Datix ID	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		
4491	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 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 has established a Planned Care Board, with a full programme of work to address FUNB, demand and capacity and a recovery programme which will include cancer patients; The plans have timescales – which are being monitored, however it is likely that it will take time to reduce waiting times to acceptable levels in the post-covid-19 environment.	Quality & Safety Committee	20	C4xL5	12 C4 x L3	↔	11.01.2021	07.06.2021	31.07.2021		
4060	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.	**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 the break even financial plan for 21/22 includes significant non-recurring funding for Covid-19 which has yet to be confirmed by Welsh Government (WG). Delivery of the 21/22 Plan is also predicated on a return to levels of efficiency savings close to pre-Covid levels (21/22 Savings target = £14.5m).	2021/22 IMTP and financial plan submitted to WG at the end of June, 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.	Bottom up savings plans at the end of June are showing a gap of £0.9m against the In year target of £14.5m for 21/22. Further develop the savings planning process identified by the COO and DoF for implementation in July onwards. Financial accountability letters and budget schedules for 21/22 to be issued and signed off by end of July. 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	05.07.2021	31.8.2021		
4629	Executive Director of Finance & Procurement	Ensure sustainability in all that we do, economically, environmentally and socially.	Financial Stability Risk	Failure to achieve or 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.	2021/22 IMTP and financial plan submitted to WG at the end of June , 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.	Bottom up savings plans at the end of June are showing a gap of £8.2m against the £16.1m Recurring savings target for 21/11. Further develop the 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	↔	10.5.2021	05.07.2021	31.8.2021		
4080	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. Update June 2021: At present no immediate change to control measures and mitigating actions. The Workforce Strategy Group will be meeting soon and these issues will be raised and addressed following which the risk will be updated as appropriate.	Quality & Safety Committee People & Culture Committee	20	C5 x L4	15 (C5xL3)	↔	01.08.2013	5.5.2021	31.07.2021		
3826	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Continue to implement actions identified in the control measures. Action plans are in the process of being reviewed so a timescale will follow once the review has been undertaken by the lead. Update June 2021 - Unscheduled Care Improvement Programme has now launched - Bridgend ILG is being provided with a Programme Manager to drive forward key projects, the key projects are yet to be launched. These projects will initially focus on the Emergency Department (ED) and Site Flow and measures will be identified that will allow us to track improvements in ED overcrowding. **Timescale: Projects due to commence July 2021.** Target Score Rationale - the rationale for the consequence score reducing at the target level is that increased resources and staffing will support improved patient experience and care reducing the consequence rating.	Quality & Safety Committee	20	C5 x L4	9 (C3xL3)	↔	24.09.2019	4.6.2021	31.7.2021		

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1793	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. 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	10 (C5xL2)	↔	16/12/2014	04.05.2021	30.06.2021		
4477	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 No change as at 5th July 2021 - Review of risk scheduled for w/c 12th July - update will be received in the next submission of the Organisational Risk Register.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	30/12/2020	05.07.2021	31.07.2021		
4632	Chief Operating Officer All Integrated Locality Groups Initially raised by Rhondda Taf Ely Integrated Locality	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Demand and capacity across the stroke pathway	**IF** there is continued high demand for stroke beds (currently located in PCH) **THEN** patients will have to be admitted to RGH or non stroke specialist beds **RESULTING in** a delay or inability in specialist stroke management, treatment and rehabilitation	Stroke patients in RGH are managed by the medicine teams and referral to MDT as required but not specific to stroke rehabilitation. Stroke admission pathways have been reconfirmed with WAST to ensure patients are admitted to PCH to access specific stroke care.	Review of the CTM Stroke Pathway. Centrally led task and finish group, leadership from Executive Lead for Stroke. Update July 2021 – a short term draft paper has been developed and will be discussed at the Stroke Planning Group Meeting on Friday 09 July 2021, with the aim of making decisions about the way ahead. Work is underway on the long term plan – this will also be discussed at the meeting on 09 July.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	05.07.2021	31.07.2021	20.08.2021		
4253	Chief Operating Officer Bridgend Integrated Locality Group	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. Use of therapeutic activities to keep patients occupied Patients not left alone / unattended in high risk areas Patients placed on observation levels according to their risk In Bridgend Locality there is a Ligature Action Plan in place and remedial work is underway, in addition to the above additional control measures include closing bathrooms and adding additional staff by night irrespective of patient observation levels, placing patients with a functional illness in bedrooms nearer to the nursing office. Remaining area for anti-ligature work is at Cefn Yr Afon site at Bridgend. Funding is approved and there is a programme of work which is due to commence June 21st 2021 after completion of higher risk areas at POW Similarly within the RTE Locality, the ligature risk within the MH inpatient setting is minimised through environmental measures. Environmental security Broadly the anti-ligature work that effects the estate i.e. taking away high and low level structures that might be used as ligatures. Relational security Use of supportive observations on a sliding scale from. Informal and planned 1:1 where the person can use time to work through urges, address low mood anxiety up to a more intensive 1:1 observation when someone is considered high risk. Processes to manage security These will be mitigating processes, such as search polices or maintenance of a safe bedroom space by restricting the type of personal items allowed, or managing a necessary high risk area through maintaining locked doors. Capital work currently underway, estimated completion date July 2021.	**RTE Locality:** RTE Locality Update: Some environmental work has already been Undertaken Anti-ligature doors to be installed to further reduce risk. Current score: 10. This risk therefore now only relates to Bridgend ILG. **Bridgend Locality:** Ligature Action Plan in place. Ligature remedial works underway - Completion of works anticipated July 21 . Update July 2021 - No Change.	Quality & Safety Committee Health, Safety & Fire Committee	20	C5xL4	10 C5xL2	↔	17/08/2020	07.06.2021	31.07.2021		
4688	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED), inability to appropriately triage patients in the Minors area of ED, compounded by two current access points that are not co-located with neither incorporating triage.	**IF:** The minors department is over capacity **Then:** there is no ability to appropriately triage and treat patients in a timely manner, neither is there visibility to observe patient acuity from a triage room as this is not co-located within the waiting area. **Resulting in:** Poor patient experience and unknown risk along with high levels of stress for staff.	Production of a flow chart for the management of patients to minors. Escalation cards. Re-direct the workforce to support the triage function. Additional doctor rostered to support the service	Emergency Department Improvement Programme established which includes the key enablers to improve the environment, template and patient flow through the Emergency Department. The programme is anticipated to take 12 months to complete. Emergency Department Improvement Plan being established to address risks in the short term as far as is reasonably practicable.	Quality & Safety Committee	20	C4xL5	12 C4 x L3	↔	11.06.2021	11.06.2021	31.07.2021		
