

| Datix ID | Strategic Risk owner | Strategic Goal | Risk Domain | Risk Title | Risk Description | Controls in place | Action Plan | Assuring Committees | Rating (current) | Heat Map Link (Consequence X Likelihood) | Rating (Target) | Trend | Opened | Last Reviewed | Next Review Date |
|----------|--|----------------|---|--|---|---|--|--|------------------|--|-----------------|-------|------------|---------------|------------------|
| 816 | Chief Operating Officer Rhondda Taf Ely Integrated Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Follow up capacity and clinic cancellations (FUNB) | If: The Health Board is unable to control and meet the capacity and demand to accommodate all hospital follow up outpatient appointments. Then: the Health Board's ability to provide high quality care may be reduced. Resulting in: Potential avoidable harm to patients who are not reviewed in a timely manner. | Clinical Service Group (CSG) plan in place to address the FUNB position across all specialties as part of the restart programme. Additional funding requirements identified. Regular meetings in place to monitor the position. | Harm review processes being implemented. Further discussions underway with Assistant Director of Nursing. Update September 2021: Colleagues within the Health Board are aware that this issue has been on the risk register for some time and significant progress was made prior to Covid-19 across the organisation, unfortunately this progress has been impacted upon by pandemic restrictions. The Health Board is now aiming to use WG Outpatient funding to run administrative validation on the lists to help support the position, and this is currently with ILGs to explore around uptake for overtime. The See on Symptom (SOS) and Patient Initiated Follow Up (PIFU) project is underway, however, it will take some time before any impact of that work is seen because of the time it will take to go speciality by speciality to implement the changes needed. This is a longer term transformation as part of the Outpatient Strategy. | Quality & Safety Committee | 16 | C4 x L4 | 12 (C4xL3) | ↔ | 18/11/2013 | 16.9.2021 | 31.03.2022 |
| 1133 | Chief Operating Officer Rhondda Taf Ely Integrated Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH). | If: the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; Then: the Health Board will be unable to deliver safe, high quality services for the local population; Resulting in: compromised safety of the patients and staff and possible harm. | ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site | ED sustainable workforce plan developed and being implemented (May 2021). Reviewed no change as at 7th September 2021. Reviewed 21.09.2021 - remains working progress. No change to mitigation and risk score. | Quality & Safety Committee. People & Culture Committee - Workforce aspect | 16 | C4 x L4 | 12 (C4xL3) | ↔ | 20.02.2014 | 31.03.2022 | 28.04.2022 |
| 2787 | Executive Director for People Health, Safety & Fire | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Absence of a robust Health Surveillance Programme for employees. | If: there is no monitoring in place for staff who work in areas of the organisation where known health risks could develop e.g. Hand, Arm Vibration (HAVs), noise, skin conditions such as contact dermatitis, respiratory etc. Then: then this means that the organisation may not be able to identify the areas and departments within the organisation that require Health Surveillance intervention. Should a reportable incident occur CTM/UB will be liable to criminal repercussions by the HSE Resulting in: it not being possible to develop a robust HS programme for the organisation without this baseline intervention as required by the Health & Safety Executive (HSE). Criminal Actions by the HSE. | OH linking with H&S to re-establish the skin surveillance programme. Plan to submit a briefing to execs in relation to the associated risks due to the absence of a health surveillance programme. | Plan to submit a briefing to execs in relation to the associated risks due to the absence of a health surveillance programme. Update May 2022: Health and Safety Team to meet with Occupational Health Team to decide priorities for provision of Health Surveillance. Timeframe: 31.7.2022. | Health, Safety & Fire Sub Committee of the Quality & Safety Committee | 16 | C4 x L4 | 8 C4xL2 | ↔ | 26.06.2017 | 3.5.2022 | 31.07.2022 |
| 2808 | Chief Operating Officer Merthyr Cynon Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Waiting Times/Performance: ND Team | If: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring | The service is operating as efficiently as possible e.g. enhanced roles for SLT/CNS/Pharmacist. Pathways have been reviewed e.g. ADOS's limited to only those cases where clinically necessary. Clinical Lead role created to support this (as below). Non-recurrent investment of the below posts have been given for 12 months, but Clinical Service Group has highlighted the requirement for these posts to be made permanent. *1.0 wte Psychiatrist (clinical lead role) *Uplift from 8a to 8b 0.6 wte Pharmacist *1.0 wte Band 3 admin *0.6 wte Band 3 HCSW Additional clinics are currently being held on weekends to address longest waiters. (WLI has been carried out in the service since 6 months of the service being set up) Meetings with National Lead for Values Based and Prudent Health Care arranged to look at modelling of the service. Bids have been submitted through successive IMTPs and previously against new WG funding sources for the ND service. Within Bridgend the Directorate is reviewing the feasibility of repatriating the SLA from Swansea Bay so that a local service can be developed | Seeking confirmation that non-recurrent funding is made permanent for fixed term posts - timeframe 31.3.2022. Consideration required for further investment in the service to allow us to meet the demands on the service and reach the Welsh Government target of 80% of assessments being seen within 26 weeks. This will also reduce the need for WLI every year. Further investment in the service following D&C review - Timeframe - 31.03.2022. | Quality & Safety Committee | 15 | C3 x L5 | 9 (C3xL3) | -- | 14.07.2017 | 06.01.2022 | 30.04.2022 |

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| 2987 | Chief Operating Officer Merthyr & Cynon Integrated Locality Group Executive Director for People (Executive Lead for Health & Safety and Fire. | Improving Care | Patient / Staff /Public Safety | Fire enforcement order is in place for the ground and first floor PCH due to inadequate fire compartments to prevent spread of fire, smoke and noxious gasses | IF: The Health Board fails to meet fire standards required in this area. Then: the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. Resulting in: potential harm, risk of fire. Possible further enforcement in the form of prosecution. | Fire Enforcement Order. An action plan and target dates for the 1st and ground floor areas at PCH is available and is subject to available finance for completion. Phase 1b of the wider programme has been completed and the UHB has now achieved remediation for physical fire issues identified in the FEN in the majority of the new Pharmacy, Dining Room and Kitchen areas at PCH which opened in January 2021. This has tackled the higher risk for fire areas of the old kitchens and improved the fire stopping below ITU as well as reducing the overall volume of area remaining in the FEN to be remediated (remediated c2000m2 of c18000m2). In addition the UHB secured Welsh Government approval in October 2020 for the Phase 2 FBC, in the sum of £220m, which will see progressive improvement of the majority of the remaining G&FF areas to be remediated for fire over the next 5 and a half years. As a reminder these works are progressive due to the need to balance them against maintaining service delivery as best as we are able and are intended to be supplemented (to run concurrently with final years of the Phase 2) by a final Phase 3 business case intended to address the final physical accommodation areas included within the FEN. Ongoing maintenance of fire systems. Increased knowledge on site of the fire issues, fire training, initial works carried out on areas as part of the scheme already. | Ground and first floor major project approved by WG to address the fire notification on PCH. In progress with completion due 2026 / 27. Annual reviews as to remediation progress are held with SWF&RS and the Health Board is required to evidence continued progression in the shortest timescale. If satisfied SWF&RS issue an annual extension letter against the FEN. The current extension runs to the 31/07/22. The Phase 2 programme has now reached a point where an additional c 3500m2 of FEN accommodation has been handed to the contractor (End of Jan 2022) as the next section to be remediated, having now decanted these areas to alternate fire compliant accommodation. An extension of a further 12 months has been granted by the Fire Service and will now expire on 31/07/2022. | Health, Safety & Fire Sub Committee of the Quality & Safety Committee | 16 | C4 x L4 | 6 | ↔ | 29.11.2017 | 13.05.2022 | 31.07.2022 |
| 3008 | Chief Operating Officer Merthyr & Cynon Integrated Locality Group | Improving Care | Patient / Staff /Public Safety | 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 SRUHB online training package to be shared. 8. Directorate will Seek out any opportunities for online updating to support current practice 9. E-learning module has been sourced for all staff to complete on line update for manual handling. | Organisational plan for compliance training. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG tripartites. As at March 2022, the Head of Quality & Safety in the ILG is meeting with the CSG to support a review of this risk. Meeting arranged for the 10th March 2022. Update May 2022 - Following discussion at the Health, Safety & Fire Safety Committee on the 5th May 2022, the CSG has been asked to undertake a review of this risk. | Health, Safety & Fire Sub Committee of the Quality & Safety Committee | 16 | C4 x L4 | 12 (C4xL3) | ↔ | 01.05.2017 | 01.12.2020 | 31.03.2022 |
| 3133 | Chief Operating Officer Facilities | Improving Care | Patient / Staff /Public Safety | Due to capacity issues to deal with Covid-19 staff not attending medical gas safety training and courses being rescheduled. | IF: Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. Then: Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). Resulting In: Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients. | PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme. Some home working is possible for access to the Patient Administration system Adastra. However, there is currently no means to transfer telephone calls from Ty Elai. Communications colleagues from both Ty Elai and RCT CBC have been consulted on this issue and have arrived at the same determination. | Monthly reporting template of Medical Device Training Compliance to be constructed and presented to COO and ILG Director leads to inform current take up of courses and improve take up of courses including Medical Gas Training. If happy continue using template on a monthly basis. Completed. Reporting template has been agreed and is now in place. Action: Use reporting template to monitor attendance. Timescale: 31/03/2022. COMPLETE Quarterly reports in place for all med device training sent to Corporate Services for dissemination to ILG management, places offered, places attended/competency assessments etc. Current med gas training attendance is 12% in latest Feb 2022 report. Based on this update the risk rating remains unchanged until the attendance for Medical Explore the possibility of relocation to a health board owned site. Options Appraisal to take to board and to discuss with co-location partners. Relocation would ensure IT systems and telephony are easily transferable to another area within the HB in the event of a major incident. This would then be able to be managed internally with no need for Local Authority input. Preliminary meeting with capital and ICT have been undertaken Options Appraisal is being undertaken. A building has identified and a awaiting a decision around space. Building has been identified as a possible location. Awaiting blueprints to see if space is suitable for requirements. Timeframe: 31.3.2022 | Quality & Safety Committee. | 16 | C4 x L4 | 8 (C4xL2) | ↔ | 01/05/2018 | 27.4.2022 | 31.05.2022 |
| 3267 | Chief Operating Officer Primary Care | Improving Care | Patient / Staff /Public Safety | Out of Hours - Contingency Plan for Business Continuity Communications Hub Ty Elai | IF: There is no ability to divert calls for services delivered from the Ty Elai Communications Hub (111, GP Out of Hours, Dental, District Nursing, Safe Haven, 111 First). Then: In the event Ty Elai should become inaccessible due to adverse weather there is a likelihood of interruption to services. Resulting In: Potential delays, impact on service to patients and their experience received. Staff impact. | Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme. Some home working is possible for access to the Patient Administration system Adastra. However, there is currently no means to transfer telephone calls from Ty Elai. Communications colleagues from both Ty Elai and RCT CBC have been consulted on this issue and have arrived at the same determination. | Based on this update the risk rating remains unchanged until the attendance for Medical Explore the possibility of relocation to a health board owned site. Options Appraisal to take to board and to discuss with co-location partners. Relocation would ensure IT systems and telephony are easily transferable to another area within the HB in the event of a major incident. This would then be able to be managed internally with no need for Local Authority input. Preliminary meeting with capital and ICT have been undertaken Options Appraisal is being undertaken. A building has identified and a awaiting a decision around space. Building has been identified as a possible location. Awaiting blueprints to see if space is suitable for requirements. Timeframe: 31.3.2022 | Quality & Safety Committee | 16 | C4 x L4 | 6 (C2xL3) | ↔ | 16.07.2018 | 11.01.2022 | 31.03.2022 |

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| 3585 | Chief Operating Officer. Bridgend Integrated Locality Group | Improving Care | Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption | Princess of Wales Emergency Department Hygiene Facilities | IF: the toilet and shower facilities are not increased within the Emergency Department. Then: at times of increased exit block the facilities are insufficient for the needs of the patients in the department. Resulting In: Poor patient experience, complaints and further concerns raised from the Community Health Council have repeatedly flagged this issue on visits to the department. | There are additional toilet facilities in the radiology department that mobile patients can be directed to however staff do whatever they can within the constraints that they have. | Additional facilities being explored as part of departmental capital works. There is a capital plan for improvement works in ED. The improvements will be – 1. NIV cubicle 2. Creation of a second patient toilet 3. Improvement to HDU area 4. Relocation of Plaster Room 5. Creation of 2 paediatric bays with adjoining paediatric waiting room 6. Redesign of waiting room and reception desk Prior to the Covid pandemic, improvements 2-6 were planned, but the creation of an NIV cubicle has taken priority. The plans are in the process of being signed off for all areas but there is no confirmed start date yet. There was / is potential for delays in sourcing materials by contractors and we need to consider the need to keep contractors as safe as possible from any Covid contact. Patient numbers are now increasing daily but we are restricting visitors and relatives attending with patients (unless required as carers etc). We have also developed a remote waiting room for patients who can safely wait in their cars. This will help to mitigate the footfall in the department when the capital work commences. June 21 Update - Capital works for NIV room still ongoing and therefore no progress yet with the rest of the capital build. NIV room to be handed back mid June and patient toilet will be the next priority for completion Update August 2021 - No Change.RCEM audit undertaken. Staffing remains ongoing issues- plans in place and frequently reviewed. ASCU staffing plan agreed at ILG level and ongoing. Surge trolleys in place to cope with additional capacity requirements. Building works progressing and some phases complete. X references to ID4458 & ID3826.Update: Awaiting update from Capital team to confirm start date for next phase of works. Patient toilet is the next priority. Update from Capital Team 6.5.2022: The ILG have been requested to provide availability for a prioritisation meeting for the 22/23 limited discretionary funding that is available - this will need to be discussed alongside their outstanding risks and prioritised for funding. | Quality & Safety Committee | 16 | C4 x L4 | 1 | ↔ | 31.05.2019 | 28.09.2021 | 31.01.2022 |
| 3638 | Executive Medical Director Pharmacy & Medicines Management | Inspiring People | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Pharmacy & Medicines Management - Training & Development Infrastructure | IF: the planned HEIW led changes to the education and training of pharmacists and pharmacy technicians with increased numbers of trainees across both primary and acute care are fully implemented Then: the there will be insufficient capacity within the medicines management team to provide the required training, supervision and management of the planned trainees. Resulting in: a lack of appropriately qualified pharmacy professionals to meet future service demands in all sectors and particularly in hard to recruit to ILGs such as Merthyr where we have established a "grow our own" model. This can impact the primary care sustainability MDT model. Also a reduction in reputation of a HB that has a very high level of % qualifying and a reduction in future applicants. Current capacity is overstretched and a robust education, training and development infrastructure is needed to meet these demands for specialist & advanced practitioners in primary and secondary care. | SBAR submitted to CBM in March 18 to increase training capacity in order to meet the demand. Included in IMTP and prioritised as number one priority. A bid was included as part of the primary care pacesetter for education and development in primary care academic hubs and was successful. This element of the ed/tr will be implemented in 2018 for 3 years with evaluation. The secondary care elements were not supported in the IMTP prioritisation process and so this still leaves significant risks. SBAR needed to describe the impact of the new technicians training qualification. Funding approved for primary care lead pharmacist - commenced in post April 2019. Included a new case in 2019/20 IMTP as high priority. SBAR for Nov CBM on new technician training requirements. Progress and evaluate primary care pacesetter plan to increase training infrastructure to inform business case to continue funding and scale up. | Update June 2021: HEIW have agreed training support grants for trainers to support pre-registration foundation posts which mitigates the risk for this group of staff. However this funding is only temporary and not guaranteed beyond 2022-23, which presents a potential risk around recruitment of suitable staff. The post-registration foundation programme has been deferred until 2022 which buys some time for health boards to explore solution to the significant financial shortfall that will arise from the lack of on going funding for these posts. Update July 2021 - No further update to that recorded in June 2021. Review 30.09.2021. Update November 2021 - as reported to the Quality & Safety Committee: Discussion with HEIW have resulted in a delay to the financial changes until 2024, which will allow the service related impact to be better transitioned into the planning cycle. Update February 2022 - Risk remains as funding for the posts will be significantly reduced from 2023 onwards as HEIW will reduce from 50% to 20% funding. The shortfall in funding between establishment and post costs remains the risk. The funding resource is being captured in the IMTP submission for 22-23 in preparedness for the impact in 2023-4. Funding gap is approximately £90k pa. This equates to 2 posts. Decision of funding is required by March 2022 to allow for recruitment process in 2023. | People & Culture Committee | 15 | C3 x L5 | 6 (C3xL2) | ↔ | 02.01.2018 | 11.02.2022 | 30.04.2022 |
| 3654 | Chief Operating Officer Merthyr & Cynon Integrated Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Gynaecology Cancer Service | IF: Demand continues to exceed the agreed manageable caseload in Gynaecology services across the Health Board. Then: there will be a delay in the pathway requiring multiple consultations on site and reliance on an individual Practitioner. Resulting in: Delay in patient pathways, poor experience, unsustainable demand on the workforce and Gynae Rapid access service development is slow progression. Risk description reframed into the if, then, resulting in format. | Hysteroscopy service business case is being updated - Increased cancer tracking - Review of pathways and service - tracking of results G17Scrub training in place and a rolling programme organised with main theatres Covid Health Board Guidelines in place. | Update April 2022: The following progress has been made on this risk: • Increased capacity in Gynaecology Day Assessment Unit (RGH) for Urgent Suspected Cancer patients • Newly established Post-Menopausal Bleeding clinic in YCR • Newly developed Standard Operating Procedure (SOP) for the Gynae Cancer Multi-Disciplinary Team • Job plans updated to ensure medical hysteroscopy cover and increased USC slots within job plans • Dedicated cancer leads in both Prince Charles Hospital and Royal Glamorgan Hospital • Review of theatre capacity and utilisation for Urgent Suspected Cancer • Purchase of additional capacity to support service improvements (e.g. ultrasound scanners, hysteroscopy stacks) A Business Case has been developed for a one stop gynaecology cancer clinic, proposed to be in RGH, with the aim to provide fast diagnosis for patients by providing access to consultant led consultations, assessments and diagnostics on the same day. Option identified for proposed location in ante-natal clinic in RGH. Further work being undertaken regarding demand and capacity modelling and by RTE ILG colleagues to understand potential capital costs for the ANC space to achieve clinical specification developed as part of the business case. Also associated with this is an ask that we have made to regain lost theatre capacity (5 sessions across PCH and RGH pre Covid to now) to enable us to address our stage 4 treatment position which we anticipate if the one stop along with the above actions are successful will move patients through to treatment stage more quickly. The risk rating has remained at 16 and even with the mitigating actions it will remain 16 as even though we are improving waiting lists on the Gynae pathway we are unable to increase our surgical capacity to treat the patient at stage 4 therefore we continue to have a delay. | Quality & Safety Committee | 16 | C4 x L4 | 9 (C3xL3) | ↔ | 18.06.2019 | 20.04.2022 | 30.06.2022 |
| 3698 | Chief Operating Officer Bridgend Integrated Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Waiting List for Autism Diagnostic Observation Schedule (ADOS) assessments and Attention Deficit Hyperactivity Disorder (ADHD) medicals over 1 year. | IF: there are delays in diagnosing children with ADHD and Autism. Then: this results in a delay in management including appropriate school placements Resulting in: potential harm to patients, poor patient experience, dignity, staff morale. Complaints. | * The team have reviewed their clinical practice in line with the rest of CTM e.g. no longer undertaking ADOS for all children * Discussions underway re: repatriating service from Swansea Bay and investing funding into enhanced local service in Bridgend * New Consultant starting June 2020 with 3 sessions to support community paed | Vacant sessions to be recruited to - Additional staff appointed who could undertake assessments would ensure this activity was managed in a timely manner. | Quality & Safety Committee | 15 | C3 x L5 | 4 | ↔ | 02.07.2019 | 04.11.2021 | 31.12.2021 |
| 3742 | Chief Operating Officer Rhondda Taf Ely Integrated Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Care of 16-18 Year Olds | IF: Children aged 16-18 years are cared for in an adult acute setting. Then: there is a concern that the care provided will not meet the required paediatric standards. Resulting in: Inappropriate care and an inappropriate setting. | Cases are managed on an individual basis dependent upon the needs of the child. Ongoing discussion with the medicine specialities and the paediatric teams about the most appropriate setting for each individual. Discussion underway with the CSGs across CTM to understand the support required and the action plan will be updated accordingly, identifying any corporate level support as required. | Discussion with CSG's to understand the support required is underway and the action will be updated accordingly, identifying any corporate level support as required. No change to mitigating action or risk score. | Quality & Safety Committee | 16 | C4 x L4 | 12 (C4xL3) | ↔ | 19.07.2019 | 09.03.2022 | 19.04.2022 |

