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

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

Er Sicrwydd/For Assurance

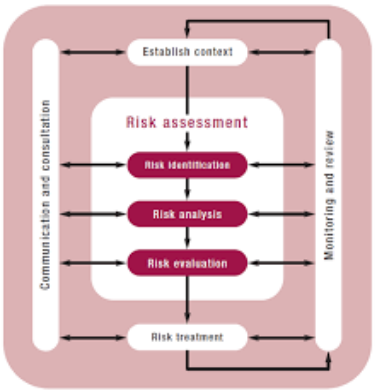
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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



(Risk Management Process, ISO 31000)

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

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

- Reviewing principal and operational risks over tolerance and, where appropriate, recommend the 'acceptance' of risks that cannot be brought within Hywel Dda University Health Board's (HDdUHB) risk appetite/tolerance to the Board.
- Provide annual reports to Audit and Risk Assurance Committee (ARAC) on the effectiveness of the risk management process and management of risks within its remit.
- Identity through discussions any new/emerging risks and ensure these are assessed by management.
- Signpost any risks outside of its remit to the appropriate HDdUHB Committee.
- Use risk registers to inform meeting agendas.

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

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

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

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

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

Asesiad / Assessment

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

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

2.6 To seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.

2.7 To recommend acceptance of risks that cannot be brought within the UHBs risk appetite/tolerance to the Board through the Committee Update Report.

2.8 Receive assurance through Sub-Committee Update Reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities

(including for hosted services and through partnerships and Joint Committees as appropriate).

There are 4 risks currently aligned to SDODC (out of the 18 that are currently on the CRR). These risks can be found at Appendix 2.

Changes Since Previous Report

Total Number of Risks	4	
New risks	1	*See Note 1*
De-escalated/Closed	0	
Increase in risk score ↑	1	*See Note 2*
No change in risk score →	2	*See Note 3*
Reduction in risk score ↓	0	

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

HYWEL DDA RISK HEAT MAP

	LIKELIHOOD →				
IMPACT ↓	**RARE 1**	**UNLIKELY 2**	**POSSIBLE 3**	**LIKELY 4**	**ALMOST CERTAIN 5**
CATASTROPHIC 5					
MAJOR 4			633	1048	1027 (↑)
MODERATE 3				1342 (NEW)	
MINOR 2					
NEGLIGIBLE 1					

Note 1 – New Risks

Since the previous report in October 2021, 1 new risk has been added to the CRR:

Risk	Lead Director	New/ Escalated	Date	Reason
Risk 1342 - Inability to plan and respond effectively to the pandemic due to changes in COVID-19 testing and reporting policy	Director of Operations	New	05/02/22	This corporate risk was approved by the Executive Risk Group on 02/02/22. The change of testing policy during the latest wave of the pandemic has made it challenging for the Health Board to fully understand where it is on the pandemic curve, and make accurate decisions in stepping up and

				down services at the right time. Whilst the Health Board is utilising other proxy data, this may not provide a full picture of activity, and may contradict the public data on COVID-19 cases in the local community. The level of risk has reduced from 20 when it was first identified in January 2022 to 12 as the peak of the 4th wave has passed.

Note 2 - Changes in Current Risk Score

There has been the following change to the current risk score of the below risk since the previous report to the Committee in October 2021:

Risk Reference & Title	Previous Risk Report Dec-21 (LxI)	Risk Score Feb-22 (LxI)	Date of Review	Update
1027 - Delivery of the Quarter 3/4 Operating Plan - Delivery of integrated community and acute unscheduled care services (Director of Operations)	4x4=16	**5x4=20** ↑	24/01/22	Levels of emergency demand continue to increase. The case incidence of COVID-19 (Omicron) has increased within the community across West Wales which has led to an increase in the proportion of staff having to self-isolate as outlined in national guidance. COVID-19 cases have also increased in hospitals and care home facilities. This has a direct impact on acute and community care bed availability alongside a reduced workforce. This has led to increasing delays in the discharge pathway and increasing delays for patients needing access to urgent and emergency care services due to reduced 'flow' and hence capacity within our Emergency Departments. Available staffing resources continue to be challenged and supply of short term and locum staffing resources remains variable. The indirect impact of COVID-19

				has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains fluid and changeable on a daily basis.

Note 3 - No change in Current Risk Score

The current risk score of the below risks are the same as the previous meeting.

