Date	1 December 2021
Agenda Item	12

INTEGRATED HEALTH AND SOCIAL CARE
WEST LOTHIAN
WORKING FOR WELLBEING

Report to Audit Risk and Governance Committee

Report Title: Risk Management Annual Reports 2020/21

Report By: Risk Manager

Summary of Report and Implications	
Purpose	This report:
	- seeks a decision ☐
	- is to provide assurance ☑
	- is for information ☑
	- is for discussion ☑
	To inform the Committee of the annual risk management reports for 2020/21 for NHS Lothian and West Lothian Council.
Recommendations	It is recommended that the Audit, Risk and Governance Committee considers the risk management annual reports.
Directions to NHS Lothian and/or West Lothian Council	A direction is not required.
Resource/ Finance/ Staffing	None.
Policy/Legal	None.
Risk	Directly relevant to the management of risk.

West Lothian Council NHS Lothian

Equality, Health Inequalities, Environmental and Sustainability Issues	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, an equality impact assessment has not been conducted.
Strategic Planning and Commissioning	Effective risk management is a pre-requisite for good performance and outcomes.
Locality Planning	None.
Engagement	NHS Lothian Quality & Safety Assurance Lead

Terms of Report	
1.1	The Committee will be aware of the IJB's risk management arrangements via the submission of regular reports on the IJB's risks to this Committee. The Committee received the IJB's risk management annual report for 2020/21 on 17 June 2021 and this concluded that appropriate risk management arrangements are in place within the IJB in accordance with the IJB's approved Risk Management Policy and Strategy.
1.2	The Committee may wish to receive similar assurance in relation to the management of risk within NHS Lothian and West Lothian Council and accordingly the risk management reports for these organisations for 2020/21 are attached as appendices to this report. The Committee is therefore invited to consider the NHS Lothian and West Lothian Council risk management annual reports.

Appendices	1. NHS Lothian Risk Management Annual Report 2020/21 2. West Lothian Council Risk Management Annual Report 2020/21
References	Report to Audit, Risk and Governance Committee 17 June 2021: Risk Management Annual Report
Contact	Kenneth Ribbons, Risk Manager Kenneth.ribbons@westlothian.gov.uk 01506 281573

NHS LOTHIAN

Audit & Risk Committee
21 June 2021

Medical Director

RISK MANAGEMENT ANNUAL REPORT

1 Purpose of the Report

1.1 The purpose of this report is to set out the Risk Management Annual Report from 1 April 2020 to 31 March 2021, to provide assurance on the management of risk across NHS Lothian.

Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

2.1 Accept moderate assurance that there are systems in place to manage risk across NHS Lothian and there is an improvement programme to further strengthen the risk system.

2.2 Note Healthcare Governance Committee accepted the following in November 2020 and May 2021:

- Significant assurance that local processes are in place to identify events which require to be reported to Healthcare Improvement Scotland (HIS) to comply with the new national notification process and note number and types of events reported
- Significant assurance on progress in implementing the statutory organisational Duty of Candour
- Moderate assurance in the progress made in improving processes for management of significant adverse events (SAEs) and in addressing the backlog
- Moderate assurance on process for safety alerts and the associated reports up to March 2020.

2.3 Note the annual Internal Audit into risk management will report to the June 2021 Audit & Risk Committee and will be used to review NHS Lothian's Risk Management Policy and Procedure (October 2018)

3 Discussion of Key Issues

3.1 The focus for 2020/2021 is set out below and are key components of NHS Lothian's Adverse Event Policy and Procedure (October 2018) and the Risk Management Policy and Procedure (October 2018) both of which seek to contribute to NHS Lothians safety culture and inform improvement programmes:

- Embed the National Notification System for Health Improvement Scotland level one reviews
- Embed the Duty of Candour processes
- Maintain adverse management and risk management processes during Covid -19
- Review the Corporate Risk Register to ensure it remains fit for purpose

3.2 **Adverse Event Management**

National Notification System (Healthcare Improvement Scotland - HIS)

3.2.1 All Boards have been required to notify HIS of all full SAE reviews for major harm or death events since 1 January 2020 (termed by HIS as level 1 reviews for category 1 adverse events).

