

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
5214	Executive Medical Director Chief Operating Officer	Improving Care	Patient / Staff /Public Safety	Critical Care Medical Cover	<b>IF:</b> Depleted Consultant Intensivist numbers at Princes Of Wales (POW) continue as a result of medical reasons, retirement and unable to recruit to vacant posts. No Middle Grade medical tier at POW. Consultant intensivist delivered service.  <b>Then:</b> Without Middle Grade tier positions the ability to attract and recruit Consultants will be limited.  <b>Resulting in:</b> the Health Board being unable to deliver safe patient care with gaps in rota. Potential for days and nights to not be consultant covered. No medical team to manage patients.	Daily management of the rota. Use of agency to cover gaps. CTM internal cover (limited options). Development of CTM strategy for Critical Care.	Workforce business proposal to fund Middle Grade tier to ELG. Digital solution to provide safe cross site Consultant cover for RGH and POW, requires IT solution across POW and RGH. Develop workforce modelling for next 2 years and 10 years. Appoint Critical Care lead across CTM to establish one department - 3 sites approach (Care Group organisational change).	Quality & Safety Committee  People & Culture Committee	20	C5xL4	10 (C5xL2)	↔	19.8.2022	19.8.2022	20.09.2022
4887	Director for Digital	Improving Care	Service / Business Interruption	Retrieval and filing of case notes in the POW Medical Records Library	<b>IF:</b> The Medical Records Filing Library at Princess of Wales is full to capacity making it very difficult for staff to retrieve and or file case notes.  <b>THEN:</b> Risk of unable to manoeuvre mobile racking, therefore unable to access case notes Risk of fire as case notes close to source of ignition Risk of Fire Service or HSE closing access department Very High risk of upper limb injury Risk of notes falling from height causing injury (some case notes are in excess 8.3kg) Risk of Fire Service or HSE closing access to department  <b>RESULTING IN:</b> If we could not retrieve any case notes, Consultants would be unable to make clinical decisions impacting on patient care. If the whole library was affected, this would impact 100 of thousands of patients care. Admissions/Outpatients would have to be cancelled staff refusing to continue to work in unsafe environment. Multiple and serious injuries to staff, possibly death.	(The case notes are very tightly packed on shelves. Mobile racking is failing due to age, lack of maintenance, and weight Case notes are being stored inappropriately on floors under desks, and insecurely at height. The working environment is congested, with no dedicated storage space for large ladders. Significant force is required to retrieve each file (123.N - this is 3 times higher than what is considered to be high force).)  Broken Racking at Bridgend Offsite Stores - Repairs have been carried out with damaged racking in Bridgend North Rd Offsite stores. Temporary use of container deployed on site.  Broken Racking at POW - On each occasion the racking has failed, the engineer has been able to repair it (£500 + VAT) but it continues to fail. Please see progress notes for more information. Access to this specific racking is permitted to Supervisors only, who only access it once a day.  The Filing Library is closed to non-Medical Records staff, aside from the Porters who require access for emergency OOH admissions.  Task and Finish group establish to address the above risks. Capacity has been identified at Glanrhyd and noticed served to SBHUB to vacate. It is hoped that we will be able to relocate notes to this area in mid-July, which will address the immediate H&S issues. Currently waiting for procurement process to be completed.	Relocation of Case Notes from POW/Bridgend Off-site Store to Glanrhyd Site. Timeframe 19.8.2022  Replace racking and review office environment of POW filing Library. Timeframe 30.01.2023  Creating additional long term storage space. Timeframe 31.07.2023.	Digital & Data Committee & Safety Committee	20	C5xL4	10 (C5xL2) <del>(4-C2xL2)</del>	↔	27.10.2021	07.07.2022	19.08.2022
4491	Chief Operating Officer All Locality Groups	Improving Care	Patient / Staff /Public Safety	Failure to meet the demand for patient care at all points of the patient journey	<b>IF:</b> The Health Board is unable to meet the demand upon its services at all stages of the patient journey.  <b>Then:</b> the Health Board's ability to provide high quality care will be reduced.  <b>Resulting in:</b> 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 FUNB, demand and capacity and a recovery programme which will include cancer patients; The plans have timescales - which are being monitored, however it is likely that it will take time to reduce waiting times to acceptable levels in the post-covid-19 environment. The PCH Improvement Programme has significantly accelerated a number of mitigating actions designed to improve flow, reduce risk and improve the quality of care in the unsheduled 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.  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.  Update July 2022 - Risk scoring unchanged. Revised Improvement trajectories for each speciality now in place updated via the Planned Care Recovery Programme Board. The Health Board is working with Cardiff and Vale University Health Board and Swansea Bay University Health Board to support recovery actions in high risk specialities.  Update September 2022 - Continue delivery of the Planned Care Recovery Actions. Reconfiguration orthopaedic inpatient operation. Commissioning the insourcing of the workforce to deliver to Theatres. Amalgamation of Health Board wide capacity plans. Significant work ongoing in relation to FUNB which is being captured in the performance reports.	Quality & Safety Committee  Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	11.01.2021	07.09.2022	31.10.2022
4071	Chief Operating Officer All Integrated Locality Groups Linked to RTE 5039 / 4513	Improving Care	Patient / Staff /Public Safety	Failure to sustain services as currently configured to meet cancer targets.	<b>IF:</b> The Health Board fails to sustain services as currently configured to meet cancer targets.  <b>Then:</b> The Health Boards ability to provide safe high quality care will be reduced.  <b>Resulting in:</b> Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	• Tight management processes to manage individual cases on the cancer pathway. • Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. • Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk • Harm review process to identify patients with waits of over 104 days and potential pathway improvements. • Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. • All three ILGs are working to maximising access to ASA level 3+4 surgery on the acute sites. • HB working to ensure haematological SACT delivery capacity is maintained. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. • Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. • Alternative arrangements for MDT and clinics, utilising Virtual options - Cancer performance is monitored through the more rigorous monthly performance review process. each ILG now reports actions against an agreed improvement trajectory.  Weekly monitoring led by the Chief Operating Officer to monitor progress. Pathology backlog clearance plan funded and in delivery.	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 March 2022, the enhanced monitoring process continues with progress being made in all specialities. There is a lag between the increase in activity which is being evidenced and the impact on the Suspected Cancer Pathway (SCP) which results in overall performance still being depressed. Improvement activity in outpatients and diagnostics is in place and being closely monitored. There is an unmitigated risk within the breast cancer speciality where are RTE ILG continue to develop an improvement plan, however, it is worth highlighting the constrained nature of breast cancer capacity across Wales. Update June 2022 - Score unchanged. Recovery trajectories and associated actions in place for each tumour site to address long waiting times and to improve overall performance against the 62 day standard. In addition there is weekly monitoring led by the Chief Operating Officer to monitor progress. Pathology backlog clearance plan funded and in delivery.  Update September 2022 - Score remains unchanged. Recovery actions continue with focus on Urology and Lower GI. Improvements are being recognised in Gynaec and Breast Surgery which are currently ahead of plan. Cancer treatments remain higher than pre-Covid levels.	Quality & Safety Committee  Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	07.09.2022	31.10.2022
4080	Executive Medical Director	Improving Care	Patient / Staff /Public Safety	Failure to recruit sufficient medical and dental staff	<b>IF:</b> the CTMUHB fails to recruit sufficient medical and dental staff.  <b>Then:</b> the CTMUHB's ability to provide high quality care may be reduced.  <b>Resulting in:</b> a reliance on agency staff, disrupting the continuity of care for patients and potentially affecting team communication. This may affect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Explore substantive appointments of staff undertaking locum work in CTMUHB • Feedback poor performance and concerns to agencies • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs	The response to Covid-19 has impacted the original timeframes for these actions due to the requirement to focus on clinical operational service delivery during the pandemic. Revised dates have been included below: 1. AMD and workforce to develop recruitment strategy - 31.3.2021 Update October 2021: The Health Board is in the process of introducing patchwork across Merthyr & Cynon ILG on 6th October and Rhondda Taf Ely on 20th October. This will give an indication of the gaps and the spend, allowing the ILG's to establish a medical recruitment strategy.  2. AMD and DMD to develop retention and engagement strategy - 31.3.2021 - Revised Date February 2022.  3. Reduce agency spend throughout CTMUHB - Update January 2022 - Patchwork rolled out across CTM. Data gathering currently. When sufficient data will have the discussions with HR and clinicians on a fair and appropriate rate card. Update July 2022: Patchwork has been introduced and the data is being used to identify gaps which will support the basis of a business case for additional recruitment aligned to the medical productivity work.  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  People & Culture Committee	20	C5 x L4	15 (C5xL3)	↔	01.08.2013	14.07.2022	31.08.2022

