommodation has temporarily sourced at YGT and Ysbytyr Seren - training at YS commences September 2021. Training capacity issues continue to be impacted due to increased requirement for training and resus services from mass vaccination centres. DNA rates for training session continue to impact on compliance rates, a specific review is underway. ILG RADAR committees now established and will monitor training compliance locally. Next review CTM RADAR November 2021. Update October 2021: Training compliance figures to date are showing an improving trend although COVID continues to impact on release of staff for training. ESR is currently being populated with Training Standards ratified by RADAR. Full report will be submitted to November RADAR meeting and risk updated. Whilst there is an improvement trend the team have advised that the risk would need to remain unchanged until data can be updated and reviewed in November RADAR meeting.	People & Culture Committee	15	C3 x L5	9 (C3xL3)	↔	20.11.2019	11.10.2021	30.11.2021
3638	Chief Operating Officer Pharmacy & Medicines Management	Provide high quality, evidence based, and accessible care.	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.	People & Culture Committee	15	C3 x L5	6 (C3xL2)	↔	02.01.2018	22.11.2021	31.12.2021
3072	Chief Operating Officer Pharmacy & Medicines Management	Provide high quality, evidence based, and accessible 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	15	C3 x L5	6 (C3xL2)	↔	05.02.2018	22.11.2021	31.12.2021
3698	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible 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. Update as at June 2021 - risk remains unchanged. Update August 2021 - No Change.	Quality & Safety Committee	15	C3 x L5	4	↔	02.07.2019	31.8.2021	31.10.2021
4672	Executive Director of Public Health - Interim Executive Lead for ICT / Digital Chief Information Officer	Provide high quality, evidence based, and accessible care.	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)	**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 DHCW annual coding quality audit. 2020/21 funding addressed backlog and proposals made to extend this into 2021/22. **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 Information and Technical Standards Clinical audit **Gaps in controls** Workforce skills & development programme Insufficient resource available to address backlog Digital solutions not yet using snomed-CT/ structurally coded data	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. Programme to address the backlog using additional sessions and agency codings ran in March and extension for 2021/22 proposed - awaiting consideration via IMTP prioritisation process **Tactical** - EPR programme with deployment of snomed-CT onotology server, WCP & E-forms etc. Update October 2021 - This has developed with Automatic Programming Interfaces (APIs) into the WCRS and WRRS presently being developed by DHCW which the Health Board hopes to put into testing in late October.	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	05.06.2021	31.07.2021

Datix ID	Strategic Risk owner	Strategic Objective	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
4671	Executive Director of Public Health - Interim Executive Lead for ICT / Digital Chief Information Officer	Provide high quality, evidence based, and accessible care.	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.	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.	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.	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	26/05/2021	15.10.2021	30.11.2021
4512	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible 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	Provide high quality, evidence based, and accessible 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.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31/01/2020	07/06/2021	30/09/2021
3337 Linked to RTE Risk 4813 and M&C 4817.	Chief Operating Officer Director of Primary Care and Mental Health Services	Provide high quality, evidence based, and accessible care.	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. Deadline - 30.06.2022	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	03.11.2021	31.01.2022
3161	Chief Operating Officer Pharmacy & Medicines Management	Provide high quality, evidence based, and accessible 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	15	C3 x L5	9 (C3xL3)	↔	24.06.2016	22.11.2021	31.12.2021
4590	Chief Operating Officer Pharmacy & Medicines Management	Provide high quality, evidence based, and accessible 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.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	05.04.2021	22.11.2021	31.12.2021

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4693	Chief Operating Officer Facilities	Provide high quality, evidence based, and accessible care.	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.	Update October 2021: 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. Amended Timescale: 31/12/2021. Still awaiting ICT to review and implement potential solutions with Clinical Engineering to address connectivity issue. Based on this update the risk remains 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. Update November 2021 - no change in this position.	Digital & Data Committee	15	15 (C3xL5)	3 (C3xL1)	↔	16.06.2021	07.10.2021	31.12.2021
