

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	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
5276	Director of Digital	Central Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives Operational Patient safety Digital Healthcare Wales Interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025.	IF: the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. THEN: operational delivery of pathology services may be severely impacted. RESULTING IN: potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	A provision will be added to the current legacy contract for a short-term extension until September 2025; this has been agreed in principle but not yet been formally implemented. A set of additional contract milestones to the new system supplier will be included in the contract change notice (CCN) for hosting; the hosting CCN has been agreed subject to Ministerial approval. The LINC programme is working with Health Boards and Trusts to review the new system suppliers revised delivery plan. There has been several meetings between Health Boards, LINC Programme and Commercial Providers. At a meeting held on the 13th December it was agreed by NHS that deployment would be sequential and in the original running order. Health Board configuration meeting scheduled with Commercial supplier for 10th January 2023. Update May 2023 - Concerns around viability of proposed implementation plans have been widely discussed and escalated. The next LINC Programme Board is scheduled for the 9th May 2023 where further discussions will take place.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	5.5.2023	31.5.2023
4922	Director of Corporate Governance Interim - Executive Director of Nursing	Central Support Function - Quality Governance (Compliance)	Assistant Director of Governance & Risk	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Covid-19 Inquiry Preparedness - Information Management	IF: The Health Board doesn't prepare appropriately for the Covid-19 enquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues.	The Covid-19 Inquiry Working Group are monitoring a number 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 and September 2022. The Assistant Director of Governance & Risk is the first point of contact for any inquiry contact and the Executive Director of Nursing is the Interim Senior Responsible Officer (SRO).	Establish a Timeline for CTMUHB - the timeline will have a few elements and uses and will continue to evolve as information is achieved. 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 for a successor to the role was unsuccessful and therefore the pace of progress in developing the Health Boards Timeline and gathering key documentation centrally is being significantly impacted which could be detrimental to the Health Board being able to efficiently and effectively respond to requests from the Inquiry. The AD for Governance & Risk is exploring other options for resourcing this role including project management support. Following a briefing meeting with Legal Counsel it was clear that the Health Boards focus should be on the timeline and documentary evidence at this stage which has heightened the risk in terms of the resource afforded to the preparedness for the inquiry. Legal Counsel advised the Health Board to pause the introduction of the All Wales Reflection document at this stage of the Inquiry. At the Covid-19 Pandemic Inquiry Working Group on the 11th October the likelihood of this risk was increased from a 4 to a 5 based on the above risk factors. Update May 2023 - The Health Board has successfully appointed to the Covid-19 Information Manager position with a planned commencement date of the 30th May 2023. The likelihood of this risk will be revisited once the new post holder has commenced and has undertaken an initial assessment of the Health Boards preparedness.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	23.11.2021	28.4.2023	30.06.2023
4491	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	IF: The Health Board is unable to meet the demand upon its services at all stages of the patient journey. Then: the Health Board's ability to provide high quality care will be reduced. Resulting in: Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Specialty specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology - it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care Board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	The Health Board has established a Planned Care Board, with a full programme of work to address FUNB, demand and capacity and a recovery programme which will include cancer patients. The plans have timescales - which are being monitored, however it is likely that it will take time to reduce waiting times to acceptable levels in the post-covid-19 environment. The PCH Improvement Programme has significantly accelerated a number of mitigating actions designed to improve flow, reduce risk and improve the quality of care in the unscheduled care pathway. Updates on this are provided through the Quality & Safety Committee including specific actions and measures. There is also a PCH Improvement Board that meets monthly with the COO as the SRO. The Health Board is centralising the operational management and decision making around all elective services with the clear aim of increasing and protecting elective activity as we deal with the pressures of the Covid-19 pandemic and winter. This process commenced in late October 2021 and greater clarity will be provided in the next review. 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 request escalated to Interim Planned Care Director. The Care Group Director of Nursing has confirmed their intention on launching a series of risk and compliance huddles over the course of April, May and June to ensure rigour, validity and accuracy behind existing risks.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 (C4 x L3)	↔	11.01.2021	28.10.2022	30.11.2022
4071	Chief Operating Officer All Integrated Locality Groups Linked to RTE 5039 / 4513	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	IF: The Health Board fails to sustain services as currently configured to meet cancer targets. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer pathway. Regular reviews of patients who are passed 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 sites 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 recommending 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 Care Group now reports actions against an agreed improvement trajectory.	Update April 2023 - New Service Level Agreement signed with Tenovus Cancer Care, for a telephone call back system to provide additional support to patients. It is a service to support the patients who are waiting/improve the patient experience. There is no additional mitigation that has been added this month. Next review 31.5.2023.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	28.04.2023	31.05.2023
4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	IF: the CTMUHB fails to recruit sufficient medical and dental staff. Then: the CTMUHB's ability to provide high quality care may be reduced. Resulting in: a reliance on agency staff, disrupting the continuity of care for patients and potentially 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 • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs • Improving induction and development of new doctors	In terms of recruitment the following actions are underway over the next 6-12 months: • Meeting with Executive Director for People held on 24.11.2022 to discuss Medical Workforce (MWF) recruitment (including PAs, Specialists) • Liaising with Care Group Medical Directors regarding their Care Group workforce planning and strategy • Once the Health Board identifies the gaps from the Medical Workforce Productivity Programme group on the establishment work stream it can then target specific areas with either Consultant, Specialist, MG cover • A report is also being prepared on British Association of Physicians of Indian Origin (BAPIO) for international recruitment. These are risks that will continue due to the National workforce availability. The Health Board will need to tackle these issues in a variety of ways - there is no one solution. The approaches include -recruitment, job planning (compliance and standardisation), establishment, new ways of working (MDT and expanding alternative roles), ADH spend and national rate cards, sickness rates, all of these impact on the workforce and are part of the programme. As the Health Board now has a planned stepwise programme it is dealing with the matter with more clarity and direction.	Quality & Safety Committee People & Culture Committee	20	C5 x L4	15 (C5xL3)	↔	01.08.2013	09.03.2023	30.04.2023
4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	IF: The Health Board fails to sustain a safe and effective ophthalmology service. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Sustainability of a safe and effective Ophthalmology service	Measure and ODTIC DU reviews nationally. - Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTIC'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 review piloting to assess all potential harms). - Additional services to be provided in Community settings through ODTIC (January 2020 start date). - Intra-vitreous injection 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 ODTIC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	Update December 2022 - There has been a significant decrease in >104 week stage 1 waiting list subsequent to additional weekend activity. At the beginning of November 2022 we were reporting 1869 RTT cases >104 weeks, The Health Board has carried out 66 additional sessions, primarily addressing cataracts and General Ophthalmology. Scheme extended into January. Consequent to this piece of work, all stage 1 cataract conversions will be sent to C&V during February and March for assessment and procedure. C&V are providing capacity for 500 stage 4 patients. CTM currently has 228 stage 4 conversions >104 weeks and this number will increase whilst we continue with the weekend activity. Validation work is being carried out in tandem with the booking of weekend work and RTT rules. Progress has been made with the regional programme, an Option Appraisal presentation has been circulated to all HB's to include 6 delivery models for local preference ranking. All options are being explored and evaluated against a set of agreed criteria. Update request escalated to Interim Planned Care Director. The Care Group Director of Nursing has confirmed their intention on launching a series of risk and compliance huddles over the course of April, May and June to ensure rigour, validity and accuracy behind existing risks.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	23.12.2022	30.1.2023

