CORPORATE RISK REGISTER SUMMARY JUNE 2020

Appendix 2

Risk Ref	Risk (for more detail see individual risk entries)	Included on BAF	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Jun-20	Trend	Target Risk Score	Risk on page no...
624	Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives.	Health Board Objectives for 2020/21 to be agreed	Miles, Karen	Business objectives/projects	6	4×4=16	4×4=16	→	4×4=16 Accepted	3
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	4×4=16	4×4=16	→	3×4=12	8
291	Lack of 24 hour access to Thrombectomy services		Carruthers, Andrew	Quality/Complaints/Audit	8	4×4=16	4×4=16	→	2×4=8	11
686	Delivering the Transforming Mental Health Programme by 2023		Carruthers, Andrew	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	2×4=8	14
627	Ability to implement the UHB Digital Strategy within current resources to support the UHB's long term strategy		Miles, Karen	Business objectives/projects	6	4×4=16	4×4=16	→	2×3=6	18
451	Cyber Security Breach		Miles, Karen	Service/Business interruption/disruption	6	3×4=12	3×4=12	→	3×4=12 Accepted	21
632	Ability to fully implement WG Eye Care Measures (ECM).		Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×4=16	3×4=12	↓	2×2=4	25
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	3×3=9	3×3=9	→	3×2=6	28
854	Risk that Hywel Dda's Response to COVID-19 will be larger than required for actual demand		Moore, Steve	Adverse publicity/reputation	8	N/A	3×3=9	NEW	2×3=6	31

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		*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*
(blue)	Detailed review of relevant information	
(pink)	Medium level review	
(purple)	Cursory or narrow scope of review	

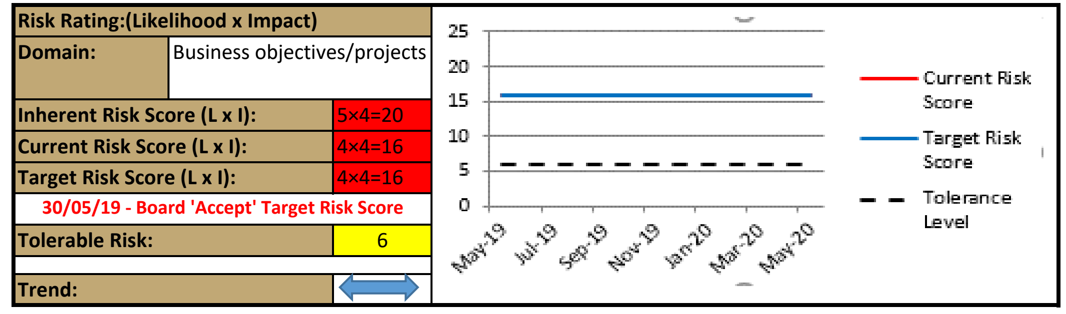
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective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

Strategic Objective:	*Health Board objectives for 2020/21 to be confirmed*

Executive Director Owner:	Miles, Karen	Date of Review:	May-19
Lead Committee:	People, Planning & Performance Assurance Committee	Date of Next Review:	Jun-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 IM&T 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):	4×4=16
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:
Although there are a number of controls in place, the risk score cannot be reduced significantly within the current capital allocation.

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 working)	**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. * The Business Planning & Performance Committee (BPPAC) 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. * When possible, aligning replacement equipment to large All Wales Capital schemes to minimise the impact on discretionary capital within the UHB. * Completion of the medical devices inventory by the operational management team which helps in the prioritisation of available funds. * Retention of a medical equipment capital contingency to manage urgent issues of repair or replacement. * Review of regulatory reports which have a capital component ie. HIW, WAO, CHC. * Investigating the potential for 'Charitable' funding rather than Discretionary Capital Programme as appropriate	Capital funding is significantly short of the level required to deal with backlog maintenance programme for estates, IM&T & equipment. An Estates Strategy aligned to the Board approved Health and Care Strategy. Uncertainty over the full funding by WG of COVID-19 related capital expenditure which if not fully funded will impact on 2020/21 DCP.	Undertake backlog maintenance through the All Wales Capital programme for new equipment, IM&T 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~~ ~~31/03/2020~~ 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 allocation has been supplemented by the allocation of year end monies from WG and the benefit of being able to retain the capital underspend which had been estimated for Cardigan ICC. In total. the equipment backlog has been supported by just over £2m more than thought possible this financial year.

