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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 June 2022
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risks Assigned to Strategic Development and Operational Delivery Committee (SDODC)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Director of Operations
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Board Secretary Charlotte Beare, Assistant Director of Assurance & Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

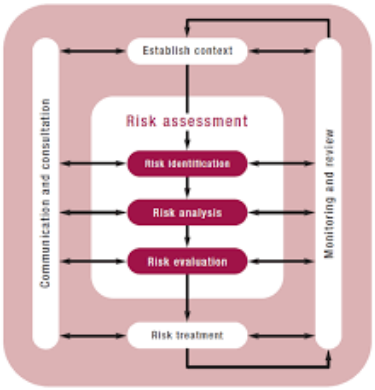
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Strategic Development & 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 principal risks on the Board Assurance Framework (BAF)/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 principal 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.
- Provide annual reports to Audit and Risk Assurance Committee (ARAC) on the effectiveness of the risk management process and management of risks within its remit.
- Identity 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 i.e. 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:

2.6 To 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 To 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).

There are 2 risks currently aligned to SDODC (out of the 15 that are currently on the CRR). These risks can be found at Appendix 2.

Changes Since Previous Report

Total Number of Risks	2	
New risks	2	*See Note 1*
De-escalated/Closed/Change of lead committee	4	*See Note 2*
Increase in risk score ↑	0	
No change in risk score →	0	
Reduction in risk score ↓	0	

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					
MAJOR 4			1350 (NEW)	1407 (NEW)	
MODERATE 3					
MINOR 2					
NEGLIGIBLE 1					

Note 1 – New Risks

Since the previous report in February 2022, 2 new risks have been added to the CRR:

Risk	Lead Director	New/ Escalated	Date	Reason
Risk 1350 - Risk of not meeting the 75% waiting times target for 2022/26 due to diagnostics capacity and delays at tertiary centre	Director of Operations	New	03/03/22	This risk has replaced the 633 – (Ability to meet the 75% target for waiting times for 2020/21 for the new Single Cancer Pathway (SCP)). The impact of COVID-19 has increased the risk of being unable to meet the target. The delays are caused by diagnostic

				capacity issues across the health board in line with the infection control guidance that still remains in place. The main area of concern is radiology. A decrease in capacity for appointments and results reporting within radiology, due to COVID-19 related sickness, current vacancies and planned annual leave 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 on a downward trajectory for quarter 3 during 2021/22. This is due to the increase in COVID-19 related sickness, management of COVID-19 related flows and the overall impact on diagnostic and critical care. The consequence of which resulted in short term planned and unplanned step down of activity within outpatients and planned surgery. This has led to an increase in the backlog of patients waiting in excess of 63 days. Performance is now at 57% (Mar 2022) and is not likely to improve over the next 3 months whilst the health board addresses the current backlog.
Risk 1407 - delivery of planned care services set out in the Annual Recovery Plan and achievement of WG Ministerial Priorities for the reduction in	Director of Operations	New	17/06/22	This risk was approved via Chair's action on 17/06/22 to replace the previous risk 1048 which related to planned care delivery in 2021/22. The combined impact of urgent and emergency care pressures (as reflected in Risk 1027) and a continuing significant

elective waiting times to target levels during 2022/23.				deficit in available staffing and financial resources continues to limit available capacity for elective, urgent and cancer pathway patients and, as a consequence, represents a risk to delivery of Ministerial Measures for the reduction in waiting lists / times during 2022/23. Limits to staffing resource both in theatre, and post operatively, was a challenge before the COVID-19 pandemic. The impact of increasing unscheduled care pressures continues to limit capacity to be dedicated to elective and surgical pathways. An elective care recovery plan has been developed which seeks to increase outpatient and treatment capacity beyond levels delivered prior to the pandemic. However, the capacity required during the 2022/23 year to enable achievement of the Ministerial Measures exceeds that currently available. Whilst outsourcing programmes are continuing supported by 'Recovery' funding provided by WG, the additional capacity required exceeds the level currently being commissioned and reflected with the UHB's Annual Recovery Plan.

Note 2 - De-escalated/Closed/Change of lead committee

Since the previous report, two corporate risks aligned to this Committee have been de-escalated.