3.2.2 Processes are now embedded through PSEAGs (Patient Safety & Experience Action Group) or equivalent senior management team forums to consider all reported events with major harm or death, to:

- decide the level of review and record decision in Datix, clearly articulating rationale if not for full SAE review
- commission appropriate review, including setting clear terms of reference
- appoint review team.

The NHS Lothian Medical Director validates all decisions for full SAE review prior to reporting to HIS.

3.2.3 Quality Improvement Support Team (QIST) staff continue to support management and review teams in implementing the new process, and maintain oversight, including monitoring of timescales and tracking of improvement plans.

3.3 **Organisational Duty of Candour (DoC)**

3.3.1 Our second Duty of Candour annual report has now been published, year ending 31st March 2020. Duty of Candour incidents are unintended or unexpected events that resulted in death or one of the harms as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition.

3.3.2 Twenty-three DoC incidents were identified since our last report. It is worth noting that it is often not evident that an `incident` has occurred at the outset, only that there has been an unexpected outcome. Further review is usually required to determine whether or not an `incident` has occurred which has directly contributed to that outcome. NHS Lothian policy and procedures require communication with patients and families about reviews, regardless of whether the threshold for the statutory organisation DoC applies. The majority of incidents fell into the category of `person`s treatment increased` (11). We followed the correct procedure in all cases although in one case the communication was dealt with via the complaints process. This means we informed the people affected, apologised to them from the organisation, and offered to meet with them. Reviews have been commissioned for each of these events, 19 of which have been completed. In each case, we reviewed what happened, what went wrong and what we could have done better and offered to feed back the outcome and learning from the events to the people affected. On five of these occasions the people affected did not wish to receive feedback on the outcome

of the review. Individual and organisational learning has been undertaken, with improvement plans developed and completed or in progress for each one.

3.4 Adverse event reviews during Covid-19 outbreak

3.4.1 Adverse event processes including governance arrangements have been maintained during the pandemic, although HIS suspended the national notification requirement in 2020 from March until May, with a restart in June.

3.4.2 Patient safety reports were considered at the HCG, acute services and REAS to assess the impact of COVID on key safety measures such as Hospital Mortality Ratio, falls etc to inform assurance and management

3.4.3 Systems are in place to identify adverse events reported as relating to COVID-19 and were developed to capture events related to the vaccination programme which commenced in December 2020. This also facilitates national reporting to Public Health Scotland. QIST staff have reviewed all and provided weekly themed reports to senior management teams up until mid-May 2021. This has now stopped, and reporting and monitoring is now embedded in routine processes.

3.4.4 A summary report has also been produced, which identifies 1,199 adverse events reported between March 2020 and March 2021 which are directly related to COVID-19. Key themes identified are:

- processes related to COVID-19
- staff related
- vaccination programme
- behaviours due to Covid restrictions – both patients and visitors/families.

3.4.5 The total number of Covid events has reduced over time, except for those related to processes which, given the nature of the pandemic, are constantly evolving. Staff related events include a variety of events such as potential exposure of staff to Covid–19, staff testing positive for Covid and skill mix/staffing level issues.

3.5 Improving processes for management of and learning from SAEs

3.5.1 Improvement work has concentrated on reliable implementation of the national notification process including improving commissioning of reviews. Process maps have been completed detailing the roles and responsibilities of management teams and reviewers, with links to toolkits on the intranet to support implementation.

3.5.2 Tailored training on the management and review of adverse events has continued although HIS suspended the national notification requirement from March until May 2020, with a restart in June 2020.

3.5.3 QIST has responded to services request, with a number of sessions delivered over Microsoft Teams in recent months and `just in time` refresher training and guidance on process for lead reviewers/review teams who have been asked to undertake full SAE reviews.

3.5.4 Face-to-face sessions on communication with patients and families which were scheduled throughout 2020 for each acute site/service, HSCPs and REAS are

currently on hold due to the pandemic. Alternative modes of delivery of this training are currently being developed, adopting a blended learning model. Pre-learning materials and filming of online material is currently being completed. A small group, face-to-face experiential learning session using role play was being tested in November 2020.