Discretionary Capital Programme as appropriate. * Communication with Welsh Government via Planning Framework and IMTP (Infrastructure & Investment Enabling Plans) and regular dialogue through Capital Review meetings. * 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. * Reports to CE&IMT SC set out priorities for imaging equipment and established a much firmer baseline position in relation to medical devices backlog. * Committed and planned capital expenditure associated with the COVID-19 pandemic has been shared with WG.		Development of a medical devices inventory.	Rees, Gareth	Completed	A Medical Devices Coordinator is now in place and maintains the UHB medical devices inventory. The Inventory Report was submitted to the CEIM&T Sub Committee at its meeting Sep18 and formed part of the capital prioritisation process for DCP which was reported to BPPAC at its meeting in Oct18 and Feb19. This has been utilised to inform the prioritisation of equipment to ensure best use of year end capital allocations. The inventory is to be updated to take account the higher than anticipated capital spend on equipment backlog issues.
		The annual planning cycle identifies key capital enabling plans and priorities. The 2019/20 planning cycle 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	To be evidenced in work in support of implementation of 'A Healthier Mid & West Wales' and inclusion in the Infrastructure and Investment Enabling Plan to be produced as part of the 2019/20 Planning Cycle; the Pre Programme Business Case shared with WG Qtr3 2019/20; the Programme Business Case planned for completion October 2020.

		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 will result in new digital general x-ray room equipment in both PPH and WGH plus new fluoroscopy equipment in GGH in addition, an allocation has been agreed to allow the replacement of the WGH MRI in 2020/21. A further allocation for imaging is expected for 2020/21 with the Glangwili Hospital 2nd CT scanner being the priority. Despite delays to the work programmes, current funded schemes are still expected to complete in 20/21.
		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 Meeting (CRM) on 30Jul19 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 2020/21m in imaging and general equipment backlog, the medical devices inventory is now to be re-assessed to establish our understanding of priority requirements in Qtr1 20/21. A particular risk remains relating to the GGH ventilators which go out of service in Dec20. These were expected to be replaced as part of the COVID-19 response however this has not happened. There remains a supply issue and a potential c£600k exposure in this regard and this has been raised with WG in Apr20.

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
	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	The Programme Business Case has been shared with WG, scrutiny and approval pending.
	IM&T 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 IM&T backlog issues contained in the PBC submitted to Welsh Government along with other UHBs in 2017 remains unresolved. Year end capital may be made available to top up DCP at the end of 2019/20 however this is insufficient to address all the risk areas.	Miles, Karen	Completed	Confirmation of capital and revenue allocation to be received for 2019/20. The funding letter was received 19/12/2019, detailing the allocation from the Digital Priorities Investment Fund (DPIF) of £1,486,000. This total is made up of £1.010m capital and £476,000 revenue. A further allocation of £151,500 capital from year end slippage. 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 not with standing the contribution from ICF funds for the establishment of the field hospitals.	Miles, Karen	30/06/2020	Capital schedules have been shared with WG as they have evolved and the open and transparent approach will continue.

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		

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

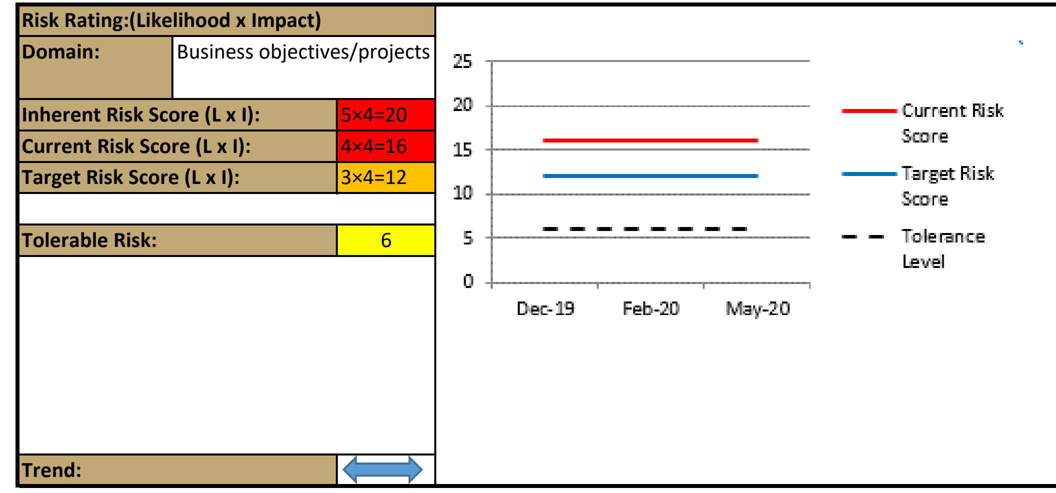
Performance against plan & budget.	Reports of delivery against capital plan & budget	1st			* DCP and Capital Governance Report - BPPAC Feb19 and CEIM&T Sub-Committee Jan20 * Radiology Equipment Risk CEIM&T Sub-Committee Jan20 * Strategic Medical Device Replacement CEIM&T Sub-Committee Jul19 * Estate Infrastructure CEIM&T Sub-Committee Nov19 * IM&T Infrastructure CEIM&T Sub-Committee Nov19 & Board Jan20					
	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:	*Health Board objectives for 2020/21 to be confirmed*

