

Bundle Audit Committee Part 2 1 April 2019

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CWM TAF UNIVERSITY HEALTH BOARD

AUDIT COMMITTEE MEETING 1 April 2019

A meeting of the Audit Committee will be held on Monday 1 April 2019 at Ynysmeurig House, Navigation Park, Abercynon. **Part 1** commences at 9.30am, to be followed by **Part 2** at 11.30am.

MR PAUL GRIFFITHS
CHAIRMAN

PART 2 – HOSTED COMMITTEES

*(Welsh Health Specialised Services Committee (WHSSC) and
Emergency Ambulance Services Committee (EASC))*

AGENDA

PART 1. PRELIMINARY MATTERS

	LEAD / ATTACHMENT
1.1 Welcome and Introductions	Chair/Oral
1.2 Apologies for absence	Chair/Oral
1.3 Declarations of Interest	Chair/Oral
1.4 'Unconfirmed' Minutes of the meeting held on 14 January 2019	Chair Attachment
1.5 Action Log	Chair Attachment
1.6 Matters Arising not contained within the Action Log	Chair/Oral

PART 2. INTERNAL CONTROL AND RISK MANAGEMENT

2.1 Update on Internal Audit Recommendations Tracker	WHSSC Director of Finance Oral update
2.2 WHSSC Corporate Risk Assurance Framework	WHSSC Committee Secretary Attachment
2.3 EASC Risk Register	Chief Ambulance Services Commissioner Attachment

PART 3. INTERNAL / EXTERNAL AUDIT REPORTS

- | | | |
|-----|---|-------------------|
| 3.1 | Internal Audit Report Risk Management | Attachment |
| 3.2 | Internal Audit Report Governance Arrangements | Attachment |

PART 4. ANY OTHER URGENT BUSINESS

- | | | |
|-----|---|------------|
| 4.1 | Audit Committee Members to meet with Auditors | Oral/Chair |
| 4.2 | Close of Part 2 of the meeting – Date and time of next meeting: | Oral/Chair |
| | <ul style="list-style-type: none">• 09.00am Monday 13 May 2019 – Draft Accounts 2018/19 | |

CWM TAF UNIVERSITY HEALTH BOARD

'UNCONFIRMED' MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 14 JANUARY 2019, AT YNYSMEURIG HOUSE, ABERCYNON

PART II – HOSTED BODIES

PRESENT

Paul Griffiths	-	Independent Member (Chair)
Maria K Thomas	-	Independent Member
Jayne Sadgrove	-	Independent Member
Dilys Jouvenat	-	Independent Member

IN ATTENDANCE

Gwenan Roberts	-	Interim Board Secretary
David Jones	-	Local Counter Fraud Specialist
Sara Utlej	-	Wales Audit Office
Kevin Smith	-	Committee Secretary, WHSSC
Stuart Davies	-	Director of Finance, WHSSC
Stephen Harrhy	-	Chief Ambulance Services Commissioner, EASC
Paul Dalton	-	NWSSSP – Head of Internal Audit & Assurance
Emma Samways	-	NWSSSP - Internal Audit & Assurance
Emma Walters	-	Committee Secretariat

AC/19/001 **WELCOME AND INTRODUCTIONS**

Paul Griffiths, Chair **welcomed** everyone to Part II of the meeting.

AC/19/002 **APOLOGIES FOR ABSENCE**

Apologies for absence were **received** from Robert Williams.

AC/19/003 **DECLARATIONS OF INTERESTS**

There were no additional Declarations of Interest to note to those already registered.

AC/19/004 **UNCONFIRMED MINUTES OF THE AUDIT COMMITTEE MEETING HELD ON 8 OCTOBER 2018**

The minutes of the Audit Committee Part II, held on 8 October 2018, were received and **APPROVED** as an accurate record.

ACTION LOG

Members of the Committee discussed the action log and the following updates were received.

18/056 – Wales Audit Review of EASC – Closure Report – Stephen Harrhy confirmed that a discussion had been held with Chris Turner and a closure report was presented to the last Emergency Ambulance Services Committee (EASC). Members **NOTED** that EASC Members were content with the actions being taken and that a review of sub-committee arrangements which reported into EASC was being undertaken. Members **NOTED** that it had also been agreed to report on any future issues by exception only.

Members **RESOLVED** to:

- **RECEIVE** and **NOTE** the updated Action Log.

MATTERS ARISING NOT CONTAINED WITHIN ACTION LOG

There were no matters arising.

PART 2. INTERNAL CONTROL AND RISK MANAGEMENT**AUDIT TRACKER**

Stuart Davies presented the report and advised that good progress was being made against a number of historical actions. Members **NOTED** that there was 1 outstanding action against the Mental Health recommendations.

Paul Griffiths welcomed the progress that had been made and raised a question in relation to the content of the tracker, which he found to be confusing and advised that it was difficult to identify what recommendation had been made. Paul Griffiths requested that the tracker was amended to ensure recommendations were understandable and clear. Stuart Davies **AGREED** to action this request (**added to the action log**).

Maria Thomas questioned when the actions in relation to CAMHS were likely to be resolved and requested an update report on the recommendations that were being taken forward. Stuart Davies advised that actions should be resolved imminently and **AGREED** to provide an interim update to the next meeting if the position had not moved further forward (**added to the action log**).

Members **NOTED** that the biggest risk was in relation to the signing off of English contracts, which remained an outstanding issue.

Members **NOTED** that the Team would continue to monitor the position.

Members **RESOLVED** to:

- **NOTE** the progress achieved in implementing the recommendations made by Internal Audit;
- **APPROVE** the contents of the report.

AC/19/008

WHSSC Corporate Risk Assurance Framework

Kevin Smith presented the report which provided Members with an update on the WHSSC risk management framework as at 31 October 2018.

Members **NOTED** that work continued to be undertaken to strengthen the processes in place and that the WHSSC internal risk group had undertaken some work to identify other risks in addition to commissioning risks, for example, health & safety risks. Members **NOTED** that a further review of other risks would be undertaken in February and it was anticipated that the number of other risks would be low in number.

Members **NOTED** that since writing the report, the risks relating to lack of capacity and the need to invest in services had now been addressed through the IMTP process. Members **NOTED** that risks in relation to schemes which had not been funded would be included in the next report to the Committee.

Members **RESOLVED** to:

- **NOTE** the update provided.

AC/19/009

EMERGENCY AMBULANCE SERVICES COMMITTEE (EASC) RISK REGISTER

Stephen Harrhy apologised for not submitting the report to this meeting and advised that he would ensure an update report is presented to the April meeting.

PART 3. INTERNAL/EXTERNAL AUDIT REPORTS

AC/19/010

INTERNAL AUDIT REPORT – NON EMERGENCY PATIENT TRANSPORT SERVICE (NEPTS) – FOLLOW UP OF BASELINE POSITION REVIEW.

Paul Dalton presented the report which was an additional piece of work the Internal Audit team were asked to undertake following the initial review undertaken in 2016/17, for which an opinion was not

provided. Members **NOTED** that the follow up review focussed on how processes were moving forward.

Stephen Harrhy advised that the Team were trying to get to a consistent approach on how NEPTS services were being commissioned across Wales. Members **NOTED** that a 5 step pathway was being introduced and agreement needed to be given as to the standards of care that needed to be delivered. Members **NOTED** that consideration was being given to the resource envelope, the models that needed to be put into place, how to put the models into operation, how to review progress being made and how to evaluate. Members **NOTED** that regular updates were being provided to the Health Minister on the progress being made.

Following discussion, Members **AGREED** to receive a further update in October as part of the audit tracker process.

Stephen Harrhy advised that a signed agreement should have been in place by the end of November, and as a result of the delays experienced in appointing a Chair of EASC, this would now be in place by the end of January.

Members **RESOLVED** to:

- **NOTE** the update provided.

PART 4. ANY OTHER URGENT BUSINESS

AC/19/011 Paul Griffiths advised that it had been agreed to hold a private meeting with Internal and External Auditors at the start of every other meeting, with the next meeting being held in February.

AC/19/012 AUDIT COMMITTEE MEMBERS TO MEET WITH THE AUDITORS

Members of the Audit Committee did not wish to meet with the Auditors on this occasion.

AC/19/013 DATE OF NEXT MEETING

Monday 1 April 2019 at 11.30am

.....
Paul Griffiths, Chair

.....
Date

AUDIT COMMITTEE ACTION LOG
From 14 January 2019
(Part 2 – Hosted Bodies)

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS At April 2019
18/043	16/4/2018	Follow Up review of Wales Audit Office Review of EASC Commissioning	The outstanding actions from the WAO Review of EASC Commissioning arrangements concerning capturing patient experience information, ambulance quality indicators, the CASC role profile and MOU with WAST to be added to the Audit Recommendations Tracker	May 2018	WHSCC Director of Finance/ Committee Secretary	On agenda
18/053	09/07/2018	Audit Tracker	Narrative contained within the recommendation column to be simplified to make less detailed	Oct 2018	WHSCC Director of Finance/ Committee Secretary	Completed
18/056	09/07/2018	Wales Audit Review of EASC – Closure Report	Dr C Turner to discuss content of the report with Mr S Harry outside of the meeting	Oct 2018	Audit Committee Chair	Completed Confirmed that discussion had been held with Chris Turner and a closure report was presented to the last Emergency Ambulance Services Committee (EASC)

Agenda Item Number 1.5

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS At April 2019
19/007	14/01/2019	Audit Tracker	Tracker to be amended to ensure recommendations were understandable and clear.	April 2019	WHSCC Director of Finance	On agenda
19/007	14/1/2019	Audit Tracker	Interim update to be provided at the next meeting in relation to progress made against CAMHS actions and recommendations	April 2019	WHSCC Director of Finance	On agenda



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Pwyllgor Gwasanaethau Iechyd
Arbenigol Cymru (PGIAC)
Welsh Health Specialised
Services Committee (WHSSC)

		Agenda Item	2.1
Meeting Title	Audit Committee	Meeting Date	01/04/2019
Report Title	Internal Audit Recommendations Tracker		
Author (Job title)	Financial Accountant		
Executive Lead (Job title)	Director of Finance	Public / In Committee	In Committee

Purpose	To provide a progress report on the implementation of internal audit recommendations			
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RATIFY ☐	APPROVE ☒	SUPPORT ☐	ASSURE ☐	INFORM ☒
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Sub Group /Committee	Audit Committee	Meeting Date	01/04/2019
	Choose an item.	Meeting Date	Click here to enter a date.

Recommendation(s)	Members are asked to: • Note the progress achieved in implementing the recommendations made by Internal Audit. • Approve the contents of this report.
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Considerations within the report (tick as appropriate)

Strategic Objective(s)	YES	NO	Link to Integrated Commissioning Plan	YES	NO	Health and Care Standards	YES	NO
							✓	
Principles of Prudent Healthcare	YES	NO	Institute for HealthCare Improvement Triple Aim	YES	NO	Quality, Safety & Patient Experience	YES	NO
							✓	
Resources Implications	YES	NO	Risk and Assurance	YES	NO	Evidence Base	YES	NO
				✓				
Equality and Diversity	YES	NO	Population Health	YES	NO	Legal Implications	YES	NO

1.0 Situation

To provide a progress report on the implementation of internal audit recommendations.

2.0 Background

The fieldwork for the 2018/19 Plan has now completed. There is 1 outstanding report to be included in the next monitoring. Progress updates on this, and other reports will be provided to committee members in due course.

Regarding internal audit reports issued from April 2016:

- 9 reports have been issued:
- 31 recommendations have been made
- All recommendations have reached their due dates for implementation
- 28 recommendations have been achieved and 3 are outstanding.
- 1 outstanding overdue recommendation has a revised, extended due date.

A summary of the overall position to date and details of progress made on the outstanding recommendations is contained in the Appendix to this report.

3.0 Assessment

Of the internal audit report on the Mental Health Programme Team:

- 2 recommendations were made, of which 1 remains outstanding. Due to considerations, outside the control of the organisation, the original due date for this recommendation was extended to consult with other health bodies.

These issues, which are operational and are not related to the outstanding audit report recommendation, are ongoing and continue to delay its implementation.

Of the internal audit report on Network Boards and Advisory Groups:

- 3 recommendations were made, of which 1 has been achieved and 2 are progressing.

4.0 Recommendations

Members are asked to:

- **Note** the progress achieved in implementing the recommendations made by Internal Audit
- **Approve** the contents of this report.

5.0 Appendices / Annexes

- Audit Recommendations Progress Tracker

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	None
Health and Care Standards	Governance, Leadership and Accountability Effective Care Choose an item.
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production Choose an item. Choose an item.
Institute for HealthCare Improvement Triple Aim	Reducing the per capita cost of health care Improving Patient Experience (including quality and Satisfaction) Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	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.
Resources Implications	None
Risk and Assurance	Internal audit assessment of the governance framework within WHSSC provides essential assurance to the Joint Committee that its decisions are made and acted upon within the strongest and most robust governance environment possible.
Evidence Base	Internal Audit Reports
Equality and Diversity	No Impact
Population Health	Ensuring a robust governance framework as documented and supported by Internal Audit will have a positive impact on the commissioning of specialised services.

Legal Implications	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	
Report History:		
Presented at:	Date	Brief Summary of Outcome
Choose an item.		
Choose an item.		

Welsh Health Specialised Services Committee

Register of Recommendations from the Internal Audit Report on the Governance Framework

April 2019

No.	Recommendation	Priority	Timescale	Lead Director	Owner	Progress	Completed
IA GF 2017 1	The Governance Action Plan contains 89 actions of which 78 are listed as complete. Of the 11 actions that are incomplete eight were originally due for completion in March 2016, and the remaining three should have been completed no later than January 2017. Most of these actions relate either to the role and purpose of the organisation, or the further development of the quality framework and associated reporting measures. In the case of the former, the lack of a permanent Managing Director has directly caused the delay, and in the latter, there has been recent and significant investment in quality resource which has taken time to organise and agree. In addition, there are seven further actions which WHSSC believe are beyond its authority and which require consultation with Welsh Government Ministers. These were all due for completion by March 2016 but there is currently little evidence of progress. Completion of actions have been delayed which undermines the effectiveness of Governance within WHSSC. All outstanding actions should be completed as soon as is possible.	MEDIUM	Dec-18	Committee Secretary	Head of Corporate Services	At a meeting on 21 March 2017, the integrated Governance Committee considered and approved a proposal that the outstanding actions from the Governance Action Plan as at 10 March 2017 were consolidated into 10 actions, as described at item 3.5 in the related report, and managed through "business as usual" processes with six-monthly progress reports to the relevant assurance committees and escalation through the WHSSC CRAF, as applicable and that the Governance Action Plan was closed. Therefore, the 11 actions identified as incomplete from the GAP are now being managed and monitored as 10 actions through a different process. Several of these items will be closed by 31 December 2017 but some (e.g., development of the WHSSC strategy) may take until 31 December 2018 to close; therefore it is proposed that progress to completion of these 10 items forms part of a future Internal Audit Review. PROGRESS: At 31.12.17 five of the ten items were completed. At March 2019 the outstanding actions were roled into the latest Internal Audit review of Governance arrangements - Action closed. Regarding the seven actions for Welsh Government; having advised Welsh Government of the actions during 2016, WHSSC regards its responsibility as complete.	COMPLETED

Welsh Health Specialised Services Committee
Register of Recommendations from the Internal Audit Report on the Mental Health Programme Team
April 2019

No.	Recommendation	Priority	Timescale	Lead Director	Owner	Progress	Completed
IA MH 2018 1	The Specialised Services Policy for Tier 4 Child and Adolescent Mental Health Services was updated in August 2014 and approved by the WHSSC Management Group in September 2014. It was due for review / revision in September 2017. Evidence was seen of the Specialist Lead for Forensic Services being prompted in October 2017 to update the CAMHS policy. The specialist inpatient CAMHS service specification is also out of date. A revised specification was taken to the Policy and Service Specification Group meeting on the 25th September 2017 and it was agreed that the Specialist Lead for Forensic Services would prepare the document in the new template for presentation at the next policy meeting prior to consultation. The Specialised Adult Gender Identity Services policy was last approved by the Joint committee in September 2012 and was due for review / revision in September 2015. the Adult Gender Identity service specification is also out of date. it is understood that the specification and policy revision cannot take place until guidance is provided by Welsh Government. NHS Wales utilises the high secure forensic services specifications that NHS England have produced as all NHS service providers are based in England. There are two medium secure forensic units in Wales, the service specifications for these form part of an overarching Long Term Agreement with the respective Health Boards. The Specialised Services Policy for Tier 4 CAMHS and Specialised Adult Gender Identity Services policy should be updated as soon as possible. Management should ensure that the specialised inpatient CAMHS service specification is updated and forwarded to the appropriate stakeholders for consultation. when guidance is received from Welsh government, the Adult Gender Identity service specification should also be updated. There is a risk that up to date evidence based service specifications are in place and mental health services are planned against specialised services policies.	HIGH	March 2018 Updated to April 2018. Updated further to Sept 2018.	Director of Nursing	MH Service Planner	The service specification for CAMHS Tier 4 is complete and is in a consultation process. The document will be circulated to stakeholders in line with the WHSSC policies group process in January 2018. The Adult gender policy and service specification is subject to external influences and will be updated as soon as Welsh Government have signed off the total funding requirement for the new pathway and associated developments including the business case for the new Welsh Gender Team and enhanced service payments for GPs. Welsh Government have now approved funding for a Project Manager and have confirmed £500k has been earmarked for the new services. PROGRESS: The consultation on the CAMHS policy has closed and we are pulling together a response to the c60 comments we received. This intended to be completed by the end of April 2018. The Gender project manager has started to draft a revised gender policy based on the interim pathway but until this has been agreed by WG & C&VUHB we can't proceed any further. PROGRESS: The CAMHS policy development has been delayed in light of a serious incident at the Ty Llidiard facility. Further development of the gender pathway is waiting for sign off from the WG Gender Partnership Board.	

Welsh Health Specialised Services Committee
Register of Recommendations from the Internal Audit Report on Network Boards and Advisory Groups
April 2019

No.	Recommendation	Priority	Timescale	Lead Director	Owner	Progress	Completed
IA BG 2018 1	There was a Terms of Reference in place for all of WHSSC's Advisory Groups. However all were overdue for review. · The Wales Renal Clinical Network Board Terms of Reference should be reviewed annually. These were approved by the Joint committee in September 2016, and last reviewed in August 2017. · The NHS Wales Gender Identity Partnership Group Terms of Reference should be reviewed annually, but was last reviewed and approved by the Joint Committee in June 2017. · The All Wales Posture and Mobility Partnership Board Terms of Reference should be reviewed annually. These were last reviewed during 2015, and approved by the Joint Committee in June 2017. There is a risk that governance arrangements are not being properly discharged. There is a risk of ineffective decision making and monitoring. The Terms of Reference for the above advisory groups and the Wales Renal Clinical Network should be reviewed as soon as practicably possible and each year going forward.	MEDIUM	Jan-19	Committee Secretary	Committee Secretary	The Terms of Reference will be reviewed as part of the bi-annual review of the Governance and Accountability Framework, which is scheduled for autumn 2018. PROGRESS: As at March 2019, This review has now started	
IA BG 2018 2	The Mental Health and Learning disabilities Collaborative Commissioning Group did not meet during 2016/17 or 2017/18. Although the Collaborative's new NHS Wales Mental Health Network Board will cover much of the work previously undertaken by the now defunct MHLG Group, the remit of the new MHLNB specifically excludes learning disabilities services, which leaves a gap in provision in relation to learning disabilities to the Joint Committee / WHSSC. the MHLG should be formally wound up and removed from the WHSSC governance structure. Consideration should be given to setting up a new advisory group to focus on learning disability services. There is a risk that governance arrangements are not properly discharged. There is a risk that ineffective decision making and monitoring.	MEDIUM	Jan-19	Director of Planning	Committee Secretary	Accepted. This will require an explanatory paper with a recommendation to Joint committee. The explanation will also explore the other areas where there may be gaps in scope between the Mental Health and Learning Disabilities Collaborative Commissioning Group and the Mental Health Network Board. PROGRESS: As of March 2019, this will be picked up as part of the review of the GAF which is underway.	

Welsh Health Specialised Services Committee
Summary of Outstanding Internal Audit Recommendations
April 2019

Report Title	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations over due (Original Date)	Recommendations with a revised due date
Performance Dashboards 14/15	April 2015	April 2015	4	4	0	0	0	0
Financial Reporting 14/15	May 2015	May 2015	5	5	0	0	0	0
Emergency Ambulance Services Committee	May 2015	June 2015	1	1	0	0	0	0
Commissioning Arrangments	November 2015	January 2016	5	5	0	0	0	0
Information Governance	March 2016	April 2016	2	2	0	0	0	0
Local Financial Controls	April 2016	May 2016	3	3	0	0	0	0
Quality Assurance Improvement Team	May 2016	May 2016	4	4	0	0	0	0
Risk Management	October 2016	February 2017	5	5	0	0	0	0
Wales Renal Clinical Network Programme Team	January 2017	January 2017	4	4	0	0	0	0
Cancer and Blood Programme Team	February 2017	April 2017	3	3	0	0	0	0
Patient Identifiable Information	March 2017	November 2017	4	4	0	0	0	0
Governance Framework	October 2017	November 2017	3	3	0	0	0	0
Mental Health Programme Team	January 2018	January 2018	2	1	1	0	1	1
Boards & Groups	September 2018	October 2018	3	1	2	0	2	0

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Pwyllgor Gwasanaethau Iechyd
Arbenigol Cymru (PGIAC)
Welsh Health Specialised
Services Committee (WHSSC)

		Agenda Item	2.2
Meeting Title	Audit Committee	Meeting Date	01/04/2019
Report Title	WHSSC Corporate Risk and Assurance Framework		
Author (Job title)	Corporate Governance Manager		
Executive Lead (Job title)	Committee Secretary	Public / In Committee	In Committee

Purpose	The purpose of this report is to provide Members with an update on the WHSSC risk management framework.			
RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☒	INFORM ☒

Sub Group /Committee	Corporate Directors Group	Meeting Date	11/03/2019
		Meeting Date	
Recommendation(s)	Note the update provided within the report. Receive assurance that risks are being appropriately assessed and managed.		

Considerations within the report (tick as appropriate)

Strategic Objective(s)	YES	NO	Link to Integrated Commissioning Plan	YES	NO	Health and Care Standards	YES	NO
	✓			✓			✓	
Principles of Prudent Healthcare	YES	NO	Institute for HealthCare Improvement Triple Aim	YES	NO	Quality, Safety & Patient Experience	YES	NO
	✓			✓			✓	
Resources Implications	YES	NO	Risk and Assurance	YES	NO	Evidence Base	YES	NO
	✓			✓			✓	
Equality and Diversity	YES	NO	Population Health	YES	NO	Legal Implications	YES	NO
		✓			✓		✓	



1. SITUATION

The purpose of this report is to provide Members with an update on the WHSSC risk management framework.

2. BACKGROUND

The Corporate Risk and Assurance Framework (CRAF) summarises the key 'live' risks that WHSSC recognises and details actions being taken to mitigate and manage them.

2.1 Current process for review of risks and assurance

The risk management framework for WHSSC as a commissioning organisation has been reviewed during the last year and the new agreed process is being rolled out throughout the organisation and refined. Directorates and/or Commissioning teams are reviewing all risks, including the risks arising out of the Integrated Commissioning Plan 2018-21, and updating the registers to the new template.

Risk assessments are completed by the Directorate and/or Commissioning teams. As a commissioning organisation risks associated with commissioning of healthcare services are assessed in three domains; safe, sustainable and effective. Non-commissioning risks currently continue to be assessed in the traditional methodology against likelihood and impact/consequence.

Risks scoring 8 or above in any domain are added to the Directorate or Commissioning team risk register for monitoring of mitigation and management.

Risks scoring 15 or above in any domain are escalated to the CRAF. All risks within the CRAF are assigned a lead Director and are aligned to an assuring committee. Each lead Director is ultimately responsible for the ownership of the assigned risk/s and the reporting of any actions in place to mitigate or manage those risks.

The CRAF is considered at the WHSSC Internal Risk Management Group. This leads to an enhanced focus on risk management generally and an improved level of triangulation between provider performance and risk for commissioning risks. A robust process for ensuring that identified risks are also recorded, where appropriate, on provider risk registers is in development.

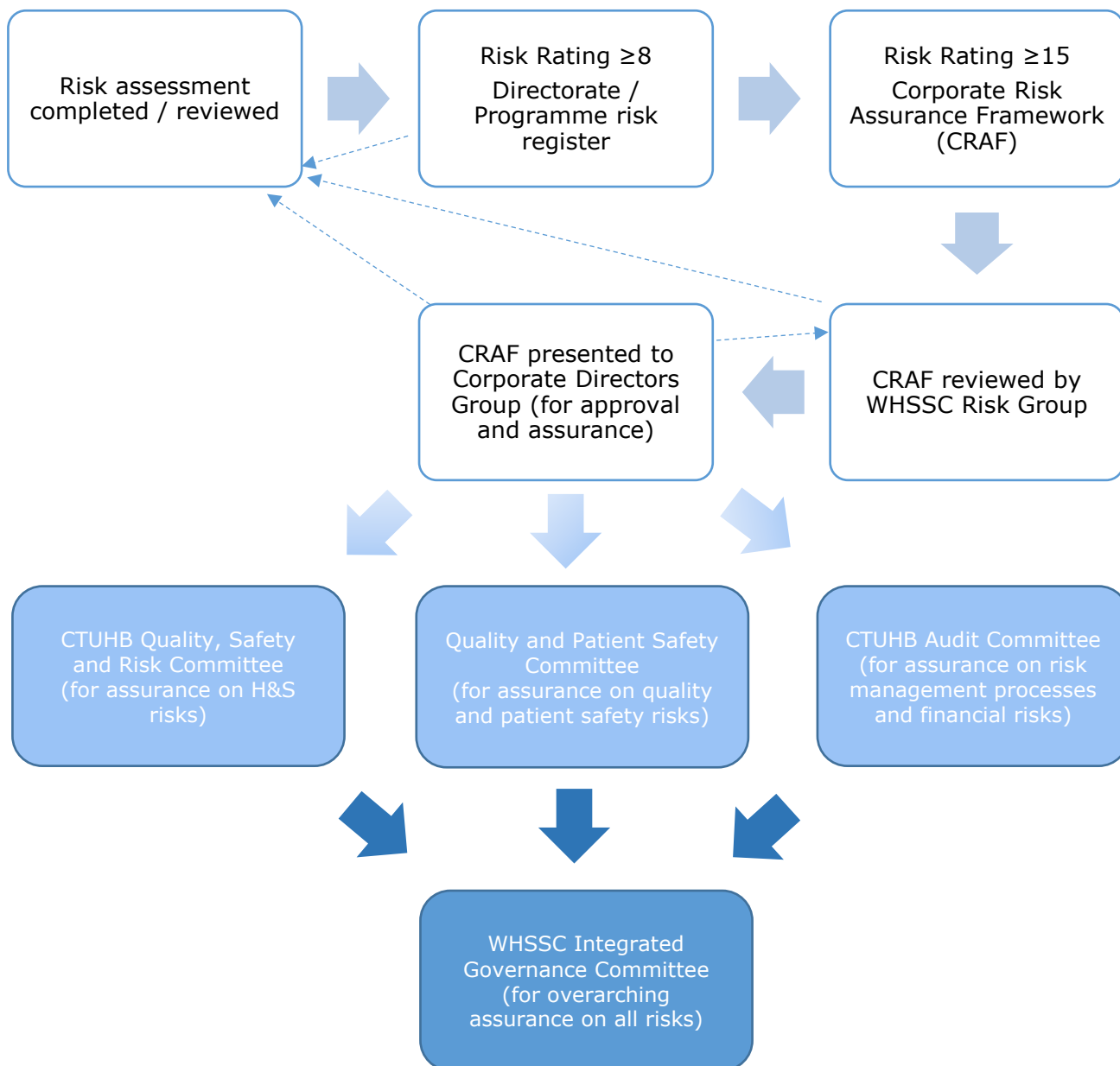
The CRAF is reported routinely to the WHSSC Corporate Directors' Group, Integrated Governance Committee and the Quality and Patient Safety



Committee. The CRAF is also reported into the Cwm Taf UHB Audit and Quality, Safety & Risk Committees.

2.2 Review and Assurance of the Corporate Risk and Assurance Framework

The diagram below shows how the Corporate Risk Assurance Framework is generated, updated, reviewed and assured.





3. ASSESSMENT

- 3.1 Work on further developing the CRAF has been undertaken over a number of months and WHSSC Officers have received and acted upon feedback from all committees (as noted above) to whom the CRAF has been presented.
- 3.2 The Internal Risk Management Group has agreed a list of potential risks (not commissioning risks) for assessment. Work is underway to assess these risks.
- 3.3 A review of the Risk Management processes within the WHSSC has been completed by Internal Audit in line with the 2018/19 Internal Audit plan. The final report will be presented to the Audit Committee for approval. The conclusion of the audit was that "the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively." A number of **low to moderate recommendations** were made and a management action plan has been prepared. Actions include a review of the Risk Management Framework and Risk on a Page document.
- 3.4 There are currently 58 risks that attract a rating of 15 or above on the risk register.
- 3.5 The Director of Planning continues to be the designated lead Director in the case of all risks currently scoring 15 or above and therefore identified on the CRAF.
- 3.6 The WHSSC Quality & Patient Safety Committee is the assurance committee for these risks and these risks are reported through the Programme Update Reports (agenda item 2.4).
- 3.7 Since the last report, 2 risks have been added to the register; namely:
- NC/039 Neurosurgery
 - WC/018 Neonatal Transport
- 3.8 There are currently 15 services in escalation. Further information is provided within the Programme Update Reports (agenda item 2.4).

4. RECOMMENDATIONS

Members are asked to:

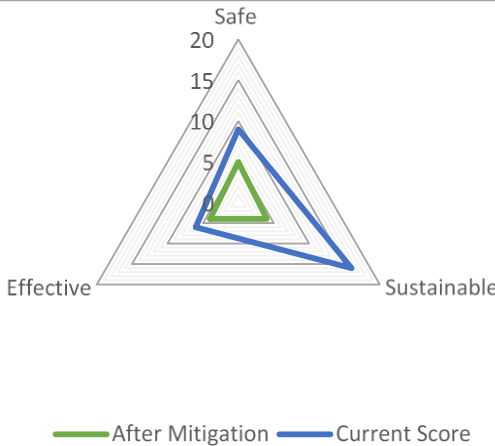
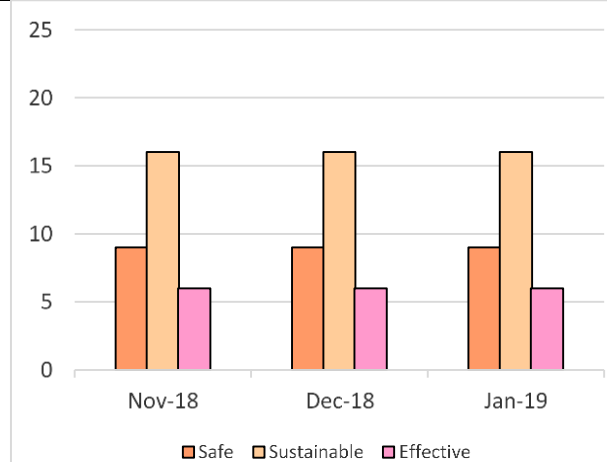
- **Note** the update provided within the report.
- **Receive assurance** that risks are being appropriately assessed and managed.