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4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	<p>IF: changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM</p> <p>THEN: 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</p> <p>Resulting In: 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.</p>	<ul style="list-style-type: none"> Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. ToR and membership of Strategy Group updated. Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway Board briefing to ensure all sighted to challenges Quarterly briefings to Quality and Safety Committee Performance data regularly presented to Performance, Planning and Finance Committee Strong CTM input to regional and national Stroke Programme Boards Unified, evidence-based pathway developed for thrombolysis Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy Designated senior operational lead for performance and improvement leadership for stroke pathway 	<p>Update May 2023 - The CTM Stroke Strategy Group has agreed an integrated action plan with a number of short, medium and long term actions, some of which have resource implications. Progress is being made in a number of areas:</p> <ul style="list-style-type: none"> SOP and patient pathway developed for stroke patients presenting at RGH WAST agreement to advise patients on acute stroke site locations Ring-fencing of stroke beds ongoing Continued CTM-wide stroke consultant rota Ongoing regional developments with CAU/UB continue. CTM consultant in post as Clinical Lead for Stroke for the South Central Wales Stroke Delivery Network. Developments underway to capture patient outcomes and experience data. Prescribing nurse and specialist pharmacist have been identified to support the initiation of the AF and BP project in Primary Care. Work is progressing on implementation. A primary care nurse will work locally with those at risk to raise awareness of the signs and symptoms of stroke. Radiographer approved CTAs now operating on all 3 acute sites, reducing delays in thrombectomy Implementing CT perfusion (CTP) scanning to extend the window of thrombolysis and thrombectomy Development of new stroke thrombolysis and thrombectomy pathway underway in response to new stroke guidelines, published in April 2023 WHSC commissioned thrombectomy service hours extended from 08:00-00:00 from 2nd May 2023. Awaiting confirmation of date for 24/7 service Discussions between CTM, Stroke Association and Public Health Wales resulted in agreement to run FAST campaign in Wales from 27th April 2023 Social media campaign funded by CTM Public Health for local FAST campaign 	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	--	05.07.2021	11.05.2023	11.06.2023
4743	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services)	Improving Care	Patient / Staff /Public Safety	Failure of appropriate security measures / Safety Fencing	<p>IF: there is a failure in security measures.</p> <p>Then: there is an increased likelihood of patients having unrestricted and inappropriate access on the site.</p> <p>Resulting In: absconding events and possible harm to the patient or members of the public</p>	<p>The risk of absconding, and self harm/ suicidal ideation for Mental Health and CAMHS patients is risk assessed on admission and reviewed regularly thereafter.</p> <p>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.</p> <p>High risk patients are escorted when outside the units</p> <p>Absconding patient policy in place</p> <p>Some fencing is in place in the areas concerned, however, it is aged and fails to provide an adequate barrier.</p>	<p>Funding Bid for approx. £385K has been submitted by Estates</p> <p>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</p> <p>Capital & Estates Update September 2022 - solution to the fencing of the stairwells has been found and funding uplift approved in August ACG. This work should commence in the early autumn completing within the financial year.</p> <p>Update October 2022 - Deputy COO Acute Services to review this risk from a pan Health Board perspective and identify actions per Care Group as appropriate. Timescale 31.12.2022.</p>	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	--	05.07.2021	1.11.2022	31.12.2022
3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety	Emergency Department (ED) Overcrowding	<p>IF: As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited to, significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information).</p> <p>Then: patients are therefore placed in non-clinical areas.</p> <p>Resulting In: Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters.</p> <p>Filling the last resus space compromises the ability to manage an immediate life threatening emergency.</p> <p>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.</p>	<p>Increased number of nursing staff being rostered over and above establishment.</p> <p>Additional repose mattresses have been purchased with associated equipment.</p> <p>Additional catering and supplies.</p> <p>Incidents generated and attached to this risk.</p> <p>Weekly report highlighting level of above risk being generated.</p> <p>All patients are triaged, assessed and treatment started while waiting to offload.</p> <p>Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released.</p> <p>Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times.</p> <p>Expansion of the bed capacity in Y5 to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital.</p> <p>Daily site wide safety meeting to ensure flow and site safety is maintained.</p> <p>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.</p> <p>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.</p> <p>Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21</p> <p>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.</p> <p>Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.</p>	<p>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.</p> <p>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 frame work 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.</p> <p>Update 3.11.2022 - mitigations to improve flow and discharge at POW now being addressed through workstreams 2, 3 and 4 of the UEC 6 goals programme, with rapid focus on reducing lost bed days due to discharge delays, formal launch of D2RA model and pathways Dec 22, along with launch of e-whiteboards/discharge referral forms.</p> <p>Update 25/04/23 - review of this risk performed by the USC SMT improvement plans in place as part of 6 goals improvement programme however this programme is not yet in implementation stage. Targeted improvement trajectories in place for USC group relating to 1-hour ambulance delays and patients waiting over 12hours within the department which will improve overcrowding. This remains an ongoing risk for all three ED's and will be reviewed regularly as implementation of targeted improvement takes place. New review date 30/07/23</p>	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	--	24.09.2019	25.04.2023	30.07.2023
4907	Executive Director of Nursing	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety	Failure to manage Redress cases efficiently and effectively	<p>IF: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases</p> <p>Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right.</p> <p>Resulting In: Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.</p>	<p>Controls are in place and include:</p> <ul style="list-style-type: none"> Regular review run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager 	<p>Update April 2023- New operating model in respect of quality, safety and governance almost fully implemented. Legal Services Manager in post. 1 claims handler post is due out to advert. Slippage monies due to vacant posts have been used for short term para legal agency to assist with the Redress backlog, in readiness for full Duty of Candour implementation.</p>	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	--	02.11.2021	28.04.2023	30.06.2023