Executive Director Owner:	Miles, Karen	Date of Review:	May-20
Lead Committee:	People, Planning & Performance Assurance Committee	Date of Next Review:	Jun-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):	4×4=16
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 30,000 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. Due to competing priorities, requests for additional resources have not been agreed by the Executive Team, therefore the UHB will only be able to achieve an average of 82% against the required target of 95% episodes coded within 1 month of discharge. A recent WAO follow up review on clinical coding concluded that clinical coding continues to be low priority for the UHB and non-compliance with completeness is impacting overall improvement in accuracy and staff morale, with the use of coding data as business intelligence being underdeveloped. Previous recommendations to be progressed.

Rationale for TARGET Risk Score:

Our current percentage compliance for Apr20 was 85%. Although the department is operating at 80% capacity, the drop in activity has meant that the UHB is still able to achieve 85% of coded activity. Although overtime has been utilised throughout the year, there is still an underlying backlog of episodes that require clinical coding.
Fundamentally the department has seen an increase of 22% in terms of episodes that required clinical coding and not the necessary increase in staffing to cope with the underlying growth.
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. The resources required to achieve the coding target are outlined below:
• 5/6 wte - Senior Clinical Coder (Band 4)

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 working)	How and when the Gap in control be addressed 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. # The coding backlog is monitored on a regular basis and reported via the IPAR and the Quality Indicators Group. Establishing the cost of contract coders to deal with the current backlog as a short term measure. # Overtime is being implemented to address some of the short fall in the completeness factor. # Reminders to end users of coded information that completeness levels does not meet national targets. # Notes are moved across the Health Board to support the teams that have less than required resources. # An outsourcing tender has been awarded to GSA for the coding of the Hywel Dda backlog, with a completion date of 27th June 2019, which is the requirement for the statutory costing returns.	Resourcing the clinical coding team, to take account of underlying growth 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	31/10/2020	This will be put forward for consideration in the IMTP 2020/23 prioritisation process.
		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 Number of episodes outstanding 95% of episodes coded within 1 month of discharge 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 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:	*Health Board objectives for 2020/21 to be confirmed*

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jun-20
Lead Committee:	People, Planning & Performance Assurance Committee	Date of Next Review:	Jul-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):	4×4=16
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 sits still have delays in CT Angiography.

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:
(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** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**

WHSSC have commissioned a service in North Bristol. Below is a link for the thrombectomy pathway with Bristol. It has the referral criteria and pathway. They are developing an imaging pathway as well. https://www.nbt.nhs.uk/clinicians/services-referral/stroke-service-clinicians/stroke-thrombectomy-service-clinicians. New all wales Thrombectomy group have been set up to discuss issues and to finalise pathway. Will set up HDUHB own Thrombectomy group (to be arranged).	Timely investigations that are required to support transfers for thrombectomy not supported 24/7 on all sites. 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. 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.

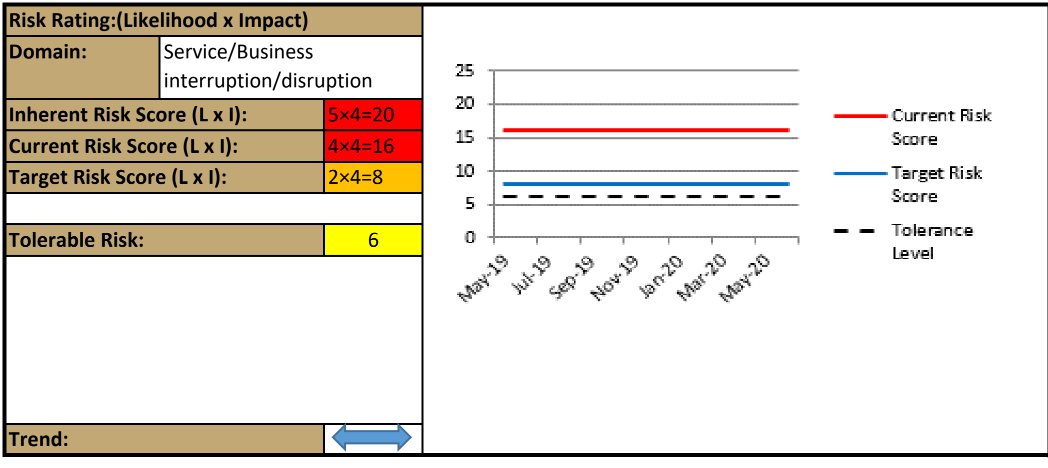
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are 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:	*Health Board objectives for 2020/21 to be confirmed*

