

# Hosted Bodies Audit & Risk Committee

Wed 21 June 2023, 09:00 - 10:00

Virtually via Microsoft Teams

## Agenda

---

### 09:00 - 09:00 1. PRELIMINARY MATTERS 0 min

#### 1.1. Welcome & Introductions

*Information Patsy Roseblade, Committee Chair*

#### 1.2. Apologies for Absence

*Information Patsy Roseblade, Committee Chair*

#### 1.3. Declarations of Interest

*Information Patsy Roseblade, Committee Chair*

---

### 09:00 - 09:00 2. CONSENT AGENDA FOR APPROVAL 0 min

#### 2.1. Unconfirmed Minutes of the meeting held on 19 April 2023

 2.1 Draft Minutes Hosted Bodies Audit Risk Committee ARC 19 April 2023 ARC 21 June 2023.pdf (7 pages)

---

### 09:00 - 09:00 3. MAIN AGENDA 0 min

#### 3.1. Action Log

*Discussion Jacqueline Evans, Committee Secretary and Associate Director of Corporate Services*

 3.1 Hosted Bodies Audit & Risk Committee Action Log ARC 21 June 2023.pdf (2 pages)

#### 3.2. Matters Arising not considered within the Action Log

*Discussion Patsy Roseblade, Committee Chair*

---

### 09:00 - 09:00 4. IMPROVING CARE 0 min

#### 4.1. WHSSC Corporate Risk Assurance Framework and Risk Register

*Discussion Jacqueline Evans, Committee Secretary and Associate Director of Corporate Services*

 4.1a WHSSC CRAF Cover Report ARC 21 June 2023.pdf (8 pages)

 4.1b Appendix 1 - WHSSC CRAF May 2023 ARC 21 June 2023.pdf (26 pages)

#### 4.2. WHSSC Audit Recommendations Tracker

*Discussion Stuart Davies, WHSSC Finance Director*

- 📄 4.2a WHSSC Audit Tracker Report ARC 21 June 2023.pdf (8 pages)
- 📄 4.2b Appendix 1 - WHSSC Audit Recommendations Progress Tracker 2022-2023 for ARC 21 June 2023.pdf (2 pages)
- 📄 4.2c Appendix 2 - Audit Wales WHSSC Governance Tracker - May 2023 v2.pdf (17 pages)

### **4.3. EASC Update (to include an update on Non Emergency Patient Transport Services and the Integrated Commissioning Action Plan )**

- 📄 4.3 EASC Update ARC\_21\_June\_2023updated ARC 21 June 2023.pdf (14 pages)
- 📄 4.3.1 EASCRiskRegister\_EASC\_16\_May2023\_ARC21June 2023.pdf (3 pages)
- 📄 4.3.2a EASC Assurance Framework\_EASC\_16May2023\_ARC 21 Jun2023.pdf (25 pages)
- 📄 4.3.2b Risk Appetite Statement ARC 21 June 2023.pdf (2 pages)
- 📄 4.3.2c Risk Domain and Scoring Matrix ARC 21 June 2023.pdf (1 pages)
- 📄 4.3.3 Welsh Language Commissioner final report and decision notice\_EASC\_16May2023.pdf (4 pages)
- 📄 4.3.4 WLC Report and Decision notice\_EASC\_16May2023.pdf (20 pages)
- 📄 4.3.5 NCCU Risk Register\_NCCUMB\_2 Mar 2023\_ARC\_21\_Jun\_2023.pdf (2 pages)
- 📄 4.3.6 EASC Performance Dashboard April 2023\_EASC\_16May2023\_ARC 21 Jun2023.pdf (23 pages)
- 📄 4.3.7 EASC Action Plan April 2023\_ARC 21 Jun 2023.pdf (8 pages)

---

## **09:00 - 09:00 5. ANY OTHER BUSINESS**

0 min

*Information*

*Patsy Roseblade, Committee Chair*

---

## **09:00 - 09:00 6. DATE AND TIME OF NEXT MEETING WEDNESDAY 16 AUGUST AT 9:00AM**

0 min

**Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB)  
Hosted Bodies Audit & Risk Committee held on the 19 April 2023 as a  
Virtual Meeting via Microsoft Teams**

**Members Present:**

Patsy Roseblade	Independent Member (Chair)
Jayne Sadgrove	Health Board Vice Chair
Carolyn Donoghue	Independent Member
Ian Wells	Independent Member

**In Attendance:**

Jonathan Morgan	Health Board Chair (In part)
Paul Dalton	NWSSP – Internal Audit & Assurance
Emma Samways	NWSSP – Internal Audit & Assurance
Sara Utlej	Audit Wales
Mark Jones	Audit Wales
Jacqui Evans	Committee Secretary/Associate Director of Corporate Services (WHSSC)
Stuart Davies	Director of Finance (WHSSC)
Steve Spill	Independent Member (WHSSC) (In part)
Gwenan Roberts	Assistant Director of Corporate Services (EASC)
Stephen Harrhy	Chief Ambulance Services Commissioner (EASC) (In part)
Philip Wardle	Academy Director, National Imaging Academy for Wales (In part)
Tracy Norris	Academy Manager, National Imaging Academy for Wales
Sally May	Director of Finance CTMUHB
Cally Hamblyn	Assistant Director of Governance & Risk
Philippa Peake-Jones	Interim Head of Corporate Governance
Emma Walters	Corporate Governance Manager (Secretariat)

**Agenda**

**Item**

**1.0.0 PRELIMINARY MATTERS**

**1.1 Welcome & Introductions**

The Chair welcomed everyone to the meeting.

The format of the proceedings in its virtual form were noted. Members also **noted** that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members **noted** that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.

## 1.2 Apologies for Absence

No apologies for absence were received.

It was noted that S Spill would not be able to join the meeting until after 10:45am.

## 1.3 Declarations of Interest

There were no additional declarations of interest to those declared previously.

## 2.0.0 CONSENT AGENDA – FOR APPROVAL

### 2.1 Unconfirmed Minutes of the Meeting held on the 13 February 2023

Resolution: The minutes were **APPROVED** as a true and accurate record

## 3.0.0 MAIN AGENDA

### 3.1 Audit & Risk Committee Action Log

J Evans presented Members with the action log. Members noted that the Welsh Health Specialised Services Committee (WHSSC) Review of Financial Limits and Reporting, had been approved by the Joint Committee during the last quarter of the last financial year, and noted that the reporting of all activities that trigger Chairs action would be reported within the accountability report from May onwards. Members noted that Chairs Urgent Action had not been initiated during this period.

In response to a query raised by the Committee Chair regarding the Standing Financial Instructions (SFI's) and the Scheme of Delegation, and whether they would now be presented to Health Board's for approval as opposed to the Audit & Risk Committee, J Evans confirmed that the Joint Committee had approved the SFI's and Scheme of Delegation at its meeting on 15 March and added that these documents would now be forwarded to Health Board's for inclusion on their Board agenda's for July 2023.

Resolution: The Action Log was **NOTED**.

### 3.2 Matters Arising not considered within the minutes or the Action Log

There were no matters arising identified.

## 4.0.0 IMPROVING CARE

### 4.1 National Imaging Academy for Wales (NIAW) Risk Register

T Norris presented Members with the report. Members noted the positive news in relation to risk 4087 in relation to capital allocation in that the Academy had

been informed that they would be receiving some capital funding this year to enable them to carry out upgrades in terms of building maintenance. P Wardle extended his thanks to R Cavill for her ongoing support in resolving this matter.

In response to a query raised by C Donoghue in relation to Risk 4689 regarding the rationale as to why Health Education Improvement Wales (HEIW) were not commissioning Radiology Trainees to the South Wales Trainee scheme, P Wardle advised that this was not a financial issue and added that there had been recognition that there needed to be an increase in the numbers of trainees to what was identified in the original business case, which had been calculated at 20 trainees per year. P Wardle advised that whilst reaching the 20 had been a challenge, this was achieved. Members noted that because the target of 20 was not being achieved every year, this needed to be highlighted as a risk. It was suggested that the risk needed to be rephrased for the next report as it implied that HEIW were not providing NIAW the numbers of trainees required.

In response to a question raised by I Wells as to whether there was confidence that all 20 trainees would remain in Wales, P Wardle advised that this was beyond the remit of the NIAW, however, commented that it is not unusual for trainees from all schemes to move to other parts of the country. Members noted that the current retention rate was between 80-90% and acknowledged that discussions were ongoing with Medical Directors in Welsh Health Board's to ensure organisations were ready to employ the trainees and to ensure that Wales was an attractive proposition for employment.

In response to a comment made by the Committee Chair, P Wardle agreed to include a glossary of terms in the next iteration of the report. P Wardle also noted that he would ensure that the calculation of the risk score (consequence x likelihood) is included in the next iteration of the risk register.

Resolution: The report was **NOTED**.

Action: Risk 4689 to be re phrased for the next report as it implied that HEIW were not providing NIAW the numbers of trainees required

Action: Glossary of terms to be included in the next iteration of the report

Action: The calculation of the risk score (consequence x likelihood) to be included in the next iteration of the risk register.

#### 4.2 **Emergency Ambulance Services Committee (EASC) Update**

S HARRY and G Roberts presented Members with the report. The following key points were noted:

- Red performance for the month of February had improved to 50.9%;
- The numbers of four hour waits had reduced from 2900 in December to around 1900 for February;
- There had been an improvement in sickness absence rates within the Welsh Ambulance Services NHS Trust (WAST);

- Average hand over per call was 1 hour 45 minutes in February compared to 2 hours 15 minutes in December;
- There had been a positive improvement in the immediate release figures which meant there had been a reduction in the number of can't sends, which had reduced from 2000 in December to 122 in February;
- The predicted position for March was not as positive as the February position;
- A consolidated EASC action plan was now in place which had been consolidated into the Commissioning Framework;
- WAST had recruited 100 additional WTE who were now in post;
- The Hear and Treat rate for February was 14% which was above what EASC had been asked to commission last year;
- The number of conveyances into hospital were down in February;
- A formal public engagement process was being undertaken in relation to the Emergency Air Ambulance Retrieval service. S Harrhy advised that he was pleased to have attended the Stakeholder Reference Group to provide an update on this matter.

In response to a query raised by P Roseblade regarding the reduction of verified incidents reported in section 2.19 and whether this was as a result of the Industrial Action, S Harrhy explained that this partly related to the industrial action and partly related to having less people needing to call for an ambulance on multiple occasions. S Harrhy advised that this was a high level report and a weekly dashboard was being produced which provided an overview of performance for each individual Health Board.

G Roberts presented Members with the EASC Risk Register and advised that this had not changed since the risk register was presented to the February meeting. Members noted the next iteration of the report would be presented to the EASC Joint Committee in May for approval. Members noted that the EASC Standing Orders had been approved at the March EASC Joint Committee and would be shared with all Health Board's for submission to their respective Board Meetings.

G Roberts provided an update in relation to the investigation that had been undertaken by the Welsh Language Commissioner in relation to an incident where a document had been added to the website in English only and not Welsh. Members noted that work was being undertaken with Digital Healthcare Wales on a piece of software that would enable documents uploaded in English to be automatically uploaded in Welsh.

Members noted that the National Collaborative Commissioning Unit (NCCU) Risk Register had not changed since the last meeting and would be next reviewed in June and noted that S Rankin had been appointed as the new Vice Chair of EASC and commenced in March.

In response to a comment made by I Wells in relation to a document that had previously been shared with Committee Members which showed a breakdown of responsibilities between EASC and Health Board's and whether this information could routinely be provided to Members, S Harrhy advised that the document I

Wells was referring to was the Integrated Commissioning Action Plan and added he would be happy to include this in future reports.

P Roseblade reminded members that each Health Board was responsible for its own population and added that the services being discussed at today's meeting were commissioned services.

P Roseblade drew attention to Risks 4506 and 4507, seeking rationale as to the consequence score changing in the assessment of the target score. P Roseblade also commented on Risks 5370 and 4507 which appeared to be the same risk but worded slightly differently. G Roberts agreed to review the queries raised.

The report was **NOTED**

Integrated Commissioning Action Plan to be included in future reports.

Resolution: Explanation to be provided in future reports as to why the consequences of risks 4506 and 4507 had changed in the assessment of the target score. Review to be undertaken of the wording of risks 5370 and 4507 to determine whether they were the same risk.

Action:

#### **Non Emergency Patient Transport Services Presentation**

#### **4.2.1**

S Harray shared a presentation with Members which provided an update on the Non Emergency Patient Transport Service (NEPTS). S Harray advised that he would be happy to include further updates in future EASC reports if Members would find this helpful.

The Committee Chair extended her thanks to S Harray for the presentation and advised that Members would welcome further updates at future meetings.

In response to a question raised by the Committee Chair as to whether WAST were equipped to deal with the increase in the numbers of patients as a result of the Scheduled Care Improvement Plans, S Harray advised that through the NEPTS Delivery Assurance Group process, the assumptions being made within the improvement plans were being shared and advised that whilst WAST would be equipped to address increased demand, there were questions whether they could make the changes in a timely manner.

Resolution: The presentation was **NOTED**.

Action: Further updates to be included in future EASC reports.

#### **4.3**

#### **WHSSC Corporate Risk Assurance Framework (CRAF) including the Risk Register**

J Evans presented the CRAF and highlighted the key matters for the attention of the Committee. Members noted that at the request of the WHSSC Integrated

Governance Committee, each risk was now assigned to the respective NHS body.

In response to a question raised by I Wells regarding the de-escalation of risks 23 and 24 and whether the position had now changed in relation to the lack of secure Mental Health beds in Wales and access to Mental Health beds in England, and whether the de-escalation related to the number of patients waiting for beds S Davies advised that both of the medium secure providers within Wales now had excess capacity as opposed to being full. Members noted that the direction of travel over the last 6 months had been to try to repatriate patients from NHS England rather than having a capacity gap which had proved difficult as clinicians were not keen to interrupt the flow of care being provided. S Davies agreed to include a reference within future reports as to the rationale behind the capacity within Wales.

C Donoghue made reference to risks 26 and 29 and advised that she felt the impact had not been expressed as to what the outcome to patients could be. C Donoghue also made reference to Risk 41 which was a very high risk which appeared to be remaining stagnant. S Davies advised that in relation to Risk 41, the WHSSC financial position had been stable during 2022/2023 and added that WHSSC had achieved an underspend of just over £13m, which had been returned to Health Board's. Members noted that WHSSC already had an approved Annual Plan as well as an approved Integrated Commissioning plan. In summary, S Davies advised that the risk had not increased as there was an agreed plan in place. C Donoghue extended her thanks to S Davies for the explanation provided.

The Committee Chair also made reference to Risk 26 and sought clarity as to why it was felt that funding would be approved when the funding release had not been supported just a month earlier. S Davies advised that there was an initial set of queries raised which had now been resolved which had enabled the release of funding. J Evans confirmed that any requests for funding were considered by the Management Group prior to being presented to Joint Committee for final approval and advised that this particular request would be presented to the May Joint Committee for approval.

The Committee Chair drew attention to the consequence score of the risks changing without any explanation, particularly when assessing the target score, commenting that there were instances where consequence risk score changed three times without rationale added. Further information was requested for future reports to explain why the consequence and impact of risks had changed.

Resolution: The report was **NOTED**.

Action: Reference to be made within future reports as to the rationale behind the capacity within Wales in relation to Mental Health beds.

Action: Explanation to be included in future reports as to why the consequence and impact score of risks had changed.

#### 4.4 WHSSC Audit Recommendations Tracker

J Evans presented the report and provided Members with key updates in respect of the implementation of recommendations from internal and external audits. Members noted that in relation to internal audit, there were only two recommendations outstanding on risk management which would be completed in July 2023.

In relation to external audit, Members noted that the tracker had been refined to only include open recommendations and noted that two recommendations remained outstanding which would be for Welsh Government to address. J Evans advised that she would be meeting with Welsh Government officials alongside the WHSSC Chair to discuss the closure of recommendations.

Resolution: The report was **NOTED**.

#### 4.5 Internal Audit Review – EASC Ambulance Handovers

E James presented Members with the report which had been given a substantial assurance rating. The Committee Chair welcomed the report which clearly set out that the process was being audited rather than the outcome.

Resolution: The report was **NOTED**

#### 5.0.0 ANY OTHER BUSINESS

There was no other business to report.

#### 6.0.0 DATE AND TIME OF NEXT MEETING

The next meeting would take place at 9:00am on Wednesday 21 June 2023.

#### 7.0.0 CLOSE

**HOSTED BODIES AUDIT & RISK COMMITTEE ACTION LOG  
FOLLOWING MEETINGS HELD ON 19 APRIL 2023**

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT June 2023
4.1	19/04/2023	National Imaging Academy for Wales (NIAW) Risk Register	<p>Risk 4689 to be re phrased for the next report as it implied that HEIW were not giving NIAW the numbers of trainees required</p> <p>Glossary of terms to be included in the next iteration of the report</p> <p>Make-up of the risk to be included in the next iteration of the report, for example, the consequence times the probability of the risk/impact of the risk.</p>	October 2023	NIAW Academy Manager	<p><b>In progress</b></p> <p>This will be updated for the October 2023 meeting</p>
4.2	19/04/2023	EASC Update	Integrated Commissioning Action Plan to be included in future reports.	June 2023	Chief Ambulance Services Commissioner	<p><b>In progress</b></p> <p>An update has been included within the EASC report in relation to the Integrated Commissioning Action Plan. A composite plan has not yet been developed and the Committee will be kept updated on progress once additional information is available.</p>
4.2	19/04/2023	EASC Update	Explanation to be provided in future reports as to why the consequences of risks 4506 and 4507 had changed. Review to be undertaken of the wording of risks 5370 and 4507 to determine whether they were the same risk.	June 2023	Assistant Director of Corporate Services (EASC)	<p><b>In progress</b></p> <p>The risks were amended to reflect that the consequences had not changed and reported to EASC. The Risk Register was presented and discussed at the last EASC and further work will take place in reviewing the risks. Once this is complete this will be reported to the Audit &amp; Risk Committee.</p>
4.3	19/04/2023	WHSSC Corporate Risk Assurance Framework (CRAF) including the Risk Register	Reference to be made within future reports as to the rationale behind the capacity within Wales in relation to Mental Health beds.	June 2023	WHSSC Director of Finance	<p><b>In Progress</b></p> <p>The Mental Health Demand and Capacity project is ongoing and the scope includes considering the number of specialised mental health beds required for Welsh patients for a number of areas including secure services, Eating Disorders, Learning Disabilities, CAMHS, Perinatal and Neuropsychiatry. This work will also inform future modelling for inclusion</p>

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT June 2023
						in the WHSSC Specialised Services Strategy for Mental Health. The Demand and Capacity report will be concluded in Summer 2023 and the Joint Committee will be updated.
4.3	19/04/2023	WHSSC Corporate Risk Assurance Framework (CRAF) including the Risk Register	Explanation to be included in future reports as to why the consequence and impact of risks had changed.	June 2023	WHSSC Committee Secretary	<b>Ongoing</b> The corporate governance team will continue to monitor and scrutinise the risk schedules and will ensure that Executives and risk owners are challenged on providing justification for any changes to the consequence and likelihood of risks. Any changes will be highlighted in the CRAF report.
<b>COMPLETED ACTIONS</b>						
4.1	12/12/2022	EASC Update	General update to be received at a future meeting of the Committee in relation to the Non- Emergency Patient Transport Service.	April 2023	Chief Ambulance Services Commissioner	<b>Completed</b> Update on Non-Emergency Patient Transport Services (NEPTS) was presented to the meeting held on 19 April 2023.
4.4	24/10/2022	WHSSC Review of Financial Limits and Reporting	CTMUHB and WHSSC Officers to consider the appropriate sequencing/routes to approval for the review of the Financial Limits and Reporting outside the meeting, with a view to revisiting the item in the Committee meeting in December 2022.	December 2022 Now February 2023 Now March 2023 Now May 2023	WHSSC Committee Secretary / Director of Corporate Governance (CTMUHB)	<b>Completed</b> The Joint Committee had approved the SFI's and Scheme of Delegation at its meeting on 15 March and these documents were forwarded to Health Board's for inclusion on their Board agenda's for May.
4.2.1	19/04/2023	NEPTS Presentation	Further updates to be included in future EASC reports.	June 2023	Chief Ambulance Services Commissioner	<b>Completed</b> The June report includes an update on the current position and next steps.



<b>Report Title</b>	<b>Corporate Risk Assurance Framework (CRAF)</b>	<b>Agenda Item</b>	4.1
<b>Meeting Title</b>	<b>Audit &amp; Risk Committee</b>	<b>Meeting Date</b>	21/06/2023
<b>FOI Status</b>	Open/Public		
<b>Author (Job title)</b>	Head of Corporate Governance and Risk and Governance Officer		
<b>Executive Lead (Job title)</b>	Committee Secretary and Associate Director of Corporate Services		

<b>Purpose of the Report</b>	The purpose of this report is to present WHSSC’s updated Corporate Risk Assurance Framework (CRAF) and outline the risks scoring 15 or above on the commissioning teams and directorate risk registers.				
------------------------------	---	--	--	--	--

<b>Specific Action Required</b>	RATIFY <input type="checkbox"/>	APPROVE <input checked="" type="checkbox"/>	SUPPORT <input type="checkbox"/>	ASSURE <input checked="" type="checkbox"/>	INFORM <input checked="" type="checkbox"/>
---------------------------------	------------------------------------	--	-------------------------------------	---	---

### Recommendation(s)

Members are asked to:

- **Note** the updated Corporate Risk Assurance Framework (CRAF) and changes to the risks outlined in this report as at 30 May 2023,
- **Note** the de-escalation of Risk 41 relating to financial climate,
- **Note** the addition of two new risks to the CRAF,
- **Note** that a Risk Scrutiny Group Meeting took place on 18 May 2023; and
- **Note** that a 6 monthly update to the Joint Committee on the CRAF will be presented on 18 July 2023.

# **CORPORATE RISK ASSURANCE FRAMEWORK (CRAF)**

## **1.0 SITUATION**

The purpose of this report is to present WHSSC's updated Corporate Risk Assurance Framework (CRAF) and outline the risks scoring 15 or above on the commissioning teams and directorate risk registers.

## **2.0 BACKGROUND**

WHSSC is committed to developing and implementing a Risk Management Strategy that will identify, analyse, evaluate and control the risks that threaten the delivery of its strategic objectives and delivering against its Integrated Commissioning Plan (ICP). The strategy is applied alongside other key management tools, such as performance, quality and financial reports, to provide the Joint Committee (JC) with a comprehensive picture of the organisation's risk profile.

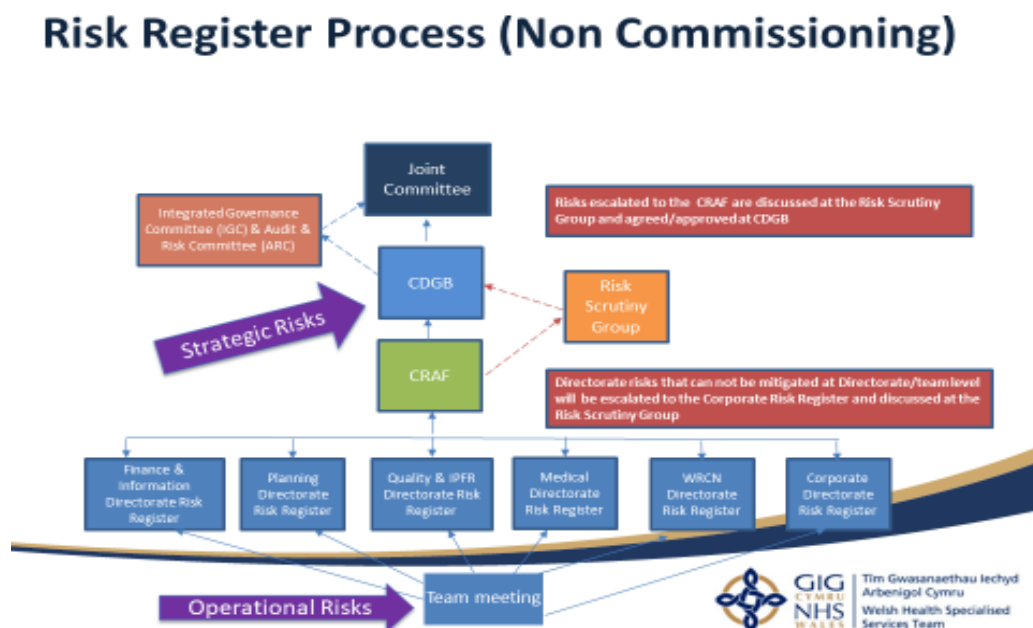
WHSSC revised its approach to assurance and risk management in April/May 2021 and developed the WHSSC risk management strategy, assessment and scoring to align with the approach undertaken in CTMUHB (our host). The JC agreed the approach, format and content of the Corporate Risk Assurance Framework (CRAF) at its meeting on the 11 May 2021 and receives the CRAF at least twice per year. The in-depth scrutiny and monitoring of corporate risks was delegated to sub-committees in order that they could provide assurance to the JC, through their Committee Update Reports, on the management of its principal risks.

The Executive Directors are responsible for reviewing and discussing their commissioning/corporate risks, and agreeing any new risks and the escalation/de-escalation of operational risks that are on directorate risk registers. It is the role of the Executive Directors to review controls and ensure appropriate action plans are in place, which might include the development of corporate risk management strategies to manage risk(s). Effective management of these risks enables the organisation to improve its chances of success and reduce the likelihood of failure.

Each directorate risk register is submitted to the newly introduced RSG on a bi-monthly basis. The membership of the RSG includes Directorate Managers who review and scrutinise the narrative, scores and mitigating actions for each risk. The risks are validated by the RSG and are subject to continuous review by the Executive Director lead for each risk. In addition to reviewing Directorate Risks, the RSG also receives a deep dive into a Commissioning Team Risk Register at each of its meetings.

Any risks identified as scoring 15 and above are captured on the CRAF and are presented to the CDGB for scrutiny on a monthly basis. The Quality & Patient Safety Committee (QPSC), the Integrated Governance Committee (IGC) and the Cwm Taf Morgannwg Audit & Risk Committee (ARC) receive the CRAF at each meeting and the Joint Committee receive the CRAF on a six monthly basis for assurance. The infographic outlined in Figure 1 below outlines the governance framework for risk management.

**Figure 1 – WHSSC Risk Management Framework**



### 3.0 ASSESSMENT

#### 3.1 Risk Summary

The May 2023 CRAF is presented at **Appendix 1** for information.

As at 30 May 2023, there are **18** risks on the CRAF. A summary of these risks is outlined below.

#### 3.2 Commissioning Risks

There are currently **13** commissioning risks open with a risk score of 15 and above, which are included on the CRAF.

Work continues with the commissioning teams to ensure the following:

- A structured statement describes the risk,
- Controls are in place that modify the risk and gaps are identified; and
- All actions that mitigate the risk are SMART and have action leads.

### 3.2.1 New Commissioning Risks

- 2 new Commissioning Risks

Ref	Initial Score	Score as at May 2023	Date risk added	Rationale
<b>Risk 47 (IF14)</b> <b>Intestinal Failure</b> Sustainability and Delivery of Service provided by Cardiff and Vale University Health Board	<b>20</b>	<b>20</b>	15 May 2023	<b>There is a risk that due to</b> issues of provider sustainability and delivery, that Cardiff and Vale University Health Board will no longer be able to provide Intestinal Failure services to the Welsh population and <b>as a consequence</b> resulting in no service available in Wales.
<b>Risk 48 (P/21/20)</b> <b>Fertility Services</b> Wales Fertility Institute (WFI)	<b>16</b>	<b>16</b>	16 May 2023	<b>There is a risk</b> the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital are not providing a safe and effective service <b>due to 7</b> major concerns identified during a relicensing inspection by HFEA in January 2023  SBUHB have escalated the issue to Gold Command based on the HEFA report, which identified 7 major concerns.

### 3.2.2 Escalated Commissioning Risks

- No risks were escalated during this period.

### 3.2.3 De-escalated Commissioning Risk

- 1 Risk was de-escalated during this period:

Ref	Initial Score	Score as at May 2023	Date de-escalated	Rationale
<b>Risk 41 (CS14) Financial Climate Risk</b>	<b>16</b>	<b>12</b>	May 2023	The risk was discussed at the executive OD session on 11 May 2023 and it was agreed to de-escalate from the CRAF and reduce score to 12, and to monitor the fluid financial position. De-escalation confirmed by RSG. Note the risk increase again in Q4 2023-2024.

### 3.2.4 Closed Risks

- No risks were closed during this period.

## 4.0 GOVERNANCE AND RISK

### 4.1 Feedback from CTMUHB Audit & Risk Committee (ARC)

On the 19 April the ARC set an action for WHSSC as follows:

*"An explanation to be included in future reports as to why the consequence and impact of risks had changed."*

Risk owners have been requested to provide detailed narrative on any changes to risk scores. The corporate governance team will monitor this and will support directorates with risk descriptions as required.

### 4.2 Internal Audit Progress

An internal audit on WHSSC's risk management process was undertaken on the 16 March 2022, and received an internal audit assessment rating of "reasonable assurance". There are two outstanding actions, relating to:

- **Risk Management Strategy** – the corporate governance team are in the process of reviewing the strategy and a draft will be presented to the CDGB 27 June prior to submission to the Joint Committee on 18 July for approval, in accordance with the scheme of delegation; and
- **Risk Management training** – once the updated risk management strategy is approved, risk management training will be rolled out to all staff in September 2023.

#### 4.3 Risk Scrutiny Group

A Risk Scrutiny Group (RSG) Meeting took place on 18 May 2023. Directorate Risk registers were discussed and reviewed. The Mental Health Department presented their Directorate Risk register. A deep dive into the Cardiac Commissioning Team Risk Register was received.

### 5.0 RECOMMENDATIONS

Members are asked to:

- **Note** the updated Corporate Risk Assurance Framework (CRAF) and changes to the risks outlined in this report as at 30 May 2023,
- **Note** the de-escalation of Risk 41 relating to financial climate,
- **Note** the addition of two new risks to the CRAF,
- **Note** that a Risk Scrutiny Group Meeting took place on 18 May 2023; and
- **Note** that a 6 monthly update to the Joint Committee on the CRAF will be presented on 18 July 2023.

<b>Governance and Assurance</b>	
<b>Link to Strategic Objectives</b>	
<b>Strategic Objective(s)</b>	Governance and Assurance
<b>Link to Integrated Commissioning Plan</b>	Implementation of agreed ICP
<b>Health and Care Standards</b>	Safe Care Effective Care Governance, Leadership and Accountability
<b>Principles of Prudent Healthcare</b>	Only do what is needed Reduce inappropriate variation Choose an item.
<b>Institute for HealthCare Improvement Quadruple Aim</b>	Improving Patient Experience (including quality and Satisfaction) Improving Health of Populations Choose an item.
<b>Organisational Implications</b>	
<b>Quality, Safety &amp; Patient Experience</b>	Ensuring the organisation has robust risk management arrangements in place that ensure organisational risks are captured, assessed and mitigating actions are taken, is a key requisite to ensuring the quality, safety & experience of patients receiving care and staff working in WHSSC.
<b>Finance/Resource Implications</b>	The risks outlined within this report have resource implications, which are being addressed by each respective Executive Director lead and taken into consideration as part of the WHSSC Integrated Commissioning Plan (ICP) processes.
<b>Population Health</b>	There are no immediate adverse population health implications.
<b>Legal Implications (including equality &amp; diversity, socio economic duty etc)</b>	It is essential that there are robust arrangements in place to identify, assess, mitigate and manage risks encountered by WHSSC. Failure to maintain such arrangements may have legal implications.
<b>Long Term Implications (incl WBFG Act 2015)</b>	The robust arrangements in place to identify, assess, mitigate and manage risks encountered by WHSSC consider the long-term impact of decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

<b>Report History (Meeting/Date/ Summary of Outcome</b>	18 May 2023 – Risk Scrutiny Group (RSG) 30 May 2023 – Corporate Directors Group Board (CDGB)
<b>Appendices</b>	Appendix 1 –Corporate Risk Assurance Framework (CRAF) May 2023



# **Corporate Risk Assurance Framework (CRAF)**

**May 2023**

**1. Dashboard of Risk**

Impact	5			<b>42</b> Referrals for adults with an eating disorder/disordered eating	<b>47</b> Sustainability and Delivery of Service provided by Cardiff and Vale University Health Board	
	4				<b>06</b> Paediatric patients waiting for surgery <b>21</b> CAMHS <b>28</b> Workforce and Capacity <b>35</b> Bed Capacity Mental Health Patients <b>38</b> No neonatal cot availability in South Wales due to staffing shortages <b>39</b> Renal Funding <b>40</b> Limited outpatient dialysis capacity in Swansea <b>44</b> Paediatric cardiac surgery <b>48</b> Wales Fertility Institute	<b>29</b> WHSSC IPFR Governance <b>33</b> Welsh Government Priority Delivery Measures <b>34</b> Lack of paediatric intensive care beds
	3					<b>03</b> Plastic Surgery Delays <b>26</b> Neuropsychiatry patients waiting times <b>43</b> Patient waiting times <b>46</b> North Wales Outreach Plastic Surgery Clinic Management Arrangements
	2					
	1					
		1	2	3	4	5
CXL				Likelihood		

**2. Corporate Risk Register/Summary of Risk**

Risk Ref	Domain	Summary of Risk	Initial Score	Current Consecutive Monthly Score	Target Score	Trend since previous month	Last Review Date	Next Review Date	Scrutiny Committee	Lead Director
3 CB03 Cancer & Blood	Impact on the safety of patients, staff or public (physical/psychological harm) Population Health	<b>Plastic Surgery Delays</b> There is a risk of poor patient experience and poor outcome for plastic surgery patients in south Wales. This is caused by failure to achieve the maximum waiting times target with some patients waiting in excess of 52 weeks. This leads to a commissioned service that does not meet waiting times standards and therefore does not provide the required quality of service.	15	15	6	Risk score remains the same ↔	18/05/23	30/06/23	Joint Committee	Director of Planning
		Provider/s: SBUHB								
6 P/21/10 Women & Children	Impact on the safety of patients, staff or public (physical/psychological harm) Population Health	<b>Paediatric patients waiting for surgery</b> There is a risk that paediatric patients waiting for surgery in the Children's Hospital of Wales are waiting in excess of 36 weeks due to COVID-19. The consequence is the condition of the patient could worsen and that the current infrastructure is insufficient to meet the backlog.	16	16	4	Risk score remains the same ↔	16/05/23	20/06/23	Joint Committee	Director of Planning
		Provider/s: CVUHB								
21 MH/21/02 Mental Health & Vulnerable Groups	Impact on the safety of patients, staff or public (physical/psychological harm) Population Health	<b>Children &amp; Adolescent Mental Health Services (CAMHS)</b> There is a risk that tier 4 providers for CAMHS cannot meet the service specification due to environmental and workforce issues, with a consequence that children could abscond/come to harm. (Ty Lliard)	16	16	8	Risk score remains the same ↔	22/05/2023	26/06/2023	Joint Committee	Director of Mental Health
		Provider/s: CTMUHB								
26 NCC046 Mental Health & Vulnerable Groups	Impact on the safety of patients, staff or public (physical/psychological harm) Population Health	<b>Neuropsychiatry patients waiting times</b> There is a risk that neuropsychiatry patients will not be able to be treated in a timely manner with the appropriate therapy support, due to staffing issues. The consequence patients will have long waiting times to access the service and the lack of availability of step down facilities to support the acute centre will also result in delays.	20	15	4	Risk score remains the same ↔	22/05/2023	26/06/2023	Joint Committee	Director of Planning
		Provider/s: CVUHB								
28 CS3 Corporate Services	Workforce and Capacity	<b>Workforce and Capacity</b> There is a risk that WHSSC is unable to keep up with the increasing work demand. Due to additional work related services currently commissioned through HB's or services which are new to Wales. As a consequence this could have an impact on teams to absorb the additional work	20	16	9	Risk score remains the same ↔	May 2023	June 2023	Joint Committee	Committee Secretary
		Provider/s: N/A								
29 CS8 Corporate Services / Quality and IPFR	Impact on the safety of patients, staff or public (physical/psychological harm) Population Health	<b>WHSSC IPFR ToR and Governance</b> There is a risk that WHSSC will be unable to meet the TOR for the All Wales IPFR panel due to the inability to achieve quoracy in the membership and consequently this may lead to delayed decision-making. In addition, there is also a risk that the current IPFR governance arrangements are not robust and as a consequence this may also lead to legal challenges in the form of judicial reviews.	16	20	4	Risk score remains the same ↔	May 2023	June 2023	Joint Committee	Director of Nursing/ Committee Secretary
		Provider/s: N/A								

Risk Ref	Domain	Summary of Risk	Initial Score	Current Consecutive Monthly Score	Target Score	Trend since previous month	Last Review Date	Next Review Date	Scrutiny Committee	Lead Director
33 CS10 Corporate Services	Impact on the safety of patients, staff or public (physical/psychological harm) Population Health	<b>Welsh Government Priority Delivery Measures</b> There is a risk the Welsh Provider Health Boards will not be able to deliver specialised services in line with the new Priority Measures due to the waiting list backlog and the shortfall in capacity as a consequence the measures will not met, patients will be waiting outside of the waiting times within the measures and WHSSC may need to seek commissioning alternatives	20	20	9	Risk score remains the same ↔	May 2023	June 2023	Joint Committee	Director of Planning
		Provider/s – All								
34 P/21/02 Women & Children	Impact on the safety of patients, staff or public (physical/psychological harm) Population Health	<b>Lack of Paediatric Intensive Care Beds</b> <i>There is a risk</i> that a paediatric intensive care bed, in the Children's Hospital for Wales, will not be available when required <i>due to</i> constraints within the service. <i>There is a consequence</i> that paediatric patients requiring intensive care will be cared for in, inappropriate areas where the necessary skills or equipment are not available or the patient being transferred out of Wales.	16	20	4	Risk score remains the same ↔	16/05/23	20/06/23	Joint Committee	Director of Planning
		Provider/s: CVUHB								
35 MH/21/06 Mental Health & Vulnerable Groups	Impact on the safety of patients, staff or public (physical/psychological harm) Population Health	<b>Bed Capacity Mental Health Patients</b> <i>There is a risk</i> that mental health patients will be unable to gain a placement <i>due to</i> the lack of available UK beds, which as <i>a consequence</i> may result in inappropriate placement	9	16	6	Risk score remains the same ↔	22/05/2023	26/06/2023	Joint Committee	Director of Mental Health
		Provider/s: SBUHB, BCUHB, NHS England, Independent Sector								
38 P/21/16 Women & Children	Impact on the safety of patients, staff or public (physical/psychological harm) Population Health	<b>Neonatal Cots</b> <i>There is a risk</i> that there will not be a Neonatal cot available across the south Wales region <i>due to</i> significant neonatal nursing shortages. <i>There is a consequence</i> that babies will need to travel to NHS England to receive their care or be cared for in an inappropriate setting whilst waiting for an available cot	16	16	4	Risk score remains the same ↔	16/05/23	20/06/23	Joint Committee	Director of Planning
		Provider/s: CVUHB								
39 WKN 06 Welsh Kidney Network	Finance including claims	<b>Renal Funding</b> <i>There is a risk that</i> now there is an inability to meet service demand through ring fenced budget allocations that life maintaining treatment may not be available. <i>As a consequence</i> additional investment required through ICP process to sustain current services and manage growth and inflationary uplifts.	12	16	4	Risk score remains the same ↔	May 2023	June 2023	Joint Committee	Programme Director
		Provider/s: N/A								
40 WKN 08 Welsh Kidney Network	Impact on the safety of patients, staff or public (physical/psychological harm)	<b>Limited outpatient dialysis capacity in Swansea</b> <i>There is a risk</i> that the number of patients receiving outpatient haemodialysis in Murrison will exceed capacity. <i>As a consequence</i> there is need for expansion of outpatient service provision to include demand from the Neath Port Talbot area and Bridgend localities.	12	16	2	Risk score remains the same ↔	May 2023	June 2023	Joint Committee	Programme Director
		Provider/s: SBUHB								
42 MH/21/15 Mental Health & Vulnerable Groups	Impact on the safety of patients, staff or public (physical/psychological harm)	<b>Referrals for adults with an eating disorder/disordered eating</b> <i>There is a risk</i> that referrals for adults with an eating disorder/disordered eating, will require longer waiting times due to changes at NHSE and the loss of our main contract. <i>The consequence</i> is that additional placements may be needed, and admissions delayed <i>due to</i> the absence of ED beds in Wales.	15	15	8	Risk score remains the same ↔	22/05/2023	26/06/2023	Joint Committee	Director of Mental Health

Risk Ref	Domain	Summary of Risk	Initial Score	Current Consecutive Monthly Score	Target Score	Trend since previous month	Last Review Date	Next Review Date	Scrutiny Committee	Lead Director
		Provider/s: Independent Sector								
<b>43</b> CB01 <b>Cancer &amp; Blood</b>	Impact on the safety of patients, staff or public (physical/psychological harm)	<b>Patient waiting times</b> There is a risk that patients are not being treated in a timely and/or appropriate way. This is caused by the AWLP service not achieving diagnostic turnaround times that meet the required standards. This could lead to poorer patient outcomes. <b>Provider/s:</b> CVUHB (subcontract in place with SBUHB)	8	15	4	Risk score remains the same ↔	18/05/23	30/06/23	Joint Committee	Director of Planning
<b>44</b> P/21/19 <b>Women and Children</b>	Impact on the safety of patients, staff or public (physical/psychological harm)	<b>Paediatric cardiac surgery</b> <b>There is a risk</b> that paediatric cardiac surgery patients referred to Bristol Children's Hospital, will have longer waits than is clinically appropriate <b>due to</b> lack of availability of a PIC bed within the Bristol Hospital. <b>There is a consequence</b> that the condition of the patient could deteriorate whilst waiting. <b>Provider/s:</b> University Hospital Bristol	16	16	4	Risk score remains the same ↔	16/05/23	20/06/23	Joint Committee	Director of Planning
<b>46</b> CB06 <b>Cancer &amp; Blood</b>	Impact on the safety of patients, staff or public (physical/psychological harm)	<b>North Wales Outreach Plastic Surgery Clinic Management Arrangements</b> There is a risk that patients may come to harm due to a lack of clinical prioritisation and oversight of waiting lists for outreach plastic surgery clinics in YG and YGC. This is caused by lack of clarity in the governance and management arrangements for these clinics. This could lead to poor patient experience and outcomes. <b>Provider/s:</b> St Helens and Knowsley NHS Trust & BCUHB	9	15	4	Risk score remains the same ↔	18/05/23	30/06/23	Joint Committee	Director of Planning
<b>47</b> <b>NEW RISK</b> IF14 <b>Intestinal Failure</b>	Impact on the safety of patients, staff or public (physical/psychological harm)	<b>Intestinal Failure</b> <b>There is a risk that due to</b> issues of provider sustainability and delivery, that Cardiff and Vale University Health Board will no longer be able to provide Intestinal Failure services to the Welsh population and <b>as a consequence</b> resulting in no service available in Wales <b>Provider:</b> University Hospital of Wales/Salford Hospital	20	20	6	<b>New Risk</b>	15/05/23	17/06/23	Joint Committee	Director of Planning
<b>48</b> <b>NEW RISK</b> P/21/20 <b>Women and Children</b>	Impact on the safety of patients, staff or public (physical/psychological harm)	<b>Fertility Services</b> <b>There is a risk</b> the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital are not providing a safe and effective service <b>due to</b> 7 major concerns identified during a relicensing inspection by HFEA in January 2023 <b>There is a consequence</b> that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes. <b>Provider:</b> SBUHB	16	16	4	<b>New Risk</b>	16/05/23	20/06/23	Joint Committee	Director of Planning

**Risk de-escalated**

<b>41</b> CS14 <b>Corporate Services</b>	Finance including claims	<b>Financial Climate Risk</b> <b>There is a risk</b> that the financial climate across the NHS is vulnerable as currently Health Boards are reporting large deficits and the annual allocation uplift anticipated will not meet the current inflationary costs pressures. Therefore the uplift required for the WHSSC ICP might not be met by Commissioning Health Boards.	16	12	4	<b>Risk score De-escalated</b> ↓	May 2023	June 2023	Joint Committee	Director of Finance
--	--------------------------	---	----	----	---	-------------------------------------	----------	-----------	-----------------	---------------------

3 Risk Schedules – Risk on a Page

<b>Risk Ref: 3 Plastic Surgery Delays (CB03)</b> <b>Risk Domain:</b> Impact on the safety of patients, staff or public (physical/psychological harm)		<b>Director Lead:</b> Director of Planning <b>Assuring Committee:</b> Joint Committee Reviewed Assurance																																																							
<b>Risk:</b> There is a risk of poor patient experience and poor outcome for plastic surgery patients in south Wales. This is caused by failure to achieve the maximum waiting times target with some patients waiting >104 weeks. This leads to a commissioned service that does not meet waiting times standards and therefore does not provide the required quality of service.		<b>Date Added to Register:</b> 26/02/21 (first identified 17/03/14)	<b>Date Last Reviewed by:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023																																																						
		<b>Provider/s:</b> SBUHB																																																							
Risk Rating (impact x likelihood)		<b>Groups discussed risk during period</b>																																																							
<table border="1"> <tr> <td>Initial</td> <td>3x5</td> <td>15</td> </tr> <tr> <td><b>Current</b></td> <td><b>3x5</b></td> <td><b>15</b></td> </tr> <tr> <td>Target</td> <td>2x3</td> <td>6</td> </tr> </table>		Initial	3x5	15	<b>Current</b>	<b>3x5</b>	<b>15</b>	Target	2x3	6	<table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Rating</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>mar-21</td><td>15</td><td>6</td></tr> <tr><td>mai-21</td><td>15</td><td>6</td></tr> <tr><td>jul-21</td><td>15</td><td>6</td></tr> <tr><td>sep-21</td><td>15</td><td>6</td></tr> <tr><td>nov-21</td><td>15</td><td>6</td></tr> <tr><td>jan-22</td><td>15</td><td>6</td></tr> <tr><td>mar-22</td><td>15</td><td>6</td></tr> <tr><td>mai-22</td><td>15</td><td>6</td></tr> <tr><td>jul-22</td><td>15</td><td>6</td></tr> <tr><td>sep-22</td><td>15</td><td>6</td></tr> <tr><td>nov-22</td><td>15</td><td>6</td></tr> <tr><td>jan-23</td><td>15</td><td>6</td></tr> <tr><td>mar-23</td><td>15</td><td>6</td></tr> <tr><td>mai-23</td><td>15</td><td>6</td></tr> </tbody> </table>		Month	Risk Rating	Target	mar-21	15	6	mai-21	15	6	jul-21	15	6	sep-21	15	6	nov-21	15	6	jan-22	15	6	mar-22	15	6	mai-22	15	6	jul-22	15	6	sep-22	15	6	nov-22	15	6	jan-23	15	6	mar-23	15	6	mai-23	15	6
Initial	3x5	15																																																							
<b>Current</b>	<b>3x5</b>	<b>15</b>																																																							
Target	2x3	6																																																							
Month	Risk Rating	Target																																																							
mar-21	15	6																																																							
mai-21	15	6																																																							
jul-21	15	6																																																							
sep-21	15	6																																																							
nov-21	15	6																																																							
jan-22	15	6																																																							
mar-22	15	6																																																							
mai-22	15	6																																																							
jul-22	15	6																																																							
sep-22	15	6																																																							
nov-22	15	6																																																							
jan-23	15	6																																																							
mar-23	15	6																																																							
mai-23	15	6																																																							
<b>What controls have we put in place for the risk:</b> <ul style="list-style-type: none"> <li>Recovery plan requested from SBUHB</li> <li>Continue to monitor progress against the recovery plan</li> <li>Request waiting list data</li> <li>This risk is included within the C&amp;B register for monitoring purposes, it is included within the overarching risk for waiting times (Risk 33(CS/10 CD03) Welsh Government Priority Delivery Measures)</li> <li>Work to change the commissioning model has progressed and approved by Joint Committee</li> <li>The outcome from these workshops i.e. a recommendation that WHSSC establish a project to re-align commissioning responsibilities between WHSSC and Health Boards was approved by Joint Committee in January 2023.</li> <li>A Project initiation Document (PID) is due to go to MG in April 2023 outlining timescales for this project.</li> </ul>		<b>What actions should we take:</b> <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>To monitor progress against the plastic surgery recovery plan via monthly commissioner assurance meetings with SBUHB. <b>Next meeting arranged for Dec 22</b></td> <td>LA-Senior Planner</td> <td>monthly</td> </tr> <tr> <td>To report on progress against the recovery plan at the Cancer &amp; Blood commissioning team meeting and to CDGB as appropriate.</td> <td>LA – Senior Planner</td> <td>monthly</td> </tr> <tr> <td>Plastic surgery service to complete the assurance template developed to evidence that the service has maximised performance given current resource constraints: treat in turn rate, outsource/insource, list validation.</td> <td>LA – Senior Planner</td> <td>Completed</td> </tr> <tr> <td>To recommend to CDG that consideration should be given to placing the service into escalation further to Joint Committee’s agreement to return to normal performance management arrangements (subject to outcome of meeting with SBUHB on recovery trajectories to be held on 30.11.22). Escalation Level 1 agreed by CDGB in December 2022 and weekly submission of activity and waiting list data is required.</td> <td>LA – Senior Planner</td> <td>Completed</td> </tr> <tr> <td>To request further detail on the recently received delivery plan and to review the recently received quality report. To re-assess the escalation level in <b>June</b>.</td> <td>LA – Senior Planner VDJ – Quality Lead</td> <td><b>June 2023</b></td> </tr> </tbody> </table>		Action	Lead	Date	To monitor progress against the plastic surgery recovery plan via monthly commissioner assurance meetings with SBUHB. <b>Next meeting arranged for Dec 22</b>	LA-Senior Planner	monthly	To report on progress against the recovery plan at the Cancer & Blood commissioning team meeting and to CDGB as appropriate.	LA – Senior Planner	monthly	Plastic surgery service to complete the assurance template developed to evidence that the service has maximised performance given current resource constraints: treat in turn rate, outsource/insource, list validation.	LA – Senior Planner	Completed	To recommend to CDG that consideration should be given to placing the service into escalation further to Joint Committee’s agreement to return to normal performance management arrangements (subject to outcome of meeting with SBUHB on recovery trajectories to be held on 30.11.22). Escalation Level 1 agreed by CDGB in December 2022 and weekly submission of activity and waiting list data is required.	LA – Senior Planner	Completed	To request further detail on the recently received delivery plan and to review the recently received quality report. To re-assess the escalation level in <b>June</b> .	LA – Senior Planner VDJ – Quality Lead	<b>June 2023</b>																																				
Action	Lead	Date																																																							
To monitor progress against the plastic surgery recovery plan via monthly commissioner assurance meetings with SBUHB. <b>Next meeting arranged for Dec 22</b>	LA-Senior Planner	monthly																																																							
To report on progress against the recovery plan at the Cancer & Blood commissioning team meeting and to CDGB as appropriate.	LA – Senior Planner	monthly																																																							
Plastic surgery service to complete the assurance template developed to evidence that the service has maximised performance given current resource constraints: treat in turn rate, outsource/insource, list validation.	LA – Senior Planner	Completed																																																							
To recommend to CDG that consideration should be given to placing the service into escalation further to Joint Committee’s agreement to return to normal performance management arrangements (subject to outcome of meeting with SBUHB on recovery trajectories to be held on 30.11.22). Escalation Level 1 agreed by CDGB in December 2022 and weekly submission of activity and waiting list data is required.	LA – Senior Planner	Completed																																																							
To request further detail on the recently received delivery plan and to review the recently received quality report. To re-assess the escalation level in <b>June</b> .	LA – Senior Planner VDJ – Quality Lead	<b>June 2023</b>																																																							
<b>Additional comments:</b> Feb 22 - Whilst the overall score should not change, it was agreed that the scoring for likelihood and impact should be the other way around, the likelihood being 5 and the impact being 3. July 22 - The commissioning team discussed and reviewed the risk and agreed the risk was to remain December 22 - Escalation level 1 agreed by CDG, i.e. weekly submission of activity and waiting list data required.																																																									

March 23 – The C&B commissioning team agreed that the escalation level should remain at 1 until further detail on the delivery plan is provided by SBUHB at the next performance meeting and secondly review of the SBUHB plastic surgery quality report has been undertaken by WHSSC's quality lead. A further review will then take place in April.

April 23 – Risk reviewed, score remains the same

May 23 – Further detail on the delivery plan not yet received therefore escalation level not yet reviewed. The PID for the Realignment of Plastic Surgery Commissioning project was approved at MG in April.

<b>Risk Ref: 6 - Paediatric patients waiting for surgery (P/21/10)</b>	<b>Director Lead:</b> Director of Planning	
<b>Risk Domain:</b> Impact on the safety of patients, staff or public (physical/psychological harm)	<b>Assuring Committee:</b> Joint Committee Reviewed Assurance	
<b>Risk:</b> There is a risk that paediatric patients waiting for surgery in the Children's Hospital of Wales are waiting in excess of 36 weeks due to COVID-19. The consequence is the condition of the patient could worsen and that the current infrastructure is insufficient to meet the backlog.	<b>Date Added to Register:</b> 24/02/21	<b>Date last reviewed by:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023
	<b>Provider/s:</b> CVUHB	

Risk Rating  
(impact x likelihood)

Initial	4x4	16
Current	4x4	16
Target	2x2	4



**Groups discussed risk during period**

- Commissioning Team - 24/05/22
- Commissioning Team - 21/06/22
- Commissioning Team - 26/07/22
- Commissioning Team - 23/08/22
- Commissioning Team - 21/09/22
- Commissioning Team - 18/10/22
- Commissioning Team - 21/11/22
- Commissioning Team - 19/12/22
- Commissioning Team - 24/01/23
- Commissioning Team - 21/03/23
- Commissioning Team - 20/04/23
- Commissioning Team - 16/05/23

**What controls have we put in place for the risk:**

- Ongoing monitoring at Quarterly Commissioner Assurance Meeting with provider
- This risk is included within the W&C register for monitoring purposes, it is included within the overarching risk for waiting times (Risk 33(CS/10 CD03) Welsh Government Priority Delivery Measures).
- Plan in place for a number of children to be outsourced to NHS England and the Private Sector.
- Performance Management arrangements to be re-instigated which will allow WHSSC to identify and monitor where the issues are that need addressing.
- Monthly escalation meetings have been established – first meeting scheduled 26/04.
- Action plan received against escalation objectives
- Continue with outsourcing to NHS England and the Private Sector.

**What actions should we take:**

Action	Lead	Date
Request information from Health Board in advance of Quarterly Commissioner Assurance Meeting to seek update on current capacity including: <ul style="list-style-type: none"> <li>Staffing establishment</li> <li>Bed and theatre capacity</li> <li>Assurance on clinical management of patients on WL</li> <li>Recovery trajectory</li> </ul>	W&C Planner	Quarterly
Requested information on long waiting patients from provider to support potential outsourcing arrangements.	W&C Planner	Complete
Meetings being scheduled with NHS England providers to discuss outsourcing capacity	W&C Planner	Complete
Requested plan from C&V to manage long waiting patients, with clear trajectories and timeframes.	W&C Planner	Complete
Requested revised recovery plan further to Joint Committee	W&C Planner	Complete
Discussing with local Health Boards scope for mutual aid.	W&C Planner	Complete
Place service in escalation Level 3	W&C Planner	Complete
Performance Management arrangements to be re-instigated	Director of Planning	Monthly
Requested revised trajectories that reach contract baseline as a minimum	Director of Planning	31/05/2023

**Additional comments:**

July 2022 – W&C Commissioning team discussed and reviewed the risk. Quarterly Assurance meeting took place provider confirmed 109 patients waiting between 52 and 104 weeks and 25 patients waiting over 105 weeks. Therefore, risk cannot be reduced.  
 Apr 23 – W&C Commissioning team reviewed the risk which remains unchanged.  
 May 23 - W&C Commissioning team reviewed the risk which remains unchanged.

<b>Risk Ref: 21 - Children &amp; Adolescent Mental Health Services (CAMHS) (MH/21/02)</b> Risk Domain: Impact on the safety of patients, staff or public (physical/psychological harm) Population Health	<b>Director Lead:</b> Director of Mental Health <b>Assuring Committee:</b> Joint Committee Reviewed Assurance	
<b>Risk:</b> There is a risk that tier 4 providers for CAMHS cannot meet the service specification due to environmental and workforce issues, with a consequence that children could abscond/come to harm. (Ty Llidiard)	<b>Date Added to Register:</b> 24/02/21	<b>Date last reviewed by:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023
	<b>Provider/s:</b> CTMUHB	

<p style="text-align: center;">Risk Rating (impact x likelihood)</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>Initial</td> <td>4x4</td> <td>16</td> </tr> <tr> <td><b>Current</b></td> <td><b>4x4</b></td> <td><b>16</b></td> </tr> <tr> <td>Target</td> <td>4x2</td> <td>8</td> </tr> </table>	Initial	4x4	16	<b>Current</b>	<b>4x4</b>	<b>16</b>	Target	4x2	8	<p style="text-align: center;">Risk Rating</p> <table border="1" style="display: none;"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Rating</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>Jan-22</td><td>16</td><td>8</td></tr> <tr><td>Feb-22</td><td>16</td><td>8</td></tr> <tr><td>Mar-22</td><td>16</td><td>8</td></tr> <tr><td>Apr-22</td><td>16</td><td>8</td></tr> <tr><td>Mai-22</td><td>16</td><td>8</td></tr> <tr><td>Jun-22</td><td>16</td><td>8</td></tr> <tr><td>Jul-22</td><td>16</td><td>8</td></tr> <tr><td>Aug-22</td><td>16</td><td>8</td></tr> <tr><td>Sep-22</td><td>16</td><td>8</td></tr> <tr><td>Okt-22</td><td>16</td><td>8</td></tr> <tr><td>Nov-22</td><td>16</td><td>8</td></tr> <tr><td>Des-22</td><td>16</td><td>8</td></tr> <tr><td>Jan-23</td><td>16</td><td>8</td></tr> <tr><td>Feb-23</td><td>16</td><td>8</td></tr> <tr><td>Mar-23</td><td>16</td><td>8</td></tr> <tr><td>Apr-23</td><td>16</td><td>8</td></tr> <tr><td>Mai-23</td><td>16</td><td>8</td></tr> </tbody> </table>	Month	Risk Rating	Target	Jan-22	16	8	Feb-22	16	8	Mar-22	16	8	Apr-22	16	8	Mai-22	16	8	Jun-22	16	8	Jul-22	16	8	Aug-22	16	8	Sep-22	16	8	Okt-22	16	8	Nov-22	16	8	Des-22	16	8	Jan-23	16	8	Feb-23	16	8	Mar-23	16	8	Apr-23	16	8	Mai-23	16	8	<p style="text-align: center;">Groups discussed risk during period</p> <ul style="list-style-type: none"> <li>Commissioning Team 27/04/22</li> <li>Commissioning Team 25/05/22</li> <li>Commissioning Team 26/06/22 – Not quorate</li> <li>Commissioning Team 27/07/22 – Cancelled</li> <li>Commissioning Team 24/08/22– Cancelled</li> <li>Commissioning Team 28/09/22</li> <li>Commissioning Team 24/10/22</li> <li>Commissioning Team 19/12/22</li> <li>Commissioning Team 23/01/23</li> <li>Commissioning Team 27/02/23 – Cancelled</li> <li>Commissioning Team 27/03/23</li> <li>Commissioning Team 24/04/23</li> <li>Commissioning Team 22/05/23</li> </ul>
Initial	4x4	16																																																															
<b>Current</b>	<b>4x4</b>	<b>16</b>																																																															
Target	4x2	8																																																															
Month	Risk Rating	Target																																																															
Jan-22	16	8																																																															
Feb-22	16	8																																																															
Mar-22	16	8																																																															
Apr-22	16	8																																																															
Mai-22	16	8																																																															
Jun-22	16	8																																																															
Jul-22	16	8																																																															
Aug-22	16	8																																																															
Sep-22	16	8																																																															
Okt-22	16	8																																																															
Nov-22	16	8																																																															
Des-22	16	8																																																															
Jan-23	16	8																																																															
Feb-23	16	8																																																															
Mar-23	16	8																																																															
Apr-23	16	8																																																															
Mai-23	16	8																																																															

**What controls have we put in place for the risk:**

- Service specification reviewed to ensure relevant information is contained and monitored with the provider
- Monitor training status of the staff at Ty Llidiard
- Quality Assurance Improvement Service (QAIS) undertake regular review ensure that environments of care are safe
- Business Plan for Physician Associate provided
- This service has been de-escalated from Level 4 to Level 3 as agreed by CDGB on 14th December 2022. Progress against de-escalation action plans, and a favourable report following the latest quality visit provided assurance to support de-escalation of service to Level 3.
- Improved leadership evident via escalation meetings.
- Further audit being conducted around the referral processes to enable consideration of further de-escalation.

**What actions should we take:**

Action	Lead	Date
NCCU CAMHS review to provide the driver for the CAMHS work stream of the mental health strategy	Senior Planning Manager	Completed
Reviewed service specification	Senior Planning Manager	Completed
Monitor training status of the staff by QAIS	Shane Mills	Completed
Submission of a discussion papers followed by a business plan for Clinical Director Dr Krishna Menon for a Physician Associate.	Dr Krishna Menon	Completed
Confirm funding arrangements on staffing position for Nursing, Therapies, Medical Staff and Service Business Manager.	Director of Finance	Completed
Action plan developed following QAIS review conducted in March 22 and managed under escalation process.	Shane Mills	March 23
Work is currently underway by NCCU to consider referral processes and assessments.	NCCU	April 23

**Additional comments:**  
 July 21- The commissioning team reviewed the risk scores and agreed to lower the target score from 12 to 8 as it was originally scored too high  
 April 22 – Score to remain as it is subject to impact of completed actions.  
 June 22 – Risk remains at current level as risk of absconding is still prevalent  
 December 23 – Service de-escalated to Level 3 however work continues to consider referral processes and assessments

March 23 – Risk score remains the same  
 April 23 – Risk reviewed agreed it is appropriate for risk score to remain the same and to be reviewed May 22<sup>nd</sup>  
 May 23 – Risk remains the same

<b>Risk Ref: 26 - Neuropsychiatry patients waiting times (NCC046)</b> <b>Risk Domain:</b> Impact on the safety of patients, staff or public (physical/psychological harm) Population Health	<b>Director Lead:</b> Director of Mental Health <b>Assuring Committee:</b> Joint Committee
<b>Risk:</b> There is a risk that neuropsychiatry patients will not be able to be treated in a timely manner with the appropriate therapy support <i>due to</i> staffing issues. <i>The consequence patients will have</i> long waiting times to access the service and the lack of availability of step down facilities to support the acute centre will also result in delays.	<b>Date Added to Register:</b> 12/02/2020 <b>Moved to MH&amp; VG register July 21</b>  <b>Provider/s:</b> CVUHB
	<b>Date last reviewed by:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023

<p>Risk Rating (impact x likelihood)</p> <table border="1"> <tr> <td>Initial</td> <td>4x5</td> <td>20</td> </tr> <tr> <td>Current</td> <td>3x5</td> <td>15</td> </tr> <tr> <td>Target</td> <td>4x1</td> <td>4</td> </tr> </table>	Initial	4x5	20	Current	3x5	15	Target	4x1	4	<p>Risk Rating</p> <table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Rating</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>des-21</td><td>20</td><td>4</td></tr> <tr><td>jan-22</td><td>20</td><td>4</td></tr> <tr><td>feb-22</td><td>20</td><td>4</td></tr> <tr><td>mar-22</td><td>20</td><td>4</td></tr> <tr><td>apr-22</td><td>20</td><td>4</td></tr> <tr><td>mai-22</td><td>20</td><td>4</td></tr> <tr><td>jun-22</td><td>20</td><td>4</td></tr> <tr><td>jul-22</td><td>20</td><td>4</td></tr> <tr><td>aug-22</td><td>20</td><td>4</td></tr> <tr><td>sep-22</td><td>15</td><td>4</td></tr> <tr><td>okt-22</td><td>15</td><td>4</td></tr> <tr><td>nov-22</td><td>15</td><td>4</td></tr> <tr><td>des-22</td><td>15</td><td>4</td></tr> <tr><td>jan-23</td><td>15</td><td>4</td></tr> <tr><td>feb-23</td><td>15</td><td>4</td></tr> <tr><td>mar-23</td><td>15</td><td>4</td></tr> <tr><td>apr-23</td><td>15</td><td>4</td></tr> <tr><td>mai-23</td><td>15</td><td>4</td></tr> </tbody> </table>	Month	Risk Rating	Target	des-21	20	4	jan-22	20	4	feb-22	20	4	mar-22	20	4	apr-22	20	4	mai-22	20	4	jun-22	20	4	jul-22	20	4	aug-22	20	4	sep-22	15	4	okt-22	15	4	nov-22	15	4	des-22	15	4	jan-23	15	4	feb-23	15	4	mar-23	15	4	apr-23	15	4	mai-23	15	4	<p>Groups discussed risk during period</p> <ul style="list-style-type: none"> <li>Commissioning Team 24/01/22</li> <li>Commissioning Team 02/03/22</li> <li>Commissioning Team 27/04/22</li> <li>Commissioning Team 25/05/22</li> <li>Commissioning Team 26/06/22 – Not quorate</li> <li>Commissioning Team 27/07/22 – Cancelled</li> <li>Commissioning Team 24/08/22– Cancelled</li> <li>Commissioning Team 28/09/22</li> <li>Commissioning Team 24/10/22</li> <li>Commissioning Team 19/12/22</li> <li>Commissioning Team 23/01/23</li> <li>Commissioning Team 27/02/23 – Cancelled</li> <li>Commissioning Team 27/03/23</li> <li>Commissioning Team 24/04/23</li> <li>Commissioning Team 22/05/23</li> </ul>
Initial	4x5	20																																																																		
Current	3x5	15																																																																		
Target	4x1	4																																																																		
Month	Risk Rating	Target																																																																		
des-21	20	4																																																																		
jan-22	20	4																																																																		
feb-22	20	4																																																																		
mar-22	20	4																																																																		
apr-22	20	4																																																																		
mai-22	20	4																																																																		
jun-22	20	4																																																																		
jul-22	20	4																																																																		
aug-22	20	4																																																																		
sep-22	15	4																																																																		
okt-22	15	4																																																																		
nov-22	15	4																																																																		
des-22	15	4																																																																		
jan-23	15	4																																																																		
feb-23	15	4																																																																		
mar-23	15	4																																																																		
apr-23	15	4																																																																		
mai-23	15	4																																																																		

**What controls have we put in place for the risk:**

- Business case received
- Developed ICP scheme
- Service transferred to the Mental Health portfolio
- Planned six monthly review meetings with the service to ensure staff have the specific training, skill and expertise to meet the needs of the existing service and provide an equitable service across Wales
- Funding release was submitted to the March 2023 MG meeting for Phase 2A of the All-Wales Neuropsychiatry Scheme. The funding release was not approved and it is going back to the April 2023 MG meeting.