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
4103	Chief Operating Officer Bridgend Integrated Locality Group	Improving Care	Patient / Staff /Public Safety	Sustainability of a safe and effective Ophthalmology service	<b>IF:</b> The Health Board fails to sustain a safe and effective ophthalmology service. <b>Then:</b> The Health Boards ability to provide safe high quality care will be reduced. <b>Resulting in:</b> 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 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 (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	Action plan developed and on going monitoring - consolidated plan coming forward covering Eye Care. The service has transitioned to Bridgend ILG and Bridgend ILG has engaged in potential national solutions to address FUNB. Update 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. 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. 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. 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. Update September 2022 - An update from the risk owners has been requested.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	20.04.2022	30.06.2022
4632	Executive Director of Therapies and Health Sciences. All-Integrated- Locality-Groups	Improving Care	Patient / Staff /Public Safety	<del>Demand and capacity across the stroke pathway</del> Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	<b>IF:</b> changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM <b>THEN:</b> avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care <b>Resulting In:</b> higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community. <b>IF there is continued high demand for stroke beds</b> (currently located in Prince Charles Hospital (PCH) and Princess of Wales Hospital (POWH)) <b>THEN:</b> patients may have a prolonged wait in getting to an appropriate stroke bed in PCH or POWH <b>Resulting In:</b> 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 POWH, limits the ability to appropriately carry out therapeutic treatment.	<del>Stroke patients in RGH are managed by the medicine teams and referral to MDT as required but not specific to stroke rehabilitation</del> <del>WAST alerted to the HB stroke pathway in CTM UHB regarding admissions to PCH or POWH only.</del> <del>Stroke admission pathways have been reconfirmed with WAST to ensure patients are admitted to PCH to access specific stroke care</del> Executive-led Stroke Strategy Group in place, with targeted task and finish under development. ToR and membership of Strategy Group updated. Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke care Regional Stroke Programme Board established Unified, evidence-based pathway developed for thrombectomy Bristol thrombectomy service becoming 24/7 in Autumn Oversight of performance via regular Performance Dashboard updates and Quality and Safety Committee reports Full engagement from clinical teams in HIW review of flow of stroke patients in May 22. National report awaited.	Update July 2022: Work ongoing via CTM Stroke Delivery Group (SDG) to align processes/pathways across CTM and to explore opportunities for improvement. ToR and membership of SDG reviewed. Working to identify additional resources to enable expansion of Early Supported Discharge Team to cover entire CTM footprint and improve flow in relation to stroke pathway. Planned visit from HIW completed in May 22 with focus on patient flow in stroke - national report awaited. A number of actions to address the identified issues are ongoing. Examples include: -Project to support optimal management of Atrial Fibrillation and Hypertension in primary care and targeted case finding amongst patient cohorts of known potential higher risk. -Liaison with Stroke Association regarding FAST campaign and review of WAST stroke pathway -Rapid work underway to develop Stroke Access Bed at both PCH and POWH -Immediate changes planned to the rehabilitation pathway -Work underway to review transfer process from RGH to PCH -Unified thrombolysis pathway agreed, unified acute stroke management pathway under development -Additional resource proposals included in the 2022/23 IMTP - funding was not available this year (7 day working, ESD, additional rehab beds). Alternative options being actively explored, with ESD provision for Bridgend as a priority -Regional developments with Cardiff and Vale progressing to plan -Advanced discussions with Cardiff and Vale to develop a shared thrombolysis on-call rota -Targeted task and finish groups under development (prevention and early intervention); acute care pathway; rehabilitation pathway)	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	05.07.2021	08.09.2022	31.10.2022
4743	Chief Operating Officer Executive Lead - Ty Llidard (DOHS) Bridgend Integrated Locality Group	Improving Care	Patient / Staff /Public Safety	Failure of appropriate security measures / Safety Fencing	<b>IF:</b> there is a failure in security measures. <b>Then:</b> there is an increased likelihood of patients having unrestricted and inappropriate access on the site. <b>Resulting In:</b> 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 Llidard 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 Capital & Estates Update September 2022 - solution to the fencing of the stairwells has been found and funding uplift approved in August ACGM. This work should commence in the early autumn completing within the financial year.	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	05.07.2021	13.05.2022	30.06.2022
5036 Link to RTE 5155	Chief Operating Officer Rhondda Taf Ely Locality Group	Improving Care	Patient / Staff /Public Safety	Pathology services unable to meet current workload demands.	<b>IF:</b> Pathology services cannot meet current service demands <b>THEN:</b> - 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. <b>Resulting In:</b> 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. A Cellular Pathology Recovery Plan paper has been submitted to the Executive team for review - end of May 2022	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 Update June 2022 - Review scheduled for the end of September 2022 to consider the improvements as a result of the mitigating actions undertaken. Update September 2022 - the Health Board continues to outsource samples and is increasing the volume of outsourcing. Regional working underway to explore longer term solutions for Pathology Services.	Quality & Safety Committee	20	C4 x L5	6 (C3xL2)	↔	02.03.2022	07.09.2022	31.10.2022

Datix ID	Strategic Risk owner	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer Bridgend Integrated Locality Group	Improving Care	Patient / Staff /Public Safety	Emergency Department (ED) Overcrowding	<b>If:</b> 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). <b>Then:</b> patients are therefore placed in non-clinical areas. <b>Resulting In:</b> 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. RCMH will undertake. 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. Risk Reviewed June 2022 - No change to risk score - next review scheduled for 1.9.2022. Update September 2022 - Risk reviewed by Nurse Director for Unscheduled Care, risk to be closed owing to multiple changes to structures and reporting systems since original risk was opened. Risks to be reviewed and understood against new framework outlined by the Six Goals Board local governance, quality and safety feedback mechanisms and unscheduled care quality and performance reporting mechanisms. Risk will be closed once the detail has been agreed and new risk superseding this current risk.	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	24.09.2019	07.09.2022	31.10.2022
4907	Director of Corporate Governance Putting Things Right / Legal Cases	Improving Care	Patient / Staff /Public Safety	Failure to manage Redress cases efficiently and effectively	<b>If:</b> The Health Board is unable to meet the demand for the predicted influx of Covid19 related, Duty of Candour, FUNB Ophthalmology Redress/Claim cases <b>Then:</b> 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. <b>Resulting in:</b> 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 panel has 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 has secured Covid funding in respect of the recruitment Covid19 specific Redress Handlers. Update July 2022: There still remains a considerable Redress backlog. Redress cases are not being managed and responded to in a timely manner impacting on ability to achieve complaint response times and resulting in Redress Cases being converted to claims. This poses a significant reputational and financial impact on the Health Board. Opportunities are being explored to realise resources from the Operating Model realignment and a spend to save case is in the process of development to plan how an increase in resource, informed by benchmarking information, to address the current caseload and improve performance. Update September 2022: The Health Board are starting to realise the risk with evidence of redress cases being moved into claims due to delays, which are being settled for less than £25k, which is non reimbursable through WRP procedures for a claim, however can be reclaimed under redress. An invest to save bid has been developed to address the redress backlog.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	02.11.2021	31.08.2022	30.09.2022