Risk Reference, Title & Risk Owner	Previous Risk Report Dec-20 (Lxl)	Risk Score Jun-21 (Lxl)	Date of Review	Update
1048 - Risk to the delivery of planned care services set out in the Annual Recovery Plan 2021/22 (Director of Operations)	4x4=16	**4x4=16**	24/01/22	The prevalence of COVID-19 has increased in recent months and this has had a further impact on inpatient pathways which has led to a number of temporary ward closures across all sites associated with COVID-19 outbreaks and the impact of wider urgent and emergency care pressures on the planned care patient pathway. Staffing challenges remain both in theatre, and post operatively. The impact of increasing unscheduled care pressures during the Autumn/Winter period has further reduced available capacity to be dedicated to elective and surgical pathways. In January 2022, the Health Board approved the application of additional measures under the WG Local Choices Framework to temporarily reduce non-urgent elective Outpatient (OP) and In-patient (IP) pathways to enable the further prioritisation of physical and staffing resources to support unscheduled care pathways. This was a temporary arrangement which was applied for 2 weeks, which

				resulted in the current risk score increasing to 20. Pathways that were affected have now been restored, reducing the current risk score back to 16. Non-urgent elective surgical pathways were also temporarily suspended across all sites with urgent/cancer IP surgery continuing at Prince Philip and Glangwili hospitals only. The pathway in Bronglais Hospital has been restored and plans are in place to restart the pathway in Withybush Hospital by early March. Discussions are continuing in respect of re-establishing the orthopaedic pathway in Prince Philip Hospital. Outsourcing programmes are continuing supported by Recovery funding provided by WG although activity rates are limited by staffing availability and at a number of independent sector locations. There is a significant challenge across the Urgent and Emergency Care system which continues to impact upon planned care pathways.
633 - Ability to meet the 1% improvement target per month for waiting times for 2020/21 for the new Single Cancer Pathway (Director of Operations)	3x4=12	**3x4=12**	08/10/21	This risk has been reviewed and a new risk which more accurately reflects the current context will be presented to the next Executive Risk Group for approval.

Argymhelliad / Recommendation

SDODC is asked to seek assurance that:

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

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

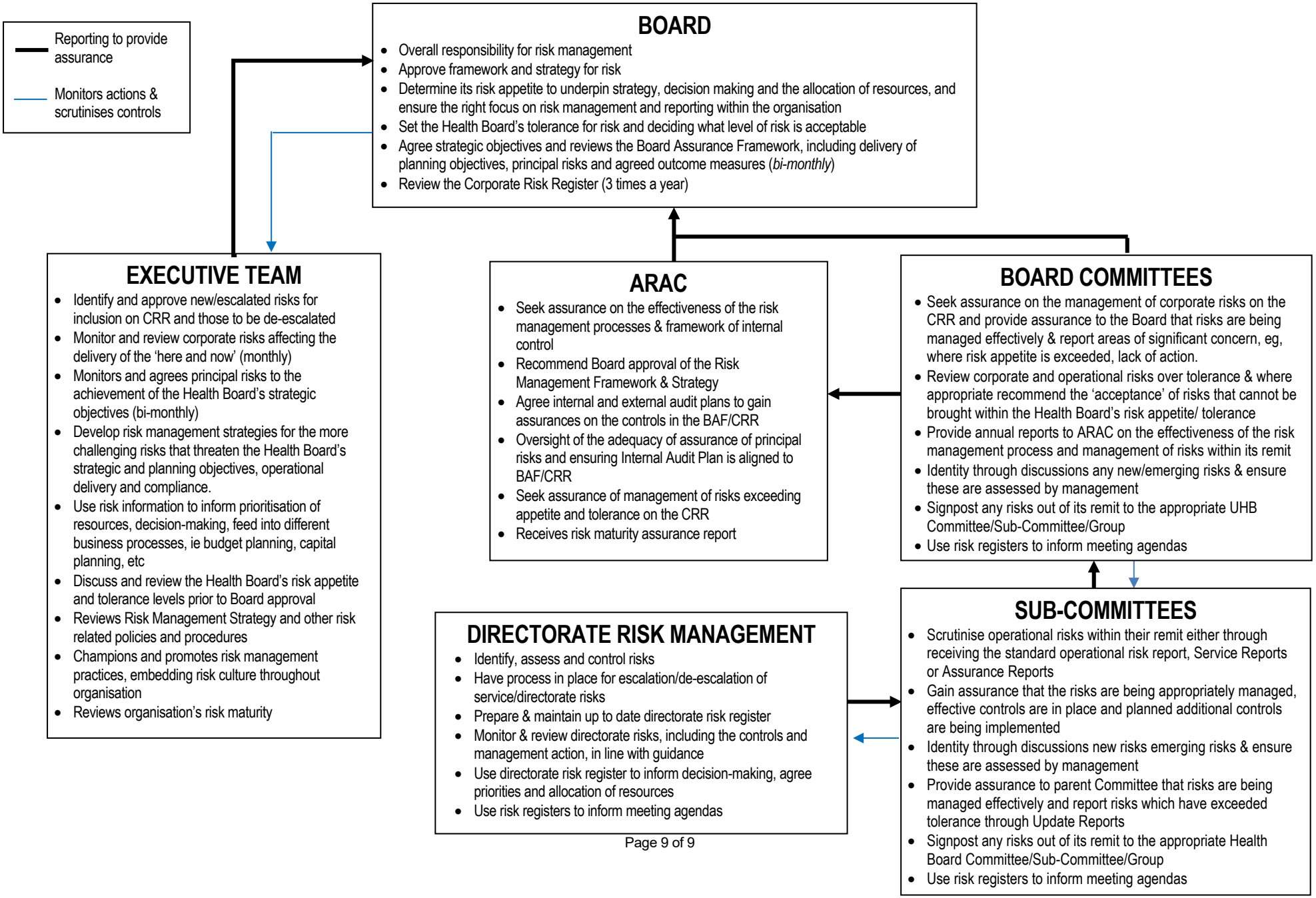
Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.6 To seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action. 2.7 To recommend acceptance of risks that cannot be brought within the UHBs risk appetite/tolerance to the Board through the Committee Update Report.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7.1 Workforce
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report	10. Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across HDdUHB's services reviewed by risk leads/owners.
Rhestr Termau: Glossary of Terms:	Current Risk Score - Existing level of risk taking into account controls in place. Target Risk Score - The ultimate level of risk that is desired by the organisation when planned controls (or actions) have been implemented. Tolerable risk – this is the level of risk that the Board agreed for each domain in September 2018 – Risk Appetite Statement.