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| 3993 | Chief Operating Officer Bridgend Integrated Locality Group | Improving Care | Patient / Staff /Public Safety | Fire Enforcement Notice - POW Theatres. | IF: The Health Board fails to meet fire standards required in this area. Then: the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. Resulting in: potential harm, risk of fire. Possible further enforcement in the form of prosecution. | Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2021. Need to plan for drop in theatres to mitigate work commencing | Need building work to be undertaken to ensure safety. Operating theatres will need to close for this to occur. Fire enforcement notice has been extended to December 2023 by South Wales Fire and Rescue Service, work is ongoing with the construction supply chain partner to complete detailed design, obtain planning permission, a costed programme and submit a business case to Welsh Government by Spring 2022. WG have requested an options review be urgently undertaken on this as the preferred decant option is indicatedly costed at £50M. The ILG are confirming availability for a management review of alternative options for delivery prior to a stakeholder session. Post this a report will need to be prepared for and discussed with WG to determine the way forward in terms of business case processes and timings. | Quality & Safety Committee Health, Safety & Fire Committee | 15 | C5xL3 | 8 | ↔ | 31.01.2020 | 13.05.2022 | 30.06.2022 |
| 4071 | Chief Operating Officer All Integrated Locality Groups Linked to RTE 4513 | Improving Care | Patient / Staff /Public Safety | 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. | <ul style="list-style-type: none"> Tight management processes to manage individual cases on the cancer pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three ILGs are working to maximising access to ASA level 3+4 surgery on the acute sites. HB working to ensure haematological SACT delivery capacity is maintained. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigorous monthly performance review process. each ILG now reports actions against an agreed improvement trajectory. | Continue close monitoring of each patient on the pathway to ensure rapid flow of patients through the pathway. Active management of the diagnostic backlog (including endoscopy) and exploration of all options to reduce this. Comprehensive planning for repatriation of theatre and haematology services for when private provision is lost. This also needs to consider options for continuation during a potential second surge. These actions are ongoing and assigned to the EDO, DPC&MH and Medical Director. The Cancer Business Unit remain fully involved in the processes to improve care and that at present they are awaiting feedback from ILGs on their plans for restarting elective and other activity and their demand and capacity assumptions. There was a refocus on this risk post Covid-19 impact and there has been a consistently improving position from February to July. During July there was a slight deterioration which is being addressed and actioned. Each ILG has returned a Cancer Recovery Plan to facilitate monitoring by the COO. This remains ongoing with individual issues addressed as they arise. An Operating Framework has been developed with a tightened Performance Management framework which will be monitored by the COO. Update January 2022 - Maintaining cancer services during this challenging time is a priority for the Health Board. The Health Board has established enhanced monitoring processes which provides further assurance of the steps the Health Board has deployed and are putting into place to re-establish appropriate performance levels within the Suspected Cancer Pathway. The risk rating has been reviewed in light of these further mitigations and a rating of 20 is considered to still be appropriate. The response to Covid-19 has impacted the original timeframes for these actions due to the requirement to focus on clinical operational service delivery during the pandemic. Revised dates have been included below: 1. AMD and workforce to develop recruitment strategy - 31.3.2021 Update October 2021. The Health Board is in the process of introducing patchwork across Menthry & Cynon ILG on 6th October and Rhondda Taf Ely on 20th October. This will give an indication of the gaps and the spend, allowing the ILG's to establish a medical recruitment strategy. 2. AMD and DMD to develop retention and engagement strategy - 31.3.2021 - Revised Date February 2022. 3. Reduce agency spend throughout CTMUHB - Update January 2022 - Patchwork rolled out across CTM. Data gathering currently. When sufficient data will have the discussions with HR and clinicians on a fair and appropriate rate card. 4) Task and Finish group to look into conversion of ADHs into permanent posts. 5) Task and Finish group Retire and return (emphasis on recruit new consultants (and therefore join on call) than R&R approach, use R&R on 1 year contracts and re-advertise posts on yearly cycle. | Quality & Safety Committee | 20 | C4 x L5 | 12 (C4 x L3) | ↔ | 01/04/2014 | 02.03.2022 | 31.05.2022 |
| 4080 | Executive Medical Director | Improving Care | Patient / Staff /Public Safety | 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. | <ul style="list-style-type: none"> 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 | <p>1. AMD and workforce to develop recruitment strategy - 31.3.2021 Update October 2021. The Health Board is in the process of introducing patchwork across Menthry & Cynon ILG on 6th October and Rhondda Taf Ely on 20th October. This will give an indication of the gaps and the spend, allowing the ILG's to establish a medical recruitment strategy.</p> <p>2. AMD and DMD to develop retention and engagement strategy - 31.3.2021 - Revised Date February 2022.</p> <p>3. Reduce agency spend throughout CTMUHB - Update January 2022 - Patchwork rolled out across CTM. Data gathering currently. When sufficient data will have the discussions with HR and clinicians on a fair and appropriate rate card.</p> <p>4) Task and Finish group to look into conversion of ADHs into permanent posts.</p> <p>5) Task and Finish group Retire and return (emphasis on recruit new consultants (and therefore join on call) than R&R approach, use R&R on 1 year contracts and re-advertise posts on yearly cycle.</p> | Quality & Safety Committee People & Culture Committee | 20 | C5 x L4 | 15 (C5xL3) | ↔ | 01.08.2013 | 07.01.2022 | 31.03.2022 |
| 4103 | Chief Operating Officer Bridgend Integrated Locality Group | Improving Care | Patient / Staff /Public Safety | 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 | <ul style="list-style-type: none"> Measure and ODTC DU reviews nationally. Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTCs, 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 enacted. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (MS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised. | <p>Action plan developed and on going monitoring - consolidated plan coming forward covering Eye Care.</p> <p>The service has transitioned to Bridgend ILG and Bridgend ILG has engaged in potential national solutions to address FUNB.</p> <p>Update August/ September 2021: New Quality and Performance Improvement Manager now in post to lead on improvements, a new pan-CTM Clinical Lead post that is currently being recruited to will support this. Update paper presented to PPF Committee in August setting out the range of actions being taken to improve the position, further update to be taken to October meeting. Further feedback from Royal College awaited.</p> <p>Update April 2022: From February 2021 Bridgend ILG took over the hosting services for Ophthalmology Health Board Wide. This brought a new management structure for the whole service. An overall Clinical Lead and Deputy was appointed which has created a much more sustainable governance structure. New consultant posts for the glaucoma services in particular have now been approved, with both areas creating substantive posts (one of which was filled this week). Vacancies with the middle grades have also been appointed to in the last 6 months which has provided additional capacity and cover for on call services.</p> <p>Administration services are also being reviewed from an overall sustainability point of view, as in comparison to other surgical areas in the Health Board it was felt that an increase in administration staff was needed. Posts are being converted wherever there is need within the service. Regular meetings with support staff are in place and liaison with key areas such as community and health records are also in place.</p> <p>Working in conjunction with Primary Care is paramount in creating a sustainable service going forward. Key areas such as glaucoma, Wet AMD and diabetic retinopathy patients are being referred to the community for their management which creates capacity in the hospital for the acute patients who need to be seen. This is a key area of funding from Welsh Government and confirmation is required to take this forward into 2022/23.</p> | Quality & Safety Committee | 20 | C4 x L5 | 12 C4 x L3 | ↔ | 01/04/2014 | 20.04.2022 | 30.06.2022 |
| 4106 | Executive Director of Nursing and Midwifery | Improving Care | Patient / Staff /Public Safety | 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. | <ul style="list-style-type: none"> Recurring advertisements of posts in and nursing continue with targeted proactive recruitment employed in areas of high agency/locum use. Provision of induction packs for agency staff Agency nursing staff are paid via an All Wales contract agreement, any off framework agency requests must be authorised by an Executive Director prior to booking (system of audit trail in place). Fixed Term Contracts being offered to all existing HCSW and RN currently on the Nurse Bank. Redesign services wherever possible to embrace a healthier Wales and therefore impact upon the workforce required to deliver services. Overtime incentives offered to workforce in response to Covid-19 pandemic. As of July 2021 - the overseas recruitment campaign has ceased pending further scoping exercises by Workforce and Organisational Development. Bi-Annual Nursing Staffing Levels Wales Act - Acuity Audit to be undertaken in June 2021 to report to Board in October 2021. Completed: This has been completed and received by the Board. Nursing & Midwifery Strategic Workforce Group re-established and has met. The Nursing Productivity Outputs will feed into this group along with monitoring roster KPIs and overall nurse recruitment including overseas. (Control Measure). | <p>Deputy Exec DON is currently reviewing the nurse rostering policy in conjunction with the workforce team in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's. Established a new nursing workforce taskforce. Consultation with Local Partnership Forum undertaken and amendments to the policy have been made as appropriate, the policy will be seeking approval at the Quality & Safety Committee in May 2021 - Timescale 31.5.2021. Update November 2021: The Revised policy which was based on SBUBH's current policy (in terms of content / KPI's etc. was taken to Local Partnership forum where it was identified further amendments were requested, these were made in terms of making the clear distinction between the current break times in some areas of POW and that of the rest of CTMUHB. The policy is currently with an ILG Nurse Director who has kindly offered to make the policy more "user friendly" Timescale: 31st December 2021</p> <p>All Wales "Safer Care Module" on e-roster system due to be received in due course. WG led so await WG timescales. No Change as at 4.5.2021. Update November 2021 - No update from WG as of November 2021</p> <p>Update May 2022: - Nursing Productivity Group established w.e.f end of March 2022. With the remit to address Nurse Agency Demand and Spend. - Nurse Roster Policy in final draft form led by the Nurse Director RTE. Due for completion and ratification end of May 2022. This policy includes KPIs to allow monitoring of effective roster management. In addition, enhanced supervision (121 Nurse/Nurse Specialising) document and process being reviewed by end of May 2022. - Safer Care Module - updated awaited from WG. Head of Nursing for Professional Practice in monthly meetings with WG Team.</p> | Quality & Safety Committee People & Culture Committee | 16 | C4 x L4 | 12 (C4xL3) | ↔ | 01/06/2015 | 06.05.2022 | 30.06.2022 |