Risk Ref & Title	Lead Director	Closed/ De-escalated	Date	Reason

633 - Ability to meet the 75% target for waiting times for 2020/21 for the new Single Cancer Pathway (SCP)	Director of Operations	Closed	02/03/22	The Executive Risk Group agreed to close this risk following a review of the risk by the service. The new risk (1350) reflects the current context and issues and the new ministerial measure for the single cancer pathway.
1342 - Inability to plan and respond effectively to the pandemic due to changes in COVID testing and reporting policy	Director of Operations	Closed	13/04/22	This risk was reviewed by the Executive Risk Group, who agreed to reduce the risk score to 9 and close the risk as no further action can be taken to mitigate the risk and responding to COVID-19 demand has become part of normal business.
1048 - Risk to the delivery of planned care services set out in the Annual Recovery Plan 2021/22	Director of Operations	Closed	17/06/22	This was closed via Chair's action on 17/06/22 as it relates to delivery of planned care services in 2021/22. A new risk (1407) has been articulated for 2022/23 (see section above).
1027 - Delivery of integrated community and acute unscheduled care services	Director of Operations	Realigned to QSEC	01/06/22	The Executive Risk Group agreed on 01/06/2022 to realign risk 1027 to the Quality, Safety and Experience Committee (QSEC) for future reporting.

Argymhelliad / Recommendation

SDODC is asked to seek 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) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.6 To 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

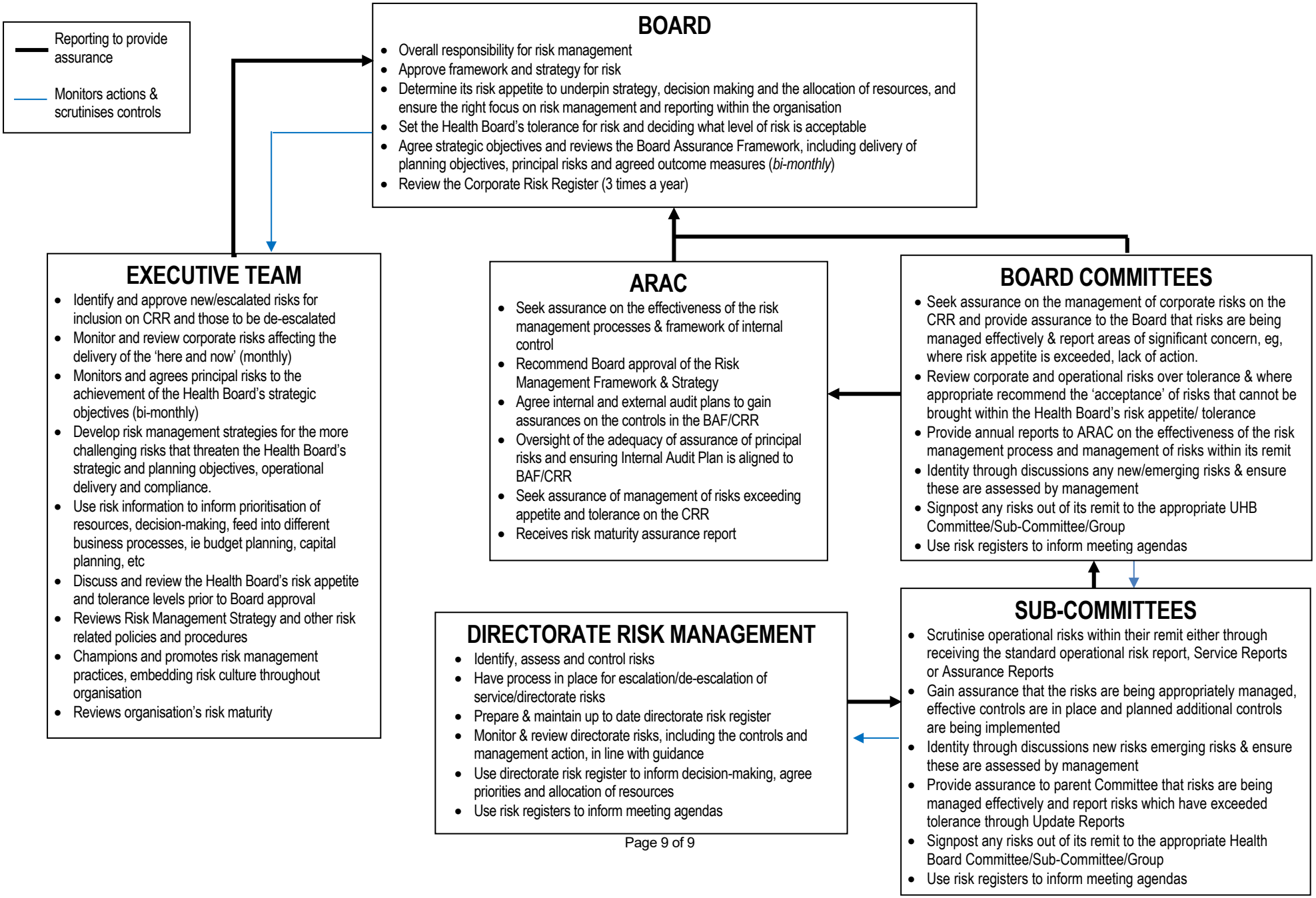
	significant concern e.g. where risk tolerance is exceeded, lack of timely action. 2.7 To recommend acceptance of risks that cannot be brought within the UHBs risk appetite/tolerance to the Board through the Committee Update Report.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7.1 Workforce
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report	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 September 2018 – 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