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Datblygu Strategol A Chyflenwi Gweithredol: Parties / Committees consulted prior to Strategic Development and Operational Delivery Committee:	Relevant Executive Directors.

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

Appendix 1 – Committee Reporting Structure



Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Feb-22	Trend	Target Risk Score	Risk on page no...
1027	Delivery of integrated community and acute unscheduled care services	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4x4=16	**5×4=20**	↑	**3×4=12**	6
1048	Risk to the delivery of planned care services set out in the Annual Recovery Plan 2021/22	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4x4=16	**4×4=16**	→	**3×4=12**	10
1342	Inability to plan and respond effectively to the pandemic due to changes in COVID testing and reporting policy	Carruthers, Andrew	Quality/Complaints/Audit	8	N/A	**4×3=12**	New	**3×3=9**	13
633	Ability to meet the 75% target for waiting times for 2020/21 for the new Single Cancer Pathway (SCP)	Carruthers, Andrew	Quality/Complaints/Audit	8	**3×4=12**	**3×4=12**	→	**3×2=6**	17

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	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on

RISK MATRIX

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

RISK ASSESSMENT - FREQUENCY OF REVIEW

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

Assurance Key:

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

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

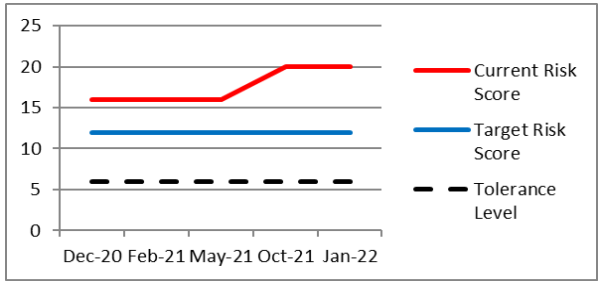
NB Assurance Map will tell you if you have

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

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jan-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Feb-22

Risk ID:	**1027**	**Principal Risk Description:**	There is a risk to the consistent delivery of timely and high quality urgent and emergency care. This is caused by increasing fragility within the urgent and emergency care (UEC) system, increasing levels of demand above staffed capacity, the impact of COVID-19 on available whole system bed and staffing resources and delays in discharges across the care system which are beyond the direct influence of the Health Board. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays and overcrowding at Emergency Departments and delayed ambulance response to community emergency calls, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.

