# Strategic Risk Register - Risk 1 | Dashboard

| | |
|---|---|
| **Risk 1** | There is a risk that Public Health Wales will be unable to fulfil its strategic objectives because it does not have the correct numbers of people with the right skills, attitudes and behaviours. . |

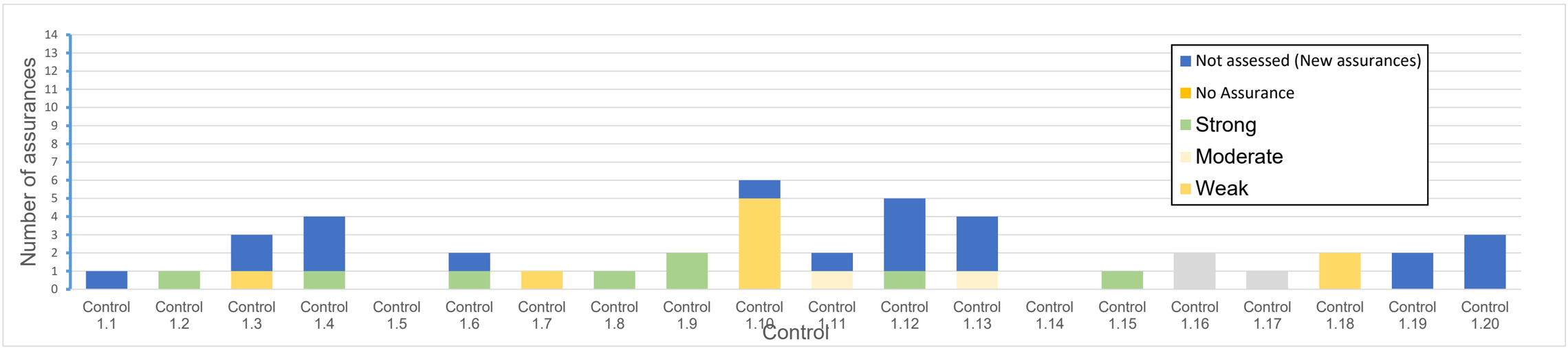
| **Sponsor and Assurance Group** | |
|---|---|
| **Executive Sponsor** | Neil Lewis, Acting Director of People and Organisational Development |
| **Assuring Group** | People and Organisational Development Committee *(Currently the Board)* |

| **Inherent Risk** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date** | | **Likelihood:** | **4** | **Impact:** | **4** | **Score:** | **16** |

| **Applicable Strategic Priorities** | |
|---|---|
| Influencing the wider determinants of health | ☒ |
| Improving mental well-being and building resilience | ☒ |
| Promoting healthy behaviours | ☒ |
| Securing a healthy future for the next generation through a focus on early years. | ☒ |
| Protecting the public from infection and environmental threats to health | ☒ |
| Supporting the development of a sustainable health and care system focused on prevention and early intervention | ☒ |
| Building and mobilising knowledge and skills to improve health and well-being across Wales | ☒ |

| **Risk Score** | | | | | | **Risk Decision** |
|---|---|---|---|---|---|---|
| **Current Risk** | | | **Target risk** | | | |
| **Likelihood** | **Impact** | | **Likelihood** | **Impact** | | **TREAT** |
| | 4 | 16 | 2 | 4 | 8 | |

| **Control Summary** | | | |
|---|---|---|---|
| | **No. of Controls** | **20** | |
| **Assurance Summary** | **No. of Assurances** | **43** | |
| | **Breakdown of Total Assurance Rating** | **Weak Assurances** | **9** |
| | | **Moderate Assurances** | **2** |
| | | **Strong Assurances** | **8** |
| | | **No Assurance** | **3** |
| | | **Not assessed** | **21** |



# Strategic Risk Register - Risk 1 | Controls

| EXISTING CONTROLS | | | SOURCES OF ASSURANCE | Level at which the Assurance is provided to | | | | | Assessment of each Assurance |
|---|---|---|---|---|---|---|---|---|---|
| No. | Control | Exec Owner | | Team / Division / Project /Programme | Directorate Team / Exec Lead | Business Exec Team / Sub Groups | Committee / Sub group | Board | |
| 1.1 | People Strategy | Acting Director – People and Organisational Development | Bi Annual Reports to PODC / Board on achievement of actions | | | X | X | X | Not Assessed |
| 1.2 | Organisational Workforce plan to support IMTP and first three years of People Strategy | | Updates provided alongside People Strategy reports to the Executive Team and Board | | | X | X | X | Strong |
| 1.3 | Corporate succession plan to outline (initially) succession into the top three tiers | | Talent and succession map | X | X | X | X | | Weak |
| | | | People Strategy (1) | X | X | X | X | | Not assessed |
| | | | Organisational workforce plan updates (2) | X | X | X | X | | Not assessed |
| 1.4 | Recruitment plan and tracker | | Corporate recruitment plan (approved by Board Jan 2020) | | | X | X | | Strong |
| | | | Recruitment plans being managed through the workstreams within the Response Plan. | | X | X | | | Not assessed |
| | | | COVID Recruitment Plan (to GOLD ) | | X | X | | | Not assessed |
| | | | Weekly workforce subgroup meeting minutes, actions and reports. (Sitrep Gold) | X | X | X | | | Not assessed |
| 1.5 | Structured approach to funding learning and development - deferred until 2021/2022 budgets | | | | | | | | |
| 1.6 | Directorate level plans focussing on change, development and recruitment. These will include areas of focus such as Microbiology and radiology | All | Directorate workforce plans (focus on BAU); | X | X | X | | | Strong |
| | | | Recruitment plans directly linked to COVID managed via the routes noted in 4. | | | | | | Not assessed |
| 1.7 | Job families | Acting Director – People and Organisational Development | Papers and minutes from the Job Families group and one to one meetings | X | X | | | | Weak |
| 1.8 | Professional appraisal and revalidation processes in place, linked through relevant bodies. | Executive Director of Quality, Nursing and Allied Health Professionals / Executive Director of Public Health Services/Medical Director | Integrated Performance Report | | X | X | X | | Strong |
| 1.9 | Training and succession plan in conjunction with Deanery/ HEIW | Acting Director – People and Organisational Development/ Executive Director of Quality, Nursing and Allied Health Professionals / Executive Director of Public Health Services/Medical Director | Training and succession plan | | X | | X | | Strong |
| | | | Stats through Integrated Performance Report | | X | X | X | | Strong |
| 1.10 | Learning and Development | Acting Director – People and Organisational Development | Programme content | X | X | | | | Weak |
| | | | Manager's Induction | X | X | | | | Weak |
| | | | Attendance registers | X | X | X | | | Weak |
| | | | ESR reports | X | X | | | | Weak |

# Strategic Risk Register - Risk 1 | Controls

| EXISTING CONTROLS | | | SOURCES OF ASSURANCE | Level at which the Assurance is provided to | | | | | Assessment of each Assurance |
|---|---|---|---|---|---|---|---|---|---|
| No. | Control | Exec Owner | | Team / Division / Project /Programme | Directorate Team / Exec Lead | Business Exec Team / Sub Groups | Committee / Sub group | Board | |
| | | | Staff survey reports | X | X | | | | Weak |
| | | | NCC training packages and records (COVID) | X | X | | | | Not Assessed |
| 1.11 | PDRs both My Contribution and Job Plans | All | IPR and compliance reports | X | X | X | X | X | Moderate |
| | | | My Contribution Action Plan | | X | X | X | | Not assessed |
| 1.12 | Staff Engagement Surveys | Acting Director – People and Organisational Development / All | NHS Staff Survey Results (scheduled late 2020 subject to Ministerial approval) | X | X | X | X | X | Strong |
| | | | PHW Wellbeing and Engagement Survey Results (during COVID) | X | X | X | | X | Not assessed |
| | | | Workforce Reports | X | X | X | X | | Not assessed |
| | | | Meeting papers from Wellbeing and Engagement Group (est. July 2020) | X | X | X | X | | Not assessed |
| | | | Published results and documented actions plans | X | X | X | X | | Not assessed |
| 1.13 | Wellbeing | Acting Director – People and Organisational Development | Staff survey results (as per 12) | X | X | X | X | | Moderate |
| | | | Absence data reporting via IPR | X | X | X | X | | Not assessed |
| | | | Resources available to staff via the Information Page and social media | x | | | | | Not assessed |
| | | | COVID Absence Dashboard | x | x | x | | | Not assessed |
| 1.14 | Establish Approach to widening access for potential (often younger) employees | | | | | | | | |
| 1.15 | Integrated Performance Report | | Exception reporting on key measures that have not been reached such as turnover and absence with plans of action attached | | X | X | X | X | Strong |
| 1.16 | Welcome, Engage, Network and Develop days (on hold due to COVID) | | Induction content (virtual provision being planned due to COVID) | X | X | | | | No Assurance |
| | | | Attendance registers (on hold due to COVID) | X | X | | | | No Assurance |
| 1.17 | Behaviours framework | | Values-aligned behaviours framework piloted, approved and launched (on hold to COVID) | | X | X | | | No Assurance |
| 1.18 | Public Health Practitioner Registration Scheme | Acting Director – People and Organisational Development / Executive Director of Health and Wellbeing | Take up reports | X | X | | | | Weak |
| | | | Number of staff registered | X | X | | | | Weak |
| 1.19 | Trade Unions; Staff Networks; Equality, Diversity & Inclusion (COVID) | Acting Director – People and Organisational Development | Weekly informal meetings with Trade Unions | | X | | | | Not assessed |
| | | | Local Partnership Forum meeting minutes and reports | | | X | | | Not assessed |
| 1.20 | Workforce Mobilisation (COVID) | Transitional Director - Knowledge | Mobilisation status dashboard | | X | X | | | Not assessed |
| | | | Skills surveys | | X | X | | | Not assessed |
| | | | Reverse mobilisation process | | X | X | | | Not assessed |

# Strategic Risk Register – Risk 1 | Action Plan

| Control Number | Gaps in controls | Gaps in assurance | | Action Plan | | Due Date | Progress |
|---|---|---|---|---|---|---|---|
| **1.1** | People Strategy to support the PHW long term strategy | Project Plan relating to transformation of People and OD Directorate with appropriate time-scales and outcomes | 1 | Consultation with key stakeholders.<br>People Strategy linked to IMTP. | Acting Director of People and Organisational Development | October 2020 | **October Update**: **ON TRACK**<br>An interim report on implementation within COVID context being prepared for BET.<br><br>**Previous update:**<br>People Strategy has been completed and approved at Board in January 2020. This has been sent for final production (**COMPLETE**) and a launch plan is being developed. |
| | | | 2 | Deliverables incorporated into People and OD departmental plan and linked to team objectives | | | |
| | | | 3 | New People and OD team structure to be developed in consultation with the organisation to ensure alignment with people strategy | | November 2020 | **October Update**: **ON TRACK**<br>Skills assessment undertaken August and Senior Team reviewing options for structure herein (delayed owing to Director leaving)<br><br>**Previous update:**<br>Interim team structure in place to support implementation of the People Strategy - **COMPLETE**. |
| **1.2** | Organisational workforce plan | Quality assurance of plan<br>Gaps in returns from Directorates | 4 | Consultation with key stakeholders and workforce planning sessions facilitated. | | November 2020 | **October Update**:<br>Organisational Workforce Plan (People Strategy 1st year actions) being reviewed and linked with emerging workforce plans from priority areas. Will be monitored via implementation of Operational Plan. **ON TRACK**<br><br>**Previous update:**<br>All actions listed have been completed with a working draft plan in place. This was delayed due to COVID. An interim report is being prepared and approach for 2020 being determined. |
| | | | 5 | Workforce plans returned to People and OD to review Trends and themes identified. | | | |
| | | | 6 | Draft to be quality assured by Skills for Health to ensure a coherent narrative. | | | |
| | | | 7 | Draft to be submitted to Execs on 27 November. | | | |
| **1.3** | An implemented corporate approach to succession planning and talent management | Quality assurance of plan | 8 | Establish a regular process going forward into 2021/22 | | October 2020 | **October Update:** Broader work on hold due to COVID<br>**Recommendation 10** - Director/CEO for HEIW programme commencing Oct 2020 is COMPLETE<br><br>**Action for Board - Close Action 10.** |
| | | | 9 | In the process of finding a date for these wider/ moderation discussions. | | | |
| | | | 10 | ~~Linking to wider work and timescale with HEIW.~~ | | | |
| | | | 11 | Finalised talent and succession map to be completed. | | | |
| **1.4** | No tracking tool against corporate recruitment plan | Gaps in data provided | 12 | Continue work as part of business process improvement activity in this area. | | November 2020 | **October Update:**<br>• A recruitment plan is in in place linked to COVID, and we are seeking additional resources to manage the delivery of plan.<br>• New Resourcing team now established within People and OD.<br>• Reactivation of business improvement work currently on hold |