4149	Chief Operating Officer Bridgend Integrated Locality Group	Improving Care	Patient / Staff /Public Safety	Failure to sustain Child and Adolescent Mental Health Services	<b>If:</b> The Health Board continues to face challenges in the CAMHS Service <b>Then:</b> there could be an impact in maintaining a quality service <b>Resulting in:</b> recruitment challenges, long waiting times and impact to the implementation of the new model of care. Loss of trust and confidence in the services provided by the Health Board. Difficulties remain in recruiting key staff and new model of care being implemented; waiting times for specialist CAMHS and the new neurodevelopmental service remains challenging. Rationale for target score: Increasing demands being placed on the Core CAMHS Services resulted in long waiting times and the service was experiencing difficulties in recruiting staff	o Reported local and Network pressures across the CAHMS Network with variable problems dependent on the area of the network. o Updates provided to Management Board on developing service model to address reported issues and additional investment secured to increase capacity within the service and to address service pressures. Waiting list initiatives in place whilst staff recruitment is being progressed. o Service Model developed around Core CAHMS in Cwm Taf Morgannwg which includes agreement with General Paediatrics to take the lead on Neurodevelopmental Services and shared care protocols with Primary Care. o New investment impact being routinely monitored internally via the SMT and via monitoring meetings with the ILG o There has been progress with being able to recruit to vacancies with a number of new appointments made. For CTM UHB, the majority of vacancies have been recruited into. The Swansea Bay locality has had more challenges in recruiting skilled staff and there has been plans in place to recruit to developmental posts to attract more interest and invest in staff training and development. More recently the team have managed to recruit into a number of posts (9 to date) with start dates in the next couple of months and interviews scheduled for HCSW and Band 5 practitioners in next month	o Monthly commissioning meeting discussions taking place across the Network in relation to service pressures and funding. Further discussions with commissioners expected by April 22 regarding service provision. 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. 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 WHSC to review service specification and gap analysis. First workshop to take place on 15th Feb 22. Community CAMHS in both CTM UHB and Swansea Bay UHB are carrying out WLI via the planned care recovery (PCR) scheme. The additional clinics and dedicated team for assessment and single point of access have helped to reduce waiting times in CTM UHB to approx. 8 weeks but proposal to continue the PCR additional clinics after April 22 to reduce waiting times and improve compliance. The waiting times in Swansea Bay UHB are much longer (average wait is 10 weeks as of Feb 22 but longest wait is 32 weeks). Further work is planned by end of March 22 on capacity and demand and the implementation of a new service model to aim to meet demand. Proposal to continue with the planned care recovery schemes post April-22 to address the backlog. Further recruitment planned for 3x crisis posts and 4 x specialist posts. There has been progress with being able to recruit to vacancies with a number of new appointments made. For CTM UHB, the majority of vacancies have been recruited into. The Swansea Bay locality has had more challenges in recruiting skilled staff and there has been plans in place to recruit to developmental posts to attract more interest and invest in staff training and development. More recently the team have managed to recruit into a number of posts (9 to date) with start dates in the next couple of months and interviews scheduled for HCSW, Band 5 practitioners in next month. Further recruitment planned for 3x crisis posts and 4 x specialist posts. - FACTS service in escalation with WHSC - draft service specification developed and actively reporting; some resolution to system issues. Outstanding action in escalation around recruitment into the Consultant post (currently service has a locum) and the clinical leadership model. Update June 2022 - risk reviewed and current scoring reflects level of risk in service. Next review due in July 2022.	Planning, Performance & Finance Committee & Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	01/01/2015	17.06.2022	01.07.2022
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)	<b>If:</b> there is no centralised decontamination facility in POWH <b>Then:</b> there are a number of areas undertaking their own decontamination via automated/manual systems. <b>Resulting In:</b> 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. AP(D) 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 WHTM guidance Maintenance programme in place for decontamination equipment 07/10/2021 - In view of aging Urology washer disinfectors, urology service managers to liaise with APDs to initiate/ agree a service contract for maintenance and servicing of equipment with an external. August 2022 Update: Lead IPC Nurse and Deputy Executive Nurse Director reviewed the Controls in Place with no updates reported for August	Centralised Decontamination Facility at POWH - 02/08/21 - SOC approved by WG and design team appointed. Project team group and working group to be set up - Timeframe 30.09.2021. Each area that decontaminates scopes/intra cavity probes(outside CSSD)has developed SOPs detailing the decontamination process. Evidence of SOPs to be shared at decontamination meeting in POWH. Lead IPCN to ask Operational Lead for Decontamination to action. 02/08/21 - Operational lead for Decontamination has requested assurance from the lead endoscopy decontamination officer in POW. Timeframe 30.11.2021. 15.12.2021 - risk peer reviewed and agreed that the risk remains as a 20. Development of a business case to create a single centralised decontamination facility on the POWH site has commenced with Welsh Government Funding support. Business case expected to be completed by Spring 2022. Availability of WG funding to create the unit remains a risk. Update June 2022 - Risk reviewed at Infection Prevention Control committee 28/06/2022 and update provided - JAG have agreed to extend accreditation in Princess of Wales for a further 6 months and have requested a progress report on plans for central decontamination. Update: Lead IPC Nurse and Deputy Executive Nurse Director reviewed the Action Plan with no updates reported for August.	Quality & Safety Committee	16	C4xL4	2 C1xL1	↔	30.12.2020	06.09.2022	25.10.2022
1133	Chief Operating Officer Rhonda Taf Ely Integrated Locality Group	Improving Care	Patient / Staff /Public Safety	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	<b>If:</b> the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; <b>Then:</b> the Health Board will be unable to deliver safe, high quality services for the local population; <b>Resulting in:</b> 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. September 2022 Review by Nurse Director for Unscheduled Care: Currently 6.3 wte ANPs in post with 3 new trainees commencing. Advert for locum Consultant in progress Ad-hoc locum for middle grade to cover for absences and planned leave	ED sustainable workforce plan developed and being implemented (May 2021). Reviewed no change as at 7th September 2021. Risk reviewed 21.09.2021 - remains working progress. Update September 2022 - Nurse Director Review 7/9/22: Unscheduled care group to review immediate workforce resource across all three acute sites by end of October 2022. Actions to then be decided in terms of immediate measures for distribution of staff, governance lines to be agreed (nursing, AHP and Medical) and immediate plan for winter months to be agreed and acted upon. Medium term and substantive plans for workforce requirements and innovations to be worked through as part of six goals board and advanced practice board.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4 x L4	12 (C4xL3)	↔	20.02.2014	07.09.2022	31.10.2022

Datix ID	Strategic Risk owner	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
3133	Chief Operating Officer Facilities	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Due to capacity issues to deal with Covid-19 staff not attending medical gas safety training and courses being rescheduled.	<b>If:</b> Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. <b>Then:</b> Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). <b>Resulting In:</b> Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	<b>Update: September 2022.</b> <b>Action:</b> Use reporting template to monitor attendance. Timescale: 31/03/2022 - Complete. <b>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. Medical gas training compliance is 33% in April 2022 report, 8.85% in July 2022 report (DW WG 31/08/2022).</b> <b>Based on this update the risk rating remains unchanged until a sufficient level of compliance for Medical Gas Training is being consistently achieved.</b> <b>Review Date: 30/11/2022</b>	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	02.09.2022	30.11.2022
3585	Chief Operating Officer Bridgend Integrated Locality Group	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Princess of Wales Emergency Department Hygiene Facilities	<b>If:</b> the toilet and shower facilities are not increased within the Emergency Department. <b>Then:</b> at times of increased exit block the facilities are insufficient for the needs of the patients in the department. <b>Resulting In:</b> 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 to 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. Update June 2022 - Additional toilet works not yet commenced. Agreement from Capital / Estates teams to undertake the work. No start date yet.	Quality & Safety Committee	16	C4 x L4	1	↔	31.05.2019	16.06.2022	01.10.2022
4106	Executive Director of Nursing and Midwifery	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Increasing dependency on agency staff cover which impacts on continuity of care, patient safety	<b>If:</b> The Health Board increasingly depends on agency staff cover <b>Then:</b> the Health Board's ability to provide stability and consistency in relation to high quality care could be impacted. <b>Resulting in:</b> 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. <del>Over time incentives offered to workforce in response to Covid-19 pandemic. Updated August 2022.</del> 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).	Deputy Exec DON is currently reviewing the nurse rostering policy in conjunction with the workforce team in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's . Established a new nursing workforce taskforce. Consultation with Local Partnership Forum undertaken and amendments to the policy have been made as appropriate, the policy will be seeking approval at the Quality & Safety Committee in May 2021- Timescale 31.5.2021. Update November 2021: The Revised policy which was based on SBUHB's current policy (in terms of content / KPI's etc. was taken to Local Partnership forum where it was identified further amendments were requested, these were made in terms of making the clear distinction between the current break times in some areas of POW and that of the rest of CTMUBH. The policy is currently with an ILG Nurse Director who has kindly offered to make the policy more "user friendly" Timescale: 31st December 2021 Update July 2022 - - Nurse Roster Policy in final draft form led by the Nurse Director RTE. Due for completion and ratification end of May 2022. As this date has passed this is being followed up for a further update by the Deputy DoN. 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 August 2022. Safer Care Module - Roll out commenced June 2022 into POW. Roll out being led by WOD/Allocate Rostering Team supported by newly appointed Senior Nurse for NSLWA (WG funded post for 18 months) - - Nursing Productivity Group established w.e.f end of March 2022. With the remit to address Nurse Agency Demand and Spend. August 2022 Update: Overseas Nurse recruitment recommenced in June 2022 as part of the All Wales Overseas Nurse Recruitment programme. A total of 91 overseas Nurses will be recruited by December 2022 (noting that these will not be qualified RN's). A newly developed retention task & finish group has been established with it's first meeting having been held in August. A gap analysis of the NHS England 7 Steps is underway. Nurse Roster policy back with DEDoN for comments. Risk ID 4106 and 4157 will be amalgamated - timeframe 30.09.2022.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	12 (C4xL3)	↔	01/06/2015	25.08.2022	21.10.2022