**What actions should we take:**

Action	Lead	Date
NCCCT to monitor the recovery plan through the six monthly Risk, Assurance and Recovery meeting.	Planning Manager	Six monthly
The scheme was scored 2 <sup>nd</sup> highest risk and has been included in the WHSSC ICP funding 21/22. Business Case received from the service in May 2021. Planning Manager to develop ICP scheme in collaboration with the Service.	Planning Manager	Completed
Funding releases paper being prepared for submission to July CDGB and monitoring group	Planning Manager	Completed
Funding release paper submitted to July Management group.	Planning Manager	Completed
Phase 2b to be considered within the mental health strategy	Senior Planning Manager	Completed
Neuropsychiatry data to be analysed to inform future mitigation actions	Senior Planning Manager	Completed

**Additional comments:**

From August 2021 the risk will be monitored going forward by the Mental Health & Vulnerable Group commissioning team as funding was approved July 21  
 CIAG approved phase 2a of Neuropsychiatry scheme phase 2b to be considered within mental health strategy.  
 June 22 – Second consultant appointed within service, therefore, risk to be discussed at July commissioning meeting with a view to lowering the risk. Phase 2a to be implemented during this financial year and CIAG bid for phase 2b should provide a basis to close this risk.

Sept 22 – Risk Score Lowered to 15 at commissioning team meeting 28/09/22. Further monitoring to continue following the implementation of further service development during 2022/23 and 2023/24.  
 March 23 – Risk score remains the same  
 April 23 – Risks reviewed agreed it is appropriate for risk score to remain the same and to be reviewed May 22<sup>nd</sup>  
 May 23 - Risk score remains the same

<b>Risk Ref: 28 Workforce and Capacity (CS3 / CD01)</b> <b>Risk Domain: Workforce and Capacity</b>	<b>Director Lead:</b> Committee Secretary <b>Assuring Committee:</b> CDGB
<b>Risk:</b> There is a risk that WHSSC is unable to keep up with the increasing work demand. Due to additional work related services currently commissioned through HB's or services which are new to Wales. As a consequence this could have an impact on teams to absorb the additional work.	<b>Date Added to Register:</b> 16.09.21
	<b>Date Last Reviewed by:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023



**What controls have we put in place for the risk:**

- A report was submitted to the Joint Committee on the 7 September 2021 and 15 March 2022 seeking support for an increase in the Direct Running Costs (DRC) budget to recruit additional staff.
- The CDGB approved the de-escalation of the workforce risk in March 2022 and it was removed from the CRAF in May 2022 and will be monitored on the corporate services directorate risk register. Following a review of risks at a risk workshop in September 2022, and in light of the increased workloads, on the 14 December 2022 the CDGB agreed to escalate the risk and increase the score from 12 to 16.
- Welsh Government has approved funding for PET project support posts and TSW to be hosted by WHSSC.
- In the long term a workforce strategy will be considered to assist with succession planning and the long term planning risk concerning workforce capacity.
- An executive OD session held in November 2022 focussed on current and future workforce and organisational development requirements. A short term workforce plan was developed to assist with the immediate issue of resourcing the increasing workforce demand. This is currently being monitored by the CDGB and is being discussed at OD sessions.
- A number of key strategic pieces of work and a general increase in the number of services has resulted in another significant increase in workloads across the organisation. The number of posts being recruited to has increased significantly over the last few months and this has had a knock on effect on the Corporate Services team who plan and assist the organisation with IT, HR and general resourcing.
- There is a lack of depth in workforce resource and cross cover as teams are small and this poses a risk to staff as workloads are increasing. In order to mitigate this in the short terms, workloads should be monitored and work should be prioritised.
- Some vacancies have arisen within the Finance department and there is a need to review the finance structure to ensure sufficient resource.
- A review of National Commissioning is currently underway and this may have an impact on staffing and resourcing across the organisation going forward. **The review is due to report by the end of May 2023.**
- Until the outcome of the review is known, vacancies are being recruited to and where funding has been agreed for new posts there are still being advertised and recruited to.**

**What actions should we take:**

Action	Lead	Date
JC approved a request to increase the Direct Running Costs (DRC) budget 2022-2023 on the 7 September 2021 to support the recruitment of the key posts to increase workforce capacity. <b>COMPLETED</b>	JE	7 September 2021
Workforce capacity review has been undertaken by CDGB and DRC shortfall to be utilised to recruit at risk for critical posts. <b>COMPLETED</b>	JE	Oct 2021
Corporate services team are working with CTMUHB to identify short terms admin pool of resource to support the administrative requirements of WHSSC, which are putting pressure on the teams. <b>COMPLETED and since then WHSSC has recruited via the bank and agency to assist with short term recruitment issues.</b>	JE	Oct 2021
An uplift to the DRC was approved by JC to allow for an additional Corporate resource. This post has now been filled substantively. <b>COMPLETED.</b>	JE	May 2022
Workforce plan developed following the Executive OD session to be monitored to ensure that the short-term impacts concerning staffing issues can be addressed. The plan will be monitored and updated to consider a mid to long-term workforce strategy for 2023-2024. This will include succession planning and capacity issues on a more strategic level.	JE	May 2023
Workloads to be monitored and work to be prioritised by Directors for their teams.	ALL	On-going

**Additional comments:**

The CDGB approved the de-escalation of the workforce risk in March 2022 and it was removed from the CRAF. Following a review of risks at a risk workshop in September 2022, and in light of the increased workloads, on the 14 December 2022 the CDGB agreed to escalate the risk and increase the score from 12 to 16. The organisation remains vulnerable as a number of departments are small and whilst recruitment is underway due to the time delay between advertising posts and staff commencing in post, there are workload challenges across the organisation.

<b>Risk Ref: 29 – WHSSC IPFR ToR &amp; Governance (CS8)</b> <b>Risk Domain:</b> Impact on the safety of patients, staff or public (physical/psychological harm) Population Health		<b>Director Lead:</b> Director of Nursing/Committee Secretary <b>Assuring Committee:</b> Joint Committee																									
<b>Risk -</b> There is a risk that WHSSC will be unable to meet the TOR for the All Wales IPFR panel due to the inability to achieve quoracy in the membership and consequently this may lead to delayed decision-making. In addition, there is also a risk that the current IPFR governance arrangements are not robust and as a consequence this may also lead to legal challenges in the form of judicial reviews.		<b>Date Added to Register:</b> 20/10/21  <b>Provider/s:</b> N/A	<b>Date last reviewed by:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023																								
Risk Rating (impact x likelihood)	<table border="1"> <tr> <td>Initial</td> <td>4x4</td> <td>16</td> </tr> <tr> <td><b>Current</b></td> <td><b>4x5</b></td> <td><b>20</b></td> </tr> <tr> <td>Target</td> <td>2x2</td> <td>4</td> </tr> </table>	Initial	4x4	16	<b>Current</b>	<b>4x5</b>	<b>20</b>	Target	2x2	4	<b>Risk Rating</b> 	<b>Groups discussed risk during period</b> RSG CDGB Quality Patient Safety Integrated Governance Committee															
Initial	4x4	16																									
<b>Current</b>	<b>4x5</b>	<b>20</b>																									
Target	2x2	4																									
<b>What controls have we put in place for the risk:</b> <ul style="list-style-type: none"> <li>A judicial review highlighted some deficiencies in the minutes and decision letters advising of a refusal to fund treatment. This de-brief has taken place and learning from this is being implemented.</li> <li>A review of the IPFR governance is underway. A member of the Corporate team will start attending IPFR and act as a governance lead advising the Chair etc. The governance lead will also be able to review the minutes, notes, and decision letters etc.</li> <li>A quality review of other IPFR notes from HB panels will be undertaken as a way of benchmarking.</li> <li>A meeting with Welsh Government took place on 10 May 2022 to discuss the authority of the Joint Committee to update and approve the ToR of the IPFR Panel, the governance process for updating the All Wales IPFR policy; and consideration of a wider review of the both the policy and governance framework of IPFR panels in Wales. WHSSC issued a letter to WG 23 May 2022. A response from WG was received on 28 July 2022 confirming agreement for WHSSC to proceed with a review of the WHSSC ToR and a “limited” review of the All Wales IPFR policy. The Joint Committee approved the approach on 6 September 2022.</li> <li>The NHS Wales Board Secretaries Group have been informed of the risk concerning the IPFR panel, and a private briefing session was arranged for them on IPFR governance for 10 June 2022.</li> <li>A new HB IM Interim Chair has been appointed from 1 August 2022 to ensure business continuity for a 6 month period to ensure business continuity. The Joint Committee approved that this interim could be extended until 31 March 2023, at its meeting on 8 November 2023.</li> <li>The formal engagement process to review the WHSSC IPFR panel ToR and the specific and limited review of the all Wales IPFR policy, was launched on 10 November 2022 for a 6 week period following the Joint Committee supporting the proposed engagement process at its meeting on the 8 November 2022. The engagement exercise closed on the 22 December 2022 and the findings are being reviewed.</li> <li>An IPFR stakeholder engagement event to review the WHSSC IPFR) panel ToR and a specific, limited review of the all Wales IPFR policy was held on the 2 December 2022, supported by a briefing from a Kings Counsel (KC) for the NHS Wales Medical Directors Peer Group and a stakeholder engagement session on the 2 December 2022.</li> <li>The updated WHSSC ToR were approved by the Joint Committee on 14 March 2023. In addition, the results of the engagement exercise for the All Wales Policy review were presented. Following approval of the ToR in March WHSSC are currently working on an implementation plan as the new ToR will involve some changes to the current membership and to ensure that HBs have sufficient time to review their WHSSC membership.</li> <li>WHSSC is also finalising the amendments to the All Wales IPFR Policy and will present this to the Joint Committee in July 2023 for approval.</li> </ul>		<b>What actions should we take:</b> <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>The Chair of the IPFR panel stepped down from the position on the 1 April 2022. WHSSC are now faced with a new challenge, as in order to recruit a suitably experienced Chair, we need to update the ToR to outline the increased time commitment and the consideration needs to be given to remunerating the chair for the time involved in dealing with complex IPFR applications. A new HB IM Interim Chair was appointed from 1 August 2022 to ensure business continuity. A further extension was approved by JC members to extend further until September 2023 so that the review of the ToR and IPFR policy can be concluded and further discussion on remuneration could also take place.</td> <td>Committee Secretary</td> <td>March 2023 September 2023</td> </tr> <tr> <td>An engagement process on the WHSSC IPFR panel ToR launched on 10 November 2022 for a 6 week period and included HBs, the AWTTTC and IPFR QAG. The engagement exercise closed on the 22 December 2023 and an update report will be taken to the JC in March 2023.</td> <td>Committee Secretary</td> <td>Complete</td> </tr> <tr> <td>The updated WHSSC ToR were presented to the Joint Committee 14 March 2023 for approval. In addition, the results of the engagement exercise for the All Wales Policy were presented.</td> <td>Committee Secretary</td> <td>Complete</td> </tr> <tr> <td>The Committee Secretary to keep the NHS Wales Board Secretaries peer group and Welsh Government informed of progress on developments.</td> <td>Committee Secretary</td> <td>On-going</td> </tr> <tr> <td>The updated All Wales IPFR Policy is scheduled to be presented to the Joint Committee in July 2023 for approval, prior to submission to the seven HBs for approval.</td> <td>Committee Secretary</td> <td>July 2023</td> </tr> <tr> <td>Full implementation of the new ToR and amended policy is planned for September 2023.</td> <td>Committee Secretary</td> <td>September 2023</td> </tr> <tr> <td>Meeting arranged with Welsh Government officials 31 May to discuss the recruitment process and potential remuneration of the Chair of the IPFR panel and lay members. A report will be submitted to the Joint Committee 18 July seeking approval for the recruitment process</td> <td>Committee Secretary</td> <td>July 2023</td> </tr> </tbody> </table>		Action	Lead	Date	The Chair of the IPFR panel stepped down from the position on the 1 April 2022. WHSSC are now faced with a new challenge, as in order to recruit a suitably experienced Chair, we need to update the ToR to outline the increased time commitment and the consideration needs to be given to remunerating the chair for the time involved in dealing with complex IPFR applications. A new HB IM Interim Chair was appointed from 1 August 2022 to ensure business continuity. A further extension was approved by JC members to extend further until September 2023 so that the review of the ToR and IPFR policy can be concluded and further discussion on remuneration could also take place.	Committee Secretary	March 2023 September 2023	An engagement process on the WHSSC IPFR panel ToR launched on 10 November 2022 for a 6 week period and included HBs, the AWTTTC and IPFR QAG. The engagement exercise closed on the 22 December 2023 and an update report will be taken to the JC in March 2023.	Committee Secretary	Complete	The updated WHSSC ToR were presented to the Joint Committee 14 March 2023 for approval. In addition, the results of the engagement exercise for the All Wales Policy were presented.	Committee Secretary	Complete	The Committee Secretary to keep the NHS Wales Board Secretaries peer group and Welsh Government informed of progress on developments.	Committee Secretary	On-going	The updated All Wales IPFR Policy is scheduled to be presented to the Joint Committee in July 2023 for approval, prior to submission to the seven HBs for approval.	Committee Secretary	July 2023	Full implementation of the new ToR and amended policy is planned for September 2023.	Committee Secretary	September 2023	Meeting arranged with Welsh Government officials 31 May to discuss the recruitment process and potential remuneration of the Chair of the IPFR panel and lay members. A report will be submitted to the Joint Committee 18 July seeking approval for the recruitment process	Committee Secretary	July 2023
Action	Lead	Date																									
The Chair of the IPFR panel stepped down from the position on the 1 April 2022. WHSSC are now faced with a new challenge, as in order to recruit a suitably experienced Chair, we need to update the ToR to outline the increased time commitment and the consideration needs to be given to remunerating the chair for the time involved in dealing with complex IPFR applications. A new HB IM Interim Chair was appointed from 1 August 2022 to ensure business continuity. A further extension was approved by JC members to extend further until September 2023 so that the review of the ToR and IPFR policy can be concluded and further discussion on remuneration could also take place.	Committee Secretary	March 2023 September 2023																									
An engagement process on the WHSSC IPFR panel ToR launched on 10 November 2022 for a 6 week period and included HBs, the AWTTTC and IPFR QAG. The engagement exercise closed on the 22 December 2023 and an update report will be taken to the JC in March 2023.	Committee Secretary	Complete																									
The updated WHSSC ToR were presented to the Joint Committee 14 March 2023 for approval. In addition, the results of the engagement exercise for the All Wales Policy were presented.	Committee Secretary	Complete																									
The Committee Secretary to keep the NHS Wales Board Secretaries peer group and Welsh Government informed of progress on developments.	Committee Secretary	On-going																									
The updated All Wales IPFR Policy is scheduled to be presented to the Joint Committee in July 2023 for approval, prior to submission to the seven HBs for approval.	Committee Secretary	July 2023																									
Full implementation of the new ToR and amended policy is planned for September 2023.	Committee Secretary	September 2023																									
Meeting arranged with Welsh Government officials 31 May to discuss the recruitment process and potential remuneration of the Chair of the IPFR panel and lay members. A report will be submitted to the Joint Committee 18 July seeking approval for the recruitment process	Committee Secretary	July 2023																									
<b>Additional comments:</b> The IPFR process gained political attention during the Senedd’s Plenary session on the 23 March 2022 and Members of the Senedd (MS) asked questions concerning the IPFR process.																											

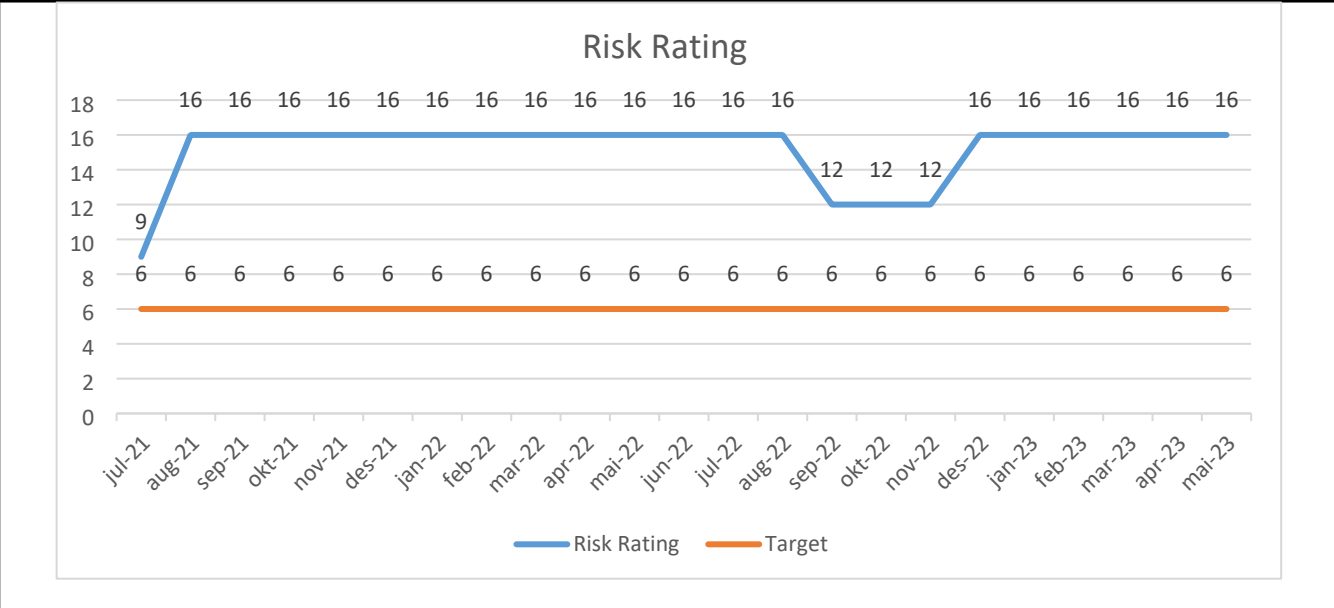
<b>Risk Ref: 33 - Welsh Government Priority Delivery Measures (CD03) (CS10)</b> <b>Risk Domain:</b> Impact on the safety of patients, staff or public (physical/psychological harm) Population Health		<b>Director Lead:</b> Director of Planning <b>Assuring Committee:</b> Joint Committee																			
There is a risk the Welsh Provider Health Boards will not be able to deliver specialised services in line with the new Priority Measures due to the waiting list backlog and the shortfall in capacity as a consequence the measures will not met, patients will be waiting outside of the waiting times within the measures and WHSSC may need to seek commissioning alternatives		<b>Date Added to Register:</b> 26 January 2022	<b>Date last reviewed by:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023																		
		<b>Provider/s:</b> All																			
Risk Rating (impact x likelihood)		<b>Groups discussed risk during period</b>																			
<table border="1"> <tr> <td>Initial</td> <td>4x5</td> <td>20</td> </tr> <tr> <td>Current</td> <td>4X5</td> <td>20</td> </tr> <tr> <td>Target</td> <td>3X3</td> <td>9</td> </tr> </table>		Initial	4x5	20	Current	4X5	20	Target	3X3	9	<p>The chart displays the Risk Rating (blue line) and Target (orange line) from January 2022 to May 2023. The Risk Rating remains constant at 20, while the Target is constant at 9.</p>										
Initial	4x5	20																			
Current	4X5	20																			
Target	3X3	9																			
<b>What controls have we put in place for the risk:</b> <ul style="list-style-type: none"> <li>WHSSC are working with HBs to share infrastructure and to develop regional approaches for high volume and specialist services.</li> <li>The JC and MG receive regular updates specialised services performance at each meeting</li> <li>The Integrated Governance Committee (IGC) oversees the Joint Committee's Integrated Commissioning Plan (ICP) for Specialised Services, scrutinising the delivery and performance of the plan. They receive regular updates on progress.</li> <li>The ICP approved by the Joint Committee on the 8 February 2022 included reference to the new measures.</li> <li>The Joint Committee received a report on the proposed WHSSC process for responding to the Ministerial Priority Measures on the 15 March 2022. The Joint Committee held a recovery workshop on the 12 July 2022 during which the Committee received comprehensive recovery presentations from providers on recovery trajectories across NHS Wales. These will be kept under review over the next few months.</li> <li>A follow up workshop was held on the 6 September at the request of the Joint Committee to focus on Paediatric recovery trajectories.</li> <li>The JC received a Recovery Update (incl Progress with Paediatric Surgery) at its meeting on 8 November 2022, and a further update will be presented on 17 January 2023.</li> <li>It was agreed with the JC in November to use the approved Escalation Framework for performance reasons and this was implemented in 3 specialties including paediatric surgery.</li> <li>We have refreshed and developed our Performance Management Framework after the pandemic, this was approved by CDGB in March 2023 and was shared with Management Group in March 2023. MG supported the approach and this will be taken to the JC for approval in May 2023.</li> <li><b>A new Performance report is being introduced and will be taken to the June 2023 MG meeting.</b></li> </ul>		<b>What actions should we take:</b> <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>The ICP was approved to the Joint Committee on the 8 February 2022 and has been submitted to Welsh Government and the planning teams at Health Boards for inclusion within the HB Integrated Medium Term Plan's (IMTP's).</td> <td>NJ/AD</td> <td>Completed</td> </tr> <tr> <td>The JC and MG will receive routine reports at each meeting on the performance of specialised services, and the impact of waiting list backlog and the shortfall in capacity.</td> <td>NJ/SD</td> <td>Monthly</td> </tr> <tr> <td>The JC held recovery workshops on 12 July, 6 September and 8 November 2022 and a number of actions were agreed which help inform further discussions. The recovery trajectories will be kept under review and monitored.</td> <td>NJ/SD</td> <td>Completed</td> </tr> <tr> <td>Following the JC recovery update on paediatric trajectories 6 September 2022 it was agreed to hold a further session in January 2023 to focus on recovery trajectories.</td> <td>NJ/SD</td> <td>Completed</td> </tr> <tr> <td>Three specialties were put into Level 1 Escalation for performance reasons in December 2022; bariatrics and plastics in SBU and paediatric surgery in CVUHB. Progress is monitored weekly and there have been improvements in both bariatrics and plastics. In March it was agreed to further escalate paediatric surgery to Level 3.</td> <td>NJ/SD</td> <td>Completed</td> </tr> </tbody> </table>		Action	Lead	Date	The ICP was approved to the Joint Committee on the 8 February 2022 and has been submitted to Welsh Government and the planning teams at Health Boards for inclusion within the HB Integrated Medium Term Plan's (IMTP's).	NJ/AD	Completed	The JC and MG will receive routine reports at each meeting on the performance of specialised services, and the impact of waiting list backlog and the shortfall in capacity.	NJ/SD	Monthly	The JC held recovery workshops on 12 July, 6 September and 8 November 2022 and a number of actions were agreed which help inform further discussions. The recovery trajectories will be kept under review and monitored.	NJ/SD	Completed	Following the JC recovery update on paediatric trajectories 6 September 2022 it was agreed to hold a further session in January 2023 to focus on recovery trajectories.	NJ/SD	Completed	Three specialties were put into Level 1 Escalation for performance reasons in December 2022; bariatrics and plastics in SBU and paediatric surgery in CVUHB. Progress is monitored weekly and there have been improvements in both bariatrics and plastics. In March it was agreed to further escalate paediatric surgery to Level 3.	NJ/SD	Completed
Action	Lead	Date																			
The ICP was approved to the Joint Committee on the 8 February 2022 and has been submitted to Welsh Government and the planning teams at Health Boards for inclusion within the HB Integrated Medium Term Plan's (IMTP's).	NJ/AD	Completed																			
The JC and MG will receive routine reports at each meeting on the performance of specialised services, and the impact of waiting list backlog and the shortfall in capacity.	NJ/SD	Monthly																			
The JC held recovery workshops on 12 July, 6 September and 8 November 2022 and a number of actions were agreed which help inform further discussions. The recovery trajectories will be kept under review and monitored.	NJ/SD	Completed																			
Following the JC recovery update on paediatric trajectories 6 September 2022 it was agreed to hold a further session in January 2023 to focus on recovery trajectories.	NJ/SD	Completed																			
Three specialties were put into Level 1 Escalation for performance reasons in December 2022; bariatrics and plastics in SBU and paediatric surgery in CVUHB. Progress is monitored weekly and there have been improvements in both bariatrics and plastics. In March it was agreed to further escalate paediatric surgery to Level 3.	NJ/SD	Completed																			
<b>Additional comments:</b> Cross Directorate Risk (CD03) - WG set 34 new Priority Delivery measures that will be formally monitored from April 2022 onwards. NHS bodies are expected to align their developing Integrated Medium term Plans (IMTPs) towards delivering these priorities and measures, and where necessary, to bring forward key actions that will ensure these are the focus for the whole organisation. There is a risk that WHSSC will be unable to deliver specialised services it has committed to delivering in the Integrated Commissioning Plan (ICP) due to the waiting list backlog.																					

<b>Risk Ref: 34 - Lack of Paediatric Intensive Care Beds (P/21/02)</b> <b>Risk Domain: Workforce</b>		<b>Director Lead:</b> Director of Planning <b>Assuring Committee:</b> Joint Committee																																																																																											
<b>Risk:</b> There is a risk that a paediatric intensive care bed, in the Children’s Hospital for Wales, will not be available when required due to constraints within the service. There is a consequence that paediatric patients requiring intensive care will be cared for in, inappropriate areas where the necessary skills or equipment are not available or the patient being transferred out of Wales.		<b>Date Added to Register:</b> 24/02/21  <b>Provider/s:</b> C&VUHB	<b>Date last reviewed by:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023																																																																																										
<b>Risk Rating</b> (impact x likelihood)	<table border="1"> <tr> <td>Initial</td> <td>3x4</td> <td>12</td> </tr> <tr> <td>Current</td> <td>4x5</td> <td>20</td> </tr> <tr> <td>Target</td> <td>2x2</td> <td>4</td> </tr> </table>	Initial	3x4	12	Current	4x5	20	Target	2x2	4	<b>Risk Rating</b> <table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Rating</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>apr-21</td><td>12</td><td>4</td></tr> <tr><td>mai-21</td><td>12</td><td>4</td></tr> <tr><td>jun-21</td><td>12</td><td>4</td></tr> <tr><td>jul-21</td><td>12</td><td>4</td></tr> <tr><td>aug-21</td><td>12</td><td>4</td></tr> <tr><td>sep-21</td><td>16</td><td>4</td></tr> <tr><td>okt-21</td><td>16</td><td>4</td></tr> <tr><td>nov-21</td><td>16</td><td>4</td></tr> <tr><td>des-21</td><td>16</td><td>4</td></tr> <tr><td>jan-22</td><td>16</td><td>4</td></tr> <tr><td>feb-22</td><td>16</td><td>4</td></tr> <tr><td>mar-22</td><td>16</td><td>4</td></tr> <tr><td>apr-22</td><td>16</td><td>4</td></tr> <tr><td>mai-22</td><td>16</td><td>4</td></tr> <tr><td>jun-22</td><td>16</td><td>4</td></tr> <tr><td>jul-22</td><td>16</td><td>4</td></tr> <tr><td>aug-22</td><td>16</td><td>4</td></tr> <tr><td>sep-22</td><td>16</td><td>4</td></tr> <tr><td>okt-22</td><td>16</td><td>4</td></tr> <tr><td>nov-22</td><td>16</td><td>4</td></tr> <tr><td>des-22</td><td>16</td><td>4</td></tr> <tr><td>jan-23</td><td>20</td><td>4</td></tr> <tr><td>feb-23</td><td>20</td><td>4</td></tr> <tr><td>mar-23</td><td>20</td><td>4</td></tr> <tr><td>apr-23</td><td>20</td><td>4</td></tr> <tr><td>mai-23</td><td>20</td><td>4</td></tr> </tbody> </table>	Month	Risk Rating	Target	apr-21	12	4	mai-21	12	4	jun-21	12	4	jul-21	12	4	aug-21	12	4	sep-21	16	4	okt-21	16	4	nov-21	16	4	des-21	16	4	jan-22	16	4	feb-22	16	4	mar-22	16	4	apr-22	16	4	mai-22	16	4	jun-22	16	4	jul-22	16	4	aug-22	16	4	sep-22	16	4	okt-22	16	4	nov-22	16	4	des-22	16	4	jan-23	20	4	feb-23	20	4	mar-23	20	4	apr-23	20	4	mai-23	20	4	<b>Groups discussed risk during period</b>  Commissioning Team - 21/06/22 Commissioning Team - 26/07/22 Commissioning Team - 23/08/22 Commissioning Team - 21/09/22 Commissioning Team - 18/10/22 Commissioning Team - 21/11/22 Commissioning Team - 19/12/22 Commissioning Team - 24/01/23 Commissioning Team - 21/02/23 Commissioning Team - 21/03/23 Commissioning Team - 20/04/23 Commissioning Team - 16/05/23
Initial	3x4	12																																																																																											
Current	4x5	20																																																																																											
Target	2x2	4																																																																																											
Month	Risk Rating	Target																																																																																											
apr-21	12	4																																																																																											
mai-21	12	4																																																																																											
jun-21	12	4																																																																																											
jul-21	12	4																																																																																											
aug-21	12	4																																																																																											
sep-21	16	4																																																																																											
okt-21	16	4																																																																																											
nov-21	16	4																																																																																											
des-21	16	4																																																																																											
jan-22	16	4																																																																																											
feb-22	16	4																																																																																											
mar-22	16	4																																																																																											
apr-22	16	4																																																																																											
mai-22	16	4																																																																																											
jun-22	16	4																																																																																											
jul-22	16	4																																																																																											
aug-22	16	4																																																																																											
sep-22	16	4																																																																																											
okt-22	16	4																																																																																											
nov-22	16	4																																																																																											
des-22	16	4																																																																																											
jan-23	20	4																																																																																											
feb-23	20	4																																																																																											
mar-23	20	4																																																																																											
apr-23	20	4																																																																																											
mai-23	20	4																																																																																											
<b>What controls have we put in place for the risk:</b> <ul style="list-style-type: none"> <li>Investment through WHSSC 2019/20 ICP to increase bed capacity to meet demand</li> <li>Ongoing monitoring at Quarterly Commissioner Assurance Meeting with provider</li> <li>Completed winter surge plan for 2021/22 which sets out clear escalation management across the South West of England region</li> <li>Received Health Board surge plan for 2022/ 23</li> <li>Reviewed information on adverse incidents have occurred as a consequence of bed availability</li> <li>Discussed Collaborative working between Adult Critical Care and Paediatric Critical Care</li> <li>Health board escalated to level 2 in line with WHSSC escalation framework</li> </ul>		<b>What actions should we take:</b> <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td> <ul style="list-style-type: none"> <li>Request information from Health Board in advance of Quarterly Commissioner Assurance Meeting to seek update on current capacity including: <ul style="list-style-type: none"> <li>Refusal rates against SLA</li> <li>Staffing establishment</li> <li>Implementation of investment</li> <li>Commissioned bed availability</li> </ul> </li> </ul> </td> <td>W&amp;C Planner</td> <td>Quarterly</td> </tr> <tr> <td> <ul style="list-style-type: none"> <li>Review risk score following analysis of data and assurances presented at Quarterly Commissioner Assurance Meeting.</li> </ul> </td> <td>W&amp;C</td> <td>Quarterly</td> </tr> <tr> <td> <ul style="list-style-type: none"> <li>Requested amended surge plan following collaborative working discussion with Adult Critical Care colleagues.</li> </ul> </td> <td>W&amp;C planner</td> <td>31/05/2023</td> </tr> <tr> <td> <ul style="list-style-type: none"> <li>Requested action plan against the escalation objectives</li> </ul> </td> <td>W&amp;C planner</td> <td>01/06/2023</td> </tr> </tbody> </table>		Action	Lead	Date	<ul style="list-style-type: none"> <li>Request information from Health Board in advance of Quarterly Commissioner Assurance Meeting to seek update on current capacity including: <ul style="list-style-type: none"> <li>Refusal rates against SLA</li> <li>Staffing establishment</li> <li>Implementation of investment</li> <li>Commissioned bed availability</li> </ul> </li> </ul>	W&C Planner	Quarterly	<ul style="list-style-type: none"> <li>Review risk score following analysis of data and assurances presented at Quarterly Commissioner Assurance Meeting.</li> </ul>	W&C	Quarterly	<ul style="list-style-type: none"> <li>Requested amended surge plan following collaborative working discussion with Adult Critical Care colleagues.</li> </ul>	W&C planner	31/05/2023	<ul style="list-style-type: none"> <li>Requested action plan against the escalation objectives</li> </ul>	W&C planner	01/06/2023																																																																											
Action	Lead	Date																																																																																											
<ul style="list-style-type: none"> <li>Request information from Health Board in advance of Quarterly Commissioner Assurance Meeting to seek update on current capacity including: <ul style="list-style-type: none"> <li>Refusal rates against SLA</li> <li>Staffing establishment</li> <li>Implementation of investment</li> <li>Commissioned bed availability</li> </ul> </li> </ul>	W&C Planner	Quarterly																																																																																											
<ul style="list-style-type: none"> <li>Review risk score following analysis of data and assurances presented at Quarterly Commissioner Assurance Meeting.</li> </ul>	W&C	Quarterly																																																																																											
<ul style="list-style-type: none"> <li>Requested amended surge plan following collaborative working discussion with Adult Critical Care colleagues.</li> </ul>	W&C planner	31/05/2023																																																																																											
<ul style="list-style-type: none"> <li>Requested action plan against the escalation objectives</li> </ul>	W&C planner	01/06/2023																																																																																											
<b>Additional comments:</b> June 22 – Quarterly Assurance meeting has not taken place since last update (May 22) July 2022 – W&C Commissioning team discussed and reviewed the risk. Quarterly Assurance meeting took place 18 <sup>th</sup> July 2022 we were notified a number of refusals in quarter 1 as a result of staff shortages Dec 22 – As service has been in a period of surge throughout December the risk score has increased. Apr 23 – W&C Commissioning team reviewed the risk which remains unchanged. May 23 - W&C Commissioning team reviewed the risk which remains unchanged.																																																																																													

<b>Risk Ref: 35 Bed Capacity Mental Health Patients (MH/21/06)</b> <b>Risk Domain: Impact on the safety of patients, staff or public (physical/psychological harm)</b>	<b>Director Lead:</b> Director of Mental Health <b>Assuring Committee:</b> Joint Committee
<b>Risk: There is a risk that mental health patients will be unable to gain a placement <i>due to</i> the lack of available UK beds, which as <i>a consequence</i> may result in inappropriate placement</b>	<b>Date Added to Register:</b> 24/02/21
	<b>Provider/s:</b> SBUHB, BCUHB, NHS England, Independent Sector
<b>Date Last Reviewed by:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023	

Risk Rating  
(impact x likelihood)

Initial	3x3	9
Current	4x4	16
Target	3x2	6



**Groups discussed risk during period**

- Commissioning Team 27/04/22
- Commissioning Team 25/05/22
- Commissioning Team 26/06/22
- Commissioning Team 26/06/22 – Not quorate
- Commissioning Team 27/07/22 – Cancelled
- Commissioning Team 24/08/22 – Cancelled
- Commissioning Team 28/09/22
- Commissioning Team 24/10/22
- Commissioning Team 19/12/22
- Commissioning Team 23/01/23
- Commissioning Team 27/02/23 – Cancelled
- Commissioning Team 27/03/23
- Commissioning Team 24/04/23
- Commissioning Team 22/05/23

**What controls have we put in place for the risk:**

- Assessment undertaken of bed capacity and demand
- Commissioning strategy to be developed
- Restructure of NHS England in to provider collaborative will further impact the availability if UK beds therefore this risk will be monitored closely.

**What actions should we take:**

Action	Lead	Date
Secure work stream is being considered under the mental health strategy.	Senior Planning Manager	Completed
Secure Services considered in its entirety under the MH strategy	Senior Planning Manager	April 24

**Additional comments:**  
 Risk discussed at July 2021 commissioning team meeting for clarity on risk title, controls in place and further actions required.  
 Discussed at August 2021 Commissioning team and score raised due to national pressures, closure of one unit in England and ongoing ligature works in Caswell.  
 Jan 22 - MH &VG Commissioning Team advised despite 80 surge beds being purchased until the end of March 22 the risk remains high and likely to increase further.  
 June 22 – Strategy out for stakeholder feedback until July 22  
 Sept 22 – Lower risk score agreed at Commissioning Team 28/09/22 due to repatriation plans in place for Welsh patients from NHSE  
 December 22 – Risk score increased at Commissioning Team on 19<sup>th</sup> December to reflect pressure in the NHSE medium secure bed provision  
 March 23 – Risk score remains the same  
 April 23 – Risk reviewed agreed it is appropriate for risk score to remain the same and to be reviewed May 22<sup>nd</sup>  
 May 23 – NHS England informed no capacity for medium secure placement in NHS England or Independent Sector therefore we may be in a position where we are unable to place

<b>Risk Ref: 38 – No neonatal cot availability in South Wales due to staffing shortages ( P/21/16)</b> <b>Risk Domain:</b> Impact on the safety of patients, staff or public (physical/psychological harm) Population Health		<b>Director Lead:</b> Director of Planning <b>Assuring Committee:</b> Joint Committee																																														
<b>Risk:</b> There is a risk that there will not be a Neonatal cot available across the south Wales region due to significant neonatal nursing shortages. There is a consequence that babies will need to travel to NHS England to receive their care or be cared for in an inappropriate setting whilst waiting for an available cot.		<b>Date Added to Register:</b> 26/07/2022	<b>Date last reviewed by:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023																																													
<b>Provider/s:</b> ABUHB, CTMUHB, CVUHB, HDUHB, SBUHB		<b>Groups discussed risk during period</b>																																														
<b>Risk Rating</b> (impact x likelihood)	<table border="1"> <tr> <td>Initial</td> <td>4x4</td> <td>16</td> </tr> <tr> <td><b>Current</b></td> <td><b>4x4</b></td> <td><b>16</b></td> </tr> <tr> <td>Target</td> <td>2x2</td> <td>4</td> </tr> </table>	Initial	4x4	16	<b>Current</b>	<b>4x4</b>	<b>16</b>	Target	2x2	4	<table border="1"> <caption>Risk Rating Line Chart Data</caption> <thead> <tr> <th>Month</th> <th>Risk Rating</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>Jul-22</td><td>16</td><td>4</td></tr> <tr><td>Aug-22</td><td>16</td><td>4</td></tr> <tr><td>Sep-22</td><td>16</td><td>4</td></tr> <tr><td>Oct-22</td><td>16</td><td>4</td></tr> <tr><td>Nov-22</td><td>16</td><td>4</td></tr> <tr><td>Dec-22</td><td>16</td><td>4</td></tr> <tr><td>Jan-23</td><td>16</td><td>4</td></tr> <tr><td>Feb-23</td><td>16</td><td>4</td></tr> <tr><td>Mar-23</td><td>16</td><td>4</td></tr> <tr><td>Apr-23</td><td>16</td><td>4</td></tr> <tr><td>May-23</td><td>16</td><td>4</td></tr> </tbody> </table>	Month	Risk Rating	Target	Jul-22	16	4	Aug-22	16	4	Sep-22	16	4	Oct-22	16	4	Nov-22	16	4	Dec-22	16	4	Jan-23	16	4	Feb-23	16	4	Mar-23	16	4	Apr-23	16	4	May-23	16	4	Commissioning Team 26/07/2022 Commissioning Team – 21/09/22 Commissioning Team – 18/10/22 Commissioning Team - 21/11/22 Commissioning Team – 19/12/22 Commissioning Team - 24/01/23 Commissioning Team - 21/02/23 Commissioning Team - 21/03/23 Commissioning Team - 20/04/23 Commissioning Team - 16/05/23
Initial	4x4	16																																														
<b>Current</b>	<b>4x4</b>	<b>16</b>																																														
Target	2x2	4																																														
Month	Risk Rating	Target																																														
Jul-22	16	4																																														
Aug-22	16	4																																														
Sep-22	16	4																																														
Oct-22	16	4																																														
Nov-22	16	4																																														
Dec-22	16	4																																														
Jan-23	16	4																																														
Feb-23	16	4																																														
Mar-23	16	4																																														
Apr-23	16	4																																														
May-23	16	4																																														
<b>What controls have we put in place for the risk:</b> <ul style="list-style-type: none"> <li>WHSSC are attending (the scheduled) SITREP meeting(s), hosted by the Maternity and Neonatal Network where the neonatal unit and maternity position is discussed. The daily SITREP meetings continue to take place, these meetings still show significant fragility within the system, and despite the cot work progressing there will be a lead in time before this will help.</li> <li>Notified Welsh Government and (WHSSC/Health Board) Directors of Nursing of current risk.</li> <li>Continue to monitor at Quarterly Commissioner Assurance Meeting encouraging an open dialogue in the interim, as necessary, with all providers, to understand refusal rates and staffing numbers.</li> <li><b>New cot day tariff implemented, overall investment of over £5m for the South &amp; West Wales</b></li> </ul>		<b>What actions should we take:</b> <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>Requested an escalation plan from each provider, on what steps are taken when staffing falls below the numbers required to open all commissioned cots</td> <td>Planning Manager</td> <td>completed</td> </tr> <tr> <td>Requested information from all provider Health Boards in advance of Quarterly Commissioner Assurance Meeting, to seek update on current position:               <ul style="list-style-type: none"> <li>Refusal rates and reasons for declined admissions</li> <li>Staffing establishment</li> <li>Adverse incidents / near misses as a consequence of closing cots and / or working over capacity</li> </ul> </td> <td>Planning Manager</td> <td>Quarterly</td> </tr> <tr> <td>The NICU visits have taken place and have been very productive and well received. Reference to these visits and the outcomes have been made in the August Quality Patient Safety report. The final NICU visit is scheduled for 05/10/22 and therefore, the action will be closed on this date.</td> <td>Head of Quality WHSSC</td> <td>Completed</td> </tr> <tr> <td>WHSSC to arrange a workforce workshop</td> <td>Planning Manager</td> <td>06 June 2023</td> </tr> </tbody> </table>		Action	Lead	Date	Requested an escalation plan from each provider, on what steps are taken when staffing falls below the numbers required to open all commissioned cots	Planning Manager	completed	Requested information from all provider Health Boards in advance of Quarterly Commissioner Assurance Meeting, to seek update on current position: <ul style="list-style-type: none"> <li>Refusal rates and reasons for declined admissions</li> <li>Staffing establishment</li> <li>Adverse incidents / near misses as a consequence of closing cots and / or working over capacity</li> </ul>	Planning Manager	Quarterly	The NICU visits have taken place and have been very productive and well received. Reference to these visits and the outcomes have been made in the August Quality Patient Safety report. The final NICU visit is scheduled for 05/10/22 and therefore, the action will be closed on this date.	Head of Quality WHSSC	Completed	WHSSC to arrange a workforce workshop	Planning Manager	06 June 2023																														
Action	Lead	Date																																														
Requested an escalation plan from each provider, on what steps are taken when staffing falls below the numbers required to open all commissioned cots	Planning Manager	completed																																														
Requested information from all provider Health Boards in advance of Quarterly Commissioner Assurance Meeting, to seek update on current position: <ul style="list-style-type: none"> <li>Refusal rates and reasons for declined admissions</li> <li>Staffing establishment</li> <li>Adverse incidents / near misses as a consequence of closing cots and / or working over capacity</li> </ul>	Planning Manager	Quarterly																																														
The NICU visits have taken place and have been very productive and well received. Reference to these visits and the outcomes have been made in the August Quality Patient Safety report. The final NICU visit is scheduled for 05/10/22 and therefore, the action will be closed on this date.	Head of Quality WHSSC	Completed																																														
WHSSC to arrange a workforce workshop	Planning Manager	06 June 2023																																														
<b>Additional comments:</b> Aug 22 - This risk replaces closed risk P/21/15 as the staffing shortages encountered are variable depending on the shift in question and are across all units. Oct 22 – nursing shortage remain and therefore no change to score. Mar 23 – W&C Commissioning team reviewed the risk which remains unchanged. Apr 23 – W&C Commissioning team reviewed the risk which remains unchanged. <b>May 23 - W&amp;C Commissioning team reviewed the risk which remains unchanged.</b>																																																

<b>Risk Ref: 39 Renal Funding (WKN 06)</b> <b>Risk Domain:</b> Finance including claims	<b>Director Lead:</b> Programme Director, WKN <b>Assuring Committee:</b> Joint Committee
<b>Risk:</b> There is a risk that now there is an inability to meet service demand through ring fenced budget allocations that life maintaining treatment may not be available. <b>As a consequence</b> additional investment is required through ICP process to sustain current services and manage growth and inflationary uplifts.	<b>Date Added to Register:</b> 14/12/22 Provider/s N/A
	<b>Date Last Reviewed by:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023



<p><b>What controls have we put in place for the risk:</b></p> <ul style="list-style-type: none"> <li>• Priority linked to safety and capacity. Financial reviews ongoing as part of management team workload.</li> <li>• Forecast activity modelling embedded. Steady state as 4% year on year growth tested annually.</li> <li>• Support for Health Boards to manage contracts effectively provided by recruitment of Deputy Network Manager, Contracting Assurance. (May 2022)</li> <li>• Renal activity and quality assurance to be included as a standing item on WHSSC SLA reviews with regional centres.</li> <li>• <b>Growth funding agreed in ICP for 2023/24</b></li> </ul>	<p><b>What actions should we take:</b></p> <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>Completion of forward look demand and capacity model aligned with finance modelling.</td> <td>WKN Manager/WKN QPS Lead/WKN Finance Manager/WKN Director</td> <td>completed</td> </tr> <tr> <td>Participate in SLA reviews with Regional Health Board Renal Centres.</td> <td>WKN Manager/WKN QPS Lead/WKN Director</td> <td>Quarterly through 2023</td> </tr> <tr> <td>Review contract inflationary uplift mechanisms to separate growth factors i.e. staffing, consumable, utility costs to enable more nuanced negotiations with independent service providers (ISPs)</td> <td>WKN Manager/WKN Finance Manager/ Procurement.</td> <td>Partially completed Growth included in ICP</td> </tr> <tr> <td><b>Contract baselines to be reviewed so that service lines are clear and understood and linked to a clear allocation</b></td> <td><b>WKN deputy manager/WKN finance manager</b></td> <td><b>June 23</b></td> </tr> </tbody> </table>	Action	Lead	Date	Completion of forward look demand and capacity model aligned with finance modelling.	WKN Manager/WKN QPS Lead/WKN Finance Manager/WKN Director	completed	Participate in SLA reviews with Regional Health Board Renal Centres.	WKN Manager/WKN QPS Lead/WKN Director	Quarterly through 2023	Review contract inflationary uplift mechanisms to separate growth factors i.e. staffing, consumable, utility costs to enable more nuanced negotiations with independent service providers (ISPs)	WKN Manager/WKN Finance Manager/ Procurement.	Partially completed Growth included in ICP	<b>Contract baselines to be reviewed so that service lines are clear and understood and linked to a clear allocation</b>	<b>WKN deputy manager/WKN finance manager</b>	<b>June 23</b>
Action	Lead	Date														
Completion of forward look demand and capacity model aligned with finance modelling.	WKN Manager/WKN QPS Lead/WKN Finance Manager/WKN Director	completed														
Participate in SLA reviews with Regional Health Board Renal Centres.	WKN Manager/WKN QPS Lead/WKN Director	Quarterly through 2023														
Review contract inflationary uplift mechanisms to separate growth factors i.e. staffing, consumable, utility costs to enable more nuanced negotiations with independent service providers (ISPs)	WKN Manager/WKN Finance Manager/ Procurement.	Partially completed Growth included in ICP														
<b>Contract baselines to be reviewed so that service lines are clear and understood and linked to a clear allocation</b>	<b>WKN deputy manager/WKN finance manager</b>	<b>June 23</b>														

**Additional comments:**  
 March 23 – The WKN core team discussed the risk and agreed the current score should remain the same in light of the cost of living pressures impacting of the inflationary uplifts requested by the ISPs  
**May 23 - The WKN team discussed the risk and agreed the score remains the same**

<b>Risk Ref: 40 Limited outpatient dialysis capacity in Swansea (WKN 08)</b> <b>Risk Domain:</b> Impact on the safety of patients, staff or public (physical/psychological harm)		<b>Director Lead:</b> Programme Director, WKN <b>Assuring Committee:</b> WKN Board																																																																
<b>Risk:</b> There is a risk that the number of patients receiving outpatient haemodialysis in Morriston will exceed capacity. As a consequence, there is need for expansion of outpatient service provision to include demand from the Neath Port Talbot area and Bridgend localities.		<b>Date Added to Register:</b> 14/12/22  <b>Provider/s</b> SBUHB	<b>Date Last Reviewed by:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023																																																															
<p style="text-align: center;">Risk Rating (impact x likelihood)</p> <table border="1"> <tr> <td>Initial</td> <td>3x4</td> <td>12</td> </tr> <tr> <td><b>Current</b></td> <td><b>4x4</b></td> <td><b>16</b></td> </tr> <tr> <td>Target</td> <td>2x1</td> <td>2</td> </tr> </table>	Initial	3x4	12	<b>Current</b>	<b>4x4</b>	<b>16</b>	Target	2x1	2	<p style="text-align: center;">Risk Rating</p> <table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Rating</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>Jan-22</td><td>9</td><td>2</td></tr> <tr><td>Feb-22</td><td>9</td><td>2</td></tr> <tr><td>Mar-22</td><td>9</td><td>2</td></tr> <tr><td>Apr-22</td><td>9</td><td>2</td></tr> <tr><td>May-22</td><td>9</td><td>2</td></tr> <tr><td>Jun-22</td><td>9</td><td>2</td></tr> <tr><td>Jul-22</td><td>9</td><td>2</td></tr> <tr><td>Aug-22</td><td>9</td><td>2</td></tr> <tr><td>Sep-22</td><td>16</td><td>2</td></tr> <tr><td>Oct-22</td><td>16</td><td>2</td></tr> <tr><td>Nov-22</td><td>16</td><td>2</td></tr> <tr><td>Dec-22</td><td>16</td><td>2</td></tr> <tr><td>Jan-23</td><td>16</td><td>2</td></tr> <tr><td>Feb-23</td><td>16</td><td>2</td></tr> <tr><td>Mar-23</td><td>16</td><td>2</td></tr> <tr><td>Apr-23</td><td>16</td><td>2</td></tr> <tr><td>May-23</td><td>16</td><td>2</td></tr> </tbody> </table>		Month	Risk Rating	Target	Jan-22	9	2	Feb-22	9	2	Mar-22	9	2	Apr-22	9	2	May-22	9	2	Jun-22	9	2	Jul-22	9	2	Aug-22	9	2	Sep-22	16	2	Oct-22	16	2	Nov-22	16	2	Dec-22	16	2	Jan-23	16	2	Feb-23	16	2	Mar-23	16	2	Apr-23	16	2	May-23	16	2	<p style="text-align: center;"><b>Groups discussed risk during period</b></p> September 2022 WKN QPS/Management Meeting August 2022 WKN Core Team Meeting October Core Team Meeting CDGB – 27 April 2023 4 April 2023 WKN Board
Initial	3x4	12																																																																
<b>Current</b>	<b>4x4</b>	<b>16</b>																																																																
Target	2x1	2																																																																
Month	Risk Rating	Target																																																																
Jan-22	9	2																																																																
Feb-22	9	2																																																																
Mar-22	9	2																																																																
Apr-22	9	2																																																																
May-22	9	2																																																																
Jun-22	9	2																																																																
Jul-22	9	2																																																																
Aug-22	9	2																																																																
Sep-22	16	2																																																																
Oct-22	16	2																																																																
Nov-22	16	2																																																																
Dec-22	16	2																																																																
Jan-23	16	2																																																																
Feb-23	16	2																																																																
Mar-23	16	2																																																																
Apr-23	16	2																																																																
May-23	16	2																																																																
<b>What controls have we put in place for the risk:</b> <ul style="list-style-type: none"> <li>Twilight dialysis shifts are opened 6 days weekly, some overflow provided in the acute dialysis facility.</li> <li>Active home haemodialysis programme to ease the pressure until expansion of existing resource is established.</li> <li>Procurement process for retender of existing units and establishment of two new units commenced Jan 2021.</li> <li>The funding release was agreed by the JC in January 2023 but there are awaiting WG sign-off. Any delays in the process has a knock on effect to the operational date of the two new builds.</li> <li>Procurement supported by WG. Contract awarded</li> <li>Implementation programme commenced</li> <li>New units in place</li> </ul> <p>NB risk score will not reach target until new units are in place and therefore additional capacity is available  Risk will need to be tolerated until then.</p>		<b>What actions should we take:</b> <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>Completion of procurement process. Preferred provider identified. Approval from JC and SBUHB Board provided. Awaiting WG sign-off.</td> <td>SBUHB SRO/WKN Manager</td> <td>Complete Contract awarded</td> </tr> <tr> <td>Support mobilisation of contract to ensure efficiency of implementation, noting that new units unlikely to be operational until September 2023.</td> <td>SBUHB SRO/WKN Manager</td> <td>Contract awarded Implementation Programme started 12 month programme September 2023</td> </tr> <tr> <td>Increase opportunity for home dialysis.</td> <td>Home Dialysis Clinical Lead/WKN Manager.</td> <td>Value in Health Bid supported investment of an additional £130K in Swansea Bay region to support home dialysis and transplantation Programme on-going Evaluation in 12 months April 2024 December 2022</td> </tr> <tr> <td>Provision to be made in the WHSSC ICP to reflect the additional costs associated with the procurement process.</td> <td>WKN Manager/WKN Finance Manager/ WHHSC Director</td> <td>complete</td> </tr> <tr> <td>Implementation Programme for new dialysis units in place</td> <td>WKN Deputy Manager</td> <td>complete</td> </tr> <tr> <td>New units in place</td> <td></td> <td>April 2024</td> </tr> </tbody> </table>		Action	Lead	Date	Completion of procurement process. Preferred provider identified. Approval from JC and SBUHB Board provided. Awaiting WG sign-off.	SBUHB SRO/WKN Manager	Complete Contract awarded	Support mobilisation of contract to ensure efficiency of implementation, noting that new units unlikely to be operational until September 2023.	SBUHB SRO/WKN Manager	Contract awarded Implementation Programme started 12 month programme September 2023	Increase opportunity for home dialysis.	Home Dialysis Clinical Lead/WKN Manager.	Value in Health Bid supported investment of an additional £130K in Swansea Bay region to support home dialysis and transplantation Programme on-going Evaluation in 12 months April 2024 December 2022	Provision to be made in the WHSSC ICP to reflect the additional costs associated with the procurement process.	WKN Manager/WKN Finance Manager/ WHHSC Director	complete	Implementation Programme for new dialysis units in place	WKN Deputy Manager	complete	New units in place		April 2024																																										
Action	Lead	Date																																																																
Completion of procurement process. Preferred provider identified. Approval from JC and SBUHB Board provided. Awaiting WG sign-off.	SBUHB SRO/WKN Manager	Complete Contract awarded																																																																
Support mobilisation of contract to ensure efficiency of implementation, noting that new units unlikely to be operational until September 2023.	SBUHB SRO/WKN Manager	Contract awarded Implementation Programme started 12 month programme September 2023																																																																
Increase opportunity for home dialysis.	Home Dialysis Clinical Lead/WKN Manager.	Value in Health Bid supported investment of an additional £130K in Swansea Bay region to support home dialysis and transplantation Programme on-going Evaluation in 12 months April 2024 December 2022																																																																
Provision to be made in the WHSSC ICP to reflect the additional costs associated with the procurement process.	WKN Manager/WKN Finance Manager/ WHHSC Director	complete																																																																
Implementation Programme for new dialysis units in place	WKN Deputy Manager	complete																																																																
New units in place		April 2024																																																																
<b>Additional comments:</b> March 23 – The WKN core team discussed the risk and agreed the score remains the same due to delays in sign-off which will have a knock on effect to the operational date of the two new builds. May 23 - The WKN team discussed the risk and agreed the score remains the same																																																																		

**Risk Ref:** 42 Referrals for adults with an eating disorder/disordered eating (MH/21/15)  
**Risk Domain:** Impact on the safety of patients, staff or public (physical/psychological harm)

**Director Lead:** Director of Mental Health  
**Assuring Committee:** Joint Committee Reviewed Assurance

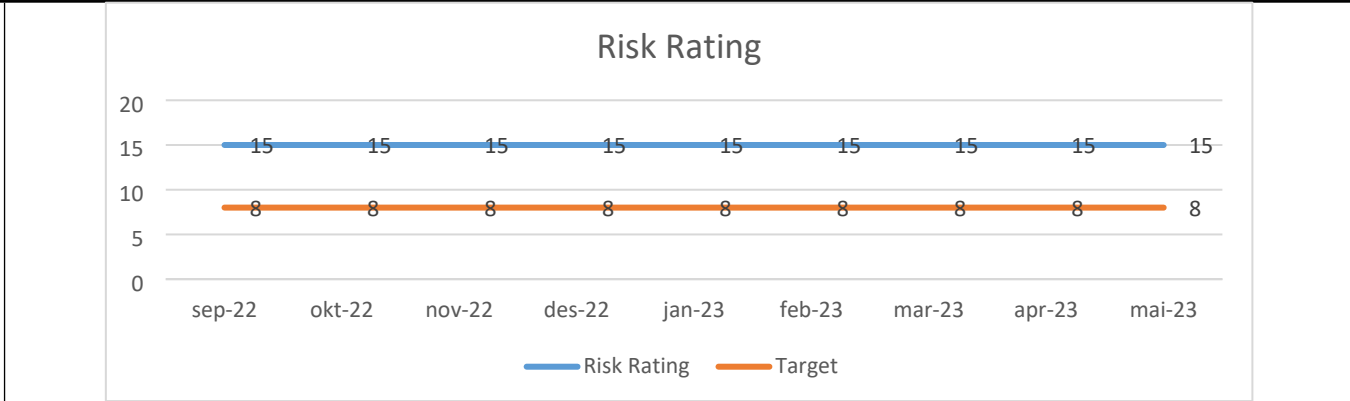
**Risk:** There is a risk that referrals for adults with an eating disorder/disordered eating, will require longer waiting times due to changes at NHSE and the loss of our main contract. **The consequence** is that additional placements may be needed, and admissions delayed **due to** the absence of ED beds in Wales.

**Date Added to Register:** 14/12/22  
**Provider/s:** Independent Sector

**Date Last Reviewed by:**  
 Joint Committee – 16 May 2023  
 Risk Scrutiny Group – 18 May 2023  
 Quality Patient Safety Committee – 18 April 2023  
 CDGB – 30 May 2023  
 CTMUHB Audit & Risk Committee – 19 April 2023  
 Integrated Governance Committee – 18 April 2023

Risk Rating  
(impact x likelihood)

Initial	5x3	15
<b>Current</b>	<b>5x3</b>	<b>15</b>
Target	4x2	8



**Groups discussed risk during period**

Commissioning Team 28/09/22  
 Commissioning Team 24/10/22  
 Commissioning Team 23/01/23  
 Commissioning Team 27/02/23 – Cancelled  
 Commissioning Team 27/03/23  
 Commissioning Team 24/04/23  
 Commissioning Team 22/05/23

**What controls have we put in place for the risk:**

- Interim Contract in place

**What actions should we take:**

Action	Lead	Date
Secure alternative contract following notice given for NHS England contract	Senior Planner/Shane Mills	Complete
Medium Term solution to be discussed and implemented - A paper is being presented to the March JC 2023.	Senior Planner / Shane Mills	April 23

**Additional comments:**  
 Sept 22 – Risk added  
 December 22 – Risk score agreed and added  
 January 22 – This risk relates to the current interim situation for the commissioning of Adult ED beds whilst a medium term solution is being sought through the appointment of a tender to provide ED Adult services for the next 2-3 years from April 23. The longer term options will be considered via the MH Strategy.  
 March 23 – Risk score remains the same  
 April 23 – Risks reviewed agreed it is appropriate for risk score to remain the same and to be reviewed May 22<sup>nd</sup>  
 May 23 – Risk remains the same

<b>Risk Ref: 43 Patient waiting times (CB01)</b> <b>Risk Domain:</b> Impact on the safety of patients, staff or public (physical/psychological harm) Population Health	<b>Director Lead:</b> Director of Planning <b>Assuring Committee:</b> Joint Committee Reviewed Assurance	
<b>Risk:</b> There is a risk that patients are not being treated in a timely and/or appropriate way. This is caused by the All Wales Lymphoma Panel (AWLP) service not achieving diagnostic turnaround times that meet the required standards. This could lead to poorer patient outcomes.	<b>Date Added to Register:</b> 12/02/21 (first identified 22/11/17)	<b>Date Last Reviewed:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023
	<b>Provider/s:</b> CVUHB (subcontract in place with SBUHB)	

<p>Risk Rating (impact x likelihood)</p> <table border="1"> <tr> <td>Initial</td> <td>2x4</td> <td>8</td> </tr> <tr> <td><b>Current</b></td> <td><b>3x5</b></td> <td><b>15</b></td> </tr> <tr> <td>Target</td> <td>4x1</td> <td>4</td> </tr> </table>	Initial	2x4	8	<b>Current</b>	<b>3x5</b>	<b>15</b>	Target	4x1	4	<p>Risk Rating</p> <table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Rating</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>Jul-21</td><td>8</td><td>4</td></tr> <tr><td>Aug-21</td><td>8</td><td>4</td></tr> <tr><td>Sep-21</td><td>8</td><td>4</td></tr> <tr><td>Oct-21</td><td>8</td><td>4</td></tr> <tr><td>Nov-21</td><td>8</td><td>4</td></tr> <tr><td>Dec-21</td><td>8</td><td>4</td></tr> <tr><td>Jan-22</td><td>8</td><td>4</td></tr> <tr><td>Feb-22</td><td>8</td><td>4</td></tr> <tr><td>Mar-22</td><td>8</td><td>4</td></tr> <tr><td>Apr-22</td><td>8</td><td>4</td></tr> <tr><td>May-22</td><td>8</td><td>4</td></tr> <tr><td>Jun-22</td><td>8</td><td>4</td></tr> <tr><td>Jul-22</td><td>8</td><td>4</td></tr> <tr><td>Aug-22</td><td>8</td><td>4</td></tr> <tr><td>Sep-22</td><td>8</td><td>4</td></tr> <tr><td>Oct-22</td><td>8</td><td>4</td></tr> <tr><td>Nov-22</td><td>12</td><td>4</td></tr> <tr><td>Dec-22</td><td>12</td><td>4</td></tr> <tr><td>Jan-23</td><td>15</td><td>4</td></tr> <tr><td>Feb-23</td><td>15</td><td>4</td></tr> <tr><td>Mar-23</td><td>15</td><td>4</td></tr> <tr><td>Apr-23</td><td>15</td><td>4</td></tr> <tr><td>May-23</td><td>15</td><td>4</td></tr> </tbody> </table>	Month	Risk Rating	Target	Jul-21	8	4	Aug-21	8	4	Sep-21	8	4	Oct-21	8	4	Nov-21	8	4	Dec-21	8	4	Jan-22	8	4	Feb-22	8	4	Mar-22	8	4	Apr-22	8	4	May-22	8	4	Jun-22	8	4	Jul-22	8	4	Aug-22	8	4	Sep-22	8	4	Oct-22	8	4	Nov-22	12	4	Dec-22	12	4	Jan-23	15	4	Feb-23	15	4	Mar-23	15	4	Apr-23	15	4	May-23	15	4	<b>Groups discussed risk during period</b>
	Initial	2x4	8																																																																																
<b>Current</b>	<b>3x5</b>	<b>15</b>																																																																																	
Target	4x1	4																																																																																	
Month	Risk Rating	Target																																																																																	
Jul-21	8	4																																																																																	
Aug-21	8	4																																																																																	
Sep-21	8	4																																																																																	
Oct-21	8	4																																																																																	
Nov-21	8	4																																																																																	
Dec-21	8	4																																																																																	
Jan-22	8	4																																																																																	
Feb-22	8	4																																																																																	
Mar-22	8	4																																																																																	
Apr-22	8	4																																																																																	
May-22	8	4																																																																																	
Jun-22	8	4																																																																																	
Jul-22	8	4																																																																																	
Aug-22	8	4																																																																																	
Sep-22	8	4																																																																																	
Oct-22	8	4																																																																																	
Nov-22	12	4																																																																																	
Dec-22	12	4																																																																																	
Jan-23	15	4																																																																																	
Feb-23	15	4																																																																																	
Mar-23	15	4																																																																																	
Apr-23	15	4																																																																																	
May-23	15	4																																																																																	
		Commissioning Team 30/09/22 Commissioning Team 08/11/22 Commissioning Team 28/11/22 Commissioning Team 12/12/22 Commissioning Team 30/01/23 Commissioning Team 02/03/23 Commissioning Team 27/03/23 Commissioning Team 17/04/23 Commissioning Team 18/05/23																																																																																	

**What controls have we put in place for the risk:**

- Mechanisms are in place to prioritise clinically urgent cases.
- Investment through the 21/22 ICP via an uplifted baseline to fund more capacity
- Monitoring monthly with quarterly commissioner assurance meetings to confirm performance and level of risk as Covid-19 impact reduces and the effects of contract adjustment are realised.
- A request has been made for the service to work more collaboratively to identify service improvements across the two sites.
- Equipment failures have caused delays and performance issues – an urgent procurement exercise is taking place with an expected installation taking place in April 2023.
- To mitigate this, a 7 day working model in the IHC laboratory has been established.
- Outsourcing lymphoma slides to a laboratory in England
- New equipment has been installed at SBUHB and is due to be installed at CVUHB in the next few weeks.**

**What actions should we take:**

Action	Lead	Date
To hold quarterly commissioner assurance meetings with the AWLP to review turnaround time performance (with monthly submission of performance data). Note: on hold while progress is made with regard to joint working arrangements between CVU and SBU.	LA -Senior Planner	<b>Completed.</b>
Managing Director (SL) and Director of Planning have met with CVUHB clinical and managerial and clinical leads. It was agreed that joint working arrangements should be developed between CVU and SBU under the Regional and Specialised Services Provider Planning Partnership. CVU team will take this forward and confirm progress to WHSSC.	LA -Senior Planner	<b>Nov 22 (completed. See additional actions below)</b>
LA to discuss AWLP performance with Director of Planning in next 1 to 1 on Friday 11 <sup>th</sup> Nov and agree appropriate action. To update Commissioning Team.	LA -Senior Planner	<b>Completed</b>
Ian Langfield will take the lead on the development of joint working arrangements between CVU and SBU under the Regional and Specialised Services Provider Planning Partnership. LA will confirm AWLP commissioning intentions.	LA – Senior Planner	<b>Completed</b>
WHSSC to write to CVU and SBU to ask them to respond to recent drop in performance levels and to advise that performance and assurance meetings will resume in the new year.	LA – Senior Planner	<b>Complete</b>
WHSSC to arrange a meeting with both sides of the service.	RE-Assistant Planner	<b>Complete</b>
Request information from HB quality colleagues regarding DATIX reports related to the service	VDJ – Quality Lead	<b>Complete</b>
Propose further escalation of the service to CDG. This will be considered at CDGB on 6 March 2023. Service escalated.	LA-Senior Planner	<b>Complete</b>
Write to service to outline expectations at escalation performance meeting on 31 <sup>st</sup> March	LA-Senior Planner	<b>Complete</b>
Escalation meeting to monitor progress against action plan.	KLS – Associate Medical Director	<b>Next meeting 9<sup>th</sup> June</b>

**Additional comments:**  
The C&B commissioning team agreed to raise the risk score based on recent decline in poor performance at both CVU and SBU and agreed to consider escalation at a future meeting when a response from both centres has been received. Performance meeting arranged in January. Revisit after this meeting.  
January 2023: The C&B commissioning team agreed to raise the risk score based on a recent meeting with the service where it was reported that poor performance at CV was due to equipment failures in the laboratory.  
March 2023: AWLP placed into formal escalation level 2. Action plan requested ahead of escalation meeting on 31<sup>st</sup> March 2023.

