Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Executive Director of Finance & Procurement	Ensure sustainability in all that we do, economically, environmentally and socially.	Financial Stability Risk	Failure to remain in financial balance in 2021/22, ~~when the significant non-recurring Covid funding received in 2020/21 is likely to reduce.~~	**IF:** The Health Board is not able to plan changes which enable current run rates of expenditure to align with the available funding for 2021/22 (including Covid funding and Planned Care recovery funding) **Then:** The Health Board will not be able to develop a break-even financial plan for 2021/22 and deliver it . The context is that the draft plan for 21/22 currently shows a deficit of £19.8m which entirely relates to Q3 and Q4, since the Health Board has only received Covid funding for non programme costs for Q1 and Q2 only. **Resulting in:** Potential deficit in 2021/22 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. The context is that very significant non-recurring funding was allocated to the Health Board in 2020/21 which may not be at the same level in 2021/22, and 21/22 funding	Arrangements are being put in place to further develop the 2021/22 IMTP and financial plan, including the Covid response, TTP, planned care and diagnostics, including prioritisation of planned changes within the available resources. Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Routine monitoring arrangements in place. Regular reporting to Management Board and Planning, Performance & Finance Committee and Board.	Review bottom up savings plans and budget setting proposals received May/June. Develop the further savings planning process identified by the COO and DoF for implementation in July onwards. Further discussions needed with Welsh Government to understand likely funding position for 21/22.	Planning, Performance & Finance Committee	20	C4 x L5	12 C4 x L3	↔	27.01.2021	10.05.2021	30.06.2021	4060
Executive Director of Finance & Procurement	Ensure sustainability in all that we do, economically, environmentally and socially.	Financial Stability Risk	Failure to achieve or reduce reduce the planned recurrent deficit of £33.9m at the end of 2021/22.	**IF**: The Health Board is not able to plan changes which enable current run rates of expenditure to align with the expected available funding for 2022/23. **Then**: The Health Board will not be able to develop a break-even financial plan for 2022/23 and deliver it . The context is that a key issue beyond 21/22 is the recurrent impact of the plan in 22/23 when it is likely that the non recurring funding for Covid in 21/22 will end or significantly reduce as well as non recurring Transformation funding ending. **Resulting in:** Potential deficit in 2022/23 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action.	Arrangements are being put in place to develop the 2021/22 IMTP, including the Covid response, TTP, planned care and diagnostics, including prioritisation of planned changes within the available resources. Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Routine monitoring arrangements in place. Regular reporting of the forecast recurring position to Management Board and Planning, Performance & Finance Committee and Board.	Review bottom up savings plans and budget setting proposals received May/June. Develop the further savings planning process identified by the COO and DoF for implementation in July onwards. Further discussions needed with Welsh Government to understand likely funding position for 22/23.	Planning, Performance & Finance Committee	20	C4 x L5	12 C4 x L3	New Risk	10.5.2021	New Risk	30.06.2021	4629
Executive Medical Director	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Explore substantive appointments of staff undertaking locum work in CTMUHB • Feedback poor performance and concerns to agencies • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs	The response to Covid-19 has impacted the original timeframes for these actions due to the requirement to focus on clinical operational service delivery during the pandemic. Revised dates have been included below: 1. AMD and workforce to develop recruitment strategy - 31.3.2021 –Revised Date September 2021. 2. AMD and DMD to develop retention and engagement strategy - 31.3.2021 – Revised Date September 2021. 3. Reduce agency spend throughout CTMUHB – ongoing - The agency spend reduction is dependent on recruitment aligned with the bank launch and switch to ADHs. The bank launch has been delayed due to problems with the rate card and recruitment through the pandemic has been challenging impacting our ability to appoint to positions. 4. Launch of 'medical bank' to Bridgend ILG locality Autumn/ Winter 2020 –Revised Date September 2021.	Quality & Safety Committee People & Culture Committee	20	C5 x L4	~~16~~ 15 (C5xL3)	↔	01.08.2013	5.5.2021	31.07.2021	4080
Chief Operating Officer Bridgend ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. Updated March 21 - All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21	Continue to implement actions identified in the control measures. Action plans are in the process of being reviewed so a timescale will follow once the review has been undertaken by the lead.	Quality & Safety Committee	20	C5 x L4	16	↔	24.09.2019	4.5.2021	30.05.2021	3826

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Chief Operating Officer All Locality Groups	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ligature Points - Inpatient Services	**IF:** the Health Board fails to minimise ligature points as far as possible across identified sites. **Then:** the risk of patients using their surroundings as ligature points is increased. **Resulting In:** Potential harm to patients which could result in severe disability or death.	Increased Staff observations in areas where risks have been identified. Any areas of the unit not being occupied by patients are to be kept locked to minimise risks. Update March 2021 - Bridgend Locality - Risk assessment process Some ant-ligature work has been completed in some bedrooms which are used for patients assessed as being at higher risk. Action plan developed with support from the head of nursing within the ILG. Heath Board has approved additional staffing by night and to fund the outstanding capital anti ligature works. Guidance issued to all staff on the implementation of local procedural guidelines. Use of therapeutic activities to keep patients occupied Nurse Director of Bridgend ILG, together with corporate colleagues submitted a briefing paper to the executive team on the 17th August 2020 this paper highlighted the need to progress with outstanding capital anti-ligature work. In addition a local action plan has been developed to help mitigate current risks this includes increasing staffing levels and the locking off of more high risk areas. The Health Board has approved the capital expenditure on the anti ligature works and the additional staffing costs .	Continue to implement actions identified in the control measures. RTE Locality Update: Reviewed 26.02.2021 RTE score is 15 and target 10. All anti ligature works completed but environment not risk free.	Quality & Safety Committee Health, Safety & Fire Committee	20	C5 x L4	10 C5 x L2	↔	17.08.2020	2.3.2021	31.3.2021	4253
Chief Operating Officer / Executive Director of Nursing & Quality (Executive Lead IPC)	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of negative pressure rooms in CTMUHB in line with WHC (2018) 033	**If:** there are no negative pressure rooms available in CTMUHB. **Then:** the service will be unable to isolate patients in an appropriate environment. **Resulting In:** Non compliance with national guidance/ WG expectation	Patients isolated in single rooms. Apply IPC precautions. Isolation policy in place. Alert organisms are dealt with by the IPCT. IPCN's liaise with wards/ departments giving IPC advice/ instruction. All alerts are discussed at weekly meetings. Patients with highly transmissible respiratory infections will be transferred to a regional centre with appropriate isolation facilities	Work with Executive Team, Capital, Estates and Shared Services colleagues to consider recommendations outlined in the WHC(2018)033 Risk currently being reviewed by the Chair of the Infection Prevention and Control Group. Update May 2021 - Lead Infection Control Nurse is engaging with the Estates / Capital Team on progress to date in relation to the provision of negative air pressure rooms. The risk therefore remains currently unchanged.	Quality & Safety Committee	20	C5 x L4	~~12~~ 10 (C5xL2)	↔	16/12/2014	04.05.2021	30.06.2021	1793
Executive Director of Nursing & Midwifery IPC - Decontamination	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is no dedicated operational lead for decontamination in CTMUHB	**If** there is no dedicated operational lead for decontamination in the Health Board. **Then:** compliance with best practice guidance/legislation will not be monitored. **Resulting in:**near misses/increased risk of infection/litigation risks.	The operational lead for decontamination role is undertaken by the Deputy Lead IPCN. The role is part time decontamination lead(0.5 WTE) and 0.5 WTE Deputy Lead IPC Nurse. The Health Board Decontamination Committee group meet quarterly. ILG decontamination meetings take place monthly. Annual audits are undertaken by Shared Services. AP(D) meetings have been set up by the assistant head of operational estates. Liaise with AE(D) and service group leads as required. The operational lead for decontamination/deputy lead IPCN participates in the all Wales decontamination meetings. Centralised decontamination facilities in RGH and PCH. A business case has been submitted to progress this forward in POW. External review of the decontamination infrastructure, governance systems and processes requested by Executive Nurse Director March 2021.	Working group to be set up to perform review. AE(D) Shared Services to form part of team. First meeting being set up to agree terms of reference/plan. Due Date: 30.06.2021	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	New Risk escalated to Org RR	30/12/2020	11/05/2021	30/06/2021	4477
Executive Director of Planning & Performance (ICT)	Provide high quality, evidence based, and accessible care.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Security at the Health Board's main Medical Records & Information Hub.	**If:** The security of the Information Hub is not improved and brought up to standard there is a risk of the hub being broken into out of hours **Then:** There is a risk that patient medical records files are stolen or damaged and equipment stolen. **Resulting In:** Potential loss of a patients medical records resulting in the ICO being informed and equipment being replaced	Additional temporary measures are in place to maintain 24 hour site security whilst a longer term solution is in place.	The Estates function has evaluated the property and detailed the requirements in order to make the area secure in the longer term. A meeting will take place w/c 1/3/2021 to review the potential plan to resolve the problem.	Digital & Data Committee	20	C5 x L4	9	↔	28/02/2021	New Risk	31.03.2021	4565
Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	• Tight management processes to manage individual cases on the cancer Pathway. • Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. • Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk • Harm review process to identify patients with waits of over 104 days and potential pathway improvements. • Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. • All three ILGs are working to maximising access to ASA level 3+4 surgery on the acute sites. • HB working to ensure haematological SACT delivery capacity is maintained. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. • Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. • Alternative arrangements for MDT and clinics, utilising Virtual options	Continue close monitoring of each patient on the pathway to ensure rapid flow of patients through the pathway. Active management of the diagnostic backlog (including endoscopy) and exploration of all options to reduce this. Comprehensive planning for repatriation of theatre and haematology services for when private provision is lost. This also needs to consider options for continuation during a potential second surge. These actions are ongoing and assigned to the EDO, DPC&MH and Medical Director. The Cancer Business Unit remain fully involved in the processes to improve care and that at present they are awaiting feedback from ILGs on their plans for restarting elective and other activity and their demand and capacity assumptions. Update April 2021 Each ILG are preparing a Cancer Recovery Plan for submission to Management Board in April 2021 that sets out clear performance targets by June 2021 and/or longer term plans for specific specialities that cannot be delivered to the June timescale.	Quality & Safety Committee	20	C4 x L5	12	↔	01/04/2014	7.4.2021	31.5.2021	4071