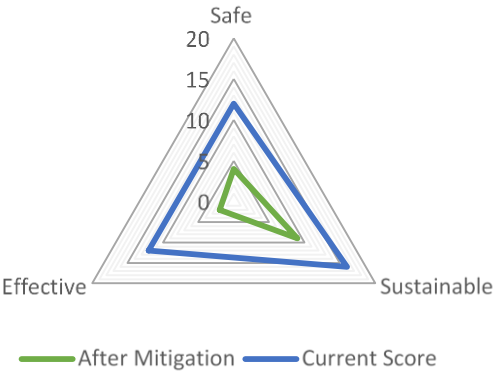
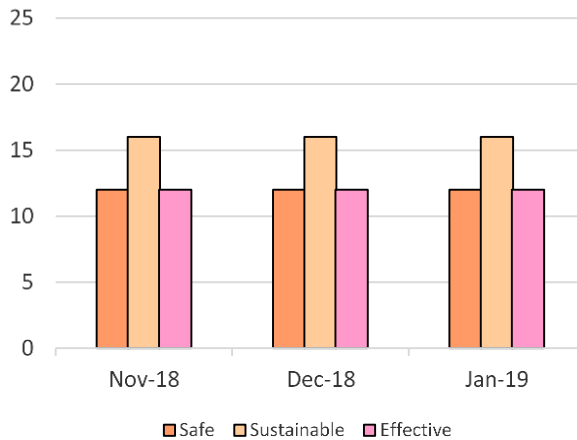


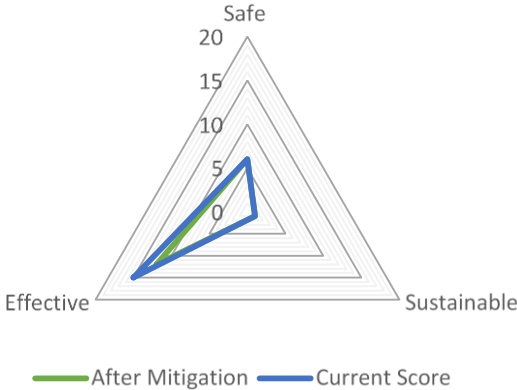
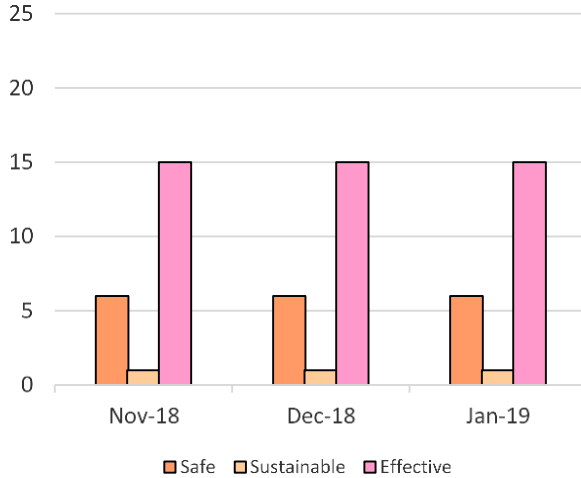
5. APPENDICIES AND ANNEXES

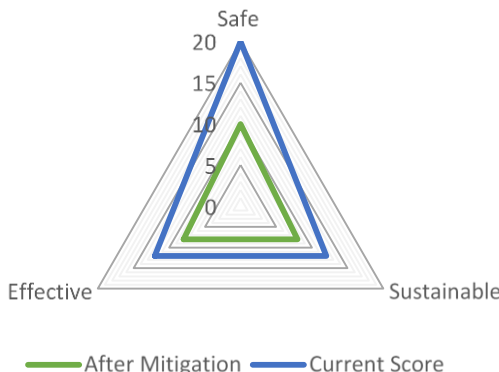
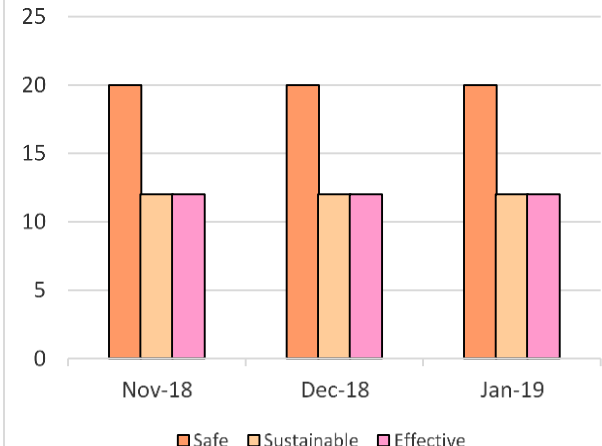
There are no annexes or appendices to this report.

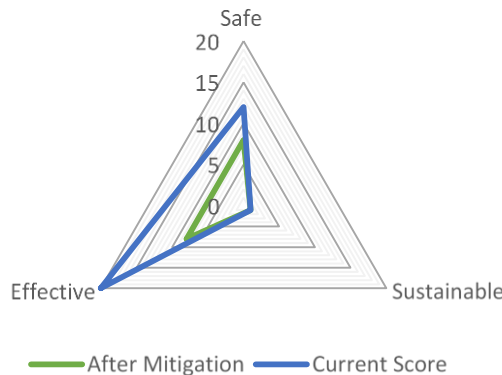
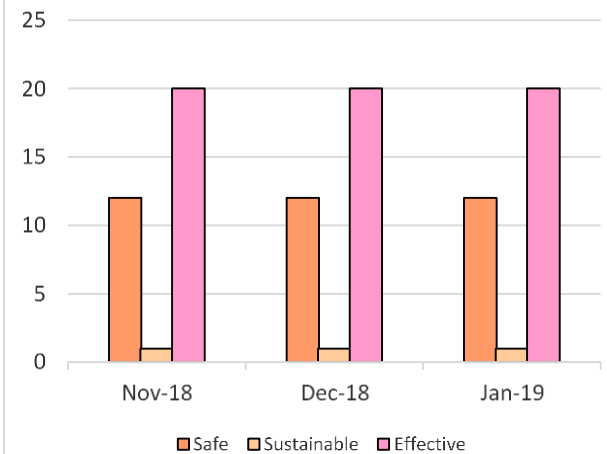
Link to Healthcare Objectives		
Strategic Objective(s)	Governance and Assurance	
Link to Integrated Commissioning Plan	Implementation of the agreed ICP	
Health and Care Standards	Safe Care Effective Care Governance, Leadership and Accountability	
Principles of Prudent Healthcare	Only do what is needed Reduce inappropriate variation	
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and satisfaction)	
Organisational Implications		
Quality, Safety & Patient Experience	Robust risk management arrangements are a requisite to the assurance of quality of care, patient safety and the patient experience.	
Resources Implications	Some improvement actions may require the application of additional resources.	
Risk and Assurance	This report and the CRAF constitute integral elements of WHSSC’s risk and assurance arrangements. This work continues to develop.	
Evidence Base	The CRAF is based on the extreme risks recorded within the Directorate and Programme risk registers.	
Equality and Diversity	There are no equality and diversity implications.	
Population Health	There are no immediate population health implications.	
Legal Implications	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.	
Report History:		
Presented at:	Date	Brief Summary of Outcome
CDG Board	11.03.2019	

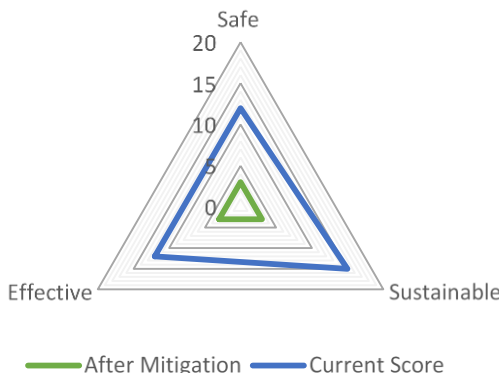
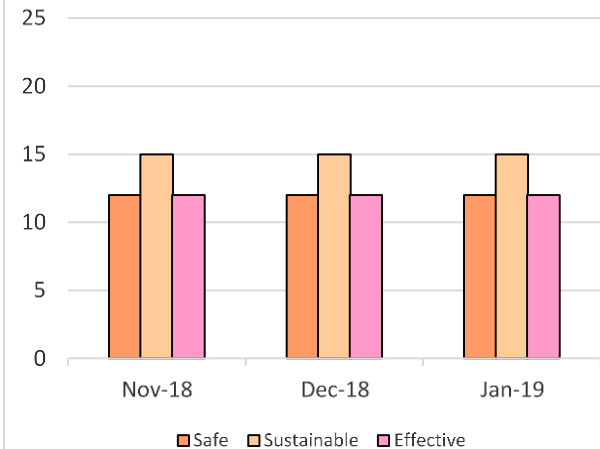
CH/011	LUNG RESECTION Risk: Risk to the sustainability of the thoracic surgery service in south Wales due to changes in thoracic surgery training and practice. Ability to provide a quality service that meets patient need for cancer and non-cancer surgery.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee		
JAN 2019				Date first assessed 02/10/2013 Date last reviewed by Programme/Directorate: C&B Commissioning 21/02/2019		
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective	 — After Mitigation — Current Score		
After Mitigation	5	4	4			
Current Score	9	16	6			
				 ■ Safe ■ Sustainable ■ Effective		
Escalation Narrative: Level 2. Bi-monthly performance meetings in place.						
Current Control Measures in Place				Description of further Control Measures Required		
i) Strategic review of the future service model for thoracic surgery in progress; ii) Interim increase in funding through the Integrated Commissioning Plan to increase capacity to deliver target level of lung resections; iii) ABMUHB and CVUHB currently implementing delivery plans to increase capacity. CVU: 3rd surgeon (locum) recruited August 2017 - took up post October; additional theatre list is not yet available - no clear timeline provided; arrangements in place to prioritise capacity for lung cancer. ABM: unable to move forward with 3rd surgeon locum appointment at current time; arrangements for weekend working in place; additional capacity previously agreed through outsourcing to Stoke but stood down whilst agreeing that pathway may need to be re-established. While these implementation plans have not been fully implemented, Service Level Agreement activity is being delivered in both centres. iv) Bi-monthly performance meetings with both South Wales providers in place.				Action	Lead	By when
				Implementation of Thoracic Surgery Review Recommendations	Managing Director	01/09/21
				Obtain update on additional theatre list at CV UHB	Planning Manager	Complete
				Bimonthly performance meetings with both CV UHB and ABM UHB	Director of Planning	On-going

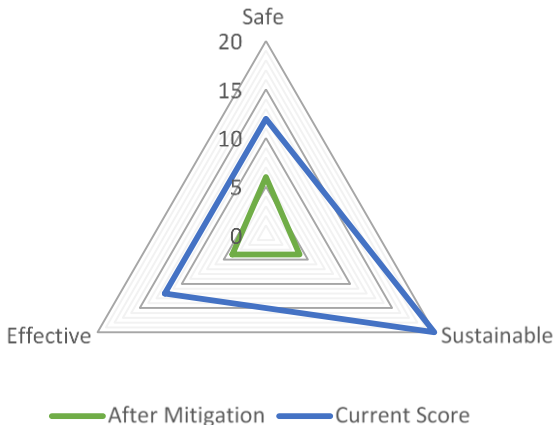
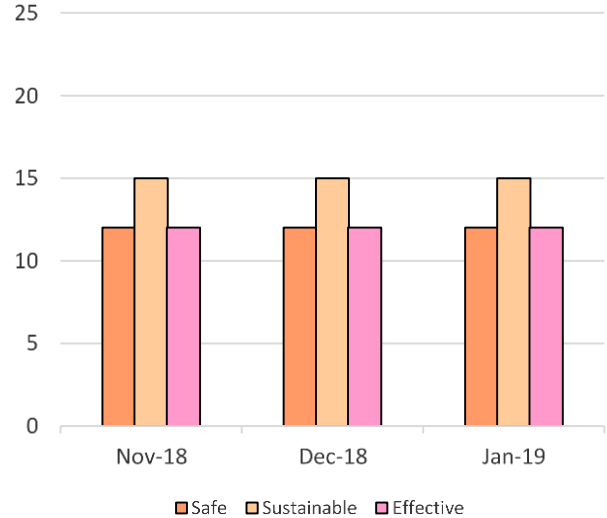
CH/016	HAEMOPHILIA Risk: Vacant consultant post since November 2016. No on-site haemophilia consultant cover at present. Out-reach clinics to Hywel Dda HB are suspended. Increased pressure on the Cardiff service to provide advice, increased outreach to Swansea and to admit patients to UHW (with impact on capacity for other haematology patients).			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 22/09/2016 Date last reviewed by Programme/Directorate: C&B Commissioning 21/02/2019	
JAN 2019					
Risk Rating				WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective		
After Mitigation	4	9	2		
Current Score	12	16	12		
Escalation Narrative:					
Current Control Measures in Place				Description of further Control Measures Required	
i) ABM continues to provide IBD CNS and other allied health professional support for both ad hoc and scheduled clinical work, supported by middle grade and consultant haematologist input from ABM as needed, utilising the more specialised advice and support from UHW as/when required. ii) IBD consultants from UHW will continue to attend a monthly clinic on site in ABM supported by the senior SpR currently on placement in ABM till Feb 2019 iii) ABM have advertised for consultant post with haemophilia component (outcome awaited); iv) IBD project in progress to bring funding under WHSSC and review service model.				Action	Lead By when
				Hub and spoke model approved in this years ICP. Consultant sessions to be provided by Cardiff CCC, implementation plan in development.	Planning Manager 04/19

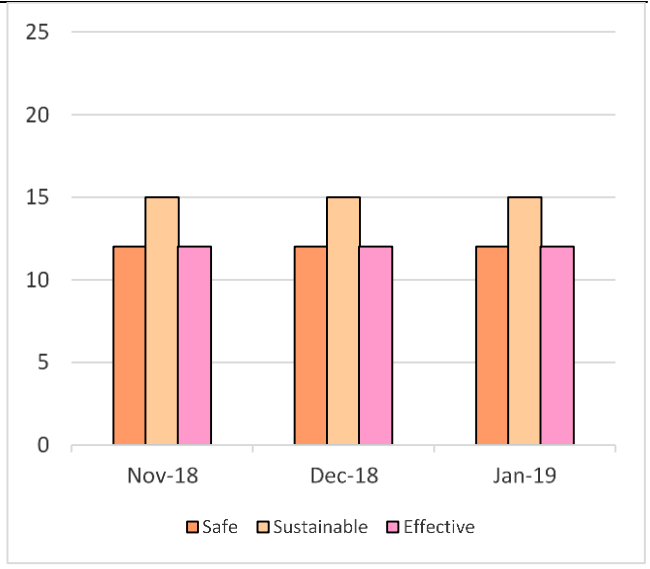
CH/018	PLASTIC SURGERY Risk: i) Failure to achieve the maximum waiting times target in plastic surgery at ABMUHB (approx. 50 patients in March 2018) with some patients waiting in excess of 52 weeks; ii) increased morbidity and disability of patients on the waiting list (usually patients requiring complex operations).			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 17/03/2014 Date last reviewed by Programme/Directorate: C&B Commissioning 21/02/2019		
JAN 2019						
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective			
After Mitigation	6	1	12			
Current Score	6	1	15			
Escalation Narrative: Level 2. Monthly performance meetings in place.						
Current Control Measures in Place				Description of further Control Measures Required		
(1) Performance management arrangements escalated to monthly executive performance meetings; 2) referral pathway workshops arranged with all referring Health Boards. All workshops now complete; summit took place on 9 July 2018; further meeting to take place on 2 October 2018; 3) Breakdown of breaching patients by indication and clinical impact has been requested but not yet received; 4) delivery plan for 2018/19 now received.				Action	Lead	By when
				Monthly performance management meetings	Director of Planning	On-going
				Revise plastic surgery contract	DoF	03/20
				Develop commissioning policy to identify those specialised plastic surgery procedures that require the unique skills of plastic surgery	Planning Mgr.	03/20

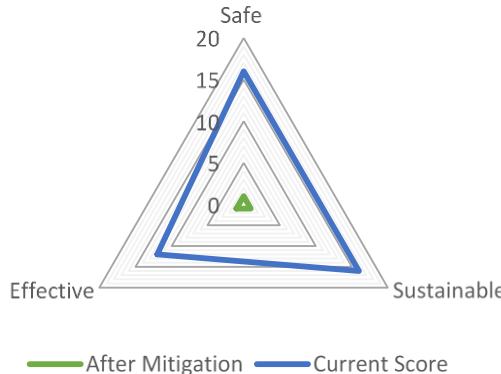
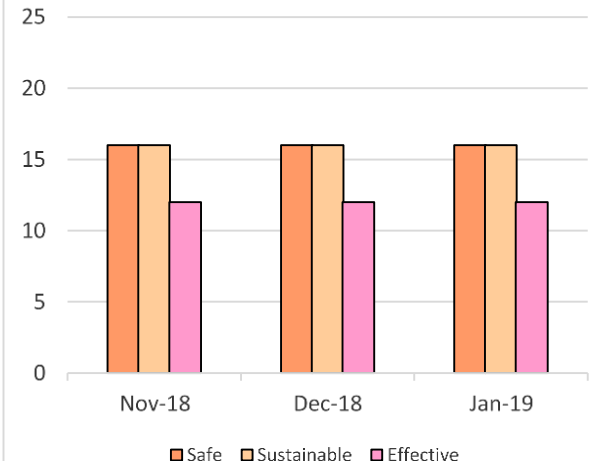
CH/020	LUNG CANCER			Director lead: Director of Planning			
JAN 2019	Risk: Lung cancer waiting times for surgery in south Wales. Excessive lung cancer waiting times contributing to a risk of poor experience, clinical outcome (including tumour becoming inoperable), and waiting times breaches.			Assuring Committee: Quality and Patient Safety Committee			
				Date first assessed 10/12/2017			
				Date last reviewed by Programme/Directorate: C&B Commissioning 21/02/2019			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	10	8	8				
Current Score	20	12	12				
							
Escalation Narrative: Level 2. Bi-monthly performance meetings in place.							
Current Control Measures in Place				Description of further Control Measures Required			
Additional local capacity through weekend working over 2017 has reduced waiting times significantly. Pathway was agreed with UHNM at Stoke to provide additional capacity for lung cancer patients. However, this pathway has been stepped down with the option to re-establish (provided the Video Conference link can be made to function to enable Stoke to join the local Multi-Disciplinary Teams).				Action		Lead	By when
				Obtain update from ABM UHB on VC link with UHNM		Planning Mgr.	09/18
				Monthly performance management meetings		Director of Planning	On-going
				Ask CVUHB & ABMUHB to submits their lung cancer breach data when submitting to Welsh Government		Director of Planning	requested not receiving
				Raise issue of intermittent lung cancer breach data from WG at Cancer Implementation Group		Planning Manager	10/18

CH/024	PET – CT POLICY Risk: Wales still has significantly lower rates of PET-CT compared to elsewhere in the UK and Europe. There is robust evidence that PET-CT will lead to a change in patient management and improved outcomes for indications excluded by the current commissioning policy. The risks are therefore: - sub-optimal management of cancers excluded by the current commissioning policy; - potential for sub-optimal outcomes; - potential for patient receiving unnecessary procedures or procedures of limited benefit; - sub-optimal utilisation of scarce healthcare resources. The reputation of WHSSC is also at risk as the current PET-CT policy excludes many of the indications included in the NHS England and NHS Scotland policies creating inequity of access across the UK.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 01/04/2017 Date last reviewed by Programme/Directorate: C&B Commissioning 21/02/2019			
JAN 2019							
Risk Rating				WHSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	8	1	8				
Current Score	12	1	20				
							
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
Patients will continue to be managed via existing diagnostic pathways. As currently, the site specific MDTs will determine best management on the diagnostic and imaging information available.				Action		Lead	By when
				All Wales PET Advisory Group (AWPET) will continue its work evaluating the evidence base and recommending additional indications, and criteria, for the ICP 2019/20.		Assistant Director Evidence and Evaluation	11/18
				Update policy with indications agreed for 19/20		Planning Manager	05/19

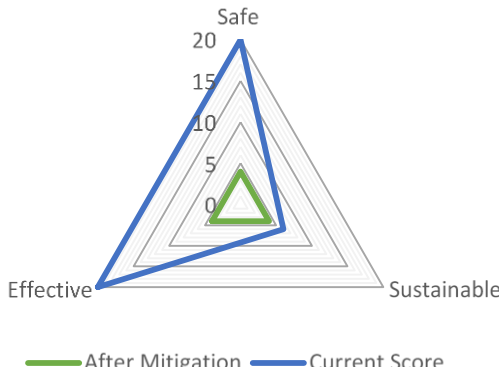
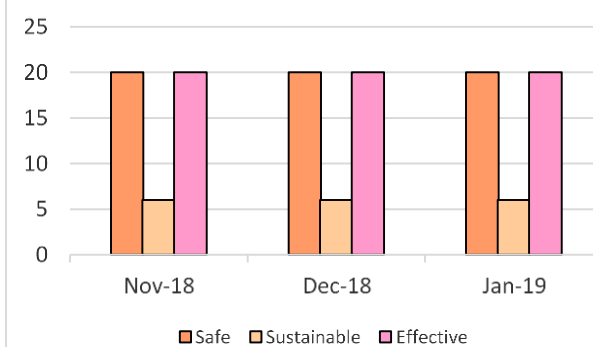
CH/028	NETs Risk: • Sustainability of NETs south Wales service. Risk to sustainability of the service with respect to its capacity to be able to monitor patients and manage their care appropriately and optimally through timely assessment and intervention to treat this complex condition; • Clinic capacity insufficient to meet demand; • An inability to meet the Task & Finish Group recommendations for the NET services in South Wales would lead to discontent amongst patient groups; • Continued inequity between patients in North and South Wales in access to timely care; • Failure to meet expectations that Welsh Government have made to patient groups; • Potential increase in patient complaints and litigation claims in terms of delay in diagnosis.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 01/04/2017 Date last reviewed by Programme/Directorate: C&B Commissioning 21/02/2019			
JAN 2019							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	3	3	3				
Current Score	12	15	12				
							
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
If the scheme is not funded, patients will be prioritised within available capacity according to clinical need.				Action		Lead	By when
				To work with the service to evaluate demand and capacity, and review the proposal for phase 2, and if required, put forward for consideration within the ICP process for 2019/20.		Planning Manager	11/18

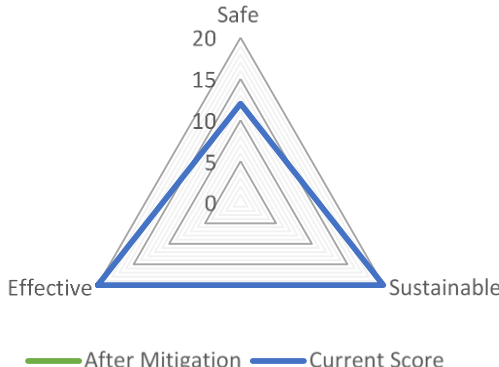
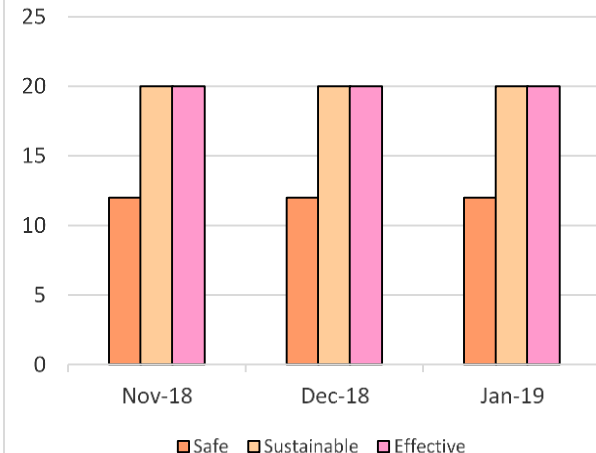
CH/029	SARCOMA Risk: Sustainability of south Wales soft tissue sarcoma service (single surgeon). Single handed surgeon providing surgery for soft tissue sarcoma in south Wales. Fragility of service (lack of cover); Not achieving quality standards which require at least 2 surgeons in MDT.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee																		
JAN 2019				Date first assessed 22/11/2017 Date last reviewed by Programme/Directorate: C&B Commissioning 21/02/2019																		
Risk Rating				WHSSC Risk Assessment Triangle																		
	Safe	Sustainable	Effective	 Safe Effective Sustainable — After Mitigation — Current Score																		
After Mitigation	6	4	4																			
Current Score	12	15	12																			
 <table border="1"><thead><tr><th>Category</th><th>Nov-18</th><th>Dec-18</th><th>Jan-19</th></tr></thead><tbody><tr><td>Safe</td><td>12</td><td>12</td><td>12</td></tr><tr><td>Sustainable</td><td>15</td><td>15</td><td>15</td></tr><tr><td>Effective</td><td>12</td><td>12</td><td>12</td></tr></tbody></table>							Category	Nov-18	Dec-18	Jan-19	Safe	12	12	12	Sustainable	15	15	15	Effective	12	12	12
Category	Nov-18	Dec-18	Jan-19																			
Safe	12	12	12																			
Sustainable	15	15	15																			
Effective	12	12	12																			
Escalation Narrative:																						
Current Control Measures in Place				Description of further Control Measures Required																		
Arrangements to establish MDT link between ROH, Birmingham and south Wales are being explored.				Action		Lead	By when															
				Make corporate approach to University Hospital Birmingham regarding link to MDT (Complete)		Director of Planning	09/18															

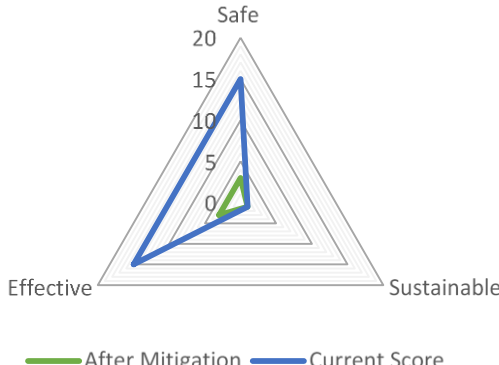
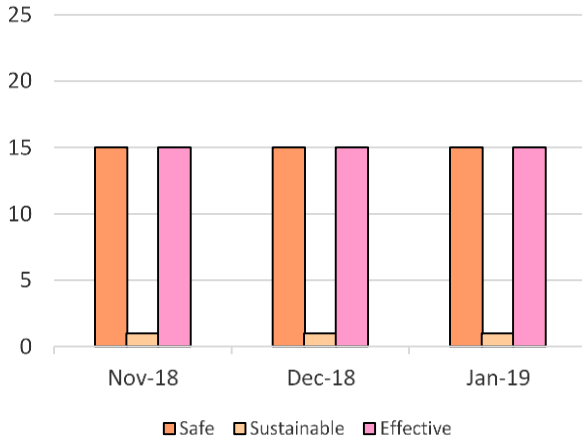


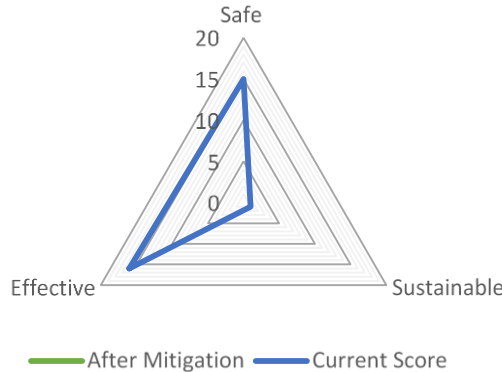
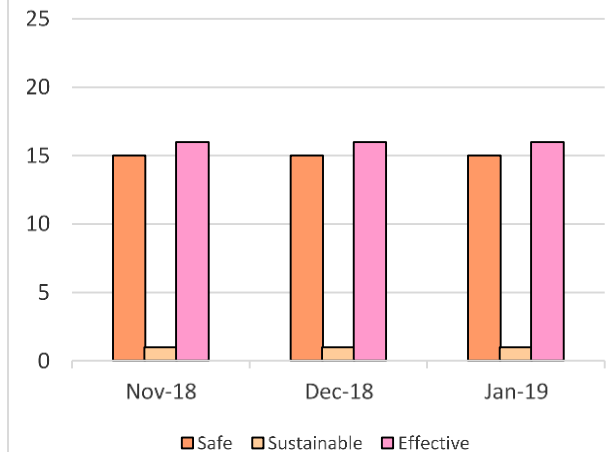
CH/032	BMT Risk: The BMT service at UHW is at risk of not gaining JACIE accreditation due to its poor facilities (space; bed numbers; lack of en-suite facilities (adults UHW); small collection area in busy day-care ward (UHW apheresis) and the processing lab (UHW)). These concerns were identified at the JACIE inspection in 2013.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 01/05/2018 Date last reviewed by Programme/Directorate: C&B Commissioning 21/02/2019			
JAN 2019							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	1	1	1				
Current Score	16	16	12				
Escalation Narrative: BMT service recently put into escalation (level 2). The patient risks associated with inadequate facilities form part of the reason for escalation.							
Current Control Measures in Place				Description of further Control Measures Required			
Assurance received from CV UHB regarding plans, including interim plans, to address this issue. JACIE inspection has taken place; initial feedback is promising but certification likely to take up to 6 months from inspection date.				Action		Lead	By when
				Obtain response from BMT re escalation and action plan		Director of Planning	09/18
				Quarterly meetings in place with service to monitor risk and mitigations.		Director of Planning	Ongoing

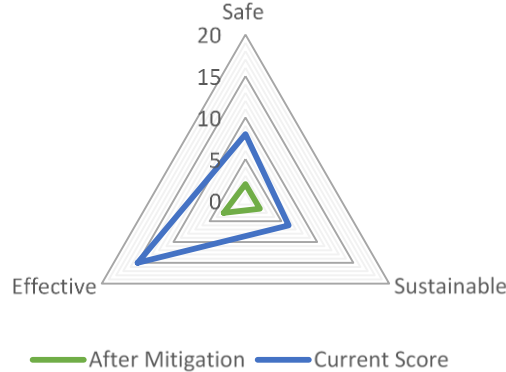
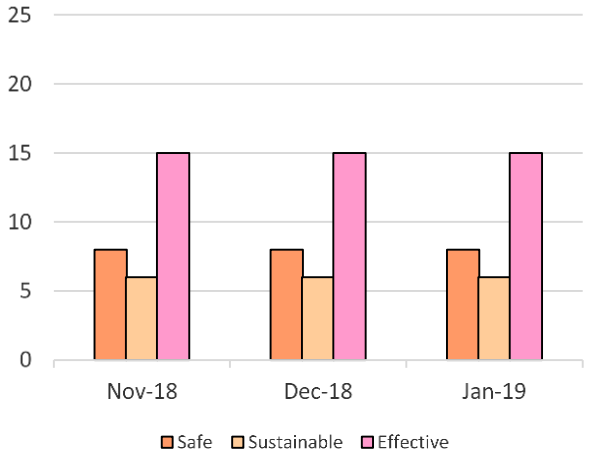
CH/033	HAEMOPHILIA Risk: Sustainability of the haemophilia service in BCUHB. Vacant consultant post in Bangor since Feb 2017. No on-site specialist haemophilia consultant cover at present.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed Date last reviewed by Programme/Directorate: C&B Commissioning 21/02/2019																		
JAN 2019																						
Risk Rating				WHSSC Risk Assessment Triangle																		
	Safe	Sustainable	Effective	Safe Effective Sustainable — After Mitigation — Current Score		<table><caption>Bar Chart Data</caption><thead><tr><th>Category</th><th>Nov-18</th><th>Dec-18</th><th>Jan-19</th></tr></thead><tbody><tr><td>Safe</td><td>12</td><td>12</td><td>12</td></tr><tr><td>Sustainable</td><td>16</td><td>16</td><td>16</td></tr><tr><td>Effective</td><td>12</td><td>12</td><td>12</td></tr></tbody></table>	Category	Nov-18	Dec-18	Jan-19	Safe	12	12	12	Sustainable	16	16	16	Effective	12	12	12
Category	Nov-18	Dec-18	Jan-19																			
Safe	12	12	12																			
Sustainable	16	16	16																			
Effective	12	12	12																			
After Mitigation	4	9	4																			
Current Score	12	16	12																			
Escalation Narrative:																						
Current Control Measures in Place				Description of further Control Measures Required																		
i) Additional outreach clinic from Liverpool held at YGC for patients from Bangor; ii) Nurse led service with telephone support from Liverpool; iii) Hub and spoke model recommended outcome of formal review- funding approved in ICP. Due to local concerns an additional meeting has been scheduled for mid March to discuss network proposal which would see consultant sessions provided by Cardiff CCC with Liverpool services providing surgical support.				Action		Lead	By when															
				Implementation of outcome of IBD service model review.		Director of Planning	04/20															