May 2023: It was noted at the escalation meeting on 12<sup>th</sup> May that errors with SBUHB data reporting had been found. Performance is therefore likely to be better than the data would suggest.

<b>Risk Ref: 44 Paediatric cardiac surgery (P/21/19)</b> <b>Risk Domain:</b> Impact on the safety of patients, staff or public (physical/psychological harm) Population Health	<b>Director Lead:</b> Director of Planning <b>Assuring Committee:</b> Joint Committee Reviewed Assurance
<b>Risk:</b> <i>There is a risk</i> that paediatric cardiac surgery patients will have longer waits than is clinically appropriate <i>due to</i> lack of availability of a PIC bed. <i>There is a consequence</i> that the condition of the patient could deteriorate whilst waiting.	<b>Date Added to Register:</b> 24/01/23
	<b>Provider/s:</b> University Hospital Bristol
<b>Date Last Reviewed by:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023	

Risk Rating (impact x likelihood)		<b>Groups discussed risk during period</b> Commissioning Team - 24/01/23 Commissioning Team - 21/02/23 Commissioning Team - 21/03/23 Commissioning Team - 20/04/23 Commissioning Team - 16/05/23									
<table border="1"> <tr> <td>Initial</td> <td>4x4</td> <td>16</td> </tr> <tr> <td><b>Current</b></td> <td><b>4x4</b></td> <td><b>16</b></td> </tr> <tr> <td>Target</td> <td>2x2</td> <td>4</td> </tr> </table>	Initial	4x4	16	<b>Current</b>	<b>4x4</b>	<b>16</b>	Target	2x2	4		
Initial	4x4	16									
<b>Current</b>	<b>4x4</b>	<b>16</b>									
Target	2x2	4									

**What controls have we put in place for the risk:**

- Fortnightly report requested from Bristol Children’s Hospital requesting detail on patient waits, steps taken to reschedule and management plan.
- Meeting with clinical team in Bristol took place to understand the mitigations, agreed trajectories will be provided

**What actions should we take:**

Action	Lead	Date
Arrange meeting with Bristol Children’s Hospital	W&C Planner	Complete
Trajectories for patients breaching waiting list standards to be shared with WHSSC.	W&C Planner	31 May 2023
Fortnightly updates being issued by the Provider to support the monitoring of patients on the waiting list.	W&C Planner	Fortnightly

**Additional comments:**  
 Mar 23 – W&C Commissioning team reviewed the risk which remains unchanged.  
 Apr 23 – W&C Commissioning team reviewed the risk which remains unchanged.  
 May 23 - W&C Commissioning team reviewed the risk which remains unchanged.

<b>Risk Ref: 46 North Wales Outreach Plastic Surgery Clinic Management Arrangements (CB06)</b> <b>Risk Domain:</b> Impact on the safety of patients, staff or public (physical/psychological harm) Population Health	<b>Director Lead:</b> Director of Planning <b>Assuring Committee:</b> Joint Committee Reviewed Assurance	
<b>Risk:</b> There is a risk that patients may come to harm due to a lack of clinical prioritisation and oversight of waiting lists for outreach plastic surgery clinics in YG and YGC. This is caused by lack of clarity in the governance and management arrangements for these clinics. This could lead to poor patient experience and outcomes	<b>Date Added to Register:</b> 09/09/22	<b>Date Last Reviewed by:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023
	<b>Provider/s:</b> St Helens and Knowsley NHS Trust & BCUHB	

<p>Risk Rating (impact x likelihood) Score to be agreed</p> <table border="1"> <tr> <td>Initial</td> <td>3x3</td> <td>9</td> </tr> <tr> <td>Current</td> <td>3x5</td> <td>15</td> </tr> <tr> <td>Target</td> <td>4x1</td> <td>4</td> </tr> </table>	Initial	3x3	9	Current	3x5	15	Target	4x1	4	<table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Rating</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>aug-22</td><td>12</td><td>4</td></tr> <tr><td>sep-22</td><td>12</td><td>4</td></tr> <tr><td>okt-22</td><td>12</td><td>4</td></tr> <tr><td>nov-22</td><td>12</td><td>4</td></tr> <tr><td>des-22</td><td>12</td><td>4</td></tr> <tr><td>jan-23</td><td>12</td><td>4</td></tr> <tr><td>feb-23</td><td>15</td><td>4</td></tr> <tr><td>mar-23</td><td>15</td><td>4</td></tr> <tr><td>apr-23</td><td>15</td><td>4</td></tr> <tr><td>mai-23</td><td>15</td><td>4</td></tr> </tbody> </table>	Month	Risk Rating	Target	aug-22	12	4	sep-22	12	4	okt-22	12	4	nov-22	12	4	des-22	12	4	jan-23	12	4	feb-23	15	4	mar-23	15	4	apr-23	15	4	mai-23	15	4	<p><b>Groups discussed risk during period</b></p> <ul style="list-style-type: none"> <li>Commissioning Team 30/09/22</li> <li>Commissioning Team 08/11/22</li> <li>Commissioning Team 28/11/22</li> <li>Commissioning Team 12/12/22</li> <li>Commissioning Team 30/01/23</li> <li>Commissioning Team 02/03/23</li> <li>Commissioning Team 27/03/23</li> <li>Commissioning Team 17/04/23</li> <li>Commissioning Team 18/05/23</li> </ul>
Initial	3x3	9																																										
Current	3x5	15																																										
Target	4x1	4																																										
Month	Risk Rating	Target																																										
aug-22	12	4																																										
sep-22	12	4																																										
okt-22	12	4																																										
nov-22	12	4																																										
des-22	12	4																																										
jan-23	12	4																																										
feb-23	15	4																																										
mar-23	15	4																																										
apr-23	15	4																																										
mai-23	15	4																																										

<p><b>What controls have we put in place for the risk:</b></p> <ul style="list-style-type: none"> <li>BCUHB has established a Task &amp; Finish Group to address the issue including colleagues from St Helen's &amp; Knowsley.</li> <li>WHSSC quality team meets regularly with the assistant director of quality BCUHB and has established links with the quality team at SH&amp;K.</li> <li>WHSSC has written formally to BCUHB to raise the concerns around the management of the outreach clinics and seek clarity on the reporting and accountability arrangements in the health board for the Task &amp; Finish Group.</li> <li>BCUHB to report to WHSSC on progress of the T&amp;F Gp at the interface planning meeting and the SLA meeting.</li> <li>It has been agreed that Welsh Government will lead the escalation of the management of the plastic surgery outreach clinics as a part of their wider escalation of the dermatology service in north Wales.</li> </ul>	<p><b>What actions should we take:</b></p> <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>WHSSC Quality team to continue to liaise closely with quality leads in BCUHB and SHK Trust.</td> <td>VDJ – Quality Lead</td> <td>Nov 22</td> </tr> <tr> <td>To follow up with regard to the letter to BCUHB to obtain a response and respond accordingly.</td> <td>Planner</td> <td>Complete</td> </tr> <tr> <td>Meeting between WHSSC, SHK and BCUHB to ascertain what is required to review all patients on the waiting list.</td> <td>LA – Senior Planner</td> <td>Complete</td> </tr> <tr> <td>Work with SHK and BCUHB to agree the terms of reference and implement the review.</td> <td>LA – Senior Planner &amp; VDJ – Quality Lead</td> <td>Complete</td> </tr> <tr> <td>Confirm WHSSC's role in the escalation led by Welsh Government</td> <td>NJ – Director of Planning / Sian Lewis – Managing Director</td> <td>Apr 23</td> </tr> <tr> <td>Monitor the findings from the patient harm review currently being undertaken by St Helen's &amp; Knowsley</td> <td>LA – Senior Planner &amp; VDJ – Quality Lead</td> <td>From Mar 23 to Jun 23</td> </tr> <tr> <td>Continue to work with BCUHB and SHK, and with Welsh Government, to support addressing the risks relating to the outreach clinics.</td> <td>Exec Team C&amp;B Comm Team</td> <td>On going</td> </tr> </tbody> </table>	Action	Lead	Date	WHSSC Quality team to continue to liaise closely with quality leads in BCUHB and SHK Trust.	VDJ – Quality Lead	Nov 22	To follow up with regard to the letter to BCUHB to obtain a response and respond accordingly.	Planner	Complete	Meeting between WHSSC, SHK and BCUHB to ascertain what is required to review all patients on the waiting list.	LA – Senior Planner	Complete	Work with SHK and BCUHB to agree the terms of reference and implement the review.	LA – Senior Planner & VDJ – Quality Lead	Complete	Confirm WHSSC's role in the escalation led by Welsh Government	NJ – Director of Planning / Sian Lewis – Managing Director	Apr 23	Monitor the findings from the patient harm review currently being undertaken by St Helen's & Knowsley	LA – Senior Planner & VDJ – Quality Lead	From Mar 23 to Jun 23	Continue to work with BCUHB and SHK, and with Welsh Government, to support addressing the risks relating to the outreach clinics.	Exec Team C&B Comm Team	On going
Action	Lead	Date																							
WHSSC Quality team to continue to liaise closely with quality leads in BCUHB and SHK Trust.	VDJ – Quality Lead	Nov 22																							
To follow up with regard to the letter to BCUHB to obtain a response and respond accordingly.	Planner	Complete																							
Meeting between WHSSC, SHK and BCUHB to ascertain what is required to review all patients on the waiting list.	LA – Senior Planner	Complete																							
Work with SHK and BCUHB to agree the terms of reference and implement the review.	LA – Senior Planner & VDJ – Quality Lead	Complete																							
Confirm WHSSC's role in the escalation led by Welsh Government	NJ – Director of Planning / Sian Lewis – Managing Director	Apr 23																							
Monitor the findings from the patient harm review currently being undertaken by St Helen's & Knowsley	LA – Senior Planner & VDJ – Quality Lead	From Mar 23 to Jun 23																							
Continue to work with BCUHB and SHK, and with Welsh Government, to support addressing the risks relating to the outreach clinics.	Exec Team C&B Comm Team	On going																							

**Additional comments:**  
Nov 22 – It was noted that an action plan has been received from BCUHB by WHSSC with assurance that governance concerns will be resolved by the end of December.  
Active discussion taking place with significant update on patient waiting lists anticipated from BCUHB. Consider escalation if assurance not received within 4 weeks.  
Feb 23 – The C&B team agreed to raise the risk score to 3x5=15 to reflect the lack of progress to date in transferring waiting list management to SHK, the delay in commencing the patient review and further risks raised by SHK NHST at the SLA meeting.  
April 23 – Risk reviewed and score remains the same  
May 23 – The commissioning team noted that the patient harm review is approximately 50% complete with all patients requiring review being offered appointments. Task & Finish Group in progress and meeting fortnightly. Welsh Government special measures for BCUHB includes plastic surgery. Risk remains until completion of harm review and SLA in place for the outreach clinics.

**Risk Ref: 47 New Risk - Intestinal Failure CVUHB (IF14)**  
**Risk Domain:** Impact on the safety of patients, staff or public (physical/psychological harm)  
 Population Health

**Director Lead:** Director of Planning  
**Assuring Committee:** Joint Committee Reviewed Assurance

**Risk:** **There is a risk that due to** issues of provider sustainability and delivery, that Cardiff and Vale University Health Board will no longer be able to provide Intestinal Failure services to the welsh population and **as a consequence** resulting in no service available in Wales.

**Date Added to Register:** 17/05/23  
**Provider:** Cardiff and Vale University Health Board

**Date Last Reviewed by :**



**What controls have we put in place for the risk:**

- Exploratory conversations with HBs in Wales as to any alternate provider
- Exploratory discussions with Bristol – potential to contract for activity there

**What actions should we take:**

Action	Lead	Date
Confirmation of provider position as soon as possible	Assistant Director of Planning	May 2023

**Additional comments:**

<b>Risk Ref: 48 NEW RISK - Wales Fertility Institute (WFI) P/21/20</b> <b>Risk Domain:</b> Impact on the safety of patients, staff or public (physical/psychological harm) Population Health		<b>Director Lead: Director of Planning</b> <b>Assuring Committee: Joint Committee Reviewed Assurance</b>																	
<i>There is a risk</i> the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital are not providing a safe and effective service <i>due to</i> 7 major concerns identified during a relicensing inspection by HFEA in January 2023 <i>There is a consequence</i> that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.		<b>Date Added to Register: 16/05/23</b>		<b>Date Last Reviewed by Quality &amp; Patient Safety Committee:</b>															
		<b>Provider/s:</b> SBUHB																	
<p>Risk Rating (impact x likelihood)</p> <table border="1"> <tr> <td>Initial</td> <td>4x4</td> <td>16</td> </tr> <tr> <td><b>Current</b></td> <td><b>4x4</b></td> <td><b>16</b></td> </tr> <tr> <td>Target</td> <td>2x2</td> <td>4</td> </tr> </table>		Initial	4x4	16	<b>Current</b>	<b>4x4</b>	<b>16</b>	Target	2x2	4	<p>Risk Rating</p> <table border="1"> <thead> <tr> <th>Category</th> <th>Value</th> </tr> </thead> <tbody> <tr> <td>Risk Rating</td> <td>16</td> </tr> <tr> <td>Target</td> <td>4</td> </tr> </tbody> </table>			Category	Value	Risk Rating	16	Target	4
Initial	4x4	16																	
<b>Current</b>	<b>4x4</b>	<b>16</b>																	
Target	2x2	4																	
Category	Value																		
Risk Rating	16																		
Target	4																		
<b>What controls have we put in place for the risk:</b> <ul style="list-style-type: none"> <li>Received the report from the HFEA to support monitoring</li> <li>Requested action plan from the service to improve against the concerns identified by the HFEA.</li> </ul>		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>Requested HFEA report from WFI</td> <td>Head of Quality WHSSC</td> <td>Completed</td> </tr> <tr> <td>Requested Action plans from WFI based on HFEA report</td> <td>Head of Quality WHSSC</td> <td>22/05/23</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>			Action	Lead	Date	Requested HFEA report from WFI	Head of Quality WHSSC	Completed	Requested Action plans from WFI based on HFEA report	Head of Quality WHSSC	22/05/23						
Action	Lead	Date																	
Requested HFEA report from WFI	Head of Quality WHSSC	Completed																	
Requested Action plans from WFI based on HFEA report	Head of Quality WHSSC	22/05/23																	
<b>Additional comments:</b> May 23 – SBUHB escalated to Gold Command based on the HEFA report which identified 7 major concerns.		<b>Groups discussed risk during period</b> Commissioning Team – 16/05/23 R																	

**Risk de-escalated**

<b>Risk Ref: 41 Financial Climate Risk (CS14)</b> <b>Risk Domain: Financial Climate Risk</b>		<b>Director Lead:</b> Director of Finance <b>Assuring Committee:</b> Joint Committee																																		
<b>Risk:</b> There is a risk that due to the constrained financial climate across the NHS the uplift required for the WHSSC 2023/24 ICP might not be affordable for Commissioning Health Boards. Currently Health Boards are reporting large deficits and the annual allocation uplift declared upfront will not meet the current inflationary cost pressures.		<b>Date Added to Register:</b> 14/12/22	<b>Date Last Reviewed by:</b> Joint Committee – 16 May 2023 Risk Scrutiny Group – 18 May 2023 Quality Patient Safety Committee – 18 April 2023 CDGB – 30 May 2023 CTMUHB Audit & Risk Committee – 19 April 2023 Integrated Governance Committee – 18 April 2023																																	
<b>Provider/s:</b>		<b>Groups discussed risk during period</b> CDGB Finance Team Meeting RSG WHSSC Executive OD Session 11 May 2023																																		
<p>Risk Rating (impact x likelihood)</p> <table border="1"> <tr> <td>Initial</td> <td>4 X 4</td> <td>16</td> </tr> <tr> <td><b>Current</b></td> <td><b>4 X 3</b></td> <td><b>12</b></td> </tr> <tr> <td>Target</td> <td>3 X 2</td> <td>6</td> </tr> </table>	Initial	4 X 4	16	<b>Current</b>	<b>4 X 3</b>	<b>12</b>	Target	3 X 2	6	<p>Risk Rating</p> <table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Rating</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>nov-22</td><td>16</td><td>6</td></tr> <tr><td>des-22</td><td>16</td><td>6</td></tr> <tr><td>jan-23</td><td>16</td><td>6</td></tr> <tr><td>feb-23</td><td>16</td><td>6</td></tr> <tr><td>mar-23</td><td>16</td><td>6</td></tr> <tr><td>apr-23</td><td>16</td><td>6</td></tr> <tr><td>mai-23</td><td>12</td><td>6</td></tr> </tbody> </table>			Month	Risk Rating	Target	nov-22	16	6	des-22	16	6	jan-23	16	6	feb-23	16	6	mar-23	16	6	apr-23	16	6	mai-23	12	6
Initial	4 X 4	16																																		
<b>Current</b>	<b>4 X 3</b>	<b>12</b>																																		
Target	3 X 2	6																																		
Month	Risk Rating	Target																																		
nov-22	16	6																																		
des-22	16	6																																		
jan-23	16	6																																		
feb-23	16	6																																		
mar-23	16	6																																		
apr-23	16	6																																		
mai-23	12	6																																		
<b>What controls have we put in place for the risk:</b> <ul style="list-style-type: none"> <li>WHSSC internal review of the Integrated Commissioning Plan (ICP) to lower initial uplift required from 4.48% to 3.89%,</li> <li>The ICP was presented to Management Group with a number of scenarios for a lower uplift and the associated risks on 27 October 2022, a recommissioning for value workshop was held on 25 November and the MG considered the final scenarios on 15 December 2022.</li> <li>A recovery workshop was held with the Joint Committee on the 12 July 2022 at their request to discuss HB recovery plans and trajectories. A follow up deep dive into paediatrics was given to the Joint Committee on the 6 September 2022, and further recovery update session on the 8 November 2022.</li> <li>A workshop to specifically focus on the scenarios was arranged for Joint Committee members on the 10 January 2023 and this was followed up with a MG workshop at the end of January 2023.</li> <li>The ICP was approved by the Joint Committee on the 13 February 2023 but with some requests that WHSSC look at achieving a 1% efficiency saving.</li> <li>A workshop was held with MG members on 23 March 2023 and a PID has been development to support the process. An update will also be provided to the May 2023 JC and this will become a standing item on the JC agenda.</li> <li>The WHSSC Executive OD session 11 May 2023 reviewed the risk in light of the WHSSC ICP being approved in February 2023, and discussions with the Joint Committee on 14 March and 16 May 2023 on future efficiencies and savings recognising the pressures on HBs delivering their respective Integrated Medium Term Plans (IMTP's).</li> </ul>	<b>What actions should we take:</b> <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>ICP presented for discussion at MG 15.12.2022 – There was a consensus that scenarios which did not provide for unavoidable growth, inflationary pressures and known recurrent activity levels would not be palatable as this would create further financial risk in the already constrained system</td> <td>Director of Finance</td> <td>15 December Completed</td> </tr> <tr> <td>A workshop to specifically focus on the scenarios has been arranged for Joint Committee members on the 10 January 2023. WHCC will present a matrix of plan uplift scenarios to JC where uplift required ranges between 1.87% - 3.89% articulating the associated risks inherent in aligning plan with any particular scenario.</td> <td>Director of Finance</td> <td>January 2023 Completed</td> </tr> <tr> <td>The ICP was approved on 13 February 2023. A 1% efficiency saving was requested by JC members. In order to ensure that this is achieved a governance system and process is being developed and this will be presented to the March JC 2023.</td> <td>Director of Planning/Director of Finance</td> <td>Completed</td> </tr> <tr> <td>The Joint Committee meeting 16 May 2023 received a presentation and discussed WHSSC &amp; HB Shared Pathway Saving Targets &amp; Milestones on Governance System &amp; Process</td> <td>Director of Planning/Director of Finance</td> <td>Completed</td> </tr> </tbody> </table>			Action	Lead	Date	ICP presented for discussion at MG 15.12.2022 – There was a consensus that scenarios which did not provide for unavoidable growth, inflationary pressures and known recurrent activity levels would not be palatable as this would create further financial risk in the already constrained system	Director of Finance	15 December Completed	A workshop to specifically focus on the scenarios has been arranged for Joint Committee members on the 10 January 2023. WHCC will present a matrix of plan uplift scenarios to JC where uplift required ranges between 1.87% - 3.89% articulating the associated risks inherent in aligning plan with any particular scenario.	Director of Finance	January 2023 Completed	The ICP was approved on 13 February 2023. A 1% efficiency saving was requested by JC members. In order to ensure that this is achieved a governance system and process is being developed and this will be presented to the March JC 2023.	Director of Planning/Director of Finance	Completed	The Joint Committee meeting 16 May 2023 received a presentation and discussed WHSSC & HB Shared Pathway Saving Targets & Milestones on Governance System & Process	Director of Planning/Director of Finance	Completed																		
Action	Lead	Date																																		
ICP presented for discussion at MG 15.12.2022 – There was a consensus that scenarios which did not provide for unavoidable growth, inflationary pressures and known recurrent activity levels would not be palatable as this would create further financial risk in the already constrained system	Director of Finance	15 December Completed																																		
A workshop to specifically focus on the scenarios has been arranged for Joint Committee members on the 10 January 2023. WHCC will present a matrix of plan uplift scenarios to JC where uplift required ranges between 1.87% - 3.89% articulating the associated risks inherent in aligning plan with any particular scenario.	Director of Finance	January 2023 Completed																																		
The ICP was approved on 13 February 2023. A 1% efficiency saving was requested by JC members. In order to ensure that this is achieved a governance system and process is being developed and this will be presented to the March JC 2023.	Director of Planning/Director of Finance	Completed																																		
The Joint Committee meeting 16 May 2023 received a presentation and discussed WHSSC & HB Shared Pathway Saving Targets & Milestones on Governance System & Process	Director of Planning/Director of Finance	Completed																																		
<b>Additional comments:</b> A series of workshops took place and this led to an acceptable composite financial position which was approved by JC on 13 February 2023. May 2023 - Agreed to de-escalate from the CRAF and reduce score to 12, and to monitor the fluid financial position. May increase again in Q4 2023-2024.																																				

**Risk Appetite Levels**

Appetite Level	Described as:
None	<b>Avoid</b> - The avoidance of risk and uncertainty is a key organisational objective.
Low	<b>Minimal</b> - Preference for ultra-safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
Moderate	<b>Cautious</b> - Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
High	<b>Open</b> - Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM).
Significant	<b>Seek</b> - Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk.  <b>Mature</b> - Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

**Risk Matrix**

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Likelihood Score (L) - What is the likelihood of the consequence occurring?				
1	2	3	4	5
Rare	Unlikely	Possible	Likely	Almost certain
This will probably never happen / recur	Do not expect it to happen / recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen / recur but it is not a persisting issue	Will undoubtedly happen / recur, possibly frequently

Consequence x Likelihood = Risk Score

Domains
Impact on the safety of patients, staff or public (physical/psychological harm)
Population Health
Quality/complaints/audit
Human resources/ organisational development/staffing/ competence
Statutory duty/ inspections
Adverse publicity/ reputation
Business objectives/ projects
Finance including claims
Service/business interruption
Environmental impact

<b>Report Title</b>	<b>Audit Recommendations Tracker</b>		<b>Agenda Item</b>	4.2	
<b>Meeting Title</b>	Audit and Risk Committee		<b>Meeting Date</b>	21/06/2023	
<b>FOI Status</b>	Public				
<b>Author</b>	Financial Accountant				
<b>Executive Lead</b>	Director of Finance				
<b>Purpose of the Report</b>	The purpose of this report is to provide the Audit and Risk Committee (ARAC) with an update on progress in respect of the implementation of recommendations from internal and external audits.				
<b>Specific Action Required</b>	RATIFY <input type="checkbox"/>	APPROVE <input type="checkbox"/>	SUPPORT <input type="checkbox"/>	ASSURE <input checked="" type="checkbox"/>	INFORM <input checked="" type="checkbox"/>
<b>Recommendation(s):</b>					
<p>Members are asked to:</p> <ul style="list-style-type: none"> <li>• <b>Note</b> the report,</li> <li>• <b>Note</b> progress achieved in implementing the recommendations made by WHSSC internal auditors,</li> <li>• Take <b>assurance</b> on the rolling programme to collate updates from services on a bi-monthly basis in order to report progress to the Audit and Risk Committee.</li> <li>• <b>Note</b> the progress made against WHSSC management responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report; and</li> <li>• <b>Note</b> the progress made against the Welsh Government responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report.</li> </ul>					

# AUDIT RECOMMENDATIONS TRACKER

## 1.0 SITUATION

The purpose of this report is to provide the Audit and Risk Committee (ARAC) with an update on progress in respect of the implementation of recommendations from internal and external audits.

## 2.0 BACKGROUND

Audits play an important independent role in providing the Joint Committee and the Audit and Risk Committee with assurance on internal controls and that systems and processes are sufficiently comprehensive and operating effectively. Therefore, it is essential that recommendations from both internal and external audits are implemented in a timely way. All reports from audits undertaken across the WHSSC are logged and monitored through the WHSSC audit tracker.

## 3. ASSESSMENT

### 3.1 Internal Audit

#### 3.1.1 Summary of Internal Audit Reports Since April 2019

Since April 2019, the following internal audit reports have been issued to WHSSC:

- 9 reports have been issued,
- 33 recommendations have been made,
- 31 recommendations have been achieved; and
- 2 recommendations are outstanding in relation to the report on Risk Management. The due dates for both items were revised to July 2023.

A summary of the overall position to date and details of progress made on the outstanding recommendations are presented in **Appendix 1** of this report.

#### 3.1.2 Summary of Planned Audits for 2023-2024

The following reviews are planned for completion by Internal Audit during 2023-2024:

Audit Theme	Quarter
Welsh Kidney Network (WKN)	Q1
Integrated Commissioning Plan (ICP)	Q1
Mental Health	Q3

The original 2022-2023 internal audit programme was impacted by the need to defer two audits into 2023-2024 (WKN and MH) to focus more on strategy implementation instead of the normal commissioning team reviews.

## 3.2 External Audit

The Audit Wales review into Committee Governance arrangements at WHSSC was undertaken between March and June 2020, however as a result of the COVID-19 pandemic, aspects of the review were paused, and re-commenced in July. A survey was issued to all Health Boards and the fieldwork was concluded in October 2020.

The findings were published in May 2021 in the [Audit Wales Committee Governance Arrangements at WHSSC](#) report.

The report outlined recommendations for WHSSC and for Welsh Government. The updated tracker document is presented at **Appendix 2<sup>1</sup>** for assurance.

### 3.2.1 WHSSC Management Response

The report outlined 4 recommendations for WHSSC and progress against the actions outlined within the management response have been monitored through the Integrated Governance Committee (IGC) and the CTMUHB Audit & Risk Committee (ARC).

The majority of actions have been completed and there are only three areas of partial compliance on the following actions:

**R3** In the short to medium term, the impact of COVID-19 presents a number of challenges. WHSSC should undertake a review and report analysis on:

- the backlog of waits for specialised services,
- potential impact and cost of managing hidden demand; and
- the financial consequences of services that were commissioned and under-delivered as a result of COVID-19

Audit Wales Recommendation		Progress update
R3b	<b>In the short to medium term, the impact of COVID-19 presents a number of challenges. WHSSC should undertake a review and report analysis on backlog of waits and the impact of managing hidden demand and financial consequences</b>	<b>Recommendation Completed</b> The Job description has been reviewed by the job evaluation panel at CTMUHB and has been banded as an 8D post. In light of the WG Review on National Commissioning Arrangements, it is proposed that the post be advertised after the Ministers announcement on the future of commissioning bodies.
Audit Wales Recommendation		Progress update
<b>R4 The current specialised services strategy was approved in 2012. WHSSC should develop and approve a new strategy during 2021</b>		
R4a	<b>Embrace New Innovations</b>	<b>Recommendation Completed</b>

<sup>1</sup> Note at the request of the ARC meeting 12 February 2023 the tracker document has been refined to only present the outstanding areas of partial compliance

		The draft strategy was presented to the Management Group on 23 March 2023, discussed at a workshop on the 17 April 2023 and was approved by the Joint Committee on 16 May 2023. View here - <a href="#">Strategies and Plans - Welsh Health Specialised Services Committee (nhs.wales)</a>
<b>Audit Wales Recommendation</b>		<b>Progress update</b>
R4b	<b>Approach to Review of Services will be considered in strategy engagement</b>	<b>Recommendation Completed</b> The draft strategy was presented to the Management Group on 23 March 2023, discussed at a workshop on the 17 April 2023 and was approved by the Joint Committee on 16 May 2023. View here - <a href="#">Strategies and Plans - Welsh Health Specialised Services Committee (nhs.wales)</a>

### 3.2.2 Welsh Government Management Response

The report outlined three recommendations for Welsh Government (WG) and progress against the WG management responses is monitored through discussions between the Chair, the WHSSC Managing Director and the Director General Health & Social Services/ NHS Wales Chief Executive.

Recommendation 5 has been completed, and Recommendations 6 & 7 are categorised as partially completed. An update on progress is outlined below:

#### **R6 Sub-regional and regional programme management**

This is linked to Recommendation 2 made to WHSSC in this report. When new regional or sub-regional specialised services are planned which are not the sole responsibility of WHSSC, ensure that effective multi- partner programme management arrangements are in place from concept through to completion (i.e. early in the development through to post-implementation benefits analysis).

**Letter from Dr Andrew Goodall to Adrian Crompton, 2 June 2021 stated:**

As you have highlighted, whilst some key service areas like major trauma have been developed successfully and with good collaboration across organisations, the timelines around

Further To a meeting with WG on 31 May 2023 it was confirmed that due to a change in portfolio within the HSSG at WG, the Committee Secretary at WHSSC will liaise with Trudi Burton, WG to keep updated on the two recommendations pertaining to the WG to obtain an

such changes have been slow and often hampered by a lack of clarity on who is driving the process. I agree with your view that end-to-end programme management of such schemes, which are not within the sole remit of WHSSC, should be strengthened. The National Clinical Framework which we published on 22 March, sets out a vision for a health system that is co-ordinated centrally and delivered locally or through regional collaborations. Implementation will be taken forward through NHS planning and quality improvement approaches and our accountability arrangements with NHS bodies.

update for Joint Committee in July 2023.

**R7 Future governance and accountability arrangements for specialised services**

A Healthier Wales included a commitment to review the WHSSC arrangements along with other national hosted and specialist advisory functions. COVID-19 has contributed to delays in taking forward that action. It is recommended that the Welsh Government set a revised timescale for the action and use the findings of this report to inform any further work looking at governance and accountability arrangements for commissioning specialised services as part of a wider consolidation of current national activity.

***Letter from Dr Andrew Goodall to Adrian Crompton, 2 June 2021 stated:***

A Healthier Wales committed to reviewing the WHSSC arrangements alongside other hosted national and specialised functions, in the context of the development of the NHS Executive function. The position of WHSSC within this landscape needs to be carefully considered. On the one hand, there are strengths in the current system whereby health boards, through the joint committee, retain overall responsibility for the commissioning of specialised services. This requires collaboration and mature discussion from both the commissioner and provider standpoint. However, I recognise the inherent risk of conflict of

Further To a meeting with WG on 31 May 2023 it was confirmed that due to a change in portfolio within the HSSG at WG, the Committee Secretary at WHSSC will liaise with Trudi Burton, WG to keep updated on the two recommendations pertaining to the WG to obtain an update for Joint Committee in July 2023.

interest in this arrangement and note the reference made in your report to the Good

Governance Institute's report of 2015 which suggested a more national model may be appropriate.

In my letter to health boards of 14 August 2019, I indicated that, as recommended by the Parliamentary Review, the governance and hosting arrangements for the existing Joint Committees would be streamlined and standardised. I also said that it was intended the NHS Executive would be become a member of the Joint Committees' Boards in order to ensure there is a stronger national focus to decision making. However, the thinking at the time was that the joint committee functions would not be subsumed into the NHS Executive function. We will continue to look at this as the NHS Executive function develops further and I will update you should there be any change to the direction of travel I indicated in 2019.

## 4.0 GOVERNANCE & RISK

Audit Wales undertake an annual programme of independent external audits on NHS services, and NHS bodies are required to present a formal management response to the recommendations through a public report.

Audit Wales have confirmed they are content for the Joint Committee to receive an update on progress on 18 July 2023. Thereafter an update will be submitted to Audit Wales and to HB Audit Committees for assurance in July/August 2023. This will ensure that all NHS bodies are able to maintain a line of sight on the progress being made, noting WHSSC's status as a Joint Committee of each HB in Wales.

## 5.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report,
- **Note** the progress achieved in implementing the recommendations made by WHSSC auditors,

- Take an **assurance** on the rolling programme to collate updates from services on a bi-monthly basis in order to report progress to the Audit and Risk Committee,
- **Note** the progress made against WHSSC management responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report; and
- **Note** the progress made against the Welsh Government responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report

<b>Governance and Assurance</b>	
<b>Link to Strategic Objectives</b>	
<b>Strategic Objective(s)</b>	Governance and Assurance
<b>Link to Integrated Commissioning Plan</b>	<b>None</b>
<b>Health and Care Standards</b>	Governance, Leadership and Accountability Effective Care
<b>Principles of Prudent Healthcare</b>	Public and professionals are equal partners through co-production
<b>NHS Delivery Framework Quadruple Aim</b>	Reducing the per capita cost of health care Improving Patient Experience (including quality and Satisfaction)
<b>Organisational Implications</b>	
<b>Quality, Safety &amp; Patient Experience</b>	There are no direct impacts arising from this report. A strong governance framework as assessed by Internal Audit reports is essential to ensuring patients experience the greatest possible levels of safety and quality in the services commissioned by WHSSC. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff.
<b>Finance/Resource Implications</b>	There are no direct impacts arising from this report.
<b>Population Health</b>	Ensuring a robust governance framework as documented and supported by Internal Audit will have a positive impact on the commissioning of specialised services.
<b>Legal Implications (including equality &amp; diversity, socio economic duty etc)</b>	There may be an adverse effect on the organisation if arrangements are not put in place to ensure robust and detailed governance arrangements as determined through internal audit assessment
<b>Long Term Implications (incl WCFG Act 2015)</b>	Ensuring a robust governance framework as documented and supported by Internal Audit will have a positive impact on the commissioning of specialised services.
<b>Report History (Meeting/Date/ Summary of Outcome)</b>	<b>13 February 2023</b> – ARC update <b>10 January 2023</b> – Joint Committee updates on Audit Wales Governance recommendations
<b>Appendices</b>	Appendix 1 – WHSSC Internal Audit Tracker Report Appendix 2 – Update on the Audit Wales report on WHSSC Committee Governance Arrangements.

**Welsh Health Specialised Services Committee**  
**Register of Recommendations from the Internal Audit Report on Risk Management**  
**February 2023**

No.	Findings	Recommendation and Risk	Priority	Timescale	Lead Director	Owner	Progress	Completed
IA RM 2022 1	<p>Since the approval of the Risk Management Strategy and the revised approach to managing risk, the risk management process has continued to evolve. As such, some parts of the evolved process are not captured in the strategy, and there are some inconsistencies with other documents. We identified:</p> <ul style="list-style-type: none"> <li>• A Risk Scrutiny Group was formed after the strategy was written, as such there is no reference to the group in the strategy or in the appended process flow charts.</li> <li>• The strategy provides some information in relation to risk appetite, though no detailed information is given on the agreed appetite level, or how the level is to be applied in the risk management process. The strategy references how a risk with a high numerical value may be acceptable, suggesting that risk appetite is applied on a risk-by-risk basis. In contrast there is a statement relating to an annual review of risk appetite by the Joint Committee to ensure progress is being made toward the risk appetite WHSSC wishes to achieve. This would suggest that appetite is set at an organisational level.</li> <li>• The strategy makes reference to processes, procedures and risk assessments in relation to risk management, but there is no detailed information contained within the strategy. The risk assessment pro forma is not appended to the strategy.</li> <li>• The risk register process flow chart contained in the Corporate Risk Assurance Framework (CRAF) cover reports set out the process for non-commissioning risks. The strategy makes no differentiation between commissioning and non-commissioning risks, implying all follow the same process.</li> </ul>	<p>As the Risk Management Strategy and new processes have been operational for nearly a year, a review of the strategy should take place to ensure it fully and accurately captures current process and information, and is aligned to other risk management documents used by WHSSC. There is a risk of an inconsistent approach to risk management across the organisation.</p>	MEDIUM	September 2022 changed to May 2023	Director of Planning	Committee Secretary	<p>WHSSC accept the recommendation and the Risk Management Strategy will be reviewed and updated to address the recommendations made, including adding reference to the newly established Risk Scrutiny Group (RSG).</p> <p><b>PROGRESS: The Risk Management Strategy was reviewed in the autumn following the risk workshop on 20th September, the Joint Committee approved its risk appetite statement in January 2023 and the strategy has been further reviewed and will be presented to the JC in July 2023.</b></p>	ONGOING
IA RM 2022 3	<p>Whilst risk management training, via a series of workshops has been provided to senior staff, it has not been rolled out to all staff. The Risk Management Strategy states all members of staff are accountable for maintaining risk awareness and identify and reporting risks to their line manager.</p>	<p>Consideration should be given to rolling out risk management training and awareness sessions across the organisation so that all staff are fully aware of their responsibility and the processes they should follow in relation to identification and management of risks.</p> <p>There is a risk that risks are not properly identified or captured if staff are not trained on the process to follow, the organisations strategy and approach or the system used to capture risk.</p>	MEDIUM	December 2022 changed to May 2023	Director of Planning	Committee Secretary	<p>WHSSC accept the recommendation and will roll out risk management training and awareness sessions across the organisation to ensure that all staff are fully aware of their responsibility and processes they should follow in relation to identification and management of risks.</p> <p><b>PROGRESS: The Corporate Governance Team have undertaken research on risk management training methodologies across other nHS bodies and are in the process of developing a training programme to coincide with the new risk management strategy. Once the risk management strategy has been approved training will be rolled out to all staff.</b></p>	ONGOING

**Welsh Health Specialised Services Committee**  
**Summary Position Regarding Progress on Internal and External Audit Reports**  
**February 2023**

<b>Summary Position Regarding Internal Audit Recommendations</b>								
<b>Report Title</b>	<b>Report Date</b>	<b>Audit Committee Date</b>	<b>Number of Recommendations Made</b>	<b>Number of Recommendations Achieved</b>	<b>Number of Recommendations Outstanding</b>	<b>Recommendations Not Yet Falling Due</b>	<b>Recommendations over due ( Original Date )</b>	<b>Recommendations with a revised due date</b>
Cardiac Services	August 2019	October 2019	3	3	0	0	0	0
Information Governance	October 2019	October 2019	4	4	0	0	0	0
Financial Systems	December 2020	April 2021	2	2	0	0	0	0
Women & Children's Services	March 2021	April 2021	2	2	0	0	0	0
Cancer and Blood Programme Team	July 2021	August 2021	1	1	0	0	0	0
Positron Emission Tomography Scanner Service	January 2022	February 2022	15	15	0	0	0	0
Risk Management 2022	May 2022	May 2022	4	2	2	0	2	2
Neurosciences and Long Term Conditions	September 2022	October 2022	1	1	0	0	0	0
Quality Assurance Reporting	October 2022	October 2022	1	1	0	0	0	0
<b>Summary Position Regarding Audit Wales Recommendations</b>								
<b>Report Title</b>	<b>Report Date</b>	<b>Audit Committee Date</b>	<b>Number of Recommendations Made</b>	<b>Number of Recommendations Outside of WHSSC Control</b>	<b>Number of Recommendations Within WHSSC Control</b>	<b>WHSSC Actions Agreed</b>	<b>Actions Completed</b>	<b>WHSSC Actions in Progress</b>
Governance Arrangements	May 2021	August 2021	7	3	4	13	13	0

## Recommendations from the Audit Wales Report Welsh Health Specialised Services Committee Governance Arrangements

### Audit Tracker– Update **May 2023**

In May 2021, Audit Wales published the “Welsh Health Specialised Services Committee Governance Arrangements”<sup>1</sup> which found that the governance, management and planning arrangements at WHSSC have improved, however the impact of COVID-19 will require a clear strategy to recover key services and that the Welsh Government’s long-term model for health and social care ‘A Healthier Wales’, and the references made to WHSSC should be re-visited.

Audit Wales made a number of recommendations for both WHSSC and Welsh Government and the management response was presented to the Joint Committee on the 13 July 2021. Progress against actions to address the recommendations will be monitored through the Integrated Governance Committee (IGC).

Response/ Action	Target Date	Exec Lead	Progress/Comments <b>May 2023</b>	RAG
<b>Recovery Planning</b>				
<p><b>R3</b> In the short to medium term, the impact of COVID-19 presents a number of challenges. WHSSC should undertake a review and report analysis on:</p> <ul style="list-style-type: none"> <li>a. the backlog of waits for specialised services, how these will be managed whilst reducing patient harm.</li> <li>b. potential impact and cost of managing hidden demand. That being patients that did not present to primary or secondary care during the pandemic, with conditions potentially worsening.</li> <li>c. the financial consequences of services that were commissioned and under-delivered as a result of COVID-19, including the under-delivery of services commissioned from England. This should be used to inform contract negotiation.</li> </ul>				
<p><b>b) Potential impact and cost of managing hidden demand.</b></p> <p>i. Introduction of demand monitoring compared to historical levels for high volume specialties, findings to be reported</p>	In place	Director of Finance	<p>i. The introduction of demand monitoring comparing historical levels for high volume specialties is routinely undertaken and the findings are reported to the WG</p>	<b>Completed</b>

<sup>1</sup> [Welsh Health Specialised Services Committee Governance Arrangements \(audit.wales\)](https://audit.wales)

Response/ Action	Target Date	Exec Lead	Progress/Comments <b>May 2023</b>	RAG
<p>to the WG Planned Care Board and HBs to inform non- WHSSC commissioned pathway development.</p> <p>ii. Appointment of an Associate Medical Director for Public Health to work with Health Board Directors of Public Health to assess impact.</p>	<p>Q3/Q4 2021-22</p> <p>Feb 2023</p>	<p>Director of Nursing &amp; Quality</p> <p>Director of Planning</p> <p>Medical Director</p>	<p>Planned Care Board and HBs to inform non- WHSSC commissioned pathway Development. Demand monitoring continuously features as part of the ICP process, board presentations to HBs and through strategic reviews highlighting variations in access using data systems,</p> <p>ii. WHSSC began the process to advertise for an Associate Medical Director for Public Health via NHS jobs in Autumn 2022. Since then delays were encountered with the process for advertising a clinical role and an agenda for change role in tandem. <b>The Job description has been reviewed by the job evaluation panel at CTMUHB and has been banded, however in light of the WG Review of National Commissioning Arrangements, it is proposed that the post be advertised after the Ministers announcement on the future of commissioning bodies.</b></p>	<p style="background-color: green; color: white; text-align: center;">RAG</p>

Response/ Action	Target Date	Exec Lead	Progress/Comments May 2023	RAG
<b>Specialised Services Strategy</b>				
<p><b>R4</b> The current specialised services strategy was approved in 2012. WHSSC should develop and approve a new strategy during 2021. This should:</p> <ol style="list-style-type: none"> <li>embrace new therapeutic and technological innovations, drive value, consider best practice commissioning models in place elsewhere, and drive a short, medium, and long-term approach for post pandemic recovery.</li> <li>be informed by a review of the extent of the wider services already commissioned by WHSSC, by developing a value-based service assessment to better inform commissioning intent and options for driving value and where necessary decommissioning.</li> </ol> <p>The review should assess services:</p> <ul style="list-style-type: none"> <li>which do not demonstrate clinical efficacy or patient outcome (stop);</li> <li>which should no longer be considered specialised and therefore could transfer to become core services of health boards (transfer);</li> <li>where alternative interventions provide better outcome for the investment (change); currently commissioned, which should continue.</li> </ul>				
<p><b>a. Embrace New Innovations</b></p> <p>i. We will continue to utilise our well-established horizon scanning process to identify new therapeutic and technological innovations, drive value and benchmark services against other commissioning models to support , short, medium, and long-term approach for post pandemic recovery,</p> <p>ii. We will continue to develop our relationship with NICE, AWMSG and HTW in relation to the evaluation of new drugs and interventions,</p> <p>iii. We will engage with developments for digital and Artificial intelligence (AI),</p>	<p>Jul 2021</p> <p>Q3 2021-22</p>	<p>Managing Director</p> <p>Director of Finance</p> <p>Director of Nursing &amp; Quality</p> <p>Director of Planning</p>	<p>i. The dual processes of horizon scanning and prioritisation is firmly embedded in WHSSC’s commissioning practice and has been applied successfully since 2016. The process helps ensure the NHS in Wales effectively commissions’ new and innovative treatments that are both clinically and cost effective, and are made available in a timely manner. Horizon scanning identifies new interventions which may be suitable for funding, and prioritisation allows them to be ranked according to a set of pre-determined criteria,</p>	<p>Completed</p>



Response/ Action	Target Date	Exec Lead	Progress/Comments <b>May 2023</b>	RAG
			<p>represented on their Assessment Group, Appraisal Group and Stakeholder Forum. A joint proposal to support all Wales policy development of HTW guidance was supported by MG in June and the HTW Executive Board in July 2021. Funding for two posts (Project Manager and Admin) to support this work is now being sought from WG</p> <p>c. WHSSC also has a close working relationship with AWMSG, focused mainly on medicines management and horizon scanning. A MoU is now being developed between WHSSC and AWMSG to formalise these links and to share knowledge and expertise. The appointment of a WHSSC Medicines Management Pharmacist (due to start January 2022) will further strengthen this partnership.</p> <p>iii. We continue to engage with developments for digital and Artificial intelligence (AI)</p>	

Response/ Action	Target Date	Exec Lead	Progress/Comments <b>May 2023</b>	RAG
			<p>iv. We continue to attend the four nations' specialised services commissioners meetings,</p> <p>v. We continue to build upon our existing relationships with the Royal Colleges,</p> <p>vi. We continue to develop our work on value-based commissioning,</p> <p>vii. We have developed a communication and engagement plan to support and inform the strategy which will be presented to the CDGB in January 2022,</p> <p>viii. It was previously agreed with Joint Committee that a stakeholder engagement exercise would be undertaken in December 2021/January 2022 to gain insight on long term ambitions and to inform how we shape and design our services for the future. This would inform the Specialised Services Strategy which would be presented to the JC in January/March 2022. The timetable for this is however being revised in response to the system pressures related to the current wave of the pandemic and the letter from Judith Paget CEO of NHS Wales regarding use of the Options Framework and the</p>	

Response/ Action	Target Date	Exec Lead	Progress/Comments <b>May 2023</b>	RAG
	May 2023		<p>necessity to step down non-essential activities.</p> <p>ix. A Project Manager (PM) has been employed on an interim basis to lead the work required to develop and agree the specialised services strategy. On the 6 September 2022 the Joint Committee approved the overall approach to developing a ten year strategy for specialised services and provided feedback on the engagement and communications plan, themes and the stakeholder survey. The engagement process was undertaken between 20 September and 22 December 2022. <b>The draft strategy was presented to the Management Group on 23 March 2023, discussed at a workshop on the 17 April 2023 and was approved by the Joint Committee on 16 May 2023. View here - <a href="#">Strategies and Plans - Welsh Health Specialised Services Committee (nhs.wales)</a></b></p>	
<p><b>b. Approach to Review of Services will be considered in strategy engagement</b></p> <p>i. The draft strategy will consider our approach to the review of the existing portfolio of commissioned services and</p>	<p>Sept 2021</p> <p>March 2022</p>	<p>Director of Finance</p> <p>Director of Nursing &amp; Quality</p>	<p>The draft new specialised services strategy:</p> <p>i. It was previously agreed with Joint Committee a stakeholder engagement exercise would be undertaken in December</p>	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments <b>May 2023</b>	RAG
<p>undertake a value based services assessment to assess if existing services are still categorised as specialised,</p> <p>ii. We will continue to undertake our annual prioritisation panel with HB's to assess new specialised services that could be commissioned,</p> <p>iii. We will continue to undertake a process of continuous horizon scanning to identify potential new and emerging services and drugs, and to focus on existing and new hyper-specialised services,</p> <p>iv. WHSSC will investigate opportunities for strengthening its information function through internal re-organisation and investment. This will include the development of an outcome manager post to support both the WHSSC strategic approach to outcome measurement as well as a feasibility analysis of currently available tools. We will pursue our planned investment to utilise the SAIL database with a view to assessing the population impact of services in a number of pilot areas. As previously agreed with the Joint Committee a stakeholder engagement exercise will be undertaken to gain insight from our stakeholders on long term ambitions and to inform how we shape and design our services for the</p>	<p>May 2023</p>	<p>Director of Planning</p>	<p>2021/January 2022 to gain insight on long term ambitions and to inform how we shape and design our services for the future. This would inform the Specialised Services Strategy which would be presented to the JC in January/March 2022. The timetable for this is however being revised in response to the system pressures related to the current wave of the pandemic and the letter from Judith Paget, CEO of NHS Wales regarding use of the Options Framework and the necessity to step down non-essential activities. A Project Manager (PM) has been employed on an interim basis to lead the work required to develop and agree the specialised services strategy. On the 6 September 2022 the Joint Committee approved the overall approach to developing a ten year strategy for specialised services and provided feedback on the engagement and communications plan, themes</p>	<p style="background-color: green; color: white; text-align: center;">RAG</p>

Response/ Action	Target Date	Exec Lead	Progress/Comments <b>May 2023</b>	RAG
<p>future. This will inform transferring commissioned services into and out of the WHSSC portfolio to meet stakeholder and patient demand.</p>			<p>and the stakeholder survey. The engagement process was undertaken between 20 September and 22 December 2022. <b>The draft strategy was presented to the Management Group on 23 March 2023, discussed at a workshop on the 17 April 2023 and was approved by the Joint Committee on 16 May 2023 – view here <a href="#">Strategies and Plans - Welsh Health Specialised Services Committee (nhs.wales)</a></b></p> <p>ii. On the 28 September 2021 the WHSSC executive team met with Improvement Cymru (IC) to discuss and explore potential options for them to support WHSSC in developing its new specialist services strategy and WHSSC agreed to hold a Quality Improvement workshop facilitated by IC in January 2022 and to develop improvement and audit days with nursing teams with a view to undertaking our own internal competency assessment to drive improvement, and considered predictive modelling for</p>	

Response/ Action	Target Date	Exec Lead	Progress/Comments <b>May 2023</b>	RAG
			<p>interventions, and international collaborative networks,</p> <p>iii. WHSSC are required to agree annually those services that should be planned on a national basis and those that should be planned locally (section 1.1.4 WHSSC SO's), to support this, following a discussion at the JC 7 September 2021 a workshop was held with the MG on the 25 November 2021 to evaluate the commissioning of services. MG members were requested to submit expressions of interest to evaluate specific commissioned services in order to evaluate the merits of the service being commissioned locally at HB level or through WHSSC.</p> <p>iv. A recovery workshop was held with the MG on the 16 December 2021 to discuss recovery Planning and Quality and Outcome Improvement for Patients. A second recovery workshop was held with the Joint Committee on the 12 July 2022 at their request to discuss HB recovery plans and trajectories. At the JC's request, a follow up deep dive into paediatrics was given to the Joint Committee on the 6 September</p>	

Response/ Action	Target Date	Exec Lead	Progress/Comments <b>May 2023</b>	RAG
			<p>2022, and further recovery update session on the 8 November 2022.</p> <p>v. The annual prioritisation panel with HB's to assess new specialised services that could be commissioned was held on the 20 July 2021,</p> <p>vi. The process of continuous horizon scanning to identify potential new and emerging services and drugs, and to focus on existing and new hyper-specialised services was undertaken between January and May 2021 and informed the prioritisation panel on the 20 July 2021,</p> <p>vii. We have investigated opportunities for strengthening our information function through internal re-organisation and investment and have strengthened the staffing model of the information function to enable more timely information. The WHSSC staffing structure has been reviewed to include a senior outcomes commissioner to design outcome systems and monitor and report outcomes.</p>	

Response/ Action	Target Date	Exec Lead	Progress/Comments <b>May 2023</b>	RAG
<b>Welsh Government Recommendation - Independent member recruitment</b>				
<b>Welsh Government Recommendation - Sub-regional and regional programme management</b>				
<b>R6</b> This is linked to Recommendation 2 made to WHSSC in this report. When new regional or sub-regional specialised services are planned which are not the sole responsibility of WHSSC, ensure that effective multi- partner programme management arrangements are in place from concept through to completion (i.e. early in the development through to post-implementation benefits analysis).				
<p><b>Letter from Dr Andrew Goodall to Adrian Crompton, 2 June 2021 stated:</b> As you have highlighted, whilst some key service areas like major trauma have been developed successfully and with good collaboration across organisations, the timelines around such changes have been slow and often hampered by a lack of clarity on who is driving the process. I agree with your view that end-to-end programme management of such schemes, which are not within the sole remit of WHSSC, should be strengthened. The National Clinical Framework which we published on 22 March, sets out a vision for a health system that is co-ordinated centrally and delivered locally or through regional collaborations. Implementation will be taken forward through NHS planning and quality improvement approaches and our accountability arrangements with NHS bodies.</p>			<p><u>WG update received 22 August 2022</u> Letter received from the Director General Health and Social Services/ NHS Wales Chief Executive Health and Social Services Group advising that she had written to Mark Isherwood, Chair of the PAPAC regarding recommendations 6 and 7 of the Audit Wales report into WHSSC Governance arrangements.</p> <p>In relation to recommendation 7, the letter stated "that a review of the WHSSC arrangements along with other national hosted and specialist advisory functions should be undertaken. WG are in the process of setting up new piece of work to review the national commissioning arrangements in NHS Wales. The scope of this work and a timetable were currently being considered. However, we will be sure to take account of the recommendations as part of the rationale behind the work".</p>	Partially Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments <b>May 2023</b>	RAG
			<p>Having described the work that was now in progress, it was suggested that the recommendations from the Audit Wales report were now completed. The letter was copied to Mr Adrian Crompton, the Auditor General for Wales for assurance. Discussion with WG on the 31 August 2022 confirmed that the recommendations could be categorised as completed.</p> <p><u>WG update received 27 September 2022</u></p> <p>WHSSC received a further update from WG advising that Audit Wales had written to the Director General Health and Social Services/ NHS Wales Chief Executive Health and Social Services Group to express the view that, at this stage, it was premature to consider the recommendations as closed and that they would like to keep them open and receive an update from WG in six months' time. WG have confirmed they are content to accept the suggestion and that WG will provide an update to Audit Wales in six months' time with a view, to closing the recommendations at that point.</p>	

Response/ Action	Target Date	Exec Lead	Progress/Comments <b>May 2023</b>	RAG
			<p>An update was given to the Joint Committee on the 17 January 2023.</p> <p><u>WG Update 31 May 2023</u> Meeting with WG confirmed that due to a change in portfolio within the HSSG at WG, the Committee Secretary at WHSSC will liaise with Trudi Burton, WG to keep updated on the two recommendations pertaining to the WG to obtain an update for Joint Committee in July 2023.</p>	
<b>Welsh Government Recommendation - Future governance and accountability arrangements for specialised services</b>				
<p><b>R7</b> A Healthier Wales included a commitment to review the WHSSC arrangements along with other national hosted and specialist advisory functions. COVID-19 has contributed to delays in taking forward that action. It is recommended that the Welsh Government set a revised timescale for the action and use the findings of this report to inform any further work looking at governance and accountability arrangements for commissioning specialised services as part of a wider consolidation of current national activity.</p>				
<p><b>Letter from Dr Andrew Goodall to Adrian Crompton, 2 June 2021 stated:</b> A Healthier Wales committed to reviewing the WHSSC arrangements alongside other hosted national and specialised functions, in the context of the development of the NHS Executive function. The position of WHSSC within this landscape needs to be</p>			<p><u>WG update received 22 August 2022</u> Letter received from the Director General Health and Social Services/ NHS Wales Chief Executive Health and Social Services Group advising that she had written to Mark Isherwood, Chair of the PAPAC regarding recommendations</p>	Partially Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments <b>May 2023</b>	RAG
<p>carefully considered. On the one hand, there are strengths in the current system whereby health boards, through the joint committee, retain overall responsibility for the commissioning of specialised services. This requires collaboration and mature discussion from both the commissioner and provider standpoint. However, I recognise the inherent risk of conflict of interest in this arrangement and note the reference made in your report to the Good Governance Institute's report of 2015 which suggested a more national model may be appropriate.</p> <p>In my letter to health boards of 14 August 2019, I indicated that, as recommended by the Parliamentary Review, the governance and hosting arrangements for the existing Joint Committees would be streamlined and standardised. I also said that it was intended the NHS Executive would become a member of the Joint Committees' Boards in order to ensure there is a stronger national focus to decision making. However, the thinking at the time was that the joint committee functions would not be subsumed into the NHS Executive function. We will continue to look at this as the NHS Executive function develops further and I will update</p>			<p>6 and 7 of the Audit Wales report into WHSSC Governance arrangements.</p> <p>In relation to recommendation 7, the letter stated, "that a review of the WHSSC arrangements along with other national hosted and specialist advisory functions should be undertaken. WG are in the process of setting up new piece of work to review the national commissioning arrangements in NHS Wales. The scope of this work and a timetable were currently being considered. However, we will be sure to take account of these recommendations as part of the rationale behind the work".</p> <p>Having described the work that was in progress, it was suggested that the recommendations from the Audit Wales report were now completed. The letter was copied to Mr Adrian Crompton, the Auditor General for Wales for assurance. Discussion with WG on the 31 August 2022 confirmed that the recommendations could be categorised as completed.</p> <p><u>WG update received 27 September 2022</u></p>	

Response/ Action	Target Date	Exec Lead	Progress/Comments <b>May 2023</b>	RAG
<p>you should there be any change to the direction of travel I indicated in 2019.</p>			<p>WHSSC received a further update from WG advising that Audit Wales had written to the Director General Health and Social Services/ NHS Wales Chief Executive Health and Social Services Group to express the view that, at this stage, it was premature to consider the recommendations as closed and that they would like to keep them open and receive an update from WG in six months' time. WG have confirmed they are content to accept the suggestion and that WG will provide an update to Audit Wales in six months' time with a view, to closing the recommendations at that point.</p> <p><u>WG Update Received 25 January 2023</u></p> <p>WG informed WHSSC that the Director General Health and Social Services/ NHS Wales Chief Executive Health and Social Services Group had written to Audit Wales to provide them with an update on a proposed review of national commissioning functions. Copies of letters issued to NHS Chairs and Chief Executives on 23 January 2023 were included, along with the terms of reference for</p>	

Response/ Action	Target Date	Exec Lead	Progress/Comments <b>May 2023</b>	RAG
			<p>an independent review which had been agreed by the Minister for Health &amp; Social Services. The review commenced week commencing 23 January and will conclude by April 2023. The terms of reference were discussed at the NHS Wales Leadership Board 24 January 2023 and NHS organisations confirmed their commitment to participating in the review.</p> <p>An update was given to the Joint Committee on the 17 January 2023 and the final report will be presented in May 2023.</p> <p><u>WG Update 31 May 2023</u> Meeting with WG confirmed that due to a change in portfolio within the HSSG at WG, Committee Secretary at WHSSC will liaise with Trudi Burton to keep updated on the two recommendations pertaining to the WG to obtain an update for Joint Committee in July 2023.</p>	



**AGENDA ITEM**

4.3

**AUDIT AND RISK COMMITTEE**

**EASC UPDATE**

<b>Date of meeting</b>	21/06/2023
<b>FOI Status</b>	Open/Public
<b>If closed please indicate reason</b>	Not Applicable - Public Report
<b>Prepared by</b>	Gwenan Roberts, Committee Secretary / Assistant Director Corporate
<b>Presented by</b>	Stephen HARRY
<b>Approving Executive Sponsor</b>	Chief Ambulance Services Commissioner
<b>Report purpose</b>	NOTE

**Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)**

<b>Committee/Group/Individuals</b>	<b>Date</b>	<b>Outcome</b>
EAS Joint Committee	May 2023	Approved
EASC Management Group	Apr 2023	Endorsed
NCCU Risk Register NCCU Management Board	Feb 2023	Approved

**ACRONYMS**

DAG	Delivery Assurance Group
EMRTS	Emergency Medical Retrieval and Transfer Service
NEPTS	Non-Emergency Patient Transport Service
WAST	Welsh Ambulance Services NHS Trust

## 1. SITUATION/BACKGROUND

- 1.1 The purpose of the report is to provide an EASC update to the CTMUHB Audit and Risk Committee (as host body) for assurance purposes.
- 1.2 The following areas are included:
  - EASC Risk Register
  - EASC Assurance Framework
  - EASC Standing Orders and Standing Financial Instructions
  - Integrated Commissioning Action Plans
  - Investigation by the Welsh Language Commissioner
  - NCCU Risk Register
  - New EASC Performance Report
  - Emergency Medical Retrieval and Transfer (EMRTS) Service Review
  - Non Emergency Patient Transport Services (NEPTS) update.

## 2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

### EASC Risk Register

- 2.1 The Risk Register was reviewed and updated by the EASC Team during early 2023 in response to issues raised at the Cwm Taf Morgannwg University Health Board Audit and Risk Committee meeting. The updated EASC Risk Register was approved at the EASC meeting on 18 May 2023. The register will be reviewed prior to the next meeting of EASC in July 2023.
- 2.2 Additional information has been included related to the ongoing system pressures and the impact on patients and the increasing risk of harm.
- 2.3 The Risk Register is attached at **Appendix 1**.
- 2.4 The Red risks are as follows:
  - Failure to deliver the Ministerial direction that EASC effectively plans, commissions and secures services within its remit; and failure to maintain collaborative relationship with providers (4503)
  - Failure to achieve agreed performance standard for category red calls (4506)
  - Failure to achieve agreed performance standard for amber category calls (4507).
  - Failure to take appropriate commissioning actions to support the provider in their management of patient safety and to minimise clinical risk during times of escalation (5005)
  - Failure to secure sufficient ambulance capacity to meet the needs of the population (5370)

- 2.5 All of the existing risks are included on the Datix Risk Management System in line with the requirements of the host body Cwm Taf Morgannwg UHB.

### **EASC Assurance Framework**

- 2.6 The updated EASC Assurance Framework is attached as **Appendix 2** has been updated in line with the changes made to the EASC Risk Register.
- 2.7 This Framework is in line with the requirements of the host body.

