Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	31 August 2023
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 Lee Davies, Director of Strategy and Planning
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

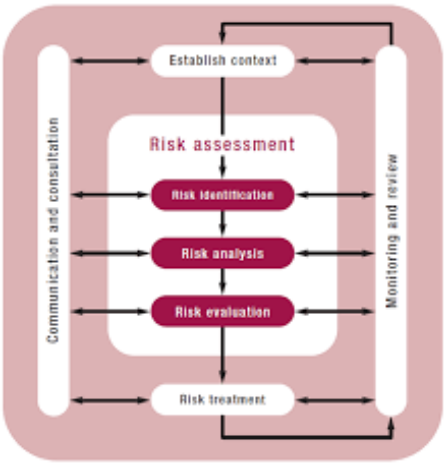
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Strategic Development & 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 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 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).

There are 3 risks assigned to the Committee from the 22 risks currently identified on the CRR. These risks can be found at Appendix 2.

Changes Since Previous Report

Total Number of Risks	3	
New risks	2	*Note 1*
De-escalated/Closed	1	*Note 2*
Increase in risk score ↑	0	
No change in risk score →	1	*Note 3*
Reduction in risk score ↓	0	

Note 1 – New risks

Two new risks have been added to Datix since 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 23/24 due to demand exceeding capacity	12/05/23	Director of Operations	**4x5=20** (Reviewed 28/07/23)	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 further proposals have been submitted to Welsh Government to access retained recovery funding not yet allocated to Health Boards, revised delivery trajectories cannot be confirmed without a supporting resource plan.	**4x3=12**

				Subject to availability of additional resources to support additional recovery actions, it is anticipated that a significant volume of additional activity will need to be supported by externally provided solutions, either via neighbouring Health Boards or via the independent sector insource / outsource market. External capacity cannot be confirmed prior to formal market testing. 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 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. Whilst no Health Board is currently achieving ministerial milestones in respect of planned care recovery, the Health Board has achieved the greatest progress compared to other Health Boards across Wales during 2022/23 and has achieved a significant improvement in the volumes of	

				Stage 1 patients waiting > 52 weeks and total pathway patients waiting > 104 weeks.	
1707 - Risk of breaching Capital Resource Limit (CRL) in 2023/24 due to additional significant demands for funding	01/05/23	Director of Strategy and Planning	**4x3=12** (Reviewed 03/08/23)	The Health Board will strive to manage its capital expenditure in line with the CRL but this will result in the Health Board having to reprioritise the investment in the Capital Programme approved by Board in March 2023. Indication from Welsh Government (WG) in the Capital Review meeting held on 21 July 2023 that funding of the fire scheme in WGH is likely and that they will also consider a submission by the UHB for Reinforced Autoclaved Aerated Concrete (RAAC) funding in 2023/24.	**4x2=8**

Note 2 – Risk closed

One risk has been closed since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Previous Risk Score	Update	Target Risk Score
1407- Risk to delivery of Annual Recovery Plan & achievement of Welsh Government (WG) Ministerial Priorities for the reduction in elective waiting times	15/06/22	Director of Operations	**3x4=12** (Risk closed on 15/05/23)	Approved for closure by Chair's action on 15th May 2023 as superseded by new risk for FY2023/24 (1657 - above).	**3x4=12**

Note 3 - No change in risk score

There have been no changes to the following risk score since reported at the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Current Risk Score	Update	Target Risk Score
1350 - Risk of not meeting the 75% waiting times target for 2022/26 due to diagnostics	04/02/22	Director of Operations	**3x4=12** (Reviewed 21/08/23)	Cancer performance has been variable since quarter 3 2021/22. Lower than predicted performance in the last three months (period to July 2023) has	**2x4=8**

capacity and delays at tertiary centre				been driven by high number of patients treated beyond target in a number of specialties, particularly in urology, lower gastro-intestinal (LGI), and lung cancers. The backlog has decreased to 379, which includes tertiary patients in July 23 (July 22: 786). The overall backlog in July 2023 decreased by 52 from the previous month. Performance is below prediction and currently at 46% for June 2023, against predicted performance of 60%. The predicted backlog for March 2024 is 236, with a predicted performance of 70% by the financial year end. The declaration of an Internal Major Incident at Withybush General Hospital in August 2023 as a result of reinforced autoclaved aerated concrete (RAAC) requires pathway changes in surgical specialities to alternative sites. This will require enhanced monitoring to mitigate impact on performance.	

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 (→) 1707 (NEW)		1657 (NEW)
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.
- 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:	6. All Apply

Quality and Engagement Act (sharepoint.com)	
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 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.

Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Aug-23	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	N/A	**5×4=20**	New Risk	**3×4=12**	3
1350	Risk of not meeting the 75% 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**	6
1707	Risk of breaching Capital Resource Limit (CRL) in 2023/24 due to additional significant demands for funding	Davies, Lee	Statutory duty/inspections	8	N/A	**3×4=12**	New risk	**2×4=8**	10

Assurance Key:

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

Key - Assurance Required	*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*
Detailed review of relevant information	
Medium level review	
Cursory or narrow scope of review	

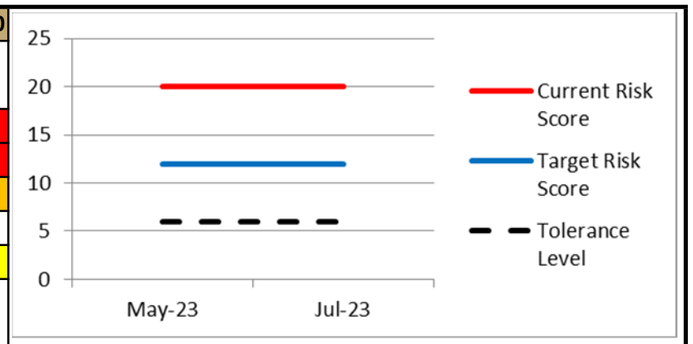
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective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

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jul-23
Lead Committee:	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Aug-23

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	

		10
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:		*New risk*



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 further proposals have been submitted to WG to access retained recovery funding not yet allocated to health boards, revised delivery trajectories cannot be confirmed without a supporting resource plan. Subject to availability of additional resources to support additional recovery actions, it is anticipated that a significant volume of additional activity will need to be supported by externally provided solutions, either via neighbouring health boards or via the independent sector insource / outsource market. External capacity cannot be confirmed prior to formal market testing. 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. Whilst no health board is currently achieving ministerial milestones in respect of planned care recovery, HDUHB has achieved the greatest progress compared to other health boards across Wales during 2022/23 and has achieved a significant improvement in the volumes of Stage 1 patients waiting > 52 weeks and total pathway patients waiting > 104 weeks.

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 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.

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. # 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. # Elective care delivery plan developed for inclusion within Annual Delivery Plan. # Additional Planned Care Recovery proposals submitted to WG May 2023.	# 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 through the year. # Sufficiency of Health records service capacity to support planned expansion of outpatient activity. # Sufficiency of Anaesthetic medical staffing capacity to support planned expansion of required operating lists.	Elective care delivery plan developed for inclusion within Annual Delivery Plan.	Jones, Keith	Completed	Plan complete and submitted within refreshed Annual Recovery Plan.
		Additional Recovery proposals submitted to WG May 2023 against WG £50m retained Recovery Fund	Jones, Keith	Completed	Additional proposals submitted. Outcome awaited.
		Opportunities to enhance dedicated elective pathway capacity across sites is dependent upon successful delivery of the transforming urgent and emergency care plan.	Jones, Keith	30/09/2023	Partially Complete - Dedicated elective capacity in place at Prince Philip Hospital and Bronglais General Hospital. Availability of dedicated elective capacity at Withybush General Hospital has been delayed until early Q3 at the earliest due to estate infrastructure challenges on the site. However, this remains under review do to the developing RAAC risk assessment work currently underway. 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 currently being explored.
		Workforce development and recruitment plan jointly developed between Planned Care & Workforce Team	Hire, Stephanie	~~30/06/2023~~ 30/08/2023	Continued progress achieved in recruitment of theatre staffing and consultant anaesthetic appointments, but levels remained below required WTE. Further review in August 2023.
		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	~~30/06/2023~~ 30/08/2023	WG allocation of additional recovery resources (confirmed 25 July 23) is significantly below the required level reflected in the Health Board's additional recovery proposals. Impact assessment currently being conducted.

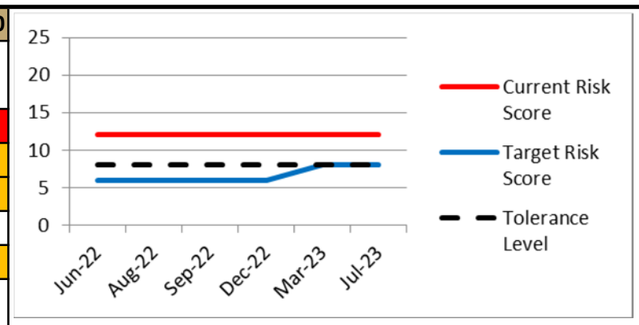
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Mar-23
Lead Committee:	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	May-23

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 capacity challenges within the first 28 days of the pathway in first Outpatients Assessment and diagnostics, particularly in the large volume tumour sites, lower GI and urology. This is compounded by a backlog of patients waiting in excess of 62 days due to the impact of COVID--19. This could lead to an impact/affect 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	

	10
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 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 and urology diagnostics. A decrease in capacity for appointments and results reporting within radiology, due to 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 variable since quarter 3 2021/22. Performance since April 2022 has been variable whilst the priority focus has been on reducing the backlog of patients awaiting diagnosis and/or treatment. Since July 2022, the number of patients waiting in excess of 62 days has reduced by 43% (data as at February 2023). Improvement trajectories are now in place, with the aim to achieve 70% by March 2024, with a backlog volume of 231 (inclusive of tertiary waits).

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.
Target risk score amended in March 2023 to reflect that current trajectories for March 2024 aims to achieve 70%, recognising that there is still further work to be done to achieve the ministerial requirement of 75%.