| Datix ID | Strategic Risk owner | Strategic Goal | Risk Domain | Risk Title | Risk Description | Controls in place | Action Plan | Assuring Committees | Rating (current) | Heat Map Link (Consequence X Likelihood) | Rating (Target) | Trend | Opened | Last Reviewed | Next Review Date |
|----------|---|----------------|--------------------------------|---|---|---|---|--|------------------|--|-----------------|-------|------------|---------------|------------------|
| 4148 | Executive Director of Nursing & Midwifery | Improving Care | Patient / Staff /Public Safety | Non-compliance with Deprivation of Liberty Safeguards (DoLS) legislation and resulting authorisation breaches | IF: the Health Board fails to adequately resource the DoLS Team to address the backlog of authorisations and adequately manage a timely and effective response to new authorisations. Then: the Health Board will be unlawfully depriving patients of their liberties and failing to comply with the DoLS legislation Resulting in: the rights, legal protection and best interests of patients who lack capacity potentially being compromised. Potential reputational damage and financial loss as a result of any challenge by the ombudsman or litigation. | During February 2022 review of this risk the control measures have been revisited and streamlined. - Prioritisation assessment is being undertaken on the urgent authorisations. - Hybrid approach to the management of authorisations which includes the ability to offer a virtual format if necessary, although face to face is the preferred mechanism. - As at February 2022, the DoLS Team have now returned to full establishment which will support the resilience within the function. - A temporary Best Interests Assessor has now commenced with the Health Board whose role will be to focus on reducing the backlog. This post has been extended for a further year following CTMUHB being granted further WG funding to address the backlog. - A temporary Practice Educator has also been appointed whose role will be to prepare the Health Board for the Liberty Protection Safeguards and ensure that all staff are trained in the Mental Capacity Act. This post has been extended for a year following CTMUHB being granted further WG funding. - From February 2022, the DoLS Training has been revised and is running virtually on a monthly basis. - Audits are undertaken by the DoLS Team to look at compliance across the Locality Groups with the support of AMaT. - Capacity issues are also being supported by addition resources sourced through CTM Staff Bank. | During February 2022 review of this risk the Mitigation Actions have been revisited and streamlined. - The Health Board has received confirmation that the Welsh Government will be offering funding to address backlogs in authorisations, to provide training in the MCA and prepare the implementation of the Liberty Protection Safeguards. This will be offered in three stages. CTMUHB have already succeeded in securing a £123,000, this has been used to extend the Best Interests Assessor and the Practice Facilitator roles. There will also be a three day Best Interests Assessor post going out to audit in May 22. It is anticipated that the Health Board will need to apply for further funding throughout the year to address any backlog and plan to implement the LPS. - The implementation of the change in legislation with regards the Liberty Protection Safeguards will improve the Health Boards compliance however the date of implementation is still awaited. The Code of Practice is currently out for consultation. - The DoLS Team are meeting with leads within the Locality Groups to work with CSGs to progress the action plan in order to enhance the awareness of the MCA, the risks associated with DoLS authorisations and timely review required and reporting compliance. This work has commenced within YCC and YCR. There are plans to extend this work throughout CTMUHB. | Quality & Safety Committee | 16 | C4 x L4 | 8 (C4xL2) | ↔ | 01/10/2014 | 06.05.2022 | 30.06.2022 |
| 4149 | Chief Operating Officer Bridgend Integrated Locality Group | Improving Care | Patient / Staff /Public Safety | Failure to sustain Child and Adolescent Mental Health Services | IF: The Health Board continues to face challenges in the CAMHS Service Then: there could be an impact in maintaining a quality service Resulting in: recruitment challenges, long waiting times and impact to the implementation of the new model of care. Loss of trust and confidence in the services provided by the Health Board. Difficulties remain in recruiting key staff and new model of care being implemented; waiting times for specialist CAMHS and the new neurodevelopmental service remains challenging. | o Reported local and Network pressures across the CAHMS Network with variable problems dependent on the area of the network. o Updates provided to Management Board on developing service model to address reported issues and additional investment secured to increase capacity within the service and to address service pressures. Waiting list initiatives in place whilst staff recruitment is being progressed. o Service Model developed around Core CAHMS in Cwm Taf Morgannwg which includes agreement with General Paediatrics to take the lead on Neurodevelopmental Services and shared care protocols with Primary Care. o New investment impact being routinely monitored internally via the SMT and via monitoring meetings with the ILG o There has been progress with being able to recruit to vacancies with a number of new appointments made. For CTM UHB, the majority of vacancies have been recruited into. The Swansea Bay locality has had more challenges in recruiting skilled staff and there has been plans in place to recruit to developmental posts to attract more interest and invest in staff training and development. More recently the team have managed to recruit into a | o Monthly commissioning meeting discussions taking place across the Network in relation to service pressures and funding. Further discussions with commissioners expected by April 22 regarding service provision o Implementation of the Choice and Partnership Approach (CAPA) with a new service model introduced ensuring the service aligns itself with All Wales Mental Health Measure. All referrals accepted to CAMHS will now receive a Part 1 Mental Health Assessment to determine the level of support required. Performance is being reported and monitored via monthly performance meetings o A number of service reviews in relation to Ty Llidard undertaken and monitored via Q,S&R Committee. Additional nursing leadership implemented and progress on required action plans and proposed staffing model. Business case being drafted for additional investment to support staffing model by start of March 22. Workshops scheduled with WHSSC to review service specification and gap analysis. First workshop to take place on 15th Feb 22 o Community CAMHS in both CTM UHB and Swansea Bay UHB are carrying out WLI via the planned care recovery (PCR) scheme. The additional clinics and dedicated team for increased capacity required for current referrals to address backlog, particularly in CTMRI /Ultrasound. Require funding and procurement of mobile scanners in the longer term. | Planning, Performance & Finance Committee & Quality & Safety Committee | 16 | C4xL4 | 8 (C4xL2) | ↔ | 01/01/2015 | 16.02.2022 | 30.04.2022 |
| 4152 | Chief Operating Officer Rhonda Taf Ely Integrated Locality Group | Improving Care | Patient / Staff /Public Safety | Back log for Imaging in all modalities / areas and reduced capacity | IF: there is a backlog of imaging and reduced capacity Then: waiting lists will continue to increase. Resulting in: delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC and Urgent patients. | Additional clinics, locum appointments, clinical validation of waiting lists, outsourcing and alternative contracting arrangements and the use of additional mobile scanners. The constraining factor in all of these measures is the availability of a suitably skilled workforce. The ending of double-time enhanced rate payments in early May 2022 presents an additional challenge. All patients requiring Radiology diagnostics as part of the Single Cancer Pathway are closely tracked and not waiting beyond 20 days. | Actions: Staffing Resource, Capacity and Demand Planning and business case. No change to risk score or mitigation. | Quality & Safety Committee | 16 | C4 x L4 | 4 | ↔ | 01/06/2020 | 04.05.2022 | 20.06.2022 |
| 4157 | Executive Director of Nursing and Midwifery | Improving Care | Patient / Staff /Public Safety | There is a risk to the delivery of high quality patient care due to the difficulty in recruiting and retaining sufficient numbers of registered nurses and midwives | IF: the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage Then: the Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff. Resulting in: Disruption to the continuity and stability of care and team communication Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover. | • Proactive engagement with HEIW continues. • Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues. • Targeted approach to areas of specific concern reported via finance, workforce and performance committee • Close work with university partners to maximise routes into nursing • Block booking of bank and agency staff to pre-empt and address shortfalls • dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act. • Deputy Exec DON is currently reviewing the nurse rostering policy in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's • Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board • Regular review by Birth Rate Plus compliant, overseen by maternity Improvement Board • Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends. successful overseas RN recruitment. - There is an operational Nursing Act Group that reconvened from April 2021. Impact assessment signed off from a Mental Health Nursing perspective in relation to an extension to the Nurse Staffing Act 2016. | Established recruitment campaign - which is monitored at the Nursing Workforce Strategic Group - group due to meet/recommence in April 2021. The Nursing and Midwifery Strategic Workforce Group did not meet in April 2021 as planned due to the need to revise membership in line with ILG structure, however, bi-monthly nursing workforce operational task force meetings have been held chaired by the Deputy Director of Nursing since February 2021. The Strategic workforce group is scheduled to meet on the 11th May 2021. This action has been overtaken by the Nursing Productivity Programme. Revised nurse rostering policy currently being taken through the relevant approval process - Timescale 31.3.2021. Consultation with Local Partnership Forum undertaken and amendments to the policy have been made as appropriate, the policy will be seeking approval at the Quality & Safety Committee in May 2021- Timescale 31.5.2021 Complete and currently with W&OD to finalise through to Approval. Await review of Birth Rate Plus Compliant Tool by WG - Timescale - WG led so await WG timescales - No further update at this time. Remains the same as at February 2022. Impact assessment relating to Health Visiting provision with regards to compliance of the draft principles of the Nurse Staffing Act 2016 to be completed by the end of March 2022. Ward Assurance Pilot Tool tested within PCH and to be rolled out across the other two Acute Hospitals by the end of April 2022. Update May 2022 - this risk is currently under review with a view to merging it with risk 4106 as mitigating action is considered to be closely aligned. Please refer to updates added in 4106. The alignment of these risks will be completed by the end of June 2022, by the Deputy Executive Director of Nursing. | Quality & Safety Committee People & Culture Committee | 16 | C4 x L4 | 12 (C4xL3) | ↔ | 01/01/2016 | 06.02.2022 | 30.06.2022 |
| 4203 | Chief Operating Officer Rhonda Taf Ely Integrated Locality Group Merthyr Cynon Locality Group | Improving Care | Patient / Staff /Public Safety | Unable to provide Surgical Services | IF: Surgical services cannot meet demand and patients are not treated in targeted timeframes (RTT) Then: Patients will not receive surgery and subsequent treatments Resulting In: Harm to patients, poor prognosis, reduced treatment options, poor quality of life, risk of claims, increased demand on wider health and social care services including emergency care, staff burnout. | Restart plans including Waiting List Initiative to increase capacity. Limited ring-fenced funding for recovery plans. Outsourcing Some pathway innovations Ongoing validation of waiting lists. M&C ILG Risk 3958 closed as merged with this risk. | Restarting elective surgery and further outsourcing to private sector. Discuss reconfiguration of acute site to enable more surgical capacity. Update from M&C ILG April 2022 - this current risk as described is in the process of being closed as the issues faced in RTE and M&C ILG are now very different a new risk will be opened for M&C ILG surgical services. Links will be made with RTE Locality as currently reflected as a joint risk. | Quality & Safety Committee | 20 | C4 x L5 | 16 (C4xL4) | ↔ | 1.7.2020 | 20.04.2022 | 30.06.2022 |
| 4217 | Executive Director of Nursing & Midwifery Infection Control | Improving Care | Patient / Staff /Public Safety | No IPC resource for primary care | IF: there is no dedicated IPC resource for primary care. Then: the IPC team is unable to provide an integrated whole system approach for infection prevention and control. Resulting In: non compliance with the reduction expectations set by WG. A significant proportion of gram negative bacteraemia, S.aureus bacteraemia and C.Difficile infections are classified as community acquired infections. | Liaise with specialist services in primary care e.g., bowel and bladder service IPC team investigate all preventable community acquired S.aureus and gram negative bacteraemia and share any learning with the IPC huddles arranged in primary care to look at community acquired. Update August 2021: the IPC team is working collaboratively with the bowel and bladder service to investigate all preventable urinary catheter associated bacteraemia. Any learning points/ actions is being shared with community teams. Work in progress to start/reintroduce RCAs/IPC huddles for community acquired C.Difficile cases | A business case for additional resources for an IPC team for primary care to be developed. Due Date: 31.08.2021 07/10/2021 - Lead IPC Nurse is a member of an All Wales task and finish group looking at the IPC workforce across Wales. Report to IPCC once national work complete - Due to complete in December 2021. SBAR to be presented to IPCC. 15/12/2021 - Risk peer reviewed and score increased from 16 (4x4) to 20 (4x5) February Update: Outcome of the IPCC National Work awaited. Deputy Director of Nursing undertaking a review of the IPC provision within the Health Board to provide capacity to the primary care function - deadline 31.3.2022 Update April 2022: HEIW will present the recommendations in a showcase event on the 03/05/22. This will be followed by local workshops. Timeframe: for this action 20.05.2022. | Quality & Safety Committee | 20 | C4 x L5 | 8 (C4xL2) | ↔ | 16/07/2020 | 29.04.2022 | 20.05.2022 |

| Datix ID | Strategic Risk owner | Strategic Goal | Risk Domain | Risk Title | Risk Description | Controls in place | Action Plan | Assuring Committees | Rating (current) | Heat Map Link (Consequence X Likelihood) | Rating (Target) | Trend | Opened | Last Reviewed | Next Review Date |
|----------|---|-----------------------|---|--|---|--|---|---|------------------|--|-----------------|--|------------|---------------|------------------|
| 4253 | Chief Operating Officer Bridgend Integrated Locality Group | Improving Care | Patient / Staff /Public Safety | Ligature Points - Inpatient Services | IF: the Health Board fails to minimise ligature points as far as possible across identified sites. Then: the risk of patients using their surroundings as ligature points is increased. Resulting In: Potential harm to patients which could result in severe disability or death. | Bridgend Locality: The anti-ligature works has not yet been completed and signed off. There are snagging issues on ward 14 and remedial decoration. On PICU the bathrooms have not been started. All works have been chased by Senior Nurse to project lead for updates on completion. Actions identified for escalation if no update received regarding completion dates. The risk score remains unchanged at present. o Increased Staff observations in areas where risks have been identified. o Any areas of the unit not being occupied by patients are to be kept locked to minimise risks o The use of safe and supportive observations o Risk assessment process for patients and environment is in situ o Some anti-ligature work has been completed in some bedrooms which are used for patients assessed as being at higher risk. | Bridgend Locality: o action plan developed with support from the head of nursing within the ILG. o Heath Board has approved additional staffing by night and to fund the outstanding capital anti ligature works. guidance issued to all staff on the implementation of local procedural guidelines. o Use of therapeutic activities to keep patients occupied Capital works remain ongoing and remain on programme to complete by July 2022. PICU and Ward 14 in POWH have an agreed programme to complete works now supplies have finally been received. Capital Projects manager has been in regular and ongoing contact with ward staff to keep them updated on the supplier delays which have been out of the health board control. Works in all other units remain on plan to complete by summer 2022 | Quality & Safety Committee Health, Safety & Fire Committee | 20 | C5xL4 | 10 C5xL2 | ↔ | 17/08/2020 | 13.5.2022 | 30.06.2022 |
| 4282 | Chief Operating Officer Facilities | Sustaining Our Future | Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption | Risks associated with the transfer to the new Planet FM System | IF: the Health Board transfers over to the new Planet FM system Then: the TAB system will no longer be supported for Support Services, Laundry Services etc Resulting In: Business Continuity / Service Delivery not being available leading to service and financial loss. Potential for system to crash with no support available to rectify. No reporting system being available. | The Health Board is still using the TAB system until suitable alternative is found. Additional control measure in place of reverting to spreadsheets being used with manual entry, with additional staff put in post. Option to transfer services over to Planet FM through a phased approach has been looked at but unfortunately this is no longer feasible. Depending on if feasible there may be costs associated with licences, training etc. with new system. This has been included within the 'Support Services Forward Work Plan' to identify a solution in place of TAB system. Following review of this risk, the Technical Services Team have agreed that the risk now needs to be increased following confirmation that Tabs will no longer be supported on an IT server from July 2021, so there will be no system in place. Five demonstrations of alternative systems have been undertaken, however they have not been suitable for the Facilities Services. Other systems continue to be looked at by the Technical Services Team. Based on this update the likelihood of the risk remains at 4, giving a high rating (from 12 to 16). The risk will be reviewed in 3 months or following any mitigating actions being undertaken. | Action: Alternative system for Technical Services and the Laundry Service to be sourced. Timescale: 31/03/2022. Alternative systems continue to be reviewed. Tabs upgrade still appears to be the best option so far and could further expand to support other disciplines in the future; examples are accommodation and Shuttle bus bookings. This version also supports full audit tools and history transfer (if required). This is a web based version with live IT support from TABS and does not need CTM ICT infrastructure. However Server maintenance and support is necessary. Based on this update the high rating of 4 x 4 = 16 remains. The risk will be reviewed in 3 months or following any mitigating actions and / or implementation of above options being undertaken. Update 27.4.2022 - Risk reviewed and no change to mitigation at this time. Next review Date: 31/05/2022 | Digital & Data Committee | 16 | C4xL4 | 4 C4xL1 | ↔ | 19/02/2020 | 27.4.2022 | 31.05.2022 |
| 4315 | Executive Director for People Health, Safety & Fire | Improving Care | Patient / Staff /Public Safety | Non Compliance of Fire Training - Provision | Insufficient staff (Fire Officers) available to provide mandatory face to face fire training. IF Limited number of places available due to the restrictions posed by social distancing so the amount of staff that can be trained at one time has been significantly reduced. THEN Risk of injury or loss of life from smoke inhalation, burns. Prosecution from the Fire Authority for not meeting the requirements of current legislation(RRFSO). RESULTING IN Legal action by an individual against the UHB should an incident occur and staff not suitably trained. | Fire Officers are trying to provide training when they and suitable rooms are available. The training is based on a risk based approach and follows the approved Training Needs Analysis. However due to the restrictions posed by social distancing the amount that can be trained at one time has been significantly reduced. Learning & Development is currently working with the Health Board Fire Officers to reinstate the fire element of Corporate Orientation, so progress is being made to address those who have had no CTMUHB fire training at all. Fire Officers in conjunction with the Nurse Education Lead continue to provide face to face training for these staff. | Recruit additional 2 Fire Officers to support the existing provision and assist in providing training across all sites/ILG. Timeframe 31.5.2022. New Fire Officer appointed 1.9.2021 on 12 month fixed term contract. Business case will be presented to extend funding to substantial appointment. Due to long term sickness and 1 x FO retiring in March 2022, this risk remains. 19/04/2022 - Due to financial constraints on the Health, Safety and Fire budget these 2 posts are on hold and will not be released until financial stability is achieved. Linked to risk 4356. Overdue/Out of date fire risk assessments due to resource issues and the amount required to be undertaken | Health Safety & Fire Sub Committee | 16 | C4 x L4 | 8 C4xL2 | New Risk Escalated to the Organisational Risk Register in May 2022 | 05.10.2020 | 19.04.2022 | 31.05.2022 |
| 4337 | Executive Lead: Director for Digital. Bridgend Integrated Locality Group | Creating Health | Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption | Integrated IT Systems | IF: The Health board is unable to deliver vital clinical information services to the Bridgend locality affecting many clinical systems that are not compatible with Cwm Taf University Morgannwg Systems. Then: The Health board will be unable to deliver safe, high quality care to patients without vital clinical information available. Resulting In: Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan. | Key Controls 1. SBUHB Service Level Agreement 2. Bridgend disaggregation and the one-CTM aggregation plan 3. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. 4. Band 7 Senior Server manager being appointed specifically to work with SBU on the transference of infrastructure and services within Princess of Wales (POW) to CTMUHB. Gaps in Control The business case for integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. SBUHB have no process in place to incorporate the needs of Bridgend users in their developments. | Progress in line with the existing plans which were agreed on the primary basis of their need to be affordable, has been made over 2020/21 with a number of new systems, such as pharmacy management introduced as pan-CTM products. However there is still considerable work required to create a unified digital infrastructure for CTM = around the clinical systems and the remainder of the ICT SLA. The business case details a funding requirement of £8 million. This was discussed at the Digital cell with WG in February 2021 and a further funding request has been submitted to WG at their request, along with complimentary proposals from Digital Healthcare Wales (DHCW) for which CTM has worked with them on. Timeframe - Mid June 2021 when DPF Funding is announced. Update October 2021 - In the absence of WG support to provide the necessary infrastructure to safely and effectively enable the boundary change the UHB took the decision, informed by a business case appraisal, to make best endeavours, using the opportunities provided to lead to integration. In addition nearly all efficiencies made by the digital and informatics team are being put to resourcing the aggregation programme. Phase 1 of which, which includes the integration of non PAS interfaced clinical systems, the helpdesk and Wi-Fi and mobilisation is nearing completion. Phase 2 is presently being planned, with the business case still awaiting agreement from the Welsh Minister for Health. Meetings have been ongoing with a Band 7 Senior Server manager being appointed specifically to work with Swansea Bay UHB on the transference of infrastructure and services within Princess of Wales (POW) to CTMUHB. No change to mitigation or risk rating. Review date extended to 25.3.2022. | Digital & Data Committee | 16 | C4 x L4 | 8 (C4xL2) | ↔ | 14.10.2020 | 31.12.2021 | 25.03.2022 |

