Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 25 April 2024 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Corporate Risks Assigned to Strategic Development and Operational Delivery Committee (SDODC) |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Andrew Carruthers, Director of Operations |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Charlotte Wilmshurst, Assistant Director of Assurance & Risk |

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

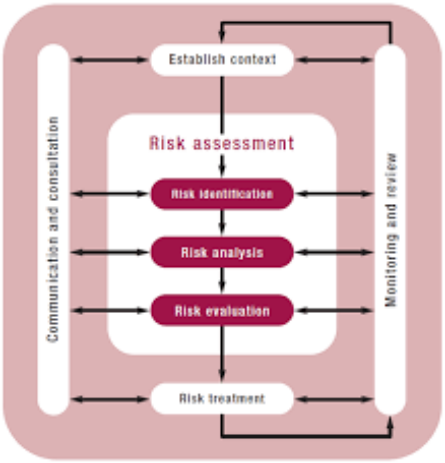
## ADRODDIAD SCAA
## SBAR REPORT

### Sefyllfa / Situation

The Strategic Development and Operational Delivery Committee (SDODC) is asked to request 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 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 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 HDdUHB'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 2 risks assigned to the Committee from the 23 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 ↑ | 0 |
| No change in risk score → | 2 |
| Reduction in risk score ↓ | 0 |

*Note 1*

***Note 1 – No change in risk score***
There have been no changes to the following risk scores since reported at the previous meeting:

| Risk Reference & Title | Date risk identified | Lead Director | Current Risk Score | Update | Target Risk Score |
|---|---|---|---|---|---|
| 1657- Risk to delivery of Ministerial Priorities relating to Planned Care recovery ambitions 2023/24 due to demand exceeding capacity | 12/05/23 | Director of Operations | **4x5=20** (Reviewed 19/03/24) | The combined impact of current uncertainty regarding resources available to support recovery actions, the availability of workforce and / or externally provided capacity and the continuing impact of post-pandemic urgent and emergency care pathway pressures (as reflected in risk 1027- Risk to delivery of timely Urgent and Emergency Care due to demand exceeding current capacity - current risk score 20) which continues to impact upon available capacity for some specialties, all pose a risk to the achievement of Ministerial Priority expectations in relation to achievement of Planned Care recovery ambitions. The Annual Plan approved by the Board in March 2023 and supporting performance trajectories highlighted significant gaps between the resourced level of capacity reflected in the plan, and the anticipated level of patient | **4x3=12** |

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| | | | | | demand to be treated during 2023/2024. Whilst additional recovery funding has been allocated to Health Boards, this is not at the level required to ensure delivery of the Ministerial milestones. Additional activity opportunities, supported by externally provided solutions, either via neighbouring Health Boards or via the independent sector insource/outsource market are being explored. Limits to staffing resource both in theatre, and post operatively, was a challenge before the COVID-19 pandemic. Whilst positive progress has been achieved in increasing outpatient activity and capacity to levels comparable with pre-pandemic volumes, significant staffing deficits within the anaesthetic medical and theatre staffing teams continues to limit the volume of elective operating sessions undertaken and therefore continues to limit progress in expanding overall activity levels to match/exceed pre-pandemic levels. The continuing legacy of the COVID-19 pandemic on Urgent and Emergency Care pathway demand and the consequential impact on available bed capacity continues to limit sufficient capacity to support activity expansion plans in key specialties. No Health Board is currently achieving Ministerial milestones in respect of Planned Care recovery. In acknowledgement of the | |

