Strategic Risk owner	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Date Risk on the RR reviewed
Executive Director of Finance & Procurement	Finance	Failure to remain in financial balance in 2021/22, when the significant non-recurring Covid funding received in 2020/21 is likely to reduce. The context is that very significant non-recurring funding was allocated to the Health Board in 2020/21 which may not be at the same level in 2021/22	**IF:** The Health Board is not able to plan changes which enable current run rates of expenditure to align with the available funding for 2021/22 **Then:** The Health Board will not be able to develop a break-even financial plan for 2021/22 and deliver it . The context is that very significant non-recurring funding was allocated to the Health Board in 2020/21 which may not be at the same level in 2021/22 **Resulting in:** Potential deficit in 2021/22 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action.	Arrangements are being put in place to develop the 2021/22 IMTP, 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. 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 to Management Board and Planning, Performance & Finance Committee and Board.	High level process and timetable agreed at December Management Board - **Completed.** Implement CTM Improvement and Value Based Healthcare. Timescale: 31.3.2021	Planning, Performance & Finance Committee	20	12	↔	01/04/2013	18.11.2020
Executive Director of Operations Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Anticipated Impact of the Opening of the Grange University Hospital (GUH).	**IF:** The flow of patients from North Aneurin Bevan University Health Board and South Powys flow via the Welsh Ambulance Service Trust is conveyed to Prince Charles Hospital (PCH) for time critical patients. **Then:** This will have an adverse impact on flow within PCH **Resulting in:** Severe impact on patient care and provision of care within the Merthyr Cynon locality.	Governance structure developed to ensure clinically led solutions identified to increase transfers from PCH to support increased demand.	Detailed Plan and Mitigations shared with the Planning, Performance and Finance Committee on the 21st December 2020.	Quality & Safety Committee	20	12	↔	12.10.2020	2.11.2020
Executive Medical Director	Patient / Staff & Public 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	• AMD and workforce to develop recruitment strategy - 31.3.2021 • AMD and DMD to develop retention and engagement strategy - 31.3.2021 • Reduce agency spend throughout CTMUHB • Launch of 'medical bank' to Bridgend ILG locality Autumn/ Winter 2020 The Health Board may be in a position to de-escalate this risk following the launch of the medical bank in the new year, coupled with the fact that the Health Board has appointed a company to undertaken overseas recruitment from December 2020 onwards.	Quality & Safety Committee People & Culture Committee	20	16	↔	01.08.2013	18.11.2020
Executive Director of Operations Pharmacy & Medicines Management	Legal / Regulatory	PCH pharmacy environment and structure including a Fire Enforcement Notice	The pharmacy at PCH site is part of the fire enforcement notice and located on the first floor with problematic access for out-patients, current issues with a very old lift which all medicines stock into the hospital is reliant on and issues with lifting and H&S of staff. **IF:** there is non compliance with the current fire enforcement notice **Then:** the HB is non compliant with legislation. **Resulting in:** potential prosecution and potential harm to staff, patients and visitors etc. in visiting the area.	Plans are progressing well to relocate the pharmacy dept. to the ground floor to comply with the fire notice, provide improved access for out-patients, increased space for storage and receipt of medicines into the hospital will not be reliant on a lift.	Relocation plans in place - Currently scheduled for Jan 2021 (slipped form original date of April 2020)	Health, Safety & Fire Sub Committee	20	2	↔	04.04.2011	11.01.2021

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Executive Director of Operations Bridgend ILG	Impact on the safety of patients, staff or public (physical/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.	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.	Continue to implement actions identified in the control measures.	Quality & Safety Committee	20	16	↔	24.09.2019	31.12.2020
Executive Director of Operations All Locality Groups	Impact on the safety of patients, staff or public (physical/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.	Continue to implement actions identified in the control measures.	Quality & Safety Committee Health, Safety & Fire Committee	20	10	↔	17.08.2020	16.10.2020
Executive Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Covid 19 emergency flow and Impact of RGH flow	**IF:** The continued high rates of admissions continue with increased number so of c19 patients during autumn 2020 **Then:** there will be a reduction in non c19 attendances causing significant constraints with regards to the safe flow of patients in PCH **Resulting in:** long WAST waits and delays and inability to increase c19 capacity on PCH site.	Associated plans opening of surge capacity of SSU and Ysbyty Seren and agreed support from C&V and ABHB and new pathways in development for RGH	See Control Measures	Quality & Safety Committee	20	12	↔	12.10.2020	25.01.2021
Executive Director of Operations	Patient / Staff & Public Safety - Physical and /or psychological harm	Ambulance Handover Times	**If:** Ambulance handovers are delayed. **Then:** 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.	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.	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.	Quality & Safety Committee	20	12	New Risk	04/12/2020	01/02/2021
Executive Director of Operations Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Provision of negative pressure rooms in CTMUHB in line with WHC (2018) 033	**If:** there are no negative pressure rooms available in CTMUHB. **Then:** the service will be unable to isolate patients in an appropriate environment. **Resulting In:** Non compliance with national guidance/ WG expectation	Patients isolated in single rooms. Apply IPC precautions. Isolation policy in place. Alert organisms are dealt with by the IPCT. IPCN's liaise with wards/ departments giving IPC advice/ instruction. All alerts are discussed at weekly meetings. 2 positive pressure ventilated lobby rooms available at PCH.	Work with Executive Team, Capital, Estates and Shared Services colleagues to consider recommendations outlined in the WHC(2018)033	Quality & Safety Committee	20	12	↔	16/12/2014	31.12.2020

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Executive Director of Operations	Patient / Staff & Public 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	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.	Quality & Safety Committee	20	12	↔	01/04/2014	11.01.2021
Executive Director of Operations Bridgend Locality	Patient / Staff & Public 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. 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	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.	Planning, Performance & Finance Committee	16	9	↓ 20	01/01/2015	18.11.2020
Executive Director of Planning, Performance & ICT	Operational - Service/Business Interruption	Revenue stream does not keep pace with increasing demands on the ICT service for both equipment and the staff to deliver a service	**IF:** The current rate of ICT revenue funding does not keep pace with increasing demands on the Department and does not comply with NHS Wales national funding recommendations. **Then:** The level and quality of service provision will continually drop due to severe reduction in ICT staffing levels. **Resulting In:** the Health Board being unable to rely on the ICT Infrastructure and systems to provide quality of care to patients in a timely manner, and the inability to run business critical applications.	1. To continue to identify risk and drive down existing costs through procurement 2. Highlight that the use of IT services to drive down costs in other areas requires additional, not reduced, IT spend 3. Paper submitted to Director of Finance outlining the increase in both kit and work load due to COVID and changes of working practice. Funding request for both revenue and capital	1. To adequate fund programs to national recommendations 2. To continue to identify risk and drive down existing costs through procurement Identifying Revenue Shortfall - identify risk and reduce costs - target due date: 07.12.2020	Digital & Data Committee	16	4	↔	01.06.2009 -	07/12/2020
Executive Director of Nursing and Midwifery	Patient / Staff & Public 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). Nurse sensitive outcome measures are positive. 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. 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 Acuity Audit scheduled for July 2020. All Wales "Safer Care" activity anticipated to be received in due course. To recommence the Nursing Workforce Governance Group (April 2021).	Quality & Safety Committee People & Culture Committee	16	9	↔	01/06/2015	18.01.2020