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Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ambulance Handover Times	**If:** Ambulance handovers are delayed. **Then:** Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. **Resulting In:** A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls.	Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protections Schemes Implemented within ILG's.	Live Flow Information Dashboard being scoped - Target Date: 31.3.2021 Unscheduled Care Board focus on SDEC/AEC, D2RA - Contact ahead 111 - Target Date: Contact Ahead: March 2021, 111: January 2021. March 2021 - the 111 system commenced in RTE and M&C Locality in November 2020 - will commence in Bridgend Locality shortly. The Unscheduled Care Improvement Programme will be launched in April 2021. A focus of this forum will be on the improvement of the urgent care pathway through the Health Board with the primary benefits being the reduction/eradication of Ambulance Handover Delays. The Unscheduled Care Improvement Board will monitor progress on the programme on a monthly basis.	Quality & Safety Committee	16	C4 x L4	12 C4 x L3	↓ 20	04/12/2020	7.4.2021	31.5.2021	4458
Chief Operating Officer Bridgend Locality	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain Child and Adolescent Mental Health Services	**IF:** The Health Board continues to face challenges in the CAMHS Service **Then:** there could be an impact in maintaining a quality service **Resulting in:** recruitment challenges, long waiting times and impact to the implementation of the new model of care. Difficulties remain in recruiting key staff and new model of care being implemented; waiting times for specialist CAMHS and the new neurodevelopmental service remains challenging. Rationale for target score: Increasing demands being placed on the Core CAMHS Services resulted in long waiting times and the service was experiencing difficulties in recruiting staff	• Reported local and Network pressures across the CAHMS Network with variable problems dependant on the area of the network. • Updates provided to Management Board on developing service model to address reported issues and additional investment secured to increase capacity within the service and to address service pressures. Waiting list initiatives in place whilst staff recruitment is being progressed. • Service Model developed around Core CAHMS in Cwm Taf Morgannwg which includes agreement with General Paediatrics to take the lead on Neurodevelopmental Services and shared care protocols with Primary Care. • New investment impact being routinely monitored A number of service reviews in relation to Ty Llidiard undertaken and monitored via Q,S&R Committee	Commissioning discussions taking place across the Network in relation to service pressures and funding. Implementation of the Choice and Partnership Approach (CAPA) and being closely monitored. Internal Enhanced Monitoring Action Plan being progressed and monitored on a fortnightly basis by Bridgend ILG. Single Point of Access being developed. Full demand and capacity plans being developed with some assumptions about additional CAMHS demand as a consequence of the pandemic.	Planning, Performance & Finance Committee	16	C4 x L4	9	↔	01/01/2015	18.11.2020	31.3.2021	4149
Executive Director of Nursing and Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Increasing dependency on agency staff cover which impacts on continuity of care, patient safety	**IF:** The Health Board increasingly depends on agency staff cover **Then:** the Health Board's ability to provide stability and consistency in relation to high quality care could be impacted. **Resulting in**: disruption to the continuity, stability of care and team communication. Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover.	Recurring advertisements of posts in and nursing continue with targeted proactive recruitment employed in areas of high agency/locum use. Provision of induction packs for agency staff Agency nursing staff are paid via an All wales contract agreement, any off framework agency requests must be authorised by an Executive Director prior to booking (system of audit trail in place). Fixed Term Contracts being offered to all existing HCSW and RN currently on the Nurse Bank. Redesign services wherever possible to embrace a healthier Wales and therefore impact upon the workforce required to deliver services. Overtime incentives offered to workforce in response to Covid-19 pandemic. The Health Board is continuing with the overseas recruitment campaign.	Deputy Exec DON is currently reviewing the nurse rostering policy in conjunction with the workforce team in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's . Established a new nursing workforce taskforce. Consultation with Local Partnership Forum undertaken and amendments to the policy have been made as appropriate, the policy will be seeking approval at the Quality & Safety Committee in May 2021- Timescale 31.5.2021. Bi-Annual Nursing Staffing Levels Wales Act - Acuity Audit to be undertaken in June 2021 to report to Board in October 2021. All Wales "Safer Care Module" on e-roster system due to be received in due course. WG led so await WG timescales. No Change as at 4.5.2021. Nursing & Midwifery Strategic Workforce Group, Chaired by the Deputy Director of Nursing to recommence in April 2021. The Nursing and Midwifery Strategic Workforce Group did not meet in April 2021 as planned due to the need to revise membership in line with ILG structure, however, bi-monthly nursing workforce operational task force meetings have been held chaired by the Deputy Director of Nursing since February 2021. the Strategic workforce group is scheduled to meet on the 11th May 2021.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	9 12 (C4xL3)	↔	01/06/2015	04.05.2021	30.06.2021	4106
Executive Director of Nursing and Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of high quality patient care due to the difficulty in recruiting and retaining sufficient numbers of registered nurses and midwives	**IF:** the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage **Then:** the Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff. **Resulting in**: Disruption to the continuity and stability of care and team communication Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover.	• Proactive engagement with HEIW continues. • Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues. • Targeted approach to areas of specific concern reported via finance, workforce and performance committee • Close work with university partners to maximise routes into nursing • Block booking of bank and agency staff to pre-empt and address shortfalls • dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act. • Deputy Exec DON is currently reviewing the nurse rostering policy in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's • Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board • Regular review by Birth Rate Plus compliant, overseen by maternity Improvement Board • Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends. successful overseas RN recruitment. - There is an operational Nursing Act Group that reconvened from April 2021.	Established recruitment campaign - which is monitored at the Nursing Workforce Strategic Group - group due to meet/recommence in April 2021.The Nursing and Midwifery Strategic Workforce Group did not meet in April 2021 as planned due to the need to revise membership in line with ILG structure, however, bi-monthly nursing workforce operational task force meetings have been held chaired by the Deputy Director of Nursing since February 2021. the Strategic workforce group is scheduled to meet on the 11th May 2021. Revised nurse rostering policy currently being taken through the relevant approval process - Timescale 31.3.2021.Consultation with Local Partnership Forum undertaken and amendments to the policy have been made as appropriate, the policy will be seeking approval at the Quality & Safety Committee in May 2021- Timescale 31.5.2021. The operational Nursing Act Group to reconvene. Completed as reconvened in April 2021 - included as a control measure. Await review of Birth Rate Plus Compliant Tool by WG - Timescale - WG led so await WG timescales - No further update at this time.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	9 12 (C4xL3)	↔	01/01/2016	04.05.2021	30.06.2021	4157

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Executive Director of Nursing and Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Patients and/or relatives/carers do not receive timely responses to matters raised under Putting Things Right resulting in learning and improvement being delayed	**IF:** The Health Board fails to provide timely responses to matters raised by patients, relatives and/or carers under Putting Things Right. **Then:** there will be a delay in identifying potential learning opportunities. **Resulting in:** variable quality in responses, not learning lessons, not meeting regulatory response times therefore increasing the number of concerns being escalated to the Ombudsman and not providing complainants with a resolution in a prompt and timely manner.	-Implementation of the Quality & Patient Safety Governance Framework - Values and behaviours work will support outcome focused care - supportive intervention from the Delivery Unit supporting redesign of complaints management - relocation of the concerns team into Integrated Locality Groups (ILGs) - Governance teams embedded within each ILG - Governance processes in place in relation to PTR guidelines and this provides assurance via their ILG Q&S committees and these report into the CTMUHB Q&S committee and Patient Experience Committee. - Corporate/Executive assurance and review undertaken weekly via Executive Director led Patient Safety review meetings and quarterly Concerns scrutiny panel meetings. -Ensure access to education, training and learning. - Review of systems in place to aid assurance and compliance with PTR guidelines in progress by Corporate Governance Team. Level 1 PTR training added to ESR training module and training ongoing for staff in the DLG's. Member of corporate team continues to provide training surrounding PTR guidelines and governance. - Shared Listening and Learning forum established with its inaugural meeting in February 2021. - ILG Concerns Management Performance is monitored via the regular Executive Led Performance Management Meetings. - Once for Wales Concerns Management System - Claims, Complaints, Incidents and others that were due to go live from 1st April delayed due to All Wales Technical issues, planned to implement 7th May 2021, which will provide greater integration across complaints, claims and incidents, it will also support All Wales learning and benchmarking.	Corporate Governance team reviewing current Datix system to reflect new DLG structures and working with WRP to ensure alignment with new Once for Wales System which is in progress. COMPLETED. Review of the Concerns Process within ILG's underway - Completed. Improvement trajectories to be established with ILG's - Completed. The Health Board has requested an external review of claims, redress and inquest processes and procedures. This review will be undertaken by the Welsh Risk Pool. Timescale: End of September 2021. The Health Board has requested an Internal Audit on the Concerns Process. Timescales: End of August 2021.	Quality & Safety Committee	16	C4 x L4	~~9~~ 12 (C4xL3)	↔	01/04/2014	04.05.2021	31.08.2021	4156
~~Executive Medical Director~~ Chief Operating Officer ~~Integrated Locality Groups~~ Bridgend Locality	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Implementing a sustainable model for emergency medicine and inpatient paediatrics across the CTMUHB footprint	**IF:** The Health Board is unable to deliver a sustainable model to deliver Emergency Medicine (EM) and inpatient paediatrics across the Health Board Footprint. **Then:** The Health Board will be unable to deliver safe high quality emergency medicine and inpatient paediatrics services. **Resulting in:** Compromised safety of patients and Staff.	Successful recruitment to EM in Royal Glamorgan Hospital and Prince Charles Hospital continues at consultant and middle grade. Model for delivery of Paediatric care in RGH significantly clearer and this is contributing to some recruitment success.	Recruitment drive continues.	Quality & Safety Committee	16	C4 x L4	6	↔	01/07/2019	18.11.2020	31.3.2021	4115
Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to achieve the 4 and 12 hour emergency (A&E) waiting times targets	**IF:** The Health Board fails to achieve the 4 and 12 hour emergency (A&E) waiting time targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Compromised safety of patients, potential avoidable harm due to waiting time delays. Potential of harm to patients in delays waiting for treatment.	Need to strengthen minors streams at DGH sites to sustain improved delivery of performance against the 4, 8 and 12 hour targets. Also variable practice across A&E departments. Consultant and middle grade gaps in RGH now filled. PCH DU report delivered and being enacted. PoW handover performance reviewed by DU & EASC/CASC team and being enacted. PoW/RGH/PCH provided full Safety and Dignity analysis to September QSR committee and Safety Briefing sitrep model and SAFER being rolled out across sites. Programme of improvement work with AM&ED, HR and Retinue teams to improve medical booking and staffing to raise shift fill (ADH initiative has been successful). Winter Plan in train through directorate and partners (RPB). Interim Site Management arrangements coming into place. Systems model in development. 1) Clear discharge planning processes in place. 2) Improvements in the patient flow and investments to support Winter planning. 3) Stay Well At Home (SW@H) Service introduced and evaluated (6 month). Transformation funding will initiate Jan/Feb 2020. 4) SW@H 2 developments and Enhanced Community Clusters being progressed through Transformation bid.	The existing controls will be maintained and developed, with monitoring in place via internal ILG meetings and the monthly ILG meetings with Directors. Given the pressure upon the UHB in the covid-19 environment, the risk will remain at level 16, with review in March .	Planning, Performance & Finance Committee & Quality & Safety	16	C4 x L4	12 C4 x L3	↔	01/04/2013	11.01.2021	31.3.2021	4070
Chief Operating Officer Bridgend ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**IF**: The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place.	Action plan developed and on going monitoring - consolidated plan coming forward covering Eye Care. The service has transitioned to Bridgend ILG and Bridgend ILG has engaged in potential national solutions to address FUNB.	Quality & Safety Committee	16	C4 x L4	12 C4 x L3	↔	01/04/2014	1.3.2021	31.3.2021	4103
Chief Operating Officer RTE Locality	Provide high quality, evidence based, and accessible 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 sand Urgent	Currently looking at plans for capacity for the whole service - unlikely to see much change in the near future. Locums to support CT service CT vans on site RGH/PCH MRI running at higher capacity Ultrasound concerning 3.2.21 Whilst mobile scanner presence allowed us to reduce the backlog (CT/MRI) routine imaging has since been stopped and has not been reinstated, which will result in a build up of back log. 19.3.21 No change.	Capacity and Demand Review required - timeframe 10.08.2021	Quality & Safety Committee	16	C4 x L4	4 (C2xL2) Target score being revisited.	New Risk escalated to Org RR	01/06/2020	10/05/2021	14/06/2021	4152
Executive Director of Nursing & Midwifery IPC - Decontamination	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Inappropriate decontamination process in place for laryngoscope handles in RTE & MC	**If:** the current decontamination process for laryngoscope handles continue **Then** staff are not following manufacturer instructions/Welsh Government guidance. **Resulting in:** possible infection transmission/poor patient care/litigation risks. A Welsh Health Circular was distributed in September 2020 outlining that laryngoscope handles must either be single use or decontaminated/sterilised in between use following manufacturer instructions via an accredited Sterile Service Department.	A wipe system is being used to decontaminate handles following use. Risk assessment completed to continue using the current process due to the additional funding required to comply with the WHC. Sheaths used to minimise contamination to the handle which is changed following use.	Assistant Medical Director for QSCE has been tasked to progress the requirements of WHC 2020 15 - Laryngscope Handles - Due Date: 30.06.2021	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	New Risk escalated to Org RR	30/12/2020	11/05/2021	30/06/2021	4478

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Executive Director of Nursing & Midwifery Infection Control	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Poor compliance with IPC training	**If** there is poor compliance with IPC training **Then** IPC practice will be compromised **Resulting in** transmission of infection/ poor patient care	Level 2 training is mandatory and delivered via e.learning Managers to monitor compliance with IPC training and report compliance to Directorate and at IPCC meetings	IPC training is available via e.learning and is a mandatory requirement for staff to complete. Reinstate face to face IPC training sessions once COVID situation improves. IPC team to arrange and discuss with Heads of Nursing/ ILG Nurse Directors. Update: 12.5.2021 -- face to face training being reinstated as COVID numbers fall. Review in June 2021.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	New Risk escalated to Org RR	04/09/2015	11/05/2021	30/06/2021	2018
Executive Director of Nursing & Midwifery Infection Control	Provide high quality, evidence based, and accessible 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 eg. 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 C.Difficile cases - back log of cases and unsustainable 03/03/2021 - there is a back log of IPC investigation relating to community cases due to the additional demands on the IPC service due to the COVID pandemic.	A business case for additional resources for an IPC team for primary care to be developed. Due Date: 31.08.2021	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	New Risk escalated to Org RR	44028	11/05/2021	30/06/2021	4217
Executive Director of Nursing & Midwifery IPC - Decontamination	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Manual decontamination of nasoendoscopes in RTE & MC	**If** the current decontamination process (Tristel 3 Step)continues to be used in RTE & MC. **Then:**inadequate decontamination of the scopes is possible resulting in transmission of infection/poor patient care. It is impossible to guarantee effective decontamination of the scopes every time due to the human factor. **Resulting In:** in variable techniques. The current manual process is not in line with WHTM guidance which recommends an automated system	A risk assessment to be completed for the use of Tristel 3 step by the ENT service group in RGH, YCR and PCH. SOPs in place for users Decontamination lead to complete assurance audits in the departments. Staff in the ENT department to undertake annual training by the representatives for Tristel 3 Step.	Naso-endoscopes should be processed using a validated and automated process in line with WHTM 01-06. Working group to be established to discuss options available to decontaminate naso-endoscopes. SBAR (options appraisal) to be developed and shared with Exec team Evidence of SOPS for manual process to be shared at local decontamination meetings Risk assessments to be shared/agreed at local decontamination meetings - Due Date: 30.06.2021	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	New Risk escalated to Org RR	30/12/2020	11/05/2021	30/06/2021	4476
Executive Director of Nursing & Midwifery IPC - Decontamination	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Decontamination of dental equipment in the community	**If** dental equipment continues to be decontaminated in community dental facilities. **Then:** the equipment may not be decontaminated effectively as a consequence of the equipment/facilities available to staff. **Resulting In:** transmission of infection/near misses/poor patient care. Some of the hand pieces cannot to processed in an automated washer/disinfector and are manually cleaned before being processed/sterilised in an autoclave. There are also difficulties maintaining clean to dirty workflows in the decontamination areas due to space restrictions. One of the main recommendations from the Welsh Government audit undertaken in November 2019 was to transport community dental equipment into an accredited Sterile Service Department in the Health Board for processing/sterilisation	Agreed SOPs in use Maintenance programmes in place for decontamination equipment Hand pieces are serviced annually Water dip tests performed quarterly Quarterly water testing performed by estates in line with WHTM Cleaning schedules in place Nominated dental nurse lead for IPC/decontamination Dental Nurse attends Decontamination committee Plans to centralise decontamination of dental equipment in CSSD/HSDU	Dental Nurse Manager to provide SOPs and Equipment Maintenance - Due Date: 25th June 2021. Action Plan to be developed - Due Date: 30.06.2021 Centralise dental equipment decontamination from Pontypridd Health Park to RGH HSDU - Due Date 30.06.2021	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	New Risk escalated to Org RR	30/12/2020	11/05/2021	30/06/2021	4482
Executive Director of Nursing & Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non-compliance with DoLS legislation and resulting authorisation breaches	**IF:** due to current capacity the Health Board fails to fully comply with the DoLS legislation. **Then:** the Health Board may have to operate outside the current legislative process. (a change in legislation is coming which will hopefully improve lawfulness) **Resulting in**: the rights, legal protection and best interests of patients who lack capacity potentially being compromised. Potential reputational damage and financial loss as a result of any challenge by the ombudsman or litigation.	Updated Narrative March 2021: • Training and DOLs Process impacted by Covid-19 pandemic due to not being able to undertake face to face capacity assessments. Staff recruited to manage demand e.g. independent best interest assessors, a full time secondment transition post and nurse bank hours. As a matter of routine the HB remain in the position that it is encouraging urgent authorisations by the managing authorities and undertaking virtual capacity assessments with standard authorisations and reviews. • Virtual DoLS processes established and in place within the HB during Covid19, this is subject to regular review and monitoring. Urgent authorisations are prioritised over standard authorisation Although this process is effective in terms of identifying patients deprived of their liberty, it is not a lawful process and does not comply with legislation. The HB is therefore at greater risk of breaching the legislation and the rights of those who lack capacity are potentially compromised. • Monthly Safeguarding People training for Covid 19 - there has been a pause in training as a result of the second wave of the pandemic as patient facing activity takes precedence. Training restrictions have also impacted upon the numbers of authorisations requested and alternative ways of delivering Level 3 DoLS & MCA awareness has been developed via TEAMS and will commence in April 2021. • DoLS legislation will subject to change following enactment of the new legislation and statutory guidance. Whilst requirements have increased, mitigation has also been revised to manage increased risk, the HB will need to be prepared for new legislation. Further conversations with our 3 local authorities have been undertaken to recommence a CTM regional understanding and preparation for the changes in legislation, supported by the Safeguarding Board. • Audits are undertaken on time to respond to requests. Virtual capacity and best interest assessments involve family, patient representatives and those who care for the patient. Streamlining and target setting implemented which has led to more authorisations taking place in a more timely manner. • Authorisation breaches are required to be reported on Datix. • The DoLS team maintain an accessible level of virtual support and advice to wards, have supported the development of a consent form for Covid testing for those who lack capacity and	The Health Board has transitioned back to face to face capacity assessments, following a return of staff from re-deployment. Funding has been received from Welsh Government to support the improvement of the Health Boards compliance with DoLS legislation. This funding will support the Health Board to improve capacity for authorisation and prepare for the new Liberty Protection Safeguards. A review will be undertaken in June 2021.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01/10/2014	29.4.2021	30.06.2021	4148