CORPORATE RISK REGISTER SUMMARY JUNE 2022

Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Jun-22	Trend	Target Risk Score	Risk on page no...
1407	Risk to delivery of Annual Recovery Plan & achievement of WG Ministerial Priorities for the reduction in elective waiting times	Carruthers, Andrew	Safety - Patient, Staff or Public	6	N/A	**4×4=16**	New risk	**3×4=12**	3
1350	Risk of not meeting the 75% waiting times target for 2022/26 due to diagnostics capacity and delays at tertiary centre	Carruthers, Andrew	Quality/Complaints/Audit	8	N/A	**3×4=12**	New risk	**3×2=6**	6

Date Risk Identified:	Jun-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of**	Jun-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of**	Jul-22

Risk ID:	**1407**	**Principal Risk Description:**	There is a risk there will be disruption to the delivery of planned care services set out in the Annual Recovery Plan and achievement of WG Ministerial Priorities for the reduction in elective waiting times to target levels during 2022/23. This is caused by the impact of urgent and emergency care pressures (as reflected in risk 1027) and a continuing significant deficit in available staffing and financial resources to support green pathways for urgent and cancer pathway patients. 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	**Risk Rating:(Likelihood x Impact)**		**No trend information available.**
				Domain:	Safety - Patient, Staff or Public
				Inherent Risk Score (L x I):	5×4=20
				Current Risk Score (L x I):	4×4=16
				Target Risk Score (L x I):	3×4=12
				Tolerable Risk:	6
				Trend:	*New risk*

Does this risk link to any Directorate (operational) risks?

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
The combined impact of urgent and emergency care pressures (as reflected in risk 1027) and a continuing significant deficit in available staffing and financial resources continues to limit available capacity for elective, urgent and cancer pathway patients and, as a consequence, represents a risk to delivery of Ministerial Measures for the reduction in waiting lists/times during 2022/23. Limits to staffing resource both in theatre, and post operatively, was a challenge before the COVID pandemic. The impact of increasing unscheduled care pressures continues to limit capacity to be dedicated to elective & surgical pathways. An elective care recovery plan has been developed which seeks to increase outpatient and treatment capacity beyond levels delivered prior to the pandemic. However, the capacity required during the 2022/23 year to enable achievement of the Ministerial Measures exceeds that currently available. Whilst outsourcing programmes are continuing supported by Recovery funding provided by WG, the additional capacity required exceeds the level currently being commissioned and reflected with the UHB's Annual Recovery Plan.	Across the UK, there is a significant challenge for health organisations in sustaining the recovery of planned care pathways as they emerge from the pandemic. The target score of 12 is based on the realistic assessment of the level of planned care work which can 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.

