PWYLLGOR DATBLYGU STRATEGOL A CHYFLENWI GWEITHREDOL
STRATEGIC DEVELOPMENT AND OPERATIONAL DELIVERY COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	19 December 2024
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risks Assigned to Strategic Development and Operational Delivery Committee (SDODC)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Charlotte Wilmshurst, Assistant Director of Assurance & Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

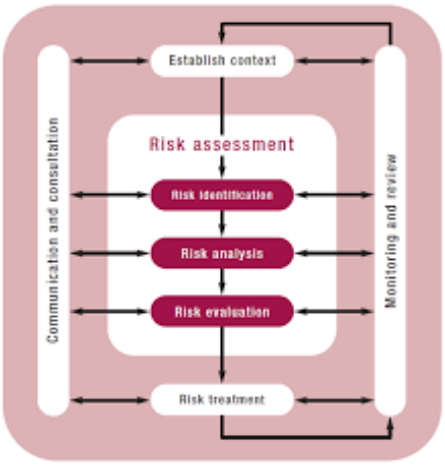
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Strategic Development and Operational Delivery Committee (SDODC) is asked to receive assurance from the lead Executive Director for the corporate risks in the attached report that these are being managed effectively.

Cefndir / Background

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



(Risk Management Process, ISO 31000)

The Board's Committees are responsible for the monitoring and scrutiny of corporate level risks within their remit. They are responsible for:

- Seeking assurance on the management of risks on the Corporate Risk Register (CRR) and providing assurance to the Board that risks are being managed effectively and report areas of significant concern, for example, where risk appetite is exceeded, lack of action, etc.

- Reviewing corporate and operational risks over tolerance and, where appropriate, recommend the 'acceptance' of risks that cannot be brought within Hywel Dda University Health Board's (HDdUHB) risk appetite/tolerance to the Board.
- Identify through discussions any new/emerging risks and ensure these are assessed by management.
- Signpost any risks outside of its remit to the appropriate HDdUHB Committee.
- Use risk registers to inform meeting agendas.

These risks have been identified by individual Directors via a top-down and bottom-up approach and are either:

- Associated with the delivery of the Health Board objectives; or
- Significant operational risks escalated that are of significant concern and require corporate oversight and management.

Each risk on the CRR has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account the gaps, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

The Board has delegated a proportion of its role of scrutiny of assurances to its Committees to make the most appropriate and efficient use of expertise. Therefore, Committees should also ensure that assurance reports relevant to the principal risks are received and scrutinised and an assessment made as to the level of assurance it provides, taking into account the validity and reliability ie source, timeliness, methodology behind its generation and its compatibility with other assurances. This will enable the Board to place greater reliance on assurances, if they are confident that they have been robustly scrutinised by one of its Committees; and provide them with greater confidence regarding the likely achievement of strategic objectives, as well as providing a sound basis for decision-making. It is the role of Committees to challenge where assurances in respect of any component are missing or inadequate. Any gaps should be escalated to the Board.

The process for risk reporting and monitoring within HDdUHB is outlined at Appendix 1.

Asesiad / Assessment

The SDODC Terms of Reference reflect the Committee's role in providing assurance to the Board that principal risks are being managed effectively by the risk owners (Executive Leads).

The Terms of Reference state the Committee's purpose is to:

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

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

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

There are two risks assigned to the Committee from the 21 risks currently identified on the CRR. These risks can be found at Appendix 2.

