| Risk Ref | Risk (for more detail see individual risk entries) | Included on BAF | Risk Owner | Domain | Tolerance Level | Previous Risk Score | Risk Score Aug-20 | Trend | Target Risk Score | Page |
|---|---|---|---|---|---|---|---|---|---|---|
| 624 | Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives. | To be confirmed | Miles, Karen | Business objectives/projects | 6 | 4x4=16 | 5x4=20 | ↑ | 4x4=16 Accepte | 3 |
| 890 | Delivery of Q2 – Ability to respond effectively and swiftly to changes in workforce demand as COVID-19 progresses | | Gostling, Lisa | Workforce/OD | 8 | N/A | 4x4=16 | New risk | 2x4=8 | 7 |
| 686 | Delivering the Transforming Mental Health Programme by 2023 | | Carruthers, Andrew | Service/Business interruption/disruption | 6 | 4x4=16 | 4x4=16 | ↔ | 2x4=8 | 9 |
| 371 | Inability to meet WG target for clinical coding and decision-making will be based on inaccurate/incomplete information | | Miles, Karen | Business objectives/projects | 6 | 4x4=16 | 3x4=12 | ↓ | 3x4=12 | 13 |
| 451 | Cyber Security Breach | | Miles, Karen | Service/Business interruption/disruption | 6 | 3x4=12 | 3x4=12 | ↔ | 3x4=12 Accepte | 16 |
| 891 | Delivery of Q2 Operating Plan - Delayed Discharges affecting whole HB | | Carruthers, Andrew | Quality/Complaints/Audit | 8 | N/A | 3x4=12 | New risk | 2x4=8 | 20 |
| 892 | Delivery of Q2 Operating Plan - Inability to recruit sufficient Registered Nurses affecting the whole HB. | | Carruthers, Andrew | Safety - Patient, Staff or Public | 6 | N/A | 3x4=12 | New risk | 2x4=8 | 22 |
| 291 | Lack of 24 hour access to Thrombectomy services | | Carruthers, Andrew | Quality/Complaints/Audit | 8 | 4x4=16 | 3x4=12 | ↓ | 2x4=8 | 24 |
| 894 | Delivery of Q2 Operating Plan – Reduced clinical workforce due to underlying medical condition, pregnancy or ethnicity (BAME) | | Gostling, Lisa | Safety - Patient, Staff or Public | 6 | N/A | 3x4=12 | New risk | 2x4=8 | 28 |
| 632 | Ability to fully implement WG Eye Care Measures (ECM) | | Carruthers, Andrew | Safety - Patient, Staff or Public | 6 | 3x4=12 | 3x4=12 | ↔ | 2x2=4 | 30 |
| 893 | Delivery of Q2 Operating Plan – Estate Capacity required for Social Distancing Measures | | Rayani, Mandy | Safety - Patient, Staff or Public | 6 | N/A | 2x5=10 | New risk | 1x5=5 | 34 |
| 633 | Ability to meet the 1% improvement target per month for waiting times for 2020/21 for the new Single Cancer Pathway | | Carruthers, Andrew | Quality/Complaints/Audit | 8 | 3x3=9 | 3x3=9 | ↔ | 3x2=6 | 37 |
| 854 | Risk that Hywel Dda's Response to COVID-19 will be larger than required for actual demand | | Moore, Steve | Adverse publicity/reputation | 8 | 3x3=9 | 2x3=6 | ↓ | 2x3=6 | 40 |

**Assurance Key:**

| 3 Lines of Defence (Assurance) | | |
|---|---|---|
| 1st Line | Business Management | Tends to be detailed assurance but lack independence |
| 2nd Line | Corporate Oversight | Less detailed but slightly more independent |
| 3rd Line | Independent Assurance | Often less detail but truly independent |

| Key - Assurance Required | |
|---|---|
| | Detailed review of relevant information |
| | Medium level review |
| | Cursory or narrow scope of review |

*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*

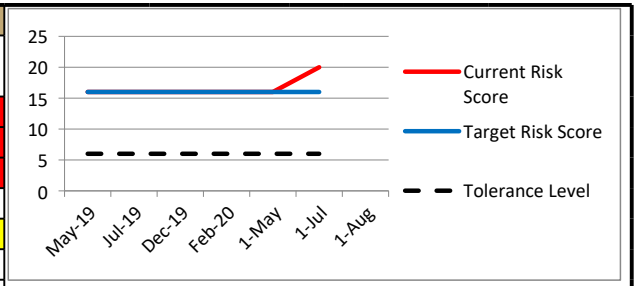
| Key - Control RAG rating | |
|---|---|
| **LOW** | Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks |
| **MEDIUM** | Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks |
| **HIGH** | Controls in place assessed as adequate/effective and in proportion to the risk |
| **INSUFFICIENT** | Insufficient information at present to judge the adequacy/effectiveness of the controls |

| | |
|---|---|
| **Strategic Objective:** | *To be confirmed* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Miles, Karen | **Date of Review:** | Aug-20 |
| **Lead Committee:** | People, Planning & Performance Assurance Committee | **Date of Next Review:** | Sep-20 |

| | | | |
|---|---|---|---|
| **Risk ID:** | **624** | **Principal Risk Description:** | There is a risk the UHB will not be able to maintain and address either the backlog maintenance or development of its estate, medical equipment and digital infrastructure, that it is safe and fit for purpose. This is caused by insufficient capital, both from the All Wales Capital Programme and Discretionary Capital allocation. This could lead to an impact/affect on delivery of strategic objectives, service improvement/development and delivery of day to day patient care. |
| **Does this risk link to any Directorate (operational) risks?** | Yes | | |

| | |
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Business objectives/projects |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 5×4=20 |
| **Target Risk Score (L x I):** | 4×4=16 |
| 30/05/19 - Board 'Accept' Target Risk Score | |
| **Tolerable Risk:** | 6 |
| **Trend:** | |




**Rationale for CURRENT Risk Score:**

This risk has increased due to the use of All Wales Capital resources in the management of COVID-19 response. Although there are a number of controls in place, the risk cannot be managed within the current capital allocation and the risk to that allocation due to the capital resources needed in the management of COVID-19. Any All Wales Capital schemes intended for funding in 2020/21 but not yet approved, are now unlikely to be funded in 2020/21.

**Rationale for TARGET Risk Score:**

The target risk score of 16 reflects the actions and processes planned and controls in place to help mitigate the risk.

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | | |
|---|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| * There is an annual programme of replacement in place for equipment, IT and Estates which follows a prioritisation process.<br>* The People Planning & Performance Assurance Committee (PPPAC) and Capital Estates & IM&T Sub Committee (CEIM&T) (to date with IM membership and wide stakeholder engagement in prioritisation process), receive reports and recommendations on the prioritisation and allocation of available capital.<br>* When possible, aligning replacement equipment to large All Wales Capital schemes to minimise the impact on discretionary capital within the UHB. | Capital funding is significantly short of the level required to deal with backlog maintenance programme for estates, digital & equipment.<br><br>An Estates Strategy aligned to the Board approved Health and Care Strategy.<br><br>Uncertainty over the full funding by | Undertake backlog maintenance through the All Wales Capital programme for new equipment, digital and estates infrastructure. The Strategy is to apply discretionary capital in a prioritised way within the UHB however to take advantage of all Wales capital schemes where possible and any additional in-year capital allocations. | Miles, Karen | ~~31/03/2019~~<br>~~31/03/2020~~<br>31/03/2021 | As previously reported, significant pressures remain on the All Wales Capital Programme which limits flexibility in relation to backlog capital. The equipment and digital allocations were supplemented by the allocation of year end monies from WG in 2019/20. |

| | | | | |
|---|---|---|---|---|
| the UHB.<br>* Completion of the medical devices inventory by the operational management team which helps in the prioritisation of available funds.<br>* Retention of a medical equipment capital contingency to manage urgent issues of repair or replacement.<br>* Review of regulatory reports which have a capital component ie. HIW, WAO, CHC.<br>* Investigating the potential for 'Charitable' funding rather than Discretionary Capital Programme as appropriate.<br>* Communication with Welsh Government via Planning Framework and IMTP (Infrastructure & Investment Enabling Plans) and regular dialogue through Capital Review meetings to understand the impact of All Wales Capital being required to support COVID 19 management, and any knock on impact on the 2020/21 DCP..<br>* Preparation of priority lists for equipment, Estates and IM&T in the event of notification of additional capital funds from Welsh Government i.e. in year slippage and to enable where possible, the preparation of forward plans. This is also addressed through the identification of high priority issues through the annual planning cycle.<br>* Reports to CE&IMT SC set out priorities for imaging equipment and established a much firmer baseline position in relation to medical devices backlog.<br>* Committed and planned capital expenditure associated with the COVID-19 pandemic has been shared with WG. | Uncertainty over the full funding by WG of COVID-19 related capital expenditure which if not fully funded will impact on 2020/21 DCP.<br><br>An updated Strategic Outline Programme for Digital Services to provide a forward look and also the backlog maintenance | Development of a medical devices inventory. | Rees, Gareth | Completed | The medical devices inventory has been updated and reflects the higher than anticipated capital spend on equipment backlog issues in 2019/20. This has been the subject of a CEIM&T report and will be used to prioritise the equipment backlog taking into account items also purchased in response to the management of Covid-19 pressures . |
| | | The annual planning cycle identifies key capital enabling plans and priorities. This will also include the start of the development of an Estates Strategy in support of the clinical strategy which will establish the timing and scope of key estate developments which will help address backlog issues across the UHB. This element will be taken forward as part of the Programme Business Case for AHMWW and finalised in the Outline Business Case planned for 2021/22. | Miles, Karen | ~~31/03/2020~~ ~~31/12/2020~~ 31/03/2021 | Evidenced in work in support of implementation of 'A Healthier Mid & West Wales' and inclusion in the Infrastructure and Investment Enabling Plan produced as part of the 2019/20 Planning Cycle; the Pre Programme Business Case shared with WG Qtr3 2019/20; the Programme Business Case is planned for completion March 2021. |
| | | Respond to Welsh Government request of 24Jul19 requesting a prioritised imaging equipment which could be provided 2019/20 (deadline for submission is 7th August 2019). Completion of these schemes has been delayed due to COVID 19 related issues. | Miles, Karen | Completed | List was submitted to WG and funding has been allocated which has resulted in new digital general x-ray room equipment in both PPH and WGH plus new fluoroscopy equipment in GGH August 2020. In addition, an allocation has been agreed to allow the replacement of the WGH MRI in 2020/21. This is likely to be delivered early 2021/22. The opportunity has also been taken to procure short term capacity through a demountable 2nd CT scanner for Glangwili. |