5267 (Capturing risks 4106 and 4157 which are now closed)	Executive Director of Nursing & Quality	Centre Support Function - Patient Care & Safety - Nursing	Deputy Executive Director of Nursing	Improving Care	Patient / Staff /Public Safety	There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses	<p>IF: the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage & Health Care Support workers (HCSW's)</p> <p>Then: The Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff.</p> <p>Resulting in: The potential for disruption to the continuity and of patient care and risk of suboptimum team communication due Potential to impact on patient safety and staff wellbeing. Financial implications of continue high use of agency cover (includes registered nurses and HCSW's)</p> <p>Please note - this risk is an amalgamation of two previous risks i.e., 4106 and 4157, these have been closed with a narrative to state this combined new risk has been created.</p>	<p>Proactive engagement with HEIW</p> <p>Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues.</p> <ul style="list-style-type: none"> Close work with university partners to maximise routes into nursing Retire and return strategy to maintain skills and expertise Dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act; this has now been rolled out to all wards within CTMUHB. Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board Regular review by Birth Rate Plus, overseen by maternity Improvement Board Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends Targeted approach to areas of specific concern reported via finance, workforce and performance committee <p>The HCSW agency shift requests will follow the same type of forms and sign off from December 2022.</p> <p>Nurse Roster Policy now approved, ratified and implemented in December 2023. This includes KPIs which will allow monitoring of effective roster management.</p> <p>Automated nursing agency invoicing system implemented within the Health Board by the Bank office team - rosters must be locked down daily to enable the system to work - provides more rigor to roster management at ward/department level.</p>	<p>NURSE ROSTERING</p> <p>Nursing Productivity Group actions are progressing well through this forum. Registered Nurse Off contract agency in hours and out of hours forms have been in place for two months - there has been a noticeable reduction in usage and thus spend on off contract Registered Nurses.</p> <p>Workforce and finance teams are working together to provide joint metrics and monitoring of agency usage and cost progress monitored via Nursing Productivity group who report into the Value & Effectiveness portfolio group.</p> <p>SAFER CARE</p> <p>Roll out continues on all sites.</p> <p>ENHANCED SUPERVISION</p> <p>Corporate nursing team are due to undertake focused work on areas who have a high number of HCSW agency requests to understand the demand in terms of whether HCSW's are required to support the supervision of an individual or group of patients, whether the requests are related to the increase acuity or due to high sickness/vacancy rates and/ or poor fill rate from bank HCSW requests.</p> <p>The risk score for this risk has been increased to 20 in January 2023 due to the fact that severe operational pressures in the clinical areas, including the opening of several different areas of unfunded beds and frequent "boarding" of additional patients on some wards mean the frequency of the likelihood which was scoring 4 ((Frequency: At least weekly) is now scored at 5 (Frequency: At least daily). This score will be reviewed in March 2023</p> <p>Update 11/05/2023: The Health Board are linking into National Retention Work-stream and contributed to drafting the National Framework. In line with NHS Wales the Health Board have implemented Exit Questionnaires and supporting interviews, where appropriate. Undertaking "Coffee mornings" for spouses of CTM UHB employees to undertake an assessment of eligibility to apply for the registered nurse adaptation process.</p> <p>The Corporate Nursing team working with People Services on focused aspects of recruitment and retention.</p> <p>The Corporate Nursing team is collaborating with the University of South Wales, in relation to International recruitment of Student Nurses to their undergraduate programmes.</p> <p>Undertaking Mobile Recruitment Fairs to support student streamlining.</p> <p>School Career Fairs - to attract younger people into the profession and also promoting the Apprenticeship Scheme.</p>	Quality & Safety Committee	20	C4xL5	C4xL3	↔	25.10.2022	11.5.2023	11.06.2023

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3131	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Mortuary Capacity	IF: There is insufficient Mortuary capacity across the Health Board, including bariatric capacity THEN: the Health Board will be unable to accommodate any increases in deaths (due to seasonal pressures, pandemics, general increases in service demand), and may exceed capacity in the event of Mortuary closure or refrigeration failure, or funeral directors/undertakers being unable to collect bodies or move bodies between sites due to adverse weather. RESULTING IN: bodies not being placed in storage that is in compliance with HTA licencing standards, No capacity for bariatric bodies, leading to HTA reportable incidents, complaints and reputational damage.	Mortuary capacity log is in operation and informs the pathology scorecard for monthly reporting (average, max and min). Business continuity plan is in place to move bodies around the sites to ensure capacity is maintained within the HB. This relies on the Health Boards contracted funeral director to move the bodies in an appropriate and dignified manner. Mortuary staff are trained to complete the mortuary capacity log on a daily basis and to ensure the business continuity plan is executed in the event of likely capacity issues. Nuttwell units in use at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) "Real time" capacity white board installed in both mortuaries so porters/APTs can visualise quickly capacity issues. Private ambulance with a dedicated driver, now in use between sites. 4X4 vehicle so can be used during inclement weather (within reason). Can transport up to 4 deceased per journey, in a dignified manner.	Long Term Mortuary Capacity Plan. (5 year lease of additional capacity based at PCH has been approved by Executive leadership team in November 2022. Additional unit delivered and preparation and equipping underway to go live by the end of January.) Ongoing discussions with the Coroner have resulted in a 1 year reprieve of post mortems by CTM staff but continuing use of Mortuary space at PCH for external Medical examiners to use from January 2023. SLA being drawn up. Plan to implement electronic white boards for mortuaries in 2023-24. April 2023 - DTS Care Group have advised that they have consciously reduced the risk as the Health Board is past the winter peak where we anticipated major issues and the 5 year rental on the new unit providing an additional 85 spaces at PCH site mitigates and reduces the risk. The Health Board continues to have the Nutwell units as additional (rather than being used as daily capacity as they were prior to January 2023) should there be a surge. The Care Group are comfortable that this risk may be dynamic but consider there is strong mitigating action in place that has been well supported and recognised by the executive team. Should the situation deteriorate the Care Group will make sure they review and amend and escalate as appropriate.	Quality & Safety Committee	16	C4xL4	C3xL2	↔	05.03.2018	23.3.2023	31.5.2023
5036 Link to RTE 5155	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Service Director - Diagnostics, Therapies and Specialties Care Group	Improving Care	Patient / Staff /Public Safety	Pathology services unable to meet current workload demands.	IF: Pathology services cannot meet current service demands. THEN: - there will be service failure - there will be continued delays in reporting of Cellular Pathology results - failure to provide OOH services required for acute care - inadequate support and accommodation for Clinical Haematology cancer patients - increased turnaround times for provision of results including timely autopsies - increased pressure on existing staff - inadequate training provision throughout - inability to repatriate services from Bridgend. RESULTING IN: 1. Failure to meet cancer targets and national cancer standards 2. Anxiety for patients waiting for delayed results 3. Unsuspected cancer cases being missed in the backlog potentially leading to patient harm. 4. Delays in the reporting of critical results and issue of blood products OOH leading to patient harm 5. Failure to meet the standards required for provision of autopsy reports for the ME service 6. Clinical incidents due to errors and poor training. 7. Poor compliance with legislation and UKAS standards (that are mandated by the HB and Welsh Government). 8. Reputational damage and adverse publicity for the HB. 9. Continued inequity of services provided to CTM patient population. 10. Suboptimal care for Haematology cancer patients	1. Triage 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 POCCT 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 10. Novation of Equipment to the Managed Service Contract Due date 3.7.2023	Blood Bank Capacity Plan Due date 1.12.2022 Demand & capacity review Due Date 31.07.2023 Workforce redesign Due date 31.07.2023 Dedicated Pathology IT resource Due Date 31.7.2023 Accommodation review Due Date 31.07.2023 Novation of Equipment to the Managed Service Contract Due date 3.7.2023 Update April 2023 - Risk score reduced to 16 to reflect current position, this is dependent upon ongoing review and continued investment from the HB. We have consciously reduced the risk to 16 as we have had funding to year end to continue the outsourcing and there is a tentative commitment for a significant amount to continue the outsourcing through 2023-24 which we are comfortable that it allows us to reduce the risk on that basis. We will keep this under review and should the situation change we will update the risk register and adjust the risk assessment appropriately.	Quality & Safety Committee	16	C4 x L4	6 (C3xL2)	↔	02.03.2022	23.3.2023	31.05.2023
5254	Executive Director of Nursing.	Centre Support Function - Quality Governance - Concerns and Claims	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour	IF: The Health Board is unable to meet the increased work demand in respect of the implementation of Duty of Candour THEN: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * New evidence framework developed * Engagement with the All Wales Duty of Candour Network to discuss implementation of the Duty * Reports run on predicted case numbers * Request to the All Wales Duty of Candour Network that an impact assessment is undertaken	Update April 2023: New operating model in respect of quality, safety and governance almost fully implemented. 1 claims handler post is due out to advert. Slippage monies due to vacant posts have been used for short term para legal agency to assist with the Redress backlog, in readiness for full Duty of Candour implementation. Local impact assessments across Wales are almost complete, which will form the basis for the National Impact Assessment.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	27.04.2023	30.06.2023