Changes Since Previous Report

Total Number of Risks	2	
New risks	0	
De-escalated/Closed	0	
Increase in risk score ↑	1	*Note 1*
No change in risk score →	1	*Note 2*
Reduction in risk score ↓	0	

Note 1 – Increase in risk score

Since the previous report, the following risk score has increased:

Risk Reference & Title	Date risk identified	Lead Director	Previous risk score (Aug 2024)	Current risk score	Rationale	Target Risk Score
1350 - Risk of not meeting the 75% Single Cancer Pathway (SCP) waiting times target for 2022 - 2026 due to diagnostics capacity and delays at tertiary centre	04/02/22	Chief Operating Officer	**4x3=12**	**4x4=16** (Reviewed 28/11/24)	The performance in September 2024 deteriorated to 40% due to several factors, including the legacy impact of radiology reporting delays, which increased during the summer period due to the dual impact of cessation of daytime Everlight external reporting, and an increase in emergency pathway demand.	**2x4=8**

					In addition, there was a negative impact on headline Single Cancer Pathway (SCP) performance achieved in recovering the skin pathway backlog which developed in previous months due to sharp increase in skin cancer referral demand and sickness/absence amongst the senior clinical team. There has been an encouraging reduction noted during October 2024 in relation to the 62 days+ backlog to 414 patients (improved by 129 patients), the largest monthly backlog reduction in the last 18 months. Further backlog reduction is forecast for November 2024. Although performance is predicted to improve significantly in November 2024 due to recovery actions within radiology and the skin pathway, the risk remains that cancer performance will not achieve 75% compliance by March 2025.	

Note 2 – No change in risk score

Since the previous report, there has been no change in the score of the following risk:

Risk Reference & Title	Date risk identified	Lead Director	Current Risk Score	Update	Target Risk Score
1842 - Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 2024/25 due to demand exceeding capacity	01/04/24	Chief Operating Officer	**5x3=15** (Reviewed 02/12/24)	The combined impact of a mismatch between demand and current/forecast capacity in key specialties, workforce limitations and limitations on the amount of recovery funding agreed by the Board all pose a risk to full achievement of Ministerial planned care recovery targets. The Annual Plan, approved by the Board in March 2024 highlighted delivery risks in Orthopaedics and Ophthalmology, and the additional recovery resource agreed by the Board is below the level required to ensure full delivery of the Ministerial milestones. Whilst delivery plans for 2024/25 reflect positive progress in increasing outpatient activity and treatment capacity, underpinned by planned improvements in workforce availability and operational productivity and efficiency, the Annual Plan signalled expected delivery gaps in both specialties. Furthermore, revised delivery expectations advised by Welsh Government (WG) since submission of the Health Board's Annual Plan have brought forward the expected target dates for achievement of the 104 week Total Pathway maximum wait from March 2025 to December 2024. Health Board performance	**3x3=9**

				in respect of planned care delivery milestones is also a key feature of its escalation to Targeted Intervention status. Opportunities are being explored to maximise capacity across Hywel Dda University Health Board (HBUHB) and Swansea Bay University Health Board (SBUHB) to support further recovery of waiting times. Both specialties have been prioritised for active exploration of regional solutions, in partnership with SBUHB, to expand available capacity and address forecast shortfalls against anticipated demand. Breach volumes in respect of the Stage 1 52-week target have improved for four consecutive months (July-Oct 2024) and are expected to be resolved by March 2025. Forecast breach volumes in respect of the Total Pathway 104-week target remain in Orthopaedics and Ophthalmology. On 15 November 2024, the Health Board received confirmation of the additional recovery financial allocation to be allocated by WG to support clearance of outstanding forecast 104-week breaches by March 2025. The delayed confirmation of this allocation has given rise to increased delivery risks due to the limited time remaining in which to secure independent sector	

				outsource capacity to supplement internal Health Board capacity. Taking the above into account, the current risk score is assessed to be lower than the inherent risk score due to the significant progress achieved in the past 12 months in improving waiting times, and current performance compares positively with other Health Boards. However the current risk score will remain unchanged until forecast monthly breach volumes further reduce in line with expectations.	

