Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYNLLUNIO POBL A SICRWYDD PERFFORMIAD
PEOPLE PLANNING AND PERFORMANCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 June 2021
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Operational Risk Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Director of Operations Huw Thomas, Director of Finance Lee Davies, Director of Strategic Development and Operational Planning
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Board Secretary Charlotte Beare, Head of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The People, Planning and Performance Assurance Committee (PPPAC) is responsible for providing assurance to the Board that operational risks aligned to PPPAC in the Datix Risk Module are being identified, assessed and managed effectively.

PPPAC is asked to seek assurance from Executive Directors that the operational risks in the attached report are being managed effectively.

Cefndir / Background

Effective risk management requires a 'monitoring and review' structure to be in place to ensure that risks are effectively identified and assessed and that appropriate controls and responses are in place.

(Risk Management Process, ISO 31000)

Operational risks should be managed within directorates under the ownership and leadership of the individual responsible Executive Director, who should establish local arrangements for the review of their risk registers, which includes the validation of the information and risk scores, and the prioritisation and identification of solutions to their risks. In addition to these local arrangements, there are formal monitoring and scrutiny processes

in place within Hywel Dda University Health Board (HDdUHB) with the aim of providing assurance to the Board that it is managing its risks effectively.

All risks identified within the Datix Risk Module must be aligned to a formal Board Committee, Sub-Committee or Group who will be responsible for monitoring and scrutinising risks which relate to their remit.

The Committee, Sub Committee and Group structure is responsible for the monitoring and scrutiny of operational risks within their remit. They are responsible for:

- Scrutinising operational risks within their remit, either through receiving the risk registers or through service reports.
- Gaining assurance that risks are being appropriately managed, effective controls are in place and planned additional controls are being implemented.
- Challenging pace of delivery of risk actions.
- Identifying through discussions, new and emerging risks and ensuring these are assessed by those with the relevant responsibility.
- Providing assurance to its parent committee that risks are being managed effectively and to report risks which have exceeded tolerance through its sub-committee/group update report: and
- Using risk registers to inform meeting agendas.

It is therefore essential that the membership of these Committees and Sub Committees includes the appropriate representation from Directorates and that they are in attendance to provide assurance and respond to queries.

The discussion should be reflected in the Committee Update Report to Board to provide assurance on the management of significant risks. This would include risks that are not being managed within tolerance levels (see attached risk appetite statement) and any other risks, as appropriate.

Asesiad / Assessment

The PPPAC Terms of Reference state that it will:

2.9 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.

2.10 Recommend acceptance of risks that cannot be brought within the UHB's risk appetite/tolerance to the Board through the Committee Update Report.

2.11 Receive assurance through Sub-Committee Update Reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

PPPAC currently has 8 Directorate level risks and 30 Service level risks allocated to it as at 7th June 2021.

The three risks presented in the attached risk register as at 7th June 2021 (Appendix 1) have been extracted from the Datix Risk Module based on the following criteria:

- PPPAC has been selected by the risk lead as the 'Assuring Committee' on Datix.
- The current risk score exceeds the tolerance level, (discussed and agreed by the Board on 27 September 2018).
- Risks are at Directorate level on Datix.

Below is a **summary** of the three risks, ranked highest to lowest by 'current risk score', which meet the criteria for submission to the PPPAC meeting on 24th June 2021. There have been no changes in risk score since they were last reported. The risk register (Appendix 1) details the responses to each risk, i.e. the risk action plan.

