Organisational Risk Register (Risks Graded 15 and Above - Review as at November 2025

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
6052	Chief Operating Officer	Facilities Directorate	Facilities Director	Sustaining Our Future	Statutory Duty, Regulation, Mandatory Requirements	Patient hydration risks associated with the replacement of aged Beverage Trolley fleet (ultrakarts)	**If**: The patient beverage trolley fleet is not maintained/replaced **Then:** Patients are unable be fed breakfast and beverages. This is an essential part of the patient care. **Resulting in:** Patient hydration and nutrition non-compliance. Existing fleet of beverage trolleys in CTM UHB require a replacement programme (as per regen trolleys). The current fleet (apart from the Seren assets) are 10 plus years old and maximum life is 10 years old if maintained. The Ultrakarts are used for patient breakfast and beverages and then on used on average 5 times a day for beverages so are heavy use. The current models at all district general and community sites are not able to be put on maintenance contracts due to age, hence non-compliant. Several sites are now running with one per two/three wards and the service level is one per ward. YCC have 1 beverage trolley that is non-repairable.	There is a repair programme in place at each site when equipment is broken. However the beverage trolleys are too old to put on maintenance contracts. Replacement is the only alternative.	There is not enough budget in revenue to purchase singularly and the beverage trolleys are manufactured to order (cost decreases with volume). An investment bid has been included in the Facilities IMTP (submitted March 2025) An agreed replacement process has been approved, the risk will remain high until such time we have sufficient spares from replaced carts to maintain the existing equipment. Update October 2025 - This risk was reviewed on the 24th September and is scheduled for review again at the end of December. At present there is no change to the risk score.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	8 (C4xL2)	↔	15.01.2025	24.09.2025	31.12.2025
5821	Executive Director of Strategy & Transformation	Central Corporate Directorate - Commissioning DTPS Care Group	Assistant Director of Transformation, Strategic and Operational Planning	Improving Care	Service / Business interruption	Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB).	If: CTM is unable to secure a new contract with an alternative commissioned provider; Then: CTM residents will have no access to secondary care immunology provision. Resulting in: unacceptable level of clinical risk for both routine and urgent referrals that are currently without any available referral option. Patient experience will be impacted by delays in onward referral for investigation, diagnosis and definitive treatment/management plan. This could lead to both informal and formal concerns being submitted to the health boards.	Working group in place to seek and secure service (meets monthly), although more regular communication and updates is sent in between meetings. Exploration of suitable providers within the NHS and also private providers undertaken. Short term contract being sought for urgent referrals and expected by end July 2024. CTM UHB Referral Management Centre currently maintaining database of both urgent and routine referrals received. CTM GP's have been informed of the challenges currently experienced with immunology provision and delays can be expected.	Update October 2025 - An executive discussion is to be held on this subject with the paper currently being drafted. An internal working group is to be established which will oversee the approach to managing this service risk. Conversations ongoing with Welsh Government and North Bristol Trust.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	4 (C4xL1)	↑	08.07.2024	20.10.2025	31.12.2025
6179	Executive Director of Public Health	Public Health - Health Protection	Executive Director of Public Health	Creating Health & Improving Care	Quality / Complaints / Assurance / Patient Outcomes Impact on the safety – Physical and/or Psychological harm	High and increasing prevalence of overweight and obesity in children and adults.	**If** there is insufficient preventative activity to reduce rates of overweight and obesity **Then** rates of obesity will remain high in CTM . **Resulting in** increased activity/acuity/complexity of patients resulting from obesity, poorer patient outcomes, increasing pressures on services, risk of clinical incidents and continuing financial pressures on the organisation There is also a continued risk from a health and safety perspective for sufficient equipment and capability to move people with extreme BMIs in the event of incidents.	A range of work is currently under way in response to high levels of obesity in CTM including: 1)Grant funded Whole system approach to healthy weight work– building momentum to influence system wide change in our obesogenic environment 2)Adult Weight Management Service – the scale of this is vastly insufficient to make a difference to population level rates of obesity 3)Children and Young People's weight management service – current time-limited funding for Pipyn, preventative family based intervention, ongoing development work to maximise population impact, scale remains small. Proposed future development of a service in line with level 3 of the All-Wales Weight Management Pathway. 4)Healthy pre- and health schools programmes – working to enable educational settings to be healthy weight environments. Current activities are insufficient for population level impact. A new action plan will be published in the Spring/Summer 2025 for Healthy Weight: Healthy Wales, the national strategy for Obesity. This will include actions across 4 domains: -healthy environments -healthy settings, -healthy people, -leadership and enabling change. The Food (Promotion and Presentation) (Wales) Regulations 2025 are due to come into force in 2026 and will introduce some restrictions on the promotion and placement of unhealthy food.	Update September 2025 The Healthy Weight Steering Group is currently developing a healthy weight road map for CTMUHB, outlining actions and strategic direction over the short, medium and long term. This will be in line with Healthy Weight: Healthy Wales, and take into consideration health board actions under the new national action plan. The Healthy Weight roadmap is under development and due at Board for approval in November 2025. There is a business case in place for sustainability and increased capacity for Pipyn (level1+), and a CYP level 3 weight management service. A level 3 weight management service will help improve outcomes for some our most disadvantaged children. Update 08.08.25 funding has not yet been released for this business case as it is dependent on savings as part of the IMTP. A further panel for scrutiny was held for all IMTP business cases on 19th August before resubmission back to ELG for consideration. Update November 2025 The mitigation remains unchanged from that reported in September 2025. The risk will be reviewed further at the end of November 2025.	Quality, Safety & Experience Committee. Strategic Development Committee.	20	C4xL5	9 C3xL3	↔	06.05.2025	17.10.2025	30.11.2025
4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - 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 is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	October 2025 - Unscheduled Care A number of actions are being taken by the care group to address the demand and improve patient experiences/outcomes. Launch UNITE (Unscheduled care Improvement, Transformation and Efficiency programme) POW ED Ambulatory Footprint opened Re-set RGH – short term de-escalation and re-alignment of Acute Medicine complete Medical workforce review and Job Planning Significant invest to save in Medical workforce UTC Pilot extended in PCH March 2026 45 min Escalation Action Cards and escalation policy implemented Weekly performance meetings established support by Unscheduled Care Dashboard Phase one GP intake back to POW Additional Ambulatory area in POW identified by the team to support the STAMP reset Targeted recruitment currently underway for additional consultant posts Single Point of Access (SPOA) meeting with Primary & Community Care. Programme established Successful recruitment of medical staff to uplift rotas and reduce reliance on agency completed CTM UHB Winter Planning progressed October 2025 - Planned Care The below is a summary of initiatives reflecting the ongoing efforts by the care group to improve capacity and meet the elective demand. Centralisation of Cataract Service: All cataract treatments have been consolidated to the POW Eye unit from 1st September 2025. Two main theatres plus sessions in the surgicube are dedicated to the service. Direct listing of cataracts has commenced. Paediatric Dental Surgery: A recovery plan has been agreed upon between the Community Dental and RGH Theatre Service to increase theatre capacity. 6Cancer Services: Performance for August was 63.4%, and September 2025 is currently unvalidated but aiming at over 63%. Key actions are required for tertiary referrals, pathology, and optimisation pathways. The backlog has started to reduce against the trajectory, with a focus on Urology, Gastrointestinal, and Gynaecology. Centralisation of Trauma & Orthopaedics: The POW theatres opened on 1st September 2025 with three dedicated arthroplasty theatres. Ward 7 is now a protected elective Orthopaedic Ward with 28 beds. Between 1st September and 22nd October, 239 elective arthroplasty cases were performed at POWH. The average length of stay has reduced to 1.9 days compared to 5 days this time last year. Theatres: Utilisation and late starts are improving, especially in the Princess of Wales Hospital (POWH), although they are still below target. Speciality deep dives are being introduced, starting with Urology, to address persistent issues. Theatres are recovering from previous disruptions, such as roof issues, but upcoming work at the Royal Glamorgan Hospital (RGH) may impact progress. The care group will monitor all impact and escalate /mitigate accordingly. Regional Outpatient Insourcing commenced at CTMUHB is ongoing. Aiming to reduce Outpatient waiting times across all specialities Progress made on >104 week. All specialities aim to maintain <104 weeks with the exception of Orthopaedics	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 C4 x L3	↔	13.7.2023	06.11.2025	06.12.2025