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



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

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
Levels of emergency demand continue to increase. The case incidence of COVID-19 (Omicron) has increased within the community across West Wales which has led to an increase in the proportion of staff having to self isolate as outlined in national guidance. COVID-19 cases have also increased in hospitals and care home facilities. This has a direct impact on acute and community care bed availability alongside a reduced workforce to staff the remaining beds. This has led to increasing delays in the discharge pathway and increasing delays for patients needing access to urgent and emergency care services due to reduced 'flow' and hence capacity within our Emergency Departments. Available staffing resources continue to fall short of required levels and supply of short term and locum staffing resources remains variable. The indirect impact of COVID-19 has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains fluid and changeable on a daily basis.	There is a significant challenge across the Urgent and Emergency Care system. The combined impact of the multi-faceted pressures which underpin this risk have led to an incremental increase in the overall level of pressure as reflected in deteriorating delays for ambulance handover, access to urgent and emergency care and delayed discharges. The extent to which these combined pressures impact upon the timeliness and quality of care provided is related to the overall availability of staffing resources on a daily / weekly basis, which in turn is influenced by increasing levels of staff sickness/absence as the winter period has progressed.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage unscheduled care risks on daily basis including multiple daily multi-site calls in times of escalation which include efficient handover from WAST into ED. # Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. # Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds. # Discharge lounge takes patients who are being discharged. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles and specifically reviews COVID-related absence and forward forecast. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites. # Regular advice on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, Social services and the Long Term Care Team support. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Winter Plans developed to manage whole system pressures. # Joint workplan with Welsh Ambulance Services NHS Trust. # 111 implemented across Hywel Dda. # Transformation fund bids in relation to crisis response being implemented across the Health Board. # IP&C support for care homes to avoid outbreaks. # Ability to deploy Health Board staff where workforce compromise is immediately threatening to continuation of care for residents. # Care Home Risk & Escalation Policy to be applied to support failing care homes as required. # Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across Health Board # COVID-19 IP&C Outbreak policy in place to coordinate management of	# Data has demonstrated that targeted improvement is required across our UEC system to reduce conveyance, conversion and discharge levels to facilitate improvements in the management of our Complex frail population, maximise enhanced 'front door' turnaround within max 72 hours and improved discharge coordination. # Fragility of Care Home Sector exacerbated by COVID related issues such as financial viability, staffing deficits, recruitment and retention of workforce. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff exacerbated by increased staff absences due to the TTP process. # Nurse staffing availability to ensure safe levels of care as a consequence vacancies and COVID 19 related	To consider alternative models of medical oversight i.e service level agreement with local GPs and HB salaried community GPs	Dawson, Rhian	Completed	Pending confirmation indemnity for the local GPs to deliver.
		Refer CRR 1219 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	31/03/2022	Ref CRR 1219 for detailed progress.
		To encourage and support staff to participate in the UHB's Covid-19 vaccination programme.	Jones, Keith	Completed	Undertaken through general communications and line management.
		Explore service provision in the community for people pending ambulance conveyance, and where conveyance is not possible to manage ambulance handover delays	Dawson, Rhian	Completed	Completed.
		Recruit additional workforce in line with safe staffing requirements for 28 beds in Amman Valley Hospital	Dawson, Rhian	Completed	Completed.
		Development of enhanced Bridging Service and to actively recruit HCSWs to support domiciliary care services	Lorton, Elaine	Completed	Completed.
		Create live UEC performance dashboard.	Dawson, Rhian	~~31/12/2021~~ 31/03/2022	UEC Dashboard 'mock up' available. Pending approval.
		Recruitment to UEC Programme Management Office	Dawson, Rhian	~~31/01/2022~~ 31/03/2022	Recruitment process underway.
		Implementation of 111 First and local streaming hub as well as enhancing Same Day Emergency Care (SDEC) provision to reduce conveyance and conversion	Dawson, Rhian	31/03/2023	Recruitment underway. £3.4m awarded by WG for UEC Programme.
		Explore and gain approval for funding for 2wte COTE consultants	Dawson, Rhian	31/03/2022	Scoping underway

# COVID-19 IP&C Outbreak policy in place to coordinate management of infection outbreaks, led by site HoNs (supported by IP&C teams). # Integrated whole system, urgent and emergency care plan agreed. # Establishment of a Discharge to Assess (D2A) Group which reports to the Unscheduled Care group. # Establishment of a D2A Escalation Transfer panel which provides senior oversight of delays, assesses risk of the delay to the patient and organisation in terms of flow compromise # To optimise step down bed capacity in the community across care homes and community hospitals # SRO in place to lead agreed Urgent and Emergency Care (UEC) programme # Supernummery HCSWs aligned to the acute response teams to support failing community care capacity # Support for complex discharge caseload management tool (SharePoint) appointed # LFT testing introduced for staff # Reminders issued to management on importance of robust management of staff sickness and the use of COVID-19 Risk Assessment to help manage staff absences. # Staff visiting restricted to those 'who have purpose' # SDEC models continuously reviewed and refined to maximise impact on admission avoidance. # Staff are encouraged to participate in the UHB's ongoing COVID-19 vaccination programme.	and COVID-19 related absence across acute and community care. # Reduced acute bed availability due to impact of COVID-19 outbreaks and reduced staffing availability. # COVID-19 has further exacerbated workforce capacity and availability of bank and agency staff who would be available. # Inability to offload ambulances to release them back for use within community. # Increased pressures at ED as a result of WAST ambulance response policy resulting in very poorly patients self-presenting. # No live dashboard demonstrating UEC performance. # Insufficient programme		