4768	Chief Operating Officer Facilities	Provide high quality, evidence based, and accessible 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 risks 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 risks due to the high price of external commercial laundry processing.	Update October 2021: SON to be submitted and if successful replacement equipment purchased and installed. Completed. SON approved and funding provided, awaiting installation. Amended Timescale: 31/12/2021. Based on this update the risk is a high risk and will be reviewed in 3 months time or depending on mitigating actions progress . As at November 2021 - No change in this position.	Quality & Safety Committee Planning, Performance & Finance Committee	15	15 (C5xL3)	5 (C5xL1)	↔	26.07.2021	07.10.2021	31.12.2021
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	Provide high quality, evidence based, and accessible care.	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. Ligature risk in Cefn Yr Afon – work won't be completed with regard to the bannisters until the work on Ward 14 has been completed as this has been prioritised. However they have replaced the new window 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.	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). No change in this position as at November 2021.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	03.11.2021	31.1.2022
4772	Chief Operating Officer Facilities	Provide high quality, evidence based, and accessible 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 risks due to the high price of external commercial laundry processing.	Update October 2021: SON to be submitted and if successful replacement software purchased and installed. Completed. SON approved and funding provided, awaiting installation. Amended Timescale: 31/12/2021. Based on this update the risk is a high risk and will be reviewed in 3 months time or depending on mitigating actions progress. Update November 2021 - no change in position.	Quality & Safety Committee Planning, Performance & Finance Committee	15	15 (C5xL3)	5 (C5xL1)	↔	27.07.2021	07.10.2021	31.12.2021
4789	Executive Director of Nursing & Midwifery Maternity Services Merthyr & CynonLocality Group Chief Operating Officer	Provide high quality, evidence based, and accessible 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	15	C5xL3	10 C5xL2	↔	16.08.2021	25.8.2021	16.10.2021

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4800 Linked to 4281.	Chief Operating Officer Executive Director of Therapies & Health Sciences Merthyr & Cynon Locality - Host of Therapies Services within the Health Board	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	The co-ordination of automatic repatriation of patients from Major Trauma Centre (s) to any site in CTMUHB.	**If:**Therapies are unable to recruit to the staffing gaps in the Major Trauma Rehabilitation roles during maternity and sickness absence **Then:** The ability to safely repatriate major trauma patients from the MTC in a timely way will not be achieved. **Resulting In**: 1. Unnecessary delays for patients to commence rehabilitation and receive care closer to home. 2. Inability to meet HB obligations as a partner in the Major Trauma Network. 3. Placement of patients in inappropriate beds, negatively impacting on flow. 4. The ultimate sanction from the major trauma network of not accepting CTM patients into the MTC and/or placing patients on an ambulance to repatriate to the emergency dept.	Where possible, the Rehabilitation coordinators work in conjunction with the Major Trauma Practitioners (MTP) based in PCH and POW. The practitioners will continue to liaise with the MTC Workforce gaps are challenging to appoint to due to specialist skill set required. Options for additional hours are being explored while longer term solution is put in place.	Prioritisation by therapies to support the delivery to the network. Active management of staff sickness, target return to work mid-late Oct. UPDATE 28/10/21 -Absence extended. No change anticipated until mid-late November.	Quality & Safety Committee	15	C3 x L5	6 C3xL2	↔	20.08.2021	28.10.2021	31.12.2021
4652	Chief Operating Officer Executive Director of Therapies & Health Sciences Merthyr & Cynon Locality - Host of Therapies Services within the Health Board	Provide high quality, evidence based, and accessible 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	Quality & Safety Committee	15	C3 x L5	9 C3xL3	↔	21.05.2021	01.10.2021	19.11.2021
4888	Executive Director for People	Provide high quality, evidence based, and accessible care.	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.	People & Culture Committee	15	C3 x L5	12 (C3xL4)	New Risk escalated November 2021	28.10.2021	28.10.2021	31.03.2022

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
4784	Chief Operating Officer Merthyr Cynon Locality Group Executive Medical Director	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Consultant presence on the neonatal unit.	**IF**: We fail to recruit the appropriate number of Paediatric consultants in PCH **Then:** The consultant cover for the neonatal unit will be inadequate **Resulting in:** Failure to adhere to BAPM standards which may impact the care of the neonate.	Locum consultant (with interest in Neonatology) covering 1. Adverts currently out for 1.0 and 0.5 wte Locum Consultants to ensure appropriate support is provided in line with standards required 2. 0.5 wte Consultant starting end of November 2021 3. Funding agreed for an additional 1.0 wte substantive Consultant 4. Job plans reviewed to include 5 Neonatal COW weeks per year.	SBAR submitted to Medical Director	Quality & Safety Committee	12 ↓ Decreased from a 16 End of October 2021	9 (C3xL3)	Risk rating decreased due to control measures now implemented as highlighted in the "Controls in Place" column. Risk will be monitored via the ILG/CSG risk register.