5276	Director of Digital	Central Corporate - Digital & Data	Pathology Directorate Manager	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	**IF:** the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. **THEN:** operational delivery of pathology services may be severely impacted. **RESULTING IN** potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	Update October 2025 Cell Path deployment pushed back to October 2025 and is now very close to Micro deployment - concerns around short time frames planned for User Acceptance Testing sign off and Cutover Qualification (CQ). Blood Sciences deployment is now delayed until 2026 due to significant issues in the aliquoting process in Biochemistry. It has been agreed to roll out on a per discipline basis instead of per Health Board. The predicted time lines are: Pre production environment – July 2025 (completed). Production Environment – Beginning of October 2025. Cell Path and Andrology – End of October 2025. Microbiology – Beginning November 2025. Blood Transfusion and Blood Sciences – No dates yet agreed, likely in the new year.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	27.10.2025	30.11.2025
3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety 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:** Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	The emergency departments across CTM remain overcrowded. There are many internal actions being undertaken within Care Group to reduce attendances, improve flow and reduce overcrowding: • CTM UHB Development of Urgent & Emergency Care Rapid Improvement Plan (45 minute ambulance handover and 90-day ED performance) • TRUE Rapid Improvement Plan through 6 Goals Programme – SRO - Deputy Exec Med Director and Deputy COO • USC CG Formalise and sign off 30/60/90-day improvement plan • Acute Medicine Transformation Programme (STAMP) – POW – 2 workshops complete – 3 further planned June/early July • New investment agreed for x3 Consultant Acute Physician posts. Targeted recruitment drive currently underway. • Single Point of Access (SPOA) meeting with Primary & Community Care. Programme established. • Targeted recruitment of Acute Medicine Consultants following new investment to provide 7/7 October 2025 TRUE rapid improvement actions being worked through. Action cards signed off and live. Acute med reset in Prince Charles Hospital and Royal Glamorgan Hospital complete. Princess of Wales Hospital STAMP programme on going and optimise ongoing. Improvement plans to create and ambulatory area in Emergency Department in Princess of Wales Hospital Escalation policy has been enacted following OMB sign off. This policy will assist in standardising and consistencies in approach across all sites. The escalation triggers and actions will assist with gridlock situations, particularly during peak winter pressures or critical incidents.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 (C4xL3)	↔	24.09.2019	06.11.2025	06.12.2025
5417	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Paediatric Dentistry - General Anaesthetic (GA) theatre list	**If...** Regular additional GA theatre lists (necessary to meet current and future demand) are not made available to the Community Dental Service team for paediatric GA. **Then...** the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024. **Resulting in...** 1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction, 2. a further increase in the number of children requiring GA, due to long waits for assessment more children need GA when assessed, conversion rate has jumped form 48% to 80%. Children can only wait 8 wks form assessment to treatment therefore there is a large backlog of assessments due to limited GA lists to provide treatment.	Current theatre lists are run on Monday mornings and Friday afternoons and are likely to be cancelled due to bank holidays. This impacts the running of the service, no additional lists are available when lists are missed. There are currently 800+ patients waiting for appointments, with some already waiting for 17 months. Patients are advised to return to their General Dental Practitioner (GDP) if they experience pain, some children are being prescribed multiple courses of antibiotics to ease dental infections that can only be alleviated by tooth extraction. There is a risk these patients will require the removal of more teeth/more require GA when assessed/children will present as an urgent case in Accident and Emergency if left untreated.	Update October 2025 On review of the plans there has been a delay in the September implementation date and it is now anticipated that from the end of November / December a sufficient number of lists will be allocated to the service to enable the backlog to be reduced and manage ongoing demand. Lists will operate from 2 acute hospital sites initially with ambition that the lists will be provided from the 3 sites, which requires further planning as we progress with these plans. Additional assessments sessions will be put in place with community dental to ensure full utilisation of the lists. The care groups will continue to monitor the position and review the risk following assurance all lists have commenced in November as planned. Available is the latest trajectory from the Care Group reflecting the trajectory and target date. It is considered that the risk score could be reduced and this will be reviewed by the Primary Care and Community Care Group ahead of the next iteration of the report.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	9 C3xL3	↔	20.04.2023	06.11.2025	06.12.2025

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
12	5753	Executive Nurse Director / Deputy Chief Executive	Children & Family Care Group	Care Group Service Director	Improving Care	Workforce / Organisational Development / Staffing / Competence	Inadequate Special School Nurse Provision	**If** the Health offer towards the current Special Schools Nursing Model is not increased and Bridgend Local Education Authority (LEA) does not contribute financially to the Service Level Agreement (SLA) in Special Schools **Then t**he Community Children's Nursing (CCN) Service are unable to meet their obligations across the five special schools in CTM and be unable to fulfil their obligation to Rhondda Cynon Taf (RCT) and Merthyr who are the only LEAs who contribute financially into the SLA **Resulting in**, Dissatisfaction and fractured relationships within RCT and Merthyr LEA, inequity of service provision across CTM special schools, risks to the children & young people (CYP), impact on Consultant Led clinics, inability of special school nurse to deliver on School Nursing Framework in Wales part 2 - Nursing in Special Schools and Healthy Child Wales (HCW) part 2, lack of access to continual professional development and peer support for the nurses based in Special Schools, continued issues with recruitment and retention of nursing staff into Special Schools	Mitigation – reviewing SLA at pace with LA, high level meetings with EDON, Nursing Director and Directors of education. Supporting staff, sharing risk across SSN schools. During periods of absence or vacancies; access to a school nurse will not be available in person 5 days per week. However, telephone advice and support will be available. These control measures do not meet expectations of Local Authority. Meetings have been held between Directors of education and Director and Executive Nurse. SBAR has been escalated to Care Group OMB but needs to be escalated to HB OMB (19/02/2025) Engagement between senior nurse and head teachers and support for special school nurses has been given.	Update October 2025 There has been a slight improvement since the schools have restarted, but remains a high risk for the care group, due to workforce vacancies, despite attempts to fill. This has been raised at the Quality , Safety and Experience Committee, and clarity from Welsh Government has been requested on their position specifically around the adherence to the framework. It has been raised to consider as an item for discussion at the Integrated Quality, Planning and Delivery (IQPD) meeting with Welsh Government.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	8 (C4xL2)	↔	16.04.2024	06.11.2025	06.12.2025