# Strategic Risk Register – Risk 1 | Action Plan

| Control Number | Gaps in controls | Gaps in assurance | | Action Plan | | Due Date | Progress |
|---|---|---|---|---|---|---|---|
| | | | | | | | **Previous update:**<br>The People and OD Directorate maintain a Recruitment spreadsheet which is populated with information on planned recruitment obtained from Directorates.<br>As well as information on posts to be advertised, this spreadsheet includes information on location of posts. This information is shared with Ops and Finance, allowing IT and Estates to also plan for this recruitment.<br>P&OD are working closely with Ops and Finance on this 'growth plan'. As part of the business process improvement work, an investment bid may be considered in order to purchase a Corporate Recruitment Tracker which would enable all Directorates to directly input their recruitment plans |
| **1.5** | | | 13 | Development of a structured approach to funding learning and development - | Acting Director of People and Organisational Development | April 2021 | **Previous update:**<br>Executive Team presented with recommendation for how learning and development is funded across the organisation. Discussion and decisions on hold due to HP response. |
| **1.10** | Management Induction | Lack of assurance around knowledge and skills to deliver within a management role | 14 | Pilot management induction following consultation with key stakeholders | | November 2020 | **October Update:** Will review on Operating Plan sign off.<br><br>**Previous update:**<br>Second induction cohort underway with final action learning sets from the pilot group scheduled for June 2020 (evaluation to follow). Summary of pilot findings so far presented to SLT in December 2019. Reviewing available learning platforms, awaiting confirmation of non-pay budget to provide managing mental health training. |
| **1.11** | My Contribution | Per IA plan – compliance and improvements needed to policy | 15 | Undertake Quality audits (planned) | | Q4 2020/2021 | **October Update**: **On track.** |
| | | | 16 | ~~Revise My Contributions Policy~~ | | October 2020 | **October Update:**<br>**COMPLETE.** The policy is now live.<br><br>**Action for Board - close action** |
| **1.14** | Approach to young people | Gaps in plan for delivery and join up with Well-being of Future Generations Act | 17 | Draft approach to be developed making links to Well-being of Future Generations Act by improving social, economic, environmental and cultural wellbeing | | April 2021 | **Previous update:**<br>Our approach to young people and engaging the future workforce is being developed by our graduate who is currently on placement with the People and OD team. Approach and options mapped and paper presented to Executive Team including younger persons strategy (held during COVID) |
| | | | 18 | Joined up approach to collaboration with schools, colleges and universities; | | | |
| | | | 19 | Young Ambassador Programme; Careers Networks; Work-placements scheme; Internships; Apprentices; Graduate Schemes | | | |

# Strategic Risk Register – Risk 1 | Action Plan

| Control Number | Gaps in controls | Gaps in assurance | | Action Plan | | Due Date | Progress |
|---|---|---|---|---|---|---|---|
| | | | 20 | Discussions to be taken forward by Deputy Director of People and OD with directorates | | | Apprenticeship providers already warning programmes may not pick up until 2021. |
| | | | 21 | Determine appropriate way forward with collaborative partners with clear outcomes and evaluation | | | |
| | | | 22 | Deliver regular management induction sessions Evaluation | | | |

# Strategic Risk Register – Risk 2 | Dashboard

| Risk 2 | There is a risk that Public Health Wales will cause significant harm to patients, service users or staff members. This will be caused by misdiagnosis or incorrect identification of serious health conditions, timeliness of service provision, the provision of inappropriate clinical advice or the failure of staff to follow correct procedures. |
|---|---|

| Applicable Strategic Priorities | |
|---|---|
| Influencing the wider determinants of health | ☒ |
| Improving mental well-being and building resilience | ☒ |
| Promoting healthy behaviours | ☐ |
| Securing a healthy future for the next generation through a focus on early years. | ☐ |
| Protecting the public from infection and environmental threats to health | ☐ |
| Supporting the development of a sustainable health and care system focused on prevention and early intervention | ☒ |
| Building and mobilising knowledge and skills to improve health and well-being across Wales | ☐ |

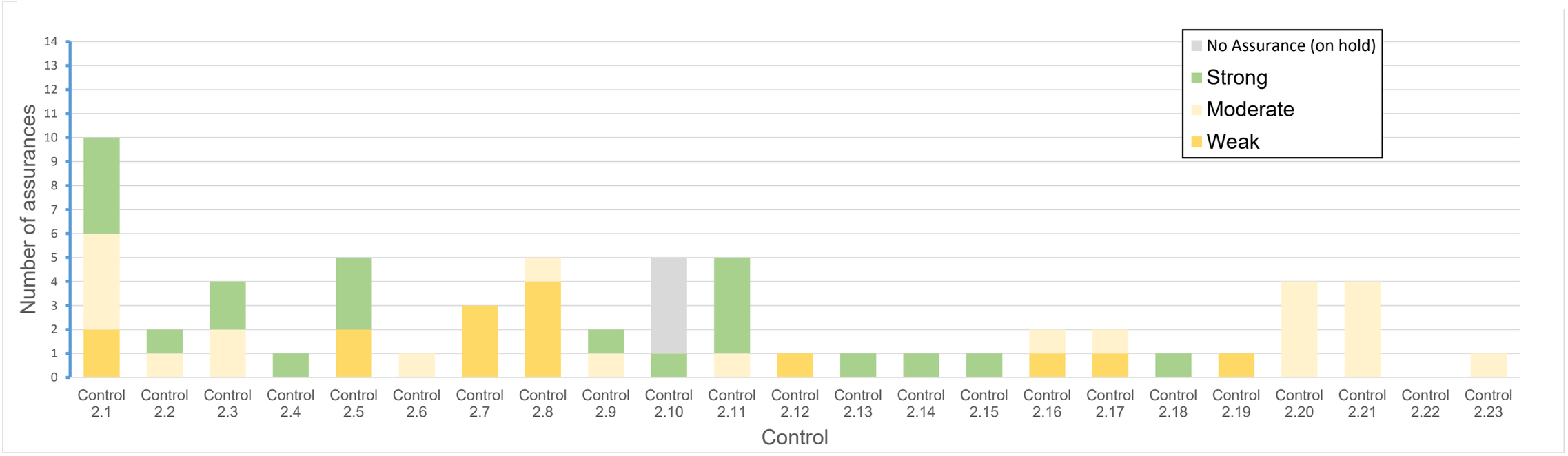
| Sponsor and Assurance Group | |
|---|---|
| **Executive Sponsor** | Rhiannon Beaumont-Wood, Executive Director Quality, Nursing and Allied Health Professionals |
| **Assuring Group** | Quality, Safety and Improvement Committee (patient and service user)<br>People and Organisational Development Committee (staff) *(temporarily being reported directly to Board)* |

| Inherent Risk | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date** | | **Likelihood:** | **5** | **Impact:** | **5** | **Score:** | **25** |

| Risk Score | | | | | | Risk Decision |
|---|---|---|---|---|---|---|
| Current Risk | | | Target risk | | | |
| Likelihood | Impact | | Likelihood | Impact | | |
| 4 | 5 | 20 | 3 | 5 | 15 | Treat |

| Control Summary | No. of Controls | 23 | |
|---|---|---|---|
| | No. of Assurances | 62 | |
| Assurance Summary | Breakdown of Total Assurance Rating | Weak Assurances | 15 |
| | | Moderate Assurances | 22 |
| | | Strong Assurances | 21 |
| | | No assurance | 4 |

***Assurance Breakdown per Control***



# Strategic Risk Register – Risk 2 | Controls

| Existing Control | | | Sources of Assurance | Level at which the Assurance is provided to | | | | | Assessment of each Assurance |
|---|---|---|---|---|---|---|---|---|---|
| No. | Control | Exec Owner | | Team / Division / Project | Directorate Team / Exec Lead | Business Exec Team / Sub Groups | Committee / Sub group | Board | |
| **2.1** | Corporate Quality Management systems | Executive Director Quality, Nursing and Allied Health | Quality Indicators Performance Monitoring as reported in the Integrated Performance Report | X | X | X | | X | Moderate |
| | | | Health and Care Standards regular Monitoring at Board - IPR – ongoing monitoring of implementation | | X | X | | X | Moderate |
| | | | Health and Care Standards - Arrangements / system in place. | X | X | X | X | | Strong |
| | | | Corporate Safeguarding Annual Report | | | X | X | | Weak |
| | | | Infection Control Annual Report | | | X | X | | Weak |
| | | | PTR Quarterly Report (IPR Monthly) | | | X | X | X | Strong |
| | | | PTR Annual Report | | | X | X | | Moderate |
| | | | Quarterly Alert exception Report | | | X | X | X | Moderate |
| | | | Annual Quality Statement | | X | X | X | X | Strong |
| | | | Quality and Clinic Audit Plan - Annual Report and update reports | | | X | X | | Strong |
| **2.2** | Professional Regulation | | Annual report to People and OD Committee /QSIC | | X | X | X | | Strong |
| | | | Quality Review Visit by medical revalidation support unit | X | X | X | X | | Moderate |
| **2.3** | Incident Reporting Management System | | Putting Thing Right - Report | | | X | X | | Moderate |
| | | | Putting Thing Right - Annual | | | X | X | | Strong |
| | | | Organisational Annual Report – (Reported to WG) | | | X | X | | Strong |
| | | | SI reporting as occurs | | | X | X | X | Moderate |
| **2.4** | Directorates Mid & end year review process | | Directorates Mid and year end reports | | X | X | | X | Strong |
| **2.5** | External Reviews | | HIW Inspections | | | X | X | X | Strong |
| | | | HSC | | | X | X | | Strong |
| | | | JAG accreditation | X | X | X | | | Weak |
| | | | UKAS Accreditation | X | X | X | X | | Weak |
| | | | Audit Wales Structured Assessment | X | X | X | X | X | Strong |
| **2.6** | Health Care Support worker programme | | Update reports (PODCOM) (Annual) | | X | X | X | | Moderate |
| ***2.7*** | Medicines Management System | Executive Director of Public Health Services/Medical Director / Executive Director Quality, Nursing and Allied Health | Medicines Management Policy | | | X | X | | Weak |
| | | | Medicines Management Procedure | | | X | X | | Weak |
| | | | Pharmaceutical SLA with Cardiff & Vale University Health Board | | | X | | | Weak |
| ***2.8*** | Medical Devices Arrangements | | Medical Devices Policy | | | X | X | | Weak |
| | | | Medical Devices Procedure | | | X | X | | Weak |
| | | | Medical Devices Registers (Microbiology Laboratories) | X | | | | | Weak |
| | | | Medical Devices Screening Division Register | X | | | | | Weak |
| | | | Medical Devices Register (Corporate) | X | | | | | Moderate |
| ***2.9*** | Public Health Services QMS | Exec Director of Public Health Services/Medical Director | Local Audit | X | | | | | Moderate |
| | | | Vertical & Horizontal Audits of Microbiology Laboratory Services | X | | | | | Strong |
| ***2.10*** | Failsafe systems | Executive Director of Public Health Services/Medical Director | Defined failsafe task and finish groups (papers and notes) to review screening programmes against policy | X | | | | | Weak |
| | | | SI reporting as occurs to Board and quarterly to QS&I Committee | | | X | X | X | Moderate |
| | | | Screening Division – Standard Operating Procedures (document development, review and approval) | X | | | | | Moderate |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| *2.11* | Microbiology Stabilisation Programme | Executive Director of Public Health Services/Medical Director | Microbiology Division – Standard Operating Procedures (document development, review and approval) | X | | | | | ***Strong*** |
| | | | Stabilisation Action Plan process Update on hold due to Covid | X | X | X | | | ***No Assurance*** |
| | | | Stabilisation Action Plan: Progress Update Reports to QSIC on hold due to Covid | | | X | X | | ***No Assurance*** |
| | | | Reports to Board (AD HOC) on hold due to Covid | | | X | | X | ***No Assurance*** |
| | | | Microbiology Programme Board Reports on hold due to Covid | | | X | | | ***No Assurance*** |
| 2.12 | Recruitment Procedures and Checks policy | Acting Director of People & Organisational Development | Appropriate job descriptions | X | | | | | **Weak** |
| 2.13 | Statutory & Mandatory training Competency and role based training and Regulatory standards | | Included in Integrated Performance Report | | | X | | X | **Strong** |
| 2.14 | People & OD Performance Information and Reports (Including Detailed recruitment MI) | | Included in Integrated Performance Report | | | X | | X | **Strong** |
| 2.15 | Personal Development Reviews 'My Contribution' | | Included in Integrated Performance Report | | | X | | X | **Strong** |
| 2.16 | Workforce Plan | | Reports to People & OD Committee (as part of the IMPT process) | | | | X | | **Moderate** |
| | | | Directorate workforce plans | | X | X | | | **Weak** |
| 2.17 | Staff Survey | | Staff Survey results | | | X | X | X | **Moderate** |
| | | | Engagement Reporting | | | X | X | | **Weak** |
| 2.18 | Leadership and Management development Programme | | Performance Data Report | | X | X | | X | **Strong** |
| 2.19 | Occupational Health provision | | Reports to QS&I Committee and POD Committee | | | | X | | **Weak** |
| 2.20 | Policies | Board Secretary & Head of Board Business Unit | Policy, Procedures and other written control documents Policy | | | X | X | X | **Moderate** |
| | | | Policy, procedures and other written control documents Procedure | | X | X | | | **Moderate** |
| | | | Policy register report to Audit and Corporate Governance Committee on compliance with Policies | | X | X | X | X | **Moderate** |
| | | | Policy register report of relevant policies to each Board Committee | | | X | X | | **Moderate** |
| 2.21 | Internal Audit Programme | | Internal audit plan | | | X | X | | **Moderate** |
| | | | Audit reports as a result of the annual programme | | X | X | X | | **Moderate** |
| | | | Annual head of internal audit report | | | X | X | X | **Moderate** |
| | | | Internal audit action log (and follow up of actions) | | X | | X | | **Moderate** |
| 2.22 | Department Standard Operating Procedures | Exec Team (report via Board Secretary) | | | | | | | |
| **2.23** | Health & Safety plan | Deputy Chief Exec/ Exec Director of Operations & Finance | Health and safety action plan and associated reports | X | X | | X | | **Moderate** |