To implement the Standard for Discharge to Assess in accordance with the WG Disharge Guidance	Dawson, Rhian	31/03/2025	Plan to be developed.
Review ambulance handover procedure in conjunction with WAST and HB Review Escalation Policy	Passey, Sian	31/03/2022	Senior level discussions with WAST have been undertaken in respect of ambulance handovers. All sites endeavour to comply with Red Release policies wherever possible.
Review Escalation Policy	Jones, Keith	Completed	HB Escalataion Policy reaffirmed. Sites regularly operating at Red (Level 4) status with limited non-urgent elective surgery undertaken at the four sites due to urgent and emergency care pressures.
Review nursing models to support increasing capacity and environments for patients	Passey, Sian	Completed	Continuous discussions with Heads of Nursing and regular operational consideration given to scoping patient profile and pathways. In conjunction with primary care colleagues additional capacity in Amman Valley Hospital.

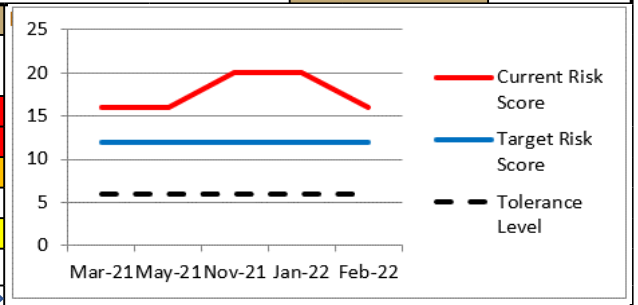
ASSURANCE MAP						Gaps in ASSURANCES				
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**	**Control RAG Rating (what the assurance is telling you about your controls**	**Latest Papers (Committee & date)**	**Identified Gaps in 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 unscheduled care metrics have been developed to measure the	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st				None identified.				
	Daily performance data overseen by service management	1st								

to measure the system performance.	Delivery Plans overseen by Unscheduled Care Improvement Programme	2nd						
	Bi-annual reports to SDOPC on progress on delivery plans and outcomes (and to Board via update report)	2nd						
	IPAR Performance Report to SDOPC & Board	2nd						
	WAST IA Report Handover of Care	3rd						
	11 x Delivery Unit Reviews into Unscheduled Care	3rd						
	Delivery Unit Report on Complex Discharge	3rd						

Date Risk Identified:	Mar-21	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Feb-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Mar-22

Risk ID:	**1048**	**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 2021/22. 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 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

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):	4×4=16
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⟷