14	4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation) while ensuring optimal performance and quality standards are consistently met	**IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM **THEN:** avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care **RESULTING In:** higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community. Additionally, the performance targets to monitor improvement of the stroke prevention and care service will be adversely affected, leading to significant challenges for the health board to include noncompliance with Quality Improvement Measures (QIMs).	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. • ToR and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Board briefing to ensure all sighted to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CTM input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	Update October 2025 Risk reframed to take into account feedback received from the September 2025 Quality, Safety & Experience Committee to capture the performance element of the risk. Medical Workforce Update 1.0 wte consultant returning from maternity leave October 25 1.0 wte consultant appointed, starting January 26 1.0 wte consultant returned from LTS - phased return Specialty Medicine Directorate aiming to appoint 2.0 wte consultant neurologists. Job plan will support 1 clinical session allocated to stroke on call rota. In terms of the risk score remaining at 16 the USC Care Group considers that the following mitigations support this rating. - there has been and will be a senior decision maker for stroke i.e. a consultant who will immediately attend all stroke calls – Monday – Friday with Thrombolysis prioritised. - CNS 6/7, based in ED, covering core hours 9-5 (some days till 1800). - Enhanced monitoring with senior leadership oversight in place, through daily breach huddles with a live improvement plan. This is undertaken using an MDT approach, we have already seen improvement in CT and admission to ASU. - Daily breach and weekly reports of top breach reasons and associated actions captured and tracked. - A robust improvement action plan is in place for the unit which focusses on leadership, workforce, IP&C, and fundamentals of care – the actions are 89% complete. -Nursing workforce and leadership now significantly improved; we have 2 x Band 7 ward manager which enables 7/7 cover for the unit. -Medical workforce stabilised with a return from mat leave and start date for new consultant end of November -Internal Audit report recently received indicates a positive outcome with an overall reasonable assurance rating. Whilst the USC Care Group acknowledge there has been limited improvement in the QIMs to date there has been clear improvement in overall quality of care which was the basis of reducing this score from a 20 to a 16.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	12 (C4 x L3)	↓	11.05.2021	06.11.2025	31.12.2025
16	6228	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Improving Care	Quality, Complaints, Assurance / Patient Outcomes	Effective and efficient management of requests from the HM Coroner	**If:** the Health Board fails to effectively respond and manage requests from the HM Coroners Office in a timely manner. **Then:** there is a risk that the Health Board will breach 'The Coroners (Investigations) Regulations 2013" in failing to provide documentation on time and take required action in a timely manner to ensure lessons have been learned. **Resulting in:** poor experience and the wellbeing impact for the families and staff members involved in inquests, reputational impact of the Health Board in terms of trust and confidence in the service, an increase in the number of Regulation 28 / 29 reports on actions to prevent future deaths, an increase in potential enactment of the Coroners powers, including under Schedule 5 - "Power to require evidence to be given or produced".	Review initiated to understand CTMUHB's position in terms of the number of inquests underway and the response to requests. Review and remap internal processes in the management of inquest cases within the organisation. Weekly coronial meetings with the Senior Coroner's Officer to discuss operational progress and individual cases. Weekly oversight meetings and briefings on cases of concern for discussion at ELG as well as performance review.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage inquests effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. Update September 2025 - Weekly escalation meeting established with Senior Coroner's Officer to highlight cases requiring urgent action. Weekly meetings with Legal & Risk to track action and progress with high-risk/high-profile inquests. Works continues to be undertaken to improve the accuracy and robustness of information contained within the Datix Cymru system. Enhanced reports and trackers being developed to support the operational management of inquests. Mechanisms for providing reporting and providing assurance to be embedded. Documentation for supporting staff with the inquest process to be finalised. Update October 2025 - on an interim basis a designated lead has aligned to the legal services function to provide greater oversight as to the Coroners Inquests activity. Whilst this is a relatively new step the risk remains as current it will be reviewed as part of the legal services recovery programme and implementation of the Organisational Change Process within the Patient Care and Safety Directorate.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	↔	3.7.2025	06.11.2025	31.12.2025
17	6229	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Improving Care	Quality, Complaints, Assurance / Patient Outcomes	Timely development of, management and response to Learning From Event Reports (LFERs)	**If:** the Health Board fails to achieve timely completion of LFERs, respond promptly to the questions from the Welsh Risk Pool Learning Advisory Panel and provide assurance that learning has been implemented and shared. **Then:** there is a risk that improvement to quality and safety in healthcare aligned to learning which flows from case investigations, and the LFER (Learning From Event Report)s is not acted upon. **Resulting in:** reputational impact of the Health Board in terms of trust and confidence in the service and assurance that lessons have been learned. Missed opportunities to improve patient care and safety following identification of areas for improvement. Financial penalties if the Welsh Risk Pool consider withholding reimbursements due to being dissatisfied with the learning and actions taken in a case.	Review initiated to understand CTMUHB's position in terms of the number of cases underway and the response to requests. Current controls: Incident Management Framework and Toolkit. Incident Investigation Training Visibility of data using the Datix System. Listening and Learning Framework	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. Update September 2025 - LFER workshop held 04/09/25 with the health board internal Legal Services team and Heads of Quality & Safety to review the recently revised LFER process and to look at implementing a revised and smarter way of working. Revised process to be further updated and to include timeframes for actions ensuring deadlines are adhered to. Final documentation to be shared at the Executive Director led Quality & Safety weekly meeting on Monday 29th September 2025 for Exec' review and approval with an action for immediate implementation. Further work will be progressed to undertake a wider review of how learning is further embedded across CTM, and will take place with support of the QI team in reviewing the Listening & Learning Framework and the Learning Repository. Collaborative work continues between the Assistant Director of Nursing and the health board assigned WRP Principal Safety & Learning Advisor, with a meeting scheduled to discuss the format and set up of an internal CTMUHB Learning From Events Report Panel, with engagement from the WRP Principal Safety & Learning Advisor. Terms of Reference for the LFER panel will be developed including membership & frequency and presented to the Executive Director led Quality & Safety weekly meeting for approval. Update October 2025 LFER pannels currently in the process of being setup with support from Welsh Risk Pool. Awaiting a number of submissions end of October for status to be determined.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	↔	3.7.2025	08.10.2025	31.12.2025