# Strategic Risk Register – Risk 2 | Action Plan

| Control Number | Gaps in controls | Gaps in assurance | | Action Plan | Exec Lead | Due Date | Progress |
|---|---|---|---|---|---|---|---|
| ***NEW*** | Absence of existing coherent and comprehensive Integrated Governance Framework | Lack of assurance mechanism in relation to effectiveness of an Integrated Governance Framework | *1* | Complete a gap analysis on current integrated governance arrangements. | Executive Director Quality, Nursing and Allied Health Professionals | December 2020 | **October Update:** On Track<br><br>**Previous update:**<br>Due to the emergency response to Covid-19 this work has been unable to progress, as all available people resources have been mobilised to work on the response. Within the current context, this action, the scope of this work needs to be revised to focus on COVID, resource issues, and Governance 'Hotspots' to target and focus the analysis. A revised date of December 2020 has been added for completion for this work. |
| | | | *2* | Develop a Quality assurance dashboard<br>. | | ~~To be determined~~ *March 2021*<br><br>*(approved by QSIC 17.11.20)* | **October Update:**<br>The standard quality indicators reported to BET/Board (eg. Complaints, incidents etc), will be developed into interactive dashboards by December 2020.<br><br>The quality assurance dashboard model is currently in development and requires further engagement with the planning team. This will be completed by March 2021.<br><br>**Previous Update:**<br>The draft Quality assurance dashboard in conjunction with a revised format for the PTR report, has been developed and will be presented to the Quality, Safety and Improvement Committee on 11 February 2020 for consideration. The management dashboard component of this action was completed and further work is ongoing to further improve the dashboard and PTR report. .This work has been superseded by the development of the Performance and Assurance Dashboard. |
| | | | *3* | Ensure the Quality Assurance Dashboard includes measures / indicators to include the IPC and safeguarding indicators | | December 2020 | **October Update: On track**<br>Safeguarding KPIs in place and reported against in the annual report. IP+C being developed and will form part of our annual reporting arrangements |
| | | | *4* | Develop an Integrated Governance Model and Implementation Plan | | April 2021 | **October Update:** This work has commenced.<br><br>**Previous Update:**<br>Integrated Governance models and implementation plan will be agreed and commenced. This work has been impacted by the Covid-19 response. |
| | | | *5* | Complete a Governance Stakeholder mapping exercise | | December 2020 | **October Update:** On track.<br><br>**Previous Update:**<br>Work has commenced to identify organisational integrated governance stakeholders. This work has been impacted the Covid- |

| Control Number | Gaps in controls | Gaps in assurance | | Action Plan | Exec Lead | Due Date | Progress |
|---|---|---|---|---|---|---|---|
| | | | | | | | 19 response but will recommence within the available resource constraints. |
| ***2.1*** | | Gaps in consistently applied, monitored and reported quality and improvement measures aligned to strategic priority outcomes and integrated performance report | 6 | Develop and approve Quality and Improvement Strategy | | ~~November 2020~~ January 2021 *(approved by QSIC 17.11.20)* | **October Update:** Progress has been made on the development of the Quality and Improvement Strategy, submission to QSIC has now been moved back to January due to COVID-19 pressures. **Action for QSIC Committee: Request change of date to January 2021**<br><br>**Previous Update:** Work is ongoing to engage key stakeholders on the Quality and Improvement Strategy and Executive Directors have been asked to identify Quality and Improvement champions and the role profile has been developed. This work has been paused due to the Quality Improvement team having been redeployed to other duties to support the Covid-19 emergency response. A meeting was held in August to agree the content of the strategy, and the first draft will be shared and engage with directorates. This will be reported to BET in October, and QSIC in November 2020. |
| | | | 7 | QNHAPS working in conjunction with planning team, to develop quality indicators with the Stage 2 workstreams in order to be able to measure and monitor outcomes and improvements. | | To be determined | **October Update:** This work is ongoing and will be progressed through the implementation of the new Operational plan.<br><br>**Previous update:** Draft indicators presented to Gold. Further work to be undertaken to refine the quality indicates by working with Stage 2 workstreams, in order that they can be incorporated into the performance and assurance dashboard. |
| | | Gaps in ownership of improvement actions at Directorate for the Health Care Standards Self-Assessment. | 8 | Support ownership in Directorates and Divisions in identifying improvements and enacting action plans | | February 2021 | **October Update:** In progress.<br><br>**Previous update:** Self-assessment template has been amended to ensure a responsible owner for each improvement action is identified. This was further explained during a workshop in October 2019, and again at the Peer Review session in January 2020. Improvement actions will continue to be monitored on a quarterly basis via the Integrated Performance Report. A report to close the 2019/20 Health and Care Standards report was received by the Quality, Safety and Improvement Committee on 7 September 2020.A revised process for 2020/21 will be re-issued and adapted to reflect the current COVID context. This will be reported to BET in February 2021, and QSIC thereafter. |

# Strategic Risk Register – Risk 2 | Action Plan

| Control Number | Gaps in controls | Gaps in assurance | | Action Plan | Exec Lead | Due Date | Progress |
|---|---|---|---|---|---|---|---|
| | | Gaps in consistently applied KPIs for IPC and Safeguarding | 9 | Develop Quality Management Dashboard to include assurance for IPC and Safeguarding to provide regular reporting to QSIC | | ~~November 2020~~ *March 2021*<br><br>*(approved by QSIC 17.11.20)* | **October Update**:<br>The IP+C and Safeguarding indicators will be reported against within annual report.<br><br>**Previous update:**<br>Work is progressing to identify KPIs in both safeguarding and IPC and these will be included in the Quality Management and Assurance Dashboard when finalised. This work has been paused as the safeguarding lead has been redeployed to support the Covid-19 emergency response. |
| | | Development of Quality and Clinical Audit Plan was not fully aligned with adherence to SOPs and improvement activity. | 10 | Further develop Quality and Clinical Audit Plan to ensure alignment with adherence to SOPs and improvement activity for next audit planning cycle | Executive Director Quality, Nursing and Allied Health Professionals | May 2021 | **October Update**:<br>Discussions ongoing with directorates to ensure their audit cycles also include reviews of their SOPs<br><br>**Previous update:**<br>The Quality and Clinical Audit Plan for 2020/21 was approved by the Quality, Safety and Improvement Committee at its meeting in September 2020. The plan will be updated and reviewed during 2020/21, and a 6 monthly report will be provided to QSIC. The 2021/22 Quality and Clinical Audit Plan will be received at QSIC in May 2021. |
| ***2.3*** | Lack of systematic and embedded approach to reflecting and learning from raising concerns (Whistleblowing) | Lack of assurance mechanism for 'raising concerns' (Whistleblowing) | 11 | Implement an organisational approach to disseminating and raising awareness of the 'Raising Concerns' (whistleblowing) policy | Board Secretary and Head of Board Business Unit | March 2021 | **October Update**:<br>Update: Work will recommence on this in December 2020.<br><br>**Previous update:**<br>This work has been temporarily paused due to the Covid-19 response but will be resumed in the coming weeks. The All Wales policy, dedicated intranet page and advice remains in place. |
| *2.7* | Absence of up to date and accurate medical devices register | | 12 | See action plan for 2.8 (Actions 14,15,16) | | | |
| *2.8* | Lack of systematic assurance mechanism in relation to management of medical devices | | *13* | Strengthen organisational governance of medical devices (including registers) | Executive Director of Public Health Services/Medical Director<br><br>Executive Director Quality, Nursing and Allied Health Professionals | ~~November 2020~~ March 2021<br><br>*(approved by QSIC 17.11.20)* | **October Update**:<br>Scoping work has commenced to review the organisation's current governance of medical devices and will report and make recommendations to strengthen where required.<br><br>**Previous update:**<br>Work has completed to review the reviewing medical asset register. The next step is to review within Public Health Services. This work has not proceeded since the beginning of the year because of competing demands in key staff to the COVID response. Externally commissioned support will be required to complete these actions. The date provided refers to the intent to commission this work. |
| | | | *14* | Review the Medical Devices Policy and Procedure (due to | | March 2021 | **October Update**:<br>As above, on target |