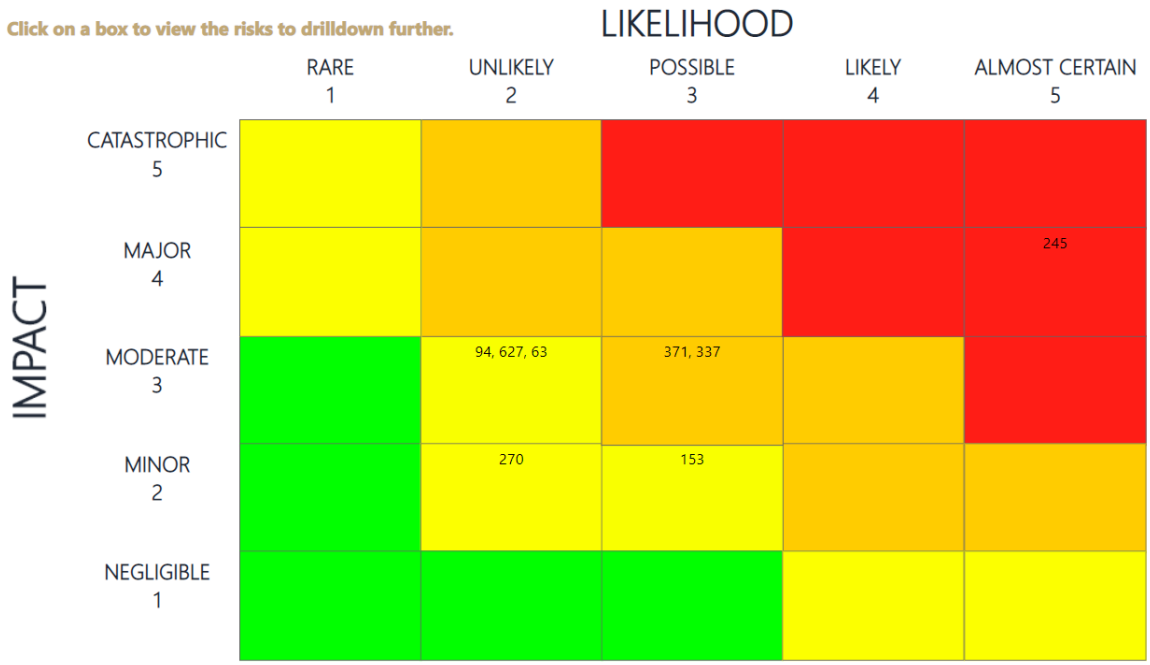
TOTAL NUMBER OF RISKS	3
NEW RISKS ENTERED ON DATIX	0
NEW RISK DE-ESCALATED FROM CORPORATE (371)	1
INCREASE IN CURRENT RISK SCORE ⇧	1
NO CHANGE IN RISK SCORE ⇔	1
REDUCTION IN RISK SCORE ⇩	0
REMOVED RISKS 894 – approved for closure by Assistant Director of Workforce & OD in January 2021 as matters surrounding shielding have been resolved 794 – approved for closure by Service Lead in March 2021 54 – targets which this risk previously related to now no longer exist, and the Health Board only reports to the Single Cancer Pathway. Approved for closure in March 2021.	3
EXTREME (RED) RISKS (based on 'Current Risk Score')	1
HIGH (AMBER) RISKS (based on 'Current Risk Score')	2

Risk Ref	Date Risk Identified	Title	Directorate	Current Risk Score	Rationale for the current risk score	Target Risk Score
245	07/02/18	Inadequate facilities to store patient records and investment in electronic solution for sustainable solution.	Central Operations: Health Records	20 ⇔	Acute and mental health services are no longer able to transfer records for storage to HDdUHB's offsite facility. As a result of historical and blood transfusion cases, further weeding and destruction programmes have been curtailed exacerbating the current situation. The relocation of deceased and non-active records has also ceased from all main hospital localities.	4
371	01/03/17	Inability to meet WG target for clinical coding and decision-making will be based on inaccurate/incomplete information	Finance: D&P: Information Services	9 **De-escalated from Corporate Risk**	Due to COVID-19, the coding backlog has reduced due to the reduced activity, however the Team are only operating at 80% capacity. This requires a number of actions to be taken, significant investment in contract coders at the end of the year. This affects the clinical information available for audit/research and the year-end costing returns for HDdUHB. Due to the ongoing pressures within the Clinical Coding Team, the Information Governance Sub-Committee has requested a recovery plan to be developed, as the team has lost 13,568 hours of coding time due to COVID-19, long term sick/shielding in Bronglais General Hospital (BGH), Social distancing in Glangwili General Hospital (GGH), Prince Phillip Hospital (PPH) and shielding in Withybush General Hospital (WGH).	6
337	01/09/16	Regional Joint Planning & Delivery Forum & A Regional Collaborative for Health (ARCH)	Strategic Development and Operational Planning	9 ⇧	Restricted input from Operational Teams due to ongoing service pressures.	6