3562	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department Overcrowding - within Majors, Minors, Clinical Assessment Unit and the GP Assessment Area at Prince Charles Hospital	**IF:** There is overcrowding as a result of capacity constraints within the emergency Department and Patients are waiting within corridors. **Then:** there is restricted ability to be responsive in emergency situations. 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. Impact on evacuation time and potential personal accidents. At times of high escalation it is challenging to clear the corridor of patients on trolleys	Escalation Plans / Cards established. Flow Manager in place Patient Safety Checklists undertaken. SOP for the Management of Patients in Corridors in place. 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.	Action to develop an escalation policy - Completed. Update October 2020: HB policy SoP approved by Management Board with regards to the care of patients in corridors. Completed. Emergency Department Improvement Programme established which includes the key enablers to improve the environment, template and patient flow through the Emergency Department. The programme is anticipated to take 12 months to complete. Emergency Department Improvement Plan being established to address risks in the short term as far as is reasonably practicable.	Quality & Safety Committee and the Health, Safety & Fire Sub Committee	20	C4xL5	12 C4 x L3	↔	22.05.2019	10/06/2021	31.07.2021		
4292	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	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:** the CSG is unable to increase the capacity within the CPU; **Then:** patients will continue to wait in excess of the acceptable timescale for a test; **Resulting In:** Long waiting time (in excess of 42 weeks), potential risk to patients from delays in identifying and treating disease and progression of disease, delays in receiving appropriate treatment, pharmacological and surgical intervention.	Referrals verified and triaged by the Cardiology team. Patients prioritised in relation to clinical need. Additional room capacity identified to increase outpatient capacity.	Staff sustainability remains and issue and will be addressed as part of the IMTP planning process.	Quality & Safety Committee	20	C4xL5	16 (C4xL4)	↑ 16 Increased from 16 to 20 in July 2021 due to increased waiting lists as a result of Covid-19	14.09.2020	17.05.2021	19.08.2021		

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4071	Chief Operating Officer All Integrated Locality Groups	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 - Cancer performance is monitored through the more rigours monthly performance review process. each ILG now reports actions against an agreed improvement trajectory.	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. Update June 2021 - New Cancer Operating Framework being launched with tightening of Performance Management infrastructure by COO to review weekly performance status - **Review August 2021.**	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	4.6.2021	31.7.2021		
4664	Executive Director of Public Health - Interim Executive Lead responsible for ICT. Chief Information Officer	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Ransomware Attack resulting in loss of critical services and possible extortion	**IF**: The Health Board suffers a major ransomware attack. **Then**: there could be potential data loss and subsequent loss of critical services. **Resulting in**: Catastrophic service loss to all clinical and business services impacting on population health management, patient care, business continuity, organisational relationships & substantial financial risk - culminating in a culture of mistrust of the Health Board and all things digital	**Key Controls**: 1. Email filters from both Microsoft and the National email relay which scan for malicious and suspicious email types and their attachments. 2. National Checkpoint firewalls that monitor for and block suspicious network traffic, including those from known malicious geographical areas. 3. National SIEM that monitors and logs suspicious external incoming traffic. As well as monitoring local network traffic for each NHS Wales organisations. 4. Local Firewalls at each of the Health Board's geographical areas that only allows inbound trusted network traffic. 5. Anti-malware software installed on all Health Board computing devices which includes ransomware behavioural intelligence. 6. Blocking and monitoring of Internet traffic. 7. Locally systems that monitor the local network for suspicious traffic. 8. A monthly patching regime to ensure that all operating systems are up to date. 9. Regular backups of critical information and device configuration which is stored off site as part of DR/BC planning. **Gaps in Controls**: 1. Current National SIEM has presented many issues in terms of access to the Health Board for identifying issues and addressing false positives. 2. The Health Board is currently not addressing the need for the national Cyber Security training to become part of mandatory training to all staff. 3. A regular co-ordinated approach to providing Phishing campaigns as part of staff awareness to indicators of compromise. 4. A process where the Health Board can monitor where staff have read important information/cyber security policies. 5. The current network Intrusion Detection/Intrusion Protection system (IDS/IPS) is no longer licensed under the new generation firewall infrastructure.	The Health Board has purchased a Phishing tool which the ICT Department in co-operation with Information Governance and Counter Fraud are using to simulate Phishing attacks. This is to help educate staff and will be used to push the organisation to add the NHS Wales national cyber security awareness training as a mandatory core competency to all staff via ESR. The ICT Department are investigating ways to improve the security of backups to ensure that these are protected from potential ransomware attacks. The ICT Department are investigating ways to segregate the current configuration of the network infrastructure to ensure that critical clinical systems are better protected from cross infection. The ICT Department will be re-introduce Cisco FirePower which is an IDS/IPS networking software. The ICT Department will be reviewing the current local Cyber Incident Response Plan which will be escalated up to senior and board level management. The SIRO/cyber leads will be undertaking a programme of introducing the NCSC Board Level toolkit to provide knowledge of cyber to Board members. The organisation is recruiting a Director of Digital Services who will be a member of the Board. This position will enhance the complexities and needs of both service delivery and information/cyber risks.	Digital & Data Committee	20	C5 x L4	15 (C5xL3)	↔	26/05/2021	05/06/2021	25/06/2021		
4743	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure of appropriate security measures / Safety Fencing	**If:** there is a failure in security measures. **Then:** there is an increased likelihood of patients having unrestricted and inappropriate access on the site. **Resulting In:** absconding events and possible harm to the patient or members of the public	The risk of absconding, and self harm/ suicidal ideation for Mental Health and CAMHS patients is risk assessed on admission and reviewed regularly thereafter. Works programme to review and renew physical barriers such as door locks and restricted window access to limit unauthorised ingress and egress from Mental Health and CAMHS units are in situ. High risk patients are escorted when outside the units Absconding patient policy in place	Funding Bid for approx. £385K has been submitted by Estates	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	New risk escalated to Org RR July 2021	05.07.2021	05.07.2021	31.08.2021		