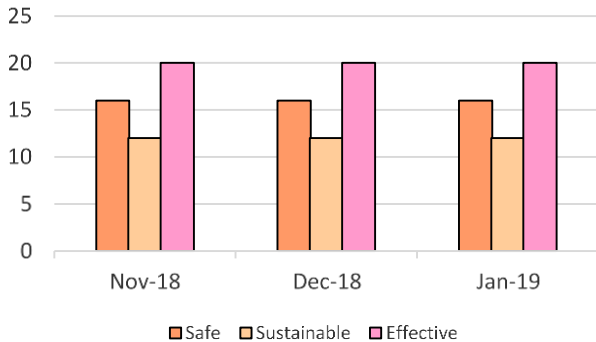
CH/035	SARCOMA Risk: No CNS in south east Wales leading to poor patient experience reported in Macmillan briefing paper which was issued as a follow up to the 2016 Wales Cancer Patient Experience Survey.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 28/09/2018 Date last reviewed by Programme/Directorate: C&B Commissioning 21/02/2019			
JAN 2019							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	4	4	4				
Current Score	20	6	20				
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
Achieved support for urgent requirement of CNS for patients in SE Wales at sarcoma pathway meeting 27/9/18; highlighted to WHSSC CDG 1/10/18; Macmillan funding applied for; CNS from Velindre is providing interim cover.				Action		Lead	By when
				Obtain clarity on the spend and staff profile in the current block element of the sarcoma contract with ABM		Planning Manager	Complete
				Write to ABM to require they work with south east health boards to agree the job plan, to set a reasonable expectation for the timescale, and require confirmation they are taking this forward.		Planning Manager	Complete

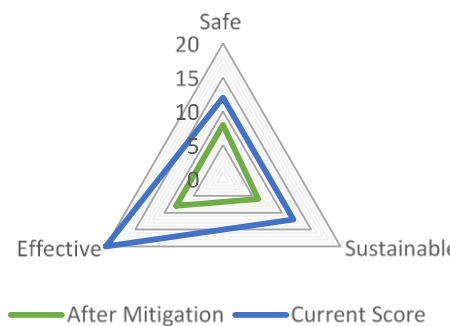
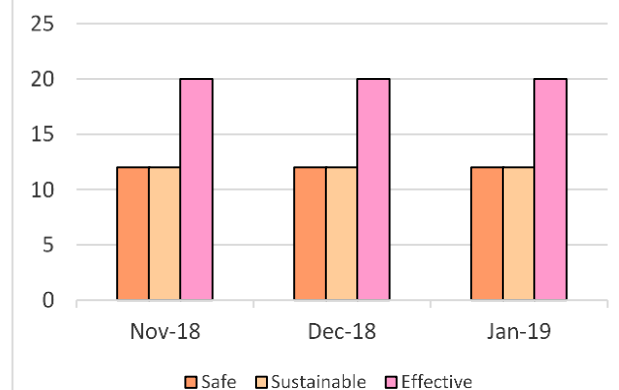
CH/036	SARCOMA Risk: Sustainability of south Wales soft tissue sarcoma service (single CNS for patients in south west Wales) Sustainable provision of CNS support			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 28/09/2018 Date last reviewed by Programme/Directorate: C&B Commissioning 21/02/2019			
JAN 2019							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	12	20	20				
Current Score	12	20	20				
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
Requirement for flexible working between SW and SE CNS is included in CNS recruitment process.				Action		Lead	By when
				Obtain clarity on the spend and staff profile in the current block element of the sarcoma contract with ABM		Planning Manager	10/18

CH/038	SARCOMA Risk: Clinical governance. Lack of clinical ownership of sarcoma patients in health boards through diagnostic stage of the pathway			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee		
JAN 2019				Date first assessed 28/09/2018 Date last reviewed by Programme/Directorate: C&B Commissioning 21/02/2019		
Risk Rating			WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective			
After Mitigation	3	1	3			
Current Score	15	1	15			
						
Escalation Narrative:						
Current Control Measures in Place			Description of further Control Measures Required			
Working to influence Health Boards to identify local sarcoma leads to address the diagnostic pathway (inc. liaising with WCN). Meeting held on 9th Nov with SE HBs (including radiology). Pathways in Cwm Taf and AB were clarified; Cardiff unclear since radiology did not attend. ABMU radiology working on a proposal for MSK clinic in SEW. Further meeting to be held in Dec with all parties to agree model.			Action		Lead	By when
			Arrange meeting in December with all south Wales health boards		Asst. Planning Manager	complete

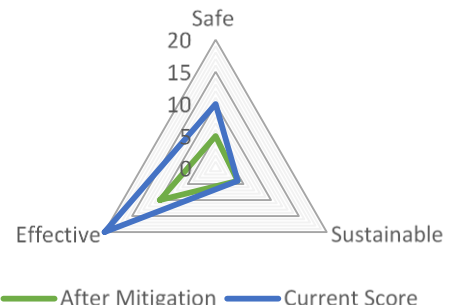
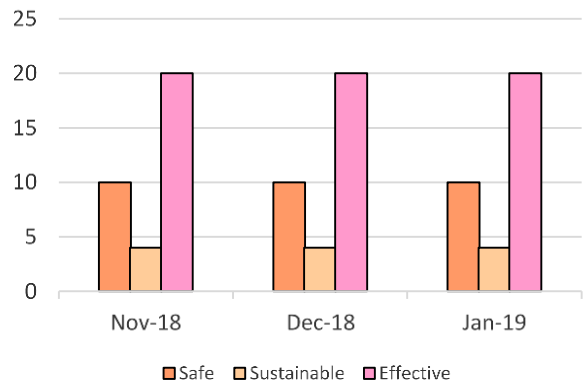
CH/040	BMT Risk: BMT South Wales laboratory capacity. Increasing demand on support laboratories for chimerism testing leading to delayed reporting and reduced ability to maintain turnaround times.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
JAN 2019				Date first assessed 01/08/2018 Date last reviewed by Programme/Directorate: C&B Commissioning 21/02/2019			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	15	1	16				
Current Score	15	1	16				
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
Note that this risk was formerly combined with CH034				Action		Lead	By when
				Include proposal for consideration in ICP 19/22		Planning Manager	complete
				Quarterly meetings in place with service to monitor risk and mitigations.		DoP	Ongoing

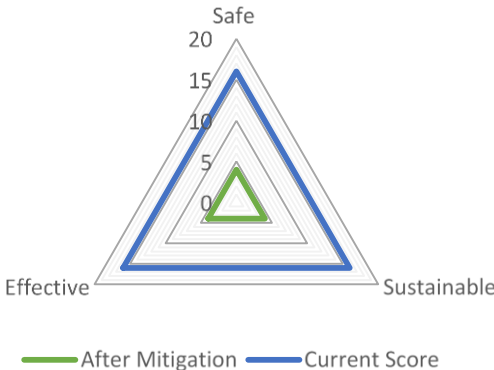
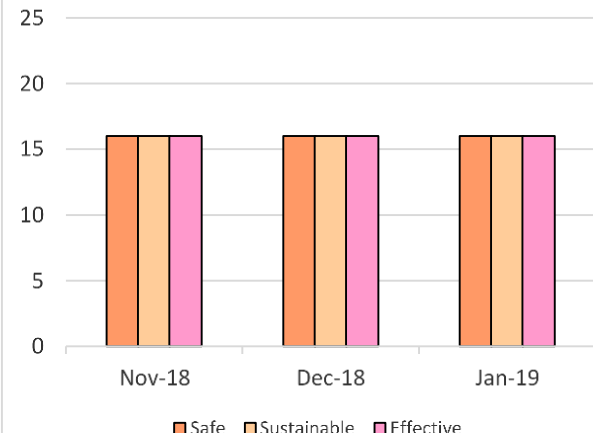
CH/041	GENETICS			Director lead: Director of Planning			
JAN 2019	Risk: Major genetic laboratory reconfiguration in England leading to inequitable access to genetic tests for patients in Wales as compared to England.			Assuring Committee: Quality and Patient Safety Committee			
				Date first assessed 09/10/2018			
				Programme/Directorate: C&B Commissioning			
				Date last reviewed 21/02/2019			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	2	2	3				
Current Score	8	6	15				
							
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
All Wales Medical Genetics Service (AWMGS) has presented these risks to Welsh Government. A proposal has been included within the WHSSC prioritisation process for the ICP 2019-22.				Action		Lead	By when
				Include proposal for consideration in ICP 19/22		Planning Manager	complete
				Produce policy for implementation of ICP scheme		Planning Manager	04/19
				Funding release for implementation of ICP scheme		Planning Manager	04/19

CT/013	CARDIAC ABLATION Risk: Safe: People with atrial fibrillation have higher risk of stroke & heart attacks, they also suffer a considerably poorer quality of life. Access to cardiac ablation for Atrial and Ventricular Tachycardia is far lower in S. Wales than in N. Wales, England, Scotland, and many countries in Europe. Lower access rates for treatment could result in patients having the burden of ill Health leading to lower quality of life or earlier death. Currently, too few patients are referred, and often referred late in the progression of their disease, leading to poorer outcomes and requirement for multiple ablation procedures. Patients are also at risk of emergency admissions from poorly controlled AF. Sustainable: infrastructure and capacity constraints access rates for complex cardiac ablation are significantly lower in S. Wales than the rest of the UK and also benchmark unfavourably at an international level. Effective: not in line with standards for ablation, the British Heart Rhythm Society audit 2013 showed access per million population was 49 in S. Wales, compared with 102 in N. Wales and 113 for England overall. The British Heart Rhythm Society has set a minimum standard of 100 AF ablation pmp.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 05/02/2016 Date last reviewed by Programme/Directorate: Asst. Planning Mgr. 12/02/2019			
JAN 2019							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	2	1	2				
Current Score	16	12	20				
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
Cardiac Ablation for Atrial Fibrillation (AF) and Ventricular Tachycardia (VT) in South Wales is included in the 2018-21 Integrated Commission Plan. Ongoing discussions between WHSSC and South Wales to discuss actions being taken to increase the delivery of the ablation service for South Wales.				Action		Lead	By when
				Write to providers to request plans to increase provision of Cardiac Ablation for AF and VF. Response received.		Dir. Of Planning	Complete
				Work with South Wales providers to determine a joint solution for increasing the numbers. re: capital and revenue cases as required. Business cases have been received from C&VUHB and ABMUHB and the proposal for investment was approved by MG in November as follows: ABMUHB funding year 1 & 2 and C&VUHB funding year 1 with further work to be undertaken with ABUHB and CTUHB and C&VUHB to understand impact of PCI repatriation and opportunities it creates for capacity at UHW.		Planning Manager	On-going
				Funding release letters sent to both providers to implement plans for increasing ablation for year 1 (2018/19) and Year 2 (2019/20)		Planning Manager	On-going

CT/014	INTERVENTIONAL CARDIOLOGY (Delivery of PPCI) Risk: Safe: Revascularisation delivery outside the 72 hours increases the risk for patients of having higher risk of future adverse cardiovascular events. Sustainable: Lack of capacity at the tertiary centre to deliver PCI. Effective: Nice guidelines recommends NSTEMI is administered within 72 hours. Currently there are welsh patients who are revascularised outside the NICE recommended target time of 72 hours due to variation in treatment times from when a patient is admitted to hospital with a PCI service to when a patient is admitted to a non PCI centre and therefore requires transfer.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 01/05/2016 Date last reviewed by Programme/Directorate: Asst. Planning Mgr. 12/02/2019		
JAN 2019						
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective			
After Mitigation	8	6	8			
Current Score	12	12	20			
Escalation Narrative:						
Current Control Measures in Place			Description of further Control Measures Required			
Limited as there is a need to agree a mechanism of monitoring the standard/outcomes. This is proving difficult due to the number of different providers/systems used.			Action		Lead	By when
			Process being implemented to measure time from first admission to PCI. Initiatives have been developed and implemented via the Cardiac Networks to address blockages in the referral pathway around transfer and repatriation. South East Wales piloting dedicated T&R capacity for 3 months, supported by WAST and 4 trolleys at UHW.		Cardiac Network	complete
			Ensure that there is sufficient capacity for NSTEMI		Health Boards	On-going
			Discussions ongoing with the Cardiac Network Lead.		Planning Manager	On-going
			Undertake a further review of current waiting times and measures put in place at the tertiary centres.		Planning Manager	31/01/19

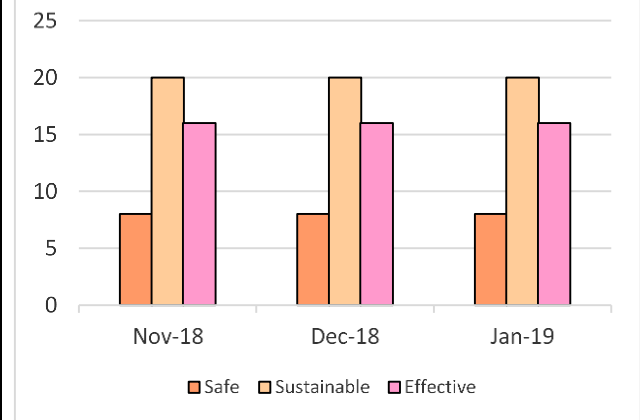
CT/029	Cardiac Surgery / TAVI - Cardiac RTT Reporting			Executive lead: Director of Planning		
JAN 2019	Risk: Safe: (1) As part of the DU work, they observed that TAVI waiting lists are not being reported at ABMUHB.			Assuring Committee: Quality and Patient Safety Committee		
	Sustainable: N/A.			Date first assessed 28/07/2017		
	Effective: (2) the Delivery Unit are currently reviewing the application of pathways start dates at tertiary cardiac centres, initial feedback suggests that this may not being robustly implemented currently 3) ABMUHB have excluded certain diagnostics from their cardiac pathways.			Date last reviewed by Programme/Directorate: Asst. Planning Mgr. 12/02/2019		
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective	Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score		Nov-18 Dec-18 Jan-19 Safe Sustainable Effective
After Mitigation	5	2	10			
Current Score	10	4	20			
Escalation Narrative:						
Current Control Measures in Place				Description of further Control Measures Required		
1) The DU review of the application of PSDs across Wales has been completed. The review confirmed the issues with PDSs and identified that the processes for transferring patient information between units is inadequate and a number of process issues. All Health Boards were asked to take forward actions to address these and provide assurance to WHSSC of the delivery of these actions. 2) TAVI waiting lists are not yet being reported, WHSSC had asked that this was completed by April 2018. 3) ABMUHB to provide an estimate of a time frame to correct the waiting list position and report the impact of this on the waiting times targets.				Action	Lead	By when
				Health Boards requested to provide separate TAVI waiting lists. WHSSC to review monthly on receipt with service providers through current performance meetings.	Planning Manager / Health Boards	On-going

CT/030	Cardiac Surgery - Cardiology to Cardiac Surgery Pathway Risk: Safe: patients are waiting longer surgery, with potential greater risk of mortality. Sustainable: N/A Effective: The current processes for transferring patients between hospitals is inadequate resulted in patients waiting longer than reported.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed Date last reviewed by Programme/Directorate: Asst. Planning Mgr. 12/02/2019			
JAN 2019							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	5	4	10				
Current Score	10	4	20				
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
WHSSC has developed an action plan from the findings of the DU report to address the pathway start dates issues. The action plan has been developed with specific responsibilities for Health Boards, Welsh Government, WHSSC and the Cardiac Network. Of the 13 agreed actions to be completed, 3 which relate to TAVI and these fall within the remit of WHSSC. The remaining 10 fall outside of the scope of WHSSC and are being progressed by individual Health Boards with the Heart Conditions Implementation Group. In regards to waiting list management WHSSC wrote out to Health Boards in December 2017 requesting assurance for the delivery of their specific responsibilities in ensuring that there is adequately trained staff for understanding the specifics of the Integrated Cardiac Pathway rules and their application of PAS; and that Health Boards are able to reassess and adjust where required the reported waiting times for all patients on the cardiac surgery waiting list.				Action		Lead	By when
				Health Boards are required to provide assurance to WHSSC for the delivery of action point 6 and 10 and progress against these actions.		Planning Mgr.	ALL RESPONSES REC'D
				1) Health Boards to provide updates to HCIG who have oversight of the remaining actions. 2) WHSSC raised concerns with Welsh Government around the delivery of the Health Board actions. Welsh Government wrote out to Health Boards in August 2018 requesting further assurance around the delivery of the actions. 3) The Health Boards responses have been submitted confirming delivery of the actions.		Health Boards	Complete
				Welsh Government have asked the DU to undertake a review of the Health Boards action plans against their responses last year to receive assurance that they have delivered against these actions particularly because there are issues around pathway start dates and late referrals.		Health Boards	July 2019

CT/032	ACHD Risk: Safe: inequitable service provision across South Wales. Sustainable: there is a single handed ACHD Consultant based at UHW which results in lack of cover for leave or sickness. Effective: gaps in meeting NHS England CHD Standards for level 2 and level 3 centres.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 23/03/2018 Date last reviewed by Programme/Directorate: Asst. Planning Mgr. 12/02/2019			
JAN 2019							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	4	4	4				
Current Score	16	16	16				
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
Phase 1 of the investment in ACHD fully implemented all staff are in post. Medical and nursing staff undertaking additional clinics to meet demand.				Action		Lead	By when
				C&VUHB are currently developing Phase 2 of the investment business case taking into consideration the gaps in meeting the NHS England Standards.		CVUHB	11/18
				The proposal for investment in Phase 2 has been developed and is being taken forward to the ICP 2019-20 prioritisation process. Funding has been approved in principle with further work required around the priority of funding of schemes agreed within the ICP.		Planning Manager	06/19

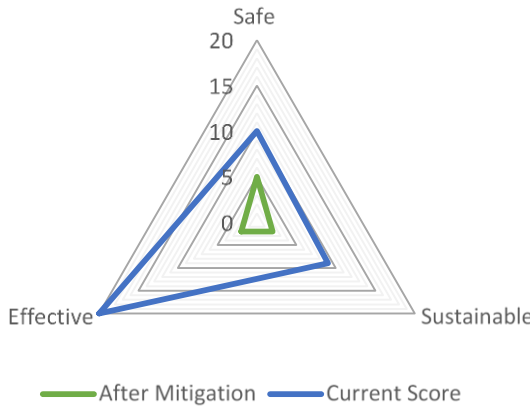
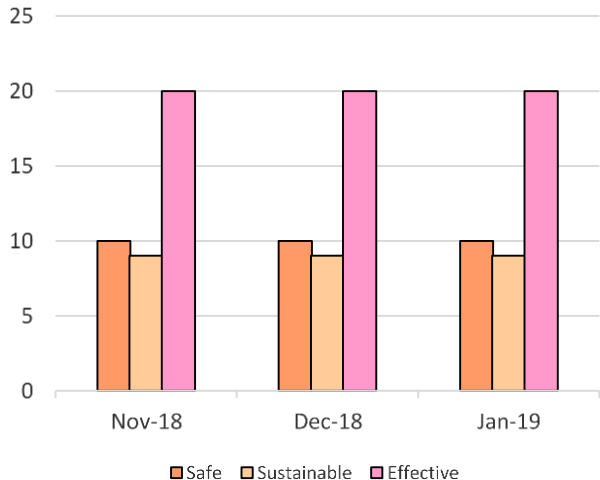
CT/036 (formerly WC/016) JAN 2019	CYSTIC FIBROSIS Risk: Safe: inpatient beds are under increasing pressure, with patients forced to wait extended periods at home placing them at clinical risk or alternatively being admitted to general ward beds with significant infection risks. Sustainable: there is a growing cohort of CF patients and it was identified by the CF Trust review of the service in UHL that inpatient capacity is insufficient to meet this demand. Funding was not approved within the 2017/18 ICP to address the issues raised. Effective: the current service is not in line with standards of care.	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
		Date first assessed 17/03/2017 Date last reviewed by Programme/Directorate: Asst. Planning Mgr. 12/02/2019

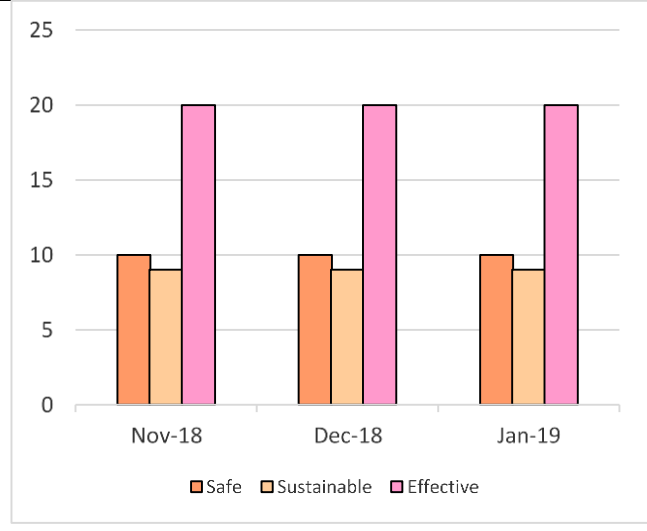
Risk Rating			WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective	
After Mitigation	3	3	3	Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score
Current Score	8	20	16	



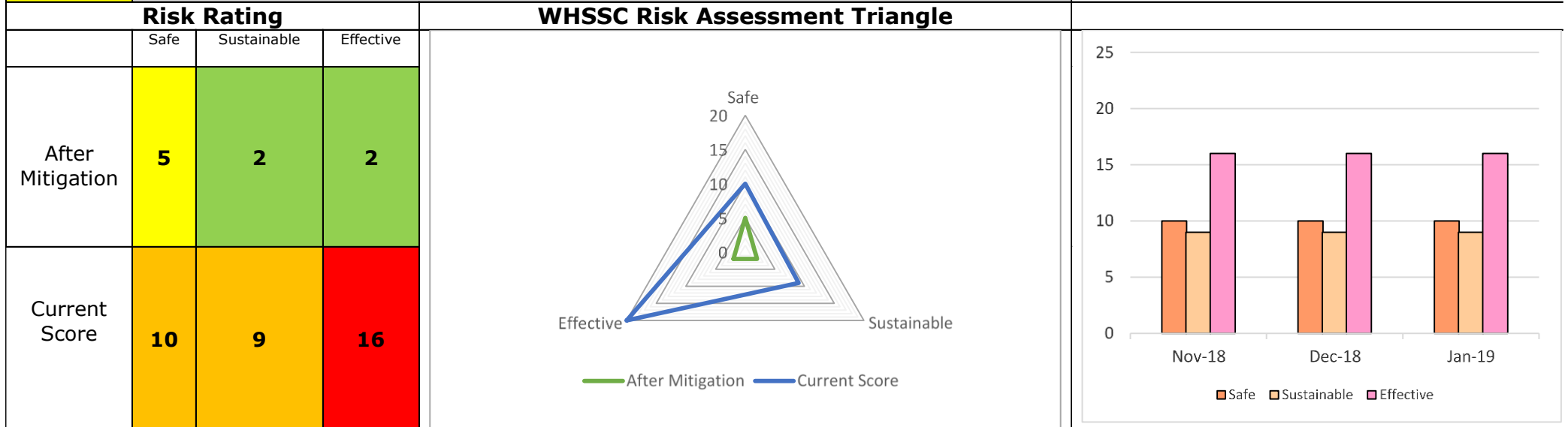
Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
Capital business case under development by C&VUHB for additional inpatient beds. Proposal submitted to prioritisation process for WHSSC 2017/18 ICP for revenue required for additional inpatient beds as well as to develop the service to manage the growing cohort of patients.	Action	Lead	By when
	Capital business case submitted to WG by C&VUHB.	C&VUHB	ONGOING
	Proposal for enhancing service in order to manage growing patient cohort submitted to 2017/18 ICP prioritisation process. However funding was not approved.	Planning Mgr.	Complete
	Presented to Management Group re: risk in Sept 17 and further work was required by C&VUHB to gain support for revenue and capital business case.	Planning Mgr.	Complete
	The business case information for Phase 2 was outstanding from the Health Board for the ICP 19/20 CIAG/MG prioritisation process. There has been several meetings with senior colleagues in C&VUHB to progress this and it has been agreed that this information would be submitted to WHSSC by 28th November for further consideration of in year funding. A paper was submitted to MG in January 2019 with further information has been requested particularly because of the limited amount of ICP funding available.	CVUHB & Planning Mgr.	ONGOING

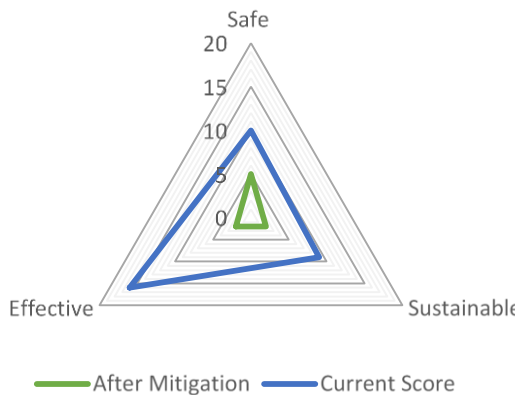
CT/037 (formerly CT/023)	CARDIAC SURGERY C&VUHB Risk: Commissioning sufficient capacity for cardiac surgery to be delivered within waiting time standards and providers delivering this level of activity. Safe: patients are waiting longer for surgery, with potential greater risk of mortality. Sustainable: insufficient capacity for cardiac surgery to be delivered within waiting time standards. Effective: failure to meet Welsh Government RTT targets for cardiac surgery.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
JAN 2019				Date first assessed 09/07/2018 Date last reviewed by Programme/Directorate: C&B Commissioning 12/02/2019			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	5	2	2				
Current Score	10	9	20				
							
Escalation Narrative: The service has been escalated to Stage 3 and a performance quality visit has been scheduled for the 19th February.							
Current Control Measures in Place				Description of further Control Measures Required			
Regular monitoring of data and monthly meetings with C&VUHB.				Action		Lead	By when
				Implementation of performance management arrangements, with providers to ensure delivery of contracted levels of operating.		Planning Manager	On-going
				Implement findings of DU review of PSDs when complete.		Planning Manager	08/17
				Ensure that diagnostics are no excluded as part of Cardiac pathways.		C&VUHB	Complete
				A WHSSC Commissioning Quality Visit is scheduled for the 19th February.		WHSSCV / CVUHB	FEB 2019

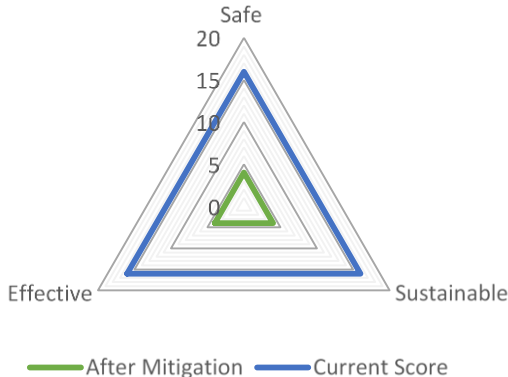
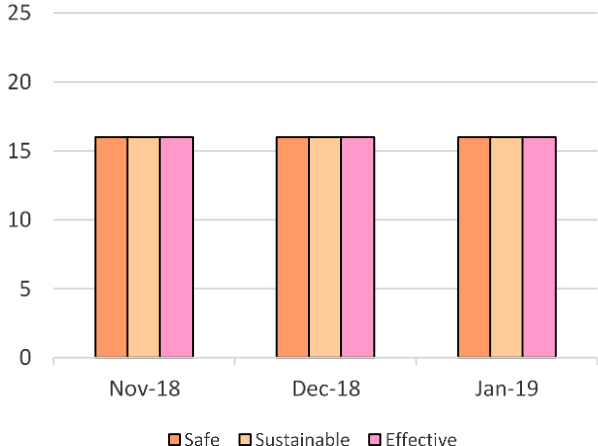


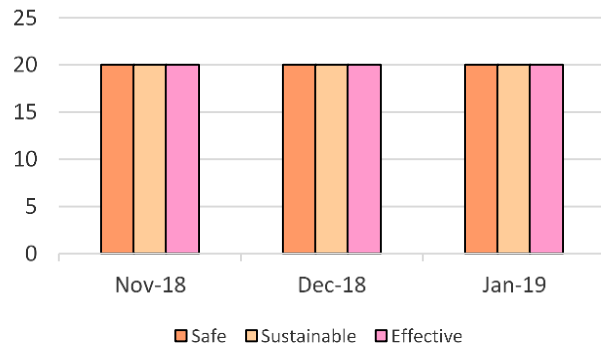
CT/038 (formerly CT/023) JAN 2019	CARDIAC SURGERY ABMUHB Risk: Commissioning sufficient capacity for cardiac surgery to be delivered within waiting time standards and providers delivering this level of activity. Safe: patients are waiting longer surgery, with potential greater risk of mortality. Sustainable: insufficient capacity for cardiac surgery to be delivered within waiting time standards. Effective: failure to meet Welsh Government RTT targets for cardiac surgery.	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
		Date first assessed 09/07/2018 Date last reviewed by Programme/Director: C&B Commissioning 12/02/2019



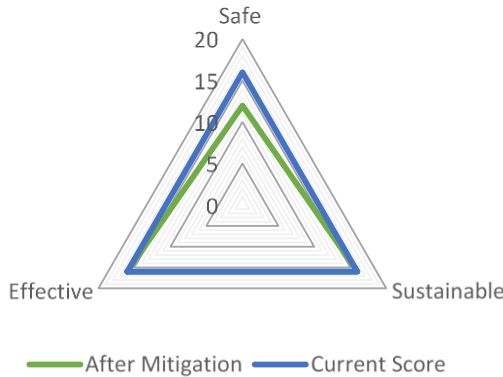
Escalation Narrative: Service in escalation level 2.			
Current Control Measures in Place	Description of further Control Measures Required		
Regular monitoring of data and bi-monthly meetings with ABMUHB.	Action	Lead	By when
	Implementation of performance management arrangements, with providers to ensure delivery of contracted levels of operating.	Planning Manager	On-going
	Implement findings of DU review of PSDs when complete.	Planning Manager	01/08/17
	Ensure that diagnostics are no excluded as part of Cardiac pathways.	ABMUHB	Complete