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| | | | | above, Welsh Government has set differential delivery milestones for each Health Board, taking account of respective waiting list volumes and length.<br><br>Hywel Dda has been requested to resolve all patients waiting in excess of three years. In addition, all Health Boards have been requested to ensure that a minimum of 97% of patients wait less than two years on total pathways by December 2023, improving this to 99% by March 2024. The Health Board is currently forecasting 239 patients as of 31 March 2024 waiting on the total pathway in excess of three years, the majority of which sit in the Orthopaedic specialty. In respect of the volume of patients less than two years by 31 March 2024, the Health Board is currently forecasting a 98.3% performance trajectory. Achievement of the 99% threshold is unlikely due to the volume of long waiting Orthopaedic patients which will remain at the end of March 2024. | |
| 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 | Director of Operations | **4x3=12** (Reviewed 22/03/24) | The impact of COVID-19 has increased the risk of being able to meet the target. The delays are caused by diagnostic capacity issues across the Health Board. The main area of concern is Radiology. A decrease in capacity for appointments and results reporting within radiology, current vacancies and planned annual leave and impact of industrial action within two | **4x2=8** |

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| | | | | of the four Health Board sites. Patients have been offered alternative appointments on other sites however some patients have not agreed to attend and have requested an appointment closer to home.<br><br>Cancer performance has been variable since Quarter 3 of 2021/2022. The consequence of which resulted in short term planned and unplanned step down of activity within Outpatients and planned surgery. This led to an increase in the backlog of patients waiting in excess of 63 days. Performance since April 2022 has been variable due to treating higher volumes of patients particularly in the Urology and Lower Gastrointestinal (LGI) pathways.<br><br>Performance was at 49% in January 2024. Performance trajectory is set to improve in 2024/2025 due to a reduction in component wait times at first Outpatient Appointment (OPA), diagnostics and treatment, with a target of 75% in place for March 2025. | |

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** | | | | | |

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|---|---|---|---|---|---|---|
| **MAJOR 4** | | | 1350 (→) | | 1657 (→) | |
| **MODERATE 3** | | | | | | |
| **MINOR 2** | | | | | | |
| **NEGLIGIBLE 1** | | | | | | |

## Argymhelliad / Recommendation

The Strategic Development and Operational Delivery Committee 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.
- 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)**<br>**Objectives: (must be completed)** | |
|---|---|
| Committee ToR Reference:<br>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.<br><br>2.7 Recommend acceptance of risks that cannot be brought within the UHBs risk appetite/tolerance to the Board through the Committee Update Report.<br><br>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:<br>Datix Risk Register Reference and Score: | Contained within the report |
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | 7. All apply |

| | |
|---|---|
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | 6. All Apply |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | All Strategic Objectives are applicable |
| All Planning Objectives Apply<br><br>Choose an item. | |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022 | 10. Not Applicable |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | Underpinning risk on the Datix Risk Module from across HDdUHB's services reviewed by risk leads/owners. |
| Rhestr Termau:<br>Glossary of Terms: | Current Risk Score - Existing level of risk taking into account controls in place.<br>Target Risk Score - The ultimate level of risk that is desired by the organisation when planned controls (or actions) have been implemented.<br>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:<br>Parties / Committees consulted prior to Strategic Development and Operational Delivery Committee: | Relevant Executive Directors. |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
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| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | No direct impacts from report however impacts of each risk are outlined in risk description. |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | No direct impacts from report however impacts of each risk are outlined in risk description. |