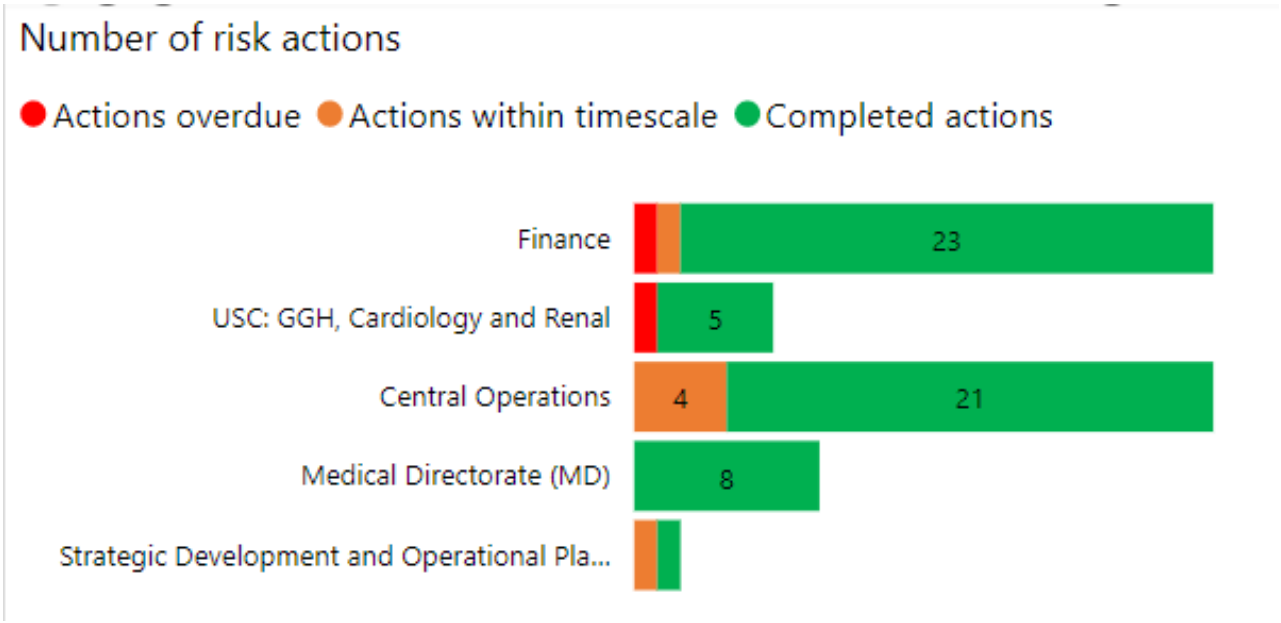
The heatmap below has been obtained from the Risk Performance dashboard. An Incident Response Improvement System (IRIS) account is required in order to access the Risk Performance dashboard, which can be obtained by completing this online form. The information reflects the risk information extracted from Datix as of 1st June 2021 based on the following criteria:

- PPPAC has been selected by the risk lead as the 'Assuring Committee' on Datix;
- Risks are at Directorate level on Datix; and
- Risks are of all tolerance levels. (PPPAC has 8 Directorate Level risks assigned to it, of which 3 are above tolerance (as noted in the table above)).

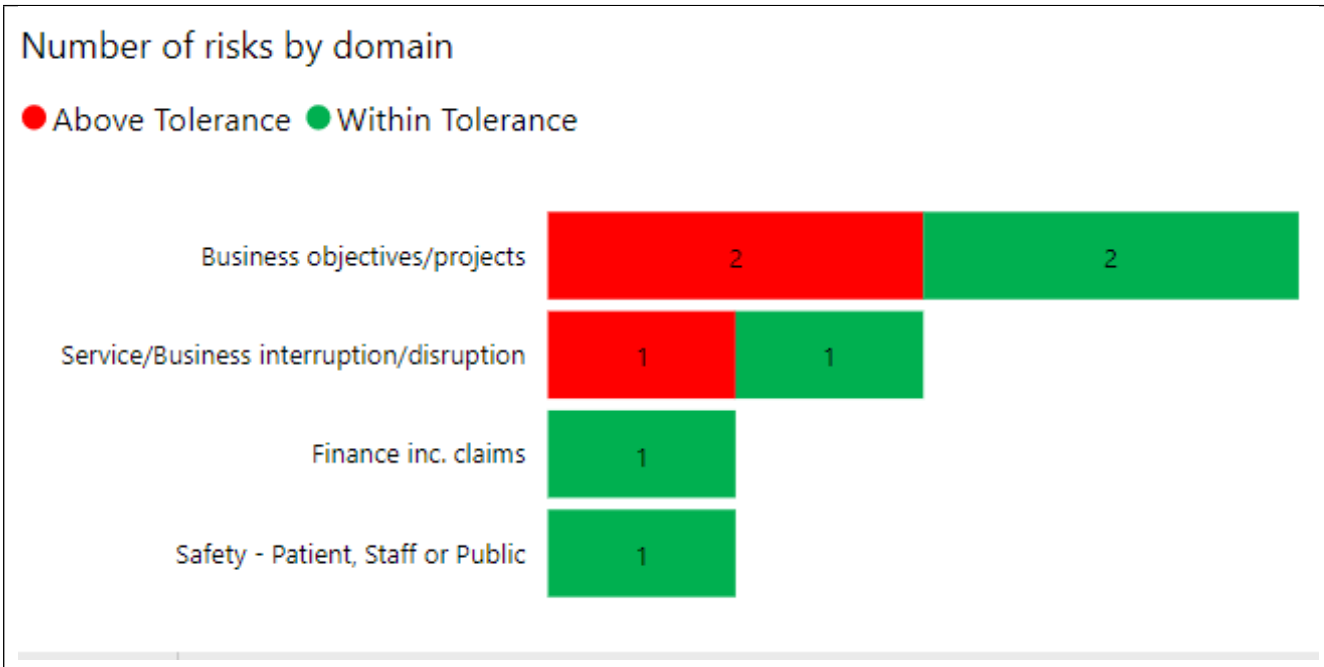
Below is a heatmap of the 8 Directorate level risks assigned to PPPAC:



Below is the number of risk actions against the 8 Directorate level risks assigned to PPPAC, grouped by Directorate. Red actions are those which are behind schedule from the original timescale, Amber actions are in progress and on schedule, and green actions are those which have been completed. There are 2 actions behind schedule against Finance and Unscheduled Care. Please note that these actions may relate to a risk that does not meet the criteria as defined to report to the Committee (i.e above tolerance).



Below is the 8 Directorate level risks assigned to PPPAC, split by ‘Above tolerance’ and ‘Within Tolerance’ (tolerance level as discussed and agreed by the Board on 27 September 2018) and grouped by Domain:



The table below details when the 8 Directorate level risks assigned to the PPPAC were last updated on Datix. Risks are required to be updated along the following timescales, dependant on their risk level:

- Extreme Risks – Monthly.
- High Risks – Bi-monthly.
- Moderate Risks – Six-monthly.
- Low Risks – Annually.

Risk numbers noted in red text in the table below denote those where a review of the risk is overdue.

	Risks updated in last month	**Risks updated within last 1-2 months**	**Risks updated within last 3-6 months**	**Risks updated within last 6-12 months**
Extreme	245			
High		337	371	
Moderate	270	627 153	63	94

Argymhelliad / Recommendation

PPPAC is asked to:

- Review and scrutinise the risks that have been included to seek assurance that all relevant controls and mitigating actions are in place.
- Discuss whether the planned actions will be implemented within stated timescales and will reduce the risk further and/or mitigate the impact if the risk materialises.

This in turn will enable PPPAC to provide the necessary assurance (or otherwise) to the Board that HDdUHB is managing these risks effectively.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference:	Contained within the body of the report

Cyfeirnod Cylch Gorchwyl y Pwyllgor:	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained within the body of the report
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2019-20	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk registers on the Datix Risk Module from across the HDdUHB's services reviewed by risk leads/owners
Rhestr Termau: Glossary of Terms:	Risk Appetite - *the amount of risk that an organisation is willing to pursue or retain*' (ISO Guide 73, 2009) Risk Tolerance - *the organisation's readiness to bear a risk after risk treatment in order to achieve its objectives* (ISO Guide 73, 2009) Hyperlinked
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cynllunio Pobl a Sicrwydd Perfformiad: Parties / Committees consulted prior to People Planning and Performance Assurance Committee:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from report however impacts of each risk are outlined in risk description.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from report however impacts of each risk are outlined in risk description.
Gweithlu: Workforce:	No direct impacts from report however impacts of each risk are outlined in risk description.
Risg: Risk:	No direct impacts from report however organisations are expected to have effective risk management systems in place.

Cyfreithiol: **Legal:**	No direct impacts from report however proactive risk management including learning from incidents and events contributes towards reducing/eliminating recurrence of risk materialising and mitigates against any possible legal claim with a financial impact.
Enw Da: **Reputational:**	Poor management of risks can lead to loss of stakeholder confidence. Organisations are expected to have effective risk management systems in place and take steps to reduce/mitigate risks.
Gyfrinachedd: **Privacy:**	No direct impacts
Cydraddoldeb: **Equality:**	Has EqIA screening been undertaken? No Has a full EqIA been undertaken? No

Risk Appetite Statement 2018/19

Introduction

The purpose of this statement is to articulate the UHB's position as to how it treats risks, and informs wider decision making and provide guidance to staff.

The main principles of the UHB's appetite for risk is that

- The lower the UHB's appetite, the less risk the UHB is willing to accept and therefore higher levels of controls should be put in place to manage the risk.
- The higher the UHB's appetite, the more risk the UHB is willing to accept and consequently the UHB will accept the usual for established systems of internal controls and will not necessarily seek to strengthen those controls above all else.