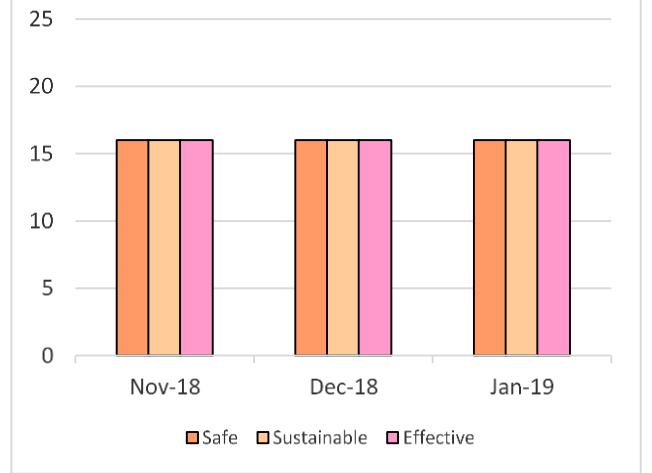
CT/039 (formerly CT/023)	CARDIAC SURGERY LHCH/BCUHB Risk: Commissioning sufficient capacity for cardiac surgery to be delivered within waiting time standards and providers delivering this level of activity. Safe: patients are waiting longer surgery, with potential greater risk of mortality. Sustainable: insufficient capacity for cardiac surgery to be delivered within waiting time standards. Effective: failure to meet Welsh Government RTT targets for cardiac surgery.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
JAN 2019				Date first assessed 09/07/2018 Date last reviewed by Programme/Directorate: C&B Commissioning 12/02/2019			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective	 — After Mitigation — Current Score			
After Mitigation	5	2	2				
Current Score	10	9	16				
Escalation Narrative: Service in escalation level 2.							
Current Control Measures in Place				Description of further Control Measures Required			
Regular monitoring of data and bi-monthly meetings with LHCH and BCUHB.				Action		Lead	By when
				Implementation of performance management arrangements, with providers to ensure delivery of contracted levels of operating.		Planning Manager	On-going
				Implement findings of DU review of PSDs when complete.		Planning Manager	08/17
				Ensure that diagnostics are no excluded as part of Cardiac pathways.		LHCH/BCU HB	Complete

CT/040	PAEDIATRIC CHRONIC HEART DISEASE (CHD) Risk: Delivery and sustainability of Paediatric CHD service South Wales. Safe: inequitable service provision across South Wales. Sustainable: insufficient input from Specialist CHD Cardiologist to outreach clinics. Particularly, in Hwyl Dda University Health Board. Effective: gaps in meeting NHS England CHD Standards for level 2 and level 3 centres.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 13/07/2018 Date last reviewed by Programme/Directorate: C&B Commissioning 12/02/2019			
JAN 2019							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	4	4	4				
Current Score	16	16	16				
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
Paediatric CHD risk highlighted as part of the business case submitted by C&VUHB in 2016. Funding was provided for C&VUHB Paediatric Cardiology to address RTT further business case awaited to address the regional service.				Action		Lead	By when
				C&VUHB Consultants are undertaking additional clinics to support and manage the risk from long waiting times.		C&VUHB	On-going
				C&VUHB to submit a business case for inclusion in this year’s ICP planning cycle.		C&VUHB	08/19

MH/108	CAMHS Risk: Reduction in inpatient capacity and associated increase in out of area placements. Limited current ability to manage funded capacity & case mix following a series of serious incidents and a sentinel event at the unit.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 10/11/2017 Date last reviewed by 31/01/2019 Programme/Directorate: Carl SHORTLAND		
JAN 2019						
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective			
After Mitigation	15	15	15			
Current Score	20	20	20			
Escalation Narrative: WHSSC/Cwm Taf are holding regular action planning meetings and overall action plan has been produced by LHB. Review of estate environment underway and report awaited from Cwm Taf estates department. All admissions to unit continue to be risk assessed on individual needs basis. individual pa						
Current Control Measures in Place			Description of further Control Measures Required			
Unit was temporarily closed to new admissions pending quality review by Quality Assurance & Improvement Team. Individual risk assessments updated and shared with patients LHBs. Service placed into stage 4 escalation by WHSSC with enhanced monitoring and support arrangements. Service de-escalated to level 3 following receipt of QAIT report with all issues incorporated into wider summary action plan.			Action		Lead	By when
			Stage 3 Escalation. Commissioning Quality Visit completed & regular action planning meetings being held.		CTUHB DPCMH/WHSSC DoN	Ongoing
			Audit Visit & Report		QAIT	w/c 26/03/2018
			Stage 4 Escalation		WHSSC DoN	De-escalated following receipt and evaluation of QAIT review and feedback with Cwm Taf at Visit on 5th April
			National capital funding requested to address environment issues in audit report to enable unit to operate in line with specification/contract		ABMU/CT/WG	30/09/2018
			Delays in capital works due to HB issues including boundary changes have been escalated to CTUHB DPCMH. Meeting to review contract/specification agreed for late December.		WHSSC/DoN	31/12/2018
			Further meeting arranged for February but capital issue unlikely to be resolved before transfer of Bridgend services to Cwm Taf UHB in April		WHSSC/DoN	28/02/2019

NC/001	SPINAL REHABILITATION Risk: There are significant risks related to delivering a sustainable service that can achieve British Society of Rehabilitation Medicine (BSRM) standards for specialised rehabilitation. Whilst the service is unable to meet staffing levels to the recommended minimum standards across a number of disciplines, the main concern is the single handed Spinal Rehabilitation Consultant. During periods of leave the Unit has to restrict the type of patient that can be admitted - this impacts on patient flow across the whole Neurosciences pathway.	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
JAN 2019		Date first assessed 01/05/2014 Date last reviewed by Programme/Directorate: Sp. Planning Mgr. 31/01/2019

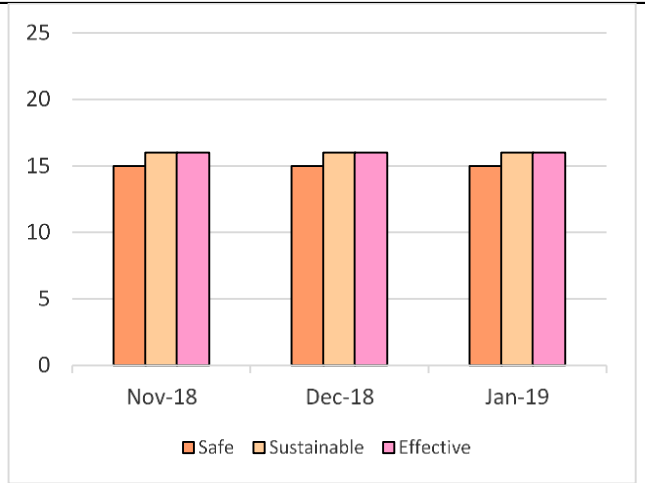
Risk Rating			WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective	
After Mitigation	12	16	16	 Safe 20 15 10 5 0 Effective Sustainable After Mitigation Current Score
Current Score	16	16	16	

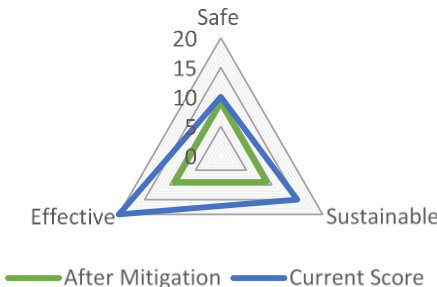


Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
A proposal to address the immediate staffing concerns was submitted for inclusion in the 2017-20 ICP. Similarly to the majority of proposals submitted, funding was not allocated to this proposal and the risk remains.	Action	Lead	By when
	Funding agreed within 2018-21 ICP. Business case going to Management Group in June. Proposal supported and agreed with a few caveats to work through the service on outcome measures when the Consultant is in post. The investment letter to be sent to the C&V Provider in July 2018 - completed.	Planning Manager	31/07/18
	The post is out to advert. Interviews to be held November 2018. Consultant appointed to commence in February / March 2019. The Admin and Med Sec post interviews are to be held mid Dec. 18.	Planning Manager	31/03/2019

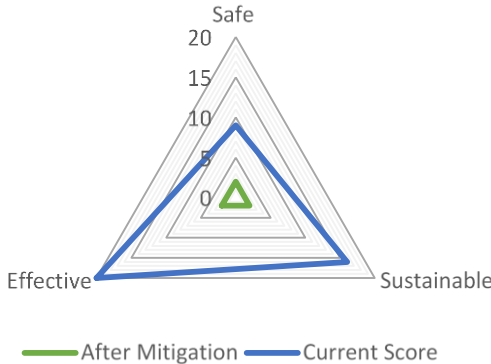
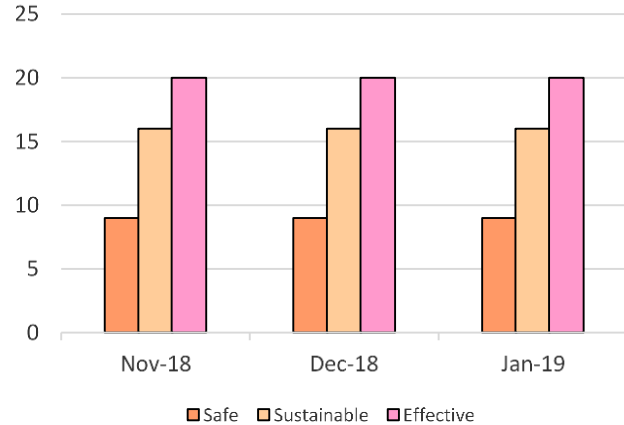
NC/010	NEURO REHABILITATION Risk: Patients not receiving their full potential due to lack of appropriate staff to support their rehabilitation.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
JAN 2019				Date first assessed 25/04/2017 Date last reviewed by Programme/Directorate: Sp. Planning Mgr. 31/01/2019
Risk Rating			WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective	Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score
After Mitigation	4	9	4	
Current Score	15	16	16	
Escalation Narrative:				
Current Control Measures in Place		Description of further Control Measures Required		
A proposal to address the immediate staffing concerns was submitted for inclusion in the 2017-20 Integrated Commissioning Plan. Similarly to the majority of proposals submitted, funding was not allocated to this proposal and the risk remains. The service has been asked to provide regular updates on any delayed repatriations. Also amendments to the Specialised Rehabilitation policy will work towards improving patient flow.		Action	Lead	By when
		Scheme submitted for Integrated Commissioning Plan but not agreed for funding in 2018-21. Resubmit for 2019-22.	Planning Manager	09/18
		Proforma to be completed by Mid Oct 18. Rated 15th in prioritisation process. To be included in the ICP 19-22	Planning Manager	31/12/18
		£150k agreed funding ICP 19-22 to fund outreach service and coordinator.	Planning Manager	30/06/2019

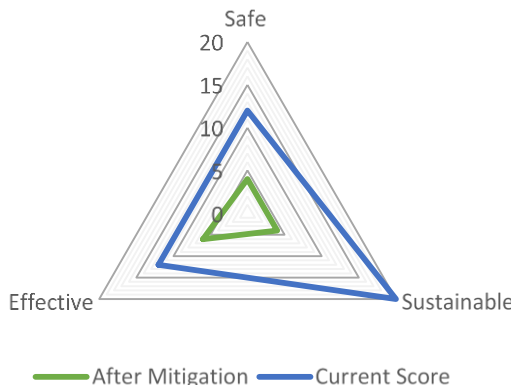
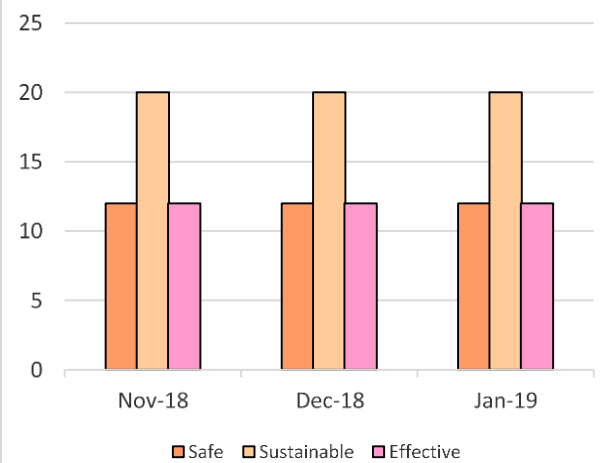


NC/012	NEUROSURGERY RTT			Executive lead: Director of Planning		
JAN 2019	Risk: Patients waiting in excess of the agreed waiting times for Neurosurgery.			Assuring Committee: Quality and Patient Safety Committee		
				Date first assessed 25/04/2017		
				Date last reviewed by Programme/Directorate: Sp. Planning Mgr. 31/01/2019		
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective			
After Mitigation	9	9	9			
Current Score	10	15	20			
Escalation Narrative: In escalation level 2 as continue to have breaches over 52 weeks although these are reducing. Commissioning visit planned following feedback on visit process from Paediatric Surgery.						
Current Control Measures in Place				Description of further Control Measures Required		
Clinical reviews are being undertaken by the Clinical Director for Neurosciences of all patients who are waiting over 52 weeks for surgery. To date, whilst a few patients have required a repeat of radiological scans, no harm has been identified as coming to the patients due to the long waits. An internal review of Neurosurgery has recently taken place which by looking at a number of performance indicators such as LOS, change in volume of waiting list, changes to demand, tried to determine reasons for high number of long waiters. This review supported the Directorate's belief that the number of emergencies was increasing and that at any one time five beds were occupied by patients awaiting repatriation or transfer. With no additional bed or theatre capacity, both the emergencies and delayed transfers have a direct impact on the number of electives that can be treated.				Action	Lead	By when
				Monthly performance meetings. RTT is decreasing. Latest reported position - June 18 = 22 > 36 weeks of which 0>52 weeks.	Planning manager	Ongoing
				Proforma to be completed by Mid Oct 18. Rated 14th in prioritisation process will be included in the ICP 19-22. Needs to be a further review of the schemes costs.	Planning Manager	31/12/2018
				November Waiting list position - 6 pts >36weeks and 0>52 weeks. The position has remained unchanged from the previous month. Issue with Intraoperative monitoring. Improvements from mid-January 19.	Planning Manager	31/01/2019

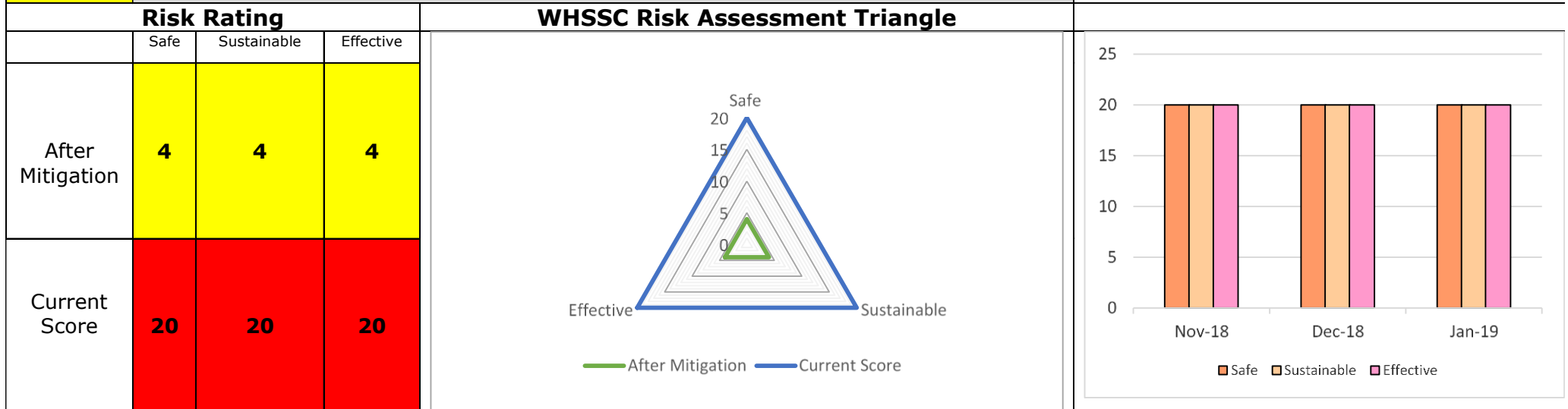
NC/014	INTERVENTIONAL RADIOLOGY			Executive lead: Director of Planning		
JAN 2019	Risk: Interventional Radiology - Ability of Cardiff & Vale University Health Board to deliver the Interventional Radiology service at University Hospital Wales. A member of the clinical team has resigned. This will increase the pressure on the interventional radiology service, and will also have an impact on other services, and WHSSC will be undertaking work to quantify this impact.			Assuring Committee: Quality and Patient Safety Committee		
				Date first assessed 01/03/2017		
				Date last reviewed by		
				Programme/Directorate: Sp. Planning Mgr. 31/01/2019		
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective	Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score		
After Mitigation	2	2	2			
Current Score	20	20	20			
				Nov-18 Dec-18 Jan-19 Safe Sustainable Effective		
Escalation Narrative:						
Current Control Measures in Place				Description of further Control Measures Required		
1) WHSSC Executives have met to discuss next steps. 2) Scoping document to be developed to include the development of a service specification and an overall strategy. 3) Meeting with service leads to be held to understand full impact on services.				Action	Lead	By when
				Informal arrangements in place with North Bristol to provide support	Planning manager	Ongoing
				Further sessions have been identified for Dec and Jan 18. Aiming to have no one waiting over 6 weeks for DSAs. Advert out for a 3rd Consultant Radiologist.	Planning Manager	Ongoing
				Interviews arranged for W/C 28/01/19 - 1 applicant.	Planning Manager	31/03/2019

NC/022	PAEDIATRIC NEUROSURGERY Risk: NHS England are due to publish the outcomes of their commissioning through evaluation for Selective Dorsal Rhizotomy (SDR) in Spring 2018. There is the potential for a change in policy in light of the reported outcomes that could mean SDR becomes a commissioned service. Currently we do not commission SDR due to lack of evidence as to its effectiveness. The procedure and intense physiotherapy which is required following the surgery costs approximately £25k per patient.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 03/03/2015 Date last reviewed by Programme/Directorate: Sp. Planning Mgr. 31/01/2019																		
JAN 2019																						
Risk Rating				WHSSC Risk Assessment Triangle																		
	Safe	Sustainable	Effective																			
After Mitigation	1	1	1	Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score																		
Current Score	16	12	12																			
<table><caption>Bar Chart Data</caption><thead><tr><th>Category</th><th>Nov-18</th><th>Dec-18</th><th>Jan-19</th></tr></thead><tbody><tr><td>Safe</td><td>16</td><td>16</td><td>16</td></tr><tr><td>Sustainable</td><td>12</td><td>12</td><td>12</td></tr><tr><td>Effective</td><td>12</td><td>12</td><td>12</td></tr></tbody></table>							Category	Nov-18	Dec-18	Jan-19	Safe	16	16	16	Sustainable	12	12	12	Effective	12	12	12
Category	Nov-18	Dec-18	Jan-19																			
Safe	16	16	16																			
Sustainable	12	12	12																			
Effective	12	12	12																			
Escalation Narrative: Increasing the risk due to NHS England funding the service July 2018.																						
Current Control Measures in Place				Description of further Control Measures Required																		
Continued monitoring of NHS England publication and announcements. Until the Commissioning through Evaluation report is published our current policy not to commission SDR remains.				Action	Lead	By when																
				Do not commission until results of NHS England Commissioning through Evaluation publish their results in Autumn 2018. 13/7/18 NHS England have agreed funding for this service. To include on ICP 19-22.	Planning Manager	31/10/18																
				This service was not successful at the prioritisation process. It was agreed that it would be reviewed next year once the full report on the service has been released.	Planning Manager	31/03/2019																

NC/023	NEURO-ONCOLOGY Risk: Delays in Neuro-oncology treatment due to the cancellation of MDT meetings if not all members are available or suitable cover in place. Inequitable care for patients in the North and the South and only 22% of patients are seen by a Clinical Nurse Specialist.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 05/04/2017 Date last reviewed by Programme/Directorate: Sp. Planning Mgr. 31/01/2019
JAN 2019				
Risk Rating				WHSSC Risk Assessment Triangle
	Safe	Sustainable	Effective	
After Mitigation	2	2	2	
Current Score	9	16	20	
				
Escalation Narrative:				
Current Control Measures in Place		Description of further Control Measures Required		
Currently members of the service are carrying out preparation for the MDT outside of their job plan through goodwill. Regular monitoring of cancer waiting times are reported and the Tertiary Centre in Cardiff is undertaking patient surveys so that more qualitative information is available. A proposal to address the staffing shortfalls was submitted for inclusion in the 2017-20 ICP. Similarly to the majority of proposals submitted, funding was not allocated to this proposal and the risk remains.		Action	Lead	By when
		Scheme submitted for ICP but not agreed for funding in 2018-21. Discussed at management group workshop 6/9/18.To be considered as part of the ICP 19-22 planning process.	Planning Manager	31/10/18
		Proforma to be completed by Mid Oct 18. Rated 11th in the Prioritisation process. To be included in the ICP 19-22.	Planning Manager	31/10/2018
		Funding of £150k has been set aside for the development of this scheme. A planned approach to delivering the scheme will be developed.		31/03/2019

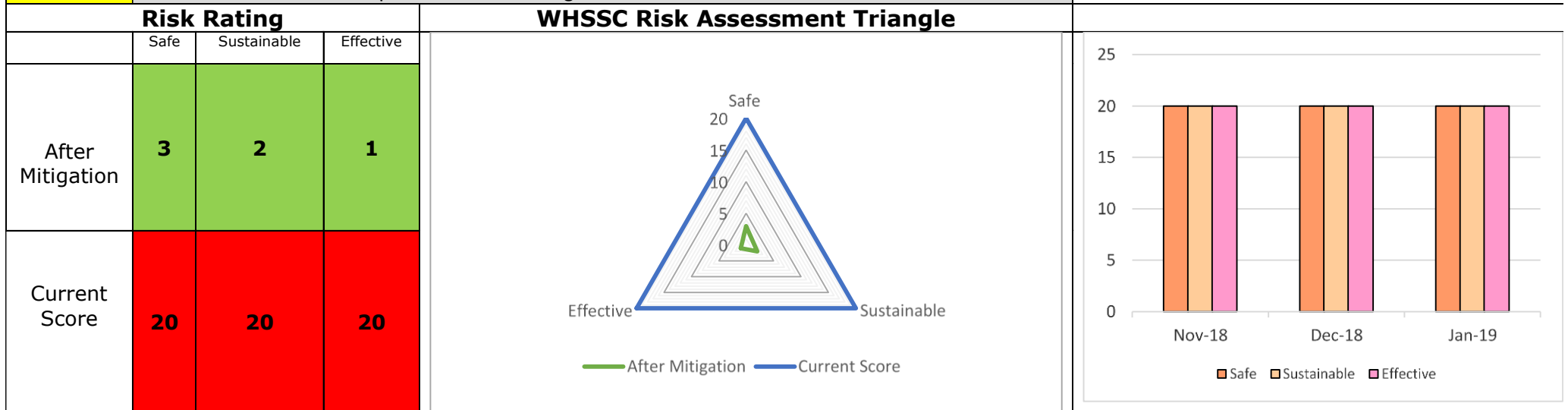
NC/026	Posture & Mobility - Prosthetics Risk: Current arrangements are not conducive to ensuring a consistent and equitable service for the War Veterans and Civilians who require access to the BCU Prosthetics Service. Staffing levels and non-pay funding have not been increased to meet the expected KPIs for War Veterans which is having a detrimental effect on the general population who access the service.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 03/07/2017 Date last reviewed by Programme/Directorate: Sp. Service Planner 31/01/2019			
JAN 2019							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	4	4	6				
Current Score	12	20	12				
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
Service are working increased overtime hours to meet the current levels of demand and as a consequence are significantly overspending against the budget. WHSSC are meeting regular with the prosthetic service to be kept up to date of any new and emerging issues as well as current performance. A proposal to address the staffing and non-pay shortfalls was submitted for inclusion in the 2017-20 Integrated Commissioning Plan. Similarly to the majority of proposals submitted, funding was not allocated to this proposal and the risk remains.				Action		Lead	By when
				Scheme submitted for ICP but not agreed for funding in 2018-21. Discussed at management group workshop 6/9/18.To be considered as part of the ICP 19-22 planning process. Policies need to be updated. Rated 6th in the prioritisation		Planning Manager	31/03/19

NC/028	ALAS ALTERNATIVE AUGMENTATIVE COMMUNICATION Risk: If no further funding is made available for equipment then patients will be assessed but will not be able to receive the equipment recommended to them. As patients' needs change over time this also reduces the effective use of staff time.	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
JAN 2019		Date first assessed 01/09/2017 Date last reviewed by 31/01/2019 Programme/Directorate: AAC



Escalation Narrative:			
Current Control Measures in Place		Description of further Control Measures Required	
Issue has been flagged with Welsh Government and a proposal was submitted for inclusion in the 2017-20 Integrated Commissioning Plan. This was not supported by Management Group who felt that this was not an issue for WHSSC. Further reflecting the high scores within the Integrated Commissioning Plan Risk Management Framework was presented to the Joint Committee in September 2017 who agreed that it was an issue that needed to be flagged to Welsh Government to resolve.	Action		By when
	Additional funding received from Welsh Government in 2018/19 which address non pay issues in the short term. Stakeholder workshops led by Welsh Government 21/06/2018 and July 18. Meeting with Welsh Government between WHSSC and the service leads. Meeting with WG and WHSSC planned for 6/8/18.		01/08/18
	Further discussions with WG Aug/Sept. 2018. Oversight Board met on 19/9/18. ICP 19-22 proforma needs to be updated. ICP 19-22 proforma submitted mid Oct 18.		30/11/2018
	Rated 3rd in the prioritisation process. To be included in the ICP 109-22		31/03/2019

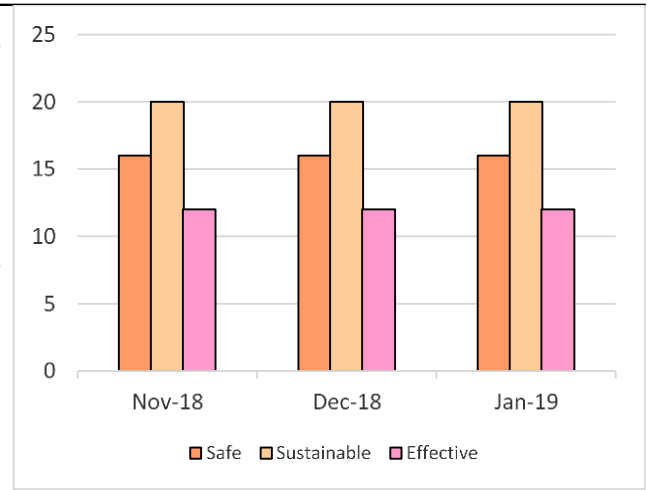
NC/029	Neurosurgery Spinal Monitoring Risk: The Development of the Complex Spinal Surgery pathway policy and service specification highlighted the shortfall in spinal cord monitoring. There is currently only 1 member of staff who is trained to undertake this role. However, the member of staff is employed by the Theatre Directorate and this function is not an integral part of his daily work. In other centres in England, Monitoring technicians are employed as part of the Neurophysiology team. This practice in Wales is out of line with national clinical guidance and in England spinal surgery (excluding lumbar surgery) would be cancelled if there wasn't spinal cord monitoring.	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
JAN 2019		Date first assessed 07/11/2017 Date last reviewed by Programme/Directorate: AAC 31/01/2019



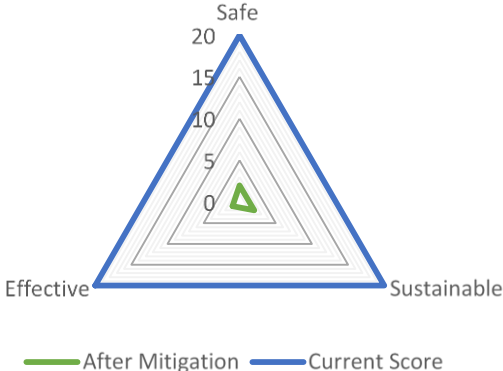
Escalation Narrative:			
Current Control Measures in Place	Description of further Control Measures Required		
Spinal cord monitoring is not routinely undertaken on spinal cord procedures.	Action	Lead	By when
	Scheme will need to be submitted for the 2019-22 Integrated Commissioning Plan.	Planning Manager	31/10/2018

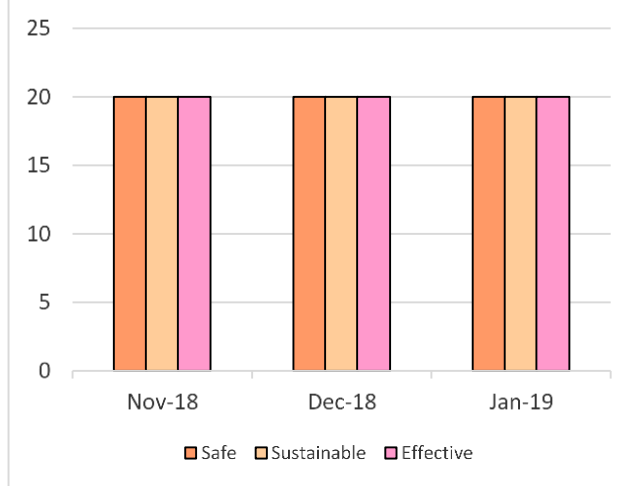
NC/031	Ketogenic Diet Risk: The service was originally provided by North Bristol NHS Trust (NBT) but ceased when Paediatric Services in Bristol were consolidated into University Hospitals Bristol NHS Trust. Individual cases are currently funded through the IPFR system Current practices rely on the availability and capacity of specialists in Bristol and figures suggest that capacity is already limited by staffing. UHB have advised that they do not have the capacity to accept Welsh Paediatric Neurology patients for all but very specialist cases. At present, only telephone consultations with the dietician are available.	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
JAN 2019		Date first assessed 15/01/2018 Date last reviewed by Programme/Directorate: Neuro 31/01/2019

Risk Rating			WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective	
After Mitigation	2	2	1	The diagram is a triangle with vertices labeled 'Safe' (top), 'Effective' (bottom left), and 'Sustainable' (bottom right). Concentric triangles represent score levels from 0 to 20. A green triangle represents the 'After Mitigation' state, and a blue triangle represents the 'Current Score' state. Legend: — After Mitigation — Current Score
Current Score	16	20	12	

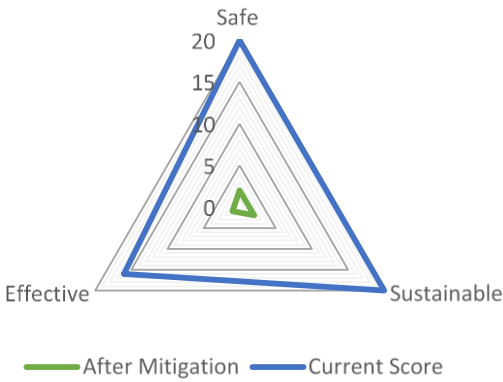


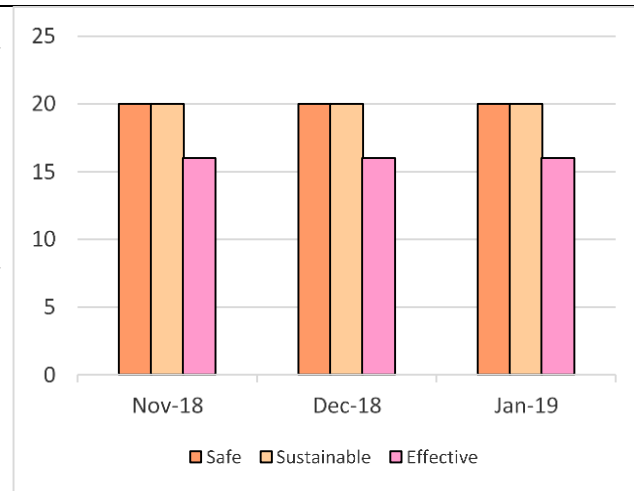
Escalation Narrative:			
Current Control Measures in Place		Description of further Control Measures Required	
A paper has been submitted to Management Group and will be included in the ICP 19-22.	Action		
	Scheme to be submitted for ICP 19-22.		Lead: Planning Manager By when: 31/10/2018
	Proforma to be completed by Mid Oct 18. Rated 17th in the Prioritisation process. To be included in the ICP 19-22.		Lead: Planning Manager By when: 31/03/2019