| | | | |
|---|---|---|---|
| Following the submission of the Strategic Medical Device Replacement report to the CEIM&T Sub-Committee, discussions need to be had with Welsh Government colleagues at the Capital Review Meetings (CRM) about the progression of a business case for funding to help address priority backlog areas. | Miles, Karen | Completed | Completed - As stated above, following the higher than anticipated levels of investment in 2019/20 and 2020/21 in imaging and general equipment backlog, the medical devices inventory is now to be re-assessed to establish priority requirements for 2021/22. It is likely that DCP funds will need to be supplements through a bid for All Wales capital to support essential replacements in 2021/22. |
| Estate Major Infrastructure backlog has been the subject of a draft Programme Business Case (PBC) which is now being refreshed following the TCS outcome with the purpose to address essential infrastructure backlog on hospital sites pending new developments as part of the UHB Health & Care Strategy. | Miles, Karen | ~~31/03/2020~~ 31/03/2021 | The PBC has been shared in draft with WG and with the Executive Team and IMs. This is now subject to further ET scrutiny before review at October PPPAC and submission to WG. Given the AWC position, funding appears unlikely during 2020/21. |
| Digital Bids have been forwarded to Welsh Government to access the £25m in capital and revenue funding available in 2019/20. This is intended however for innovation and the Digital backlog issues contained in the PBC submitted to Welsh Government along with other UHBs in 2017 remains unresolved. | Miles, Karen | Completed | Further digital allocations are anticipated in 2020/21. The digital expenditure related to the COVID-19 response has been the subject of a WG allocation letter to the UHB. |
| Discussions with WG through the Capital Review Meetings and finance will continue to address the controls associated with COVID-19 related capital funding. The working assumption is that spending will be fully funded by WG however there are identified pressures which are not yet funded. These will be discussed further at the Sept CRM. | Miles, Karen | 9/30/2020 | Capital schedules have been shared with WG as they have evolved and the open and transparent approach will continue as new COVID related capital pressures are identified. Further clarity on funding is expected Sep20. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Performance against plan & budget. | Reports of delivery against capital plan & budget | 1st | | | * DCP and Capital Governance Report - PPPAC Jun20 and CEIM&T Sub-Committee Jun20<br>* Radiology Equipment Risk CEIM&T Sub-Committee Jan20<br>* Strategic Medical Device Replacement CEIM&T Sub-Committee Jul20<br>* Estate Infrastructure CEIM&T Sub-Committee Jul20<br>* IM&T Infrastructure CEIM&T Sub-Committee Jul20 | | | | | |
| | Capital Audit Tracker in place to track implementation of audit recommendations | 1st | | | | | | | | |
| | Monitoring returns to WG include Capital Resource Limit | 1st | | | | | | | | |
| | Datix & risk reporting at an operational management level | 1st | | | | | | | | |
| | BPPAC & CEIM&T Sub-Committee reporting (supported by sub-groups) | 2nd | | | | | | | | |
| | Bi-monthly Capital Review Meetings with WG to discuss/monitor Capital Programme | 2nd | | | | | | | | |
| | NWSSP Capital & PFI Reports on capital audit | 3rd | | | | | | | | |
| | WAO Structured Assessment 2017 | 3rd | | | | | | | | |

| | |
|---|---|
| **Strategic Objective:** | *To be confirmed* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Gostling, Lisa | **Date of Review:** | Jul-20 |
| **Lead Committee:** | People, Planning & Performance Assurance Committee | **Date of Next Review:** | Aug-20 |

| | | | |
|---|---|---|---|
| **Risk ID:** | **890** | **Principal Risk Description:** | There is a risk the UHB will be unable to respond effectively and swiftly to changes in workforce demand (capacity and capability) required to react to the number of possible scenarios which may present as the pandemic progresses. This is caused by the unpredictability of service changes, required to manage the pandemic as it progresses, to produce an effective and agile workforce plan and identify the workforce needs across the whole Health Board system. This could lead to an impact/affect on difficulties in service provision, capacity and capability. |
| **Does this risk link to any Directorate (operational) risks?** | 870 | | |

| | | |
|---|---|---|
| **Risk Rating:(Likelihood x Impact)** | | **No trend information available.** |
| **Domain:** | Workforce/OD | |
| **Inherent Risk Score (L x I):** | 5×4=20 | |
| **Current Risk Score (L x I):** | 4×4=16 | |
| **Target Risk Score (L x I):** | 2×4=8 | |
| **Tolerable Risk:** | 8 | |
| **Trend:** | *New* | |

**Rationale for CURRENT Risk Score:**

The COVID 19 Pandemic has highlighted the need for an agile and responsive workforce. Workforce planning is a key component in identifying any workforce gaps and putting in place actions to mitigate any workforce deficits which would ultimately impact on patient care. Given that the scale of the possible pandemic and the short time lines we are working to, activity is compressed into smaller sequences, which means the likelihood and severity of the risk is increased.

**Rationale for TARGET Risk Score:**

Workforce planning activity is taking place within a methodology and framework led by the Workforce Planning Task & Finish Group with the actions below in place to mitigate and create responsive to workforce planning and is being given priority and resource to respond to the current risks. Therefore through effective planning, engagement and dialogue through a structured framework the HB can be responsive to the workforce challenges putting in place mitigating actions or creating appropriate escalation plans.

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Workforce Planning Task and Finish Group established 3 June 2020.<br><br>Workforce Planner in place.<br><br>Project Management plan for workforce planning in place and project for operationalizing Field Hospitals. | Lack of effective and cohesive workforce planning structure and systems in place.<br><br>Embedding workforce plan to NHS 6 step planning methodology. | Agree organisational wide scenarios to test workforce availability. | Walmsley, Tracy | Completed | Completed. NB Modelling scenarios may change again complete as at 31 July 2020 |
| | | Test modelling scenarios with planning cell. | Walmsley, Tracy | Completed | Completed. NB Modelling scenarios may change again complete as at 31 July 2020 |
| | | Develop and implement a consistent framework for organisational wide WFP including a profiling methods of our COVID & NON COVID workforce. | Walmsley, Tracy | 31/03/2021 | Strategic framework in place and currently been piloted at corporate level however needs to consistently used and embedded throughout organisation at operational level. |

| | | | |
|---|---|---|---|
| Create agile methods for workforce movement/development & implement workforce plans. | Walmsley, Tracy | 30/09/2020 | Contained within Quarter 2 plan. Further plans to be developed following workforce planning T&F Group on 4 August 2020. |
| Enable capacity and capability in Work Force Plan. | Walmsley, Tracy | 30/09/2020 | Team to support Workforce planning and role design to be put in place. |
| Develop corporate workforce plans based on agreed scenarios. | Walmsley, Tracy | ~~16/07/2020~~ 31/07/2020 | Currently developing high level corporate plan and engaging with services. |
| Creation of a recruitment plan based on assessment of gaps from above analysis. | Gostling, Lisa | ~~17/07/2020~~ 30/08/2020 | On track for development. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) |
|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | |
| None identified. | Development of Workforce Plan overseen by Workforce Planning T&F Group (1st line, | 1st | | | |
| | W&OD Leadership Group challenge and review of current workforce plan (2nd line, | 2nd | | | |
| | PPPAC receives assurance of effectiveness of WFP (2nd line, | 2nd | | | |

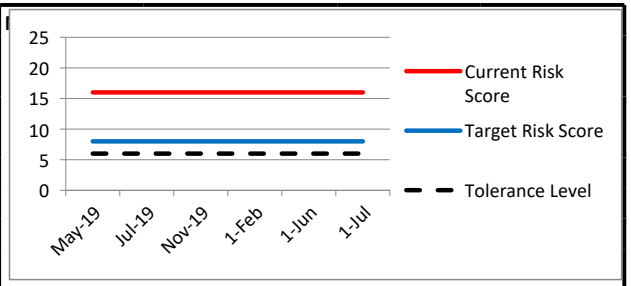
| Gaps in ASSURANCES | | | | |
|---|---|---|---|---|
| Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Workforce Planning to be included in Bronze Groups. | | | | |
| | | | | |
| | | | | |

| | |
|---|---|
| **Strategic Objective:** | *To be confirmed* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Carruthers, Andrew | **Date of Review:** | Jul-20 |
| **Lead Committee:** | People, Planning & Performance Assurance Committee | **Date of Next Review:** | Aug-20 |

| | | | |
|---|---|---|---|
| **Risk ID:** | **686** | **Principal Risk Description:** | There is a risk that the UHB will be unable to fully deliver Transforming Mental Health (TMH) Programme by 2023. This is caused by a number of key challenges, specifically the securing of £20/29m capital to implement TMH, potentially increased revenue costs from newer buildings, limited capital resources to fund implementation of both TMH and HCS, potential delays from co-production with service users, staff and key stakeholders, understanding of IT requirements, and adequate programme support. This could lead to an impact/affect on the UHB's ability to meet the rising demand on mental health services, meeting service users' expectations, recruitment and retention of professional staff, and result in adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

| | |
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Service/Business interruption/disruption |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 4×4=16 |
| **Target Risk Score (L x I):** | 2×4=8 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

Delivery of TMH is critical to the UHB's ability to manage the increasing demand on mental health services and improving recruitment and retention in key professional groups. Whilst there are work streams in place to identify keys risks and issues, the delivery of TMH is reliant on a significant amount of capital. Capital resources are limited and there is a risk that some elements of TMH may need to align with the UHB's Transforming Clinical Services programme which could result in a delay in the overall delivery of TMH. Capital is also dependent on the UHB demonstrating that it will be able to manage the increasing revenue costs associated with the increasing demand on services since the development of the TMH.