3.5.5 Processes for local senior management team approval of falls and pressure ulcer reviews are now embedded. Summary reports, including themes for improvement actions are provided to all senior management teams and to acute and Board nurse and medical directors to maintain an overview. The first falls report was considered at the Nurse Directors group in August 2020.

3.5.6 All deaths of people using our mental health and substance misuse services are recorded and reviewed. This presents a significant challenge to services in identifying sufficient capacity to undertake these reviews, particularly in HSCPs, where the majority of these deaths occur. These events account for the majority of reviews over 6 months old (105 out of 175 as at first week in April 2021). Improvement work is well advanced in testing a briefing document in Edinburgh HSCP to identify those cases where there is most opportunity for learning through a more in-depth review. This process also ensures that all cases have a proportionate and appropriate level of review and enables more meaningful involvement of the local clinical team who have cared for that person. Additional clinical resource has been identified by Edinburgh HSCP to support this work and to address the backlog. Similar work is being undertaken in REAS, though the volume of cases is much lower.

3.6 **Risk Register**

3.6.1 The NHS Lothian Corporate Risk Register (CRR) has been subject to change due to the Covid-19 pandemic, the 3-year Recovery Plan and capital plans. In response to these contextual changes and following discussion at the Audit and Risk committee and Board it seemed timely to review the risks on the Corporate Risk Register and the associated processes.

3.6.2 The Corporate Management Team (CMT) agreed in February 2021 based on the methodology set out below to review a number of risks on the corporate risk register in order to strengthen the risk management system.

3.6.3 **Methodology** The following have been used to inform the questions set out below and guide the review:

- NHS Lothian Risk Management Policy
- NHS Lothian Risk Management Procedure
- Diagram one below (3.7.2)

1. What is the risk that cannot be managed at an operational level and what information/data supports the escalation of this risk?
2. Does the risk description articulate the residual risk not being managed at a service level?
3. Who owns this risk and associated controls and do the controls set out clear lines of accountability?
4. Is there a plan in place to manage this risk which will be appraised at a senior management level and by a governance committee of the Board?
5. Does the risk grading reflect the plans in place to manage the risk and any remaining residual risk?

6. Is there a clear relationship between the risk grading, plans in place and level of assurance accepted by the governance committees of the Board?
7. Is there any overlap/duplication of risk across the CRR?

3.6.4 Table 1 below sets the CMT recommendations approved by the Board in April 2021 and rationale, based on meetings with executive owners. The outcome of the risks under review will be presented to the June 2021 Board.

Table 1 Risk Register recommendations and Rationale

Risk ID	Opened	Risk Title	Recommendation	Rationale
Close				
4813	**23/07/19**	Royal Hospital for Children & Young People/Dept of Clinical Neurosciences	Remove from the CRR	Services will be fully operational by the end of March 2021
4694	**04/04/19**	Waste Management	Remove from the CRR	This risk was accepted onto the CRR due to unforeseen external provider availability which resulted in additional financial risk and H&S issues. The financial risk has been addressed, a new contractor is in place and any residual service risk is being managed at an operational level with clear management oversight
3527	**26/07/13**	Medical Workforce	Remove from the CRR	Aspect of the Medical Workforce within our control are being managed at an operational level and captured on operational risk registers
Review/Amalgamate				
3454	**13/02/13**	Learning from Complaints	Review this risk	This risk requires review with a focus on performance and set within the context of the corporate objectives.
3600	**23/04/14**	Finance	Review this risk	This is a long-standing risk on the CRR and as such warrants review
3726	**11/03/15**	Timely Discharge of Inpatients (Previously Unscheduled Care:	Review the risk description with a focus on community capacity, with clear control owners across the system and measurement framework which would inpatient and community measures	Ensure clarity with respect to the focus and management of this risk and reduce duplication across other risks on the CRR such as 4 hour emergency access standard.
3829	**10/10/15**	GP Sustainability.	Review this risk	This is a longstanding risk and the GP landscape has been subject to significant change and as a result this risk merits review.
4693	**04/04/19**	Brexit/EU exit	Review this risk	This risk has been reviewed and will be downgraded to medium from high risk with regular review in place to assess potential risks