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Executive Director of Nursing and Midwifery	Patient / Staff & Public 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 • Retire and return strategy to maintain skills and expertise • 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 with a plan to roll these audits to all wards during 2020 • 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, overseen by maternity Improvement Board • Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends	Continue recruitment campaign - Monitored at Nursing Workforce monthly group. Successful overseas RN recruitment ongoing Action plans, to include annual plan of work to be created and monitored via the Nursing and Midwifery workforce group and Nursing Staffing Act group Review of Skill Mix within Teams To recommence the Nursing Workforce Governance Group (April 2021).	Quality & Safety Committee People & Culture Committee	16	9	↔	01/01/2016	18.01.2021
Executive Director of Nursing and Midwifery	Patient / Staff & Public Safety - Quality Complaints & Audit	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 District General Hospitals - Preservation of the governance resource within the princess of Wales Hospital - New ILG structures now in place - 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.	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.	Quality & Safety Committee	16	9	↔	01/04/2014	18.11.2020
Executive Medical Director Executive Director of Operations Integrated Locality Groups	Patient / Staff & Public Safety - Physical and /or psychological harm	Implementing a sustainable model for emergency medicine and inpatient paediatrics across the CTMUHB footprint	**IF:** The Health Board is unable to deliver a sustainable model to deliver Emergency Medicine (EM) and inpatient paediatrics across the Health Board Footprint. **Then:** The Health Board will be unable to deliver safe high quality emergency medicine and inpatient paediatrics services. **Resulting in:** Compromised safety of patients and Staff.	Successful recruitment to EM in Royal Glamorgan Hospital and Prince Charles Hospital continues at consultant and middle grade. Model for delivery of Paediatric care in RGH significantly clearer and this is contributing to some recruitment success. No change at the moment but this will need to be reviewed again as responsibility transfers to ILGs.	Recruitment drive continues.	Quality & Safety Committee	16	6	↔	01/07/2019	18.11.2020
Executive Director of Operations	Patient / Staff & Public Safety - Physical and /or psychological harm	Failure to achieve the 4 and 12 hour emergency (A&E) waiting times targets	**IF:** The Health Board fails to achieve the 4 and 12 hour emergency (A&E) waiting time 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. Potential of harm to patients in delays waiting for treatment.	Need to strengthen minors streams at DGH sites to sustain improved delivery of performance against the 4, 8 and 12 hour targets. Also variable practice across A&E departments. Consultant and middle grade gaps in RGH now filled. PCH DU report delivered and being enacted. PoW handover performance reviewed by DU & EASC/CASC team and being enacted. PoW/RGH/PCH provided full Safety and Dignity analysis to September QSR committee and Safety Briefing sitrep model and SAFER being rolled out across sites. Programme of improvement work with AM&ED, HR and Retinue teams to improve medical booking and staffing to raise shift fill (ADH initiative has been successful). Winter Plan in train through directorate and partners (RPB). Interim Site Management arrangements coming into place. Systems model in development. 1) Clear discharge planning processes in place. 2) Improvements in the patient flow and investments to support Winter planning. 3) Stay Well At Home (SW@H) Service introduced and evaluated (6 month). Transformation funding will initiate Jan/Feb 2020. 4) SW@H 2 developments and Enhanced Community Clusters being progressed through Transformation bid.	The exisiting controls will be maintained and developed, with monitoring in place via internal ILG meetings and the monthly ILG meetings with Directors. Given the pressure upon the UHB in the covid-19 environment, the risk will remain at level 16, with review in March .	Planning, Performance & Finance Committee & Quality & Safety	16	12	↔	01/04/2013	11.01.2020

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Executive Director of Operations	Patient / Staff & Public 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.	Action plan developed and on going monitoring - consolidated plan coming forward covering Eye Care	Quality & Safety Committee	16	12	↔	01/04/2014	18.11.2020
Executive Director of Operations	Legal / Regulatory	Increase requirement to store the paper patient record for longer due to: *Delay in the DPN project & the* *Increased retention period due to the Infected Blood Inquiry*	**IF:** The Health Board fails to ensure there is sufficient storage capacity to safely and securely store paper patient records as destruction of the files is delayed. **Then:** there could be potential data loss and poor records management processes and communication. Health, Safety and Fire risks will escalate due to overcrowded and inappropriate storage. **Resulting in:** possible breaches to the GDPR, safeguarding and information governance risks. Possible injuries to staff due to manual handling/trip hazards and breaches of Fire Safety procedures.	Delivering the Digitisation of health records, alongside the records hub will ensure a sustainable, safe and secure storage solution. Interim storage may be required in the meantime, due to the Infected Blood Inquiry, as digitisation has been delayed Requirement to stop disposing of records in line with the Infected Blood Inquiry; impact being closely monitored potentially to use a building leased by the Welsh Government to assist. Initiation of Document Management System, Clinical Portal interface and E-forms all follow as part of the project over the next year Ensure Records management processes fully applied in Williamstown to maximise use of available physical capacity Ensure no temporary storage solutions are agreed, without full consideration of the Executive.	Action Plan currently being updated.	Digital & Data Committee	16	8	↔	02/07/2018	18.11.2020
Executive Director of Public Health	Operational - Core Business / Business Objectives	Risk of interruption to service sustainability, provision & destabilising the financial position re: Brexit	**IF:** the health board is impacted by a "no deal" Brexit. **Then:** there could be an interruption to service delivery. **Resulting in:** the inability to provide sustainable service delivery.	Full planning preparations aimed to be stood up in September. Due to these current developments and the Covid-19 Pandemic the risk has increased from that in previous planning periods. Gap analysis/risk assessment on Brexit and Audit Wales self-assessment completed. Service Group Business Continuity plans updated– particularly in Medicines Management; Facilities (food); ICT; Workforce; Estates; R&D Working with other HBs and Welsh NHS Confederation learn lessons from other organisations and provide information on SharePoint to allow opportunities for staff across the HB to identify and areas of concern Work nationally with Welsh Government, Local Resilience Forums and other HBs and Trusts to share business continuity plans. Continue with strong controls in place to ensure "business as usual" through robust business continuity plans. active on SRO and Health Securities groups Emergency Planning, Preparedness & Response (EPPR) for the CTM sites Workforce actively pursuing the gap analysis. Assessment of potential risks to the flow of personal data following Brexit Active with NWSSP to provide detail on product lines and non stock items Taking part in Operation Yellowhammer reporting (with WG) Undertaken a number of business continuity exercises to test existing business continuity plans to identify any gaps in resilience.	Service Groups to ensure their business continuity arrangements ensure sustainability in the event of any impact as a result of a "no deal" Brexit. Supported by the Emergency Planning Officer. This an ongoing action so no specific timescales have been assigned.	Planning, Performance & Finance Committee	16	8	↔	01/11/2018	18.11.2020