The following risk appetite levels, developed by the Good Governance Institute, have been included, for information, to help the discussion in relation to appetite;

Appetite Level	Described as:	What this means
None	Avoidance of risk and uncertainty is a key organisational objective.	*Avoidance of loss is key objective, play safe, avoidance of developments. Priority for tight controls and oversight.*
Low	*Minimal*, or as little as reasonably possible, is preferred for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.	*Prepared to accept the possibility of very limited financial loss if essential. Win any challenges re compliance. Innovations avoided unless essential.*
Moderate	*Cautious* is preferred for safe delivery options that have low degree of inherent risk and may only have limited potential for reward.	*Prepare to accept some possibility of some financial loss. Limited tolerance for sticking neck out. Tendency to stick with status quo, innovation in practice avoided unless really necessary.*
High	*Open* and willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM).	*Prepared to invest for return & minimise the possibility of financial loss. Value and benefits considered. Gains outweigh adverse consequences. Innovation supported.*
Significant	*Seek* and be eager to be innovative and too chose options offering potentially higher business rewards (despite greater inherent risk). Or also described as *mature* and confident in setting high levels of risk appetite because controls, forwards scanning and responsiveness systems are robust.	*Investing for best possible return & acceptance of possibility of financial loss. Chances of losing any challenge are real and consequences would be significant. Desire to break the mould. High levels of devolved authority – management by trust not control.*

Risk Appetite Statement

Hywel Dda's approach is to *minimise* its exposure to safety, quality, compliance and financial risk, whilst being *open* and willing to consider taking on risk in the pursuit of delivery of its objective to become a population health based organisation which focuses on keeping people well, developing services in local communities and ensuring hospital services are safe, sustainable, accessible and kind, as well as efficient in their running.

The UHB recognises that its appetite for risk will differ depending on the activity undertaken, and that its acceptance of risk will be based on ensuring that potential benefits and risks are fully understood before decisions on funding are made, and that appropriate actions are taken.

The UHB's risk appetite takes into account its capacity for risk, which is the amount of risk it is able to bear (or loss we can endure) having regard to its financial and other resources, before a breach in statutory obligations and duties occurs.

The UHB's appetite for risk across its activities is provided in the following table;

RISK APPETITE & TOLERANCE LEVELS FOR EACH RISK DOMAIN (*links back to Risk Scoring Matrix*)			
Risk Impact Domains	**Risk Appetite /appetite to take risk**	**Risk Tolerance /tolerance level for risk**	**Rationale**
Safety of Patients, Staff or Public	None	6	The UHB will hold the safety of people who use its services in the highest regard and will always aim to do no harm. The UHB will at all times act to *avoid* risk and uncertainty that could result in poor care, non-compliance with clinical and professional standards and non-compliance with statutory duties. Only in exceptional circumstances would the Board have an appetite to make a decision that may jeopardise it.
Quality, Complaints or Audit	Low	8	The UHB will provide high quality services ensuring value for money in a competitive arena and, depending on the circumstances will accept some risks that could limit its ability to fulfil this objective. This is in recognition that it is possible to deliver a service that is sub-optimal in terms of quality and patient experience, but is still clinically safe.
Workforce & OD	Low	8	The UHB will continue to employ and retain staff that meet the high quality standards of the organisation and provide on-going training to ensure all staff reach their full potential, always mindful of the professional and managerial capacity and capability of the organisation and staff well-being. In certain circumstances, the UHB will accept risks associated with the delivery of its strategy where the development of new staffing models and roles is necessary.
Statutory Duty or Inspections	Low	8	Non-compliance with legal and statutory requirements undermines public and stakeholder confidence in the Board, therefore the UHB will not accept any risk which (if realised) would result in non-compliance with its statutory duties and regulatory requirements.
Adverse Publicity or Reputation	Low	8	The UHB will maintain high standards of conduct and will not accept risks that could cause reputational damage to the Board and undermine public and stakeholder confidence associated with the day to day delivery of services. The Board will only consider accepting risks in certain circumstances, such as