4148	Executive Director of Nursing & Midwifery	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Non-compliance with Deprivation of Liberty Safeguards (DoLS) legislation and resulting authorisation breaches	<b>If:</b> 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. <b>Then:</b> the Health Board will be unlawfully depriving patients of their liberties and failing to comply with the DoLS legislation <b>Resulting in:</b> 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 CTMUBH 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 CTMUBH 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. August 2022 Update: As a result of enhanced WG funding MCA training has been reviewed and delivered virtually and face to face across sites within CTMUBH. Both YCC and YCR staff have received bespoke training in response to concerns raised by the DU. In addition, training has been agreed and planned to be delivered to service groups within all three ILG. Compliance is being monitored through the Safeguarding Executive Group. Quarter 1 had the highest recorded number of referrals in a quarter, this coincides with the additional training. It is reassuring that the referrals are correctly identifying those people who need urgent and standard DoLS.	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. CTMUBH have already succeeded in securing a £123,000, this has been used to extend the Best Interest Assessor and the Practice Facilitator roles. There will also be a three day Best Interest 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 CTMUBH. Update July 2022 - funding of £90K received to facilitate continued improvement in MCA awareness and training. Training sessions being delivered to targeted areas in the UHB to improve awareness and therefore quality of care and safety. A Learning Event is planned to highlight the issues in respect of capacity, the MCA and planned changes as a result of new legislation. No further steer on the implementation of LPS. Awaiting feedback in relation to the consultation on the code of practice. Update August 2022 - CTMUBH have received further WG funding of £184K. A further four BIA posts have recently gone out to advert. Two further Mental Capacity Practitioners will be advertised in September 2022. It is anticipated that the substantial increase in the teams resources will enable the BIA to address the current backlog and respond to the increase in DoLS requests. The appointment of two further MCA Practitioners will allow for increased capacity to deliver MCA training and prepare for further LPS training throughout CTMUBH. Sessions to highlight the issues in respect of capacity, the MCA and planned changes as a result of new legislation have commenced. Comments in respect of the proposed code of conduct have been submitted to WG by CTMUBH. Once all vacancies have been filled it is anticipated that the backlog of outstanding authorisations can be significantly reduced and the risk reviewed.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01/10/2014	25.08.2022	21.10.2022

Datix ID	Strategic Risk owner	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
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	<b>If:</b> there is a backlog of imaging and reduced capacity <b>Then:</b> waiting lists will continue to increase. <b>Resulting in</b> 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.	Increased capacity required for current referrals to address backlog, particularly in CT/MRI/Ultrasound. Require funding and procurement of mobile scanners in the longer term. Actions: Staffing Resource, Capacity and Demand Planning and business case. <b>No change to risk score or mitigation.</b>	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	04.05.2022	30.06.2022
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	<b>If:</b> The Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage <b>Then:</b> the Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff. <b>Resulting in:</b> 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.	<ul style="list-style-type: none"> <li>Proactive engagement with HEIW continues.</li> <li>Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues.</li> <li>Targeted approach to areas of specific concern reported via finance, workforce and performance committee</li> <li>Close work with university partners to maximise routes into nursing</li> <li>Block booking of bank and agency staff to pre-empt and address shortfalls</li> <li>dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act.</li> <li>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</li> <li>Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board</li> <li>Regular review by Birth Rate Plus compliant, overseen by maternity Improvement Board</li> <li>Implementation of the Quality &amp; Patient Safety Governance Framework including triangulating and reporting related to themes and trends.</li> <li>successful overseas RN recruitment.</li> <li>- There is an operational Nursing Act Group that reconvened from April 2021.</li> <li>Impact assessment signed off from a Mental Health Nursing perspective in relation to an extension to the Nurse Staffing Act 2016.</li> </ul> <p>August 2022 Update: Nurse Staffing Act group set up and in place. Maternity and Neonatal Improvement Board (MNB) group set up and in place.</p>	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 WF&D 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. August 2022 Update: The Health Board receives a draft birth rate and compliance report which the Director of Maternity reviews the completes the outputs. A full data set of compliance is completed and sent to WG by the Director of Midwifery. An initial point review audit has been completed on all Wards in CTM using the Ward Assurance template populated through AMaT (Audit Management and Tracking system). An updated paper is being presented to the November 2022 Quality & Safety Committee. Risk ID 4106 and 4157 will be amalgamated - timeframe 30.09.2022.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	12 (C4xL3)	↔	01/01/2016	25.08.2022	21.10.2022
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.)	<b>If:</b> the Health Board fails to deliver against the Emergency Department Metrics <b>Then:</b> 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. <b>Resulting In:</b> 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. BLG update: RCeM audit undertaken. Staffing remains ongoing issues- plans in place and frequently reviewed. ASCU staffing plan agreed at ILG level and ongoing. Surge trolleys in place to cope with additional capacity requirements. Building works progressing and phases complete. X references to ID3826 & ID3585. Update March 2022, significant work continues to be underway in this area. A Local system reset (perfect fortnight) commenced on the 2nd March 2022 with the aim of being a system wide learning event to establish an improved grip across the patient pathway and a set of improvement projects that can be deployed. Further update to be provided at the completion of the event. Within M&C ILG the PCH Improvement Programme continues to deliver improvement with the feedback from the second unannounced Health Inspectorate Wales Visit in January 2022 providing clear evidence of significant improvement in patient safety and experience. Overwhelming demand activity continues to provide challenging operational context, this is being addressed through joint working with Improvement Cymru and an external provider to deploy a real time flow management process with the specific objective of improving the pace of the patient along the pathway. June 2022 - Six Goals Board established with specific focus on actions to support improvements at the front door. Update September 2022 Update - UEC Six Goals Improvement Programme now commenced - workstream 2 (integrated front door) - rapid mobilisation of other elements of the front door (SDEC, Acute frailty assessment, Hot/rapid access clinics) to facilitate ED de-crowding and timely ambulance offload.	Quality & Safety Committee Planning, Performance & Finance Committee	16	C4 x L4	12 (C4 x L3)	↔	04/12/2020	13.09.2022	31.10.2022
4679	Executive Director for People (Executive Lead for Occupational Health)	Improving Care	Patient / Staff /Public Safety	Absence of a TB vaccination programme for staff	<b>If:</b> the Health Board is not providing TB vaccination to staff <b>Then:</b> Staff and patients are at risk of contracting TB <b>Resulting in:</b> 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 CTMUB. 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. Update May 2022 - Training to be provided to the CTM OH nurses from the CAV OH nurses via a 'train the trainer' approach. Dates being arranged for May 2022. All necessary paperwork in place. Update June 2022 - Training Ongoing. Risk reviewed and remains same. Update August 2022: training has been delayed due to staffing issues within OH department. New dates have been identified in September. New recruits continue to be risk assessed for active TB symptoms and where appropriate new staff from areas of high risk of TB are screened for latent TB.	Quality & Safety Committee People & Culture Committee	16	C4xL4	8 C4xL2	↔	09.06.2021	22.08.2022	31.10.2022