Risk ID	Opened	Risk Title	Recommendation	Rationale
				that cannot be managed at an operational and/or national level.
4820	**29/07/19**	Delivery of level 3 recovery plans	Review this risk	To reduce overlap with other risks on the CRR, associated plans and measures such as Access to Treatment. Timely discharge of inpatients etc to strengthen the management of risks across the CRR
3189	**19/10/15**	Facilities Fit for Purpose	Review this risk	There is a need to clearly articulate the risks that are not being managed at an operational level. This may lead to revised or new risks related to the RIE estate (end of the PFI contract) which has both financial and patient safety implications. The Finance Director has agreed to develop this risk.
3455	**13/02/13**	Violence & Aggression.	Review this risk	This is a long standing risk on the CRR and there is a need to articulate risks that are not being managed at an operational level supported by data as there is currently clear management oversight at a service level through the H&S operational groups and H&S Committee at the Board.
3328	**01/03/13**	Roadways/ Traffic Management	Review this risk	This Risk would benefit from a review to identify residual risk, associated mitigation plans including control owners. An initial review would suggest that the focus should be on the 4 inpatient sites where there is a mismatch between demand and capacity resulting risky behaviour plus verbal and physical aggression to traffic management staff.
1076	**11/06/07**	Healthcare Associated Infection	Review this risk	This risk would benefit from a review in the light of interrelated risks on the CRR which include Facilities fit for purpose, COVID-19 and Water Safety Risk, to clarify the focus of this risk and identify the plans in place to manage the risk including control owners
3203	**26/03/12**	4 Hours Emergency Access Standard (Organisational)	Combine the organisational and patient risk on the Corporate Risk Register.	The management oversight and plans to mitigate these two risks are the same. Having one risk will ensure clarity with respect to control owners, management oversight, mitigation plans and governance reporting

