

Bundle Audit Committee Part 2 14 January 2019

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CWM TAF UNIVERSITY HEALTH BOARD

AUDIT COMMITTEE MEETING 14 January 2019

A meeting of the Audit Committee will be held on Monday 14 January 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 8 October 2018	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

PART 3. INTERNAL / EXTERNAL AUDIT REPORTS

- | | | |
|-----|--|-------------------|
| 3.1 | Internal Audit Report – EASC Non-Emergency Patient Transport Service – Follow Up of Baseline Position Review | Attachment |
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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: <ul style="list-style-type: none">• 09.00am Monday 1 April 2019 | Oral/Chair |

CWM TAF UNIVERSITY HEALTH BOARD

'UNCONFIRMED' MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 8 OCTOBER 2018, AT YNYSMEURIG HOUSE, ABERCYNON

PART II – HOSTED BODIES

PRESENT

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

IN ATTENDANCE

Gwenan Roberts	-	Interim Board Secretary
Sara Utey	-	Wales Audit Office
Kevin Smith	-	Committee Secretary, WHSSC
Stuart Davies	-	Director of Finance, WHSSC
Paul Dalton	-	NWSSSP – Head of Internal Audit & Assurance
Emma Samways	-	NWSSSP - Internal Audit & Assurance
Emma Walters	-	Committee Secretariat
Marcus Longley	-	UHB Chair

AC/18/060

WELCOME AND INTRODUCTIONS

Chris Turner, Chair **welcomed** everyone to Part II of the meeting.

AC/18/061

APOLOGIES FOR ABSENCE

Apologies for absence were **received** from Stephen Harrhy and Robert Williams.

AC/18/062

DECLARATIONS OF INTERESTS

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

AC/18/063

UNCONFIRMED MINUTES OF THE AUDIT COMMITTEE MEETING HELD ON 9 JULY 2018

The minutes of the Audit Committee Part II, held on 9 July 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 – Chris Turner advised that he would obtain an update from Stephen Harrhy outside of the meeting **(action log updated)**.

Members **RESOLVED** to:

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

MATTERS ARISING NOT CONTAINED WITHIN ACTION LOG

Stuart Davies provided Members with an update in relation to issues experienced on HRG4. Members were reminded that discussions had been taking place with NHS England with challenge placed regarding the validity of price increases. Members **NOTED** that even though provision had been made in the accounts for the increases, liability from NHS England remained in place and the issue still remained as a risk.

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

Stuart Davies presented the report and apologised for its late submission. Members **NOTED** that 5 recommendations remained outstanding, 3 of which related to the signing off of English service level agreements (SLAs).

Members **NOTED** that there were 2 outstanding recommendations in relation to Governance which were actions for the Welsh Government to resolve and take forward.

A discussion was held in relation to CAMHS service escalation. Members **NOTED** that substantial progress had been made against the action plan and Members **NOTED** that the service had been de-escalated from Level 4 to 3 in South Wales.

Members **RESOLVED** to:

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

WHSSC Corporate Risk Assurance Framework

Kevin Smith presented the report which had been amended to reflect that robust processes were in place and now identified how risks were being assessed.

Members **NOTED** that work was ongoing to develop the Corporate Risk Assurance Framework with the latest version of the report taking into consideration feedback received from the WHSSC Integrated Governance Committee.

Members **NOTED** that the Director of Planning was responsible for all risks rated 15 or above and that additional work had been undertaken on other types of risk, for example financial risks and risks relating to Brexit.

Following discussion at the last meeting, Kevin Smith provided Members with an update as to how the escalation process worked within WHSSC. Members **NOTED** that WHSSC Directors review the escalation process to determine what level of escalation was required and what actions needed to be undertaken (**action log updated**).

Members **NOTED** that all risks continued to be monitored by the WHSSC Quality, Safety & Risk Committee.

Chris Turner thanked Kevin Smith for the report and advised that the process appeared to be developing well.

Members **RESOLVED** to:

- **NOTE** the update provided.

**EMERGENCY AMBULANCE SERVICES COMMITTEE (EASC)
RISK REGISTER**

Gwena Roberts presented the Risk Register which was last received by the EAS Committee at its July meeting. The Risk Register was also presented to the Cwm Taf UHB Quality, Safety & Risk Committee in September.