| Control Number | Gaps in controls | Gaps in assurance | | Action Plan | Exec Lead | Due Date | Progress |
|---|---|---|---|---|---|---|---|
| | | | | Medical Devices and IVD Regulations) | | | **Previous update:**<br>This work has been temporarily paused due to the Covid-19 response but will be resumed in the coming weeks. A revised date of March 2021 has been added for completion of this work. |
| | | | 15 | Scope non-clinical areas to ensure that no devices remain unaccounted for in the governance arrangements | | November 2020 | **October Update**:<br>As above, on target<br><br>**Previous update:**<br>Work has completed to review the reviewing medical asset register. The next step is to review within Public Health Services. This work has not proceeded since the beginning of the year because of competing demands in key staff to the COVID response. Externally commissioned support will be required to complete these actions. The date provided refers to the intent to commission this work. |
| ***2.10*** | Delivery of the National Health Protection Service Transformation Programme | | 16 | See Action in Risk 3 | | | |
| ***2.20*** | Process inconsistently applied for updating and disseminating new/ updated policies | | 17 | Development of existing procedure to ensure a consistent approach to policy development, approval and communication that is timely and effective. | Board Secretary and Head of Board Business Unit | January 2021 | **October Update**:<br>On track.<br><br>**Previous update:**<br>This is in progress. The Policy for policies, and procedures and other written control documents has been revised and approved by the Board. The procedure will be consulted on during the Autumn. Work will then commence on improving communication and compliance. |
| ***2.21*** | Clear picture of all audit related activity across the organisation (corporate & clinical) | | 18 | Develop a comprehensive overview that collates and summarises all audit activity planned for April 2021 onwards – repeat on an annual basis | Board Secretary and Head of Board Business Unit / Executive Director Quality, Nursing and Allied Health Professionals | April 2021 | **October Update**:<br>Work is scheduled to commence and target remains on track. Mapping exercise from PHW Quality and Clinical Audit Plan to domains of the NHS Wales Delivery Framework completed. Further discussions planned with BDU to ensure, as an organisation, we have clear oversight regarding clinical audits. |
| ***2.22*** | Confirmation of appropriate processes being in place within each directorate for updating and disseminating new/updated standard operating procedures | Gap in assessment of adherence with SOPs and testing using Quality and Clinical Audit. | 19 | Conduct Audit of what Standard Operating Procedures (SOPs) processes are in place in each directorate that meets a required standard. | Executive team members (reported via Board Secretary and Head of Board Business Unit) | February 2021 | **October Update**:<br>This work commenced prior to COVID within Public Health Services, and will now be resumed. |
| | | | 21 | Test compliance and adherence with SOPs | | April 2021 | |

| Strategic Risk Register – Risk 2 | Action Plan |
|---|---|

| Control Number | Gaps in controls | Gaps in assurance | | Action Plan | Exec Lead | Due Date | Progress |
|---|---|---|---|---|---|---|---|
| *new* | | | 22 | ~~Compliance with minimum standards for IPC (for reactivation of Screening Services)~~ | Executive Director Quality, Nursing and Allied Health Professionals | October 2020 | **October Update**:<br>Completed for October. Advice provided to screening services prior to any reactivation, in line with agreed guidance. This is an ongoing process and will also be part of the monitoring arrangements for implementation of the Operational plan, via the Reactivation workstream.<br><br>**Action approved for closure at QSIC Committee 17.11.20** |
| *new* | | | *23* | Once for Wales Datix system to be implemented by March 2021 | | March 2021 | **October Update**:<br>Paper to BET in November 2020<br><br>**Previous update:**<br>The implementation of the entire system has been brought forward to March 2021 subject to Public Health Wales agreed the WG timeline. Public Health Wales are considering the resource implications. |

# Strategic Risk Register – Risk 3 | Dashboard

| | |
|---|---|
| **Risk 3** | There is a risk that Public Health Wales will fail to deliver a sustainable, high quality and effective infection and screening services. This will be caused by a lack of sufficient workforce capacity; over-reliance on existing systems/procedures, lack of sufficient change capacity and an estate and infrastructure which is not fit for purpose. |

| **Sponsor and Assurance Group** | |
|---|---|
| **Executive Sponsor** | Dr Quentin Sandifer, Executive Director Public Health Services / Medical Director |
| **Assuring Group** | Quality, Safety and Improvement Committee<br>Audit and Corporate Governance Committee |

| **Inherent Risk** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date** | | **Likelihood:** | **5** | **Impact:** | **5** | **Score:** | **25** |

| **Risk Score** | | | | | | **Risk Decision** |
|---|---|---|---|---|---|---|
| **Current Risk** | | | **Target risk** | | | |
| **Likelihood** | **Impact** | 20 | **Likelihood** | **Impact** | 15 | **TREAT** |
| 4 | 5 | | 3 | 5 | | |

| **Applicable Strategic Priorities** | |
|---|---|
| Influencing the wider determinants of health | ☐ |
| Improving mental well-being and building resilience | ☐ |
| Promoting healthy behaviours | ☐ |
| Securing a healthy future for the next generation through a focus on early years. | ☐ |
| Protecting the public from infection and environmental threats to health | ☒ |
| Supporting the development of a sustainable health and care system focused on prevention and early intervention | ☒ |
| Building and mobilising knowledge and skills to improve health and well-being across Wales | ☐ |

# Strategic Risk Register - Risk 3 | Controls

| Existing Control | | | Sources of Assurance | Level at which the Assurance is provided to | | | | |
|---|---|---|---|---|---|---|---|---|
| No. | Control | Exec Owner | | Team / Division / Project / Programme | Directorate Team / Exec Lead | Business Exec Team / Sub Groups | Committee / Sub group | Board |
| 3.1 | Policies and Procedures * (document development, review and approval)<br><br>* including Standard Operating Procedures | Executive Director Public Health Services / Medical Director | Corporate Policy and Control Document Reviews – corporate register update reports | X | X | X | X | X |
| | | | Health Protection Division – Standard Operating Procedures (document development, review and approval) | X | X | | | |
| | | | Microbiology Division – Standard Operating Procedures (document development, review and approval) | X | X | | | |
| | | | Screening Division – Standard Operating Procedures (document development, review and approval) | X | | | | |
| 3.2 | UK Accreditation Service (UKAS) -Accreditation | | Reports to Quality, Safety and Improvement Committee | | X | X | X | |
| | | | Action Plan and Reports – Divisional Senior Management Teams | X | | | | |
| 3.3 | Professional Regulation – Medical, Nursing and Multi-Disciplinary Staff | Executive Director Public Health Services / Medical Director Executive Director Quality, Nursing and Allied Health Professionals | Medical, Nursing and Multi-Disciplinary Staff Revalidation - Annual Report to People and Organisational Development Committee / Quality, Safety and Improvement Committee | | | | X | |
| | | | Quality review visit by Medical and Multi-Disciplinary Revalidation support unit | | | X | X | |
| | | | Quality Indicators Performance Monitoring | | | X | X | X |
| | | | Monitor registered and revalidation | | X | | | |
| | | | Medical, Nursing and Multi-Disciplinary Appraisal Process – Quality Indicator | | | X | X | X |
| | | | Medical Job Planning Process – Quality Indicator | | | X | | X |
| 3.4 | Health and Safety Management System | Deputy Chief Executive and Executive Director Operations and Finance | Update Reports to Health and Safety Group | X | X | X | X | |
| | | | Health and Safety Action Plan | | X | X | X | |
| | | | Microbiology Division Health and Safety Sub-Groups (reports to Divisional SMTs) | X | X | | | |
| | | | Update Reports to People and Organisational Development Committee | | X | X | X | |
| 3.5 | Business Continuity Arrangements (for Public Health Services) | Executive Director Public Health Services / Medical Director | Business Continuity Action Plans (Public Health Services) | X | X | X | | |
| | | | Emergency Planning and Business Continuity Group Meeting minutes | | X | | | |
| | | | Learning and Development Prospectus for Business – Training and Exercise reports to Emergency Planning and Business Continuity Group | | X | | | |
| | | | Emergency Planning and Business Continuity Annual Work Plan | | X | | | |
| | | | Emergency Planning and Business Continuity Documentation (regular review and update) | X | X | | | |
| | | | Emergency Planning and Business Continuity Report - Audit and Corporate Governance Committee | X | | | X | |
| 3.6 | National Health Protection Service (NHPS) Transformation Programme (including Microbiology Stabilisation) | Executive Director Public Health Services / Medical Director | National Health Protection Service Transformation (Programme) Board - Meeting Minutes and Papers | X | X | X | | |
| | | | National Health Protection Service Transformation Programme Plan(s) | X | X | X | | |
| | | | Microbiology Stabilisation Plan | X | X | X | | |
| | | | Stabilisation/Transformation Reports to QSI Committee and Board | | | X | X | X |
| | | | Divisional Assurance Reports to DLT (inform Executive Director Reports – see 3.7) | X | X | | | |

# Strategic Risk Register - Risk 3 | Controls

| Existing Control | | | Sources of Assurance | Level at which the Assurance is provided to | | | | |
|---|---|---|---|---|---|---|---|---|
| **No.** | Control | Exec Owner | | Team / Division / Project / Programme | Directorate Team / Exec Lead | Business Exec Team / Sub Groups | Committee / Sub group | Board |
| **3.7** | Directorate Business and Financial Management Systems and Processes | Executive Director Public Health Services / Medical Director | Reports provided to SMTs and DLT | X | X | | | |
| | | | Public Health Services Directorate Leadership Team (DLT) meeting minutes and papers (bi-monthly) | X | X | | | |
| | | | Senior Management Team (SMT) Meeting minutes and papers (monthly) | X | | | | |
| | | | Directorate Leadership Team Finance Sub-Group meeting minutes and papers (monthly) | | X | | | |
| | | | Divisional Assurance Reports to DLT (inform Executive Director Reports) | X | X | X | | |
| | | | Executive Director Reports (to Executive and Board) | | | X | | X |
| | | | Mid and End of Year Review Reports (Executive scrutiny) | | X | X | | |
| **3.8** | Quality Management Systems (including informatics and information managements systems) | Executive Director Public Health Services / Medical Director Executive Director Quality, Nursing and Allied Health Professionals | Health and Care Standards Reporting | | X | X | X | X |
| | | | Reporting on Quality Impact Framework Implementation Plan | | X | X | X | |
| | | | Local Audits | X | X | X | X | |
| | | | Vertical and Horizontal Audits of Microbiology Laboratory Services | X | | | | |
| | | | Quality and Clinical Audit Plan – Annual Report | | X | X | X | |
| | | | Quality and Clinical Audit Plan – Bi-annual report to Quality, Safety and Improvement Committee | | X | X | X | |
| | | | Mid and End of Year Review Reports (Executive scrutiny) | | X | X | | |
| | | | Informatics Programmes/Project Board Reports (minutes, papers and reports via Annual Plan) | X | X | X | | |
| **3.9** | Incident Reporting Management System | Executive Director Public Health Services / Medical Director Executive Director Quality, Nursing and Allied Health Professionals | Putting Things Right - Annual Report | | | X | X | |
| | | | Putting Things Right - Quarterly Alert Exception Report (Quality, Safety and Improvement Committee) | | | X | X | |
| | | | Serious Incident Reporting (Quarterly) to Quality, Safety and Improvement Committee | | | X | X | |
| **3.10** | Failsafe Systems | Executive Director Public Health Services / Medical Director | Defined failsafe task and finish groups to review screening programmes against policy | X | X | X | X | |
| | | | Review of serious incidents to determine if further failsafe required (Microbiology and Screening) | X | X | X | | |
| | | | Screening Division – Standard Operating Procedures (document development, review and approval) | X | X | | | |
| | | | Microbiology Division – Standard Operating Procedures (document development, review and approval) | X | X | | | |
| | | | Health Protection Division – Standard Operating Procedures (document development, review and approval) | X | X | | | |
| **3.11** | Infection, Prevention and Control Systems | Executive Director Public Health Services / Medical Director Executive Director Quality, Nursing and Allied Health Professionals | Infection Reporting Dashboard | X | X | X | | |
| | | | Health Protection Situational Awareness Reports – (monthly report to Executive) | X | X | X | | |
| | | | Public Health Wales Infection, Prevention Control Group – minutes and papers (minutes received by Quality, Safety and Improvement Committee) | X | X | X | X | |
| | | | Agreed criteria for escalation (reviewed on an annual basis) | X | X | X | | |

# Strategic Risk Register - Risk 3 | Controls

| Existing Control | | | Sources of Assurance | Level at which the Assurance is provided to | | | | |
|---|---|---|---|---|---|---|---|---|
| **No.** | Control | Exec Owner | | Team / Division / Project / Programme | Directorate Team / Exec Lead | Business Exec Team / Sub Groups | Committee / Sub group | Board |
| **3.12** | Workforce/Recruitment Planning | Executive Director Public Health Services / Medical Director | Reports of progress against Workforce Plans | X | X | X | | |
| | | | Reports to the People and Organisational Development Committee (part of annual Integrated Medium Term Plan planning cycle) | | | X | X | |
| | | | Health Protection and Microbiology Workforce subcommittees minutes and papers (report to Senior Managements Teams) | X | | | | |
| **3.13** | DESW Optimisation and Transformation Programme | | Monitoring progress against plans (reports) | X | X | X | | |
| | | | Divisional Assurance Reports to DLT (inform Executive Director Reports – see 3.7) | X | X | | | |
| | | | Optimisation/Transformation Reports to Quality, Safety and Improvement Committee and Board | | | X | X | |