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Feb-20
Lead Committee:	Business Planning and Performance Assurance Committee	Date of Next Review:	Mar-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 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 working)	**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). Mental Health Implementation Group established to oversee delivery of the TMH Implementation Programme.	Lack of dedicated Programme Director and adequate programme support. (down 7 and 4) Lack of agreed capital investment which is dependent on a balanced	Re-establish programme support from Transformation Programme Office (TPO) following COVID-19 planning phase	Carroll, 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.

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. First proof of concept sites operational. UHB Patient and Public Involvement team support for delivery phase of TMH. Programme Business Case (PCB) submitted to WG to deliver TMH for consideration. TMH programme fully aligned with TCS to ensure that risk of delays to TMH developments are minimised and opportunities for support are maximised.	revenue position which will be able to address estates, IT and infrastructure requirements. Competing demand for capital with Transforming Clinical Services Programme.	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	New action.
		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, Liz	31/12/2020	New action.
		Explore the benefits of agile working to reduce revenue costs of TMH and contribute to the cost neutrality of the overall programme.	Carroll, Liz	01/07/2020	Work has started as part of feedback to WG on PCB.
		Establish continuous review process of demand and capacity within Adult Mental Health Services.	Carroll, Liz	~~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, 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.

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
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 * HOS reports - BP&PAG - Jan20 * MHLAC Update - Board - Jul18 * Planning Sub Committee -	Assurance structure for Transforming Mental Health & Learning Disabilities	Review and implementation of an assurance structure for TMH&LD	Carroll, Liz	31/07/2020	New action
	Regular reports received at Local Mental Health Partnership Board and MH&LD Business Planning & Performance Assurance Group	2nd								

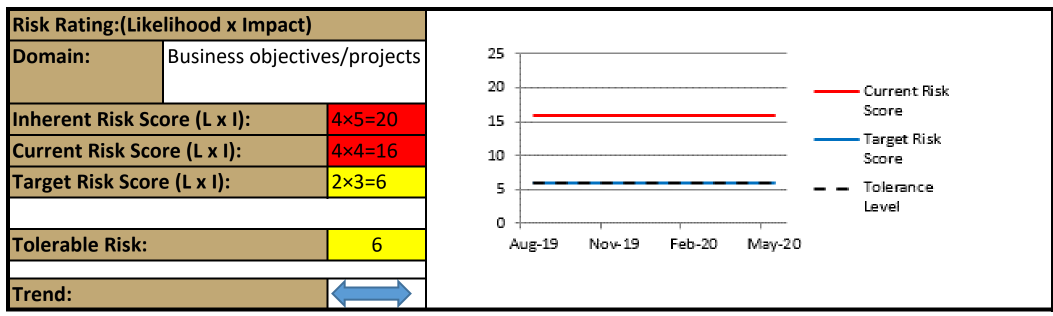
	TMH Plan is monitored by TMHLD Implementation Group and Planning Sub-Committee and to Board on request	2nd			Mar20						

Strategic Objective:	*Health Board objectives for 2020/21 to be confirmed*

Executive Director Owner:	Miles, Karen	Date of Review:	May-20
Lead Committee:	People, Planning & Performance Assurance Committee	Date of Next Review:	Jun-20

Risk ID:	627	Principal Risk Description:	There is a risk the digital capability of the organisation not supporting the delivery of the outputs from the Transforming Clinical Services Programme (A Healthier Mid and West Wales: Health and Care Strategy). This is caused by a lack of resources to support the implementation of the UHB digital strategy. This could lead to an impact/affect on delays in implementing the Health Board's long term strategy and improvements to support the delivery of safe and effective 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):	4×5=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:

The current Informatics Teams are not resourced to take forward the current strategic options. Around 96% of staff time is dedicated to “keeping the lights on" which comprises of ensuring that the infrastructure is robust and operational. The teams are not resourced to take forward any innovation or new builds at this time. Anything that is currently progressed, in terms of new builds is undertaken at the expense of guaranteeing robust ICT systems. There has been a reduction in the risk score as additional analytical support has been made available for the modelling element of the clinical services strategy.