4479	Executive Director of Nursing & Midwifery	Central Support Function - Infection, Prevention and Control	Deputy Lead Infection Prevention Control Nurse & Decontamination Officer.	Improving Care	Patient / Staff /Public Safety	No Centralised decontamination facility in Princes of Wales Hospital (POWH)	IF: there is no centralised decontamination facility in POWH THEN: there are a number of areas undertaking their own decontamination via automated/manual systems. Resulting In: possible mismanagement of the decontamination processes/near misses/increased risk of infection/litigation risks and non compliance with national guidance/best practice documents. The hospital site is at risk of losing their JAG accreditation in Endoscopy if plans to centralise decontamination is not progressed. There is no dirty - clean flow for procedure room 2 in endoscopy. There is some decontamination equipment in HSOU 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 WHM guidance 7. Maintenance programme in place for decontamination equipment 07/10/2021 - In view of aging Urology washer disinfectors, urology service managers to liaise with APDs to initiate/ agree a service contract for maintenance and servicing of equipment with an external.	Centralised Decontamination Facility at POWH - 02/08/21 - SOC approved by WG and design team appointed. Project team group and working group to be set up - Timeframe 30.09.2021. Each area that decontaminates scopes/intra cavity probes(outside CSSD)has developed SOPs detailing the decontamination process. Evidence of SOPs to be shared at decontamination meeting in POWH. Lead IPCN to ask Operational Lead for Decontamination to action. Update 3.5.2023 - Update 03.05.23 business case still being developed due to delays in tender returns and analysis. However scheme being subject to strategic review in light of consideration of the benefits of a regional solution	Quality & Safety Committee	16	C4xL4	2 (C1xL1)	↔	30.12.2020	3.5.2023	3.7.2023
1133	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	IF: the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; THEN: the Health Board will be unable to deliver safe, high quality services for the local population; Resulting in: compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site. 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. 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	12.10.2022	07.03.2023
3133	Chief Operating Officer	Central Support Function -Facilities	Governance and compliance manager, Facilities	Improving Care	Patient / Staff /Public Safety	Due to capacity issues to deal with Covid-19 staff not attending medical gas safety training and courses being rescheduled.	IF: Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. THEN: Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). Resulting In: Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TMA 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.	Update April 2023: Action: Use reporting template to monitor attendance. Complete. TMA has been undertaken. Action: Med Device Trainer to review with another UHB what can be delivered via e-learning to support some elements of this subject. Timescale: 31/05/2023. Medical Device Training is in constant communication with clinical leads to create and adapt solutions to increase Medical Gas Training compliance across the UHB. As of Dec 22 the current Medical Gas training details for CTMUHB are as follows: Total Staff Requiring Training - 2287, Staff Trained - 168, Compliance Percentage - 7.34%, Untrained Staff - 2119. No significant increase in compliance. Attendance still poor for this subject matter, Med Device Trainer reviewing with another UHB what can be delivered via e-learning to support some elements of this subject, such as refresher training, however attendance would be required for initial training (WG 21/02/2023). The current risk rating will remain unchanged until Medical Gas Training Compliance increases significantly. As this remains at high risk, a review will be completed in 3 months. Review Date: 31/05/2023	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	30.3.2023	31.05.2023

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3585	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Operational: Core Business Objectives Environmental / Estates Impact Projects Including systems and processes, Service /business interruption	Princess of Wales Emergency Department Hygiene Facilities	If: the toilet and shower facilities are not increased within the Emergency Department. Then: at times of increased exit block the facilities are insufficient for the needs of the patients in the department. Resulting In: Poor patient experience, complaints and further concerns raised from the Community Health Council have repeatedly flagged this issue on visits to the department.	There are additional toilet facilities in the radiology department that mobile patients can be directed to however staff do whatever they can within the constraints that they have. Additional facilities being explored as part of departmental capital works.	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 footprint in the department when the capital work commences. Update February 2023 - Commencement of capital works in ED which will include a second, disabled access patient toilet. This will be situated within the main department and will be accessible for within the clinical area.	Quality & Safety Committee	16	C4 x L4	1	--	31.05.2019	06.02.2023	30.04.2023
4148	Executive Director of Nursing & Midwifery	Central Support Function - Quality Governance (Quality & Patient Safety)	Assistant Director Quality, Safety & Safeguarding	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	If: the Health Board fails to adequately resource the DoLS Team to address the backlog of authorisations and adequately manage a timely and effective response to new authorisations. Then: the Health Board will be unlawfully depriving patients of their liberties and failing to comply with the DoLS legislation Resulting in: the rights, legal protection and best interests of patients who lack capacity potentially being compromised. Potential reputational damage and financial loss as a result of any challenge by the ombudsman or litigation.	During February 2023 review of this risk the control measures have been revisited and streamlined. - 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. - An action plan will be overseen by the Deputy Head of Safeguarding to monitor the management of the backlog. - Welsh Government have agreed to a change of use of current 22/23 funding to appoint an agency to clear the current backlog. This agency includes Best Interest Assessors and section 12 Doctors to undertake assessments. - The current backlog is reviewed regularly to ensure that urgent authorisations are prioritised. - A further part time and full time Best Interest assessor were appointed in December 2022, their induction is now complete and they are fully integrated into the DoLS team.	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. CTMUB has 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 CSOs 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 CTMUB. Update April 2023 - The Government have announced that LPS will not be progressed during this Parliament. However, Welsh Government are committed to strengthening DoLS and continuing to raise awareness of the Mental Capacity Amendment Act 2019. Therefore, further funding is available to CTMUB to help reduce the DoLS backlog and provide training and awareness for MCA. A proposal has been submitted to retain the additional Best Interest Assessors and Mental Capacity act Practitioners. In addition, to utilise funding to appoint an agency to clear the current backlog of DoLS, this will include the use of 12 Doctors. Should funding be approved, the backlog of DoLS will be cleared within approximately two months. It has been confirmed that this funding is recurrent, which will allow CTMUB to sustain a model that continues to complete DoLS in line with statutory guidance.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	--	01/10/2014	20.04.2023	20.06.2024
4152	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Back log for imaging in all modalities / areas and reduced capacity	If: there is a backlog of imaging and reduced capacity Then: waiting lists will continue to increase. Resulting in: delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC and Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	WLIs are being undertaken by consultants to reduce reporting backlogs, this is part of the work agreed via Planned Care Recovery (PCR) funding. Use of fixed term locum staff to help relieve pressure from vacancies. Overtime payments have been made in line with agreed PCR schemes for sessions to help reduce backlogs. Weekend scanning sessions being provided and added lunchtime lists as overtime being run. Re-vesting of referrals against BMUS guidance, review of pathways/criteria, increased productivity per scanner. Close monitoring of USC waiting times and working collaboratively with Cancer Business Unit and other colleagues. There is an ongoing review of capacity plans for the whole service but without additional investment the WG target will not be met. Update April 2023 - PCR funding bid for 2 biochemists - FITT testing - new vetting criteria	Quality & Safety Committee	16	C4 x L4	4	--	01/06/2020	17.04.2023	15.05.2023
4458	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches.)	If: the Health Board fails to deliver against the Emergency Department Metrics Then: The Health Boards ability to provide safe high quality care will be reduced. Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. Resulting In: A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls. Compromised safety of patients, potential avoidable harm due to waiting time delays. Potential of harm to patients in delays waiting for treatment.	Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protection 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. 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. Update 3.11.2022 - now being addressed via UEC 6 goals programme, workstreams 2, 3 and 4. Aim to improve whole hospital/system flow, implementing D2RA model and pathways Dec 22, implementing enabling processes to improve flow and discharge - including e-whiteboards/e-discharge referrals, discharge hub, additional components of integrated front door (including acute frailty ax, hot clinics, SDEC), discharge lounges on each site.	Quality & Safety Committee Planning, Performance & Finance Committee	16	C4 x L4	12 (C4 x L3)	--	04/12/2020	3.11.2022	31.12.2022