4747	Chief Operating Officer Primary Care Services	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Overnight District Nursing Service Merthyr and Cynon, Rhondda and Taff Ely	**If**: there continues to be unplanned absence within the very small overnight Registered District Nursing Team. **Then:** there will be a detrimental impact on the ability to deliver services to housebound / vulnerable patients. **Resulting In:** Patients being conveyed to the Emergency Department instead of being cared for at home; pressures on existing team members leading to very long shifts and deterioration in wellbeing and further absence; pressures on other part of Out of Hours teams; transfer of pressures on day time District Nursing services.	1.Substantive staff are undertaking extra shifts and bank shifts are offered 2. Where there is no shift fill, an extra HCA is rostered on as a method of reinforcing the team. 3. GPOOH colleagues are asked to support with urgent calls 4. Fixed term vacancies out to advert	To seek to deploy nurses employed into the 111 Flow Centre into the overnight service. Continue to see overtime and bank cover where required. To assess safe establishment levels and advertise additional RN to cover the Bridgend Locality. Timescale: 31.08.2021	Quality & Safety Committee People & Culture Committee	12 ↓ Decreased from a 16 End of October 2021	6 (C3xL2)	This risk has been reduced as there has recently been a fixed term position within the team filled, providing an additional member of staff. Therefore whilst the risk still remains as the team is small for the area it is covering with the fixed term post being filled.
4360	Executive Director for People Health , Safety & Fire Function	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Changing the use of rooms/departments without input/advice from the relevant fire advisor.	**If** The Health Board does not follow the procedures in relation to input and advice from the relevant fire advisor. **Then:** Risks within the workplace are increased which in turn increases the risk to patients staff and visitors. Required information for emergencies situations could be inaccurate. **Resulting In** Increased risk of enforcement, increased risks to life. Confusion to those responding to incidents delaying response and assistance leading to increased risk to life again. Reframed into the new "If, then, resulting in" format as at June 2021.	CTMUHB have access to Fire Build Forms, these are in place to document the required action necessary to change either the use of a single room (FB1) or more than one room (FB2). These forms provide documented evidence that the user has the necessary information to perform the change effectively and that the correct advise has been given. http://ctuhb-intranet/dir/fire/Change%20of%20Use%20%20Room/Forms/AllItems.aspx Non compliance with this requirement is identified via Fire Risk Assessment reviews. Communication plan has been developed and is on the SharePoint page to provide guidance for management on the appropriate Fire Build Forms for room/Departmental changes. Reframed risk description as at June 2021	A communications plan to be developed to ensure all relevant managers are aware of the need to complete the appropriate Fire Build Forms for room/departmental changes. **Completed and on Website.** ILG Leads to ensure that any planned changes of use or alterations a fire build form (FB1 for single room / FB2 for multiple rooms is completed by the relevant manager / lead and forwarded to their locality Fire Officer for comments. This issue has been raised through the ILG Health Safety & Fire Risk Assessment Groups where it will be monitored going forward. Face to Face Fire Training and the Senior Management specific training session will support this activity. Face to Face training has currently stood down as a result of the response to Covid-19, however discussions are underway as to when they could be re-introduced.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	12 ↓ Decreased from a 16 End of October 2021	9 (C3xL3)	This risk has been reduced following a the function reviewing their risk score and considering that a risk rating of 12 was a more appropriate risk rating for this activity.