# Strategic Risk Register - Risk 3 | Action Plan

| Control No. | Gaps in controls | Gaps in assurance | | Action Plan | Exec Lead | Due Date | Progress |
|---|---|---|---|---|---|---|---|
| **3.4** | | | 1 | Delivery of Estates Action Plan and Health / Safety Action Plan | Deputy Chief Executive / Executive Director of Finance and Operations | -- | Ongoing delivery of estate / Health and Safety action plan in relation to Microbiology Laboratory estate. All actions in relation to HSE Improvement notices are complete and notices removed. |
| **3.5** | Approval of Business Continuity Plans | Assurance reporting to Audit and Corporate Governance Committee | 2 | Strengthen arrangements for approval of Business Continuity Plans and assurance reporting | Executive Director Public Health Services / Medical Director | To be determined | **October Update:** Business Continuity risk assessment in the context of EU exit is planned to take place during November 2020, with a report to the Business Executive Team in December 2020.<br><br>**Previous update:** No further progress has been made on this action plan due to the organisation's ongoing "enhanced response" to the COVID-19 pandemic. The Business Continuity Arrangements for all areas of the organisation have been enacted. A recent assessment of Business Continuity Plans and the resources needed to maintain critical services has been undertaken in March 2020, the outcome of which was presented to the Gold Group to inform decision-making concerning resource allocation. Business Continuity considerations are regularly considered by the Executive Team and Gold Group, as part of the ongoing strategic management of the organisation. |
| **3.7** | Resilience of business management systems and processes | Assurance reporting – general (strengthening required) | 3 | Public Health Services Directorate Governance Review: Action Plan | | To be determined | **October Update:** No further update. This action is suspended due to the organisation's ongoing "enhanced response" to the COVID-19 pandemic.<br><br>**Previous update:** Public Health Wales' ongoing "enhanced response" to the COVID-19 pandemic is the priority for the organisation and currently involves the deployment of the majority of resource within the Public Health Services Directorate. As a consequence no further progress has been made with regard to this action plan. |
| **3.6** | | | 4 | Delivery of the National Health Protection Service Transformation Programme | | April 2021 | **October Update:** Attempts to recruit to posts approved in the Welsh Government funded plan are ongoing. A further business plan for additional investment in Health Protection is being developed.<br><br>**Previous update:** No further progress has been made on this action plan due to the organisation's ongoing "enhanced response" to the COVID-19 pandemic. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **3.8** | | Additional source of assurance for Quality Management Systems, in relation to screening information management systems | 5 | Implementation of Cervical Screening Information Management System (CSIMS) | Executive Director Public Health Services / Medical Director<br>Deputy Chief Executive / Executive Director of Finance and Operations | ~~December 2020~~<br>To be determined<br><br>*(approved by QSIC 17.11.20)* | **October Update:** The timescales of December 2020 will not be met due to disruption of work to support coronavirus pandemic. NHAIS will continue to be available after December 2020. Impact of medical devises regulations on the timescales of the development need to be fully understood. Additional members identified for Project Board to take work forward.<br><br>Previous update:<br>Work is progressing within current capacity that is not directed to COVID-19 response, recognising risk to disruption of work with competing urgent priorities to support the "enhanced response" to the coronavirus pandemic. Testing planned to continue in April 2020 as information that NHS England progressing with system so NHAIS may not be available from December 2020. |
| **3.10 & 3.13** | | Gap in assurance relating to failsafe systems in Diabetic Eye Screening Wales | 6 | Implementation of risk-based diabetic eye screening | Executive Director Public Health Services / Medical Director | April 2021 | **October Update:** This is part of the delivery of the DESW optimisation and transformation programme as detailed below. |
| | | | 7 | Delivery of the DESW Optimisation and Transformation Programme | | To be determined | **October Update:** The Diabetic Eye Screening Programme was temporarily paused on 16 March 2020 in line with Welsh Government, Chief Medical Officer and Executive Team approval. Optimisation work has been undertaken during the pause especially around quality assurance of grading, training for screeners and photographers and the appointment of regional nurses. The screening programme restarted in September 2020. DESW transformation work has been taken forward with new project lead and team appointed. Key work has been undertaken to support the reinstatement of the programmes. Main current task is to lead informatics system upgrade which is planned for January 2020 and necessary step for optimisation and transformational work. |
| | | | 8 | Review to ensure that our Screening and Microbiology operating systems are all 'failsafe' | | December 2020 | **October Update:** Progress has been made on this action plan although this has been slower due to the organisation's ongoing "enhanced response" to the COVID-19 pandemic. Update on failsafe work taken to QSIC in November. |

# Strategic Risk Register – Risk 5 | Dashboard

| | |
|---|---|
| **Risk 5** | There is an increased risk as a result of COVID-19 that Public Health Wales will fail to provide the level of system leadership needed to deliver the population health gains articulated in the long term strategy. This insufficient capacity/ resource within the organisation, policy and prioritisation decisions of external agencies and wider social, economic and environmental factors. |

| **Applicable Strategic Priorities** | |
|---|---|
| Influencing the wider determinants of health | ☒ |
| Improving mental well-being and building resilience | ☒ |
| Promoting healthy behaviours | ☒ |
| Securing a healthy future for the next generation through a focus on early years. | ☒ |
| Protecting the public from infection and environmental threats to health | ☒ |
| Supporting the development of a sustainable health and care system focused on prevention and early intervention | ☒ |
| Building and mobilising knowledge and skills to improve health and well-being across Wales | ☒ |

## Sponsor and Assurance Group

| | |
|---|---|
| **Executive Sponsor** | Jyoti Atri, Interim Executive Director Health and Wellbeing |
| **Assuring Group** | Business Executive Team and Board |

| **Inherent Risk** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date** | | **Likelihood:** | **5** | **Impact:** | **5** | **Score:** | **25** |

| **Risk Score** | | | | | | **Risk Decision** |
|---|---|---|---|---|---|---|
| **Current Risk** | | | **Target risk** | | | **TREAT IN PART TOLERATE IN PART – WHICH IS WHY 25 (9/10)** |
| **Likelihood** | **Impact** | 25 | **Likelihood** | **Impact** | 15 | |
| 5 | 5 | | 3 | 5 | | |

# Strategic Risk Register – Risk 5 | Controls

| EXISTING CONTROLS | | | SOURCES OF ASSURANCE | Level at which the Assurance is provided to | | | | |
|---|---|---|---|---|---|---|---|---|
| **No.** | **Control** | **Exec Owner** | **Assurance** | **Team / Division / Project / Programme** | **Directorate Team / Exec Lead** | **Business Exec Team / Sub Groups** | **Committee / Sub group** | **Board** |
| **5.1** | Building a Healthier Wales programme | Executive Director – Health and Wellbeing | BaHW agreed revised priorities in the COVID context, minutes of Co-ordinating Group meeting 05.10.20 | X | X | X | | X |
| | | | Building a Healthier Wales to receive spending plans against £7.2m allocations to Health Boards as part of their oversight role (on hold) PHW and HB have been asked to submit their spending plans for 20/21 against this allocation to WG. Many are unlikely to be able to spend the entire allocation due to capacity being redirected to COVID-19 management. | X | X | X | | |
| | | | BaHW Co-ordinating Group TOR and minutes | X | X | X | | X |
| | | | BaHW Project Group TOR and minutes | X | X | X | | X |
| **5.2** | Development of behaviour change capacity and skills | | Update reports | X | X | X | | X |
| **5.3** | Dialogue with Boards across Wales to support shift towards prevention and scale up of evidence based interventions | | Biannual joint accountability meetings paperwork (on hold) | X | X | X | | X |
| | | | Framework for Board to Boards | X | X | X | | X |
| | | | Notes from Board to Boards (on hold) | X | X | X | | X |
| | | | IMTP (on hold) | X | X | X | | X |

Due to Covid-19, all of the above controls and assurances are currently on hold. The assurance level will evaluated when decisions are made about future activities.

# Strategic Risk Register – Risk 5 | Action Plan

| Control Number | Gaps in controls | Gaps in assurance | | Action Plan | Exec Lead | Due Date | Progress |
|---|---|---|---|---|---|---|---|
| **5.3** | Ensuring there is increasing investment in prevention across the public sector | | 1 | Establish baseline spend on prevention | Executive Director – Health and Wellbeing | To be determined | **October update:**<br>Most of these actions identified are intended to be advanced at a future point as Building a Healthier Wales is currently on hold due to COVID-19.<br><br>There is likely to be a role for CWW in taking forward one of more of the revised BAHW priorities.<br><br>There is renewed interest in Behavioural science and its application to COVID control measures. As a result we are developing a programme of work which will be commissioned. |
| | | | 2 | Develop a mechanism to track the spend on prevention | | | |
| **5.3** | Ensuring that additional investment in prevention is spent in line with the evidence and results in improved outcomes | | 3 | Commission evaluation once for Wales | | | |
| | | | 4 | Building a Healthier Wales to establish mechanisms for oversight | | | |
| **5.3** | Galvanising voluntary sector resources for evidence based preventative interventions | | 5 | Revised Terms of reference and work plan for CWW | | | |
| **5.2** | Development of behaviour change capacity and skills | | 6 | Successful recruitment to Programme Director Post | | | |
| | | | 7 | Grants/contracts awarded | | | |
| **5.1** | Strengthen governance arrangements with DPHS | | 8 | Update MOUs with Health Boards | Deputy Chief Executive/ Executive Director of Operations Finance<br>Board Secretary and Head of Board Business Unit | | |
| | | | 9 | Update honorary contracts with DPHS | Executive Director – Health and Wellbeing<br>Acting Director – People and Organisational Development | | |
| **New control identified relating to policy** | | | 10 | Utilise the WHO CC to act as a policy think tank for WG and other Public Health stakeholders. Deliver the work plan of the WHO CC. | Director of Policy and International Health (the WHO CC) | Ongoing | The WHO CC is progressing its agreed joint work plan with WHO and has already submitted two annual reports (for 2018/19 and for 2019/20) to WHO. The WHO CC has also been through scrutiny (Deep Dive, 2019 and Progress Update, 2020) at the KRIC. The WHO CC benefits to Wales, supporting Public Health Wales system leadership role and working closely with Welsh Government, are apparent. We are enabling and strengthening Wales' international 'influencer' role and our organisational national and global leadership role through developing a formal agreements (MoU) between Wales and the WHO going forward, signed in 2020. As part of this, we are applying and developing further state of the art public health tools and approaches first in Wales, making it a health equity innovation site for Europe. The Health |

# Strategic Risk Register – Risk 5 | Action Plan

| Control Number | Gaps in controls | Gaps in assurance | | Action Plan | Exec Lead | Due Date | Progress |
|---|---|---|---|---|---|---|---|
| | | | | | | | Equity Status Report initiative is a key example of this (together with our work on Evidencing Value/SROI and ACEs)<br><br>**October update:**<br>Currently risk remains as core funding for some key elements of this work has ended in April 2020 and funding, we applied for, through the annual investment processes, wasn't received due to the COVID-19 pandemic outbreak. The work on the Welsh Health Equity Status Report initiative (WHESRi), Solutions Platform and Evidencing Value was put on hold during the COVID-19 response, March to September 2020 |
| **New control identified relating to policy** | | | 11 | Continue the periodic meetings with Cabinet Secretaries, Ministers and their officials across Government as appropriate in order to inform them on the work of Public Health Wales and support the application of health in all polices in their respective areas. | Chief Executive / Chair | Ongoing | **October update: Ongoing**<br><br>Relevant meetings have taken place between Chief Executive / Chair and appropriate government ministers. |