4203	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Unable to provide Surgical Services	**If:** Surgical services cannot meet demand and patients are not treated in targeted timeframes (RTT) **Then:** Patients will not receive surgery and subsequent treatments **Resulting In:** Harm to patients, poor prognosis, reduced treatment options, poor quality of life, risk of claims, increased demand on wider health and social care services including emergency care, staff burnout. Since March 2020 COVID 19 Pandemic has resulted in Surgery being ceased for Urgent and Routine listed patients.	Restart plans including Waiting List Initiative to increase capacity. Limited ring-fenced funding for recovery plans. Outsourcing Some pathway innovations Ongoing validation of waiting lists.	Restarting elective surgery and further outsourcing to private sector. Discuss reconfiguration of acute site to enable more surgical capacity.	Quality & Safety Committee	20	C4 x L5	16 (C4xL4)	New risk escalated to Org RR July 2021	01.07.2020	15.06.2021	01.09.2021		
4149	Chief Operating Officer Bridgend Integrated Locality Group	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. Loss of trust and confidence in the services provided by the Health Board. Difficulties remain in recruiting key staff and new model of care being implemented; waiting times for specialist CAMHS and the new neurodevelopmental service remains challenging. Rationale for target score: Increasing demands being placed on the Core CAHMS 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 - Regular WHSSC monitoring meetings to be held. Update July 2021 – Ty Llidiard WHSSC escalation level raised from 3 to 4. Risk description and control measures updated. Risk rating reveiwed and consequence rating increased from a 4 to a 5.	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. Update June 2021 - CSG and ILG continue to develop and progress business case proposals to improve service provision and access and recruitment / retention initiatives. Regular WHSSC monitoring meetings to be held.	Planning, Performance & Finance Committee & Quality & Safety Committee	20	C5 x L4	9 (C3xL3)	↗ Increased from a 16 21.7.2021	01/01/2015	21.07.2021	31.8.2021		
3742	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based and accessible Care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of 16-18 Year Olds	**If**: Children aged 16-18 years are cared for in an adult acute setting. **Then:** there is a concern that the care provided will not meet the required paediatric standards. **Resulting in**: Inappropriate care and an inappropriate setting.	Cases are managed on an individual basis dependent upon the needs of the child. Ongoing discussion with the medicine specialties and the paediatric teams about the most appropriate setting for each individual. Discussion underway with the CSGs across CTM to understand the support required and the action plan will be updated accordingly, identifying any corporate level support as required.	Discussion with CSG's to understand the support required is underway and the action will be updated accordingly, identifying any corporate level support as required.	Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	19.07.2019	07.06.2021	07.09.2021		

Datix ID	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		
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	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	12 (C4xL3)	↔	01/06/2015	04.05.2021	30.06.2021		
4157	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		
4156	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	12 (C4xL3)	↔	01/04/2014	04.05.2021	31.08.2021		
4458	Chief Operating Officer All Integrated Locality Groups	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches.)	**If:** the Health Board fails to deliver against the Emergency Department Metrics **Then:** The Health Boards ability to provide safe high quality care will be reduced. Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. **Resulting In:** A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls. Compromised safety of patients, potential avoidable harm due to waiting time delays. Potential of harm to patients in delays waiting for treatment.	Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protections Schemes Implemented within ILG's. Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	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. Given the decrease in compliance for 12 and 4 hour waits, it is impossible to outline progress at this point. It is anticipated that the work of the Urgent Care Improvement Group will be able to report some improvement in the coming months. Review in August 2021	Quality & Safety Committee Planning, Performance & Finance Committee	16	C4 x L4	12 (C4 x L3)	↔	04/12/2020	4.6.2021	31.7.2021		
4706	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based and accessible Care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure of appropriate security measures in mental health services.	**If:** there is a failure in security measures. **Then:** there is an increased likelihood of patients leaving the ward without the knowledge of staff **Resulting In:** absconding events and possible harm to the patient or members of the public	The following control measures are in place: - Signs are placed on doors to ensure staff check the doors lock behind them. - Patients are on appropriate levels of observations - Problems are escalated to estates as they arise	There has been a proposal that Estates undertake environmental checks accompanied by leads within the respective Mental Health Clinical Service Groups to work together to review onsite security systems in mental health services.	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	↔	22.06.2021	22.06.2021	22.07.2021		
4567	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of endocrine surgical service in RTE	**If:** there is no provision of a dedicated endocrine surgical consultant for the surgical management of endocrine patients. **Then:** patients with primary hyperparathyroidism, thyroid and adrenal disorders will need to be referred to the UHW for their surgery **Resulting In:** a risk of patients coming to preventable harm due to the lack of surgical management options within CTM and delays waiting to be seen.	Surgical colleagues are considering the options in relation to capacity and resource. Discussion with surgical colleagues at UHW for complex cases. Patients managed on a case by case basis.	Surgical colleagues are considering the options for the future provision of the service within CTM. Discussion with surgical colleagues at UHW for complex cases. Patients managed on a case by case basis.	Quality & Safety Committee	16	C4 x L4	12 C4 x L3	↔	03.03.2021	28.06.2021	31.07.2021		

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4103	Chief Operating Officer Bridgend Integrated Locality Group	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. Update June 2021 - Position paper submitted to Management Board and Quality & Safety Committee .The ILG is in the final stages of Quality Assuring the submission of data to the Royal College of Ophthalmologists in readiness for the external review that has been commissioned. Update July 2021 Evidence submitted for Royal College review.	Quality & Safety Committee	16	C4 x L4	12 C4 x L3	↔	01/04/2014	08.06.2021	31.7.2021		
4152	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	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 patients.	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.	Increased capacity required for current referrals to address backlog, particularly in CT/MRI /Ultrasound. Require funding and procurement of mobile scanners in the longer term. Actions: Staffing Resource, Capacity and Demand Planning and business case.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	07/06/2021	14/06/2021		