18	6231	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Sustaining our Future	Standard Duty, regulation, mandatory requirements.	Proactive management and compliance with cases that qualify for consideration under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.	**If:** the Health Board fails to comply and proactively manage cases that qualify for consideration under NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. **Then:** there will be a missed opportunity to deal with concerns under a single and consistent method for grading, investigating and to actively involve the person raising the concern in an open and engaged manner to put things right. **Resulting in:** Delays in improving patient safety and experience as a result of identifying how services may have improved as a result of concerns notified and dealt with under these arrangements. Early resolution of cases which provide an opportunity for closure for families and staff as well as effective and efficient learning to be implemented. Avoidable costs should a case proceed to litigation due to failure to comply proactively with the arrangements. Reputational impact of the Health Board in terms of trust and confidence in the service and assurance that lessons have been learned	Review initiated to understand CTMUHB's position in terms of the number of cases underway and the response to requests. Current controls: Putting Things Right - Handling Concerns Procedures Engagement with Legal & Risk Services. Experienced Concerns Handlers in post.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. Update September 2025: The organisation is maintaining performance in the management of concern responses within 30 days. The acknowledgement within 2 working days has been improved, however, will need additional time and support to embed, thus providing confidence to lessen the risk. Work continues to attend to the responses in early resolution and tailor the outcome of the Organisational Change Process changes to reflect the resource needs in attending to focus on localised early resolution. Update October 2025 - Focussed activity is underway in terms of reviewing systems and processes. CTM has also benchmarked with other Health Boards to learn and share best practice. As part of the recovery plan detailed scrutiny on early resolutions has been undertaken which has identified areas of improvement that need to be rectified at pace in order to improve the rate of compliance. This programme of work will entail communicating with service users to ensure to inform as to the status of their concerns.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	↔	3.7.2025	06.11.2025	31.12.2025
21	5045	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Access to Neurology Inpatient and Outpatient Services for CTM Residents	**If:** there is no clear direction and commissioning intentions set out in respect of neurology service provision for the residents of RTE; **Then**: existing service pressures in respect of the consultant workforce, availability of diagnostic tests, inpatient demand, care of women on valproate medication, provision of epilepsy specialist nursing services, lack of ante natal epilepsy services and outpatient demand and waiting times will continue; **RESULTING IN**: a risk of harm from late diagnosis; patient condition deterioration; delays starting appropriate treatments, long waiting times; medication issues and potentially sudden unexpected deaths. There is also an issue around reporting of waiting times for neurology patients.	An additional Locum Consultant working out of RGH providing inpatient and outpatient neurology services support. Plan to appoint x3 consultant neurologists within CTM as part of the Neurology Liaison Plan.	Update September: Ongoing capacity challenges are faced in Royal Glamorgan Hospital and Prince Charles Hospital with long waiting times, lack of epilepsy nurse service and a lack of inpatient provision. Agreement has been given to appoint 2x Consultant Neurology Liaison posts within CTM in line with the plan for developing a neurology liaison model across CTM; the care group have been working with the CTM recruitment & retention lead to pull together a recruitment pack that will maximise the chances of successfully recruiting to the posts. The care group have also been working with commissioning colleagues to progress development of the neurology LTA with C&V and SBUHB, so that it accurately reflects current service provision and that as a commissioner of neurology services, CTM are receiving the appropriate level of service. Update from C&V received. Summary: • Confirmed that the reporting of the WL would stay with C&V until >52wk backlog is cleared. • Nobody waiting over 104 weeks. • The locum started in Dec 24 and will remain in post until Dec 25 • Performance against 52 weeks continues to improve with a total of 576 patients above that target at end of August. Further assurance requested via Commissioning colleagues of delivery of the remaining 575 patients >52 weeks. The locum consultant in RGH is expected to remain in post until at least the end of December 2025 and there has been some funding allocated for WLI's to support both C&V and CTM. The care group have requested further assurance via CTM commissioning colleagues on the delivery of the remaining >52 weeks patient cohort. Update October 2025 Consultant in Liaison Neurology vacancy live and closes 16 November. The risk continues to be monitored and reviewed by the care group.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	09.3.2022	06.11.2025	31.12.2025
22	5576	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Sustaining Our Future	Workforce / Organisational Development / Staffing / Competence	Palliative Medicine Staffing	**If** the Health Board are unable to recruit to the vacant Palliative Medicine Consultant post in Ysbyty Cwm Cynon (YCC) for Merthyr/Cynon. **Then**.. there will be a 60% gap in palliative medicine consultant cover. This is in addition to an already understaffed consultant compliment. **Resulting In**.. a negative impact to the delivery of Specialist Palliative Care (SPC) inpatients at YCC. As well as negatively impact on capacity in the other SPC Centres in Royal Glamorgan Hospital and Princess Of Wales Hospital, as remaining Consultants will be required to cover. They are already low as a workforce establishment. Despite this the SPC Centre in YCC will not meet the required standards to retain the SPC status.	Unit is currently open with strict criteria for acceptance End of Life patients only when accepted by a consultant. Limited cover from other SPC centres provided but this individual has now retired, and only remote cover has been secured from other SPC sites going forward. Recruitment in specialist agencies being sought. Additional middle grade cover sought but will have limited impact as not meeting national standards	Update September 2025 The Care Group has had a successful recruitment to all the vacant SPC CNS vacancies restoring 7 day working for the service as a whole across the Health Board footprint. Risk score currently remains unchanged. Update October 2025 With the recent changes to the services at Ysbyty Cwm Cynon there is a reduced impact on the staffing. A comprehensive review of this risk is planned in collaboration with key colleagues. This will ensure that all relevant perspectives are considered ahead of the next articulation. This collaborative approach will allow us to discuss and address any implications arising from the recent changes in the service.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	11.10.2023	06.11.2025	31.12.2025

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
23	4973	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Clinical Medical Cover within CTM Adult Mental Health Services	**If:** CTM Mental Health Service fails to implement adequate senior medical cover across adult in-patient and CMHT services **Then:** the Health Board's ability to provide quality care, a safe environment for patients and a good standard of training for junior doctors will be reduced and potentially compromise the safety of patients and staff **Resulting in**: sub-optimal care to patients, inability to discharge its legal duties under the Mental Health Act, due to insufficient numbers of suitably skilled and experienced Approved Clinicians. Junior doctor supervision will be reduced which may affect future recruitment, patient safety/experience compromised and staff well being will be poor.	Functional inpatient model in place with 3 consultants to cover. Redeployment out of the service and resignation has led to a further depleted workforce and cover will reduce to two consultants from January 2025 with additional middle grade support. Rehabilitation service is at a critically low level with urgent closure of one service needed. Redeployment from inpatients to Rehabilitation of locum has had knock on effect on inpatients. Difficulty recruiting to locum posts due to introduction of rate card and need to have Welsh AC approval. Permission to go out to non-DE has been provided. Weekly cover rota going out to inpatients and rehab wards to ensure all are aware of the cover arrangements. Two PAs recruited to Rehab and IP in Jan/March 2025 which will free up senior time The Adult Directorate is managing medical staffing through "escalated action" procedures with daily scrutiny and communication pressures and counter measures to release the Consultant body. Daily reviews with Retinue on the availability of staff	Substantive jobs which are new posts are being developed and advertised. Substantive and significant programme of work running alongside this in the Medical Workforce Productivity in place. International recruitment drive looking to recruit two Specialty Doctors to Inpatients and Rehab in August 2025. Update October 2025 Medical staffing remains fragile across the whole of Adult Mental Health Services. There are significant pressures across inpatient services at Consultant level and particularly in relation to availability of Approved Clinicians. Recent recruitment activity has been unsuccessful. Mitigation plans include the use of Health Education Improvement Wales funding to secure a recruitment agency to fill two post and focused work to secure ST6's due to complete training in the next six months. Sufficient Approved Clinician input remains challenging and the recent recruitment processes for a Multi Professional Approved Clinician has not been successful. Care Group continue to monitor service fragility.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	12 (C4xL3)	↔	06.01.2022	06.11.2025	31.12.2025