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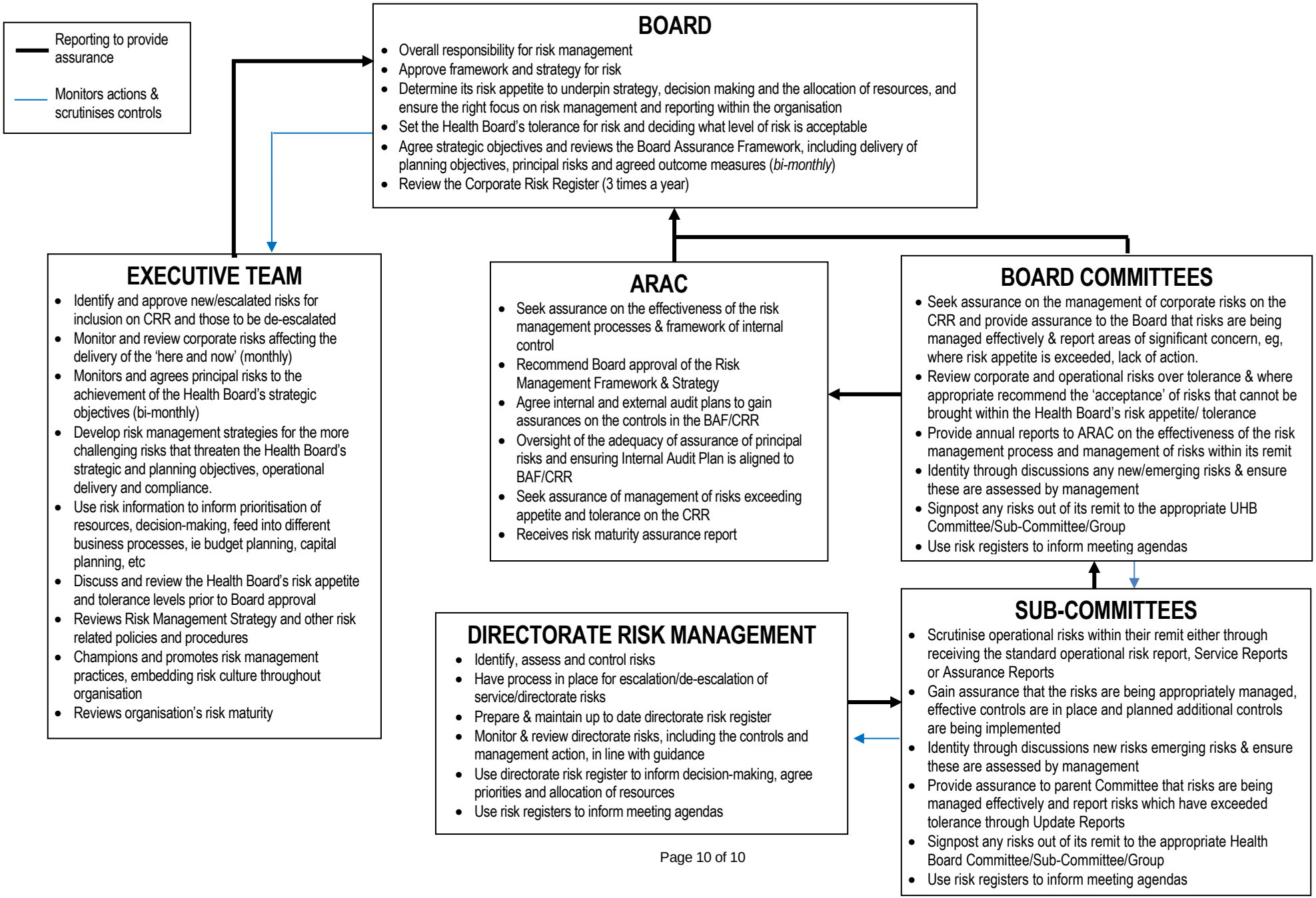
| **Gweithlu:**<br>**Workforce:** | No direct impacts from report however impacts of each risk are outlined in risk description. |
| **Risg:**<br>**Risk:** | No direct impacts from report however organisations are expected to have effective risk management systems in place. |
| **Cyfreithiol:**<br>**Legal:** | 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:**<br>**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:**<br>**Privacy:** | No direct impacts |
| **Cydraddoldeb:**<br>**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 Mar-24 | Trend | Target Risk Score | Risk on page no... |
|---|---|---|---|---|---|---|---|---|---|
| 1657 | Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 23/24 due to demand exceeding capacity | Carruthers, Andrew | Safety - Patient, Staff or Public | 6 | 5×4=20 | 5×4=20 | → | 3×4=12 | 3 |
| 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 | 3×4=12 | 3×4=12 | → | 2×4=8 | 7 |