4478	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 No change as at 5th July 2021 - Review of risk scheduled for w/c 12th July - update will be received in the next submission of the Organisational Risk Register.	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	↔	30/12/2020	05.07.2021	31.07.2021		
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	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. No change as at 5th July 2021 - Review of risk scheduled for w/c 12th July - update will be received in the next submission of the Organisational Risk Register.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	04/09/2015	05.07.2021	31.07.2021		
4217	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 e.g.. bowel and bladder service IPC team investigate all preventable community acquired S.aureus and gram negative bacteraemia and share any learning with the IPC huddles arranged in primary care to look at community acquired 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 No change as at 5th July 2021 - Review of risk scheduled for w/c 12th July - update will be received in the next submission of the Organisational Risk Register.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	44028	05.07.2021	31.07.2021		
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	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 No change as at 5th July 2021 - Review of risk scheduled for w/c 12th July - update will be received in the next submission of the Organisational Risk Register.	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	↔	30/12/2020	05.07.2021	31.07.2021		
4482	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 The Infection Prevention and Control Committee met w/c 27th June 2021 and agreed to review the wording of this risk. IPC to link in with Assistant Director of Primary Care and update will be submitted in time for the next review of the Organisational Risk Register..	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	↔	30/12/2020	05.07.2021	31.08.2021		

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4148	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.	• 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 nursing workforce are strong advocates for the rights of individuals who lack capacity. A member of the DoLS teams has been allocated as a link for each ILG. • Audit of the service continues and a business scorecard will be produced on for each ILG Q&S bi-monthly and on an organisational wide perspective on a quarterly basis for review by the CTMUHB Safeguarding Executive Group and the CTM Safeguarding Adult Quality Assurance Group. Quality Assurance Group.	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. June 2021 - Review with DoLS team with a plan to develop Court of Protection Training, Communications in preparation for LPS, Increasing Health Board Signatories, performance management to reduce breach, use of WG grant to develop eLearning for greater HB MCA/Best Interests awareness. There is a further risk in relation to the observance of the new Liberty Protection Safeguards Legislation (LPS). There will be no Supervisory Body to undertake the assessments themselves. The assessments will be undertaken at ward level as part of the ordinary care planning. Therefore if the ward level assessments are deficient the DOL will not be authorised and there is a risk of allowing the patient to leave and risk them coming to harm for which the Health Board could be liable in damages; or unlawfully depriving patients of their liberty until such time as they get the correct evidence in place – this could also attract damages and potentially awards of costs if appealed to court. Therefore the Health Board needs to ensure it is acting lawfully is to ensure that there is sufficient time, resources and training for those making ward level decisions for people who lack capacity to ensure they are working in compliance with the MCA from the outset. Legal & Risk colleagues are reporting a more aggressive trend from those representing patients and a growing appetite for costs and damages related to poorly managed deprivation of liberty. A LPS co-ordinator role has been submitted for transformation monies to support implementation. No further update as at 5th July 2021.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01/10/2014	05.07.2021	31.07.2021		
4116	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. High visibility, communications and engagement from CEO office internally with staff and externally with key stakeholders since Sept 2020. Media have been given increased access to interviews and filming, most recently in ED at all three acute sites for BBC Wales, ITV and C4. Stakeholder database reviewed in May 2021 to ensure it is as up to date as possible.	Stakeholder engagement survey planned for August 2020 -Stakeholder engagement survey delayed due to Covid-19 outbreaks in autumn but re-scheduled for spring 2021. Update June 2021 - Stakeholder database has undergone a significant review to ensure that it is as up to date as possible in readiness for the survey. Currently exploring the procurement of a company to undertake the survey independently from the Health Board. Anticipated that the survey will be live by the end of summer 2021 - Review Date: 31.8.2021.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01.07.2019	5.5.2021	31.8.2021		
3585	Chief Operating Officer. Bridgend Integrated Locality Group	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. June 21 Update - Capital works for NIV room still ongoing and therefore no progress yet with the rest of the capital build. NIV room to be handed back mid June and patient toilet will be the next priority for completion Update July 2021 - No Change.	Quality & Safety Committee	16	C4 x L4	1	↔	31.05.2019	08.06.2021	30.09.2021		
4337	Executive Director of Public Health - Interim Executive Lead for ICT Bridgend Integrated Locality Group	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.	**Key Controls** SBUHB Service Level Agreement Bridgend disaggregation and the one-CTM aggregation plan Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. **Gaps in Control** The business case for integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. SBUHB have no process in place to incorporate the needs of Bridgend users in their developments.	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, along with complimentary proposals from Digital Healthcare Wales (DHCW) for which CTM has worked with them on. Timeframe - Mid June 2021 when DPIF Funding is announced.	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	26.5.2021	30.06.2021		
4684	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department Environment at Prince Charles Hospital	**If:** there is no change to the template for the environment of the Emergency Department at Prince Charles Hospital to improve the areas for Major, Minors, Fractures and GP Assessment. **Then:** there will continue to be challenges to the safety of patients and the management of patient flow through the appropriate departments/areas. **Resulting in:** Potential delays for patients in accessing the right treatment in a timely and efficient manner. Poor Patient experience. The environment does not allow for the EPIC model of consultant oversight which will impact clinical oversight across all areas and silo working.	Caring for patients in corridors SOP established and followed. Flow Manager in place. Additional staff are rostered into the functions above core establishment to support staffing levels. Escalation Plans and Cards established. Surge Capacity Plan in place.	Phase 2 of the PCH Development Plans include the Emergency Department template. Emergency Department Improvement plans being formalised / developed.	Quality & Safety Committee & Health, Safety & Fire Sub Committee	16	C4 x L4	8 (C4xL2)	↔	10.06.2021	10.06.2021	31.07.2021		

