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:	26 October 2021
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, Head of Assurance and Risk

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

Er Sicrwydd/For Assurance

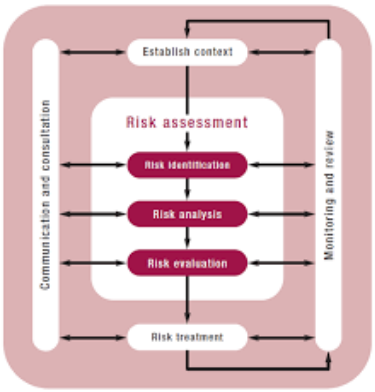
ADRODDIAD SCAA
SBAR REPORT

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

This is the first Corporate Risk Report to be presented to SDODC following the introduction of the new Committee structure introduced on 1 August 2021.

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 that:

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 3 risks currently aligned to SDODC (out of the 14 that are currently on the CRR). These risks can be found at Appendix 2.

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5					
MAJOR 4			633	1027 1048	
MODERATE 3					
MINOR 2					
NEGLIGIBLE 1					

There have been no changes in the following risk scores since they were reported to the People, Planning and Performance Assurance meeting in June 2021. The Executive Team reviewed Risks 1027 and 1048 at its recent Executive Risk Session, and agreed that these would be updated prior to the Board in November 2021.

Risk Reference, Title & Risk Owner	Previous Risk Report Dec-20 (Lxl)	Risk Score Jun-21 (Lxl)	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)	4×4=16	**4×4=16**	26/05/21	While case incidence of COVID-19 has regressed and its direct impact on acute care reduced, the level of risk escalation remains. The indirect impact of COVID-19 has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. As a consequence, we continue therefore to have reduced availability of beds across acute sectors. This has

				reduced staffed bed availability across both sectors and has led to increasing delays in the discharge pathway and increasing delays for patients accessing unscheduled care services due to reduced capacity at Emergency Departments (ED). The situation remains fluid and changeable.
1048 - Risk to the delivery of planned care services set out in the Annual Recovery Plan 2021/22 (Director of Operations)	N/A (new risk in June's report)	**4x4=16**	26/05/21	Limits to staffing resource both in theatre, and post operatively, was a challenge before COVID-19. The additional factors of providing separate staffing teams for red and green areas, is an added challenge and has shaped the model of provision suggested on each site. It is evident that our realisable capacity in the short term will not match that available prior to March 2020. The plans that have been developed do however reflect the maximum capacity HDdUHB can achieve within the footprint of our existing hospital sites, particularly during the first half of 2021. Whilst the plan for increased delivery of elective work (outlined within the HDdUHB Annual Plan) is progressing in accordance with the plan outlined, challenges and risks around availability of supporting bed and theatre capacity remain which limits the ability of our clinical teams to expand activity delivery to pre-COVID-19 levels.
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	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

				Glangwili General Hospital (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 2021, capacity will increase to 81%. High acuity elective cancer surgery with green pathway and green Intensive Therapy Unit(ITU)/Higher Dependency Unit(HDU) commenced in Prince Phillip Hospital (PPH) & Bronglais General Hospital (BGH) on 6 July 2020 with Withybush General Hospital (WGH) commencing intermediate surgery on the 10 August 2020. Following the second wave of COVID-19 in December 2020, all green HDU/ITU pathways have been reinstated and the surgical backlog has been addressed. A full COVID-19 plan is in place.