4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Improving Care	Patient / Staff /Public Safety	Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.	<b>If</b> 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), <b>Then:</b> the critical service will be unable to meet the need of patients requiring therapy. <b>Resulting in:</b> 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 been 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. Update July 2022: no change to mitigations; Emerging discussions are taking place in relation to critical care which are likely to impact this risk; Further updates will be provided in 2 months' time Update August 2022 - risk reviewed and no change. Further review added 29.09.2022. No funding has been allocated to enable recruitment of AHP workforce to meet GPC standards. Options appraisal for the existing AHP critical care workforce will be undertaken, which will include consideration of consolidation onto a single site for some of AHP professions with minimal staffing. AHP Clinical Director to review the options and propose a plan by October 2022.	Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	20.08.2021	01.08.2022	29.09.2022

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
4906	Director of Corporate Governance Putting Things Right / Legal Cases	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Failure to provide evidence of learning from events (Incidents and Complaints)	<b>If:</b> The Health Board is unable to produce evidence of learning from events. <b>Then:</b> 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. <b>Resulting in:</b> 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.  Update September 2022: Work continues in this area, however this is still proving a challenging area of work. The new operational model has ensured that this area of work is included as part of the Care Group Governance Team.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	31.08.2022	30.09.2022
4908	Director of Corporate Governance Putting Things Right / Legal Cases	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Failure to manage Legal cases efficiently and effectively	<b>If:</b> The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers <b>Then:</b> 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. <b>Resulting in:</b> Risk to quality and safety of patient care, resulting from lack of capacity to management cases in an 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.  Update July 2022: There still remains a considerable Redress backlog. Redress cases are not being managed and responded to in a timely manner impacting on ability to achieve complaint response times and resulting in Redress Cases being converted to claims. This poses a significant reputational and financial impact on the Health Board. Opportunities are being explored to realise resources from the Operating Model realignment and a spend to save case is in the process of development to plan how an increase in resource, informed by benchmarking information, to address the current caseload and improve performance.  Update September 2022 - Benchmarking exercise completed, which demonstrates low staffing to workload capacity with counterparts across Wales. Invest to save bid has been drafted with a hope to recruit 2 Redress Handlers. In addition opportunities are being explored to realign resources from the changes to quality and safety within the Operating Model review and workshop is being held in Sept 2022 to review skill mix in the claims handling team..	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	31.08.2022	30.09.2022
4922	Director of Corporate Governance Corporate Compliance	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Covid-19 Inquiry Preparedness - Information Management	<b>If:</b> The Health Board doesn't prepare appropriately for the Covid-19 enquiry <b>THEN:</b> the organisation will not be able to respond to any requests for info <b>RESULTING IN:</b> poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues.	The Covid-19 Inquiry Working Group are monitoring a number of 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.  The Health Board has a Covid-19 Inquiry CTM Preparedness Plan which is monitored via the Covid-19 Inquiry Working Group.  The Board and Quality & Safety Committee received a detailed update on the preparedness progress at their respective meetings in March 2022.	Established Timeline for CTMUBH - the timeline has a few elements and uses and will continue to evolve as information is archived. The Senedd also update their information page every two weeks so as time goes on this document will remain a dynamic working document. The timeline is up to date at the moment as far as UK Government, Senedd and WHO information provides. This Timeline does not include the Health Board Information as this requires the archiving of documents in order to populate it.  Archiving Information against the Timeline is yet to commence as the current Covid-19 Information Manager resigned from the role and left the Health Board at the end of August. Recruitment has commenced for a successor to the role with a closing date of the 7.9.2022.  The Covid-19 Working Group are also exploring how to introduce the All Wales Reflection document and the approach for leavers and starters on Office 365. Further update to be shared at the end of August 2022.  A meeting with the appointed Legal Counsel is arranged for the 27th September to support the Health Board in its preparedness for the inquiry and share the activity to date.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	23.11.2021	31.08.2022	31.10.2022
4940	Executive Director of Nursing Patient, Care and Safety.	Improving Care	Quality, Complaints & Audit	Delay to full automated Implementation of Civica	<b>If:</b> the Information team are not be able to complete the necessary data extraction requirements, <b>Then:</b> there will be a delay to the roll out of the automated survey process within the Civica system, <b>Resulting in:</b> a lack of service user feedback and opportunity to areas of improvement as well as 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, KHP 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.  August 2022 Update: Value Based Health Care are working together with patient safety and quality to ensure the Health Board can align patient/peoples engagement / feedback. There is an objective in the new WG transformation strategy where we all have to work together and embed proms and prems. There is currently only one member of staff working on the Civica system (PT)and therefore resource is currently a major factor for the implementation and maintenance of the system. No change to the challenges relating to the full automation of Civica which remains an issue. Due to this CTM response rate to patient feedback is considerably lower when compared to other Health Boards e.g SBUBH, HDUBH, ABUBH, BCUBH. Volunteers within POW are now actively engaging with patients in regards to the Have your say/ patient experience survey	Implementation of the Civica System. Information Team has completed provision of all data feeds (August 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.  August 2022 Update - 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. CIVICA system piloted in PoW in August using volunteers to capture feedback using the CIVICA system via IPADS.	Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	09.12.2021	25.08.2022	21.10.2022
5014	Chief Operating Officer Rhonda Taf Ely Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Care of Obstetric & Gynaecology patients in the ED at the Royal Glamorgan Hospital	<b>If</b> patients continue to present at the ED at the RGH with obstetric and gynaecology related issues and if boundary changes and diverts at times of high demand lead to increased risks for this patient cohort .  <b>THEN</b> they will need to transfer to the ED at PCH where the appropriate services are in place.  <b>RESULTING IN</b> a delay in the provision of appropriate care and treatment and this could lead to in-utero death, neonatal injury or disability, death of a pregnant lady due to blood loss and a loss of reproductive ability.	Pathways in place and subject to regular review. WAST is aware of the patient pathway and the need for O&G patients to go straight to PCH. Patients self presenting at the RGH ED would be prioritised for transfer to PHC Emergency cases would receive immediate general surgical care from non O&G specialists	None identified at current time	Quality & Safety Committee	16	C4 x L4	9 (C3xL3)	↔	15.02.2022	06.07.2022	07.11.2022
4722	Chief Operating Officer Rhonda Taf Ely - Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Senior Medical Workforce Shortfall	<b>If</b> the gaps in the senior medical workforce in RTE are not addressed (2wte vacancy OP, 1wte LTS, 1wte Non clinical duties plus maternity leave and isolation) <b>Then</b> 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.  <b>Resulting in</b> poor quality and unsafe patient care, increasing concerns, risk of litigation, compromise of the UHB's reputation and removal of UHB from Psychiatry training programme.	Regular meetings with interim CSGD and Consultants to plan cover arrangements and support on weekly basis.  Medical model change to functional inpatient at the RGH MHU covered by 3 Locum Inpatient consultants (22 sessions - 12/6/6) to cover 2 x Treatment Wards (28 beds) and 1 x PICU (6 beds).  Recruitment - Vacancies out to advert for locum and substantive contracts. Exploring options for overseas recruitment. All staff being offered additional hours.  In-patient team has been bolstered by an additional Registrar and 2 x SHOs ANP's covering appropriate PCMHSS AND CMHT clinics.	Update 06/06/22 - Vacant post in Rhonda Adult MH and been notified that Locum for Taff Ely who also covers in patient wards 1 day a week will be leaving the end of this week. This leaves 2 vacancies in sectors for adult and an inpatient day short fall.  Update Sept-22 - All adverts agreed to go in BMJ as part of wider recruitment drive. JDs have been reviewed and refreshed.	People & Culture Committee Quality & Safety Committee	16	C4xL4	6 (C2xL3)	↔	28/06/2021	07.09.2022	31.10.2022

Datix ID	Strategic Risk owner	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