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4686	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Management of Controlled Drugs within the Theatres Department at Prince Charles Hospital	**If:** dedicated Pharmacy support to manage controlled drugs within the Theatres department at Prince Charles hospital is not improved. **Then:** there is a risk to medicines management and compliance with the requirements to manage controlled drugs **Resulting in:** Medicines not being stored and controlled appropriately within required standards.	Controlled Drugs are locked when not in use. Review of the Medi Well System undertaken. New equipment ordered to improve storage solutions within Theatres.	Task and Finish Group to be established to look at the flow and realign the environment - further update in July 2021. Theatres improvement plan developed. Swipe card system to be extended for 24hrs a day. Request for dedicated pharmacy support made.	Quality & Safety Committee & Health, Safety & Fire Sub Committee	16	C4 x L4	8 (C4xL2)	↔	10.06.2021	10.06.2021	31.07.2021		
4685	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Patient Flow within the Theatres Department at Prince Charles Hospital	**If:** we fail to alter the patient flow (in and out) of the Theatres department. **Then:** there is an increased waiting time for patients waiting to enter theatres and potential harm to staff and patients exiting theatres. **Resulting in:** failure to comply with the appropriate theatre standards, inefficiencies, delays for staff and patients, possible cross-contamination.	Maintaining the safety of patients is paramount at all times to ensure the inefficiencies and problems with flow do not impact upon patient safety, however, this control measure does in itself then present a delay for patients waiting as the current flow is not efficient.	Task and Finish Group to be established to look at the flow and realign the environment - further update in July 2021. Theatres improvement plan developed.	Quality & Safety Committee & Health, Safety & Fire Sub Committee	16	C4 x L4	8 (C4xL2)	↔	10.06.2021	10.06.2021	31.07.2021		
2987	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	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. Possible further enforcement in the form of prosecution.	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. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	6	↔	29.11.2017	02.02.2021	30.04.2021		
4294	Chief Operating Officer Merthyr & Cynon Integrated Locality Group Rhondda Taf Ely Integrated Locality Group	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. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Quality & Safety Committee	16	C4 x L4	6	↔	14.09.2020	07.07.2021	19.08.2021		
3958	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	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 As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	14.01.2020	14.01.2020	31.03.2021		
3682	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	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. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	People & Culture Committee	16	C4 x L4	6	↔	26.06.2019	4.12.2020	31.3.2021		
3011	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	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. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Quality & Safety Committee	16	C4 x L4	6	↔	01.06.2017	4.12.2020	31.3.2021		
3008	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	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. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	01.05.2017	01.12.2020	31.3.2021		

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3654	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Gynaecology Cancer Service	**If:** Demand continues to exceed the agreed manageable caseload in Gynaecology services across the Health Board. **Then**: there will be a delay in the pathway requiring multiple consultations on site and reliance on an individual Practioner. **Resulting in**: Delay in patient pathways, poor experience, unsustainable demand on the workforce and Gynae Rapid access service development is slow progression. Risk description reframed into the if, then, resulting in format.	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. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Quality & Safety Committee	16	C4 x L4	9 (C3xL3)	↔	18.06.2019	12.05.2021	11.06.2021		
3133	Chief Operating Officer Facilities	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.	**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). Reviewed 5.7.2021 - no change.	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	05.07.2021	31.07.2021		
4356	Executive Director for People Health, Safety & Fire Function	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Overdue/Out of date fire risk assessments due to resource issues and the amount required to be undertaken	**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.	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. An initial 12 months funding has been secured to appoint a Fire Officer - post currently out to advert.	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. Update June 2021: Recruitment has focussed on an appointment of a Fire Officer who will be able to undertake the Fire Risk Assessment reviews as well as undertake training as required. No specific Fire Safety Trainers are considered to be required at this time. Fire Officer post currently being advertised. Review - July 2021. Update July 2021 - Recruitment to Fire Officer post underway and pending a successful shortlisting exercise interviews are planned for circa mid July.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	26.10.2020	5.7.2021	31.7.2021		
4360	Executive Director for People Health , Safety & Fire Function	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.	**If** The Health Board does not follow the procedures in relation to input and advice from the relevant fire advisor. **Then:** Risks within the workplace are increased which in turn increases the risk to patients staff and visitors. Required information for emergencies situations could be inaccurate. **Resulting In** Increased risk of enforcement, increased risks to life. Confusion to those responding to incidents delaying response and assistance leading to increased risk to life again. Reframed into the new "If, then, resulting in" format as at June 2021.	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. http://ctuhb-intranet/dir/fire/Change%20of%20Use%20%20Room/Forms/AllItems.aspx Non compliance with this requirement is identified via Fire Risk Assessment reviews. Communication plan has been developed and is on the SharePoint page to provide guidance for management on the appropriate Fire Build Forms for room/Departmental changes. Reframed risk description as at June 2021	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. **Completed and on Website.** ILG Leads to ensure that any planned changes of use or alterations a fire build form (FB1 for single room / FB2 for multiple rooms is completed by the relevant manager / lead and forwarded to their locality Fire Officer for comments. This issue has been raised through the ILG Health Safety & Fire Risk Assessment Groups where it will be monitored going forward. Face to Face Fire Training and the Senior Management specific training session will support this activity. Face to Face training has currently stood down as a result of the response to Covid-19, however discussions are underway as to when they could be re-introduced.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	28.10.2020	19.05.2021	24.09.2021		
4500	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	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. 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. At June 2021 - no change to the above update.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	8 (C4xL2)	↔	21.12.2020	07.06.2021	31.07.2021		
816	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	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	Clinical Service Group (CSG) plan in place to address the FUNB position across all specialties as part of the restart programme. 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. No change in risk rating as at June 2021.	Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	18/11/2013	10.05.2021	10/08/2021		