| Datix ID | Strategic Risk owner | Strategic Goal | Risk Domain | Risk Title | Risk Description | Controls in place | Action Plan | Assuring Committees | Rating (current) | Heat Map Link (Consequence X Likelihood) | Rating (Target) | Trend | Opened | Last Reviewed | Next Review Date |
|----------|--|----------------|--------------------------------|---|---|--|--|--|------------------|--|-----------------|-------|------------|---------------|------------------|
| 4339 | Director of Corporate Governance Information Governance Function | Improving Care | Legal / Regulatory | Failure to complete a timely and robust Data Protection Impact Assessment (DPIA) | If: the organisation fails to complete a timely DPIA for processing activities associated with new projects and systems. Then: there is a risk that the organisation will not be able to deliver on tightly aligned programme plans, leading to other critical dependencies no longer being available Resulting in: major digital implementations being delayed by significant periods of time, resources being lost and benefit opportunities being missed. | A full DPIA may not be required in all circumstances, however, the Information Governance Team will always undertake the initial DPIA checklist which then determines the level of assessment required. Where the risk of sharing is high, the Health Board has an obligation to approach the ICO for their consideration. Current position: 600% increase in Data Protection Impact Assessment in the last 12-18 months. Information Governance Team providing specialist expert advice and support to teams across the organisation. Information Governance training as part of the Statutory and Mandatory training compliance captures the DPIA requirements. Information Governance Policy for the Health Board. Data Privacy Impact Assessment Procedure for the Health Board - updated to clearly indicate timescales for responding and the key stages in the DPIA process. This will allow risks and mitigations to be identified at the earliest opportunity. Information Governance included within a "Good Governance" slot on the Welcome Day Induction Programme. Monthly IG Awareness Sessions reinstated from March 2022. | Continue to raise awareness through training and induction. Monthly IG Awareness Sessions have been reinstated and are being held monthly (virtually at present). Identify IG Champions through TNA to increase capacity within Health Board and reduce reliance on central team. Timeframe May 2022. Review risk in June 2022. Funding sources being explored by the Executive Lead and Assistant Director of Governance & Risk to strengthen the resource in the team to support the increase in DPIA requests being received. - See risk 4699. | Digital & Data Committee | 16 | C4 x L4 | 8 C4xL2 | ↔ | 19.10.2020 | 13.05.2022 | 30.06.2022 |
| 4356 | Executive Director for People Health, Safety & Fire Function | Improving Care | Legal / Regulatory | Overdue/Out of date fire risk assessments due to resource issues and the amount required to be undertaken | If: Fire Risk Assessments are not completed and reviewed in a timely manner. Then: Significant findings on the FRA may have changed which could compromise the safety of patients, staff, visitors/contractors and building fabric. Resulting in: Increased risk of fire/harm, enforcement action by Enforcing Authority i.e. Notification of Deficiencies (IN01) which will further escalate to Enforcement Notices (EN01) if no remedial action is taken. | There are FRA's in place however a substantial number have not been reviewed by the review date. Fire safety advisors are reviewing FRA's in areas where it is safe to do so (Covid restrictions are in place in many areas). A concentrated effort will be necessary to reduce the number of overdue FRA's. Despite the appointment of an additional fire officer in 2021, this risk is likely to increase in the first part of 2022 due to the retirement and loss of 2 other fire officers (Specifically in Merthyr Cynon ILG area) To try and mitigate this risk, fire officer property allocations have been reassigned and only high risk FRA (patient sleeping areas) will be the main focus of the Team until the 2 fire officer vacancies are appointed. | It is recommended that additional fire safety resources are provided to support the work of the fire officers to undertake FRA reviews. As referred to in Risk ID:4315, 2 x Band 5 additional fire safety trainers to be appointed. Agreement on additional fire safety training resource (Risk ID 4315) will create additional time for the Fire Officers to undertake this activity - Due by date 31.03.2021. Update June 2021: Recruitment has focussed on an appointment of a Fire Officer who will be able to undertake the Fire Risk Assessment reviews as well as undertake training as required. No specific Fire Safety Trainers are considered to be required at this time. Fire Officer post currently being advertised. Review - July 2021. Update July 2021 - Recruitment to Fire Officer post underway and pending a successful shortlisting exercise interviews are planned for circa mid July. Appointment of 2 vacant Fire Officer Posts - deadline 31.03.2022 | Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee | 16 | C4 x L4 | 8 (C4xL2) | ↔ | 26.10.2020 | 03.05.2022 | 30.06.2022 |
| 4458 | Chief Operating Officer All Integrated Locality Groups | Improving Care | Patient / Staff /Public Safety | Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches.) Impact on the safety - Physical and/or Psychological harm | If: the Health Board fails to deliver against the Emergency Department Metrics Then: The Health Boards ability to provide safe high quality care will be reduced. Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. Resulting In: A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls. Compromised safety of patients, potential avoidable harm due to waiting time delays. Potential of harm to patients in delays waiting for treatment. | Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protections Schemes Implemented within ILG's. Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board. | The Unscheduled Care Improvement Board will monitor progress on the programme on a monthly basis. Given the decrease in compliance for 12 and 4 hour waits, it is impossible to outline progress at this point. It is anticipated that the work of the Urgent Care Improvement Group will be able to report some improvement in the coming months. BILG update: RCGM audit undertaken. Staffing remains ongoing issues- plans in place and frequently reviewed. ASCU staffing plan agreed at ILG level and ongoing. Surge trolleys in place to cope with additional capacity requirements. Building works progressing and phases complete. X references to ID3826 & ID3585. Update March 2022, significant work continues to be underway in this area. A Local system reset (perfect fortnight) commenced on the 2nd March 2022 with the aim of being a system wide learning event to establish an improved grip across the patient pathway and a set of improvement projects that can be deployed. Further update to be provided at the completion of the event. Within M&C ILG the PCH Improvement Programme continues to deliver improvement with the feedback from the second unannounced Health Inspectorate Wales Visit in January 2022 providing clear evidence of significant improvement in patient safety and experience. Overwhelming demand activity continues to provide challenging operational context, this is being addressed through joint working with Improvement Cymru and an external provider to deploy a real time flow management process with the specific objective of improving the pace of the patient along the pathway. | Quality & Safety Committee Planning, Performance & Finance Committee | 16 | C4 x L4 | 12 (C4 x L3) | ↔ | 04/12/2020 | 02.03.2022 | 30.04.2022 |
| 4479 | Executive Director of Nursing & Midwifery Infection Control / Decontamination | Improving Care | Patient / Staff /Public Safety | No Centralised decontamination facility in Princess of Wales Hospital (POWH) Impact on the safety - Physical and/or Psychological harm | If: there is no centralised decontamination facility in POWH Then: there are a number of areas undertaking their own decontamination via automated/manual systems. Resulting In: possible mismanagement of the decontamination processes/near misses/increased risk of infection/litigation risks and non compliance with national guidance/best practice documents. The hospital site is at risk of losing their JAG accreditation in Endoscopy if plans to centralise decontamination is not progressed. There is no dirty - clean flow for procedure room 2 in endoscopy. There is some decontamination equipment in HSDU that needs replacement. The decontamination equipment in Urology is at the end of its life and there are regular service disruptions due to failed weekly water testing results. | Monthly audits undertaken in all decontamination facilities in POWH by the lead endoscopy decontamination officer and results shared at local decontamination meetings. APD/support available on site. Monthly ILG decontamination meetings take place where all concerns are escalated to the HB Decontamination Committee meeting. SOPs in place Water testing carried out as per WHFM guidance Maintenance programme in place for decontamination equipment 07/10/2021 - In view of aging Urology washer disinfectors, urology service managers to liaise with APDs to initiate/ agree a service contract for maintenance and servicing of equipment with an external. 15.12.2021 - risk peer reviewed and agreed that the risk remains as a 20. Development of a business case to create a single centralised decontamination facility on the POWH site has commenced with Welsh Government Funding support. Business case expected to be completed by Spring 2022. Availability of WG funding to create the unit remains a risk. Update February 2022 - Final design to be signed off by all parties. To await WG monies for centralised decontamination facility. Deadline: 1.6.2022. Risk peer reviewed and agreed that the risk should be reduced to a 16 (4x4). Availability of WG funding to create the facility remains a risk. Target rating reduced to a risk of 1x1 as the centralised decontamination facility will have a direct impact on the consequence. Update April 2022: 29/04/22 - JAG audit undertaken on the 27/04/22. Unit scored a red/amber rating which is a reduction from the previous year. It's unclear whether JAG will award accreditation based on the audit findings. Due to uncertainty around WG monies, a contingency plan needs to be developed for ageing equipment/decontamination infrastructure in POW. Review date for this action: 1.6.2022. | Centralised Decontamination Facility at POWH - 02/08/21 - SOC approved by WG and design team appointed. Project team group and working group to be set up - Timeframe 30.09.2021. Each area that decontaminates scopes/intra cavity probes(outside CSSD)has developed SOPs detailing the decontamination process. Evidence of SOPs to be shared at decontamination meeting in POWH. Lead IPCN to ask Operational Lead for Decontamination to action. 02/08/21 - Operational lead for Decontamination has requested assurance from the lead endoscopy decontamination officer in POW. Timeframe 30.11.2021. | Quality & Safety Committee | 16 ↓ 20 | C4xL4 | 2 C1xL1 | ↔ | 30.12.2020 | 29.04.2022 | 01.06.2022 |
| 4491 | Chief Operating Officer | Improving Care | Patient / Staff /Public Safety | Failure to meet the demand for patient care at all points of the patient journey Impact on the safety - Physical and/or Psychological harm | If: The Health Board is unable to meet the demand upon its services at all stages of the patient journey. Then: the Health Board's ability to provide high quality care will be reduced. Resulting in: Potential avoidable harm to patients | Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub speciality codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology - it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating. | The Health Board has established a Planned Care Board, with a full programme of work to address FUIB, demand and capacity and a recovery programme which will include cancer patients; The plans have timescales - which are being monitored, however it is likely that it will take time to reduce waiting times to acceptable levels in the post-covid-19 environment. The PCH Improvement Programme has significantly accelerated a number of mitigating actions designed to improve flow, reduce risk and improve the quality of care in the unscheduled care pathway. Updates on this are provided through the Quality & Safety Committee including specific actions and measures. There is also a PCH Improvement Board that meets monthly with the COO as the SRO. The Health Board is centralising the operational management and decision making around all elective services with the clear aim of increasing and protecting elective activity as we deal with the pressures of the Covid-19 pandemic and winter. This process commenced in late October 2021 and greater clarity will be provided in the next review. Update March 2022 - All of the existing controls and actions continue. An additional £26.1 million recovery fund has been allocated by Welsh Government to support the recovery programme within the Health Board. Work is currently underway as part of the IMTP 2022-2023 to develop the overarching Health Board Recovery Plan and this will focus on the following areas: Carry forward of existing capacity increase schemes in 2021-2022, Orthopaedics, Cancer, Regional Cataract Services, Implementation of the recommendations from the national endoscopy programme, Strengthened diagnostic and imaging services, Implementation of the Critical Care Plan and Stroke Pathway. The IMTP process will drive the development and prioritisation of these plans ahead of implementation in 2022-2023. Additionally as part of the IMTP Process we will be able to complete robust capacity and demand planning for all surgical specialities for the first time, this will allow us to fully understand our likely trajectory for recovery during 2022-2023 and beyond. | Quality & Safety Committee | 20 | C4xL5 | 12 C4 x L3 | ↔ | 11.01.2021 | 02.03.2022 | 31.05.2022 |

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|----------|---|-----------------------|--------------------------------|--|---|---|--|---|------------------|--|-----------------|-------|------------|---------------|------------------|
| 4512 | Chief Operating Officer Rhondda Taf Ely Integrated Locality Group | Improving Care | Patient / Staff /Public Safety | Care of patients with mental health needs on the acute wards. | If: there is a consistent number of patients with mental health needs who are being cared for on the acute wards without RMN support or there are delays in discharge an appropriate EMI setting; Then: patients who have been sectioned and / or are under medication review may remain on wards where specialist mental health therapy and input is not possible; Resulting in: incidents of staff and patients assaults may occur; poor patient experience; increased supervision needed. | MHL team contacted for each patient who required support; 1:1 patient supervision where required; Ward manager and senior nurse undertake regular patient reviews; Regular meetings with the mental health CSG in place. | Regular meetings with the mental health CSG in place, number of working groups established and working well. No change to mitigation or risk score. | Quality & Safety Committee | 15 | C3 x L5 | 9 (C3xL3) | ↔ | 30/12/2020 | 09.03.2022 | 10.05.2022 |
| 4590 | Chief Operating Officer Executive Medical Director Pharmacy & Medicines Management | Improving Care | Patient / Staff /Public Safety | Critical Care Pharmacist Resource | If: additional resource is not identified to increase the critical care clinical pharmacy service Then: there is a risk that insufficient support can be provided to meet national standards and there would be lack of capacity to support future surges in demand, such as Covid. Resulting In: an increasing risk to patient safety, increased workload for critical care nursing and medical staff and lack of appropriate support for digital developments such as e-prescribing | SBAR included in Medicines management and advised to include in ACT directorate IMTPs. Meetings to discuss potential funding arranged with ACT leads. Baseline level of service (0.2wte) pharmacist time per site. A small pool of CC trained pharmacists are providing clinical services to acute wards which would be impacted if they are redeployed to support ITU, resulting in risk to patient safety and flow on acute wards. | June 21: Current situation included in planning review of CTMUHB ICU services. Aim is to secure funding for 1WTE 8a specialist pharmacist for each critical care in RGH, POW and PCH and also supporting technician resources Update November 2021 as reported to the Quality & Safety Committee: Discussions are ongoing with ILGs so that pharmacy resource costs are included in any new business cases e.g. PACU and progress can be made to meeting the standards. Update February 2022: Discussion are ongoing with ILG's and submission for funding was made in Medicines Management in IMTP Feb 2022. | Quality & Safety Committee | 15 | C3 x L5 | 9 (C3xL3) | ↔ | 05.04.2021 | 23.02.2022 | 30.04.2022 |
| 4629 | Executive Director of Finance & Procurement | Sustaining Our Future | Financial Stability Risk | Failure to achieve or reduce the planned recurrent deficit of £33.9m at the end of 2021/22. | If: The Health Board is not able to plan changes which enable current run rates of expenditure to align with the expected available funding for 2022/23. Then: The Health Board will not be able to develop a break-even financial plan for 2022/23 and deliver it . The context is that a key issue beyond 21/22 is the recurrent impact of the plan in 22/23 when it is likely that the non recurring funding for Covid in 21/22 will end or significantly reduce as well as non recurring Transformation funding ending. Resulting in: Potential deficit in 2022/23 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. | 2021/22 IMTP and financial plan submitted to WG at the end of June , including the Covid response, TIP, planned care and diagnostics, including prioritisation of planned changes within the available resources. Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Routine monitoring arrangements in place. Regular reporting of the forecast recurring position to Management Board and Planning, Performance & Finance Committee and Board. | Bottom up savings plans at the end of June are showing a gap of £8.2m against the £15.1m Recurring savings target for 21/22. Further develop the savings planning process identified by the COO and DoF for implementation in July onwards. Further discussions needed with Welsh Government to understand likely funding position for 22/23. Update August 2021 - No change this month. Further information is anticipated on the WG funding position for 21/22 in September 2021. Update as at November 2021: the forecast recurrent deficit was increased to £50.9m in the month 7 finance report. Although Further work will continue on recurring savings within the Health Board further discussion and actions are needed as part of the financial planning process for 2022-2023. Reviewed 6.01.2021 - No changes made to mitigating action or risk rating. Reviewed 4 March 22- Forecast recurrent deficit at the end of 21/22 is £44.5m. The forecast core plan deficit for 22/23 is currently £28.0m (excluding Exceptional items and ongoing Covid response costs). An Accountable Officer Letter was sent to WG on 28 Feb confirming that we are not able to submit a balanced core plan for 22/23. Awaiting a response. No change to risk rating. | Planning, Performance & Finance Committee | 20 | C4 x L5 | 12 (C4 x L3) | ↔ | 10.5.2021 | 04.03.2022 | 30.04.2022 |
| 4632 | Chief Operating Officer All Integrated Locality Groups | Improving Care | Patient / Staff /Public Safety | Demand and capacity across the stroke pathway | If there is continued high demand for stroke beds (currently located in Prince Charles Hospital (PCH) and Princess of Wales Hospital (POW)) THEN: patients may have a prolonged wait in getting to an appropriate stroke bed in PCH or POW RESULTING in: impact for patients in relation to a delay in appropriate treatment or therapy. Impact on the patient flow in the Royal Glamorgan Hospital. Limited therapy space due to the physical space within the ward at PCH and POW, limits the ability to appropriately carry out therapeutic treatment. | Stroke patients in RGH are managed by the medicine teams and referral to MDT as required but not specific to stroke rehabilitation. WAST alerted to the HB stroke pathway in CTMUHB regarding admissions to PCH or POW only. Stroke admission pathways have been reconfirmed with WAST to ensure patients are admitted to PCH to access specific stroke care. | Review of the CTM Stroke Pathway. Centrally led task and finish group, leadership from Executive Lead for Stroke. Update July 2021 – a short term draft paper has been developed and will be discussed at the Stroke Planning Group Meeting on Friday 09 July 2021, with the aim of making decisions about the way ahead. Work is underway on the long term plan – this will also be discussed at the meeting on 09 July. Deep dive in YCR with regards to stroke rehabilitation and length of stay – await findings Update August 2021 - Long term planning continues after very positive meeting in July 2021. Short term action plan will be developed by mid August 2021 for decision on actions to be taken by COO. Update September 2021 - for the short term plan, there is now a plan in advanced draft form which outlines actions with assigned officer leads. This will be discussed at the meeting on the 17th September 2021 and any additional progress will be reported in October 2021. Update October 2021 – at a meeting of the Board, Stroke Services were an agenda item and senior clinical staff were available to present and discuss – it was reported that colleagues were pleased to have had the opportunity to hear more and gain a wider understanding. At the Stroke Planning Meeting of 05 October the Short Term Plan was discussed again and it was agreed that the issues identified would be included in the IMTP. There will be a further meeting on 04 November 2021 and another update will be available then. Update November 2021 - Deputy Director of Therapies and Health Sciences has been identified as the designated lead for stroke and will be taking forward to the short term plan under the accountability of the COO and Executive Director of Therapies and Health Sciences. Update March 2022, the Deputy Director of Therapies and Health Sciences has worked closely with all stakeholders to develop the first draft of the Stroke Medium Term Improvement Plan Business Case this is currently for review with all Operational Teams and will be brought forward as part of the IMTP 2022-2023 process for sign off. We anticipate given the focus of the recovery fund specifically including stroke that this business case has a route for being supported. Confirmation will be received as part of the IMTP process in April 2022. | Quality & Safety Committee | 20 | C4 x L5 | 12 (C4 x L3) | ↔ | 05.07.2021 | 02.03.2022 | 31.05.2022 |
| 4652 | Chief Operating Officer Executive Director of Therapies & Health Sciences Merthyr & Cynon Locality - Host of Therapies Services within the Health Board | Improving Care | Patient / Staff /Public Safety | Therapies provision to increased numbers of stroke patients in Prince Charles Hospital (PCH), Princess of Wales (POW), Ysbyty Cwm Rhondda (YCR) and community/out patients | If: Current increase in numbers of stroke patients across these sites continues, then the ability of OT SLT Physio and Dietetics to respond and provide a quality service to these patients will reduce and not be sustainable without additional resource. Then: this will impact on quality of care, patient flow, safe discharges and staff wellbeing. Resulting In: Reduced quality of patient care, poorer patient outcomes, issues with patient flow and negative impact on staff well-being. | Additional hours offered to staff, but limited pool to draw from; seeking locum cover at financial risk, but lack of availability due to national workforce shortages. | Scoping of short and medium term solutions via Stroke Planning Group, currently meeting monthly to review whole HB stroke pathway . Review end of September 2021. Please also see risk 4632 in relation to the stroke pathway. Update: progress made in equipping new therapy space at POW and PCH; therapy workforce staffing model provided for potential service developments identified via Health Board stroke delivery group - increase to 14 rehabilitation beds at YCR and Health Board-wide provision of early supported discharge. Participation in weekly Multi Disciplinary Meetings for stroke patients at RGH for outliers from acute units. | Quality & Safety Committee | 20 16 | C4 x L5 | 12 (C4xL3) | ↔ | 21.05.2021 | 24.3.2022 | 13.5.2022 |