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Nursing, Quality & Safety	Legal / Regulatory	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.	Updated Narrative December 2020: • 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 - considering pausing 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 is developing. • 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. • 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. • Audit of the service continues and a business scorecard produced on a quarterly basis for review by the CTMUHB Safeguarding Executive Group and the CTM Safeguarding Adult Quality Assurance Group.	To resume face to face assessments as soon as it is safe to do so. A retrospective audit of authorisations during the Covid period to be completed and reported to the Safeguarding Executive Group. The Safeguarding Executive Group to establish a working group with multidisciplinary representation to consider the implications for the UHB on how the LPS scheme will have an impact on the current authorisation process for DoLS. Timescale: Paused for Covid 19 new date not yet set.	Quality & Safety Committee	16	9	↔	01/10/2014	15.12.2020
Director of Corporate Governance	Provide high quality, evidence based and accessible care	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 workstream 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	Stakeholder engagement survey planned for August 2020 -Stakeholder engagement survey delayed due to Covid-19 outbreaks in autumn but re-scheduled for spring.	Quality & Safety Committee	16	6	↔	01.07.2019	12.01.2021
Executive Director of Planning, Performance & ICT	Operational - Service/Business Interruption	Unsupported Server Operating Systems	**IF:** An upgrade to a supported server operating system is not achievable. **Then:** The infrastructure and applications running on the server will be unable to be sufficiently patched with the critical and security patches, as well as having third party vendor support for both hardware and software (both operating systems and applications). **Resulting In:** The increased risk of a virus infection, intrusion resulting in loss of information, and a denial of service to either clinical or business critical applications.	1. Plan of Action to upgrade current operating systems. 2. Where equipment cannot be upgraded replacement stock available. 3. Rolling replacement programme includes replacement of remaining equipment. 4. Where operating system cannot be replaced there is Risk Assessment document from OSSMB to mitigate the risks. 5. With new national licensing agreement in place outdated servers can now be upgraded.	1. To implement the control measures highlighted by OSSMB where devices cannot be replaced. 2.To either upgrade or replace existing devices with supported operating system.	Digital & Data Committee	16	4	↔	11/07/2017 -	07/12/2020

Strategic Risk owner	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Date Risk on the RR reviewed
Executive Director of Planning, Performance & ICT	Operational - Service/Business Interruption	Windows 7 OS devices not being replaced by end of life	**IF**: An upgrade to a supported server operating system is not achievable **Then**: The infrastructure and applications running on the server will be unable to be sufficiently patched with the critical and security patches, as well as having third party vendor support for both hardware and software (both operating systems and applications). **Resulting In:** The increased risk of a virus infection, intrusion resulting in loss of information, and a denial of service to either clinical or business critical applications.	1. There has been a programme to introduce the newer Windows 10 operating system to new requests for equipment and any device refreshes. 2. With the introduction of the new national licensing agreement with Microsoft NHS Wales has had an extension on the support of Windows 7 devices for a further 12 months ending in January 2021	1. Staff resources are required to refresh the current Windows 7 devices. 2. To replace the existing Windows 7 devices by January 2021. 3. A current strategic review of Desktop services is taking place within the ICT Department	Digital & Data Committee	16	4	↔	07/12/2018 -	07/12/2020
Executive Director of Operations Bridgend ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Neonatal Capacity/Stabilisation cot at Princess of Wales	**If**: The neonatal unit at POW is required to deliver ITU level care in the stabilisation cot **Then:** This cot is not staffed, therefore the overall staffing position on the unit is depleted while this is managed, noting that in the absence of a 24/7 retrieval service this can be for extended periods. The stabilisation cot requires 1:1 nursing which is the equivalent of staffing for 2 HDU costs or 4 SCU cots. **Resulting In:** A risk of being unable to provide appropriate levels of care to the babies on the unit as staffing will be below the required levels as per BAPM requirements	* Utilise available staff as effectively as possible depending on the capacity position at the time * Escalation policy in place to limit maternity services to reduce the risks of further admissions to neonates * Seek additional staffing e.g. through bank, agency, overtime when required	To continue to implement the activity/actions outlined in the control measures.	Quality & Safety Committee	16	3	↔	31.05.2019	30.11.2019
Executive Director of Operations Bridgend ILG	Environmental Impact	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	Quality & Safety Committee	16	1	↔	31.05.2019	31.12.2020
Executive Director of Planning & Performance (ICT) Bridgend ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	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.	IT maintenance is currently supported by Swansea Bay UHB via a service level agreement. There are currently a number of systems that are not compatible with Cwm Taf Morgannwg systems and we are 18months post boundary change.	Action Plan currently being updated.	~~Quality & Safety Committee~~ Digital & Data Committee	16	8	↔	14.10.2020	31.03.2021
Executive Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Health & Safety risk of patients and staff in A&E Corridor at the Prince Charles Hospital	**IF:** Patients are waiting within the corridor of the A&E Department within PCH due to a lack of capacity. **Then:** 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.	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. At times of high escalation it is challenging to clear the corridor of patients on trolleys It is policy for RGH and PCH to offload all WAST patients with 15 minutes of arrival regardless of how many patients are in the department. There needs to be a review of how many patients is safe to hold inside the department at any given time.	Action to develop an escalation policy. Update October 2020: HB policy SoP approved by Management Board with regards to the care of patients in corridors.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	9	↔	22.05.2019	25.01.2021

Strategic Risk owner	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Date Risk on the RR reviewed
Executive Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/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.	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. Update October 2020: Phase 1 on track with restaurant and pharmacy opening 2021, awaiting outcome of meeting I Oct 2020 with regards to further funding for Phase 2, estimated timescale for 5-6years	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.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	6	↔	29.11.2017	22.02.2021
Executive Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Long waiting times and large backlog of patients awaiting Cardiac Echo	**IF:** The health Board is unable to meet the demands for patients awaiting Echo scans for both follow up surveillance **Then:** The RTT WG target will not be met and waits may be 26weeks **Resulting in:** Potential risk to patients from delays in identifying and treating disease and progression of disease	Forms were verified and triaged by Cardiology team. Patients prioritised in relation to clinical need and rated between urgent and routine. I/P room identified away from main department to increase outpatient capacity and to prevent cross infection risks to outpatient services for both staff (inc returning shielders)and patients Clinically urgent completed and move to routine. New forms triaged as received. Overall loss of capacity post Covid circa 56 / month due to test time changes. (+ currently 1.0 wte lts further 120/month. Will submit SBAR to highlight capacity deficit and cost solutions	See Control Measures Risk also raised via Rhondda Locality which will be reviewed alongside this risk - Datix ID 4292.	Quality & Safety Committee	16	6	↔	14.09.2020	12.10.2020
Executive Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Cancer Performance - Gastroenterology Outcome of Covid-19	**IF:** Routine diagnostic activity is not recommenced in full during the C19 pandemic **Then:** there will continue to be a backlog of patients awaiting diagnostic investigations **Resulting in:** Potential harm to patients due to delay in diagnosis and treatment	Endoscopy services have restarted as part of new normal timetables. Backlog is being booked and should be cleared by end of July. 22.9.20 Discussions health board wide to reduce overdue and to work to safe capacity.	See Control Measures	Quality & Safety Committee	16	9	↔	27.07.2020	02.11.2020
Executive Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Elective patients surgery cancelled when high level bed pressures are experienced	**IF:** Elective patients surgery is cancelled when high bed pressures are experienced **Then:** There will continue to be a backlog of patients awaiting treatment/procedures to improve their health and wellbeing **Resulting in:** Potential harm to patients due to delay in treatment/procedures	Consultants are asked clinical opinion when each patient case is cancelled. 12/10/20 insufficient capacity to meet current trauma demand and no short term plan to re-introducing elective orthopaedics during C19 pandemic. Seal area identified but delayed due to RGH IPC issues. As per UHB SoP, clinical prioritization undertaken weekly to list patients with high clinical need. Risk to patients who cannot access	See Control Measures	Quality & Safety Committee	16	8	↔	14.01.2020	31.03.2021
Executive Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Risk to Obstetric Theatres National Standards	**If:** There is an aim for 'Gold standard' compliance with theatre staffing standards. Workforce is used from midwifery establishment, and the establishment is impacted by this. **Then:** Midwifery workforce reduced to undertake theatre roles and undertake an agreed robust there is a competency training Programme in the UHB for midwifery staff who scrub **Resulting In:** inefficient staff utilization, where there is a national shortage in the workforce.	Scrub training in place and a rolling programme organised with main theatres There is a business case that has been previously been partially approved for revised staffing levels to achieve compliance with the national standards Acuity impact with no additional resource when midwives are used as scrub midwives impacting on ability to provide a full compliment of midwives for labour ward. Staffing and birth-rate acuity compliance.	Action: Service to update and re submit business case for the Surgical CSG to take ownership of maternity theatres.	~~Quality & Safety Committee~~ People & Culture Committee	16	6	↔	26.06.2019	01.03.2021

