Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Executive Medical Director	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Explore substantive appointments of staff undertaking locum work in CTMUHB • Feedback poor performance and concerns to agencies • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs	• AMD and workforce to develop recruitment strategy 31.3.2021 • AMD and DMD to develop retention and engagement strategy - 31.3.2021 • Reduce agency spend throughout CTMUHB • Launch of 'medical bank' to Bridgend ILG locality Autumn/ Winter 2020 The Health Board may be in a position to de-escalate this risk following the launch of the medical bank in the new year, coupled with the fact that the Health Board has appointed a company to undertaken overseas recruitment from December 2020 onwards.	Quality & Safety Committee People & Culture Committee	20	C5 x L4	16	↔	01.08.2013	27.1.2021	31.3.2021	4080
Chief Operating Officer Bridgend ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases.	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. Updated March 21 - 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	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.	Quality & Safety Committee	20	C5 x L4	16	↔	24.09.2019	2.3.2021	31.3.2021	3826
Chief Operating Officer All Locality Groups	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ligature Points - Inpatient Services	**IF:** the Health Board fails to minimise ligature points as far as possible across identified sites. **Then:** the risk of patients using their surroundings as ligature points is increased. **Resulting In:** Potential harm to patients which could result in severe disability or death.	Increased Staff observations in areas where risks have been identified. Any areas of the unit not being occupied by patients are to be kept locked to minimise risks. Update March 2021 - Bridgend Locality - Risk assessment process Some ant-ligature work has been completed in some bedrooms which are used for patients assessed as being at higher risk. Action plan developed with support from the head of nursing within the ILG. 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. Use of therapeutic activities to keep patients occupied Nurse Director of Bridgend ILG, together with corporate colleagues submitted a briefing paper to the executive team on the 17th August 2020 this paper highlighted the need to progress with outstanding capital anti-ligature work. In addition a local action plan has been developed to help mitigate current risks this includes increasing staffing levels and the locking off of more high risk areas. The Health Board has approved the capital expenditure on the anti ligature works and the additional staffing costs .	Continue to implement actions identified in the control measures. RTE Locality Update: Reviewed 26.02.2021 RTE score is 15 and target 10. All anti ligature works completed but environment not risk free.	Quality & Safety Committee Health, Safety & Fire Committee	20	C5 x L4	10	↔	17.08.2020	2.3.2021	31.3.2021	4253
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Covid 19 emergency flow and Impact of Royal Glamorgan Hospital (RGH) flow	**IF:** The continued high rates of admissions continue with increased numbers of Covid-19 patients during autumn 2020 **Then:** there will be a reduction in non Covid-19 attendances causing significant constraints with regards to the safe flow of patients in Prince Charles Hospital (PCH). **Resulting in:** Lengthy Welsh Ambulance Service Trust (WAST) waits and delays and inability to increase Covid-19 capacity on PCH site.	Associated plans opening of surge capacity of SSU and Ysbyty Seren and agreed support from C&V and ABHB and new pathways in development for RGH	See Control Measures	Quality & Safety Committee	20	C5 x L4	12	↔	12.10.2020	25.01.2021	31.3.2021	4331
Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ambulance Handover Times	**If:** Ambulance handovers are delayed. **Then:** Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. **Resulting In:** A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls.	Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protections Schemes Implemented within ILG's.	Live Flow Information Dashboard being scoped - Target Date: 31.3.2021 Unscheduled Care Board focus on SDEC/AEC, D2RA - Contact ahead 111 - Target Date: Contact Ahead: March 2021, 111: January 2021. Update March 2021 - the 111 system commenced in RTE and M&C Locality in November 2020 - will commence in Bridgend Locality shortly.	Quality & Safety Committee	20	C4 x L5	12	↔	04/12/2020	1.3.2021	31.3.2021	4458

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Chief Operating Officer / Executive Director of Nursing & Quality (Executive Lead IPC)	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of negative pressure rooms in CTMUHB in line with WHC (2018) 033	**If:** there are no negative pressure rooms available in CTMUHB. **Then:** the service will be unable to isolate patients in an appropriate environment. **Resulting In:** Non compliance with national guidance/ WG expectation	Patients isolated in single rooms. Apply IPC precautions. Isolation policy in place. Alert organisms are dealt with by the IPCT. IPCN's liaise with wards/ departments giving IPC advice/ instruction. All alerts are discussed at weekly meetings. Patients with highly transmissible respiratory infections will be transferred to a regional centre with appropriate isolation facilities	Work with Executive Team, Capital, Estates and Shared Services colleagues to consider recommendations outlined in the WHC(2018)033 Risk currently being reviewed by the Chair of the Infection Prevention and Control Group.	Quality & Safety Committee	20	C5 x L4	12	↔	16/12/2014	2.3.2021	31.3.2021	1793
Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	• Tight management processes to manage individual cases on the cancer Pathway. • Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. • Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk • Harm review process to identify patients with waits of over 104 days and potential pathway improvements. • Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. • All three ILGs are working to maximising access to ASA level 3+4 surgery on the acute sites. • HB working to ensure haematological SACT delivery capacity is maintained. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. • Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. • Alternative arrangements for MDT and clinics, utilising Virtual options	Continue close monitoring of each patient on the pathway to ensure rapid flow of patients through the pathway. Active management of the diagnostic backlog (including endoscopy) and exploration of all options to reduce this. Comprehensive planning for repatriation of theatre and haematology services for when private provision is lost. This also needs to consider options for continuation during a potential second surge. These actions are ongoing and assigned to the EDO, DPC&MH and Medical Director. 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.	Quality & Safety Committee	20	C4 x L5	12	↔	01/04/2014	3.3.2021	30.04.2021	4071
Executive Director of Nursing and Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Increasing dependency on agency staff cover which impacts on continuity of care, patient safety	**IF:** The Health Board increasingly depends on agency staff cover **Then:** the Health Board's ability to provide stability and consistency in relation to high quality care could be impacted. **Resulting in**: disruption to the continuity, stability of care and team communication. Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover.	Recurring advertisements of posts in and nursing continue with targeted proactive recruitment employed in areas of high agency/locum use. Provision of induction packs for agency staff Agency nursing staff are paid via an All wales contract agreement, any off framework agency requests must be authorised by an Executive Director prior to booking (system of audit trail in place). Fixed Term Contracts being offered to all existing HCSW and RN currently on the Nurse Bank. Redesign services wherever possible to embrace a healthier Wales and therefore impact upon the workforce required to deliver services. Overtime incentives offered to workforce in response to Covid-19 pandemic. The Health Board is continuing with the overseas recruitment campaign.	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. Update as at March 2021 - Policy has been revised and the Deputy Head of Workforce is currently taking the policy through the relevant approval process - timescale 31.3.2021. Acuity Audit to be undertaken in June 2021 to report to Board in July 2021. All Wales "Safer Care Module" on e-roster system due to be received in due course. WG led so await WG timescales. Nursing & Midwifery Strategic Workforce Group, Chaired by the Deputy Director of Nursing to recommence in April 2021.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	9	↔	01/06/2015	01.03.2021	30.04.2021	4106
Executive Director of Nursing and Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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.	Established recruitment campaign - which is monitored at the Nursing Workforce Strategic Group - group due to meet/recommence in April 2021. Revised nurse rostering policy currently being taken through the relevant approval process - Timescale 31.3.2021. Action plans, to include annual Nursing & Midwifery Strategic Workforce Group and Nursing Staffing Act group - Timescale 31.07.2021 Await review of Birth Rate Plus Compliant Tool by WG - Timescale - WG led so await WG timescales.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	9	↔	01/01/2016	01.03.2021	30.04.2021	4157

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Executive Director of Nursing and Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Patients and/or relatives/carers do not receive timely responses to matters raised under Putting Things Right resulting in learning and improvement being delayed	**IF:** The Health Board fails to provide timely responses to matters raised by patients, relatives and/or carers under Putting Things Right. **Then:** there will be a delay in identifying potential learning opportunities. **Resulting in:** variable quality in responses, not learning lessons, not meeting regulatory response times therefore increasing the number of concerns being escalated to the Ombudsman and not providing complainants with a resolution in a prompt and timely manner.	-Implementation of the Quality & Patient Safety Governance Framework - Values and behaviours work will support outcome focused care - supportive intervention from the Delivery Unit supporting redesign of complaints management - relocation of the concerns team into Integrated Locality Groups (ILGs) - Governance teams embedded within each ILG - Governance processes in place in relation to PTR guidelines and this provides assurance via their ILG Q&S committees and these report into the CTMUHB Q&S committee and Patient Experience Committee. - Corporate/Executive assurance and review undertaken weekly via Executive Director led Patient Safety review meetings and quarterly Concerns scrutiny panel meetings. -Ensure access to education, training and learning. - Review of systems in place to aid assurance and compliance with PTR guidelines in progress by Corporate Governance Team. Level 1 PTR training added to ESR training module and training ongoing for staff in the DLG's. Member of corporate team continues to provide training surrounding PTR guidelines and governance. - Shared Listening and Learning forum established with its inaugural meeting in February 2021. - ILG Concerns Management Performance is monitored via the regular Executive Led Performance Management Meetings. - Once for Wales Concerns Management System - Complaints and Claims module due to go to live 1st April 2021 which will provide greater integration across complaints, claims and incidents, it will also support All Wales learning and benchmarking.	Corporate governance team reviewing current Datix system to reflect new DLG structures and working with WRP to ensure alignment with new Once for Wales System which is in progress. **COMPLETED.** Review of the Concerns Process within ILG's underway - timescale 30.04.2021. Improvement trajectories to be established with ILG's - Timescales 30.04.2021.	Quality & Safety Committee	16	C4 x L4	9	↔	01/04/2014	01.03.2021	1.5.2021	4156