Members **NOTED** that the Amber Review had been added as risk and a report on the review would be presented to the next EAS Committee meeting. Members **NOTED** that there was still a delay in appointing to the Chair of EASC.

Members **RESOLVED** to:

- **NOTE** the update provided.

PART 3. INTERNAL/EXTERNAL AUDIT REPORTS

AC/18/069

INTERNAL AUDIT REPORT – HIGH COST DRUGS

Emma Samways presented the report, the objective of which was to look at 3 particular drug treatments which had high cost spend. Members **NOTED** that a reasonable assurance rating had been allocated with 2 medium and 1 low priority recommendation being made.

Members **NOTED** that further work would be undertaken by the WHSSC team regarding mortality and ensuring the mortality register was being kept up to date and that a Welsh version of the English Commissioning guidelines was in the process of being developed.

Members **RESOLVED** to:

- **NOTE** the update provided.

AC/18/070

INTERNAL AUDIT REPORT – NETWORK BOARDS

Paul Dalton presented the report which had been allocated a reasonable assurance rating. Members **NOTED** that 3 medium priority recommendations had been made and that a positive management response had been received from the WHSSC team. Stuart Davies advised that the recommendations made within the report had been accepted.

Members **RESOLVED** to:

- **NOTE** the update provided.

PART 4. ANY OTHER URGENT BUSINESS

AC/18/071

Maria Thomas extended her thanks to Chris Turner for the leadership he had shown to the Committee and advised that he would be sadly missed. Chris Turner in thanking Maria Thomas extended his thanks to all colleagues for their support in his role as Chair of Audit Committee.

AC/18/072

AUDIT COMMITTEE MEMBERS TO MEET WITH THE AUDITORS

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

DATE OF NEXT MEETING

Monday 14 January 2019 at 9.00am

.....
Dr Chris Turner, Chair

.....
Date

AUDIT COMMITTEE ACTION LOG
From 8 OCTOBER 2018
(Part 2 – Hosted Bodies)

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS At January 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	Oral update
18/054	09/07/2018	~~WHSCC Corporate Risk Assurance Framework~~	~~Escalation processes to be shared with Audit Committee Members~~	Oct 2018	~~WHSCC 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 Harrhy outside of the meeting	Oct 2018	Audit Committee Chair	Dr C Turner to obtain an update from Mr Harrhy outside of the meeting.



GIG
CYMRU
NHS
WALES

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

		Agenda Item	2.1
Meeting Title	Audit Committee	Meeting Date	14/01/2019
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		Meeting Date	
	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 commenced. There is 1 outstanding report, with all fieldwork completed, that should be ready to place before the next committee. 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
- 3 recommendation are not yet due for implementation
- 25 recommendations have been achieved, 2 recommendations have been superseded by later audit reports.
- 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 WHSSC Governance Framework:

- 3 recommendations were made, of which 2 have been achieved and 1 is not yet due for implementation.

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.

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

- 3 recommendations were made, of which 1 has been achieved and 2 have not yet fallen due for implementation.

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 Welsh Renal Clinical Network Review Report
January 2019