Strategic Risk owner	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Date Risk on the RR reviewed
Executive Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Non compliance with appropriate fetal growth detection and management guidance	This is an All Wales risk for all HB`s **If:** there is a lack of USS slots to address the demand we will not be in compliance with the guidance for fetal surveillance and wellbeing. **Then:** 1. Compliance against the Growth Assessment Protocol (GAP) cannot be met. CTMUHB does not have a 7 day USS service which would support compliance and the management of the small for gestation age (SGA) fetus. **Resulting In:**: Women at the greatest risk of SGA receive less surveillance of growth than women with uncomplicated pregnancies resulting in potential harm.	1. Capacity to comply with GAP/GROW 3 weekly - current regime 3-4 weekly 2. Woman are risk assessed, they are allocated one of two pathways. One pathway SFH can be delivered, Serial scanning (37% of population) unable to receive full recommended scanning regime or protocol due to scanning capacity issues. Current regime 4 weekly as apposed to three weekly. 4. The Directorate is working closely with the Radiology department to review low value scans requested. 5. The Directorate is reviewing the option of midwife sonographers being employed. 7. Scanning group for the UHB established. 8. Continued to be reviewed with changes to patient flow due to 'The Grange'	See Control Measures. Radiology to develop sustainable service plan to increase capacity and workforce.	Quality & Safety Committee	16	6	↔	01.06.2017	30.03.2021
Executive Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/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.	~~Quality & Safety Committee~~ Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	12	↔	01.05.2017	01.12.2020
Executive Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Gynaecology Cancer Service	This affects Gynaecology services across CTMUHB - delay in the pathway requiring multiple consultations on site - Service relies on an individual practitioner - Demand is currently in excess of agreed manageable caseload - Hysteroscopy service capacity requires business case supporting for service development - Gynae Rapid access service development is slow progression	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	Action: Agreed COVID pathways. Service to re-submit gynaecology 'one stop' Service.	Quality & Safety Committee	16	9	↔	18.06.2019	30.09.2020
Executive Director of Operations	Provide high quality, evidence based, and accessible care.	Due to capacity issues to deal with Covid-19 staff not attending medical gas safety training and courses being rescheduled.	(Facilities Risk Register Reference CE11) **ILG:** CSO Facilities Hub **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.	Cylinders to be standardised on ward areas for patient transfer where possible. 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. Health Board to report compliance with the Patient Safety Notice. Completed. Recruit B4 role to be advised of all new medical equipment installations and oversee user training prior to issue. Completed. Medical Gas Cylinder Policy developed and to be approved by Quality & Safety Committee. Timescale extended to allow for committees to restart afer the Christmas period. Timescale: 31/01/2021. Band 4 role now in post. Training has been undertaken for Porters and graduate nurses. However, staff currently in post still not attending due to current circumstances with Covid-19. Based on this update the risk rating remains unchanged until Medical Gas Policy has been approved by Quality & Safety Committee.	Quality & Safety Committee.	16	8	↔	01/05/2018	11/12/2020

Strategic Risk owner	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Date Risk on the RR reviewed
Executive Director of Operations	Ensure sustainability in all that we do, economically, environmentally and socially.	Replacement of the auto remat system for processing of clothing and coats due to age.	(Facilities Risk Register 11476) **ILG:** CSO Facilities Hub **If:** Auto remat system requires upgrading as risk of breaking down and parts becoming scarce. **Then:** Potential delay to laundry service for the organisation. **Resulting In:** Business and service objectives not being completed and financial loss from service disruption.	Continue to maintain at cost including maintenance, overtime and parts where available. Contingency Plan in place with options included such as using other equipment available, using another laundry and additional agency staff if required.	Undertake gap analysis of laundry services against WHTM 01-04 and BS EN 14065: 2016. Completed. Purchase and installation of new system with capital funding required through SON. SON submitted and still awaiting response from CMG on funding. Timescale for completion has been extended following confirmation on 07/12/2020 that the laundry service will move under NWSSP from 1st April 2021. Timescale: 31/03/2021 Review contingency plans to ensure adequacy in light of risk. Contingency plans reviewed, maintaining equipment as much as possible until parts are no longer available. Timescale for completion has been extended following confirmation on 07/12/2020 that the laundry service will move under NWSSP from 1st April 2021. Timescale: 31/03/2021 Based on this update the risk remains unchanged until new system has been installed and is compliant.	~~Quality & Safety Committee~~ Planning, Performance & Finance Committee	16	8	↔	16/12/2016	11/12/2020
Executive Director of Workforce & OD	Provide high quality, evidence based, and accessible care.	Site Specific Fire Documents Require updating on some sites.	Site specific documents on a number of sites have outdated information. We have a duty under the RR(FS) 2005 to provide site specific information for oncoming fire crews. Hospital and other healthcare estates are constantly evolving environments that must be flexible enough to accommodate new layouts and changes of use as and when required. It is important to provide up to date site specific information for attending fire crews to highlight hazards etc., and for the crews to make informed decisions, failure to do so could put persons at risk and the possibility of enforcement action from the Enforcing Authority.	There are site specific documents available on a number of our sites throughout CTMUHB, however where changes to our sites have occurred it should be ensured the site specific documents are updated to reflect the change.	Agreement on additional fire safety training resource (Risk ID 4315) will create additional time for the Fire Officers to undertake this activity. Additional 2 x band 5 fire safety trainers approved until 31 March 2021 by Director of Workforce and OD	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	9	↔	30.10.2020	12.04.2021
Executive Director of Workforce & OD All Locality Groups	Provide high quality, evidence based, and accessible care.	Management of Security Doors in all Hospital Settings	Following several serious incidents following patients absconding from clinical areas, the HSE have issued an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions: In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action. **IF:** the Health Board do not comply with the notice. **THEN:** the Health Board may be subject to prosecution by the HSE **RESULTING IN**: Large Fines and poor publicity.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding.	Identify the measures needed to protect patients at risk and enter them on to the Risk Register for consideration. Discussions with Bridgend ILG and Capital/Estates - Due by 31.12.2020. Merthyr/Cynon and Rhondda/Taf Ely ILGs will work closely with Bridgend ILG to identify any learning and implement any recommendations	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	8	↔	30.09.2020	14.12.2020