3656	Executive Director For People. 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.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	18.06.2019	19.05.2021	31.08.2021		

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4281	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	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	7.06.2021	10/07/2021		
1133	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; **Then:** the Health Board will be unable to deliver safe, high quality services for the local population; **Resulting in:** compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce.	ED sustainable workforce plan developed and being implemented (May 2021).	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4 x L4	12 (C4xL3)	New risk escalated to Org RR July 2021	20.02.2014	17.06.2021	31.07.2021		
4699	Director of Corporate Governance Information Governance Function	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to deliver a robust and sustainable Information Governance Function	**If:** the Health Board fails to adequately resource the Information Governance Function following an increase in activity and demand since the boundary change and new operating model. **Then:** the health and wellbeing of staff along with the ability to comply with legislation and service delivery will be impacted. **Resulting in:** an impact on the workforce (poor morale, health and wellbeing, retention), Impact on Service Delivery and Compliance with Legislation	Work programme prioritised to focus on the "must do's": - Urgent Data Sharing Agreements - Responding to FOI's from the Public - Responding to Subject Access Requests - Responding to IG activity that relates to the safety of the public, responding to queries from external agencies such as Police investigations etc. - Significant incident investigations and concerns. -ICO activity and audit	Benchmarking with other organisations in Wales undertaken. Business case for additional IG resource developed to seek funding.	Digital & Data Committee	16	C4xL4	8 C4xL2	New Risk escalated to Org RR July 2021	20.02.2014	29.06.2021	31.07.2021		
4741	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	Failure to respond to Population Health Inequalities	**If:** the Health Board is not in a position to provide appropriate resource to respond to the risk stratification and population health segmentation data that will be available in the next couple of months. **Then:** it will not be able to act upon the new information and support primary care with the anticipatory care measures identified in response to the population health needs **Resulting in:** the Health Board being unable to narrow the gap in population health inequalities, poor reputation, loss of trust and confidence from stakeholders e.g. GPs, population partners. It will also impact how the Health Board uses opportunities arising from the transformation fund.	The Health Board is currently exploring multiple funding streams for population health management, and sustainability planning for Transformation Fund.	As indicated in the control measures the Health Board is exploring options for seeking additional resources which will include working in partnership e.g. with the Regional Partnership Board to reconfigure existing resources to ensure there is capacity to follow up the intelligence with action.	Population Health & Partnerships Committee	16	C4xL4	8 C4xL2	New Risk escalated to Org RR July 2021	05.07.2021	05.07.2021	31.08.2021		
4282	Chief Operating Officer Facilities	Provide high quality, evidence based, and accessible care.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Risks associated with the transfer to the new Planet FM System	**If:** the Health Board transfers over to the new Planet FM system **Then:** the TAB system will no longer be supported for Support Services, Laundry Services etc **Resulting In**: Business Continuity / Service Delivery not being available leading to service and financial loss. Potential for system to crash with no support available to rectify. No reporting system being available.	The Health Board is still using the TAB system until suitable alternative is found. Additional control measure in place of reverting to spreadsheets being used with manual entry, with additional staff put in post. Option to transfer services over to Planet FM through a phased approach has been looked at but unfortunately this is no longer feasible. Depending on if feasible there may be costs associated with licences, training etc. with new system. This has been included within the 'Support Services Forward Work Plan' to identify a solution in place of TAB system. Following review of this risk, the Technical Services Team have agreed that the risk now needs to be increased following confirmation that Tabs will no longer be supported on an IT server from July 2021, so there will be no system in place. Five demonstrations of alternative systems have been undertaken, however they have not been suitable for the Facilities Services. Other systems continue to be looked at by the Technical Services Team. Based on this update the likelihood of the risk remains at 4, giving a high rating (from 12 to 16). The risk will be reviewed in 3 months or following any mitigating actions being undertaken.	Action: Alternative system for Technical Services and the Laundry Service to be sourced. Timescale: 31/07/2021.	Digital & Data Committee	16	C4xL4	4 C4xL1	New Risk escalated to Org RR July 2021	19/02/2020	15/06/2021	15/09/2021		
3899	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 Update June 2021 - no change to risk scoring. The next review is scheduled for the RADAR meeting on the 28th June 2021.	People & Culture Committee	15	C3 x L5	9 (C3xL3)	↔	20.11.2019	08.06.2021	31.07.2021		

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3638	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.	Update June 2021: HEIW have agreed training support grants for trainers to support pre-registration foundation posts which mitigates the risk for this group of staff. However this funding is only temporary and not guaranteed beyond 2022-23, which presents a potential risk around recruitment of suitable staff. The post-registration foundation programme has been deferred until 2022 which buys some time for health boards to explore solution to the significant financial shortfall that will arise form the lack of on going funding for these posts. Update July 2021 - No further update to that recorded in June 2021. Review 30.09.2021.	People & Culture Committee	15	C3 x L5	6 (C3xL2)	↔	02.01.2018	10.06.2021	30/09/2021		
3072	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.	Quality & Safety Committee	15	C3 x L5	6 (C3xL2)	↔	05.02.2018	29.06.2021	04.08.2021		
4110	Executive Director for People	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 approved.	Begin a programme of translation focusing on the job descriptions advertised most frequently - e.g. nursing vacancies. 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. No change to risk as at 5th July 2021 – risk undergoing review to consider further mitigating action and further update will be received at the Management Board in August 2021.	People & Culture Committee	15	C3 x L5	9 (C3xL3)	↔	02/07/2018	5.7.2021	31.07.2021		
3698	Chief Operating Officer Bridgend Integrated Locality Group	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. Update as at June 2021 - risk remains unchanged.	Quality & Safety Committee	15	C3 x L5	4	↔	02.07.2019	08.06.2021	27.07.2021		
3685	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	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. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Quality & Safety Committee People & Culture Committee	15	C3 x L5	6 (C3xL2)	↔	26.06.2019	01.12.2020	31.3.2021		