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Director of Corporate Governance Chief Executive	Provide high quality, evidence based, and accessible care.	Adverse publicity/ reputation	Organisational Reputation - Lack of confidence in the services and care provided by the organisation.	**IF:** the Health Board does not effectively engage with its stakeholders, communities and staff to demonstrate listening and learning from external reviews and more recently the Health Boards response to Covid-19 **Then:** Trust and confidence in the services of the Health Board will be negatively impacted. **Resulting in:** negative media coverage, lack or credibility with our communities and staff, ineffective communication, loss of commitment, deteriorating morale, increase in staff turnover and recruitment.	Rebuild trust and confidence programme under Targeted Intervention Improvement Programme underway. Maintaining public confidence in the Health Boards response to the Covid-19 Pandemic through regular and robust communication and messaging through the Health Board's communication channels. Improved staff engagement and involvement, new approaches to partnership engagement and involvement. Additional capacity bid included in TI investment bid under the TI programme to WG. Additional capacity bid included in TI investment bid under the SW Programme. Ensure balanced news stories are regularly reported and communicated. Relationships with the media have been strengthened. Partnership working with Channel 4 and proactive engagement with other media outlets - resulting in positive working relationships and fair media coverage. 'In Committee' meetings have been significantly reduced. TTP Communications work stream focussed on provision of accurate and timely information to the Public. Live streaming of the Board meetings now in place to improve transparency and involvement. New Health Board Values and Behaviours were officially launched in October 2020, World Values Day, following the Let's Talk staff engagement programme. The launch was further complemented by a peer recognition 'wall of thanks' campaign throughout Oct/Nov/Dec and a Staff Gratitude Event in December which recognised all CTM staff for their contributions throughout 2020 pandemic year.	Stakeholder engagement survey planned for August 2020 -Stakeholder engagement survey delayed due to Covid-19 outbreaks in autumn but re-scheduled for spring 2021.	Quality & Safety Committee	16	C4 x L4	~~6~~ 8 (C4xL2)	↔	01.07.2019	5.5.2021	31.5.2021	4116
Chief Operating Officer. Bridgend ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Neonatal Capacity/Stabilisation cot at Princess of Wales	**If**: The neonatal unit at POW is required to deliver ITU level care in the stabilisation cot **Then:** This cot is not staffed, therefore the overall staffing position on the unit is depleted while this is managed, noting that in the absence of a 24/7 retrieval service this can be for extended periods. The stabilisation cot requires 1:1 nursing which is the equivalent of staffing for 2 HDU costs or 4 SCU cots. **Resulting In:** A risk of being unable to provide appropriate levels of care to the babies on the unit as staffing will be below the required levels as per BAPM requirements	* Utilise available staff as effectively as possible depending on the capacity position at the time * Escalation policy in place to limit maternity services to reduce the risks of further admissions to neonates * Seek additional staffing e.g. through bank, agency, overtime when required	Funding required - included on IMTP. Review date extended until end of March 2021. SBAR and Business cases for funding of the stabilisation cot have also been submitted to various meetings . Core Workforce requirements are being reviewed with a view to enhancing the Nursing workforce model and increasing medical consultant workforce capacity. NN services are aligning with Maternity Improvement programme of work whilst developing elements that are defined for neonatal provision including a Quality improvement programme of work	Quality & Safety Committee	16	C4 x L4	3	↔	31.05.2019	22.12.2020	31.03.2021	3584
Chief Operating Officer Bridgend ILG	Provide high quality, evidence based, and accessible care.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Princess of Wales Emergency Department Hygiene Facilities	**If:** the toilet and shower facilities are not increased within the Emergency Department. **Then:** at times of increased exit block the facilities are insufficient for the needs of the patients in the department. **Resulting In:** Poor patient experience, complaints and further concerns raised from the Community Health Council have repeatedly flagged this issue on visits to the department.	There are additional toilet facilities in the radiology department that mobile patients can be directed to however staff do whatever they can within the constraints that they have.	Additional facilities being explored as part of departmental capital works. There is a capital plan for improvement works in ED. The improvements will be – 1. NIV cubicle 2. Creation of a second patient toilet 3. Improvement to HDU area 4. Relocation of Plaster Room 5. Creation of 2 paediatric bays with adjoining paediatric waiting room 6. Redesign of waiting room and reception desk Prior to the Covid pandemic, improvements 2-6 were planned, but the creation of an NIV cubicle has taken priority. The plans are in the process of being signed off for all areas but there is no confirmed start date yet. There was / is potential for delays in sourcing materials by contractors and we need to consider the need to keep contractors as safe as possible from any Covid contact. Patient numbers are now increasing daily but we are restricting visitors and relatives attending with patients (unless required as carers etc). We have also developed a remote waiting room for patients who can safely wait in their cars. This will help to mitigate the footfall in the department when the capital work commences.	Quality & Safety Committee	16	C4 x L4	1	↔	31.05.2019	10.03.2021	31.03.2021	3585
Executive Director of Planning & Performance (ICT) Bridgend ILG	Ensure sustainability in all that we do, economically, environmentally and socially.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	IT Systems	**IF:** The Health board is unable to deliver vital clinical information services to the Bridgend locality affecting many clinical systems that are not compatible with Cwm Taf University Morgannwg Systems. **Then:** The Health board will be unable to deliver safe, high quality care to patients without vital clinical information available. **Resulting In:** Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan.	IT maintenance is currently supported by Swansea Bay UHB via a service level agreement. There are currently a number of systems that are not compatible with Cwm Taf Morgannwg systems and we are 18months post boundary change.	Progress in line with the existing plans which were agreed on the primary basis of their need to be affordable, has been made over 2020/21 with a number of new systems, such as pharmacy management introduced as pan-CTM products. However there is still considerable work required to create a unified digital infrastructure for CTM = around the clinical systems and the remainder of the ICT SLA. The business case details a funding requirement of £8 million. This was discussed at the Digital cell with WG in February 2021 and a further funding request has been submitted to WG at their request.	~~Quality & Safety Committee~~ Digital & Data Committee	16	C4 x L4	8	↔	14.10.2020	16.02.2020	31.03.2021	4337

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Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Health & Safety risk of patients and staff in A&E Corridor at the Prince Charles Hospital	**IF:** Patients are waiting within the corridor of the A&E Department within PCH due to a lack of capacity. **Then:** there is an increased risk of an unsafe evacuation due to corridor space, personal accidents, breach in confidentiality and poor patient experience. **Resulting In:** Potential harm to patients, staff and visitors, poor patient experience, increase in incidents and complaints. Failure to comply with legislation if confidentiality is breached due to overcrowding in corridors.	Fire safety checks are to be carried out daily by the NIC to ensure all fire exits are accessible. When patients are nursed in the corridor due to lack of capacity, the emergency pressures escalation procedure is to be followed to de-escalate as quickly as possible. At times of high escalation it is challenging to clear the corridor of patients on trolleys It is policy for RGH and PCH to offload all WAST patients with 15 minutes of arrival regardless of how many patients are in the department. There needs to be a review of how many patients is safe to hold inside the department at any given time.	Action to develop an escalation policy. Update October 2020: HB policy SoP approved by Management Board with regards to the care of patients in corridors.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	9	↔	22.05.2019	12/10/2020	31.3.2021	3562
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire enforcement order is in place for the ground and first floor PCH due to inadequate fire compartments to prevent spread of fire, smoke and noxious gasses	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire.	Fire Enforcement Order. An action plan and target dates for the 1st and ground floor areas at PCH is available and is subject to available finance for completion. Phase 1b of the wider programme has progressed to the point that the UHB has now achieved remediation for physical fire issues identified in the FEN in the majority of the new Pharmacy, Dining Room and Kitchen areas at PCH which opened in January 2021. This has tackled the higher risk for fire areas of the old kitchens and improved the fire stopping below ITU as well as reducing the overall volume of area remaining in the FEN to be remediated. In addition the UHB secured Welsh Government approval in October 2020 for the Phase 2 FBC, in the sum of £220m, which will see progressive improvement of the majority of the remaining G&FF areas to be remediated for fire over the next 5 and a half years. As a reminder these works are progressive due to the need to balance them against maintaining service delivery as best as we are able and are intended to be supplemented (to run concurrently with final years of the Phase 2) by a final Phase 3 business case intended to address the final physical accommodation areas included within the FEN.	Please see detailed update in control measures.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	6	↔	29.11.2017	02.02.2021	30.04.2021	2987
Chief Operating Officer Merthyr & Cynon ILG RTE Locality	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long waiting times and large backlog of patients awaiting Cardiac Echo	**IF:** The health Board is unable to meet the demands for patients awaiting Echo scans for both follow up surveillance **Then:** The RTT WG target will not be met and waits may be 26weeks **Resulting in:** Potential risk to patients from delays in identifying and treating disease and progression of disease	Forms were verified and triaged by Cardiology team. Patients prioritised in relation to clinical need and rated between urgent and routine. I/P room identified away from main department to increase outpatient capacity and to prevent cross infection risks to outpatient services for both staff (inc returning shielders)and patients Clinically urgent completed and move to routine. New forms triaged as received. Overall loss of capacity post Covid circa 56 / month due to test time changes. (+ currently 1.0 wte lts further 120/month. Will submit SBAR to highlight capacity deficit and cost solutions	See Control Measures Risk also raised via Rhondda Locality which will be reviewed alongside this risk - Datix ID 4292.	Quality & Safety Committee	16	C4 x L4	6	↔	14.09.2020	12.10.2020	31.03.2021	4294
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Cancer Performance - Gastroenterology Outcome of Covid-19	**IF:** Routine diagnostic activity is not recommenced in full during the C19 pandemic **Then:** there will continue to be a backlog of patients awaiting diagnostic investigations **Resulting in:** Potential harm to patients due to delay in diagnosis and treatment	Endoscopy services have restarted as part of new normal timetables. Backlog is being booked and should be cleared by end of July. 22.9.20 Discussions health board wide to reduce overdue and to work to safe capacity.	See Control Measures	Quality & Safety Committee	16	C4 x L4	9	↔	27.07.2020	02.11.2020	31.03.2021	4235
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Elective patients surgery cancelled when high level bed pressures are experienced	**IF:** Elective patients surgery is cancelled when high bed pressures are experienced **Then:** There will continue to be a backlog of patients awaiting treatment/procedures to improve their health and wellbeing **Resulting in:** Potential harm to patients due to delay in treatment/procedures	Consultants are asked clinical opinion when each patient case is cancelled. 12/10/20 insufficient capacity to meet current trauma demand and no short term plan to re-introducing elective orthopaedics during C19 pandemic. Seal area identified but delayed due to RGH IPC issues. As per UHB SoP, clinical prioritization undertaken weekly to list patients with high clinical need. Risk to patients who cannot access. Feasibility study undertaken for elective list in YCC.	See Control Measures	Quality & Safety Committee	16	C4 x L4	8	↔	14.01.2020	14.01.2020	31.03.2021	3958