Strategic Risk owner	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Date Risk on the RR reviewed
Executive Director of Workforce & OD	Provide high quality, evidence based, and accessible care.	Overdue fire risk assessments	**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 Deficiencies (IN01) which will further escalate to Enforcement Notices (EN01) if no remedial action is taken. At time of assessment there are 138 FRA's overdue, resulting in non compliance with the RR(FS)O 2005.	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.	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.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	6	↔	26.10.2020	14.01.2021
Executive Director of Workforce & OD	Provide high quality, evidence based, and accessible care.	Changing the use of rooms/departments without input/advice from the relevant fire advisor.	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. The consequences of not seeking the relevant information prior to change the use of an area could result in a number of failings relating to fire safety and would only be recognised when the fire advisor carries out a FRA or the Enforcing Authority/Shared Services carry out an audit which may result in enforcement action under the RR(FS)O 2005. Typical failings are: Plans not being updated Fire Alarm Cause and Effect not being amended Rooms not being made up as hazard room enclosures when necessary Fire alarm system not being extended Emergency lighting not being extended Breaches in compartmentation.	The Fire Build forms have been available for some considerable time across the Health Board. There appears to be a reluctance to use them, or simply staff/contractors are unaware of them. Staff/contractors should made aware of the Fire Build Forms and the consequences to the Health Board for not using them. http://ctuhb-intranet/dir/fire/Change%20of%20Use%20%20Room/Forms/AllItems.aspx	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. Non compliance with this requirement identified via Fire Risk Assessment reviews will be reported as an incident via the Health Board's Incident Management System (Datix) Reinforce previous communication across all Health Board wards/departments about the need to complete the Fire Build Forms prior to making any changes to a room or department. Due Date 31.12.2020.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	9	↔	28.10.2020	26.04.2021
Executive Director of Operations Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Risk of absconding from Ward 23.	**If**: Estates work and Covid-19 pathway remodelling is not undertaken urgently **Then:** Mental health patients may continue to abscond **Resulting In**: Potential harm to themselves or the public	All patients risks for suitability of admission to ward 23 assessed. Patients discouraged from smoking where possible. Any patient who goes out into garden is supervised by ward staff at all times. All staff will try to de-escalate increasingly volatile situations. Prompt alert if patients can not safely be stopped from absconding. Staff to follow guidance for managing absconding patients.	Security fence to be erected Remodel ward layouts so that area is no longer used as acute ward space	Quality & Safety Committee	16	4	↔	04/11/2020	31.12.2020

Strategic Risk owner	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Date Risk on the RR reviewed
Executive Director of Therapies & Health Sciences	Provide high quality, evidence based, and accessible care.	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.	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.	Quality & Safety Committee People & Culture Committee	16	9	New Risk	21.12.2020	31.12.2020
Executive Director of Operations Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	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	Organisation plan in place to address the FUNB position across all specialties. Additional funding requirements identified. Regular meetings in place to monitor the position.	Harm review processes being implemented	Quality & Safety Committee	16	12	↔	18/11/2013	31.12.2020
Executive Director of Workforce & OD Health & Safety	Provide high quality, evidence based, and accessible care.	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. Require scoping report to inform the development of a robust Health Surveillance programme. Collaborative working will be required between OHWB, H&S, Workforce, staff side and line managers to implement the programme.		Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	8	New Risk	18.06.2019	5.1.2021
Executive Director of Operations	Provide high quality, evidence based, and accessible care.	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 **This risk replaces risk 4095, 4100 and 4069 - See Closed Risks**	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 undertaken when needed. • The UHB 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 UHB has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and UHB levels via scheduled and formal performance	The exisiting controls will be maintained and developed, with monitoring in place via internal ILG meetings and the monthly ILG meetings with Directors. Given the pressure upon the UHB in the covid-19 environment, the risk will remain at level 16, with review in March .	Quality & Safety Committee	16	9	New Risk	11.01.2021	New Risk

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Executive Director of Operations Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Long waiting times and large backlog for Cardiac Echo	**If:** For old Cwm Taf template Total of 2720 pts awaiting Echo scans for both follow up surveillance to monitor disease progress and new referrals governed by RTT. RT -ILG 1520 pts of which 873 would form part of RTT 570 pts waiting greater than 8 weeks longest wait 45 weeks. **Then:** Potential risk to patients from delays in identifying and treating disease and progression of disease e.g. valves, LV function . **Resulting in:** Delays in receiving appropriate treatment pharmacological, intervention , surgical. Potential risk litigation. triage process reliant on available referral information to assess urgency.	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 76 / month due to test time changes. Ill health retirement further 97 / month capacity loss.	Plans to submit SBAR to highlight capacity deficit and cost solutions.	Quality & Safety Committee	16	9	↔	10.09.2020	12.01.2021
Executive Director of Public Health	Patient / Staff & Public Safety - Physical and /or psychological harm	Potential Harm and poor experience for Patients as a result of the Health Board's focus and response to the Covid-19 Pandemic	**IF:** the Health Boards resources and focus is directing into managing the response to the Covid-19 pandemic. **Then**: the Health Board's ability to provide high quality care may be reduced. **Resulting in:** potential harm to patients as a result of reduced service provision and capacity to respond to other areas of the Health Board's population Health need.	Planning preparedness, contingency structures through the Resetting CTM structures. Critical services are operating. Governance process in place for financial and non-financial decision making to support, all predicated on Quality Impact Assessments. Quality & Safety Committee has continued to meet to ensure scrutiny and assurance on behalf of the Board. Indicators of quality and patient safety for all services continue to be closely monitored throughout Covid-19. Processes and guidance in place to ensure clarity on areas such as safeguarding and child protection. Implementation of the Test Track and Trace Programme in June 2020. Regular Population Health Surveys conducted in relation to Covid-19 to gauge attitudes and risk perception within communities. Compliance with National Guidance. The QIA process for service changes relating to Covid-19 management will include an assessment of related impact on any existing service delivery. Deaths are monitored via the mortality review process. Monitoring incidents, complaints and feedback through social media. Monitoring Core quality and safety metrics.	The QIA process for services changes relating to COVID-19 Management will include an assessment of related impact on any existing service delivery.	Quality & Safety Committee	15	12	↔	23/03/2020	18.11.2020
Executive Nurse Director	Patient / Staff & Public Safety - Physical and /or psychological harm	Wearing for FFP3 masks for 2 hours in a high risk area. Normal time spent in ITU performing procedures can be up to 3-4 hours.	**IF:** the FFP3 masks are used for a period of greater than 2 hours at a time. **Then:** there is an increased risk of integrity of the mask and discomfort to the wearer. **Resulting in:** an increase risk to the user of exposure to the Covid-19 virus if utilised for greater periods. Using FFP3 masks for a period of greater that 2 hours at a time increased risk of integrity of mask and the discomfort to the wearer. To change the mask more frequently will require the user to remove all Personal Protective Equipment and remove themselves form the environment. If the mask is utilised for greater periods this can increase the risk to the user of the COVID virus. The user will also need to rehydrate etc. due to the increased body heat generated from the full PPE equipment.	Staff are disposing of mask on exiting the unit and to use a new mask before entering.	Update in progress following measures that have been put in place to mitigate this risk which may have reduced the risk rating.	~~Quality & Safety Committee~~ Health, Safety & Fire Sub Committee of the Quality & Safety Committee	15	4	↔	May-20	18.11.2020