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

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
The prevalence of COVID-19 has increased in recent months and this has had a further impact of inpatient pathways which has led to a number of temporary ward closures across all sites associated with COVID outbreaks and the impact of wider urgent and emergency care pressures on the planned care patient pathway. Limits to staffing resource both in theatre, and post operatively, was a challenge before COVID. The impact of increasing unscheduled care pressures during the Autumn/Winter period has further reduced available capacity to be dedicated to elective & surgical pathways. In January 2022, the Health Board approved the application of additional measures under the WG Local Choices Framework to reduce non-urgent elective Outpatient (OP) and In-patient (IP) pathways to enable the further prioritisation of physical and staffing resources to support unscheduled care pathways. This was a temporary arrangement which was applied for 2 weeks, which resulted in the current risk score increasing to 20. Pathways that were affected have now been restored, reducing the current risk score back to 16. At the present time, non-urgent elective surgical pathways have been temporarily suspended across all sites with urgent/cancer IP surgery continuing at Prince Philip and Glangwili hospitals only. The pathway in Bronglais Hospital has been restored and plans are in place to restart the pathway in Withybush Hospital by early March. Discussions are continuing in respect of re-establishing the orthopaedic pathway in Prince Philip Hospital. Outsourcing programmes are continuing supported by Recovery funding provided by WG although	Across the UK, there is a significant challenge for health organisations in sustaining the recovery of planned care pathways as they emerge from the latest wave of the pandemic. The target score of 12 is based on the realistic assessment of the level of planned care work which can be achieved across the footprint of the HB over the next 12 months and acknowledges this will not reflect levels achieved pre-pandemic due to the current staffing challenge and the impact on capacity and throughput of expected requirements to maintain social distancing and enhanced IP&C procedures.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage planned care risks on daily basis including multiple daily multi-site calls in times of escalation. # Prioritised review of patients based on an agreed risk stratification model. # Provision of 'green' pathway beds on 4 sites (where staffing allows). # Discharge lounge takes patients who are being discharged. # 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. # Risk assessed establishment of AMBER post-operative critical care pathway as a more practical alternative to dedicated GREEN post-operative critical care pathway to increase the flow of appropriate patients. # Robust sickness absence management arrangements in place. # Comprehensive programme of outsourcing of planned care volumes in place utilising capacity available vis independent sector providers # Weekly review of outsourcing volumes and further opportunities progressed jointly by Planned Care and Commissioning teams. # Planned Care Recovery Programme for 2021/22 in place. # LFD testing rolled out across selected planned care wards and clinical areas.	# Limited impact of the wider urgent and emergency care plan in reducing capacity pressures on acute sites and the ability to protect sufficient 'green' pathway capacity for elective patients. # Nurse staffing availability to ensure safe levels of care as a consequence vacancies and COVID 19 related absence across ward, critical care and theatre areas # Reduced acute bed availability due to impact of COVID-19 outbreaks and reduced staffing availability # COVID-19 has further exacerbated workforce capacity and availability of bank and agency staff who would be available. # Limitations of the physical estate on hospital sites to enable protected/dedicated green pathway critical care facilities # Timeliness of the All Wales Commissioning Framework to support rapid decision making	Plan for Q1-4 levels of capacity to be agreed via 2021/22 Annual Plan	Jones, Keith	Completed	Plan confirmed via Annual Recovery Plan.
		Opportunities to enhance dedicated green pathway capacity across sites are subject to continuous review and discussion between respective acute sites and Planned Care Directorate	Jones, Keith	Completed	Non-urgent elective surgical pathways have been temporarily suspended across all sites with urgent/cancer in-patient (IP) surgery continuing at Prince Philip and Glangwili hospitals only. Non-urgent outpatient pathways temporarily suspended for 2 weeks (Jan2022), recommenced 24Jan22. Plans to re-establish IP surgical pathways at Bronglais (early Feb22) and Withybush hospitals (end Feb22).
		Refer CRR 1219 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	31/03/2022	Ref CRR 1219 for detailed progress.
		Review of overall acute nurse staffing resource availability with support from acute site and directorate heads of nursing.	Passey, Sian	Completed	Staffing deficits confirmed. Current delivery progressing in accordance with available staffing.
		To remind services to of the need to undertake robust sickness absence management to ensure staff are able to return to work safely and promptly	Jones, Keith	Completed	Actioned however impact of updated shielding guidance continues to limit the return of affected staff.
		Planned Care Recovery programme (beyond Mar22) to be developed and agreed.	Jones, Keith	Completed	Plan for 2021/22 confirmed. Longer term recovery proposals (beyond Mar22) currently being reviewed via IMTP development. Extent and scope of delivery will be determined by agreed funding level.
		To support routine testing of staff	Carruthers, Andrew	Completed	LFT rolled out across selected planned care wards and clinical areas.

				and commissioning of independent sector activity levels when supported by non-recurrent funding released part-way through the year. # Operational delivery challenges (staffing) experienced by independent sector providers which, to date,		Development of ward based post operative enhanced care pathways as an alternative to dedicated green critical care facilities.	Jones, Keith	~~31/05/2021~~ 31/03/2022	Implemented at PPH & BGH. Development plans continuing at other sites, timelines dependent on staffing availability.
						Development of plans to enhance capacity through consideration of demountable facilities and opportunities to develop regional solutions for key pathways (eg cataract surgery).	Jones, Keith	~~31/03/2021~~ 30/04/2022	Modular unit construction underway - expected to be operational in Apr22. Physical refurbishment work at Amman Valley Hospital in progress to enable release and dedication of day surgery theatre for cataract surgery.
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 identified.				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Acute Services Triumvirate	1st								
	Bi-monthly reports to SDOPC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDOPC & Board	2nd								

Date Risk Identified:	Jan-22		**Executive Director Owner:**	Carruthers, Andrew		**Date of**	Jan-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care		**Lead Committee:**	Strategic Development and Operational Delivery Committee		**Date of**	Mar-22
Risk ID:	**1342**	**Principal Risk Description:** There is a risk that the Health Board will be unable to plan and respond effectively to the pandemic and make effective decisions on critical business continuity issues, the application of Local Choices Framework and delivery of essential services. This is caused by the daily COVID case reports that the HB relies on to enable it to monitor, track and plan its response to COVID only include PCR test results and does not reflect the recent shift in	**Risk Rating:(Likelihood x Impact)**		**No trend information available.**		
			Domain:	Quality/Complaints/Audit			
			Inherent Risk Score (L x I):	5×5=25			
			Current Risk Score (L x I):	4×3=12			
			Target Risk Score (L x I):	3×3=9			
			Tolerable Risk:	8			
Does this risk link to any Directorate (operational) risks?			**Trend:**	*New*			

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
The change of testing policy during the latest wave of the pandemic has made it challenging for the Health Board to fully understand where it is on the pandemic curve, and make accurate decisions in stepping up and down services at the right time. Whilst the Health Board is utilising other proxy data, this may not provide a full picture of what is going on, and may contradict the public data on COVID cases in the local community. The level of risk has reduced from 20 when it was first identified to 12 as the peak of the 4th wave has passed.	It is anticipated that understanding of and confidence in proxy data sources will strengthen over time.