### **EASC Standing Orders and Standing Financial Instructions**

- 2.8 Members are asked to note that the EASC Standing Orders and Standing Financial Instructions were approved at the EAS Joint Committee meeting on 14 March 2023. Some final work was required to complete the SFI Authorisation Matrix which has now been completed and will be shared with all health boards in Wales for inclusion with the individual health board standing orders as required.

### **Integrated Commissioning Action Plans (ICAPS)**

- 2.9 The EASC Team have continued to progress with the development of the ICAPS, working with health boards and WAST to transition actions from the development to the delivery phase. To reflect the work being undertaken in the delivery phase, health boards and WAST have decided to include additional team members in the ICAP meeting process.
- 2.10 The ICAPS template is currently on version 4 and was planned to be updated to version 5 in May. Work has been undertaken by health boards to realign their actions in the ICAPS to their 2023/26 IMTPs. Version 5 of the ICAPS will be available from July 2023.
- 2.11 Recognising that the work that has been achieved to date and now that the ICAPS have moved to a delivery phase, the EASC Team will be revising the frequency and approach to the ICAP meetings from May 2023.
- 2.12 In May and June 2023, the EASC Team have worked with health boards and WAST to review version 4 of the ICAPS. The work has performance data to identify areas for development and to align to IMTPs. The work has also reviewed shared learning opportunities across health boards, to explore alternative actions for system improvements.
- 2.13 Members will be aware that the Internal Audit undertaken on the development of the ambulance handover improvement plans and the subsequent transition to the ICAP process provided substantial assurance on the work. There was one low priority recommendation to strengthen the capturing of risk and this has now been incorporated into the ICAP meeting template.

## **Investigation by the Welsh Language Commissioner**

- 2.14 Members are asked to note the ongoing investigation by the Welsh Language Commissioner (WLC).
- 2.15 A member of the public had concerns regarding the availability of documentation on the EASC website and related to the EMRTS Service Development Proposal in November 2022. The member of the public had visited the website and had been unable to find a Welsh language version of the EMRTS Service Development Proposal on the website.
- 2.16 A full response (which confirmed responsibility and provided evidence of the EASC Team approach) was submitted to the Commissioner in line with the timescale stipulated.
- 2.17 Ongoing work is taking place supported by the Welsh Language Team at Cwm Taf Morgannwg UHB. The Commissioner has asked that changes are made to the website software and work has started with Digital Health and Care Wales to ensure this is completed.
- 2.18 The Commissioner found that EASC had failed to comply with Standard 39 and therefore had failed to ensure that every Welsh Language page on the website was fully functional and therefore treated the Welsh Language less favourably than the English language on the website. Also, a failure to comply with Standard 60 and failed to promote the use of the Welsh version of the EASC Website by providing service of inferior quality to the service on the English version of the website. **Appendices 3&4**
- 2.19 EASC must now take steps to ensure that content cannot be published on one site without the other and provide written evidence that enforcement action has been completed.
- 2.20 In apologizing to EASC, the following actions have been taken. More robust training has been provided to members of the EASC Team to ensure the ability to add to the websites at any time. Work is underway with the CTM Welsh Language team and a meeting has already taken place with staff from Digital Health and Care Wales to seek a software solution to this matter.
- 2.21 There are now three months to comply and ensure that this does not recur.
- 2.22 A further update will be provided when the work has been completed.

## **National Collaborative Commissioning Unit (NCCU) Risk Register**

- 2.23 The Risk Register was presented and approved at the NCCU Management Board meeting in February 2023.
- 2.24 The Risk Register is attached at **Appendix 5** (all risks presented).
- 2.25 There are 7 risks identified, 3 amber risks, 2 yellow and 2 green risks. There are no red risks at the time of reporting.

2.26 All of the risks are included and have been updated on the Datix Risk Management System in line with the requirements of the host body Cwm Taf Morgannwg UHB

### New EASC Performance Dashboard


2.27 EASC approved the use of a new performance dashboard at the last meeting. The Performance Dashboard is available at **Appendix 6**

## Performance Report | Summary and contents


Contents (Ctrl+Click to go to the required slide and the house symbol to return to summary).


- |                                      |                                  |
|--------------------------------------|----------------------------------|
| 1. Front page                        | 19. Handover delays over 4-hours |
| 2. Summary and contents              | 20. Trajectory                   |
| 3. 999 call demand                   | 21. RED/AMBER release requests   |
| 4. 111 Wales to 999 Transfers        | 22. Unit Hour Production (UHP)   |
| 5. 999 call answer times             | 23. Glossary of Terms            |
| 6. All incidents and RED performance |                                  |
| 7. Hear and Treat                    |                                  |
| 8. See and Treat                     |                                  |
| 9. RED incidents                     |                                  |
| 10. RED incident response time       |                                  |
| 11. AMBER incidents                  |                                  |
| 12. AMBER incident response times    |                                  |
| 13. GREEN incidents                  |                                  |
| 14. GREEN incident response times    |                                  |
| 15. Transported to Tier 1 site       |                                  |
| 16. Transported to non-Tier 1 site   |                                  |
| 17. Handover delays over 15-minutes  |                                  |
| 18. Handover delays over 60-minutes  |                                  |

#### Data acquisition key

 Data acquisition: EASC Ambulance Service Indicators

 Data acquisition: WAST Qlik Sense

 Data acquisition: WAST Data Academy SQL

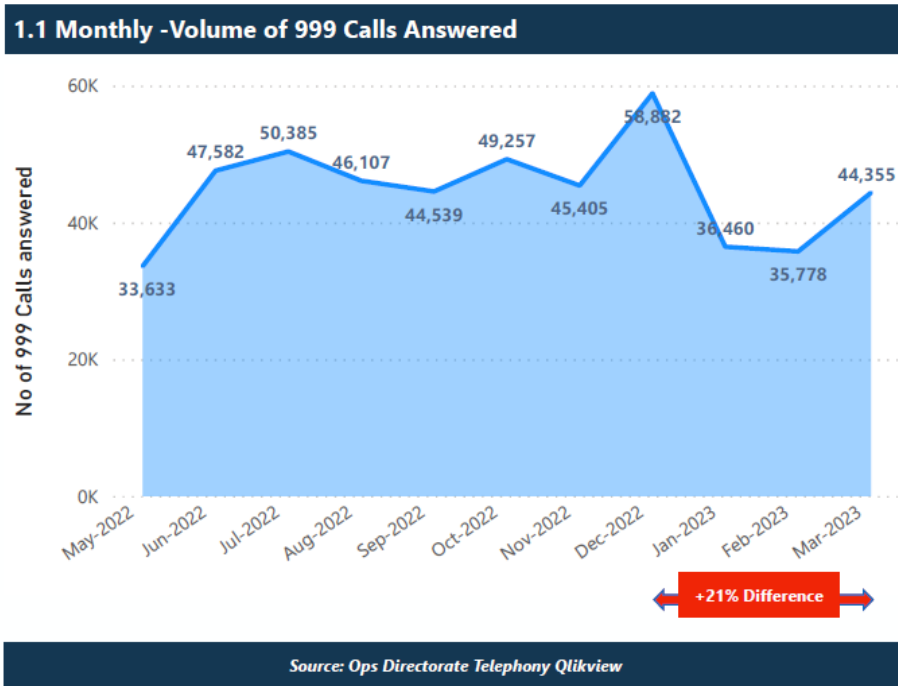
 Data acquisition: WAST Microsoft Excel

## Performance Report | Glossary of Terms

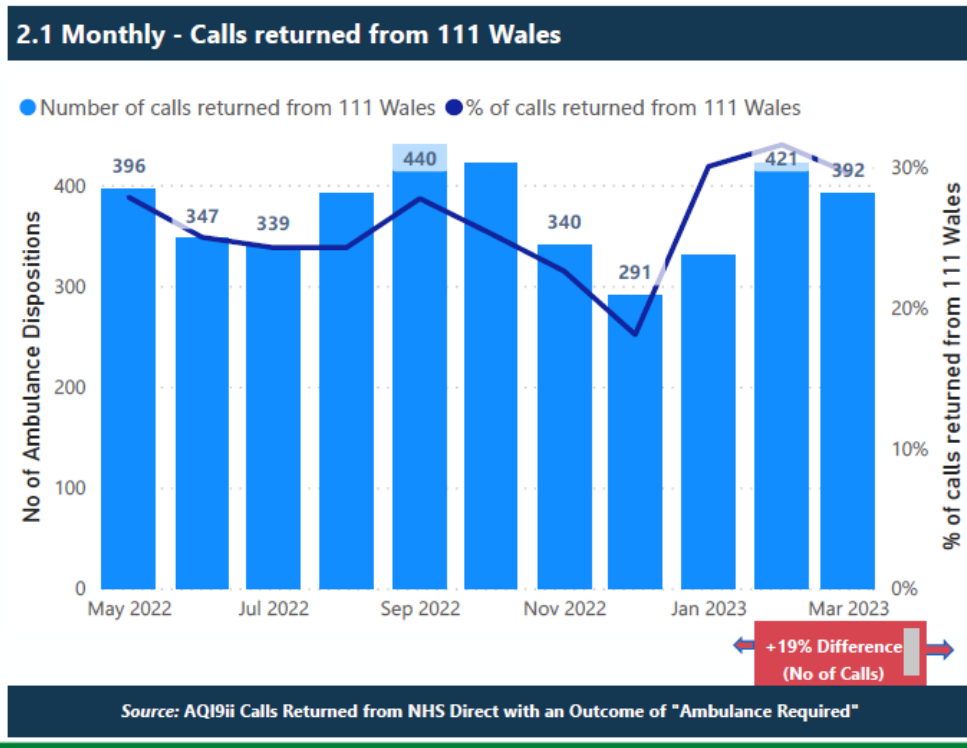
Verified Incidents ambulance service	All incidents recorded in the Call Ambulance System excluding duplicate incidents, errors, information calls, calls made in error or test calls or calls passed to another
Ambulance Dispositions	All Calls with a final outcome of "Referred to 999"
Destinations other than ED	This includes Minor Injury Units (MUIs) and Major Acutes
Red Incidents	The 'Red' category of call is for immediate life-threatening conditions where a person is in imminent danger of death.
Amber Incidents	The 'Amber' category of call is for those patients with serious conditions that are not immediately life-threatening, but which are urgent and may need treatment and care at the scene or rapid transport to a healthcare facility.
Green Incidents	The 'Green' category of call is for non-serious conditions which can often be managed by other health services, including healthcare advice or through self-care.
Hear and Treat	'Hear and Treat' is the telephone advice that callers who do not have serious or life threatening conditions receive from an ambulance service after calling 999. They may receive advice on how to care for themselves or where they might go to receive assistance.
See and Treat	See and treat is when a patient receives advice and care at scene and does not need to be taken to hospital.
UHP (Unit Hour Production)	The actual number of hours the Welsh Ambulance Services NHS Trust were able to produce against planned hours (number of available shifts)

2.28 The dashboard presents time series information across a number of periods, including daily, monthly and annual time periods.

- 2.29 Of particular note within the dashboard for this reporting period:
- 24% increase in 999 call volumes from Feb 23 to Mar 23

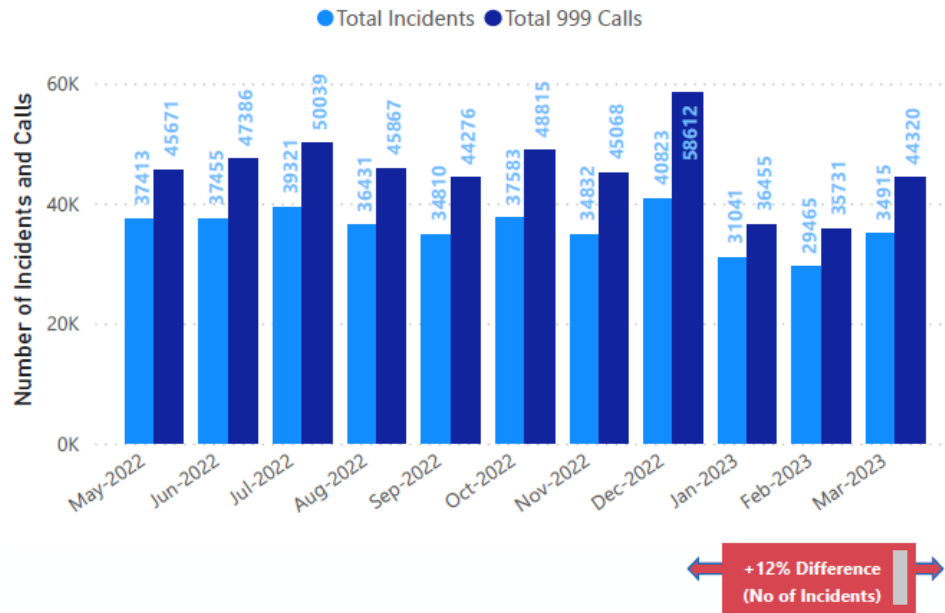


- 19% increase in 111 calls returned to 999 between Jan 23 and Mar 23



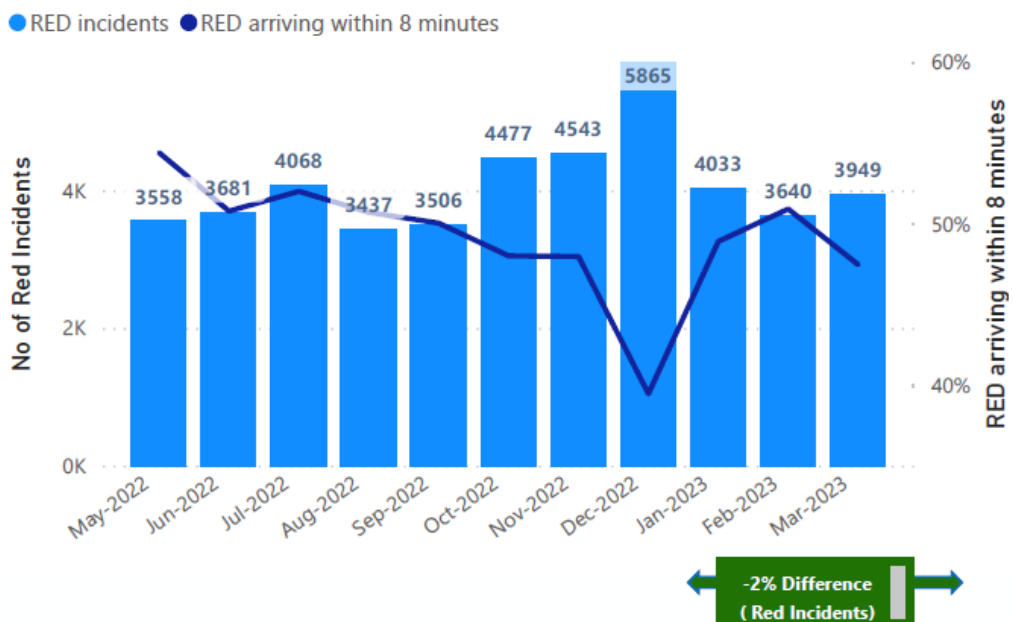
- 12% Increase in incidents Jan 23 to Mar 23

#### 4.1 Monthly Volume of Incidents and Calls



- Red median deterioration with downward trend in the longest red

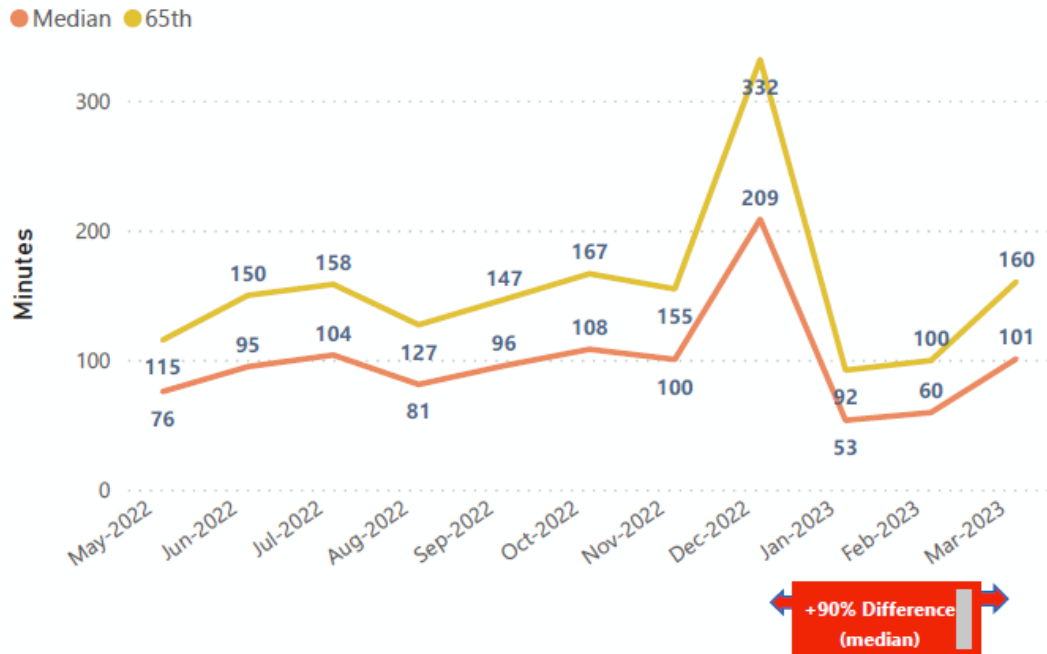
#### 7.1 Monthly Volume of Red Incidents and Red % Performance



Source: AQI11 Number of RED category incidents resulting in an emergency response

- Longest Amber waits have deteriorated

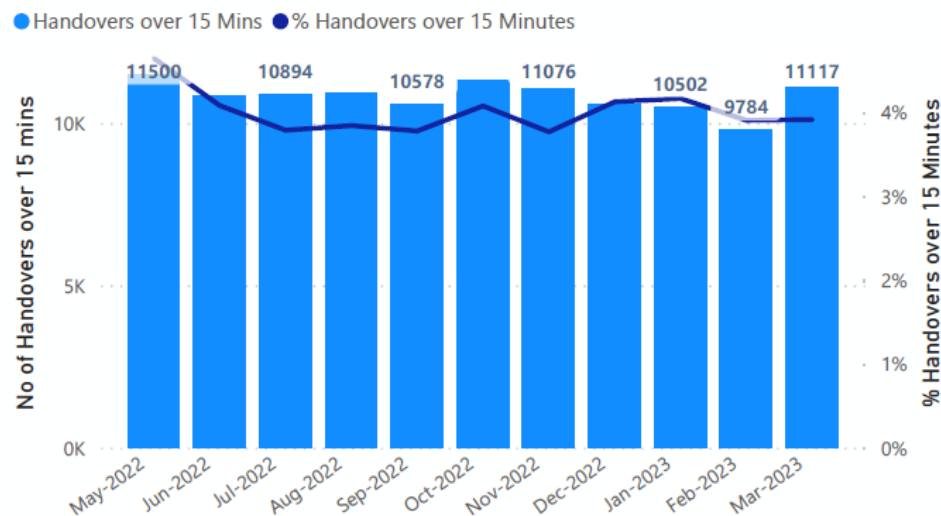
### 10.1 Median and 65th Percentile Amber Response Time (Minutes)



Source: AQI11 Amber Category Median, 65th and 95th Response Minutes

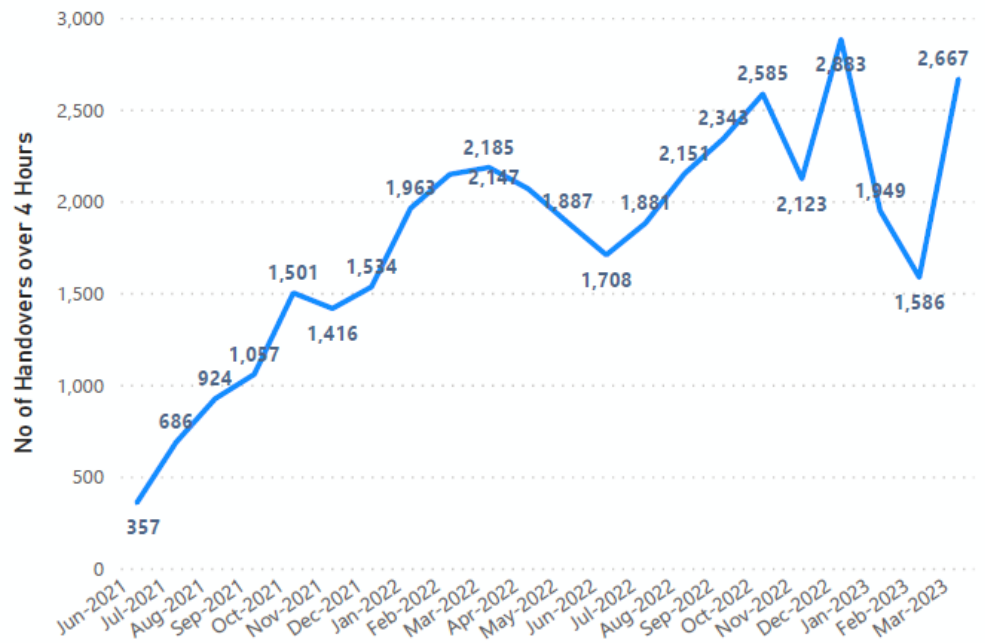
- Ambulance Handover delays in 2022, were 178% higher than 2019

### 15.1 Volume of Handovers over 15 minutes

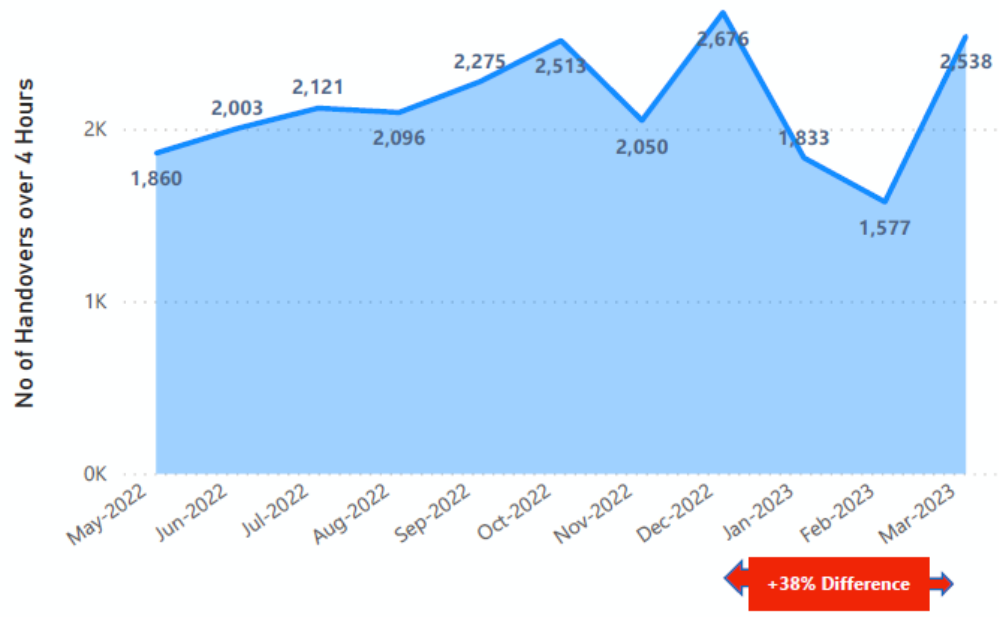


- Handover over 4 hours have deteriorated significantly from Feb 23 to Mar 23

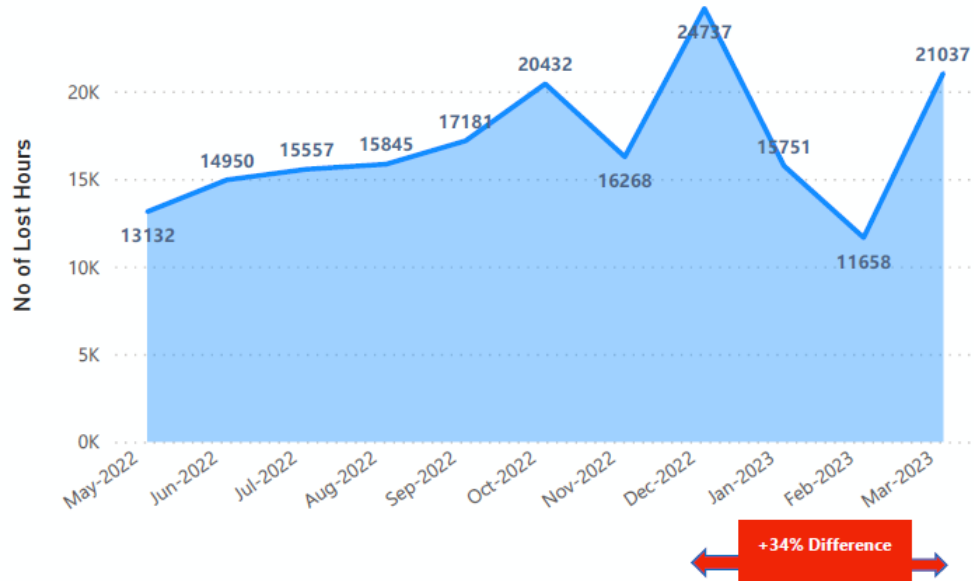
### 18.1 4 Hour Trajectory



### 17.1 Number of Handovers over 4 Hours

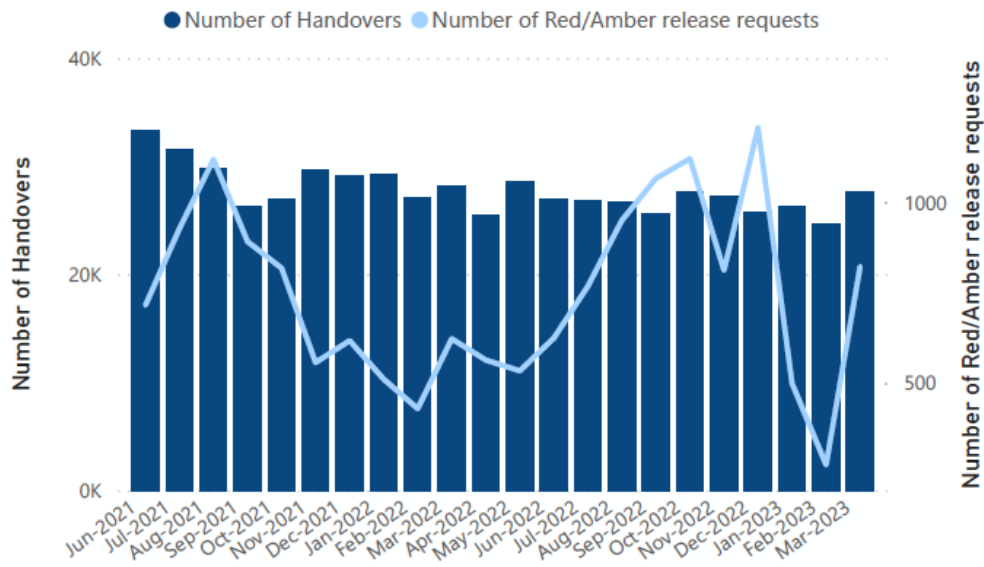


### 17.2 Hours lost for handovers over 4 Hours



Immediate release information

### 19.2 Red/Amber Release Request v Total Handovers



Source: WAST Red/Amber 1 Immediate Release Weekly Update / AQI20i Total Number of Handovers

## **Emergency Medical Retrieval and Transfer Service (EMRTS)**

- 2.30 The formal engagement process related to the EMRTS Service Review being taken by the Chief Ambulance Services Commissioner for EASC has been completed.
- 2.31 The former Community Health Councils across Wales had suggested that the process should last not less than 8 weeks.
- 2.32 The process included developing a comprehensive bilingual website, creating a number of bilingual engagement materials, holding face to face and online meetings across Wales.
- 2.33 Phase one of the process started on 15 March and completed on 12 June 2023. Work is now underway to capture all issues raised and develop options for consideration by EASC in the autumn.
- 2.34 Members should note that the way the EMRT service is provided will not change. Further information is available here <https://easc.nhs.wales/engagement/sdp/>.

## **EASC Action Plan**

- 2.35 The EASC Team are currently reviewing the EASC Action Plan and following confirmation (from Welsh Government) of the EASC Integrated Medium Term Plan (IMTP) the commitments will be included and will be the basis of the ongoing EASC Action Plan.
- 2.36 The latest EASC Action Plan is attached at **Appendix 7** and further iterations will be presented to the Committee.

## **Non-Emergency Patient Transport Services (NEPTS) Update**

- 2.37 As health services recommenced since the COVID19 pandemic, the requirement of the Non-Emergency Patient Transport Service (NEPTS) has changed. The EASC Team have supported health boards and WAST to realign the NEPTS service with the needs of health boards. The NEPTS service is monitored through NEPTS Delivery Assurance Group (DAG), developing and implementing national, regional and localised solutions to improve the performance and quality of the service.
- 2.38 As part of the annual commissioning cycle review, for 2023/24 the EASC Team will be reviewing the NEPTS Quality and Delivery Commissioning Framework. The review will be undertaken in collaboration with health boards and WAST and align the framework to organisations IMTPS for 2023/26.
- 2.39 In 2016, the Welsh Government approved a Business Case for the modernisation of the NEPTS. Following a review of the actions of the business case in 2022, it has been acknowledged that the actions were completed. To continue with the development of NEPTS, at the June 2023 NEPTS DAG, the EASC Team proposed the development of a new long-term strategy for NEPTS.

2.40 The NEPTS DAG members endorsed this proposal. The EASC Team will present a report of the next steps of the development of a long-term strategy as the next NEPTS DAG in August 2023 and will report to the EAS Joint Committee in due course.

### **3. KEY RISKS/MATTERS FOR ESCALATION**

3.1 The updated EASC risk register captures the key actions being taken to mitigate and control the risks relating to red performance. Additional information had been included and related to the ongoing system pressures and the impact on patients and the increasing risk of harm.

3.2 The controls that are in place are included in the WAST Performance Improvement Plan (PIP) and the EASC Action Plan coordinated by the Chief Ambulance Services Commissioner (CASC) (submitted to the Minister on a monthly basis), these are monitored at:

- bi-monthly Quality and Delivery meetings between the EASC Team and WAST.
- The PIP focuses on the actions being taken by WAST to mitigate risks and to increase capacity and emergency ambulance performance including red performance
- monthly meetings with Welsh Government officials with a focus on the actions being taken across the urgent and emergency care system (including the commissioning of additional emergency ambulance clinician capacity, system escalation and demand management).

3.3 As reported above the work to mitigate and control the risks relating to red performance is ongoing with progress monitored on a commissioner-provider level, via the EASC governance arrangements and also with oversight by Welsh Government.

3.4 Members should note that the Integrated Commissioning Action Plan meetings continue to take place between the EASC Team, key operational health board staff and WAST to further develop and monitor progress of health board handover improvement plans. The process to date has delivered:

- Collaborative Infrastructure to develop thinking, identify innovation and establish local commissioning arrangements for emergency ambulance services
- Local ambulance handover improvement plans for each local health board in Wales
- Commitment through board structures to deliver ambulance handover actions operationally

- An all Wales composite handover delay plan that identifies similarity and areas for targeted investment
- Weekly dashboards to support and monitor performance against agreed trajectories
- Internal Audit have recently provided substantial assurance on the process and the report will be taken through the EASC governance routes.

3.5 Work is being continued to deliver Goal 4 for the Six Goals for Urgent and Emergency Care Programme (Goal 4 lead Stephen Harray). The Integrated Commissioning Action Plans (iCAPS) for each health board have been developed and will support the national delivery of Goal 4.

3.6 Work is continuing to quantify the level of harm to patients and concerns regarding the safety of patients due to the number of handover delays and lost hours in the previous six months, although these have reduced.

3.7 Further updates will be provided in relation to the investigation by the Welsh Language Commissioner.

#### 4. IMPACT ASSESSMENT

<b>Quality/Safety/Patient Experience implications</b>	Yes (Please see detail below) The impact of handover delays will inevitably affect the patient experience and also quality and safety aspects of patient care. Specific mitigations are the responsibility of the health boards and the Welsh Ambulance Services NHS Trust working together. Learning lessons of peaks in demand will be really important
<b>Related Health and Care standard(s)</b>	Governance, Leadership and Accountability
<b>Equality impact assessment completed</b>	Not required
<b>Legal implications / impact</b>	There are no specific legal implications related to the activity outlined in this report.
<b>Resource (Capital/Revenue £/Workforce) implications / Impact</b>	There is no direct impact on resources as a result of the activity outlined in this report.

<p><b>Link to Commissioning Intentions</b></p>	<p>The Committee’s overarching role is to ensure its Commissioning Strategy for Emergency Ambulance Services utilising the five step patient pathway outlined within the National Collaborative Commissioning Quality and Delivery Agreement and the related outcomes for each care standard aligned with the Institute of Healthcare Improvement's (IHI) ‘Quadruple Aim’ are being progressed.</p>
<p><b>Link to Main WBFG Act Objective</b></p>	<p>Commitment to corporate social responsibility and improving health &amp; social equity, work with our staff, partners and communities to build strong local relationships and solid foundations of the past</p>

## 5. RECOMMENDATIONS

5.1 The Audit and Risk Committee is asked to:

- **NOTE** the EASC Risk Register
- **NOTE** the EASC Assurance Framework
- **NOTE** the Standing Orders and Standing Financial Instructions have been approved by EASC and now complete will be shared with health boards
- **NOTE** the ongoing work on the Integrated Commissioning Action Plans (ICAPS)
- **NOTE** the ongoing investigation by the Welsh Language Commissioner
- **NOTE** the NCCU Risk Register
- **NOTE** the new EASC Performance Report
- **NOTE** the completion of Phase 1 of the EMRTS Service Review of the formal engagement process
- **NOTE** the EASC Action Plan and the plan to report on the EASC IMTP once approved by the Welsh Government
- **NOTE** the ongoing work with the Non Emergency Patient Transport Service.

## EASC RISK REGISTER

Datix ID	Portfolio	Risk Domain (Strategic Objective)	Risk Title	Risk Description	Controls in place	Action Plan	Sources of Assurance	Rating (current)	Rating (Target)	Trend	Opened	Review date
4260	Chief Ambulance Services Commissioner	Set the Strategic Commissioning direction	Failure to produce agreed Commissioning Frameworks and Commissioning Intentions	<p><b>IF:</b> There is a failure to produce and agree Commissioning Frameworks and commissioning intentions</p> <p><b>Then:</b> The commissioned providers would not be clear regarding expectations for the quality, effectiveness and efficiency of services within an agreed financial plan.</p> <p><b>Resulting in:</b> Lack of clarity in the direction of the commissioned organisations (WAST and EMRTS)</p>	<ul style="list-style-type: none"> <li>Ensuring a programme approach to developing commissioning frameworks for delivery with focus on monitoring progress through the EASC Sub Groups</li> <li>Commissioning Intentions collaboratively developed and agreed with quarterly updates to be provided</li> <li>Forward look developed for all EASC Sub Groups including receiving progress on the deliverables within the plans</li> <li>Regular reporting of the Commissioning Update from EASC Sub Groups to the EAS Joint Committee on progress</li> <li>Commitment from the EASC for commissioning cycles</li> <li>EMS Commissioning Framework refreshed</li> <li>Local integrated commissioning action plans developed by HBs and WAST, process supported by EASC Team</li> </ul>	EASC Commissioning Cycle in place to set out the process and timeline for the development of Commissioning Intentions and Commissioning Frameworks; Commissioning Intentions agreed for EMS, NEPTS and EMRTS monitored at each EASC Management Group (bi-monthly) meeting and with quarterly updates to EASC; Commissioning Frameworks enacted for all commissioned services, Refreshed Emergency Ambulance Services Commissioning Framework agreed at September EASC meeting	<ul style="list-style-type: none"> <li>EASC Commissioning Cycle</li> <li>EASC Commissioning Intentions</li> <li>Commissioning Frameworks – reported to EASC every meeting (quarterly information)</li> <li>Minutes of EASC Sub Group meetings monitoring progress against plans</li> <li>Quarterly updates against EASC IMTP and Commissioning Intentions</li> </ul>	4x1 = 4	CXL 4x1=4	↔	01/08/2020	Reviewed 9 Jan 2023 Next review August 2023
4502	Chief Ambulance Services Commissioner	Meet the Ministerial direction to produce an EASC IMTP	Failure to develop an agreed EASC IMTP for endorsement by the Joint Committee seeking approval from the Welsh Government	<p><b>IF:</b> There is no agreement for the EASC IMTP</p> <p><b>Then:</b> The Commissioning Frameworks and Commissioning Intentions would not be supported</p> <p><b>Resulting in:</b> Lack of clarity in the direction of the commissioned organisations (WAST and EMRTS)</p>	<ul style="list-style-type: none"> <li>CASC Quality and Delivery meeting held monthly to discuss quality and performance matters</li> <li>Detailed work to deliver EASC IMTP overseen by EASC Management Group</li> <li>EASC IMTP (2022 to 2025) approved by EASC (March 2022)</li> <li>EASC IMTP Quarterly update reports via EASC Commissioning Update reports to EASC</li> <li>CASC IQPD (Integrated Quality and Performance Delivery) meeting with Welsh Government bi-monthly</li> <li>CASC meetings with Welsh Government planning department</li> <li>EASC IMTP 2022-25 confirmed as acceptable (with accountability conditions) by Welsh Government with quarterly updates in-year</li> </ul>	EASC IMTP recently confirmed as acceptable by WG (with accountability conditions); Quarterly updates now to be provided;	<ul style="list-style-type: none"> <li>Consistency between EASC IMTP with WAST IMTP and also with Health Boards</li> <li>Letter of support received from the Welsh Government with accountability conditions</li> <li>EASC Approval of the plan and WG confirmation</li> <li>Quarterly IMTP updates to EASC and its sub groups</li> </ul>	4x1=4	CXL 4x1= 4	↔	01/08/2020	Reviewed 9 Jan 2023 Next review August 2023
4503	Chief Ambulance Services Commissioner	Effective Commissioning	Failure to deliver the Ministerial direction that EASC effectively plans, commissions and secures services within its remit; and failure to maintain collaborative relationship with providers	<p><b>IF:</b> The EASC fail to plan and secure services and maintain effective collaborative relationships with providers</p> <p><b>Then:</b> The purpose and effectiveness of the EAS Joint Committee would not be met</p> <p><b>Resulting in:</b> Potential Ministerial and Welsh Government intervention</p>	<ul style="list-style-type: none"> <li>Agreed collaborative commissioning methodology</li> <li>Review and refine commissioning arrangements and refresh Commissioning Frameworks</li> <li>Effective function of the EASC Joint Committee</li> <li>Independent Chair</li> <li>Effective governance arrangements in place</li> <li>CASC and Welsh Government IQPD meetings (bi-monthly)</li> <li>Minister meets with the Chair and CASC quarterly</li> <li>Meet regularly with providers to ensure continued development of open and transparent relationship</li> <li>Model Standing Orders agreed for EASC</li> <li>July 2021 Special meeting of EASC with Minister and clear expectations received</li> <li>Ministerial Summit meeting on Handover Improvement plans (as a result of increasing numbers of hours lost)</li> </ul>	<ul style="list-style-type: none"> <li>Commissioning framework and monitoring at EASC and its sub groups</li> <li>Annual Governance Statement produced</li> <li>Monitoring of EASC IMTP at EASC and sub groups</li> <li>Review and refine governance arrangements</li> <li>Maintaining close working and collaborative relationships during unprecedented system pressures</li> <li>EASC action plan for Ministerial priorities and monthly monitoring return commitment including Integrated Commissioning Action Plans</li> </ul>	<ul style="list-style-type: none"> <li>Internal and external audit</li> <li>Welsh Government</li> <li>EASC Committee members</li> <li>Annual Governance Statement</li> <li>Strategic Commissioning intentions and Commissioning Frameworks</li> <li>Continued engagement with the commissioning process and EASC Governance</li> <li>EASC Action Plan with monthly update to the Minister and review</li> <li>Chair's appraisal letter with Minister</li> <li>ICAP meeting implementation plan</li> </ul>	5x3=15	CXL 5x1=5	↑	01/08/2020	Reviewed 9 Jan 2023 Next review April 2023
4504	Chief Ambulance Services Commissioner	Outcome measurement	Failure to respond to requirements identified within commissioned work related to the ambulance services	<p><b>IF:</b> Work commissioned is failed to be acted upon</p> <p><b>Then:</b> risks and issues identified will not be acted upon and implemented</p> <p><b>Resulting in:</b> a missed opportunity to improve services for patients leading to harm</p>	<ul style="list-style-type: none"> <li>Forward plan (Annual Business Plan) for EASC and all sub groups</li> <li>Development of action plans which are received, endorsed and approved by the EASC for action</li> <li>Action log for EASC and all sub groups</li> <li>Regular review of Ambulance Service Indicators with dedicated group jointly chaired with WAST</li> <li>Commissioning intentions - including measurement across the system</li> <li>Commissioner request for system wide measures</li> <li>Ongoing refresh of the Commissioning Frameworks</li> </ul>	<ul style="list-style-type: none"> <li>Governance and planning for EASC and all sub groups and supporting meetings</li> <li>Reviews of the commissioning frameworks</li> <li>EASC Action Plan and monthly monitoring return commitment</li> </ul>	<ul style="list-style-type: none"> <li>Amber Review</li> <li>ORH Report D&amp;C EMS</li> <li>Emergency Ambulances Framework - updated Sept 2022</li> <li>McClelland Review of Welsh Ambulance Services (2013)</li> <li>Internal and external audit</li> <li>CASC IQPD meeting with Welsh Government</li> <li>Annual Governance Statement</li> </ul>	4x3=12	CXL 4 x2 = 8	↑	01/08/2020	Reviewed 9 Jan 2023 Next review April 2023

## EASC RISK REGISTER







Datix ID	Portfolio	Risk Domain (Strategic Objective)	Risk Title	Risk Description	Controls in place	Action Plan	Sources of Assurance	Rating (current)	Rating (Target)	Trend	Opened	Review date
4505	Chief Ambulance Services Commissioner	Ministerial direction	Failure to achieve the agreed Chair's objectives with the Minister	<p><b>IF:</b> The agreed Chair's objectives with the Minister are not delivered</p> <p><b>Then:</b> Then the confidence of the Minister will be potentially compromised</p> <p><b>Resulting in:</b> The Minister not being assured that necessary progress has been made in the commissioning of ambulance services and the wider connections to unscheduled care services in Wales</p>	<ul style="list-style-type: none"> <li>Regular meetings with the EASC team to discuss any issues as well as quality issues and the development of improved reporting arrangements</li> <li>Cross reference to the work to deliver the Six Goals for Urgent and Emergency Care Programme and particularly Goal 4</li> </ul>	<ul style="list-style-type: none"> <li>Commissioner support for commissioning</li> <li>EASC Commissioning intentions</li> <li>Refresh Commissioning Frameworks</li> <li>EASC IMTP</li> <li>Focus on' sessions at EASC to discuss wider system issues</li> </ul>	<ul style="list-style-type: none"> <li>Minister's response following Chair's appraisal</li> <li>Six Goals for Urgent and Emergency Care Programme delivery particularly Goal 4</li> <li>Updated objectives for Chair received</li> </ul>	3x2=6	CXL 3 x2 = 6	↔	01/08/2020	Reviewed 9 Jan 2023 Next review October 2023
4506	Chief Ambulance Services Commissioner	Securing safe ambulance services	Failure to achieve agreed performance standard for category red calls which is 65% of calls responded to within 8 minutes	<p><b>IF:</b> The red performance level is less than 65% response rate within 8 minutes across Wales as a whole on a monthly basis</p> <p><b>Then:</b> The core target will be missed</p> <p><b>Resulting in:</b> Unsatisfactory service for the people of Wales (or within specific health board areas) with increased likelihood of harm, disability and death.</p>	<ul style="list-style-type: none"> <li>The necessary resources secured in the EASC IMTP</li> <li>Performance monitoring on a daily basis and month to date position</li> <li>Bi monthly CASC IQPD meetings with Welsh Government</li> <li>CASC monthly Quality and Delivery Meeting with the Welsh Ambulance Services NHS Trust</li> <li>Commissioner element of EMS Demand and Capacity plan for additional staff supported – implementation being monitored</li> <li>Quality and Safety Report presented at every EASC meeting</li> <li>Commissioner element of EMS Demand and Capacity plan for additional staff supported – implementation being monitored</li> <li>Quality and Safety Report presented at every EASC meeting</li> <li>Commissioner element of EMS Demand and Capacity plan for additional staff supported;</li> </ul>	<ul style="list-style-type: none"> <li>Delivery of EASC IMTP and WAST IMTP</li> <li>Implementation of the commissioning intentions through the commissioning agreement</li> <li>Role of the EASC Management Group to provide oversight on operational performance</li> <li>Development of WAST performance improvement plan</li> <li>EASC Action Plan includes detailed clinical review of red incidents to understand clinical need of patients to assess improvement opportunities</li> </ul>	<ul style="list-style-type: none"> <li>Ambulance Service Indicators</li> <li>Daily weekly and monthly performance reports</li> <li>Remedial Action plans (if required)</li> <li>Specific targeted actions as required</li> <li>Commissioner Ambulance Availability Taskforce</li> <li>Implementation of the Demand and Capacity Review</li> <li>Commissioner EASC Action Plan including monthly submission and review</li> <li>CASC liaison with Chief Operating Officers</li> <li>Additional £3m investment in year to support front line services which will also support the commencement of the Cymru High Acuity Response Unit (CHARU)</li> </ul>	5x5=25	CXL 5x3= 15	↔	Aug-20	Reviewed 9 Jan 2023 Next review April 2023
4507	Chief Ambulance Services Commissioner	Securing safe ambulance services	Failure to achieve agreed performance for amber category calls	<p><b>IF:</b> The average and longest times for amber incidents do not reduce</p> <p><b>Then:</b> Patients will not receive the care they need in a timely manner</p> <p><b>Resulting in:</b> unsatisfactory service for the people of Wales (or within specific health board areas) with increased likelihood of harm, disability and death.</p>	<ul style="list-style-type: none"> <li>The necessary resources secured in the EASC IMTP/ Annual Plan</li> <li>performance monitoring on a daily basis and month to date position</li> <li>CASC Monthly quality and delivery meetings with WAST</li> <li>Bi monthly CASC Quality and Delivery meeting with Welsh Government</li> <li>CASC monthly Quality and Delivery Meeting with the Welsh Ambulance Services NHS Trust</li> <li>Commissioner element of EMS Demand and Capacity plan for additional staff supported and implementation being monitored</li> <li>Quality and Safety Report presented at every EASC meeting</li> <li>Weekly dashboard shared across NHS Wales – sent to all EASC members and key senior NHS staff</li> </ul>	<ul style="list-style-type: none"> <li>EASC IMTP accepted with accountability conditions awaiting outcome of WAST IMTP</li> <li>Implementation of the commissioning intentions through the commissioning agreement</li> <li>Role of the EASC Management Group to provide oversight on operational performance</li> <li>Development of WAST performance improvement plan</li> <li>Weekly dashboard of management information developed and shared across NHS Wales to capture progress</li> <li>EASC Action plan includes detailed clinical review of amber incidents to understand clinical need of patients to assess improvement opportunities</li> </ul>	<ul style="list-style-type: none"> <li>Ambulance Service Indicators</li> <li>Daily weekly and monthly performance reports</li> <li>Remedial Action plans (if required)</li> <li>Specific targeted actions as required</li> <li>Commissioner Ambulance Availability Taskforce</li> <li>Implementation of the Demand and Capacity Review</li> <li>EASC Action Plan for Minister including monthly submission and review</li> <li>CASC liaison with Chief Operating Officers (multiple arenas)</li> </ul>	5x5=25	CXL 5x3= 15	↔	Aug-20	Reviewed 9 Jan 2023 Next review April 2023
4508	Chief Ambulance Services Commissioner	Set the Strategic Commissioning Direction	Failure by the whole system, policy makers, commissioners and providers to utilise EASC in matters which relate to its areas of responsibility during times of escalation	<p><b>IF:</b> The system does not utilise the arrangements in place at EASC</p> <p><b>Then:</b> The governance and purpose of EASC will be undermined</p> <p><b>Resulting in:</b> a lack of consistency, duplication of services and resources, poor governance and non compliance with the Statutory Instrument leading to unnecessary system pressures</p>	<ul style="list-style-type: none"> <li>Accountable officers of health boards are members of EASC</li> <li>Memorandum of understanding and commitment from all EASC members</li> <li>Sharing information on service developments</li> <li>Alignment to the 6 Goals for Urgent and Emergency Care Programme Board</li> <li>Model Standing Orders agreed and reviewed annually</li> <li>Commissioning Frameworks reviewed</li> </ul>	<ul style="list-style-type: none"> <li>Collaborative commissioning agreements</li> <li>EASC Management group representing all organisations</li> <li>Aligning EASC IMTP with WAST and Health board IMTPs</li> <li>CASC meeting with Welsh Government planners</li> <li>CASC IQPD meeting with Welsh Government</li> <li>CASC Quality and Delivery meeting with WAST</li> <li>Chair of EASC and CASC meetings with Health Boards</li> <li>CASC Member of NHS Leadership Board</li> </ul>	<ul style="list-style-type: none"> <li>Memorandum of understanding</li> <li>Independent Chair Governance arrangements</li> <li>Commitment to collaborative nature of working</li> <li>External audit</li> <li>Welsh Government and Commissioner support for EASC</li> <li>EASC Action Plan</li> <li>EASC Standing orders and Standing Financial Instructions</li> </ul>	4x2 =8	CXL 4x1= 4	↔	Aug-20	Reviewed 9 Jan 2023 Next review April 2023

## EASC RISK REGISTER

Datix ID	Portfolio	Risk Domain (Strategic Objective)	Risk Title	Risk Description	Controls in place	Action Plan	Sources of Assurance	Rating (current)	Rating (Target)	Trend	Opened	Review date
5005	Chief Ambulance Services Commissioner	Effective Commissioning	Failure to take appropriate commissioning actions to support the provider in their management of patient safety and to minimise clinical risk during times of escalation	<p><b>IF:</b> Commissioning actions are not taken to manage patient safety and minimise clinical risks</p> <p><b>Then:</b> Patients are more likely to come to harm</p> <p><b>Resulting in:</b> poorer patient outcomes and patient experience, increased SAIs, litigation and reputational damage</p>	<ul style="list-style-type: none"> <li>•Discussion at EASC Committee</li> <li>•Discussion at EASC Management Group</li> <li>•CASC and WAST Quality &amp; Delivery meeting</li> <li>•Sought clarification from WAST re Equality Impact Assessment</li> <li>•Agree red lines for handover delays to improve ambulance availability</li> <li>•Securing of funding for additional emergency ambulance capacity</li> <li>•Quality and Safety Report received at every EASC meeting</li> </ul>	<ul style="list-style-type: none"> <li>•Joint escalation plan developed and approved at NHS Leadership Board (not yet actioned)</li> <li>•Commissioning Operational Delivery Unit (not yet actioned) to avoid unilateral WAST decision-making</li> <li>•Provide necessary funding to WAST</li> </ul>	<ul style="list-style-type: none"> <li>•WAST Equality Impact Assessment (to be completed)</li> <li>•Commitment to collaborative nature of working and implementation of system-wide escalation policy</li> <li>•Ongoing discussions around system-wide escalation</li> <li>•EASC Management Group agreed to set up two task and finish groups</li> <li>1. Response to Healthcare Inspectorate Wales review related to handover delays</li> <li>2. Appendix B</li> </ul>	5x4 = 20	CXL 5x1 = 5	↑	Dec-21	Reviewed 9 Jan 2023 Next review April 2023
5006	Chief Ambulance Services Commissioner	Outcome measurement	Failure to receive timely and quality assured information for publication as a result of the transition to new information systems (ECNS, ePCR)	<p><b>IF:</b> Timely and quality assured data is not provided</p> <p><b>Then:</b> EASC will be unable to publish data or assure itself of the quality of service provision</p> <p><b>Resulting in:</b> a lack of consistency and public confidence, duplication of services and resources, poor governance and non compliance with reporting requirements set out in the commissioning framework</p>	<ul style="list-style-type: none"> <li>•Regular meetings with the project team to discuss any issues as well as with the clinical audit team around the development of reporting arrangements</li> <li>•Weekly dashboard shared across NHS Wales – sent to all EASC members and key senior NHS staff</li> </ul>	<ul style="list-style-type: none"> <li>•Provide oversight on operational performance</li> <li>•Implementation plans for new information systems (ECNS, ePCR)</li> </ul>	<ul style="list-style-type: none"> <li>•Ambulance Service Indicators</li> <li>•Daily weekly and monthly performance reports</li> <li>•Remedial Action plans (if required)</li> <li>•Specific targeted actions as required</li> <li>•Ambulance Service Indicator Group meetings</li> </ul>	3x3 = 9	CXL 3x2 = 6	↓	Dec-21	Reviewed 9 Jan 2023 Next review April 2023
5370	Chief Ambulance Services Commissioner	Effective Commissioning	Failure to secure sufficient ambulance capacity to meet the needs of the population	<p><b>IF:</b> sufficient ambulance capacity is not available</p> <p><b>Then:</b> organisational and clinical safety levels of escalation will be higher and for longer durations within the clinical safety plan and patients will not receive a response</p> <p><b>Resulting in:</b> increasing number of patients not receiving an ambulance response which is an unsatisfactory service for the people of Wales (or within specific health board areas) with increased likelihood of harm, disability and death.</p> <p>Lack of compliance with statutory requirements for EASC.</p>	<ul style="list-style-type: none"> <li>•The necessary resources secured in the EASC IMTP performance monitoring on a daily basis and month to date position</li> <li>•Bi monthly CASC IQPD meetings with Welsh Government</li> <li>•CASC monthly Quality and Delivery Meeting with the Welsh Ambulance Services NHS Trust</li> <li>•Commissioner element of EMS Demand and Capacity plan for additional staff supported – implementation being monitored</li> <li>•Quality and Safety Report presented at every EASC meeting</li> </ul>	<ul style="list-style-type: none"> <li>•Delivery of EASC IMTP and WAST IMTP</li> <li>•Implementation of the commissioning intentions through the commissioning agreement</li> <li>•Role of the EASC Management Group to provide oversight on quality and safety</li> <li>•Development of WAST performance improvement plan</li> <li>•EASC Action Plan includes detailed clinical review of red incident to understand clinical need of patients to assess improvement opportunities</li> <li>•Actions from the Ministerial summit on handover improvement</li> </ul>	<ul style="list-style-type: none"> <li>•Ambulance Service Indicators</li> <li>•Daily weekly and monthly performance reports</li> <li>•Remedial Action plans (if required)</li> <li>•Implementation of the Demand and Capacity Review</li> <li>•EASC Action Plan including monthly submission and review</li> <li>•CASC liaison with Chief Operating Officers</li> <li>•Additional £3m investment in year to support front line services which will also support the commencement of the Cymru High Acuity Response Unit (CHARU)</li> <li>•EASC receive a quality and safety report at each meeting</li> </ul>	5x5 = 25	CXL5x2=10	New	Jan-23	Developed on 9 Jan 2023 Next review April 2023

## EMERGENCY AMBULANCE SERVICES COMMITTEE EASC ASSURANCE FRAMEWORK



### Section 1 - Summary

Risk no	Strategic / Principal Risk	Strategic Goal	Lead(s) for this risk	Assurance committee(s)	Current score	Trajectory
1.	Failure to produce agreed Commissioning Frameworks and commissioning intentions	<b>Set the Strategic Commissioning plan</b>	Chief Ambulance Services Commissioner	Emergency Ambulance Services Committee	<b>4</b> (C4xL1)	
2.	Failure to develop an agreed EASC IMTP for endorsement by the Joint Committee seeking approval from the Welsh Government	<b>Meet the Ministerial direction to produce an EASC IMTP</b>	Chief Ambulance Services Commissioner	Emergency Ambulance Services Committee	<b>4</b> (C4xL1)	
3.	Failure to deliver the Ministerial direction that EASC effectively plans, commissions and secures services within its remit; and failure to maintain collaborative relationship with providers	<b>Effective Commissioning</b>	Chief Ambulance Services Commissioner	Emergency Ambulance Services Committee	<b>15</b> (C5xL3)	
4.	Failure to respond to requirements identified within commissioned work related to the ambulance services	<b>Outcome measurement</b>	Chief Ambulance Services Commissioner	Emergency Ambulance Services Committee	<b>12</b> (C4xL3)	
5.	Failure to achieve the agreed Chair's objectives with the Minister	<b>Ministerial direction</b>	Chief Ambulance Services Commissioner	Emergency Ambulance Services Committee	<b>6</b> (C3xL2)	
6.	Failure to achieve agreed performance standard for category red calls which is 65% of calls responded to within 8 minutes	<b>Securing safe ambulance services</b>	Chief Ambulance Services Commissioner	Emergency Ambulance Services Committee Audit and Risk Committee	<b>25</b> (C5xL5)	



Risk no	Strategic / Principal Risk	Strategic Goal	Lead(s) for this risk	Assurance committee(s)	Current score	Trajectory
7.	Failure to achieve agreed performance standard for amber category calls	<b>Securing safe ambulance services</b>	Chief Ambulance Services Commissioner	Emergency Ambulance Services Committee  Audit and Risk Committee	<b>25 (C5xL5)</b>	
8.	Failure by the whole system, policy makers, commissioners and providers to utilise EASC in matters which relate to its areas of responsibility during times of escalation	<b>Set the Strategic Commissioning Plan</b>	Chief Ambulance Services Commissioner	Emergency Ambulance Services Committee  Audit and Risk Committee	<b>8 (C4xL2)</b>	
9.	Failure to take appropriate commissioning actions to support the provider in their management of patient safety and to minimise clinical risk during times of escalation	<b>Effective Commissioning</b>	Chief Ambulance Services Commissioner	Emergency Ambulance Services Committee  Audit and Risk Committee	<b>20 (C5xL4)</b>	
10.	Failure to receive timely and quality assured information for publication as a result of the transition to new information systems (ECNS, ePCR)	<b>Outcome measurement</b>	Chief Ambulance Services Commissioner	Emergency Ambulance Services Committee  Audit and Risk Committee	<b>12 (C3xL3)</b>	
11.	'New' Failure to secure sufficient Ambulance capacity to meet the needs of the population	<b>Effective Commissioning</b>	Chief Ambulance Services Commissioner	Emergency Ambulance Services Committee  Audit and Risk Committee	<b>25 (C5xL5)</b>	New



CTMUHBs Risk Appetite Statement	 Draft CTMUHB Risk Appetite Statement.doc
CTMUHBs Risk Domain and Scoring Matrix	 Draft All Wales Risk Domain Matrix.doc

## Section 2 Strategic Risk Heat Map

Current risk scores in **black**

Target risk scores in *grey italic*

Consequence	5		3		9	6, 7, 11
	4		4 / 4	8 / 6, 7		
	3		5 / 5,10		10	
	2					
	1	1,2 / 1,2,3,8,9				
CxL		1	2	3	4	5
Likelihood						

### Section 3 – Strategic Risks

Strategic Goal: <b>Set the Strategic Commissioning plan</b>		Risk score <b>4</b>
Strategic Risk: Failure to produce an agreed Strategic Commissioning plan and commissioning intentions (Risk No 1 / 4260)		
<b>If</b> There is a failure to produce and agree Commissioning Frameworks and commissioning intentions	<b>Then:</b> The commissioned providers would not be clear regarding expectations for the quality, effectiveness and efficiency of services within an agreed financial plan.	<b>Resulting in:</b> Lack of clarity in the direction of the commissioned organisations (WAST and EMRTS)

	Consequence	Likelihood	Score	Risk Trend
Inherent	4	1	4	
<b>Current</b>	4	1	4	
Target	4	1	4	
Risk Appetite	<b>Cautious</b> ( <i>quality and safety; trust and confidence; legal and regulatory</i> )			

Risk Lead	<ul style="list-style-type: none"> <li>Chief Ambulance Services Commissioner</li> </ul>	Assurance committee	<ul style="list-style-type: none"> <li>Emergency Ambulance Services Committee</li> <li>CTMUHB Audit and Risk Committee (for assurance)</li> </ul>
-----------	---	---------------------	---

Controls	Assurances reported to Committee
<p><b>Strategies and Plans</b> Ensuring a program approach to planning and delivery with focus on monitoring progress through the EASC Sub Groups</p> <p><b>Governance Structures</b> Regular reporting from EASC Sub Groups to the EAS Joint Committee on progress</p> <p>Forward look developed for all EASC Sub Groups including receiving progress on the deliverables within the plans</p> <p><b>Commissioning Processes</b></p> <ul style="list-style-type: none"> <li>Commissioning Intentions collaboratively developed and agreed</li> <li>Commitment from the EASC for strategic commissioning cycles</li> <li>Ongoing work to refresh the EMS Commissioning Framework</li> <li>Local integrated commissioning action plans (iCAPs) developed by HBs and WAST, process supported by EASC Team</li> </ul> <p><b>Improvement Programmes</b></p> <ul style="list-style-type: none"> <li>To be confirmed</li> </ul>	<ul style="list-style-type: none"> <li>Performance Report</li> <li>EASC Commissioning Cycle for the development of Commissioning Intentions and Commissioning Frameworks agreed</li> <li>Commissioning Intentions agreed for EMS, NEPTS and EMRTS monitored at each EASC Management Group (bi-monthly) meeting</li> <li>Commissioning Frameworks enacted for all commissioned services</li> </ul> <p>Bi monthly reporting via report to EASC – the EASC Commissioning Update:</p> <ul style="list-style-type: none"> <li>Commissioning Framework</li> <li>Integrated Medium Term Plan</li> <li>Commissioning Intentions</li> </ul>


Gaps in Controls and Assurances	Actions and mitigations
<ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• EASC IMTP (confirmed as acceptable by WG with accountability conditions)</li> <li>• EASC Commissioning Cycle</li> <li>• EASC Commissioning Intentions</li> <li>• Minutes of EASC Sub Group meetings monitoring progress against plans</li> <li>• Commissioning Frameworks</li> <li>• Local Integrated Commissioning Action Plans developed in each health board</li> </ul>

Linked National Priority Measures	Current Performance - Highlights
<p><b>Six Goals of Urgent and Emergency Care</b> 11. Percentage of total conveyances taken to a service other than a Type One Emergency Department</p>	

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
4508	Failure by the whole system, policy makers, commissioners and providers to utilise EASC in matters which relate to its areas of responsibility during times of escalation	<b>8</b>

[Click here to go back to the summary Section](#)

<b>Strategic Goal: Meet the Ministerial direction to produce an EASC IMTP</b>		<b>Risk score</b>
<b>Strategic Risk:</b> Failure to develop an agreed EASC IMTP for endorsement by the Joint Committee seeking approval from the Welsh Government (Risk 2 / 4502)		<b>4</b>
<b>If</b> There is no agreement for the EASC IMTP	<b>Then:</b> The Commissioning Frameworks and commissioning intentions would not be supported	<b>Resulting in:</b> Lack of clarity in the direction of the commissioned organisations (WAST and EMRTS)

	Consequence	Likelihood	Score	Risk Trend 
Inherent	4	1	4	
Current	4	1	4	
Target	4	1	4	
Risk Appetite	<b>Cautious</b> ( <i>quality and safety; trust and confidence; legal and regulatory</i> )			

<b>Risk Lead</b>	<ul style="list-style-type: none"> <li>Chief Ambulance Services Commissioner</li> </ul>	<b>Assurance committee</b>	<ul style="list-style-type: none"> <li>Emergency Ambulance Services Committee</li> <li>CTMUHB Audit and Risk Committee (for assurance)</li> </ul>
------------------	---	----------------------------	---

Controls	Assurances reported to Committee
<p><b>Strategies and Plans</b> EASC IMTP 2022-2025 approved by EASC March 2022; EASC IMTP 2023-2026 drafted (February 2023) EASC IMTP (2020 to 2023) approved by EASC (January 2020) EASC Annual Plan 2021-22 approved EASC 9 March 2021</p> <p><b>Governance Structures</b> CASC Quality and Delivery meeting held monthly to discuss Quality and performance matters (under review) Detailed work to deliver EASC IMTP overseen by EASC Management Group Forward look developed for all EASC Sub Groups including receiving progress on the deliverables within the plans CASC IQPD (Integrated Quality and Performance Delivery) meeting with Welsh Government bi-monthly; CASC meetings with Welsh Government planning department</p> <p><b>Commissioning Processes</b></p> <ul style="list-style-type: none"> <li>EASC IMTP 2022-25 submitted to Welsh Government with bi-monthly updates in-year</li> </ul> <p><b>Improvement Programmes</b></p> <ul style="list-style-type: none"> <li>To be confirmed</li> </ul>	<p>Consistency between EASC IMTP with WAST IMTP and also with Health Boards; Awaiting letter of support from the Welsh Government; EASC Approval of the plan; Bi-monthly IMTP updates to EASC</p> <p>EASC IMTP 2022-2025 confirmed as acceptable by WG (with accountability conditions)</p>

Gaps in Controls and Assurances	Actions and mitigations
<ul style="list-style-type: none"> <li></li> </ul>	Bi monthly reporting via report to EASC – the EASC Commissioning Update: <ul style="list-style-type: none"> <li>• Commissioning Framework</li> <li>• Integrated Medium Term Plan</li> <li>• Commissioning Intentions</li> </ul>


Linked National Priority Measures	Current Performance - Highlights

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score

[Click here to go back to the summary Section](#)



<b>Strategic Goal: Effective Commissioning</b>		<b>Risk score 15</b>
<b>Strategic Risk:</b> Failure to deliver the Ministerial direction that EASC effectively plans, commissions and secures services within its remit; and failure to maintain collaborative relationship with providers (Risk No 3 /4503)		
<b>If</b> The EASC fail to plan and secure services and maintain effective collaborative relationships with providers	<b>Then:</b> The purpose and effectiveness of the EAS Joint Committee would not be met	<b>Resulting in:</b> Potential Ministerial and Welsh Government intervention

	Consequence	Likelihood	Score	Risk Trend 
Inherent	5	1	5	
<b>Current</b>	<b>5</b>	<b>3</b>	<b>15</b>	
Target	5	1	5	
Risk Appetite	<b>Cautious</b> ( <i>quality and safety; trust and confidence; legal and regulatory</i> )			

<b>Risk Lead</b>	<ul style="list-style-type: none"> <li>Chief Ambulance Services Commissioner</li> </ul>	<b>Assurance committee</b>	<ul style="list-style-type: none"> <li>Emergency Ambulance Services Committee</li> <li>CTMUHB Audit and Risk Committee (for assurance)</li> </ul>
------------------	---	----------------------------	---

Controls	Assurances reported to Committee
<p><b>Strategies and Plans</b></p> <ul style="list-style-type: none"> <li>July 2021 Special meeting of EASC with Minister and clear expectations received</li> <li>Minister meets with the Chair quarterly;</li> <li>Meet regularly with providers to ensure continued development of open and transparent relationship</li> </ul> <p><b>Governance Structures</b></p> <ul style="list-style-type: none"> <li>Regular reporting to the EAS Joint Committee on progress</li> <li>Effective function of the EASC Joint committee</li> <li>Independent Chair</li> <li>Effective governance arrangements in place</li> <li>CASC and Welsh Government IQPD meetings (bimonthly)</li> <li>Model Standing Orders agreed for EASC</li> </ul> <p><b>Commissioning Processes</b></p> <ul style="list-style-type: none"> <li>Agreed collaborative commissioning methodology</li> <li>review and refine commissioning arrangements and refresh Commissioning Framework;</li> </ul> <p><b>Improvement Programmes</b></p> <ul style="list-style-type: none"> <li>To be confirmed</li> </ul>	<ul style="list-style-type: none"> <li>Internal and external audit</li> <li>Welsh Government</li> <li>EASC Committee members</li> <li>Annual Governance Statement</li> <li>Strategic Commissioning intentions and Commissioning Frameworks</li> <li>Continued engagement with the commissioning process and EASC Governance</li> <li>EASC Action Plan with monthly update to the Minister and review</li> <li>Chairs appraisal letter with Minister</li> <li>Integrated Commissioning Action plans – implementation plan agreed</li> </ul>


Gaps in Controls and Assurances	Actions and mitigations
	<ul style="list-style-type: none"> <li>• Commissioning framework and monitoring at EASC and its sub groups</li> <li>• Annual Governance Statement</li> <li>• Monitoring of EASC IMTP at EASC and sub groups</li> <li>• Review and refine governance arrangements</li> <li>• Maintaining close working and collaborative relationships during unprecedented system pressures</li> <li>• EASC action plan for Ministerial priorities and monthly monitoring return commitment including Integrated Commissioning Action Plans</li> </ul>

Linked National Priority Measures	Current Performance - Highlights

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
5005	Failure to take appropriate commissioning actions to support the provider in their management of patient safety and to minimise clinical risk during times of escalation	<b>15</b>

[Click here to go back to the summary Section](#)

<b>Strategic Goal: Outcome measurement</b>		<b>Risk score 12</b>
<b>Strategic Risk: Failure to respond to requirements identified within commissioned work related to the ambulance services (Risk No 4 / 4504)</b>		
<b>IF:</b> Work commissioned is failed to be acted upon	<b>Then:</b> risks and issues identified will not be acted upon and implemented	<b>Resulting in:</b> a missed opportunity to improve services for patients

	Consequence	Likelihood	Score	Risk Trend 
Inherent	4	1	4	
<b>Current</b>	4	3	<b>12</b>	
Target	4	1	4	
Risk Appetite	<b>Cautious</b> ( <i>quality and safety; trust and confidence; legal and regulatory</i> )			

<b>Risk Lead</b>	<ul style="list-style-type: none"> <li>Chief Ambulance Services Commissioner</li> </ul>	<b>Assurance committee</b>	<ul style="list-style-type: none"> <li>Emergency Ambulance Services Committee</li> <li>CTMUHB Audit and Risk Committee (for assurance)</li> </ul>
------------------	---	----------------------------	---

Controls	Assurances reported to Board and committees
<p><b>Strategies and Plans</b></p> <ul style="list-style-type: none"> <li>Forward plan (Annual Business Plan) for EASC and all sub groups</li> <li>Development of action plans which are received, endorsed and approved by the EASC for action</li> <li>EASC IMTP confirmed as acceptable by WG with accountability conditions</li> <li>EASC Action Plan and monthly monitoring return commitment</li> </ul> <p><b>Governance Structures</b></p> <ul style="list-style-type: none"> <li>Forward plan (Annual Business Plan) for EASC and all sub groups</li> <li>Regular review of Ambulance Service Indicators;</li> </ul> <p><b>Commissioning Processes</b></p> <ul style="list-style-type: none"> <li>Commissioning intentions - including measurement across the system</li> <li>Commissioner request for system wide measures</li> <li>Refresh of Commissioning Frameworks</li> </ul> <p><b>Improvement Programmes</b></p> <ul style="list-style-type: none"> <li>To be confirmed</li> </ul>	<ul style="list-style-type: none"> <li>Amber Review</li> <li>ORH Report D&amp;C EMS</li> <li>Emergency Ambulance Services Framework - updated and approved at EASC in September 2022</li> <li>McClelland Review of Welsh Ambulance Services (2013)</li> <li>Internal and external audit</li> <li>CASC IQPD meeting with Welsh Government</li> <li>Annual Governance Statement</li> <li></li> </ul>
Gaps in Controls and Assurances	Actions and mitigations
<ul style="list-style-type: none"> <li></li> </ul>	<ul style="list-style-type: none"> <li>Governance and planning for EASC and all sub groups and supporting meetings</li> <li>review of the commissioning frameworks</li> <li>EASC action plan and monthly monitoring return commitment</li> </ul>




Linked National Priority Measures	Current Performance - Highlights

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
5006	Failure to receive timely and quality assured information for publication as a result of the transition to new information systems (ECNS, ePCR)	<b>9</b>

[Click here to go back to the summary Section](#)



<b>Strategic Goal: Ministerial Direction</b>		<b>Risk score</b> <b>6</b>
<b>Strategic Risk: Failure to achieve the agreed Chair's objectives with the Minister (Risk No 5 / 4505)</b>		
<b>IF:</b> The agreed Chair's objectives with the Minister are not delivered	<b>Then:</b> Then the confidence of the Minister will be potentially compromised	<b>Resulting in:</b> The Minister not being assured that necessary progress has been made in the commissioning of ambulance services and the wider connections to unscheduled care services in Wales

	Consequence	Likelihood	Score	Risk Trend 
Inherent	3	2	6	
<b>Current</b>	<b>3</b>	<b>2</b>	<b>6</b>	
Target	3	2	6	
Risk Appetite	<b>Cautious</b> ( <i>quality and safety; trust and confidence; legal and regulatory</i> )			

<b>Risk Lead</b>	<ul style="list-style-type: none"> <li>Chief Ambulance Services Commissioner</li> </ul>	<b>Assurance committee</b>	<ul style="list-style-type: none"> <li>Emergency Ambulance Services Committee</li> <li>CTMUHB Audit and Risk Committee (for assurance)</li> </ul>
------------------	---	----------------------------	---


<b>Controls</b>	<b>Assurances reported to Board and committees</b>
<p><b>Strategies and Plans</b></p> <ul style="list-style-type: none"> <li>Cross reference to the work to deliver the Six Goals for Urgent and Emergency Care Programme and particularly Goal 4</li> </ul> <p><b>Governance Structures</b></p> <ul style="list-style-type: none"> <li>Regular meetings with the EASC team to discuss any issues as well as quality issues and the development of improved reporting arrangements</li> </ul> <p><b>Commissioning Processes</b></p> <ul style="list-style-type: none"> <li>Regular meetings with the Minister</li> </ul> <p><b>Improvement Programmes</b></p> <ul style="list-style-type: none"> <li>To be confirmed</li> </ul>	<p>Minister's response following Chair's appraisal Six Goals for Urgent and Emergency Care Programme delivery particularly Goal 4</p> <p>Updated Chair's Objectives received</p>
<b>Gaps in Controls and Assurances</b>	<b>Actions and mitigations</b>
<ul style="list-style-type: none"> <li></li> </ul>	<ul style="list-style-type: none"> <li>Commissioner support for commissioning</li> <li>Commissioning intentions</li> <li>Refresh Commissioning Frameworks</li> <li>EASC IMTP</li> <li>'Focus on' sessions at EASC to discuss wider system issues</li> </ul>

Linked National Priority Measures	Current Performance - Highlights
<b>Six Goals of Urgent and Emergency Care</b> 11. Percentage of total conveyances taken to a service other than a Type One Emergency Department	

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score

[Click here to go back to the summary Section](#)

<b>Strategic Goal: Securing Safe Ambulance Services</b>		<b>Risk score 25</b>
<b>Strategic Risk:</b> Failure to achieve agreed performance standard for category red calls which is 65% of calls responded to within 8 minutes(Risk No 6 / 4506)		
<b>IF:</b> The red performance level is less than 65% for each health board area and across Wales as a whole on a monthly basis	<b>Then:</b> The core target will be missed	<b>Resulting in:</b> Unsatisfactory service for the people of Wales (or within specific health board areas) with increased likelihood of harm, disability and death.