25	4885	Director of Corporate Governance / Board Secretary	Corporate Governance	Corporate Governance	Improving Care Sustaining our Future	Quality / Complaints / Assurance / Patient Outcomes	Failure to deliver and sustain effective Policy Management System and Process	If: the Health Board fails to maintain an effective policy management process/system to monitor, store and manage the review of policy and procedural documentation Then: there is a risk that staff may act in a manner that is not consistent with strategic and functional expectations. Policies and procedures may not be readily accessible to support decision making and service delivery, and the Health Board may not be protected from litigation if policies and procedures are not regularly reviewed to reflect changes in standards and/or legislation. Resulting in: Policies not being readily available for reference in decision making / emergency situations to support courses of action. Non compliance with new standards and legislative changes leading to possible legal challenge. Limited version control which could impact decision making if there are inconsistent or varying versions of a policy available.	The Policy for the Development, Review and Approval of Organisational Wide Policies is extant and sets out the process to follow. Policy and Procedure advice and guidance is available from the Clinical Policy lead and the Assistant Director of Governance & Risk for non clinical policies. SharePoint Intranet page acts as document library.	October 2025 Update: The project to review the non-clinical policies is underway in compliance with the objectives set out in the Project Initiation Document with an update being received at the Executive Management Board (EMB) on the 29th September. The revised "Policy on Policies" is currently out for consultation and now provides a more simplified policy and process to follow. The new master library is in development and the new system for monitoring is established as a structure but not yet being populated. The front facing policy page for staff has been designed and ready for population. The downloading of documents from the existing sharepoint site is underway but has required a significant amount of resource time and therefore the impact on the original timeframe of the 31st December has been flagged as a risk to EMB as it is likely that this will not be met.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	26.10.2021	8.10.2025	31.12.2025
26	5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Cross Health Board Data Sharing	IF: Digital services across Wales are unable to resolve an ongoing issue with the ability to share patient data in both directions across health boards/trusts Then: Clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data Resulting in: Potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments	For CTM, this is a particular issue in Prince Charles Hospital as there is a lot of patient cross over at the boundary of Aneurin Bevan Health Board. As a health board we continue to raise this as a serious patient safety issue and will continue to press for a quicker solution with Digital Health Care Wales. CTMUHB have asked for alternate options for a quicker solution and timescales to be aligned with these. This has been added as an agenda item for discussion at the next All Wales Medical Director meeting.	Digital Health Care Wales have been working on the ability to share data in both directions so data flows in the Health Board systems – this has been an issue for some time. ABUHB have allocated some project resource to scope, map and plan the work needed, however, resources will need to be allocated by C&V and AB to get the work done. There was a strong commitment from Pan-South East Wales Regional Digital to work closer together and link into a wider regional programme board, this was repeated at the regional planning meeting. Update May 2025 - No change to risk score or mitigation this period. Executive Medical Director to raise risk again at next All Wales Medical Director meeting. Update 23 June 2025 -- Still no movement here. Its within the discussion of Digital HealthCare Wales provider status and open sharing of data between Health Boards. The current proposal has not been agreed between ABUHB and DHCW. CTMUHB are asking and raising the concern, however, cannot directly resolve. Update September 2025 - remains as August 2025. It is raised at the relevant forums (All Wales Medical Director Meetings) regularly. No changes to risk score. Update October 2025 - remains as reported previously. The risk continues to be raised at the relevant forums (All Wales Medical Director Meetings) regularly.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 C4xL2	↔	26.04.2024	27.10.2025	31.12.2025
27	5579	Executive Director of Public Health	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	**IF** there is no children and young person's weight management service **Then** the Health Board will be unable to support children and young people to manage their overweight and obesity **Resulting in** non-compliance with national standards and pathways, significant risk to patients with increase in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Non-finance dependant controls: 1) Level 1 service via PIPYN continues to be delivered in Merthyr (PHW funding until 26) and Taff Ely and Rhondda (Cluster funding until 26) 2) Written first line advice and guidance on the management of referrals available and provided to referrers and shared with families and carers 3)Business case developed submitted and submitted for IMTP consideration. Business case proposes a phased approach at levels 1 and 3 and was developed in collaboration with stakeholders. Finance-dependent controls: 1)Set up service if funding identified via IMTP process.	Update September 2025 - Risk reviewed 19 August. No change to the risk score and mitigations remain current as outcome of the Integrated Medium Term Plan discussions is awaited. Update October 2025 No change or movement with further mitigations for this risk. The risk continues to be monitored by the care groups to manage any changes.	Quality, Safety & Experience Committee Strategic Development Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	06.11.2025	31.12.2025
31	6294	Chief Operating Officer	Planned Care - Care Group	Service Director Planned Care	Sustaining our Future	Workforce / Organisational Development / Staffing / Competence	Insufficient Consultant Workforce - Endoscopy / Gastroenterology	**If** the Consultant posts cannot be filled, **then** it will impact on Service Delivery and affect our ability to deliver both diagnostics and clinical services to patients. **If** the Consultants that are currently in post were no longer in post, **then** this would significantly affect our ability to deliver both diagnostics and clinical services to patients. Furthermore it would impact on ability to support inpatient services at POW. Fragility of the Consultant workforce is contributing to potential gaps within the on call bleed rota, with little redundancy. This could **result in** a situation in which the on call-bleed rota could not be covered. Unsustainable service provision to safely care for inpatients.	In terms of recruitment posts remain out to advert. Locum in post for one of the vacancies however they are due to leave in the near future due to other obligations. There has been no interest from agencies in supporting the vacancies.	Mitigating actions currently limited. Continuing to advertise for posts.	Quality, Safety & Experience Committee Operational Delivery Committee	16 New risk escalated November 2025	C4 x L4	9 (C3xL3)	New risk escalated to the Organisational Risk Register in November 2025	07.08.2025	06.11.2025	31.12.2025