Executive Medical Director Chief Operating Officer Integrated Locality Groups	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Implementing a sustainable model for emergency medicine and inpatient paediatrics across the CTMUHB footprint	**IF:** The Health Board is unable to deliver a sustainable model to deliver Emergency Medicine (EM) and inpatient paediatrics across the Health Board Footprint. **Then:** The Health Board will be unable to deliver safe high quality emergency medicine and inpatient paediatrics services. **Resulting in:** Compromised safety of patients and Staff.	Successful recruitment to EM in Royal Glamorgan Hospital and Prince Charles Hospital continues at consultant and middle grade. Model for delivery of Paediatric care in RGH significantly clearer and this is contributing to some recruitment success.	Recruitment drive continues.	Quality & Safety Committee	16	C4 x L4	6	↔	01/07/2019	18.11.2020	31.3.2021	4115
Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**IF**: The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place.	Action plan developed and on going monitoring - consolidated plan coming forward covering Eye Care. The service has transitioned to Bridgend ILG and Bridgend ILG has engaged in potential national solutions to address FUNB.	Quality & Safety Committee	16	C4 x L4	12	↔	01/04/2014	1.3.2021	31.3.2021	4103
Executive Director of Nursing & Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non-compliance with DoLS legislation and resulting authorisation breaches	**IF:** due to current capacity the Health Board fails to fully comply with the DoLS legislation. **Then:** the Health Board may have to operate outside the current legislative process. (a change in legislation is coming which will hopefully improve lawfulness) **Resulting in**: the rights, legal protection and best interests of patients who lack capacity potentially being compromised. Potential reputational damage and financial loss as a result of any challenge by the ombudsman or litigation.	Updated Narrative March 2021: • Training and DOLs Process impacted by Covid-19 pandemic due to not being able to undertake face to face capacity assessments. Staff recruited to manage demand e.g. independent best interest assessors, a full time secondment transition post and nurse bank hours. As a matter of routine the HB remain in the position that it is encouraging urgent authorisations by the managing authorities and undertaking virtual capacity assessments with standard authorisations and reviews. • Virtual DoLS processes established and in place within the HB during Covid19, this is subject to regular review and monitoring. Urgent authorisations are prioritised over standard authorisation Although this process is effective in terms of identifying patients deprived of their liberty, it is not a lawful process and does not comply with legislation. The HB is therefore at greater risk of breaching the legislation and the rights of those who lack capacity are potentially compromised. • Monthly Safeguarding People training for Covid 19 - there has been a pause in training as a result of the second wave of the pandemic as patient facing activity takes precedence. Training restrictions have also impacted upon the numbers of authorisations requested and alternative ways of delivering Level 3 DoLS & MCA awareness has been developed via TEAMS and will commence in April 2021. • DoLS legislation will subject to change following enactment of the new legislation and statutory guidance. Whilst requirements have increased, mitigation has also been revised to manage increased risk, the HB will need to be prepared for new legislation. Further conversations with our 3 local authorities have been undertaken to recommence a CTM regional understanding and preparation for the changes in legislation, supported by the Safeguarding Board. • Audits are undertaken on time to respond to requests. Virtual capacity and best interest assessments involve family, patient representatives and those who care for the patient. Streamlining and target setting implemented which has led to more authorisations taking place in a more timely manner. • Authorisation breaches are required to be reported on Datix. • The DoLS team maintain an accessible level of virtual support and advice to wards, have supported the development of a consent form for Covid testing for those who lack capacity and	To resume face to face assessments as soon as it is safe to do so. A retrospective audit of authorisations during the Covid period to be completed and reported to the Safeguarding Executive Group. The Safeguarding Executive Group to establish a working group with multidisciplinary representation to consider the implications for the UHB on how the LPS scheme will have an impact on the current authorisation process for DoLS. Timescale: Paused for Covid 19 new date not yet set.	Quality & Safety Committee	16	C4 x L4	9	↔	01/10/2014	2.3.2021	30.04.2021	4148

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Director of Corporate Governance	Provide high quality, evidence based, and accessible care.	Adverse publicity/ reputation	Organisational Reputation - Lack of confidence in the services and care provided by the organisation.	**IF:** the Health Board does not effectively engage with its stakeholders, communities and staff to demonstrate listening and learning from external reviews and more recently the Health Boards response to Covid-19 **Then:** Trust and confidence in the services of the Health Board will be negatively impacted. **Resulting in:** negative media coverage, lack or credibility with our communities and staff, ineffective communication, loss of commitment, deteriorating morale, increase in staff turnover and recruitment.	Rebuild trust and confidence programme under Targeted Intervention Improvement Programme underway. Maintaining public confidence in the Health Boards response to the Covid-19 Pandemic through regular and robust communication and messaging through the Health Board's communication channels. Improved staff engagement and involvement, new approaches to partnership engagement and involvement. Additional capacity bid included in TI investment bid under the TI programme to WG. Additional capacity bid included in TI investment bid under the SW Programme. Ensure balanced news stories are regularly reported and communicated. Relationships with the media have been strengthened. Partnership working with Channel 4 and proactive engagement with other media outlets - resulting in positive working relationships and fair media coverage. 