**Rationale for TARGET Risk Score:**

The Mental Health and Learning Disabilities Directorate has completed a consultation in respect of a revised service model which should reduce the reliance on our inpatient services. Delivery of the TMH programme within the timescales agreed by Board is dependent on securing the required capital and programme support therefore the target score reflects the uncertainty associated with both these requirements. COVID-19 has provided the UHB with the opportunity to implement changes earlier than planned, such as merging CMHTs, changing and streamlining ways of working.

| Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk) | Gaps in CONTROLS | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Open commitment and mandate from the Board on the implementation of the TMH Programme. Board approved implementation plan (Jan18).<br><br>Mental Health Implementation Group established to oversee delivery of the TMH Implementation Programme.<br><br>Established work streams in place for Pathway and Access Design, Workforce and Cultural Change, Transport, and Estates and infrastructure, IT, Partnerships & Commissioning and Data & Evaluation.<br><br>First proof of concept sites operational.<br><br>UHB Patient and Public Involvement team support for delivery phase of TMH.<br><br>Programme Business Case (PCB) submitted to WG to deliver TMH for consideration which has now been returned with comments which are being addressed in readiness for resubmission.<br><br>TMH programme fully aligned with TCS to ensure that risk of delays to TMH developments are minimised and opportunities for support are maximised. | Lack of agreed capital investment which is dependent on a balanced revenue position which will be able to address estates, IT and infrastructure requirements.<br><br>Competing demand for capital with Transforming Clinical Services Programme.<br><br>As we operationalize the implementation of TMH this will be aligned to the Directorate governance structure. | Establish continuous review process of demand and capacity within Adult Mental Health Services. | Jones, Richard | ~~01/01/2020~~ ~~30/06/2020~~ 31/10/2020 | Discussions held between Transformation Programme Office, Assistant Director of Informatics and Transforming Mental Health team to explore options. Work plan has been proposed by Assistant Director of Informatics to build bespoke demand and capacity model to meet need. Service lead has reviewed workforce requirements to meet demand in 24/7 Community Mental Health Centres. |
| | | Confirmation that Adult Mental Health Service will remain revenue neutral following completion of demand and capacity process and Transforming Mental Health workforce review. | Carroll, Mrs Liz | ~~31/03/2020~~ 31/08/2020 | Further implementation of proof of concept initiatives including the use of IT resources has taken place as part of the UHB's response to COVID-19. These will be reviewed to understand the impact on the TMH estate requirements. Initial review findings will be included in the UHB response to PCB initial feedback response from WG. A cost neutral MHLD Accommodation Strategy will be developed through 2020/21. |
| | | The Business Case has been returned from Welsh Government with a number of queries. The Planning Department are coordinating a response at a quick turnaround. | Williams, Paul | ~~30/06/2020~~ 31/08/2020 | Currently with Planning to be submitted to Welsh Government. |
| | | During COVID-19 there has been an acceleration of some aspects of TMH other than progress around the business case that has been submitted to Welsh Government. | Carroll, Mrs Liz | 31/12/2020 | New action. |

| | | | |
|---|---|---|---|
| Re-establish programme support from Transformation Programme Office (TPO) following COVID-19 planning phase | Carroll, Mrs Liz | 30/09/2020 | TMH Project support team was in place prior to COVID-19. Recruitment of Project support staff to be discussed with Transformation Director. |
| Explore the benefits of agile working to reduce revenue costs of TMH and contribute to the cost neutrality of the overall programme. | Carroll, Mrs Liz | ~~31/07/2020~~ 31/12/2020 | Work has started as part of feedback to WG on PCB. |
| Review and implementation of an assurance structure for TMH&LD | Carroll, Mrs Liz | Completed | Due to COVID-19 the TMH Implementation Group has been stood down. In the meantime we will monitor the implementation of the strategy through the MH&LD Directorate Bronze Group and other associated structures within the Directorate. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) |
|---|---|---|---|---|---|
| **Performance Indicators** | **Sources of ASSURANCE** | **Type of Assurance (1st, 2nd, 3rd)** | **Required Assurance / Current Level** | | |
| N/A | Work streams report progress, key risks and issues to Transforming MH&LD Programme Group | 1st | | | * TMH Progress Report - Board - Sep18, Nov18, Jul19 & Nov19<br><br>* HOS reports - BP&PAG - Jan20<br><br>* MHLAC Update - Board - Jul18 |
| | Regular reports received at Local Mental Health Partnership Board and MH&LD Business Planning & Performance Assurance Group | 2nd | | | |

| Gaps in ASSURANCES | | | | |
|---|---|---|---|---|
| **Identified Gaps in Assurance:** | **How are the Gaps in ASSURANCE will be addressed<br>Further action necessary to address the gaps** | **By Who** | **By When** | **Progress** |
| As we operationalize the implementation of TMH this will be aligned to the Directorate governance structure. | | | | |
| | | | | |

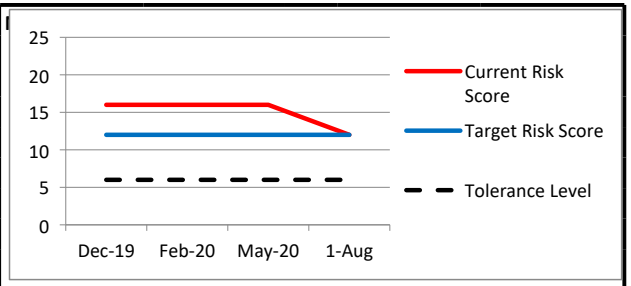
| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | TMH Plan is monitored by TMHLD Implementation Group and Planning Sub-Committee and to Board on request | 2nd | | | * Planning Sub Committee - Mar20 | | | | |

| | |
|---|---|
| **Strategic Objective:** | *To be confirmed* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Miles, Karen | **Date of Review:** | Aug-20 |
| **Lead Committee:** | People, Planning & Performance Assurance Committee | **Date of Next Review:** | Sep-20 |

| | | | |
|---|---|---|---|
| **Risk ID:** | **371** | **Principal Risk Description:** | There is a risk 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 could lead to an impact/affect on the existing backlog of 20,000 episodes that require clinical coding (this increases by 2,000 per month with a projected backlog of 44,000 by end of 2019/20), 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. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

| | |
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Business objectives/projects |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 3×4=12 |
| **Target Risk Score (L x I):** | 3×4=12 |
| **Tolerable Risk:** | 6 |
| **Trend:** | |




**Rationale for CURRENT Risk Score:**

Due to COVID-19,the coding backlog has reduced to 15,692 due to the reduced activity, however the team are only operating at 80% capacity. The backlog increases by 2,000 per month. 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 the UHB.
Funding has been secured for the additional 4.5 WTE clinical coders and 2 WTE clerking staff, appointments are to be made in August 2020 with a structured training plan in place to ensure compliance with the target within 18 months.

**Rationale for TARGET Risk Score:**

Our current percentage compliance for Apr20 was 87.2%, which is below the required target of 95% of episodes clinical coded within 1 month post discharge. Following the additional resources made available by the Health Board the following posts are due to be advertised:
- 4.5 Senior Clinical Coders (Band 4)
- 2.5 Clinical Coding Clerks

Alongside this further work will be undertaken with Betsi Cadwaladr Health Board and Capita to ascertain the ability to automate some high volume cases, to reduce the pressure upon the clinical coding team.
The requirement for additional resources should also be considered against the aging workforce with 5 staff have indicated that the will be retiring within the next 2-3 years, and the fact that it takes 18 months to train a clinical coder. Therefore the Health Board will not see significant improvements instantly.

| **Key CONTROLS Currently in Place:**<br>(The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are | **How and when the Gap in control be addressed**<br>Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| # 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.<br># 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.<br># Overtime is being implemented to address some of the short fall in the completeness factor.<br># Reminders to end users of coded information that completeness levels does not meet national targets.<br># Notes are moved across the Health Board to support the teams that have less than required resources.<br># 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. | Resourcing the clinical coding team, to take account of underlying growth<br><br>A revised workforce plan for the succession planning for the department | 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. |

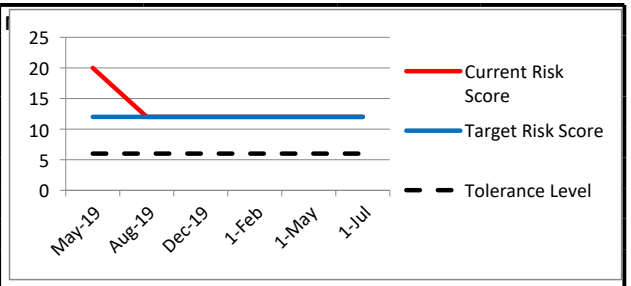
| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Number of episodes coded<br><br>Number of episodes outstanding<br><br>95% of episodes coded within 1 month of discharge<br><br>98% of episodes coded in a rolling 12 months | Department monitoring of KPIs | 1st | | | Information Governance Sub-Committee Jul18, Sep18, Nov18, Feb19, Apr19, May19, Jul19, Sep19<br><br>WAO Clinical Coding Follow-up Update - ARAC - Apr20 | None identified | | | | |
| | IGSC monitoring of Clinical Coding Targets | 2nd | | | | | | | | |
| | WAO Follow-up Report on Clinical Coding - Apr19 | 3rd | | | | | | | | |

| | |
|---|---|
| **Strategic Objective:** | *To be confirmed* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Miles, Karen | **Date of Review:** | Aug-20 |
| **Lead Committee:** | People, Planning & Performance Assurance Committee | **Date of Next Review:** | Oct-20 |

| | | | |
|---|---|---|---|
| **Risk ID:** | **451** | **Principal Risk Description:** | There is a risk the Health Board experiencing a cyber security breach. This is caused by a lack of defined patch management policy, lack of management on non-ICT managed equipment on network, end of life equipment no longer receiving security patching from the software vendor, lack of software tools to identify software vulnerabilities and staff awareness of cyber threats/entry points. This could lead to an impact/affect on a disruption in service to our users cause by the flooding of our networks of virus traffic, loss of access to data caused by virus activity and damage to server operating systems. |
| **Does this risk link to any Directorate (operational) risks?** | 451, 356 | | |

| | |
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Service/Business interruption/disruption |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 3×4=12 |
| **Target Risk Score (L x I):** | 3×4=12 |
| **30/05/19 - Board 'Accept' Target Risk Score** | |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

There are daily threats to systems which are managed by NWIS and UHB. Current patching levels within the UHB of is on average 91% for desktop/laptops and 88% for the server infrastructure (Apr20). The patching levels fluctuate during the month depending on the number of updates released by the 3rd party vendor. Alongside the fluctuations there is lack of capacity to undertake this continuous work at the pace required. Impact score is 4 as a cyber-attack has the potential to severely disrupt service provision across all sites for a significant amount of time, however the processes and controls in place have reduced the likelihood due to the improvements in patching.