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	<b>IF:</b> 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  <b>Then:</b> 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  <b>Resulting in:</b> 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.  <b>September 2022 Update - it was agreed at the August PCR Board meeting that funding would be made available to support an additional Consultant, uplift to for a member of the Pharmacy staff, the appointment of an Administrative Assistant and a Health Care Support Worker.</b>  <b>In addition, Welsh Government has announced that there will be funding for ND services across Wales over the next few years. The funding will be allocated to Regional Partnership Boards for distribution in-line with Regional Integration Fund aligned to the six national models of care with emphasis on taking a whole system approach with education, social care, health and 3rd sector working to deliver new models of care.</b>  <b>This risk will be reviewed for de-escalation based on the above mitigation.</b>	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	13.09.2022	31.10.2022
3993	Chief Operating Officer Bridgend Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	<b>IF:</b> The Health Board fails to meet fire standards required in this area.  <b>Then:</b> the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised.  <b>Resulting in:</b> 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 indicatively 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.  Update June 2022 - No changes to risk scoring. Worked through a new hybrid solution and there is a meeting with Welsh Government on the 12th July 2022.  <b>Update September 2022 from Capital &amp; Estates - initial meeting with WG indicated that further work required to follow up on alternative options to the 6 theatre modular build so follow up WG meeting being arranged for late October / early November. Supply Chain partner reengaged to undertake more detailed engineering and design works,</b>	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	04.07.2022	31.08.2022
4512	Chief Operating Officer Rhonda Taf Ely Integrated Locality Group	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Care of patients with mental health needs on the acute wards.	<b>IF:</b> 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;  <b>Then:</b> 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;  <b>Resulting in:</b> 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. , number of working groups established and working well.	Regular meetings with the mental health CSG in place, number of working groups established and working well.  No change to mitigation or risk score.  <b>Update September 2022 - update requested from the Deputy COO - Primary Care, Community and Mental Health</b>	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	30/12/2020	09.03.2022	10.05.2022
4590	Executive Medical Director Pharmacy & Medicines Management	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Critical Care Pharmacist Resource	<b>IF:</b> additional resource is not identified to increase the critical care clinical pharmacy service  <b>Then:</b> 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.  <b>Resulting In:</b> 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.  <b>Update August 2022 - Currently 40% gap in staff in post vs standards (1.5 wte) across all acute sites. Funding agreed for RGH and staff recruited into post. Currently non-recurrent. Funding request submitted within IMTP.</b>	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	05.04.2021	08.09.2022	08.10.2022
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	<b>IF:</b> If we do not have this specialist service  <b>THEN:</b> 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.  <b>RESULTING IN:</b> 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  Update June 2022: Funding for Consultant Orthogeriatrician identified and two COTE elderly posts in place.  <b>Update September 2022 - COTE and Orthogeriatrician service model being finalised for PCH. Timescale within next 3 months.</b>	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	30.06.2021	07.09.2022	03.10.2022

Datix ID	Strategic Risk owner	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
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	<b>If:</b> 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. <b>Then:</b> 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 CTMUBH laundry being outsourced to commercial laundries. The costs will be significantly higher than those incurred in-house. <b>Resulting In:</b> •Potential of service failure due to existing system. •Potential of CTM sites being without bedding and linen at existing volumes and turnaround times. •Potential increased costs resulting from having to outsource laundry processing to commercial laundries in the event of equipment failure.	The All - Wales Laundry review continues, and at the current time, it is likely that services will be provided from CTM laundry until at least 2024. After this time, the equipment could be moved and rehoused elsewhere to continue to support CTM and the All-Wales Laundry agenda.  Previous IMTP submissions have included as a priority E375K 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 Laundry is being monitored remotely by the system supplying company. This ensures that we are able to run the system and any problems quickly rectified on the 13 stage CBW. The 10 stage new software has now been installed and updated and all snagging completed. We were in the process of arranging a date for the 13 stage CBW software to be updated when the bolts on the 10 stage sheared, this will be repaired Monday 4th July 2022 we will then arrange for the new software to be updated on the 13 stage.  There is a robust contingency plan in place we are able to continue with a normal service until these issues are resolved. We also have the ability to call upon the other L4 region production units. The contingency plan provides for a 5 day full service with ability to call on the other L4 within the All Wales Laundry agreement to produce our linen if needed.	<b>Update September 2022</b> SON to be submitted and if successful replacement software purchased and installed. Timescale: 30/11/2022.  SON approved and funding provided, awaiting installation. Update from Deputy Linen Services Manager that order has been raised to replace.  10 stage press received completed software upgrade.  However, since the last review of this risk on the washer the bolts sheared off the press reducing production by 50%. A contractor has been to site to try and carry out repairs but so far have not been able to due to the severity of the problem.  The contractor has now gone back to the manufacture on the next steps. Dependent on what the manufacture suggests, it's also lead time and down time of this machine, we are looking at the machine out of service for the next few months leaving the laundry only operating at 50% capacity and limited resilience if the other stage washer fails.  Until there is a response received from the contractor, there are no definite answers on parts, costs or timescales. All departments, including Facilities, Estates and NWSSP have been informed of the issue.  As a contingency the 13 stage press is being monitored and will be upgraded after the 06/09/2022.  Based on this update the risk remains as a high risk and will be reviewed in 3 months time or once the repairs have been undertaken and software has been installed.  Review Date: 30/11/2022	Quality & Safety Committee  Planning, Performance & Finance Committee	15	15 (C5xL3)	5 (C5xL1)	↔	27.07.2021	02.09.2022	30.11.2022
4920	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Improving Care	Patient / Staff /Public Safety  Impact on the safety - Physical and/or Psychological harm	Capacity within the ED/ Medical Rehabilitation and Orthopaedic Inpatient Occupational Therapy Service within Princess of Wales	<b>If:</b> clinical capacity remains significantly reduced due to staff sickness and vacancies <b>Then:</b> clinical service delivery will be negatively compromised. <b>Resulting in:</b> 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  <b>Update September 2022 - Last review 30.8.22 next rv 31.10.22. No change to mitigations, recruitment in progress, and improvement in staffing is expected by November.</b>	Quality & Safety Committee	15	C3 x L5	12 (C3xL4)	↔	27.11.2021	30.08.2022	31.10.2022
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	<b>If</b> the Community Dental Service is unable to recruit a special care dentist, <b>then</b> there will be no dedicated specialist to undertake the appropriate assessment and dental treatment under GA for vulnerable adults in a timely manner, <b>resulting in</b> 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.  <b>September 2022 Update - Risk position discussed within Primary Care and rating being reviewed and will be updated once considered via the Primary Care processes.</b>	Quality & Safety Committee	15	C3xL5	3 C1xL3	↔	04.01.2022	13.09.2022	31.10.2022
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	<b>If:</b> Mental Health Services do not have a single integrated clinical information system that captures all patients details. <b>Then:</b> Clinical staff may make a decision based on limited patient information available that could cause harm. <b>Resulting In:</b> Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	1. Process in place for clinical teams to access information via local authority and health board teams. 2. Clinical teams will only use historical information as part of their current risk assessment and if this is not available they will judge the risk accordingly. 3. Merthyr and Cynon and Bridgend CGS leads have confirmed that WCCIS is on their CSG risk register and their updates have been provided within this section, therefore aligned. 4. WCCIS Programme Board establishment for CTM will be finalised by the 30th June 2021, Merthyr and Cynon CGS Lead will Chair this group. The Chair of this group will report to the Senior Responsible Officer. The Task and Finish Groups to be established and aligned to this Programme board Programme will be established by the 31st July 2021. 5. Local Authority have recently developed reports for Mental Health which identifies practitioner caseloads, admissions and discharges and care plan for compliance. 6. 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. This role is leading on the development and implementation plan. 11. Business Case Identifying additional ICT resource to progress the disaggregation process developed and awaiting approval. Workforce capacity impacts on programme deliverables.	1. A Business Case has been developed which identifies additional staff resource required to progress the disaggregation process to bring all CTMUBH staff who currently use WCCIS via local authority over to CTMUBH WCCIS platform. Requires Programme Board approval.  Business Case pending approval.  2. Director of Digital, CTMUBH undertaking a review to understand if WCCIS remains the best solution to progress for CTMUBH in general and for Mental Health specifically.  WCCIS "go-live" at ABUHB in August 2022. Lessons learnt group is attended by CTUHB Project Manager.  Update 26.8.2022 - Risk reviewed with no change to risk rating.  Digital / ICT Update August 2022 - Business Case identifying additional ICT resource to progress the disaggregation process developed and awaiting approval. Workforce capacity impacts on programme deliverables.	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	26.08.2022	04.11.2022