NC/032	Thrombectomy 1 Risk: Neuroradiology - Service Development - Lack of Neuro-interventional Consultants and the ongoing recruitment difficulties at the Cardiff centre to provide a robust 24/7 service.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee		
JAN 2019				Date first assessed 01/04/2018		
				Date last reviewed by Programme/Directorate: Neuro 31/01/2019		
Risk Rating			WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective	 Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score		
After Mitigation	2	2	1			
Current Score	20	20	20			
Escalation Narrative:						
Current Control Measures in Place				Description of further Control Measures Required		
Possible arrangements with the Bristol centre to provide out of hours cover. It is highly likely that a premium cost will be charged for this service.				Action	Lead	By when
				Project Initiation Document and Service Specification completed and will be submitted to the weekly Corporate Directors meeting for discussion (Oct 18)	Planning Manager	On-going
				Proforma to be completed by Mid Oct 18. Was not prioritised in the Prioritisation process as WG/ JC had already agreed to support this service with a separate funding stream.	Planning Manager	31/03/2019



NC/033	Thrombectomy 2 Risk: Neuroradiology - Service Development - Bed Capacity at the Cardiff centre particularly with the development of the Major Trauma Centre	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
JAN 2019		Date first assessed 01/04/2018 Date last reviewed by Programme/Directorate: Neuro 31/01/2019

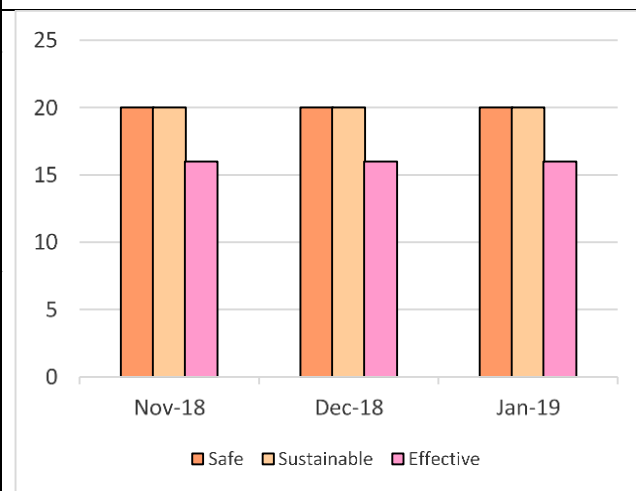
Risk Rating			WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective	
After Mitigation	2	2	1	
Current Score	20	20	16	



Escalation Narrative:			
Current Control Measures in Place	Description of further Control Measures Required		
Business Case has been submitted by the service for the ICP 19-22. This investment supports the sustainability of the service to deliver the WG RTT targets.	Action	Lead	By when
	Project Initiation Document and Service Specification completed and will be submitted to the weekly Corporate Directors meeting for discussion (Oct 18)	Planning Manager	On-going
	Proforma to be completed by Mid Oct 18. Was not prioritised in the Prioritisation process as WG/ JC had already agreed to support this service with a separate funding stream.	Planning Manager	31/03/2019

NC/034	Thrombectomy 3 Risk: Neuroradiology - Service Development - Rapid access to appropriate imaging (Non contrast CT scan and CT Angiogram as a minimum)	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
JAN 2019		Date first assessed 01/04/2018 Date last reviewed by Programme/Directorate: Neuro 31/01/2019

Risk Rating			WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective	
After Mitigation	2	2	1	Safe Effective Sustainable — After Mitigation — Current Score
Current Score	20	20	16	

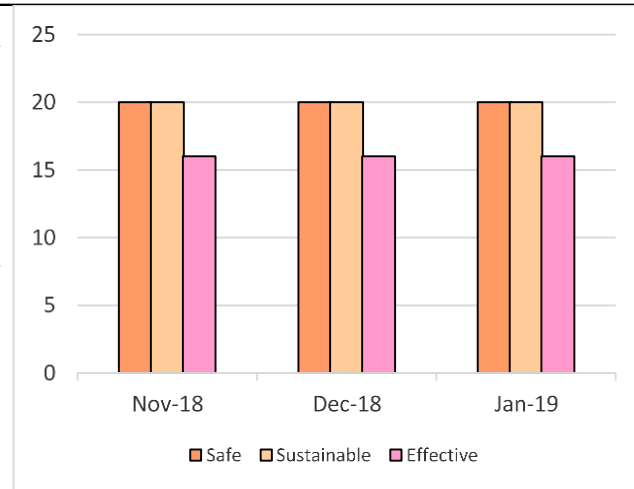


Escalation Narrative:

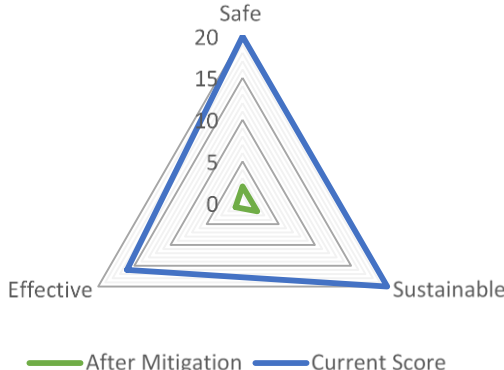
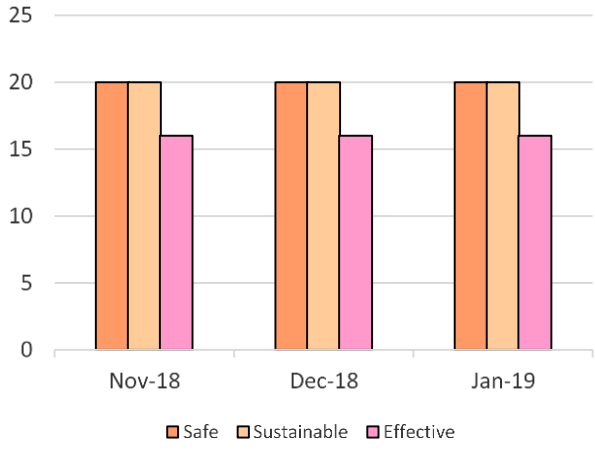
Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
Discuss and agree an operational process with the Radiology teams in all centres with a view to possible investment and include this in the ICP 19-22.	Project Initiation Document and Service Specification completed and will be submitted to the weekly Corporate Directors meeting for discussion (Oct 18)	Planning Manager	On-going
	Proforma to be completed by Mid Oct 18. Was not prioritised in the Prioritisation process as WG/ JC had already agreed to support this service with a separate funding stream.	Planning Manager	30/03/2019

NC/035	Thrombectomy 4 Risk: Neuroradiology - Service Development - Safe and rapid transport to the specialist centre for patients who have been identified for this clinical treatment.	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
JAN 2019		Date first assessed 01/04/2018 Date last reviewed by Programme/Directorate: Neuro 31/01/2019

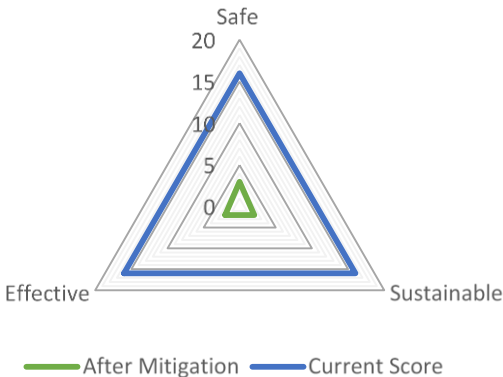
Risk Rating			WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective	
After Mitigation	2	2	1	Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score
Current Score	20	20	16	

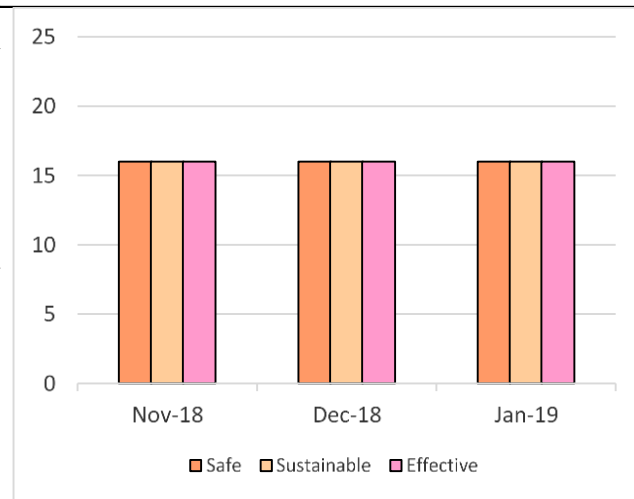


Escalation Narrative:			
Current Control Measures in Place		Description of further Control Measures Required	
Discuss and agree an operational process with WAST to meet the demand.	Action		By when
	Project Initiation Document and Service Specification completed and will be submitted to the weekly Corporate Directors meeting for discussion (Oct 18)		Planning Manager
	Proforma to be completed by Mid Oct 18. Was not prioritised in the Prioritisation process as WG/ JC had already agreed to support this service with a separate funding stream.		31/03/2019

NC/036	Thrombectomy 5 Risk: Neuroradiology - Service Development - Post operative care			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
JAN 2019				Date first assessed 01/04/2018 Date last reviewed by Programme/Directorate: Neuro 31/01/2019			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	2	2	1				
Current Score	20	20	16				
							
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
Business Case has been submitted by the service for the ICP 19-22. This investment supports the sustainability of the service to deliver the WG RTT targets.				Action		Lead	By when
				Project Initiation Document and Service Specification completed and will be submitted to the weekly Corporate Directors meeting for discussion (Oct 18)		Planning Manager	On-going
				Proforma to be completed by Mid Oct 18. Was not prioritised in the Prioritisation process as WG/ JC had already agreed to support this service with a separate funding stream.		Planning Manager	31/03/2019

NC/039	Neurosurgery Risk: Development of SDR surgery. Inequity for Welsh patients as they do not have access to surgery as English children.	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
JAN 2019		Date first assessed 05/10/2018 Date last reviewed by Programme/Directorate: Neuro 31/01/2019

Risk Rating			WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective	
After Mitigation	3	2	2	 Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score
Current Score	16	16	16	

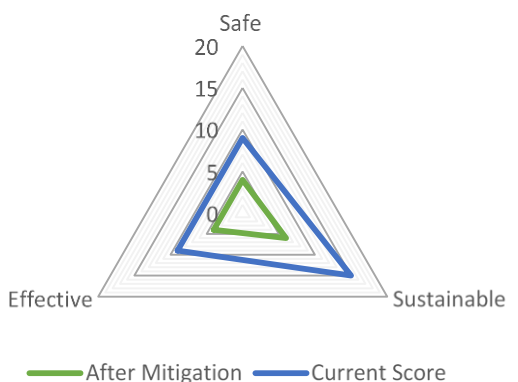


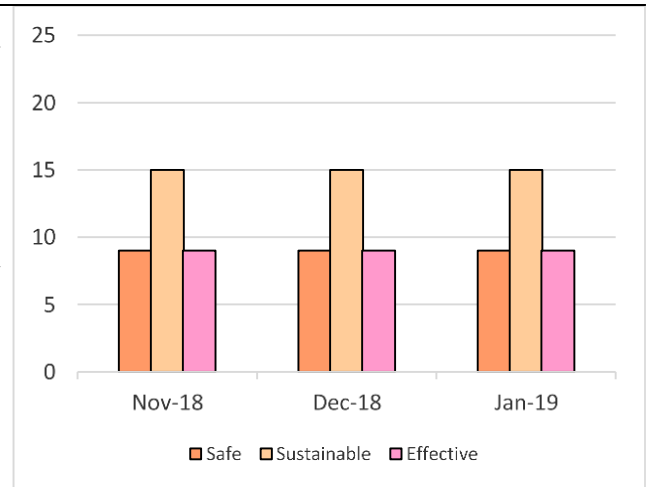
Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
Funding release proforma to be taken to Management Group this month recommending it to be included in the ICP 19 -22	Scheme will need to be submitted for the 2019-22 ICP.	Planning Manager	On-going
	Submitted for prioritisation Oct 2018.	Planning Manager	31/10/2018

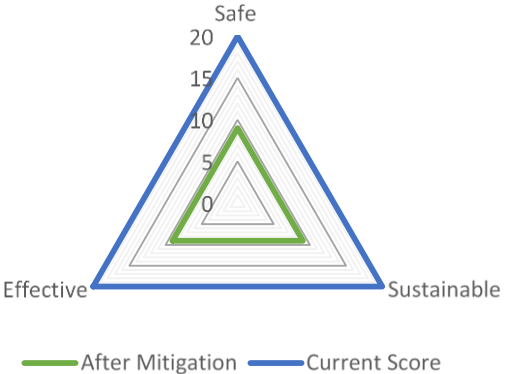
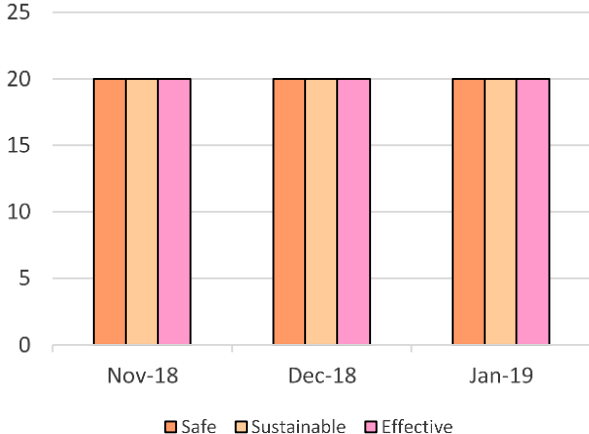
NC/040	Neurosurgery - Paediatrics Risk: Effective - Waiting times for Paediatrics to receive a MRI is outside of the standard. An inequitable service between North and South Wales. The Provider risk for this service is high, as currently there is staff funding for three days of 7.5 hours of scanning. There is significant pressure on scanning time during the week and other work would need to be displaced to accommodate the sedated patients. Further risks to the service for consideration is the shortfall of trained radiographers until at least 2019 and displacing work from current lists from the Children’s hospital scanner to a Sunday may not be possible at the moment due to the nature of the work and isolation of the MRI vans to provide emergency cover.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee		
JAN 2019				Date first assessed 12/10/2018 Date last reviewed by Programme/Directorate: Neuro 31/01/2019		
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective	Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score		
After Mitigation	2	2	2			
Current Score	16	16	16			
				Nov-18 Dec-18 Jan-19 Safe Sustainable Effective		
Escalation Narrative:						
Current Control Measures in Place				Description of further Control Measures Required		
A meeting was held with the Consultant to discuss the Paediatric MRI service and the long waiting times. The service would like to offer a sedation service for patients requiring a MRI. This cannot be provided currently due to insufficient anaesthetic and radiology sessions. The service are only able to deliver 2 GA sessions per week. In addition to the GA sessions currently provided, a sedation service offering 3 sessions per week which would be able to treat 14 patients would be of benefit and offer more flexibility to deliver an MRI service.				Action	Lead	By when
				A scheme will be submitted for the ICP 2019-22 planning process	Planning Manager	On-going
				Proforma to be completed by Mid Oct 18. Rated 13th in the prioritisation process. To be included in the ICP 19-22.	Planning Manager	31/03/2019

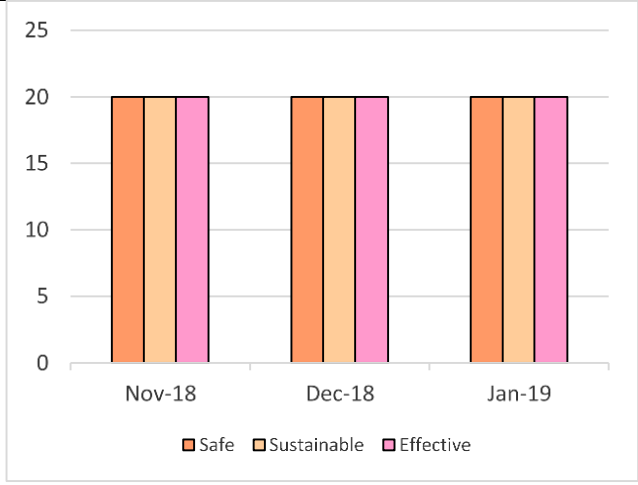
NC/041	Posture and Mobility Service - Discontinued Wheelchairs - North Wales Service Risk: Safe: Due to the long waits and the requirement to build the wheelchair to meet the specific needs of the patient; this could impact on the patients' safety, as the interim wheelchair may not be able to meet all these needs. Sustainable: When wheelchairs break down, patients will have to be managed on an unplanned basis and will experience long waits for replacement wheelchairs as they will require complete new chairs rather than repairs due to lack of parts available for existing wheelchairs. Such waits could be detrimental to a patient's health as chairs are specifically built around their physical needs such as cushioned to improve their posture for respiratory difficulties and prevent pressure sores. Effective: Lack of wheelchair would also render patients housebound, reducing their independence. This will have a huge effect on a patient's mental health and could increase the number of primary care contacts that they have.	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
JAN 2019		Date first assessed 24/04/2017 Date last reviewed by Programme/Directorate: Neuro 31/01/2019

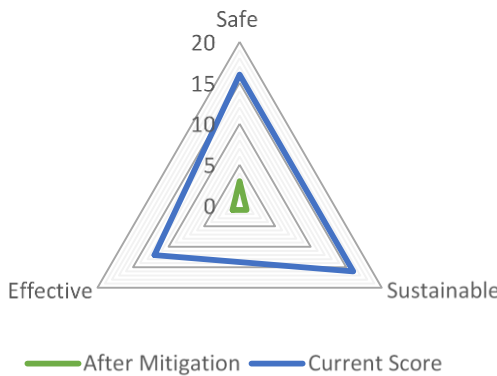
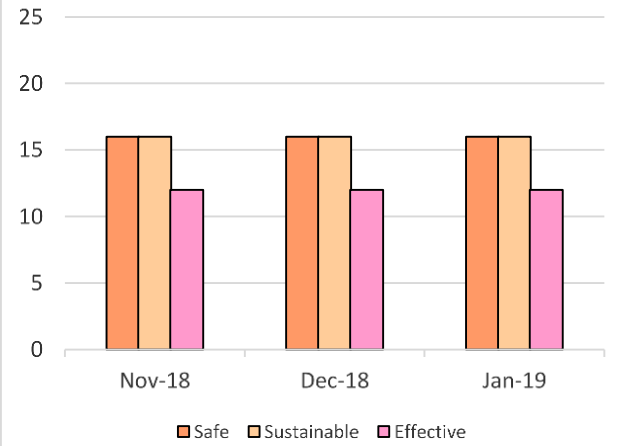
Risk Rating				WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective	 Safe Effective Sustainable — After Mitigation — Current Score	
After Mitigation	4	6	4		
Current Score	9	15	9		

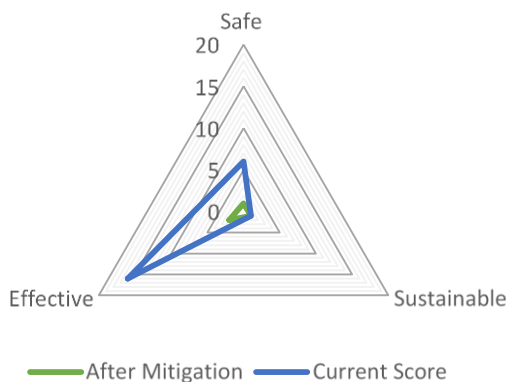
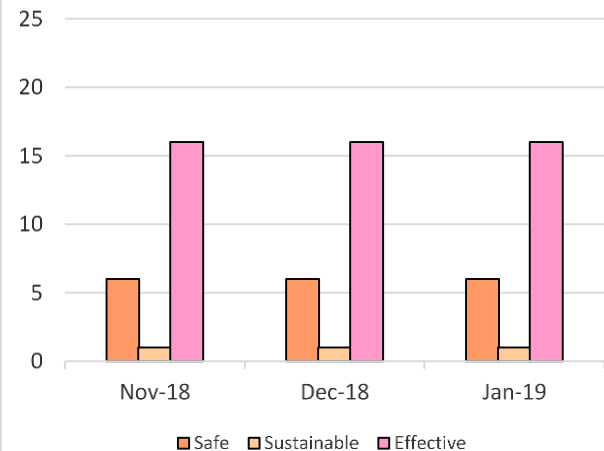


Escalation Narrative:			
Current Control Measures in Place		Description of further Control Measures Required	
Proposal to replace the discontinued chairs as part of a three year replacement programme will be submitted as part of the ICP 2019/22 Planning Process. There are currently 343 wheelchairs out of the stock of 1400 that are affected.		Action	Lead
		A scheme will be submitted for the ICP 2019-22 planning process	Planning Manager
		Proforma to be completed by Mid Oct 18. Rated 4th in the prioritisation process. To be included in the ICP 19-22 Plan.	31/03/2019

NC/042	Major Trauma Risk: Revenue requirement to support the implementation of major trauma network for the South Wales population. Safe: To provide a more robust approach to the management of severely injured patients with life threatening conditions in the south Wales region. Sustainable: To support the delivery of a sustainable service. Effective: To address inequity of the service in South and West Wales and South Powys in line with the NHS England Quality Indicators for Major Trauma.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
JAN 2019				Date first assessed 18/10/2018 Date last reviewed by Programme/Directorate: Neuro 31/01/2018			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	9	9	9				
Current Score	20	20	20				
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
Revenue requirement to support the implementation of major trauma network for the South Wales population. Safe: To provide a more robust approach to the management of severely injured patients with life threatening conditions in the South Wales region. Sustainable: To support the delivery of a sustainable service. Effective: To address inequity of the service in South and West Wales and South Powys in line with the NHS England Quality Indicators for Major Trauma.				Action		Lead	By when
				Scheme will need to be submitted for the 2019-22 ICP.		Acting Director of Planning	On-going
				Proforma to be completed by Mid Oct 18. Was not prioritised in the Prioritisation process as WG/ JC had already agreed to support this service with a separate funding stream.		Planning Manager	On-going

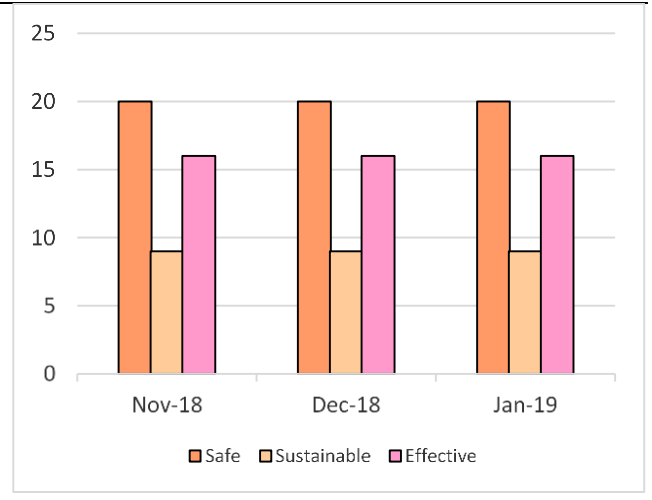


WC/008	FETAL MEDICINE Risk: Currently Fetal medicine services for patients in South Wales, with the exception of ABU patients, are treated at the University Hospital of Wales. There are currently a number of risks to the sustainability and safety of the service in particular there are a significant waits, against national standards, for patients to be seen which is directly impacting on patients that need referring on to Fetal Cardiology, this is in the main due to capacity constraints. As the service is currently delivered by two consultants (0.8 wte) annual leave and working patterns are impacting on the delivery of the service as it is not available for 52 weeks of the year. The reporting of Fetal abnormality scanning is currently carried out by a Consultant Radiologist working in the service, however this person is shortly due to retire. This element of the role is no longer part of the Consultant Radiology training curriculum and therefore once this individual has retired it is unlikely that the Radiology directorate will be able to recruit a replacement with the same skill set.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 07/07/2016 Date last reviewed by Programme/Directorate: KM 31/01/2019			
JAN 2019							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	3	1	1	 Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score			
Current Score	16	16	12				
				 Nov-18 Dec-18 Jan-19 Safe Sustainable Effective			
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
The service in C&V provide additional ad-hoc sessions in order to meet access standards and plan leave to ensure cover except for unplanned reasons e.g. Sickness absence. Informal Links with English providers to source cover where needed.				Action		Lead	By when
				Monitor the implementation of the funded scheme that was approved in 2018/19		Planner	03/19
				Resource map funding from HB's to WHSSC		Assistant Director of Finance	03/19

WC/009	IVF Risk: Waiting Times to commence IVF - Patients requiring fertility treatment in North Wales access services from Liverpool and Shrewsbury. Patients in Shrewsbury despite being seen for their first appointment within 26 weeks they are waiting significant periods of time before commencing actual treatment which is inequitable with patients accessing services from Liverpool, this has a direct impact on patients that require expediting due to contributing factors such as age.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 07/07/2016 Date last reviewed by Programme/Directorate: KM 31/01/2019			
JAN 2019							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	1	1	2				
Current Score	6	1	16				
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
The Shrewsbury service has been place in escalation stage 2 and monthly performance meetings have been instigated. A standard performance report will be developed in order to measure against key deliverables.				Action		Lead	By when
				Continue to monitor waiting times and outcomes through quarterly meetings with each provider.		Planner / Finance manager	On-going
				Requested demand and capacity data from all three providers.		Planner / Finance manager	On-going
				Continuously review the contract currency and arrangements at all IVF providers.		Asst. Finance Manager / Finance manager	On-going
				Escalation Stage II TO COMMENCE January 2019		Planner	February 2019

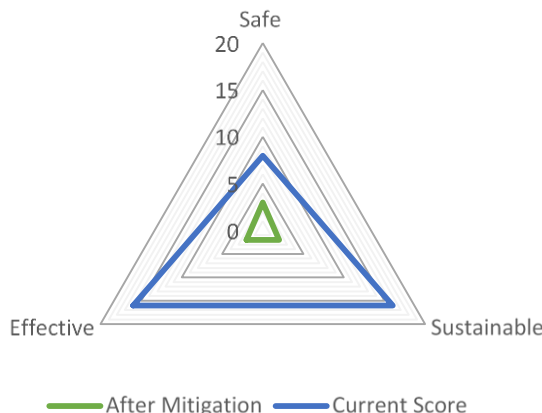
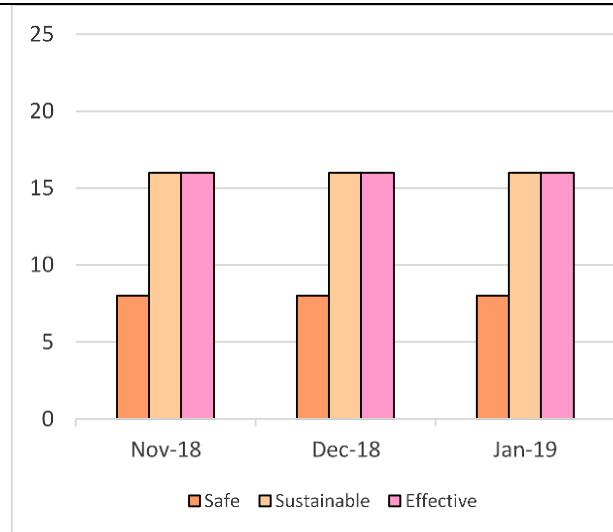
WC/014	Paediatric Intensive Care Units PICU Risk: Lack of PICU Capacity at UHW - Patients requiring Paediatric Intensive Care in South and West Wales are treated at the Children's Hospital for Wales. There have been a number of occasions over the last few months when the service has been unable to admit patients due to capacity or nurse staffing issues. This leads to a delay in admission, and can result in delayed admissions, or even the need for a patient to be transferred to an alternative unit outside of Wales.	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
JAN 2019		Date first assessed 12/01/2017 Date last reviewed by Programme/Directorate: KM 31/01/2019

Risk Rating			WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective	
After Mitigation	5	4	4	 Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score
Current Score	20	9	16	



Escalation Narrative: The service is at stage II of the escalation process and regular monthly meetings are taking place.