No.	Recommendation	Priority	Timescale	Lead Director	Owner	Progress	Completed
IA WRCN 2017 1	SLA's with Welsh Health Boards are re-negotiated and agreed on an annual basis to take account of changes in the type and level of services being commissioned. The SLAs cover all of the services commissioned by WHSSC from each provider, including those relating to Renal services. However, the value of renal services within the overall SLAs is relatively small. For example, the total value of services commissioned from Cardiff and Vale UHB is around £186m with the value of the renal services representing approximately 12% (£23m) of the contract value. The overall contracting risk in relation to the WRCN is further reduced as renal dialysis services provided by Independent Sector Providers (ISPs) are subject to separate framework contracts between the Health Board and ISP. Across Wales 57% of dialysis sessions are currently provided by ISPs. At the time of our audit fieldwork the SLAs, with the Welsh Health Boards for 2016/17, were in the process of being issued by WHSSC. We note that WHSSC Management approved the 2016/17 standard template SLA in August 2016. Whilst this represents a risk for WHSSC as a whole, we acknowledge that the agreement of the SLAs is outside the direct control of the WRCN. In addition, we identified that WHSSC did not have a timetable for issuing and agreeing SLAs with Welsh Health Boards for 2016/17. There is a risk that a dispute might arise with a provider health organisation, as a formally agreed SLA or contract is not in place. Management should ensure that all SLAs relating to 2016/17 are agreed and signed as soon as practically possible. Any SLAs that have not yet been agreed should be highlighted to a relevant committee, explaining the associated risk. In addition, management should ensure that an appropriate timetable is established for issuing and agreeing future SLAs.	HIGH	Apr-17	Director of Finance	WRCN Manager	The agreement and signing of contracts is a high level WHSSC issue which would apply to all the programme teams including the WRCN. The ability to influence this strategic process is limited and the risk does not sit with the WRCN. The proportionality of the renal elements in the larger contracts is relatively small - often around 20%. A significant proportion of the activity and its funding are linked to national contracts (e.g. Unit Haemodialysis and high cost medicines) and are effectively passed through to the commissioners. It should also be reflected that the WRCN commissioned services work within a ring-fence, effectively looking to absorb ongoing cost pressures for as long as possible, using internally generated savings to manage demand. All net investment into the services, even from the ring-fence, are approved by the WRCN Board and have to be ratified by the joint Committee. As the evidence has demonstrated, the WRCN collects, analyses and uses a huge amount of data to oversee the commissioning and performance management of renal services for the Welsh population. With this in mind, and accepting the need for generic headlines, there is some discomfort in suggesting that renal services are not effectively commissioned. Two critical points to make which are objectively evidenced: 1. The performance of renal services in Wales as measured by the UK Renal Registry has risen annually since 2008. Wales now is the 'best' against a number of parameters compared to the other home nations https://www.renalreg.org/publications-reports/; and 2. the WRCN has returned funding back to WHSSC at the end of each financial year on a non-recurrent basis (this can be sourced from the WHSSC accounts). These two points suggest that renal services in Wales are effectively commissioned. Appreciating the point generally about the agreement and signing off of contracts is important but it needs to be targeted at the parts of the organisation most able to resolve.	COMPLETED

						WHSSC Comments In assigning a risk level to the issue of providers returning signed contracts, it is essential that this is placed in context: - the legal contracts for all ISP providers are held by the overall parent Trust and not by the WRCN - for example, CVUHB hold all the contracts for the SE Wales on behalf of the network - therefore the existence or otherwise of a temporarily unsigned SLA between CVUHB and WHSSC has no impact on the contracts for provision of ISP services and therefore does not present a risk let alone a high risk to commissioning; - the same is true for host providing Trusts in England, although these are generally much less material; - throughout the period of operation of WHSSC and its predecessor organisations there has not been an occasion when the absence of a signed returned contact has translated into a real risk or dispute resulting in any service disruption or financial risk. it is not accepted that this is therefore a high risk area. Audit Note: We acknowledge management's response to this finding and recommendation. Whilst we have noted that the responsibility of ensuring contracts and agreements are signed does not lie within WRCN; the scope of our review included reference to the formal agreement of service contracts. We have attributed a high priority to the implementation of the recommendation as we do not consider this finding to lie within the definitions of a medium priority recommendation as set out in Appendix B of this report. PROGRESS: All Welsh SLAs for 2017/18 have been signed which will cover the material expenditure for this group of services. Note that no English contracts can be signed until the HRG4+ funding issues is resolved.	
						PROGRESS: October 2018. Final 2017/18 contract positions have been reached with Liverpool, Shrewsbury, Wirral and University Hospitals Birmingham.	
IA WRCN 2017 2	Annual contracts should be agreed with English NHS providers covering all the services commissioned by WHSSC from each provider, including those relating to Renal Services. We identified that WHSSC did not have a timetable for issuing and agreeing contracts with English NHS providers for 2016/17. In addition, as part of our audit fieldwork, we reviewed a sample of four contracts with English providers and note that: - baseline costs for 2016/17 have been agreed via email between WHSSC and the Royal Liverpool and Broadgreen and Birmingham University Hospital. Whilst we understand that 'inferred' contractual relationships exist on the basis, the core contracts have yet to be agreed; and - no formal contract or agreements of costs for 2016/17 have been agreed with the Wirral University Teaching hospital NHS Foundation Trust. Historically the value of renal services commissioned from this provider is around £300k. We understand that WHSSC have been chasing the Trust for a response to its contract agreement a request but this has yet to be received. Management should ensure that all contracts relating to 2016/17 are agreed and signed as soon as practically possible. Any contracts that have not yet been agreed should be highlighted to the relevant committee, explaining the associated risk.	MEDIUM	Apr-17	Director of Finance	WHSSC Officers	Management response included in finding 1. PROGRESS: All Welsh SLAs for 2017/18 have been signed which will cover the material expenditure for this group of services. Note that no English contracts can be signed until the HRG4+ funding issues is resolved. There are only 3 LTA contracts with NHS England that the WRCN has the direct responsibility for commissioning services with. Financial values for 17-18 have been agreed with the Royal Liverpool and Broadgreen and the Wirral Teaching Hospitals. In light of the WHSSC quality agenda all LTA documentation has been reviewed for compliance with national and WRCN quality standards for transplant and dialysis. Once the HRG4+ issue has been resolved these contracts will be signed. Negotiations are ongoing with the Royal Shrewsbury and Telford following 2 contract and quality visits in recent months in order to attempt to resolve dialysis capacity issues. The WRCN is working closely with BCU LHB and the Royal Shrewsbury to coordinate access across all units in the area.	COMPLETED