32	2713	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Service Director - DTPS	Sustaining Our Future	Workforce / Organisational Development / Staffing / Competence	Backlog of Reporting Radiology Examinations	**IF** there is consistent backlog of Radiology reports **THEN** there will a delay in patient diagnosis and treatment, which could lead to poorer patient outcomes **Resulting in** impact on patient outcomes, delay in diagnosis of patient condition and any additional interventions/treatment that may be required following diagnosis due to an excessive backlog and increasing demand in imaging services. There is also a risk of damage to the reputation of the Organisation due to the failure to meet performance targets. There is also risk of work related stress due to pressure placed on existing Radiologist workforce to meet the demands of the service The reporting backlog has been compounded by; Reduced effective Radiologist workforce due to retirements, sickness, secondment, maternity leave and limited available Radiologist workforce. RadIS merger which caused problems for outsourcing as prior imaging has not been available as it previously has been. National Cyber attack, computer & RadIS patches which caused two weeks downtime for reporting. Colon CT - All barium enema examinations are now scanned in CT which has increased the specialist reporting significantly with no increase in Radiologist support. Long term inability to recruit Radiologists as there are insufficient numbers trained in the UK.	Radiologists performing extra reporting sessions in addition to their normal working hours. Radiographers trained to report accident & emergency images. Up to date job plans for all Radiologists. Datix incident and concerns procedures in place.	There is a significant backlog of reporting radiology examinations, with just over 10,000 X-rays pending. Current mitigation measures include rostering SPRs for extra reporting, outsourcing MSK cases, utilising training posts and the returning from parental leave. We are aiming to address the backlog in the more likely clinical urgent cases (chest x rays) by December as a priority.	Quality, Safety & Experience Committee. Operational Delivery Committee	16 New risk escalated November 2025	C4 x L4	6 (C2xL3)	New risk escalated to the Organisational Risk Register in November 2025	08.02.2017	6.11.2025	15.12.2025
33	6379	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Service Director - DTPS	Improving Care	Safety & Wellbeing Patients / Staff and Public	CT Scanners at RGH damaged by power outage and manual generator/UPS switch over	**IF** the manual switch over following a power outage is not rectified. **THEN** the CT scanners/tubes may become damaged **RESULTING IN** no CT service on site, causing significant delay in patient outcomes, and significant cost to repair (circa £350k per tube)	Discussion with manufacturer and All Wales procurement Discussion with estates team Estates will ensure CT is switched on first, for generator to kick in Regular weekly meeting with GE and estates to monitor	Action plan required urgently to show regular monitoring. If a separate or modified UPS is required then a statement of need for Capital consideration will be required.	Quality, Safety & Experience Committee Operational Delivery Committee	16 New risk escalated November 2025	C4 x L4	4 C4xL1	New risk escalated to the Organisational Risk Register in November 2025	20.10.2025	06.11.2025	31.12.2025
34	6318	Chief Operating Officer	Mental Health Care Group	Service Director - MHLD	Improving Care	Safety & Wellbeing Patients / Staff and Public	Tier 3 SHED Team Service Delivery	**If:** The level of vacancies continues in the C+V UHB service for high risk eating disorder patients (SHED) **Then:** The service will be unable to fully deliver assessment and treatment interventions for CTM UHB residents. **Resulting in:** Patient safety concerns for a number of high risk patients	There are regular meetings with the SHED team to discuss the caseload.	Escalated at OMB 29.10.25 risk rating increased following dialogue with CMHTS. escalated to service director and director of nursing. The care group will progress with an action plan to mitigate the risk and the Care Group Service Director has requested a meeting with CAVUHB senior Mental Health leadership team to consider a route forward.	Quality, Safety & Experience Committee Operational Delivery Committee	16 New risk escalated November 2025	C4 x L4	C3xL2 = 6	New risk escalated to the Organisational Risk Register in November 2025	29.08.2025	6.11.2025	31.12.2025
35	6280	Chief Operating Officer	Planned Care - Care Group	Service Director - Planned Care	Improving Care	Safety & Wellbeing Patients / Staff and Public	Suspension of the Regional Hepato-Pancreato-Biliary service model	**If...** The commissioning of this service is not prioritised as part of the regional commissioning arrangements **Then...** there will be no Regional service for Severe Acute Pancreatitis **Resulting in....** sub optimal care for this group of acutely unwell patients	Each case currently being discussed on a case by case basis between neighbouring Health Board Medical Directors, however, this will add delays to an already complex and time sensitive treatment pathway.	As this is a service that is regionally commissioned the Health Board will need to have ongoing discussion with the Joint Commissioning Committee as to a way forward.	Quality, Safety & Experience Committee Operational Delivery Committee	16 New risk escalated November 2025	C4 x L4	9 C3xL3	New risk escalated to the Organisational Risk Register in November 2025	06.08.2025	6.11.2025	31.12.2025

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
36	5877	Chief Operating Officer	Primary Care and Community Care Group	Service Director - Primary Care	Improving Care	Service / Business interruption	New Worker Contract for Out of Hour GPs	**IF** the new worker contract for out of hours GPs is implemented (ambition is for Dec 2025) it will require the application of Working Time Regulations. **THEN** there will be a significant impact on shift fill rates. **RESULTING in** the Health Boards ability to fill shifts across the whole roster having a negative impact on both WAST and ED departments.	Recruitment of more GPs who do not also work day time in other roles. Whilst the weekend service will be affected to some degree, weekday evening service will be most adversely affected as any GP working until midnight will not be able to work in practice the next morning.	Additional recruitment of GPs is critical to establish the service.	Quality, Safety & Experience Committee Operational Delivery Committee	16 New risk escalated November 2025	C4 x L4	C3xL2 = 6	New risk escalated to the Organisational Risk Register in November 2025	07.08.2024	7.11.2025	01.12.2025
37	6232	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Sustaining our Future	Safety & Wellbeing Patients / Staff and Public	Stability of the Legal Services Function	**If:** the Health Board fails to adequately equip the Legal Services Function with the resources and support to fulfil the requirements of the function. **Then**: there is a risk to staff turnover and retention, wellbeing and morale. Risk to the reputation of the function and the Health Board as an employer of choice. Lack of resilience and capacity to fulfil the obligations under the relevant legislation surrounding the activity of the function. **Resulting in:** an adverse impact to the wellbeing and morale of staff leading to increased sickness absence and staff turnover. Lack of job satisfaction. Increasing risk of breaching relevant legislation due to lack of sustainable resources and resilience of the existing function. Loss of Trust and Confidence in the Legal Service Function / Reputation.	Review initiated to understand CTMUHB's position in terms of the number of inquests underway and the response to requests. Current controls: OCP underway to consider structures of the function. Benchmarking and learning from other organisations.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. Update September 2025 -The recovery programme continues to make progress in standardising and stabilising processes and work plans. The Organisational Change Process remains delayed as a result of the prioritisation of work and gaps in senior leadership owing to non-work-related absence. Update October 2025 - position remains as reported in September 2025. A designated lead has been assigned to the Legal Services Function to provide stability and oversight on an interim basis.	Quality, Safety & Experience Committee Operational Delivery Committee	15	C3xL5	C3xL2 = 6	↔	3.7.2025	6.11.2025	31.12.2025
38	6217	Executive Medical Director	Children & Family Care Group	Care Group Service Director	Improving Care	Quality / Complaints / Assurance / Patient Outcomes	A number of Nationally reportable incidents have been raised since February 2025 within Obstetrics / Maternity	If: the safeguards and quality systems and processes are not robust Then: - mothers and babies may not receive the best evidence based care Resulting in - Potential for patients to have poor outcomes and experience within the service.	Rapid reviews have been undertaken on all cases with findings and learning from each. Meetings held with Care Group and executive team to decide on way forward. Action plan put in place by the clinical teams and care group. (details of all actions within that action plan).	Update September 2025 External review commissioned on Nationally Reported Incidents. Action plan put in place by the clinical teams and care group. (details of all actions within that action plan) - the action plan and risk will be further reviewed once external report received. Response received from obstetrician reviewer with further information requested. Update October 2025 The Health Board is still awaiting obstetric review from the external clinician in order to be able to review the risk and continuation of actions.	Quality, Safety & Experience Committee.	15	C5xL3	10 (C5xL2)	↔	14.05.2025	6.11.2025	31.12.2025