# Strategic Risk Register – Risk 6 | Dashboard

| Risk 6 | There is a risk that Public Health Wales will fail to secure and align resources to deliver its statutory functions including its response to the COVID-19 pandemic. This will be caused by funding cuts or inability to make required savings, secure funding (replaced generate income) or move resources within the organisation |
|---|---|

| Applicable Strategic Priorities | |
|---|---|
| Influencing the wider determinants of health | ☒ |
| Improving mental well-being and building resilience | ☒ |
| Promoting healthy behaviours | ☒ |
| Securing a healthy future for the next generation through a focus on early years. | ☒ |
| Protecting the public from infection and environmental threats to health | ☒ |
| Supporting the development of a sustainable health and care system focused on prevention and early intervention | ☒ |
| Building and mobilising knowledge and skills to improve health and well-being across Wales | ☒ |

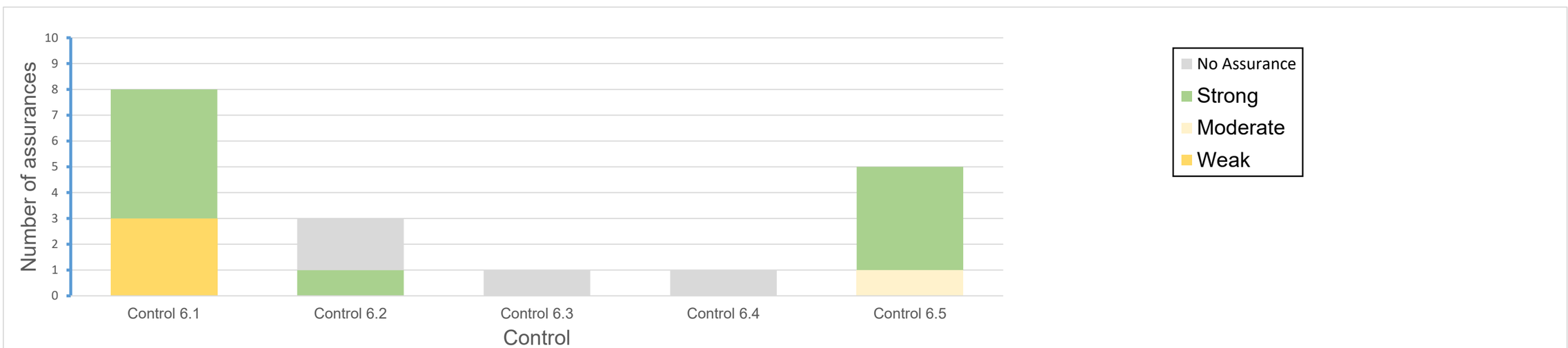
| Sponsor and Assurance Group | |
|---|---|
| **Executive Sponsor** | Huw George, Deputy Chief Executive / Director of Finance and Operations |
| **Assuring Group** | Audit and Corporate Governance Committee |

| Inherent Risk | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date** | | **Likelihood:** | **3** | **Impact:** | **5** | **Score:** | **15** |

| Risk Score | | | | | | Risk Decision |
|---|---|---|---|---|---|---|
| Current Risk | | | Target risk | | | |
| Likelihood | Impact | 15 | Likelihood | Impact | 10 | TREAT |
| 3 | 5 | | 2 | 5 | | |

| Risk Score | | | | | | Risk Decision |
|---|---|---|---|---|---|---|
| Current Risk | | | Target risk | | | |
| Likelihood | Impact | 16 | Likelihood | Impact | 8 | TREAT |
| | 4 | | 2 | 4 | | |

| Control Summary | No. of Controls | 5 |
|---|---|---|
| Assurance Summary | No. of Assurances | 18 |
| | Breakdown of Total Assurance Rating | Weak Assurances: 3 |
| | | Moderate Assurances: 1 |
| | | Strong Assurances: 10 |
| | | No Assurances: 4 |



# Strategic Risk Register - Risk 6 | Controls

| Existing Control | | | Sources of Assurance | Level at which the Assurance is provided to | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| No. | Control | Exec Owner | | Team / Division / Project | Directorate Team / Exec Lead | Business Exec Team / Sub Groups | Committee / Sub group | Board | Assessment of each assurance |
| 6.1 | Public Health Wales Financial plan | Deputy Chief Executive/Executive Director of Operations and Finance | Welsh Government and Board approved Strategic Plan (IMTP) | | | X | | X | Strong Assurance |
| | | | Board approved Annual Plan | | | X | | X | Strong Assurance |
| | | | Integrated Performance Report (Service/Finance/Quality/ People) | | | X | X | X | Strong Assurance |
| | | | Monthly Finance Reports | X | X | X | | | Weak Assurance |
| | | | Monthly monitoring returns | | X | | | | Weak Assurance |
| | | | Directorate finance reports | | X | | | | Weak Assurance |
| | | | Annual accounts | | | X | X | X | Strong Assurance |
| | | | Audits of financial systems and audit management | | | X | X | | Strong Assurance |
| 6.2 | Joint Executive Team meetings (currently paused due to Covid-19) | Executive Team | Integrated Performance Report (Service/Finance/Quality/ People) | | | X | X | X | Strong Assurance |
| | | | Mid and end of year Review Papers | X | X | X | | | No Assurance |
| | | | Joint Executive Team Report | | | X | | X | No Assurance |
| 6.3 | Quality and Delivery Meetings (currently paused due to Covid-19) | Deputy Chief Executive/Executive Director of Operations and Finance | Integrated Performance Report (Service/Finance/Quality/ People) | | | X | | X | No Assurance |
| 6.4 | Mid and End of Year Reviews (currently paused due to Covid-19) | Executive Directors | Mid and End of year Review Reports | | X | X | | X | No Assurance |
| 6.5 | Strategic Priority Coordination Group | Deputy Chief Executive/Executive Director of Operations and Finance | Long Term Strategy - Working to achieve a healthier future for Wales | | | X | | X | Strong Assurance |
| | | | Welsh Government and Board approved Strategic Plan (IMTP) | | | X | | X | Strong Assurance |
| | | | Board approved Annual Plan | | | X | | X | Strong Assurance |
| | | | Change control summary report | | | X | | X | Moderate Assurance |
| | | | Integrated Performance Report (Service/Finance/Quality/ People) | | | X | X | X | Strong Assurance |

# Strategic Risk Register – Risk 6 | Action Plan

| Control Number | Gaps in controls | Gaps in assurance | | Action Plan | Exec Lead | Due Date | Progress |
|---|---|---|---|---|---|---|---|
| **6.2, 6.4, 6.5** | Outcome measures and performance metrics | | **1** | Finalise outcome measures for our strategic priorities and organisation | Deputy Chief Executive/Executive Director of Operations and Finance | March 2021 | On hold due to COVID-19. Draft outcome measures have been developed through the Strategic Priority Groups and workshops held with the Executive Team and Board. Due to COVID-19 this work has been paused and will be finalised when we stand down our COVID-19 response. A revised deadline of 31 March 2021 has been included however this may need to be reviewed as the pandemic response continues. |
| **6.1** | Evidence of efficiency across the organisation | | **2** | Monitor savings from organisational efficiency work streams | | Ongoing | **October Update:**<br>Latest position reported to Welsh Government through our monitoring returns on 13 October.<br><br>**Previous Update:**<br>Continues to be in progress. The Finance Team continues to monitor progress against our Savings plans which includes organisational efficiency workstreams. |
| **6.1** | Model for monitoring savings and investments | | **3** | Review organisational plans to enable resources to be redirected as required | | March 2021 | **October Update:**<br>As part of the development of the 12-18 Operational Plan, priority plans have been reviewed to ensure that enabling functions understand the resources that are required to take forward the plan. This has included reviewing the existing enabler resources and identifying areas were service could be reduced to free up capacity. The plans will continue to be reviewed. Budgets have also been reviewed and investments redirected to support agreed revised organisational priorities. |
| **6.2, 6.3, 6.4, 6.5** | Revised Performance Management Framework aligned to new Strategy and governance arrangements | | **4** | Incorporate wider approach to value and impact into the organisations 12 month operating Plan | | March 2022 | **October Update:**<br>Through development of the organisations 12-18 month operating plan, value and impact is a key element that will be incorporated into our work going forward. This will be taken forward as part of the organisation's priority on Population Health and through the work on ensuring decision making is fit for purpose. |
| **6.1** | Covid-19 costs not included in 2020/2021 budget allocation | | **5** | Secure funding from WG for COVID costs | | December 2021 | **October Update:**<br>In progress. £15m non-pay and £2.4m pay to cover COVID-19 costs incurred to date. Confirmation of further funding allocation expected from Welsh Government in November. Reported as part of Integrated Performance Report/ Response Dashboard to Executive Team and Board |

# Strategic Risk Register – Risk 6 | Action Plan

| Control Number | Gaps in controls | Gaps in assurance | | Action Plan | Exec Lead | Due Date | Progress |
|---|---|---|---|---|---|---|---|
| **6.1** | Additional requirements not included in PHW IMTP 2020-23 | | **6** | Work up and submit BC's for new developments as a result of COVID (eg 24/7 working) | | January 2021 | **October Update:** Business case for TAT approved. IP5 Lab 2 specification finalised and working towards a handover date of 7 December 2020. Health Protection Business Case currently under development for submission to Welsh Government by the end of October. Mass vaccination NHS project group which includes representation from PHW established to develop plans for a public campaign to be rolled out. |
| **6.1** | Operational Plan 2020-21 did not include response to COVID-19 | | **7** | Development of a resourced organisational delivery plan for next 12 months | | October 2020 | **October Update:** Complete. Operational Plan has been approved by Board on 29 October 2020. Implementation plan and process for monitoring to be developed with planning leads and Programme team. **Action for Board – Close Action** |

# Strategic Risk Register – Risk 7 | Dashboard

| | |
|---|---|
| **Risk 7** | There is a risk that Public Health Wales will fail to deliver and effectively present accurate, relevant data/ statistics and/ or evidence based research/ evaluation to dynamically and actively inform and maximise the impact of public health action especially relating to our response to COVID-19. This will be caused by a lack of workforce capacity with the relevant skills and knowledge to rapidly respond to changing and increasing demands of COVID-19 and technological advances in data science; staff having an over-reliance on existing systems/procedures and a lack of sufficient change capacity. |

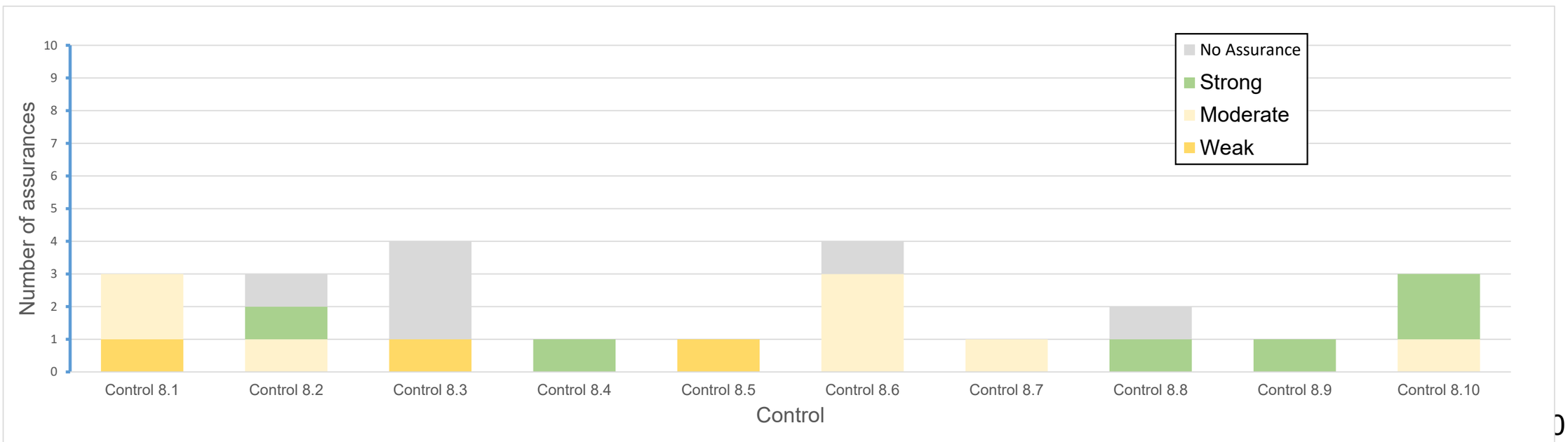
| **Sponsor and Assurance Group** | |
|---|---|
| **Executive Sponsor** | Sian Bolton (Transition Director – Knowledge) |
| **Assuring Group** | Knowledge Research and Information Committee |

| **Applicable Strategic Priorities** | |
|---|---|
| Influencing the wider determinants of health | ☒ |
| Improving mental well-being and building resilience | ☒ |
| Promoting healthy behaviours | ☒ |
| Securing a healthy future for the next generation through a focus on early years. | ☒ |
| Protecting the public from infection and environmental threats to health | ☒ |
| Supporting the development of a sustainable health and care system focused on prevention and early intervention | ☒ |
| Building and mobilising knowledge and skills to improve health and well-being across Wales | ☒ |

| **Inherent Risk** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date** | | **Likelihood:** | **3** | **Impact:** | **4** | **Score:** | **12** |

| **Risk Score** | | | | | | **Risk Decision** |
|---|---|---|---|---|---|---|
| **Current Risk** | | | **Target risk** | | | |
| **Likelihood** | **Impact** | 16 | **Likelihood** | **Impact** | 8 | **Treat** |
| 4 | 4 | | 2 | 4 | | |

| **Control Summary** | **No. of Controls** | **10** | |
|---|---|---|---|
| **Assurance Summary** | **No. of Assurances** | **23** | |
| | **Breakdown of Total Assurance Rating** | **Weak Assurances** | **3** |
| | | **Moderate Assurances** | **8** |
| | | **Strong Assurances** | **6** |
| | | **No Assurance** | **6** |