Strategic Risk owner	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Date Risk on the RR reviewed
Director of Operations	Patient / Staff & Public Safety - Physical and /or psychological harm	Covid 19 - Gold Risk - 002 Critical Care Beds and Equipment	**IF:** there is an insufficient number of critical care beds, medicines and ventilators. **Then:** the Health Board's ability to provide high quality and safe care would be reduced. **Resulting in**: potential harm to patients.	• Suspend non-urgent outpatient appointments and ensure urgent appointments are prioritised • Suspend non-urgent surgical admissions and procedures (whilst ensuring access for emergency and urgent surgery) • National work regularly shared • Local model well underway and informing capacity planning. • More detailed capacity plan available and being shared with WG as requested • Redeploy and retrain staff released from inpatients, day cases and outpatients • UK government removing restrictions on the export of any UK bound stocks. • New systems in place for the assessment and management of stock in hospitals. • Movement of stock between health boards. • Minimising wastage of critical care medicines in the ward and in aseptic production units. • Daily situation report providing stock levels relative to critical care bed usage by health board. • Regular calls between NHS pharmacy procurement leads used to support mutual aid through the movement of stock between health boards. • USC dashboard (to remain Level 1 Green / Level 2 Amber) • Capacity Plan in place with modelling throughout the covid-19 period	• Ensure local stock levels are maintained at levels proportionate to anticipated short term demand, underpinned by regular replenishment from normal supply routes and NHS Supply Chain - under constant review. • Working to ensure robust arrangements are in place to identify and move stock rapidly between hospitals and health boards should the need arise	Quality & Safety Committee	15		↔	13.05.2020	18.11.2020
Executive Director of Nursing & Midwifery Changed from WF&OD	Patient / Staff & Public 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.	Recruitment of key roles to support training requirements - complete see updated in Control Measures. New RADAR committee is being established and meeting on 14th September 2020. Progress reports regarding training compliance will be submitted to this committee for review. Review date for this risk has been changed to 15.9.2020, after the RADAR meeting to include decisions made at that meeting. Agreed to review training compliance levels for each ILG following a review of training standards. Reviewed Standards will be submitted to next RADAR committee 14.12.20.	People & Culture Committee	15	6	↔	20.11.2019	18.11.2020
Executive Director of Planning, Performance & ICT	Impact on the safety of patients, staff or public (physical/psychological harm)	Shortage of IT Storage space	**IF:** The lack of enough storage space for ICT equipment is not sufficient. **Then:** Equipment will be required to be stored in temporary locations which are not designed for storage. **Resulting In**: a risk to the Health and Safety of ICT staff and the risk to the equipment being either damaged, lost or stolen.	1. Ensuring regular disposal of old redundant hardware using third party company, to keeping stock down to a minimum 2. Vigorous and robust procedures in place for the procurement of new equipment. 3. identifying fully any additional storage requirements of every new system requested. 4. Due to the progression of Ground and first discussions are underway around possible areas that ICT can move into for build and storage which is key to be able to deliver a service	1. To identify extra/sufficient storage space for obsolete and new equipment 2. The temporary storage of the ECC area now under discussion	Digital & Data Committee	15	3	↔	02.05.2011 -	07/12/2020
Planning, Performance & ICT	Operational - Service/Business Interruption	Server: System Resilience and Disaster Recovery	**IF:** The resilience of ICT Server based services are not fully documented, and corresponding disaster recovery plans, including an overarching business continuity / disaster recovery plan are not documented. **Then:** The risk of clinical and business systems not being available for extended periods increase. **Resulting In:** the Health Board's ability to provide quality care and business critical information.	1. The impact of the loss of IT Server based services from the failure of a critical server, server room, or Site needs to be understood. 2. Documentation needs to be further developed, including test evidence and recovery procedures. 3. Recent internal audit has highlighted significant gaps in the DR for the Health Board.	1. Develop plans, documentation and test schedules to ensure that servers and the services they provide can be recovered. 2. As part of this work, develop tests to allow the Recovery Point and Recovery Times to be better understood. 3. For each IT service (e.g.. DHCP, Citrix, Exchange, File and Print, Hyper-v, SQL) develop inbuilt resilience	Digital & Data Committee	15	6	↔	28/02/2017 -	07/12/2020
Planning, Performance & ICT	Impact on the safety of patients, staff or public (physical/psychological harm)	Current DAKS/OSCAR Crash System Coverage within RGH	**IF:** coverage for the current DECT system does not reach the newly built McMillian Centre at RGH. **Then:** When Clinicians, who are part of the crash team, are called to the Centre as part of an emergency, they will be unable to receive any further alerts for emergencies back in the main building. **Resulting In:** the compromised safety of patients which could result in severe disability or even death.	Whilst the crash team are attending a patient at the MacMillian Centre they will not be able to receive alerts but the remaining members of the crash team who will be on the main site will have the alerts.	To provide system coverage to the McMillan Centre by installing additional base units, or provision a different system.	Digital & Data Committee	15	5	↔	09/10/2019 -	07/12/2020

Strategic Risk owner	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Date Risk on the RR reviewed
Planning, Performance & ICT	Service/Business Interruption	DAKS/OSCAR System requires Upgrade (EOL)	**IF:** The current end of life DAKS/OSCAR System is not replaced. **Then:** There is a risk of failure in the system that cannot be rectified due to lack of vendor support. **Resulting In**: no handsets being able to function leading to the compromised safety of patients.	1.There are none in place. 2. This cannot be managed until either the DECT system is upgraded (see risk 3857), or an alternative technical solution is put in place.	To upgrade or replace existing DAKS/OSCAR System.	Digital & Data Committee	15	8	↔	09/10/2019 -	07/12/2020
Director of Operations Pharmacy & Medicines Management	Workforce	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.	June 2019: Briefing paper detailing risks and recommendations to be submitted to CBM summer 2019 Dec 2019: All Wales working groups established and discussions ongoing with HEIW regarding changes and capacity and resources required. Jan 2020: SBAR submitted to HEIW and CBM in response to consultation on pre-registration pharmacist proposals Oct 20 discussions on going with HEIW and COVID impact on training now to be included in this risk. SBAR to be included in 2021/22 IMTP	People & Culture Committee	15	6	↔	02.01.2018	11.01.2021
Director of Operations Pharmacy & Medicines Management	Impact on the safety of patients, staff or public (physical/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	Quality & Safety Committee	15	6	↔	05.02.2018	11.01.2021
Workforce and Organisational Development	Legal / Regulatory	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 with all the Welsh Language requirements **Then:** the Health Board's will not be compliant with the duties outlined in the Welsh Language Standards. **Resulting in:** damage to the reputation of the Health Board, negative publicity and contact with the Welsh Language Commissioner. As a consequence of an internal assessment of the Standards and their impact on the CTMUHB, it is recognised that the Health Board will not be fully compliant with all applicable Standards. This risk is particularly high in: translation services due to demand exceeding capacity.	The Welsh Language team has undertaken a self-assessment of the requirements of the Standards and how they apply to Cwm Taf Morgannwg. Close constructive working relationships are in place with the Welsh Language Commissioner's Office. Strong networks are in place amongst Welsh Language Officers across NHS Wales to inform learning and development of responses to the Standards. Regular reports to the Board to raise awareness. Working Group set up to support managers. Developing a new bilingual skills strategy. Welsh courses provided to staff. Ward Audits to monitor progress with compliance - ongoing and options to revisit are currently being discussed.. Continue to review and act on the UHBs Self-Assessment findings and related improvement actions; ensure Board is fully sighted. Implement the first year of a 5 year plan outlining the extent to which the health board can carry out consultations in Welsh. All nursing JDs are translated and advertise bilingually. Compliance with Statutory requirements outlined in Welsh Language Standards.	Welsh Language in Primary Care Policy developed and being progressed for Board Committee approval - 31.11.2020 Begin a programme of translation focusing on the job descriptions advertised most frequently - e.g nursing vacancies. Compliance with this standard with take many years due to the limited capacity of the translation team. Action plans have been given to the heads of ILGs, Corporate Services and Workforce and OD to ensure senior management are aware of their WL responsibilities. Continue to develop the Welsh Language skills of the workforce through online learning. Due date:31.3.2021	People & Culture Committee	15	9	↔	02/07/2018	01.12.2020