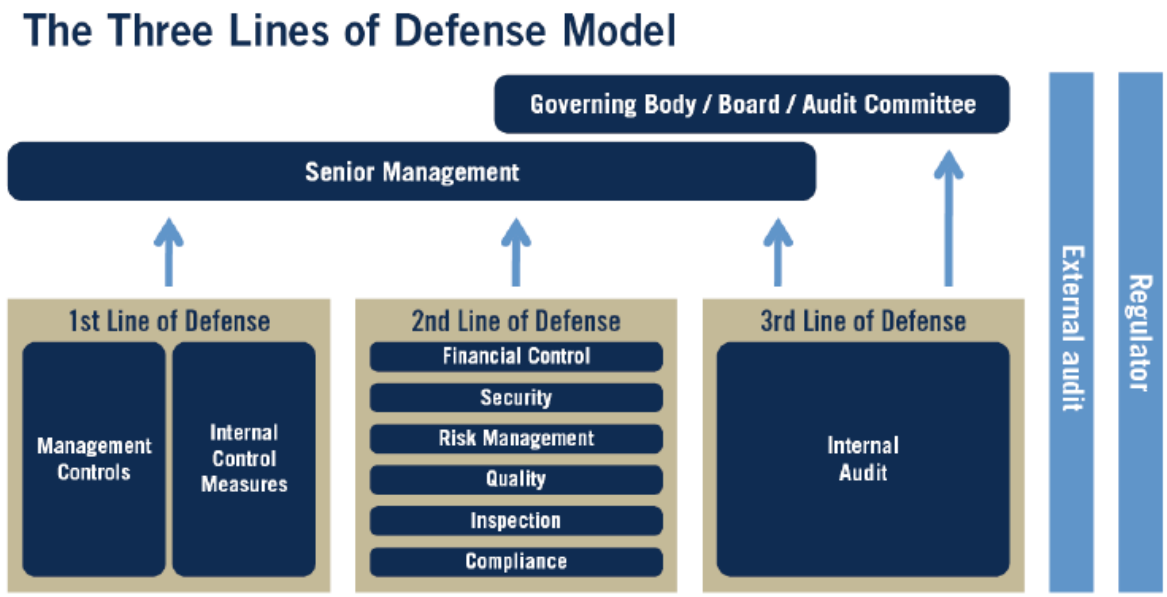
Risk ID	Opened	Risk Title	Recommendation	Rationale
4688	**21/03/19**	Patient safety in RIE ED	Combine the organisational and patient risk on the Corporate Risk Register and clearly state plans in place to mitigate the risk, control owners etc.	See above
3211	**02/04/12**	Access to Treatment (Organisation Risk)	Combine the organisational and patient risk on the Corporate Risk Register and state the key plans in place to manage this risk including control owners as there is considerable overlap between the two risks with respect to plans, measures, and oversight	The management oversight and plans to mitigate these two risks are the same. Having one risk will ensure clarity with respect to control owners, management oversight, mitigation plans and governance reporting
4191	**16/05/17**	Access to Treatment (Patient Risk)	Combine the organisational and patient risk on the Corporate Risk Register and state the key plan in place to manage this risk including accountability. .	See above
Remain				
4984	**19/03/20**	Covid-19	Remain on the CRR and include vaccine availability. Gold command to review the grading	This risk cannot be managed at an operational level, with a number of controls out with Lothian
4921	**28/10/19**	Bed Capacity in Acute Mental Health	No change to this risk on the CRR	This risk is clearly articulated and there are dedicated plans in place to mitigate the risk.
5034	**29/06/20**	Care Homes	No change to this risk on the CRR	This risk cannot be managed at an operational level. Significant infrastructure and systems for management oversight have been put in place within a tight timeframe, however, risks currently remain around providing assurance on the 4 aspects of care the Nurse Director is accountable for.
5020	**10/06/20**	Water Safety (Legionella)	No change to this risk on the CRR	This risk has been magnified as service have been reduced due to COVID. Water safety plans are being developed to support remobilisation and embed systems of control.
3828	**19/10/15**	Nursing Workforce	No change to this risk on the CRR.	Well written, clearly articulated risk, with clear plans in place to mitigate the risk

3.7 Role of the Corporate Management Team

3.7.1 It was agreed at the February 2021 CMT that the CRR would be managed through the CMT and subject to review every two months, with the risk manager in attendance to ensure proactive management, including timely feedback from assurance committees and alignment of assurance levels and risk grading.

3.7.2 The CMT would make recommendations to the Board with respect to new and/or amended risks, with a clear articulation of the risk that cannot be managed at an operational level, explicit plans to mitigate the risk along with associated measures to assess the impact of these plans. This collective oversight strengthens the NHSL risk management system including our assurance system and mirrors the diagram set out below.

Diagram 1



Graphic taken from The IIA Position Paper The Three Lines of Defense in Effective Risk Management and Control *published in 2013, adapted from ECIIA/FERMA Guidance on the 8th EU Company Law Directive, article 41*

3.8 Chairs' Risk Assurance Meeting

3.8.1 The Audit & Risk Committee approved the following Chairs' Risk Assurance meeting to take place during summer 2021:

Overall Aim
To establish a consistent and effective approach to the oversight of Risk in Board Committees

Session Objectives
Enhance understanding of:

- NHS Lothians Risk Management System at a corporate level by committee chairs:
  - Risk architecture, how are risks identified, assessed, recorded and the role of the A&R Committee
- How decisions are made to manage/treat the risk:
  - Action plans, management oversight, measuring impact
- The role of Committees and Chairs in providing oversight:
  - Key questions of management
- The linkage between risk management, levels of assurance and committee response
- Summary of discussion and next step

3.9 **Internal Audit Risk Management**

3.9.1 Every year Internal Audit conducts a review of an aspect of the NHSL risk system. The audit, which is about to complete, focuses on the controls in place (design and operation) to ensure risks are managed at an operational level at a divisional level on the hierarchy and how this is managed within Acute services and at an HSCP level. The audit will consider how at this level, risks are captured ensuring risks are not duplicated and how this links to the corporate risk register, including appropriate escalation and de-escalation of risks, focusing on how risks are escalated to a corporate risk level.