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|----------|---|-----------------|--|--|--|--|--|--|------------------|--|-----------------|-------|------------|---------------|------------------|
| 4664 | Executive Lead: Director for Digital. Chief Information Officer | Creating Health | Legal / Regulatory | Ransomware Attack resulting in loss of critical services and possible extortion | IF: The Health Board suffers a major ransomware attack. Then: there could be potential data loss and subsequent loss of critical services. Resulting in: Catastrophic service loss to all clinical and business services impacting on population health management, patient care, business continuity, organisational relationships & substantial financial risk - culminating in a culture of mistrust of the Health Board and all things digital | Key Controls: 1. Email filters from both Microsoft and the National email relay which scan for malicious and suspicious email types and their attachments. 2. National Checkpoint firewalls that monitor for and block suspicious network traffic, including those from known malicious geographical areas. 3. National SIEM that monitors and logs suspicious external incoming traffic. As well as monitoring local network traffic for each NHS Wales organisations. 4. Local Firewalls at each of the Health Board's geographical areas that only allows inbound trusted network traffic. 5. Anti-malware software installed on all Health Board computing devices which includes ransomware behavioural intelligence. 6. Blocking and monitoring of Internet traffic. 7. Locally systems that monitor the local network for suspicious traffic. 8. A monthly patching regime to ensure that all operating systems are up to date. 9. Regular backups of critical information and device configuration which is stored off site as part of DR/BC planning. 10. Cyber Incident response plan developed and being iteratively developed Gaps in Controls: 1. Current National SIEM has presented many issues in terms of access to the Health Board for identifying issues and addressing false positives. 2. The Health Board is currently not addressing the need for the national Cyber Security | CTMUHB is amalgamating the issues arising from the Cyber Essentials plus, the NIS-D assessment and the NCS board framework in a single plan. Elements of this need to be taken forward at the UHB level, others nationally. - Timeframe: Quarterly updates The ICT Department are investigating ways to improve the security of backups to ensure that these are protected from potential ransomware attacks. Timeframe - 21.02.2022 The ICT Department are investigating ways to segregate the current configuration of the network infrastructure to ensure that critical systems are better protected from cross infection. Timeframe - 21.02.2022 The ICT Department will re-appraise a case to re-introduce Cisco FirePower which is an IDS/IPS networking software. Timeframe -1.4.2022 The ICT Department will be reviewing and further testing the developing Cyber Incident Response Plan - Timeframe - 1.02.2022 Medical Engineering and the ICT team to develop a programme for assessing risks presented by medical devices and possible mitigations. Timeframe - 21.04.2022 | Digital & Data Committee | 20 | C5 x L4 | 15 (C5xL3) | ↔ | 26/05/2021 | 31.12.2021 | 21.01.2022 |
| 4671 | Executive Lead: Director for Digital. Chief Information Officer | Creating Health | Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects | NHS Computer Network Infrastructure unable to meet demand | IF: The Health Board suffers regular local and/or national network issues and/or outages to clinical and critical business systems. Then: there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated. Resulting in: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: Loss of information integrity and accessibility as multiple copies of clinical records. Threat of malware being introduced on to the network from unmanaged data, systems and software. Possible breaches to the GDPR, safeguarding and information governance risks. Mistrust by staff of the ICT systems and services they are using | There are various Service Management boards from ADIs, service delivery and infrastructure management which have representatives from each NHS Wales organisation and departments. These meet regularly with a governance structure to escalate any service delivery and security incidents and risks. SLAs are in place between DHCW and NHS Wales organisations and incidents are escalated up via the national Service Point Service Management system. The Health Board has the Risk Audit Governance & Cyber Security Board which meets monthly to discuss and take action on service delivery incidents. Local and National Infrastructure reviews are presently underway. CTMUHB has a large digital infrastructure refresh and expansion programme which is well funded with local and national support and is close to completing the infrastructure review. Operational weekly meetings take place to manage and learn from all new and ongoing major incidents. National infrastructure review is close to completing and making recommendations. Gaps in controls: Approach to cloud is variable across Wales, this presents numerous risks ranging from Information Governance and privacy to workforce (minimal skills available) and finance (revenue based and a lot more expensive) | The organisation is recruiting a Director of Digital Services who will be a member of the Infrastructure and comms staffing plans were agreed 24 months ago and are being delivered as funding and staffing are available (recognising priorities changed during Covid). The Health Board to develop a robust incident management process. This is to ensure that regular outages of national systems and infrastructure are escalated to the appropriate governance structures to address such issues locally and nationally. Update October 2021 - Progress has been made with the firewall replacement completed at PCH increasing bandwidth to 3GB and 10 GB by May 2022, RGH is planned for mid-October 2021. Enhanced WIFI has been made available on all sites. Server back ups have been optimised to reduce the overloading and DHCW are half way through their infrastructure and application initiatives which will also improve service availability and responsiveness. Weekly meetings are now taking place to discuss and update all new and ongoing major incidents. As at March 2022 - no change to risk score or mitigation. | Digital & Data Committee | 15 | C3 x L5 | 9 (C3xL3) | ↔ | 26/05/2021 | 05.03.2022 | 30.04.2022 |
| 4672 | Executive Lead: Director for Digital. Chief Information Officer | Creating Health | Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects | Access to a complete and coded medical record. | IF: The Health Board is not able to record information accurately and reliably & does not address the 25000 backlog of uncoded FCEs Then: the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete Resulting in: Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc. | Operational controls: Coding key performance indicators covering productivity, demand and backlog robustly monitored Digitised Patient Notes programme board monitors scanning times, adherence of contractor to terms and quality of staff in maintaining a record DHCW annual coding quality audit. Coding Improvement and transformation plan established incorporating additional trained coding capacity, coding at source, use of data captured in other systems and e-forms implemented. Natural language programming resource deployed and outputs of programme being validated. Tactical - EPR programme with deployment of snomed-CT ontology server, WCP & E-forms etc. Tactical controls: Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme Gaps in controls Scanning time of outpatient activity to digitise the record is at 8 days of maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor Insufficient resource available to address coding backlog Digital solutions not yet using snomed-CT/ structurally coded data Information and Technical Standards Clinical audit | o Work is ongoing to improve the quality of clinical data held within Clinical Systems. o Data quality improvements efforts are ongoing in collaboration with colleagues from the relevant clinical areas and the Software Development team (MITS data fields are being updated/amended and TOMs OPCS codes are being refreshed to the latest version). - OPCS: Classification of Interventions and Procedures Code - there is no fixed completion date as this is dependent on the pace of improvement. The plan is to review progress quarterly. o MediCode 360 Go Live scheduled for completion by the end of February 2022 (this provides automated template coding capabilities, medical history assurance, live data quality checks and data quality analytics). o Work is underway to develop mechanisms to batch feed data from MITS, TOMs, McKesson Cardiology, Medilogik Endoscopy Management System (EMS) and MediSoft Ophthalmology into MediCode 360 ARC (automated template coding module) back end. Proposal for an interim target operating model will be completed by the end of February 2022. Funding approved to procure contract clinical coders to support the delivery of national clinical coding targets. Risk Rating remains unchanged at this current time and this decision is based on the wider risk profile not just the mitigation that is being put into place to address the coding of our consultant engagement. | Digital & Data Committee | 15 | C3 x L5 | 9 (C3xL3) | ↔ | 05.06.2021 | 05.03.2022 | 30.04.2022 |
| 4679 | Executive Director for People (Executive Lead for Occupational Health) | Improving Care | Patient / Staff /Public Safety | Absence of a TB vaccination programme for staff | IF: the Health Board is not providing TB vaccination to staff Then: Staff and patients are at risk of contracting TB Resulting in: Failure to comply with the Department of Health and Social Care guidance and lack of confidence in the service | The 'fitness letter' issued by Occupational Health to the appointing line manager following an employee health clearance highlights vaccination status. Screening for latent TB for new entrants and offering T spot testing to assess positive or negative. | Action plan collated-To clarify current screening process in relation to local and National guidance via specialist respiratory nurses prior to administering BCG. OH Senior screening nurse to compile written instructions and staff information leaflet. Training requested via the respiratory team. Meeting to discuss training needs set for 9th June 2021 Update January 2022 - Training of OHN to deliver BCG vaccinations remains outstanding due to difficulty resourcing training within CTMUHB. Alternative training has now been resourced via CAV UHB Respiratory Team and dates for training to be agreed. Continuing to risk assess TB status as part of Pre-employment clearance process. Update March 2022 - Ongoing difficulties accessing BCG training in CTM and CAV UHB. OH currently exploring alternative training options in order to introduce BCG vaccinations. TB assessment as part of pre employment Health Questionnaire screening process ongoing. | Quality & Safety Committee People & Culture Committee | 16 | C4xL4 | 8 C4xL2 | ↔ | 09.06.2021 | 07.03.2022 | 29.04.2022 |
| 4688 | Chief Operating Officer Merthyr & Cynon Integrated Locality Group | Improving Care | Patient / Staff /Public Safety | Emergency Department (ED), inability to appropriately triage patients in the Minors area of ED, compounded by two current access points that are not co-located with neither incorporating triage. | IF: The minors department is over capacity Then: there is no ability to appropriately triage and treat patients in a timely manner, neither is there visibility to observe patient acuity from a triage room as this is not co-located within the waiting area. Resulting in: Poor patient experience and unknown risk along with high levels of stress for staff. | Production of a flow chart for the management of patients to minors. Escalation cards. Re-direct the workforce to support the triage function. Additional doctor rostered to support the service | Emergency Department Improvement Programme established which includes the key enablers to improve the environment, template and patient flow through the Emergency Department. The programme is anticipated to take 12 months to complete. Emergency Department Improvement Plan being established to address risks in the short term as far as is reasonably practicable. Risk reviewed in December 2021 - no change to score and risk assessment at this time. | Quality & Safety Committee | 20 | C4xL5 | 12 C4 x L3 | ↔ | 11.06.2021 | 08.12.2021 | 07.03.2022 |

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| 4699 | Director of Corporate Governance Information Governance Function | Creating Health | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation | Failure to deliver a robust and sustainable Information Governance Function | If: the Health Board fails to adequately resource the Information Governance Function following an increase in activity and demand since the boundary change and new operating model. Then: the health and wellbeing of staff along with the ability to comply with legislation and service delivery will be impacted. Resulting In: an impact on the workforce (poor morale, health and wellbeing, retention), Impact on Service Delivery e.g. delays in approving Data Sharing Agreements, Data Protection Impact Assessments, Subject Access Requests and FOI requests. Compliance with Legislation such as the Data Protection Act, FOI Act and GDPR Regulations could also be impacted. | Context: The IG Team (1 WTE and 2 PTE) have experienced the following increase in activity: 1. 300% increase in FOI requests and a 500% increase in complexity (number of questions asked per FOI request); 2. 600% increase in Data Protection Impact Assessments to be undertaken; and 3. 225% increase in the number of Information Sharing Agreements being handled . Work programme prioritised to focus on the "must do's": - Urgent Data Sharing Agreements - Responding to FOIs from the Public - Responding to Subject Access Requests - Responding to IG activity that relates to the safety of the public, responding to queries from external agencies such as Police investigations etc. - Significant incident investigations and concerns. - ICO activity and audit | Benchmarking with other organisations in Wales undertaken. Business case for additional IG resource completed. Funding sources being explored by the Executive Lead and Assistant Director of Governance & Risk - Timeframe: 31.03.2022. The control measures and risk prioritisation exercise undertaken by the IG Team is captured and detailed in this risk assessment and linked to Risk ID 5004. Alternative ways of working have been explored with no sustainable solution identified. The fundamental risk treatment option to manage this risk, given the significant increase in activity in this area is an increase in resource. In this regard, an increase in resource was included in the IMTP for 2022/2023,. Update May 2022 - IMTP funding request was denied. Other sources of funding and/or opportunities for seeking addition support will continue to be explored, however, as funding is not currently available then the Health Board is asked to consider its risk treatment in terms of Tolerating/Accepting the risks facing the organisation. | Digital & Data Committee | 20 | C4xL5 | 8 C4xL2 | ↔ | 18.06.2021 | 06.05.2022 | 30.06.2022 |
| 4706 | Chief Operating Officer Rhondda Taf Ely Integrated Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Failure of appropriate security measures in mental health services. | If: there is a failure in security measures. Then: there is an increased likelihood of patients leaving the ward without the knowledge of staff Resulting In: absconding events and possible harm to the patient or members of the public | The following control measures are in place: - Signs are placed on doors to ensure staff check the doors lock behind them. - Patients are on appropriate levels of observations - Problems are escalated to estates as they arise | There has been a proposal that Estates undertake environmental checks accompanied by leads within the respective Mental Health Clinical Service Groups to work together to review onsite security systems in mental health services. Timeframe 30.11.2021. Update April 2022: Action plan developed with Estates. Consideration to be given to installation of alarm system to alert when doors are not locked. Due date 31/05/2022 | Quality & Safety Committee | 16 | C4 x L4 | 4 (C4xL1) | ↔ | 22.06.2021 | 14.04.2022 | 30.06.2022 |
| 4721 | Chief Operating Officer Rhondda Taf Ely Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Shift of the boundary for attendances at the ED. | If: the current boundary change to redirect emergency cases from the lower Cynon Valley to the Royal Glamorgan Hospital is not reviewed: THEN: patients will continue to be admitted to a hospital further from their home RESULTING IN: increased pressure on the medical teams to manage an increased patient cohort, lack on continuity of care with follow up arrangements closer to home | Boundary change currently subject to review to understand the impact across CTM. | Boundary change currently subject to review to understand the impact across CTM. Update April 2022 - Meeting to be convened between M&C and RTE clinicians to agree way forward. For discussion at Execs 25th April. Review 30.06.2022. | Quality & Safety Committee | 20 | C4xL5 | 12 (C4xL3) | ↔ | 28/06/2021 | 20.04.2022 | 30.06.2022 |
| 4732 | Chief Operating Officer Merthyr Cynon Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Lack of orthogeriatrician as NICE guidance and KP11 NHFD | If: If we do not have this specialist service THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality. RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too. | The already stretched on call medical team are contacted for ad hoc advice. There is no COTE service and no specialist advice available | Recommendation: Employ a frailty team at each site to care for this complex group of patients. This may have cost benefits such as reduced length of stay, reduced complications and reduced complaints. Timeframe: 31.01.2022 | Quality & Safety Committee | 15 | C3 x L5 | 4 (C2 x L2) | ↔ | 30.06.2021 | 08.12.2021 | 03.10.2022 |
| 4743 | Chief Operating Officer Bridgend Integrated Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Failure of appropriate security measures / Safety Fencing | If: there is a failure in security measures. Then: there is an increased likelihood of patients having unrestricted and inappropriate access on the site. Resulting In: absconding events and possible harm to the patient or members of the public | The risk of absconding, and self harm/ suicidal ideation for Mental Health and CAMHS patients is risk assessed on admission and reviewed regularly thereafter. Works programme to review and renew physical barriers such as door locks and restricted window access to limit unauthorised ingress and egress from Mental Health and CAMHS units are in situ. High risk patients are escorted when outside the units Absconding patient policy in place Some fencing is in place in the areas concerned, however, it is aged and fails to provide an adequate barrier. | Funding Bid for approx. £385K has been submitted by Estates Update April 2022: The Car Park Security Fencing in the Bridgend Locality is now largely complete with minor 'snagging issues' to close off. Door systems in Ty Llidiard CAMHS have been upgraded to include an alarm system on the Mag-lock doors. If the Mag-lock does not engage within a set time frame, then an alarm will sound. Multi storey Car Park at Princess of Wales Hospital has had anti-climb security fencing fitted. This was a WG Capital scheme and is awaiting final project sign-off to complete the works. The only outstanding area is the stairwell which will require more detailed technical design work to identify a solution. That work has commenced and once complete the works can be tendered. This will require further funding in 22/23 | Quality & Safety Committee | 20 | C5 x L4 | 15 (C5xL3) | ↔ | 05.07.2021 | 13.05.2022 | 30.06.2022 |
| 4753 | Chief Operating Officer Executive Medical Director Pharmacy & Medicines Management | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Maternity : Lack of pharmacy clinical service, medicines governance and medicines safety | If: the Health Board fails to resource pharmacist time for maternity services in all acute sites Then: the Health Board will be unable to support maternity services with development of medicines procedures, audit of and training on medicines procedures and processes, scrutiny and intervention on medicines prescribing, support patients with their medicines and breast feeding concerns. Resulting in: medicines related incidents and harm continuing with little or no learning actions put in place, limited governance for medicines use, minimal training for new staff, no pro-active medicines safety initiatives. This risk has been highlighted by the delivery unit and they have indicated it should be prioritized. | Very limited support for maternity from pharmacy provided on an ad hoc basis when urgent issues arise or incidents. Medicines Management Training. Local Audit. | Business case for Pharmacy resource to be considered by Obstetrics and Gynaecology directorate and considered as part of the maternity improvement plan and to be prioritised for funding. Review date: 10.09.2021 Funding identified for a maternity and neonate lead pharmacist, recruitment underway with interview planned for early November. The risk score remains until recruitment finalised and appointment made. Update February 2022 - Service being delivered as Pharmacist appointed as funding initially agreed, funding from within ILG and Neonatal budget. Funding planned to be transferred into Medicines management staff budget and therefore risk remains until this final step has been completed. | Quality & Safety Committee | 16 | C4xL4 | 8 C4xL2 | ↔ | 09.07.2021 | 11.02.2022 | 30.04.2022 |