Current Control Measures in Place	Description of further Control Measures Required		
- The retrieval teams are now responsible for identifying an available PICU bed when called to support a transfer, reducing the impact on PICU staff trying to manage this whilst delivering clinical care. - Proposal developed for 2017/18 Integrated Commissioning Plan for additional commissioned PICU bed. - Funding approved for additional PICU bed within the ICP.	Action	Lead	By when
	Monitor implementation of the scheme approved in Dec 2019	Planner	02/2019
	Monthly meetings with provider to monitor demand and activity.	Planner	Ongoing

WC/015	CLEFT LIP & PALATE (CLP) Risk: Lack of resource for full MDT of CLP service: The Cleft Lip and Palate service for patients in South and West Wales is delivered at Morriston Hospital. Currently there are significant capacity shortfalls in the full MDT and sustainability issues due to likely retirements, this is causing significant delays for patients. Patients are experiencing delays in visits from a CNS and delays in access to dental and audiology services.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 17/03/2017 Date last reviewed by Programme/Directorate: KM 31/01/2019		
JAN 2019						
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective			
After Mitigation	3	2	2			
Current Score	8	16	16			
Escalation Narrative:						
Current Control Measures in Place			Description of further Control Measures Required			
- CLP service monitored via audit meetings as part of South Wales/South West Network. - The service reports data to the CRANE database.			Action		Lead	By when
			Proposals for enhancing the full Multi-Disciplinary Team and to increase operating capacity taken through 2017/18 Integrated Commissioning Plan prioritisation process but not approved. Seek funding in future ICPs.		Planner	On-going
			Service to continue to maximise delivery within existing resource		Planner	On-going
			Regular dialogue with the service to monitor performance		Planner	On-going

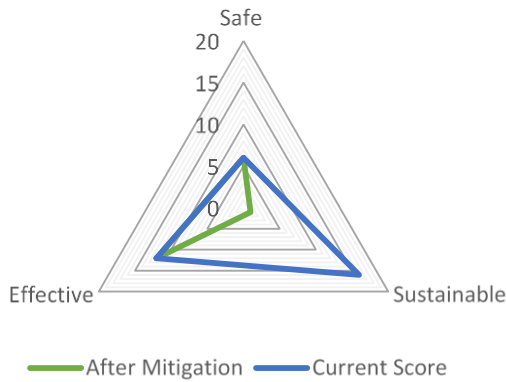
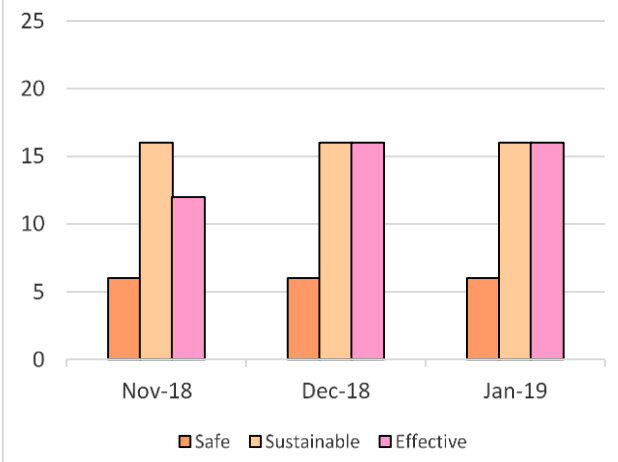
WC/018	NEONATAL TRANSPORT Risk: Lack of 24/7 dedicated Neonatal transport in South Wales. The Neonatal transport service in South Wales is delivered by three HBs on a one in three week rota basis. The Neonatal standards require access to dedicated 24/7 transport, however in South Wales the current service is operating 12 hours per day. If a baby is delivered out of hours that needs transferring they remain in the unit in which they were delivered and stabilised until a transport service becomes available. This could be over 12 hours which is a significant risk to time critical transfers such as babies that require cooling.	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
JAN 2019		Date first assessed 26/04/2017 Date last reviewed by Programme/Directorate: KM 31/01/2019

Risk Rating			WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective	
After Mitigation	12	4	12	Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score
Current Score	12	4	16	
				25 20 15 10 5 0 Nov-18 Dec-18 Jan-19 Safe Sustainable Effective

Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
- All units have 1 cot funded to be staffed at a 1:1 ratio in line with the highest level of care to manage patients out of hours. - Protocols are in place for the management of babies in the unit in which they are delivered. - Ad-hoc arrangements are urgently implemented in emergency situations however these are not formalised.	Action	Lead	By when
	Action plan to be developed with network following recommendations within the case note review	Planner	02/19
	development of governance lead for the service	Planner	02/19
	JC agreed to full review of current neonatal service model to take place throughout 2019/20.	Planner	03/19

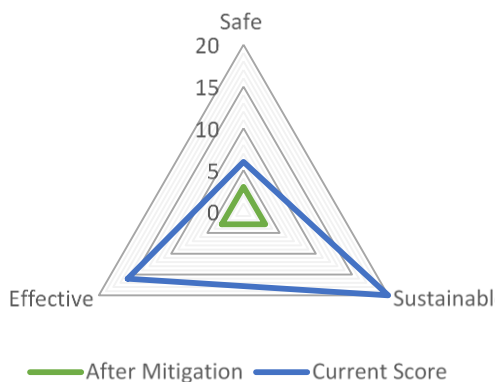
WC/019	BAHA AND COCHLEAR Risk: Significant waiting times (over 52 weeks) for BAHA and Cochlear implants in South Wales for adults. The BAHA and Cochlear service for south Wales patients is managed centrally by C&V however patients are managed at both Bridgend Hospital and UHW. Adult patients are waiting 52 weeks for BAHA and cochlear implants in line with the WHSSC policy, however this does not align with other RTT specialities. The wait for this procedure impacts on social interactions, work, home-life.	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
JAN 2018		Date first assessed 25/04/2017 Date last reviewed by Programme/Directorate: KM 31/01/2019

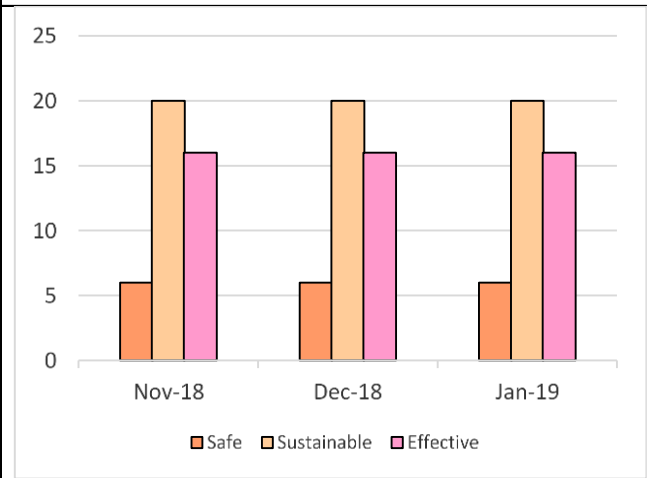
Risk Rating				WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective		
After Mitigation	6	1	12		
Current Score	6	16	12		
					

Escalation Narrative:

Current Control Measures in Place		Description of further Control Measures Required		
Additional funding has been released to support the service to reduce waiting times over a two year period.	Action		Lead	By when
	Review recurrent demand for BAHA and cochlear implants.		Planner	On-going
	Regular dialogue with service to monitor achievements against 26 week RTT		Planner	03/19

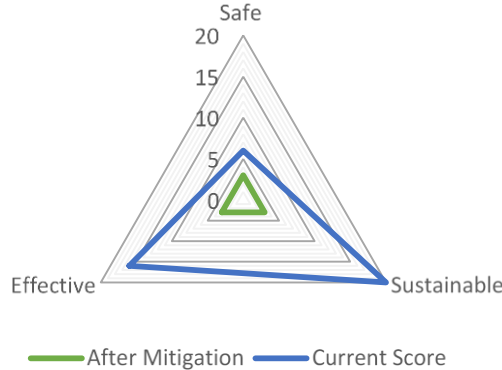
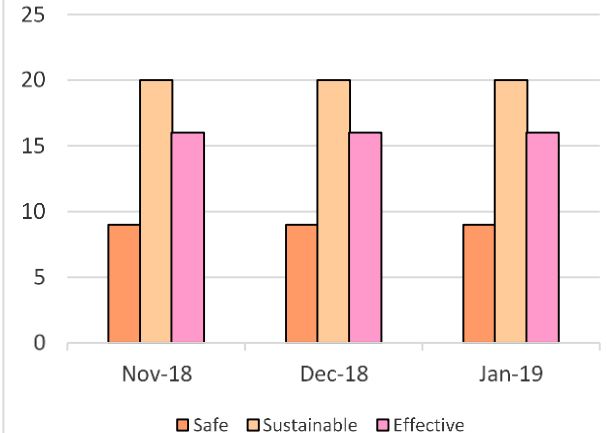
WC/020	PAEDIATRIC ENDOCRINOLOGY	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
JAN 2019	Risk: Inequitable service for Endocrinology patients in Wales. Paediatric Endocrinology services are delivered in Alder Hey for North Wales patients, Cardiff and Vale for South and West and Bristol for patients from the East. WHSSC has overall commissioning responsibility for the service however the funding has not been resource mapped. The disjointed nature of the service is causing significant inequity of care for patients. Also as the service is not formally commissioned by WHSSC there are capacity constraints that mean patients are not being followed up in a timely manner as per national standards. This is a clinical risk as patients are potentially remaining on drugs for longer than necessary. For ABU patients there are also no out-of-hours arrangements in place.	Date first assessed 25/04/2017 Date last reviewed by Programme/Directorate: KM 31/01/2019

Risk Rating			WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective	
After Mitigation	3	3	3	 — After Mitigation — Current Score
Current Score	6	20	16	



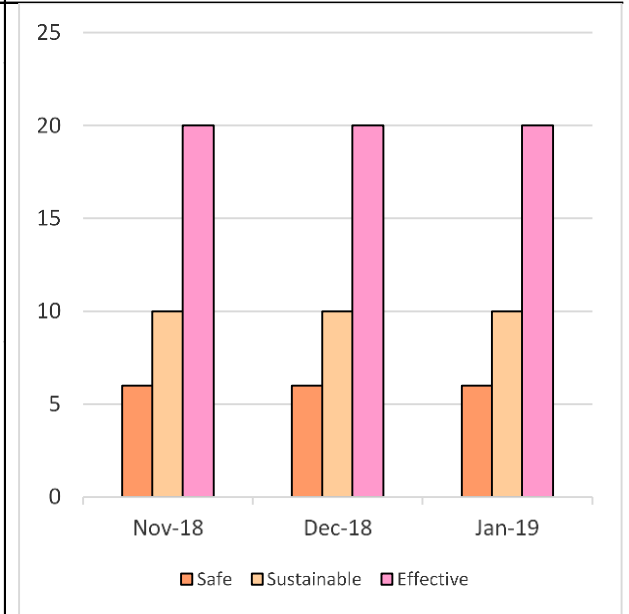
Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
Dialogue with C&V to understand current service model. Current service providing increased capacity on a goodwill basis. Development of business case to be consider for inclusion within the 2019/20 ICP.	Action	Lead	By when
	Prioritisation taken place, the scheme is identified within the ICP	Planner	03/2019
	Resource map the funding to WHSSC	Finance Manager	03/2019
	Service specification ready to be put on website once service has been approved for funding through the ICP	Planner	03/2019

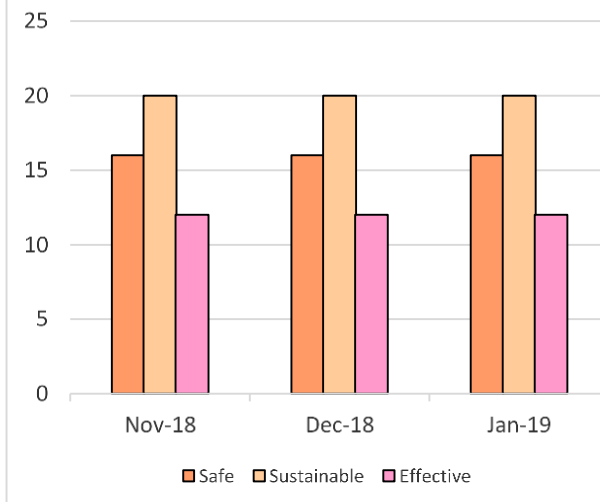
WC/022	PAEDIATRIC RHEUMATOLOGY Risk: Limited and unsustainable Paediatric Rheumatology service in South Wales. The Paediatric Rheumatology service in South Wales is currently delivered by an adult Rheumatologist that is due to retire within the next few years (no precise date as yet). It is very unlikely that their replacement will take on paediatric services therefore leaving a significant gap in service in South Wales. Further, the current service does not meet standards and has been identified by the National Rheumatoid Arthritis Association as an outlier within the UK. There is a risk to patients that they cannot currently access a full MDT and that the limited service that they can access is at risk when the Consultant currently delivering the service retires.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 24/04/2017 Date last reviewed by Programme/Directorate: KM 31/01/2019		
JAN 2019						
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective			
After Mitigation	2	2	2			
Current Score	9	20	16			
Escalation Narrative:						
Current Control Measures in Place			Description of further Control Measures Required			
Patients are referred to Bath and Bristol for specialist pain services when required via IPFR.			Action		Lead	TBC
			Planning Team currently working on service specification		Acting Director of Planning	03/2019
			WHSS Team to include commissioning proposal in 2019/20 ICP		Acting Director of Planning	03/2019

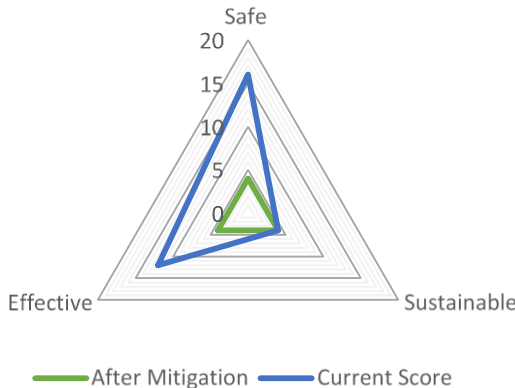
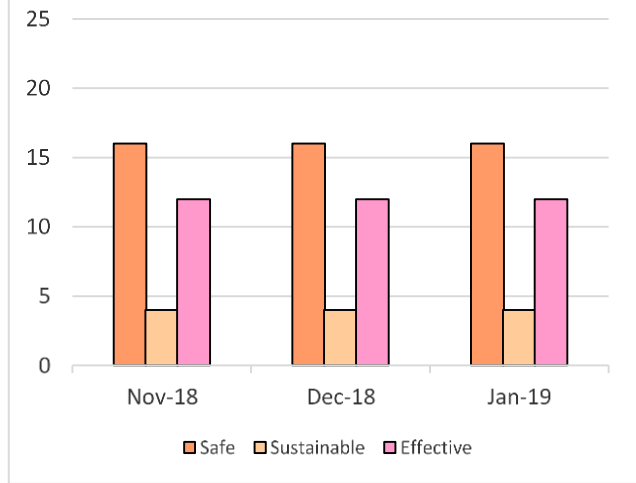
WC/029	CLEFT LIP & PALATE WAITING TIMES Risk: Significant waiting times for adult patients waiting for revisional surgery. The Cleft Lip and Palate service for patients in South and West Wales is delivered at Morriston Hospital. Due to a shortfall in funded theatre capacity within CLP services, babies and children are being prioritised meaning that very long waiting times are being reported for adult revisional surgery. Additional operating capacity has been put in place within ABMU to address this, however this is not sufficient to address the backlog and recurrent demand.	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 17/03/2017 Date last reviewed by Programme/Directorate: KM 31/01/2019
JAN 2019		

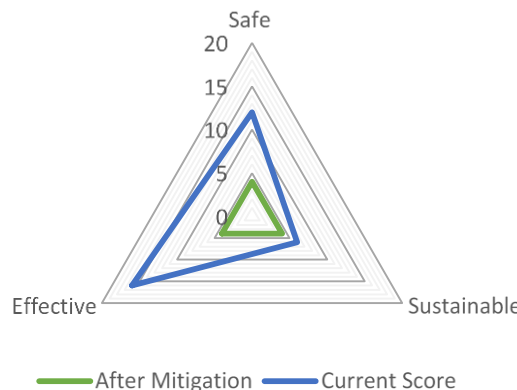
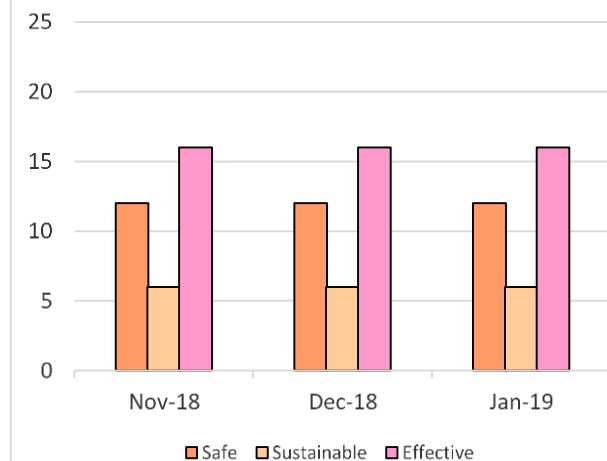
Risk Rating			WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective	
After Mitigation	3	3	3	Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score
Current Score	6	10	20	



Escalation Narrative:			
Current Control Measures in Place	Description of further Control Measures Required		
Additional operating capacity put in place by ABMU, it is not currently clear whether this will continue since the decision has been made not to fund via the 2017/18 Integrated Commissioning Plan.	Action	Lead	By when
	Business case has been prioritised as part of the ICP process, awaiting confirmation of the plan	Planner	03/2019

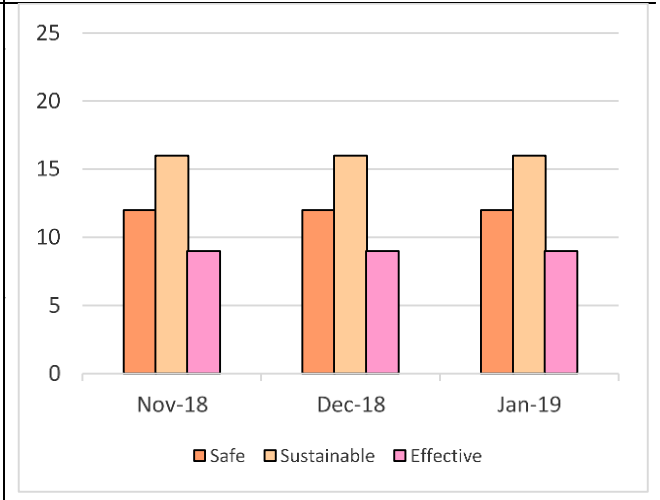
WC/036	PAEDIATRIC SURGERY Risk: Quality and sustainability of Paediatric Surgery in South Wales. Paediatric Surgery for patients in South and West Wales is delivered at the Children’s Hospital for Wales. A number of historic concerns and incidents were recently reported and therefore the HB commissioned a case note review to be carried out by the Royal College of Surgeons. The review identified a number of concerns around clinical behaviours and practise. Due to the historic nature of these concerns and incidents indicated issues with compliance with governance arrangements. Concerns were also identified around the clinical decision making by Consultant staff and the fragility within the workforce.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 01/08/2017 Date last reviewed by Programme/Directorate: KM 31/01/2019																		
JAN 2019																						
Risk Rating				WHSSC Risk Assessment Triangle																		
	Safe	Sustainable	Effective	 — After Mitigation — Current Score																		
After Mitigation	4	4	4																			
Current Score	16	20	12																			
				 <table border="1"><thead><tr><th>Month</th><th>Safe</th><th>Sustainable</th><th>Effective</th></tr></thead><tbody><tr><td>Nov-18</td><td>16</td><td>20</td><td>12</td></tr><tr><td>Dec-18</td><td>16</td><td>20</td><td>12</td></tr><tr><td>Jan-19</td><td>16</td><td>20</td><td>12</td></tr></tbody></table>			Month	Safe	Sustainable	Effective	Nov-18	16	20	12	Dec-18	16	20	12	Jan-19	16	20	12
Month	Safe	Sustainable	Effective																			
Nov-18	16	20	12																			
Dec-18	16	20	12																			
Jan-19	16	20	12																			
Escalation Narrative: The service has been placed in Stage III of the WHSSC escalation process. A commissioning quality re-visit took place on the 16th of May 2018 the outcome of the meeting will be shared with the HB imminently.																						
Current Control Measures in Place				Description of further Control Measures Required																		
The Paediatric Surgery service has been placed in escalation level 3. A Commissioning Quality visit took place on the 26th of January where an action plan was agreed. The HB holds 2 weekly executive led quality meetings attended by the WHSSC DoN. A follow-up meeting is planned for the 16th of May.				Action		Lead	By when															
				Clear assurance on internal governance arrangements.		Planner	Ongoing															
				Measures put in place by the HB to manage behaviours and retention and quality of staff.		Planner	Ongoing															
				Regular discussion with HB to ensure progress is being made.		Planner	Ongoing															

WC/037	NEONATAL TRANSPORT Risk: Governance and subsequent safety issues with the 12 hour neonatal transport service. The current service is provided by three Health Boards on a one in three rota. The three providers are ABMU/C&V/ABU. It has become evident through carrying out a case note review that there are significant gaps in documentation kept and there is no clear governance lead which poses significant safety and effective risks. Due to the volume of the service the risk to sustainability is low.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 23/07/2018 Date last reviewed by Programme/Directorate: KM 31/01/2019			
JAN 2019							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	4	4	4				
Current Score	16	4	12				
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
Letter has been issued to all CEO's notifying them of WHSSC concerns. Requested a governance lead from on the three providers is identified. Full review due to be carried out – looking at the current service model for delivery.				Action		Lead	By when
				Draft ToR for review following meeting with potential reviewer, shared with network for comment awaiting response		Planner	03/19
				Discussion with network to explore and develop the role of the transport sub-group		Planner	03/19

WC/038	BAHA AND COCHLEAR Risk: The BAHA and Cochlear service for south Wales patients is managed centrally by C&V however patients are managed at both Bridgend Hospital and UHW. Currently there is no maintenance or replacement policy for south Wales patients. There are limited numbers within the contract for upgrades and maintenance to take place however this does not align with the average life of an implant which is 6 years. There is therefore risk to patients’ wellbeing and quality of life that cannot have their implant upgraded/maintained as there is no policy in place.			Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 23/07/2018 Date last reviewed by Programme/Directorate: KM 31/01/2019			
JAN 2019							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	4	4	4				
Current Score	12	6	16				
							
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
Requested urgent meeting with C&V to discuss the risks. Requested business case from C&V to inform 2019/20 IMTP.				Action		Lead	By when
				Business case has been prioritised as part of the ICP process, awaiting confirmation of the plan		Planner	03/19

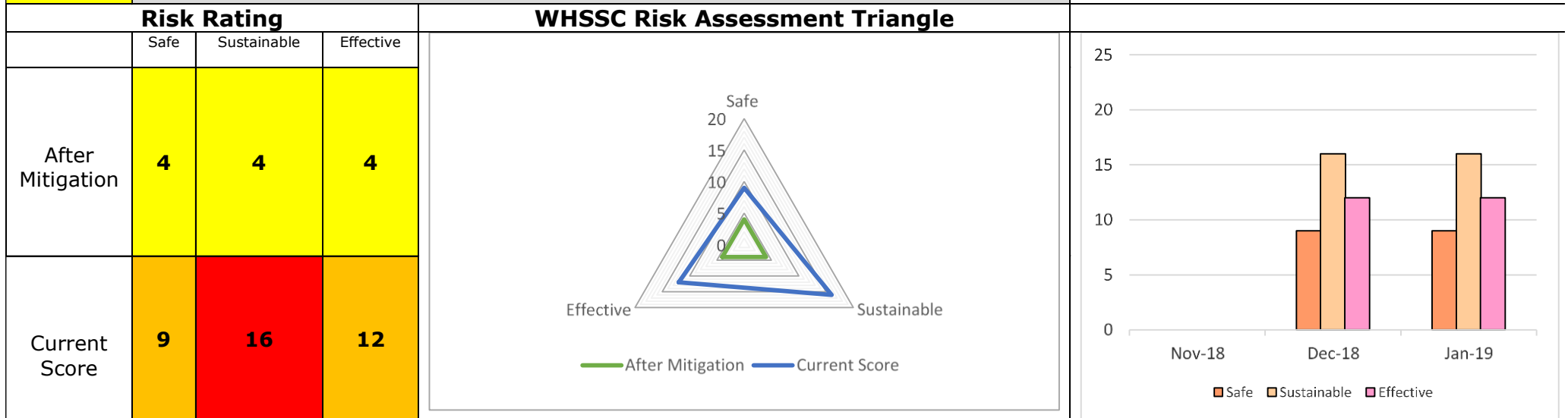
WC/039	INHERITED METABOLIC DISEASES (IMD)– PAEDIATRIC SERVICES Risk: Fragility of current paediatric IMD service due to the imminent retirement of sole consultant delivering the service. The current IMD service is delivered for south Wales patients by one consultant based at Cardiff and Vale. This consultant is due to retire	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
JAN 2019		Date first assessed 04/10/2018 Date last reviewed by Programme/Directorate: KM 31/01/2019

Risk Rating			WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective	
After Mitigation	4	4	4	Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score
Current Score	12	16	9	



Escalation Narrative:			
Current Control Measures in Place		Description of further Control Measures Required	
Requested business case from C&V to inform 2019/20 IMTP.	Action		Lead
	Business case has been prioritised as part of the ICP process, awaiting confirmation of the plan		Planner
	Discussion with Birmingham Children's Hospital to extend current contracting arrangement to mitigate shortfall in support.		03/19

WC/041	Paediatric Oncology - Share care arrangement with Hywel Dda Risk: The Current paediatric oncology service for south and west patients is delivered at the Children's Hospital for Wales, Cardiff. There is however a share care agreement with Hywel Dda to deliver care close to home for patients from the west. The single handed consultant delivering this service has resigned and will no longer be in service as of the end of January 2019. There is insufficient capacity at the CHfW to address this shortfall.	Executive lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 12/12/2018 Date last reviewed by Programme/Directorate: KM 31/01/2019
JAN 2019		



Escalation Narrative:			
Current Control Measures in Place	Description of further Control Measures Required		
- Requested urgent meeting with Hywel Dda to discuss any plans that may be in place. - Discussions have taken place with Cardiff and Vale to escalate.	Action	Lead	By when
	Requested urgent meeting with Hywel Dda to discuss plans	Planner	02/19

Audit Committee Report

**EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE
RISK REGISTER**

Executive Lead: Chief Ambulance Services Commissioner (CASC)

Author: Interim Board Secretary

Contact Details for further information: Gwenan Roberts 01443 744800 or gwenan.roberts@wales.nhs.uk

Purpose of the Audit Committee Report

The purpose of this report is for the Audit Committee to receive and review the updated Joint Emergency Ambulance Services Committee Risk Register which was last considered and discussed at the Emergency Ambulance Services Joint Committee held on 5 February 2019. The host body Audit Committee received the Risk Register at its meeting on 8 October 2018.

Governance

Link to the Commissioning Agreement

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) 'Triple Aim' are being progressed.

This report focuses on all the above objectives, but specifically on **providing** strong governance and assurance.

Supporting evidence

The development of this report has where appropriate been informed by updates provided through established governance processes.

Engagement – Who has been involved in this work?

The Emergency Ambulance Services Commissioning Team has contributed to the development of information contained within this report along with senior officers from the Welsh Ambulance Services NHS Trust.

Audit Committee Report Resolution to:							
APPROVE	✓	ENDORSE		DISCUSS		NOTE	
Recommendation		The Audit Committee is asked to: • APPROVE the Emergency Ambulance Services Joint Committee’s Risk Register and the removal of one risk.					
Summarise the Impact of the Audit Committee Report							
Equality and diversity		There are no equality and diversity implications contained within this report.					
Legal implications		There are no legal implications contained within this report.					
Population Health		No impact.					
Quality, Safety & Patient Experience		Ensuring the Committee and its Sub Groups make fully informed decisions is dependent on the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff.					
Resources		No impact.					
Risks and Assurance		Ensuring the Committee is fully sighted on key areas of its business and related risks, is essential to robust assurance processes.					
Health & Care Standards		The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes but within a Governance Framework. This report focuses mainly on Governance & Accountability but also spans many of the 7 quality themes.					
Workforce		No impact.					
Freedom of Information status		Open					

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE RISK REGISTER

1. **SITUATION / PURPOSE OF REPORT**

The purpose of this report is for the Audit Committee to receive and review the updated Joint Emergency Ambulance Services Committee Risk Register which was last considered and discussed at the Emergency Ambulance Services Joint Committee held on 5 February 2019. The host body Audit Committee received the Risk Register at its meeting on 8 October 2018.

2. **BACKGROUND / INTRODUCTION**

The EASC Members have in the past received and reviewed the Committee Risk Register routinely at every Joint Committee meeting. The register is also reviewed at the Audit Committee of the Host Body (Cwm Taf UHB) for further Independent Member focused scrutiny.

Members will be interested to **NOTE** that the Chair of EASC has asked for a Committee development session to discuss the risk register including the Committee's risk appetite and the connection of risk management to the commissioning framework. This has been scheduled to take place in May 2019.

Any proposed changes to the Register, since last considered by EASC have been identified in red font. Members will note that at the November EASC meeting they considered and added a new risk relating to Major Trauma, developed at the request of the EASC, following discussion in September. EASC members considered the register from a commissioner perspective, although clearly some elements of the recorded risks also have a provider (this includes Health Boards and the Welsh Ambulance Services NHS Trust (WAST)) dynamic.

In relation to Major Trauma services for Mid and South Wales, Health Boards did approve the recommendations from the All Wales Collaborative Group at their respective Board meetings on 29 March 2018. Members will **NOTE** the commitment from EASC to undertake an evidence and clinical outcome based review to inform any proposals to expand the air ambulance coverage of Emergency Medical Retrieval and Transfer Service (EMRTS).

As a consequence of discussions held at the May and October meetings of the Committee, where progress was made in commissioning the Amber Review it was considered appropriate to assess and add a related risk to the Committee's Risk Register.

3. **ASSESSMENT / GOVERNANCE AND RISK ISSUES**

Risk and Assurance Framework

Under the current hosting agreement with Cwm Taf UHB, hosted bodies comply with their Risk Management Strategy and Risk Assurance Framework, Risk Management Policy and Risk Assessment Procedure.

The objective of the Risk Management Strategy and Risk Assurance Framework is to define a strategic direction for risk management, which provides a clear path on which all future risk management initiatives are based.

The aim of the Risk Management Policy is to:

- Ensure that the culture of risk management is effectively promoted to staff ensuring that they understand that the 'risk taker is the risk manager' and that risks are owned and managed appropriately
- Utilise the agreed approach to risk when developing and reviewing the Resource and Operational Plan
- Embed both the principles and mechanisms of risk management into the organisation
- Involve staff at all levels in the process and
- Revitalise its approach to risk management, including health and safety.

The risk register is informed by risks identified and assessed, prior to being placed on the Joint Committee risk register for review.

The Joint Committee Risk Register forms part of the process in terms of the identification and management of strategic risks in relation to the commissioning of Emergency Ambulance Services:

- The Risk Register continues to develop and is a 'living' document and should be in a state of constant change to reflect increases, decreases and the elimination of risks
- The Risk Register will be subject to continuous review by the Chief Ambulance Services Commissioner and the work of the Joint Committee Sub Groups
- It is for the Joint Committee to determine whether there is sufficient assurance in the rigour of internal systems to be confident that there are adequate controls over the management of principal risks to the Joint Committees overall strategic commissioning objectives, outlined within related collaborative commissioning framework(s).

EASC Members agreed the approach to its risk management arrangements and their reporting routinely to the Joint Committee; they also discussed risk tolerance and agreed that this would be based on the approach, adopted by the host body, adapted from [The Good Governance Pocket Guide for NHS Wales Boards](#) (page 37 onwards).

On risk appetite, Boards (or the Joint Committee) might consider:

- What significant risks are the Board (or Joint Committee on behalf of member Boards) willing to take? and what are the significant risks they are not willing to take?
- What are the strategic objectives of the Joint Committee? Are they clear? What is explicit and what is implicit in those objectives?
- Is the Board (Joint Committee) clear about the nature and extent of the significant risks it is willing to take in achieving its strategic objectives?

- Does the Board (Joint Committee) need to establish clearer governance over the risk appetite and tolerance of the organisation?
- What steps has the Board (Joint Committee) taken to ensure oversight over the management of the risks?

At its last meeting, Members asked that the delay in the appointment of an Independent Chair to replace Professor McClelland, whose term of office ended in April, be added to the register, which has been completed.

The Joint Committee is asked to consider the following table, (which also reflects discussions had by the Joint Committee at its May and October 2018 meetings) as its updated risk register for commissioning arrangements.

The Committee has 12 risks on its register – and it is suggested that the risk in relation to a vacant chair position be removed as now resolved.

The highest risks identified include:

- Failure to ensure the commissioning of emergency ambulance services is appropriately clinically categorised (15)
- Failure to progress WAST staffing roster changes across Wales in alignment with demand patterns identified within the ORH report (15)
- Failure to provide alternative services.

Risk Reference	Description of risk identified	Initial Score	July 2018 Score	Current Score	Overall Trend	Last Reviewed	Mitigation / Comments
EASC 07	Failure to progress WAST staffing roster changes across Wales in alignment with demand patterns identified within the ORH report.	15	15	15	⇒	JANUARY 2019	• Realign rosters (primarily UCS); • Progress implementation and evaluation of Roster Pilots; and • Adopt (if evaluation favourable) successful pilots across Health Board areas, as appropriate.
EASC 06	WAST failure to ensure robust workforce plan in place to respond to National Collaborative Commissioning Framework Agreement (this includes implementation of the Band 6 Paramedic Model in Wales)	15	10	10	↓	JANUARY 2019	• Requirement for WAST to develop a Workforce Plan to respond to National Collaborative Framework Agreement • WAST Workforce Plan needs to align with Demand & Capacity Modelling • WAST need to effectively manage staff sickness & absence in alignment with NHS Wales Sickness Policy • WAST to implement the National Agreement reached on NHS Wales Paramedic Band 6 Model.
EASC 08	Failure to provide alternative services	12	15	15	↑	JANUARY 2019	• Directory of services not complete, now concentrating on 5 key areas • Pilots in place and being evaluated across 2 Health Board areas.
EASC 09 (added Sept 2016)	Failure to deliver commissioning arrangements for non-emergency patient transport	12	12	12	⇒	JANUARY 2019	• Collaborative working and accurate baseline information required by WAST and Health Boards • Need to progress arrangements associated with the Plurality model
EASC 02	Failure to deliver Emergency Ambulance Performance Targets – Red1	20	12	12	↓	JANUARY 2019	• Need for WAST to staff to required roster levels • Need for Health Boards and WAST to work together to minimise handover delays.