			service or transformational change, if it is assessed that risk of undermining public or stakeholder confidence is outweighed by the longer term benefits that the change would bring for the local population, and that the impacts have been fully assessed and managed.
Business Objectives or Projects	Low	6	The UHB's success depends on the delivery of its objectives to achieve its objectives and gain the confidence of its stakeholders. Therefore the UHB will not accept any risk which (if realised) would result in it not meeting its key objectives.
Finance including Claims	Low	6	Achieving financial balance and delivery of savings plans is a key objective, and therefore the Board will not accept any risk that will (if realised) threaten this, unless a financial response is required to manage those risks associated with patient safety. To support the long term success of the organisation, the UHB will need to *seek* risks. These would need to focus first and foremost on the maintenance of quality and safety to clinical care, be aligned to its objectives, and the return of investment would need to be clear, as would the potential loss. The potential benefits and associated risks would need to be fully understood before developments are authorised and appropriate measures to mitigate risk are established.
Service or Business interruption or disruption	Low	6	The UHB would prefer as little disruption or compromise to operational areas as reasonably possible, except in very exceptional circumstances. There must be business continuity plans and disaster recovery plans in place to ensure that if identified risks materialise, the damage is limited, ie, the scale of disruption is minimum, and costs are contained.

Risk Appetite Map

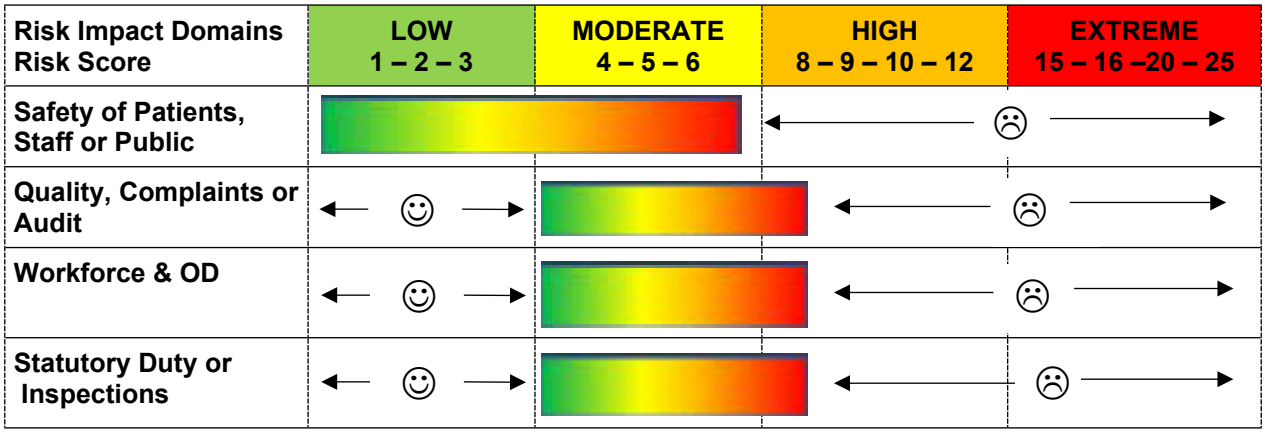
The UHB's risk appetite is demonstrated below in an easy to follow guide for the benefit of management and staff.

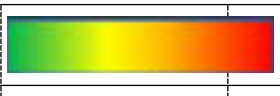
Key

☺ Comfortable – Risks below bar do not present a major threat as long as managed sensibly

☹ Dangerous – Risks above the bar represent risks the UHB is unwilling to take or tolerate

Manageable – Risks need careful management but may be worth taking or can be tolerated



Adverse Publicity or Reputation	☺		☹
Business Objectives or Projects	☺		☹
Finance including Claims	☺		☹
Service or Business interruption or disruption	☺		☹