Strategic Risk owner	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Date Risk on the RR reviewed
Director of Operations Bridgend ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Waiting List for Autism Diagnostic Observation Schedule (ADOS) assessments and Attention Deficit Hyperactivity Disorder (ADHD) medicals over 1 year.	**If:** there are delays in diagnosing children with ADHD and Autism. **Then:** this results in a delay in management including appropriate school placements **Resulting in:** potential harm to patients, poor patient experience, dignity, staff morale. Complaints.	* The team have reviewed their clinical practice in line with the rest of CTM e.g. no longer undertaking ADOS for all children * Discussions underway re: repatriating service from Swansea Bay and investing funding into enhanced local service in Bridgend * New Consultant starting June 2020 with 3 sessions to support community paeds	Vacant sessions to be recruited to - Additional staff appointed who could undertake assessments would ensure this activity was managed in a timely manner.	Quality & Safety Committee	15	4	↔	02.07.2019	16.09.2020
Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm) Quality / Complaints / Audit	No Midwifery Specialist for pregnant women with vulnerabilities	**IF:** there is no dedicated services for substance misuse women, prescription medication, or women with vulnerabilities (social) - national best practice is for there to be a lead in vulnerabilities to see women in a dedicated clinic with the multidisciplinary teams which without leads to disjointed care for our most at risk patient group. **Then:** unidentified opportunities to co-ordinate risk management and support in 'A Healthier Wales' in pregnancy will be missed. **Resulting In:** potential harm to mothers and babies care provision and outcomes.	Women in PCH/RGH are seen in a general Ante Natal clinics Women in POW currently seen in a dedicated clinic, with an SLA agreement with Swansea Bay UHB .2 resource. The directorate need to develop a Statement of need to secure resources to support services across the HB and ensure standardised service delivery.	Action: Service to develop business case for implementing specialist service for women with vulnerabilities.	Quality & Safety Committee People & Culture Committee	15	6	↔	26.06.2019	01.12.2020
Executive Director of Clinical Services Operations	Provide high quality, evidence based, and accessible care.	Telecommunications upgrade required with operational components for cardiac arrest and emergency fire numbers.	(Facilities Risk Register Reference 11480B) **ILG:** CSO Facilities Hub **If:** The telecommunications system for cardiac arrest and emergency fire numbers is not upgraded. **Then:** Potential for system crashes. **Resulting In:** Potential delay in contacting the necessary person(s), leading to patient not having efficient and effective treatment.	Contingency plan for telecommunications in place. Working with ICT team to attempt to implement technical solutions available as quickly as possible. ICT funding agreement in place, no SON requirement.	Commission management consultancy firm to undertake strategic review of existing ICT infrastructure. Completed. Review contingency plan for telecommunications to ensure adequacy in light of risk. Contingency plan reviewed and internally there is a contingency where radios are provided and all emergency calls only are communicated via this link should the system crash. Completed. 4C's management consultancy firm commissioned, undertaking review currently with a view to making recommendations for solutions. ICT still looking at compatible solutions, looking at RGH first due to asbestos issues at PCH. Solutions now found and 4 companies are in the running for bids. 4 companies are currently attending site in order to provide bids. New telecomm system due to be installed across PCH and RGH by 31st March 2021. Timescale: 31/03/2021 Based on this update the risk remains unchanged until new telecommunication system is installed and is compliant	~~Quality & Safety Committee.~~ Digital & Data Committee	15	6	↔	21/08/2017	11/12/2020
Executive Director of Clinical Services Operations	Provide high quality, evidence based, and accessible care.	Potential cyber security risk relating to brand of medical device monitoring system.	(Facilities Risk Register Reference S9) **ILG:** CSO Facilities Hub **If:** Potential cyber security risk (CVE-2020-1472) identified relating to a specific brand of medical device monitoring system. Should a threat be successful. **Then:** Potential changes and disruption to the operation of monitoring equipment could occur. **Resulting In:** Service/business interruption and potential harm to patients being treated.	The medical device system is protected by firewalls but these will not prevent access.	Clinical Engineering to discuss with manufacturer about software patching to find and implement a solution. Contacted manufacturer and problem now identified on the manufacturers online support portal as a vulnerability. Received response from the manufacture that the software patch will be available in January. Once patch has been installed by manufacturer Clinical Engineering will install the patch on the two servers and equipment affected within the Health Board and issue has been resolved for compliance. Clinical Engineering has reviewed all other medical device systems and has identified no other medical device systems that are vulnerable to this threat. Timescale: 31/01/2021 Based on this update the risk remains unchanged until patch has been successfully installed and issue has been resolved for compliance by Clinical Engineering.	~~Quality & Safety Committee.~~ Digital & Data Committee	15	5	↔	23/09/2020	11/12/2020
Executive Director of Planning & Performance (ICT)	Provide high quality, evidence based, and accessible care.	The ICT Digital Strategy Review	**IF:** The ICT Digital Strategy is not reviewed it will not reflect the current digital strategic direction **Then:** The Health Board will not have a digital strategy to support both the local and National initiatives around the new ways of working **Resulting In:**Not having a digital agenda to be able to progress the health board both in both clinical and no clinical areas.	The Chief Information Officer is now in post Discussions are on going around the possibility of consultants being engaged to work on updating the Digital Strategy	To prepare a brief on what is required from a consultancy service To work with the Chief Information Officer (CIO) and ILG leads to understand the requirements for the strategy, taking into consideration the new ways of working	Digital & Data Committee	15	5	↔	09.11.2020	31.12.2020

Strategic Risk owner	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Date Risk on the RR reviewed
Executive Director of Operations Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Delivery of the rehabilitation for repatriated major trauma patients.	**If:** The business case for enhanced rehabilitation services linked to Major Trauma is not supported. **Then:** Patients will not receive the appropriate level of clinical intervention. **Resulting In:** Poorer clinical outcomes, increased lengths of stay (with associated clinical risks) and poor patient experience.	Ensuring current nursing and therapies have access to a training programme - however there are concerns about deliverability during Covid pandemic. The new rehabilitation coordinator post will support the delivery of the immediate care planning once a patient is repatriated. Advance notice means we can ensure staff are aware of immediate needs. The network has systems in place to support early care planning and preparation where possible i.e. The health board is aware of the number of patients likely to be transferred 'Rehabilitation prescription' describes nursing and therapy needs prior to repatriation. Rehabilitation coordinators link with counterparts in UHW to ensure our rehabilitation offer is clear to the patient and their family prior to transfer.	The development of the business case will require support from business partners in planning, HR and finance. Recurrent investment may be required as an outcome of the business case	Quality & Safety Committee	15	6	↔	10/09/2020	31.12.2020
Executive Director of Operations Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Care of Patients with Mental Health needs on Community Hospital Sites.	**If:** there is a consistent number of patients with mental health needs which are being cared for in community hospital without RMN support or there are delays in discharge to the appropriate EMI setting. **Then:** Patients who have been sectioned and/or are under medication review may remain on the community ward where specialist mental health therapies and input is not possible. **Resulting In:** Incidents of staff and patient assaults may occur. Poor patient experience as not receiving the appropriate support in the appropriate setting. Staff impact due to increased supervision being required to manage behaviour..	MHL Team contacted for each patient for support 1:1 Supervision provided for each patient to reduce risk of harm Ward Manager and Senior Nurse Review patients daily 13/08/2020- reviewed in Tier 2 Gov meeting- new risk gone onto register. Remains high risk 14/08/2020 - remains high risk, Senior Nurse liaising with Mental Health team to establish if mental health can provide some more support to staff on the ward. There are currently 9 patients on site needing input from the mental health team.	02/12/2020 - remains high risk, Head of Nursing organising weekly meetings with Mental Health Team to discuss patients on site. There are currently a high number of supervisory patient also on the transfer list to come to YCR.	Quality & Safety Committee	15	6	↔	10/08/2020	31.12.2020

Datix ID	Executive Portfolio	Risk Domain	Risk Title	Risk Description
4273	Executive Director of Clinical Services Operations	Provide high quality, evidence based, and accessible care.	Inappropriate equipment being placed in clinical bag waste.	(Facilities Risk Register Reference W4) **ILG:** Merthyr Cynon ILG, CSO Facilities Hub **If:** Inappropriate waste (e.g. oxygen cylinders) are disposed of amongst the clinical bag waste. **Then:** Inappropriate waste would go through the clinical waste contractor processing plant, creating contamination and possible damage to the machine (e.g. explosion of cylinder). **Resulting In:** Serious incident at clinical waste contractor facility. As this is an 'All Wales' contract, the effects of any downtime would cause disruption not just to CTM but to all of neighbouring health boards. The contractor has the right to cease collections, affecting disposal service delivery and causing Health Board reputational harm.