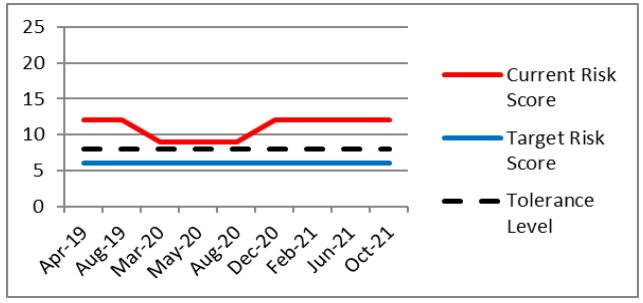
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Processes and systems for collection of HB data in place: - Daily reporting & monitoring of PCR positive cases per 100,000 - Daily reporting & monitoring of hospitalised cases split by those that are undergoing active treatment for COVID, recovering from COVID and those who have tested positive for COVID as a secondary diagnosis - Daily reporting & monitoring of staff sickness absence during anticipated 2 week peak period - Daily data on incidences and outbreaks in local schools/year	Not having a consolidated, accurate data source reflecting the positive COVID cases in the community to enable the monitoring and identification of risk and provide a timely and	Working with WAST to ensure they flag at an early stage any increase in ambulance responses coded as pandemic flu or breathing difficulties	Carruthers, Andrew	31/03/2022	Discussions have taken place.
		The Health Board to support national communications of importance of reporting LFD results	Hughes-Moakes, Alwena	Completed	A number of communications have been issued by Health Board in

groups/classes related to COVID-19 UHB Analytics department collate, analyse and present data to inform decision-making Multiplex testing				effective response to changes in infection rates within the local community PCR tests are only being undertaken on limited groups within the community, eg in-patients, pre-operative patients/ those		Exploring inclusion of daily reporting & monitoring of LFD positive cases per 100,000 into daily report/dashboard	Carruthers, Andrew	31/01/2022	Data is still being qualified.
						Request modelling cell to provide a weekly report triangulating the available data (to include waste water, PCR, LFD, positive hospital cases)	Carruthers, Andrew	11/02/2022	New action
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**
	Information department collates WPAS data in the data warehouse (eg hospital admissions, emergency attendances, etc)	1st				Duplication of test reporting	Understanding the LFD testing data to avoid double-counting with PCR testing	Carruthers, Andrew	31/01/2022	Initial priority contacts have been made with DCHW and awaiting their response on clarification
	Weekly COVID Monitoring meeting reviews data received from both external and internal sources	1st								
	Oversight of current data and agreement of HB response at Silver/Tactical Meeting	2nd								
	HSSG COVID 19 planning and response group (update on national modelling)	2nd								
	Public Health Acute Response and Ongoing Support (previously Public Health Gold Cell)	2nd								
	DHCW provides the Health Board with validated data on a daily basis (eg PCR & LFD test)	3rd								

Date Risk Identified:	Sep-18	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Oct-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Dec-21

Risk ID:	**633**	**Principal Risk Description:**	There is a risk of the UHB not being able to meet the 75% target for waiting times for 2020/21 for the new Single Cancer Pathway (SCP). This is caused by the lack of capacity and the impact of COVID on our ability to meet an expectedincrease in demand for diagnostics and treatment delays at our tertiary centre. This could lead to an impact/affect on meeting patient expectations in regard to timely access for appropriate treatment, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from WG.

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	3×2=6
Tolerable Risk:	8
Trend:	⟷



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

Rationale for CURRENT Risk Score:

The impact of COVID-19 may increase the risk of being unable to meet the target due to recommendations from Royal Colleges to suspend diagnostics and some surgery that are aerosol generating. During the pandemic, endoscopy was centralised in GGH. Endoscopy services were reinstated on all 4 hospital sites, with capacity increasing to 53%. With the introduction of a Green pathway in Endoscopy as of 7th June 21, capacity will increase to 81%. High acuity elective cancer surgery with green pathway and green ITU/HDU commenced in PPH & BGH on 6 July 2020 with WGH commencing intermediate surgery on the 10 Aug 2020. Following the second wave of COVID in December, all green HDU/ITU pathways have been reinstated and the surgical backlog has been addressed. A full Covid-19 plan is in place.