The 'heat map' below includes the risks currently aligned to SDODC:

HYWEL DDA RISK HEAT MAP

	LIKELIHOOD →				
IMPACT ↓	**RARE 1**	**UNLIKELY 2**	**POSSIBLE 3**	**LIKELY 4**	**ALMOST CERTAIN 5**
CATASTROPHIC 5			1842 (→)		
MAJOR 4				1350 (↑)	
MODERATE 3					
MINOR 2					
NEGLIGIBLE 1					

Argymhelliad / Recommendation

SDODC is asked to **RECEIVE ASSURANCE** that:

- All identified controls are in place and working effectively;
- All planned actions will be implemented within stated timescales and will reduce the risk further and/or mitigate the impact, if the risk materialises; and
- Challenge where assurances are inadequate.

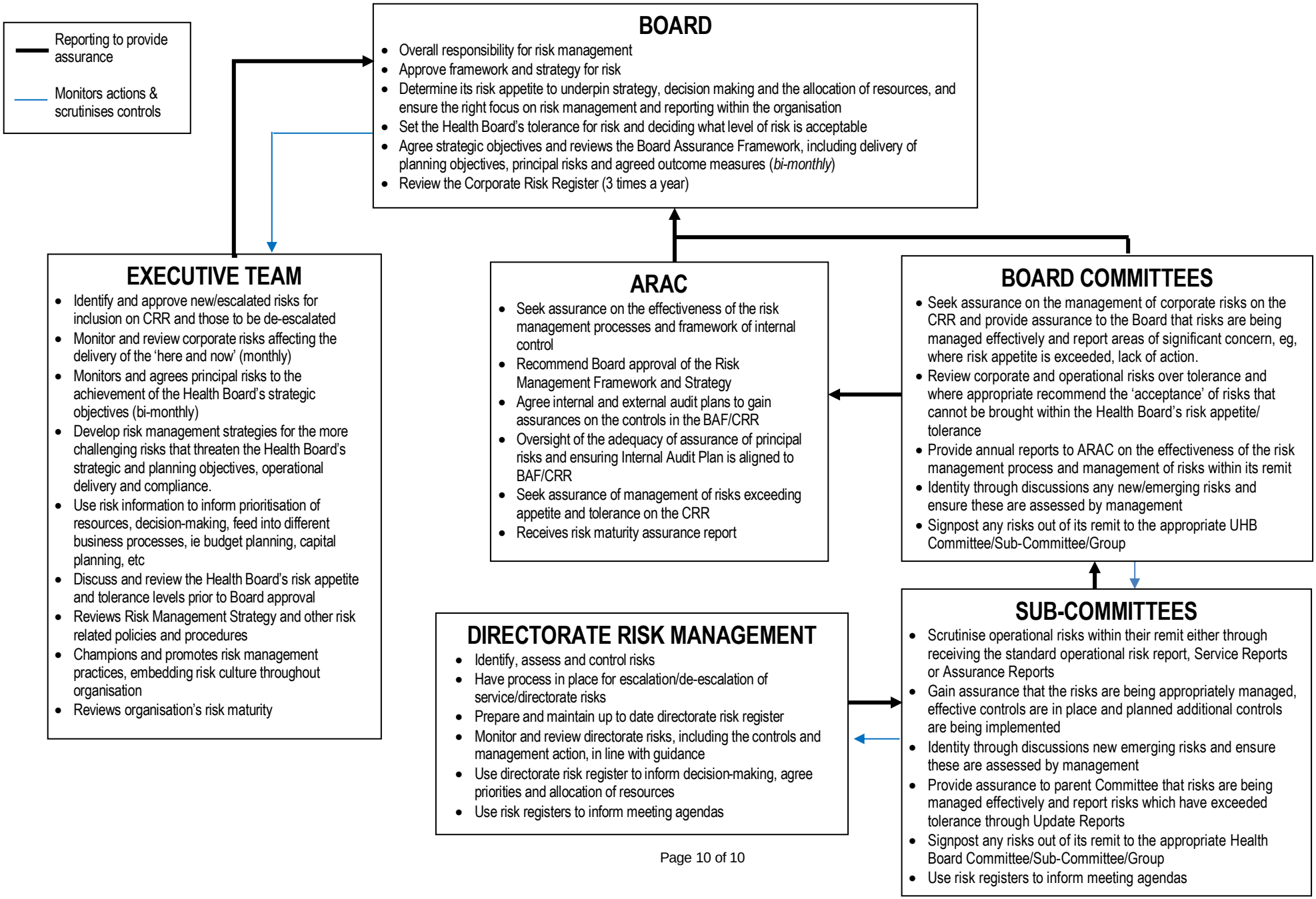
This in turn will enable SDODC to provide the necessary assurance (or otherwise) to the Board through its Update Report, that HDdUHB is managing these risks effectively.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.6 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g., where risk tolerance is exceeded, lack of timely action. 2.7 Recommend acceptance of risks that cannot be brought within the UHBs risk appetite/tolerance to the Board through the Committee Update Report. 2.8 Receive assurance through Sub-Committee Update Reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained within the report
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across HDdUHB's services reviewed by risk leads/owners.
Rhestr Termau: Glossary of Terms:	Current Risk Score - Existing level of risk taking into account controls in place. Target Risk Score - The ultimate level of risk that is desired by the organisation when planned controls (or actions) have been implemented. Tolerable risk – this is the level of risk that the Board agreed for each domain in January 2024 - Risk Appetite Statement.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Datblygu Strategol a Chyflenwi Gweithredol: Parties / Committees consulted prior to Strategic Development and Operational Delivery Committee:	Relevant Executive Directors.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	No direct impacts from report however impacts of each risk are outlined in risk description.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	No direct impacts from report however impacts of each risk are outlined in risk description.
Gweithlu: **Workforce:**	No direct impacts from report however impacts of each risk are outlined in risk description.
Risg: **Risk:**	No direct impacts from report however organisations are expected to have effective risk management systems in place.
Cyfreithiol: **Legal:**	No direct impacts from report however proactive risk management including learning from incidents and events contributes towards reducing/eliminating recurrence of risk materialising and mitigates against any possible legal claim with a financial impact.
Enw Da: **Reputational:**	Poor management of risks can lead to loss of stakeholder confidence. Organisations are expected to have effective risk management systems in place and take steps to reduce/mitigate risks.
Gyfrinachedd: **Privacy:**	No direct impacts
Cydraddoldeb: **Equality:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.