**Rationale for TARGET Risk Score:**

Increased patching levels will help to reduce to impact of disruption from a cyber threat. However this work is continuous and is dependent on obtaining the appropriate level of resources to undertake the patching anti-virus work at pace. The target risk score of 12 reflects the wider risk to other applications not Microsoft. The Board have accepted that there is an inherent cyber risk to the organisation, and have therefore accepted that the risk cannot be reduced lower than 12.

| **Key CONTROLS Currently in Place:**<br>(The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are | **How and when the Gap in control be addressed**<br>Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Controls have been identified as part of the national Cyber Security Task & Finish Group.<br><br>Continued rollout of the patches supplied by third party companies, such as Microsoft, Citrix, etc.<br><br>£1.4m national investment in national software to improve robustness of NWIS.<br><br>Further Task and Finish Group established to review the future patching arrangements within NHS Wales - this will lead future work locally to implement recommendations.<br><br>Capital funding has been made available by WG in 2018/19 to improve cyber security - this will be used to purchase required software/equipment for penetration testing.<br><br>Additional UHB funding. | Lack of comprehensive patching across all systems used in UHB.<br><br>Lack of staffing capacity to undertake continuous patching at pace.<br><br>Lack of dedicated maintenance windows for updating critical clinical systems. | Work with system owners to arrange suitable system down-time or disruption. | Solloway, Paul | Ongoing | Patching policies have been created however little progress has been made due to lack of resources. Service catalogue creation is progressing well and this will be amalgamated with Information Asset Owners group to agree down-time for the key local systems. However patching KPI's will not be met until sufficient technical resources are in place. |
| | | Continue to implement the recommendations of the Stratia report | Solloway, Paul | Ongoing | The additional resources will be targeted towards the recommendations |
| | | Implement the national products previously purchased (i.e. Security Information Event Management (SIEM) | Solloway, Paul | Ongoing | The additional resources will be targeted towards the recommendations |
| | | Hire agency staff until such time that a permanent resource can be appointed. | Tracey, Anthony | 31/09/20 | The first round of appointments did not provide suitable candidates so agency staff will be used to provide progression of the recommendations. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| No of cyber incidents.<br><br>Current patching levels in UHB.<br><br>No of maintenance windows agreed with system owners.<br><br>Removal of legacy equipment. | Department monitoring of KPIs | 1st | | | External Security Assessment - IGSC - Jul 18<br><br>Update on WAO IT follow-up - ARAC - Oct19 | National accreditation. | Progress the attainment of certificates and assurances as outlined by the National Cyber Security Centre (NCSC) | Tracey, Anthony | Ongoing | Regular reports on progress on External assessment to IGSC |
| | IGSC monitoring of cyber security workplan addressing recent internal and external audits/assessments | 2nd | | | | | | | | |
| | IGSC monitoring of National External Security Assessment | 2nd | | | | | | | | |
| | Follow-up Information Backup, Disaster Recovery & Business Continuity and Data Quality: Update on Progress | 3rd | | | | | | | | |
| | NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB) Oct17 | 3rd | | | | | | | | |
| | WAO IT risk assessment (part of Structured Assessment 2018 | 3rd | | | | | | | | |
| | Internal Audit IM&T Security Policy & Procedures Follow-Up - Reasonable Assurance | 3rd | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| IM&T Assurance - Follow Up - Reasonable Assurance - May20 | 3rd | | | | | | | |
| Cyber Security (Stratia Report) - Reasonable Assurance - Feb20 | 3rd | | | | | | | |

| | |
|---|---|
| **Strategic Objective:** | *To be confirmed* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Carruthers, Andrew | **Date of Review:** | Aug-20 |
| **Lead Committee:** | People, Planning & Performance Assurance Committee | **Date of Next Review:** | Sep-20 |

| | | | |
|---|---|---|---|
| **Risk ID:** | **891** | **Principal Risk Description:** | There is a risk patients will stay longer in hospital and increased risk of HAI as they cannot be discharged in a timely manner. This is caused by a range of health and social care related reasons including transfers to other provision, a variety of assessments and capacity within the external domiciliary, residential and nursing care market. This could lead to an impact/affect on the delivery of the Q2 Operating Plan as the front door being blocked, cancelled operations and use of surge areas which cannot be appropriately staffed. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

| | | |
|---|---|---|
| **Risk Rating:(Likelihood x Impact)** | | **No trend information available.** |
| **Domain:** | Quality/Complaints/Audit | |
| **Inherent Risk Score (L x I):** | 5×4=20 | |
| **Current Risk Score (L x I):** | 3×4=12 | |
| **Target Risk Score (L x I):** | 2×4=8 | |
| **Tolerable Risk:** | 8 | |
| **Trend:** | *New* | |

| **Rationale for CURRENT Risk Score:** |
|---|
| Currently there is good flow through the hospitals and no significant issues relating to hospital transfers, assessments and care capacity. However, the reintroduction of more planned admissions in the hospitals could lead to higher demand and pressure across the system. |

| **Rationale for TARGET Risk Score:** |
|---|
| The risk can never be eliminated and is to a large extent dominated by staffing and market pressures. Therefore a risk score of 8 would be a tolerable level to ensure effective flow through the acute sites into community. |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Operational Command calls are in place in all three Counties which provide early warning to all stakeholders within the County unscheduled care system (including Local Authority).<br><br>Stakeholders work together on daily basis to resolve challenges relating to care availability and hence manage the risk where able.<br><br>Each County and hospital site have joint discharge resource and arrangements providing a daily focus on expediting transfers out of acute hospital.<br><br>Each County system has an escalation process in place which reviews 'stranded' patients at senior level to expedite transfers out of acute hospital.<br><br>Each County system manages their caseload of patients with complex | Disproportionate demand and a high reliance for care and support on discharge<br><br>Deconditioning in hospital creating greater demand on a finite long term care (social and nursing care) resource.<br><br>Unrealistic expectations of patients, families and carers in relation to care and support<br><br>Inconsistent approach to implementation of Red2Green and SAFER patient bundles | Robust implementation of the Hospital Discharge Requirements across the whole system (includes Local Authority Partners) | Dawson, Rhian | 30/09/2020 | Work under development. |
| | | Work with Regional partners to scope current baseline and assess position against discharge requirements, intermediate care principles and standards (includes right sizing services) and associated integrated outcomes framework and what 'good' should look like - use this to refine our controls in Q3 | Dawson, Rhian | 31/08/2020 | Work under development. |

| | | | | |
|---|---|---|---|---|
| needs daily through 'SharePoint'.<br><br>Community highlights pressures in each County System daily on the 10am Acute Hospital Escalating Pressures call. | Suboptimal implementation of Hospital discharge standards | Review of current unscheduled care performance and improvement governance structure and introduction of forum to ensure accountability for delivery and improvement | Carruthers, Andrew | 31/08/2020 | Work under development. |
| | | Each County System to review current baseline and implement improvement plan. | Dawson, Rhian | 31/08/2020 | Work underway. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) |
|---|---|---|---|---|---|
| **Performance Indicators** | **Sources of ASSURANCE** | **Type of Assurance (1st, 2nd, 3rd)** | **Required Assurance / Current Level** | | |
| Performance Indicators for Tier one targets<br><br>A suite of unscheduled care metrics have been developed to measure the system performance which includes demand and flow across primary care and community | Medically optimised and ready to transfer patients are reported 3 times daily on situation reports (1st line, | 1st | | | N/A |
| | | | | | |
| | County daily reporting of risk and escalation levels of community health and social care provision (1st line, | 1st | | | |
| | Delayed discharges reported to WG (1st line, | 1st | | | |
| | Community Bronze Group monitors regularly 2nd line, | | | | |

| Gaps in ASSURANCES | | | | |
|---|---|---|---|---|
| **Identified Gaps in Assurance:** | **How are the Gaps in ASSURANCE will be addressed<br>Further action necessary to address the gaps** | **By Who** | **By When** | **Progress** |
| Whole System Outcomes Framework and associated performance measures<br><br>Regional Forum for stakeholders to consider current position across whole system of unscheduled care and accountable for implementing improvements | Develop Outcomes Framework and submit for approval to Tactical Health and Social Care Group (IEG) | Carruthers, Andrew | 31/08/2020 | Approval of Outcomes Framework pending 3rd August 2020. |
| | Agreement of Regional Unscheduled Care Forum being considered at IEG | Paterson, Jill | 30/09/2020 | Discussions underway. |
| | Informatics department developing automated reporting for the Outcomes Framework | Tracey, Anthony | 30/09/2020 | Work underway. |
| | | | | |
| | | | | |

| | |
|---|---|
| **Strategic Objective:** | *To be confirmed* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Carruthers, Andrew | **Date of Review:** | Jul-20 |
| **Lead Committee:** | People, Planning & Performance Assurance Committee | **Date of Next Review:** | Sep-20 |

| | | | |
|---|---|---|---|
| **Risk ID:** | **892** | **Principal Risk Description:** | There is a risk that patients will come to harm from reduced NHS services. This is caused by deficit 314.26 WTE nursing vacancies across Acute Hospital Services. This could lead to an impact/affect on the significant reduction in the range of services that can be provided and the ability to open surge capacity. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

| | | |
|---|---|---|
| **Risk Rating:(Likelihood x Impact)** | | **No trend information available.** |
| **Domain:** | Safety - Patient, Staff or Public | |
| **Inherent Risk Score (L x I):** | 4×4=16 | |
| **Current Risk Score (L x I):** | 3×4=12 | |
| **Target Risk Score (L x I):** | 2×4=8 | |
| **Tolerable Risk:** | 6 | |
| **Trend:** | *New risk* | |

**Rationale for CURRENT Risk Score:**

The Health Board's inability to recruit sufficient Registered Nurses to fill all existing vacancies due to a national shortage of qualified nurses.

**Rationale for TARGET Risk Score:**

â— There are key controls in place to mitigate risk of harm to patients and maintain RN staffing levels to deliver services within the Health Board.
â— The Health Board has in place a structured workforce planning framework for Registered Nurse Recruitment.