'In Committee' meetings have been significantly reduced. TTP Communications work stream focussed on provision of accurate and timely information to the Public. Live streaming of the Board meetings now in place to improve transparency and involvement. New Health Board Values and Behaviours were officially launched in October 2020, World Values Day, following the Let's Talk staff engagement programme. The launch was further complemented by a peer recognition 'wall of thanks' campaign throughout Oct/Nov/Dec and a Staff Gratitude Event in December which recognised all CTM staff for their contributions throughout 2020 pandemic year.	Stakeholder engagement survey planned for August 2020 -Stakeholder engagement survey delayed due to Covid-19 outbreaks in autumn but re-scheduled for spring 2021.	Quality & Safety Committee	16	C4 x L4	6	↔	01.07.2019	12.01.2021	30.04.2021	4116
Chief Operating Officer. Bridgend ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Neonatal Capacity/Stabilisation cot at Princess of Wales	**If**: The neonatal unit at POW is required to deliver ITU level care in the stabilisation cot **Then:** This cot is not staffed, therefore the overall staffing position on the unit is depleted while this is managed, noting that in the absence of a 24/7 retrieval service this can be for extended periods. The stabilisation cot requires 1:1 nursing which is the equivalent of staffing for 2 HDU costs or 4 SCU cots. **Resulting In:** A risk of being unable to provide appropriate levels of care to the babies on the unit as staffing will be below the required levels as per BAPM requirements	* Utilise available staff as effectively as possible depending on the capacity position at the time * Escalation policy in place to limit maternity services to reduce the risks of further admissions to neonates * Seek additional staffing e.g. through bank, agency, overtime when required	Funding required - included on IMTP. Review date extended until end of March 2021. SBAR and Business cases for funding of the stabilisation cot have also been submitted to various meetings . Core Workforce requirements are being reviewed with a view to enhancing the Nursing workforce model and increasing medical consultant workforce capacity. NN services are aligning with Maternity Improvement programme of work whilst developing elements that are defined for neonatal provision including a Quality improvement programme of work	Quality & Safety Committee	16	C4 x L4	3	↔	31.05.2019	22.12.2020	31.03.2021	3584
Chief Operating Officer Bridgend ILG	Provide high quality, evidence based, and accessible care.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Princess of Wales Emergency Department Hygiene Facilities	**If:** the toilet and shower facilities are not increased within the Emergency Department. **Then:** at times of increased exit block the facilities are insufficient for the needs of the patients in the department. **Resulting In:** Poor patient experience, complaints and further concerns raised from the Community Health Council have repeatedly flagged this issue on visits to the department.	There are additional toilet facilities in the radiology department that mobile patients can be directed to however staff do whatever they can within the constraints that they have.	Additional facilities being explored as part of departmental capital works. There is a capital plan for improvement works in ED. The improvements will be – 1. NIV cubicle 2. Creation of a second patient toilet 3. Improvement to HDU area 4. Relocation of Plaster Room 5. Creation of 2 paediatric bays with adjoining paediatric waiting room 6. Redesign of waiting room and reception desk Prior to the Covid pandemic, improvements 2-6 were planned, but the creation of an NIV cubicle has taken priority. The plans are in the process of being signed off for all areas but there is no confirmed start date yet. There was / is potential for delays in sourcing materials by contractors and we need to consider the need to keep contractors as safe as possible from any Covid contact. Patient numbers are now increasing daily but we are restricting visitors and relatives attending with patients (unless required as carers etc). We have also developed a remote waiting room for patients who can safely wait in their cars. This will help to mitigate the footfall in the department when the capital work commences.	Quality & Safety Committee	16	C4 x L4	1	↔	31.05.2019	10.03.2021	31.03.2021	3585
Executive Director of Planning & Performance (ICT) Bridgend ILG	Ensure sustainability in all that we do, economically, environmentally and socially.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	IT Systems	**IF:** The Health board is unable to deliver vital clinical information services to the Bridgend locality affecting many clinical systems that are not compatible with Cwm Taf University Morgannwg Systems. **Then:** The Health board will be unable to deliver safe, high quality care to patients without vital clinical information available. **Resulting In:** Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan.	IT maintenance is currently supported by Swansea Bay UHB via a service level agreement. There are currently a number of systems that are not compatible with Cwm Taf Morgannwg systems and we are 18months post boundary change.	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.	~~Quality & Safety Committee~~ Digital & Data Committee	16	C4 x L4	8	↔	14.10.2020	16.02.2020	31.03.2021	4337

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Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long waiting times and large backlog of patients awaiting Cardiac Echo	**IF:** The health Board is unable to meet the demands for patients awaiting Echo scans for both follow up surveillance **Then:** The RTT WG target will not be met and waits may be 26weeks **Resulting in:** Potential risk to patients from delays in identifying and treating disease and progression of disease	Forms were verified and triaged by Cardiology team. Patients prioritised in relation to clinical need and rated between urgent and routine. I/P room identified away from main department to increase outpatient capacity and to prevent cross infection risks to outpatient services for both staff (inc returning shielders)and patients Clinically urgent completed and move to routine. New forms triaged as received. Overall loss of capacity post Covid circa 56 / month due to test time changes. (+ currently 1.0 wte lts further 120/month. Will submit SBAR to highlight capacity deficit and cost solutions	See Control Measures Risk also raised via Rhondda Locality which will be reviewed alongside this risk - Datix ID 4292.	Quality & Safety Committee	16	C4 x L4	6	↔	14.09.2020	12.10.2020	31.03.2021	4294