Appendix 1 – Committee Reporting Structure



Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Nov-24	Trend	Target Risk Score	Risk on page no...
1350	Risk of not meeting the 75% SCP waiting times target for 2022 - 2026 due to diagnostics capacity and delays at tertiary centre	Carruthers, Andrew	Quality/Complaints/Audit	8	4×3=12	4×4=16	↑	2×4=8	3
1842	Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 24/25 due to demand exceeding capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×3=15	5×3=15	→	3×3=9	8

Assurance Key:

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

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

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

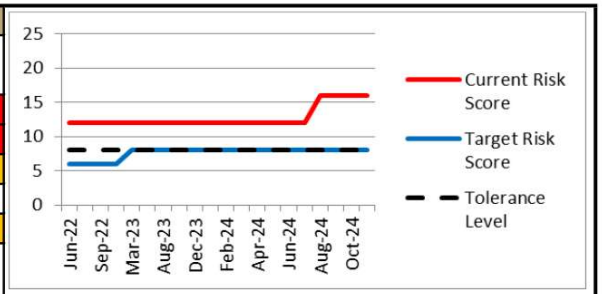
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective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

Date Risk Identified:	Feb-22		
Strategic Objective:	5. Safe and sustainable and accessible and kind care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Nov-24
Lead Committee:	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Dec-24