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

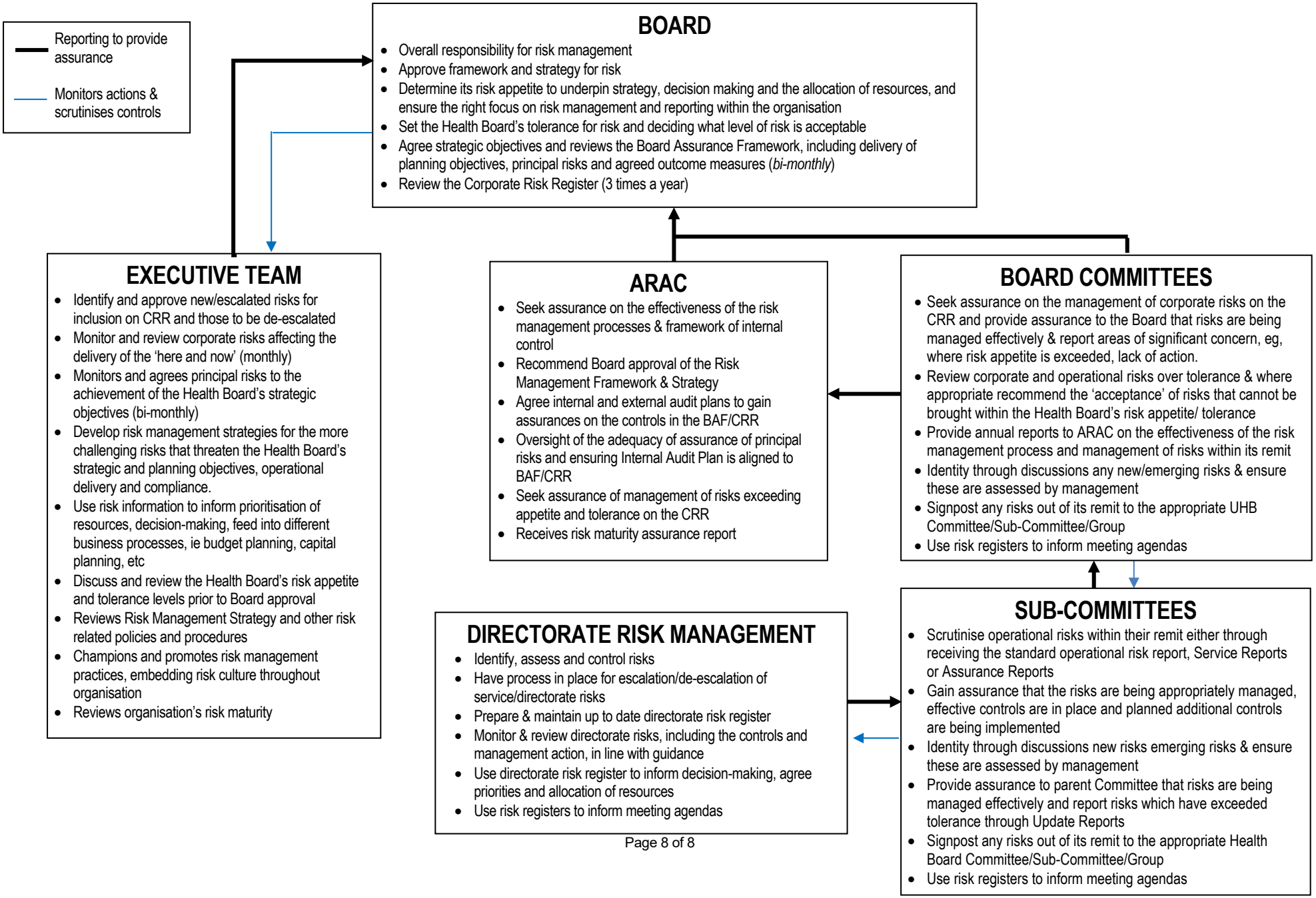
	appetite/tolerance to the Board through the Committee Update Report.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7.1 Workforce
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic 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 Oct-21	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	4×4=16	4×4=16	→	3×4=12	3
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	4×4=16	4×4=16	→	3×4=12	7
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	11

Assurance Key:

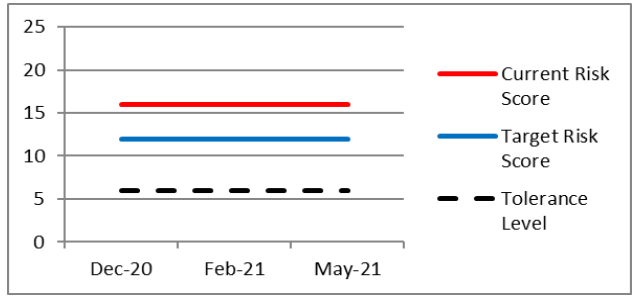
3 Lines of Defence (Assurance)		
1st Line	Business Ma	Tends to be detailed
2nd Line	Corporate O	Less detailed but slightly
3rd Line	Independent	Often less detail but truly