	In addition, management should ensure that an appropriate timetable is established for issuing and agreeing non NHS Wales contracts. There is a risk that a dispute might arise with a provider health organisation as a formally agreed SLA or contract is not in place.					PROGRESS: October 2018. Final 2017/18 contract positions have been reached with Liverpool, Shrewsbury, Wirral and University Hospitals Birmingham. As the WRCN is only responsible for the renal elements of services contained in the above much larger contracts, with WHSSC being responsible for the remainder.	
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Welsh Health Specialised Services Committee
Register of Recommendations from the Internal Audit Cancer and Blood Programme Review Report
January 2019

No.	Recommendation	Priority	Timescale	Lead Director	Owner	Progress	Completed
IA CA 2016 1	SLAs with Welsh Health Boards and service contracts with English NHS providers should be agreed on an annual basis. The SLAs and contracts cover all the services commissioned by WHSSC from each provider, including those relating to Cancer services. The agreements are re-negotiated on an annual basis to take account of changes in the type and level of services being commissioned. We identified that WHSSC did not have a timetable for issuing and agreeing SLA's with Welsh Health Boards, or contracts with English providers for 2016/17. At the time of our audit field work the SLAs with the Welsh Health Boards for 2016/17 were in the process of being issued by WHSSC. We note that WHSSC management approved the 2016/17 standard template SLA in August 2016. Whilst this represents a risk for WHSSC as a whole we acknowledge that the agreement of the overall SLAs is outside the direct control of the Cancer and Blood programme team. We also reviewed a sample of 5 non Welsh NHS providers to establish if heads of agreement contracts had been signed for 2016/17. The programme team was unable to provide evidence of signed contracts for any of the 5 providers. The cumulative value of the contracts is £11,174,000. There is a risk that services are not effectively planned and commissioned. Management should ensure that all SLA's and contracts relating to 2016/17 are agreed and signed as soon as practically possible. Any contracts that have not yet been agreed should be highlighted to the relevant committee explaining the associated risk. In addition, management should ensure that an appropriate timetable is established for issuing and agreeing future SLAs (within NHS Wales)and other non NHS Wales contracts.	HIGH	Apr-17	Director of Finance	Director of Finance	SLA's have been agreed in principle for some time in 2016/17 and WHSSC has sent signed copies to Health Boards together with reminders of the importance of signing as well as agreeing. Despite escalation it is providing difficult to achieve compliance from Health Boards. Signing by Health Boards is not within the authority of WHSSC to control. However, will continue to press for signed copies of SLAs and contracts to be returned. There are clear contractual frameworks in place for cancer services within SLAs and there are not any disputes in 2015/16 and 2016/17. The risk of a dispute is low. PROGRESS: All Welsh SLAs for 2017/18 have been signed which will cover the material expenditure for this group of services. Note that no English contracts can be signed until the HRG4+ funding issue is resolved. PROGRESS: Finalisation of English contracts for 2017/18 is ongoing. Negotiations are ongoing with NHS England and the department of Health. Where possible contracts have been finalised and closed down for the financial year 2017-18. PROGRESS: English LTA contracts for 2017/18 have now been closed down. HRG 4+ charges for 2017/18 were subsidised by NHS England and the charges to WHSSC from NHS Trusts for that year have been dropped.	COMPLETED