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| 4772 | Chief Operating Officer Facilities | Improving Care | Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service/business interruption | Replacement of press software on the 13 & 10 stage CBW presses | If: The 10 & 13 stage Lavatec presses have old software control systems, and are both vulnerable to failure. Following a fault developing and a recent maintenance call out it was identified that the 10 stage press is working intermittently caused by a software problem. Then: If the 10 Stage press control system fails the consequence of not purchasing the software replacement would result in the laundry service being unable to produce to full capacity and reduced to around 55%. If the Stage 10 press control system software fails then it could also impact on the Stage 13 press. The consequence of both presses failing and not purchasing the software replacement would result in the laundry service being unable to process any laundry which will result in all CTM/UBH laundry being outsourced to commercial laundries. The costs will be significantly higher than those incurred in-house. Resulting In: •Potential of service failure due to existing system. •Potential of CTM sites being without bedding and linen at existing volumes and turnaround times. •Potential increased costs resulting from having to outsource laundry processing to commercial laundries in the event of equipment failure. | The All - Wales Laundry review continues, and at the current time, it is likely that services will be provided from CTM laundry until at least 2024. After this time, the equipment could be moved and rehoused elsewhere to continue to support CTM and the All-Wales Laundry agenda. Previous IMP submissions have included as a priority £375K for a replacement automated sorting and roll cage washer/dryer system at the laundry. The software that controls system for the CBW forms an integral part of the current press. Benefits of equipment being replaced: •Reduced risk of service failure and therefore improved confidence in continued production. •Easier to diagnose and put right any mechanical defects. The consequence of not purchasing the replacement software would result in the laundry service being unable to process laundry at full capacity. This would mean that there is a real risk of CTM sites being without the ability to process adequate quantities of common user items such as sheets and pillowcases and other items used for income generation projects. If the 10 Stage press control system fails the consequence of not purchasing the software replacement would result in the laundry service being unable to produce to full capacity and reduced to around 55%. This would mean that there is a real risk of CTM sites being without the ability to process adequate quantities of common user items such as sheets and pillowcases and other items used for income generation projects. | SON to be submitted and if successful replacement software purchased and installed. Timescale: 31/03/2022. SON approved and funding provided, awaiting installation. Update from Deputy Linen Services Manager that order has been raised to replace. The press tank for the 13 stage has now been replaced with software to the 10 & 13 presses on course for being updated by end of March 22 Based on this update the risk is a high risk and will be reviewed in 3 months time or once the software has been installed. Update 27.4.2022 - Risk reviewed and no change to mitigation at this time. Next review Date: 31/05/2022 | Quality & Safety Committee Planning, Performance & Finance Committee | 15 | 15 (C5xL3) | 5 (C5xL1) | ↔ | 27.07.2021 | 27.4.2022 | 31.05.2022 |
| 4780 | Executive Director for People Health, Safety & Fire | Improving Care | Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation | Patient Handling Training | Insufficient staff (Fire Officers) available to provide mandatory face to face fire training. If Limited number of places available due to the restrictions posed by social distancing so the amount of staff that can be trained at one time has been significantly reduced. THEN Risk of injury or loss of life from smoke inhalation, burns. Prosecution from the Fire Authority for not meeting the requirements of current legislation(RRFSO). RESULTING IN Legal action by an individual against the UHB should an incident occur and staff not suitably trained. | Two Band 3 Training Assistants continue to deliver Inanimate Load Handling Training so staff groups such as Admin & Clerical are not at risk. The current Training Post for Bridgend is vacant, new Trainer commencing employment 31st August 2021. Trainer in post at Tonteg is on LTS (Long Covid). Manual Handling Advisor picking up training where possible which is impacting on their ability to function within their role. | Mitigating action is to increase the establishment within the Manual Handling Team by at least one extra Trainer, one extra Assistant and another Risk and Safety Officer. As at 03/05/2022 - Currently the Health Board does not have additional monies to support these posts. To review later in the year to see if improvements in the financial forecast have improved. Review position: 31.8.2022. | Health Safety & Fire Sub Committee | 16 | C4 x L4 | 4 C2xL2 | New Risk Escalated to the Organisational Risk Register in May 2022 | 06.08.2021 | 03.05.2022 | 31.08.2022 |
| 4798 | Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation | Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital. | If the therapy services (physiotherapy, speech and language therapy, dietetics, occupational therapy) continue to not be at the recommended staffing levels according to national level requirements (GPCs), Then: the critical service will be unable to meet the need of patients requiring therapy. Resulting in: significant negative impact on patient outcomes, ability to recover from critical illness and length of stay in critical care unit and consequently in hospital longer than needed. | Currently staff stretch to cover and prioritise patient need as much as possible. During winter pressures have tried in the past to recruit locums but availability still remains an issue for some services and not sustainable. Sighted within HB Critical Care Board as significant gap and within peer review response. Update 16-9-21 Continuing with therapy business case as actions below. No other updates | Completed comprehensive business case detailing recommendations for staffing, gaps, impact and consequences of gaps Next steps require consideration for prioritising of funding for gaps in therapy posts in critical care within ILGs to decrease risk RTE critical care short-term planning business case, identified RGH therapies workforce requirement, however these would need to be recruited to recurrently, as unable to recruit to fixed term tenure. Update: The Therapy workforce model has been completed for three bespoke staffing options for a Tier 1 unit with 4-8 PACU beds as part of the reconfiguration work. | Quality & Safety Committee | 16 | C4xL4 | 8 C4xL2 | ↔ | 20.08.2021 | 29.04.2022 | 28.07.2022 |
| 4809 | Executive Director for People Health, Safety & Fire | Improving Care | Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation | Non Compliance with Mandatory Violence and Aggression Training | training review was undertaken to identify HB violence and aggression training requirements. Following review the HB is unable to achieve full compliance on any training module. This is due to a lack of training resource within the Health Safety and Fire Team. If the training is not delivered, then the organisation will not be compliant with mandatory Violence and Aggression Training. Restraint training is mandatory for inpatient acute services for Mental Health and CAMHS. Training is delivered by inpatient staff and the Health Safety and Fire Personal Safety Advisor. If there is insufficient training resource available then the organisation will be unable to maintain compliance on annual refreshers. If the PSA is unable to deliver key aspects of their role due to the high demand for violence and aggression training delivery then advice to clinical areas is greatly reduced. Resulting in non compliance of mandatory training and a risk of injuries to both staff and patients and possible claims. | Personal Safety Advisor delivers training modules with some support from part time trainers within Mental Health and CAMHS. However there is insufficient resource to ensure compliance within the entire organisation. Trained tutors available from clinical areas. The PSA regularly has to support training due to ward based trainers unable to be released to deliver. This role is not currently included in their job description which has resulted in some trainers resigning from delivering, hence compounding the lack of training resource. The availability of the PSA to offer personal advice to clinical areas is greatly reduced due to the excessive training requirement. | Module D PMVA Training Provision / Programme Delivery - Meeting to be arranged with Senior Managers within Mental Health to review the management, coordination and delivery of PMVA training. in late March when revised PMVA report completed. Meeting has taken place and Mental Health colleagues are reviewing how best this training provision can be supported by them. Further meeting scheduled for late April 2022. Senior Managers have devised an audit to all specialist clinical areas identifying their violence and aggression mandatory requirements. The PSA has been provided with some audit but this work is incomplete. A further meeting is yet to be arranged. Timeframe 31.5.2022. Additional Training Resource Required: Funding for addition trainers have been produced in the way of a business case. Timeframe 31.5.2022. | Health Safety & Fire Sub Committee | 16 | C4 x L4 | 9 C3xL3 | New Risk Escalated to the Organisational Risk Register in May 2022 | 31.08.2021 | 04.05.2022 | 30.06.2022 |
| 4827 | Executive Director for People Health, Safety & Fire | Improving Care | Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation | Lack of Lead for Face Fit Training along with Face Fit Trainers | If the organisation fails to appoint and provide a fully qualified face fit testing lead and suitable number of Face Fit Testers. Then there is a potential for staff to be exposed to airborne viruses eg Covid, flu, etc; Resulting in lack of assurance that the risk is being adequately managed at a local and Board level further resulting in a high risk of prosecution by the Health and Safety Executive. | Departmental Trainers have been trained but not in the numbers required by the organisation. Many of those trained during the first phase has now returned to substantive posts and are unable to undertake this role. Also may now be out of compliance for annual review of practice. Single H&S Coordinator is taking up this role on a part-time basis but this is inadequate for the requirements due to the commitments of his substantive post and the demands/size of the organisation. Departmental trainers are in post across the organisation but not all are able to fulfil this role either due to returning to busy substantive roles or being out of compliance of their annual review. Despite posts being added to Trac, it has become apparent that there is no funding available in the UHB to support this work. Discussions are underway between the Director for People and the Deputy Director of Nursing. No clear plan available to address this risk currently. | SBAR completed outlining the requirements regarding Fit Testing. As at 3.5.2022 it has been confirmed that there is no funding available and it has been added to the Health Board's priority list. Further update is awaited from the Strategic Leadership Team. | Health Safety & Fire Sub Committee | 16 | C4 x L4 | 9 C3xL3 | New Risk Escalated to the Organisational Risk Register in May 2022 | 01.02.2021 | 03.05.2022 | 30.06.2022 |

| Datix ID | Strategic Risk owner | Strategic Goal | Risk Domain | Risk Title | Risk Description | Controls in place | Action Plan | Assuring Committees | Rating (current) | Heat Map Link (Consequence X Likelihood) | Rating (Target) | Trend | Opened | Last Reviewed | Next Review Date |
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| 4833 | Chief Operating Officer Executive Director of Therapies & Health Sciences Merthyr & Cynon Locality - Host of Therapies Services within the Health Board | Improving Care | Patient / Staff /Public Safety | There is a risk to the delivery of high quality physiotherapy and rehabilitation to in-patients on all sites across the Health Board. | IF: The level of physiotherapy staffing remains significantly below normal operating levels. THEN: The health boards ability to provide essential physiotherapy interventions will be compromised. RESULTING IN: Poorer clinical outcomes, missed opportunities to discharge patients and support patient flow and have a negative impact on moral and staff wellbeing | 1. All posts advertised as soon as possible (some recruitment challenges at band 6) 2. Robust use of clinical prioritisation tools to support clinical decision-making 3. Exploring availability of agency staff 4. Regular links by head and assistant head with clinical leads and staff on the ground to re-evaluate regularly and support difficult decision-making. | Communicated the staffing challenges to the Head of community nursing and the YCC senior nurse. They are aware of the pressures on the staff and will support them in their clinical prioritisation. Locum secured for 1 month tenure (national shortage, limits pool available), but risk has not reduced due to increased demand to provide physio cover at YYS and to ABUHB planned care recovery outsourced orthopaedics. Update: Staffing remains pressured on all three acute sites and in community hospitals, clinical prioritisation and flexing of staff continues, whilst supporting staff well-being and highlighting service pressures via daily RAG rating | Quality & Safety Committee | 15 | C3 x L5 | 9 (C3xL3) | -- | 20.09.2021 | 2.3.2022 | 24.6.2022 |
| 4888 | Executive Director for People | Creating Health | Statutory duty / Inspections | Insufficient resource in the Welsh Language Team | IF: the resources of the Welsh Language Team remains as it is, the Health Board will not be able to fully meet its legislative duties set out in Compliance notice (no7) issued by the Welsh Commissioner in November 2018. Then: the team will not be able to effectively monitor compliance, there will be a reduction in staff and community engagement and cultural activities and the demand for translation will continue to exceed capacity. Resulting in: Significant use of expensive external translation agencies, non-compliance in many areas of the health board (including hosted bodies) and a high risk of investigations, financial penalties and reputational damage. | *Translation team prioritise patient related work. *Careful management of compliance monitoring and translation for Primary Care (work with Dental completed) *Ongoing programme of translation of the Health Board website and Social Media. (Member of team attends Communication team meetings) *Use of external translation agencies for large pieces of work e.g. Annual Reports. | Low level of resources in the Welsh Language Team impacts the Health Board's ability to meet the Welsh Language Standards. Develop a business case setting out the additional resources required within the Welsh Language Team to enable the Health Board to implement the actions set out in the Welsh Language Commissioners compliance notice. The business case needs to be reviewed/approved by the People and Culture Committee and appropriate Executive Forum. The business case needs to be incorporated into the IMTP for 2022/2023. A business will be submitted to the People and Culture Committee following a discussion with the Assistant Director. (NOV 21). Timeframe for completion: 31.03.2022. Risk Reviewed March 2022 - and the above mitigation remains. | People & Culture Committee | 15 | C3 x L5 | 12 (C3xL4) | -- | 28.10.2021 | 04.03.2022 | 31.03.2022 |
| 4906 | Director of Corporate Governance Putting Things Right / Legal Cases | Improving Care | Patient / Staff /Public Safety | Failure to provide evidence of learning from events (Incidents and Complaints) | IF: The Health Board is unable to produce evidence of learning from events. Then: the Health Board will be unable to recoup any costs from Welsh Risk Pool for personal injury or clinical negligence claims made against the Health Board. Resulting in: Risk to quality and patient safety with potential for further claims as learning and improvement will not have taken place. Financial impact to the Health Board | Controls are in place and include: * Monitored and reported through the weekly Executive Quality & Safety meeting. * Regular engagement and meetings with the Executive team to assist in gathering of learning. Improvement plan implemented by WRP with monthly targets to submit the backlog. * Learning From Event Report (LFER) Standard Operating Procedure devised and disseminated * LFER 'How to Guide' devised and disseminated * Ad-hoc training available on request. * Internal targeted monitoring in place. | The Health Board are developing a Learning Framework to ensure Learning is captured and shared across the organisation. Currently at consultation stage. The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023 Welsh Risk Pool have implemented a targeted improvement plan. Initial target was marginally missed, however, work continues to meet the overall deadline for 1st June. | Quality & Safety Committee | 16 | C4 x L4 | 8 (C4xL2) | ↔ | 02.11.2021 | 13.05.2022 | 30.06.2022 |
| 4907 | Director of Corporate Governance Putting Things Right / Legal Cases | Improving Care | Patient / Staff /Public Safety | Failure to manage Redress cases efficiently and effectively | IF: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, Duty of Candour, FUNB Ophthalmology Redress/Claim cases Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim. | Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager * Covid-19 monies secured for one Band 5 Redress Handler to take forward the Covid-19 related cases. A Redress panels have been established where required and meetings with ILGs undertaken when required to ensure legal aspects have been reviewed and validated. | The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023. The Health Board are reviewing the Covid funding in respect of the recruitment Covid19 specific Redress Handlers. Completed. Update April 2022 - Covid-19 monies secured for 1 Band 5 Redress Handler. There still remains a considerable Redress backlog. Business case in the process of development to plan how to address the backlog. | Quality & Safety Committee | 16 | C4 x L4 | 8 (C4xL2) | ↔ | 02.11.2021 | 13.05.2022 | 30.06.2022 |
| 4908 | Director of Corporate Governance Putting Things Right / Legal Cases | Improving Care | Patient / Staff /Public Safety | Failure to manage Legal cases efficiently and effectively | IF: The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties | Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager Some funding secured in respect of one Band 5 Redress Handler, however there still remains a Redress backlog and there has been an influx of inquests. A Redress panels have been established where required and meetings with ILGs undertaken when required to ensure legal aspects have been reviewed and validated. | The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023. Update April 2022 - Some funding secured in respect of one Band 5 Redress Handler, however there still remains a Redress backlog and there has been an influx of inquests. A benchmarking exercise is underway of Legal Services teams across NHS Wales. Timeframe end of May 2022. | Quality & Safety Committee | 16 | C4 x L4 | 8 (C4xL2) | ↔ | 02.11.2021 | 13.05.2022 | 30.06.2022 |