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk to Obstetric Theatres National Standards	**If:** There is an aim for 'Gold standard' compliance with theatre staffing standards. Workforce is used from midwifery establishment, and the establishment is impacted by this. **Then:** Midwifery workforce reduced to undertake theatre roles and undertake an agreed robust there is a competency training Programme in the UHB for midwifery staff who scrub **Resulting In:** inefficient staff utilization, where there is a national shortage in the workforce.	Scrub training in place and a rolling programme organised with main theatres There is a business case that has been previously been partially approved for revised staffing levels to achieve compliance with the national standards Acuity impact with no additional resource when midwives are used as scrub midwives impacting on ability to provide a full compliment of midwives for labour ward. Staffing and birth-rate acuity compliance.	Action: Service to update and re submit business case for the Surgical CSG to take ownership of maternity theatres.	People & Culture Committee	16	C4 x L4	6	↔	26.06.2019	4.12.2020	31.3.2021	3682

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Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non compliance with appropriate fetal growth detection and management guidance	This is an All Wales risk for all HB`s **If:** there is a lack of USS slots to address the demand we will not be in compliance with the guidance for fetal surveillance and wellbeing. **Then:** 1. Compliance against the Growth Assessment Protocol (GAP) cannot be met. CTMUHB does not have a 7 day USS service which would support compliance and the management of the small for gestation age (SGA) fetus. **Resulting In:**: Women at the greatest risk of SGA receive less surveillance of growth than women with uncomplicated pregnancies resulting in potential harm.	1. Capacity to comply with GAP/GROW 3 weekly - current regime 3-4 weekly 2. Woman are risk assessed, they are allocated one of two pathways. One pathway SFH can be delivered, Serial scanning (37% of population) unable to receive full recommended scanning regime or protocol due to scanning capacity issues. Current regime 4 weekly as apposed to three weekly. 4. The Directorate is working closely with the Radiology department to review low value scans requested. 5. The Directorate is reviewing the option of midwife sonographers being employed. 7. Scanning group for the UHB established. 8. Continued to be reviewed with changes to patient flow due to 'The Grange'	See Control Measures. Radiology to develop sustainable service plan to increase capacity and workforce.	Quality & Safety Committee	16	C4 x L4	6	↔	01.06.2017	4.12.2020	31.3.2021	3011
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk of injury due unavailability of opportunities to train and maintain compliance with Manual handling training.	**If:** There is a lack of manual handling training there is the risk of potential injury to a member of staff or injury to the patient. **Then:** There are a number of clinicians who have not had the opportunity to meet the requirements for manual handling training. **Resulting In:** Potential harm being caused to both staff and patients.	1. Staff are aware of the risks associated with manual handling. 2. All staff have been informed to consider the ergonomics of the environment that this activity is being undertaken. 3.Appropriate equipment is available in the clinical areas or on request from the MH team e.g. pat slides, slide sheets, hoists. 4. Manual Handling risk assessments are incorporated into the admission bundles 5. The training group are planning training for clinical staff with the manual handling department - current position that this can not be supported 7. Ask other HB`s their MH requirements SBUHB online training package to be shared. 8. Directorate will Seek out any opportunities for online updating to support current practice 9. E-learning module has been sourced for all staff to complete on line update for manual handling.	Organisational plan for compliance training.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	12	↔	01.05.2017	01.12.2020	31.3.2021	3008
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Gynaecology Cancer Service	This affects Gynaecology services across CTMUHB - delay in the pathway requiring multiple consultations on site - Service relies on an individual practitioner - Demand is currently in excess of agreed manageable caseload - Hysteroscopy service capacity requires business case supporting for service development - Gynae Rapid access service development is slow progression	Hysteroscopy service business case is being updated - Increased cancer tracking - Review of pathways and service - tracking of results G17Scrub training in place and a rolling programme organised with main theatres	Action: Agreed COVID pathways. Service to re-submit gynaecology 'one stop' Service.	Quality & Safety Committee	16	C4 x L4	9	↔	18.06.2019	30.09.2020	31.3.2021	3654
Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Due to capacity issues to deal with Covid-19 staff not attending medical gas safety training and courses being rescheduled.	(Facilities Risk Register Reference CE11) **ILG:** CSO Facilities Hub **If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. 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.	Issue of limited attendance raised at Medical Devices Governance Board on 08/04/2021 and Assistant Director Facilities agreed to take forward with Chief Operating Officer (COO). Training dates and flyer have been provided by Medical Device Trainer to Assistant Director Facilities so that he can take to ILG Directors next meeting to be held 13/04/2021. Action: ILG Director leads to improve take up of Medical Gas Training. Timescale: 31/07/2021. Based on this update the risk rating remains unchanged until the required attendance for Medical Gas Training is being consistently achieved. (DW 12/04/2021).	Quality & Safety Committee.	16	C4 x L4	8	↔	01/05/2018	21.04.2021	31.07.2021	3133
Executive Director for People Chief Operating Officer and All Locality Groups	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Management of Security Doors in all Hospital Settings	**IF**: the Health Board do not comply with the notice. **THEN**: the Health Board may be subject to prosecution by the HSE **RESULTING IN:** Large Fines and poor publicity. Following several serious incidents following patients absconding from clinical areas, the HSE have issued an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions: In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding.	Identify the measures needed to protect patients at risk and enter them on to the Risk Register for consideration. Discussions with Bridgend ILG and Capital/Estates - Due by 31.12.2020. Merthyr/Cynon and Rhondda/Taf Ely ILGs will work closely with Bridgend ILG to identify any learning and implement any recommendations, Bridgend ILG Update: Full review of door security undertaken across the ILG. Works to fit door alarms at Ty Llidiard currently in progress and due to be completed by the end of March.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	C4 x L4	8	↔	30.09.2020	14.12.2020	31.3.2021	4417

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Executive Director for People	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Overdue fire risk assessments	**If:** Fire Risk Assessments are not completed and reviewed in a timely manner. **Then:** Significant findings on the FRA may have changed which could compromise the safety of patients, staff, visitors/contractors and building fabric. **Resulting in**: Increased risk of fire/harm, enforcement action by Enforcing Authority i.e. Notification of Deficiencies (IN01) which will further escalate to Enforcement Notices (EN01) if no remedial action is taken. At time of assessment there are 138 FRA's overdue, resulting in non compliance with the RR(FS)O 2005.	There are FRA's in place however a substantial number have not been reviewed by the review date. Fire safety advisors are reviewing FRA's in areas where it is safe to do so (Covid restrictions are in place in many areas). A concentrated effort will be necessary to reduce the number of overdue FRA's.	It is recommended that additional fire safety resources are provided to support the work of the fire officers to undertake FRA reviews. As referred to in Risk ID:4315, 2 x Band 5 additional fire safety trainers to be appointed. Agreement on additional fire safety training resource (Risk ID 4315) will create additional time for the Fire Officers to undertake this activity - Due by date 31.03.2021.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	C4 x L4	6	↔	26.10.2020	30.10.2020	31.03.2021	4356
Executive Director for People	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Changing the use of rooms/departments without input/advice from the relevant fire advisor.	CTMUHB have access to Fire Build Forms, these are in place to document the required action necessary to change either the use of a single room (FB1) or more than one room (FB2). These forms provide documented evidence that the user has the necessary information to perform the change effectively and that the correct advise has been given. The consequences of not seeking the relevant information prior to change the use of an area could result in a number of failings relating to fire safety and would only be recognised when the fire advisor carries out a FRA or the Enforcing Authority/Shared Services carry out an audit which may result in enforcement action under the RR(FS)O 2005. Typical failings are: Plans not being updated Fire Alarm Cause and Effect not being amended Rooms not being made up as hazard room enclosures when necessary Fire alarm system not being extended Emergency lighting not being extended Breaches in compartmentation.	The Fire Build forms have been available for some considerable time across the Health Board. There appears to be a reluctance to use them, or simply staff/contractors are unaware of them. Staff/contractors should made aware of the Fire Build Forms and the consequences to the Health Board for not using them. http://ctuhb-intranet/dir/fire/Change%20of%20Use%20%20Room/Forms/AllItems.aspx	A communications plan to be developed to ensure all relevant managers are aware of the need to complete the appropriate Fire Build Forms for room/departmental changes. Non compliance with this requirement identified via Fire Risk Assessment reviews will be reported as an incident via the Health Board's Incident Management System (Datix) Reinforce previous communication across all Health Board wards/departments about the need to complete the Fire Build Forms prior to making any changes to a room or department. Due Date 31.12.2020.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	C4 x L4	9	↔	28.10.2020	28.10.2020	26.04.2021	4360
Chief Operating Officer RTE Locality	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk of absconding from Ward 23.	**If**: Estates work and Covid-19 pathway remodelling is not undertaken urgently **Then:** Mental health patients may continue to abscond **Resulting In**: Potential harm to themselves or the public	All patients risks for suitability of admission to ward 23 assessed. Patients discouraged from smoking where possible. Any patient who goes out into garden is supervised by ward staff at all times. All staff will try to de-escalate increasingly volatile situations. Prompt alert if patients can not safely be stopped from absconding. Staff to follow guidance for managing absconding patients. All patients are risk assessed.	Work with Estates ongoing. A Statement of Need has been submitted to fund additional fencing being installed.	Quality & Safety Committee	16	C4 x L4	4	↔	04/11/2020	26.2.2021	30.04.2021	4401
Executive Director of Therapies & Health Sciences	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of high patient care due to the difficult in recruiting sufficient numbers of registered therapists and health scientists.	**If:** the Health Board fails to recruit and retain a sufficient number of therapists and health scientists due to increasing numbers of vacancies and shortages of professional staff. **Then:** the Health Board's ability to provide certain services may be compromised. **Resulting in:** increased waiting times for diagnosis and treatment, missed opportunities to diagnose at an earlier stage, potential for poorer outcomes for patients.	Links via the Director Therapies to HEIW for planning. Proactive recruitment for difficult to fill posts. Use of Agency/Locum staff where available. Update as at April 2021 Director of Therapies & Health Sciences have supported participation in streamlining to appoint AHP summer 2021 graduates to band 5 vacancies. This is the first time AHPs have recruited in this way and it is too soon to ascertain whether this will impact positively on staff retention.	Continue with active recruitment wherever possible. Ensure workforce plans included and supported in the Integrated Medium Term Plan (IMTP). Utilise 'novel' staffing approaches where indicated. April 2021 The review of the graduate approach to the Band 5 Vacancies will be on a 6-9 month timeline as the graduates are not due to commence until late summer.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	9	↔	21.12.2020	12.04.2021	31.5.2021	4500