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| * Daily staffing review which takes into account patient acuity and dependency.<br>* Review of Staffing across all wards to move staff to cover deficits if possible.<br>* Use of Substantive Registered Nurses working extra hours and overtime.<br>* Temporary replacement via Bank and agency to back fill vacant shifts.<br>* Block booking of RNs via on contract agencies<br>* Service Level Agreement (SLA) with on contract agencies for Partnership Nurses Initiative at BGH.<br>* Bank and Agency pool pilot at WGH.<br>* Escalation to premium agency on basis of Risk Assessments.<br>* Baseline nursing establishments are calculated on the principles of | • Potential risk of lack of available RN supply via Bank and Agency.<br><br>• Substantive contract in post staff unable to work extra hours.<br><br>• Poor response to Health Board Recruitment Campaign. | Forward planning of cover for existing RN vacancies 6 weeks in advance through block booking of bank and agency utilising the electronic rostering system | Cotterell, Mrs Carol | Completed | Successful RN block booking contracts across all hospital sites and Successful SLA on Agency Partnership Nurses in BGH. |
| | | Daily Review of RN Staffing across all Ward/Departments using flexible movement of staff with appropriate skills across areas. | Cotterell, Mrs Carol | 15/07/2020 | Continuous Practice. |

| | | | | |
|---|---|---|---|---|
| decision making outlined in the Nurse Staffing Level (Wales) Act and are reviewed 6 monthly by Director of Nursing Midwifery and Patient Experience.<br>* Active Workforce and OD Planning Framework for Nurse Recruitment<br>* Implementation of a) Hospital site based Recruitment Fayres; and b)"Grow your own Initiative" - HCSWs trained to Level 4 accessing shortened RN Training programmes<br>* Salary paid incentives to HCSWs undertaking RN training courses and returning to work in the Health Board following qualification.<br>* Workforce and OD Strategic Workforce Planning Framework in place<br>* Workforce and OD RN Recruitment Strategy in place.<br>* Development of HCSW Expanded role Band 3/4 in place.<br>* Forward Planning of vacancy coverage though Electronic R roster system with direct interface to nurse bank supply in place<br>* Contractual arrangements for block booking of RNs through on contract agencies - continuous practice.<br>* Trial of Bank pool system in operation on one hospital site<br>* Flexible use of substantive contract staff to work additional hours or overtime. | | Development of "Grow your own" initiative with access to shortened RN training courses, working with Workforce & OD Team/Assistant Director Operational Nursing & Quality -Acute Services / Heads of Nursing. | Cotterell, Mrs Carol | Completed | Effective recruitment of Newly Registered Nurses from UWS cohort March/September 2019/2020. Continuous Practice. Grow your own initiative in place. |
| | | Development of HCSW roles expanded skills and scope of practice to Band 3/4. | Cotterell, Mrs Carol | Completed | Increasing numbers of HCSWs accessing shortened RN Training courses. HCSW Role Development to Band 4 in place. |

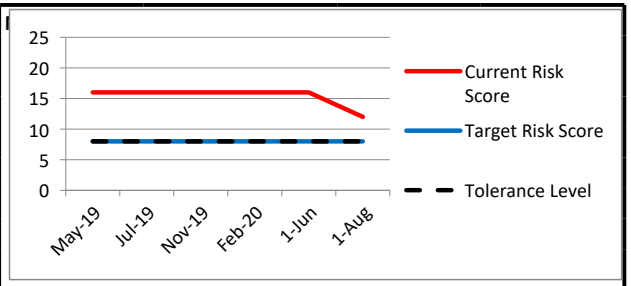
| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| | Nurse Staffing Level (Wales) Act 2016: 6 monthly review and sign off of Nurse Staffing Levels by Director of Nursing Midwifery and Patient Experience (1st line, | 1st | | | | None | | | | |
| | Workforce Cell within Command Structure (2nd line, | 2nd | | | | | | | | |

| | |
|---|---|
| **Strategic Objective:** | *To be confirmed* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Carruthers, Andrew | **Date of Review:** | Aug-20 |
| **Lead Committee:** | People, Planning & Performance Assurance Committee | **Date of Next Review:** | Oct-20 |

| | | | |
|---|---|---|---|
| **Risk ID:** | **291** | **Principal Risk Description:** | There is a risk patients having poorer outcomes and increased mortality due to the lack of access to mechanical clot retrieval services (thrombectomy). This is caused by thrombectomy services being withdrawn by Cardiff and Vale Health Board due to a lack of interventional neuroradiologists. This could lead to an impact/affect on increased mortality rates, increased dependency of patients and an inability to access a National Institute for Health and Care Excellence (NICE) approved intervention within 5 hours of onset of stroke symptoms. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

| | |
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Quality/Complaints/Audit |
| **Inherent Risk Score (L x I):** | 4×4=16 |
| **Current Risk Score (L x I):** | 3×4=12 |
| **Target Risk Score (L x I):** | 2×4=8 |
| **Tolerable Risk:** | 8 |
| **Trend:** | |




**Rationale for CURRENT Risk Score:**

Mechanical intervention for Stroke is available at North Bristol NHS Trust (NBT) (and Walton Centre NHS Foundation Trust for Bronglais Hospital). However this service is only available Mon to Fri 9-5pm therefore there is still a risk during out of hours. During the COVID -19 situation there has been no significant changes to the pathway. All 4 sites have been able to transfer patients when required.
Some HDUHB sites still have delays in 24/7 CT Angiography. All 4 sites have Mon-Sun 9-5 CT angiography. There is a plan for Bristol to be available from Sep20 to be 9-5, 7 day a week service.

**Rationale for TARGET Risk Score:**

The uncertainty surrounding the changes proposed in the Transforming Clinical Services programme have a significant impact upon the development of acute and hyper acute services within the UHB. Thrombectomy services continue to be sought and escalated with English Neuroscience units until the Cardiff and Vale service is reinstated and the instigation of a WHSSC commissioned service with North Bristol NHS Trust.

Mechanical intervention for Stroke is now available at Bristol (and Walton for Bronglais. However this service is only available 9am to 5pm (at Bristol) Mon to Fri. The risk for out of hours would stay the same.

| **Key CONTROLS Currently in Place:**<br>(The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are | **How and when the Gap in control be addressed**<br>Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| WHSSC have commissioned a service in North Bristol.<br>Below is a link for the thrombectomy pathway with Bristol.<br>It has the referral criteria and pathway.<br>They are developing an imaging pathway as well.<br>https://www.nbt.nhs.uk/clinicians/services-referral/stroke-service-clinicians/stroke-thrombectomy-service-clinicians.<br>New all wales Thrombectomy group have been set up to discuss issues and to finalise pathway. A HDUHB Thrombectomy group to be established (to be arranged).<br>There is a plan for Bristol to be available from Sep20 to be 9-5, 7 day a week service. | Timely investigations that are required to support transfers for thrombectomy not supported 24/7 on all sites.<br><br>Work is ongoing to ensure that CT Angiography is available in all Hywel Dda units to provide the necessary diagnostic investigations prior to transfer to a specialist neuroscience centre. | Develop and review the Thrombectomy pathway, throughout the Health Board. | Andrews, Bethan | Completed | Review of thrombectomy pathway undertaken, no facility to procure ad hoc services from North Bristol or Stoke. National Stroke Implementation Group have worked with WHSSC to commission an all Wales Thrombectomy service with North Bristol NHS Trust for Welsh patients.<br><br>North Bristol Trust has issued a Thrombectomy check list and referral document. Pathway for referral is being worked on by clinicians who have been involved with WHSSC regarding setting up service with Bristol. However we are still waiting for full guidance. |
| | | Development of pathway and protocols for the referral of stroke patients within each of the Hywel Dda Acute Hospitals to suitable neuroscience in England. | Mansfield, Simon | Completed | Briefing paper and protocols developed for the direct commissioning of ad hoc thrombectomy services from English Neuroscience units. |
| | | Negotiate short-term commissioning arrangements with neuroscience units. | Teape, Joe (Inactive User) | Completed | Completed - however unable to secure new commissioning arrangements whilst WHSSC work to commission all Wales service |
| | | Work with WHSSC to ensure all Wales thrombectomy service is commissioned. | Teape, Joe (Inactive User) | Completed | A service is now available from Bristol 9 to 5 Monday to Friday. However no service out of hours, therefore this action stays open. There is a plan for Bristol to be available from Sep20 to be 9-5, 7 day a week service. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Datix incident reports | Daily/weekly/monthly/ monitoring arrangements by management | 1st | | | Thrombectomy Report - ET - Sep17. | | | | | |
| | Executive Performance Reviews | 2nd | | | | | | | | |
| | IPAR Performance Report to BPPAC & Board | 2nd | | | | | | | | |
| | Stroke Delivery Group review of patient cases | 2nd | | | | | | | | |

| | |
|---|---|
| **Strategic Objective:** | *To be confirmed* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Gostling, Lisa | **Date of Review:** | Jul-20 |
| **Lead Committee:** | People, Planning & Performance Assurance Committee | **Date of Next Review:** | Sep-20 |

| | | | |
|---|---|---|---|
| **Risk ID:** | **894** | **Principal Risk Description:** | There is a risk the workforce will be depleted due to large numbers of staff having to work in alternative roles,or shielding, work from home or in non-clinical roles. This is caused by the government guidance in relation to assessing those who are unable to work in patient facing roles or Covid 19 areas due to their underlying medical condition, pregnancy or ethnicity. This could lead to an impact/affect on the HB's ability to provide enough staff to fill our current rota's and inpatient beds along with our ability to surge our capacity into field hospitals if required. |
| **Does this risk link to any Directorate (operational) risks?** | 875 | | |

| | |
|---|---|
| **Risk Rating:(Likelihood x Impact)** | **No trend information available.** |
| **Domain:** | Safety - Patient, Staff or Public |
| **Inherent Risk Score (L x I):** | 4×4=16 |
| **Current Risk Score (L x I):** | 3×4=12 |
| **Target Risk Score (L x I):** | 2×4=8 |
| **Tolerable Risk:** | 6 |
| **Trend:** | *New risk* |

| **Rationale for CURRENT Risk Score:** |
|---|
| Due to the Covid 19 pandemic there is a risk that staff within the BAME categories in particular will be at greater risk. This will result in the possibility of not enough staff available to cover staff rota's. |

| **Rationale for TARGET Risk Score:** |
|---|
| Due to the Covid 19 pandemic there is a risk that staff within the BAME categories in particular will be at greater risk. This will result in the possibility of not enough staff available to cover staff rota's |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Risk assessments for those in vulnerable category being undertaken and managers required to review these at regular intervals.<br><br>Home-working options, telemedicine and staff deployment options are available.<br><br>FAQs developed and updated so staff and managers are made aware of what is required.<br><br>15/07/2020 Further information and guidance disseminated by global | Process for offer of PPE to be developed and implemented by Nursing Directorate. | Ensure the risk assessment process is disseminated to all managers. | Morgan, Steve | Completed | All managers to undertake this action. Line Managers have been requested to review risk assessments previously undertaken in light of the revised guidance. |
| | | Ensure reviewed governance guidance is communicated and FAQs updated. | Morgan, Steve | Completed | The FAQ's have been updated to reflect the revised approach to risk assessment. |

| | | | | |
|---|---|---|---|---|
| 15/07/2020 Further information and guidance disseminated by global link and available on the HB Intranet page. | | Workforce contacting managers with staff in the BAME group to ensure that appropriate risk assessments are being undertaken for this staff group. | Morgan, Steve | Completed | The Workforce action has been completed - All Line Managers of BAME staff have been asked to encourage individuals to complete the risk assessment documentation. It is the respective Line Managers that will need to progress this action. |
| | | Process for offer of PPE to be developed and implemented by Nursing Directorate. | Gostling, Lisa | ~~30/06/2020~~ 30/09/2020 | Director of Service to advise Nursing Directorate. |