4906	Executive Director of Nursing	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	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)	If: The Health Board is unable to produce evidence of learning from events. Then: the Health Board will be unable to recoup any costs from Welsh Risk Pool for personal injury or clinical negligence claims made against the Health Board. Resulting in: Risk to quality and patient safety with potential for further claims as learning and improvement will not have taken place. Financial impact to the Health Board	Controls are in place and include: - Monitored and reported through the weekly Executive Quality & Safety meeting. - Regular engagement and meetings with the Executive team to assist in gathering of learning. - Improvement plan implemented by WRP with monthly targets to submit the backlog. - Learning From Event Report (LFER) Standard Operating Procedure devised and disseminated - LFER 'How to Guide' devised and disseminated - Ad-hoc training available on request. - Internal targeted monitoring in place.	Update April 2023: The new operational model review in respect of quality, safety & governance has ensured that the facilitation of LFERs sits within the Care Group Governance Teams, with Patient Safety Improvement Managers taking a lead of facilitation and assisting Clinical Service Groups with improvements and learning from events. This transition came into place in April 2023. Training and a buddy system has been implemented to support this transition. LFER status is regularly reviewed in the weekly Patient Safety, Complaints and Legal Services data meeting, weekly Executive Patient Safety Meeting and Quality & Safety Committee. Better LFER reports are available per care group to allow for better oversight by the Care Group triumvirate. WRP are no longer accepting incomplete LFERs and therefore this will drive better and more timely completion of LFERs. Quality assurance procedure now in place to ensure learning is of the required standard. Increasing the approval rate. The approval rate is being monitored via the Executive Patient Safety meeting.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	--	02.11.2021	27.4.2023	27.06.2023
4679	Executive Director for People (Executive Lead for Occupational Health)	Central Support Function - Occupational Health	Head of Service - Employee Health (Occupational Health)	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Absence of a TB vaccination programme for staff	If: the Health Board is not providing TB vaccination to staff Then: Staff and patients are at risk of contracting TB Resulting in: Failure to comply with the Department of Health and Social Care guidance and lack of confidence in the service	The 'fitness letter' issued by Occupational Health to the appointing line manager following an employee health clearance highlights vaccination status. Screening for latent TB for new entrants and offering T spot testing to assess positive or negative.	Update for May 2023 - A new process has been mapped which needs to be ratified with the Occupational Health Dr position. Specialist Respiratory Nurse Teave and Pharmacy before training and implementation of TB screening can take place. A meeting is being arranged to progress.	Quality & Safety Committee People & Culture Committee	16	C4xL4	8 (C4xL2)	--	09.06.2021	21.04.2023	30.06.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	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	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff / Public Safety	Waiting Times/Performance: ND Team	<p>IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity</p> <p>Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes</p> <p>Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring</p>	<p>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).</p> <p>Recurrent funding agreed at Planned Care Board 25/08/2022 and successfully appointed 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 HCWS - appointed Nov 22</p> <p>Meetings with National Lead for Values Based and Prudent Health Care taken place to look at modelling of the service.</p> <p>Bids have been submitted through successive IMTPs and previously against new WG funding sources for the ND service.</p> <p>Internal working group in place to repatriate SLA from Swansea Bay so that a local service can be developed</p> <p>WG funding (£12m) announced for ND services - health, education and third sector. SBARS being developed to bid for funding to enhance provision moving forwards.</p> <p>WLI agreement following Neurodivergence Improvement Programme funding via RPB until end of March 2023 to address longest waiters achieved no patients to be waiting over 104 weeks at end of March 2023. WLI agreed to continue April 2023 onwards to maintain current wait times whilst additional funding is being agreed through regional partnership board to develop a pan CTM model.</p>	<p>Seeking confirmation that non-recurrent funding is made permanent for fixed term posts - timeframe 31.3.2022.</p> <p>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.</p> <p>September 2022 Update - It was agreed at the August PCR Board meeting that funding would be made available to support an additional Consultant, uplift for a member of the Pharmacy staff, the appointment of an Administrative Assistant and a Health Care Support Worker.</p> <p>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.</p> <p>October 2022: Risk remains unchanged however, review underway with Clinicians. Next review 31.12.2022.</p> <p>Next review scheduled for 1.3.2023 regarding mitigating action - Consideration required for further investment in service.</p> <p>April 2023 - Improvement in waiting times with no children waiting >104 weeks. additional funding agreed through regional partnership board so the service model is being reformed.</p>	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	--	14.07.2021	25.04.2023	31.05.2023
3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff / Public Safety	Fire Enforcement Notice - POW Theatres.	<p>IF: The Health Board fails to meet fire standards required in this area.</p> <p>Then: the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised.</p> <p>Resulting in: potential harm, risk of fire. Possible further enforcement in the form of prosecution.</p>	<p>Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation.</p> <p>Staff training on lift evacuation.</p> <p>Closed storage cupboards purchased for safe storage of equipment.</p> <p>"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.</p> <p>Need to plan for drop in theatres to mitigate work commencing</p>	<p>Need building work to be undertaken to ensure safety. Operating theatres will need to close for this to occur.</p> <p>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.</p> <p>Progress has been made in identifying a preferred short term decant option for theatres which has a high level costing attached. Paper drafted for ELG consideration prior to further WG discussions to enable the commencement of detailed design work and a business case submission to secure WG funding.</p> <p>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.</p> <p>Update September 2022 from Capital & 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.</p> <p>Update November 2022 - Risk remains unchanged as the options work is ongoing and meeting with WG is likely to be at the end of November with an outcome to the options review being discussed at that meeting. It is expected that this meeting will confirm the preferred way forward.</p> <p>Updated Dec 22 - WG and SWFRS meetings deferred until January due to potential crossover of enabling and decant options with the planned procurement of the BA site in Llantrisant. Clinical engagement and option appraisal session planned for the 11th January to confirm preferred options for provision of decant theatres to support the main works taking place. Mobile theatres (revised design) have been visited and are being reconsidered as an option.</p>	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	--	31.01.2020	3.5.2023	3.7.2023
4732	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff / Public Safety	Lack of orthogeriatrician NICE guidance and KPI1 NHFD	<p>IF: If we do not have this specialist service</p> <p>THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality.</p> <p>RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too.</p>	<p>The already stretched on call medical team are contacted for ad hoc advice.</p> <p>There is no COTE service and no specialist advice available</p>	<p>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</p> <p>Update June 2022: Funding for Consultant Orthogeriatrician identified and two COTE elderly posts in place.</p> <p>Update September 2022 - COTE and Orthogeriatrician service model being finalised for PCH. Timescale within next 3 months.</p>	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	--	30.06.2021	07.09.2022	03.10.2022