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| 4920 | Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm | Capacity within the ED/ Medical/ Rehabilitation and Orthopaedic Inpatient Occupational Therapy Service within Princess of Wales | IF: clinical capacity remains significantly reduced due to staff sickness and vacancies Then: clinical service delivery will be negatively compromised. Resulting in: increased length of stay, potential clinical incidents, poor clinical outcomes for patients, and increase in complaints. It will impact on staff wellbeing within the team and increase incidence of staff sickness. | Regular team meetings to support prioritisation and wellbeing. Updating AHP lead in Bridgend ILG on potential impact. | Recruitment of locum. Additional hours offered, resulting in part-time staff working additional hours. Redeployment of staff according to clinical priority, utilising a therapies version of daily "safe to start" with AHP Clinical Director, where staffing is monitored daily | Quality & Safety Committee | 15 | C3 x L5 | 12 (C3xL4) | ↔ | 27.11.2021 | 2.2.2022 | 31.5.2022 |
| 4922 | Director of Corporate Governance Information Governance Function | Improving Care | Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm | Covid-19 Inquiry Preparedness - Information Management | IF: The Health Board doesn't prepare appropriately for the Covid-19 inquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues. | The Covid-19 Inquiry Working Group are monitoring a number or preparedness risks such as: - Retention and Storage of information, emails and communication - Capturing reflections of key decision makers prior to any departure from the Health Board - Organisational Member. A key area of development is the Timeline for the Pandemic Inquiry and the information archive. Timeframe: June 2022. | Covid - 19 Information Manager will develop a detailed action plan to support the Health Boards preparedness for a Covid-19 Inquiry. Timeframe 31st March 2022. Regular updates to be provided to the Board /Q&S Committee on preparedness for the Inquiry. Update being received at the March Quality & Safety Committee. | Quality & Safety Committee | 16 | C4xL4 | 8 (C4xL2) | ↔ | 23.11.2021 | 20.04.2022 | 30.06.2022 |
| 4923 | Chief Operating Officer Merthyr Cynon Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm | Increase in infection on ITU | IF: The ILG do not progress with Capital Works in order that Critical Care can return to a unit that is fit for purpose. THEN : The current ITU originally designed to temporary House ITU through Covid is not conducive to deliver safe, effective and dignified care Issue are many - bed spacing too close unable to distance patient due to the demand for ITU beds - no room for the equipment required to nurse an ITU patient - lack of storage on the area current storage held on a different floor and in metal containers outside - use of agency staff is over 50% on some shifts having worked in multiple areas before coming to work on our ITU - short staffed nursing 2-1 on a ventilator which is working against current GPIC guidelines, nurse are looking after multiple patient cross contamination is a higher risk for those patients nursed 2:1 - DTOC patients ready for discharged held in ITU this increases risk e.g. they request use of commodes by bedside, they move around the unit near other patients RESULTING IN: Increased risk of infection transmission, poor care delivery-not dignified. Not meeting WG guidance re bed spacing for Critical Care and Covid. Has a negative impact on staff morale, recruitment and retention. | Increased cleaning on the unit environmental audits hand hygiene audits 3x week bare below elbow audits 3 x week enhanced rate of pay to encourage own staff to work to reduce the agency usage. Await move back to previous ITU area Risk reviewed 8/12/21 | See Control Measures. | Quality & Safety Committee | 15 | C3 x L5 | 9 (C3xL3) | ↔ | 24.11.2021 | 8.12.2021 | 31.05.2022 |
| 4940 | Executive Director of Nursing Patient, Care and Safety. | Improving Care | Quality, Complaints & Audit | Delay to full automated Implementation of Civica | IF: the Information team are not able to complete the necessary data extraction requirements, Then: there will be a delay to the roll out of the automated survey process within the Civica system, Resulting in: a lack of service user feedback and opportunity to areas of improvement as well a good practice. | The Health Board launched the electronic "Have your Say" and Generic Patient Experience Survey on the 13.02.22. Posters containing QR codes are displayed on notice boards in our hospital sites, KHHP and Dewi Sant. In addition links are available on our internal and external webpages, along promotion on available social media channels. A small card (like a business card) containing a QR code has been developed which will be displayed in main thoroughfares such as Emergency Departments, Outpatients and community settings. Their will be made available to staff that are providing services in patients' homes. Exploration is taking place as to how the posters/cards can be promoted within the wider non-health board community settings. Update May 2022: pdate May 2022 - No change to current level of risk. The Merthyr & Cynon PALS Team continue to attend the Emergency Care Centre to engage with patients on the completion of Have You Say and the Emergency Care Specific Survey. In addition the team are also visiting Inpatient Paediatrics areas to support completion of Have You Say, along with a Parent / Carer survey. There is currently no PALS team with the Rhondda & Taf Locality and a significantly reduced capacity within Bridgend. Engagement with the Have You and Generic Patient Experience Survey has plateaued, with evidence of participation beginning to decrease. To address a number of activities are planned including further promotion on the Health Board's Social Media channels, use of volunteers to support patients/ service users with the completion of surveys and drop in sessions on the 3 main DGH sites to increase awareness in relation to gathering feedback and promotion of the benefits of Civica. Participation the both the Maternity Surveys and Frailty Survey has continued to increase. Challenges relating to the full automation of Civica remain an issue, with no target date in pace for resolving. Without dedicated information resource, it is likely that further survey will stall, as there is not the capacity within Clinical Teams to support manual input of survey responses. | Information Team support is required to fully implement the Civica Service User Feedback System. Implementation of the Civica System. Information Team to identify resources required to undertake actions required to support the implementation of the Civica system. Undertaking any recruitment processes and escalating where demand can not be met. Deadline 31.3.2022 Whilst the overall consequence and likelihood of the risk is not extremely high, the SMS component remains high as currently there is no target date for full implementation of the automated element of Civica which would increase real time response rates. Reactive feedback continues to be received and reported on via complaints, claims and compliments. | Quality & Safety Committee | 16 | C4 x L4 | 12 (C4xL3) | ↔ | 09.12.2021 | 03.05.2022 | 31.05.2022 |
| 4971 | Chief Operating Officer Primary Care | Improving Care | Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm | Adult Special Care Dentistry | IF the Community Dental Service is unable to recruit a special care dentist, then there will be no dedicated specialist to undertake the appropriate assessment and dental treatment under GA for vulnerable adults in a timely manner, resulting in more patients waiting, longer waiting times, patients being in pain and some having to access secondary care dental services as an urgent or emergency care. | Patients can be seen within the CDS for advice and treatment under local anaesthesia where this can be tolerated by the patient. A Consultant advert has been placed 3 times alongside a Specialist level post to widen the opportunity for recruitment. No applications received. If either post is recruited in to the risk will be mitigated. Although it will take some time to clear the current waiting list. Patients will be contacted regularly as part of safety netting to check that their condition is not deteriorating and no one is left in pain. | All the patients on the list are being reviewed and contacted regularly to assess if their dental condition has deteriorated or if they are in pain. Consideration is being given as to whether treatment can be undertaken in a local routine dental practice as opposed to the community dental service (CDS). This is very much on an individual basis. Discussions are taking place with Medical Staffing, HEIW and Cardiff Dental School with regard to the possibility of recruiting from abroad. Especially in view this is a national recruitment problem and other Health Boards are in a similar position. | Quality & Safety Committee | 15 | C3xL5 | 3 C1xL3 | New Risk escalated to the Org Risk Register May 2022 | 04.01.2022 | 13.05.2022 | 30.06.2022 |

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| 4975 | Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Safe and appropriate repatriation of patients following vascular surgery and participation in the regional MDT | IF: The funding to support the business case for a Clinical Vascular coordinator cannot be identified prior to the launch of the regional vascular network (March 2022) THEN: The Health Board will not be able to meet its obligation to the network. Patients transferred from the Major Arterial Centre in UHW may not be identified (as not able to participate in the MDT) and placed in a suitable in-patient setting. Patients who are discharged home may not be known to services. RESULTING IN: The inability to coordinate care and the inability to provide suitable equipment, rehabilitation, secondary prevention and family support. Leading to potential clinical incidents, poor clinical outcomes, increased length of stay, increase in complaints and concerns and reputational damage for the Health Board. | There are well developed informal pathways have been in place since vascular surgery moved from RGH to UHW in 2020. Teams in UHW are aware of the transfer process to the community hospitals. | Financial approval being sought to secure funding for an Allied Health Professional Leadership Post. Timeframe: 28.6.2022. Alternative ways of working have been explored with no sustainable solution identified. The fundamental risk treatment option to manage this risk, given the significant increase in activity in this area is an increase in resource. In this regard, an increase in resource has been included in the IMTP for 2022/2023. If funding is not available then the Health Board will need to consider its risk treatment in terms of Tolerating/Accepting the risks facing the organisation. | Quality & Safety Committee | 15 | C3xL5 | 6 (C3xL2) | New Risk escalated to the Organisational Risk Register in May 2022 | 14.1.2022 | 2.3.2022 | 6.6.2022 |
| 5017 | Chief Operating Officer Merthyr Cynon Locality Group | Improving Care | Statutory duty / Inspections | Implementation of the Additional Learning Needs (ALN) Act | IF: Relevant Staff have lack of education on the new ALN Act Then: Failure to Comply will occur Resulting in: Failure to Comply with ALN Act and the associated consequences. | Champion identified within community child health to be involved in implementation group and disseminate information to wider team. However, there is no additional resource available to support with the time required to undertake this role | 1. Education of broader paediatric team, 2. dedicated time identified in job plan for ALN champion, 3. Appropriate admin & IT support. I have added to the Datix. Is this adequate? | Quality & Safety Committee | 16 | C4 x L4 | 4 (C2 x L2) | ↔ | 06.02.2022 | 06.02.2022 | 06.05.2022 |
| 5036 | Chief Operating Officer Rhonda Taf Ely Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation | Pathology services unable to meet current workload demands. | IF: Pathology services cannot meet current service demands THEN: - there will be service failure - there will be continued delays in reporting of Cellular Pathology results - failure to provide OOH services required for acute care - inadequate support and accommodation for Clinical Haematology cancer patients - increased turnaround times for provision of results including timely autopsies - increased pressure on existing staff - inadequate training provision throughout - inability to repatriate services from Bridgend. RESULTING IN: 1. Failure to meet cancer targets and national cancer standards 2. Anxiety for patients waiting for delayed results 3. Unsuspected cancer cases being missed in the backlog potentially leading to patient harm. 4. Delays in the reporting of critical results and issue of blood products OOH leading to patient harm 5. failure to meet the standards required for provision of autopsy reports for the ME service 6. Clinical incidents due to errors and poor training. 7. Poor compliance with legislation and UKAS standards (that are mandated by the HB and Welsh Government). 8. Reputational damage and adverse publicity for the HB. 9. Continued inequity of services provided to CTM patient population. 10. Suboptimal care for Haematology cancer patients | 1. Triaging of patient samples (into urgent & routine) as they arrive into Cellular Pathology. 2. Outsourcing of routine Cellular Pathology backlog to an external laboratory (LDPATH) 3. Expansion of Cellular Pathology into POCT training room. 4. Capital bids being progressed for ageing equipment. 5. All Wales LINC programme for implementation of Pathology LIMS and downstream systems. 6. Use of locums throughout all departments. 7. Advertisement and recruitment for vacant posts 8. Use of overtime to cover OOH services. 9. Business case to increase capacity of CNS support for Clinical Haematology patients | Blood Bank Capacity Plan 31/05/2022 Demand & capacity review 30/06/2022 Workforce redesign 30/06/2022 Dedicated Pathology IT resource 30/06/2022 Accommodation review 30/06/2022 Novation of Equipment to the Managed Service Contract 30/09/2022 | Quality & Safety Committee | 20 | C4 x L5 | 6 (C3xL2) | New Risk Escalated May 2022 | 02.03.2022 | 03.05.2022 | 06.05.2022 |
| 5040 | Executive Lead: Director of Digital Chief Information Officer (SIRO) | Creating Health | Operational: • Core Business • Business Objectives • Projects Including systems and processes, Service/business interruption | Digital Healthcare Wales (DHCW interdependencies) | IF: The Health Board can not integrate new applications into its digital architecture in a timely fashion Then: there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend aggregation and the deployment of the new Emergency Department system) not being delivered Resulting in: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: 1. Loss of information integrity and accessibility as multiple copies of clinical records. 2. Failure and delay of digital system deployments (e.g. WEDES) 3. Possible breaches to the GDPR, safeguarding and information governance risks. 4. Mistrust by staff of the ICT systems and services they are using 5. Money being wasted | A Myrddin strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome SLAs are in place between DHCW and NHS Wales organisations, however their fulfilment has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months Gaps in controls: WG have agreed some funding for the PAS element, however the DHCW IMTP continues to be a top down decision process rather than one being based on HB (user / customer) needs - driven in part by demand overwhelming their capacity (much of which is either Covid born or results from the significant overrun in establishing a minimum viable product to replace CanISC) and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying vacancies in critical areas with no capacity to cover the work from within. As a consequence programme to digitise the Emergency Department processes and records has been suspended. | National Data Resource Programme has accelerated plan to open up the architecture, with API management procured for all of Wales. National Funding received from WG for PAS integration work to create a second team supporting data migration. CTMUHB appointment process has commenced | Digital & Data Committee | 15 | C3xL5 | 9 C3xL3 | ↔ | 07.02.2022 | 05.03.2022 | 01.04.2022 |