Risk Reference	Description of risk identified	Initial Score	July 2018 Score	Current Score	Overall Trend	Last Reviewed	Mitigation / Comments
EASC 01	Failure to put in place robust Corporate Governance arrangements.	15	9	9	↓	JANUARY 2019	- Governance arrangements continue to evolve, mature and strengthen. - Need to ensure related recommendations from WAO National Report are fully implemented.
EASC 03	Failure to commission safe Emergency Ambulance Services (against the agreed Collaborative Commissioning Framework Agreement)	12	9	9	↓	JANUARY 2019	Framework agreement in place, continuous review and monitoring arrangements also in place.
EASC 04	Failure to commission EAS within the resources agreed by the EAS Joint Committee.	12	9	9	↓	JANUARY 2019	- WAST & EASC IMTP / Commissioning Plan approved. - CASC secure confirmation from Provider body that resource envelope not exceeded.
EASC 05	Failure to deliver the new Ambulance Quality Indicators.	9	9	9	⇒	JANUARY 2019	- Seeking continuous improvement - Accurate and timely clinical information essential
EASC 10 (added Sept 2016)	Failure to deliver commissioning arrangements for emergency medical retrieval and transfer service	12	9	9	↓	JANUARY 2019	Collaborative working required by WAST and Health Boards
EASC 11 (added November 2017)	Failure to engage EASC & WAST in revised commissioning implications following any agreed Major Trauma Centre / Network arrangement changes across South Wales.	12	12	12	⇒	JANUARY 2019	- Boards considered and approved related recommendations on 29 March 2018 - Implications for WAST / EMRTS needs to be fully quantified and reflected within any revised commissioning arrangements.
~~EASC 12 (added May 2018)~~	~~Delay in the appointment of an Independent Chair to replace Professor McClelland whose term ended in April 2018.~~	N/A	N/A	8	N/A	JANUARY 2019	~~Vice Chair in Place~~ ~~Vacancy now advertised by Welsh Government (WG).~~
EASC 13 (added July 2018)	Failure to ensure the commissioning of emergency ambulance services is appropriately clinically categorised	15	15	15	⇒	JANUARY 2019	- New Clinical desk - Lessons learned from previous work on red category - Ambulance release protocol - Amber Review

The Joint Committee considered revisions to the risk register attached below, which should reflect discussions held at the Joint Committee meeting in July 2018.

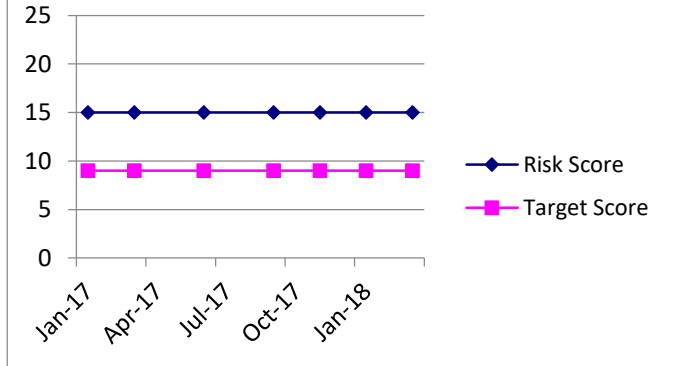
Members should note that some of the risks raised are joint risks that require consideration and ownership within individual organisations and the Welsh Ambulance Services Trust.

4. **RECOMMENDATION**

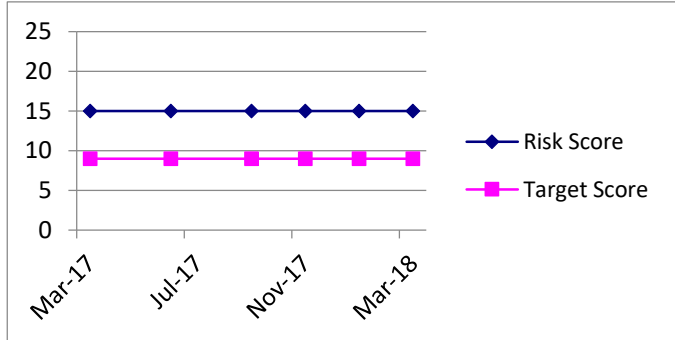
The Audit Committee is asked to:

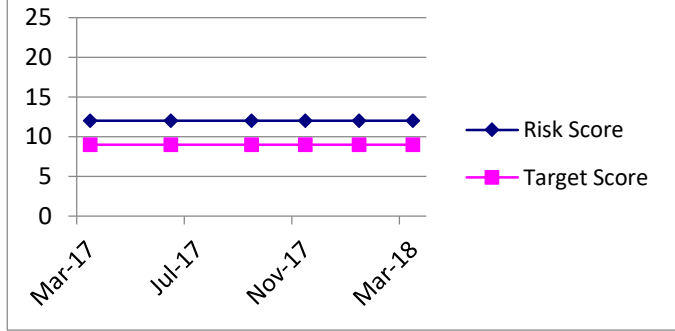
- **APPROVE** the Joint Committee's Risk Register and the removal of one risk.

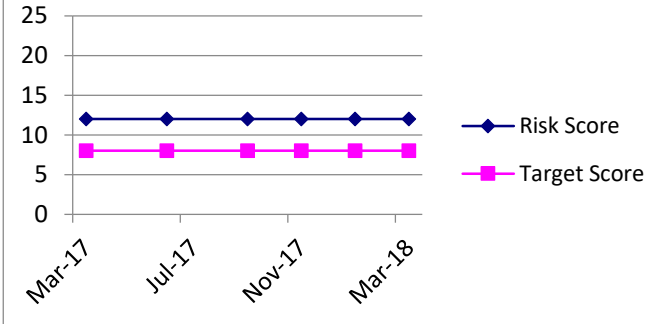
Freedom of Information status	Open
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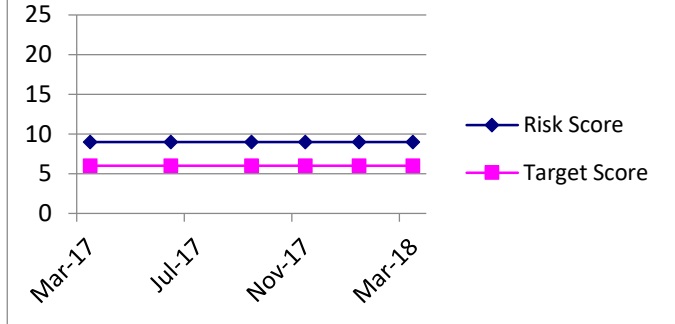
Objective: Workforce		Director Lead: WAST, Director of Operations																			
Risk: Failure to progress WAST staffing roster changes across Wales in alignment with demand patterns identified within the ORH report.		Assuring Committee: Emergency Ambulance Services Committee																			
		Date last reviewed: JANUARY 2019																			
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9	<table><caption>Risk Score Data</caption><tr><th>Date</th><th>Risk Score</th><th>Target Score</th></tr><tr><td>Jan-17</td><td>15</td><td>9</td></tr><tr><td>Apr-17</td><td>15</td><td>9</td></tr><tr><td>Jul-17</td><td>15</td><td>9</td></tr><tr><td>Oct-17</td><td>15</td><td>9</td></tr><tr><td>Jan-18</td><td>15</td><td>9</td></tr></table>	Date	Risk Score	Target Score	Jan-17	15	9	Apr-17	15	9	Jul-17	15	9	Oct-17	15	9	Jan-18	15	9	Rationale for current score: There has been some progress across NHS Wales Health Board areas in addressing staff roster issues aligned with workforce plans and recruitment. There remain pockets of further action relating to AB UHB and Hywel Dda that will assist performance improvement and reduce the risk score towards target. Rationale for target score: The target score reflects the requirement to ensure a consistent application of roster management / approach across NHS Wales Health Board areas that is more appropriately aligned to demand.	
Date	Risk Score	Target Score																			
Jan-17	15	9																			
Apr-17	15	9																			
Jul-17	15	9																			
Oct-17	15	9																			
Jan-18	15	9																			
Level of Control =60%																					
Date added to the risk register March 2015																					
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																			
- WAST have arrangements in place that assist the development of Health Board aligned rosters. - Deployment of staff / crews across NHS Wales to ensure rosters are aligned with demand management - ORH Report commissioned and related management actions being progressed in response, which are reflected within the mitigating actions table.		Action	Lead	Deadline																	
		Implementation of actions following the outcome of demand and capacity modelling	WAST Ops Director	Ongoing																	
		Align roster improvement actions across Health Board areas in response to known demand.	WAST Ops Director	Ongoing																	
		Progress implementation and evaluation of Roster Pilots; and Adopt (if evaluation favourable) successful pilots across Health Board areas, as appropriate.	WAST Ops Director	Ongoing																	
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)																			
Improvement in staffing and roster management across Health Boards.		Maximum deployment of WAST crews to HB areas.																			
Current Risk Rating		Additional Comments																			
Current Risk Rating : 5 x 3 = 15																					

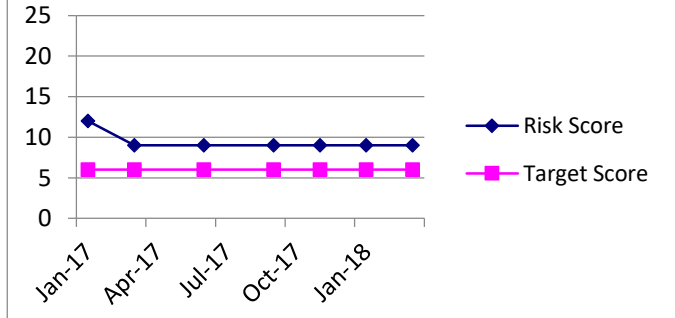
Objective: Workforce		Director Lead: WAST Director of Operations/Director of Wforce&OD																	
Risk: WAST failure to ensure robust workforce plan in place to respond to National Collaborative Commissioning Framework Agreement (this includes implementation of the Band 6 Paramedic Model in Wales)		Assuring Committee: Emergency Ambulance Services Committee																	
		Date last reviewed: JANUARY 2019																	
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 2 = 10 Target: 5 x 2 = 10 Level of Control =60% Date added to the risk register March 2015	<table><caption>Risk Rating Data</caption><thead><tr><th>Date</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Jan-17</td><td>15</td><td>10</td></tr><tr><td>Jun-17</td><td>15</td><td>10</td></tr><tr><td>Nov-17</td><td>10</td><td>10</td></tr><tr><td>Mar-18</td><td>10</td><td>10</td></tr></tbody></table>	Date	Risk Score	Target Score	Jan-17	15	10	Jun-17	15	10	Nov-17	10	10	Mar-18	10	10	Rationale for current score: There has been some progress across NHS Wales Health Board areas in addressing staff roster issues aligned with workforce plans and recruitment. Rationale for target score: The target score reflects the requirement to ensure a consistent application of roster management / deployment approach across NHS Wales Health Board areas that is more appropriately aligned to demand.		
Date	Risk Score	Target Score																	
Jan-17	15	10																	
Jun-17	15	10																	
Nov-17	10	10																	
Mar-18	10	10																	
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																	
- Workforce plan in place and good progress with staff recruitment. - National negotiations concluded and agreement reached for NHS Wales Paramedic Band 6 role. Agreed transitional arrangements in place to support, where required, those Band 5 Paramedics who wish to develop competencies to take on Band 6 role.		<table><thead><tr><th>Action</th><th>Lead</th><th>Deadline</th></tr></thead><tbody><tr><td>Workforce Plan to respond to National Collaborative Framework Agreement and includes workforce redesign for further improvement</td><td>WAST Ops Director</td><td>Ongoing</td></tr><tr><td>WAST need to effectively manage staff sickness & absence in alignment with NHS Wales Sickness Policy</td><td>WAST Ops Director</td><td>Ongoing</td></tr><tr><td>WAST Workforce Plan needs to align with Demand & Capacity Modelling</td><td>WAST Ops Director</td><td>Oct 17</td></tr><tr><td>WAST to implement the National Agreement reached on NHS Wales Paramedic Band 6 Model.</td><td></td><td>In Progress</td></tr></tbody></table>	Action	Lead	Deadline	Workforce Plan to respond to National Collaborative Framework Agreement and includes workforce redesign for further improvement	WAST Ops Director	Ongoing	WAST need to effectively manage staff sickness & absence in alignment with NHS Wales Sickness Policy	WAST Ops Director	Ongoing	WAST Workforce Plan needs to align with Demand & Capacity Modelling	WAST Ops Director	Oct 17	WAST to implement the National Agreement reached on NHS Wales Paramedic Band 6 Model.		In Progress		
Action	Lead	Deadline																	
Workforce Plan to respond to National Collaborative Framework Agreement and includes workforce redesign for further improvement	WAST Ops Director	Ongoing																	
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WAST Workforce Plan needs to align with Demand & Capacity Modelling	WAST Ops Director	Oct 17																	
WAST to implement the National Agreement reached on NHS Wales Paramedic Band 6 Model.		In Progress																	
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)																	
General improvement in staffing and roster management / deployment.		Consistency of reporting / including exception reporting needed.																	
Current Risk Rating		Additional Comments		Ref No.															
Current Risk Rating : 5 x 2 = 10		Recent adverse media reporting on WAST workforce recruitment / deployment of staff.		006															

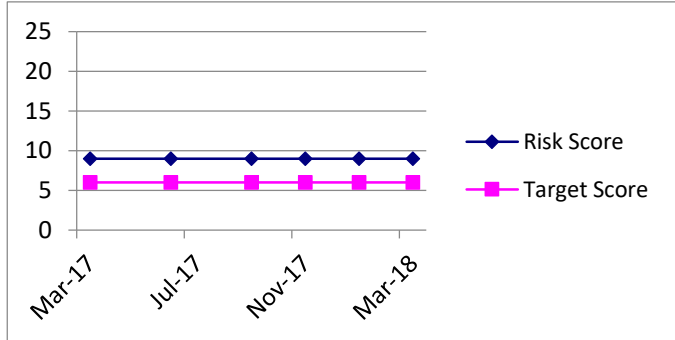
Objective: Commissioning Services in line with Agreed Framework.		Director Lead: CASC																
Risk: Failure to provide alternative services		Assuring Committee: Emergency Ambulance Services Committee																
		Date last reviewed: JANUARY 2019																
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 5 x 3 = 15 Target: 3 x 3 = 9 Level of Control =60% Date added to the risk register March 2015	 <table><caption>Risk Rating Data</caption><thead><tr><th>Date</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Mar-17</td><td>15</td><td>9</td></tr><tr><td>Jul-17</td><td>15</td><td>9</td></tr><tr><td>Nov-17</td><td>15</td><td>9</td></tr><tr><td>Mar-18</td><td>15</td><td>9</td></tr></tbody></table>	Date	Risk Score	Target Score	Mar-17	15	9	Jul-17	15	9	Nov-17	15	9	Mar-18	15	9	Rationale for current score: The pre hospital pathways and alternative service options require further development if routine deployment to A&E departments is to be avoided. Rationale for target score: The target score has been set that better reflects a system that provides with and through health boards, services that support appropriate patients in being cared for at home or in the community.	
Date	Risk Score	Target Score																
Mar-17	15	9																
Jul-17	15	9																
Nov-17	15	9																
Mar-18	15	9																
Controls (What are we currently doing about the risk?) - Some positive review / evaluation of HB specific pilots - where successful and where resource allows, need to consider rolling out across NHS Wales. - Revised EASC Sub Groups in place to oversee such work. - Integrated Performance Dashboard developed, which along with the new CAD will assist capture more meaningful data to help inform evaluation of those alternative services that are worth expanding and developing.		Mitigating actions (What more should we do?) <table><thead><tr><th>Action</th><th>Lead</th><th>Deadline</th></tr></thead><tbody><tr><td>• Directory of Services not completed, therefore ensuring focus on 5 key actions. This work is ongoing.</td><td>CASC</td><td>2018/19</td></tr><tr><td>• Need to ensure successful pilot schemes are rolled out across NHS Wales.</td><td>WAST CEO / CASC</td><td>2018/19</td></tr><tr><td></td><td></td><td></td></tr></tbody></table>		Action	Lead	Deadline	• Directory of Services not completed, therefore ensuring focus on 5 key actions. This work is ongoing.	CASC	2018/19	• Need to ensure successful pilot schemes are rolled out across NHS Wales.	WAST CEO / CASC	2018/19						
Action	Lead	Deadline																
• Directory of Services not completed, therefore ensuring focus on 5 key actions. This work is ongoing.	CASC	2018/19																
• Need to ensure successful pilot schemes are rolled out across NHS Wales.	WAST CEO / CASC	2018/19																
Assurances (How do we know if the things we are doing are having an impact?) WAST and A&E Performance data / monitoring.		Gaps in assurance (What additional assurances should we seek?) Continue to evaluate effectiveness of delivery of the Collaborative Commissioning Framework Agreement.																
Current Risk Rating		Additional Comments	Ref No. 008															
Current Risk Rating : 5 x 3 = 15																		

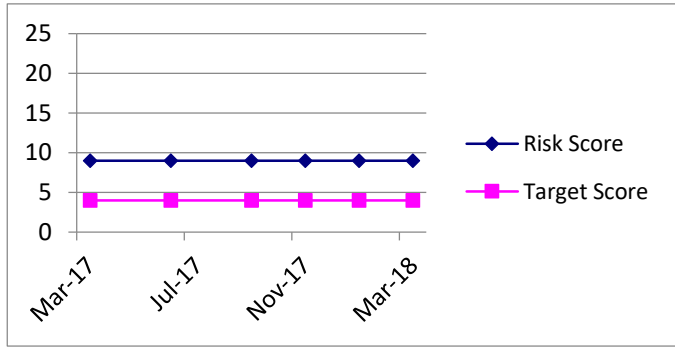
Objective: Commissioning Services in line with Agreed Framework.		Director Lead: CASC																
Risk: Failure to deliver commissioning arrangements for non emergency patient transport (NEPT) services		Assuring Committee: Emergency Ambulance Services Committee																
		Date last reviewed: JANUARY 2019																
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 3 = 12 Target: 3 x 3 = 9 Level of Control = 60% Date added to the risk register March 2015	 <table><caption>Risk Score Data</caption><thead><tr><th>Date</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Mar-17</td><td>12</td><td>9</td></tr><tr><td>Jul-17</td><td>12</td><td>9</td></tr><tr><td>Nov-17</td><td>12</td><td>9</td></tr><tr><td>Mar-18</td><td>12</td><td>9</td></tr></tbody></table>	Date	Risk Score	Target Score	Mar-17	12	9	Jul-17	12	9	Nov-17	12	9	Mar-18	12	9	Rationale for current score: Maintaining the status quo, with a large number of providers, whilst developing agreed commissioning framework agreement, consistent with the development of the plurality model. Rationale for target score: The score reflects the large number of providers, including statutory and non statutory providers where even with the plurality model there will remain an element of risk.	
Date	Risk Score	Target Score																
Mar-17	12	9																
Jul-17	12	9																
Nov-17	12	9																
Mar-18	12	9																
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																
- Baseline assessment review undertaken with support of Internal Audit. - WAST / Health Boards submitting data returns to inform baseline - Agreed commitment from CEOs to ensure accuracy of data submissions by providers - Agreed commitment to continue to deliver and maintain status quo		Action	Lead	Deadline														
		Collaborative working required by WAST and Health Boards	Director of Ops WAST / COOs / CASC	ongoing														
		Development and implementation of the plurality model	Dir of Ops WAST / COOs / CASC	Ongoing														
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)																
Revised / changing service model informed by developing commissioning framework		Completeness and accuracy of data submissions from all contributors																
Current Risk Rating		Additional Comments		Ref No. 009														
Current Risk Rating : 4 x 3 = 12		Internal Audit Baseline Review was not assuring and identified a number of provider related risks with current service set-up.																

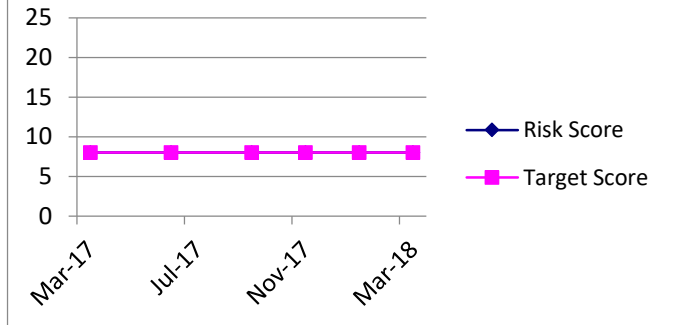
Objective: Commissioning Services in line with Agreed Framework.		Director Lead: CASC / HB Executive Leads / WAST Director of Operations Assuring Committee: Emergency Ambulance Services Committee																
Risk: Failure to deliver Emergency Ambulance Performance Targets – Red1		Date last reviewed: JANUARY 2019																
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 4 x 2 = 8 Level of Control = 80% Date added to the risk register March 2015 <table><caption>Risk Score and Target Score Data</caption><thead><tr><th>Date</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Mar-17</td><td>12</td><td>8</td></tr><tr><td>Jul-17</td><td>12</td><td>8</td></tr><tr><td>Nov-17</td><td>12</td><td>8</td></tr><tr><td>Mar-18</td><td>12</td><td>8</td></tr></tbody></table>	Date	Risk Score	Target Score	Mar-17	12	8	Jul-17	12	8	Nov-17	12	8	Mar-18	12	8	Rationale for current score: Red 1 performance improved significantly since the introduction of the Ambulance Quality Indicators. Rationale for target score: The introduction of the AQIs which ensures the most appropriate deployment of resource to those in greatest need influences the level of acceptable target risk.		
Date	Risk Score	Target Score																
Mar-17	12	8																
Jul-17	12	8																
Nov-17	12	8																
Mar-18	12	8																
Controls (What are we currently doing about the risk?) - AQIs piloted successfully and fully introduced from 2017/18 which has resulted in sustained improvement and delivery of the target. - PACEC review commissioned via EASC on behalf of the Cabinet Secretary made a number of recommendations to further sustain improvements.		Mitigating actions (What more should we do?) <table><thead><tr><th>Action</th><th>Lead</th><th>Deadline</th></tr></thead><tbody><tr><td>• WAST staffing to required levels</td><td>WAST</td><td>Ongoing</td></tr><tr><td>• Handover delays at Health Boards minimised</td><td>HB leads</td><td>Ongoing</td></tr><tr><td>• Implement PACEC recommendations</td><td>CASC</td><td>As per Action Plan</td></tr></tbody></table>			Action	Lead	Deadline	• WAST staffing to required levels	WAST	Ongoing	• Handover delays at Health Boards minimised	HB leads	Ongoing	• Implement PACEC recommendations	CASC	As per Action Plan		
Action	Lead	Deadline																
• WAST staffing to required levels	WAST	Ongoing																
• Handover delays at Health Boards minimised	HB leads	Ongoing																
• Implement PACEC recommendations	CASC	As per Action Plan																
Assurances (How do we know if the things we are doing are having an impact?) Consistent and sustained delivery of Red 1 target.		Gaps in assurance (What additional assurances should we seek?) Continue to ensure the right categories of patients are receiving the right level of Emergency Ambulance response.																
Current Risk Rating Current Risk Rating : 4 x 3 = 12		Additional Comments		Ref No. 002														

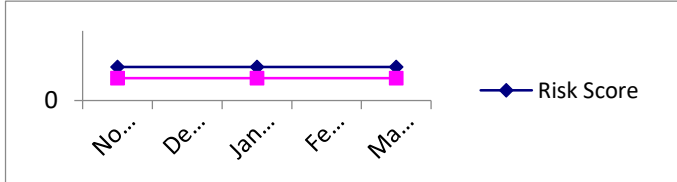
Objective: EASC Governance		Director Lead: CASC / Committee Sec																
Risk: Failure to put in place robust Corporate Governance arrangements		Assuring Committee: Emergency Ambulance Services Committee																
		Date last reviewed: JANUARY 2019																
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 3 x 3 = 9 Target: 3 x 2 = 6 Level of Control = 80% Date added to the risk register March 2015	<table><caption>Risk Score Data</caption><thead><tr><th>Date</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Mar-17</td><td>9</td><td>6</td></tr><tr><td>Jul-17</td><td>9</td><td>6</td></tr><tr><td>Nov-17</td><td>9</td><td>6</td></tr><tr><td>Mar-18</td><td>9</td><td>6</td></tr></tbody></table>	Date	Risk Score	Target Score	Mar-17	9	6	Jul-17	9	6	Nov-17	9	6	Mar-18	9	6	Rationale for current score: Generally good progress made in strengthening and maturing EASC governance arrangements during a period of significant change. Rationale for target score: There should be a low tolerance of weak governance	
Date	Risk Score	Target Score																
Mar-17	9	6																
Jul-17	9	6																
Nov-17	9	6																
Mar-18	9	6																
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																
- Strong governance arrangements established. - De-coupled from WHSSC (Joint Governance Framework) and EASC equivalent introduced - Board reporting including Chairs Summary and Forward work plan introduced. - New model Standing Orders drafted by WG Officials – including change to voting requirements at EASC		Action	Lead	Deadline														
		Need to deliver the agreed management response to the related WAO governance recommendations.	CASC / Comm Sec	Complete														
		Need to ensure revised sub groups of EASC have clear terms of reference and are delivering against these under delegated authority of the Joint Committee	CASC / Comm Sec	Complete but review to be undertaken														
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)																
Overall a general improvement can be demonstrated in the role, function and delivery of EASC agenda, also reviewed by Internal Audit from a governance perspective.		We need to continue to review progress with these developing arrangements and reporting into Committee to ensure the Sub Groups appropriately discharge their Terms of Reference																
Current Risk Rating		Additional Comments		Ref No.														
Current Risk Rating : 3 x 3 = 9		Nominated Membership and attendance at Sub Groups requires ongoing review.		001														

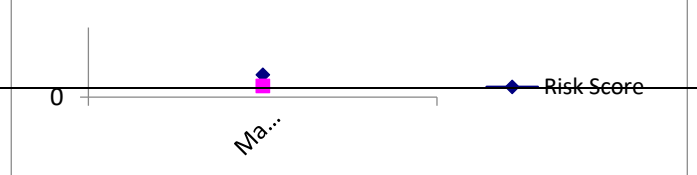
Objective: Commissioning Services in line with Agreed Framework.		Director Lead: CASC																			
Risk: Failure to commission safe Emergency Ambulance Services (against the agreed Collaborative Commissioning Framework Agreement)		Assuring Committee: Emergency Ambulance Services Committee																			
		Date last reviewed: JANUARY 2019																			
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 3 x 3 = 9 Target: 3 x 2 = 6 Level of Control = 80% Date added to the risk register March 2015	<table><caption>Risk Score Data</caption><thead><tr><th>Date</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Jan-17</td><td>12</td><td>6</td></tr><tr><td>Apr-17</td><td>9</td><td>6</td></tr><tr><td>Jul-17</td><td>9</td><td>6</td></tr><tr><td>Oct-17</td><td>9</td><td>6</td></tr><tr><td>Jan-18</td><td>9</td><td>6</td></tr></tbody></table>	Date	Risk Score	Target Score	Jan-17	12	6	Apr-17	9	6	Jul-17	9	6	Oct-17	9	6	Jan-18	9	6	Rationale for current score: General improvement in performance against agreed AQIs and Red 1 target performance improved significantly. More work to do in relation to the Amber AQI category. Rationale for target score: Safety remains number 1 priority for commissioning and service delivery	
Date	Risk Score	Target Score																			
Jan-17	12	6																			
Apr-17	9	6																			
Jul-17	9	6																			
Oct-17	9	6																			
Jan-18	9	6																			
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																			
- Collaborative Commissioning Framework Agreement in place - AQIs established and embedded - Rich data available to assess delivery of services against Framework agreement. - PACEC report commissioned by Cabinet Secretary – completed Amber review - implementation programme developed		Action	Lead	Deadline																	
		Framework agreement in place, needs to be continuously reviewed and monitored to ensure delivery.	CASC	Ongoing																	
		Clinical Audit Data to be analysed and available to support commissioning decisions	WAST Dir of Ops	Ongoing																	
		PACEC Closure report	CASC	Complete																	
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)																			
Positive outcomes for patient accessing emergency ambulance services.		Develop further the messaging from AQIs and strengthen Patient Experience capturing.																			
Current Risk Rating		Additional Comments		Ref No. 003																	
Current Risk Rating : 3 x 3 = 9																					

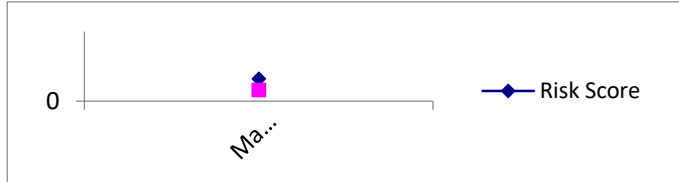
Objective: Commissioning Services in line with Agreed Framework.		Director Lead: Chief Ambulance Services Commissioner		
Risk: Failure to commission EAS within the resources agreed by the EAS Joint Committee		Assuring Committee: Emergency Ambulance Services Committee		
		Date last reviewed: JANUARY 2019		
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 3 x 3 = 9 Target: 3 x 2 = 6 Level of Control = 70% Date added to the risk register March 2015		Rationale for current score: Staying within allocated EASC resource and areas of reported progress with delivery against the National Collaborative Commissioning Framework Agreement Rationale for target score: Likelihood of delivery within agreed framework		
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)		
- Monthly finance reports via (WHSSC Finance Director) into CASC / Senior Management team. - Routine financial updates presented to Joint Committee. - EASC IMTP in place, which is reviewed and refreshed annually.		Action	Lead	Deadline
		Agreed Commissioning plan approved. Need to ensure delivery.	CASC / WAST	Ongoing
		Ensure delivery of agreed commissioning plan within agreed resource envelope	Provider leads	Ongoing
		Ensure implementation of WAO management response including refresh of the MoU with all parties.	CASC	Complete
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)		
Good levels of performance and positive outcomes for patients who are receiving the right response to their categorised condition.		Stronger patient experience / patient outcome data needed.		
Current Risk Rating		Additional Comments		Ref No. 004
Current Risk Rating : 3 x 3 = 9				