Risk ID:	**1350**	**Principal Risk Description:**	There is a risk of the Health Board not being able to meet the 75% target by March 2025, and 80% by March 2026 for waiting times in the ministerial measures for the Single Cancer Pathway (SCP). This is caused by by reduced capacity to meet the expected demand for diagnostics and treatment delays at our tertiary centre, and the fragility within key tumour sites. This could lead to an impact/affect on on increased number of patients waiting in excess of 62 days and meeting patient expectations in regard to timely access for appropriate treatment which could potentially lead to poorer outcomes and patient experience, adverse publicity/reduction in stakeholder confidence, and increased scrutiny/escalation from Welsh Government.
Does this risk link to any Directorate (operational) risks?		1223, 114, 111, 1537, 1699, 1722, 1723, 797	

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:

The performance in September 2024 has deteriorated to 40% due to â€‹factors including:

Legacy impact of Radiology reporting delays, which increased during summer period due to dual impact of cessation of daytime Everlight external reporting, and an increase in emergency pathway demandâ€‹

Negative impact on headline Single Cancer Pathway (SCP) performance of positive progress achieved in recovering the Skin pathway backlog which developed in previous months due to sharp increase in skin cancer referral demand and sickness/absence amongst senior clinical teamâ€‹

Correspondingly, an encouraging reduction noted in October 2024 relating to the 62 day+ backlog to 414 patients (improved by 129 patients), the largest monthly backlog reduction in past 18 months. Further backlog reduction is forecast for November 2024.â€‹

Although performance is predicted to improve significantly in November 24 due to recovery actions within radiology and Skin pathway, the risk remains that cancer performance will not achieve 75% compliance by March 2025

Rationale for TARGET Risk Score:

The aim is to treat patients within target waiting times, which has now been confirmed as 75% non-adjusted 2022-2026.

The tolerance level will be met if plans to increase diagnostic capacity, utilising allocated recovery funding are realised. Publication of performance data by WG recommenced in Feb21 with health boards only reporting against the SCP, with no wait adjustment.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# A GI Improvement Group has been established to support the implementation of the NOP for the GI Pathways. # Accelerated imaging from Endoscopy to CT within the GI pathway now in place across all sites, reduction time on patient pathway by 23 days # Fully established cancer tracking team in place to allow patients to be proactively tracked through their pathways. # A new cancer dashboard developed by Informatics with the support of Business Intelligence (BI) SCP funding from the Wales Cancer Network. This is now live with access for Cancer Services staff and Service Managers, allowing MDTs to actively monitor tumour site specific patients on a SCP. # The health board have been piloting the use of Quarterly Planning and Monitoring reports developed by the NHS Executive since July 23. This has facilitated the development of targeted improvement plans per tumour site and subsequent weekly monitoring thus providing assurance of the robustness of plans. # As per the Wales Bowel Cancer Initiative, a successful FIT10 screening in the management of USC patients on a colorectal pathway was implemented in Jun20. A Straight to FIT test is being implemented within the health board, where depending on the result of the FIT test, as to whether an OPA or any further investigations are required, which will reduce the pathway by 14 days. On 6th April the health board introduced FIT10 screening into Primary care. This has resulted in a reduction in demand of 30% for first OPA. # Virtual appointments are being undertaken via digital solutions e.g. Attend Anywhere. # Weekly Cancer Watchtower meetings where services managers are in attendance. The function of this group is to monitor and address service demand, capacity and risk issues. # Monthly performance meetings with Welsh Government. # Trajectory performance plans have been developed for each tumour site by the relevant services, with regards to improving performance. This also includes Backlog Trajectory plans on how these improvements will be achieved. # Robust Urology diagnostic recovery plan to eliminate patients waiting more than 28 days in place, with committed resource allocation from recovery money. Monitoring of Urology diagnostic improvement trajectory via Cancer watchtower. # Cancer Pathway Review to be discussed at the MDT Business meetings	Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP. Key diagnostic information systems do not support effective demand / capacity planning. Need for the implementation of new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways. Delays in data reporting, with a lag of 2 months.	Establish accelerated Neck lump pathway to reduce diagnostic pathway	Lewis, Caroline	31/12/2024	engagement required with Radiology and SBUHB
		Work with NHSE to review referral rates and patterns within primary care to reduce and refine demand to secondary care	Humphrey, Lisa	31/03/2025	Mapping in progress
		update TOR as per internal audit recommendation	Bennett, Debra	31/10/2024	In progress
		Assess the impact of OPA Laryngeal biopsy on overall performance for Head and Neck	Lewis, Caroline	~~30/10/2024~~ 31/12/2024	In progress. Requires 6 months data in order to commence.
		Roll out gynaecology one stop hysteroscopy to reduce diagnostic pathway across all sites	Freeman, Lyndon	31/12/2024	One stop in place for BGH and GGH - planning for WGH by end of December
		Radiology to work with cancer services and the NHSE to improve productivity and efficiency processes	Roberts-Davies, Gail	31/12/2024	In progress