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 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 -	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.	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	Completed	Project Manager appointed and took up post in Apr22. This will be a 2 year fixed term appointment to run alongside the optimisation project. Request made 18th November to the WCN for sessions to develop and strengthen our Cancer Recovery plan and maximise optimum pathway opportunities
		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~~ 31/07/2023	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, which is ongoing as of March 2023. A draft C&D has been carried out by the Radiology service in collaboration with the Delivery Unit. An SBAR that contains the cost of associated gaps in service provision has been developed in draft and presented to Cancer Delivery Board. Next step is to present to the SOBM in May 2023.
		Review access to green surgical pathways across all sites to include access to green critical care.	Humphrey, Lisa	Completed	As of March 2023, service now operating as at pre-covid capacity. Action complete.
		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.

# Deep dive pathway review for poorest performing tumour sites urology, lower GI, gynaecology. # Continue to escalate concerns regarding tertiary centre capacity and associated delays.		Each MDT to review and adopt recommended optimal tumour site specific pathways. (Timescales may change depending on COVID)	Humphrey, Lisa	~~31/03/2023~~ 30/09/2023	The Macmillan Cancer Quality Improvement Manager is working with the teams with regards to implementing the new pathways.

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 * Risk 633 QSEAC - Feb21 & Aug21 * 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								

Date Risk Identified:	May-23
Strategic Objective:	6. Sustainable use of resources

Executive Director Owner:	Davies, Lee	**Date of Review:**	Aug-23
Lead Committee:	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Oct-23

Risk ID:	**1707**	**Principal Risk Description:**	There is a risk that the Health Board will breach its statutory duty to breakeven against the Capital Resource Limit (CRL) in 2023/24. This is caused by the pressures being placed on the capital resource available in year by the need to underwrite the current expenditure on the Withybush General Hospital (WGH) Phase 1 Fire Scheme and the requirement to undertake survey works in WGH on the condition of reinforced autoclaved aerated concrete (RAAC) planks and the need to undertake remedial works. This is exacerbated by uncertainty on additional funding by Welsh Government to support these streams of work as at July 2023. This could lead to an impact/affect on the Health Board's ability to undertake/progress other capital projects which could impact on the Health Board's ability to resolve immediate issues and problems in patient environments and the ability to undertake clinical work on all sites if equipment breakdowns occur.
Does this risk link to any Directorate (operational) risks?		1382, 1596, 1539, 1096, 1040	

10	
Domain:	Statutory duty/inspections
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:	*New risk*

No trend information available.

Rationale for CURRENT Risk Score:
The Health Board's CRL is under significant pressure due to the fact that the Health Board is currently underwriting the overspend on WGH Phase 1 Fire Schemes along with picking up the cost of the RAAC survey and remedial works. The Health Board has already had to review it's approved capital programme for 2023/24 to manage these costs in the short term. Without any additional capital support from Welsh Government for these schemes, it remains likely that the Health Board will breach it's CRL and be unable to deal with emergency issues and breakdowns as they arise in year.

Rationale for TARGET Risk Score:
The Health Board will strive to manage it's capital expenditure in line with the CRL but this will result in the Health Board having to reprioritise the investment in the Capital Programme approved by Board in March 2023. Indication from WG in the Capital Review meeting held on 21st July 2023 that funding of the fire scheme in WGH is likely and that they will also consider a submission by the UHB for RAAC funding in 2023/24.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
1. Timely financial reporting to Capital Monitoring Group, Capital Sub-Committee, Strategic Development and Operational Delivery Committee, Sustainable Resources Committee, Board and Welsh Government as key areas of concern emerge. 2. Bi-Monthly reporting to the Capital Sub-Committee, Strategic Development and Operational Delivery Committee and Sustainable Resources Committee regarding the capital risk. 3. Accountable Officer Letter issued to WG. 4. Regular updates to WG on the pressures on the DCP and the impact of RAAC costs.

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**
Aligning the reporting of the risk and the potential impact between the Board Committees, ensuring that the reporting into SDODC reflects the potential impact on the delivery against the fire notices reported into Health and Safety Committee.	Ensure that the content of the SDODC reports and the DCP pressures reflects any potential impact on the delivery of the Fire Schemes.	Williams, Paul	31/08/2023	SDODC report in August to reflect.
	Review with WG potential for additional capital to support the RAAC remedial works.	Williams, Paul	31/08/2023	WG have asked the UHB to submit an estimate of the likely costs in 2023/24 for funding consideration.
	May be the need to re-prioritise the DCP again following Capital Review Meeting with WG in July.	Williams, Paul	30/09/2023	Ongoing meeting of a sub-group of the Capital Planning Group meeting every 2 weeks to review schemes on hold and bids against the contingency reserve.

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**		
Performance against the Capital Resource Limit.	Performance against plan monitored through Capital Monitoring Group with key internal stakeholders	1st			Executive Team 21/06/2023 SDODC 26/06/2023
	Review of RAAC costs and impact on DCP at the end of each survey stage	1st			
	Performance reports through to Capital Sub-Committee	1st			
	SDODC oversight of performance	2nd			
	Accountable Officer Letter to WG	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**

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.