4606	Chief Operating Officer Primary Care Services	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Resumption of Orthodontic Services	**If:** In compliance with WG guidance, if the Health Board is unable to resume orthodontic services over the next 2 years where patients (under 18) do not meet the IOTN of over 4. **If:** the Health Board does not secure funding for establishing a new Orthodontic contract to meet demand following boundary changes. **Then:** patients will experience significant delays in accessing treatment. **Resulting in:** • Those patients with milder cases incurring further delays in addition to having already experienced long waits for treatment. • It is likely this will increase the number of appeals/challenges/complaints from families, currently CTM does not have an appeals process in place. • Pressure on GDPs to communicate this to families and manage patient/family expectation • Risk that patients/families will be offered/coerced into private treatment as an alternative	The Health Board will continue negotiations with the relevant Health Board regarding treatment/payment of historic patient on waiting lists/ and new referrals. The service continues to be provided as it did pre-covid-19 pandemic, the commissioning arrangements with other Health Boards for Bridgend patients are still in place as nothing has changed. What has changed is longer waiting list as a result of Covid-19 and change to the national guidance on the prioritisation of referrals based on need and some patients referred may now not meet new criteria for orthodontic treatment. There is a national review of orthodontics taking place to inform this.	1. Health Board to address concerns regarding guidance directly with WG and through local ortho MCN Chair. 2. Appeals process to be developed to manage complaints/challenges 3. Raise issue regarding additional ortho funding in June during annual WG Dental Team visit to Health Board. Update June 2021 - No change to the risk at present. A detailed report is being received at the Primary Care Board on the 9th June 2021 for consideration following which the detail and recommendations will be submitted to either the Management Board or the Primary Care Performance meeting as appropriate. **Review: 31.07.2021**	Quality & Safety Committee	12 ↓ 15 in October 2021	9 (C3xL3)	This risk has been reduced following a targeted training session on risk where risks within the function have been subsequently reviewed and a risk rating of 12 was considered to be a more appropriate risk rating for this activity.
4110	Executive Director for People	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the CTMUHB)	**IF:** the Health Board fails to comply, monitor and report with all the Welsh Language Standards requirements **Then**: the Health Board will not be compliant with its statutory duties outlined in the Welsh Language Standards. **Resulting in**: possible investigations by the Welsh Language Commissioner which could lead to damage to the reputation of the Health Board, negative publicity and financial penalties.	The Welsh Language Unit has undertaken a self-assessment of the requirements of the Standards and how they apply to Cwm Taf Morgannwg. •Close constructive working relationships are in place with the Welsh Language Commissioner's Office. •Strong networks are in place amongst Welsh Language Officers across NHS Wales to inform learning and development of responses to the Standards. •Staff are able to access free Welsh courses. •A team of translators prioritise work according to risk levels. *Piloting of an online Ward auditing process to assess compliance around communication with patients. *Translation of priority job descriptions (work with children/ elderly) * Established a resourceful Welsh Language area on SharePoint for managers and staff including documentation in the use of Welsh language internally * Bi-lingual Skills Strategy * Implementation of the first year of a five year plan to increase clinical consultations in welsh * Welsh Language Primary Care Policy * Health Board wide Welsh Language Standards progress monitoring action plan which is a live document on SharePoint * Bilingual website and social media accounts * Patient surveys are bilingual through the Civica system	Update November 2021 Establishing a new Welsh Language Standards Working Group, Chairs by the Executive Director for People. An email has been drafted for Hywel Daniel, Executive Director of People including a draft Terms of Reference to send to Senior Leadership in the ILGs, Primary Care and Hosted Bodies. First meeting will hopefully be scheduled in November 2021. Timeframe: 31.12.2021. The Welsh Language Manager will run a learning and development session for senior leadership to ensure they are aware of their responsibilities to implement the Welsh Language Standards.This session will be delivered during the first session of the new Welsh Language Standards Working Group. Timeframe: 31.12.2021. The Welsh Language Manager will develop a robust process and plan that will facilitate the dissemination and return of regular departmental action plans. Existing action plans will be updated and distributed to Senior Leadership via the new Welsh Language Standards Working Group. Timeframe: 31.12.2021. The People and Culture Committee when developing a cycle of business for 2022 needs to incorporate Welsh Language Standards Compliance updates, to be presented and reported twice yearly, to provide assurance to the Board. Timeframe: Implemented by 31.3.2022.	People & Culture Committee	12 ↓ 15 in October 2021	9 (C3xL3)	This risk has been reduced in grading following review of existing control measures and mitigating actions where it was considered that a score of 12 was a more appropriate risk score for this activity. The resource implications prevalent in this risk have been captured in new risk 4888 escalated this month.