**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 |

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| **Date Risk Identified:** | May-23 |
| **Strategic Objective:** | 5. Safe and sustainable and accessible and kind care |

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

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| **Risk ID:** | **1657** | **Principal Risk Description:** | There is a risk of non-delivery of ministerial priority expectations in relation to delivery of planned care recovery ambitions through 2023/24. This is caused by by current uncertainty regarding resources available to support recovery actions, the availability of workforce and /or externally provided capacity, and the continuing impact of post-pandemic urgent and emergency care (UEC) pathway pressures (as reflected in risk 1027) which continue to impact upon available capacity for some specialties. 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 | |

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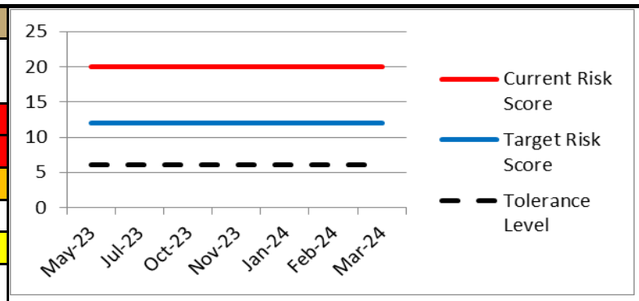
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Safety - Patient, Staff or Public |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 5×4=20 |
| **Target Risk Score (L x I):** | 3×4=12 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

The combined impact of current uncertainty regarding resources available to support recovery actions, the availability of workforce and /or externally provided capacity and the continuing impact of post-pandemic urgent and emergency care pathway pressures (as reflected in risk 1027) which continue to impact upon available capacity for some specialties, all pose a risk to achievement of ministerial priority expectations in relation to achievement of planned care recovery ambitions. The Annual Plan approved by the Board in March 2023 and supporting performance trajectories highlight significant gaps between the resourced level of capacity reflected in the plan, and the anticipated level of patient demand to be treated during 2023/24. Whilst additional recovery funding has been allocated to health boards, this is not at the level required to ensure delivery of the ministerial milestones. Additional activity opportunities, supported by externally provided solutions, either via neighbouring health boards or via the independent sector insource / outsource market are being explored. Limits to staffing resource both in theatre, and post operatively, was a challenge before the COVID pandemic. Whilst positive progress has been achieved in increasing outpatient activity & capacity to levels comparable with pre-pandemic volumes, significant staffing deficits within the Anaesthetic medical and theatre staffing teams continues to limit the volume of elective operating sessions undertaken and therefore continues to limit progress in expanding overall activity levels to match/exceed pre-pandemic levels. The continuing legacy of the COVID-19 pandemic on urgent and emergency care pathway demand and the consequential impact on available bed capacity continues to limit sufficient capacity to support activity expansion plans in key specialties. No health board is currently achieving ministerial milestones in respect of planned care recovery.

In acknowledgement of the above, Welsh Government has set differential delivery milestones for each Health Board, taking account of respective waiting list volumes and length. Hywel Dda has been requested to resolve all patients waiting in excess of 3 years. In additional, all Health Boards have been requested to ensure that a minimum of 97% of patients wait less than 2 years on total pathways by December 2023, improving this to 99% by March 2024.

The Health Board is currently forecasting 239 patients as at 31st March 2024 waiting on the total pathway in excess of 3 years, the majority of which sit in the orthopaedic specialty. In respect of the volume of patients less than 2 years by 31st March 2024, the Health Board is currently forecasting a 98.3% performance trajectory. Achievement of the 99% threshold is unlikely due to the volume of long waiting orthopaedic patients which will remain at the end of March.

**Rationale for TARGET Risk Score:**

Across the UK, there is a significant challenge for health organisations in sustaining the recovery of planned care pathways post pandemic. The target score of 12 is based on the realistic assessment of the level of planned care work which could be achieved both internally across the UHB and via maximum utilisation of capacity available within the independent sector, should available resource levels support commissioning of activity to the level required.