Welsh Health Specialised Services Committee

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

January 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. Regarding the seven actions for Welsh Government; having advised Welsh Government of the actions during 2016, WHSSC regards its responsibility as complete.	

Welsh Health Specialised Services Committee
Register of Recommendations from the Internal Audit Report on the Mental Health Programme Team
January 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
January 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.	
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.	
IA BG 2018 3	We reviewed the minutes of the last seven Joint Committee meetings held between July 2017 and July 2018 to ensure reports were being regularly received from advisory groups and boards. The All Wales Posture and Mobility Partnership Board had not submitted any reports to the Joint Committee during the period that we reviewed. WE note that the group had met in December 2017, and again in March 2018, but the last report from that group that was submitted to the Joint Committee was in March 2017. There is a risk that governance arrangements are not being properly discharged. There is a risk of ineffective decision making and monitoring. The All Wales Posture and Mobility Partnership Board should be reminded of the requirement to submit a report to the Joint Committee following each advisory group meeting.	MEDIUM	Oct-18	Committee Secretary	Committee Secretary	Accepted. The chair of the All Wales Posture and Mobility Partnership Board will be reminded.	COMPLETED

Welsh Health Specialised Services Committee
Summary of Outstanding Internal Audit Recommendations
January 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	2	1	1	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	2	0	0

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

		Agenda Item	2.2
Meeting Title	Audit Committee	Meeting Date	14/01/2019
Report Title	WHSSC Corporate Risk and Assurance Framework		
Author (Job title)	Business Support Officer		
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 as at 31 October 2018.			
RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☒	INFORM ☒

Sub Group /Committee		Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: 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
		✓			✓		✓	



1.0 SITUATION

The purpose of this report is to provide Members with an update on the WHSSC risk management framework as at 31 October 2018.

2.0 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.