# Strategic Risk Register - Risk 7 | Controls

| Existing Control | | | Sources of Assurance | Level at which the Assurance is provided to | | | | | Assessment of each Assurance |
|---|---|---|---|---|---|---|---|---|---|
| No | Control | Exec Owner | | Team / Division / Project | Directorate Team / Exec Lead | Business Exec Team / Sub Groups | Committee / Sub group | Board | |
| 8.1 | **Policies and procedures (including Standing Operating Procedures)** | Board Secretary & Head of Board Business Unit | Corporate Policy and Control Document Reviews – Corporate Register update reports to Committees | x | x | x | x | x | **Moderate** |
| | | Transition Director - Knowledge | Health Intelligence Division – Standard Operating Procedures (document development, review and approval) approved by the Director | x | x | x | | | **Weak** |
| | | | Research and Evaluation Division – Standard Operating Procedures (document development, review and approval) approved by the Director | x | x | x | | | **Moderate** |
| 8.2 | **Official Statistics National requirements** | Transition Director - Knowledge | Report to Committee on adherence to the Code of Practice for Statistics (UK Statistics Authority) | x | x | x | x | | **Moderate** |
| | | | Independent Regulation (UK Statistics Authority) (reported to KRI Committee – currently not meeting due to COVID-19) | x | x | x | x | | **No assurance** |
| | | | External scrutiny (including UK Statistics Authority and Welsh Government) ensuring that correct process is followed. The Office of Statistics Regulation undertakes assessments, systematic reviews and compliance checks | x | x | x | x | | **Strong** |
| 8.3 | **Quality Assurance processes** | | Report of Data Quality Management Task and Finish Group to KRIC – (Work suspended due to COVID) | x | x | x | x | | **No assurance** |
| | | | Minutes and actions - Population Health Intelligence Network Steering Group (not currently meeting due to COVID-19) | x | x | x | | | **No assurance** |
| | | | Written assurances from external data owners eg NWIS/ ONS re their quality assurance processes | x | x | x | | | **Weak** |
| | | | Evaluation of projects and programmes which are reported annually to the KRI Committee (Evaluations relating to COVID-19 currently reported to GOLD and/or BET) | x | x | x | x | | **No assurance** |
| 8.4 | **Corporate induction relating to confidentiality, Information Governance etc** | Acting Director – People & Organisational Development | Knowledge Directorate compliance reported through the integrated performance report to Board | x | x | x | x | x | **Strong** |
| 8.5 | **Skills and development training for specialist roles (e.g. analysts/ evidence reviewers)** | Transition Director - Knowledge | Attendance at specialised training<br>Specialist qualifications | x | x | | | | **Weak** |
| 8.6 | **Directorate business systems & processes** | | Notes/ Actions of monthly SMT meetings | x | x | | | | **Moderate** |
| | | | Minutes/ Actions of Wider SMT meetings | x | x | | | | **Moderate** |
| | | | Executive bi-monthly paper to the Business Executive Team on Knowledge Directorate alignment to Strategic Priorities (Currently suspended due to COVID-19) | x | x | x | | | **No assurance** |
| | | | Mid and End of Year reviews (to Chief Executive) | x | x | x | | | **Moderate** |
| 8.7 | **Incident reporting system (data or research)** | | Information Governance Report detailing any data breaches | x | x | x | x | | **Moderate** |
| 8.8 | **Workforce Plan** | | Reports of progress against workforce plans (replaced with COVID-19 workforce plans at present) | x | x | x | x | | **Strong** |

# Strategic Risk Register - Risk 7 | Controls

| Existing Control | | | Sources of Assurance | Level at which the Assurance is provided to | | | | | Assessment of each Assurance |
|---|---|---|---|---|---|---|---|---|---|
| No | Control | Exec Owner | | Team / Division / Project | Directorate Team / Exec Lead | Business Exec Team / Sub Groups | Committee / Sub group | Board | |
| | | | Report to the People and OD Committee (as part of annual Integrated Medium Term Plan planning cycle) (POD Committee suspended at present due to COVID-19) | x | x | x | x | | No assurance |
| 8.9 | **Business Continuity arrangements** | | Business Continuity Action Plan (Knowledge Directorate) | x | x | x | | | Strong |
| 8.10 | **Quality Management Systems** | | Health and Care Standards reporting | x | x | x | x | | Strong |
| | | | Clinical and Quality Audit Plan detailing local audits – bi-annual report to QSIC | x | x | x | x | | Strong |
| | | | Mid and End of Year reviews (to Chief Executive) | x | x | x | | | Moderate |

# Strategic Risk Register – Risk 7 | Action Plan

| Control Number | Gaps in controls | Gaps in assurance | Action Plan | Exec Lead | Due Date | *Progress* |
|---|---|---|---|---|---|---|
| 8.1 | Policies and procedures | Lack of Standard Operating Procedures (SOPs) for all processes within the Knowledge Directorate | Undertake base line of current SOPs in place within the Knowledge Directorate | Transition Director/ Knowledge | To be determined | The actions identified are intended to be advanced at a future point as this is currently on hold due to COVID-19. |
| | | | Identify gaps in relation to SOPs | | | |
| | | | Develop SOPs that are required and a consistent approach for approval/ logging | | | |
| | | | Disseminate to all Knowledge Directorate staff | | | |
| | | | Review SOPs annual (ensure process in place to undertake review and log review) | | | |
| 8.2 | Official Statistics | Lack of audit (undertaken internally) to provide assurance that the process is adhered to | Undertake an audit of a sample of Official Statistics produced, across the organization to confirm adherence to Official Statistics Processes | | To be determined | The actions identified are intended to be advanced at a future point as this is currently on hold due to COVID-19. |
| 8.3 | Quality Assurance Processes | Lack of formal Standard Operating Procedures for Data Quality Management across all Directorates | Collate baseline information and present data quality management report to KRI Committee. | | To be determined | The actions identified are intended to be advanced at a future point as this is currently on hold due to COVID-19. |
| | | | Identify gaps in relation to SOPs across the organisation relation to Data Quality Management | | | |
| | | Lack of central register of assurances from external data owners eg NWIS etc | Work with the relevant Directorates to ensure required SOPs are developed and disseminated as appropriate | | | |
| | | | Create central register of assurances from external data owners | | | |
| 8.5 | Skills and development training | Lack of dedicated data science team with appropriate skills, knowledge and experience | Skills requirement for Data Science Team determined | | To be determined | The actions identified are intended to be advanced at a future point as this is currently on hold due to COVID-19. |
| | | | Recruitment of data scientists with identified skills | | | |
| | | | Data Science Strategy developed | | | |
| | | | Capturing of minimal skills required at each level within the directorate for specialist roles (e.g. analysts and evidence reviewers) | | | |
| 8.8 | Workforce Plans | Lack of Data Analyst/ Scientist capacity to undertake surveillance on COVID-19 | Implement recruitment plan identified by Workforce Work stream in Phase 2 Implementation Plan | | October 2020 | **October Update**<br>On Track. As at 15 October 2020 – 82% of the 17WTE surveillance posts have been appointed |
| 8.10 | Quality Management Systems | Lack of year on year plan for scheduled local audits within the Knowledge Directorate | Identify a rolling programme of audit to be completed internally for the Knowledge Directorate. This will then inform the organisational Clinical and Quality Audit Plan | | To be determined | The actions identified are intended to be advanced at a future point as this is currently on hold due to COVID-19. |

# Strategic Risk Register – Risk 8 (COVID-19) - DRAFT

**Dashboard**

| | |
|---|---|
| **Risk 8 (COVID)** | There is a risk that Public Health Wales will fail to effectively discharge its statutory responsibilities in protecting the public during the COVID-19 pandemic and ensure the organisation has an effective plan for recovery as the pandemic recedes<br>This will be caused by:<br>1. Failure to ensure that our role and responsibilities are clearly laid out, effectively communicated to partners and the public and that we frame our response and actions in accordance with these. This will require us to not accept activities that fall outside of our role that result in us vicariously accepting responsibility and accountability for actions that we do not have the authority to enact.<br>2. Failure to sufficiently scale up our core response activities during the recovery phase of the pandemic in order to effectively support the system in Wales to protect the public, optimise outcomes for individuals and the population, facilitate the functioning of essential services and support the Welsh Government in the reviewing of social restrictions.<br>3. Failure to effectively balance the dynamics between responding to the ongoing pandemic- which remains the key priority of the organisation, fulfilling our broader statutory functions in relation to the population health (including the safe reactivation of services and functions), whilst preparing and responding to any resurgence in the transmission of coronavirus.<br>4. Failure to effectively support the health and wellbeing of our staff within the current working environment and the challenges to remote working.<br>5. Failure to sufficiently influence policy and public health interventions. |

| Applicable Strategic Priorities | |
|---|---|
| Influencing the wider determinants of health | ☒ |
| Improving mental well-being and building resilience | ☒ |
| Promoting healthy behaviours | ☒ |
| Securing a healthy future for the next generation through a focus on early years. | ☒ |
| Protecting the public from infection and environmental threats to health | ☒ |
| Supporting the development of a sustainable health and care system focused on prevention and early intervention | ☒ |
| Building and mobilising knowledge and skills to improve health and well-being across Wales | ☒ |

| Sponsor and Assurance Group | |
|---|---|
| **Executive Sponsor** | Tracey Cooper, Chief Executive |
| **Assuring Group** | Board through the Business Executive Team |

| Inherent Risk | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date** | 10/08/2020 | **Likelihood:** | **4** | **Impact:** | **5** | **Score:** | **20** |

| Risk Score | | | | | | Risk Decision |
|---|---|---|---|---|---|---|
| Current Risk | | | Target risk | | | |
| **Likelihood** | **Impact** | | **Likelihood** | **Impact** | | |
| **4** | **5** | 20 | **2** | **5** | 10 | **Treat** |