	Consequence	Likelihood	Score	Risk Trend
Inherent	5	3	15	
<b>Current</b>	<b>5</b>	<b>5</b>	<b>25</b>	
Target	5	3	15	
Risk Appetite	<b>Cautious</b> ( <i>quality and safety; trust and confidence; legal and regulatory</i> )			

Risk Lead	<ul style="list-style-type: none"> <li>Chief Ambulance Services Commissioner</li> </ul>	Assurance committee	<ul style="list-style-type: none"> <li>Emergency Ambulance Services Committee</li> <li>CTMUHB Audit and Risk Committee (for assurance)</li> </ul>
-----------	---	---------------------	---

Controls	Assurances reported to Board and committees
<p><b>Strategies and Plans</b></p> <ul style="list-style-type: none"> <li>The necessary resources secured in the EASC IMTP</li> <li>performance monitoring on a daily basis and month to date position</li> <li>EASC Action Plan includes detailed clinical review of red incidents to understand clinical need of patients to assess improvement opportunities</li> </ul> <p><b>Governance Structures</b></p> <ul style="list-style-type: none"> <li>CASC monthly Quality and Delivery Meeting with the Welsh Ambulance Services NHS Trust</li> <li>Bi monthly CASC IQPD meetings with Welsh Government</li> </ul> <p><b>Commissioning Processes</b></p> <ul style="list-style-type: none"> <li>Commissioner element of EMS Demand and Capacity plan for additional staff supported</li> </ul> <p><b>Improvement Programmes</b></p> <ul style="list-style-type: none"> <li>To be confirmed</li> </ul>	<ul style="list-style-type: none"> <li>Ambulance Service Indicators</li> <li>Daily weekly and monthly performance reports</li> <li>Remedial Action plans (if required)</li> <li>Specific targeted actions as required</li> <li>Commissioner Ambulance Availability Taskforce</li> <li>Implementation of the Demand and Capacity Review</li> <li>EASC Action Plan including monthly submission and review</li> <li>CASC liaison with Chief Operating Officers</li> <li>Quality and Safety Report presented at every EASC meeting</li> <li>Commissioner element of EMS Demand and Capacity plan for additional staff supported – implementation being monitored</li> <li>Quality and Safety Report presented at every EASC meeting</li> <li>Commissioner element of EMS Demand and Capacity plan for additional staff supported</li> </ul>
<b>Gaps in Controls and Assurances</b>	<b>Actions and mitigations</b>
<ul style="list-style-type: none"> <li></li> </ul>	<ul style="list-style-type: none"> <li>Delivery of EASC IMTP and WAST IMTP</li> </ul>


- Implementation of the commissioning intentions through the commissioning agreement
- Role of the EASC Management Group to provide oversight on operational performance
- Development of WAST performance improvement plan
- Additional £3m investment in year to support front line services which will also support the commencement of the Cymru High Acuity Response Unit (CHARU)

Linked National Priority Measures	Current Performance - Highlights
<b>Six Goals of Urgent and Emergency Care</b> 11. Percentage of total conveyances taken to a service other than a Type One Emergency Department	

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
4507	Failure to achieve agreed performance standard for amber category calls	<b>25</b>

[Click here to go back to the summary Section](#)

<b>Strategic Goal: Securing Safe Ambulance Services</b>		<b>Risk score 25</b>
<b>Strategic Risk: Failure to achieve agreed performance standard for category amber calls (Risk No 7 / 4507)</b>		
<b>IF:</b> The average time for amber performance calls does not reduce year on year	<b>Then:</b> Patients will not receive the care they need in a timely manner	<b>Resulting in:</b> unsatisfactory service for the people of Wales (or within specific health board areas with increased likelihood of harm, disability and death.

	Consequence	Likelihood	Score	Risk Trend 
Inherent	5	3	15	
<b>Current</b>	<b>5</b>	<b>5</b>	<b>25</b>	
Target	5	3	15	
Risk Appetite	<b>Cautious</b> ( <i>quality and safety; trust and confidence; legal and regulatory</i> )			

<b>Risk Lead</b>	<ul style="list-style-type: none"> <li>Chief Ambulance Services Commissioner</li> </ul>	<b>Assurance committee</b>	<ul style="list-style-type: none"> <li>Emergency Ambulance Services Committee</li> <li>CTMUHB Audit and Risk Committee (for assurance)</li> </ul>
------------------	---	----------------------------	---

Controls	Assurances reported to Board and committees
<p><b>Strategies and Plans</b> The necessary resources secured in the EASC IMTP/ Annual Plan</p> <p>EASC Action plan includes detailed clinical review of amber incidents to understand clinical need of patients to assess improvement opportunities</p> <ul style="list-style-type: none"> <li><b>Governance Structures</b></li> <li>performance monitoring on a daily basis and month to date position</li> <li>CASC Monthly quality and delivery meetings with WAST</li> <li>Bi monthly CASC Quality and Delivery meeting with Welsh Government</li> <li>CASC monthly Quality and Delivery Meeting with the Welsh Ambulance Services NHS Trust</li> </ul> <p><b>Commissioning Processes</b></p> <ul style="list-style-type: none"> <li>Commissioner element of EMS Demand and Capacity plan for additional staff supported</li> </ul> <p><b>Improvement Programmes</b></p> <ul style="list-style-type: none"> <li>To be confirmed</li> </ul>	<ul style="list-style-type: none"> <li>Ambulance Service Indicators</li> <li>Daily weekly and monthly performance reports</li> <li>Remedial Action plans (if required)</li> <li>Specific targeted actions as required</li> <li>Commissioner Ambulance Availability Taskforce</li> <li>Implementation of the Demand and Capacity Review</li> <li>EASC Action Plan for Minister including monthly submission and review</li> <li>CASC liaison with Chief Operating Officers</li> </ul>


Gaps in Controls and Assurances	Actions and mitigations
<ul style="list-style-type: none"> <li></li> </ul>	<ul style="list-style-type: none"> <li>• Delivery of EASC Annual Plan and WAST IMTP Implementation of the commissioning intentions through the commissioning agreement</li> <li>• Role of the EASC Management Group to provide oversight on operational performance</li> <li>• Development of WAST performance improvement plan</li> <li>• Weekly dashboard of management information developed and shared across NHS Wales to capture progress</li> <li>• Quality and Safety Report presented at every EASC meeting</li> <li>• Weekly dashboard shared across NHS Wales – sent to all EASC members and key senior NHS staff</li> </ul>

Linked National Priority Measures	Current Performance - Highlights
<p><b>Six Goals of Urgent and Emergency Care</b> 11. Percentage of total conveyances taken to a service other than a Type One Emergency Department</p>	

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
4506	Failure to achieve agreed performance standard for category red calls	<b>25</b>

[Click here to go back to the summary Section](#)

<b>Strategic Goal: Set the Strategic Commissioning plan</b>		<b>Risk score</b> <b>8</b>
<b>Strategic Risk:</b> Failure by the whole system, policy makers, commissioners and providers to utilise EASC in matters which relate to its areas of responsibility during times of escalation (Risk No 8 / 4508)		
<b>If</b> The system does not utilise the arrangements in place at EASC	<b>Then:</b> The governance and purpose of EASC will be undermined	<b>Resulting in:</b> a lack of consistency, duplication of services and resources, poor governance and non compliance with the Statutory Instrument leading to unnecessary system pressures

	Consequence	Likelihood	Score	Risk Trend 
Inherent	4	1	4	
<b>Current</b>	4	2	8	
Target	4	1	4	
Risk Appetite	<b>Cautious</b> ( <i>quality and safety; trust and confidence; legal and regulatory</i> )			

<b>Risk Lead</b>	<ul style="list-style-type: none"> <li>Chief Ambulance Services Commissioner</li> </ul>	<b>Assurance committee</b>	<ul style="list-style-type: none"> <li>Emergency Ambulance Services Committee</li> <li>CTMUHB Audit and Risk Committee (for assurance)</li> </ul>
------------------	---	----------------------------	---

Controls	Assurances reported to Committee
<p><b>Strategies and Plans</b> EASC IMTP developed and submitted (confirmed as acceptable by WG with accountability conditions)</p> <p><b>Governance Structures</b></p> <ul style="list-style-type: none"> <li>Accountable officers are members of EASC</li> <li>Memorandum of understanding and commitment from all EASC members</li> <li>Model Standing Orders agreed and reviewed annually</li> </ul> <p><b>Commissioning Processes</b></p> <ul style="list-style-type: none"> <li>Sharing information on service developments</li> <li>Alignment to the 6 Goals for Urgent and Emergency Care Policy Steering Board</li> <li>Commissioning Frameworks reviewed</li> </ul> <p><b>Improvement Programmes</b></p> <ul style="list-style-type: none"> <li>To be confirmed</li> </ul>	<ul style="list-style-type: none"> <li>Memorandum of understanding and commitment from all EASC members</li> <li>Independent Chair</li> <li>Governance arrangements</li> <li>Commitment to collaborative nature of working</li> <li>External audit</li> <li>Welsh Government and Commissioner support for EASC</li> <li>EASC Standing orders and Standing Financial Instructions</li> <li>EASC Action Plan</li> <li>Accountable officers of health boards are members of EASC</li> <li>Sharing information on service developments</li> <li>Alignment to the 6 Goals for Urgent and Emergency Care Programme Board</li> <li>Model Standing Orders agreed and reviewed annually</li> <li>Commissioning Frameworks reviewed</li> </ul>
Gaps in Controls and Assurances	Actions and mitigations
<ul style="list-style-type: none"> <li></li> </ul>	<ul style="list-style-type: none"> <li>Collaborative commissioning agreements</li> <li>EASC Management group representing all organisations</li> <li>Aligning EASC IMTP with WAST and Health board IMTPs</li> </ul>

	<ul style="list-style-type: none"> <li>• CASC meeting with Welsh Government planners</li> <li>• CASC IQPD meeting with Welsh Government</li> <li>• CASC Quality and Delivery meeting with WAST</li> <li>• Chair of EASC and CASC meetings with Health Boards</li> <li>• CASC Member of NHS Leadership Board</li> </ul>
--	--

Linked National Priority Measures	Current Performance - Highlights
<b>Six Goals of Urgent and Emergency Care</b> 11. Percentage of total conveyances taken to a service other than a Type One Emergency Department	

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
4260	Failure to produce an agreed Strategic Commissioning plan and commissioning intentions	<b>4</b>

[Click here to go back to the summary Section](#)



<b>Strategic Goal: Effective Commissioning</b>	<b>Risk score 20</b>
<b>Strategic Risk:</b> Failure to take appropriate commissioning actions to support the provider in their management of patient safety and to minimise clinical risk during times of escalation (Risk No 9 / 5005)	

<b>If</b> Commissioning actions are not taken to manage patient safety and minimise clinical risks	<b>Then:</b> Patients are more likely to come to harm	<b>Resulting in:</b> poorer patient outcomes and patient experience, increased SAIs, litigation and reputational damage
---	--	---

	Consequence	Likelihood	Score	Risk Trend  
Inherent	<b>5</b>	<b>1</b>	<b>5</b>	
<b>Current</b>	<b>5</b>	<b>4</b>	<b>20</b>	
Target	<b>5</b>	<b>1</b>	<b>5</b>	
Risk Appetite	<b>Cautious</b> ( <i>quality and safety; trust and confidence; legal and regulatory</i> )			

Risk Lead	<ul style="list-style-type: none"> <li>Chief Ambulance Services Commissioner</li> </ul>	Assurance committee	<ul style="list-style-type: none"> <li>Emergency Ambulance Services Committee</li> <li>CTMUHB Audit and Risk Committee (for assurance)</li> </ul>
-----------	---	---------------------	---

Controls	Assurances reported to committee
<b>Strategies and Plans</b>  EASC IMTP developed and submitted (confirmed as acceptable by WG with accountability conditions)  <b>Governance Structures</b> <ul style="list-style-type: none"> <li>Discussion at EASC Committee</li> <li>Discussion at EASC Management Group</li> <li>CASC and WAST Quality &amp; Delivery meeting</li> <li>Agree red lines for handover delays to improve ambulance availability</li> </ul> <b>Commissioning Processes</b> <ul style="list-style-type: none"> <li>Sought clarification from WAST re Equality Impact Assessment</li> </ul> <b>Improvement Programmes</b> <ul style="list-style-type: none"> <li>To be confirmed</li> </ul>	<ul style="list-style-type: none"> <li>WAST Equality Impact Assessment (to be completed)</li> <li>Commitment to collaborative nature of working and implementation of system-wide escalation policy</li> <li>Ongoing discussions around system-wide escalation</li> <li>Agree red lines for handover delays to improve ambulance availability</li> <li>Securing of funding for emergency ambulance capacity</li> <li>EASC Management Group agreed to set up two task and finish groups               <ol style="list-style-type: none"> <li>Response to Healthcare Inspectorate Wales review related to handover delays</li> <li>Appendix B</li> </ol> </li> </ul>
Gaps in Controls and Assurances	Actions and mitigations
<ul style="list-style-type: none"> <li></li> </ul>	<ul style="list-style-type: none"> <li>Joint escalation plan developed and approved at NHS Leadership Board</li> <li>Commissioning Operational Delivery Unit to avoid unilateral WAST decision-making</li> <li>Provide necessary funding to WAST</li> </ul>




Linked National Priority Measures	Current Performance - Highlights

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
4503	Failure to deliver the Ministerial direction that EASC effectively plans, commissions and secures services within its remit; and failure to maintain collaborative relationship with providers	<b>15</b>

[Click here to go back to the summary Section](#)

<b>Strategic Goal: Outcome measurement</b>		<b>Risk score 12</b>
<b>Strategic Risk: Failure to receive timely and quality assured information for publication as a result of the transition to new information systems (ECNS, ePCR) (Risk No 10 /5006)</b>		
<b>IF:</b> Timely and quality assured data is not provided	<b>Then:</b> EASC will be unable to publish data or assure itself of the quality of service provision	<b>Resulting in:</b> a lack of consistency and public confidence, duplication of services and resources, poor governance and noncompliance with reporting requirements set out in the commissioning framework

	Consequence	Likelihood	Score	Risk Trend 
Inherent	3	2	6	
<b>Current</b>	<b>3</b>	<b>3</b>	<b>9</b>	
Target	3	2	6	
Risk Appetite	<b>Cautious</b> ( <i>quality and safety; trust and confidence; legal and regulatory</i> )			

<b>Risk Lead</b>	<ul style="list-style-type: none"> <li>Chief Ambulance Services Commissioner</li> </ul>	<b>Assurance committee</b>	<ul style="list-style-type: none"> <li>Emergency Ambulance Services Committee</li> <li>CTMUHB Audit and Risk Committee (for assurance)</li> </ul>
------------------	---	----------------------------	---

Controls	Assurances reported to Board and committees
<p><b>Strategies and Plans</b></p> <p>EASC IMTP developed and approved subject to accountability conditions</p> <p><b>Governance Structures</b></p> <ul style="list-style-type: none"> <li>Regular meetings with the project team to discuss any issues as well as with the clinical audit team around the development of reporting arrangements</li> <li>Weekly dashboard of management information developed and shared</li> </ul> <p><b>Commissioning Processes</b></p> <ul style="list-style-type: none"> <li>Commissioning updates provided to every EASC meeting</li> </ul> <p><b>Improvement Programmes</b></p> <ul style="list-style-type: none"> <li>To be confirmed</li> </ul>	<ul style="list-style-type: none"> <li>Ambulance Service Indicators</li> <li>Daily weekly and monthly performance reports</li> <li>Remedial Action plans (if required)</li> <li>Specific targeted actions as required</li> <li>Ambulance service indicator group recommenced</li> </ul>
<b>Gaps in Controls and Assurances</b>	<b>Actions and mitigations</b>
<ul style="list-style-type: none"> <li></li> </ul>	<ul style="list-style-type: none"> <li>Provide oversight on operational performance</li> <li>Implementation plans for new information systems (ECNS, ePCR)</li> </ul>



Linked National Priority Measures	Current Performance - Highlights

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
4504	Failure to respond to requirements identified within commissioned work related to the ambulance services	<b>12</b>

[Click here to go back to the summary Section](#)

<b>Strategic Goal: Effective Commissioning</b>		<b>Risk score 25</b>
<b>Strategic Risk: Failure to secure sufficient ambulance capacity to meet the needs of the population (Risk number 5370)</b>		
<b>IF:</b> sufficient ambulance capacity is not available	<b>Then:</b> organisational and clinical safety levels of escalation will be higher and for longer durations within the clinical safety plan and patients will not receive a response	<b>Resulting in:</b> increasing numbers of patients not received an ambulance response which is an unsatisfactory service for the people of Wales (or within specific health board areas) with increased likelihood of harm, disability and death

	Consequence	Likelihood	Score	Risk Trend
Inherent	5	5	25	New
<b>Current</b>	<b>5</b>	<b>5</b>	<b>25</b>	
Target	5	2	10	
Risk Appetite	<b>Cautious</b> ( <i>quality and safety; trust and confidence; legal and regulatory</i> )			

<b>Risk Lead</b>	<ul style="list-style-type: none"> <li>Chief Ambulance Services Commissioner</li> </ul>	<b>Assurance committee</b>	<ul style="list-style-type: none"> <li>Emergency Ambulance Services Committee</li> <li>CTMUHB Audit and Risk Committee (for assurance)</li> </ul>
------------------	---	----------------------------	---

Controls	Assurances reported to Board and committees
<p><b>Strategies and Plans</b></p> <ul style="list-style-type: none"> <li>The necessary resources secured in the EASC IMTP</li> <li>Performance monitoring on a daily basis and month to date position</li> </ul> <p><b>Governance Structures</b></p> <ul style="list-style-type: none"> <li>Quality and Safety Report presented at every EASC meeting</li> <li>CASC monthly Quality and Delivery Meeting with the Welsh Ambulance Services NHS Trust</li> <li>Bi monthly CASC IQPD meetings with Welsh Government</li> </ul> <p><b>Commissioning Processes</b></p> <ul style="list-style-type: none"> <li>Commissioning updates provided to every EASC meeting</li> <li>Commissioner element of EMS Demand and Capacity plan for additional staff supported – implementation being monitored</li> </ul> <p><b>Improvement Programmes</b></p> <ul style="list-style-type: none"> <li>To be confirmed</li> </ul>	<ul style="list-style-type: none"> <li>Ambulance Service Indicators</li> <li>Daily weekly and monthly performance reports</li> <li>Remedial Action plans (if required)</li> <li>Specific targeted actions as required</li> <li>Ambulance service indicator group recommended</li> <li>EASC Action Plan including monthly submission and review</li> <li>CASC liaison with Chief Operating Officers</li> <li>Additional £3m investment in year to support front line services which will also support the commencement of the Cymru High Acuity Response Unit (CHARU)</li> <li>EASC receive a quality and safety report at each meeting</li> </ul>

Gaps in Controls and Assurances	Actions and mitigations
<ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Delivery of EASC IMTP and WAST IMTP</li> <li>• Implementation of the commissioning intentions through the commissioning agreement</li> <li>• Role of the EASC Management Group to provide oversight on quality and safety</li> <li>• Development of WAST performance improvement plan</li> <li>• EASC Action Plan includes detailed clinical review of red incident to understand clinical need of patients to assess improvement opportunities</li> <li>• Actions from the Ministerial summit on handover improvement</li> </ul>

Linked National Priority Measures	Current Performance - Highlights

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
4504	Failure to respond to requirements identified within commissioned work related to the ambulance services	<b>12</b>

## Cwm Taf Morgannwg University Health Board

### Risk Appetite Statement (DRAFT)

#### 1. Introduction:

Public sector organisations cannot be culturally risk averse and be successful. Effective and meaningful risk management in government remains more important than ever in taking a balanced of risk and opportunity in delivering public services. Risk management is an integral part of good governance and corporate management mechanisms. An organisation's risk management framework harnesses the activities that identify and manage uncertainty, allows it to take opportunities and to take managed risks not simply to avoid them, and systematically anticipates and prepares successful responses. A key consideration in balancing risks and opportunities, supporting informed decision-making and preparing tailored responses is the conscious and dynamic determination of the organisation's **risk appetite**.<sup>1</sup>

The Health Board should make a strategic choice about the style, shape and quality of risk management and should lead the assessment and management of opportunity and risk. The Board should determine and continuously assess the nature and extent of the principal risks that the organisation is exposed to and is willing to take to achieve its objectives - **its risk appetite** - and ensure that planning and decision-making reflects this assessment. Effective risk management should support informed decision-making in line with this risk appetite, ensure confidence in the response to risks and ensure transparency over the principal risks faced and how these are managed.<sup>2</sup>

#### 2. Cwm Taf Morgannwg University Health has adopted the following **Risk Appetite Matrix**:

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimalist	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

#### 3. Cwm Taf Morgannwg University Health Boards **Risk Appetite Statement**:

The Health Boards risk appetite has been defined following consideration of organisational risks, issues and consequences. Appetite levels will vary, in some areas our risk tolerance may be cautious in others we may be eager for risk and are willing to carry risk in the pursuit of important strategic objectives.

The Health Board will always aim to operate organisational activities at the levels defined below. Where activities are projected to exceed the defined levels, this will be escalated through the appropriate governance mechanisms to the Board for ratification.

- **Quality and Safety risks** - (including physical and/or psychological harm) of its patients, workforce and the public) - the Health Board has adopted a **Cautious** stance for quality and safety risks, with a preference for safer delivery options, tolerating a cautious degree of residual risk and choosing the option most likely to result in successful delivery, high quality care and value for money services to its population.
- **Reputation / Adverse Publicity (Trust in Confidence) risks** - the Health Board has adopted a **Cautious** stance for reputational risks, with a preference for safer delivery options, tolerating a cautious degree of residual risk and choosing the option most likely to result in successful delivery, high quality care and value for money services to its population.
- **Business Continuity risks** - the Health Board has adopted a **Cautious** stance for Business Continuity Risks. The Board will receive ongoing assurance from the testing of business continuity plans.
- **Legal / Regulatory Compliance risks** - the Health Board has adopted a **Cautious** stance for Legal, Regulatory and Compliance risks, seeking a preference for adhering to responsibilities and safe delivery options with little residual risk. The Board will receive assurance that compliance regimes are in place.

<sup>1</sup> Government Finance Function – Risk Appetite Guidance Note – August 2021 – V2.0

<sup>2</sup> The Orange Book – Section A

- **Data and Information Management risks** – the Health Board has adopted a **Cautious** stance for data and information management risks seeking a preference for adhering to responsibilities and safe delivery options with little residual risk. There is acceptance for the need for operational effectiveness with risk mitigated through careful management of information sharing and limiting distribution.
- **Financial stability risks** – the Health Boards stance for financial risk is varied as follows:
  - **Averse** for financial propriety and regularity risks with a determined focus to maintain effective financial control framework accountability structures.
  - **Averse** – in terms of risks related to the Health Boards qualification of accounts, associated process and deviation from reporting timescales.
  - **Minimal** – as to risk relating to breaching individual control totals.
  - **Cautious** – in relation to the Health Boards budget spend with the intention that it should maximise the use of resource each year. The Health Board will seek safe delivery options with little residual risk that only yield some upside opportunities. The Board would receive ongoing assurance through reporting structures that policies and procedures are in place to comply with HMT guidance.
- **Assets and Estates risks** – the Health Board has adopted **Cautious** and **Open** stances for assets and estates respectively, seeking value for money but with a preference for proven delivery options have that a cautious residual risk. this means that the Health Board will us solutions for purchase, rental, disposal, construction, and refurbishment that ensures it protects the public purse from as much risk as possible, producing good value for money whilst fully meeting organisational objectives.
- **Technological advances** - the Health Board has adopted an **Open** stance for risks associated with technological advances accepting that system and technology developments can enable improved delivery. Responsibility for non-critical decisions may be devolved in accordance with the Scheme of Delegation. Plans aligned with functional standards and organisational governance.

DRAFT

## Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
<b>Safety &amp; Well-being - Patients/ Staff/Public</b>	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
<b>Quality/ Complaints/ Assurance/ Patient Outcomes</b>	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
<b>Workforce/ Organisational Development/ Staffing/ Competence</b>	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. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
<b>Statutory Duty, Regulation, Mandatory Requirements</b>	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
<b>Adverse Publicity or Reputation</b>	Rumours. Low level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
<b>Business Objectives or Projects</b>	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 targets. 10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
<b>Financial Stability &amp; Impact of Litigation</b>	Small loss. Risk of claim remote.	Loss of 0.1-0.25% of budget Claim less than £10,000.	Loss of 0.25-0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
<b>Service/ Business Interruption</b>	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
<b>Environment/Estate/ Infrastructure</b>	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
<b>Health Inequalities/ Equity</b>	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:					
Likelihood:		Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur		Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible		At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally		At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue		At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently		At least daily	5	10	15	20	25



Paul Mears  
Prif Weithredwr  
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

**Trwy e-bost:**  
[Paul.Mears@wales.nhs.uk](mailto:Paul.Mears@wales.nhs.uk)

Ein cyf: CS1081

21/04/2023

Annwyl Brif Weithredwr,

### Ymchwiliad gorfodi safonau CS1081: Adroddiad ac hysbysiad penderfynu terfynol

Ysgrifennaf atoch i rannu adroddiad ac hysbysiad penderfynu **terfynol** fy ymchwiliad i gydymffurfiaeth Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg gyda safonau'r Gymraeg.

Ar 17/03/2023, rhoddais gyfle i chi a'r achwynydd wneud sylwadau am yr adroddiad a'r hysbysiad penderfynu arfaethedig. Ar 06/04/2023, cadarnhaodd y bwrdd iechyd nad oedd yn dymuno gwneud unrhyw sylwadau ar yr adroddiad. Nid wyf felly wedi gwneud unrhyw newid i'r adroddiad yn sgil yr ymgynghoriad.

Rhaid i chi ddarparu tystiolaeth ysgrifenedig eich bod wedi cwblhau cam gorfodi 1 erbyn **21/07/2023**. Anfonwch eich tystiolaeth at [ymchwiliadau@cyg-wlc.cymru](mailto:ymchwiliadau@cyg-wlc.cymru).

Mae gennych yr hawl i apelio yn erbyn fy nyfarniad ac unrhyw gamau gorfodi rwyf wedi eu gosod. Mae gwybodaeth am y broses apelio ar wefan Tribiwnlys y Gymraeg ac yn y daflen sydd wedi ei chynnwys gyda'r llythyr hwn. Unwaith y bydd yr hawl i apelio wedi dod i ben, byddaf yn diweddarau'r [gofrestr camau gorfodi](#) ar fy ngwefan.

Diolch ichi am eich cydweithrediad yn ystod yr ymchwiliad yma. Mae croeso i chi gysylltu â James Whittaker ([James.Whittaker@cyg-wlc.cymru](mailto:James.Whittaker@cyg-wlc.cymru)) os oes gennych unrhyw gwestiynau am gynnwys y llythyr.

Yn gywir,

Comisiynydd y Gymraeg  
Siambrau'r Farchnad  
5-7 Heol Eglwys Fair  
Caerdydd CF10 1AT

0845 6033 221  
post@comisiynyddygybraeg.org  
Croesewir gohebiaeth yn y Gymraeg a'r Saesneg

comisiynyddygybraeg.org

Welsh Language Commissioner  
Market Chambers  
5-7 St Mary Street  
Cardiff CF10 1AT

0845 6033 221  
post@welshlanguagecommissioner.org  
Correspondence welcomed in Welsh and English

welshlanguagecommissioner.org



Comisiynydd y  
Gymraeg  
Welsh Language  
Commissioner

**Efa Gruffudd Jones**  
Comisiynydd y Gymraeg

**Copi:**

- **Rheolwr Gwasanaethau Cymraeg BIP CTM:** Ben Screen ([Ben.Screen@wales.nhs.uk](mailto:Ben.Screen@wales.nhs.uk));
- **Swyddog y Gymraeg BIP CTM:** Helen Summers ([Helen.Summers2@wales.nhs.uk](mailto:Helen.Summers2@wales.nhs.uk));
- **Pennaeth Polisi a Chydymffurfiaeth BIP CTM:** Claire Nicholas ([Claire.Nicholas@wales.nhs.uk](mailto:Claire.Nicholas@wales.nhs.uk));
- **Cyfarwyddwr Cynorthwyol Polisi a Chydymffurfiaeth BIP CTM:** Karen Wright ([Karen.Wright8@wales.nhs.uk](mailto:Karen.Wright8@wales.nhs.uk));
- **Prif Gomisiynydd Gwasanaethau Ambiwylans:** Stephen Harrhy ([ctm\\_casc\\_easc@wales.nhs.uk](mailto:ctm_casc_easc@wales.nhs.uk));
- **Ysgrifennydd EASC:** Gwenan Roberts ([gwenan.roberts@wales.nhs.uk](mailto:gwenan.roberts@wales.nhs.uk));
- **Cadeirydd EASC:** Chris Turner ([chris.turner2@wales.nhs.uk](mailto:chris.turner2@wales.nhs.uk))

Comisiynydd y Gymraeg  
Siambrau'r Farchnad  
5-7 Heol Eglwys Fair  
Caerdydd CF10 1AT

0845 6033 221  
[post@comisiynyddygyymraeg.org](mailto:post@comisiynyddygyymraeg.org)  
Croesewir gohebiaeth yn y Gymraeg a'r Saesneg

[comisiynyddygyymraeg.org](http://comisiynyddygyymraeg.org)

Welsh Language Commissioner  
Market Chambers  
5-7 St Mary Street  
Cardiff CF10 1AT

0845 6033 221  
[post@welshlanguagecommissioner.org](mailto:post@welshlanguagecommissioner.org)  
Correspondence welcomed in Welsh and English

[welshlanguagecommissioner.org](http://welshlanguagecommissioner.org)



Paul Mears  
Chief Executive  
Cwm Taf Morgannwg University Health Board

**By email:**  
[Paul.Mears@wales.nhs.uk](mailto:Paul.Mears@wales.nhs.uk)

Our ref: CS1081

21/04/2023

Dear Chief Executive

**Standards enforcement investigation CS1081: Final report and decision notice**

Please find enclosed the **final** report and decision notice of my investigation into Cwm Taf Morgannwg University Health Board's compliance with Welsh language standards.

On 17/03/2023, I gave you and the complainant an opportunity to comment on the proposed report and decision notice. On 06/04/2023, the health board confirmed that it did not wish to comment on the report. I have therefore made no changes to the report as a result of the consultation.

You must provide written evidence that enforcement action 1 has been completed by 21/07/2023. Please send your evidence to at [ymchwiliadau@cyg-wlc.cymru](mailto:ymchwiliadau@cyg-wlc.cymru).

You have the right to appeal against my determination and against any enforcement action I have imposed. Information on the appeals process can be found on the Welsh Language Tribunal's website and in the leaflet enclosed with this letter. Once the right of appeal has expired, I will update the [Register of Enforcement Action](#) on my website.

Thank you for your co-operation during the investigation. Please do not hesitate to contact James Whittaker ([James.Whittaker@cyg-wlc.cymru](mailto:James.Whittaker@cyg-wlc.cymru)) if you have any questions about the content of this letter.

Yours sincerely,

Comisiynydd y Gymraeg  
Siambrau'r Farchnad  
5-7 Heol Eglwys Fair  
Caerdydd CF10 1AT

0845 6033 221  
post@comisiynyddygybraeg.org  
Croesewir gohebiaeth yn y Gymraeg a'r Saesneg

comisiynyddygybraeg.org

Welsh Language Commissioner  
Market Chambers  
5-7 St Mary Street  
Cardiff CF10 1AT

0845 6033 221  
post@welshlanguagecommissioner.org  
Correspondence welcomed in Welsh and English

welshlanguagecommissioner.org



**Efa Gruffudd Jones**  
Welsh Language Commissioner

**Copy:**

- **CTM UHB Welsh Language Services Manager:** Ben Screen ([Ben.Screen@wales.nhs.uk](mailto:Ben.Screen@wales.nhs.uk));
- **CTM UHB Welsh Language Officer:** Helen Summers ([Helen.Summers2@wales.nhs.uk](mailto:Helen.Summers2@wales.nhs.uk));
- **CTM UHB Head of Policy and Compliance:** Claire Nicholas ([Claire.Nicholas@wales.nhs.uk](mailto:Claire.Nicholas@wales.nhs.uk));
- **CTM UHB Assistant Director of Policy and Compliance:** Karen Wright ([Karen.Wright8@wales.nhs.uk](mailto:Karen.Wright8@wales.nhs.uk));
- **Chief Ambulance Service Commissioner:** Stephen Harrhy ([ctm\\_casc\\_easc@wales.nhs.uk](mailto:ctm_casc_easc@wales.nhs.uk));
- **EASC Secretary:** Gwenan Roberts ([gwenan.roberts@wales.nhs.uk](mailto:gwenan.roberts@wales.nhs.uk));
- **EASC Chair:** Chris Turner ([chris.turner2@wales.nhs.uk](mailto:chris.turner2@wales.nhs.uk))

Comisiynydd y Gymraeg  
Siambrau'r Farchnad  
5-7 Heol Eglwys Fair  
Caerdydd CF10 1AT

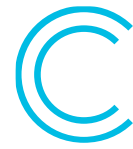
0845 6033 221  
[post@comisiynyddygyymraeg.org](mailto:post@comisiynyddygyymraeg.org)  
Croesewir gohebiaeth yn y Gymraeg a'r Saesneg

[comisiynyddygyymraeg.org](http://comisiynyddygyymraeg.org)

Welsh Language Commissioner  
Market Chambers  
5-7 St Mary Street  
Cardiff CF10 1AT

0845 6033 221  
[post@welshlanguagecommissioner.org](mailto:post@welshlanguagecommissioner.org)  
Correspondence welcomed in Welsh and English

[welshlanguagecommissioner.org](http://welshlanguagecommissioner.org)



Comisiynydd y  
Gymraeg  
Welsh Language  
Commissioner

---

# Standards enforcement investigation: Report and decision notice

This report was prepared in accordance with sections 73 and 74 of the Welsh Language (Wales) Measure 2011

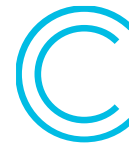
The investigation of a suspicion of failure to comply with standards set by Welsh Ministers was conducted in accordance with section 71 and Schedule 10 of the Welsh Language (Wales) Measure 2011

**Cwm Taf Morgannwg University Health Board (D)**

Case number: CS1081

Date: 21/04/2023

---



---

## Background

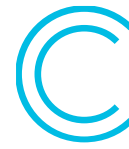
The principal aim of the Welsh Language Commissioner, an independent body established by the Welsh Language (Wales) Measure 2011, is to promote and facilitate the use of Welsh. This is done by raising awareness of the official status of the Welsh language in Wales, by imposing standards on organisations, and by regulating compliance with the Welsh Language Measure. This, in turn, will lead to the establishment of rights for Welsh speakers.

Two principles will underpin the Commissioner's work:

- in Wales, the Welsh language should be treated no less favourably than the English language;
- persons in Wales should be able to live their lives through the medium of Welsh if they choose to do so.

### Contact details

- Phone: 0345 6033 221
- Email: [post@welshlanguagecommissioner.wales](mailto:post@welshlanguagecommissioner.wales)
- Website: [welshlanguagecommissioner.wales](http://welshlanguagecommissioner.wales)
- Post: Welsh Language Commissioner  
Market Chambers  
5–7 St Mary Street  
Cardiff  
CF10 1AT



---

# Legislative context

## Part 4 of the Welsh Language Measure

- i. Part 4 of the Welsh Language Measure sets out a legal framework for imposing a duty on some organisations to comply with one or more standards in relation to the Welsh language. Organisations subject to standards are known as 'relevant persons'. The standards apply to the following areas:
  - service delivery;
  - policy making;
  - operational;
  - promotion;
  - record keeping.
- ii. The duties resulting from the standards require that relevant persons should not treat the Welsh language less favourably than the English language, and should promote and facilitate the use of the Welsh language.
- iii. Compliance notices given to relevant persons by the Commissioner under Part 4 of the Welsh Language Measure specify the standards requiring compliance, together with the days from which it is required to comply with each standard or to comply with each standard in a particular respect ('imposition days'). Copies of the compliance notices that are in force will be on the Commissioner's website.
- iv. Whilst a compliance notice specific to a relevant person is in force, that person will be required to comply with the standards specified within it.

## Part 5 of the Welsh Language Measure

- v. Part 5 of the Welsh Language Measure gives the Commissioner statutory regulatory functions to ensure that relevant persons comply with their duties. Duties may include compliance with Welsh language standards (as stated above), and also requirements imposed on persons by the Commissioner in accordance with section 77 of the Welsh Language Measure as a result of a failure to comply with a relevant requirement. The Commissioner's Enforcement Policy provides advice and information regarding how the Commissioner will exercise those regulatory functions.
- vi. The regulatory functions resulting from Part 5 of the Welsh Language Measure are:
  - to consider whether or not to investigate if the conduct of relevant persons is complained about;
  - to investigate suspected failures by relevant persons to comply with duties, to determine investigations and to produce investigation reports;
  - to consider whether or not to take further action (by giving recommendations or advice) if an investigation finds that there was no failure to comply;
  - to take one of the three steps below if an investigation finds that there was a failure to comply:
    - take no further action;
    - do one or more of the following:
      - require the relevant person to prepare an action plan for the purpose of preventing the continuation or repetition of the failure;
      - require the relevant person to take steps for the purpose of preventing the continuation or repetition of the failure;
      - publicise the relevant person's failure to comply with the relevant requirement;
      - require the relevant person to publicise the failure to comply with the relevant requirement;
      - impose a civil penalty on the relevant person.
    - do one or more of the following:
      - give the relevant person or any other person recommendations;
      - give the relevant person or any other person advice;
      - seek to enter into a settlement agreement with the relevant person.
  - to make applications to a county court for orders to enforce compliance;
  - to comply with the duties resulting from appeals and applications for reviews made to the Welsh Language Tribunal;
  - to produce an enforcement policy document;
  - to create and maintain a register of enforcement action.
- vii. The Commissioner will follow the required statutory processes in exercising the Commissioner's regulatory functions.
- viii. The Commissioner's Enforcement Policy contains full information regarding the way in which the Commissioner will exercise the Commissioner's regulatory functions under Part 5 of the Welsh Language Measure.

# Contents

1	Terms of reference	1
2	Evidence taken as part of the investigation	3
3	Compliance with standard 39: Assessment, findings and determination	6
4	Compliance with standard 60: Assessment, findings and determination	11
5	Further action	13
	Decision notice	14

# 1 Terms of reference

## Suspicion of failure to comply with Welsh language standards

- 1.1 On 11/11/2022, I received a complaint from a member of the public. It met the conditions of section 93 of the Welsh Language Measure and was therefore a valid complaint.
- 1.2 The complaint related to documentation on a webpage<sup>1</sup> on the Emergency Ambulance Services Committee's (EASC) website. The webpage in question relates to a service development proposal developed by the Emergency Medical Retrieval and Transfer Service (EMRTS) and the Welsh Air Ambulance Charity (WAAC).
- 1.3 On 11/11/2022, a member of the public (P) visited the Welsh language version of the webpage to observe the proposal in question.
- 1.4 However, P alleged that the service development proposal document<sup>2</sup> had been published on the English version of the webpage, but had not been published at all on the corresponding Welsh version of the webpage.
- 1.5 P felt that this was an example of the Welsh language being treated less favourably than the English language as there was less information available to those who chose to source information in Welsh (on the Welsh language website) than those who chose to do the same thing in English (on the English language website).

## Confirming responsibility for the relevant service

- 1.6 On 22/11/2022, my officers wrote to the deputy chair of EASC to confirm who was responsible for publishing the document on the website in question.
- 1.7 On 05/12/2022, I received a response from the EASC secretary. EASC confirmed that it was responsible for publishing the document on the website.
- 1.8 EASC stated that it is a joint committee of all the health boards in Wales hosted by Cwm Taf Morgannwg University Health Board (D). EASC added that it utilises D's policies and procedures on behalf of all health boards in Wales and that EASC is required to comply with D's standards.
- 1.9 As a result of the above evidence, I established that Cwm Taf Morgannwg University Health Board is the person ultimately responsible for providing the services relevant to the allegation made by P (namely the service provided specifically by EASC).
- 1.10 Further to confirming the information above, EASC confirmed that P's allegation is correct in that the Service Development Proposal had not been published on the

---

<sup>1</sup> <https://easc.nhs.wales/engagement/sdp/>

<sup>2</sup> <https://easc.nhs.wales/commissioning/emrts/sdp/files/emrts-service-development-proposal/>

Welsh language website on 11/11/2022. EASC stated that the document was not added to the Welsh part of the website until 15/11/2022.

- 1.11 EASC explained that this had occurred as the member of the team with responsibility for adding information to the website was on leave. EASC stated that this risk to the work of the Committee had not been identified previously as information is usually added on a bi-monthly basis.
- 1.12 EASC confirmed that it is now training another member of staff to be able to be sure that information is added equally for both Welsh and English to avoid the same failure from happening again.
- 1.13 EASC apologised unreservedly regarding this delay in ensuring the (Welsh) website had the right documentation for the public.

### Relevant standards

- 1.14 D has a duty to comply with the standards below, and that was also the case on the date relevant to the complaint:

#### **Standard 39**

You must ensure that—

- (a) the text of each page of your website is available in Welsh,
- (b) every Welsh language page on your website is fully functional, and
- (c) the Welsh language is not treated less favourably than the English language on your website.

**Imposition day:** 30/11/2019

#### **Standard 60**

You must promote any Welsh language service that you provide, and advertise that service in Welsh.

**Imposition day:** 30/05/2019

### Decision to investigate

- 1.15 The complaint led me to suspect that D had treated the Welsh language less favourably than the English language on its website (in terms of the content of the Welsh webpage in question). It also led me to suspect that D had failed to promote the use of the Welsh version of the website, by failing to ensure that the content of the Welsh version of the website was of the same standard as the English version of the website.
- 1.16 Based on the above, I decided to conduct an investigation under section 71 of the Welsh Language Measure. This was to determine whether there had been a failure by D to comply with the above standards. I informed D and P of my decision, and gave notice of the proposed terms of reference, on 16/12/2022.
- 1.17 I gave notice of the final terms of reference of the investigation to P and D on 05/01/2023.

## 2 Evidence taken as part of the investigation

### Evidence notice and the evidence received

- 2.1 On 05/01/23, I issued an evidence notice requiring D to provide me with the following information. I received the below response from D on 02/02/2023.

#### Information and documents

1. Please explain each stage of the process of publishing new content and documents on the Emergency Ambulance Services Committee (EASC) website.

*“(a) The Emergency Ambulance Services Committee (EASC) web content is written in English.*

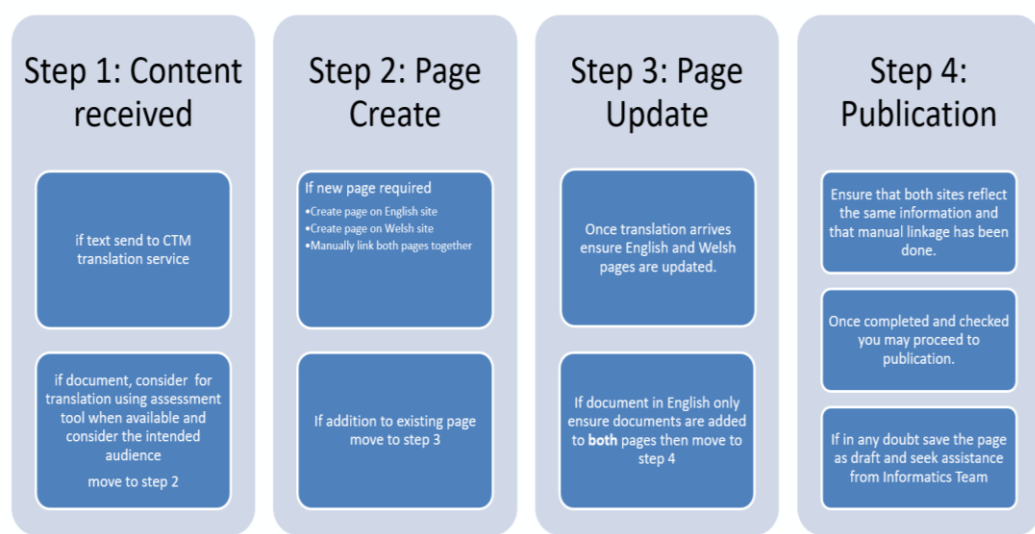
*“(b) Once written it's sent for translation to the Welsh language team at Cwm Taf Morgannwg University Health Board (CTMUHB).*

*“(c) The Head of Informatics at EASC publishes the information in both languages at the same time.*

*In relation to documents, it is written in English and sent for translation if we think it should be available in Welsh. We then publish the documents on both sides of the website.*

*However, this did not happen on this occasion and this was a one off situation and the internal process described here is robust to ensure that we treat both languages equally as always.*

#### Website Updates



*As a hosted organisation EASC Team are required to comply with the Cwm Taf Morgannwg University Health Board policies and procedures and will work with the Welsh language team to ensure that all standards are maintained."*

- 2. Please explain what general arrangements you have in place to ensure that you do not publish new content on an English page on the EASC website without also publishing equivalent content on the corresponding Welsh page at the same time.**

*“See above. There is support from the Welsh Language Team at CTMUHB to publish bilingual information, and this is enough to ensure that we usually comply with standards.*

*The Committee Secretary is responsible for updating the EASC website. As previously reported, the issue occurred as the member of the team with responsibility for adding information to the website was on leave.*

*This risk to the work of the Committee had not been identified previously as information is added usually on a bi-monthly basis. We are now training another member of staff to be able to be sure that information is added equally for both Welsh and English to avoid this happening again.”*

- 3. Please confirm whether there is a provision(s) on the EASC website’s content management system that prevents you from being able to publish new content on an English page without also doing the same thing on the corresponding Welsh page at the same time.**

*“Mura is unable to prevent content from being published in English only, should the user wish to do so. However, it must be noted that Health and Digital Care Wales is responsible for Mura and its features, and EASC cannot change that. In terms of ensuring that our content is bilingual, however, see above.”*

- 4. Please explain what general arrangements you have in place to check and ensure that content on the Welsh-language website is consistent and of the same standard as content on the English-language website.**

*“See above for the support from CTM UHB’s Welsh Language Team, who have been proactive and looked over our website in the past to check that it is bilingual. As a result of this investigation, we will do so more often from now on.*

*An internal review of the website has taken place and generally the EASC team are now more aware of the requirements. A regular review is planned (Committee Secretary and Head of Informatics) on a monthly basis to ensure that the Welsh language standards are maintained.”*

- 5. Please provide any further information or evidence that you wish for the Commissioner to consider when determining your compliance with standards 39 and 60.**

*“This investigation by the Commissioner will be reported in the EASC Annual Governance Statement which is reported to the host body CTMUHB.*

*Staff in the team have been reminded of the policies in relation to the Welsh language.*

*Staff are mandated to complete the Welsh language training on the Electronic Staff Record.*

*Of the 30 staff in the Unit – three staff have fluent Welsh language skills and two staff identify as learners."*

**6. Please provide a copy of any policy, procedure, guidance or other document that you wish for the Commissioner to consider when determining your compliance with standards 39 and 60.**

The following documents were provided:

- "MURA Content Management System: Best Practice & Accessibility for Web Content Managers"
- "MURA Content Management System: User Guide for Web Content Managers".

# 3 Compliance with standard 39: Assessment, findings and determination

## Standard wording

3.1 The standard, as worded in the compliance notice issued to D, states

### **Standard 39**

You must ensure that—

- (a) the text of each page of your website is available in Welsh,
- (b) every Welsh language page on your website is fully functional, and
- (c) the Welsh language is not treated less favourably than the English language on your website.

**Imposition day:** 30/11/2019

## Requirements of the standard

3.2 A body must ensure that:

- the text of each page of its website is available in Welsh
- every Welsh language page on its website is fully functional, and
- the Welsh language is not treated less favourably than the English language on that website.

## Interpretations

3.3 Schedule 1, Part 3, Paragraph 49 of the regulations states:

*“For the purpose of standards 39 to 41 (websites), 44 (apps) and 45 (social media), references to treating the Welsh language no less favourably than the English language include, amongst other matters (and in addition to specific matters referred to in any individual standard), treating the Welsh language no less favourably as regards —*

*(a) the visual presentation of the material (for example in relation to the colour, size, font and format of any text), or*

*(b) when material is published on the website, app or social media;*

*but it does not mean that Welsh language material must appear on the same page as English language material, or on a page that a person is likely to find before the English language page when searching.”*

3.4 Paragraph 4.11.19 of my draft code of practice for the Welsh Language Standards (No. 7) Regulations 2018 states:

*“Other matters’ may include treating the Welsh language no less favourably as regards:*

- *the material's language order*
- *the standard and quality of the material*
- *the position and prominence of the material*
- *when and how the material is published*
- *the publication format of the material*
- *the clarity and accuracy of the material (for example in terms of the meaning and expression of any text), and*
- *the content of the material (for example in terms of the detail or quality of the information it contains)."*

3.5 Paragraphs 4.11.39 and 4.11.40 of the draft code of practice explain the meaning of the term 'fully functional' in the wording of standard 39:

*"The term means that a body ensures that the Welsh language page, the Welsh language text, the Welsh language homepage or app in question functions in at least the same way or as well as the English language version, and without any restrictions or errors.*

*This may include ensuring:*

*[...]*

- *that the Welsh language versions include the same information as the English language versions of any web page [...]."*

### **Considering compliance with the standard**

- 1.18 P's complaint related to an allegation that D had published a service development proposal document<sup>3</sup> on the English version of the Emergency Ambulance Services Committee's (EASC) website, but had failed to publish the document on the Welsh version of the website.
- 1.19 D acknowledges this allegation and accepts that it is correct. D also confirms that the document was not added to the Welsh version of the website until 15 November 2022, more than a fortnight after it was added to the English version of the website.
- 1.20 According to P, the document in question provided important information regarding the proposal and the rationale for the proposal to relocate the air ambulance bases in Caernarfon and Welshpool, and centralise the service for north Wales in the centre of the region.
- 1.21 The Welsh version of the website contained no reference at all to this document.
- 1.22 In his complaint, P stated that D's failure to publish the document on the Welsh version of the website is an example of the Welsh language being treated less favourably than the English language, as there was less information available to

<sup>3</sup> <https://easc.nhs.wales/commissioning/emrts/sdp/files/emrts-service-development-proposal/>

those who chose to source information in Welsh (on the Welsh language website) than those who chose to do the same thing in English (on the English language website).

- 1.23 Although seemingly a minor failure, such a failure to publish the document on the Welsh version of the website could have had a negative impact on P and his ability to contribute effectively to the consultation that was underway on the proposal. Had P not also looked at the English version of the website, P would not have been aware of this document's existence. Therefore, he would not have been aware of all the information available to him about the proposal, in order to submit full and informed representations during the consultation.
- 1.24 In future, it is essential that D takes more care when publishing content on its website, so that users of the Welsh version of the website have equal access to the same important information about D's plans as users of the English version of the website.
- 1.25 I understand that D has already taken steps to this end since being made aware of P's complaint. Specifically, I note that D has trained another member of staff to be able to be sure that information is added equally for both Welsh and English to avoid this happening again. I also note that D has committed to checking the content of the website more frequently from now on to ensure compliance with the requirements of the standards. I also acknowledge that D has undertaken an internal audit of the website following the complaint and that this has led to opportunities to remind staff of the requirements of the standards and the policies for implementing them. I also understand that the complaint will be reported in the EASC Annual Statement, meaning that senior staff within the organisation will be made aware of the failure in question.
- 1.26 However, it remains the case that the website's content management system allowed an officer to upload a document to the English version of the website without uploading a document to the Welsh version at the same time. The system should have fail-safes in place to ensure that officers cannot add content to just one side of the website. I understand that Digital Health and Care Wales is responsible for the MURA system that D uses and that therefore D has no direct control over the features within this system. However, D remains responsible for ensuring that the systems it uses allow and facilitate compliance with the standards.
- 1.27 The MURA system does not fully support D's compliance with the standards as it allows content to be generated just on the English version of the website, in direct breach of the Welsh language standards. It is possible that D may want to inform Digital Health and Care Wales of the failures identified during this investigation and discuss ways of strengthening the system in future to ensure compliance with the requirements of the standards going forward.

## Findings

- 3.6 Standard 39 requires D to ensure (amongst other things) that the Welsh language is treated no less favourably than the English language on its websites.

- 3.7 This includes ensuring that the Welsh language is treated no less favourably in terms of the information included on the Welsh pages of its websites (compared to the corresponding English pages).
- 1.28 On 11/11/2022, a member of the public (P) visited a webpage<sup>4</sup> on the Welsh version of the Emergency Ambulance Services Committee's (EASC) website to observe the service development proposal that had been developed by the Emergency Medical Retrieval and Transfer Service (EMRTS) and the Welsh Air Ambulance Charity (WAAC).
- 1.29 On the webpage in question, a series of documents had been published providing information about the proposal.
- 1.30 On the English version of the page, a service development proposal<sup>5</sup> had been published (since 02/11/2022).
- 1.31 On the Welsh version of the page, the document had not been published at all (in either language). The document was not published on the Welsh version of the webpage until 15/11/2022, more than a fortnight after D published the document on the corresponding English page.
- 1.32 By failing to ensure that the document in question was available on the Welsh language page at the same time as the corresponding English language page, D acted in breach of standard 39, by treating the Welsh language less favourably than the English language.
- 1.33 Standard 39 also requires D to ensure (amongst other things) that every Welsh language page on its websites is fully functional. This includes ensuring that Welsh language pages contain the same amount of information as the corresponding English language page.
- 1.34 Therefore, D's failure to ensure that the document in question (that had been published on the English version of the website) had also been published on the Welsh version of the website was an example of D failing to meet the requirements of standard 39, by not ensuring that every Welsh language page on its website was fully functional.

### **Determination of whether there has been a failure to comply with standard 39**

- 3.8 I determine that D has failed to comply with standard 39.
- 3.9 I do so on the grounds that D did the following by failing to publish a specific document on the Welsh language version of the <https://pgab.gig.cymru/> website at all (which had been published on the corresponding English language page):
- failed to ensure that every Welsh language page on the website was fully functional;

---

<sup>4</sup> <https://pgab.gig.cymru/gwasanaethau-a-gomisiynir/gwasanaeth-adalw-a-throsglwyddo-meddygol-brysgatmb/cdg/>

<sup>5</sup> <https://easc.nhs.wales/commissioning/emrts/sdp/files/emrts-service-development-proposal/>

- treated the Welsh language less favourably than the English language on the website.

## 4 Compliance with standard 60: Assessment, findings and determination

### Standard wording

4.1 The standard, as worded in the compliance notice issued to D, states:

#### **Standard 60**

You must promote any Welsh language service that you provide, and advertise that service in Welsh.

**Imposition day:** 30/05/2019

### Requirements of the standard

4.2 A body must promote any Welsh language service that it provides and advertise that service in Welsh.

### Interpretations

4.3 Paragraphs 4.17.8-4.17.9 of my draft code of practice state the following in relation to the terms 'promote' and 'advertise':

4.17.8 With regards to standard 60 to 'promote' and 'advertise' include a body actively promoting and raising awareness of every Welsh language service provided by the body by highlighting the fact that a Welsh language service is available and by encouraging use of that service.

4.17.9. The following are possible examples of compliance:

[...]

- ensuring that the users' journey to using services in Welsh is of the same standard and quality as the service in English
- ensuring that Welsh language services are given prominence, are easily accessible, are actively promoted and are available constantly."

### Considering compliance with the standard

4.4 I have already established when considering D's compliance with standard 39 that D has treated the Welsh language less favourably than the English language, by publishing the document in question on the English version of the website and failing to publish the document at all (in either language) on the Welsh version of the website.

4.5 This failure to ensure that the Welsh version of the website provided a service of the same quality and standard to users as the service provided on the English version

of the website meant that D has failed to promote the use of the Welsh version of the website appropriately.

- 4.6 Providing a Welsh language service which is of the same standard at least as the corresponding English language service is crucial to ensure that users choose to use that Welsh language service. Providing an inconsistent or inferior Welsh language service (in comparison with the corresponding English language service) undermines confidence and trust in Welsh language services. This may prevent people from using them again and encourage them to choose services in English in the belief that they are of a higher standard and more reliable than Welsh language services.
- 4.7 In this case, D provided a service of inferior quality in Welsh to P, by failing to publish a document on the Welsh version of the website which was easily available on the English version of the website. Furthermore, P would not have been aware of the relevant document's existence had he not checked the English version of the website. This may have had a negative impact on P's perception of the quality of the Welsh language service that D provides on its website, discouraging him from using it again and persuading him to opt for the English language service instead.
- 4.8 Therefore, if D wishes to promote the use of its Welsh language services appropriately in accordance with the standards, it is crucial that the Welsh language services that it provides are always of the same quality as its English language services. D failed to do so in this case and this, in turn, led to a failure to promote the use of the Welsh version of the website.