and plans put in place to address and improve any bottlenecks or issues. Pathway reviews will also be a standing agenda item on the Oncology Quality & Safety meeting to ensure governance and part of the relevant Directorate Quality & Safety meetings # Process in place to improve component wait times and reduce patients waiting more than 14 day for first Outpatient Appointments (OPA) and 28 days for Diagnostics. # One to one escalation meetings held with Cancer Watchtower leads and Tumour Site Service Managers for tumour sites that require intervention. # New Endoscopy booking process implemented in November 2023 which tracks all patients referred for an endoscopy on a USC priority. If capacity is identified as a trending breach reason, the Service Management team supports targeted intervention to address these concerns in order to reduce time on patient pathways. # One Stop Hysteroscopy within Gynaecology implemented in May 2024 at Bronglais General Hospital, with plan to implement across all sites during Q2 of 2024/25 # Pathway changes in Head and Neck to include Laryngeal Biopsy at first OPA, reducing reliance on pan-endoscopy # Health Board wide internal escalation framework now in place to support the monitoring of performance targets, with a TI de-escalation target of 60% for three months (as at May 2024) FIT review complete to inform planning to realign FIT pathway to Primary care in line with NOP. * 8 additional radiology reporting sessions in place agreed up to March 25 Skin treatment recovery plan in place to end March 25 to reduce overall treatment volumes to a sustainable level of 100				
	Radiology to work with NHSE to refine demand and capacity planning	Roberts-Davies, Gail	31/12/2024	in progress
	Work with multidisciplinary team to reallocate FIT pathway to primary care in line with NOP and rest of Wales	Humphrey, Lisa	31/03/2025	Planning in progress

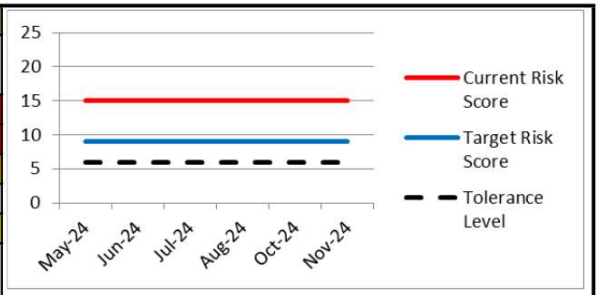
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Internal targets - Looking at the performance per tumour site individually that have the biggest impact on overall performance Skin Urology LGI Gynaecology Breast Reducing component waits Patient waiting more than 14 days for first OPA Patients waiting a diagnostic procedure and report more than 28 days Patients with a confirmed diagnosis of cancer waiting more than 62 days	Daily/weekly/monthly/ monitoring arrangements by management	1st			* Implementation of Single Cancer Pathway Report - BPPAC - Feb20 * COVID-19 Impact on Cancer Services - Board - May20 * Cancer Updated to QSEAC Jun20 & OpQSESC Jul20 * Risk 633 QSEAC - Feb21 & Aug21 * IPAR Report - Board - Nov22	None identified.				
	Monitor outpatient appointments booked beyond 10 days to identify common themes	1st								
	IPAR Performance Report to SDODC & Board	2nd								
	Monthly oversight by Delivery Unit, WG	3rd								