4772	Chief Operating Officer	Central Support Function - Facilities	Governance and compliance manager, Facilities	Improving Care	Operational: Core Business Business Objectives Environmental / Estates Impact Projects	Replacement of press software on the 13 & 10 stage CBW presses	<p>IF: The 10 & 13 stage Lavatec presses have old software control systems, and are both vulnerable to failure. Following a fault developing and a recent maintenance call out it was identified that the 10 stage press is working intermittently caused by a software problem.</p> <p>Then: If the 10 Stage press control system fails the consequence of not purchasing the software replacement would result in the laundry service being unable to produce to full capacity and reduced to around 55%. If the Stage 10 press control system software fails then it could also impact on the Stage 13 press. The consequence of both presses failing and not purchasing the software replacement would result in the laundry service being unable to process any laundry which will result in all CTMUB laundry being outsourced to commercial laundries. The costs will be significantly higher than those incurred in-house. Resulting In:</p> <ul style="list-style-type: none"> •Potential increased costs resulting from having to outsource laundry processing to commercial laundries in the event of equipment failure. 	<p>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.</p> <p>Previous IMTP submissions have included as a priority £375k for a replacement automated sorting and roll cage washer/dryer system at the laundry. The software that controls system for the CBW forms an integral part of the current press.</p> <p>Benefits of equipment being replaced:</p> <ul style="list-style-type: none"> •Reduced risk of service failure and therefore improved confidence in continued production. •Easier to diagnose and put right any mechanical defects. <p>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.</p> <p>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.</p>	<p>Update April 2023: SON to be submitted and if successful replacement software purchased and installed. Timescale: 31/05/2023.</p> <p>SON approved and funding provided, awaiting installation. Update from Deputy Linen Services Manager that order has been raised to replace.</p> <p>10 stage press received completed software upgrade.</p> <p>We are now ready for the installation of the software upgrade to the 13-stage press. All items needed for the upgrade have been received by the supplier. The in-house electrical work has been completed. The supplier has provided an installation date for the end of March 2023 - beginning of April 2023. This will allow the installation of the new chemical system to be installed prior to the upgrade. The upgrade comes as part of a new chemical contract between NWSSP and Ecolab who will be providing the equipment as part of the contract.</p> <p>Based on this update the risk remains as a high risk and will be reviewed in 3 months time or once the software has been installed.</p> <p>Review Date: 31/05/2023</p>	Quality & Safety Committee Planning, Performance & Finance Committee	15	15 (C5xL3)	5 (C5xL1)	--	27.07.2021	13.04.2023	31.05.2023
3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff / Public Safety	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	<p>IF: Mental Health Services do not have a single integrated clinical information system that captures all patients details.</p> <p>Then: Clinical staff may make a decision based on limited patient information available that could cause harm.</p> <p>Resulting In: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.</p>	<p>1. Process in place for clinical teams to access information via local authority and health board teams.</p> <p>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.</p> <p>3. 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 established and aligned to this Programme board.</p> <p>4. Local Authority have recently developed reports for Mental Health which identifies practitioner caseloads, admissions and discharges and care plan for compliance.</p> <p>5. Deployment order in place for all existing WCCIS mental health staff users</p> <p>6. Community Drug and Alcohol Team in Bridgend have now moved over to WCCIS, early implementation learning continues to take place.</p> <p>7. WCCIS Regional Working Group now has a representative from the Health Board to maintain pace of delivery for WCCIS mental health rollout.</p> <p>8. CTM have set up a Project Board in partnership to prepare for implementation of WCCIS</p> <p>9. Project manager has been recruited. This role is leading on the development and implementation plan.</p> <p>10. Business Case identifying additional ICT resource to progress the disaggregation process developed and awaiting approval. Workforce capacity impacts on programme deliverables.</p> <p>Patient Safety Controls:</p> <ul style="list-style-type: none"> • CSG's have undertaken initial review and rationalised staff access to all information systems to understand the presenting need for access. • CSG's have introduced mechanisms to monitor and control access to FACE/WCCIS/W Drive to ensure prudent access to patient information. • Each clinical team has at least one staff member with resources and training to access information in line with agreed permissions to ensure ease of access to available information from all systems. • RTE lead nurse will lead pan CTM MDT working group to develop consistent approach to clinical record keeping and monitor ongoing IG process/ workstreams (Meeting date in November to be confirmed). 	<p>1. A Business Case has been developed which identifies additional staff resource required to progress the disaggregation process to bring all CTMUB staff who currently use WCCIS via local authority over to CTMUB WCCIS platform. Requires Programme Board approval.</p> <p>Business Case pending approval.</p> <p>2. Director of Digital, CTMUB undertaking a review to understand if WCCIS remains the best solution to progress for CTMUB in general and for Mental Health specifically.</p> <p>WCCIS "go-live" at ABUHB in August 2022. Lessons learnt group is attended by CTUHB Project Manager.</p> <p>3. Options Appraisal completed with plans to present to the ELG on the 7th November 2022 with a view to progress to full Business Case.</p> <p>A service improvement and learning team is being established and the role of this team will be to develop robust oversight and mitigations in relation to record keeping until such time and integrated system is available.</p> <p>Update April 2023 - Use of Welsh Community Care Information System (WCCIS) in Mental Health Services - The HB has committed to rollout of v5 within 2023/24. The Director of Digital will be the SRO, working closely with the Service Director as digital and operation have to be aligned on the implementation process. The Programme Board is due to convene May 2023.</p>	Quality & Safety Committee	15	C5xL3	6	--	07/11/2018	28.04.2023	31.05.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	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
4601 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer Director of Primary Care and Mental Health Services Rhonda Taf Ely Locality	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	IF: Mental health inpatient environments fall short of the expected design and standards. Then: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. Resulting in: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommending a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed.	1. Discussions to commence with Welsh Government in relation to the inpatient environment. 2. A scoping document case to be prepared and submitted to Welsh Government – COMPLETE scoping Document submitted and agreement to commence a Strategic Outline Business Case received. 3. Develop a strategic outline business case. Timescale March 22 currently scoping the configuration of a future focused mental health unit - paused due to pandemic 4. If the strategic outline business case is accepted, progress to the development of an outline then a full business case. 5. work paused due to pandemic. Resource to be identified to progress business case process 6. A Quality Improvement Programme in relation to inpatient care is being developed and a workstream in relation to therapeutic environments is being established with the aim of optimising the patient experience. Inaugural workshop to take place early 2023. 7. Recruitment has taken place for Assistant Director of Strategic Transformation and this role will lead a range of strategic programmes including recommending a new capital business case for a new Mental Health Unit. COMPLETE Update April 2023: A Quality Improvement Programme in relation to inpatient care is being developed and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop is scheduled to take place on the 26th April. Estates escalation review undertaken in all 4 CSG areas. Estates strategic review in development which will align with RPM capital funding, RTE and Bridgend have significant opportunities for rationalizing and improving estate.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	--	15.06.2021	25.04.2023	01.06.2023
5207	Executive Director of Strategy & Transformation	Primary & Community Care Group or Central Function?	Deputy Director of Strategy and Partnerships	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation	Care Home Capacity	IF: the rising costs of delivering care in private facilities drives a number of providers to cease trading. Then: there will be a loss of capacity within the system. Resulting in: 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 continue 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. CTMUHB is working with Care Inspectorate Wales (CIW)and the local authorities to understand the implications of the HB providing care services either as a provider in its own right or in partnership with a local authority Update April 2023 - No changes made bar next review date as cost of living crisis still relevant.	Quality & Safety Committee Planning, Performance & Finance Committee	15	C5xL3	10 (C3xL2)	↔	19.8.2022	13.04.2023	30.06.2023
4217	Executive Director of Nursing & Midwifery Infection Control	Central Support Function - Infection Prevention and Control	Lead Infection, Prevention and Control Nurse	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	No IPC resource for primary care	IF there is no dedicated IPC resource for primary care. Then: the IPC team is unable to provide an integrated whole system approach for infection prevention and control. Resulting In: non compliance with the reduction expectations set by WG. A significant proportion of gram negative bacteraemia, S.aureus bacteraemia and C.Difficile infections are classified as community acquired infections.	Liaise with specialist services in primary care e.g., bowel and bladder service IPC team investigate all preventable community acquired S.aureus and gram negative bacteraemia and share any learning with the IPC huddles arranged in primary care to look at community acquired. Update August 2021: the IPC team is working collaboratively with the bowel and bladder service to investigate all preventable urinary catheter associated bacteraemia. Any learning points/ actions is being shared with community teams. Work in progress to start/reintroduce RCAs/IPC huddles for community acquired C.Difficile cases.	Update 11/05/23 - IPC Nurse Consultant, HARP Team has not commenced honorary contract with CTM as yet. Meeting arranged between Lead IPC Nurse and Nurse Consultant end May 2023. Deputy Executive Director of Nursing to undertake strategic review of IPC service.	Quality & Safety Committee	15	C3xL5	6 (C3xL2)	↔	16/07/2020	11.05.2023	11.7.2023