4338	Executive Director of Operations Executive Director of Finance, Procurement (Estates) Bridgend ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Asbestos Content in roof of main building.	Asbestos is a known significant risk to health. It has long since been banned in construction but there is a recognition that older buildings may still have Asbestos in them (usually roof). Asbestos has been linked through extensive research to lung cancer, asbestosis, mesothelioma and other respirator illness through long term exposure. **If:** he Health Board is unable to safely remove the significant asbestos risk in the roof structure of Maesteg Community Hospital through a structured and planned estates strategy. **Then:** The Health Board

Controls in place	Action Plan
Policies and procedures are in place, however currently not being adhered to as incidents show. Waste Manager has posted bulletins on SharePoint highlighting the incidents and what staff are required to do in order to prevent these incidents from occurring in future. Communication link between Waste Manager and Clinical Waste Contractor to ensure that any inappropriate waste incidents are reported as soon as possible to identify source / location of incident. Identified need to provide clearer control measures including regular audits of waste holds, and bins to record compliance.	Raise as a risk on Datix. Completed. Notify Fire Manager and Health & Safety Team and also request tracking of the cylinders to locate site location where disposal took place to investigate further. Completed. Provide another SharePoint News bulletin through Communications Team . Completed. Waste Manager to set up regular audits of waste holds and bins to record compliance, keeping audits on file. Completed. Review contingency plans to ensure adequacy in light of risk. **Timescale: 15/01/2020.** Contingency plans have been reviewed and as a result regular audits of waste holds and bins to record compliance are now being undertaken. Also Waste Porters have been instructed to remain vigilant regarding notifying the Waste Manager immediately should any inappropriate waste be found. Completed. Based on this update it has been agreed with the service lead to reduce the risk from severity 4 x likelihood 4 = 16 to 4 x 2 = 8 but still remain a moderate risk based on regular audits of waste holds and bins to record compliance now being in place.

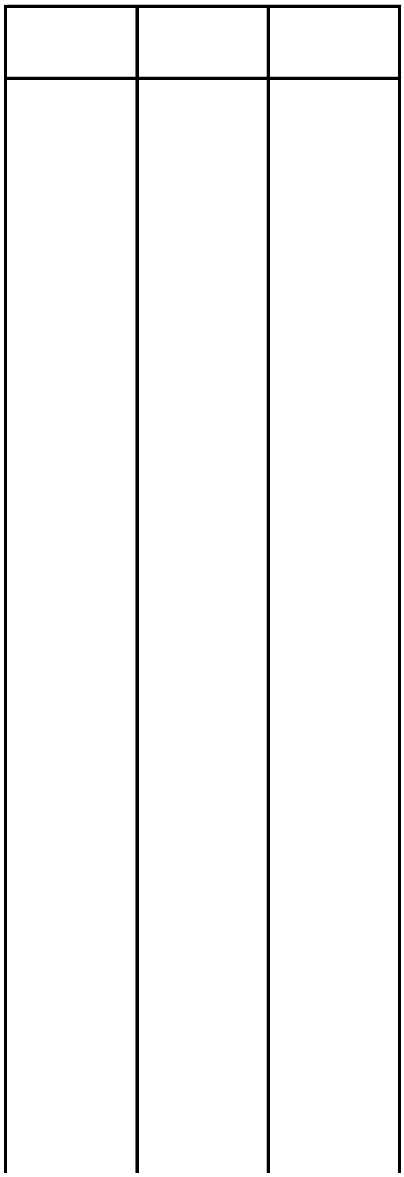
The roof structure has remained undisturbed at present which does not further escalate the risk of loose fibres being released. The capital team are aware of the problem.	Continued PPM and remedial repair to maintain operational status

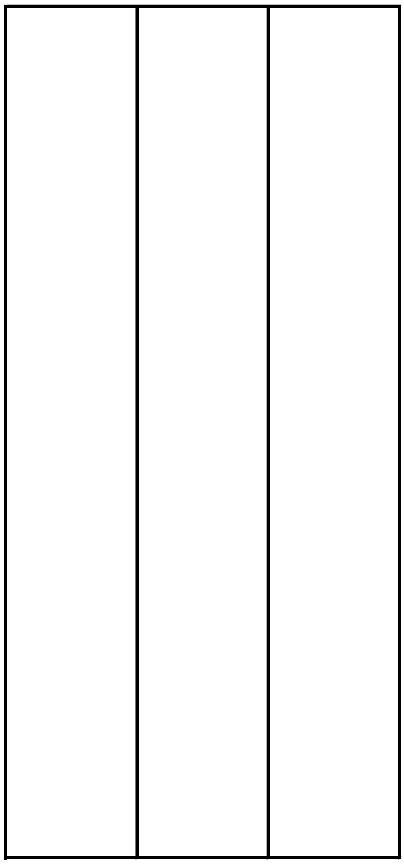
Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Date Last Reviewed
Monitored by Facilities Business Governance & Performance Group and Facilities Service Risk Review Meetings Scrutinised by the Quality & Safety Committee.	8	4	↓ 16	17/07/2020	11.12.2020

~~Quality & Safety Committee~~ Health, Safety & Fire Sub Committee of the Quality & Safety Committee	12	16	↓ 16	14.10.2020	31.03.2021

Comments						
Contingency plans have been reviewed and as a result regular audits of waste holds and bins to record compliance are now being undertaken. Also Waste Porters have been instructed to remain vigilant regarding notifying the Waste Manager immediately should any inappropriate waste be found. Completed. Based on this update it has been agreed with the service lead to reduce the risk from severity 4 x likelihood 4 = 16 to 4 x 2 = 8 but still remain a moderate risk based on regular audits of waste holds and bins to record compliance now being in place. Will be monitored and reviewed on the Facilities Function Risk Register.						

Risk deescalated as repair work currently underway to rectify the problem.						





Closed Risks
November 2020 (Management Board 18.11.2020)

Datix ID	Executive Portfolio	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Last reviewed
4272	Executive Director of Clinical Services Operations	Ensure sustainability in all that we do, economically, environmentally and socially.	Replacement of linen monorail sorting system and inclines due to age.	(Facilities Risk Register Reference 11477) **ILG:** CSO Facilities Hub **If:** Monorail system requires upgrading as risk of breaking down and parts becoming scarce. **Then:** Potential delay to laundry service for the organisation. **Resulting In:** Business and service objectives not being completed and financial loss from service disruption.	Continue to maintain at cost including maintenance schedule twice a year service, overtime and parts where available. Contingency Plan with options included such as using other equipment available, using another laundry and additional agency staff if required.	Undertake gap analysis of laundry services against WHTM 01-04 and BS EN 14065: 2016. Completed. Purchase and installation of new system with capital funding required through SON. **Timescale: 02/01/2020.** Review contingency plans to ensure adequacy in light of risk. **Timescale: 02/01/2020.**	Monitored by Facilities Business Governance & Performance Group and Facilities Service Risk Review Meetings Scrutinised by the Quality & Safety Committee.	8	8	↓ 16	16/12/2016	19.11.2020