Rationale for TARGET Risk Score:

The aim is to treat patients within target waiting times, which has now been confirmed as 75% for the first year, 80% for the 2nd year and 85% thereafter non adjusted. Due to the pause in Cancer elective surgery over the christmas period for a 4 weeks , there was no HDU/ITU green pathway available, caused a surgical backlog for cancer surgery. This backlog has now been addressed.
The tolerance level will be met if the UHB continues to meet the 1% per month improvement trajectory throughout 2021/22. Publication of performance data by WG recommenced in February 2021 with health boards only reporting against the SCP, with no wait adjustment.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Working with all Wales Cancer Network to gain full understanding of implications of new pathway. Implementation Group established, reporting to Cancer Board with awareness / engagement sessions held on each hospital site. Shadow monitoring in place	Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP. Full engagement for all	Demand & capacity assessment work continuing. Solutions will necessitate regional cooperation to address anticipated capacity gaps.	Humphrey, Lisa	~~31/03/2020~~ 31/03/2021 31/12/2021	Initial planned work with Delivery Unit suspended and will be under constant review in light of COVID and recovery planning phase. Work is ongoing .

Shadow monitoring in place. Further Demand & Capacity exercise planned 2020/21 with support from Delivery Unit. New Cancer tracking module in W-PAS now fully operational as of Dec19 with tracking team in place from Dec19 to allow patients to proactively tracked through treatment pathways. Routine daily communication feed from ED to cancer information team which helps identify the point of suspicion. COVID-19 escalation plan in place. Monitoring data of patients whose treatments have changed or suspended (some through patient choice) as a result of COVID-19. A 4-week follow up process has been implemented for these. Utilisation the private sector for surgery during COVID-19. Joint working with regional colleagues to offer patients on a tertiary pathway surgery locally. Resumed aerosol generated diagnostics cross all 4 hospital sites.Due to the current COVID situation, these services are now being scaled back with Endoscopy services being mainly centralised in GGH. Reinstated high acuity elective Cancer surgery with green pathway and green ITU/HDU has commenced on PPH and BHG sites as of 06/07/2020, and WGH Intermediate surgery from 10/08/20. Due to the current COVID situation, only urgent cancer elective surgery will be carried out from the 21st December for a period of 4 -6 weeks due to staffing levels. All patient are being clinically prioritised to ensure no harm is caused by the delay. 7 Day Diagnostic Group and RDC. FIT and Digital Delivery of Care.	Full engagement for all supporting services. Performance is lower than USC/NUSC published performance. Key diagnostic information systems do not support effective demand / capacity planning. Need for new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways.	See above re diagnostic services plus improved systems to support identification of 'date of suspicion'.	Humphrey, Lisa	~~31/03/2019~~ 31/08/2019 31/07/2020 31/10/2020 31/03/2021 31/08/2021	HB performance compares well with other HBs however below current SCP performance level. Ongoing work in progress with OPD, Diagnostic & ED teams along with the informatics department to improve real time identification of date of suspicion. Informatics are beginning to pick up routine reporting requests which were on hold due to COVID-19.
		Each MDT to review and adopt recommended optimal tumour site specific pathways	Humphrey, Lisa	~~31/08/2020~~ 30/09/2020 31/03/2021 31/12/2021	Each MDT is currently assessing implications of published proposed pathways. A Macmillan Cancer Quality Improvement Manager post which was developed to work with the teams with regards to implementing the new pathways has been appointed to and the new appointee took up post on 1st November 2020. Agreement over funding was delayed as a result of COVID-19.
		Explore opportunities for alternative providers to address tertiary centre delays for cancer treatment.	Humphrey, Lisa	Completed	Some arrangements were agreed however these have been suspended due to COVID-19, however COVID has provided opportunities to enable new arrangements to be put in place with regional centres.

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
Deliverable indicator targets - 1% improvement per month during 2020/21. Shadow performance data.	Daily/weekly/monthly/ monitoring arrangements by management	1st			* Implementation of Single Cancer Pathway Report - BPPAC - Feb20 * IPAR Report - Board - Jan21 * COVID-19 Impact on Cancer Services - Board - May20	No gaps identified.				
	Executive Performance Reviews (suspended due to COVID-19)	2nd								
	Service plans in response to COVID-19 overseen and agreed by Bronze Acute & Gold	2nd								
	IPAR Performance Report to PPPAC & Board	2nd								
	Monthly oversight by Delivery Unit, WG	3rd								