Whilst efforts to make further progress towards the Ministerial Measures continue, the Health Board has signalled through its Annual Recovery Plan that full achievement of both the Stage 1 and Total pathway measures by the respective target dates is unachievable without sufficient additional enabling resource to support further recovery actions.

The tolerable risk (6) remains unchanged for the level highlighted during 2022/23 and reflects the longer term recovery ambitions of the Health Board to reduce waiting lists and length of wait to the lowest levels possible.

As at the end of December 2023, the HB achieved the minimum 97% threshold for the number of patients waiting less than 2 years on total pathways.

Current forecasts suggest the HB will resolve all patients waiting 3 years+ in all specialties with the exception of orthopaedics. Consequently, the forecast volume of orthopaedic patients expected to be waiting in excess of 2 years by March 2024 is likely to compromise the HB's achievement of the minimum 99% threshold for the total number of patients waiting less than 2 years on total pathways by March 2024.

| Key CONTROLS Currently in Place:<br>(The existing controls and processes in place to manage the risk) | Gaps in CONTROLS | | | | |
|---|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed**<br>Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| # Comprehensive daily management systems in place to manage planned care risks on daily basis including multiple daily multi-site calls in times of escalation.<br># Prioritised review of patients based on an agreed risk stratification model.<br># Provision of dedicated elective beds on 3 sites.<br># The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles.<br># Delivery plans in place supported by daily, weekly and monthly monitoring arrangements.<br># Escalation plans for acute and community hospitals (within limits of staffing availability).<br># 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.<br># Robust sickness absence management arrangements in place.<br># Comprehensive programme of outsourcing of planned care volumes in place utilising capacity available via independent sector providers.<br># Weekly review of outsourcing volumes and further opportunities progressed jointly by Planned Care and Commissioning teams.<br># Elective care delivery plan developed for inclusion within Annual Delivery Plan.<br># Additional Planned Care Recovery proposals submitted to WG May 2023.<br># Elective optimisation improvement programme in place to improve theatre activity productivity and efficiency, including improvements to waiting list scheduling and pre-operative assessment processes | # Limited impact to date of the wider urgent and emergency care plan in reducing capacity pressures on acute sites and the ability to protect sufficient elective pathway capacity for elective patients.<br># Theatre staffing availability to support expansion of theatre capacity at required pace and level.<br># Timeliness of the All Wales Commissioning Framework to support rapid decision making and commissioning of independent sector activity levels when supported by non-recurrent funding released part-way through the year.<br># Sufficiency of Health records service capacity to support planned expansion of outpatient activity.<br># Sufficiency of Anaesthetic medical staffing capacity to support planned expansion of required operating lists.<br># Sustainability challenges remain in a number of specialty areas which have been targeted for in-depth review via the Clinical Services Plan | Opportunities to enhance dedicated elective pathway capacity across sites is dependent upon successful delivery of the transforming urgent and emergency care plan. | Jones, Keith | Completed | Partially Complete - Dedicated elective capacity in place at Prince Philip Hospital and Bronglais General Hospital. From October 2023, the day surgical unit at Withybush General Hospital has been re-established following its temporary utilisation as a medical bed surge area due to the RAAC project. Limited dedicated elective pathway capacity at Glangwili Hospital to support sufficient internal capacity for Urology & ENT surgery. Proposals for an alternative configuration of dedicated planned care capacity at Prince Philip Hospital are unable to be progressed due to overall pressure on bed capacity. Plans for re-establishment of elective inpatient pathway at Withybush Hospital with effect from April 2024 have been agreed. |
| | | Workforce development and recruitment plan jointly developed between Planned Care & Workforce Team | Hire, Stephanie | ~~30/06/2023~~ ~~30/08/2023~~ ~~31/03/2024~~ 30/06/2024 | Continued progress achieved in recruitment of theatre staffing and consultant anaesthetic appointments, but levels remained below required WTE. This has enabled a re-establishment of an elective in-patient pathway at Withybush from April 2024, and further increases in the total volume of theatre sessions across the Health Board. Further review to be undertaken in June 2024. |