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
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	<b>IF:</b> Mental health inpatient environments fall short of the expected design and standards.  <b>Then:</b> 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.  <b>Resulting in:</b> 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.  RGH MHU are currently in the process of extensive anti-ligature upgrades as part of a capital work scheme, including all doors and ensuite on ward admissions/21/22 and PICU being upgraded.  PICU is now complete and contractors are currently working on Ward 21. Following this work will proceed to admissions and 22 in turn.	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. Update - 28.06.22 with no change to action plan or current risk rating.  5. Full Business Case paused due to pandemic. Resource to be identified to progress full Business Case.  Update - 26.08.22	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	26.08.2022	04.11.2022
4253	Chief Operating Officer Bridgend Integrated Locality Group	Improving Care	Patient / Staff /Public Safety  Impact on the safety - Physical and/or Psychological harm	Ligature Points - Inpatient Services	<b>IF:</b> the Health Board fails to minimise ligature points as far as possible across identified sites.  <b>Then:</b> the risk of patients using their surroundings as ligature points is increased.  <b>Resulting In:</b> Potential harm to patients which could result in severe disability or death.	<b>Bridgend Locality:</b> 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.	<b>Bridgend Locality:</b> o action plan developed with support from the head of nursing within the ILG. o Health 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  Update 25.5.2022 - Major Works complete and official handover undertaken on the 25th May 2022 with contractor. Risk scoring reduced from a 20 to a 15. The Target Score has not been met as there are still works to complete internally with Estates.	Quality & Safety Committee  Health, Safety & Fire Committee	15	C5xL3	10 (C5xL2)	↔	17/08/2020	25.05.2022	30.06.2022
5207	Executive Director of Strategy & Transformation	Improving Care	Patient / Staff /Public Safety  Impact on the safety - Physical and/or Psychological harm  & Statutory Duty / Legislation	Care Home Capacity	<b>IF:</b> the rising costs of delivering care in private facilities drives providers to cease trading.  <b>Then:</b> there will be a loss of capacity within the system.  <b>Resulting in:</b> exacerbated delays in hospital flow, an impact on wait times and increased admission to hospital for displaced patients. Patient experience will be impacted due to increased hospital stays. There will also be a longer term impact on residential care opportunities.	Multi Agency Operational Group established that effectively risk assesses the homes and manages any emergent contractual/ provider/ safeguarding issues, we wonder if this is forward looking enough in the current context.  Local Authorities have regular contact with Care Homes to assess any challenges that they are facing and will intervene as appropriate based on risk and circumstances.	Via the Regional Partnership Board and other partnership meetings questions will continued to be escalated to seek assurance.  Reports on specific incidents will be taken to Planning, Performance & Finance Committee.  Care Providers will continue to engage with Welsh Government to escalate their concerns around the current position.	Quality & Safety Committee  Planning, Performance & Finance Committee	15	C5xL3	10 (C5xL2)	New Risk Escalated August 2022	19.8.2022	19.8.2022	31.10.2022
4217	Executive Director of Nursing & Midwifery Infection Control	Improving Care	Patient / Staff /Public Safety  Impact on the safety - Physical and/or Psychological harm	No IPC resource for primary care	<b>IF:</b> there is no dedicated IPC resource for primary care.  <b>Then:</b> the IPC team is unable to provide an integrated whole system approach for infection prevention and control.  <b>Resulting In:</b> 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.  Update June 2022: Risk reviewed and discussed at Infection Prevention Control (IPC) Committee on 28/06/2022 - IPC workforce review undertaken which needs further discussion with Exec Director of Nursing. Next review scheduled for August 2022.  August 2022 Update: Risk score amended based on control measures in place. No additional measures implemented. Lead IPC Nurse to scope primary care services in next 4 weeks. reviewed by Lead IPC Nurse and Deputy Executive Nurse Director 06/09/2022, risk reduced from 20 (4x5) to 15 (3x5). Consequence score amended and reduced to 3 (from 4).	Quality & Safety Committee	15 ↓ 20 September 2022	C4+L5 C3xL5	8 (E4+L2)  6 (C3xL2)	↓	16/07/2020	06.09.2022	21.10.2022
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.	<b>IF:</b> the current boundary change to redirect emergency cases from the lower Cynon Valley to the Royal Glamorgan Hospital is not reviewed:  <b>THEN:</b> patients will continue to be admitted to a hospital further from their home  <b>RESULTING IN:</b> 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.  No change to mitigation or risk score.  Update September 2022 - Following review of this risk scoring by the COO the consequence score has been reassessed as a 3. This risk remains under constant review.	Quality & Safety Committee	15 ↓ 20	C3xL5	12 (C3xL4)	↓	28/06/2021	07.09.2022	31.10.2022

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
4975	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Improving Care	Patient / Staff /Public Safety	Safe and appropriate repatriation of patients following vascular surgery and participation in the regional MDT	<p><b>IF:</b> 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)</p> <p><b>THEN:</b> 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.</p> <p><b>RESULTING IN:</b> 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.</p>	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.	<p>Financial approval being sought to secure funding for an Allied Health Professional Leadership Post. Timeframe: 28.6.2022.</p> <p>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.</p> <p>Update July 2022: no change to mitigations, matching of the Job Description for the role required is in progress.</p>	Quality & Safety Committee	12 ↓ Decreased from 15 in September 2022	6 (C3xL2)	Risk Reviewed on the 29th July 2022 and the likelihood score reduced to 3, overall risk now 12, so remove from Organisational Risk Register. Update: The Job Description for the role required is progressed and due to be advertised. Will be monitored on the Therapies Risk Register.
3267	Chief Operating Officer Primary Care	Improving Care	Patient / Staff /Public Safety	Out of Hours - Contingency Plan for Business Continuity Communications Hub Ty Elai	<p><b>If:</b> 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).</p> <p><b>Then:</b> In the event Ty Elai should become inaccessible due to adverse weather there is a likelihood of interruption to services.</p> <p><b>Resulting In:</b> Potential delays, impact on service to patients and their experience received. Staff impact.</p>	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.	<p>Explore the possibility of relocation to a health board owned site. Options Appraisal to take to board and to discuss with co-location partners.</p> <p>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.</p> <p>Preliminary meeting with capital and ICT have been undertaken</p> <p>Options Appraisal is being undertaken. A building has identified and awaiting a decision around space. Building has been identified as a possible location. Awaiting blueprints to see if space is suitable for requirements.</p> <p>Timeframe: 31.3.2022</p>	Quality & Safety Committee	12 ↓ Decreased from 16 in September 2022	6 (C2xL3)	The situation has been reviewed and there are discussions with the LA in relation to an update on the IT infrastructure in Ty Elai and internal discussions regarding taking this in-house and even alternative location.  Based on the above mitigation the risk score has been reduced.
5109	Chief Operating Officer Rhondda Taf Ely Locality Group	Improving Care	Patient / Staff /Public Safety	Poor air-conditioning & increased environmental temperatures in Pathology labs	<p>Pathology laboratories at both hospital sites have poor air conditioning and ventilation, resulting in increased temperatures particular during spring and summer months when the external temperatures have increased.</p> <p><b>IF:</b> An air-conditioning solution is not implemented in Pathology laboratories.</p> <p><b>THEN:</b> Critical analysers will fail (max temperatures for most is 32°C), inappropriate storage of room temperature reagents &amp; consumables (18°C - 25°C)</p> <p><b>RESULTING IN:</b> loss of service and delays in critical results, impacting patient flow and safety. Financial loss due to inappropriate storage of room temperature reagents/consumables that will no longer be deemed safe for use.</p>	Temperature monitoring (Manual and Electronic) Open Windows to improve ventilation. Business Continuity Policies in place	SON has been written and submitted to ILG Potable air con solution to be pursued for Summer months.	Quality & Safety Committee	8 ↓ 16	4 (C2xL2)	Risk score reviewed and decreased to a risk score of 8 (moderate) in light of reduced environmental temperatures and the fact we now have portable air con units.