Date Risk Identified:	Apr-24		
Strategic Objective:	5. Safe and sustainable and accessible and kind care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Dec-24
Lead Committee:	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Jan-25

Risk ID:	**1842**	**Principal Risk Description:**	There is a risk of non-delivery of planned care ministerial targets by March 2025. This is caused by a mismatch between demand and current/forecast capacity in key specialties, workforce limitations, and the impact of the Health Boards' financial forecast for 2024/25, which limits the amount of recovery funding agreed by the Board to ensure full achievement of the respective ministerial delivery targets. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increasing pressure of adverse publicity/reduction in stakeholder confidence, and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?		1548, 180, 523, 525, 632, 958, 1083, 1027, 1628, 1629	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	5×3=15
Target Risk Score (L x I):	3×3=9
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

The combined impact of a mismatch between demand and current/forecast capacity in key specialties, workforce limitations and limitations on the amount of recovery funding agreed by the Board all pose a risk to full achievement of ministerial planned care recovery targets. The Annual Plan, approved by the Board in March 2024 highlighted delivery risks in Orthopaedics and Ophthalmology, and the additional recovery resource agreed by the Board is below the level required to ensure full delivery of the ministerial milestones.

Whilst delivery plans for 2024/25 reflect positive progress in increasing outpatient activity & treatment capacity, underpinned by planned improvements in workforce availability and operational productivity and efficiency, the Annual Plan signalled expected delivery gaps in both specialties. Furthermore, revised delivery expectations advised by Welsh Government since submission of the Health Board's Annual Plan have brought forward the expected target dates for achievement of the 104 week Total Pathway maximum wait from March 2025 to December 2024. Health Board performance in respect of planned care delivery milestones is also a key feature of its escalation to Targeted Intervention status.

Opportunities being explored to maximise capacity across Hywel Dda University Health Board and Swansea Bay University Health Board to support further recovery of waiting times

Both specialties have been prioritised for active exploration of regional solutions, in partnership with Swansea Bay University Health Board (SBUHB), to expand available capacity and address forecast shortfalls against anticipated demand.

Breach volumes in respect of the Stage 1 52 week target have improved for four consecutive months (July-Oct 2024), and are expected to be resolved by March 2025. Forecast breach volumes in respect of the Total Pathway 104 week target remain in Orthopaedics and Ophthalmology. On 15th November 2024, the Health Board received confirmation of the additional recovery financial allocation to be allocated by WG to support clearance of outstanding forecast 104 week breaches by March 2025. The delayed confirmation of this allocation has given rise to increased delivery risks due to the limited time remaining in which to secure independent sector outsource capacity to supplement internal HB capacity.

Rationale for TARGET Risk Score:

The target score of 9 reflects the continuing delivery ambitions which remain, despite the workforce and resource limitations reflected in the Annual Plan. At the end of March 2024, 98.5% of all patients waiting experienced a wait of less than 2 years (104 weeks). Of note, positive progress achieved both in respect of effective demand management and transformation of outpatient pathways has ensured that overall waiting list demand has not grown with waiting list volumes at their lowest level for 2 years. This offers positive indicatons for future improvements in waiting times in 2025/26 onwards.

Opportunities to make further progress towards the Ministerial targets in 2024/25 in Orthopaedics will continue to be explored, including exploration of the regional opportunities referred to.

The tolerable risk (6) reflects the longer term recovery ambitions of the Health Board to reduce waiting lists and length of wait to the lowest levels possible.