## Findings

- 4.9 Standard 60 requires D to promote any Welsh language service that it provides.
- 4.10 By publishing a specific document on the English version of the <https://easc.nhs.wales/> website and failing to publish the document at all on the Welsh version of the website, D failed to ensure that the Welsh version of the website provided a service of the same quality and standard to users as the service provided on the English version of the website.
- 4.11 Therefore, D failed to promote the Welsh version of the website. Instead, a service was provided which discouraged users from choosing to access the website in Welsh as it was inferior to the English version of the website.

## Determination of whether there has been a failure to comply with standard 60

- 4.12 I determine that D has failed to comply with standard 60.
- 4.13 I do so on the grounds that D failed to promote the use of the Welsh version of the <https://pgab.gig.cymru> website, by providing a service of inferior quality to the service available on the English version of the website.

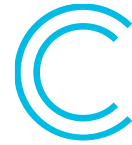
## 5 Further action

- 5.1 Section 77 of the Welsh Language Measure allows me to take further action where there has been a failure to comply.
- 5.2 In the case of my determination that D has failed to comply with **standard 39**, I shall be taking further action to prevent the continuation or repetition of that failure.
- 5.3 In the case of my determination that D has failed to comply with **standard 60**, I have decided not to take any further action. My decision is based on the fact that the enforcement actions that I have decided to impose following the non-compliance with standard 39 will contribute to ensuring that the inconsistency between the Welsh and English versions of the website will not continue.
- 5.4 By ensuring that the Welsh and English pages of the website are consistent and of the same standard, D will contribute to promoting public confidence in the use of the Welsh version of the website.
- 5.5 Details of the further action are set out below.

### **Standard 39: Requirement to take steps in accordance with section 77 of the Welsh Language Measure**

1. D must take steps to ensure that content cannot be published on an English page, without publishing the same content (in Welsh if required) on the corresponding Welsh page at the same time.
2. D must provide the Welsh Language Commissioner with sufficient written evidence that enforcement action 1 has been completed.

**Timetable:** Within **3 months** of issuing the final determination.



Comisiynydd y  
Gymraeg  
Welsh Language  
Commissioner

---

## Decision notice

---

To: Cwm Taf Morgannwg University Health Board (D)  
Case number: CS1081  
Date: 21/04/2023

### Determination

---

As a result of a complaint received from a member of the public, I carried out an investigation under section 71 of the Welsh Language (Wales) Measure 2011 in order to determine whether D has failed to comply with one of the Welsh language standards with which it has a duty to comply.

The standards relevant to the investigation are as follows:

#### **Standard 39**

You must ensure that—

- (a) the text of each page of your website is available in Welsh,
- (b) every Welsh language page on your website is fully functional, and
- (c) the Welsh language is not treated less favourably than the English language on your website.

**Imposition day:** 30/11/2019

#### **Standard 60**

You must promote any Welsh language service that you provide, and advertise that service in Welsh.

**Imposition day:** 30/05/2019

### I determine that D failed to comply with standard 39

The basis of my determination is that D did the following by failing to publish a specific document on the Welsh language version of the <https://pgab.gig.cymru/> website at all (which had been published on the corresponding English language website):

- failed to ensure that every Welsh language page on the website was fully functional;

- treated the Welsh language less favourably than the English language on the website.

## **I determine that D failed to comply with standard 60.**

The basis of my determination is that D failed to promote the use of the Welsh version of the <https://pgab.gig.cymru> website, by providing a service of inferior quality to the service available on the English version of the website.

## **Further action**

---

In accordance with section 77 of the Welsh Language Measure, I have decided to take further action to prevent the continuation or repetition of the failure to comply with standard 39.

Details of the further action are set out below.

### **Standard 39: Requirement to take steps in accordance with section 77 of the Welsh Language Measure**

1. D must take steps to ensure that content cannot be published on an English page, without publishing the same content (in Welsh if required) on the corresponding Welsh page at the same time.
2. D must provide the Welsh Language Commissioner with sufficient written evidence that enforcement action 1 has been completed.

**Timetable:** Within **3 months** of issuing the final determination.

## **Right of appeal to the Welsh Language Tribunal**

---

Where the Commissioner has determined that there has not been a failure to comply with a standard, the complainant may appeal to the Welsh Language Tribunal. Where the Commissioner determines that a person has failed to comply with a relevant requirement, that person can appeal to the Welsh Language Tribunal. Additionally, when the Commissioner has decided to take enforcement action in relation to a failure, D may appeal to the Welsh Language Tribunal on the grounds that the enforcement actions are unreasonable or disproportionate. There is more information about the process in the enclosed leaflet, and on the Welsh Language Tribunal's website.

## **Consequences of failure to comply with a requirement of this decision notice**

---

Should D fail to comply with any requirement within this decision notice, the Commissioner may apply for a county court order requiring its compliance.

Portfolio	Risk Domain (Strategic Objective)	Risk Title	Risk Description	Controls in place	Action Plan	Sources of Assurance	Rating (current)	Rating (Target)	Trend	Opened	Review date
Managing Director NCCU	Meet the planning guidance and produce an NCCU Annual Business Plan	Failure to develop an agreed NCCU Annual Business Plan for endorsement by the Management Board	<b>IF:</b> There is no agreement for the NCCU Annual Business Plan <b>Then:</b> The work of the NCCU would not be supported <b>Resulting in:</b> Lack of clarity in the direction of the commissioned organisations	Regular meetings with HBs Regular meetings with WG Regular meetings with Shared Services Regular meetings with WHSSC Detailed work to deliver NCCU Annual Business Plan overseen by the Management Board NCCU ABP approved by Management Board Managing Director meetings with Welsh Government planning department	Agreed timescales with Management Board for the development of the draft NCCU Annual Business Plan, now agreed	Consistency between NCCU ABP and HB, WHSSC and Shared Services IMTPs Letter of support from the Welsh Government Management Board approval of the plan Bi-monthly ABP progress updates to Management Board	4x1=4	CXL 4x1= 4		01/06/2022	01/06/2023
Managing Director NCCU	Effective Commissioning	Failure to deliver the Ministerial direction and HB requirements that the NCCU effectively plans, commissions and secures services within its remit; and failure to maintain collaborative relationship with providers	<b>IF:</b> The NCCU fail to plan and secure services and maintain effective collaborative relationships with providers <b>Then:</b> The purpose and effectiveness of the NCCU Management Board would not be met <b>Resulting in:</b> Potential Ministerial and Welsh Government intervention	Agreed collaborative commissioning methodology Review and refine commissioning arrangements and refresh commissioning and procurement frameworks Undertake quality assurance visits and reviews Effective function of the NCCU Management Board Effective governance arrangements in place Meet regularly with providers to ensure continued development of open and transparent relationship	Commissioning and procurement frameworks and monitoring arrangements; Monitoring of NCCU Annual Business Plan at Management Board Review and refine governance arrangements; Maintaining close working and collaborative relationships during unprecedented system pressures;	Internal and external audit Welsh Government Management Board members Commissioning and procurement frameworks Continued engagement with the commissioning process	5x2=10	CXL 5x1=5		01/06/2022	01/06/2023
Managing Director NCCU	Outcome measurement	Failure to respond to requirements identified within commissioned work related to Mental Health, CAMHS and Learning Disabilities services	<b>IF:</b> Work commissioned is failed to be acted upon <b>Then:</b> Risks and issues identified will not be acted upon and implemented <b>Resulting in:</b> A missed opportunity to improve services for mental health, CAMHS and LD patients	Reviews and annual visits for all providers Undertake bespoke reviews Implement escalation policy if necessary Forward plan (Annual Business Plan) for Management Board; Action log for Management Board and all subgroups Regular review of key performance indicators Refresh of commissioning and procurement frameworks	Governance and planning for Management Board Review of commissioning and procurement frameworks Review of inspection and review visits Quarterly meetings with HBs and WHSSC Regular meetings with WG Commissioner action plan and monthly monitoring return commitment	Commissioning and procurement framework review programme Internal and external audit Inspection visits Escalation and de-escalation of providers	3x2=6	CXL 3x1=3		01/06/2022	01/06/2023
Managing Director NCCU	Provider performance	Failure to identify poor performing service providers	<b>IF:</b> The required standards of service/level performance are not achieved <b>Then:</b> The patients will receive inadequate care <b>Resulting in:</b> Potential harm and the long term exacerbation of mental health issues for patients	Agreed commissioning and procurement frameworks Regular audits and reviews Escalation framework Inspection mechanisms Real time feedback Protocols for moving patients to different providers	Compliance with agreed protocols and processes Annual visit Audits and spot checks undertaken Oversight of escalation	Annual Position Statement Safety and performance Indicators (CCAPS) Quarterly meetings with HBs, WHSSC and Shared Services Annual attendance at CTM UHB Quality & Safety Committee Link to lead Chief Executive Officer lead for MH Link to WG	4x2=8	CXL 4x1=4		01/06/2022	01/06/2023
Managing Director NCCU	Undertake regular reviews of commissioning and procurement frameworks	Failure to undertake regular reviews will result in out of date frameworks and non-compliance with procurement strategies	<b>IF:</b> Frameworks aren't reviews regularly <b>Then:</b> Frameworks will become out of date and non-compliant <b>Resulting in:</b> Poor standards of patient care, value for money and legal challenges	Work with Shared Services to review commissioning and procurement frameworks in line with agreed timescales	Tried and tested review mechanisms followed Programme management approach adopted to ensure timescales are delivered Collaborative working between NCCU and Shared Services Procurement Division Liaison with HBs and service providers	Memoranda of understanding Compliance with procurement processes Approval through Shared Services governance Internal and external audit; Healthcare Inspectorate Wales (HIW) and WG	4x1=4	CXL 4x1=4		01/06/2022	01/06/2023
Managing Director NCCU	Effective commissioning	Failure to take appropriate actions to support the providers in their management of patient safety and to minimise clinical risk	<b>IF:</b> actions are not taken to manage patient safety and minimise clinical risks <b>Then:</b> Patients are more likely to come to harm <b>Resulting in:</b> Poorer patient outcomes and patient experience, increased SAIs, litigation and reputational damage	Discussion at Management Board Quarterly meetings with all HBs, WHSSC and Shared Services Annual Report to CTM UHB Quality & Safety Committee Annual Position Statement	Escalation and suspension protocols for providers Protocol to move patients between providers	Reports for each service provider Safety reports generated through CCAPS Annual Position Statement	3x2=6	CXL 3x1=3		01/06/2022	01/06/2023

Portfolio	Risk Domain (Strategic Objective)	Risk Title	Risk Description	Controls in place	Action Plan	Sources of Assurance	Rating (current)	Rating (Target)	Trend	Opened	Review date
Managing Director NCCU	Outcome measurement	Failure to receive timely and quality assured information	<p><b>IF:</b> Timely and quality assured data is not provided</p> <p><b>Then:</b> The QAIS / NCCU will be unable to assure itself of the quality of service provision</p> <p><b>Resulting in:</b> Providers being on commissioning and procurement frameworks while unable to deliver the required standards of patient care</p>	<p>CCAPS real time information system in place;</p> <p>Audit checks undertaken as part of annual inspection visits;</p> <p>Agreement with DHCW to manage the CCAPS system</p> <p>Weekly dashboard of management information developed and shared</p>	<p>Data requirements included in commissioning and procurement frameworks;</p> <p>CCAPS system regularly reviewed and updated;</p> <p>Regular reports generated for HBs, senior managers and providers</p>	<p>Annual Report;</p> <p>Keeping daily, weekly, monthly performance reports; Remedial Action plans (if required);</p> <p>Specific targeted actions as required</p>	3x2=6	CXL 3x1=3		01/06/2022	01/06/2023

Latest data loaded

**March 2023**



# Emergency Ambulance Services Committee

## Ambulance Data Portal | Performance Report

Click here to enter

GENERAL RELEASE | PUBLIC

# Performance Report | Summary and contents

**Contents (Ctrl+Click to go to the required slide and the house symbol to return to summary).**

1. Front page
2. Summary and contents
3. 999 call demand
4. 111 Wales to 999 Transfers
5. 999 call answer times
6. All incidents and RED performance
7. Hear and Treat
8. See and Treat
9. RED incidents
10. RED incident response time
11. AMBER incidents
12. AMBER incident response times
13. GREEN incidents
14. GREEN incident response times
15. Transported to Tier 1 site
16. Transported to non-Tier 1 site
17. Handover delays over 15-minutes
18. Handover delays over 60-minutes

19. Handover delays over 4-hours
20. Trajectory
21. RED/AMBER release requests
22. Unit Hour Production (UHP)
23. Glossary of Terms

## Data acquisition key



**Data acquisition:** EASC Ambulance Service Indicators



**Data acquisition:** WAST Qlik Sense



**Data acquisition:** WAST Data Academy SQL



**Data acquisition:** WAST Microsoft Excel

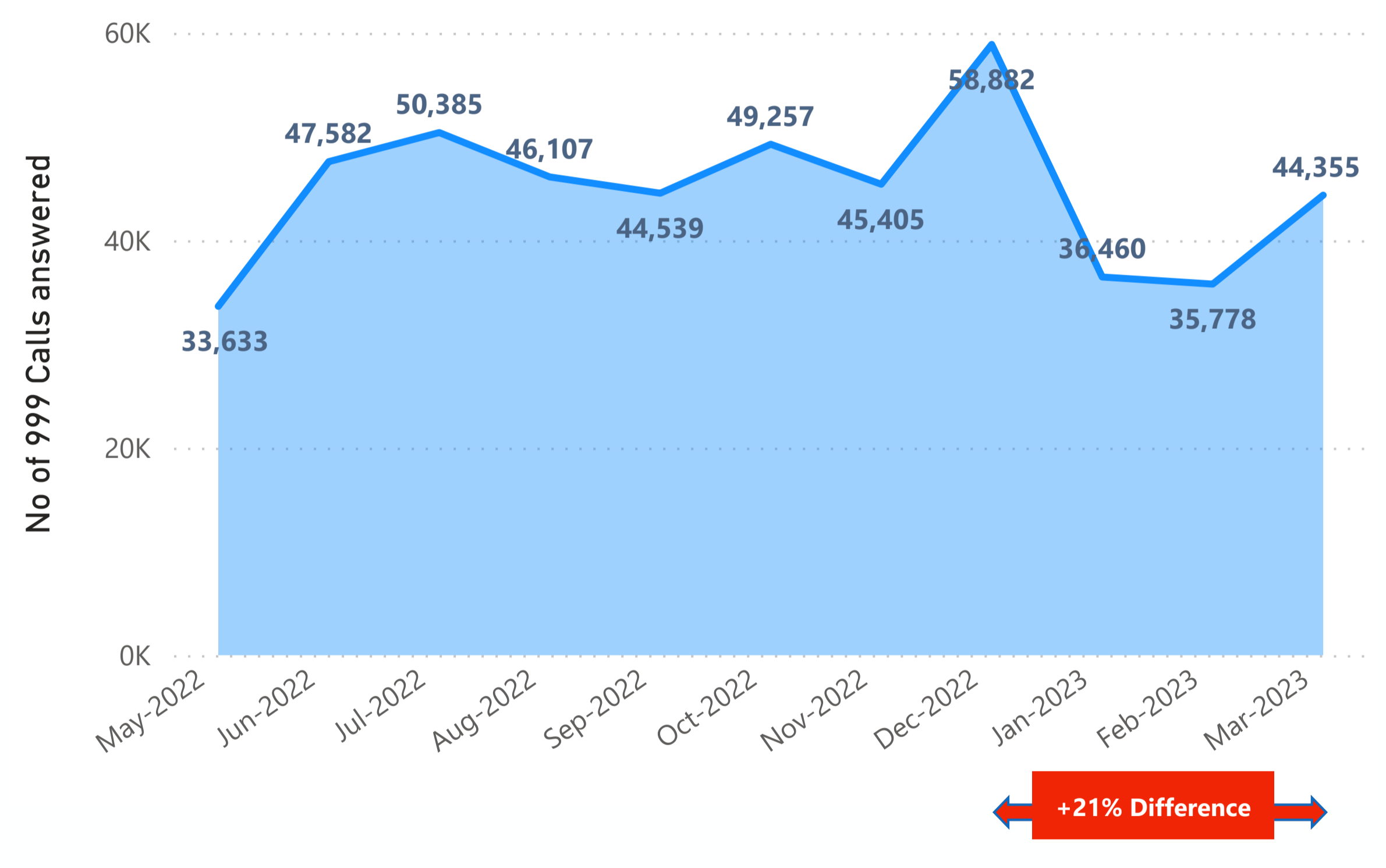
GENERAL RELEASE | PUBLIC



# Performance Report | 999 calls demand

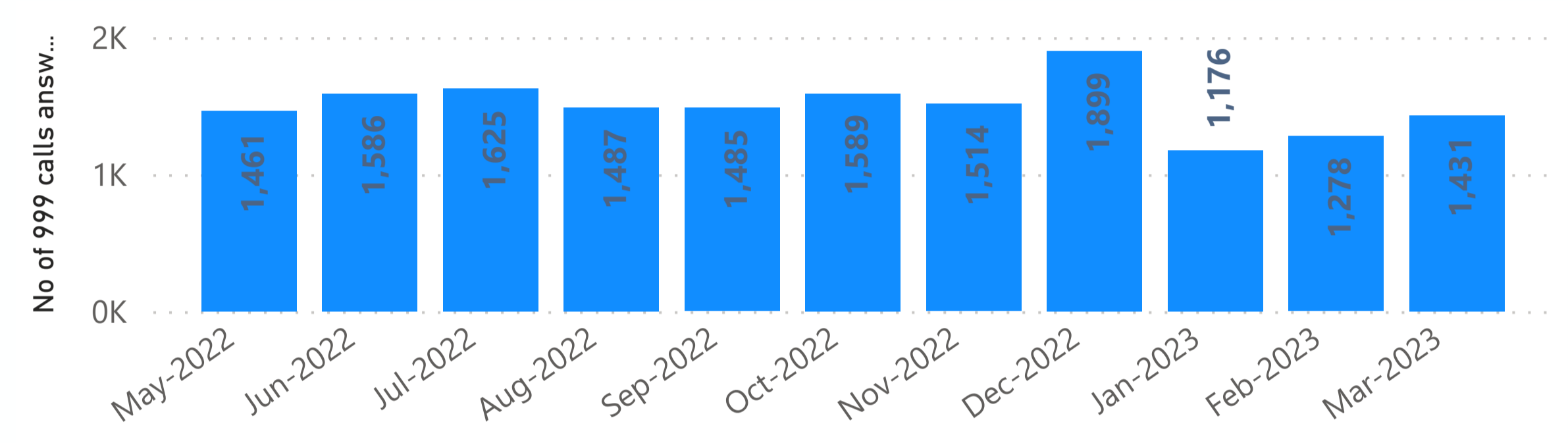
The number of 999 calls has seen an upward trend until December 2022. From December to February, there has been a reduction in 999 calls. March 2023 saw a 24% increase from February 2023.

## 1.1 Monthly - Volume of 999 Calls Answered

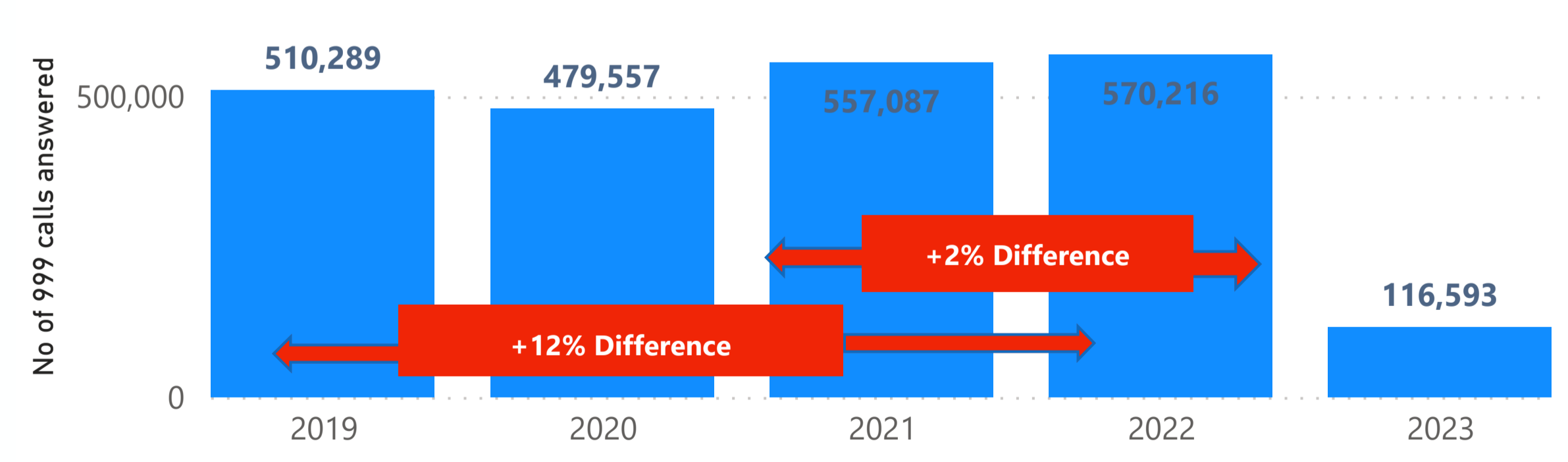


Source: Ops Directorate Telephony Qlikview

## 1.2 Daily Average - 999 Calls Answered



## 1.3 Annualised Data - Volume of Calls Answered



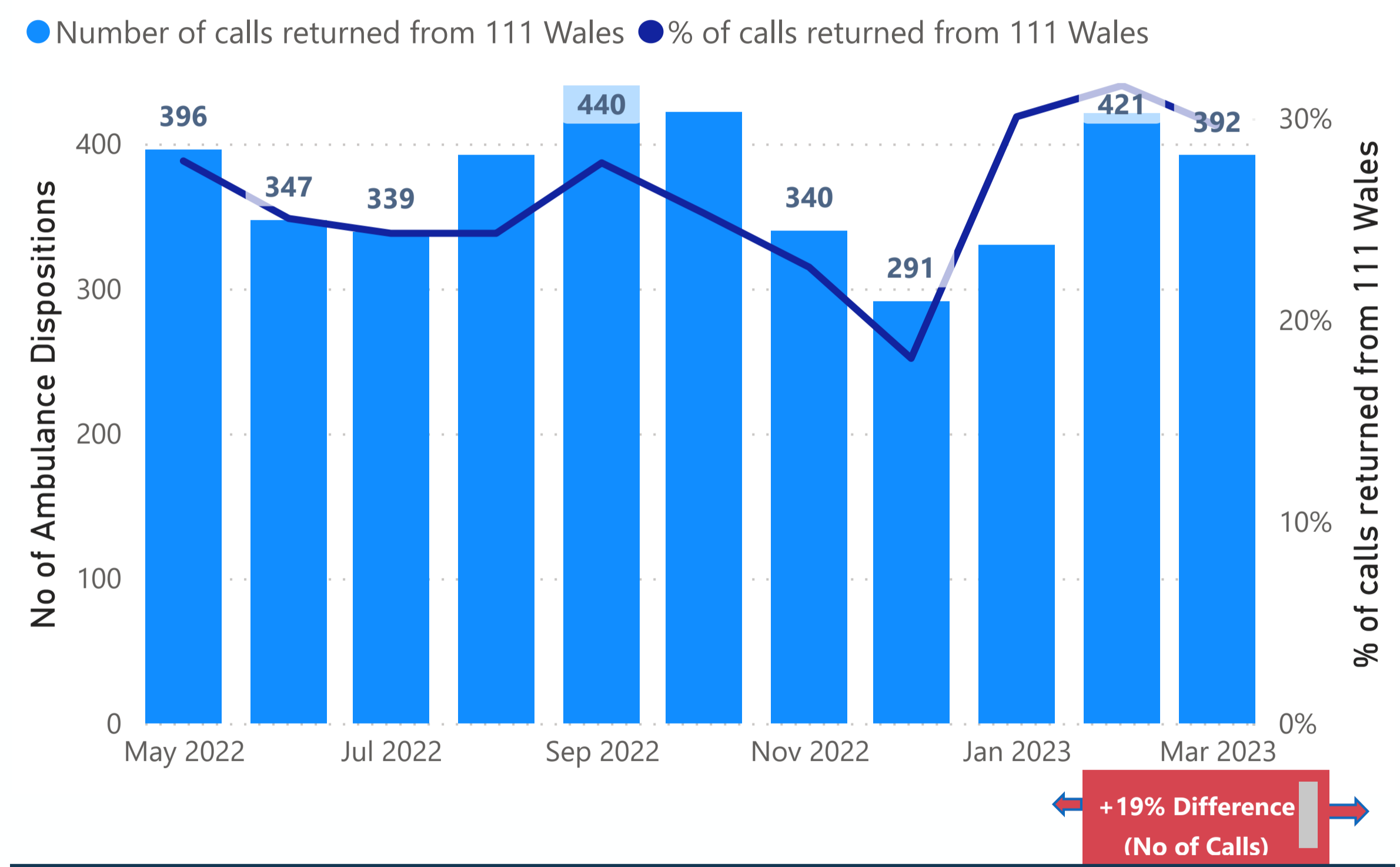
GENERAL RELEASE | PUBLIC



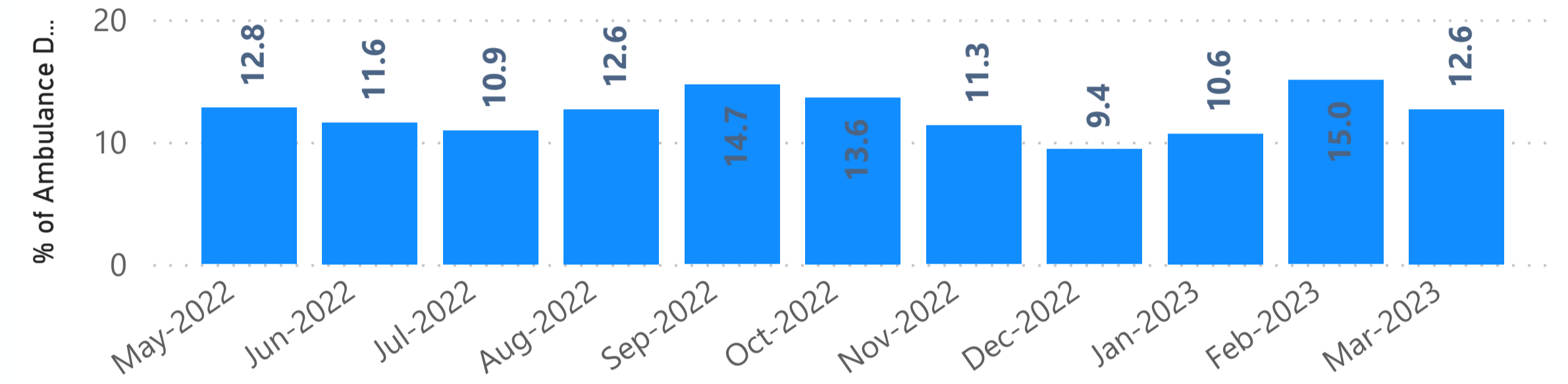
# Performance Report | 111 Wales to 999 Transfers

Calls returned from 111 Wales are increasing from December 2022, despite a small dip in calls in March 2023. There has been a 19% increase from January 2023 to March 2023. The % of calls returned from 111 Wales has seen a sharp increase from December 2022 to February 2023 with a reduction in March 2023. Daily average figures remain constant.

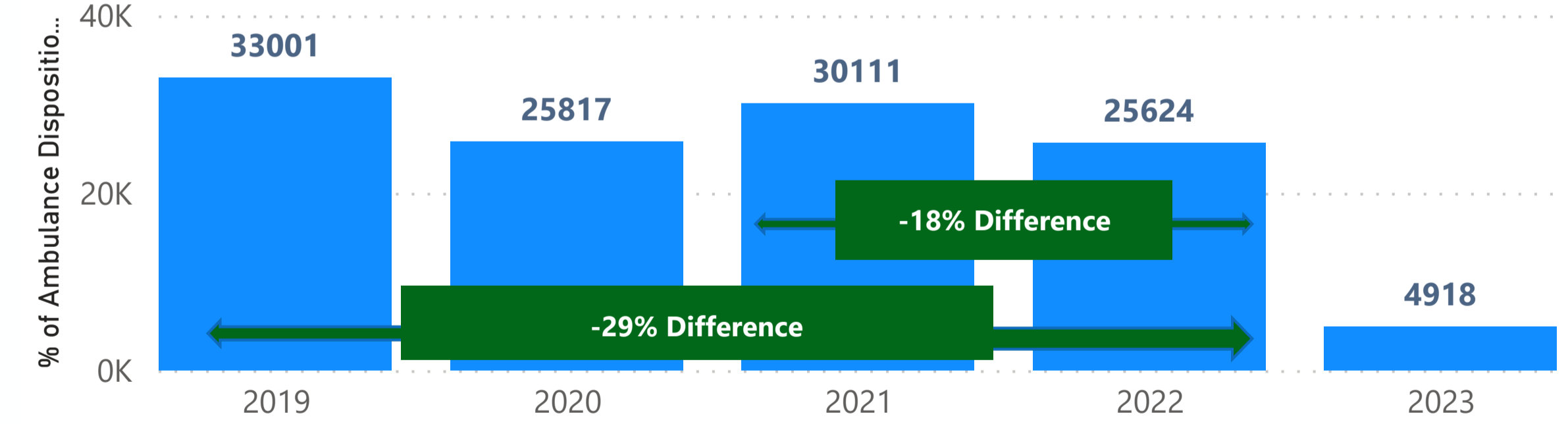
## 2.1 Monthly - Calls returned from 111 Wales



## 2.2 Daily Average - Calls Returned from 111 Wales



## 2.3 Annualised Data - Total Calls Returned from 111 Wales



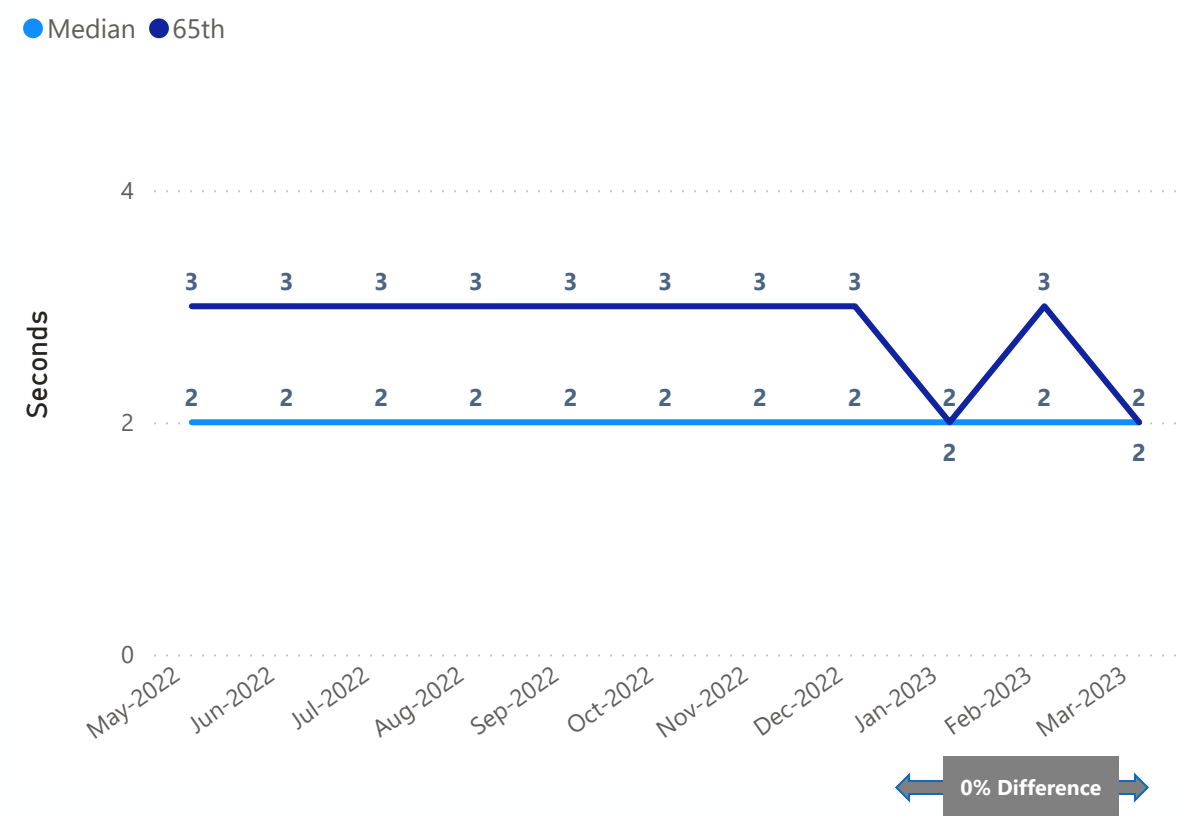
Source: AQ19ii Calls Returned from NHS Direct with an Outcome of "Ambulance Required"

GENERAL RELEASE | PUBLIC

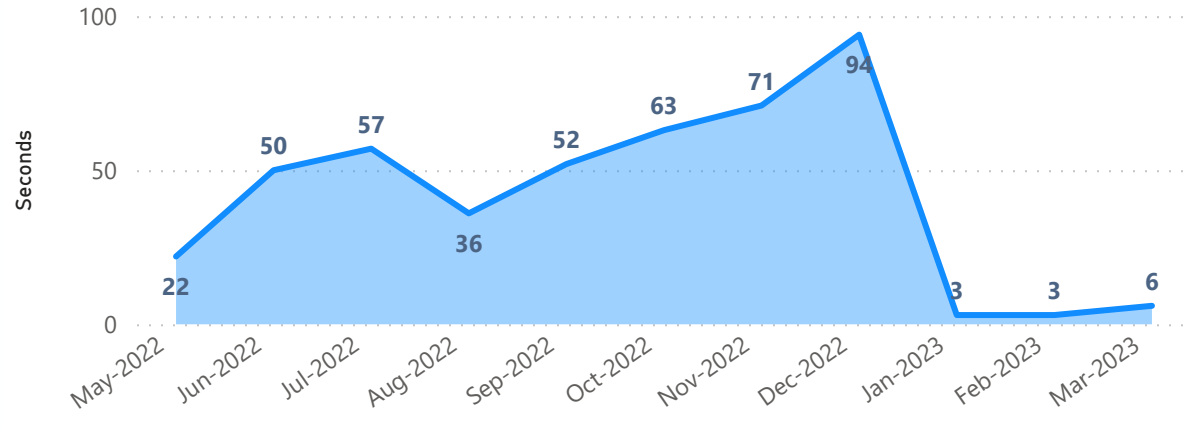
# Performance Report | 999 call answer times

999 call answer times have remained constant. The 95th percentile showed a steady increase up to December 2022 and then reduced substantially from January 2023 onwards. March 2023 was 50% higher than February 2023, but still remained low overall for the period shown.

## 3.1 Median and 65th - 999 Calls: Time to Answer



## 3.2 95th Percentile



## 3.3 Call Abandonment - TBC

Source: AQ17ii 999 Calls: Time to Answer Median, 65th and 95th percentile (in seconds)

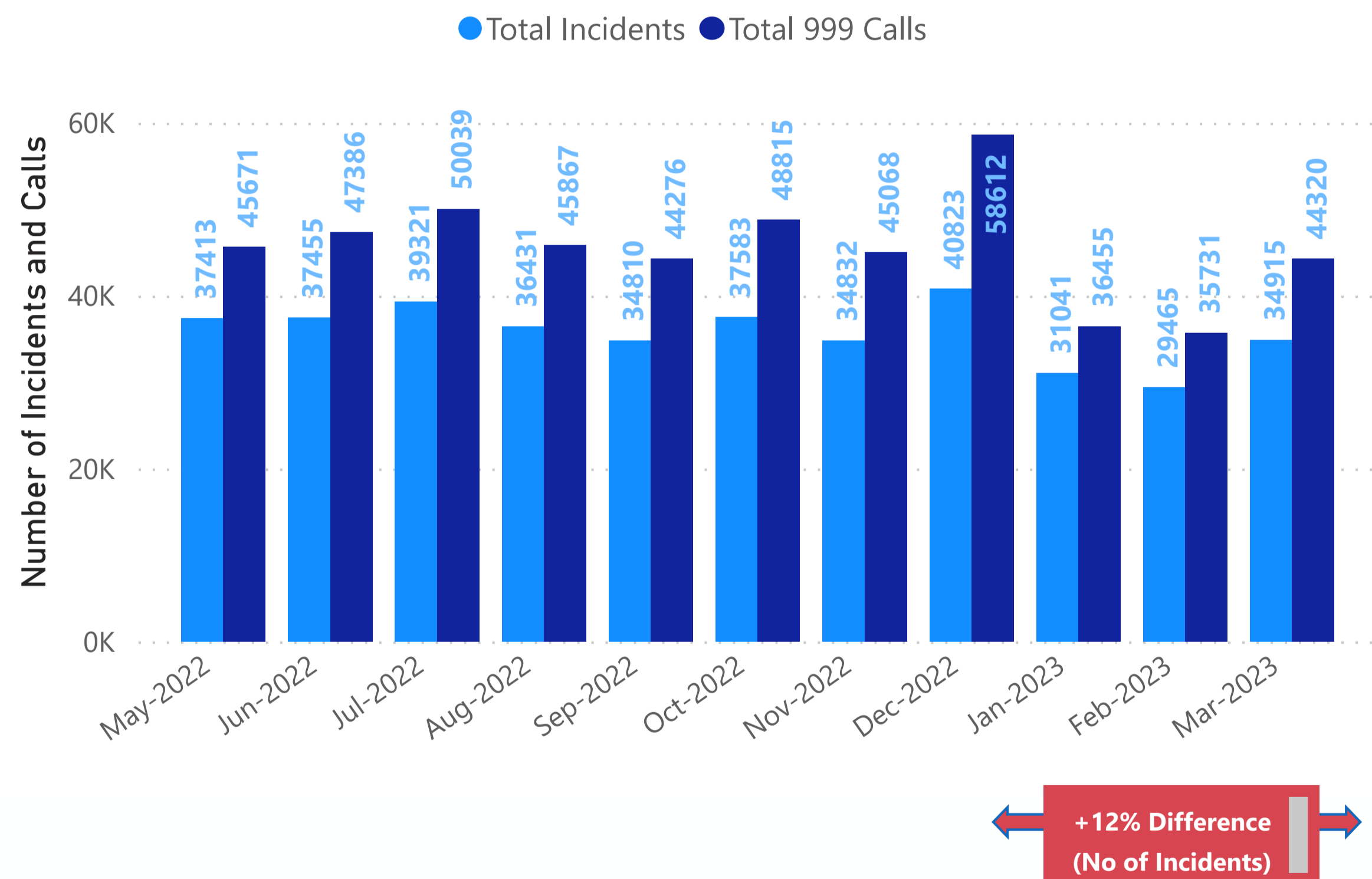
GENERAL RELEASE | PUBLIC



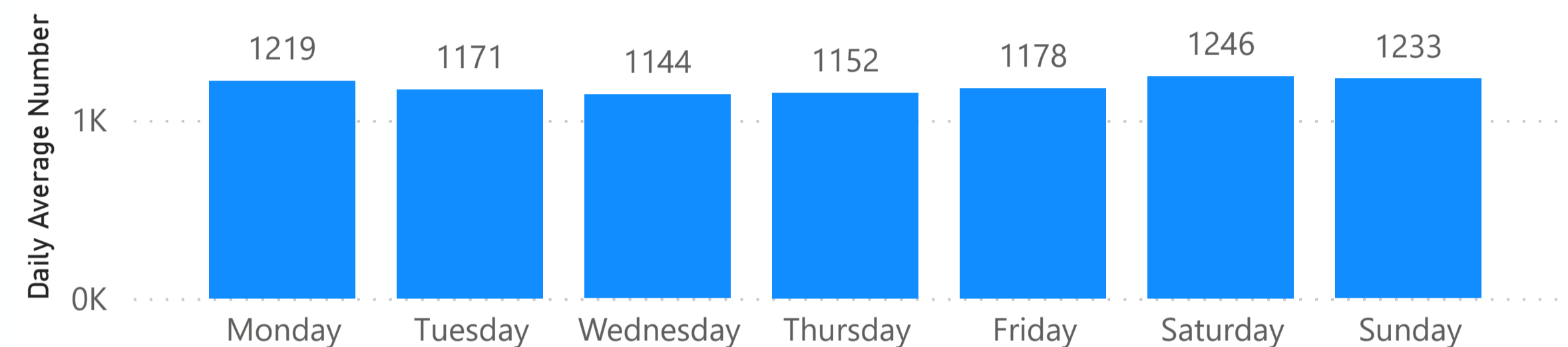
# Performance Report | All incidents

Overall there is a downward trend of the number of incidents until February 2023, despite a spike in incidents in December 2022. March 2023 saw a 18% increase in the number of incidents as compared to February 2023. There has been a 12 % increase in the number of incidents from January to March 2023. Total 999 calls has also seen a downward trend until February 2023 with an increase in March 2023.

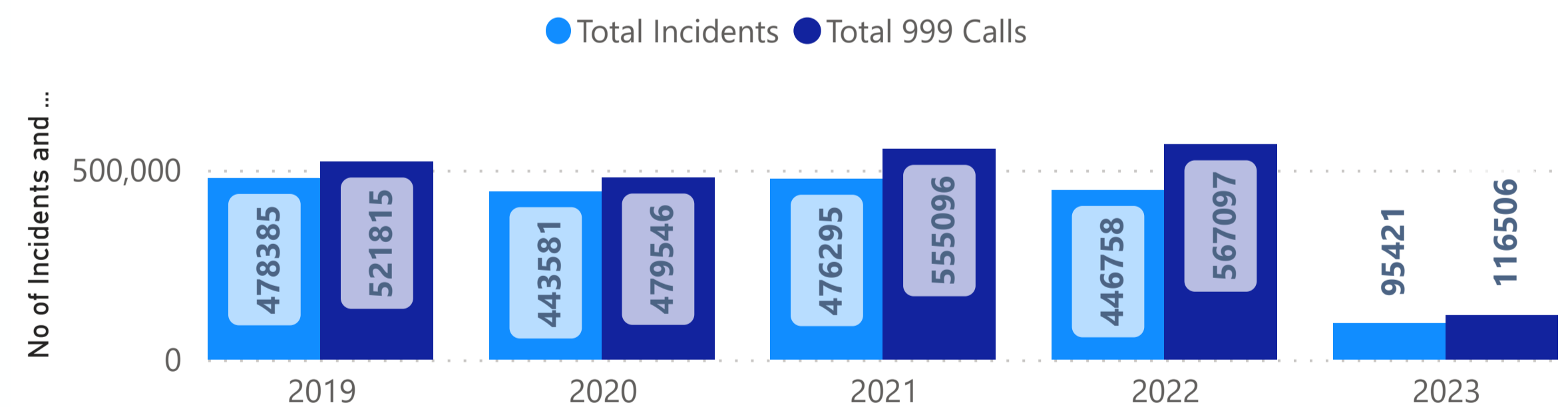
## 4.1 Monthly Volume of Incidents and Calls



## 4.2 Average Daily Incidents - 2022



## 4.3 Annualised Data - Total Incidents and Calls



Source: AQ15 Total number of incidents; Avg Daily Incidents - WAST SQL Data Academy

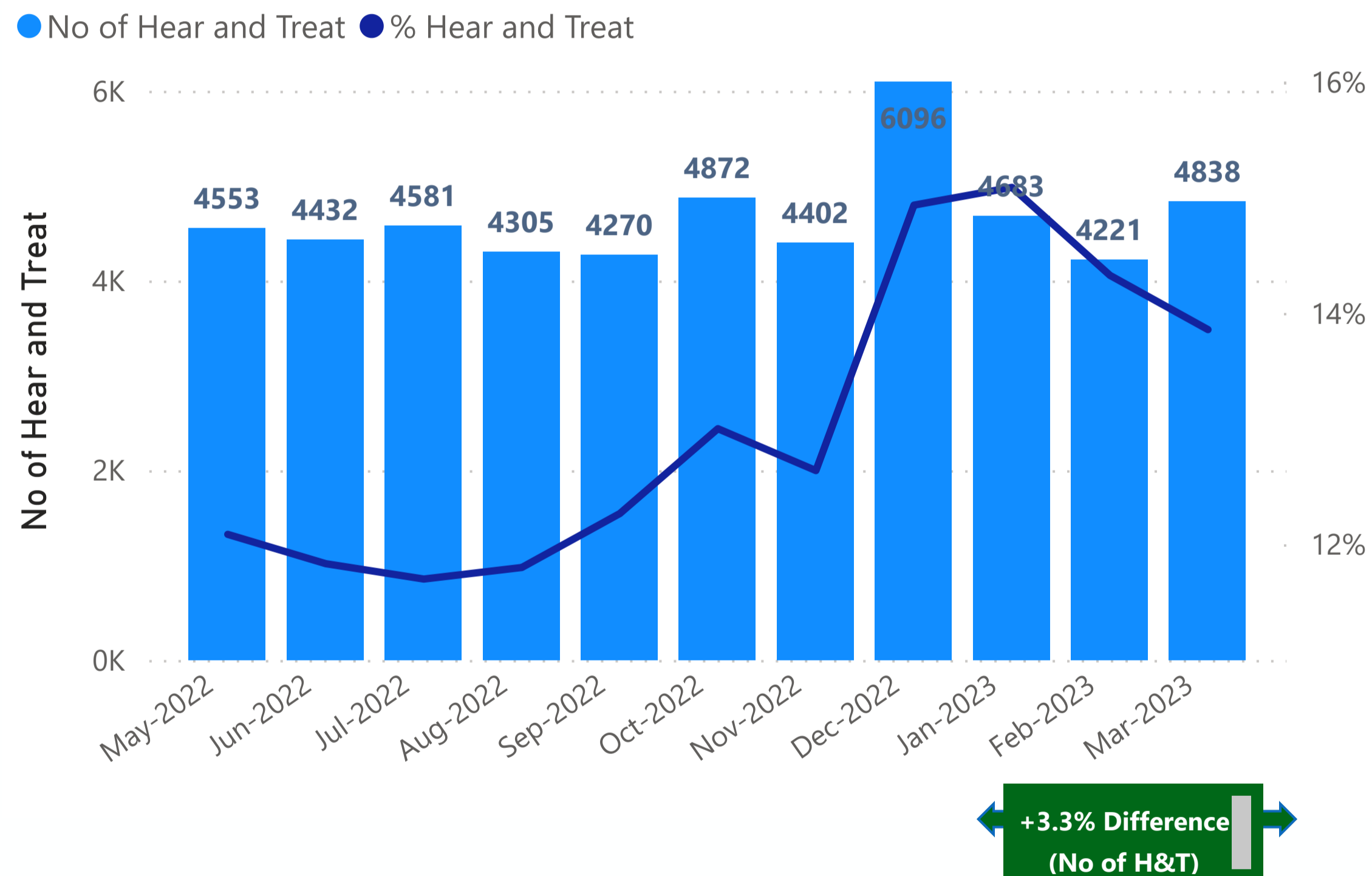
GENERAL RELEASE | PUBLIC



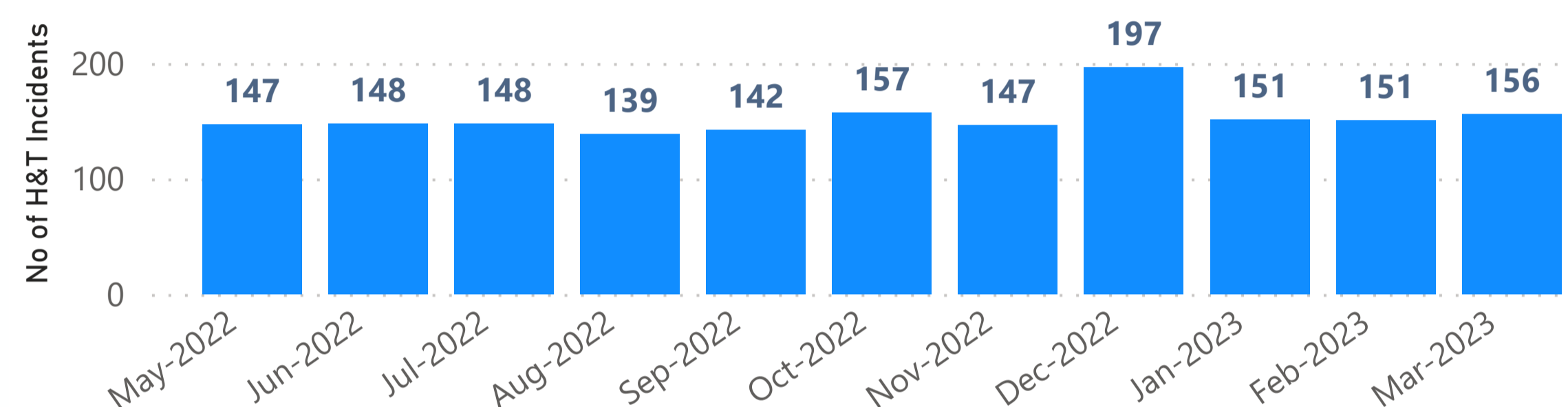
# Performance Report | Hear and Treat

There has been a reduction in Hear and Treat incidents since reaching a peak in December 2022. In March 2023, the number of hear and treat incidents was the third highest for the time period, but the Hear and Treat % was lowest since November 2022 at 13.8% The daily average in March 2023 is higher compared to the previous month and is constant to the time period shown.

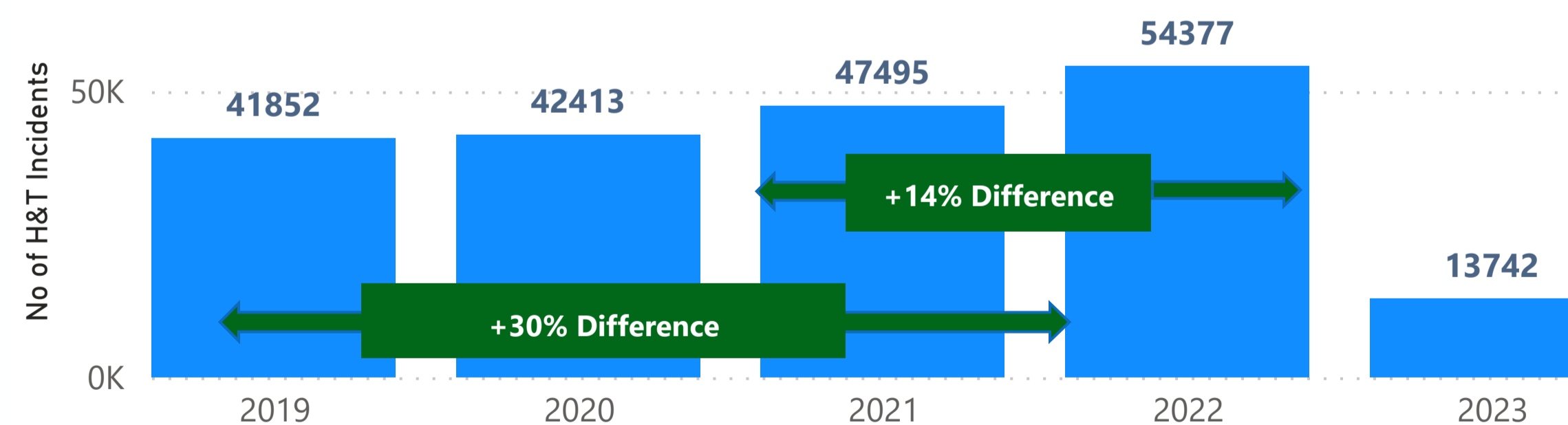
## 5.1 Monthly - Volume of Hear and Treat Incidents



## 5.2 Daily Average - Number of Hear and Treat Incidents



## 5.3 Annualised Data - Number of Hear and Treat Incidents



Source: AQ10i Number of calls ended following WAST telephone assessment (Hear and Treat)

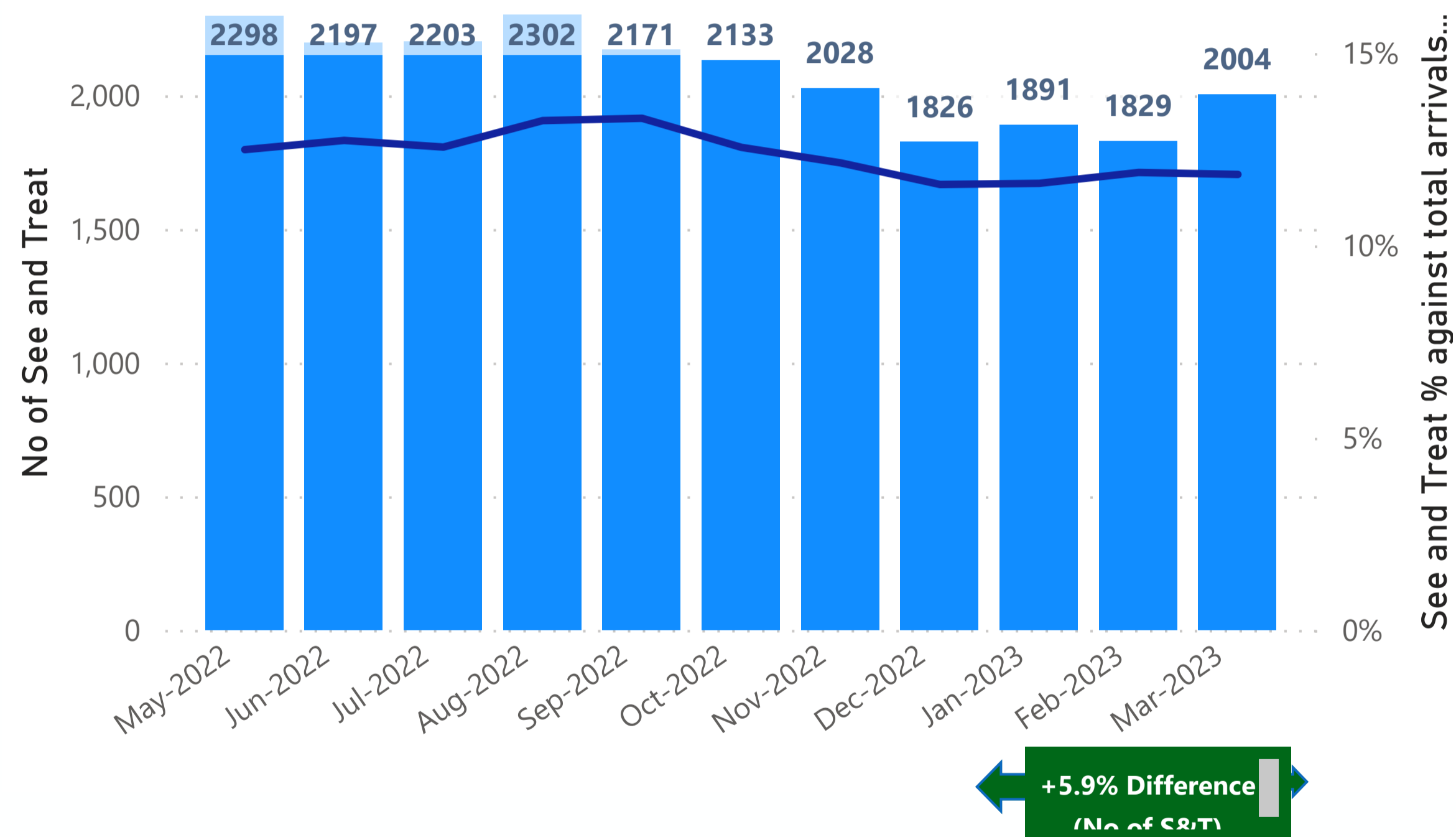
GENERAL RELEASE | PUBLIC

# Performance Report | See and Treat

There is a steady downward trend for See and Treat until February 2023. The number of See and Treat incidents in March 2023 was 10% higher than the previous month. The See and Treat % saw a slight decrease from February to March 2023 despite the number of See and Treat incidents increasing. The daily average of incidents is consistent.

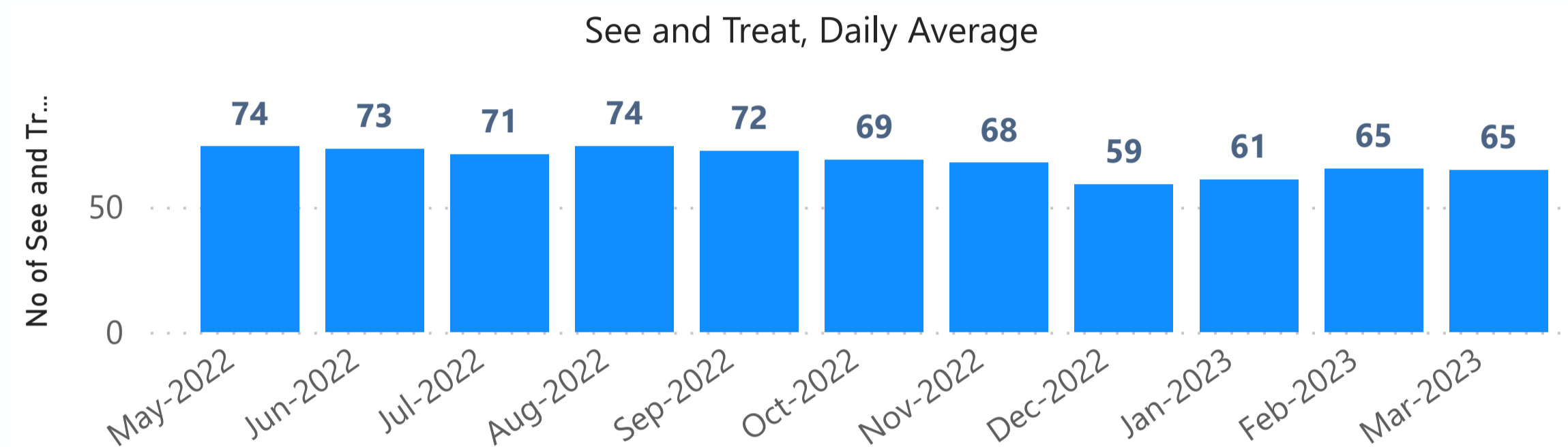
## 6.1 Monthly Volume of See and Treat Responses

● No of See and Treat ● See and Treat % against total arrivals at scene

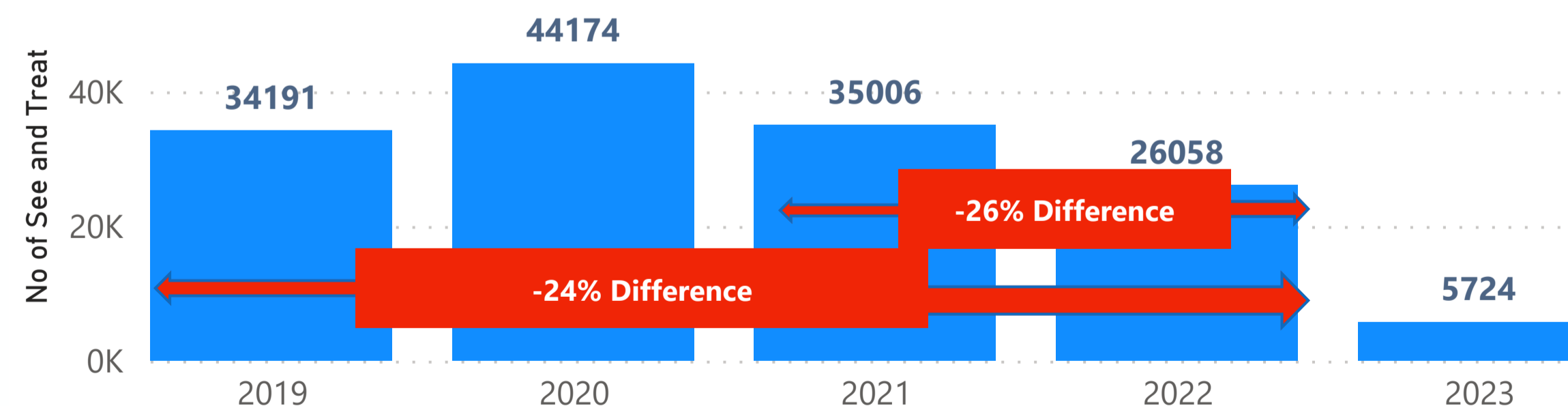


Source: AQI19i Total Number of Incidents where an Ambulance Resource Attended Scene

## 6.2 Daily Average - Number of See and Treat Responses



## 6.3 Annualised Data - Number of See and Treat Responses



GENERAL RELEASE | PUBLIC

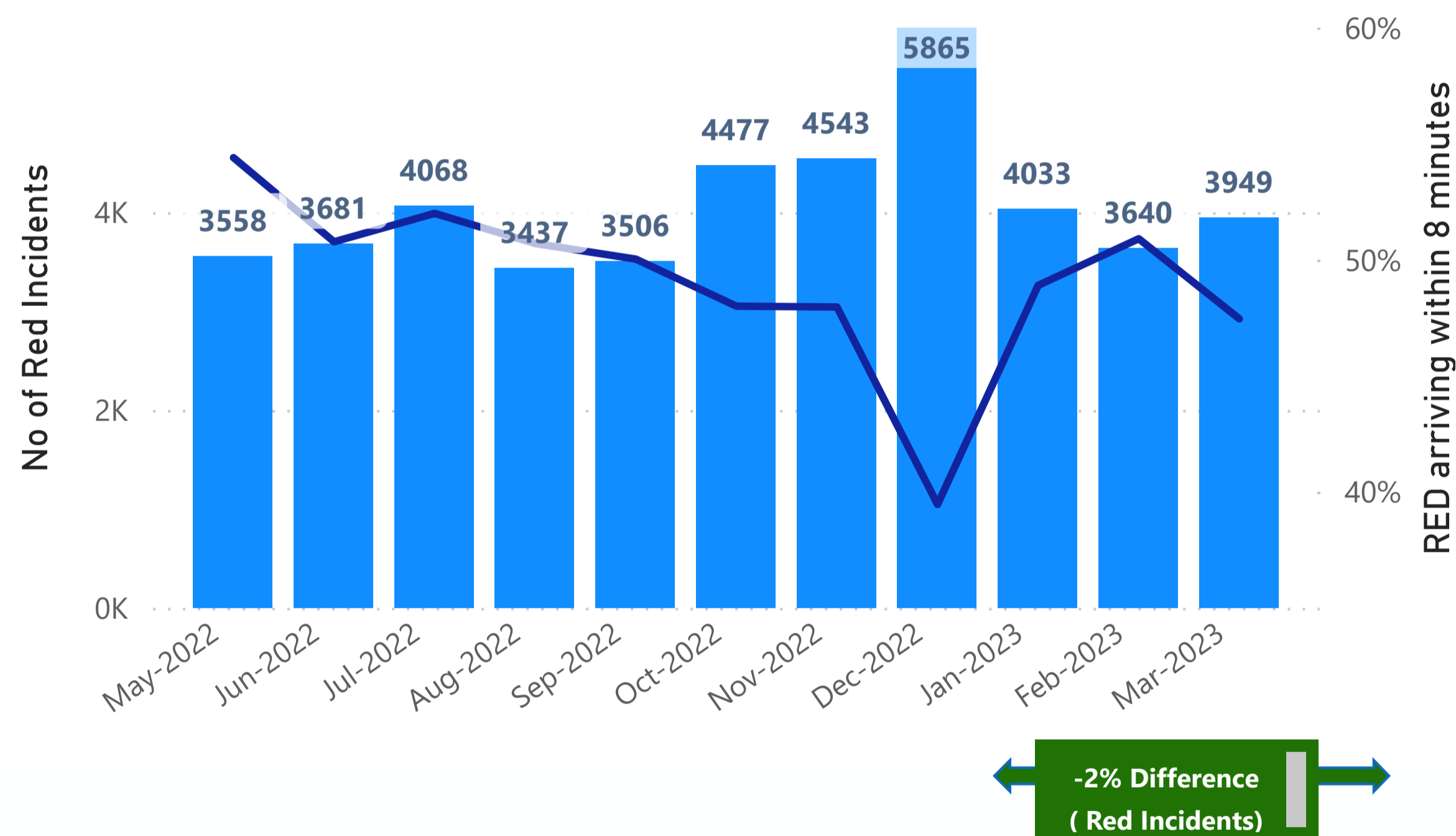


# Performance Report | RED incidents

Since December 2022, there is a downward trend of the number red incidents since December 2022 with the lowest figure in February 2023 at 3640. March 2023 saw a 8.5% increase in the number of red incidents with a decline in the red 8 minute % performance by 3%.