41	3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Corporate - Digital & Data	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of a Single Electronic Patient Record in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Control measures updated September 2023. 1. A PID has been developed which outlines the processes, resources and timelines sought - this to be discussed in September Programme Board. 2. The Business Case to be refreshed on the back of the PID once approved. It will need to identify additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. 3. Business case to be progressed following Board approval. 4. A new MHLD Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme	Update July 2025 -The Care Group are currently in the third week of the procurement process which has allowed suppliers to bid. This is scheduled to finish on 5th July when the Care Group should be in a position to know how many suppliers are in the procurement activity. Update September 2025 - no further update at this point. Risk reviewed and no change to score. Update October 2025 1.Awaiting recommendation/outcome report 2.Report will be taken to Programme Board and Executive Board for approval 3.Supplier to be known 4.Procurement process to conclude	Quality, Safety & Experience Committee Operational Delivery Committee	15	C5xL3	6	↔	07/11/2018	06.11.2025	31.12.2025
42	4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April. Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case is to be prepared and submitted to WG. Inpatient Improvement Programme established April 2023	Update September 2025 Risk reviewed 27 August 2025 - no change at present Meeting arranged with Adult Directorate to fully update mitigation to include; Potential ward moves Cessation of PICU SLA with SBUHB Impact of National programmes of work Changes to the RGH inpatient model Single S136 suite Update October 2025 Routine ligature audits have identified key environmental risks on one of our wards at Royal Glamorgan Hospital. Estates work is planned and until this is completed additional staff are being rostered to supervise the particular area.	Quality, Safety & Experience Committee Operational Delivery Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	06.11.2025	31.12.2025
43	5820	Executive Director of Public Health	Public Health - Health Protection	Health Protection Team	Improving Care & Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding.	**IF** as a result of the reduced allocation of Health Protection resource the Health Protection Team has insufficient resources to deliver a safe and sustainable service. **THEN** there may not be sufficient resources to deliver all elements of vaccination and immunisation (which is the first line of defence against infectious disease) in accordance with the NIF. The health board response to infectious disease or environmental hazards will also be significantly hindered and work to address gaps in equity of access will be limited. **RESULTING in** avoidable harm to patients in vulnerable groups and harm to the public as a result of insufficient health protection interventions delivered. This also poses a reputational risk as a consequence	Governance structure agreed in Health Protection. Health Protection Board established. Recruitment underway to Health Protection structure. A series of planning workshops with partners agreed to review resources available, develop Health Protection strategy and highlight ongoing gaps	A workforce structure has been approved by ELG and work to identify gaps is ongoing which will be reviewed once recruitment is complete. Work with partners is ongoing to reduce inefficiencies and develop A collaborative Health Protection (HP) plan based on all resources available to ensure priorities can be clearly defined and delivered. Work with CTM finance is needed to ensure the HB allocation is maximised to support HP priorities. Welsh Government discussions are ongoing with regards to the reduced allocation N/B - Whilst this risk is not scored at a level of 15 and above - the Executive Lead considers this risk to be of a contentious nature that should be escalated to the Board via the Organisational Risk Register. Update October 2025 - Reviewed at Strategic Group Meeting and current risk score remains unchanged.	Quality, Safety & Experience Committee Strategic Development Committee	12 Please see note in column J	C4xL3	8 (C4xL2)	↔	01.07.2024	17.10.2025	31.12.2025

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
5691 Closed Session due to business sensitivities	Chief Operating Officer	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	CCTV System Failure in Prince Charles Hospital and Princess of Wales Hospital	Business Sensitive - Detail captured in closed session.						
6111	Executive Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Medical Examiner Delays	**If:** there continues to be delays in length of time for scrutiny of deaths by the Medical Examiner Service **Then:** death certification will not be completed in a timely manner and so increasing the length of stay of the deceased **Resulting in:** complaints from bereaved relatives due to delayed funerals, inability to view loved ones, and deterioration in condition due to delay and inability to comply with WG bereavement framework and mortuary capacity being overwhelmed	Bereavement database updated to track cases and ensure timely attendance by doctors following scrutiny. Bereavement teams to provide estimated timescales for scrutiny based on database. Daily monitoring of daily occupancy. Funeral directors to be contacted by mortuary teams. All contingency capacity HB wide activated in line with mortuary escalation action card. Use of contracted funeral director staircase if required. Use of medilink sessions to manage post mortem demand.	Plan to improve timely death certification by CTMUHB specific QR code to alert wider staff and reduce delays and education videos from MES to improve accuracy. Continue to improve on communication with families around delays and estimated timescales. Update September 2025 The requirement for QR code solution has been escalated to the Director of Digital to help find a solution. Respite awaited. QR code with additional details would improve communication between departments and potentially speed up the process for families. Update November 2025 - QR Code solution now live and active. Process should now be sped up and performance will be monitored closely.	Quality, Safety & Experience Committee. Operational Delivery Committee.	12 (C4xL3) Risk score reduced from a 20 to a 12	8 (C4xL2)	As both OR Code solutions have commenced and are working well this risk is proposed for de-escalation. The Team will remain a watching brief on submissions in order to identify any issues. The likelihood has been reduced to a 3 rather than the target level of 2 in the interim whilst the new process is monitored closely.
5304	Chief Operating Officer	Sustaining Our Future	Environmental / Estate / Infrastructure	The Air Handling Unit (AHU) for the pharmacy aseptic production suite	The AHU at the Royal Glamorgan hospital (RGH) is 25 years old, therefore is at higher risk of failing to meet the required standards due to its age and design, with four recent incidents occurring. **If** the AHU is not maintained to the required standard this could **then** lead to further closures at short notice or production being halted. **Resulting in**: • Patient Safety and Quality: Delays in supplying treatments, particularly for cancer patients, which could compromise patient outcomes. There is also a risk of severe patient harm if regulatory compliance cannot be maintained. • Complaints and Patient Experience: Increased waits to start treatment or delays in treatment, leading to poor patient satisfaction and an increased number of complaints. • Reputational Risk: Negative publicity due to increased waiting times for cancer treatments or the inability to provide certain treatments, resulting in reduced patient and clinician confidence. • Financial Risk: Increased medicines expenditure and wastage from having to outsource aseptically prepared products from external suppliers. • Research and Innovation: No opportunity to conduct clinical trials involving aseptically prepared products.	The output from the AHU is continuously monitored internally & externally The estates department maintain the AHU regularly here are contingency plans in place to outsource products from elsewhere.	Capital resource approved and the service is working with project manager on timelines which will then initiate a review of the risk to see if mitigations are successful and risk score can be reduced. Update October 2025 Upon reviewing the risk, the risk score has been reduced to 12. NWSSP verification is complete and the AHU is functioning as expected. However, it is considered to be at the end of its shelf life; therefore, appropriate controls are in place for regular monitoring. To ensure prompt action and escalation if the risk fluctuates rapidly or if testing fails, both internal and external monitoring will be conducted.	Quality, Safety & Experience Committee Operational Delivery Committee	12 (C4xL3) Risk score reduced from a 16 to a 12	4 (C4xL1)	Proposed for de-escalation as upon reviewing the risk, the risk score has been reduced to 12. NWSSP verification is complete and the AHU is functioning as expected. However, it is considered to be at the end of its shelf life; therefore, appropriate controls are in place for regular monitoring. To ensure prompt action and escalation if the risk fluctuates rapidly or if testing fails, both internal and external monitoring will be conducted.