Risk Ref	Status of Risk	Health and Care Standards	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Detailed Risk Decision	Review date
245	Directorate Level Risk	Standard 3.5 Record Keeping	Central Operations: Health Records	Rees, Gareth	Bennett, Mr Steven	01-Dec-11	There is a risk of avoidable interruption to business continuity affecting all clinical teams. This is caused by poor and inadequate facilities within the Health Records Service with insufficient storage capacity to meet patient records demand added to a lack of investment in electronic systems to deliver a sustainable model. This will lead to an impact/affect on patient record service rendering it unable to store records securely with potential for loss, damage or inappropriate disclosure of patient records leading to breach of confidentiality, review and sanction by the ICO, significant service disruption with several localities compromised, indirect adverse impact to patient safety arising from inappropriate clinical decisions, leading to poor patient care, complaints and litigation. Risk location, Health Board wide.	# Annual weeding and destruction programme agreed and facilitated across the Health Board up to 2018/19. # Electronic clinic systems including: PACS (radiology), LIMS (Pathology), WAP e-referrals, CANIS (Cancer), Diabetes 3, Selma, Myrddin & Secretarial systems/shared drives (Clinic Letters). # Alteration to current racking and purchase of additional racking at GGH. Resourcing of additional racking for the offsite facility. # Agreed and approved Health Records strategies, policies and procedures (approved Aug15). # Electronic Records Project Group undertaking scoping work for Turnaround Project for long term solution (Sep18). # Health Records Modernisation Programme Group reviewing records management arrangements and e-working (May 19) # Overtime process for condensing offsite storage facility supported by BPPAC and Exec Team.	Service/Business interruption/disruption	6	5	4	20	Implement the agreed weeding plan for 2018/2019.	Bennett, Mr Steven	Completed	All non active 2016 records have now been relocated from the Health Records departments to the offsite storage facility.	People, Planning and Performance Assurance Committee	1	4	4	Treat	22-Mar-21
														Implementation of the weeding and destruction plan 2017/2018.	Bennett, Mr Steven	Completed	The weeding plan for 2017/2018 was agreed and the plan was implemented in priority order. The plan has now been completed for all hospital localities removing and relocating all non-current records from 2015. The weeding programme for 2018/19 was unable to be undertaken due to the public inquiry into infected blood products during 1970s and 1980s.						
														Full implementation of Welsh Admin Portal (WAP) electronic referral system.	Tracey, Anthony	31/12/2018 31/03/2020 31/03/2021 31/07/2021	The e-referral has now been fully implemented within 17 specialties across the health board. Testing is underway in 5 specialties, training has started in 3 specialties and mapping has been completed in another specialty. 10 specialties are currently under review due to low referral numbers.						

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														Develop a business case for the implementation of a scanning solution to deal with long term issue.	Rees, Gareth	31/03/2019 31/03/2021 31/07/2021 31/12/2021	The Health Records Modernisation Programme Group has identified 5 specific work streams and to accelerate progress it was considered essential that dedicated resources were provided to augment the efforts. To ensure delivery there was a requirement for 1.8 WTE support staff from the programme management office. Recently a designated project manager has been identified and allocated to the work group, however additional resource will be required to support all work streams. These discussions have recently recommenced following the delay due to covid.						
														Re-establish Health Records Group.	Bennett, Mr Steven	**Completed**	First meeting of the Health Records Group took place on the 19th October 2018.						
														Include on Internal Audit Plan.	Wilson, Joanne	**Completed**	Already included on IA Plan 2018/19 - planned for Q3.						
														Development of an implementation plan to improve management of storage arrangements for current records by information asset owners across the UHB.	Bennett, Mr Steven	**Completed**	Implementation plan has been endorsed by the Executive Team in Dec18 however funding resources will need to be appropriately supported to deliver the outcomes.						
														Develop a Health Records management paper identifying current issues and including an options appraisal to resolve the interim lack of storage capacity for presentation at BPPAC and Exec team.	Bennett, Mr Steven	**Completed**	Paper submitted to BPPAC on 27th June 2019 and option 5 within the paper noted by group members as most appropriate option. Paper also presented at Executive Team by Deputy CEO & Director of Operations for approval.						
														Implementation of the agreed overtime process for condensing records at the Health Records storage facility.	Bennett, Mr Steven	**Completed**	Process implemented on 13th July 2019, with agreed reviews every 5 weeks.						

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														Implementation of agreed weeding plan for 2019/2020	Bennett, Mr Steven	Completed	All 2017 and 2018 non active records have now been relocated to the offsite storage facility.						
														Implementation of a scanning solution	Rees, Gareth	31/03/2023	An SBAR was submitted to the Exec Team in March 2020 outlining the requirement for PMO support, financial investment and potential savings associated with a scanning solution. Further discussions will be required following any agreement to progress a business case for the procurement of a scanning solution. These discussions have been delayed due to the covid pandemic.						
337	Directorate Level Risk		Strategic Development and Operational Planning: Transformation	Ryan-Davies, Libby	Warm, Daniel	01-Sep-16	There is a risk of key services will not be planned on a regional basis which is a requirement of Welsh Government. This is caused by timelines for immediate service pressures. This will lead to an impact/affect on the Health Board will fail to address service fragility within timescales required in key service areas e.g. Orthopedics, Ophthalmology, Pathology and Dermatology etc. Increased waiting times, potentially leading to poorer outcomes and experience for patients. Reputational damage to the Health Board. Risk location, Health Board wide.	Agreed a list service priorities for 2021/22 and are articulated in the draft annual plans for the two Health Boards. A revised list of priorities areas for ARCH is currently under review. The CEOs of the two Health Boards along with the Swansea University lead for ARCH are to agree the priorities following the review.	Business objectives/projects	6	3	3	9	Continue with bi-monthly regional Joint Planning and Delivery Forum meetings which are supported by the bi-weekly Joint Planning and Delivery Forum.	Hughes, Samantha	Completed	Bi-weekly Joint Planning & Delivery Forum Meetings have been set up to ensure work is undertaken between Committee meetings. Work is currently focusing on firming up Service Delivery Plans for the October 2019 Committee meeting and respective IMTPs	People, Planning and Performance Assurance Committee	2	3	6	Treat	23-Mar-21
														Continue with bi-monthly regional Joint Planning and Delivery Forum meetings which are supported by the bi-weekly Joint Planning and Delivery Forum, as a result of the agreed priorities for 2021/22.	Ryan-Davies, Libby	03/01/2019 31/03/2021 30/06/2021	Agreement of the priority areas as articulated in the draft 21/22 annual plans for both Health Boards. This will be further supported by the review of all priority areas in Q1 of 21/22. Priorities to be discussed at PPPAC in April 2021, and to be agreed at its meeting in June 2021.						