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4606	Chief Operating Officer Primary Care Services	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. The service continues to be provided as it did pre-covid-19 pandemic, the commissioning arrangements with other Health Boards for Bridgend patients are still in place as nothing has changed. What has changed is longer waiting list as a result of Covid-19 and change to the national guidance on the prioritisation of referrals based on need and some patients referred may now not meet new criteria for orthodontic treatment. There is a national review of orthodontics taking place to inform this.	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. Update June 2021 - No change to the risk at present. A detailed report is being received at the Primary Care Board on the 9th June 2021 for consideration following which the detail and recommendations will be submitted to either the Management Board or the Primary Care Performance meeting as appropriate. **Review: 31.07.2021**	Quality & Safety Committee	15	C3 x L5	12 (3x4)	↔	23/04/2021	07/06/2021	31.07.2021		
4218	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 influence practice.	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 No change as at 5th July 2021 - Review of risk scheduled for w/c 12th July - update will be received in the next submission of the Organisational Risk Register.	Quality & Safety Committee	15	C3 x L5	3 (C3xL1)	↔	16/07/2020	05.07.2021	1.09.2021		
4672	Executive Director of Public Health - Interim Executive Lead for ICT / Digital Chief Information Officer	Provide high quality, evidence based, and accessible care.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Absence of coded structured data & inability to improve our delivery of the national clinical coding targets and standards (target is 95% completeness within month coded, and 98% on a rolling 3 month period)	**IF:** The Health Board is not able to record information accurately and reliably & does not address the 25000 backlog of uncoded FCEs **Then:** the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete **Resulting in:** Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc.	**Operational controls:** Coding key performance indicators covering productivity, demand and backlog robustly monitored DHCW annual coding quality audit. 2020/21 funding addressed backlog and proposals made to extend this into 2021/22. **Tactical controls:** Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme Information and Technical Standards Clinical audit **Gaps in controls** Workforce skills & development programme Insufficient resource available to address backlog Digital solutions not yet using snomed-CT/ structurally coded data	Coding Improvement and transformation plan established incorporating additional trained coding capacity, coding at source, use of data captured in other systems and e-forms implemented. Programme to address the backlog using additional sessions and agency codings ran in March and extension for 2021/22 proposed - awaiting consideration via IMTP prioritisation process **Tactical** - EPR programme with deployment of snomed-CT onotology server, WCP & E-forms etc	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	05.06.2021	31.07.2021		
4671	Executive Director of Public Health - Interim Executive Lead for ICT / Digital Chief Information Officer	Provide high quality, evidence based, and accessible care.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	NHS Computer Network Infrastructure unable to meet demand	**IF**: The Health Board suffers regular local and/or national network issues and/or outages to clinical and critical business systems. **Then**: there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated. **Resulting in**: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: Loss of information integrity and accessibility as multiple copies of clinical records. Threat of malware being introduced on to the network from unmanaged data, systems and software. Possible breaches to the GDPR, safeguarding and information governance risks.	There are various Service Management boards from ADIs, service delivery and infrastructure management which have representatives from each NHS Wales organisation and departments. These meet regularly with a governance structure to escalate any service delivery and security incidents and risks. SLAs are in place between DHCW and NHS Wales organisations and incidents are escalated up via the national Service Point Service Management system. The Health Board has the Risk Audit Governance & Cyber Security Board which meets monthly to discuss and take action on service delivery incidents. Local and National Infrastructure reviews are presently underway.	Infrastructure and comms actions plans were agreed 24 months ago and are being delivered as funding and staffing are available (recognising priorities changed during Covid). The Health Board to develop a robust incident management process. This is to ensure that regular outages of national systems and infrastructure are escalated to the appropriate governance structures to address such issues locally and nationally.	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	26/05/2021	26/05/2021	25/06/2021		
4512	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of patients with mental health needs on the acute wards.	**If:** there is a consistent number of patients with mental health needs who are being cared for on the acute wards without RMN support or there are delays in discharge an appropriate EMI setting; **Then:** patients who have been sectioned and / or are under medication review may remain on wards where specialist mental health therapy and input is not possible; **Resulting in:** incidents of staff and patients assaults may occur; poor patient experience; increased supervision needed.	MHL team contacted for each patient who required support; 1:1 patient supervision where required; Ward manager and senior nurse undertake regular patient reviews; Regular meetings with the mental health CSG in place.	Actions being reviewed	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	30/12/2020	07/06/2021	13/07/2021		
3993	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**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. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2021. Need to plan for drop in theatres to mitigate work commencing	Need building work to be undertaken to ensure safety. Operating theatres will need to close for this to occur.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31/01/2020	07/06/2021	30/09/2021		

Datix ID	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		
3337	Chief Operating Officer Director of Primary Care and Mental Health Services	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**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.	1. Process in place for clinical teams to access information via local authority and health board teams. 2. Clinical teams will only use historical information as part of their current risk assessment and if this is not available they will judge the risk accordingly. 3. Merthyr and Cynon and Bridgend CGS leads have confirmed that WCCIS is on their CSG risk register and their updates have been provided within this this section, therefore aligned. 4. WCCIS Programme Board establishment for CTM will be finalised by the 30th June 2021, Merthyr and Cynon CGS Lead will Chair this group. The Chair of this group will report to the Senior Responsible Officer. The Task and Finish Groups to be established and aligned to this Programme board Programme will be established by the 31st July 2021. 5. Local Authority have recently developed reports for Mental Health which identifies practitioner caseloads, admissions and discharges and care plan for compliance. 6. Community Drug and Alcohol Team in Bridgend have now moved over to WCCIS, early implementation learning continues to take place.	1. Deployment order to be in place for all existing WCCIS mental health staff users. 2. WCCIS Regional Working Group to have a representative from the UHB to maintain pace of delivery for WCCIS mental health rollout. 3.CTM to set up a Project Board in partnership to start preparing for implementation of WCCIS 4. Project manager has been recruited too, preemployment checks in place, develop and lead on the implementation plan. 5. CTM team to network and learn from ABUHB to inform rollout. A CTM programme Board has now being established and will oversea the delivery and governance of this work. Deadline - 30.06.2022	Quality & Safety Committee	15	C5xL3	6	New Risk escalated July 2021	07/11/2018	17/06/2021	31/07/2021		