Rationale for TARGET Risk Score:

An updated Digital Programme Plan has been developed with resources mapped against specific themes, to illustrate which programmes / projects / products will be developed, however without additional investment the UHB will miss the opportunities that digital can provide. The newly established Bronze Digital Group will be assessing the priorities, and developing a revised Digital Programme Plan.

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 working)	How and when the Gap in control be addressed Further action necessary to address the controls gaps	By Who	By When	Progress
Board approved the 5 year Digital Strategy - Jan17. Board Approved the updated 2018 Digital Plan, and Operational Delivery Plan. Development of a Digital Futures Programme.	Resourcing of digital strategy. Resourcing of digital programme to deliver the Health and Care Strategy.	Where resources are required then Business Cases will be developed, in line with the digital plan.	Tracey, Anthony	~~31/03/2018~~ Mar20 in line with the budget setting exercise	Progress is being monitored via the Planning Sub-Committee and the CE&IM&T Committee. As part of the revised Digital Programme Plan, a detailed resource plan was included alongside a refreshed Strategic Outline Programme (SOP), which provided further information on the projects / schemes and timescales that will be delivered if additional resources were to be made available.

		A paper has been prepared to request additional revenue resources from the Executive Team.	Tracey, Anthony	31/12/2019	Progress is being monitored via the Planning Sub-Committee and the CE&IM&T Committee. The Planning Sub Committee has approved the establishment of a digital steering group to take forward the digital agenda. A number of sub-groups will also be established to ensure that a robust resource plan is identified, and to also improve the project management of large projects.
		Work with the 'A Healthier Mid and West Wales' Team to ensure that there is synergy and cross mapping of requirements.	Tracey, Anthony	Completed	An initial meeting has taken place between the Project Team and the ADI and CCIO, to ensure that the Digital Plan is linked to the strategy. Following the meeting a revised Digital Plan will be developed and presented as part of the updated enabling plans.
		Develop a clear vision/scope for the digital workstream following the formal feedback from the consultation.	Tracey, Anthony	Completed	An initial meeting has taken place between the newly appointed management consultants and the Director of Planning, Performance, Informatics and Commissioning along with the ADI to provide an update specification of the work required to enable digital transformation.
		A revised proposal for additional resources for a digital futures programme will be discussed with the Executive Team.	Tracey, Anthony	Completed	A detailed resource plan was included alongside a refreshed Strategic Outline Programme (SOP), which provided further information on the projects / schemes and timescales that will be delivered if additional resources were to be made available.

		Based around the new ways of working within Digital a further paper to be developed and presented to the Tactical and Gold to request additional revenue resources to move the digital programme plan forward with pace.	Tracey, Anthony	31/05/2020	To be updated
		Establish new governance structure to take forward the Digital Programme Plan.	Tracey, Anthony	31/05/2020	To be updated.

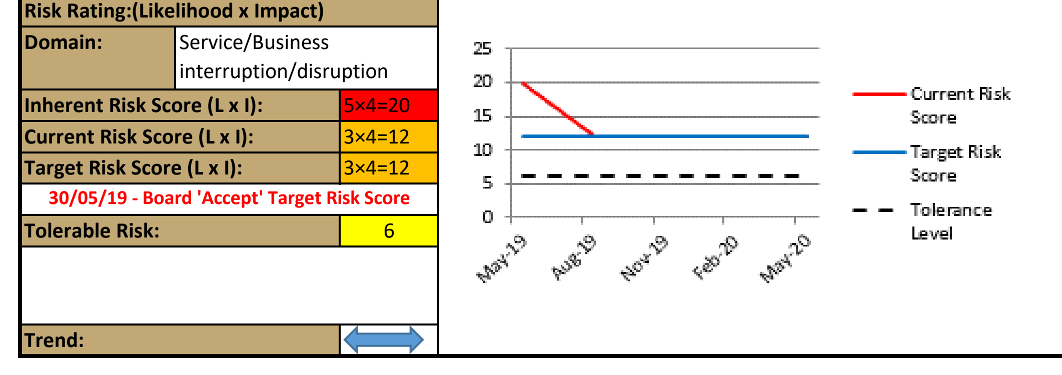
ASSURANCE MAP				**Control RAG Rating (what the assurance is telling you about your controls**	**Latest Papers (Committee & date)**	**Gaps in ASSURANCES**				
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**			**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
	Signed off project plans by the relevant committees	1st			Digital strategy/plans included in annual plan document-action to Board.	Lack of committee oversight	Information to be supplied to Planning Sub-Committee and CE&IM&T.	Tracey, Anthony	Completed	A newly established Digital Steering Group under the auspices of the Planning Sub Committee to ensure the appropriate governance is in place for the digital plan.
	Delivery of digital plans are overseen by Digital Steering Group (reports to Planning Sub Committee)	2nd								