| Datix ID | Strategic Risk owner | Strategic Goal | Risk Domain | Risk Title | Risk Description | Controls in place | Action Plan | Assuring Committees | Rating (current) | Heat Map Link (Consequence X Likelihood) | Rating (Target) | Trend | Opened | Last Reviewed | Next Review Date |
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| 3337 Linked to RTE Risk 4813 and M&C 4817. | Chief Operating Officer Director of Primary Care and Mental Health Services | Creating Health | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Use of Welsh Community Care Information System (WCCIS) in Mental Health Services | If: Mental Health Services do not have a single integrated clinical information system that captures all patients details. Then: Clinical staff may make a decision based on limited patient information available that could cause harm. Resulting In: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace. | 1. Process in place for clinical teams to access information via local authority and health board teams. 2. Clinical teams will only use historical information as part of their current risk assessment and if this is not available they will judge the risk accordingly. 3. Merthyr and Cynon and Bridgend CGS leads have confirmed that WCCIS is on their CGS risk register and their updates have been provided within this section, therefore aligned. 4. WCCIS Programme Board establishment for CTM will be finalised by the 30th June 2021. Merthyr and Cynon CSS Lead will Chair this group. The Chair of this group will report to the Senior Responsible Officer. The Task and Finish Groups to be established and aligned to this Programme board Programme will be established by the 31st July 2021. 5. Local Authority have recently developed reports for Mental Health which identifies practitioner caseloads, admissions and discharges and care plan for compliance. 6. Deployment order in place for all existing WCCIS mental health staff users 7. Community Drug and Alcohol Team in Bridgend have now moved over to WCCIS, early implementation learning continues to take place. 8. WCCIS Regional Working Group now has a representative from the Health Board to maintain pace of delivery for WCCIS mental health rollout. 9. CTM have set up a Project Board in partnership to prepare for implementation of WCCIS 10. Project manager has been recruited, pre-employment checks in place . This role will develop and lead on the implementation plan. 11. Business Case identifying resource to progress rollout developed and awaiting approval. 11- WCCIS Regional Working Group to have a representative from the UHB to maintain pace of delivery for WCCIS mental health rollout 13- Project manager has been recruited too, pre-employment checks in place, develop and lead on the implementation plan | 1. In mid January 22 a meeting was held with ICT colleagues to discuss current workforce capacity as this is having an impact on some of the programme deliverables. 2. A Business Case has been developed which identifies additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. Update 18.04.22 - Meeting 25.04.22 to review Business Case. Approval pending WCCIS "go-live" at ABMUHB anticipated in May 2022. Deadline - 30.06.2022 Update 18.4.2022 - Risk reviewed and no change to mitigating actions or risk rating. | Quality & Safety Committee | 15 | C5xL3 | 6 | ↔ | 07/11/2018 | 18.04.2022 | 1.6.2022 |
| 3826 Linked to 4839 and 4841 in Bridgend | Chief Operating Officer Bridgend Integrated Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Emergency Department (ED) Overcrowding | If: As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited to, significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). Then: patients are therefore placed in non-clinical areas. Resulting In: Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing. | Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. - Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. - Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board. | Continue to implement actions identified in the control measures. Action plans are in the process of being reviewed so a timescale will follow once the review has been undertaken by the lead. Update June 2021 - Unscheduled Care Improvement Programme has now launched - Bridgend ILG is being provided with a Programme Manager to drive forward key projects, the key projects are yet to be launched. These projects will initially focus on the Emergency Department (ED) and Site Flow and measures will be identified that will allow us to track improvements in ED overcrowding. Timescale: Projects due to commence July 2021. . RCEM audit undertaken. Staffing remains ongoing issues- plans in place and frequently reviewed. ASCU staffing plan agreed at ILG level and ongoing. Surge trolleys in place to cope with additional capacity requirements. Building works progressing and phases complete. X references to ID4458 & ID3585 Update September 2021 - Health Board to engage with WAST colleagues to consider how transfers can be reduced. Meeting with the Chief Operating Officer's and WAST colleagues scheduled for the 10th September. Further update will be received in the October review of this risk. Estates walk around on the 27th September considered the environmental improvement plan which is dependent on the department being de-escalated (i.e. reduced demand into the department to release clinical areas) in order to commence work. | Quality & Safety Committee | 20 | C5 x L4 | 15 (C5xL3) | ↔ | 24.09.2019 | 28.10.2021 | 31.01.2022 |
| 4417 (Linked to Risk IDs 4706 and 4703) | Executive Director for People Health, Safety & Fire | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation | Management of Security Doors in All Hospital Settings | Following several serious incidents following patients absconding from clinical areas, the HSE have issue 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 units, wards and premises where in-patients may be at risk from wandering, absconding or escaping in RTE Locality. 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. Identify the measures needed to protect patients at risk. Record the significant findings. Led by Leads in the relevant ILG Sections. Timeframe 31.5.2022. Health Board Learning: Learning has been shared via H&S groups. Local action to be taken by managers. Bridgend Review requested in April 22 Health Safety and Fire Group to ensure action plans are active and risks have been re reviewed. Timeframe July 2022. | Health Safety & Fire Sub Committee | 16 | C4 x L4 | 8 (C4xL2) | New Risk Escalated to the Organisational Risk Register in May 2022 | 30.09.2020 | 3.5.2022 | 31.05.2022 |
| 4500 Linked to 4483. | Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | There is a risk to the delivery of high patient care due to the difficult in recruiting sufficient numbers of registered therapists and health scientists. | If: the Health Board fails to recruit and retain a sufficient number of therapists and health scientists due to increasing numbers of vacancies and shortages of professional staff. Then: the Health Board's ability to provide certain services may be compromised. Resulting in: increased waiting times for diagnosis and treatment, missed opportunities to diagnose at an earlier stage, potential for poorer outcomes for patients. | Links via the Director Therapies to HEIW for planning. Proactive recruitment for difficult to fill posts. Use of Agency/Locum staff where available. Director of Therapies & Health Sciences have supported participation in streamlining to appoint AHP summer 2021 graduates to band 5 vacancies. This is the first time AHPs have recruited in this way and it is too soon to ascertain whether this will impact positively on staff retention. | Continue with active recruitment wherever possible. Ensure workforce plans included and supported in the Integrated Medium Term Plan (IMTP). Utilise 'novel' staffing approaches where indicated. Update: AHP workforce education commissioning completed. Band 5 2021 cohort recruited via streamlining is complete and 2022 cohort is in progress. Gaps remain in higher banded vacancies, as increase in annual workforce commissioning will take time to filter through. Gaps in vacancies are exacerbated by lengthy on-boarding process | Quality & Safety Committee People & Culture Committee | 16 | C4 x L4 | 8 (C4xL2) | ↔ | 21.12.2020 | 9.3.2022 | 6.6.2022 |

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| 4691 Linked to RTE Risks 4803, 4799, 3273 and 3019. | Chief Operating Officer Director of Primary Care and Mental Health Services Rhondda Taf Ely Locality | Sustaining Our Future | Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption | New Mental Health Unit | IF: Mental health inpatient environments fall short of the expected design and standards. Then: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. Resulting in: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace. | Bridgend CSG - Capital anti-ligature scheme in PICU, Ward 14, Angleton is due to be completed by the end of July 2022. Contractors have returned to site and work is awaiting sign-off. The mitigating environment and staffing measures put in place last year are still in place. Anecdotally it is reported that the ward feels safer by night, the challenge for the ward team is to now use QI methodology to make a case for continuing with these staffing levels after the capital work is complete. No incidents involving suspended ligatures have been reported since these measures were implemented. This is reflected in Bridgend CSG risk register. Annual revisiting of all patient ligature risks progress Statement of Needs via capital process for any ligature risks assessed as needing resolution. SRU/ Pinewood – anti-ligature work has been completed. RTE CSG - RTE specific environmental risk mitigation plan in place and under regular review. Anti-Ligature and Bathroom upgrade works are currently being planned for the MHU in RGH as part of a capital works scheme. Upgrade works to Admission / Ward 21 / Ward 22 & PICU and smaller improvement works on Seren. Work is in progress on PICU and Seren with a view to progressing to the adult inpatient wards next. | 1. Discussions to commence with Welsh Government in relation to the inpatient environment. 2. A strategic case to be prepared and submitted to Welsh Government - COMPLETE . Strategic Outline Document submitted and agreement to commence a Strategic Outline Business Case received. 3. If the strategic case conversation is supported by Welsh Government, develop a strategic outline business case. Timescale March 22 4. If the strategic outline business case is accepted, progress to the development of a full business case. Reviewed 18.04.22 with no change to current risk rating. | Quality & Safety Committee | 15 | 15 (C3xL5) | 6 (C3xL2) | ↔ | 15.06.2021 | 13.05.2022 | 30.06.2022 |

| Datix ID | Strategic Risk owner | Strategic Objective | Risk Domain | Risk Title | Risk Description | Controls in place | Action Plan | Assuring Committees | Rating (current) | Rating (Target) | De-escalation Rationale |
|----------|---|---------------------|---|---|--|---|---|----------------------------|------------------|---|--|
| 4866 | Chief Operating Officer Executive Director of Therapies & Health Sciences Merthyr & Cynon Locality - Host of Therapies Services within the Health Board | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Lack of dedicated dietetic provision to Upper GI Oncology patients across CTMUHB. | IF: there is no funding identified to support the recruitment of specialist dedicated upper GI oncology dietitians THEN: The health board is not able to provide a clinical service in line with local, national and international guidelines or clinical standards for this patient group Resulting in: Lack of specialist nutrition intervention impacting on patient safety, poorer treatment outcomes, increased hospital admissions, increased length of stay and poorer quality of life. | Identification of virtual support from existing clinical teams. Collaboration with the clinical teams and across each ILG to identify and provide initial first line advice. | Business case Presented at Macmillan panel and funding for dedicated Upper GI dietetic posts was agreed for 2 years from Macmillan with cost pressure sitting in therapies Awaiting completion of contractual agreement to progress with recruitment, so gaps remain in workforce but progressing at pace. Update 25/2/22, funding agreed with Macmillan, recruitment is in progress. | Quality & Safety Committee | 12 ↓ 20 | 8 C4xL2 | Update 3.5.22: funding for staff has been identified, and recruitment is in progress. Risk reduced to 12 (4 x3), de-escalate from Organisational Risk Register. Monitored via Therapies Risk Register. |
| 4722 | Chief Operating Officer Rhondda Taf Ely Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Senior Medical Workforce Shortfall If the gaps in the senior medical workforce in RTE are not addressed (2wte vacancy OP, 1wte LTS, 1wte Non clinical duties plus paternity leave and isolation). Then routine work such as clinics will be cancelled, clinical decision making will be delayed and emergency escalation compromised along with the ability of the service to discharge the powers of the Mental Health Act. It is also possible that the training of junior doctors will be negatively affected. Resulting in poor quality and unsafe patient care, increasing concerns, risk of litigation, compromise of the | Regular meetings with interim CSGD and Consultants to plan cover arrangements and support on weekly basis. All staff being offered additional hours. Locum consultant covering all Rhondda Mental Health Act work. ANP's covering appropriate PCMHSS AND CMHT clinics. | Increase capacity of consultant teams by planned cancelation non-urgent work. This would need to be approved by ILG and Board due to unintended consequences of wider system. Recruitment - Vacancies out to advert for locum and substantive contracts. Exploring options for overseas recruitment. | Quality & Safety Committee | 12 ↓ 20 | 6 | The risk has been reduced on the basis of two Consultants returning from absence and the fact that the interim model has been working well, evidencing benefits as well as mitigating the risk. Further actions: continue to monitor remaining vacancies. Interim staffing model to be evaluated with potential to remain in place longer-term. (The interim model placed a single Consultant over the inpatient service instead of the previous in-reach model). | |
| 5031 | Executive Nurse Director Clinical Education | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation | Clinical Education & Training Accommodation If: There continues to be a limited availability of dedicated clinical education and training accommodation required for face to face training activity. Then: the Health Boards ability to provide high quality essential clinical skills training would be reduced. Resulting in: a risk that clinical staff are not up-to-date with their skills training and therefore potentially not able to offer the most up-to-date evidence based care to patients. | Temporary alternative arrangements continue to be sourced however they are short term and do not provide for continuity and sustainability of training provision. Examples of training impacted include resuscitation and clinical skills training, health care support worker training, nurse education including clinical skills. Assessment of required training has been undertaken for delivery in another format has been considered and is in place.eg move to virtual/online. However it is necessary to continue to deliver some training face to face | Investigate existing estate for alternative training accommodation. Alternative training accommodation needs to be sought for each of the 3 localities. YGT is currently being utilised for staff based within RTE and MC localities. This is currently a temporary arrangement. Timeframe 30.03.2022. | Quality & Safety Committee | 12 ↓ 15 | 6 C2xL3 | Update 28.4.22. Two Training rooms in the RTE locality utilised for vaccination in the pandemic have been released back to Clinical Education relieving the urgency of the situation. Risk of likelihood of recurrence there fore reduced to 4 and a rating of 12. | |

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| 4873 | Chief Operating Officer Rhondda Taf Ely Locality Group | Improving Care | Patient / Staff / Public Safety Impact on the safety – Physical and/or Psychological harm | The Implementation of the TRAK 2016 LIMS within Blood Transfusion If The implementation of the blood transfusion Trak 2016 project is delayed (deadline 31st December 2021). Then: The departments current LIMS (Telepath) will be unsupported by the supplier (current contract ends December 31st 2021) Resulting in: The department and the health board being exposed to risk in terms of a) increased errors in relation to patient blood management. b) governance - the MHRA can issue a cease and desist | The Trak 2016 implementation project is progressing within the department with as much resource as possible diverted to the project but a number of facets of the project are subject to external bodies (e.g. DHCW; Haemonetics; Intersystem) and unknown variables (e.g. anything that may be found via testing and validation). A large amount of risk will be mitigated by the negotiation of a short term extension of the current LIMS provider (Telepath). | Implement the L2016 Trak LIMS solution for blood transfusion. The implementation of the blood transfusion Trak 2016 project has a deadline of the 31st of December 2021. In order to mitigate the risk around any possible slippage of this project, it is recommended that a short term extension to the current contract is negotiated. Update 16.12.2021 - Reviewed - Telepath contract extension has been agreed, and is currently progressing through the health board approval process. | Quality & Safety Committee | 12 ↓ 16 | 6 C3xL2 | De-escalate - now a moderate risk (4 x 3 = 12) Trak implementation progressing, albeit at a slightly slower rate due to the department's staffing issues. (TP 12/04/2022). Risk reviewed and reduced due to extension of the Telepath contract. Risk of the use of separate systems across the health board still in place, risk remains. (TP 03/05/2022) |
| 4997 | Chief Operating Officer Merthyr & Cynon Locality | Improving Care | Patient / Staff / Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation | IF: An appropriate substantive consultant medical staffing model is not in place for Ysbyty Cwm Cynon wards with a current recruitment process in progress. THEN: The deficit of a substantive plan has given cause for concern in gaps over consultant level review and advice being made available to the existing senior nurses and middle grade doctors based at YCC. RESULTING IN: The potential delay in assessments, appropriate and prompt discharge arrangements, management of complex social and medical conversations, senior decision making and oversight of issues | <ul style="list-style-type: none"> Specialty Doctors on site 9-5 Out of hours medical cover by rota 5-9pm and weekends Emergency senior consultant support. Clearly defined escalation pathway in place between YCC and PCH. Locality nurse director visited site to ensure safety. <p>Clinical director meeting with SAS doctors to discuss plan in principle for RTE specialty doctor to cover for 6 months.</p> <p>The medical director reviewed the current situation with the ILG Director of Ops and concluded that the immediate action needs to be that any concerns regarding YCC patients will be escalated to the on call team in PCH until there is substantive support in place. This may result in more transfers in the short term. Escalation process has been agreed and re-circulated.</p> <p>Consultant support was secured from the stroke team in PCH for a temporary basis in March 2022 but ceased due to service pressures in PCH.</p> <p>A temporary 6 month consultant post has been agreed and put out to recruitment - anticipated interview date 09/05/22.</p> | <ul style="list-style-type: none"> Interview Date set for locum Consultant 23rd May, GP model planned for implementation of 6 month pilot on one ward from mid-May. PCH Consultant supporting SAS doctors 1 session a week. Emergency cover arrangements remain in place. Once Consultant in post risk will be deescalated. | Quality & Safety Committee | 8 ↓ 12 16 | C4 x L2 | Consultant interviews pending (23rd May 2022). Risk being managed at local level (18.5.22). |

| Datix ID | Strategic Risk owner | Strategic Objective | Risk Domain | Risk Title | Risk Description | Controls in place | Action Plan | Assuring Committees | Rating (current) | Rating (Target) | Closure Rationale |
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| 4841 | Chief Operating Officer Bridgend Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Sustainability of Mental Health Services in CTM | IF: a bespoke admission for a young person at Ty Llidiard continues beyond a short-term period of two weeks Then: Male staff from across CTM adult mental health services will be required. Resulting in: depleted and fragile adult mental health services | 1. Attempt to rapidly assess and treat young person to alleviate risks and potentially reduce staffing demand 2. Collaborative planning across adult mental health services and CAMHS to build a staffing model that considers all risks 3. Secure additional staffing from other sources | Working with WHSSC to seek alternative placement. Timeframes in discussion WHSSC and will be confirmed. Consideration of external commissioning of adult mental health inpatient provision to mitigate against reduced staff levels underway. | Quality & Safety Committee | Closed | Closed | Bridgend ILG have confirmed that this risk no longer presents a risk to the locality and will now be closed. |
| 4294 | Chief Operating Officer Merthyr & Cynon Integrated Locality Group Rhondda Taf Ely Integrated Locality Group | Improving Care | Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm | Long waiting times and large backlog of patients awaiting Cardiac Echo | IF: The health Board is unable to meet the demands for patients awaiting Echo scans for both follow up surveillance Then: The RTT WG target will not be met and waits may be 26weeks Resulting in: Potential risk to patients from delays in identifying and treating disease and progression of disease | Forms were verified and triaged by Cardiology team. Patients prioritised in relation to clinical need and rated between urgent and routine. I/P room identified away from main department to increase outpatient capacity and to prevent cross infection risks to outpatient services for both staff (inc returning shielders)and patients Clinically urgent completed and move to routine. New forms triaged as received. Overall loss of capacity post Covid circa 56 / month due to test time changes. (+ currently 1.0 wte lts further 120/month. Will submit SBAR to highlight capacity deficit and cost solutions. Updated SBAR awaiting finance review will upload once completed review again in 3 months awaiting ILG feedback | See Control Measures As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates. | Quality & Safety Committee | Closed | Closed | Risk closed on 5/05/2022 due to lower referral rates and the current waits are 13 weeks but still above 8 week target. The referral rates are returning to pre covid level plus the UHB is outsourcing which is increasing referral rates for diagnostics by 200 / month for various tests. |