Objective: Commissioning Services in line with Agreed Framework.		Director Lead: Richard Lee, Director of Operations														
Risk: Failure to deliver the new Ambulance Quality Indicators		Assuring Committee: Emergency Ambulance Services Committee														
		Date last reviewed: JANUARY 2019														
Risk Rating (consequence x likelihood): Initial: 3 x 3 = 9 Current: 3 x 3 = 9 Target: 2 x 2 = 4 Level of Control = 80% Date added to the risk register October 2015 	Rationale for current score: Generally improvements made in the Red1 response rates, which has resulted in improved performance delivery and achievements of the targets. More work to be progressed in relation to the Amber Category, in line with the PACEC report and its related recommendations. Rationale for target score: With the work progressed on ensuring the right response is made to emergency ambulance calls there should be few occasions with minimum consequences, when a response is delayed or inappropriately deployed.															
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)														
- AQIs piloted 1 year in advance of being adopted. - PACEC review commissioned to help inform development of related work. - Routine quarterly reporting of AQIs - Stats Wales reporting in place - Data can be analysed by HB and locality		<table><tr><th>Action</th><th>Lead</th><th>Deadline</th></tr><tr><td>Seeking continuous improvement and related actions to inform same.</td><td>CASC WAST</td><td>Ongoing ¼ rly reporting</td></tr><tr><td>Accurate and timely clinical information is considered essential.</td><td>WAST</td><td>Ongoing ¼ rly reporting</td></tr><tr><td>Need for strengthened patient outcome data and improved capturing of the patient experience.</td><td>WAST / CASC (Picker)</td><td>Ongoing ¼ rly reporting</td></tr></table>	Action	Lead	Deadline	Seeking continuous improvement and related actions to inform same.	CASC WAST	Ongoing ¼ rly reporting	Accurate and timely clinical information is considered essential.	WAST	Ongoing ¼ rly reporting	Need for strengthened patient outcome data and improved capturing of the patient experience.	WAST / CASC (Picker)	Ongoing ¼ rly reporting		
Action	Lead	Deadline														
Seeking continuous improvement and related actions to inform same.	CASC WAST	Ongoing ¼ rly reporting														
Accurate and timely clinical information is considered essential.	WAST	Ongoing ¼ rly reporting														
Need for strengthened patient outcome data and improved capturing of the patient experience.	WAST / CASC (Picker)	Ongoing ¼ rly reporting														
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)														
PACEC closure report (March 18) with related improvement actions.																
Current Risk Rating		Additional Comments		Ref No. 005												
Current Risk Rating : 3 x 3 = 9																

Objective: Commissioning Services in line with Agreed Framework.		Director Lead: Clinical Director, EMRTS														
Risk: Failure to deliver commissioning arrangements for emergency medical retrieval and transfer service.		Assuring Committee: Emergency Ambulance Services Committee														
		Date last reviewed: JANUARY 2019														
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current:4 x 2 = 8 Target: 4 x 2 = 8 Level of Control =70% Date added to the risk register March 2015 	Rationale for current score: Agreed commissioning arrangements for EMRTS being delivered. Rationale for target score: EMRTS is a well lead, managed and resourced service, the target risk appetite reflects this.															
Controls (What are we currently doing about the risk?) - Commissioning agreement established and being delivered against. - Delivery Assurance Group in place. - Robust data in place that enables monitoring of related activity. - Gateway review expected in May / June 2019 - Presentation on EMRTS received in November 2018 - funding streams and phasing to be considered further		Mitigating actions (What more should we do?) <table><tr><th>Action</th><th>Lead</th><th>Deadline</th></tr><tr><td> - Ongoing collaborative working required by WAST and Health Boards. </td><td>CASC / CD EMRTS / HB Leads</td><td>Ongoing</td></tr><tr><td> - Delivery of the Gateway Review recommendations. </td><td>CASC / CD EMRTS</td><td>As per Gateway</td></tr><tr><td></td><td></td><td></td></tr></table>			Action	Lead	Deadline	Ongoing collaborative working required by WAST and Health Boards.	CASC / CD EMRTS / HB Leads	Ongoing	Delivery of the Gateway Review recommendations.	CASC / CD EMRTS	As per Gateway			
Action	Lead	Deadline														
Ongoing collaborative working required by WAST and Health Boards.	CASC / CD EMRTS / HB Leads	Ongoing														
Delivery of the Gateway Review recommendations.	CASC / CD EMRTS	As per Gateway														
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)														
Current Risk Rating		Additional Comments		Ref No. 010												
Current Risk Rating : 4 x 2 = 8																

Objective: Commissioning Services in line with Agreed Framework.		Director Lead: CASC		
Risk: Failure to engage EASC & WAST in revised commissioning implications following any agreed Major Trauma Centre / Network arrangement changes across South Wales.		Assuring Committee: Emergency Ambulance Services Committee		
		Date last reviewed: JANUARY 2019		
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 3 = 12 Target: 4 x 2 = 8		Rationale for current score: Requirement for the implications on Emergency Ambulance (including Air Ambulance) implications to be fully considered and quantified that help to inform commissioning intentions for any agreed revised Major Trauma Centre / Network Model.		
Level of Control = 60%		Rationale for target score: The Emergency Ambulance requirements for any new Major Trauma model are fully quantified and met within an agreed commissioning framework.		
Date added to the risk register March 2015				
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)		
- Major Trauma Expert Panel established to consider and inform direction of travel - Agreed engagement / consultation process developed with the Wales Collaborative and following discussion with CHCs and endorsement by Health Boards / Trusts. - Health Boards approved the recommendations of the Collaborative at their Board meetings on 29 March 2018.		Action	Lead	Deadline
		EASC to play an active role in the development of any new Major Trauma Centre / Network model, post the outcome of the Consultation process	CASC / CD EMRTS	ongoing
		EASC to scope a review of EMRTS coverage (taking evidence based approach).	CASC / CD EMRTS	Nov 2018 complete
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)		
Current Risk Rating	Additional Comments		Ref No. 011	
Current Risk Rating : 4 x 3 = 12				

Objective: Joint Committee Leadership		Director Lead: ~~CASC~~	
Risk: Delay in the appointment of an Independent Chair to replace Professor McClelland whose term ended in April 2018.		Assuring Committee: ~~Emergency Ambulance Services Committee~~	
		Date last reviewed: ~~November 2018~~	
Risk Rating (consequence x likelihood): Initial: $4 \times 2 = 8$ Current: $4 \times 2 = 8$ Target: $4 \times 1 = 4$		Rationale for current score: The Chair's term of office ended in April 2018. There has been a delay with the Public Appointments Unit at Welsh Government progressing the arrangement to replace the Independent Chair. This has recently (May 2018) been advertised.	
Level of Control = 80%		Rationale for target score: The Emergency Ambulance Committee only has 1 Independent Member (who also Chairs the Committee) any related delays should be mitigated and eliminated.	
Date added to the risk register May 2018			
			
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)	
Committee Vice Chair in place, which can support the ongoing work of the Committee pending the appointment of an Independent Member Chair.		Action	Lead
		Vice Chair in place that can provide continuity for a short period of time, pending the appointment of a replacement chair.	CASC / Vice Chair
		WG Public appointments unit have advertised for a new Chair.	WG
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)	
		No appointment made for position.	
Current Risk Rating		Additional Comments	
Current Risk Rating : $4 \times 2 = 8$			
		Ref No. 012	

Objective: Commissioning Services in line with Agreed Framework.		Director Lead: CASC		
Risk: Failure to ensure the commissioning of emergency ambulance services is appropriately clinically categorised		Assuring Committee: Emergency Ambulance Services Committee		
		Date last reviewed: JANUARY 2019		
Risk Rating (consequence x likelihood): Initial: N/A Current: 5 x 3 = 15 Target: 5 x 2 = 10		Rationale for current score: Concerns relating to the volume and clinical categorisation of patient in the Amber category.		
Level of Control = %		Rationale for target score: The Emergency Ambulance Services Committee need to be assured that the services commissioned appropriately respond to the clinically categorised patients		
Date added to the risk register July 2018				
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)		
• New Clinical desk • Lessons learned from previous work on red category • Ambulance release protocol • Links to Clinical Risk and Assurance Review		Action	Lead	Deadline
		• Amber Review published	CASC / Asst CASC	complete
		• Amber Review Implementation Programme developed	Asst CASC	Feb 2019
Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)		
Current Risk Rating		Additional Comments		Ref No. 013
Current Risk Rating : 5 x 3 = 15				

Risk management

Internal Audit Report

Welsh Health Specialised Services Committee

March 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A
Appendix B

Management Action Plan
Assurance opinion and action plan risk rating

Review reference:	CTU-1819-42
Report status:	Internal Audit Report
Fieldwork commencement:	20 November 2018
Fieldwork completion:	13 February 2019
Draft report issued:	21 February 2019
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Final report issued:	11 March 2019
Auditors:	Paul Dalton – Head of Internal Audit Emma Samways – Deputy Head of Internal Audit Murray Gard – Principal Auditor
Executive sign off:	Kevin Smith - Committee Secretary & Head of Corporate Services
Distribution:	Cathie Steele - Corporate Governance Manager
Committee:	Audit Committee

ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Health Specialist Services Committee no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

A review of the Risk Management processes within the Welsh Health Specialised Services Committee ('WHSSC' or the 'organisation') was completed in line with the 2018/19 Internal Audit plan.

Effective risk management is a key component of corporate and clinical governance and is integral to the delivery of organisational objectives. Risk management consists of defined steps which help us understand risks and their impact. Good risk management awareness and practice at all levels is a critical success factor for any organisation and needs to be seen as integral to effective management practice.

The relevant lead for the assignment is the Committee Secretary and Head of Corporate Services.

2. Scope and Objectives

The objective of this audit was to evaluate and determine the adequacy of the systems and controls in relation to risk management in order to provide assurance to the Audit Committee that risks material to the achievement of the system's objectives are managed appropriately. The areas that the review sought to provide assurance on were:

- WHSSC has an up to date, comprehensive risk management strategy and policy that provides clear guidance on the organisation's approach to risk management, including the responsibilities of individuals and committees.
- The risk management strategy and policy is appropriately applied, including the application of risk appetite.
- There are clear links between the Organisational Risk Register and the Corporate Risk Assurance Framework.
- Monitoring and scrutiny of the Organisational Risk Register and Corporate Risk Assurance Framework take place at appropriate committees, with updates and amendments clearly identifiable and justified.

3. Associated Risks

The potential risks considered in this review are as follows:

- Risks materialise as the policy is not appropriately applied.
- Risks materialise as monitoring and scrutiny is not appropriately undertaken.
- Organisational objectives are not fully achieved as risks materialise.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with risk management processes is reasonable assurance.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

We identified that overall there are suitable arrangements and processes in place for control and governance of risk management. We note good practice in WHSSCs assessment and accountability for risk associated with commissioning.

We identified one high priority finding relating to the organisational risk register that captures risks that do not relate to commissioning. This risk register is not in place and has been in development for some time.

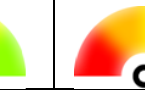
We also note that elements of the integrated risk management framework are not up to date and do not reflect the operating practices within WHSSC in all instances.

The monitoring of the recorded commissioning risks is robust, with directors named with individual responsibility, and monitoring taking place at various groups and committees within the organisation, and at the Audit Committee.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	A risk management strategy and policy are in place.			✓	
2	The risk management strategy and policy is appropriately applied, including the application of risk appetite.		✓		
3	Links between the organisational risk register and the Corporate Risk Assurance Framework.		✓		
4	Monitoring and scrutiny of the Organisational Risk Register and Corporate Risk Assurance Framework.			✓	

* The above ratings are not necessarily given equal weighting when generating the audit opinion.

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the system control/design for risk management.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the operation of the designed system/control for risk management.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: WHSSC has an up to date, comprehensive risk management strategy and policy that provides clear guidance on the organisation's approach of risk management, including the responsibilities of individuals and committees.

We note the following area of good practice:

- WHSCC has in place an Integrated Risk Management Framework which is a strategic document describing the key principles, processes, procedures and responsibilities in place.

We identified the following findings:

- The minutes of the Corporate Directors Groups, where the Integrated Risk Management Framework was approved could not be traced.

Objective 2- The Integrated Risk Management Framework is appropriately applied including application of risk appetite.

We note the following area of good practice:

- WHSCC has set its strategic approach to risk-taking by defining its risk appetite thresholds within its risk appetite statement, which is contained within the Integrated Risk Management Framework.

We identified the following findings:

- There was no evidence of an annual review of the risk appetite in line with the framework.
- In terms of application of the framework we identified discrepancies within the document including incomplete sections and some aspects that have not been carried out, such as the development of a Board Assurance Framework.

Objective 3 - There are clear links between the Organisational Risk Register and the Corporate Risk Assurance Framework.

We note the following area of good practice:

- A detailed Corporate Risk Assurance Framework (CRAF) has been established for the risks associated with commissioning activities. The CRAF includes risks that are escalated from Directorate and Programme Risk Registers.

We identified the following finding:

- There is no CRAF or Directorate risk registers documenting the risks relating to non-commissioning activities. However, we acknowledge that work is ongoing to develop this.

Objective 4 - Monitoring and scrutiny of the Corporate Risk Assurance Framework.

We identified the following areas of good practice:

- Risks on the CRAF have a lead Director, and the risks are assigned to the Quality and Patient Safety Committee to ensure appropriate review, scrutiny and where relevant updating.
- Directors, as risk owners, are appropriately sighted and involved in the development of the CRAF, through their attendance at sub-committees, including the Corporate Directors Group.
- The CRAF is routinely reported to the Audit Committee.

We identified the following finding:

- Our review of a sample of individual risks on the CRAF, identified a small number of issues in relation to accuracy, completeness and scrutiny arrangements.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	1	3	0	4

Finding 1 – Identification of organisational risks (Control design)	Risk
The risks included on the Corporate Risk Assurance Framework (CRAF) relate to commissioning, with the Director of Planning assigned as the lead director responsible for all of them. Wider organisational risks relating to areas such as workforce, finance, new legislation (General Data Protection Regulations), and Brexit implications are not formally recorded. However, we acknowledge that these are being assessed by the organisation's Risk Management Group. We attended the November 2018 meeting of the Risk Management Group where risks that were not related to commissioning were assigned to lead officers for assessment and scoring.	Risks materialise as monitoring and scrutiny is not appropriately undertaken.
Recommendation	Priority level
1. Management should ensure that the assessment of organisational risks are clearly documented in departmental risk registers where relevant. 2. Any departmental risk that scores high enough, should be escalated onto the CRAF for ongoing monitoring.	High
Management Response	Responsible Officer/ Deadline
Accepted. At the February meeting of the Internal Risk Management Group members provided a progress update on the risks allocated for assessment. The majority of risks presented scored less than 15 and therefore will be monitored	Committee Secretary, September 2019

through the directorate risk register. Those scoring over 15 will be escalated to the Corporate Risk Assurance Framework, which will be reviewed and approved by the Corporate Directors Group.

Assessment of risks is a live process and therefore risks maybe escalated and deescalated throughout the year.

Finding 2 – Integrated Risk Management Framework (Operating effectiveness)	Risk
The main guidance document within the organisation for risk management is the Integrated Risk Management Framework. We read the framework document and considered how it aligns to current operating practices. We note the following points: • Evidence of approval of the document by the Corporate Directors Group could not be obtained. • At the time of our audit fieldwork the 'Integrated Commissioning Plan (ICP) Risk Management Arrangements' section of the framework has not been populated. Given the ICP is a key document for WHSSC, we would expect the arrangements for managing the risks associated with delivery of the plan to be clearly articulated. • The framework makes reference to a Corporate Risk Assurance Framework (CRAF), a Board Assurance Framework (BAF) and a corporate risk register. However, only the CRAF exists and management have acknowledged that the framework needs to be reviewed to reflect this. • The risk reporting and escalation chart within the Appendices does not align to current practice.	Risks materialise as the policy is not appropriately applied.

Recommendation 2	Priority level
1. The Integrated Risk Management Framework should be reviewed for appropriateness, relevance and completeness. 2. A revised framework should be approved by the relevant committee and evidence of approval recorded in the committee minutes.	Medium
Management Response	Responsible Officer/ Deadline
Accepted 1. The Integrated Risk Management Framework has been reviewed and presented to the February meeting of the Internal Risk Management Group for consultation. The comments received during the consultation will be considered, and the framework amended where appropriate. 2. The revised framework will be presented to the Corporate Directors Group for ratification.	Committee Secretary, 30 June 2019 Committee Secretary, 30 June 2019

Finding 3 - Risk appetite (Operating Effectiveness)	Risk
WHSCC's risk appetite statement is contained within the Integrated Risk Management Framework. A risk maturity matrix is included as an appendix to the framework and has been used as a guide to set risk appetite. However, the risk appetite statement itself is brief comprising of three statements stating what the organisations appetite is in relation to commissioning risks, fraud and finance risk, and governance and accountability risk. In other organisations we have seen more detailed risk appetite statements, covering a wider range of business areas and descriptions. We could evidence that risk appetite had been discussed by the Joint Committee in January 2018, however at the time of the audit fieldwork no plans had been made for the annual review. Within the framework, the accountabilities section for the Joint Committee states '<i>The Joint Committee is responsible for setting the strategic direction for risk and overseeing the integrated risk management arrangements across the organisation</i>'. We have been informed by the Corporate Governance Manager that this responsibility has been delegated to the Managing Director who sits on the Corporate Directors Group (CDG), who approved the framework and therefore risk appetite. However we could not be provided with any documentation to support this delegation.	Risks materialise as monitoring and scrutiny is not appropriately undertaken.

Recommendation 3	Priority level
1. In line with the Integrated Risk Management Framework, the organisation should review its risk appetite on an annual basis, with any decisions made regarding the risk appetite properly recorded in relevant minutes and the framework updated accordingly. 2. Consideration should be given as to whether the Corporate Directors Group is the correct forum for approving the Integrated Risk Management Framework given that the framework itself states that the Joint Committee is responsible for setting the strategic direction for risk within the organisation.	Medium
Management Response	Responsible Officer/ Deadline
Partial Acceptance 1. The risk appetite statement will be reviewed as part of the refresh of the Integrated Risk Management Framework and then annually following approval of the framework. 2. Management consider that the Corporate Directors Group is the correct forum for approval of the risk management framework as the Managing Director has "responsibility for maintaining appropriate governance structures and procedures as well as a sound system of internal control that supports achievement of the Joint Committee's policies, aims and objectives". This delegation will be made clearer during the forthcoming review of the Scheme of Delegation.	Committee Secretary, 30 June 2019

Finding 4 – Corporate Risk Assurance Framework accuracy (Operating effectiveness)	Risk
We tested a sample of five risks on the CRAF to ensure that movements in risk scores were justifiable and appropriate. We note that: • Original risk scores are not noted on the CRAF. Where risk scores had moved it is difficult to identify these changes, furthermore there was no annotation on the CRAF to state what additional controls had been implemented to mitigate the risk and support the lower score. • For 1/5 risks in our sample, an action had not been assigned a lead officer, and an implementation timescale had not been recorded. • For risk WC/38 we note the following action to be completed 'Requested business case from C&V to inform 2019/20 IMTP', with a target date of October 2018. However, the report submitted to the Quality and Patient Safety Committee in January 2019 does not give an update on this action.	Organisational objectives are not fully achieved as risks materialise.
Recommendation 4	Priority level
1. The CRAF should be kept up to date with information in relation to actions that have taken place, lead officers and timescales. 2. Where risk scores have been amended, reasons should be recorded to demonstrate the reason for the change.	Medium

3. Consideration should be given to including original risks scores so that movements over time can be tracked.	
Management Response	Responsible Officer/ Deadline
Noted As part of the review of the Integrated Risk Management Framework these findings will be considered. However, it must be noted that the premise behind the CRAF is a risk on a page.	Committee Secretary, 30 June 2019

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings



Substantial assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.



Reasonable assurance - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.



Limited assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.



No assurance - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

Governance arrangements

Welsh Health Specialised Services Committee

Internal Audit Report

2018/19

March 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A	Management Action Plan
Appendix B	Assurance opinion and action plan risk rating
Review reference:	CTU-1819-43
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Fieldwork commencement:	4 February 2019
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Auditors:	Emma Samways Stuart Bodman
Executive sign off:	Kevin Smith, Committee Secretary and Head of Corporate Services
Distribution:	Cathie Steele, Corporate Governance Manager
Committee:	Audit Committee

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1. Introduction and Background

A review of the Governance Arrangements within the Welsh Health Specialised Services Committee ('WHSSC' or the 'organisation') was completed in line with the 2018/19 Internal Audit Plan.

The aim of WHSSC is to ensure that specialised services are commissioned from providers that: have the appropriate experience and expertise; are able to provide a robust, high quality and sustainable service; are safe for patients; and are cost effective for NHS Wales.

In recent years WHSSC has been subject to governance reviews from the Good Governance Institute in 2015, and in the same year to a Clinical Governance review by Health Inspectorate Wales (HIW). The actions from both reviews were collated into a single action plan.

In 2017/18 we reviewed the progress that WHSSC had made against the actions within the plan. However, we did not review the structure or effectiveness of governance arrangements, and agreed with management to undertake this work as part of our 2018/19 Internal Audit programme.

In addition, in this year's work programme we have reviewed the arrangements in place for WHSSC's Sub-Committees.

The relevant lead for the assignment is the Committee Secretary and Head of Corporate Services.

2. Scope and Objectives

The objective of this audit was to evaluate and determine the adequacy of the systems and controls in relation to governance arrangements in order to provide assurance to the Audit Committee that risks material to the achievement of system's objectives are managed appropriately.

The areas that the review sought to provide assurance on were:

- The Joint Committee and its Sub-Committees are operating in accordance with regulations and meetings are being held with the correct frequency, composition and membership.
- Sub-Committees are delivering on their terms of reference and regularly reporting to the Joint Committee.
- Appropriate mechanisms are in place for monitoring and reporting WHSSC performance, and actions are taken to address any identified issues.
- Joint Committee provided clear and timely updates to Local Health Boards.

In addition, we followed upon the findings raised in our 2017/18 governance review.

3. Associated Risks

The potential risks considered in this review were as follows:

- The objectives of WHSSC are not achieved.
- Issues arise as governance arrangements are not effectively identifying and escalating issues.
- Areas of poor performance are not identified and addressed.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with governance arrangements is Reasonable assurance.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

WHSSC has governance arrangements in place which are generally working effectively, and are supported by detailed Standing Orders. These are implemented via regular meetings of the Joint Committee and its five sub-committees (Management Group, Integrated Governance Group, Quality and Patient Safety Committee, All Wales Individual Patient Funding Request Panel, All Wales Renal Clinical Network Group).

All of the terms of reference documents relating to the Joint Committee and its five sub-committees set out their respective mandates, role and responsibilities, membership, meeting frequency, quoracy attendance levels, and processes for escalation and reporting of key issues that may be identified.

Additionally, the purpose and objectives of the Joint Committee and its five sub-committees, as stated in their terms of reference, are reflected within their respective agendas and minutes.

WHSSC has appropriate mechanisms for regular internal and external monitoring and reporting of its performance via the Joint Committee and its Management Group sub-committee through to Welsh Government.

We note the regular attendance of Local Health Board Chief Executive members who engage with the issues and actions identified. Furthermore, summary reports are provided to them of the progress made on issues and actions in-between Joint Committee meetings.

The key issues that we identified during our audit that require management attention relate to: terms of reference documents that have not been reviewed; attendance of individuals or representatives at sub-committees; and the ongoing issue relating to non-quoracy at the Quality and Patient Safety Committee.

Furthermore, there was little evidence to support the organisation's progress in implementing the recommendations made in our 2017/18 report on governance.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Operation of Committees			✓	
2	Sub-Committees Delivery & Reporting				✓
3	Monitoring and Reporting Performance				✓
4	Joint Committee reporting to Local Health Boards				✓
5	Follow up of 2017/18 Report findings			✓	

* The above ratings are not necessarily given equal weighting when generating the audit opinion.

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the system control/design for governance arrangements.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as a weakness in the operation of the designed system/control for governance arrangements.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: The Joint Committee and its Sub-Committees are operating in accordance with regulations and meetings are being held with the correct frequency, composition and membership.

We note the following areas of good practice:

- WHSSC Joint Committee Standing Orders include the frequency of meetings, its mandate, roles & responsibilities, its membership, quorate attendance level, and the process for reporting and escalation of issues.
- The terms of reference for all five Sub-Committees stated the frequency of meetings, their mandate, constituent membership, member roles and responsibility, quorate attendance level and the process for reporting and escalation of issues to Welsh Government.
- All five of the Joint Committee meetings scheduled and held in accordance with the WHSSC annual business cycle between May 2018 and January 2019 were appropriately supported by a documented agenda, supporting action logs that showed evidence of ongoing review, and progress of issues raised.

We identified the following findings:

- The terms of reference (ToR) for two of the five Sub-Committees had not been reviewed. The Management Group ToR were due for review in September 2017 and the Welsh Renal Clinical Network were due for review in August 2017. At the time of the audit the revised terms of reference for the Welsh Renal Clinical Network were awaiting Joint Committee approval in March 2019.
- A review of sub-committee attendance identified that the Medical Director and Chair of the Quality and Patient Safety Committee have failed to attend two of the three Integrated Governance Committee meetings that we sampled. Similarly a representative from Hywel Dda University Health Board has only attended three of the six meetings of the Management Group sampled from 2018/19.

Furthermore, the non-attendance by some members at the Quality and Patient Safety Committee has meant that in July 2018 the meeting did not achieve quoracy. This is a recurring issue that has been escalated to the Joint Committee and by the Chair of WHSSC to Welsh Government.

Objective 2: Sub-Committees are delivering on their terms of reference and regularly reporting to the Joint Committee.

We note the following area of good practice:

- All five sub-committee's purpose and objectives, as stated in their terms of reference, are reflected within their agendas and minutes.

We identified the following finding:

- In October 2018 the Management Group noted an action for a report to be referred to the Quality and Patient Safety Committee. The subsequent agenda of the Quality and Patient Safety Committee did not include the report and as no minutes have yet been produced for this meeting it could not be verified that the report had been received.

Objective 3: Appropriate mechanisms are in place for monitoring and reporting WHSSC performance, and actions are taken to address any identified issues.

We note the following areas of good practice:

- WHSSC has appropriate mechanisms in place for regular internal and external monitoring and reporting of its performance via the Joint Committee, its Management Group sub-committee, and through to Welsh Government.

We did not identify any findings under this objective.

Objective 4: Joint Committee provides clear and timely updates to Local Health Boards.

We note the following areas of good practice:

- Our review of Joint Committee meeting minutes relating to 2018/19 confirmed there is regular attendance by Local Health Board Chief Executives who clearly engage with the issues and actions that are identified.
- Summary reports of the key actions points arising from each Joint Committee meeting are issued via email to the Chief Executives of the Local Health Boards and progress updates of identified issues or actions raised are provided in-between Joint Committee meetings.

We did not identify any findings under this objective.

Objective 5: Follow up on the findings raised in our 2017/18 Governance review.

We identified the following finding:

- Absence of verifiable progress in implementation of the outstanding actions from the 2017/18 Internal Audit Governance Report and a lack of progress reporting and monitoring at Integrated Governance Committee or the Quality and Patient Safety Committee.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	0	3	1	4

Finding 1 - Terms of Reference (Control design)	Risk
We reviewed the terms of reference (ToR) for the Joint Committee and five sub-committees and identified: • The Management Group ToR was due for review in September 2017 and has not yet been reviewed. • The Welsh Renal Clinical Network Group ToR was due for review in August 2017. At the time of our audit a revised ToR was due to be presented to the March 2019 Joint Committee for approval.	The objectives of WHSSC are not achieved.
Recommendation	Priority level
It should be ensured that sub-committee terms of reference are subject to regular review and update in accordance with their review cycle to ensure that any changes in mandate, meeting frequency, membership and quoracy is kept up to date.	Medium
Management Response	Responsible Officer/ Deadline
A review of the Management Group was undertaken in 2017. As part of the review the Managing Director and Committee Secretary met with the individual members of Management Group and the CEO of each LHB. The review resulted in a report to the Joint Committee that, if approved in its totality, would have resulted in a substantial re-write of the ToR; however the recommendations were	Committee Secretary – March 2020

not fully agreed, rather action was agreed to undertake an Organisational Development (OD) exercise, which recently commenced. It is anticipated that the ToR will be reviewed on conclusion of the OD exercise later in 2019. An earlier review would have resulted in an inability to approve revised ToR, so was regarded as inappropriate by the Managing Director and Committee Secretary.

The revised ToR for the Welsh Renal Clinical Network Group will be presented to the March 2019 Joint Committee for approval.

Committee Secretary – March 2019

Finding 2 - Attendance at committees (Operating effectiveness)	Risk
Our review of attendance at 2018/19 committees highlighted the following points: • Non-attendance of members at the Quality and Patient Safety Committee has been identified within the organisation as an ongoing issue and has resulted in the June 2018 meeting failing to meet quoracy levels. We acknowledge that this issue has been raised with Welsh Government. • Of the six Management Group meetings that we sampled we identified that a representative from Hywel Dda UHB had only attended half of the meetings. However, the ToR state minimum required membership attendance is 75%. • Of the three Integrated Governance Committee meetings that we sampled the Chair of the Quality and Patient Safety Committee and WHSSC Medical Director did not attend two of the meetings. The ToR requires their attendance, though on these occasions it did not affect the quoracy of the meeting.	The objectives of WHSSC are not achieved.
Recommendation	Priority level
1. Officers should be reminded of the importance of attending committee meetings. 2. Attendance should be monitored and any persistent non-attendees reported through the committee and action taken where necessary.	Medium

Management Response	Responsible Officer/ Deadline
Accepted. 1. Officers will be reminded of the importance of attending committee meetings. 2. Attendance will be monitored and any persistent non-attendees reported through the committee and action taken where necessary.	Committee Secretary – June 2019 Committee Secretary – December 2019

Finding 3 - Implementation of previous audit recommendations (Operating effectiveness)	Risk
In 2017/18 we reviewed the level of implementation of the outstanding recommendations made in the Good Governance Institute review and the Health Inspectorate Wales (HIW) review. We recommended that the 10 outstanding recommendations needed to be implemented and in addition two further recommendations in relation to governance matters were made. At the time of our review this year there was evidence to support varying levels of completion and progress in respect of the 10 consolidated Good Governance and HIW actions. However, there is no evidence of formal monitoring or reporting of the implementation status of the outstanding actions at either the Integrated Governance Committee, or the Quality and Patient and Safety Committee between June 2018 and February 2019. One of the other recommendations in relation to defining the role of the networks has now been implemented. The final recommendation has not yet been implemented. We note that the target completion timescale in respect of this recommendation had not been realistically set and did not take into consideration the Parliamentary Review that impacted on delivery of the stated actions.	Areas of poor performance are not identified and addressed.

Recommendation	Priority level
All previously agreed recommendations should be implemented as agreed and the Integrated Governance Committee and the Quality and Patient Safety Committee should review the ongoing progress with the implementation of the outstanding actions.	Medium
Management Response	Responsible Officer/ Deadline
Accepted. An update report will be presented to the Integrated Governance Committee. Arrangements for monitoring of the actions will be put in place.	Committee Secretary – December 2019

Finding 4 - Referral of information between groups (Operating effectiveness)	Risk
Our review of the flow of information between committees identified one instance where, in October 2018 the Management Group requested that a report that it had received on the South Wales Neonatal Transport Case Review, should also be reported to the Quality and Patient Safety Committee. We reviewed the agenda of the following Quality and Patient Safety Committee from January 2019 and note that the item had not been put on the scheduled for discussion. Furthermore, as the minutes for the meeting had not yet been produced, it could not be determined if this report was discussed.	Areas of poor performance are not identified and addressed.
Recommendation	Priority level
Where reports are referred for noting between committees, it should be ensured that effective processes are in place to ensure this takes place in a timely manner.	Low
Management Response	Responsible Officer/ Deadline
Noted. The report following the South Wales Neonatal Transport Case Note review was shared with the Members of the Quality and Safety Committee in January 2019 as an annex to the Women and Children Commissioning Team report. However, we accept that the minutes were not available at the time of the Internal Audit Review.	No further action.

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings



Substantial assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.



Reasonable assurance - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.



Limited assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.



No assurance - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.