Taking the above into account, the current risk score is assessed to be lower than the inherent risk score due to the significant progress achieved in the past 12 months in improving waiting times, and current performance compares positively with other Health Boards. However the current risk score will remain unchanged until forecast monthly breach volumes further reduce in line with expectations.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage planned care risks on daily basis including multiple daily multi-site calls in times of escalation. # Prioritised review of patients based on an agreed risk stratification model. # Provision of dedicated elective beds on 3 sites. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Quarterly deep dive reviews of all specialty delivery plans and delivery assumptions to ensure full account of OP transformation and theatre productivity and efficiency opportunities # Escalation plans for acute and community hospitals (within limits of staffing availability). # Outpatient transformation programme in place with a continuing focus on alternatives to face to face delivery of outpatient care to enable increases in care volumes delivered. # Robust sickness absence management arrangements in place. # Quarterly review of job plans, with ongoing recruitment. # Elective care delivery plan developed for inclusion within Annual Delivery Plan. # Additional Planned Care Recovery proposals developed to utilise the additional recovery funding committed by the Board # Elective optimisation improvement programme in place to improve theatre activity productivity and efficiency, including improvements to waiting list scheduling and pre-operative assessment processes # Productive & Effective Elective Care Improvement Plan produced to drive productivity and efficiency improvements # Planned Care Delivery Workstream established, reporting to Integrated Quality, Financial Performance Delivery (IQFPD), as part of revised Targeted Intervention governance arrangements. #South West Wales Regional Orthopaedic Delivery Programme	# Workforce staffing availability to support further expansion of theatre capacity # Sufficiency of Anaesthetic medical staffing capacity to support further expansion of required operating lists. # Sustainability challenges remain in a number of specialty areas which have been targeted for in-depth review via regional planning programmes for key specialties and the Clinical Services Plan review. # Widespread adoption of national best practice guidance to improve elective optimisation and utilisation of available operating capacity # Deficiencies within pre-operative assessment process and overall capacity to support required volume of Pre-Operative Assessment Clinic (POAC) assessments	Recruitment of additional orthopaedic surgeons to increase operating capacity within specialty to maximise utilisation of remaining sessions	Hire, Stephanie	~~30/09/2024~~ 31/01/2025	2 surgeons appointed, and commenced in post in September 2024, however one has submitted a resignation letter and due to finish in October 2024. This position will need to be re-advertised. In addition, 2 further arthroplasty surgeons have been appointed, with likely start date of January 2025.
		Monitor progress with implementation of revised pre-operative assessment protocols to ensure alignment with best practice (Getting It Right First Time - GIRFT)	Hire, Stephanie	~~30/09/2024~~ 31/12/2024	Pre-Operative Assessment Clinic (POAC) pathway improvement plans progressing, including: 1)Piloting a screening tool which commenced in August 2024 for three months; 2)the development of a POAC assessment document. Further improvements have also been identified relating to the assessment document; and 3)the development of an electronic booking system to support the identification of available slots. However, issues remain with non-cohort lists as priority for POAC slots are given to USC and cohort patients.

established # South West Wales Regional Ophthalmology Programme established in November 2024		Additional outsource & insource solutions to be explored to supplement internal capacity in orthopaedics and ophthalmology.	Jones, Keith	31/12/2024	Expression of interest (EOI) launched October 2024. Formal tenders invited w/c 15th Nov following confirmation of WG additional allocation. Tenders due for evaluation 3rd Dec 2024 with Chair's Action scheduled 11th Dec 20024 to consider any proposed awards.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**		
A suite of planned care metrics have been developed to measure the system performance.	Activity volumes are reported daily on situation reports	1st			Annual Plan 2024/25
	Daily performance data overseen by service management	1st			
	Delivery Plans overseen by Acute Services Triumvirate	1st			
	Bi-monthly reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd			
	IPAR Performance Report to SDODC & Board	2nd			
	Welsh Government IQFPD & Enhanced Monitoring Meetings	3rd			

Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
None				