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:**	May-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care			**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Jun-21
Risk ID:	**1027**	**Principal Risk Description:**	There is a risk there will be disruption to the delivery of our Recovery Plans. This is caused by increasing fragility within the urgent and emergency care (UEC) system, the impact of COVID-19 on available bed and staffing resources and delays in discharges that are beyond the remit 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 at the front door 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):	4×4=16		
				Target Risk Score (L x I):	3×4=12		
				Tolerable Risk:	6		
Does this risk link to any Directorate (operational) risks?		yes		**Trend:**	⟷		



Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
While case incidence of COVID-19 has regressed and its direct impact on acute care reduced, the level of risk escalation remains. The indirect impact of COVID-19 has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. As a consequence we continue therefore to have reduced availability of beds across acute sectors. This has reduced staffed bed availability across both sectors and has led to increasing delays in the discharge pathway and increasing delays for patients accessing unscheduled care services due to reduced capacity at ED departments. The situation remains fluid and changeable. This risk will be refreshed in Q2.	There is a significant challenge across the Urgent and Emergency Care system

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage unscheduled care risks on daily basis including multiple daily multi-site calls in times of escalation. # 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. # Continued use of Field Hospital capacity. # 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. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites. # Regular training 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. # Care Home Risk and Escalation Policy.	# Data has demonstrated that targeted improvement required across our UEC system to reduce conveyance, conversion and improve management of our Complex frail population and ensure 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, increasing number of care home bed voids following outbreaks. # Fragility of Domiciliary care due to recruitment and retention of staff exacerbated by increased staff absences due to the TTP process. # Inability to secure GP medical oversight for step	To appoint HCSWs as supernummary aligned to the acute response teams to support failing community care capacity (secondary to COVID outbreak).	Dawson, Rhian	Completed	Appointed and in post.
		To consider alternative models of medical oversight i.e appointment of GP locums aligned to acute physicians	Dawson, Rhian	31/07/2021	Pending hibernation of Field Hospital will release medical oversight.
		Refer CRR 1018 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	31/12/2020	Ref CRR 1018 for detailed progress.
		To appoint additional support to lead on enhancement/ implementation of the Complex Discharge caseload management tool (SharePoint).	Dawson, Rhian	Completed	Appointed.
		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. Impact of updated shielding guidance continues to limit the return of affected staff.

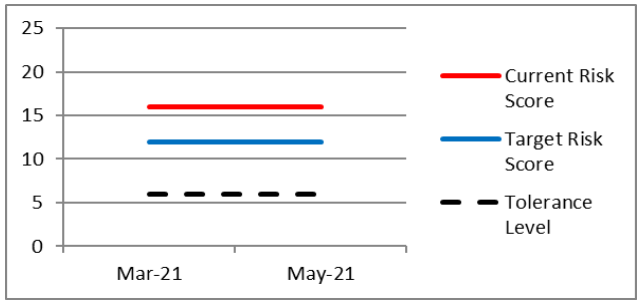
# Ability to deploy Health Board staff where workforce compromise is immediately threatening to continuation of care for residents. # Care Home risk & Escalation Policy to be applied to support failing care homes as required. # COVID-19 IP&C Outbreak policy in place to coordinate management of infection outbreaks, led by site HoNs (supported by IP&C teams). # Integrated whole system, cross-sector Winter Preparedness Plan agreed Oct20. # Establishment of a Discharge to Assess 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	down/ intermediate care beds. # Inability to secure multidisciplinary resource to support discharge to assess model in the community. # Insufficient informatics support to enhance Complex Discharge caseload management tool. # Nurse staffing availability to ensure safe levels of care as a consequence vacancies 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	To encourage and support staff to participate in the UHB's Covid-19 vaccination programme.	Carruthers, Andrew	Completed	Actioned.
		To support asymptomatic testing pathfinders.	Carruthers, Andrew	Completed	LFT rolled out across targeted clinical areas (outbreak wards, Chemotherapy Day Units & selected planned care wards). Full rollout to priority groups be completed by May21.
		Each County System to produce UEC Improvement plans Implementation of Programme Management Structure in UEC Improvement Secure UEC Transformation fund to resource key deliverables that will enhance improvement capability	Dawson, Rhian	31/07/2021	Bid Submitted. Programme Management Structure to be agreed and implemented.