## 7.1 Monthly Volume of Red Incidents and Red % Performance

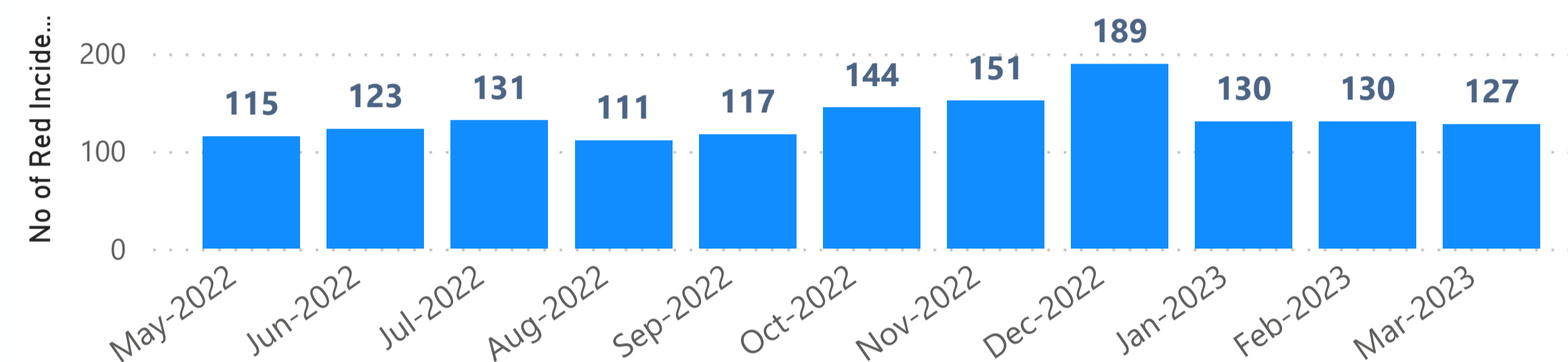
● RED incidents ● RED arriving within 8 minutes



Source: AQI11 Number of RED category incidents resulting in an emergency response

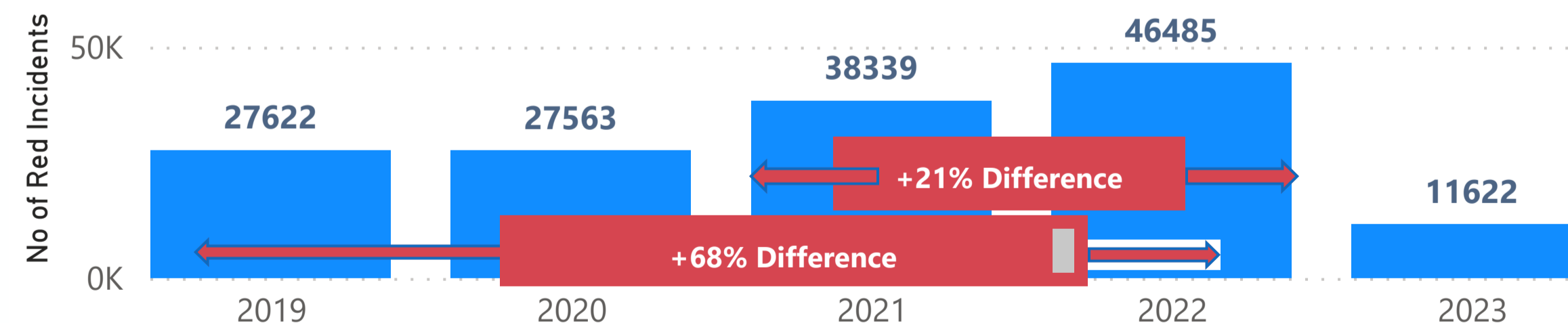
## 7.2 Daily Average - Red Volume

Red Volume: daily average



## 7.3 Annualised Data - Volume of Red Incidents and Red 8 min %

Volume of Red incidents and Red 8 min % in the 12 months to current month

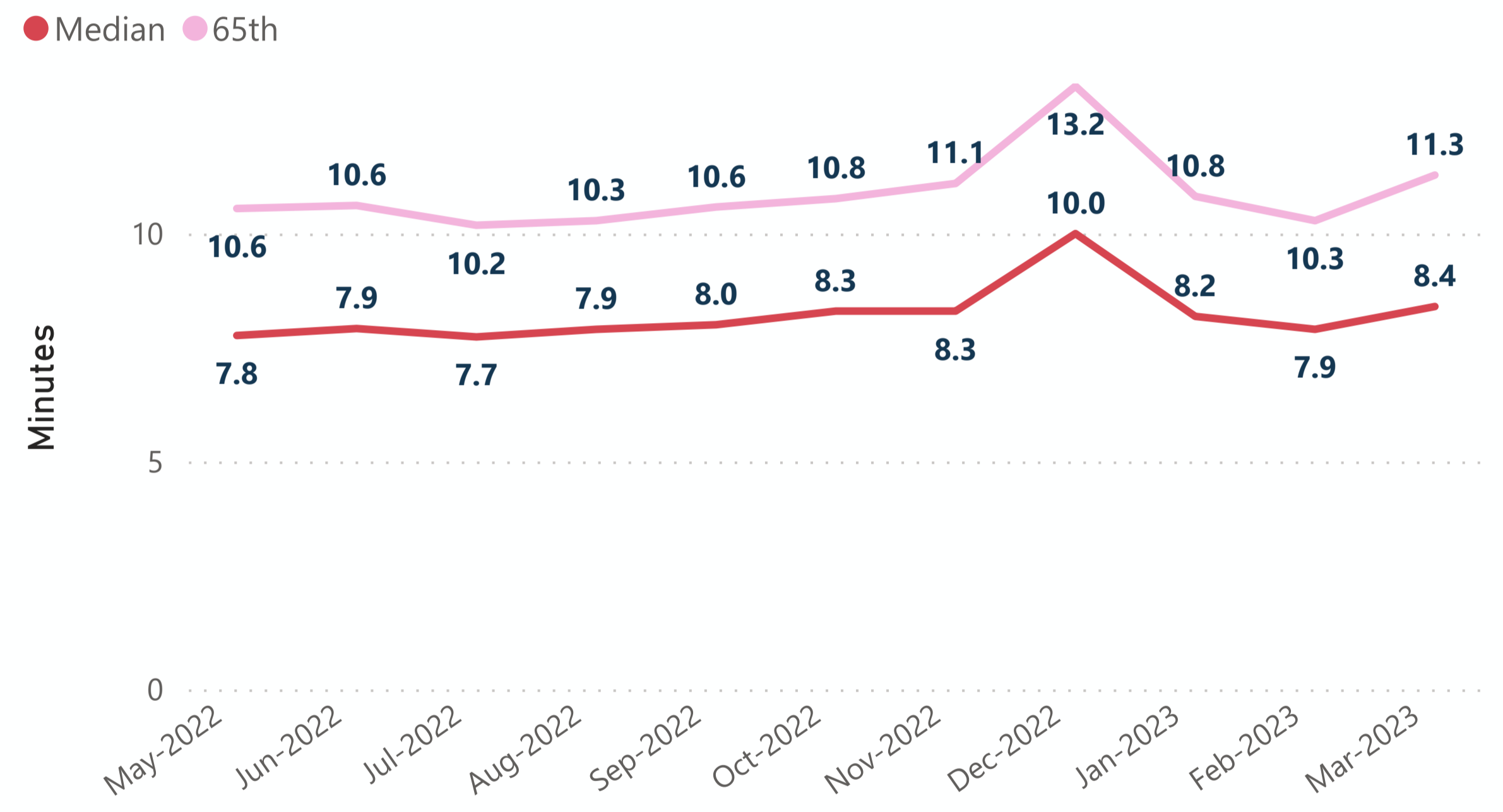


GENERAL RELEASE | PUBLIC

# Performance Report | RED incident response time

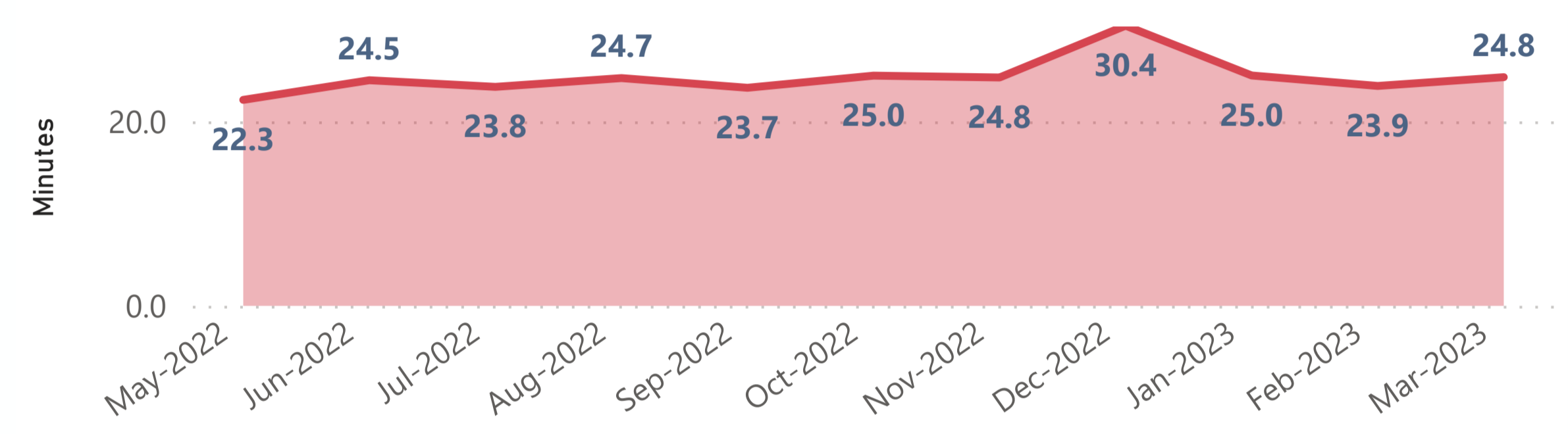
Despite seeing red median and 65th peak to a all-time high in December 2022, red median and 65th has remained consistent throughout the time period reported. March saw an 6.3% increase from the previous month. The longest red was on a slightly upward trend until December 2022 but has steadily been decreasing.

## 8.1 Median and 65th Percentile Red Response Time (Minutes)

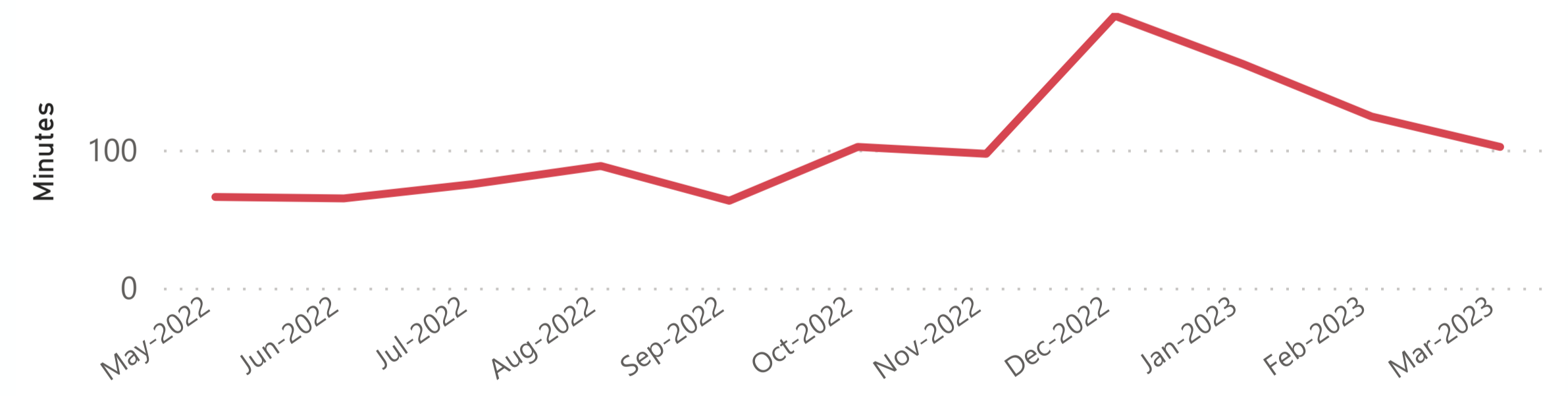


+2.4% Difference (Median)

## 8.2 95th Percentile Red Response Time (Minutes)



## 8.3 Longest Red



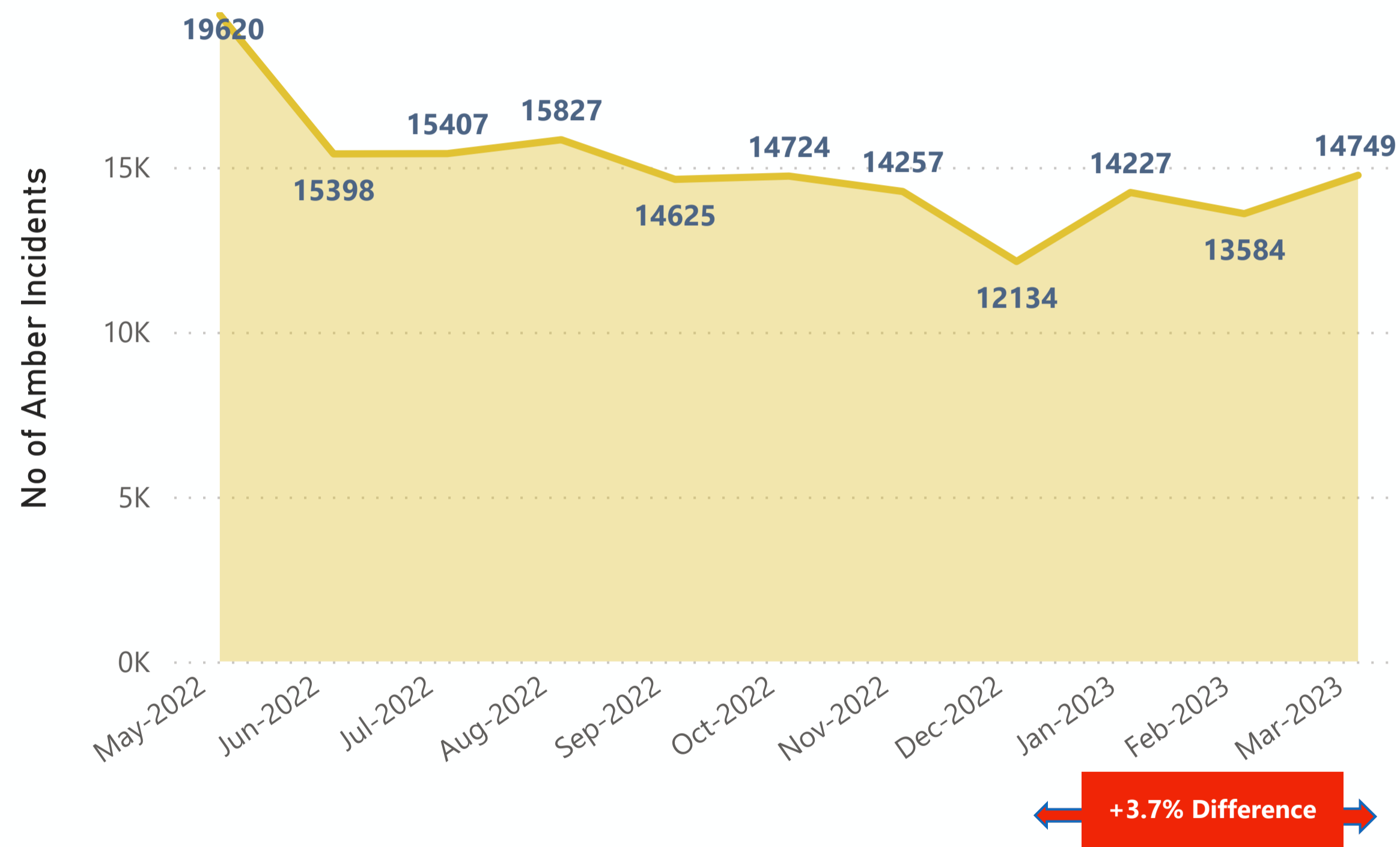
Source: AQI11 Red Category Median, 65th and 95th Response Minutes

GENERAL RELEASE | PUBLIC

# Performance Report | AMBER incidents

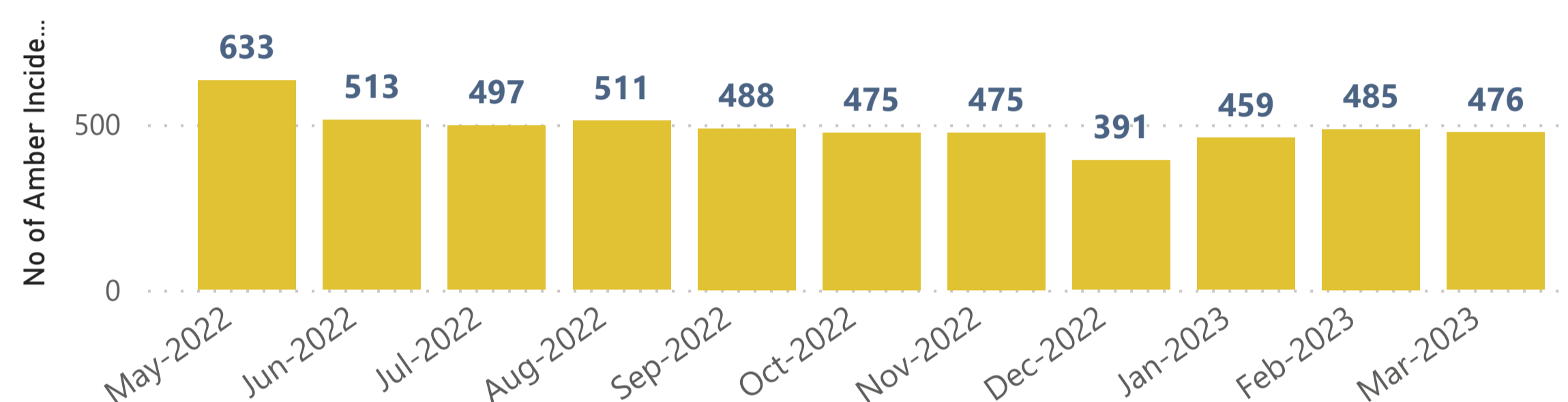
The number of amber incidents are on a downward trend for the time period reported, despite seeing a 8% increase in March 2023 as compared to the previous month. The daily average has seen an increase since December 2022 but is still lower than last year's daily average.

## 9.1 Monthly Volume of Amber Incidents

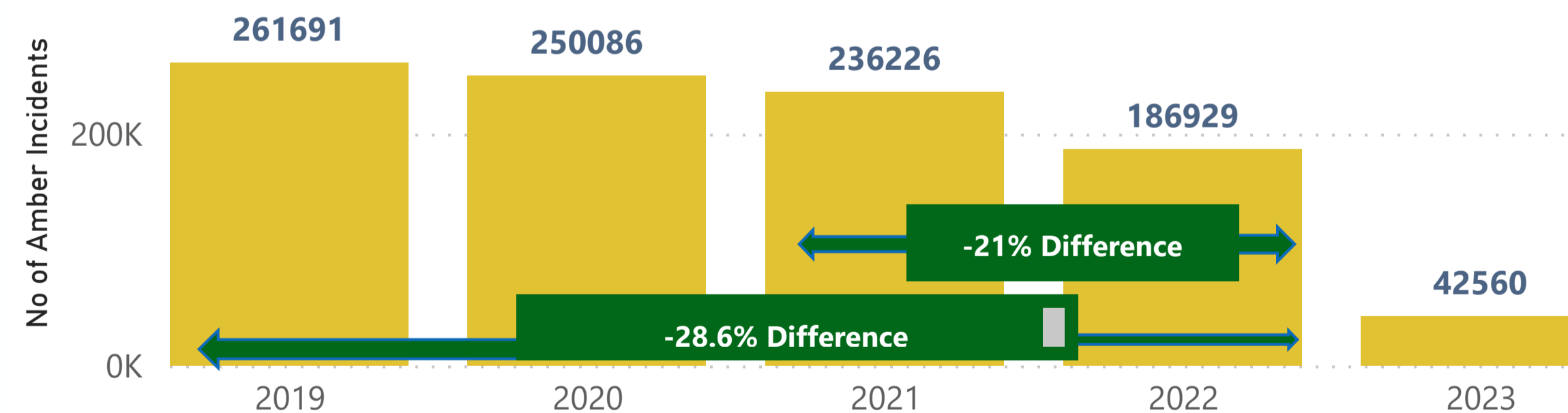


Source: AQ111 Number of Amber category incidents resulting in an emergency response

## 9.2 Daily Average - Number of Amber Incidents



## 9.3 Annualised Data - Number of Amber Incidents



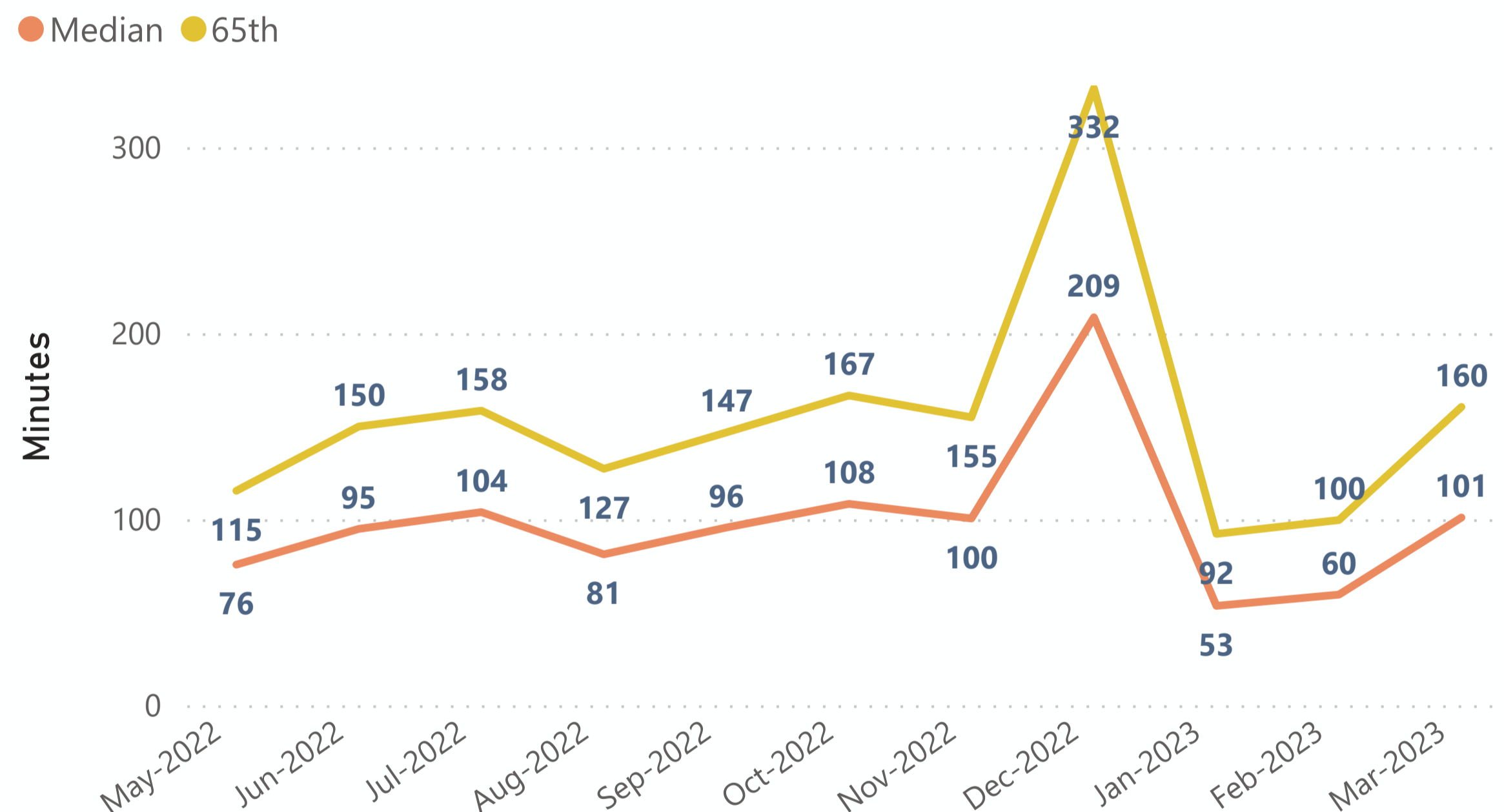
GENERAL RELEASE | PUBLIC



# Performance Report | AMBER incident response times

Amber Median and 65th percentile are at its lowest in January 2023 at 53.47 minutes. Since January 2023, there has been a steady increase in Amber Median and 65th percentile, with March 2023 being 50% higher as compared to the previous month. The 95th percentile is steadily increasing throughout the time period, with March 2023 being the second highest for the period reported.

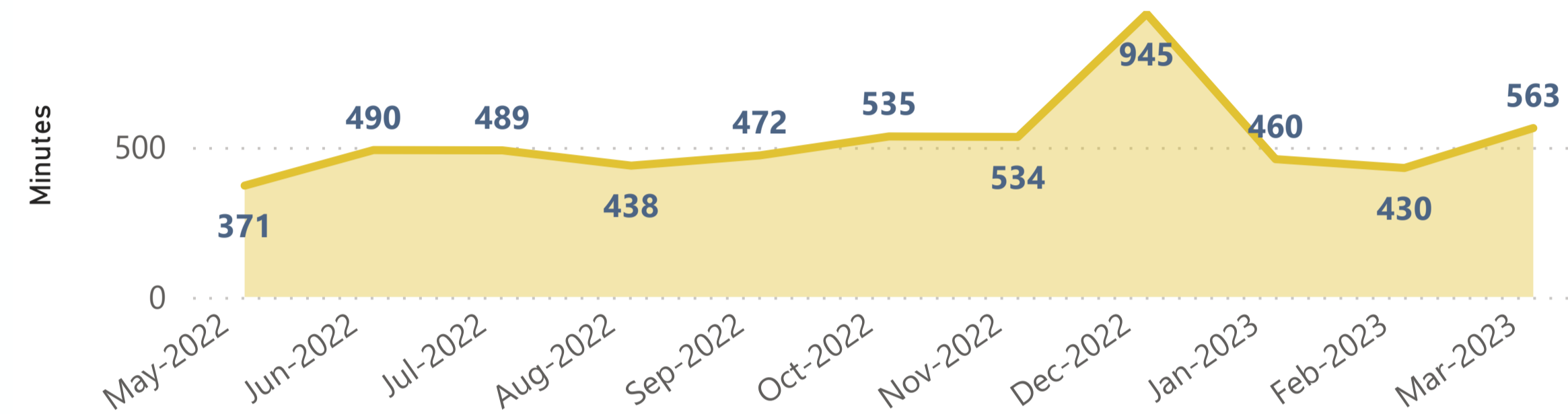
## 10.1 Median and 65th Percentile Amber Response Time (Minutes)



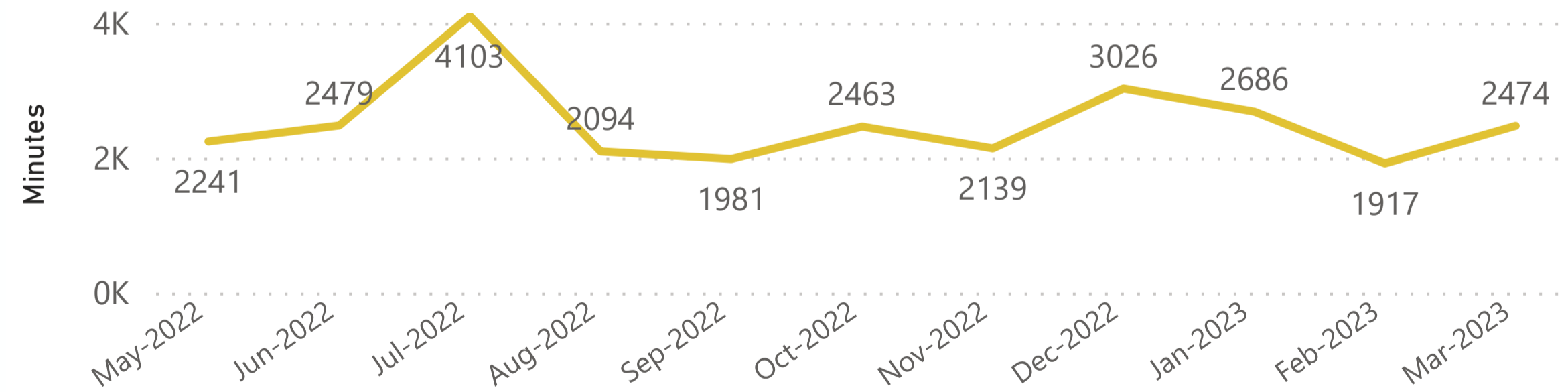
+90% Difference (median)

Source: AQ11 Amber Category Median, 65th and 95th Response Minutes

## 10.2 95th Percentile Amber Response Time (Minutes)



## 10.3 Longest Amber (Minutes)



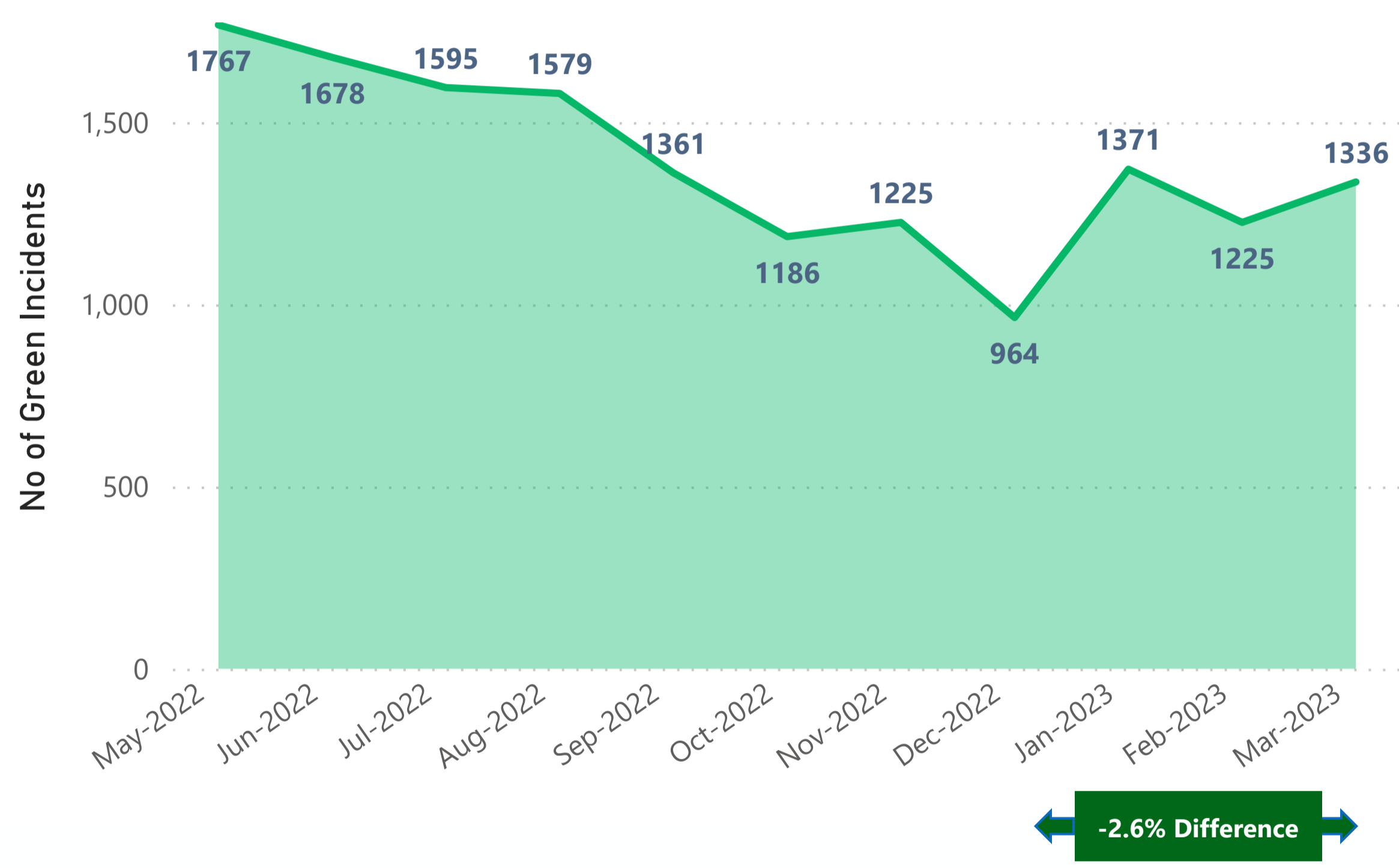
GENERAL RELEASE | PUBLIC



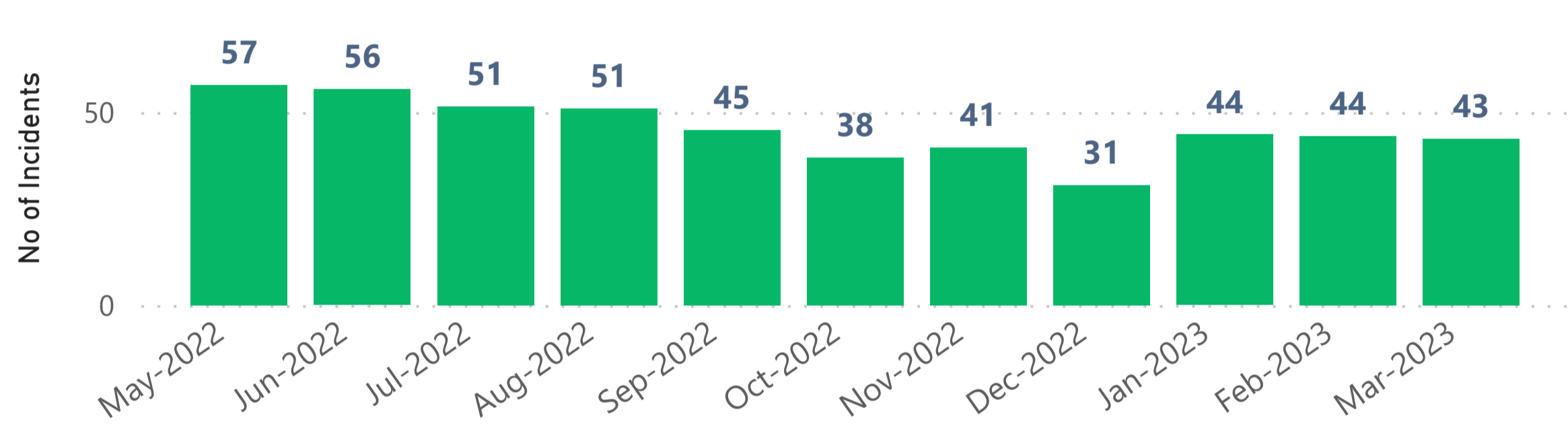
# Performance Report | GREEN incidents

The number of green incidents has been reducing up to December 2022. Since December 2022, there has been an upward trend in the number of green incidents. March 2023 saw a 9% increase as compared from the previous month. The daily average has reduced throughout the period.

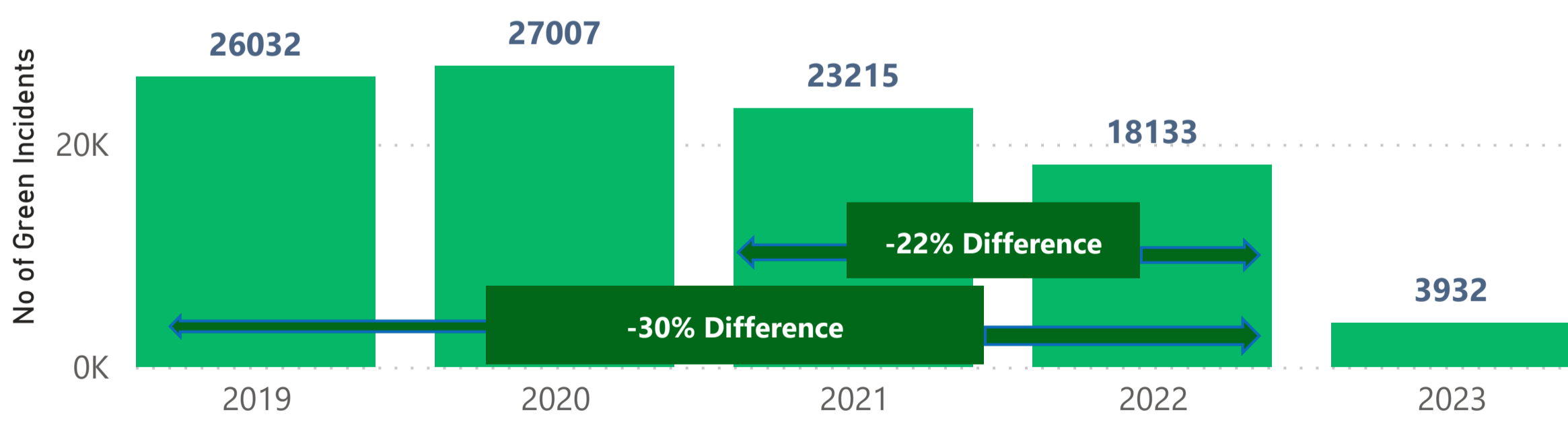
## 11.1 Monthly Volume of Green Incidents



## 11.2 Daily Average - Number of Green Incidents



## 11.3 Annualised Data - Number of Green Incidents



Source: AQI11 Number of Green category incidents resulting in an emergency response

GENERAL RELEASE | PUBLIC



[HTTPS://EASC.NHS.WALES](https://EASC.NHS.WALES)  
 CTM\_CASC\_EASC@WALES.NHS.UK  
 @NCCU\_CYMRU

NB. Ambulance indicator and performance data is published on the penultimate Thursday of the month with the exception of February 2023 when it is the last Thursday. As such only those in the public domain are shown on this slide.

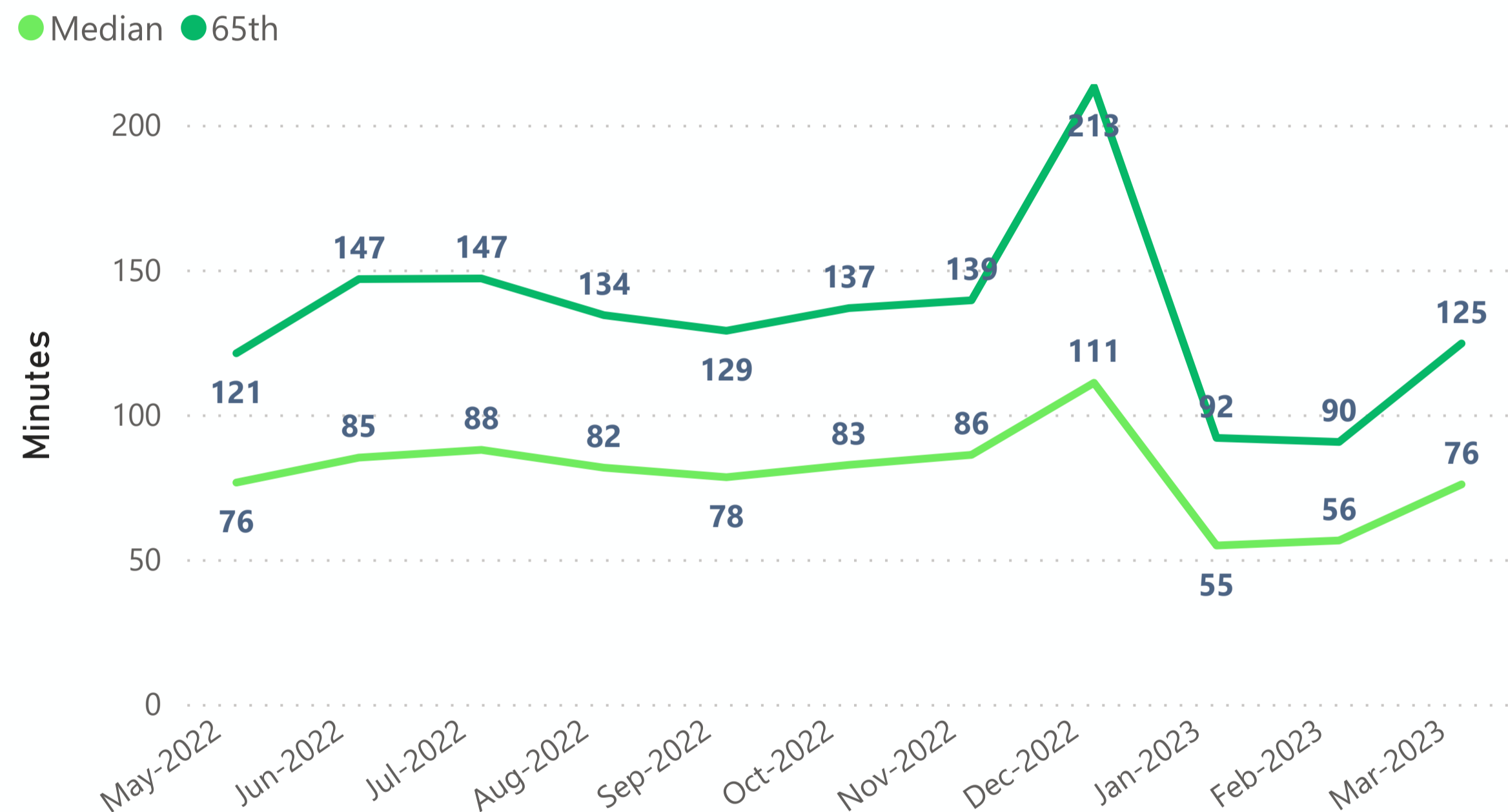




# Performance Report | GREEN incident response times

Green median is at its lowest in January, with steady increases in both February and March 2023. The 65th percentile saw a reduction from January to February before increasing by 39% in March 2023. The average number of green incidents has remained static despite seeing an increase in

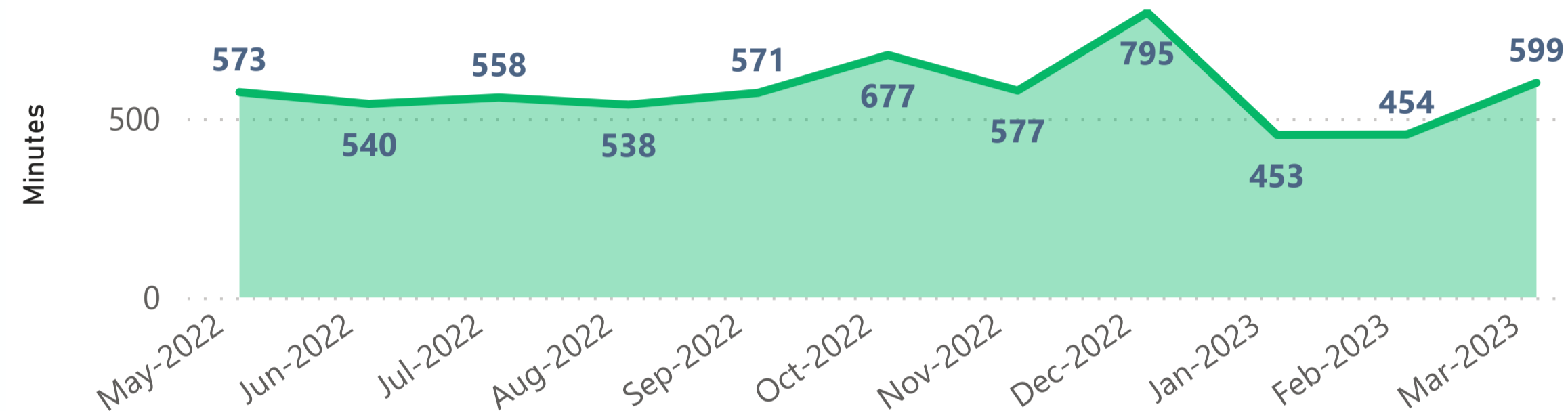
## 12.1. Median and 65th Percentile Green Response Time (Minutes)



+38.2% Difference (Median)

Source: AQI11 Green Category Median, 65th and 95th Response Minutes

## 12.2 95th Percentile Green Response Time (Minutes)



## 12.3 Longest Green TBC

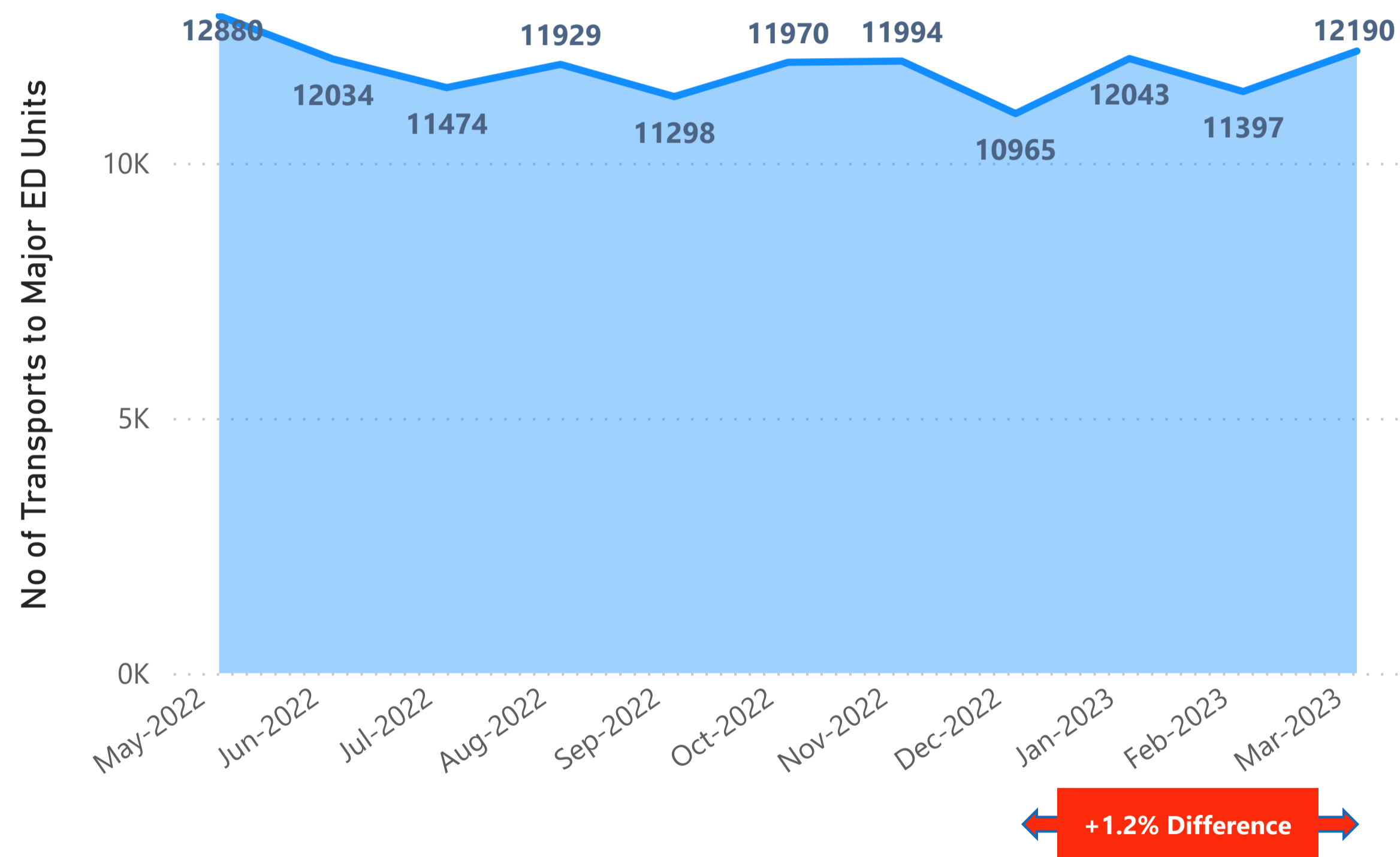
GENERAL RELEASE | PUBLIC



# Performance Report | Transported to Tier 1 site

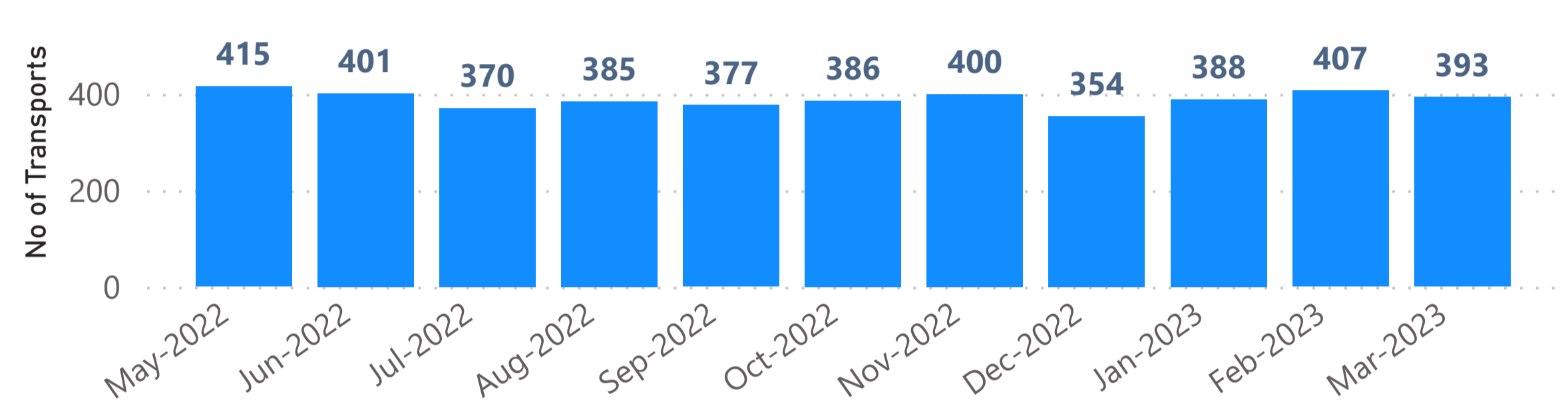
The number of incidents transported to Tier 1 sites was the second highest in March 2023 for the time period reported. March 2023 saw a 7% increase in the volume of transport to Major ED units as compared to the previous month. The average number of daily incidents transported in March was lower than the previous month.

## 13.1 Monthly Volume of Transport to Major ED Units

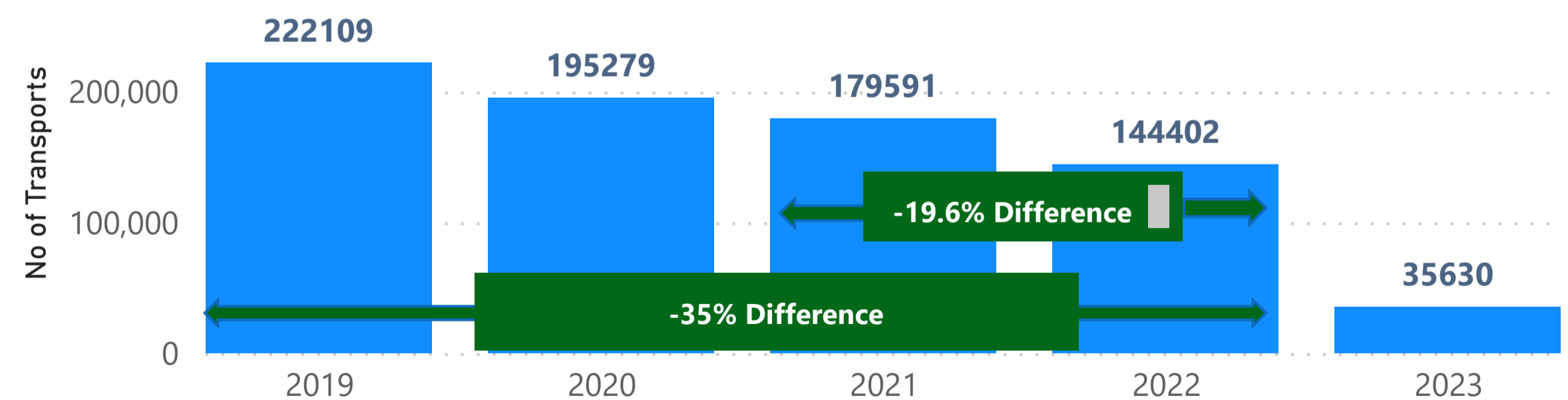


Source: AQI19ii Tier 1 Major A&E Units

## 13.2 Daily Average - Number of Transport to Major ED Units



## 13.3 Annualised Data - No of Transport to Major ED Units

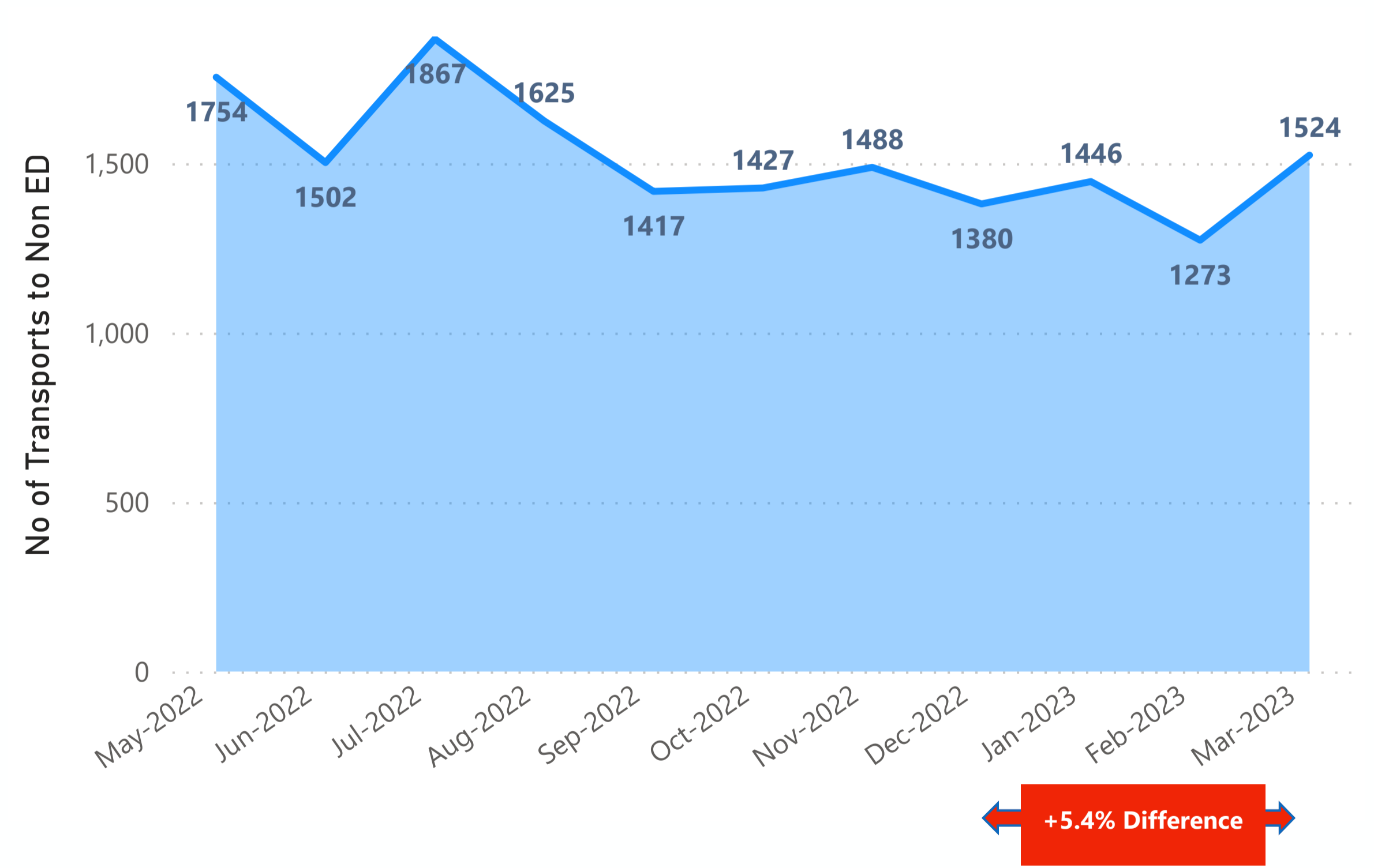


GENERAL RELEASE | PUBLIC

# Performance Report | Transported to non-Tier 1 site

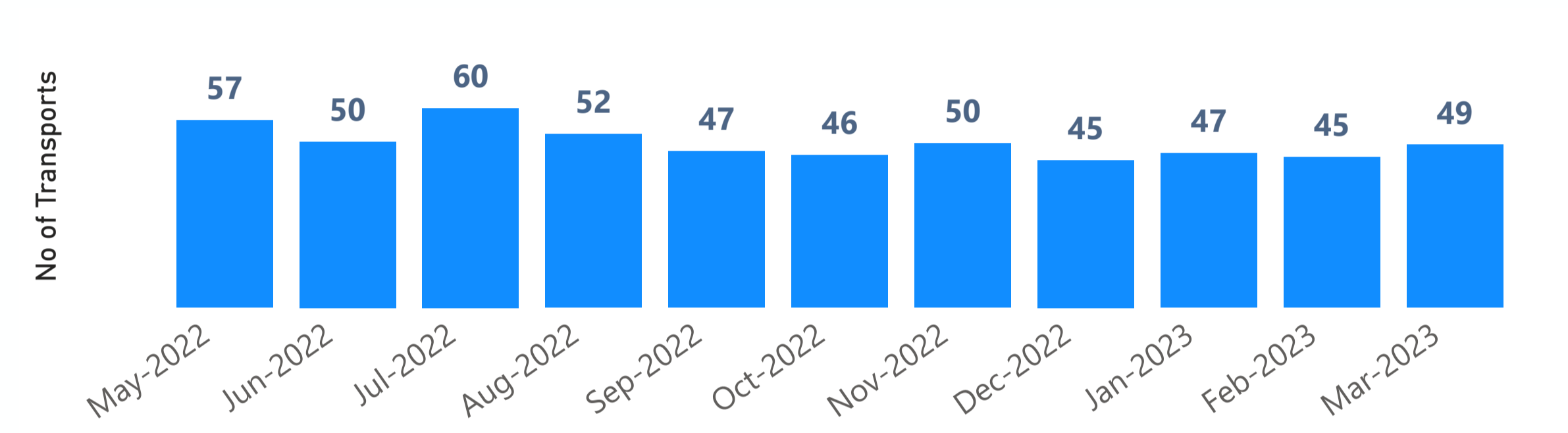
The number of incidents transported to non Tier 1 sites has reduced throughout the period, despite seeing a 20% increase in March 2023 as compared the the previous month. The daily average has remained constant, although March 2023 saw an increase to 49 as compared to 45 in the previous month.

## 14.1 Monthly Volume of Transport to non Major ED

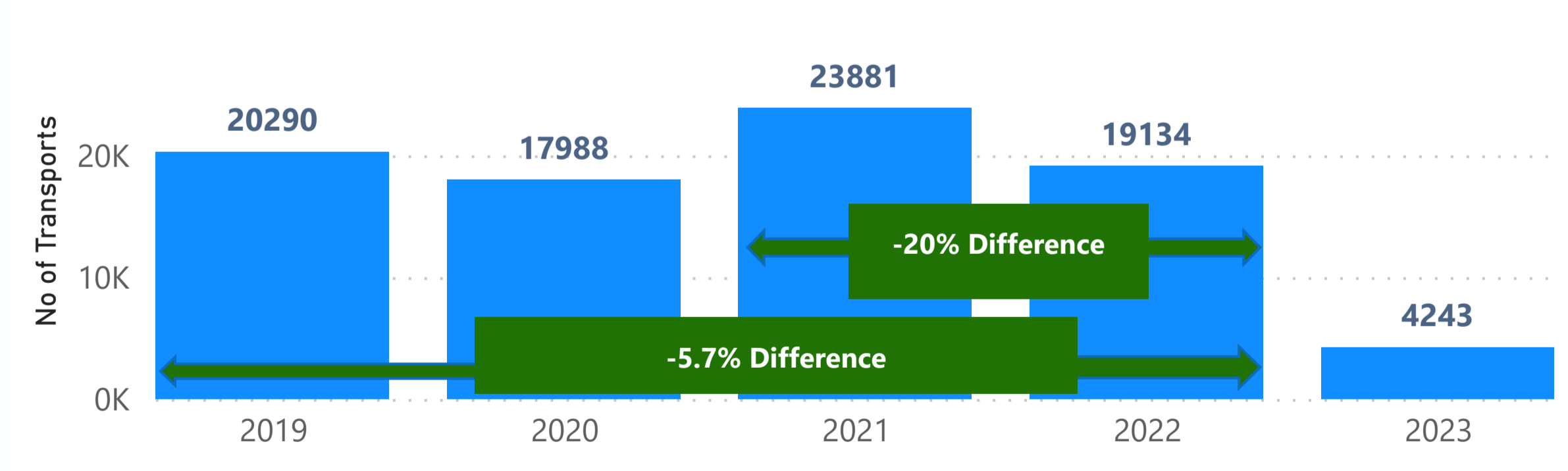


Source: AQI19ii Total number of patients conveyed to hospital by type / AQI19ii Tier 1 Major A&E Units

## 14.2 Daily Average - Transport to Non Major ED



## 14.3 Annualised Data - Transport to Non Major ED



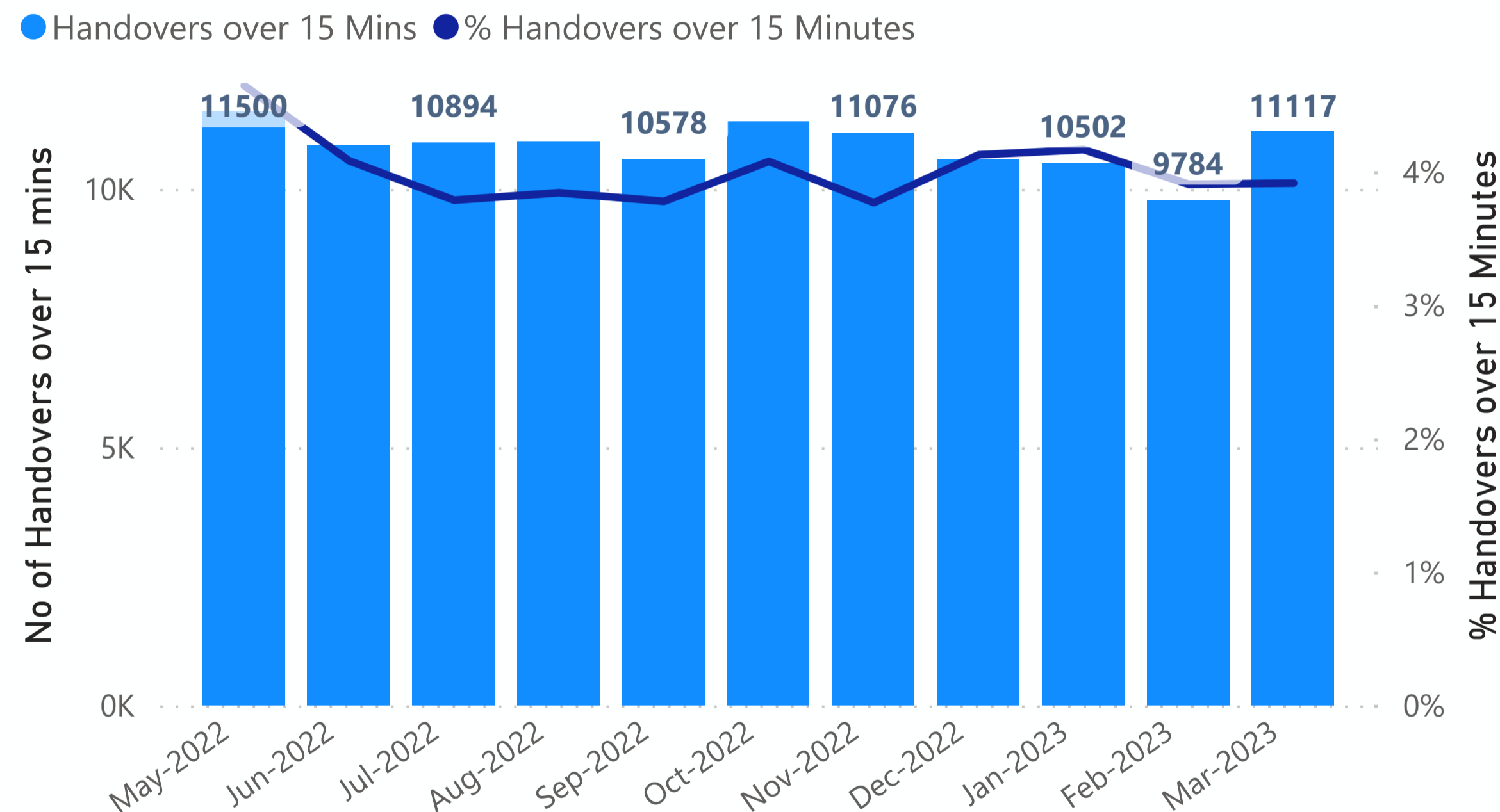
GENERAL RELEASE | PUBLIC



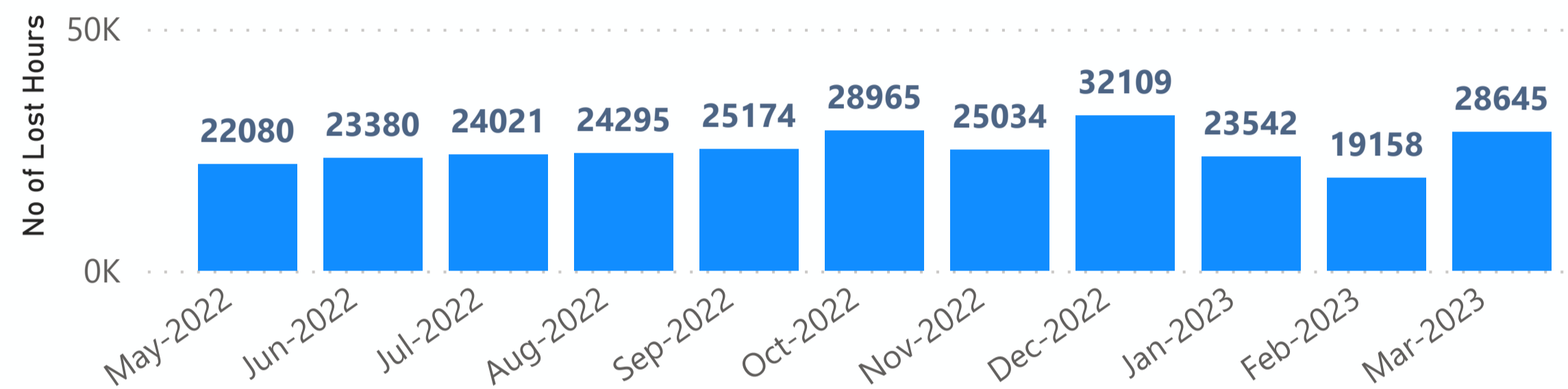
# Performance Report | Handover delays over 15-minutes

Handover delays over 15 minutes has remained constant throughout the period up until January 2023. March 2023 saw an increase of 13.6% the number of handover delays over 15 minutes. There has been a 49.5% increase in hours lost from February 2023 to March 2023.