Chief Operating Officer Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Follow up capacity and clinic cancellations (FUNB)	**If:** The Health Board is unable to control and meet the capacity and demand to accommodate all hospital follow up outpatient appointments. **Then:** the Health Board's ability to provide high quality care may be reduced. **Resulting in**: Potential avoidable harm to patients	Organisation plan in place to address the FUNB position across all specialties. Additional funding requirements identified. Regular meetings in place to monitor the position.	Harm review processes being implemented. Further discussions underway with Assistant Director of Nursing.	Quality & Safety Committee	16	C4 x L4	12	↔	18/11/2013	10.05.2021	10/08/2021	816
Executive Director of Workforce & OD Health & Safety	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Health Surveillance	**If:** There is an absence of a robust Health Surveillance (HS) Scoping Report. **Then:** The Organisation will not be able to identify the areas and department within the organisation that require Health Surveillance Intervention. **Resulting In:** The Health Board not being able to develop a HS Programme for the organisation as required by the Health & Safety Executive (HSE). Employees working in specific areas/conditions without the relevant health surveillance.	Directors and line managers responsible for own areas and should have own Health & Safety measures such as risk assessments, safe systems of work in place however this does not address any Health Surveillance needs of CTM employees. Require scoping report to inform the development of a robust Health Surveillance programme. Collaborative working will be required between OHWB, H&S, Workforce, staff side and line managers to implement the programme.	As at March 2021. Head of Health, Safety and Fire agreed to review the risk and associated action plan requirements.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	8	↔	18.06.2019	5.1.2021	31.3.2021	3656

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Chief Operating Officer	Provide high quality, evidence based, and accessible care.`	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey.	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing undertaken when needed. • The UHB will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The UHB has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and UHB levels via scheduled and formal performance	The existing controls will be maintained and developed, with monitoring in place via internal ILG meetings and the monthly ILG meetings with Directors. Given the pressure upon the UHB in the covid-19 environment, the risk will remain at level 16, with review in March .	Quality & Safety Committee	16	C4 x L4	9	↔	11.01.2021	11/01/2021	31/03/2021	4491
Chief Operating Officer Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long waiting times and large backlog for Cardiac Echo	**If:** For old Cwm Taf template Total of 2720 pts awaiting Echo scans for both follow up surveillance to monitor disease progress and new referrals governed by RTT. RT -ILG 1520 pts of which 873 would form part of RTT 570 pts waiting greater than 8 weeks longest wait 45 weeks. **Then:** Potential risk to patients from delays in identifying and treating disease and progression of disease e.g. valves, LV function . **Resulting in:** Delays in receiving appropriate treatment pharmacological, intervention , surgical. Potential risk litigation. triage process reliant on available referral information to assess urgency.	Forms were verified and triaged by Cardiology team. Patients prioritised in relation to clinical need and rated between urgent and routine. I/P room identified away from main department to increase outpatient capacity and to prevent cross infection risks to outpatient services for both staff (inc returning shielders) and patients Clinically urgent completed and move to routine. New forms triaged as received. Overall loss of capacity post Covid circa 76 / month due to test time changes. Ill health retirement further 97 / month capacity loss.	Plans to submit SBAR to highlight capacity deficit and cost solutions.	Quality & Safety Committee	16	C4 x L4	9	↔	10.09.2020	14/09/2020	19.05.2021	4292
Executive Director for People	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Site Specific Fire Documents Require updating on some sites.	Site specific documents on a number of sites have outdated information. We have a duty under the RR(FS) 2005 to provide site specific information for oncoming fire crews. Hospital and other healthcare estates are constantly evolving environments that must be flexible enough to accommodate new layouts and changes of use as and when required. It is important to provide up to date site specific information for attending fire crews to highlight hazards etc., and for the crews to make informed decisions, failure to do so could put persons at risk and the possibility of enforcement action from the Enforcing Authority.	There are site specific documents available on a number of our sites throughout CTMUHB, however where changes to our sites have occurred it should be ensured the site specific documents are updated to reflect the change.	Agreement on additional fire safety training resource (Risk ID 4315) will create additional time for the Fire Officers to undertake this activity. Additional 2 x band 5 fire safety trainers approved until 31 March 2021 by Director of Workforce and OD.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	C4 x L4	9	↔	30.10.2020	30.10.2020	12.04.2021	4392
Executive Director of Public Health	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential Harm and poor experience for Patients as a result of the Health Board's focus and response to the Covid-19 Pandemic	**IF:** the Health Boards resources and focus is directing into managing the response to the Covid-19 pandemic. **Then**: the Health Board's ability to provide high quality care may be reduced. **Resulting in:** potential harm to patients as a result of reduced service provision and capacity to respond to other areas of the Health Board's population Health need.	Planning preparedness, contingency structures through the Resetting CTM structures. Critical services are operating. Governance process in place for financial and non-financial decision making to support, all predicated on Quality Impact Assessments. Quality & Safety Committee has continued to meet to ensure scrutiny and assurance on behalf of the Board. Indicators of quality and patient safety for all services continue to be closely monitored throughout Covid-19. Processes and guidance in place to ensure clarity on areas such as safeguarding and child protection. Implementation of the Test Track and Trace Programme in June 2020. Regular Population Health Surveys conducted in relation to Covid-19 to gauge attitudes and risk perception within communities. Compliance with National Guidance. The QIA process for service changes relating to Covid-19 management will include an assessment of related impact on any existing service delivery. Deaths are monitored via the mortality review process. Monitoring incidents, complaints and feedback through social media. Monitoring Core quality and safety metrics. The Health Board's vaccination programme continues to move at a fast pace, which will ease	The QIA process for services changes relating to COVID-19 Management will include an assessment of related impact on any existing service delivery. Continuing to roll out the Health Boards Vaccination Programme.	Quality & Safety Committee	15	C5 x L3	12	↔	23/03/2020	08/02/2021	30.04.2021	4105

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Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Covid 19 - Gold Risk - 002 Critical Care Beds and Equipment	**IF:** there is an insufficient number of critical care beds, medicines and ventilators. **Then:** the Health Board's ability to provide high quality and safe care would be reduced. **Resulting in**: potential harm to patients.	• Suspend non-urgent outpatient appointments and ensure urgent appointments are prioritised • Suspend non-urgent surgical admissions and procedures (whilst ensuring access for emergency and urgent surgery) • National work regularly shared • Local model well underway and informing capacity planning. • More detailed capacity plan available and being shared with WG as requested • Redeploy and retrain staff released from inpatients, day cases and outpatients • UK government removing restrictions on the export of any UK bound stocks. • New systems in place for the assessment and management of stock in hospitals. • Movement of stock between health boards. • Minimising wastage of critical care medicines in the ward and in aseptic production units. • Daily situation report providing stock levels relative to critical care bed usage by health board. • Regular calls between NHS pharmacy procurement leads used to support mutual aid through the movement of stock between health boards. • USC dashboard (to remain Level 1 Green / Level 2 Amber) • Capacity Plan in place with modelling throughout the covid-19 period	• Ensure local stock levels are maintained at levels proportionate to anticipated short term demand, underpinned by regular replenishment from normal supply routes and NHS Supply Chain - under constant review. • Working to ensure robust arrangements are in place to identify and move stock rapidly between hospitals and health boards should the need arise.	Quality & Safety Committee	15	C5 x L3	10	↔	13.05.2020	18.11.2020	31.3.2021	4186
Executive Director of Nursing & Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Clinical staff resuscitation training compliance	**IF:** there continues to be poor compliance with resuscitation training in relation to clinical staff. **Then:** the Health Board's ability to provide high quality and safe care would be reduced. **Resulting in:** a risk that clinical staff are not up-to-date with their resuscitation training and therefore potentially not able to offer the most up-to-date evidence based care to patients requiring resus. There is a secondary risk that if ESR records are not accurate there is no clear organisational picture which of our staff are resus trained and who are not, presenting a particular risk for rota planning.	ESR record is being reviewed and data checked for accuracy - doctors records need updating as currently ESR not routinely used by Medical staff. New models of training with robust demand and capacity training planning in place need to be identified. This will need to have appropriate resus officer training capacity. An internal restructure has now taken place to ensure a more robust management line. Resus dept is now managed by the Senior Nurse Clinical Education. 2 x band 7 resuscitation practitioner posts successfully recruited to and both in post end of May 2020. Covid re-emergence in September / October will have a further impact on training availability & compliance levels. Staff availability for training also impacted. All training taking place is compliant with social distancing / PPE requirements for COVID. High turnover/ retirement / long term sickness/ redeployment due to Covid of qualified Resuscitation staff recently have all impacted on capacity to deliver training. Key appointments have now been made, redeployed staff are returning and recruitment to current vacancies in is place.	At the December 2020 meeting the RADAR Committee received an update on the Resuscitation Training Compliance Risk and were advised that the compliance position has deteriorated further during 2020 due to Covid pressures. Training was cancelled in the first wave and release of staff for training has also impacted through the second wave. The Committee has agreed a number of actions to be presented at the March 2021 meeting: • Review of agreed training standards against which compliance is measured. • Review of training formats to include e-learning options. • Review resus departments demand and capacity for training. Timescale - 31.3.2021 Situation reviewed at March 2021 Radar. E-Learning options have now been incorporated into our training standards and key appointments in the Resus department have now started in their posts. Training compliance however has deteriorated further due to a second wave of covid impacting on release of staff and continuing difficulties in securing adequate training accommodation particularly in RTE and Bridgend localities. Work continues to assess training demand and capacity. Risk however cannot be reduced until improvement is seen. Next review at RADAR June 2021	People & Culture Committee	15	C3 x L5	6 9 (C3xL3)	↔	20.11.2019	29.04.2021	30.06.2021	3899