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 for Tier 1 targets. A suite of unscheduled care metrics have been developed to measure the system performance.	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								
	Delivery Plans overseen by Unscheduled Care Improvement Programme	2nd								
	Bi-annual reports to PPPAC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	Fortnightly monitoring of Winter Plan 2020 delivery.	2nd								
	IPAR Performance Report to PPPAC & 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:**	May-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Jun-21

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 , in the short term, the legacy of the impact of the 2nd wave on available capacity and a continuing significant deficit in available staffing resources to support green pathways for urgent and cancer pathway patients. These pressures have necessitated the HB to apply the WG Local Options Framework of actions to prioritise resources for COVID and other essential emergency pathways. 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:**
While case incidence of COVID-19 has regressed and its direct impact on acute care reduced, the level of risk escalation remains. Limits to staffing resource both in theatre, and post operatively, was a challenge before COVID. The additional factors of providing separate staffing teams for red and green areas, is an added challenge and has shaped the model of provision suggested on each site. It is evident that our realisable capacity in the short term will not match that available prior to Mar20. The plans we have outlined do however reflect the maximum capacity we can achieve within the footprint of our existing hospital sites, particularly during the first half of 2021. Whilst the plan for increased delivery of elective work (outlined within the HDUHB Annual Plan) is progressing in accordance with the plan outlined, challenges and risks around availability of supporting bed and theatre capacity remain which limits the ability of our clinical teams to expand activity delivery to pre-COVID levels, and further waves of the pandemic.	Across the UK, there is a significant challenge for health organisations in sustaining the recovery of planned care pathways as they emerge from the 2nd 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 the	**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.	# 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	Plan for Q1 & Q2 levels of capacity to be agreed via 2021/22 Annual Plan	Jones, Keith	Completed	Initial plan completed Mar021. Updated plan to be reflected in refreshed Annual Plan to be submitted Jun21.
		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	Green pathways re-established on 4 sites.
		Refer CRR 1018 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	~~31/03/2021~~ 30/06/2021	Updated Workforce Plan to be reflected in refreshed Annual Plan due for submission Jun21.
		Assistant Director of Nursing (Acute Services) leading a review of overall acute nurse staffing resource availability with support from acute site and directorate heads of nursing	Jones, Keith	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.

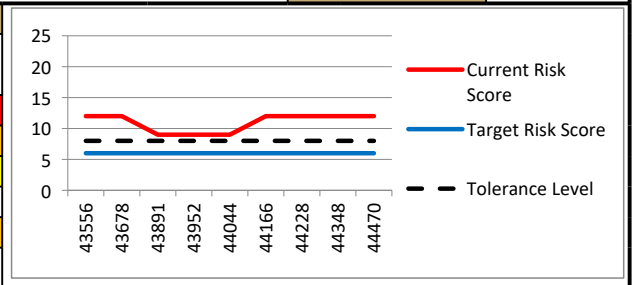
		Planned Care Recovery programme to be formally established within HB, setting out governance arrangements at Gold, Silver and Bronze levels.	Jones, Keith	~~31/03/2021~~ 31/07/2021	Initial recovery proposals approved by WG with additional funding support confirmed. Delivery Plan for Planned Care Recovery Programme GOLD Planning Objective due for consideration by Executive Team 26May21.
		To support routine testing of staff	Carruthers, Andrew	Completed	LFT rolled out across selected planned care wards and clinical areas.
		Development of ward based post operative enhanced care pathways as an alternative to dedicated green critical care facilities.	Jones, Keith	31/05/2021	Implemented at PPH. Development 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	Completed	Proposal submitted to WG April 2021. Non-recurrent funding for 2021/22 confirmed by WG. Formal proposal due to be considered by Board July 2021.

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 for Tier 1 targets. 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 PPPAC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	Fortnightly monitoring of Winter Plan 2020 delivery	2nd								
	IPAR Performance Report to PPPAC & Board	2nd								

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:	**Rationale for TARGET 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.	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	**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.	Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP.	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	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								