4721	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Shift of the boundary for attendances at the ED.	IF: the current boundary change to redirect emergency cases from the lower Cynon Valley to the Royal Glamorgan Hospital is not reviewed: THEN: patients will continue to be admitted to a hospital further from their home RESULTING IN: increased pressure on the medical teams to manage an increased patient cohort, lack on continuity of care with follow up arrangements closer to home	Boundary change currently subject to review to understand the impact across CTM.	Boundary change currently subject to review to understand the impact across CTM. Update April 2022 - Meeting to be convened between MBC 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	C3xL5	12 (C3xL4)	↔	28/06/2021	11.10.2022	30.11.2022
4887	Director for Digital	Central Support - Digital & Data Function	Medical Records Manager	Improving Care	Service / Business Interruption	Retrieval and filing of case notes in the POW Medical Records Library	IF: 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. THEN: 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 RESULTING IN: 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 falling 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 SBUHB 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.	Update May 2023 - Relocation of case notes has taken place, these notes are now in storage at Glanrhyd hospital site. This has helped the situation in medical records Bridgend but still does not allow for sustainable growth of notes into the future. In response to this the destruction of notes embargo due to the infect blood enquiry has now come to an end and a piece of work is needed to understand the resource needed to scope and undertake destruction of suitable notes to future support the storage risk around patient notes. Based on this latest mitigation position the likelihood score has been reduced to a 3.	Digital & Data Committee & Quality & Safety Committee	15 ↓ 20	C5xL3	10 (C5xL2)	--	27.10.2021	3.5.2023	3.6.2023

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
4908	Executive Director of Nursing	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Legal cases efficiently and effectively	If: The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads The Health Board are reviewing the Covid funding in respect of the recruitment Covid19 specific Redress Handlers. Meetings with Care Groups to be established in respect of complaint responses 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 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. Update October 2022 - Invest to save bid has been completed and submitted for consideration, 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. A workshop has been held with the Legal Services team to review ways of working moving forward into the new operating model. Update December 2022: - Invest to save bid was unsuccessful, therefore alternative funding options being explored. Some limited capacity will be realised in the new operating model for quality, safety and governance. CTM commissioned Legal and Risk to provide assistance and direction on the historic redress cases, however L&R have no capacity to take these over. Therefore, will have to be dealt with in turn, as part of the backlog.	Quality & Safety Committee	12 (C4xL3) reduced from a risk score of 16.	8 (C4xL2)	Invest to save bid was unsuccessful, therefore alternative funding options being explored. The new operating model is now at implementation phase with any vacancies being advertised. Once in post, there will be some extra capacity. An action plan to prioritise older cases has been developed. Extra capacity will be used to focus on the backlog in readiness for the implementation of Duty of Candour. Risk score has been reduced as a result of the above mitigation. At the Q&S Committee on the 16th March, members considered it premature to de-escalate this risk score as the action plan has not been completed. This has been deferred back to the risk owner for consideration on the 17.3.2023. Further rationale for de-escalation added as follows: Update April 2023: New operating model in respect of quality, safety and governance almost fully implemented. Legal Services Manager now in post. 1 claims handler post is due out to advert. Slippage monies due to vacant posts have been used for short term para legal agency to assist with the Redress backlog, in readiness for full DoC
5214 (Capturing risks 4590 and 4798 which are now closed)	Executive Medical Director / Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Critical Care Medical Cover If: Critical Care workforce issues across Medical, Therapies and Pharmacy teams. Requirements for standards set out in national GPICS documents - Critical Care provision. Unable to sustain 3x level III units across CTM due to these workforce issues. Need to provide a sustainable model to drive quality of care for patients. Mitigate the impact of Critical Care changes on other specialties. Agreement for new outline mode 2x Level III and 1x Tier 1 unit. Then: Critical Care Leadership group established to drive programme with pan-CTM CC group representing all sites to support CC Leadership. Colleague awareness that need them all as well as expanding the MDT workforce, including delivering care in new ways. Options appraisal with robust business case to support the clinical needed changes to the current model. Workforce integral to business case. Agreed funding in place and recruitment of Middle Grade tier currently happening at POW. Resulting in: Workforce in Critical Care integral to planning and model development. 2 year interim model to enable broader CTM plans with long term model to be determined. Recruitment process to change to sell the new model approach to fill funded gaps. PMO to support the model planning and implementation. Clear timeline of activity for CC Leadership to deliver stages of programme.	Daily management of the rota. Use of agency to cover gaps. CTM internal cover (limited options). Development of CTM strategy for Critical Care. SBAR included in Medicines management and advised to include in ACT directorate IMTPs. Currently staff stretch to cover and prioritise patient need as much as possible. During winter pressures have tried in the past to recruit locums but availability still remains an issue for some services and not sustainable.	Update 12.4.2023 - 3 Critical Care related risks (4590, 4798 and 5214) combined. RR score reflected to overall score of 12. The risk of workforce establishment (and all the factor related to that) have been incorporated into the Medical Workforce Productivity Group. This group is chaired by the Medical Director who is responsible for this risk. The MPWG reports monthly and is overseen and accountable to the Value and Effectiveness Committee and the Transformation Board. As such it is under close scrutiny on a continual basis. By this process any areas of increased risk will be highlighted rapidly and addressed.	Quality & Safety Committee People & Culture Committee	12 (C4xL3) reduced from a risk score of 20	8 (C4xL2)	Update 12.4.2023 - 3 Critical Care related risks (4590, 4798 and 5214) combined. RR score reflected to overall score of 12.	
4920	Executive Director of Therapies & Health Sciences	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Capacity within the ED/ Medical/ Rehabilitation and Orthopaedic Inpatient Occupational Therapy Service within Princess of Wales If: clinical capacity remains significantly reduced due to staff sickness and vacancies Then: clinical service delivery will be negatively compromised. Resulting in: increased length of stay, potential clinical incidents, poor clinical outcomes for patients, and increase in complaints. It will impact on staff wellbeing within the team and increase incidence of staff sickness.	Regular team meetings to support prioritisation and wellbeing. Updating AHP lead in Bridgend ILG on potential impact.	Recruitment of locum. Additional hours offered, resulting in part- time staff working additional hours. Redeployment of staff according to clinical priority, utilising a therapies version of daily "safe to start" with AHP Clinical Director, where staffing is monitored daily 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. Update October 2022 - No change to mitigations, recruitment still in progress. Update 28.12.2022 - two vacancies are anticipated to be recruited to March 2023 following the return of maternity leave and retire and return employee. Ongoing discussion with staff member temporarily re deployed due to Long COVID regarding returning to substantive post. Review 31.3.2023 Update February 2023 - No change for this period, next planned review is due 31.3.2023. Update April 2023: risk deescalated to a score of 12 (consequence score of 3, and a probability score of 4), as new staff are being recruited and staff are returning from maternity leave and sickness absence.	Quality & Safety Committee	12 (C3xL4) reduced from a risk score of 15	12 (C3xL4) Target score is being revised hence the risk has not been closed.	As a result of the following update the risk likelihood has been reduced. risk deescalated to a score of 12 (consequence score of 3, and a probability score of 4), as new staff are being recruited and staff are returning from maternity leave and sickness absence.	