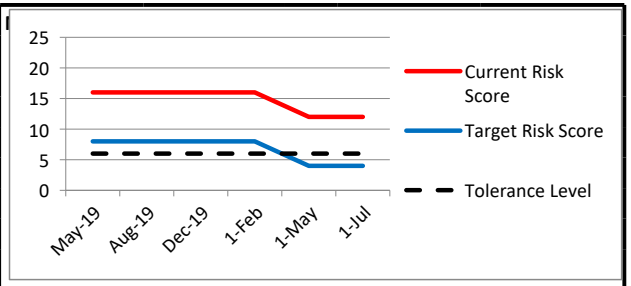
| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Monitoring no's/% of Risk Assessments completed and BAME staff in work. | Workforce Senior Team meetings review and discuss the monitoring process. | | | | | None identified. | | | | |
| | Bronze Workforce Group reviews effectiveness of WPF??? | | | | | | | | | |
| | PPPAC receives assurance of delivery of Q2 plan and associated risks?? | | | | | | | | | |

| | |
|---|---|
| **Strategic Objective:** | *To be confirmed* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Carruthers, Andrew | **Date of Review:** | Jul-20 |
| **Lead Committee:** | People, Planning & Performance Assurance Committee | **Date of Next Review:** | Sep-20 |

| | | | |
|---|---|---|---|
| **Risk ID:** | **632** | **Principal Risk Description:** | There is a risk the UHB not being able to fully comply the WG Eye Care Measures (ECMs). This is caused by a lack of identified on-going funding to support Community Optometrists to undertake enhance referrals and also the capacity within the Hospital Eye Service to support progress with the ECM Plan due to on-going recruitment challenges.<br>This could lead to an impact/affect on delivery of the Ophthalmology RTT plan, lead to delays in the treatment and care of patients, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from WG. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

| | |
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Safety - Patient, Staff or Public |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 3×4=12 |
| **Target Risk Score (L x I):** | 2×2=4 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

The response to COVID-19 has resulted in the prioritisation of urgent treatment whereby the Ophthalmology Service is providing treatment for sight threatening conditions only (risk factor 1 (R1)). This has seen a reduction in the number of overall patients waiting for treatment (Feb20 - 18716, Mar20 - 18334, Apr - 16756, May20 - 16083) and the overall cohort number for R1's is also reducing (Feb20 - 13671, Mar20 - 13170, Apr20 - 11660, May20 - 11261) as the clinicians have been triaging all patients, those who have been waiting over 25% of their target date have been offered an appointment first through clinical prioritisation.

**Rationale for TARGET Risk Score:**

Should the current position with COVID-19 continue for a prolonged period of time then the service would be in a much improved position to comply with the ECM, namely the compliance against R1.

| Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk) | Gaps in CONTROLS | | | | |
|---|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| # Eye Care Action Plan in place.<br># Ophthalmology RTT delivery plan in place.<br># Eye Care Collaborative Group established and meet quarterly to oversee performance against eye care standards.<br># ECM Coordinators recruited.<br># WG Monitoring information from W-PAS 18.1.Standards is now functional and information is being submitted.<br># Primary Care Communications campaign to include a short video to increase awareness on the range of services Community Optometrists can offer.<br># Direct communication sent to all patients on a new or follow up waiting list informing them of new Eye Care Measures.<br># Identification of sustainable funding solutions from Apr20 onwards. This is being considered as part of the UHB's developing 3 Year Plan and the resource implications of this have been highlighted.<br>COVID ACTIONS<br># The service have maintained treatment/review for imminently sight threatening conditions (Health Risk Factor 1)<br># The clinical team will continue to see all ages of patients in the IVT service including Wet AMD, DMO & RVO.<br># Primary Care Optometric Support:<br>- From 20th April 2020 Optometrists with medical retina qualification to support IVT clinics, including but not limited to assessment and treatment of sight threatening AMD.<br>- 4 optometric practices/day across HDUHB to offer acute eye care support, ensuing that only those eye conditions which require surgery or laser treatment are referred on to the hospital eye service.<br><br># In order to continue with ophthalmology services for emergencies and | Lack of 3 year balanced plan for ophthalmology.<br><br>Lack of ongoing funding post COVID to utilise primary care to meet eye care standards.<br><br>Delay in go-live of IT systems to support shared care / remote delivery of evaluations away from acute sites.<br><br>Agreement of clinical pathways with professional bodies for use during COVID-19.<br><br>Lack of Glaucoma Consultant in Hywel Dda. | Identify funding sources to support primary care. | Hire, Stephanie | ~~31/05/2019~~<br>~~31/10/2019~~<br>~~31/03/2020~~<br>~~30/06/2020~~<br>~~31/07/2020~~<br>31/08/2020 | Welsh Government have provided project funding, however, there will be the requirement to identify sustainable funding to continue the use of this scheme beyond Mar20. Funding requirement has been identified as part of the 3 year plan that has been developed. Due to COVID, temporary funding has been identified to support Community Optometrists to undertake duties alongside Ophthalmologists in AMD clinics. Discussion ongoing regarding OPD Transformation Funding. |
| | | Negotiating Welsh Government guidelines on Ophthalmology with Clinical Team. | Buckingham, Carly | ~~30/06/2020~~<br>~~31/07/2020~~<br>31/08/2020 | Clinical Team requested to work with Swansea Bay UHB Consultants to develop clear clinical guidelines on delivery of Ophthalmology services. The clinical body in Hywel Dda and Swansea Bay have been asked to write a plan of how we would deliver services by end of May20. Working with Optometric Advisor to develop shared care models as appropriate. |

| | | | | |
|---|---|---|---|---|
| urgent follow up patients, the UHB has temporarily commissioned eye casualty service and urgent follow-up clinic from BMI Werndale:<br># The On Call rota will continuing to be maintained from The Blue Suite, Outpatients Department, GGH.<br><br>During Q.1 of COVID:<br>• All Emergency and Urgent OPD work continued Monday - Friday 9a.m. - 5p.m. in BMI Werndale<br>• AMD continued in Crymych, Aberaeron Integrated Care Centre and Amman Valley Hospital. There has been an increased capacity at AVH during COVID and all interventional treatment has been on time.<br>• Consultants prioritised all cases and continued to treat VR patients.<br>• The response to COVID had let the services to explore and develop alternative ways of working. This has included training Optometrists to work collaboratively with the Hospital Eye Service.<br>• There have been opportunities to explore the use of telemedicine and build links with community IT structures to develop new practices.<br>• In addition to the Acute Eye Service response the Community response involved closing all practices apart from 13, which stayed open for emergency eye care only.<br>• A dedicated phone line, supported by the Low Vision Screening Wales Team opened to direct patients to services.<br>• 4 prescribing hubs set up across the Health Board were successful in reducing the number of patients requiring Hospital Eye Services.<br>• Of the 400 patients who accessed the hubs, the independent prescribers managed 88% within the hubs. A paper had now been developed to provide this service on a cluster basis across the Health Board. | | Named Glaucoma Consultant to be responsible for the Glaucoma cohort of patients in Hywel Dda. | Buckingham, Carly | ~~30/06/2020~~<br>~~31/07/2020~~<br>31/08/2020 | Hywel Dda and Swansea Bay Clinical Team have been asked to develop a service design for a Regional Glaucoma. Discussions with Swansea Bay on Regional model to mitigate risk has been requested by end of May20. Regional workshop arranged for Jul20 and scoping being undertaken by management teams in SB & HDUHB. Initial ARCH workshop held 24/07/2020 where actions agreed. Meeting w/c 3/08/2020 to discuss further progress. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Reduction in number of follow-ups.<br><br>Reduction in the number of patients, assessed as health risk factor 1, waiting outside of target date.<br><br>Delivery of zero 36 week RTT breaches.<br><br>Reduction in the number of Serious Incidents relating to Hospital Eye Services. | Monitoring arrangements by management | 1st | | | * EC Collaborative Group Meeting Aug19<br><br>* QSEAC SBAR Nov19<br><br>* BPPAC SBAR Dec19<br><br>* IPAR Mth 11 - Board Mar20 | Lack of All Wales Electronic Patient Record for Ophthalmology. | Root and branch review of operational, workforce and financial plans and sustainability models. | Buckingham, Carly | ~~31/10/2019~~ ~~31/01/2020~~ ~~31/03/2020~~ ~~30/06/2020~~ ~~31/07/2020~~ 31/08/2020 | Discussions commenced with Swansea Bay to deliver a regional Ophthalmology service for the South West Wales Region. ARCH have confirmed support with this work-stream. Paediatric Ophthalmology confirmed as the first sub-speciality to undergo a regional discussion for joint working. Regional workshop arranged for Jul20. Initial ARCH workshop held 24/07/2020 where actions agreed. Meeting w/c 3/08/2020 to discuss further progress. |
| | Executive Performance Reviews (currently suspended due to COVID) | 2nd | | | | | Roll out and implementation of National Electronic Patient Record for Ophthalmology | Tracey, Anthony | 13/07/2020 | This will depend on the All Wales Implementation Group and All Wales Procurement process. First Minister has just signed off Full Business Case for OpenEyes software on a 'once for Wales' procurement programme - 6 - 8 week turnaround. |
| | IPAR Performance Report to PPPAC & Board | 2nd | | | | | | | | |
| | Monthly oversight by WG | 3rd | | | | | | | | |

| | |
|---|---|
| **Strategic Objective:** | *To be confirmed* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Rayani, Mandy | **Date of Review:** | Aug-20 |
| **Lead Committee:** | People, Planning & Performance Assurance Committee | **Date of Next Review:** | Oct-20 |

| | | | |
|---|---|---|---|
| **Risk ID:** | **893** | **Principal Risk Description:** | There is a risk that patients will come to harm from reduced NHS services. This is caused by significant increase in estate requirements due to social distancing and requirements needed to ensure safe services. This could lead to an impact/affect on on the delivery of the Q2 Delivery Plan from a significant reduction in the range of pre-COVID services that can be re-established and a reduction of 44 beds going into the winter period. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

| | | |
|---|---|---|
| **Risk Rating:(Likelihood x Impact)** | | **No trend information available.** |
| **Domain:** | Safety - Patient, Staff or Public | |
| **Inherent Risk Score (L x I):** | 4×5=20 | |
| **Current Risk Score (L x I):** | 2×5=10 | |
| **Target Risk Score (L x I):** | 1×5=5 | |
| | | |
| **Tolerable Risk:** | 6 | |
| **Trend:** | *New* | |