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	**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. # 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. # Comprehensive programme of outsourcing of planned care volumes in place utilising capacity available via independent sector providers # Weekly review of outsourcing volumes and further opportunities progressed jointly by Planned Care and Commissioning teams. # Planned Care Recovery Programme for 2022/23 in place.	# 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. # Theatre staffing availability to support expansion of theatre capacity at required pace and level. # 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	Revised elective care delivery plan developed for inclusion within refreshed Annual Delivery Plan to be submitted June 2022.	Jones, Keith	30/06/2022	Draft plan developed.
		Opportunities to enhance dedicated elective pathway capacity across sites is dependent upon successful delivery of the transforming urgent and emergency care plan.	Jones, Keith	31/03/2023	Insufficient elective pathway capacity at Glangwili Hospital to support sufficient internal capacity for
		Workforce development and recruitment plan jointly developed between Planned Care & Workforce Team	Hire, Stephanie	31/03/2023	Partial progress achieved in recruitment of theatre staffing resources.
		Targeted review of Health Records service vacancies and recruitment plans, led by Health Records service and supported by Planned Care & Workforce teams.	Rees, Gareth	31/07/2022	19 WTE vacancies identified. Recruitment priorities subject to ecalated review.
		Modular Unit to enable enhanced day surgical provision awaiting completion at Prince Philip Hospital.	Jones, Keith	TBC	Commissioning period delayed due to engineering issues. Timescale for resolution awaited

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. A suite of planned care metrics have been developed to measure the system performance.	Activity volumes are reported daily on situation reports	1st				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								

Date Risk Identified:	Feb-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of**	May-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of**	Jul-22

Risk ID:	**1350**	**Principal Risk Description:**	There is a risk of the UHB 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 the reduced capacity due to the impact of COVID-19 on our ability to meet the expected demand for diagnostics and treatment delays at our tertiary centre. This could lead to an impact/affect on 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	**Risk Rating:(Likelihood x Impact)**	**No trend information available.**
				Domain: Quality/Complaints/Audit	
				Inherent Risk Score (L x I): 5×4=20	
				Current Risk Score (L x I): 3×4=12	
				Target Risk Score (L x I): 3×2=6	
				Tolerable Risk: 8	
Does this risk link to any Directorate (operational) risks?				**Trend:** *New risk*	

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
The impact of COVID-19 has increased the risk of being unable to meet the target. The delays are caused by diagnostic capacity issues across the health board in line with the infection control guidance that still remains in place. The main area of concern is Radiology. A decrease in capacity for appointments and results reporting within radiology, due to COVID-19 related sickness, current vacancies and planned annual leave 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 on a downward trajectory for quarter 3 during 2021/22. This is due to the increase in COVID related sickness, management of COVID related flows and the overall impact on diagnostic and critical care. The consequence of which resulted in short term planned and unplanned step down of activity within outpatients and planned surgery. This has led to an increase in the backlog of patients waiting in excess of 63 days. Performance is now at 57% (Mar 22)and is not likely to improve over the next 3 months whilst the health board addresses the current backlog.	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	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# A SCP Diagnostic Group with all the relevant service managers is in place to look at the capacity & demand for diagnostic services, looking at what capacity is required for a 7 day turnaround diagnostic service. # Fully established cancer tracking team in place to allow patients to be proactively tracked through their pathways. # A new cancer dashboard has now been developed by Informatics with the support of Business Intelligence (BI) SCP funding from the Wales Cancer Network. This is now live with accesses for Cancer Services staff and Service Managers. This will allow MDTs to actively monitor tumour site specific patients on a SCP. # A Rapid Diagnosis Clinic (RDC) has been launched within the health board. Currently 1 clinic per week being held in PPH. Funding has now been secured and plans are being discussed to role this service out across all 3 counties. # 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. This initiative is due to be rolled out to primary care by the endoscopy service by April 2023. # Digital Delivery of Care was implemented during the first wave of the pandemic, resulting in two thirds of patients receiving virtual appointments and only a third requiring face to face appointments. # 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 are currently being 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. # Cancer Pathway Review Panel has been implemented to identify any risk for those patients who have not received their treatment within 146 days. # 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). # Deep dive pathway review for poorest performing tumour sites - urology, lower GI, gynaecology. # Continue to escalate concerns regarding tertiary centre capacity and associated delays	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. Access to green pathways and tertiary centres fluctuates depending on COVID-19.	The Wales Cancer Network are employing Single Cancer Pathway (SCP) Project Managers for each health board across Wales to support the SCP work and the optimisation of the National Optimal Pathways	Humphrey, Lisa	31/03/2024	Project Manager appointed and took up post in Apr22. This will be a 2 year fixed term appointment to run alongside the
		Work with newly appointed Head of Radiology to: 1) explore outsourcing opportunities and internal solutions to increase capacity to appointments and reporting utilising non recurrent recovery money. 2) Investigating current capacity for diagnostics to ensure a 7-day turnaround as per the National Optimal Pathways.	Humphrey, Lisa	31/03/2023	Initial Meeting with Head of Radiology 09Mar22 to scope schedule of work for demand & capacity (C&D) plan for radiology and explore short term opportunities to increase capacity. A draft C&D has been
		Review access to green surgical pathways across all sites to include access to green critical care.	Humphrey, Lisa	30/04/2022	BGH & WGH Green elective pathway has been re-established. A plan for pre COVID theatre capacity to
		Introduce a central point of contact for navigator as a pilot to coordinate radiology USC appointments and reporting from Mar22	Humphrey, Lisa	Completed	The Radiology Navigator took up post in April 22.
		Each MDT to review and adopt recommended optimal tumour site specific pathways	Humphrey, Lisa	~~31/03/2023~~ timescales may change depending on COVID	The Macmillan Cancer Quality Improvement Manager is working with the teams with regards to implementing the new pathways. Due to the pandemic, the services have not been able to implement the new pathways in full, due to the restrictions