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Cancer Performance - Gastroenterology Outcome of Covid-19	**IF:** Routine diagnostic activity is not recommenced in full during the C19 pandemic **Then:** there will continue to be a backlog of patients awaiting diagnostic investigations **Resulting in:** Potential harm to patients due to delay in diagnosis and treatment	Endoscopy services have restarted as part of new normal timetables. Backlog is being booked and should be cleared by end of July. 22.9.20 Discussions health board wide to reduce overdue and to work to safe capacity.	See Control Measures	Quality & Safety Committee	16	C4 x L4	9	↔	27.07.2020	02.11.2020	31.03.2021	4235
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Elective patients surgery cancelled when high level bed pressures are experienced	**IF:** Elective patients surgery is cancelled when high bed pressures are experienced **Then:** There will continue to be a backlog of patients awaiting treatment/procedures to improve their health and wellbeing **Resulting in:** Potential harm to patients due to delay in treatment/procedures	Consultants are asked clinical opinion when each patient case is cancelled. 12/10/20 insufficient capacity to meet current trauma demand and no short term plan to re-introducing elective orthopaedics during C19 pandemic. Seal area identified but delayed due to RGH IPC issues. As per UHB SoP, clinical prioritization undertaken weekly to list patients with high clinical need. Risk to patients who cannot access. Feasibility study undertaken for elective list in YCC.	See Control Measures.	Quality & Safety Committee	16	C4 x L4	8	↔	14.01.2020	14.01.2020	31.03.2021	3958
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non compliance with appropriate fetal growth detection and management guidance	This is an All Wales risk for all HB`s **If:** there is a lack of USS slots to address the demand we will not be in compliance with the guidance for fetal surveillance and wellbeing. **Then:** 1. Compliance against the Growth Assessment Protocol (GAP) cannot be met. CTMUHB does not have a 7 day USS service which would support compliance and the management of the small for gestation age (SGA) fetus. **Resulting In:**: Women at the greatest risk of SGA receive less surveillance of growth than women with uncomplicated pregnancies resulting in potential harm.	1. Capacity to comply with GAP/GROW 3 weekly - current regime 3-4 weekly 2. Woman are risk assessed, they are allocated one of two pathways. One pathway SFH can be delivered, Serial scanning (37% of population) unable to receive full recommended scanning regime or protocol due to scanning capacity issues. Current regime 4 weekly as apposed to three weekly. 4. The Directorate is working closely with the Radiology department to review low value scans requested. 5. The Directorate is reviewing the option of midwife sonographers being employed. 7. Scanning group for the UHB established. 8. Continued to be reviewed with changes to patient flow due to 'The Grange'	See Control Measures. Radiology to develop sustainable service plan to increase capacity and workforce.	Quality & Safety Committee	16	C4 x L4	6	↔	01.06.2017	4.12.2020	31.3.2021	3011
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Gynaecology Cancer Service	This affects Gynaecology services across CTMUHB - delay in the pathway requiring multiple consultations on site - Service relies on an individual practitioner - Demand is currently in excess of agreed manageable caseload - Hysteroscopy service capacity requires business case supporting for service development - Gynae Rapid access service development is slow progression	Hysteroscopy service business case is being updated - Increased cancer tracking - Review of pathways and service - tracking of results G17Scrub training in place and a rolling programme organised with main theatres	Action: Agreed COVID pathways. Service to re-submit gynaecology 'one stop' Service.	Quality & Safety Committee	16	C4 x L4	9	↔	18.06.2019	30.09.2020	31.3.2021	3654
Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Due to capacity issues to deal with Covid-19 staff not attending medical gas safety training and courses being rescheduled.	(Facilities Risk Register Reference CE11) **ILG:** CSO Facilities Hub **If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score.	Cylinders to be standardised on ward areas for patient transfer where possible. Completed. To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Health Board to report compliance with the Patient Safety Notice. Completed. Recruit B4 role to be advised of all new medical equipment installations and oversee user training prior to issue. Completed. Medical Gas Cylinder Policy developed and to be approved by Quality & Safety Committee. Timescale extended to allow for committees to restart after the Christmas period. Timescale: 31/01/2021. Band 4 role now in post. Training has been undertaken for Porters and graduate nurses. However, staff currently in post still not attending due to current circumstances with Covid-19. Based on this update the risk rating remains unchanged until Medical Gas Policy has been approved by Quality & Safety Committee. Timescale: 31.3.2021. Based on this update the risk rating remains unchanged until the required attendance for Medical Gas Training is being consistently achieved..	Quality & Safety Committee.	16	C4 x L4	8	↔	01/05/2018	09/02/2021	31.03.2021	3133