Strategic Objective:	*Health Board objectives for 2020/21 to be confirmed*

Executive Director Owner:	Miles, Karen	Date of Review:	May-20
Lead Committee:	People, Planning & Performance Assurance Committee	Date of Next Review:	Jun-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 88% for desktop/laptops and 81% 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. A paper was prepared for the Formal Executive Team in Sep18 which identified the revenue resources required. 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: (The existing controls and processes in place to manage the risk)
Controls have been identified as part of the national Cyber Security Task & Finish Group. Continued rollout of the patches supplied by third party companies, such as Microsoft, Citrix, etc. £1.4m national investment in national software to improve robustness of NWIS. Further Task and Finish Group established to review the future patching arrangements within NHS Wales - this will lead future work locally to implement recommendations. 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.

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** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Lack of comprehensive patching across all systems used in UHB. Lack of staffing capacity to undertake continuous patching at pace. Lack of dedicated maintenance windows for updating critical clinical systems.	Continue to focus on critical and security updates to clinical critical systems.	Solloway, Paul	Completed	These are implemented when received however this work does take time with current staffing resource level.
	Review of cyber security measures underway following wannacry virus incident.	Solloway, Paul	Completed	Additional resources were received from Welsh Government to implement the necessary software to monitor cyber incidents. A further all Wales bid was submitted for additional staff to undertake the remedial work, confirmed on the 28Feb20 that the UHB is able to go out to recruit. The aim is to have these staff in post in Apr20 to take forward the recommendations of the Stratia and Internal Audit reports.
	Implement local UHB workplan developed in response to the National External Security Assessment.	Tracey, Anthony	~~30/09/2019~~ ~~31/03/2020~~ 31/08/2020	Progress is reported to IGSC at every meeting. However as outlined by Internal Audit the slow progress can be attributable to the lack of dedicated resources. As outlined above the Welsh Government have indicated that we are able to go out to recruitment for additional staff, which it is anticipated will begin in April20.

		A paper has been prepared to request additional revenue resources from the Executive Team.	Tracey, Anthony	Completed	The Executive Team considered the paper and acknowledged that the steps outlined should be incorporated within Emergency Planning procedures as recommended. The Executive Team also requested that money saving opportunities elsewhere will need to be considered, and a risk assessment exploring all options needs to be undertaken and presented to the Board for considerations. The Executive Team acknowledged the importance of Cyber Security and requested a Dashboard on compliance to be developed, which is now operational highlighting server/desktop areas where additional patching is needed.
		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.
		Purchase Vulnerability Scanning to adopt a proactive approach to identifying cyber threats.	Tracey, Anthony	Completed	The required software was purchased with year end capital released from Welsh Government. It has been implemented and is operational within the Health Board.

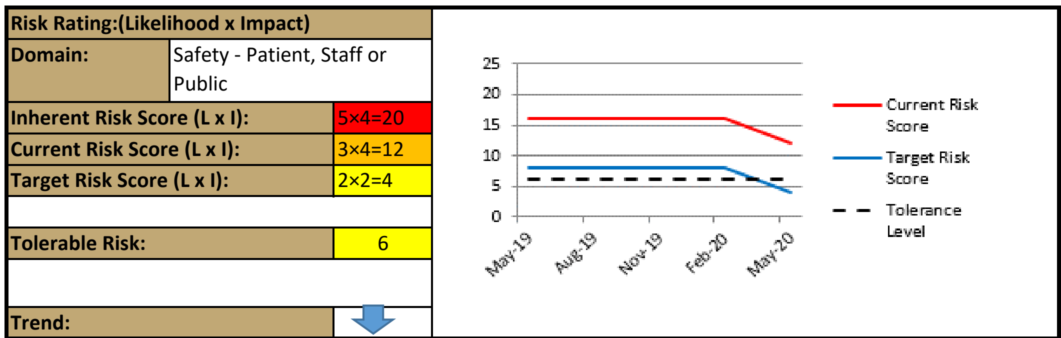
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
No of cyber incidents. Current patching levels in UHB. No of maintenance windows agreed with system owners. Removal of legacy equipment.	Department monitoring of KPIs	1st			External Security Assessment - IGSC - Jul 18 Update on WAO IT follow-up - ARAC - Oct19	Lack of committee oversight.	Update IGSC TORs to include responsibility to monitor cyber security.	Tracey, Anthony	Completed	Regular reports on progress on External assessment.
	IGSC monitoring of cyber security workplan addressing recent internal and external audits/assessments	2nd					Internal Audit (IA) of GDPR (Dec 18) and cyber security (Sep 18).	Tracey, Anthony	Completed	The IA GDPR final report in Apr19 reported 'Substantial Assurance' whilst the Internal Audit deferred Cyber Security to the 2019/20 Internal Audit Plan.
	IGSC monitoring of National External Security Assessment	2nd					The Internal Audit work plan has a further review on Cyber Security programmed in for Qtr4 of 2019/20	Tracey, Anthony	Completed	The Internal Audit report gave "Reasonable Assurance" for Cyber Security with 2 Recommendations (1 High and 1 Medium)
	Follow-up Information Backup, Disaster Recovery & Business Continuity and Data Quality: Update on Progress	3rd					Achieve the Cyber Essential certification.	Tracey, Anthony	~~31/03/2020~~ 31/03/2021	Work is continuing on achieving certification.
	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								