**Rationale for CURRENT Risk Score:**

All areas in process of being risk assessed to allow services to be re-introduced in line with current social distancing guidelines. Staff need to be able to work safely in the workplace to allow facilitating reintroduction of patients to our services. For staffing reception areas, these are being prioritised by risk and protected by either physical controls or PPE (highest priority areas completed). For ward areas, reviews ongoing to maximise inpatient capacity through introduction of control measures such as physical barriers between patients. Where this is not possible, spacing will need to be increased to meet UK guidance. Patients not receiving essential NHS care could result in death in certain cases, perhaps more so in individuals that require to attend our sites, hence impact score of 5.Although social distancing risk assessments have been conducted for many areas, until all areas have suitable and sufficient control measures in place the likelihood would need to remain 'possible'

**Rationale for TARGET Risk Score:**

The TARGET score focuses on reducing the likelihood of an incident as the impact score would remain at 5 (as outlined under CURRENT score). By introducing effective social distancing measures such as screening in high priority areas and alternative solutions in other areas, such as PPE, staff would be able to man more areas thus allowing services to resume as far as reasonably practicable. In terms of inpatient bed space, by reviewing all ward spaces and field hospitals against current guidelines and introducing either physical barriers or increasing spaces, as many services as possible will be able to return , however, there will always be some impact on services whilst control measures stay in place, therefore the likelihood descriptor would be reduced to 'unlikely'.

| **Key CONTROLS Currently in Place:**<br>(The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are | **How and when the Gap in control be addressed**<br>Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| • A review of all ward areas for 2m space isolation is complete in GGH and ongoing elsewhere. Where 2m isolation cannot be achieved, dividing partitions may be a satisfactory solution to ensure that areas are clinically safe and social distancing / space isolation is enabled.<br>• Once requirements are agreed by the Site Management Teams, the Estates Department will be costing solutions based on the above requirements.<br>• In terms of staffing reception areas to facilitate the resuming of services, these are being prioritised by risk and protected by either physical controls such as screening or by utilising suitable PPE.<br>• The Estates Department are costing solutions based on the above requirements.<br>• 2m space isolation not being met currently in certain areas. | Reviews are ongoing at the present time by both the Site Management Teams and Estates Departments to design, prioritise and cost required works in order to introduce adequate social distancing measures whilst minimising the impact on patient services. | Completion of bed reviews on all sites in line with social distancing guidelines and identification of suitable control measures to minimise patient impact. To include field hospitals and community. | Rees, Gareth | 31/08/2020 | GGH Complete. Commence on site 17/08/20. Completion of Works 01/09/20. |
| | | Discretionary Projects Team to develop costings for all measures identified by site management in the above action. | Annison, Maggie | 31/08/2020 | GGH Complete - STA created by Hospital Head of Nursing based on costings provided. |
| | | Undertake installation works of physical bed management social distancing measures outlined above i.e. screening etc. once funded. | Williams, Heather | 31/12/2020 | GGH to be completed 01/09/20. WGH, PPH submitted numbers required. Completing Single Tender documentation. |
| | | Undertake a social distancing requirement assessment of all receptions and switchboards that are key to the re-introduction of services | Williams, Heather | Completed | Nearing completion. To be reviewed alongside the H&S review (below) and prioritised via a risk based approach. |
| | | Independently review the (above) social distancing requirement assessment. | Harrison, Tim | Completed | Complete. Independent review undertaken of all acute receptions and community sites. |
| | | Undertake installation works of Priority 1 physical social distancing measures. | Williams, Heather | 31/08/2020 | Started on all sites. Priority 1 locations due to complete by 31/08/20. |
| | | Undertake installation works of Priority 2 physical social distancing measures. | Williams, Heather | 30/09/2020 | Priority 2 areas are currently being costed with target completion date of 30/09/20 |

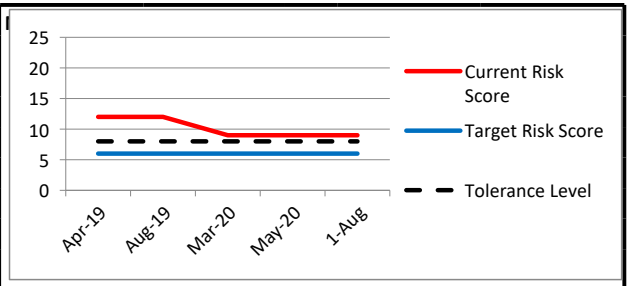
| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| | Oversight is provided by the weekly Social Distancing Cell, Chaired by Director of NQPE (1st line, | 1st | | | N/A yet. | None identified. | | | | |

| | |
|---|---|
| **Strategic Objective:** | *To be confirmed* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Carruthers, Andrew | **Date of Review:** | Aug-20 |
| **Lead Committee:** | People, Planning & Performance Assurance Committee | **Date of Next Review:** | Oct-20 |

| | | | |
|---|---|---|---|
| **Risk ID:** | **633** | **Principal Risk Description:** | There is a risk of the UHB not being able to meet the 1% improvement target per month for waiting times for 2020/21 for the new Single Cancer Pathway (SCP Performance targets tbc by WG and implementation is likely to be brought forward as a result of COVID-19). This is caused by the lack of capacity to meet expected increase in demand for diagnostics and treatment delays at tertiary centre. This could lead to an impact/affect on meeting patient expectations in regard to timely access for appropriate treatment, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from WG. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

| | |
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Quality/Complaints/Audit |
| **Inherent Risk Score (L x I):** | 4×4=16 |
| **Current Risk Score (L x I):** | 3×3=9 |
| **Target Risk Score (L x I):** | 3×2=6 |
| **Tolerable Risk:** | 8 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

The impact of COVID-19 may increase the risk of being unable to meet the target due to recommendations from the Royal Colleges to suspend diagnostics and some surgery that are aerosol generating. During the pandemic, endoscopy was centralised in GGH. Endoscopy services have now been reinstated on all 4 hospital sites, but due to only having 50% of the pre-COVID lists and lists only having 30% of the usual capacity, this may still cause delays to investigations being carried out. High acuity elective cancer surgery with green pathway and green ITU/HDU commenced in PPH & BGH on 6 July 2020 with WGH due to commence surgery on the 10 August 2020. A full COVID-19 Cancer escalation plan is in place and is updated when new guidance is issued.

**Rationale for TARGET Risk Score:**

The aim is to treat patients within target waiting times (which are yet to be confirmed). Some treatments were changed or were suspended during COVID-19. The backlog is now being addressed, and patients are being contacted with regards to dates for their treatment. The tolerance level will be met if the UHB continues to meet the 1% per month improvement trajectory throughout 2020/21.

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Working with all Wales Cancer Network to gain full understanding of implications of new pathway.<br><br>Implementation Group established, reporting to Cancer Board with awareness / engagement sessions held on each hospital site. | Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP - unlikely to be addressed by August 2019 | Demand & capacity assessment work continuing. Solutions will necessitate regional cooperation to address anticipated capacity gaps. | Humphrey, Lisa | ~~31/03/2020~~ 31/03/2021 | Initial planned work with Delivery Unit suspended and will be under constant review in light of COVID and recovery planning phase. |

| | | | | | |
|---|---|---|---|---|---|
| Shadow monitoring in place.<br><br>Further Demand & Capacity exercise planned 2020/21 with support from Delivery Unit.<br><br>New Cancer tracking module in W-PAS now fully operational as of Dec19 with tracking team in place from Dec19 to allow patients to proactively tracked through treatment pathways.<br><br>Routine daily communication feed from ED to cancer information team which helps identify the point of suspicion.<br><br>COVID-19 escalation plan in place.<br><br>Monitoring data of patients whose treatments have changed or suspended (some through patient choice) as a result of COVID-19.<br><br>A 4-week follow up process has been implemented for these.<br>Utilisation the private sector for surgery during COVID-19.<br><br>Joint working with regional colleagues to offer patients on a tertiary pathway surgery locally.<br><br>Resumed aerosol generated diagnostics cross all 4 hospital sites.<br><br>Reinstated high acuity elective Cancer surgery with green pathway and green ITU/HDU has commenced on PPH and BHG sites as of 06/07/2020, and WGH planned from 10/08/20. | Full engagement for all supporting services.<br><br>Performance is lower than USC/NUSC published performance.<br><br>Key diagnostic information systems do not support effective demand / capacity planning.<br><br>Need for new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways. | See above re diagnostic services plus improved systems to support identification of 'date of suspicion'. | Humphrey, Lisa | ~~31/03/2019~~<br>~~31/08/2019~~<br>~~31/07/2020~~<br>31/10/2020 | HB performance compares well with other HBs however below current USC/NUSC performance level. Ongoing work in progress with OPD, Diagnostic & ED teams along with the informatics department to improve real time identification of date of suspicion. Informatics are beginning to pick up routine reporting requests which were on hold due to COVID-19. |
| | | Each MDT to review and adopt recommended optimal tumour site specific pathways | Humphrey, Lisa | ~~31/08/2020~~<br>30/09/2020 | Each MDT is currently assessing implications of published proposed pathways. A Macmillan Cancer Quality Improvement Manager post which was developed to work with the teams with regards to implementing the new pathways is now vacant. Agreement over funding was delayed as a result of COVID-19. The recruitment process has started however there are small delays due to annual leave. |
| | | Explore opportunities for alternative providers to address tertiary centre delays for cancer treatment. | Humphrey, Lisa | Completed | Some arrangements were agreed however these have been suspended due to COVID-19, however COVID has provided opportunities to enable new arrangements to be put in place with regional centres. |