4 Key Risks

4.1 Failure to fully implement NHS Lothian's risk management policies and procedures could have an adverse effect on our current exposure to risk. The main threat is from not fully engaging with staff. This is being addressed by continued engagement with staff in the design and implementation of the actions set out in this paper.

5 Risk Register

5.1 The actions set out in this paper seek to enhance the Board's risk register assurance mechanisms.

6 Impact on Inequality, Including Health Inequalities

6.1 The findings of the Equality Diversity Impact Assessment are that although the production of this Annual Report does not have any direct impact on health inequalities, the assurance given on the component areas of risk within this document provides evidence that the elements of the processes are established to deliver NHS Lothian's corporate objectives in this area. The current Risk Management Policy and Procedure have been fully impact assessed and amended in the response to the assessment.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 No strategy, policy and/or service change proposed in this paper.

8 Resource Implications

8.1 The resource implications are directly related to the actions required against each risk.

Jo Bennett
Associate Director for Quality Improvement & Safety

1 June 2021

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DATA LABEL: PUBLIC

RISK MANAGEMENT ANNUAL REPORT 2020/21

Audit, Risk and Counter Fraud Unit
14 June 2021

CONTENTS

1.0 INTRODUCTION

1.1 This report sets out the risk management work undertaken during the financial year ending 31 March 2021.

1.2 Heads of Service are responsible for ensuring that risks to their business objectives are effectively managed. The Audit, Risk and Counter Fraud Manager acts as the council's corporate risk manager and is responsible for ensuring that arrangements are in place within the council to enable managers to effectively discharge these responsibilities.

1.3 This is done by:

- preparing and maintaining corporate procedures on risk management and business continuity planning;
- administering the council's corporate risk register;
- providing advice and information to services on risk management and business continuity matters;
- monitoring services' management of risk;
- providing training as considered necessary.

1.4 The council's corporate risk register is held on Pentana, the council's performance management system, and contains 225 risks.

1.5 Performance information relevant to risk management is set out in appendix A to this report.

2.0 RISK MANAGEMENT AND BUSINESS CONTINUITY

Risk Management Policy

2.1. A revised Risk Management Policy was considered by the Partnership and Resources Policy Development and Scrutiny Panel on 7 February 2020 and the Governance and Risk Committee on 24 February 2020. Following a delay due to the Covid-19 pandemic, the Policy was approved by Council Executive on 6 October 2020.

Governance and Risk Committee

2.2. The remit of the Governance and Risk Committee requires it to maintain an overview of the council's risk management arrangements.

2.3. The Committee met four times during 2020/21. Every meeting of the Committee received reports on the council's high risks, and on the management of health and safety. At its November 2020 and March 2021 meetings the Committee received reports on the council's strategic risks.

2.4. A variety of other risk related reports were submitted to the Committee during the year including reports on:

- concurrent risks including the impact of EU exit and Covid-19;
- the council's insurance arrangements;
- the management of risk within operational properties including legionella, gas safety, fire safety, and asbestos;

- workforce planning.

2.5. On 25 January 2021 the Committee received a report on progress in relation to the council's corporate risk management strategy.

Executive Management Team

2.6. The Executive Management Team (EMT) is the council's most senior management body and comprises the Chief Executive, Depute Chief Executives, and the Head of Finance and Property Services. The EMT considers reports on the council's high and strategic risks every two months. The EMT also receives reports on outstanding audit and inspection recommendations, and considers progress in completing them.

Governance and Risk Board

2.7. The Governance and Risk Board is an officer group chaired by the Depute Chief Executive (Corporate, Operational and Housing) which meets quarterly to review risk management, business continuity, and governance matters. The Audit, Risk and Counter Fraud Manager and Senior Auditor attend the meetings and assist with the administration by preparing the agendas and action notes.

2.8. The Board approves its workplan each March and examples of risk related matters considered by the Board during 2020/21 include:

- the council's high and strategic risks;
- health and safety risks;
- information technology related risks;
- business continuity planning arrangements;
- statutory compliance (legionella, asbestos, fire safety) performance indicators;
- insurance claims statistics;
- outstanding audit and inspection recommendations.