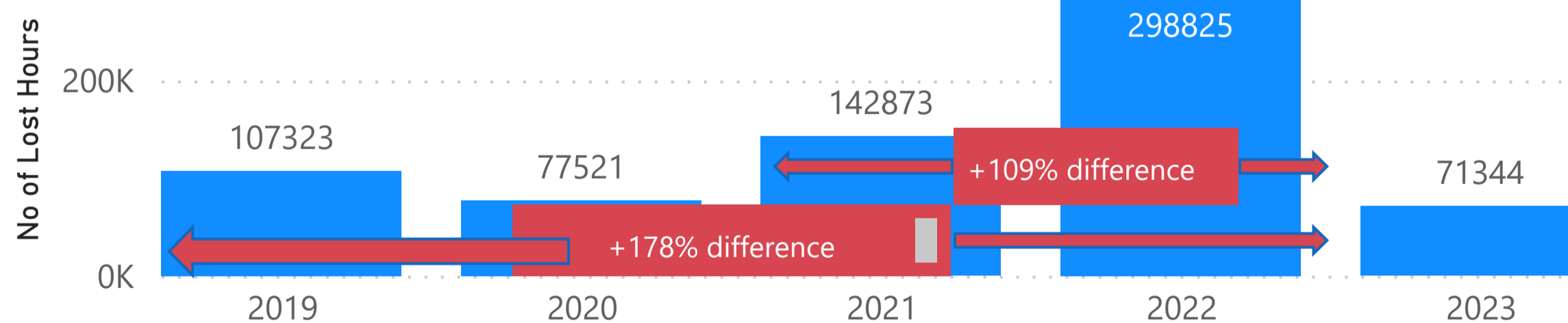
## 15.1 Volume of Handovers over 15 minutes



## 15.2 Hours lost for handovers over 15 minutes



## 15.3 Hours Lost for handovers over 15 minutes



Source: AQI20i Total Number of Handovers / AQI20i Number of Notification to Handover within 15 minutes

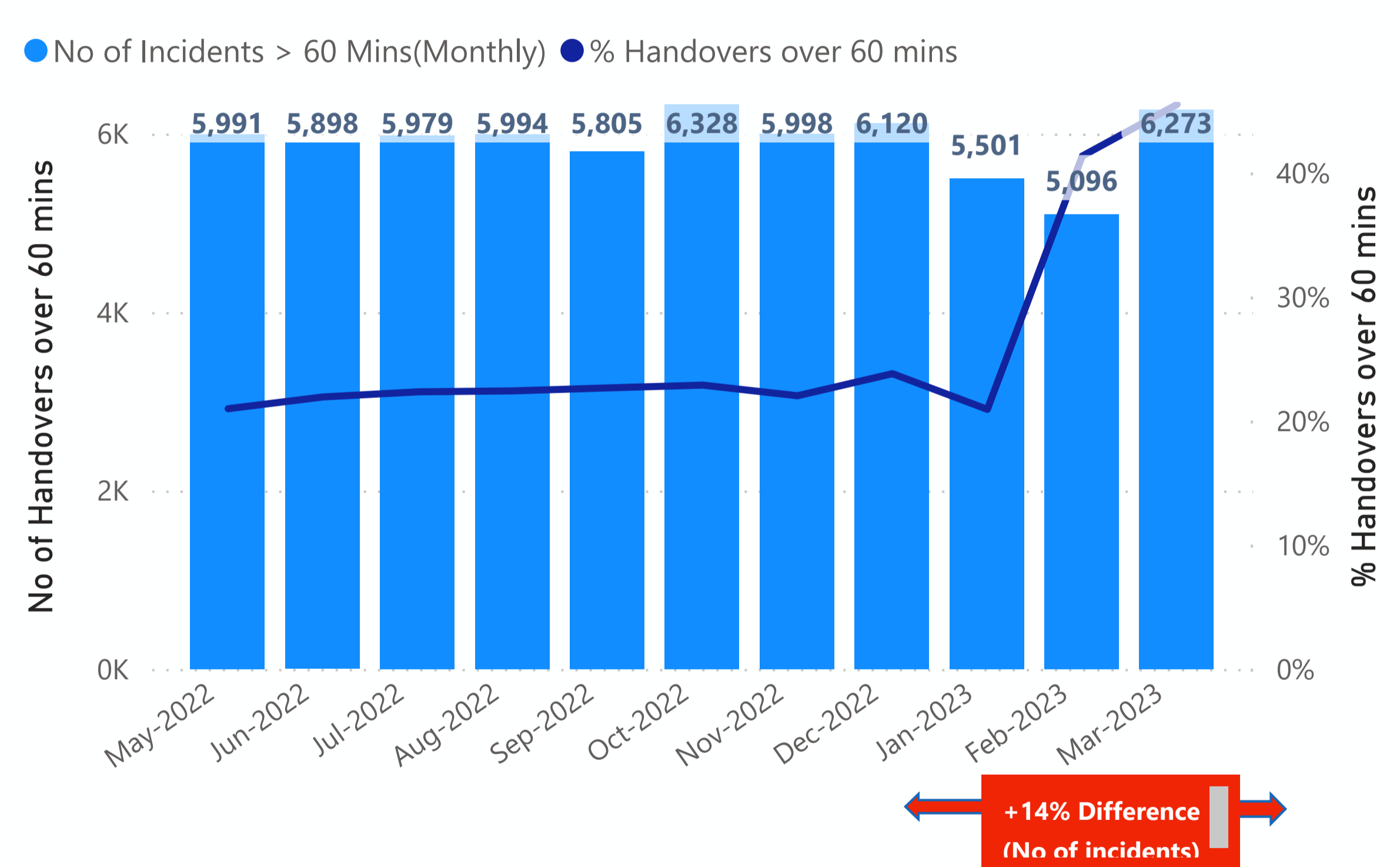
GENERAL RELEASE | PUBLIC



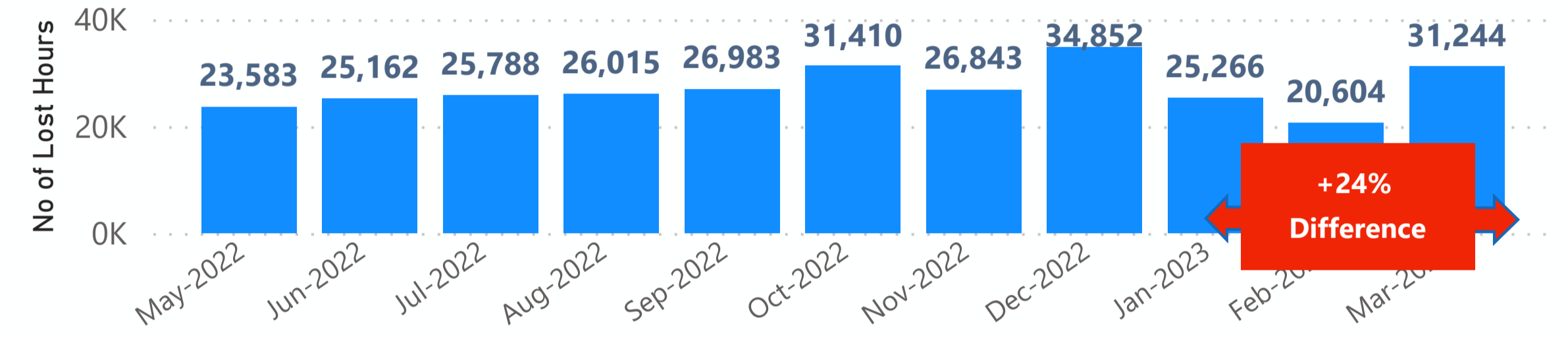
# Performance Report | Handover delays over 60-minutes

In March 2023, there has been a 23% increase in the number of handover delays over 60 mins as compared to the previous month. The % Handovers over 60 minutes increased from 41% in February 2023 to 45% in March 2023. There was a 24% increase in hours lost for handovers over 60 minutes from January to March 2023.

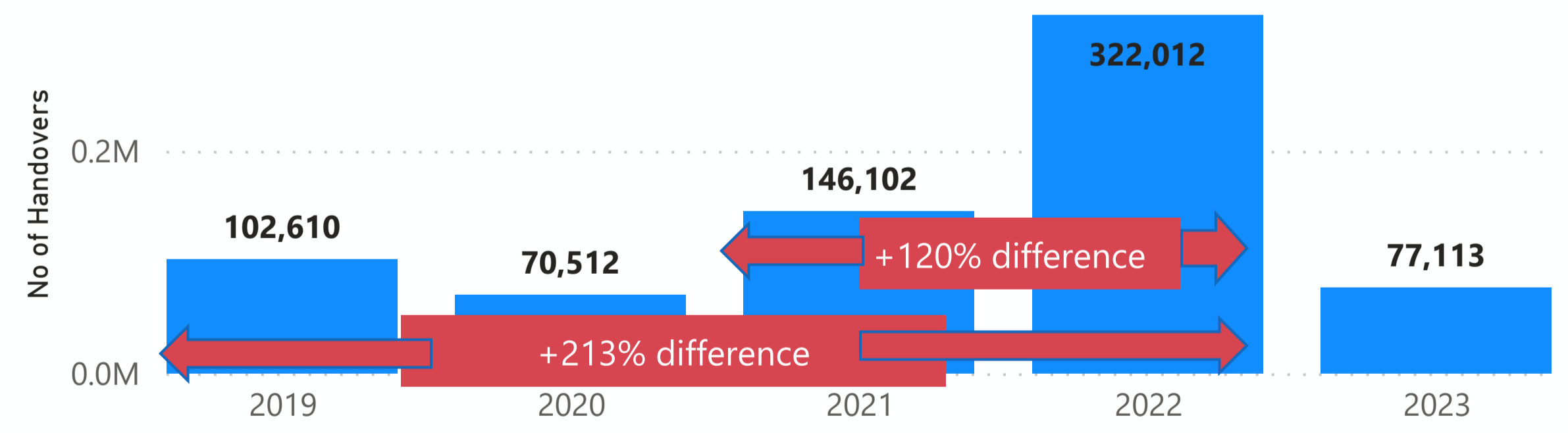
## 16.1 Number of Handovers over 60 minutes



## 16.2 Hours lost for handovers over 60 minutes



## 16.3 Hours Lost for haandovers over 60 minutes



Source: Welsh Ambulance Services NHS Trust Data Academy SQL

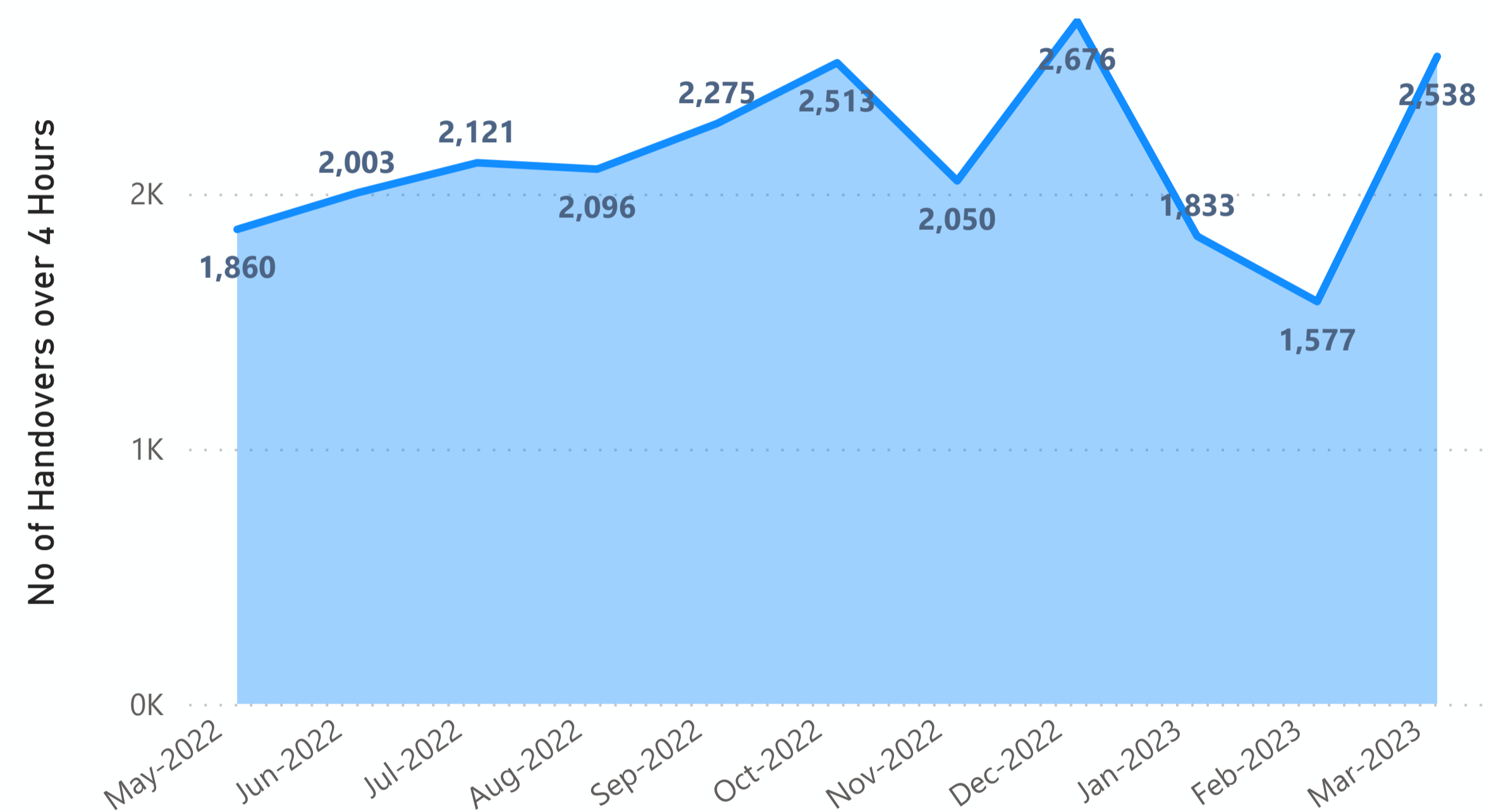
GENERAL RELEASE | PUBLIC



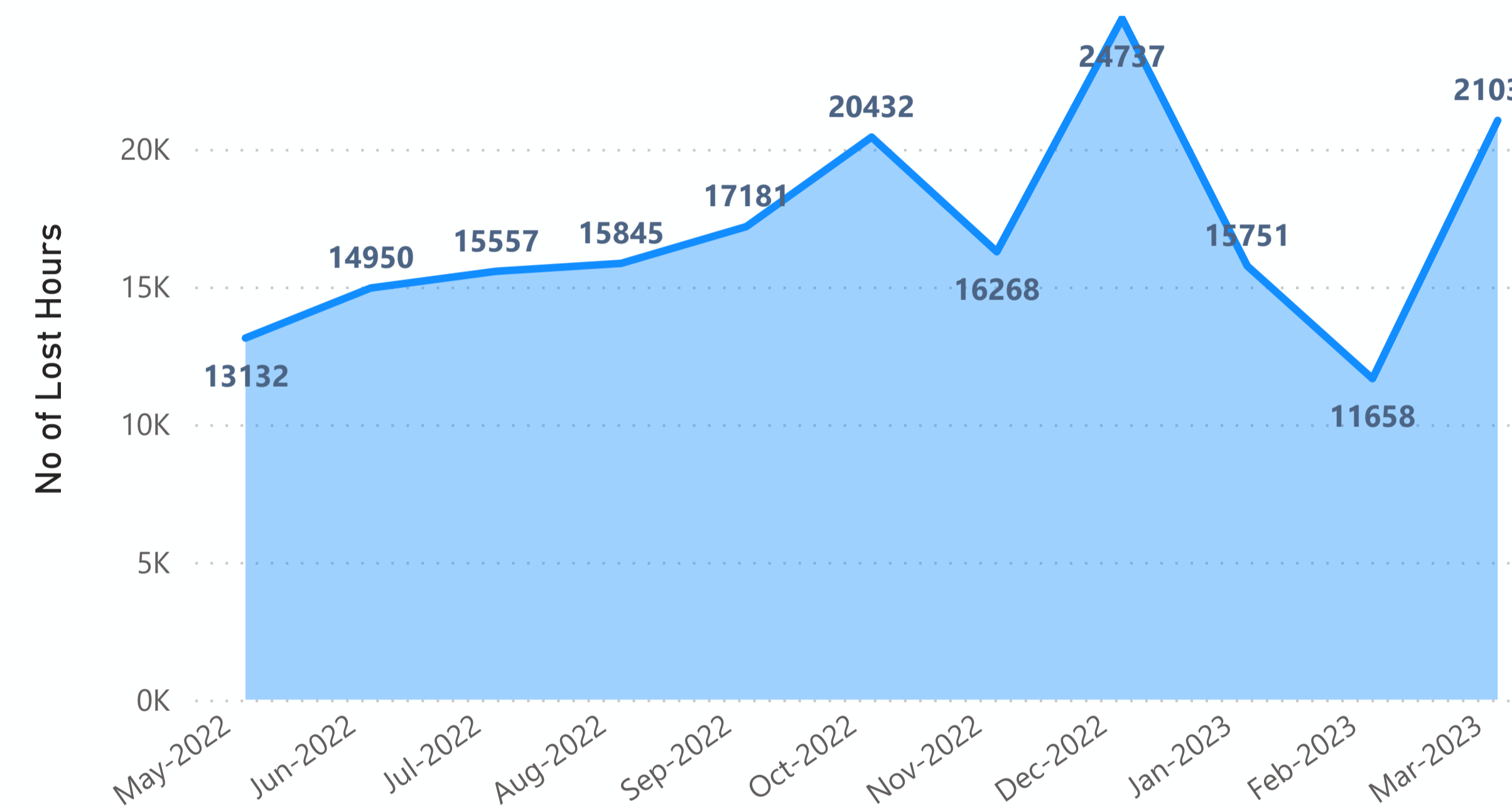
# Performance Report | Handover delays over 4-hours

There was a 38% increase in the number of delays over 4 hours from January 2023 to March 2023. There was a 34% increase in lost hours between January 2023 to March 2023. The hours lost for people waiting over 4 hours was at its second highest in March 2023.

### 17.1 Number of Handovers over 4 Hours



### 17.2 Hours lost for handovers over 4 Hours



+38% Difference

+34% Difference

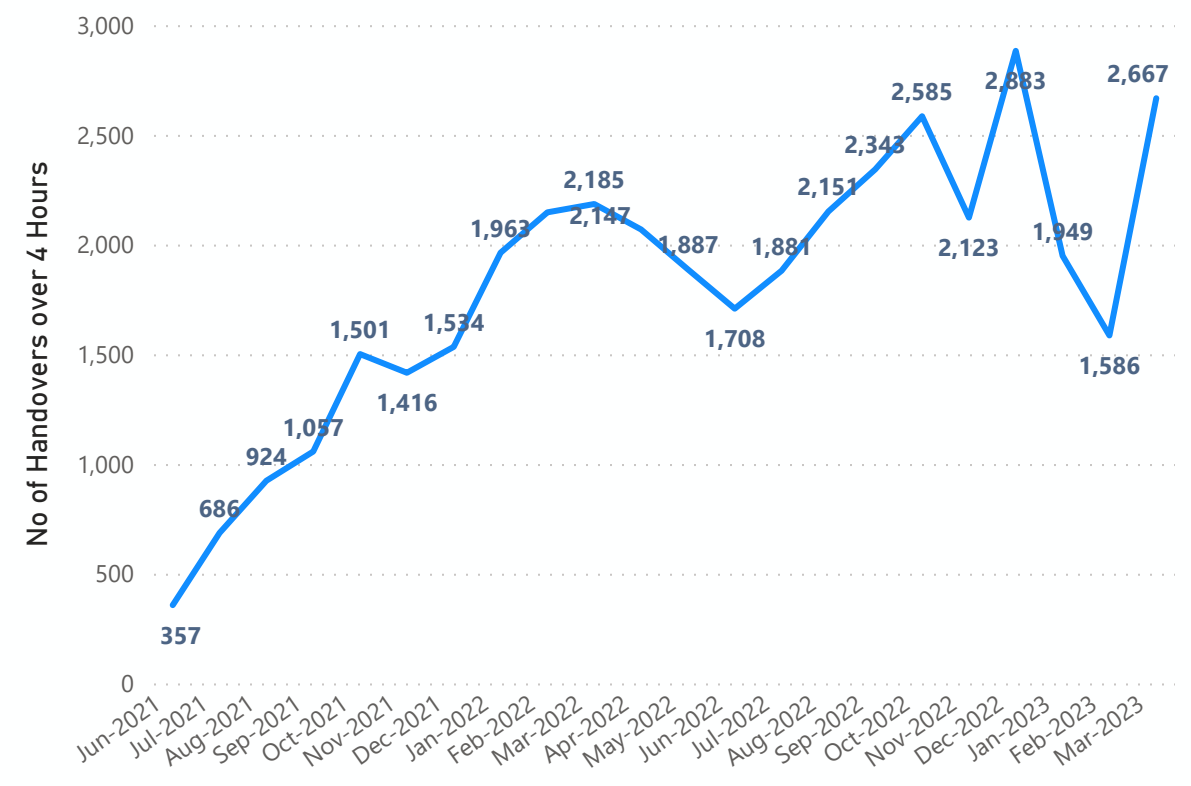
Source: Welsh Ambulance Services NHS Trust Data Academy SQL

GENERAL RELEASE | PUBLIC

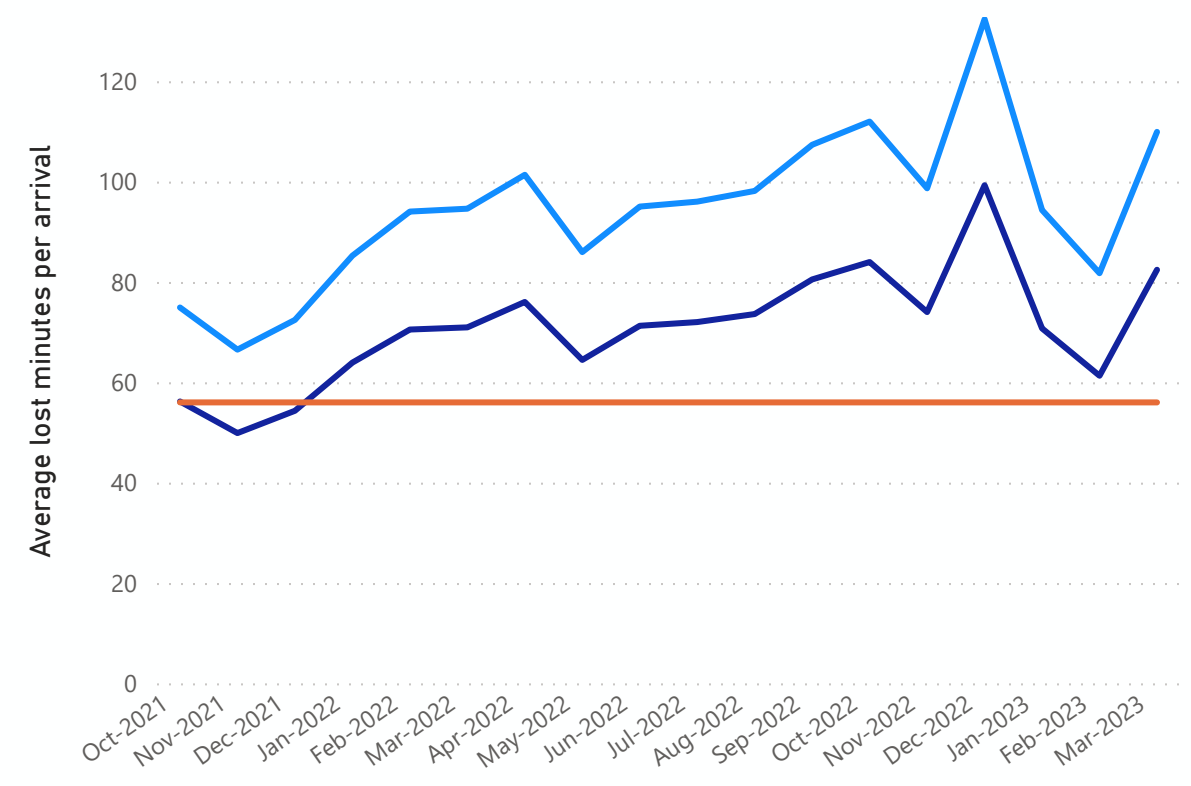
# Performance Report | Trajectory

There was an upward trend in the 4 hour trajectory despite a reduction in February 2023. There is a 68% increase in the 4 hour trajectory from February to March 2023. March 2023 was the third highest for average lost minutes per arrival for the time period shown.

## 18.1 4 Hour Trajectory



## 18.2 Average Lost Minutes per Arrival (All Vehicles)



Source: 4 hour Trajectory - Hospital Handover Delays by Time Band delays . Please note that numbers of delays may be duplicated here as they may fall in several time bands Average Lost Minutes - Welsh Ambulance Services NHS Trust Data Academy SQL

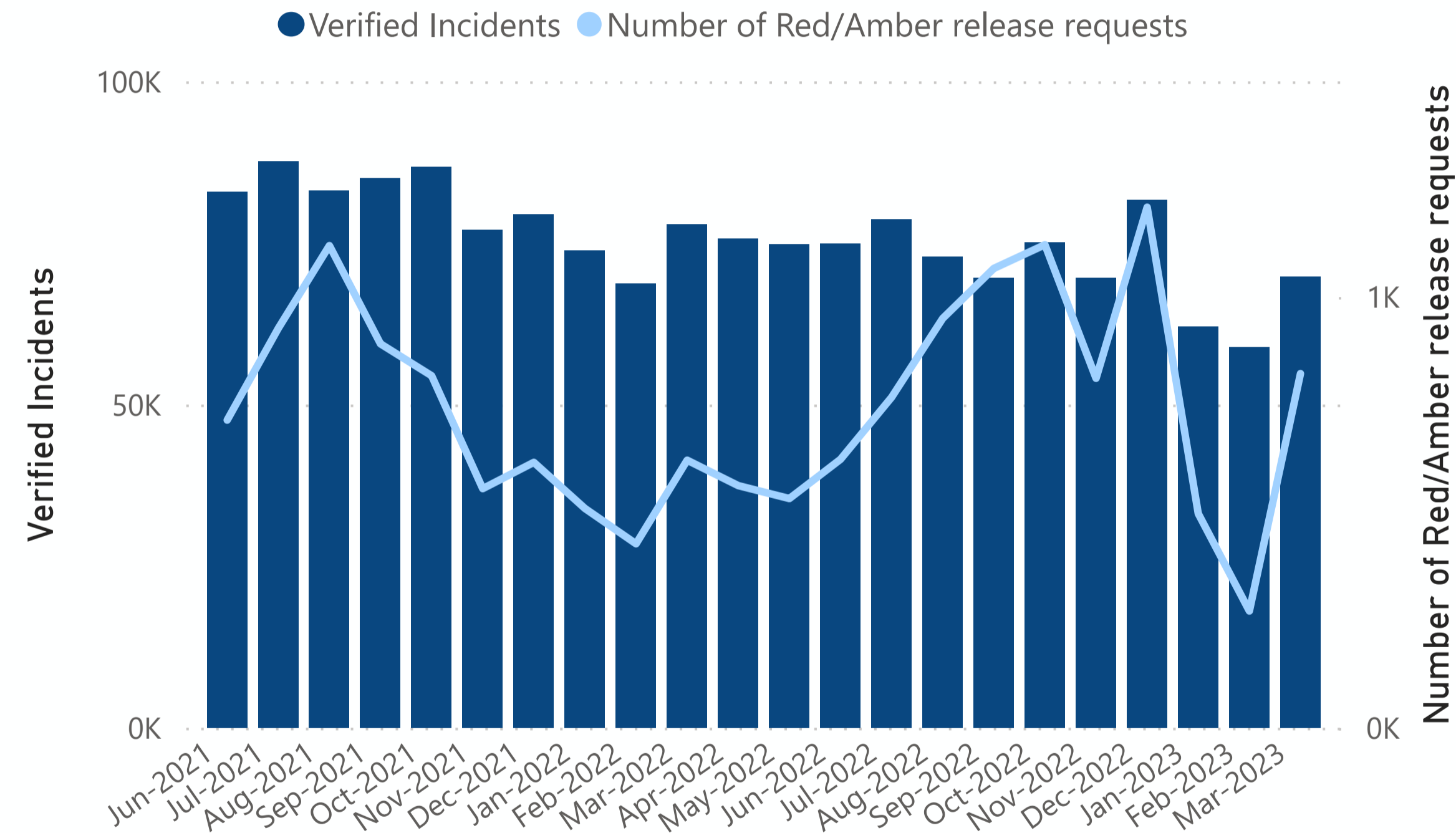
**GENERAL RELEASE | PUBLIC**

# Performance Report | RED/AMBER release requests

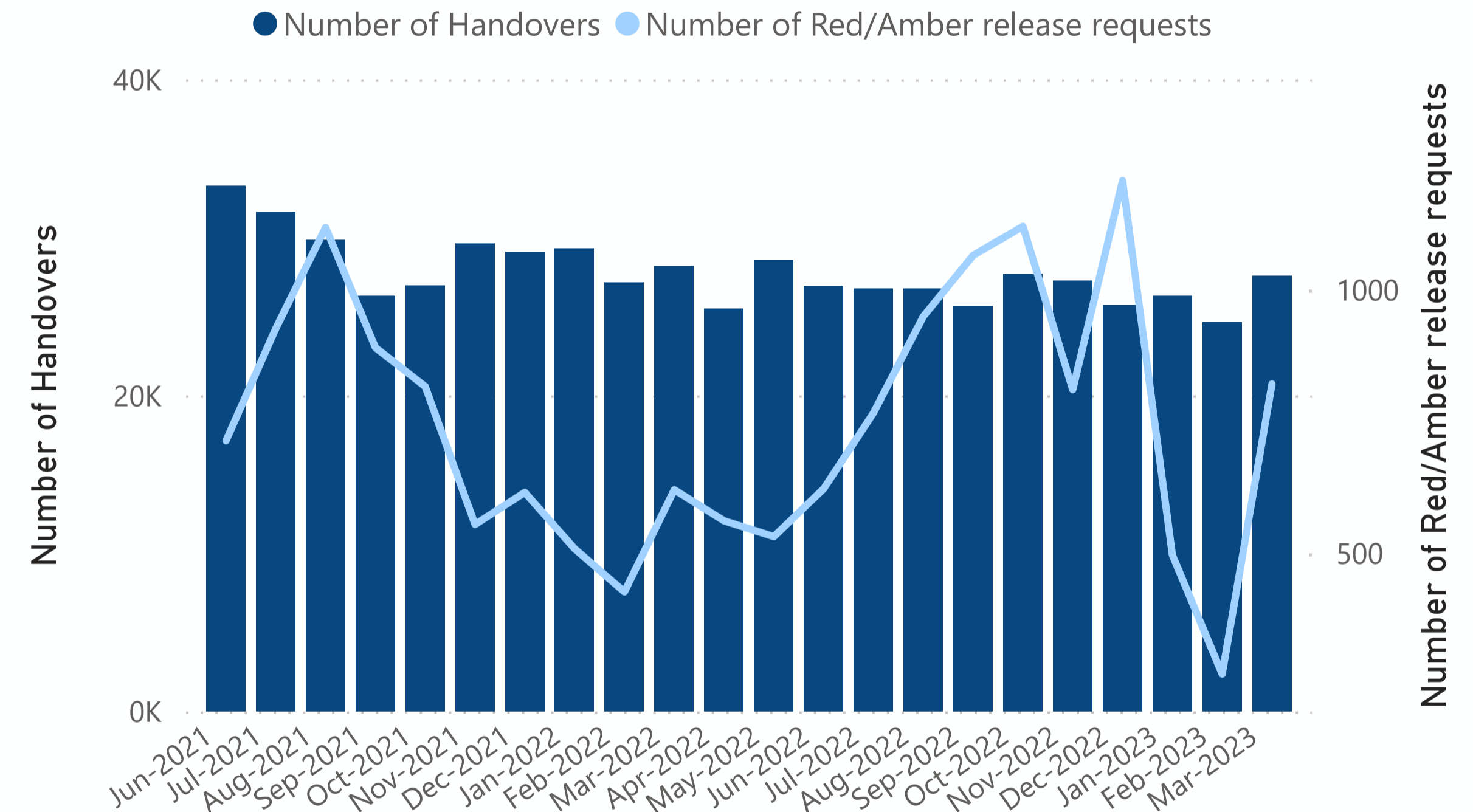


There is a downward trend of both incidents and release requests throughout the period, with March 2023 being higher than the previous month for both incidents and requests. Despite Handovers and Release requests declining since December 2022, March 2023 saw an increase of 12% in the number of handovers, as compared to February 2023.

## 19.1 Red/Amber Release Request v Verified Incidents



## 19.2 Red/Amber Release Request v Total Handovers



Source: WAST Red/Amber 1 Immediate Release Weekly Update / AQI5 Total number of incidents

Source: WAST Red/Amber 1 Immediate Release Weekly Update / AQI20i Total Number of Handovers

GENERAL RELEASE | PUBLIC



# Performance Report | Unit Hour Production (UHP)

Lowest Recorded UHP

## 86.80%

All Wales Latest Month

Average Recorded UHP

## 90.3%

All Wales Latest Month

Highest Recorded UHP

## 99.40%

All Wales Latest Month

Lowest Recorded UHP

## 86.1%

N Wales Latest Month

Lowest Recorded UHP

## 80.4%

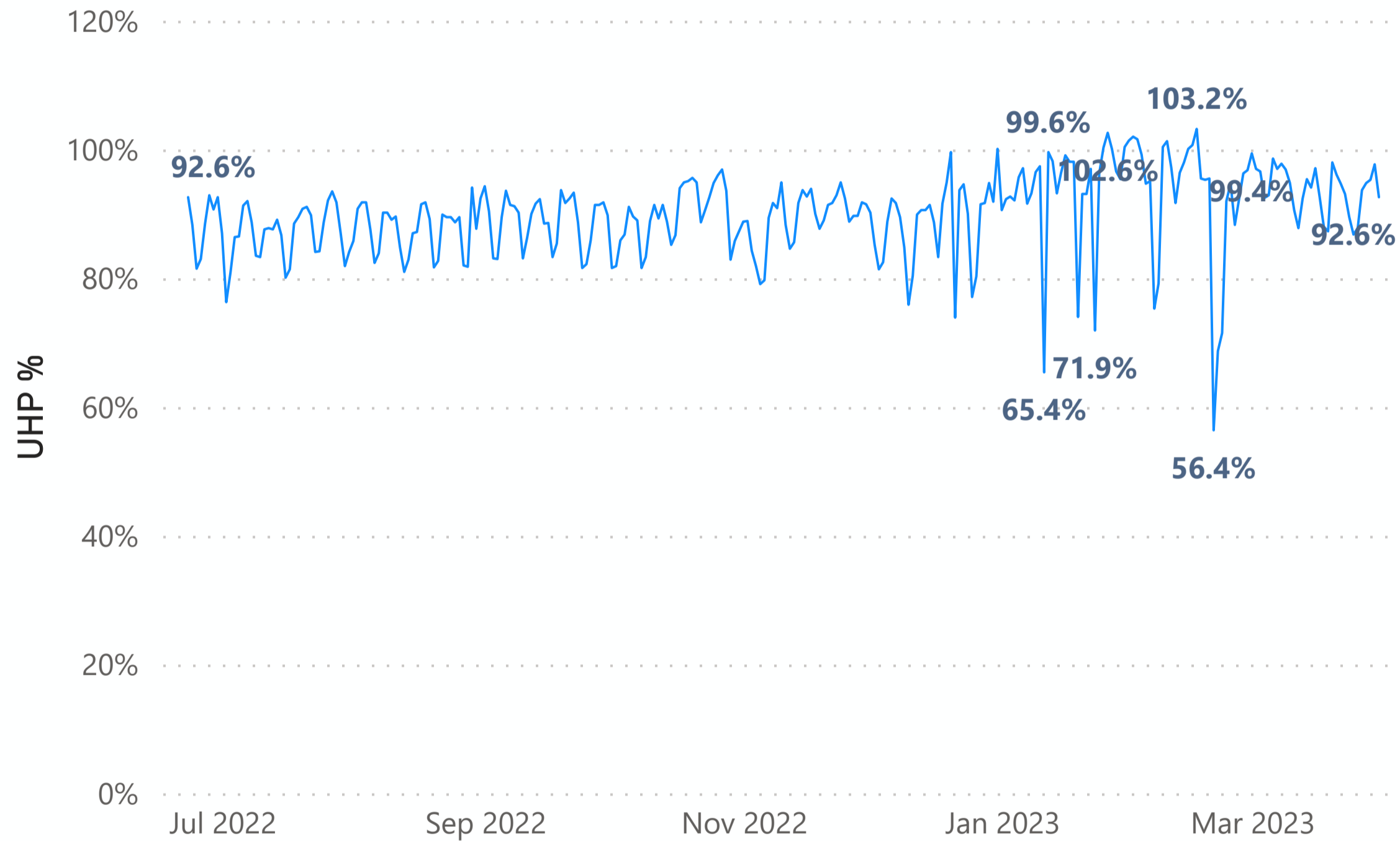
C&W Wales Latest Month

Lowest Recorded UHP

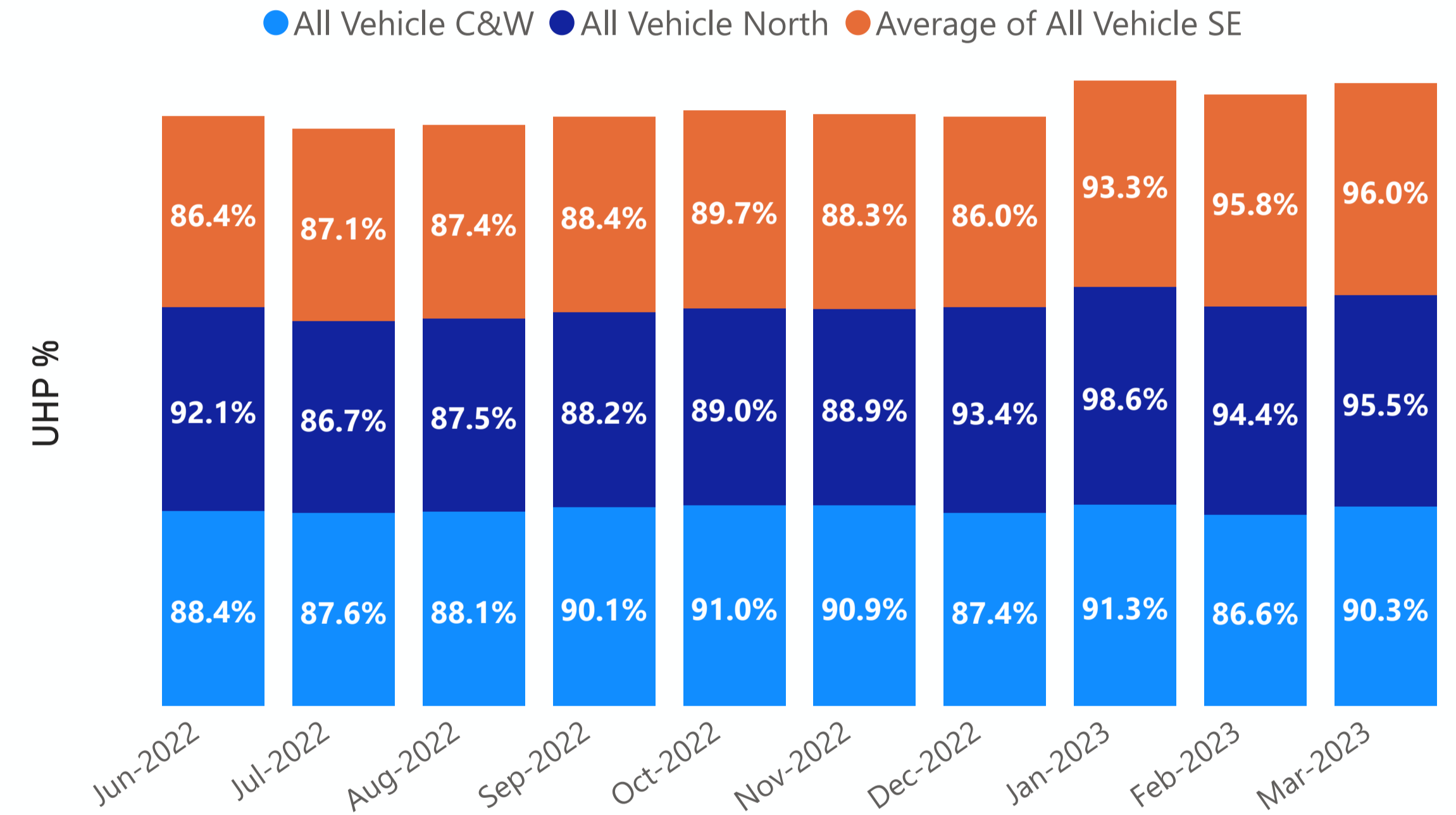
## 89.0%

SE Wales Latest Month

## 20.1 Daily UHP %



## 20.2 Monthly Average UHP % by Area



Source: Welsh Ambulance Services NHS Trust EMS File

GENERAL RELEASE | PUBLIC

# Performance Report | Glossary of Terms

Verified Incidents ambulance service	All incidents recorded in the Call Ambulance System excluding duplicate incidents, errors, information calls, calls made in error or test calls or calls passed to another
Ambulance Dispositions	All Calls with a final outcome of "Referred to 999"
Destinations other than ED	This includes Minor Injury Units (MUIs) and Major Acutes
Red Incidents	The 'Red' category of call is for immediate life-threatening conditions where a person is in imminent danger of death.
Amber Incidents	The 'Amber' category of call is for those patients with serious conditions that are not immediately life-threatening, but which are urgent and may need treatment and care at the scene or rapid transport to a healthcare facility.
Green Incidents	The 'Green' category of call is for non-serious conditions which can often be managed by other health services, including healthcare advice or through self-care.
Hear and Treat	'Hear and Treat' is the telephone advice that callers who do not have serious or life threatening conditions receive from an ambulance service after calling 999. They may receive advice on how to care for themselves or where they might go to receive assistance.
See and Treat	See and treat is when a patient receives advice and care at scene and does not need to be taken to hospital.
UHP (Unit Hour Production)	The actual number of hours the Welsh Ambulance Services NHS Trust were able to produce against planned hours (number of available shifts)

GENERAL RELEASE | PUBLIC

## **Emergency Ambulance Services Committee: Action Plan**

This spreadsheet contains data tables pertaining to the Welsh Ambulance Services NHS Trust Ambulance Service on both a daily and yearly basis. We have edited these data tables and the accompanying cover sheet, table of contents and notes worksheet to meet the legal accessibility regulations. It is intended to be an accessible spreadsheet. The data has been quality assured by the Welsh Ambulance Services NHS Trust Health Informatics Department prior to submission.

Also included is the Emergency Ambulance Services Committee action plan

### **Source**

Welsh Ambulance Services NHS Trust Qlik Management Information  
Welsh Ambulance Services EMS Performance Tracker

### **Caveats**

- \* Data is correct at time of collection
- \* Area and Dates Covered: All Wales for date period
- \* For information relating to Incidents - the patients local health board has been used to determine the national figure
- \* For information relating to hospital handovers and hospital lost hours - the hospital attended has been used to determine the national figure

### **Disclaimer**

The information presented has been prepared using sources believed by the National Collaborative Commissioning Unit to be reliable and accurate. It must be used as management information only unless otherwise stated and is not for public release.

### **Contact details**

Email: [CTM\\_CASC\\_EASC@wales.nhs.uk](mailto:CTM_CASC_EASC@wales.nhs.uk)

## Table of contents

Worksheet name	Worksheet description	Date this data was first published	Next publication date	Source
Action Plan	EASC Action Plan	Friday, August 05, 2022	Thursday, June 8, 2023	Emergency Ambulance Services Committee Local Health Boards
Wales_Overview_Daily	Welsh Ambulance Services NHS Trust: National Daily view (1 month)	Friday, August 05, 2022	Thursday, June 8, 2023	Welsh Ambulance Services NHS Trust
Wales_Overview_12month	Welsh Ambulance Services NHS Trust: National 12-month overview	Friday, August 05, 2022	Thursday, June 8, 2023	Welsh Ambulance Services NHS Trust

**WAST Actions**

#	Action	Detail	Source / Request	Monitoring Route	Due Date	Impact	Progress	Confidence	Comments	Supporting Documents
1	Red Variation Modelling		CASC Q&D	CASC Q&D	21st Oct	Low	On Track	High	Presented to EAS Committee on 6 September 2022 Further work ongoing through CASC Q&D - Red Deep Dive - Include Q&D update.	<a href="#">Red Variables</a>
1.1	Spring Modelling	Spring Modelling Forecast 2023/24	Normal Business	CASC Q&D	TBC	TBC	TBC	TBC		
1.1	Winter Modelling	Winter modelling forecast 2022/23	Normal Business	CASC Q&D	End Oct	Low	On Track	High	Implementation of Tactical forecasting & modelling for seasons	
1.1	Summer Modelling		Normal Business	CASC Q&D	W/C 4th July	Low	On Track	High	Implementation of Tactical forecasting & modelling for seasons	Complete
1.2	Roster Review Implementation	Revised Rosters as per 2019 D&C Review. Equivalent efficiency of 74 WTE	Commissioning Intentions (CI2-A3)	CASC Q&D / EASC	Complete	High	On Track	High	Roster Review Complete	EASC Provider Report (Jan 23) Extract * Final batch of EMS rosters went live mid-Nov, marking the end of a 2.5yr project including 146 rosters, 80 working parties, and 1,800 staff. The project will now be evaluated to support longer-term benefits realisation and learning. Complete
1.3	Sickness Improvement Plan	40 Point improvement plan and trajectory	Commissioning Intentions (CI2-A1)	CASC Q&D	2023	High	Limited	Medium	Improvement seen, but risk remain around delivery of trajectory. <b>Managing Attendance Programme</b> – the programme plan pulls together the activities already being delivered across WAST and introduces new activities to support attendance in a connected, supportive and sensitive way.	<a href="#">Sickness Absence &amp; Staff Wellbeing Presentation</a>
1.4	Post Production Lost Hours Improvement	Modernised workforce practice policy implementation and reduction in lost hours	Commissioning Intentions (CI3-A1 & CI3-P1)	CASC Q&D		High	Off Track	Low	Work currently paused due to ongoing industrial action.	
1.5	Daily Missed Red Review by ODU				Complete	Medium	On Track	High	Missed reds are discussed, reviewed daily by exception on the 0930 and 2030 huddles. Local management teams provided with a subscribed report and reds are reviewed by the Locality Management Teams.	
1.6	Cymru High Acuity Response Unit (CHARU)				Sep-22	High	Limited	Medium	Proposal being developed/implemented to accelerate full roll out of CHARU	<a href="#">Cymru High Acuity Response Unit Presentation</a>
1.7	Emergency Communication Nurse System (ECNS) Optimisation	Roll out plan for optimisation / expansion of ECNS system following go live	CASC Q&D	CASC Q&D	Ongoing	Medium	On Track	High	Review of remote clinical support commissioned by the CASC.	
1.8	£3m recruitment	Initial commitment to deliver 100 WTE by the end of 2022. Baseline for growth 1691 WTE		CASC Q&D / EASC	Feb-23	High	On Track	High	Action Complete. Assumptions in both EASC and WAST IMTP 2023/24 of central support for ongoing funding.	

**Health Board Actions**

#	Action	Detail	Source / Request	Monitoring Route	Due Date	Impact	Progress	Confidence	Comments	Supporting Documents
2	25% Reduction in avg lost mins per arrival	reduction in minutes lost per ambulance arrival from October 2021 levels (~74min) by end of September 2022	EASC Commitment / 6 Goal Update 19th May 2022	Fortnightly Tripartite Meetings / WG IQPD	Sep-22	High	Limited	Low	We have kept the rating the same and are seeing improvement in some areas	<a href="#">Ambulance Handover Improvement Trajectories Presentation</a> <a href="#">Ambulance Handover Improvement Trajectories</a>
2.1	No 4 hour offload delays	Eradication of ambulance handover delays over 4 hours by end of September 2022	EASC Commitment / 6 Goal Update 19th May 2023	Fortnightly Tripartite Meetings / WG IQPD	Sep-22	High	Limited	Low	Progress is being made but is not consistent currently across Wales	<a href="#">Ambulance Arrival 4-hour Improvement Trajectories Presentation</a> <a href="#">Ambulance Arrival 4-hour Improvement Trajectories</a> <a href="#">Weekly handover by time band</a>
2.2	Health Board Handover Improvement Plans	Individual health board improvement plans		Fortnightly Tripartite Meetings / WG IQPD	Ongoing	High	Limited	Medium	Incorporated into iCAPS	<a href="#">Health Board Handover Improvement Plans</a>
2.3	Front door flow and ED capacity	Individual health board improvement plans		Fortnightly Tripartite Meetings / WG IQPD	Ongoing	High	Limited	Medium	Incorporated into iCAPS	<a href="#">Health Board Handover Improvement Plans</a>

2.4	Internal capacity and flow (including Surge Capacity)	Individual health board improvement plans		Fortnightly Tripartite Meetings / WG IQPD	Ongoing	Medium	Limited	Medium	Incorporated into ICAPS	<a href="#">Health Board Handover Improvement Plans</a>
2.5	Community and social care	Individual health board improvement plans		Fortnightly Tripartite Meetings / WG IQPD	Ongoing	High	Off Track	Low	Incorporated into ICAPS	<a href="#">Health Board Handover Improvement Plans</a>

### Health Board and WAST Actions

#	Action	Detail	Source / Request	Monitoring Route	Due Date	Impact	Progress	Confidence	Comments	Supporting Documents
3	Immediate Release Compliance			Fortnightly Tripartite Meetings / WG IQPD	01-Aug-22	Low	Limited	Low	Recognise work being undertaken at health board and site level to support immediate release requests.	<a href="#">Immediate Release Policy</a> <a href="#">Red / Amber Release Requests</a>
3.1	Admission avoidance schemes			Fortnightly Tripartite Meetings / WG IQPD		High	Limited	Medium	Incorporated into ICAPS	<a href="#">Health Board Handover Improvement Plans</a>
3.2	Transfer and discharge			Fortnightly Tripartite Meetings / WG IQPD		Medium	On Track	Medium	Additional regional NEPTS resource purchased by WAST for winter 2022/23 - WAST IMTP Q4 23/24 Development of a proof of concept for the delivery of a national transfer and discharge service. DCMO letter. Ongoing requests by BCUHB, HDUHB and SBUHB.	

### Health Board ICAP Progress (ABUHB)

#	Action	Detail	Source / Request	Monitoring Route	Due Date	Impact	Progress	Confidence	Comments	Supporting Documents
2.2	Co-ordination planning and support for populations at greater risk of needing urgent or emergency care	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					<a href="#">January ICAP Updated Document</a>
2.3	Signposting people with urgent care needs to the right place, first time	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.4	Clinically safe alternatives to admission to hospital	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.5	Rapid response in a physical or mental health crisis	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.6	Optimal hospital care and discharge practice from the point of admission	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.7	Home first approach and reduce the risk of readmission	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					

### Health Board ICAP Progress (BCUHB)

#	Action	Detail	Source / Request	Monitoring Route	Due Date	Impact	Progress	Confidence	Comments	Supporting Documents
2.2	Co-ordination planning and support for populations at greater risk of needing urgent or emergency care	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					<a href="#">January ICAP Updated Document</a>
2.3	Signposting people with urgent care needs to the right place, first time	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.4	Clinically safe alternatives to admission to hospital	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.5	Rapid response in a physical or mental health crisis	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.6	Optimal hospital care and discharge practice from the point of admission	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.7	Home first approach and reduce the risk of readmission	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					

### Health Board ICAP Progress (CTMUHB)

#	Action	Detail	Source / Request	Monitoring Route	Due Date	Impact	Progress	Confidence	Comments	Supporting Documents
---	--------	--------	------------------	------------------	----------	--------	----------	------------	----------	----------------------

2.2	Co-ordination planning and support for populations at greater risk of needing urgent or emergency care	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					<a href="#">January ICAP Updated Document</a>
2.3	Signposting people with urgent care needs to the right place, first time	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.4	Clinically safe alternatives to admission to hospital	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.5	Rapid response in a physical or mental health crisis	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.6	Optimal hospital care and discharge practice from the point of admission	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.7	Home first approach and reduce the risk of readmission	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					

**Health Board ICAP Progress (CVUHB)**

#	Action	Detail	Source / Request	Monitoring Route	Due Date	Impact	Progress	Confidence	Comments	Supporting Documents
2.2	Co-ordination planning and support for populations at greater risk of needing urgent or emergency care	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					<a href="#">January ICAP Updated Document</a>
2.3	Signposting people with urgent care needs to the right place, first time	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.4	Clinically safe alternatives to admission to hospital	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.5	Rapid response in a physical or mental health crisis	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.6	Optimal hospital care and discharge practice from the point of admission	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.7	Home first approach and reduce the risk of readmission	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					

**Health Board ICAP Progress (HDUHB)**

#	Action	Detail	Source / Request	Monitoring Route	Due Date	Impact	Progress	Confidence	Comments	Supporting Documents
2.2	Co-ordination planning and support for populations at greater risk of needing urgent or emergency care	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					<a href="#">January ICAP Updated Document</a>
2.3	Signposting people with urgent care needs to the right place, first time	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.4	Clinically safe alternatives to admission to hospital	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.5	Rapid response in a physical or mental health crisis	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.6	Optimal hospital care and discharge practice from the point of admission	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.7	Home first approach and reduce the risk of readmission	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					

**Health Board ICAP Progress (PTHB)**

#	Action	Detail	Source / Request	Monitoring Route	Due Date	Impact	Progress	Confidence	Comments	Supporting Documents
2.2	Co-ordination planning and support for populations at greater risk of needing urgent or emergency care	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					<a href="#">January ICAP Updated Document</a>
2.3	Signposting people with urgent care needs to the right place, first time	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.4	Clinically safe alternatives to admission to hospital	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					

2.5	Rapid response in a physical or mental health crisis	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.6	Optimal hospital care and discharge practice from the point of admission	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.7	Home first approach and reduce the risk of readmission	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					

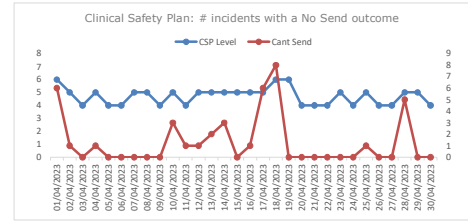
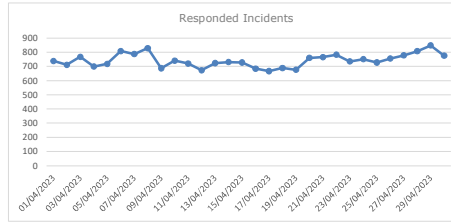
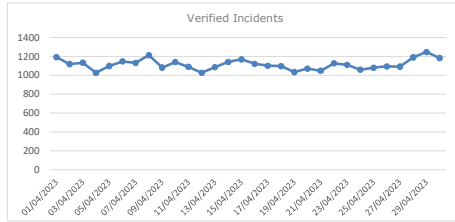
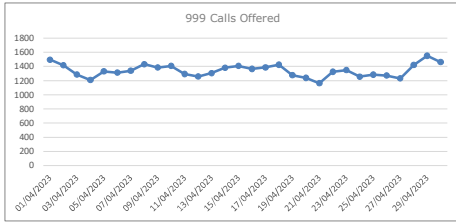
**Health Board ICAP Progress (SBUHB)**

#	Action	Detail	Source / Request	Monitoring Route	Due Date	Impact	Progress	Confidence	Comments	Supporting Documents
2.2	Co-ordination planning and support for populations at greater risk of needing urgent or emergency care	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					<a href="#">January ICAP Updated Document</a>
2.3	Signposting people with urgent care needs to the right place, first time	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.4	Clinically safe alternatives to admission to hospital	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.5	Rapid response in a physical or mental health crisis	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.6	Optimal hospital care and discharge practice from the point of admission	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					
2.7	Home first approach and reduce the risk of readmission	Integrated Commissioning Action Plan		Fortnightly Tripartite Meetings / WG IQPD	Ongoing					

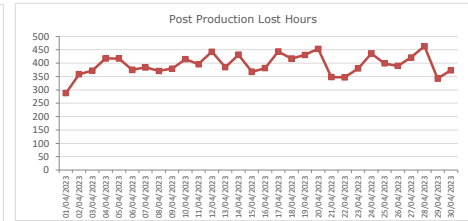
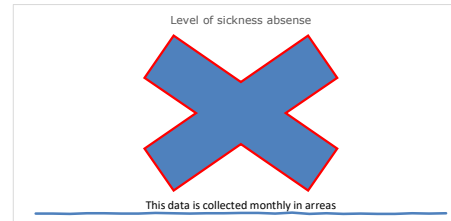
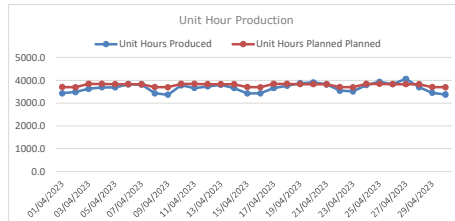
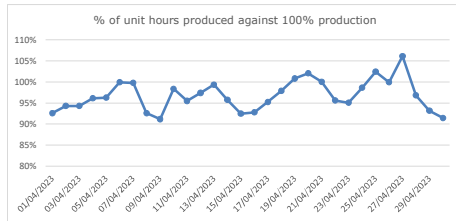
# Welsh Ambulance Services NHS Trust: National Daily view (1 month)

Please note: the current months data is updated following the WAST data upload at 10:30am

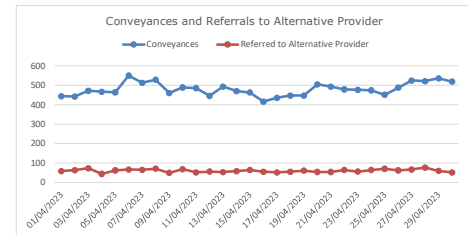
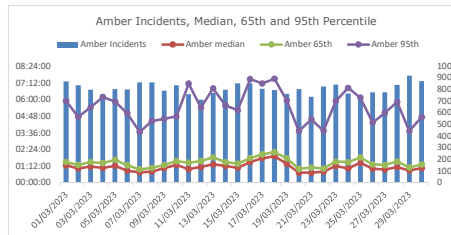
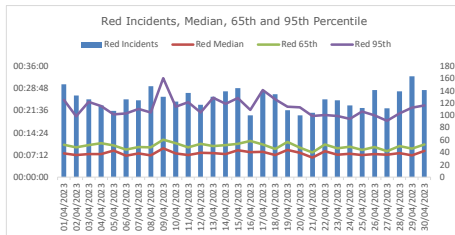
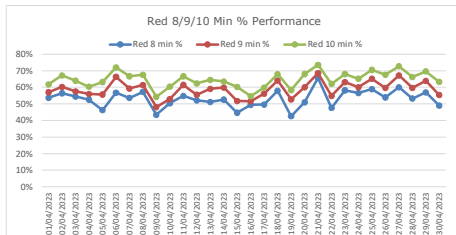
## Demand



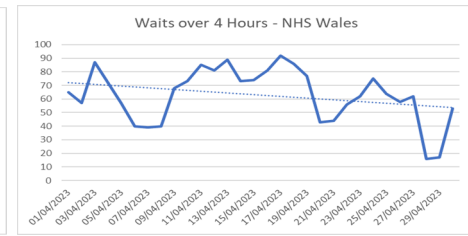
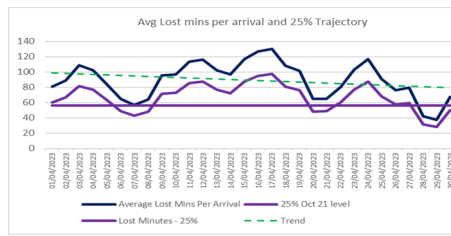
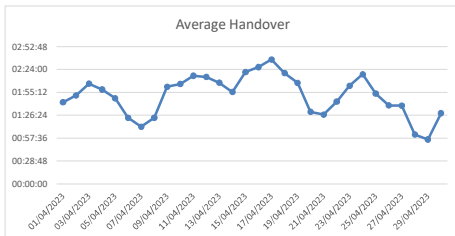
## Capacity



## Outcome



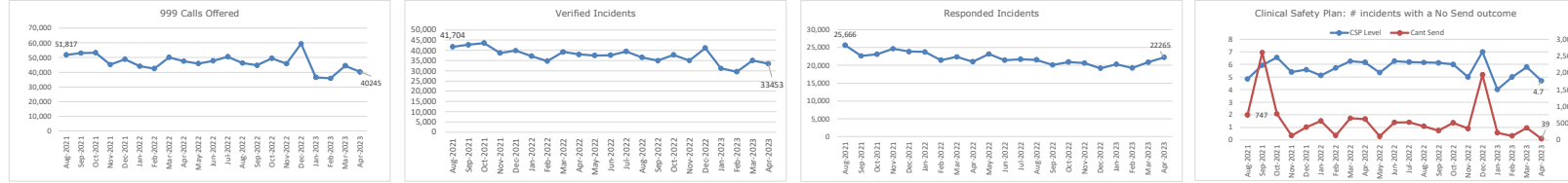
## System Efficiency



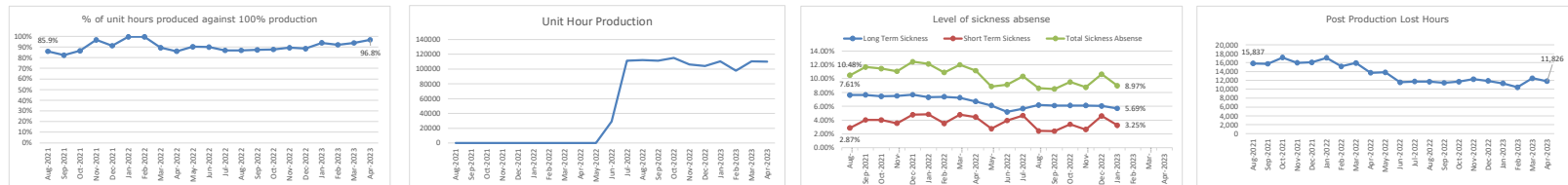
# Welsh Ambulance Services NHS Trust: National 12-month overview

Please note: the current months data will always be lower than previous months as the data builds over the month

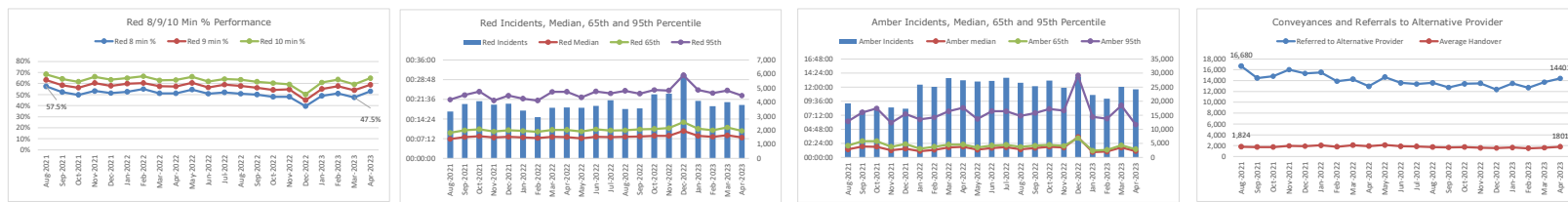
## Demand



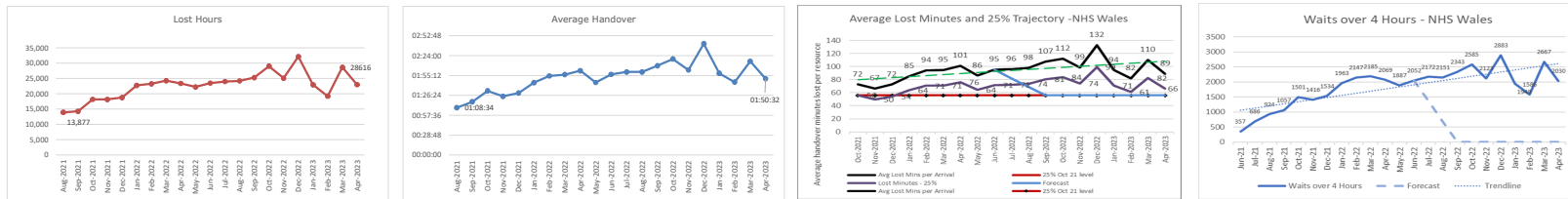
## Capacity



## Outcome



## System Efficiency



## Release Availability