| Existing Control | | | Sources of Assurance | Level at which the Assurance is provided to | | | | |
|---|---|---|---|---|---|---|---|---|
| **No.** | **Control** | **Exec Owner** | | **Team / Division / Project** | **Directorate Team / Exec Lead** | **Business Exec Team / Sub Groups** | **Committee / Sub group** | **Board** |
| **1.1** | Organisational Governance Structure *(Business Executive team, Board, Quality and Safety Committee, Audit and Corporate Governance Committee)* | Executive Director Public Health Services / Medical Director | COVID-19 assurance reports and updates – formal reports (written or verbal) provided to all relevant meetings | | X | X | X | X |
| | | Deputy Chief Executive, Executive Director Operations and Finance | Integrated performance report / performance and assurance dashboard | | X | X | X | X |
| **1.2** | Incident response governance arrangements *(Gold Group and Incident Management team)* | Executive Director Public Health Services / Medical Director | Gold Terms of Reference | | | X | | |
| | | | Gold Minutes of meetings | | X | X | | |
| | | | Gold meeting papers | | X | X | | |
| | | | Programme Delivery Confidence Assessment (weekly) | | | X | | X |
| | | | Surveillance report (weekly) | | X | X | | |
| | | | IMT papers | X | X | | | |
| | | | Daily sit rep reports | | X | X | | |
| | | | Daily surveillance data | | X | X | | |
| | | | PHE IMT minutes, papers and guidance | | X | | | |
| | | | Minutes, reports and Sitreps from respective cells / components of the governance structure | X | X | | | |
| | | | Test, Trace, Protect Plan | X | X | X | X | X |
| **1.3** | Emergency response plan | Chef Executive / Executive Director Public Health Services / Medical Director | Emergency Planning Framework | | | X | X | X |
| **1.4** | Business continuity plans<br>• PHW business continuity framework<br>• Critical service continuity plans (screening, health protection, informatics) | Deputy Chief Executive, Executive Director Operations and Finance / Executive Director Public Health Services / Medical Director | Business Continuity Framework | | | X | X | X |
| | | | PHW organisational recovery plan | | | X | | X |
| | | | Critical service level continuity plans | | | X | | |
| | | Acting Director of People and Organisational Development | People Strategy / Workforce reports | | | X | | X |
| **1.5** | Management of Welsh Government requests for advice | Transitional Director - Knowledge | Decision and Advice log | X | X | | X | |
| **1.6** | WG strategic oversight Group for Test, Trace and Track (Programme Board) | Executive Director Public Health Services / Medical Director / Chief Executive | Minutes of meetings and papers | | X | | | |
| **1.7** | Learning and research | Director of Policy and International Health, WHO Collaborating Centre on Investment for Health and Well-being | International evidence reviews | | X | X | | X |
| | | | Population 'How are we Doing' reports | | X | X | | X |
| | | Strategic Responsible Officers (SRO) of workstream | Evaluations commissioned of key work-streams | | X | X | | |
| | | Transitional Director - Knowledge | Research team work programme for COVID-19 | | X | X | | |
| | | Executive Director Public Health Services / Medical Director | Consultation on key documents/operational models | | X | X | | |
| **1.8** | Communication plans and activity | Deputy Chief Executive, Executive Director Operations and Finance | Analysis of communications performance external and internal | | X | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Quality assurance arrangements in place to provide accessible information for different communication needs | X | X | | | |
| | | | Programme workstream updates / Sitreps | | X | | | |
| | | | Daily surveillance data published | X | X | X | | X |
| | | | Weekly staff communications (often daily communication) | X | X | | | |
| **1.9** | Health and Safety and Infection Prevention assessments and control plan for workforce | Deputy Chief Executive, Executive Director Operations and Finance / Executive Director Quality, Nursing and Allied Health Professionals | Standard Operating Procedures | | | X | X | |
| | | | Monitoring of social distancing measures and process for PPE equipment | | X | | | |
| | | | Assessment undertaken of IPC needs re; COVID advice given from the HARP team | | X | | | |
| | | | PPE stock control process implemented | | X | | | |
| **1.10** | Implementation of guidance and policies to protect workforce (e.g. 2 metre working guidance, remote working policies, HR policy variations) move to above | Deputy Chief Executive, Executive Director Operations and Finance / Executive Director Quality, Nursing and Allied Health Professionals | Health and Safety Risk Assessments | | | X | X | |
| | | | Staff Risk assessments | | | X | | X |
| | | | Workforce related COVID-19 policies updates | | | X | | X |
| | | | Assurance reports | | | X | | X |
| **1.11** | Monitoring of conditions to identify and reactivate statutory services not currently active | Executive Director Public Health Services / Medical Director / Transitional Director - Knowledge | Screening services reactivation – assurance and update papers | | X | X | X | X |
| | | | UK and WG screening committee advice | X | X | X | | |
| | | | UK Joint Committee on vaccination and immunisation | X | X | | | |
| | | | WG immunisation committee advice | X | X | | | |
| | | | Welsh Health Circulars | | X | X | X | |
| | | | Standard Operating Procedures – screening and health protection | X | X | | | |
| | | | Accreditation reports | X | X | X | X | |
| | | | Public Health Wales Health Intelligence Surveillance | X | X | X | | |
| | | | Public Health Wales Health Protection Surveillance | X | X | X | | |
| **1.12** | Supply chain and procurement reports (sampling and testing) | Deputy Chief Executive, Executive Director Operations and Finance | Weekly monitor and tracking status report | | | X | | X |
| **1.13** | Workforce and resilience | Acting Director of People and Organisational Development | People Strategy | X | X | X | | X |
| | | | Staff risk assessments | X | X | X | | X |
| | | | Staff communication (daily) | X | X | X | | |
| | | | Recruitment Plans and delivery of new staffing posts | X | X | X | | X |

# Board Assurance Framework – Risk 8 (COVID) | Action Plan

| Control Number | Gaps in controls | Gaps in assurance | | Action Plan | Exec Lead | Due Date | Progress |
|---|---|---|---|---|---|---|---|
| ***1.1*** | | | 1 | Regular review of Board and Committee arrangements – reinstating key governance arrangements proportionate to the demands of the response | Chief Executive / Board Secretary and Head of Board Business Unit | Monthly review | **October update:** Monthly review ongoing. Board approve the paper recommending further refinements at its meeting on 29 October 2020. |
| ***1.2*** | | | 2 | Periodically review the Gold group terms of reference to ensure relevance to the changing environment. | Executive Director Public Health Services / Medical Director / Board Secretary and Head of Board Business Unit | ~~End October~~ End November | **October update:** Terms of reference review in progress, will be completed to align with the change of post holder for Executive Director Public Health Services<br><br>**Action for Board - Requesting change of date to end on November.** |
| ***1.2*** | | *Oversight of Incident Management Team and supporting assurance reports* | 3 | Review the terms of reference and operating arrangements for the Incident Management Team | Executive Director Public Health Services / Medical Director / Board Secretary and Head of Board Business Unit | End Nov | **October update** Review of terms of reference underway and on schedule for completion by the end of November. |
| ***1.2*** | *Key measures of performance* | | 4 | Incorporate key measures to monitor the effectiveness of our work across the workstreams in the Implementation Plan for Test Trace Protect | Executive Director Public Health Services / Medical Director / workstream SROs | | **October update:**<br><br>Board approved the operational plan on 29 October 2020m milestones and success measures have been incorporated into the plan. |
| ***1.4*** | *Revised Operating Plan (organisational)* | | 5 | ~~Develop and approve a revised Operational Plan~~ | Executive Director Public Health Services / Medical Director / workstream SROs | End Oct | **October update:** Complete<br><br>**Action for Board – Action to be closed** |
| ***1.6*** | | *Evidence based decision making* | 6 | Undertake serial evaluation of the effectiveness of our communications | Deputy Chief Executive, Executive Director Operations and Finance | Ongoing | |
| ***1.6*** | Workforce capacity and capability | | 7 | Source additional capacity to support the Communications Team including additional media management and strategic communications expertise | Deputy Chief Executive, Executive Director Operations and Finance | End October | |
| ***1.7*** | | *Evidence based decision making* | 8 | Ensure that key operational aspects of the work are evaluated through the pandemic and learning applied | Transitional Director - Knowledge | Ongoing | **October update:** The identification, recording and dissemination of COVID learning is a key element of the Operational Plan. Learning identified will feed into the organisational COVID narrative which will be collated within a searchable repository. |
| ***1.7*** | | *Evidence based decision making* | 9 | Ensure that we use best available evidence to inform public health interventions through surveillance activity and international learning | Executive Director Public Health Services / Medical Director | Ongoing | |

# Board Assurance Framework – Risk 8 (COVID) | Action Plan

| Control Number | Gaps in controls | Gaps in assurance | | Action Plan | Exec Lead | Due Date | Progress |
|---|---|---|---|---|---|---|---|
| ***New*** | England led activities | | 10 | Develop and agree action plan to ensure PHE led activities that impact on Wales can continue to be delivered. | Executive Director Public Health Services / Medical Director | ~~End October~~ January 2020 | **October update:** Request change of date to January 2021<br><br>**Action for Board – change of date to January 2021** |

# Strategic Risk Register – Risk 9 | Dashboard

| | |
|---|---|
| **Risk 9** | There is a risk that Public Health Wales will fail to sufficiently consider, exploit and adopt new and existing technologies. This will be caused by the inability to keep up to date with relevant new and emergent technologies, their potential application and having insufficient skills to develop the case for investment. |

| **Sponsor and Assurance Group** | |
|---|---|
| **Executive Sponsor** | John Boulton, Director for NHS Quality Improvement and Patient Safety |
| **Assuring Group** | Executive Team<br>Board |

| **Inherent Risk** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date** | | **Likelihood:** | **3** | **Impact:** | **3** | **Score:** | **9** |

| **Risk Score** | | | | | | **Risk Decision** |
|---|---|---|---|---|---|---|
| **Current Risk** | | | **Target risk** | | | |
| **Likelihood** | **Impact** | 9 | **Likelihood** | **Impact** | 6 | **TREAT** |
| 3 | 3 | | 3 | 2 | | |

| **Applicable Strategic Priorities** | |
|---|---|
| Influencing the wider determinants of health | ☒ |
| Improving mental well-being and building resilience | ☒ |
| Promoting healthy behaviours | ☒ |
| Securing a healthy future for the next generation through a focus on early years. | ☒ |
| Protecting the public from infection and environmental threats to health | ☒ |
| Supporting the development of a sustainable health and care system focused on prevention and early intervention | ☒ |
| Building and mobilising knowledge and skills to improve health and well-being across Wales | ☒ |

# Strategic Risk Register - Risk 9 | Controls

| Existing Control | | | Sources of Assurance | Level at which the Assurance is provided to | | | | |
|---|---|---|---|---|---|---|---|---|
| No. | Control | Exec Owner | | Team / Division / Project | Directorate Team / Exec Lead | Business Exec Team / Sub Groups | Committee / Sub group | Board |
| **9.1** | Internal Innovation strategy implementation | Director for NHS Quality Improvement and Patient Safety | Innovation steering group | | **X** | | | X |
| **9.2** | Innovation group (Board advisory group) | Director for NHS Quality Improvement and Patient Safety | Terms of Reference | | | | | X |
| | | | Minutes of meetings | | | **X** | | X |

# Strategic Risk Register – Risk 9 | Action Plan

| Control Number | Gaps in controls | Gaps in assurance | | Action Plan | Exec Lead | Due Date | *Progress* |
|---|---|---|---|---|---|---|---|
| **New** | Oversight committee for Innovation and technology implementation | | 1 | Establishment of a New Technology and Innovation Advisory Forum to advise the Board | Director for NHS Quality Improvement and Patient Safety | Feb 2020 | First meeting 26/2/2020<br>**Postponed due to COVID-19. No further dates set as yet and unlikely to be in Q1/2 of 2020/21** |
| **New** | Links to external innovation networks in Wales | | 2 | Development of a formal working relationship with the Life Sciences hub | | January 2020 | Upcoming meetings to develop MOU and shared work plan<br><br>**On hold due to COVID-19** |
| **New** | Climate to support innovative thinking and practice | | 3 | Embedding a culture of innovation through a series of 'firestarter events' and dedicated presence at annual Public Health Conference | | Ongoing | Will progress as RIIC in post<br><br>**On hold due to COVID-19** |
| **New** | Budget to support innovation | | 4 | Creation of innovation fund to support internal innovation programme | | March 2020 | **Investment bid submitted but on hold due to COVID-19** |
| **New** | | | 6 | Develop dedicated internal communications plans to support innovation work | Deputy Chief Executive/Executive Director of Operations and Finance | March 2020 | **On hold due to COVID-19** |
| **New** | | | 7 | National and International horizon scanning to be embedded into the strategic planning process | | Ongoing | **On hold due to COVID-19** |