4620	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Access to Neath Port Talbot Hospital to deliver breast surgery (mainly cancer patients)	**If:** There continues to be a lack of clarity about the Breast services Service Level Agreement (SLA) with SBUHB to provide services in NPTH **Then:** There is very limited ward space available for overnight stays and it is only on an ad-hoc arrangement **Resulting In:** Inappropriate and unsafe discharges	Patients are individually risk assessed. High risk operations have been facilitated in Royal Glamorgan Hospital however this impacts on other surgical lists. The RTE CSGM has asked the Bridgend CSGM for overnight capacity in Princess of Wales Hospital. In addition the RTE CSGM has asked for high risk cancer patients to be operated on in Royal Glamorgan Hospital (RGH). This is a challenge because it diverts current RGH theatre and green ward capacity and as new demand this has never been factored in to our theatre and ward plans.	Chief Operating Officer to discuss SLA monitoring arrangements with SBUHB. Commissioning arrangements being discussed with SBUHB to establish clear responsibilities under the SLA. RTE ILG reviewing options for delivering this care at RGH.	Quality & Safety Committee	15	C5xL3	10 (C5xL2)	New risk escalated to Org RR July 2021	06.05.2021	15.06.2021	03.09.2021		
3161	Chief Operating Officer Pharmacy & Medicines Management	Provide high quality, evidence based, and accessible care.	Legal / Regulatory	Lack of Wholesaler Dealers Authorisation	**If:** tthe Health Board fails to provide the significant time and resource to secure a Wholesaler Dealer's Authorisation and a Home Office Licence **Then:** it would be unable to sell or supply medicines outside the organisation **Resulting In:** Non-compliance with criminal law and Medicines HealthCare Regulatory Agency Regulations. The ability to respond to the Covid-19 Vaccine requirements and protecting population health.	WDA working group established to progress training, governance and infrastructure requirements to submit to MHRA in August 21, a case will be submitted to Vaccine Board.	Business case being progressed. July 21 case submitted to COVID Vaccine Board	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	New risk escalated to Org RR July 2021	24.06.2016	07.07.2021	16.08.2021		
4590	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	Critical Care Pharmacist Resource	**If:** additional resource is not identified to increase the critical care clinical pharmacy service **Then:** there is a risk that insufficient support can be provided to meet national standards and there would be lack of capacity to support future surges in demand, such as Covid. **Resulting In:** an increasing risk to patient safety, increased workload for critical care nursing and medical staff and lack of appropriate support for digital developments such as e-prescribing	SBAR included in Medicines management and advised to include in ACT directorate IMTPs. Meetings to discuss potential funding arranged with ACT leads. Baseline level of service (0.2wte) pharmacist time per site. A small pool of CC trained pharmacists are providing clinical services to acute wards which would be impacted if they are redeployed to support ITU, resulting in risk to patient safety and flow on acute wards.	June 21: Current situation included in planning review of CTMUHB ICU services Aim is to secure funding for 1WTE 8a specialist pharmacist for each critical care in RGH, POW and PCH and also supporting technician resources	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	New risk escalated to Org RR July 2021	05.04.2021	07.07.2021	30.09.2021		
4693	Chief Operating Officer Facilities	Provide high quality, evidence based, and accessible care.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Electrocardiogram (ECG) carts not connecting to hospital network	**If:** The GE ECG carts use DHCP to obtain an IP address from the network so that they can connect to the SBUHB MUSE system and download ECGs. If they are not able to connect to the hospital network then they cannot identify patient demographics from the wrist band using the online ADT functionality. **Then:** This is causing a backlog of tests not being stored centrally and only held locally on the machines. The machines are only capable of storing 200 tests before overwriting historic tests on a first in first out principle. **Resulting In:** the Health Board having no method of recording what tests have been deleted and failed to store on the MUSE server. In addition to this ICT (SBUHB) have looked at the situation and informed us that the wireless connectivity for these machines are running out of IP addresses depending on the number of wireless devices also live on the network at the time. This makes the connection of machines to the network random and unsustainable for the service. This could result in service / business interruption and delays.	There are no control measures that can be put into action currently. Situation is being escalated to SBUHB ICT. The Health Board can only rely on paper copies of the ECGs being kept in the patient notes. There is no mitigation options for digital review and storage of ECGs with GE MUSE System. Based on this update the risk has been scored as a high risk (Consequence 3 x Likelihood 5 = 15) and will be reviewed in 3 months time or when mitigating actions have been implemented.	Action: ICT (SBUHB) to review potential solutions with Clinical Engineering to address the wireless connectivity for these machines and the running out of IP addresses. Timescale: 16/09/2021.	Digital & Data Committee	15	15 (C3xL5)	3 (C3xL1)	New risk escalated to Org RR July 2021	16.06.2021	16.06.2021	16.09.2021		

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	Rating (Target)	Trend	Rationale for de-escalation	Datix ID
No risks were de-escalated this period													

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
4105	Executive Director of Public Health	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. 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 pressure on the hospitals as case numbers and severity reduce in time. The QIA process for services changes relating to COVID-19 Management developed and includes an assessment of related impact on any existing service delivery.	Continue to embed the QIA Process. Continuing to roll out the Health Boards Vaccination Programme.	Quality & Safety Committee	10 (C5xL2)	10 (C5xL2)	Risk Closed	23.03.2020	05.07.2021	Risk Closed as target score achieved. Vaccination Programme successful and will continue to be rolled out across the population as appropriate. The QIA process will continue to be embedded for service changes relating to Covid-19 and the risk will be monitored and should the risk likelihood change it will be escalated to the Organisational Risk register as and when required.
4235	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	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 As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Quality & Safety Committee	16	C4 x L4	Risk Closed	27.07.2020	05.07.2021	This risk is captured within the overarching risk 4071 - "Failure to sustain services as currently configured to meet cancer targets". Therefore this risk will be closed to avoid duplication.
3584	Chief Operating Officer. Bridgend Integrated Locality Group	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	* 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	8	3	Risk Closed	31.05.2019	05.07.2021	This risk has been closed. Staffing is 3+1 so stabilisation cot is being funded and covered. CHANTs now operating 24/7 care.