4218	Executive Director of Nursing & Midwifery Infection Control	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Reduced on site Consultant Microbiologist cover for the Bridgend ILG	The Microbiology cover for the Bridgend locality is provided by Public Health Wales Microbiologists via a SLA with Swansea Bay UHB. There are differences in policies/procedures and therefore a lack of standardisation across CTM. There is also a lack of standardisation for multi resistant organism definitions and sampling methods for C.Difficile infection. **If:** there is no dedicated on site Microbiology cover **Then:** there will be no antimicrobial/ ITU ward rounds, no root cause analysis to learn from incidents. **Resulting in:** mismanagement of patients/ inappropriate treatment and no learning to influence practice.	Senior Infection Prevention and Control Nurse on site to support Bridgend ILG with IPC related issues. Lead/ Deputy IPC Nurse to support. IPC Nurses to discuss any concerns with Microbiologist on call for Bridgend ILG The Medical Director for the Bridgend ILG has arranged a meeting to discuss	SLA for Microbiology cover for Bridgend ILG - To revisit SLA with Public Health Wales laboratory. Medical Director for Bridgend ILG to email Medical Director to discuss concerns regarding the SLA. Due date: 29.10.2021.	Quality & Safety Committee	9 ↓ 15 in October 2021	3 (C3xL1)	This risk has been reduced in grading following review of existing control measures and mitigating actions where it was considered that a score of 9 was a more appropriate risk score for this activity due to an increased Microbiologist cover at Princess of Wales Hospital.

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
4156	Director of Corporate Governance	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Patients and/or relatives/carers do not receive timely responses to matters raised under Putting Things Right resulting in learning and improvement being delayed	**IF:** The Health Board fails to provide timely responses to matters raised by patients, relatives and/or carers under Putting Things Right. **Then:** there will be a delay in identifying potential learning opportunities. **Resulting in:** variable quality in responses, not learning lessons, not meeting regulatory response times therefore increasing the number of concerns being escalated to the Ombudsman and not providing complainants with a resolution in a prompt and timely manner.	-Implementation of the Quality & Patient Safety Governance Framework - Values and behaviours work will support outcome focused care - supportive intervention from the Delivery Unit supporting redesign of complaints management - relocation of the concerns team into Integrated Locality Groups (ILGs) - Governance teams embedded within each ILG - Governance processes in place in relation to PTR guidelines and this provides assurance via their ILG Q&S committees and these report into the CTMUHB Q&S committee and Patient Experience Committee. - Corporate/Executive assurance and review undertaken weekly via Executive Director led Patient Safety review meetings and quarterly Concerns scrutiny panel meetings. -Ensure access to education, training and learning. - Review of systems in place to aid assurance and compliance with PTR guidelines in progress by Corporate Governance Team. Level 1 PTR training added to ESR training module and training ongoing for staff in the DLG's. Member of corporate team continues to provide training surrounding PTR guidelines and governance. - Shared Listening and Learning forum established with its inaugural meeting in February 2021. - ILG Concerns Management Performance is monitored via the regular Executive Led Performance Management Meetings. - Once for Wales Concerns Management System - Claims, Complaints, Incidents and others that were due to go live from 1st April delayed due to All Wales Technical issues, planned to implement 7th May 2021, which will provide greater integration across complaints, claims and incidents, it will also support All Wales learning and benchmarking.	Corporate Governance team reviewing current Datix system to reflect new DLG structures and working with WRP to ensure alignment with new Once for Wales System which is in progress. COMPLETED. Review of the Concerns Process within ILG's underway - Completed. Improvement trajectories to be established with ILG's - Completed. The Health Board has requested an external review of claims, redress and inquest processes and procedures. This review will be undertaken by the Welsh Risk Pool. Review completed. Findings due beginning August 2021 The Health Board has requested an Internal Audit on the Concerns Process. Timescales: End of August 2021. Findings from the Internal Audit Report anticipated by the end of October 2021. Concerns Improvement underway with 3 workstreams: 1) Systems and processes 2) Work force, Training & Education 3) Strategy & Campaign. Organisational Learning Framework to be developed - First draft an Timeframes and actions will be revisited when findings of the Internal Audit review have been received in order to incorporate any recommendations as appropriate. Update November 2021 - Draft Report of the Welsh Risk Pool "Review of Procedures for the management of claims, redress and coronial investigations at CTMUHB" received at the end of October 2021. Management response to recommendations being developed and the risk will be reviewed as appropriate to incorporate any recommendations as appropriate.	Quality & Safety Committee	Closed	8 C4xL2	This risk has been reviewed this period and superseded by new risk - which has a scored with a risk rating of 12 which will be managed by the Functions Organisational Risk Register and does not require escalation to the Organisational Risk Register at this point. This risk is available from the Director of Corporate Governance and/or Head of Legal Services upon request. New risk: Datix ID: 4905 - Failure to implement Welsh Risk Pool (WRP) and Internal Audit (IA) Review recommendations, risk rated as a 12.