Strategic Objective:	*Health Board objectives for 2020/21 to be confirmed*

Executive Director Owner:	Carruthers, Andrew	Date of Review:	May-20
Lead Committee:	People, Planning & Performance Assurance Committee	Date of Next Review:	Jul-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. 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) and the overall cohort number for R1's is also reducing (Feb20 - 13671, Mar20 - 13170, Apr20 - 11660) 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)
Eye Care Action Plan in place. # Ophthalmology RTT delivery plan in place. # Eye Care Collaborative Group established and meet quarterly to oversee performance against eye care standards. # ECM Coordinators recruited. # WG Monitoring information from W-PAS 18.1.Standards is now functional and information is being submitted. # Primary Care Communications campaign to include a short video to increase awareness on the range of services Community Optometrists can offer. # Direct communication sent to all patients on a new or follow up waiting list informing them of new Eye Care Measures. # 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. COVID ACTIONS # The service have maintained treatment/review for imminently sight threatening conditions (Health Risk Factor 1) # The clinical team will continue to see all ages of patients in the IVT service including Wet AMD, DMO & RVO. # Primary Care Optometric Support: - 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. - 4 optometric practices/day across HDUHB to offer acute eye care support, ensuring that only those eye conditions which require surgery or laser treatment are referred on to the hospital eye service. # In order to continue with ophthalmology services for emergencies and urgent follow up patients, the UHB has temporarily commissioned eye casualty service and urgent follow-up clinic from BMI Werndale: # The On Call rota will continuing to be maintained from The Blue Suite, Outpatients Department, GGH.

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**
Lack of 3 year balanced plan for ophthalmology. Lack of ongoing funding post COVID to utilise primary care to meet eye care standards. Delay in go-live of IT systems to support shared care / remote delivery of evaluations away from acute sites. Agreement of clinical pathways with professional bodies for use during COVID-19. Lack of Glaucoma Consultant in Hywel Dda.	Identify funding sources to support primary care.	Hire, Stephanie	~~31/05/2019~~ ~~31/10/2019~~ ~~31/01/2020~~ ~~31/03/2020~~ 30/06/2020	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.
	Negotiating Welsh Government guidelines on Ophthalmology with Clinical Team.	Buckingham, Carly	30/06/2020	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.
	Named Glaucoma Consultant to be responsible for the Glaucoma cohort of patients in Hywel Dda.	Skiadaresi, Miss Eirini	30/06/2020	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.