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| Subject to availability of additional resources to support additional recovery actions, access to sufficient external insource / outsource capacity will be dependent upon formal market testing | Hire, Stephanie | Completed | Allocation received (£6.6m) was less than the required level to support full delivery. Board approved release of £2.8m to support further additional activity is being targeted to support further improvements. Delivery plan against the £2.8m was agreed and has supported further reductions in long waiting patients to March 2024. |
| With the establishment of a South West Wales Regional Orthopaedic Delivery Programme, opportunities being explored to maximise capacity across HDUHB and SBUHB to support further recovery of waiting times | Jones, Keith | Completed | In-year delivery plan developed which has supported delivery until the 31st March 2024. Planning continuing between HDUHB and SBUHB to support further regionalisation of elective orthopaedic pathways and thereby further enhance available capacity for 2024/25. These have been included within the annual plan which has been submitted for Board approval in March 2024. Updates on progress reflected in the routine operational updates to Board. Impact of the longer term plan will be reflected in a revised risk for 2024/25. |
| Commencement of "perfect month initiative" in March 2024 to help maximise the volume of elective orthopaedic operating capacity, and identify learning opportunities to support improved productivity and throughput during 2024/25. | Hire, Stephanie | Completed | Impact curtailed to three weeks during March 2024 due to the impact of the BMA junior doctors industrial action. Formal evaluation underway with learning event scheduled for April 2024, the outcomes of which inform further improvement actions. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Performance indicators.<br><br>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 2023/24 - Board (Mar23, May23, Jul23) | None | | | | |
| | 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 | | | | | | | | |
| | WG IQPD & Enhanced Monitoring Meetings | 3rd | | | | | | | | |

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

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

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| **Risk ID:** | **1350** | **Principal Risk Description:** | There is a risk of the Health Board not being able to meet the 75% target for waiting times in the ministerial measures for 2022/26 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.<br><br>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 | |

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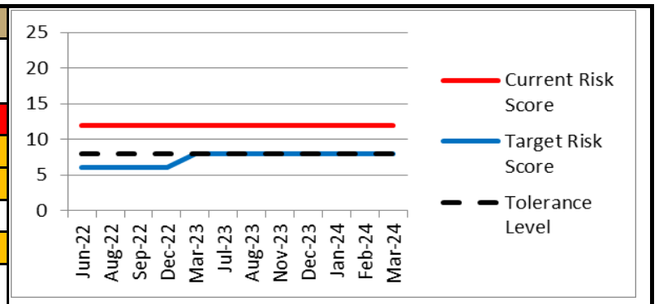
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Quality/Complaints/Audit |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 3×4=12 |
| **Target Risk Score (L x I):** | 2×4=8 |
| **Tolerable Risk:** | 8 |
| **Trend:** | ⇔ |




**Rationale for CURRENT Risk Score:**

The impact of COVID-19 has increased the risk of being able to meet the target. The delays are caused by diagnostic capacity issues across the health board . The main area of concern is Radiology. A decrease in capacity for appointments and results reporting within radiology, current vacancies and planned annual leave and impact of industrial action within two of the four health board sites. Patients have been offered alternative appointments on other sites, however some patients have not agreed to attend and have requested an appointment close to home.