Risk Ref	Status of Risk	Health and Care Standards	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Detailed Risk Decision	Review date
371	Directorate Level Risk	Standard 3.4 Information Governance and Communications Technology	Finance: D&P: Information Services	Tracey, Anthony	Beynon, Gareth	01-Mar-17	There is a risk of that the UHB will not improve its delivery against the national completeness target for clinical coding (of 95% within month coding and 98% on a rolling 12 months) and that inaccurate/incomplete information will be used in decision-making in relation to service delivery and clinical strategy. This is caused by insufficient staff numbers within the Clinical Coding Department (reduced to 80% capacity due to COVID-19). This will lead to an impact/affect on the existing backlog of 13,000 episodes that require clinical coding (this increases by 2,000 per month with a projected backlog of 30,000 by end of 2020/21), the Welsh costing returns which use the derived Healthcare Resource Grouping (HRG) as a key element and that any reconfiguration of clinical services might not achieve the UHB's strategic goals to improve patient care. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	# Processes have been reviewed to identify any improvements that can be made to current working practices. The review has been unsuccessful in identifying any gains. # The coding backlog is monitored on a regular basis and reported via the IPAR and the Quality Indicators Group. Establishing the cost of contract coders to deal with the current backlog as a short term measure. # Overtime is being implemented to address some of the short fall in the completeness factor. # Reminders to end users of coded information that completeness levels does not meet national targets. # Notes are moved across the Health Board to support the teams that have less than required resources. # An outsourcing tender has been awarded to GSA for the coding of the Hywel Dda backlog, with a completion date of 27th June 2019, which is the requirement for the statutory costing returns.	Business objectives/projects	6	3	3	9	Overtime is offered to all members of the clinical coding team in attempt to have an impact into the growing backlog.	Beynon, Gareth	Completed	Overtime is offered to staff, minimal uptake due to work pressure fatigue.	People, Planning and Performance Assurance Committee	2	3	6	Treat	01-Mar-21
														Move staff from teams that are better resourced to teams that are less resourced in attempt to tackle some backlog.	Beynon, Gareth	Completed	Due to current pressures on all sites this has had minimal effect.						
														Move notes across the Health Board to support the teams that have less than required resources.	Beynon, Gareth	Completed	Workload is transported across sites in attempt to minimise the backlog, currently there is very little impact.						
														Resource calculations indicate that an additional 4.5 WTE clinical coders and 2.5 WTE clerks are needed to ensure current target is met.	Beynon, Gareth	Completed	Decisions have been made and approved to allow for the recruitment of the required additional resource.						
														Develop a workforce plan to address current shortfall and address future staffing/succession needs (current shortfall is calculated as 5.5wte clinical coders and 2.5 WTE clerks)	Beynon, Gareth	Completed	Funding for additional staff has been approved with posts due to be advertised.						
														Additional funding has been provided to the Clinical Coding Team for 1 additional coder	Beynon, Gareth	Completed	The interviews for a fully trained coder were unsuccessful, therefore a further job advert was release for a trainee coder. Interviews for a trainee coder took place on the 10Dec19, and we appointed 2 trainee coders, however it should be noted that it will take 18 months for the individual to be fully trained and therefore the impact upon the coding backlog will not be seen until the individual is fully trained.						
														A further tender will be placed out to market for a weekend contract coder	Beynon, Gareth	Completed	The contract weekend coders, began on 02Nov19 and are targeting the backlog cases. Due to COVID-19 the contractor is not currently available.						

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														A Recovery Plan has been requested by the Information Governance Sub-Committee to address the backlog	Beynon, Gareth	30/04/2021	To be presented to the next meeting.						