The Following Risks have been de-escalated from the Organisational Risk Register as they have been addressed in an overarching risk as articulated in Column 'I' . These will be reviewed to see if they remain on Local Risk Registers or closed in their entirety.											

4652 - Linked to overarching stroke risk 4632.	Chief Operating Officer  Executive Director of Therapies & Health Sciences  Merthyr & Cynon Locality - Host of Therapies Services within the Health Board	Improving Care	Patient / Staff /Public Safety  Impact on the safety – Physical and/or Psychological harm	Therapies provision to increased numbers of stroke patients in Prince Charles Hospital (PCH), Princess of Wales (POW), Ysbyty Cwm Rhondda (YCR) and community/out patients  <b>If:</b> 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.  <b>Then:</b> this will impact on quality of care, patient flow, safe discharges and staff wellbeing.  <b>Resulting In:</b> 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.  Update July 2022 - no change to mitigations, there are plans that this risk will be combined with other stroke related risks on ORR (4632).  Update August 2022 - POW room is now complete and being used, no additional funding has been provided for any of the Therapies stroke elements of the pathway. Challenges remain at all stages. Issues were raised at Stroke Planning group on 25.07.2022 and are included in the HB action plan. Therapies will be represented at stroke pathway resilience task and finish group	Quality & Safety Committee	20	C4 x L5	This risk has been recommended for removal from the ORR (but will remain on the therapies risk register) as it will be combined into a single stroke risk on the organisational RR, led by the COO and Executive Director of Therapies and Health Sciences., This risk is now captured within the single risk, ID 4632.
4203 -	Chief Operating Officer  Rhondda Taf Ely Integrated Locality Group  Merthyr Cynon Locality Group	Improving Care	Patient / Staff /Public Safety  Impact on the safety – Physical and/or Psychological harm	Meeting demand to address the surgical backlog following COVID-19 and managing recurrent demand  <b>If:</b> Surgical services cannot meet demand and patients are not treated in targeted timeframes (RTT)  <b>Then:</b> Patients will not receive surgery and subsequent treatments  <b>Resulting In:</b> Harm to patients, poor prognosis, reduced treatment options, poor quality of life, risk of claims, increased demand on wider health and social care services including emergency care, staff burnout.  Since March 2020 COVID 19 Pandemic has resulted in Surgery being ceased for Urgent and Routine listed patients.	Restart plans including Waiting List Initiative to increase capacity. Limited ring-fenced funding for recovery plans. Outsourcing Some pathway innovations Ongoing validation of waiting lists.  M&C ILG Risk 3958 closed as merged with this risk.	Restarting elective surgery and further outsourcing to private sector. Discuss reconfiguration of acute site to enable more surgical capacity. 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.  M&C Update: August 2022- A new risk will be added for M&C surgical services will be reviewed on new care group alignment with reference to alignment to organisational risk 4491.	Quality & Safety Committee	20	C4 x L5	This risk has been recommended for removal from the ORR (but will remain on the service risk register) as it is captured in the overarching planned care recovery risk 4491. COO Reviewed 7.9.2022.
816	Chief Operating Officer  Rhondda Taf Ely Integrated Locality Group	Improving Care	Patient / Staff /Public Safety  Impact on the safety – Physical and/or Psychological harm	Follow up capacity and clinic cancellations (FUNB)  <b>If:</b> The Health Board is unable to control and meet the capacity and demand to accommodate all hospital follow up outpatient appointments.  <b>Then:</b> the Health Board's ability to provide high quality care may be reduced.  <b>Resulting in:</b> Potential avoidable harm to patients who are not reviewed in a timely manner.	CSG plan to address the FUNB position across all specialties as part of the restart programme and additional funding requirements have been identified but not supported at present. Regular meetings in place to monitor the position and it needs to be acknowledged that it will take a number of years to address the backlog 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	This risk has been recommended for removal from the ORR (but will remain on the service risk register) as it is captured in the overarching planned care recovery risk 4491. COO Reviewed 7.9.2022.

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	<p><b>If:</b> Demand continues to exceed the agreed manageable caseload in Gynaecology services across the Health Board.</p> <p><b>Then:</b> there will be a delay in the pathway requiring multiple consultations on site and reliance on an individual Practitioner.</p> <p><b>Resulting in:</b> Delay in patient pathways, poor experience, unsustainable demand on the workforce and Gynae Rapid access service development is slow progression.</p> <p>Risk description reframed into the if, then, resulting in format.</p>	<p>Hysteroscopy service business case is being updated</p> <ul style="list-style-type: none"> <li>- Increased cancer tracking</li> <li>- Review of pathways and service</li> <li>- increased capacity in Gynaecology Day Assessment Unit (RGH) for Urgent Suspected Cancer patients</li> <li>- newly established Post Menopausal Bleeding clinic</li> <li>- newly developed Standard Operating Procedure for Gynae Cancer MDT</li> <li>- Job plans updated to ensure medical hysteroscopy cover</li> <li>- Review of theatre capacity and utilisation</li> <li>- Review of job plans for cancer leads</li> <li>- Purchase of additional capital to support service improvements</li> <li>- Job plans review to increase Urgent Suspected Cancer slots within job plans</li> </ul> <p>Covid Health Board Guidelines in place.</p>	<p>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. Update July 2022 - Risk mitigation and scoring remain unchanged. There is work ongoing to consider aligning this risk with Risk ID 4071 - Failure to sustain services as currently configured to meet cancer targets. Update September 2022 - to be reviewed in light of new Care Model alignment and proposal to incorporate into risk 4071.</p>	Quality & Safety Committee	16	C4 x L4	This risk has been recommended for removal from the ORR (but will remain on the service risk register) as it is captured in the overarched Datix Risk ID 4071 - Failure to sustain services as currently configured to meet cancer targets.
5080	Chief Operating Officer  Bridgend Locality Group	Improving Care	Patient / Staff /Public Safety  Impact on the safety – Physical and/or Psychological harm	Therapy Input for Stroke patients	<p><b>If</b> we continue to with the lack of qualified Occupational and Physiotherapy input for the Stroke patients who are severely impaired and require significant interventions throughout the hospital, <b>then</b> there will be a severe impact on the rehab of these patients, <b>resulting in</b> increased length of stay for these patients.</p>	<p>BILG are reviewing the situation daily and are trying to be as flexible with staff cover across sites as possible.</p>	<p>Mitigating action to follow from BILG.</p>	Quality & Safety Committee	15	15 (C3xL5)	This risk has been recommended for removal from the ORR (but will remain on the therapies risk register) as it will be combined into a single stroke risk on the organisational RR, led by the COO and Executive Director of Therapies and Health Sciences., This risk is now captured within the single risk, ID 4632.

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
4753	Executive Medical Director Pharmacy & Medicines Management	Improving Care	Patient / Staff /Public Safety	Maternity : Lack of pharmacy clinical service, medicines governance and medicines safety Impact on the safety – Physical and/or Psychological harm	<b>IF:</b> the Health Board fails to resource pharmacist time for maternity services in all acute sites <b>Then:</b> 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. <b>Resulting in:</b> 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.  Update July 2022 - Deputy Medical Director: Pharmacist now in post and has done a great deal of activity in relation to the governance of prescribing and medicines management resulting in the signing off of the IMSOP recommendation around neonatal pharmacy. Risk mitigation and score will be reviewed during August.	Quality & Safety Committee			Clinical Pharmacist appointed as designate pharmacist for maternity and regularly visits and meets with managers. Therefore risk mitigated at current time and risk has been closed.
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. Impact on the safety – Physical and/or Psychological harm	<b>IF:</b> The level of physiotherapy staffing remains significantly below normal operating levels.  <b>THEN:</b> The health boards ability to provide essential physiotherapy interventions will be compromised.  <b>RESULTING IN:</b> 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  Update June 2022 - workforce evaluation to take place to determine the bed/staff ratio requirement for CTMUHB Physiotherapy inpatient staffing model. Following this scoping work, the risk will be updated. Asked for review date to be changed to reflect this.	Quality & Safety Committee			Reviewed 30.8.2022, risk closed as likelihood score reduced to 2, overall risk score of 6. Review of current workforce issues shows a significant improvement, due to reduction in Covid- related absence and the appointment of Band 5s via streamlining.