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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 April 2023
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risks Assigned to Strategic Development and Operational Delivery Committee
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Director of Operations
SWYDDOG ADRODD: **REPORTING OFFICER:**	Charlotte Wilmshurst Assistant Director of Assurance & Risk

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

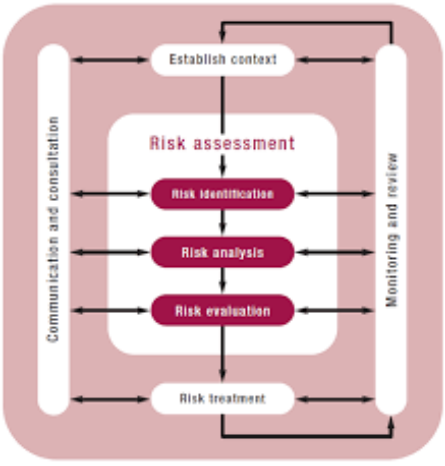
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Strategic Development and Operational Delivery Committee (SDODC) is asked to 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 ie source, timeliness, methodology behind its generation and its compatibility with other assurances. This will enable the Board to place greater reliance on assurances, if they are confident that they have been robustly scrutinised by one of its Committees; and provide them with greater confidence regarding the likely achievement of strategic objectives, as well as providing a sound basis for decision-making. It is the role of Committees to challenge where assurances in respect of any component are missing or inadequate. Any gaps should be escalated to the Board.

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

Asesiad / Assessment

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

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

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 two risks assigned to the Committee from the 17 risks currently identified on the CRR. These risks can be found at Appendix 2.

Changes Since Previous Report

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

Note 1- No change in risk score
There have been no changes to 1 risk score since they were 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 capacity and delays at tertiary centre	04/02/22	Director of Operations	**3x4=12** (Reviewed 24/03/23)	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 hospital 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. As at February 2023, the number of	**2x4=8**

				patients waiting in excess of 62 days has reduced to43%). 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).	

Note 2 - Reduction in risk score
The following risk has reduced its current risk score since the previous meeting

Risk Reference & Title	Date risk identified	Lead Director	Previous Risk Score	Current Risk Score	Update	Target Risk Score
1407- Risk to delivery of Annual Recovery Plan & achieve-ment of Welsh Government (WG) Ministerial Priorities for the reduction in elective waiting times	15/06/22	Director of Operations	**4x4=16**	**3x4=12** (Reviewed 24/03/23)	The combined impact of urgent and emergency care pressures (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-19 pandemic. Whilst positive progress has been	**3x4=12**

					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. Although no Health Board in Wales was able to achieve the Ministerial milestones for Stage 1 outpatient and total pathway waiting times by December 2022, the Health Board achieved the greatest progress and performance levels towards these milestones and continues to further improve waiting times across the majority of specialties. Whilst the Health Board does not expect to achieve zero breach	

					performance by June 2023 (for Stage 1 patients waiting >52 week) and total pathway patients waiting >104 weeks), the current risk impact and therefore overall risk score has been reduced to current target level (12) to reflect the forecast 73% reduction in the volume of outpatients waiting >52 weeks by end March 2023 and the forecast 60% reduction in the volume of total pathway patients waiting >104 weeks by end March 2023, compared to peak levels during 2022/23. A new risk is being drafted for the delivery of planned care Ministerial priorities for 2023/24.	

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 (→)		

MODERATE 3				1407 (↓)	
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
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability

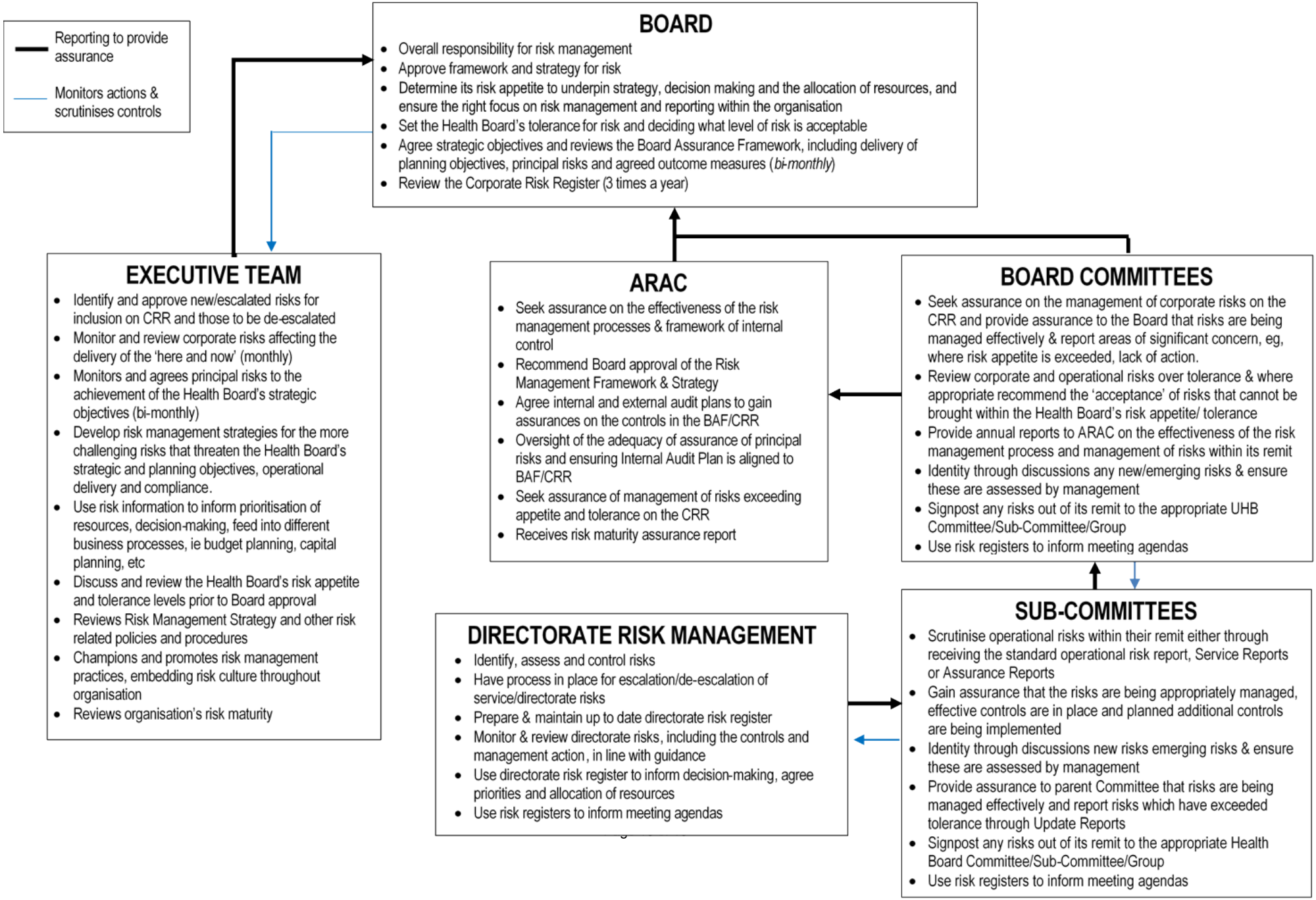
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	10. Not Applicable

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



Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Dec-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	4×4=16	**4×3=12**	↓	**4×3=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	3×4=12	**3×4=12**	→	**2×4=8**	6

Assurance Key:

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

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

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

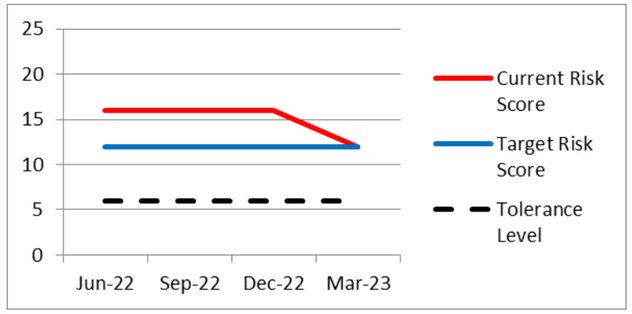
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective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

Date Risk Identified:	Jun-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:	**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 scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?		1548, 180, 523, 525, 632, 958, 1083, 1027, 1628, 1629	

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



Rationale for CURRENT Risk Score:

The combined impact of urgent and emergency care pressures (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. 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.