3567	Chief Operating Officer	Improving Care	Quality / Complaints / Assurance / Patient Outcomes	Capacity of Cellular Pathology Service - Space	**If**: there is not enough laboratory and office space for Cellular Pathology to operate the core service safely or support increasing demand, service disaggregation and future Health board changes; **Then:** the service will be unable to work effectively and efficiently in line with Duty of Quality guidance and recognised Health board standards for IP&C, H&S etc. **Resulting in:** - Inability to meet increasing demand - increase in staff stress and compromised well being due to working in suboptimal conditions. - Poor cancer performance and inability to meet expected turnaround times, impacting on Health Board cancer performance - poor quality patient care due to delays in diagnosis or misdiagnosis - Increase in clinical incidents, complaints and potential for reputational damage. - Inability to effectively disaggregate the current SLA with Swansea Bay and repatriate services from Bridgend impacting clinical services across CTM. - inability to support full digital rollout and support regional reporting in line with WG strategic direction - delayed development of advanced scientist dissection to support increasing reporting capacity and delivery of workforce modernisation - loss of tissue leading to Serious incidents and Regulatory non-compliance with HTA and potential compromise of HTA license. - financial risk of outsourcing - threat to strategic regionalisation project due to the scale of the lack of capacity in CTM	SOPs are in place to standardise practice and mitigate risk of variation in practice caused by limitations of the laboratory environment. Controls to reduce the use of reception/dissection as a thoroughfare including signage and demarcation belt. Workflows established to maximize efficiency of limited space. Block and slide filing removed from laboratory area where possible. System of work including check established in dissection to minimize risk of error. IPC and H&S environment inspections undertaken to assess impact of laboratory environment on clinical effectiveness and risk to patients and staff.	Mitigating Action Plan includes: Engagement with estates to review small scale projects to increase laboratory space. Engagement and participation in Regional Scoping group to scope options including estates to look at long term solutions. Update September 2025 Risk reviewed on the 20 August 2025 - Procuring workbenches to support initial conversion of office space to support initial Invest to Save paper of increase of one Pathologist and associated workload. Awaiting estates work to convert the office. Statement of Need (SON) for feasibility study of preferred option for medium term option to be prepared. Update October 2025 Reviewed by Care Group Service Director. Risk remains, however, current controls are expected to mitigate this risk at a level of 12 unless there is a new trigger. Department changes are being considered with Infection Prevention Control team relocation. Non-financial appraisal completed for Regional Estates options; top two will proceed to financial assessment. Local feasibility study approved for short-term improvements. Assessing both local options and regional timelines due to urgent need.	Quality, Safety & Experience Committee Operational Delivery Committee	12 (C4xL3) Risk score reduced from a 16 to a 12	6 C3xL2	DTPS Care Group Service Director has reviewed the risk and proposed for de-escalation. The rationale for de-escalation is that current controls are expected to mitigate this risk at a level of 12 unless there is a new trigger. Department changes are being considered with Infection Prevention Control team relocation. Non-financial appraisal completed for Regional Estates options; top two will proceed to financial assessment. Local feasibility study approved for short-term improvements. Assessing both local options and regional timelines due to urgent need.
5646	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	The impact of "Right Care Right Person" (RCRP) approach.	**If:** South Wales Police (SWP) implement Right Care Right Person **Then:** In some circumstances the Health Board will not be able to routinely call upon SWP to assist with people in mental health crisis or with social care issues, for example, missing patients, welfare checks and supervising people who are detained on S136 Mental Health Act. **Resulting in**: Increased risks to our staff and the people who use our services.	Multi-agency planning meetings have been arranged to review policies. This is an emerging picture and one which the Health Board are developing a fuller mitigation against, it is also a picture which has a gradual phased roll out over the next year. Nurse Director for the Care Group will be drafting a report for Operational Management Board later in the month but timelines have not allowed for this at submission to the Organisational Risk Register.	Update October 2025 The final Phases of RCRP went live in March 25. There have been no incidents escalated through the health board in relation to RCRP. In the RCRP Health Board wide meeting held on June 25 it was agreed to recommend a reduction in the likelihood score from 4 to 3 which would give an overall score of 12. This position was considered at the MH&LD Care Group OMB in July but with the release of the SWP revised S135/6 policy it was agreed to wait to review. This policy has not been released. At the MH&LD Care Group OMB in October 25 it was agreed that it was unlikely the policy is not going to adversely affect the frequency of RCRP related incidents and therefore the Likelihood scoring. The risk score is therefore recommended for reduction to 12.	Quality, Safety & Experience Committee Mental Health Act Monitoring Committee	12 (C4xL3) Risk score reduced from a 16 to a 12	8 C4xL2	Proposed for de-escalation. At the MHLD Care Group Operational Management Board in October 25 it was agreed that it was unlikely the policy is not going to adversely affect the frequency of RCRP related incidents and therefore the likelihood scoring was reduced. The risk score is therefore recommended for reduction to 12.
4218	Executive Director of Nursing / Deputy CEO	Improving Care	Safety&Well-being Patients/Staff/Public	Reduced on site Consultant Microbiologist/ IPC Doctor cover for Bridgend	**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 influence practice. IPC Doctor support is required to help support/deliver the IPC and decontamination agenda Concerns raised regarding SLA and role of microbiologist under it to support IPC.	Service Level Agreement (SLA) for microbiology support under review at present moment. IPC team continues to invite microbiologists on duty at Princess Of Wales (POW) Hospital in all investigations/Root Cause Analysis. Working towards joint meetings between IPC, microbiology for POW and microbiology for the other sites to work towards same processes and support across CTM.	SLA to be reviewed. IPC has sent GAP analysis and SBAR with identified gaps and concerns to inform new SLA. Risk Monitored by the Infection Prevention and Control Committee. Update October 2025 - Temporary arrangements have been put in place to secure access to a Microbiologist on site to provide the cover required whilst the discussions on the SLA continue. In light of the temporary arrangements and the improvement that provides the risk score has been reduced from a 16 to a 12 but will continue to be monitored locally.	Quality, Safety & Experience Committee	12 (C4xL3) Risk score reduced from a 16 to a 12	4 (C4xL1)	Proposed for de-escalation. 6.11.2025 - Temporary arrangements have been put in place to secure access to a Microbiologist on site to provide the cover required whilst the discussions on the SLA continue. In light of the temporary arrangements and the improvement that provides the risk score has been reduced from a 16 to a 12 but will continue to be monitored locally.

	A	B	C	D	E	F	G	H	I	J	K
1	Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
2	6102	Director of Digital	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Patient Pathways - Working in WPAS Instances.	**If**: A patient is moved between Swansea Bay University Health Board WPAS and Cwm Taf WPAS and their pathway is closed in one before it is opened in the other. **Then:** The pathway will not be automatically re-opened by the systems (this must be manually transacted) and the pathway will remain closed. **Resulting in:** The incorrect ending of the patient pathway, as they will not be visible on the system, which could lead to possible patient harm/ death.	Monitor records/ processes through agreed Standard Operating Procedure's and ensure corrective actions are taken until mitigation is successful. Flagging to users/ management where examples of this not being followed are identified.	Review current business processes and Standard Operating Procedures to clarify the importance of opening the CTM record before closing the Swansea Bay University Health Board record. This process prevents delays in urgent pathway management, as highlighted by flagged dermatology cancer referrals that were discharged on WPAS but not set up on another system at the time of checking. It is anticipated that the target score will not be achieved until CTMUHB have a fully migrated PAS systems and the whole organisation is using a singular PAS system for patient pathways. Update October 2025 - Patients are no longer being moved across two separate instances of WPAS in CTM. Therefore this risk can be closed form a Digital & Data perspective	Quality, Safety & Experience Committee. Operational Delivery Committee.	Nov-25	Risk proposed for closure as target score met. Rationale for closure is that Patients are no longer being moved across two separate instances of WPAS in CTM. Therefore this risk can be closed form a Digital & Data perspective.