Executive Director of Planning, Performance & ICT	Ensure sustainability in all that we do, economically, environmentally and socially	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Shortage of IT Storage space. (The ground and first floor work at PCH requires the ICT store and build areas to be relocated to alternative accommodation. As yet a suitable area has area has not been found. The accommodation will need to be suitable for large delivery trucks to deliver ICT equipment and either ground floor or lift access to the area.)	**IF:** The lack of enough storage space for ICT equipment is not sufficient. **Then:** Equipment will be required to be stored in temporary locations which are not designed for storage. **Resulting In**: a risk to the Health and Safety of ICT staff and the risk to the equipment being either damaged, lost or stolen.	1. Ensuring regular disposal of old redundant hardware using third party company, to keeping stock down to a minimum 2. Vigorous and robust procedures in place for the procurement of new equipment. 3. identifying fully any additional storage requirements of every new system requested. 4. Due to the progression of Ground and first discussions are underway around possible areas that ICT can move into for build and storage which is key to be able to deliver a service	1. To identify extra/sufficient storage space for obsolete and new equipment. Completed extra storage space secured. 2. The temporary storage of the ECC area now under discussion.	Digital & Data Committee	15	C3 x L5	3 3x1	↔	02.05.2011 -	07/12/2020	01.04.2021	632
Chief Operating Officer Pharmacy & Medicines Management	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Pharmacy & Medicines Management - Training & Development Infrastructure	**IF:** the planned HEIW led changes to the education and training of pharmacists and pharmacy technicians with increased numbers of trainees across both primary and acute care are fully implemented **Then:** the there will be insufficient capacity within the medicines management team to provide the required training, supervision and management of the planned trainees. **Resulting in:** a lack of appropriately qualified pharmacy professionals to meet future service demands in all sectors and particularly in hard to recruit to ILGs such as Merthyr where we have established a "grow our own" model. This can impact the primary care sustainability MDT model. Also a reduction in reputation of a HB that has a very high level of % qualifying and a reduction in future applicants. Current capacity is overstretched and a robust education, training and development infrastructure is needed to meet these demands for specialist & advanced practitioners in primary and secondary care.	SBAR submitted to CBM in March 18 to increase training capacity in order to meet the demand. Included in IMTP and prioritised as number one priority. A bid was included as part of the primary care pacesetter for education and development in primary care academic hubs and was successful. This element of the ed/tr will be implemented in 2018 for 3 years with evaluation. The secondary care elements were not supported in the IMTP prioritisation process and so this still leaves significant risks. SBAR needed to describe the impact of the new technicians training qualification. Funding approved for primary care lead pharmacist - commenced in post April 2019. Included a new case in 2019/20 IMTP as high priority. SBAR for Nov CBM on new technician training requirements. Progress and evaluate primary care pacesetter plan to increase training infrastructure to inform business case to continue funding and scale up.	June 2019: Briefing paper detailing risks and recommendations to be submitted to CBM summer 2019 Dec 2019: All Wales working groups established and discussions ongoing with HEIW regarding changes and capacity and resources required. Jan 2020: SBAR submitted to HEIW and CBM in response to consultation on pre-registration pharmacist proposals Oct 20 discussions on going with HEIW and COVID impact on training now to be included in this risk. SBAR to be included in 2021/22 IMTP Review of mitigating action scheduled for April 2021.	People & Culture Committee	15	C3 x L5	6	↔	02.01.2018	04/02/2021	01/04/2021	3638

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Chief Operating Officer Pharmacy & Medicines Management	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Temperatures in medicines storage room on the wards in Prince Charles Hospital not fit for purpose.	**If** there is no control of the temperatures in all the medicines storage rooms on the wards in Prince Charles Hospital. The medicines storage room have pipes in ducts which give off significant heat year round and increased issues in the summer months. **Then:** medicines are being kept above the required temperatures as stated in their specifications of storage as part of their license from MHRA. **Resulting in:** medicines stored at a higher temperature than their specifications which could result in them being less active or denatured and affect patient outcomes.	Some wards are placing small fans in rooms but this does not reduce the temperature. alternative rooms for storage have been discussed but unable to progress due to other ward priorities A SON for air conditioning for each ward will be progressed by medicines management on behalf of ILG	A SON for air conditioning for each ward will be progressed by medicines management on behalf of ILG, however, due to COVID-19 this will be considered in 21-22. Risk will be reviewed in May 2021.	Quality & Safety Committee	15	C3 x L5	6	↔	05.02.2018	04.02.2021	03.05.2021	3072
Executive Director of Workforce & Organisational Development	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the CTMUHB)	**IF:** the Health Board fails to comply with all the Welsh Language requirements **Then:** the Health Board's will not be compliant with the duties outlined in the Welsh Language Standards. **Resulting in:** damage to the reputation of the Health Board, negative publicity and contact with the Welsh Language Commissioner. As a consequence of an internal assessment of the Standards and their impact on the CTMUHB, it is recognised that the Health Board will not be fully compliant with all applicable Standards. This risk is particularly high in: translation services due to demand exceeding capacity.	The Welsh Language team has undertaken a self-assessment of the requirements of the Standards and how they apply to Cwm Taf Morgannwg. Close constructive working relationships are in place with the Welsh Language Commissioner's Office. Strong networks are in place amongst Welsh Language Officers across NHS Wales to inform learning and development of responses to the Standards. Regular reports to the Board to raise awareness. Working Group set up to support managers. Developing a new bilingual skills strategy. Welsh courses provided to staff. Ward Audits to monitor progress with compliance - ongoing and options to revisit are currently being discussed.. Continue to review and act on the UHBs Self-Assessment findings and related improvement actions; ensure Board is fully sighted. Implement the first year of a 5 year plan outlining the extent to which the health board can carry out consultations in Welsh. All nursing JDs are translated and advertise bilingually. Compliance with Statutory requirements outlined in Welsh Language Standards.	Welsh Language in Primary Care Policy developed and being progressed for Board Committee approval - Completed. Begin a programme of translation focusing on the job descriptions advertised most frequently - e.g. nursing vacancies. Compliance with this standard with take many years due to the limited capacity of the translation team. Action plans have been given to the heads of ILGs, Corporate Services and Workforce and OD to ensure senior management are aware of their WL responsibilities. Completed. Continue to develop the Welsh Language skills of the workforce through online learning. Due date for remaining actions :31.3.2021	People & Culture Committee	15	C3 x L5	9	↔	02/07/2018	1.3.2021	31.3.2021	4110
Chief Operating Officer Bridgend ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting List for Autism Diagnostic Observation Schedule (ADOS) assessments and Attention Deficit Hyperactivity Disorder (ADHD) medicals over 1 year.	**If:** there are delays in diagnosing children with ADHD and Autism. **Then:** this results in a delay in management including appropriate school placements **Resulting in:** potential harm to patients, poor patient experience, dignity, staff morale. Complaints.	* The team have reviewed their clinical practice in line with the rest of CTM e.g. no longer undertaking ADOS for all children * Discussions underway re: repatriating service from Swansea Bay and investing funding into enhanced local service in Bridgend * New Consultant starting June 2020 with 3 sessions to support community paeds	Vacant sessions to be recruited to - Additional staff appointed who could undertake assessments would ensure this activity was managed in a timely manner.	Quality & Safety Committee	15	C3 x L5	4	↔	02.07.2019	16.09.2020	01.06.2021	3698
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No Midwifery Specialist for pregnant women with vulnerabilities	**IF:** there is no dedicated services for substance misuse women, prescription medication, or women with vulnerabilities (social) - national best practice is for there to be a lead in vulnerabilities to see women in a dedicated clinic with the multidisciplinary teams which without leads to disjointed care for our most at risk patient group. **Then:** unidentified opportunities to co-ordinate risk management and support in 'A Healthier Wales' in pregnancy will be missed. **Resulting In:** potential harm to mothers and babies care provision and outcomes.	Women in PCH/RGH are seen in a general Ante Natal clinics Women in POW currently seen in a dedicated clinic, with an SLA agreement with Swansea Bay UHB .2 resource. The directorate need to develop a Statement of need to secure resources to support services across the HB and ensure standardised service delivery.	Action: Service to develop business case for implementing specialist service for women with vulnerabilities.	Quality & Safety Committee People & Culture Committee	15	C3 x L5	6	↔	26.06.2019	01.12.2020	31.3.2021	3685

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Chief Operating Officer Executive Director of Planning, Performance and ICT	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Telecommunications upgrade required with operational components for cardiac arrest and emergency fire numbers.	(Facilities Risk Register Reference 11480B) **ILG:** CSO Facilities Hub **If:** The telecommunications system for cardiac arrest and emergency fire numbers is not upgraded. **Then:** Potential for system crashes. **Resulting In:** Potential delay in contacting the necessary person(s), leading to patient not having efficient and effective treatment.	Contingency plan for telecommunications in place. Working with ICT team to attempt to implement technical solutions available as quickly as possible. ICT funding agreement in place, no SON requirement. Contingency plan reviewed and there is a contingency where radios are provided and all emergency calls only are communicated via this link should the system crash. Commission management consultancy firm to undertake strategic review of existing ICT infrastructure. Completed. Review contingency plan for telecommunications to ensure adequacy in light of risk. Contingency plan reviewed and internally there is a contingency where radios are provided and all emergency calls only are communicated via this link should the system crash. Completed. 4C's management consultancy firm commissioned, undertaking review currently with a view to making recommendations for solutions. ICT still looking at compatible solutions, starting with RGH. Solutions now found and 4 companies are in the running for bids. 4 companies are currently attending site in order to provide bids. Bids have now been received and are being reviewed in order to choose suitable company to install. New telecomm system still on course to be installed across PCH and RGH by 31st March 2021	Work on the new telecomm system installation has now started and is still ongoing currently due to covid pressures. At the current stage of this work there will be a number of porting exercises taking place within switchboard RGH over the coming weeks. This will mean switchboard RGH will be out of operation for approx. 6 minutes, however there is a possibility that it could not work which could result in being out of use for a longer period. Contingency has been put in place for this work as the contractors will be on site as well as our IT Comms team, however it has been included together with the contingency within this risk as it will affect the Cardiac arrest line. Action: New telecomm system to be installed across PCH and RGH. Timescale: 31/07/2021 Based on this update the risk remains unchanged until installation of new telecommunication system is complete and is compliant (DW 21/04/2021).	Digital & Data Committee	15	C3 x L5	6	↔	21/08/2017	22.4.2021	31.7.2021	4286