Although no HB in Wales was able to achieve the ministerial milestones for Stage 1 outpatient and total pathway waiting times by December 2023, HDUHB achieved the greatest progress and performance levels towards these milestones and continues to further improve waiting times across the majority of specialties. Whilst the HB does not expect to achieve zero breach performance by June 2023 (for Stage 1 patients waiting>52 week) and total pathway patients waiting>104 weeks), the current risk impact and therefore overall risk score has been reduced to current target level (12) to reflect the forecast 73% reduction in the volume of outpatients waiting>52 weeks by end March 2023 and the forecast 60% reduction in the volume of total pathway patients waiting >104 weeks by end March 2023, compared to peak levels during 2022/23.

Rationale for TARGET Risk Score:

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.

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 unlikely.

It should be noted that although the overall target risk score for 2022/23 remains at 12, the target likelihood and impact scores have been revised (reversed) for the remainder of 2022/23 to reflect the continuing likelihood that the ministerial measures will not be achieved by March 2023, but taking account of a revised impact assessment due to the significant reduction achieved in the volume of patients breaching both milestones.

The tolerable risk (6) for the remainder of 2022/23 has been left unchanged.

In light of progress achieved through 2022/23, a new risk and associated target risk score will be developed for 2023/24, taking account of the Board-approved recovery plan for 2023/24 and a recommended tolerance score for Board consideration if this varies from the TRR.

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. # 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 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.	Revised elective care delivery plan developed for inclusion within refreshed Annual Delivery Plan to be submitted June 2022.	Jones, Keith	Completed	Plan complete and submitted within refreshed Annual Recovery Plan.
		Opportunities to enhance dedicated elective pathway capacity across sites is dependent upon successful delivery of the transforming urgent and emergency care plan.	Jones, Keith	Completed	Dedicated elective capacity in place at PPH, BGH and WGH sites. Dedicated elective pathway capacity at Glangwili Hospital to support sufficient internal capacity for Urology & ENT surgery commenced in February 2023.
		Workforce development and recruitment plan jointly developed between Planned Care & Workforce Team	Hire, Stephanie	~~31/03/2023~~ 31/06/2023	Continued progress achieved in recruitment of theatre staffing and consultant anaesthetic appointments, but levels remained below required WTE.
		Targeted review of Health Records service vacancies and recruitment plans, led by Health Records service and supported by Planned Care & Workforce teams.	Rees, Gareth	Completed	Significant improvement in staffing levels achieved.
		Modular Unit to enable enhanced day surgical provision awaiting completion at Prince Philip Hospital.	Jones, Keith	Completed	Unit opened 05Dec22.

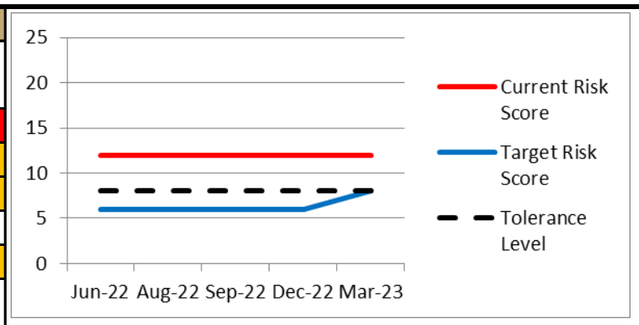
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

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



Rationale for CURRENT Risk Score:

The 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 - 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.	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.
		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								

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.