Cancer performance has been variable since quarter 3 2021/22. The consequence of which resulted in short term planned and unplanned step down of activity within outpatients and planned surgery. This led to an increase in the backlog of patients waiting in excess of 63 days. Performance since April 2022 has been variable due to treating higher volumes of patients particularly in the Urology and LGI pathways. Performance was at 49% in January 2024. Performance trajectory is set to improve in 2024/25 due to a reduction in component wait times at 1st OPA, diagnostics and treatment, with a target of 75% in place for 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:<br>(The existing controls and processes in place to manage the risk) | Gaps in CONTROLS | | | | |
|---|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed**<br>Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| # A GI Improvement Group has been established. The aim is to implement the NOP for the GI Pathways.<br># Fully established cancer tracking team in place to allow patients to be proactively tracked through their pathways.<br># 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.<br># 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.<br># 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.<br># Virtual appointments are being undertaken via digital solutions e.g. Attend Anywhere.<br># 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.<br># Monthly performance meetings with Welsh Government. | Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP.<br><br>Key diagnostic information systems do not support effective demand / capacity planning.<br><br>Need for the implementation of new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways.<br><br>Access to green pathways and tertiary centres fluctuates depending on COVID-19. | Work with newly appointed Head of Radiology to:<br><br>1) explore outsourcing opportunities and internal solutions to increase capacity to appointments and reporting utilising non recurrent recovery money.<br><br>2) Investigating current capacity for diagnostics to ensure a 7-day turnaround as per the National Optimal Pathways. | Humphrey, Lisa | ~~31/03/2023~~ ~~31/07/2023~~ ~~30/11/2023~~ 31/03/2024 | Process in place to implement demand capacity modelling tool in line with SBUHB.<br><br>Radiology are reviewing referral pathway mapping, working with ARCH to build a new Radiology dashboard with support from the Strategic Workforce Team to review workforce elements. The aim is to more timely examinations and reports which will improve the patient pathway and reduce the risk of long waits for investigations and reporting of results, and reduced times on patient pathways.<br><br>The Radiology dashboard was launched in January 2024. |

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| # 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.<br># Weekly monitoring of Urology diagnostic improvement trajectory via Cancer watchtower.<br># Cancer Pathway Review Pathway reviews to be discussed at the MDT Business meetings 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<br># Process in place that improves time for patients to first outpatient appointment to improve the 28 day performance target (all patients to be informed etc).<br># Continue to escalate concerns regarding tertiary centre capacity and associated delays.<br># One to one escalation meetings held with Cancer Watchtower leads and Tumour Site Service Managers for tumour sites that require intervention.<br># 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. | | Each MDT to review and adopt recommended optimal tumour site specific pathways. | Humphrey, Lisa | ~~31/03/2023~~ ~~30/09/2023~~ 31/03/2024 | The Macmillan Cancer Quality Improvement Manager is working with the teams with regards to implementing the new pathways. One-to-one escalation meetings are held when intervention is required with Cancer Watchtower leads and Tumour site service managers. A new Endoscopy booking process is now in place. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed<br>Further action necessary to address the gaps | By Who | By When | Progress |
| Internal targets - Looking at the performance per tumour site individually concentrating on those tumour sites under 50% ie Gynae, Lower GI and Urology.<br><br>Monitoring the 28 day performance and overall performance for each tumour site. | Daily/weekly/monthly/ monitoring arrangements by management | 1st | | | * Implementation of Single Cancer Pathway Report - BPPAC - Feb20<br>* COVID-19 Impact on Cancer Services - Board - May20<br>* Cancer Updated to QSEAC Jun20 & OpQSESC Jul20<br>* Risk 633 QSEAC - Feb21 & Aug21<br>* IPAR Report - Board - Nov22 | None identified. | | | | |
| | Monitor outpatient appointments booked beyond 10 days to identify common themes | 1st | | | | | | | | |
| | Service plans in response to COVID-19 overseen and agreed by Bronze Acute & Gold (when instigated) | 2nd | | | | | | | | |
| | IPAR Performance Report to SDODC & Board | 2nd | | | | | | | | |
| | Monthly oversight by Delivery Unit, WG | 3rd | | | | | | | | |