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 concentrating on those tumour sites under 50% ie Gynae, Lower GI and Urology. 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 * COVID-19 Impact on Cancer Services - Board - May20 * Cancer Updated to QSEAC Jun20 & OpQSESC Jul20	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								

RISK SCORING MATRIX

Likelihood x Impact = Risk Score

Likelihood	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	This will probably never happen/recur (except in very exceptional circumstances).	Do not expect it to happen/recur but it is possible that it may do so.	It might happen or recur occasionally.	It might happen or recur occasionally.	It will undoubtedly happen/recur, possibly frequently.
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	(0-5%*)	(5-25%*)	(25-75%*)	(75-95%*)	(>95%*)
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				

Risk Impact Domains	Negligible - 1	Minor - 2	Moderate - 3	Major - 4	Catastrophic - 5
Safety of Patients, Staff or Public	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention.	Moderate injury requiring professional intervention.	Major injury leading to long-term incapacity/disability.	Incident leading to death.
	No time off work.	Requiring time off work for >3 days	Requiring time off work for 4-14 days.	Requiring time off work for >14 days.	Multiple permanent injuries or irreversible health effects.
		Increase in length of hospital stay by 1-3 days.	Increase in length of hospital stay by 4-15 days.	Increase in length of hospital stay by >15 days.	An event which impacts on a large number of patients.
			Agency reportable incident.	Mismanagement of patient care with long-term effects.	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	Peripheral element of treatment or service suboptimal.	Overall treatment or service suboptimal.	Treatment or service has significantly reduced effectiveness.	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment/service.
	Informal complaint/inquiry.	Formal complaint.	Formal complaint -	Multiple complaints/ independent review.	Gross failure of patient safety if findings not acted on.
		Local resolution.	Escalation.	Low achievement of performance/delivery requirements.	Inquest/ombudsman inquiry.
		Single failure to meet internal standards.	Repeated failure to meet internal standards.	Critical report.	Gross failure to meet national standards/performance requirements.
		Minor implications for patient safety if unresolved.	Major patient safety implications if findings are not acted on.		
		Reduced performance if unresolved.			
Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.

Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Inequalities/ Equity	Minimal or no impact on our attempts to reduce health inequalities/improve health equity	Minor impact on our attempts to reduce health inequalities or lack of clarity on the impact we are having on health equity	Moderate impact on our attempts to reduce health inequalities or lack of sufficient information that would demonstrate that we are not widening the gap. Indications that we are having no positive impact on health improvement or health equity	Major impact on our attempts to reduce health inequalities. Validated data suggesting we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity

RISK MATRIX

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

RISK ASSESSMENT - FREQUENCY OF REVIEW

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

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Ma	Tends to be detailed
2nd Line	Corporate O	Less detailed but slightly
3rd Line	Independent	Often less detail but truly

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

NB Assurance Map will tell you if

K - Control RAG rating	
LOW	Significant concerns over
MEDIUM	Some areas of concern ov
HIGH	Controls in place assessed
INSUFFICIENT	Insufficient information a