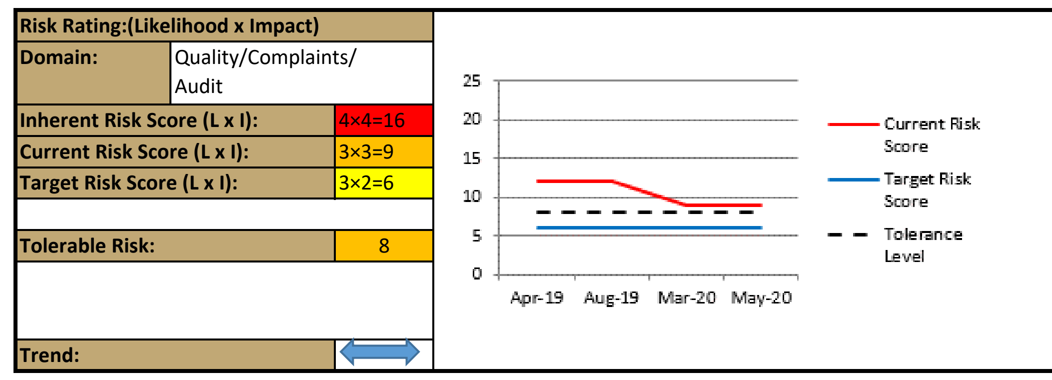
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are 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. Reduction in the number of patients, assessed as health risk factor 1, waiting outside of target date. Delivery of zero 36 week RTT breaches. Reduction in the number of Serious Incidents relating to Hospital Eye Services.	Monitoring arrangements by management	1st			* EC Collaborative Group Meeting Aug19 * QSEAC SBAR November 2019 * BPPAC SBAR December 2019 * 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	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.
	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:	*Health Board objectives for 2020/21 to be confirmed*

Executive Director Owner:	Carruthers, Andrew	Date of Review:	May-20
Lead Committee:	People, Planning & Performance Assurance Committee	Date of Next Review:	Jul-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. This has affected the following areas, upper GI, lower GI and head and neck. A full COVID-19 Cancer escalation plan is in place and is updated when new guidance is issued. There are plans to restart aerosol generating procedures and surgery from week beginning 25May20, phased over a 4 week period for the 4 sites.

Rationale for TARGET Risk Score:
The aim is to treat patients within target waiting times (which are yet to be confirmed)however some treatments have changed or been suspended during COVID-19 and there will be a backlog when these resume over the next few months. 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)
Working with all Wales Cancer Network to gain full understanding of implications of new pathway. Implementation Group established, reporting to Cancer Board with awareness / engagement sessions held on each hospital site. Shadow monitoring in place. Further Demand & Capacity exercise planned 2020/21 with support from Delivery Unit. 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. Routine daily communication feed from ED to cancer information team which helps identify the point of suspicion. COVID-19 escalation plan in place. Monitoring data of patients whose treatments have changed or suspended (some through patient choice) as a result of COVID-19. A 4-week follow up process has been implemented for these. Utilisation the private sector for surgery during COVID-19. Joint working with regional colleagues to offer patients on a tertiary pathway surgery locally.

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** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP - unlikely to be addressed by August 2019 Full engagement for all supporting services. Performance is lower than USC/NUSC published performance. Key diagnostic information systems do not support effective demand / capacity planning. Need for new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways.	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.
	See above re diagnostic services plus improved systems to support identification of 'date of suspicion'.	Humphrey, Lisa	~~31/03/2019~~ ~~31/08/2019~~ 31/07/2020	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.
	Each MDT to review and adopt recommended optimal tumour site specific pathways	Humphrey, Lisa	31/08/2020	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 will now be initiated.
	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. Shadow performance data.	Daily/weekly/monthly/ monitoring arrangements by management	1st			* Implementation of Single Cancer Pathway Report - BPPAC - Feb20 * IPAR Report Mth11- Board - Mar20 * COVID-19 Impact on Cancer Servcies - Board - May20	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:	*Health Board objectives for 2020/21 to be confirmed*

Executive Director Owner:	Moore, Steve	Date of Review:	May-20
Lead Committee:	People, Planning & Performance Assurance Committee	Date of Next Review:	Jul-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):	3×3=9
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. Field hospital development is also staged so later stages may be able to be postponed as real world data becomes apparent.

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: (The existing controls and processes in place to manage the risk)
Modelling cell established to provide regular updates on planning numbers, linked into the Welsh Government modelling group and other Health Boards. The approach to field hospital development is phased as far as possible so that our response can be flexed downward should this be required. Welsh Government direction to risk over provision rather than under provision will limit reputational damage. All developments subject to a business case approach to ensure value for money is considered alongside other issues. Board oversight and sign off of decision-making at all levels of the Command Structure. Good Communications with Community Health Council, local politicians and Local Authorities. Regular media engagement (internal/external). Revised Strategic Planning Requirements Directive from Gold to Tactical on 27/04/20 includes field hospitals available as alternative sites. WG informed of COVID-19 related costs on regular basis. Financial Framework/Business Case approval process in place.

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** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Clarity about COVID-19 funding arrangements. Ability to respond to planning assumptions.	Explore funding streams at national level, including use of European Social Fund.	Moore, Steve	30/09/2020	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 Finance Report Month M01 - FC - May20 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**	**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.**

	(< 1 day).		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. 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

	LIKELIHOOD →				
IMPACT ↓	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.