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Chief Operating Officer Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk of absconding from Ward 23.	**If**: Estates work and Covid-19 pathway remodelling is not undertaken urgently **Then:** Mental health patients may continue to abscond **Resulting In**: Potential harm to themselves or the public	All patients risks for suitability of admission to ward 23 assessed. Patients discouraged from smoking where possible. Any patient who goes out into garden is supervised by ward staff at all times. All staff will try to de-escalate increasingly volatile situations. Prompt alert if patients can not safely be stopped from absconding. Staff to follow guidance for managing absconding patients. All patients are risk assessed. Reduction in Covid-19 positive patients will hopefully allow for ward remodelling which will reduce risk further in future.	Work with Estates ongoing. A Statement of Need has been submitted to fund additional fencing being installed.	Quality & Safety Committee	16	C4 x L4	4	↔	04/11/2020	26.2.2021	30.04.2021	4401
Executive Director of Therapies & Health Sciences	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of high patient care due to the difficult in recruiting sufficient numbers of registered therapists and health scientists.	**If:** the Health Board fails to recruit and retain a sufficient number of therapists and health scientists due to increasing numbers of vacancies and shortages of professional staff. **Then:** the Health Board's ability to provide certain services may be compromised. **Resulting in:** increased waiting times for diagnosis and treatment, missed opportunities to diagnose at an earlier stage, potential for poorer outcomes for patients.	Links via the Director Therapies to HEIW for planning. Proactive recruitment for difficult to fill posts. Use of Agency/Locum staff where available.	Continue with active recruitment wherever possible. Ensure workforce plans included and supported in the Integrated Medium Term Plan (IMTP). Utilise 'novel' staffing approaches where indicated.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	9	↔	21.12.2020	05.02.2021	31.03.2021	4500
Chief Operating Officer Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Follow up capacity and clinic cancellations (FUNB)	**If:** The Health Board is unable to control and meet the capacity and demand to accommodate all hospital follow up outpatient appointments. **Then:** the Health Board's ability to provide high quality care may be reduced. **Resulting in**: Potential avoidable harm to patients	Organisation plan in place to address the FUNB position across all specialties. Additional funding requirements identified. Regular meetings in place to monitor the position.	Harm review processes being implemented.	Quality & Safety Committee	16	C4 x L4	12	↔	18/11/2013	14.12.2020	10/08/2021	816
Chief Operating Officer	Provide high quality, evidence based, and accessible care.`	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey.	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing undertaken when needed. • The UHB will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The UHB has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and UHB levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified	The existing controls will be maintained and developed, with monitoring in place via internal ILG meetings and the monthly ILG meetings with Directors. Given the pressure upon the UHB in the covid-19 environment, the risk will remain at level 16, with review in March .	Quality & Safety Committee	16	C4 x L4	9	↔	11.01.2021	11/01/2021	31/03/2021	4491

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Chief Operating Officer Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long waiting times and large backlog for Cardiac Echo	**If:** For old Cwm Taf template Total of 2720 pts awaiting Echo scans for both follow up surveillance to monitor disease progress and new referrals governed by RTT. RT -ILG 1520 pts of which 873 would form part of RTT 570 pts waiting greater than 8 weeks longest wait 45 weeks. **Then:** Potential risk to patients from delays in identifying and treating disease and progression of disease e.g. valves, LV function . **Resulting in:** Delays in receiving appropriate treatment pharmacological, intervention , surgical. Potential risk litigation. triage process reliant on available referral information to assess urgency.	Forms were verified and triaged by Cardiology team. Patients prioritised in relation to clinical need and rated between urgent and routine. I/P room identified away from main department to increase outpatient capacity and to prevent cross infection risks to outpatient services for both staff (inc returning shielders) and patients Clinically urgent completed and move to routine. New forms triaged as received. Overall loss of capacity post Covid circa 76 / month due to test time changes. Ill health retirement further 97 / month capacity loss.	Plans to submit SBAR to highlight capacity deficit and cost solutions.	Quality & Safety Committee	16	C4 x L4	9	↔	10.09.2020	14/09/2020	19.05.2021	4292
Executive Director of Public Health	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential Harm and poor experience for Patients as a result of the Health Board's focus and response to the Covid-19 Pandemic	**IF:** the Health Boards resources and focus is directing into managing the response to the Covid-19 pandemic. **Then**: the Health Board's ability to provide high quality care may be reduced. **Resulting in:** potential harm to patients as a result of reduced service provision and capacity to respond to other areas of the Health Board's population Health need.	Planning preparedness, contingency structures through the Resetting CTM structures. Critical services are operating. Governance process in place for financial and non-financial decision making to support, all predicated on Quality Impact Assessments. Quality & Safety Committee has continued to meet to ensure scrutiny and assurance on behalf of the Board. Indicators of quality and patient safety for all services continue to be closely monitored throughout Covid-19. Processes and guidance in place to ensure clarity on areas such as safeguarding and child protection. Implementation of the Test Track and Trace Programme in June 2020. Regular Population Health Surveys conducted in relation to Covid-19 to gauge attitudes and risk perception within communities. Compliance with National Guidance. The QIA process for service changes relating to Covid-19 management will include an assessment of related impact on any existing service delivery. Deaths are monitored via the mortality review process. Monitoring incidents, complaints and feedback through social media. Monitoring Core quality and safety metrics.	The QIA process for services changes relating to COVID-19 Management will include an assessment of related impact on any existing service delivery. Continuing to roll out the Health Boards Vaccination Programme.	Quality & Safety Committee	15	C5 x L3	12	↔	23/03/2020	08/02/2021	30.04.2021	4105
Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Covid 19 - Gold Risk - 002 Critical Care Beds and Equipment	**IF:** there is an insufficient number of critical care beds, medicines and ventilators. **Then:** the Health Board's ability to provide high quality and safe care would be reduced. **Resulting in**: potential harm to patients.	• Suspend non-urgent outpatient appointments and ensure urgent appointments are prioritised • Suspend non-urgent surgical admissions and procedures (whilst ensuring access for emergency and urgent surgery) • National work regularly shared • Local model well underway and informing capacity planning. • More detailed capacity plan available and being shared with WG as requested • Redeploy and retrain staff released from inpatients, day cases and outpatients • UK government removing restrictions on the export of any UK bound stocks. • New systems in place for the assessment and management of stock in hospitals. • Movement of stock between health boards. • Minimising wastage of critical care medicines in the ward and in aseptic production units. • Daily situation report providing stock levels relative to critical care bed usage by health board. • Regular calls between NHS pharmacy procurement leads used to support mutual aid through the movement of stock between health boards. • USC dashboard (to remain Level 1 Green / Level 2 Amber) • Capacity Plan in place with modelling throughout the covid-19 period	• Ensure local stock levels are maintained at levels proportionate to anticipated short term demand, underpinned by regular replenishment from normal supply routes and NHS Supply Chain - under constant review. • Working to ensure robust arrangements are in place to identify and move stock rapidly between hospitals and health boards should the need arise.	Quality & Safety Committee	15	C5 x L3	10	↔	13.05.2020	18.11.2020	31.3.2021	4186
Chief Operating Officer Pharmacy & Medicines Management	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Temperatures in medicines storage room on the wards in Prince Charles Hospital not fit for purpose.	**If** there is no control of the temperatures in all the medicines storage rooms on the wards in Prince Charles Hospital. The medicines storage room have pipes in ducts which give off significant heat year round and increased issues in the summer months. **Then:** medicines are being kept above the required temperatures as stated in their specifications of storage as part of their license from MHRA. **Resulting in:** medicines stored at a higher temperature than their specifications which could result in them being less active or denatured and affect patient outcomes.	Some wards are placing small fans in rooms but this does not reduce the temperature. alternative rooms for storage have been discussed but unable to progress due to other ward priorities A SON for air conditioning for each ward will be progressed by medicines management on behalf of ILG	A SON for air conditioning for each ward will be progressed by medicines management on behalf of ILG, however, due to COVID-19 this will be considered in 21-22. Risk will be reviewed in May 2021.	Quality & Safety Committee	15	C3 x L5	6	↔	05.02.2018	04.02.2021	03.05.2021	3072

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Chief Operating Officer Bridgend ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting List for Autism Diagnostic Observation Schedule (ADOS) assessments and Attention Deficit Hyperactivity Disorder (ADHD) medicals over 1 year.	**If:** there are delays in diagnosing children with ADHD and Autism. **Then:** this results in a delay in management including appropriate school placements **Resulting in:** potential harm to patients, poor patient experience, dignity, staff morale. Complaints.	* The team have reviewed their clinical practice in line with the rest of CTM e.g. no longer undertaking ADOS for all children * Discussions underway re: repatriating service from Swansea Bay and investing funding into enhanced local service in Bridgend * New Consultant starting June 2020 with 3 sessions to support community paeds	Vacant sessions to be recruited to - Additional staff appointed who could undertake assessments would ensure this activity was managed in a timely manner.	Quality & Safety Committee	15	C3 x L5	4	↔	02.07.2019	16.09.2020	01.06.2021	3698
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No Midwifery Specialist for pregnant women with vulnerabilities	**IF:** there is no dedicated services for substance misuse women, prescription medication, or women with vulnerabilities (social) - national best practice is for there to be a lead in vulnerabilities to see women in a dedicated clinic with the multidisciplinary teams which without leads to disjointed care for our most at risk patient group. **Then:** unidentified opportunities to co-ordinate risk management and support in 'A Healthier Wales' in pregnancy will be missed. **Resulting In:** potential harm to mothers and babies care provision and outcomes.	Women in PCH/RGH are seen in a general Ante Natal clinics Women in POW currently seen in a dedicated clinic, with an SLA agreement with Swansea Bay UHB .2 resource. The directorate need to develop a Statement of need to secure resources to support services across the HB and ensure standardised service delivery.	Action: Service to develop business case for implementing specialist service for women with vulnerabilities.	Quality & Safety Committee People & Culture Committee	15	C3 x L5	6	↔	26.06.2019	01.12.2020	31.3.2020	3685