Chief Operating Officer Executive Director of Planning, Performance and ICT	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential cyber security risk relating to brand of medical device monitoring system.	(Facilities Risk Register Reference S9) **ILG:** CSO Facilities Hub **If:** Potential cyber security risk (CVE-2020-1472) identified relating to a specific brand of medical device monitoring system. Should a threat be successful. **Then:** Potential changes and disruption to the operation of monitoring equipment could occur. **Resulting In:** Service/business interruption and potential harm to patients being treated.	The medical device system is protected by firewalls but these will not prevent access. Clinical Engineering have discussed with manufacturer about software patching to find and implement a solution. Contacted manufacturer and problem now identified on the manufacturers online support portal as a vulnerability. Received response from the manufacture that the software patch will be available in January. Once patch has been installed by manufacturer Clinical Engineering will install the patch on the two servers and equipment affected within the Health Board and check issue has been resolved for compliance. Clinical Engineering has reviewed all other medical device systems and has identified no other medical device systems that are vulnerable to this threat.	The Specialist Healthcare Scientist in Clinical Engineering has continued to chase the manufacturer for a solution. Following a meeting with them held on 13/01/2021, the manufacturer has accepted fault and has agreed to installing a newer version of software as a solution. The solution will involve a significant amount of downtime of equipment in all critical areas which is not viable during covid pressures. Due to this Clinical Engineering are now awaiting an action plan from the manufacturer for installing the newer software whilst minimising disruption to services. Specialist Healthcare Scientist provided an update on 13/04/2021 that Clinical Engineering have had a commitment from the company to install the update with an expectation that they will be able to start planning the work in May. The supplier has stated that they have a huge backlog on high level engineering work currently. However, Clinical Engineering will engage with them to expedite this. Action: Supplier to install new software patch. Timescale: 31/07/2021. Based on this update the risk remains unchanged until work has begun from the supplier and the newer version of software has been successfully installed by the manufacturer and the issue has been resolved for compliance by Clinical Engineering.	Digital & Data Committee	15	C3 x L5	5	↔	23/09/2020	21.04.2021	31.07.2021	4306
Chief Operating Officer Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Delivery of the rehabilitation for repatriated major trauma patients.	**If:** The business case for enhanced rehabilitation services linked to Major Trauma is not supported. **Then:** Patients will not receive the appropriate level of clinical intervention. **Resulting In:** Poorer clinical outcomes, increased lengths of stay (with associated clinical risks) and poor patient experience.	Ensuring current nursing and therapies have access to a training programme - however there are concerns about deliverability during Covid pandemic. The new rehabilitation coordinator post will support the delivery of the immediate care planning once a patient is repatriated. Advance notice means we can ensure staff are aware of immediate needs. The network has systems in place to support early care planning and preparation where possible i.e. The health board is aware of the number of patients likely to be transferred 'Rehabilitation prescription' describes nursing and therapy needs prior to repatriation. Rehabilitation coordinators link with counterparts in UHW to ensure our rehabilitation offer is clear to the patient and their family prior to transfer.	Develop a business case to identify and address the specific rehabilitation needs of patients repatriated to CTM from the Major Trauma Centre. This would need to encompass inpatient and community needs across the whole of the Health Board. The Business case will require Management Board / IMTP approval and release of funding. Recruitment and training of required staff then needs to take place. Timescale: 30.9.2021 changed from 31.3.2021 due to the impact of the Covid-19 impact.	Quality & Safety Committee	16	C4xL4	9	↔	10/09/2020	09/04/2021	30/09/2021	4281
Chief Operating Officer Primary Care	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Resumption of Orthodontic Services	**If:** In compliance with WG guidance, if the Health Board is unable to resume orthodontic services over the next 2 years where patients (under 18) do not meet the IOTN of over 4. **If:** the Health Board does not secure funding for establishing a new Orthodontic contract to meet demand following boundary changes. **Then:** patients will experience significant delays in accessing treatment. **Resulting in:** • Those patients with milder cases incurring further delays in addition to having already experienced long waits for treatment. • It is likely this will increase the number of appeals/challenges/complaints from families, currently CTM does not have an appeals process in place. • Pressure on GDPs to communicate this to families and manage patient/family expectation • Risk that patients/families will be offered/coerced into private treatment as an alternative	The Health Board will continue negotiations with the relevant Health Board regarding treatment/payment of historic patient on waiting lists/ and new referrals.	1. Health Board to address concerns regarding guidance directly with WG and through local ortho MCN Chair. 2. Appeals process to be developed to manage complaints/challenges 3. Raise issue regarding additional ortho funding in June during annual WG Dental Team visit to Health Board.	Quality & Safety Committee	15	C3 x L5	12 (3x4)	New Risk	23/04/2021	07/05/2021	TBC	4606

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Chief Operating Officer RTE Locality	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Increase requirement to store the paper patient record for longer due to: *Delay in the DPN project & the* *Increased retention period due to the Infected Blood Inquiry*	**IF:** The Health Board fails to ensure there is sufficient storage capacity to safely and securely store paper patient records as destruction of the files is delayed. **Then:** there could be potential data loss and poor records management processes and communication. Health, Safety and Fire risks will escalate due to overcrowded and inappropriate storage. **Resulting in:** possible breaches to the GDPR, safeguarding and information governance risks. Possible injuries to staff due to manual handling/trip hazards and breaches of Fire Safety procedures. These hazards extend to record stores across the Health Board as capacity to accept their excess records is compromised.	Digitisation of general patient records commenced on 18/3/21. This will gradually create storage space at the central records hub over 2 years, to ensure a sustainable, safe and secure storage solution. Interim storage may be required in the meantime, due to the impact of delayed digitisation and Infected Blood Inquiry embargo on managed record destruction until late 2023. Impact being closely monitored as areas outside the Hub are being affected due to compromised capacity to store additional records and destroy their excess. An Electronic Document Management System, Clinical Portal interface have been introduced; E-forms will follow as part of the project over the next year. Ensure Records management processes fully applied in all record stores to maximise use of available physical capacity. N.B. Limited opportunity for this, as destruction procedure cannot be applied to non-digitised records. Ensure no temporary storage solutions are agreed, without full consideration of the Executive.	Digital Patient Notes (Phase 1) was delayed but has now gone live. This will enable a limited regular destruction of digitised notes from this point forward, despite the continued record destruction embargo, as the content is held digitally. All other non-digital records are still under embargo until late 2023. This overarching record storage risk now also incorporates Bridgend Medical Records stores, where no digitisation can begin for at least 2 years, hence the overall consequence of 3 and likelihood of 5. The impact being closely monitored. Areas outside Medical Records are also being affected, due to inability to destroy their archived records at the Hub; this prevents them transferring their excess records to this site. All possible measures are being taken to manage the storage areas and maximise use of the space. Digitisation of general patient records commenced on 18/3/21. This will gradually create storage space at the central records hub over 2 years, to ensure a sustainable, safe and secure storage solution . An Electronic Document Management System and Clinical Portal interface have been introduced via this programme; E-forms will follow over the next year. To date, @13,500 deceased and live records have been digitised and @244 consultant and nurse-led teams are live on the use of the DPN software. Procurement of digital dictation for 400 users will also assist by	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↓ 16	02/07/2018	07.05.2021	31.07.2021	4109
Chief Operating Officer RTE Locality	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Impact on Speech and Language Therapy (SLT) and Dietetics staffing capacity with relocation of tissue transfer surgical procedures to RGH	Patients undergoing this type of surgery require intensive SLT and Dietetics due the impact on eating drinking and communication and all of this care will now be provided in CTM rather than jointly with another Health Board. Possible delay in discharge from hospital if waiting for SLT/dietetics input.	Patients will be seen by SLT and Dietitian but there will be a delay in response due to no increase in staffing to accommodate this increase in demand from 15th March and will need to monitor quality of input that can be given.	See Control Measures	Quality & Safety Committee	15	C3 x L5	2 Target score to be revisited.	New risk added to org RR	10/03/2021	23/04/2021	10/06/2021	4577
Executive Director of Nursing & Midwifery Infection Control	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Reduced on site Consultant Microbiologist cover for the Bridgend ILG	The Microbiology cover for the Bridgend locality is provided by Public Health Wales Microbiologists via a SLA with Swansea Bay UHB. There are differences in policies/procedures and therefore a lack of standardisation across CTM. There is also a lack of standardisation for multi resistant organism definitions and sampling methods for C.Difficile infection. **If:** there is no dedicated on site Microbiology cover **Then:** there will be no antimicrobial/ ITU ward rounds, no root cause analysis to learn from incidents. **Resulting in:** mismanagement of patients/ inappropriate treatment and no learning to	Senior Infection Prevention and Control Nurse on site to support Bridgend ILG with IPC related issues. Lead/ Deputy IPC Nurse to support. IPC Nurses to discuss any concerns with Microbiologist on call for Bridgend ILG The Medical Director for the Bridgend ILG has arranged a meeting to discuss	SLA for Microbiology cover for Bridgend ILG - To revisit SLA with Public Health Wales laboratory. Medical Director for Bridgend ILG to email Medical Director to discuss concerns regarding the SLA. Due date: 1.09.2021	Quality & Safety Committee	15	C3 x L5	3 (C3xL1)	New risk added to org RR	16/07/2020	11/05/2021	30/06/2021	4218

Datix ID	Executive Portfolio	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Last reviewed	Comments
4331	Chief Operating Officer Merthyr & Cynon ILG	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Covid 19 emergency flow and Impact of Royal Glamorgan Hospital (RGH) flow	**IF:** The continued high rates of admissions continue with increased numbers of Covid-19 patients during autumn 2020 **Then:** there will be a reduction in non Covid-19 attendances causing significant constraints with regards to the safe flow of patients in Prince Charles Hospital (PCH). **Resulting in:** Lengthy Welsh Ambulance Service Trust (WAST) waits and delays and inability to increase Covid-19 capacity on PCH site.	Associated plans opening of surge capacity of SSU and Ysbyty Seren and agreed support from C&V and ABHB and new pathways in development for RGH	See Control Measures	Quality & Safety Committee	10 (5x2)	12	↓ 20	12.10.2020	7.4.2021	Closed as target score met. The Surge Action Plans and reduction in flow has reduced the likelihood of this risk.