EU Exit Working Group

2.9. The EU Exit Working Group continued to meet on a regular basis during 2020/21 to consider risks arising from EU exit and maintain an overview of the EU exit risk register. As stated previously, the Governance and Risk Committee has been updated on developments via the concurrent risks reports.

Risk Management Working Group

2.10. The Risk Management Working Group is an officer group comprised of representatives from all services ("risk champions") which meets quarterly. The council's HR Manager (Health and Safety) is a member of the group and is the risk champion for Corporate Services. The group is chaired by the Audit, Risk and Counter Fraud Manager and its purpose is to disseminate advice and information on risk management and business continuity matters, act as a forum for the discussion of risk management matters,

encourage the effective management of risk within services, and to promote effective business continuity arrangements within services.

Gallagher Bassett Risk Review

2.11. The council's risk consultant, Gallagher Bassett, provides free risk consultancy and training as part of the insurance contract. Gallagher Bassett undertook an occupational stress risk management review during 2020/21 which was reported to the Governance and Risk Committee on 25 January 2021.

2.12. The report included an agreed action plan completed by management and the agreed actions will be followed up by the internal audit team in 2021/22 to determine progress in implementing them.

Service Management Teams

2.13. The Audit Risk and Counter Fraud Manager works with all services to review and where necessary improve the quality of their risks in the corporate risk register, for example in relation to descriptions, risk scores, key controls and mitigating actions. All service management teams were visited at least twice during 2020/21.

Risk Management and Business Continuity Procedures

2.14. The council's risk management and business continuity procedures were reviewed and updated during the year. These are resident on the Audit Risk and Counter Fraud Unit's intranet site and are accessible to all services.

Corporate Business Continuity Plan

2.15. The council's corporate business continuity plan is reviewed annually. The revised plan was submitted to the Governance and Risk Board on 30 November 2020. The Board asked for further consideration to be given to the council's response to the Covid-19 pandemic and a further revised plan was submitted to the Board on 17 May 2021. The plan is held on Pentana, which is externally hosted, and the plan would therefore be available in the event of a loss of the council's IT network.

Desktop Test

2.16. The risk management plan 2020/21 included provision for conducting a desktop test of the business continuity arrangements for an operational building. This had to be postponed due to the impact of the Covid-19 pandemic. A desktop test was therefore included in the 2021/22 risk management plan and a test of the arrangements at Whitehill service Centre is planned for August 2021.

3.0 CONCLUSION

3.1. The Audit, Risk and Counter Fraud Manager works with the Executive Management Team, Governance and Risk Board, service management teams and risk champions to ensure that effective risk management arrangements are in place within the council which enable services to identify, assess and manage risks to their objectives.

Kenneth Ribbons
Audit, Risk and Counter Fraud Manager

APPENDIX A

Risk Management - Performance Information

Status	Reference	Performance Indicator	Comment	Current Target	2020/21 Value	2019/20 Value	2018/19 Value	2017/18 Value
	P:IA020	Percentage of customers who rated the overall quality of risk management advice as good or excellent.	Based on the annual survey of customers.	100%	100%	95%	100%	100%
	P:IA021	Percentage of risks subject to annual documented risk assessment in Pentana.	Based on the position at 31 March of the financial year.	100%	100%	95%	100%	95%
	P:IA022	Percentage of risk actions outstanding after their original due date.	In relation to all risk actions due for completion in the previous four years.	2%	8% (see note)	8%	6%	8%
	IA024	Percentage of customers who rated the overall quality of business continuity advice as good or excellent.	Based on the annual survey of customers.	100%	100%	100%	94%	100%
	P:IA025	Percentage of WLC1 activities with an up to date Business Continuity Plan.	Based on responses received from heads of service.	100%	100%	100%	100%	N/A

Note

P:IA022 Percentage of risk actions outstanding after their original due date: progress will be more closely monitored during 2021/22 and there will be greater engagement with services with a view to encouraging timeous completion.