Chief Operating Officer Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Delivery of the rehabilitation for repatriated major trauma patients.	**If:** The business case for enhanced rehabilitation services linked to Major Trauma is not supported. **Then:** Patients will not receive the appropriate level of clinical intervention. **Resulting In:** Poorer clinical outcomes, increased lengths of stay (with associated clinical risks) and poor patient experience.	Ensuring current nursing and therapies have access to a training programme - however there are concerns about deliverability during Covid pandemic. The new rehabilitation coordinator post will support the delivery of the immediate care planning once a patient is repatriated. Advance notice means we can ensure staff are aware of immediate needs. The network has systems in place to support early care planning and preparation where possible i.e. The health board is aware of the number of patients likely to be transferred 'Rehabilitation prescription' describes nursing and therapy needs prior to repatriation. Rehabilitation coordinators link with counterparts in UHW to ensure our rehabilitation offer is clear to the patient and their family prior to transfer.	The development of the business case will require support from business partners in planning, HR and finance. Recurrent investment may be required as an outcome of the business case. Timescale: 30.9.2021 changed from 31.3.2021 due to the impact of the Covid-19 impact.	Quality & Safety Committee	15	C3 x L5	6	↔	10/09/2020	2.3.2021	30.05.2021	4281

Datix ID	Executive Portfolio	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Date Last Reviewed	Comments
4248	Chief Operating Officer RTE Locality	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of Patients with Mental Health needs on Community Hospital Sites.	**If:** there is a consistent number of patients with mental health needs which are being cared for in community hospital <u>without</u> RMN support or there are delays in discharge to the appropriate EMI setting. **Then:** Patients who have been sectioned and/or are under medication review may remain on the community ward where specialist mental health therapies and input is not possible. **Resulting In:** Incidents of staff and patient assaults may occur. Poor patient experience as not receiving the appropriate support in the appropriate setting. Staff impact due to increased supervision being required to manage behaviour..	MHL Team contacted for each patient for support 1:1 Supervision provided for each patient to reduce risk of harm Ward Manager and Senior Nurse Review patients daily 13/08/2020- reviewed in Tier 2 Gov meeting- new risk gone onto register. Remains high risk 14/08/2020 - Senior Nurse liaising with Mental Health team to establish if mental health can provide some more support to staff on the ward. There are currently 9 patients on site needing input from the mental health team.	02/12/2020 - remains high risk, Head of Nursing organising weekly meetings with Mental Health Team to discuss patients on site. There are currently a high number of supervisory patient also on the transfer list to come to YCR. 31.01.21 - a good working relationship has proven beneficial between senior nurse for YCR and senior nurse for MHLT.	Quality & Safety Committee	9	6	↓ From 15	10.08.2020	31.01.2021	This risk has been de-escalated due to better support from the Mental Health Liaison Team and enhanced support and presence of new Head of Nursing for Communities.
4332	Chief Operating Officer M&C Locality	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Anticipated Impact of the Opening of the Grange University Hospital (GUH).	**IF**: The flow of patients from North Aneurin Bevan University Health Board and South Powys flow via the Welsh Ambulance Service Trust is conveyed to Prince Charles Hospital (PCH) for time critical patients. **Then:** This will have an adverse impact on flow within PCH **Resulting in**: Severe impact on patient care and provision of care within the Merthyr Cynon locality.	Following review of patient flow from AB and South Powys, the actions put into place and recruitment of key roles in ED has mitigated the risk to inpatient care , activity and flow within Merthyr & Cynon ILG. There is a continued potential for a spike in demand that will be closely monitored by the Head of Patient flow .	Detailed plan in place with clinical engagement & development of patient pathways with Powys team. Planning discussions ongoing with AB colleagues with review of existing pathway agreements and development of future pathways.	Quality & Safety Committee	12	C3 x L4	↓ From 20	12.10.2020	9.3.2021	Following review of patient flow from AB and South Powys, the actions put into place and recruitment of key roles in ED has mitigated the risk to inpatient care , activity and flow within Merthyr & Cynon ILG. There is a continued potential for a spike in demand that will be closely monitored by the Head of Patient flow. This risk has been de-escalated to the ILG / CSG Risk Register as appropriate and consideration will now be given by M&C Locality to consider if the risk can be closed as target level met.

Datix ID	Executive Portfolio	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Last reviewed	Comments
4150	Executive Director of Nursing & Midwifery	Patient / Staff & Public Safety - Physical and /or psychological harm	Wearing for FFP3 masks for 2 hours in a high risk area. Normal time spent in ITU performing procedures can be up to 3-4 hours.	**IF:** the FFP3 masks are used for a period of greater than 2 hours at a time. **Then:** there is an increased risk of integrity of the mask and discomfort to the wearer. **Resulting in:** an increase risk to the user of exposure to the Covid-19 virus if utilised for greater periods. Using FFP3 masks for a period of greater that 2 hours at a time increased risk of integrity of mask and the discomfort to the wearer. To change the mask more frequently will require the user to remove all Personal Protective Equipment and remove themselves form the environment. If the mask is utilised for greater periods this can increase the risk to the user of the COVID virus. The user will also need to rehydrate etc. due to the increased body heat generated from the full PPE equipment.	Staff are disposing of mask on exiting the unit and to use a new mask before entering.		Health, Safety & Fire Sub Committee of the Quality & Safety Committee	6	6	Closed	May-20	18.11.2020	Target rating met as control measures in place have mitigated this risk.