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
5014	Chief Operating Officer	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	If patients present at the ED at the RGH with obstetric and gynaecology related issues there is a risk that there could be delays in treatment and transferred required to hospitals with obstetric and gynaecology services. Then they will need to be transferred to a site with the appropriate services Resulting In 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	Update May 2023: Children and Families Care Group have reviewed this risk and advised that any incidents are investigated and learning used to update SOPs e.g. The obstetric SOP is frequently reviewed to incorporate learning and improvements. There is a meeting on the 25th May to meet and review Gynae and Obs pathways between the Care Group and ED in RGH . The Care Group have revisited the scoring for this risk and determined that the likelihood should be reduced to possible. It is possible hat it could happen and when it does the consequence could be major.	Quality & Safety Committee	12 (C4xL3) reduced from a risk score of 16.	C4 x L2	As a result of the Children and Families Care Group review and current mitigation the likelihood of this risk occurring has been re-assessed and reduced. Therefore this risk is de-escalated from the Organisational Risk Register.

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Ora RR	Closure Rationale
4253	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety	Ligature Points - Inpatient Services	IF: the Health Board fails to minimise ligature points as far as possible across identified sites. Then: the risk of patients using their surroundings as ligature points is increased. Resulting In: Potential harm to patients which could result in severe disability or death.	Bridgend Locality: The anti-ligature works has not yet been completed and signed off. There are snagging issues on ward 14 and remedial decoration. On PICU the bathrooms have not been started. All works have been chased by Senior Nurse to project lead for updates on completion. Actions identified for escalation if no update received regarding completion dates. The risk score remains unchanged at present. o Increased Staff observations in areas where risks have been identified. o Any areas of the unit not being occupied by patients are to be kept locked to minimise risks o The use of safe and supportive observations o Risk assessment process for patients and environment is in situ o Some ant-ligature work has been completed in some bedrooms which are used for patients assessed as being at higher risk.	Bridgend Locality: o action plan developed with support from the head of nursing within the ILG. o Heath Board has approved additional staffing by night and to fund the outstanding capital anti ligature works. guidance issued to all staff on the implementation of local procedural guidelines. o Use of therapeutic activities to keep patients occupied 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. Bridgend 28.10.22 All anti-ligature works in PICU, Ward 14, Angleton have been completed and areas handed over subject to completion of a few outstanding snags by the contractors. Work is awaiting final sign-off. Review end of December 2022 with a review of revisiting the risk score. Update May 2023 - From a capital perspective they have undertaken all the required anti ligature works to which this original risk referred and these have all been signed off by estates.	Quality & Safety Committee Health, Safety & Fire Committee	Jan-23	Risk Closed 13.1.2023 - Health Board Capital works department have signed off all of the schemes connected to the anti ligature work. On Hold in closure section. This will not be removed from the Organisational Risk Register whilst sufficient assurance is sought to the satisfaction of the Audit & Risk Committee. Confirmation received that the capital works have been completed. Consideration at the Audit & Risk Committee in April 2023. May 2023 - to close as confirmation of works completed received.
4590	Executive Medical Director	Diagnostics, Therapies and Specialties Care Group	Patient / Staff /Public Safety	Critical Care Pharmacist Resource	IF: additional resource is not identified to increase the critical care clinical pharmacy service Then: there is a risk that insufficient support can be provided to meet national standards and there would be lack of capacity to support future surges in demand, such as Covid. Resulting In: an increasing risk to patient safety, increased workload for critical care nursing and medical staff and lack of appropriate support for digital developments such as e-prescribing	SBAR included in Medicines management and advised to include in ACT directorate IMTPs. Meetings to discuss potential funding arranged with ACT leads. INCLUDED in the Reconfiguration Group work for sustainable model. New Chief Pharmacist aware of issue and forming part of their evaluation of Pharmacy model across CTM. SBAR included in Medicines management and advised to include in ACT directorate IMTPs. 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. 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. UPDATE DECEMBER 22 - new Reconfiguration Group to address all workforce shortfall issues (inc Pharmacy), also part of new CP plans	Quality & Safety Committee	May-23	Risk Closed as amalgamated into Datix Risk ID 5214 - captured in the de-escalation section of the Organisational Risk Register/
4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Diagnostics, Therapies and Specialties Care Group	Patient / Staff /Public Safety	Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.	IF the therapy services (physiotherapy, speech and language therapy, dietetics, occupational therapy) continue to not be at the recommended staffing levels according to national level requirements (GPICs), Then: the critical service will be unable to meet the need of patients requiring therapy, Resulting in: significant negative impact on patient outcomes, ability to recover from critical illness and length of stay in critical care unit and consequently in hospital longer than needed.	Currently staff stretch to cover and prioritise patient need as much as possible. During winter pressures have tried in the past to recruit locums but availability still remains an issue for some services and not sustainable. Sighted within HB Critical Care Board as significant gap and within peer review response. Update 16-9-21 Continuing with therapy business case as actions below. No other updates	Discussions with all 3 critical care units regarding repurposing of funds to develop SLT posts. Nursing leaders aware and case being taken to next Operational Management Board. Three separate organisational critical care risks for workforce (medical, therapies, pharmacy) on Risk Register. Single combined risk has been drafted.	Quality & Safety Committee	May-23	Risk Closed as amalgamated into Datix Risk ID 5214 - captured in the de-escalation section of the Organisational Risk Register/
4512	Chief Operating Officer	Unscheduled Care Group	Patient / Staff /Public Safety	Care of patients with mental health needs on the acute wards.	IF: there is a consistent number of patients with mental health needs who are being cared for on the acute wards without RMN support or there are delays in discharge an appropriate EMI setting; Then: patients who have been sectioned and / or are under medication review may remain on wards where specialist mental health therapy and input is not possible; Resulting in: incidents of staff and patients assaults may occur; poor patient experience; increased supervision needed.	MHL team contacted for each patient who required support; 1:1 patient supervision where required; Ward manager and senior nurse undertake regular patient reviews; Regular meetings with the mental health CSG in place. , 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. Update September 2022 - update requested from the Deputy COO - Primary Care, Community and Mental Health. Update October 2022 - Deputy COO - Primary Care, Community and Mental Health and Interim Clinical Service Group Manager, Mental Health are reviewing this risk and consider that the risk score will be reduced in the next update of the Organisational Risk Register. Timeframe assigned: 31.12.2022.	Quality & Safety Committee	May-23	Update 24 th April 2023, risk has been reviewed and updated, no longer a site risk and individual risk assessments are completed on patients should there be delays, this will capture the impact and actions for the patient therefore progressed to closure.

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
5323	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Patient / Staff /Public Safety	Fluoroscopy Room has become Obsolete	<p>IF room 3 in POW is not replaced</p> <p>THEN there will be situations where there is no interventional Radiology service at POW (during maintenance and potential break down of Room 6)</p> <p>RESULTING IN having to transfer very unwell patients to other hospitals, pressure on staff and services at other sites to accommodate. Overall poorer patient experience and potentially outcomes.</p>	<p>Utilising Room 6 to its full capacity</p> <p>Some Barium lists being performed at RGH when possible</p>	<p>Completion of SON to support replacement of Room3 - Timeframe 27.1.2023</p> <p>30.1.23 RGH has list every other Friday SON submitted, initial agreement to fund new room Welsh Government funding received in 22/23 to procure new equipment - currently in storage. Detailed design work completed for new room and works out to tender. Works expected to be undertaken over the summer and completed by autumn</p>	Quality & Safety Committee	May-23	<p>Updated April 2023 - SON submitted and has been approved and is progressing. initial agreement to fund new room</p> <p>17.4.23 Patients continuing to transfer to RGH - Equipment purchased, awaiting building works at POW.</p> <p>Target score met.</p>