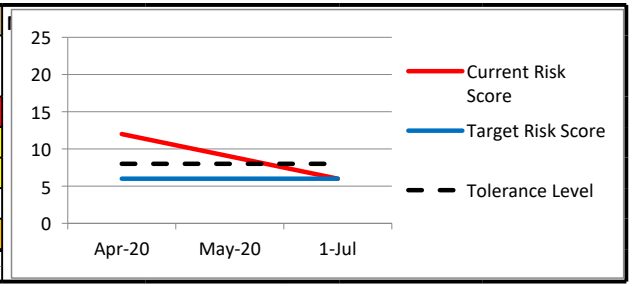
| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Deliverable indicator targets - 1% improvement per month during 2020/21.<br><br>Shadow performance data. | Daily/weekly/monthly/ monitoring arrangements by management | 1st | | | * Implementation of Single Cancer Pathway Report - BPPAC - Feb20<br>* IPAR Report Mth3- Board - Jul20<br>* COVID-19 Impact on Cancer Services - Board - May20<br>* Cancer Updated to QSEAC Jun20 & OpQSESC Jul20 | No gaps identified. | | | | |
| | Executive Performance Reviews (suspended due to COVID-19) | 2nd | | | | | | | | |
| | Service plans in response to COVID-19 overseen and agreed by Bronze Acute & Gold | 2nd | | | | | | | | |
| | IPAR Performance Report to PPPAC & Board | 2nd | | | | | | | | |
| | Monthly oversight by Delivery Unit, WG | 3rd | | | | | | | | |

| | |
|---|---|
| **Strategic Objective:** | *To be confirmed* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Moore, Steve | **Date of Review:** | Jul-20 |
| **Lead Committee:** | People, Planning & Performance Assurance Committee | **Date of Next Review:** | Sep-20 |

| | | | |
|---|---|---|---|
| **Risk ID:** | **854** | **Principal Risk Description:** | There is a risk that UHB's response to COVID-19 proves to be larger than needed for actual demand. This is caused by incorrect modelling assumptions or changes in the progression of the pandemic. This could lead to an impact/affect on abortive costs and possible reputational damage. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

| | |
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Adverse publicity/reputation |
| **Inherent Risk Score (L x I):** | 5×3=15 |
| **Current Risk Score (L x I):** | 2×3=6 |
| **Target Risk Score (L x I):** | 2×3=6 |
| **Tolerable Risk:** | 8 |
| **Trend:** | |




**Rationale for CURRENT Risk Score:**

Likelihood recognises that limits to our ability to grow our bed base reduce the risk of over capacity and our modelling is informing the scale of gap. It also reflects revised planning assumptions for Welsh Government for winter COVID-19 demand which will be close to available Field Hospital capacity.

**Rationale for TARGET Risk Score:**

Planning has been based on current planning assumptions and the Public Health Plan being effective.

| **Key CONTROLS Currently in Place:**<br>(The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed**<br>Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Modelling cell established to provide regular updates on planning numbers, linked into the Welsh Government modelling group and other Health Boards.<br><br>Welsh Government direction to risk over provision rather than under provision will limit reputational damage.<br><br>All developments subject to a business case approach to ensure value for money is considered alongside other issues.<br><br>Board oversight and sign off of decision-making at all levels of the Command Structure.<br><br>Good Communications with Community Health Council, local politicians and Local Authorities.<br><br>Regular media engagement (internal/external).<br><br>Revised Strategic Planning Requirements Directive from Gold to Tactical on 27/04/20 includes field hospitals available as alternative sites.<br><br>WG informed of COVID-19 related costs on regular basis.<br><br>Financial Framework/Business Case approval process in place. | Clarity about COVID-19 funding arrangements. | Explore funding streams at national level, including use of European Social Fund. | Moore, Steve | 9/30/2020 | Work underway |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| None identified. | Response to COVID-19 reviewed through Command and Control Structure | 2nd | | | Responding to the COVID-19 Pandemic - Board - Apr20, May20 & Jun20<br>Finance Report Month M01 - FC - May20<br>Q1 Covid-19 Costs - FC - May20 | Internal and External Audit Plans in 20/21 are being reviewed to incorporate review of organisational response to COVID-19. | | | | |
| | Board oversight of Response to COVID-19 | 2nd | | | | | | | | |
| | Finance Committee (FC) review of COVID-19 costs as part of monthly finance report | 2nd | | | | | | | | |
| | WG support (to date) of UHB response to COVID-19 | 3rd | | | | | | | | |

# RISK SCORING MATRIX

| Likelihood x Impact = Risk Score | | | | | |
|---|---|---|---|---|---|
| **Likelihood** | **1** | **2** | **3** | **4** | **5** |
| **Descriptor** | **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost Certain** |
| **Frequency - How often might it/does it happen?** (how many times will the adverse consequence being assessed actually be realised?) | This will probably never happen/recur (except in very exceptional circumstances). | Do not expect it to happen/recur but it is possible that it may do so. | It might happen or recur occasionally. | It might happen or recur occasionally. | It will undoubtedly happen/recur, possibly frequently. |
| | Not expected to occur for years.* | Expected to occur at least annually.* | Expected to occur at least monthly.* | Expected to occur at least weekly.* | Expected to occur at least daily.* |
| | * time-framed descriptors of frequency | | | | |
| | | | | | |
| **Probability - Will it happen or not?** (what is the chance the adverse consequence will occur in a given reference period?) | **(0-5%*)** | **(5-25%*)** | **(25-75%*)** | **(75-95%*)** | **(>95%*)** |
| | *used to assign a probability score for risks related to time-limited or one off projects or business objectives. | | | | |
| | | | | | |
| **Risk Impact Domains** | **Negligible - 1** | **Minor - 2** | **Moderate - 3** | **Major - 4** | **Catastrophic - 5** |
| **Safety of Patients, Staff or Public** | Minimal injury requiring no/minimal intervention or treatment. | Minor injury or illness, requiring minor intervention. | Moderate injury requiring professional intervention. | Major injury leading to long-term incapacity/disability. | Incident leading to death. |
| | No time off work. | Requiring time off work for >3 days | Requiring time off work for 4-14 days. | Requiring time off work for >14 days. | Multiple permanent injuries or irreversible health effects. |
| | | Increase in length of hospital stay by 1-3 days. | Increase in length of hospital stay by 4-15 days. | Increase in length of hospital stay by >15 days. | An event which impacts on a large number of patients. |
| | | | Agency reportable incident. | Mismanagement of patient care with long-term effects. | |
| | | | An event which impacts on a small number of patients. | | |
| **Quality, Complaints or Audit** | Peripheral element of treatment or service suboptimal. | Overall treatment or service suboptimal. | Treatment or service has significantly reduced effectiveness. | Non-compliance with national standards with significant risk to patients if unresolved. | Totally unacceptable level or quality of treatment/service. |
| | Informal complaint/inquiry. | Formal complaint. | Formal complaint - | Multiple complaints/ independent review. | Gross failure of patient safety if findings not acted on. |
| | | Local resolution. | Escalation. | Low achievement of performance/delivery requirements. | Inquest/ombudsman inquiry. |
| | | Single failure to meet internal standards. | Repeated failure to meet internal standards. | Critical report. | Gross failure to meet national standards/performance requirements. |
| | | Minor implications for patient safety if unresolved. | Major patient safety implications if findings are not acted on. | | |
| | | Reduced performance if unresolved. | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Workforce & OD** | Short-term low staffing level that temporarily reduces service quality (< 1 day). | Low staffing level that reduces the service quality. | Late delivery of key objective/ service due to lack of staff. | Uncertain delivery of key objective/service due to lack of staff. | Non-delivery of key objective/service due to lack of staff. |
| | | | Unsafe staffing level or competence (>1 day). | Unsafe staffing level or competence (>5 days). | Ongoing unsafe staffing levels or competence. |
| | | | Low staff morale. | Loss of key staff. | Loss of several key staff. |
| | | | Poor staff attendance for mandatory/key training. | Very low staff morale.<br>No staff attending mandatory/ key training. | No staff attending mandatory training /key training on an ongoing basis. |
| **Statutory Duty or Inspections** | No or minimal impact or breach of guidance/ statutory duty. | Breach of statutory legislation. | Single breach in statutory duty. | Enforcement action | Multiple breaches in statutory duty. |
| | | Reduced performance levels if unresolved. | Challenging external recommendations/ improvement notice. | Multiple breaches in statutory duty. | Prosecution. |
| | | | | Improvement notices. | Complete systems change required. |
| | | | | Low achievement of performance/delivery requirements. | Low achievement of performance/delivery requirements. |
| | | | | Critical report. | Severely critical report. |
| **Adverse Publicity or Reputation** | Rumours. | Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met. | Local media coverage – long-term reduction in public confidence. | National media coverage with <3 days service well below reasonable public expectation. | National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly). |
| | Potential for public concern. | | | | Total loss of public confidence. |
| **Business Objectives or Projects** | Insignificant cost increase/ schedule slippage. | <5 per cent over project budget. Schedule slippage. | 5–10 per cent over project budget. Schedule slippage. | Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met. | Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met. |
| **Finance including Claims** | Small loss. | Loss of 0.1–0.25 per cent of budget. | Loss of 0.25–0.5 per cent of budget. | Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget. | Non-delivery of key objective/ Loss of >1 per cent of budget. |
| | Risk of claim remote. | Claim less than £10,000. | Claim(s) between £10,000 and £100,000. | Claim(s) between £100,000 and £1 million. | Failure to meet specification/ slippage |
| | | | | | Claim(s) >£1 million. |
| **Service or Business interruption or disruption** | Loss/interruption of >1 hour. Minor disruption. | Loss/interruption of >8 hours. | Loss/interruption of >1 day. | Loss/interruption of >1 week. | Permanent loss of service or facility. |
| | | Some disruption manageable by altered operational routine. | Disruption to a number of operational areas within a location and possible flow onto other locations. | All operational areas of a location compromised. Other locations may be affected. | Total shutdown of operations. |
| **Environmental** | Minimal or no impact on the environment. | Minor impact on environment. | Moderate impact on environment. | Major impact on environment. | Catastrophic/critical impact on environment. |

# RISK MATRIX

| IMPACT ↓ | LIKELIHOOD → | | | | |
|---|---|---|---|---|---|
| | RARE | UNLIKELY | POSSIBLE | LIKELY | ALMOST CERTAIN |
| | 1 | 2 | 3 | 4 | 5 |
| CATASTROPHIC 5 | 5 | 10 | 15 | 20 | 25 |
| MAJOR 4 | 4 | 8 | 12 | 16 | 20 |
| MODERATE 3 | 3 | 6 | 9 | 12 | 15 |
| MINOR 2 | 2 | 4 | 6 | 8 | 10 |
| NEGLIGIBLE 1 | 1 | 2 | 3 | 4 | 5 |

# RISK ASSESSMENT - FREQUENCY OF REVIEW

| RISK SCORED | DEFINITION | ACTION REQUIRED (GUIDE ONLY) | MINIMUM REVIEW FREQUENCY |
|---|---|---|---|
| 15-25 | Extreme | Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required. | This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly. |
| 8-12 | High | Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required. | This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly. |
| 4-6 | Moderate | Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures. | This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months. |
| 1-3 | Low | Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required. | This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually. |