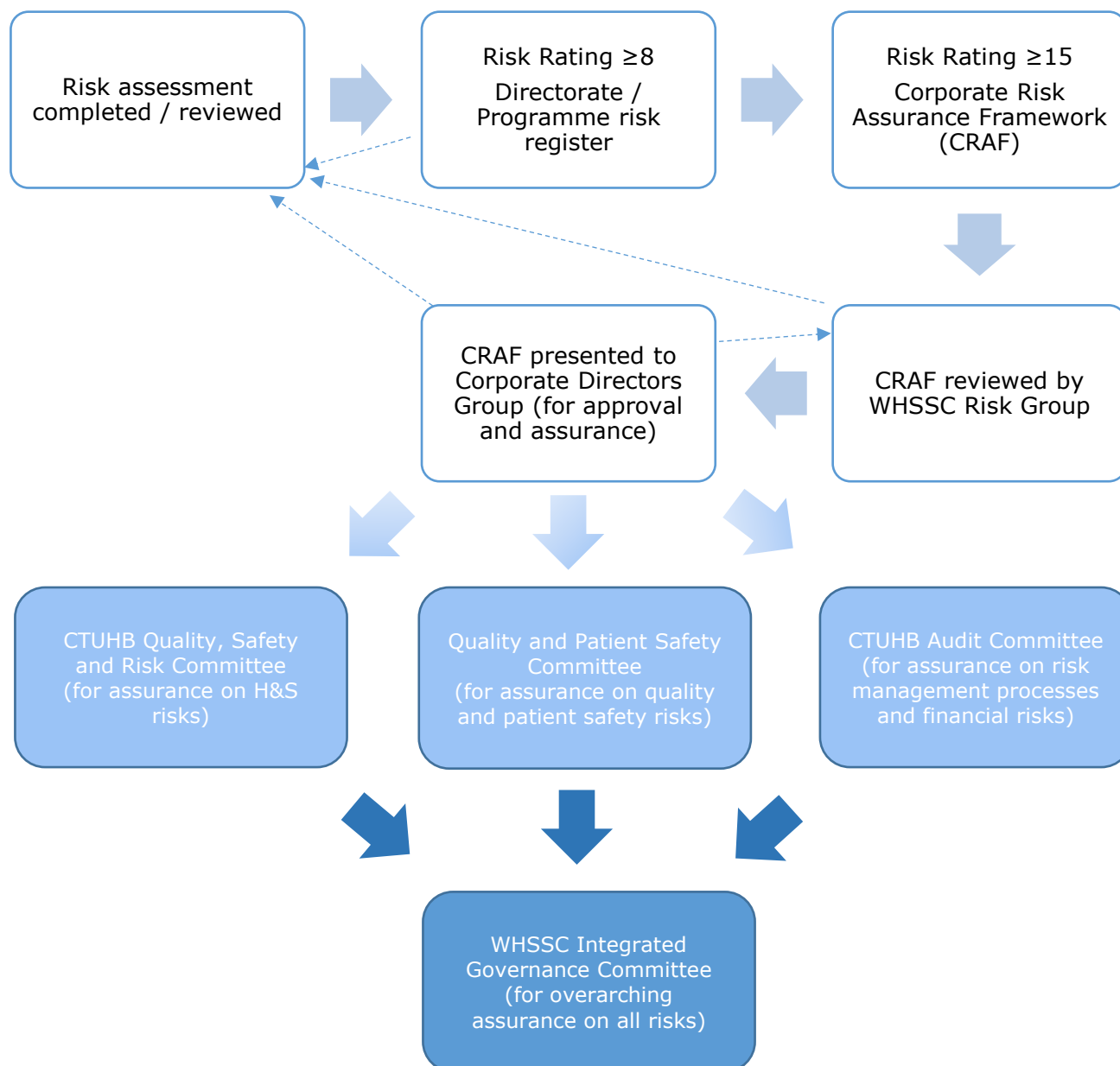
The CRAF is considered at the WHSSC Internal Risk Management Group. This leads to an enhanced focus on risk management generally and an improved level of triangulation between provider performance and risk for commissioning risks. A robust process for ensuring that identified risks are also recorded,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





3.0 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 Action agreed at IGC (14.08.18) individual risks on a page now show services in escalation.
- 3.3 There are currently 11 services in escalation as of the most recent report dated September 2018 - detailed in Table 1.
- 3.4 Internal Risk Group meeting held on 28 November 2018. Members agreed allocation of non-commissioning risks. In addition, group identified a number of risks rated 8 or less.
- 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. The WHSSC Quality & Patient Safety Committee is the assurance committee for these risks.
- 3.6 In the meantime the Directorate and Programme risk registers continue to be reviewed monthly – they are 'live' documents.
- 3.7 Since the last report, 3 risks have been added to the register, namely:
- NC/040 Neurosurgery Paediatrics
 - NC/041 Posture and Mobility North Wales
 - NC/042 Major Trauma Implementation



Table 1. Services in Escalation as at September 2018

Speciality	Level of Escalation	Mitigating action[s]	Movement from previous month
Adult Posture & Mobility	2	Quarterly meetings occur with all three providers but discussions have taken place separately with North Wales regarding their worsening position.	→
BMT	2	The BMT service in south Wales has recently been placed into level 2 escalation to explore further concerns raised. The first meeting was held in June where the data requirements to assess the potential risks were agreed	→
Cardiac surgery	2	Performance meetings continue bi-monthly with ABMUHB.	→
	3	Monthly performance meetings continue with C&VUHB	
Lymphoma Panel	2	Performance meetings are in place with the All Wales Lymphoma Panel (CVUHB and ABMUHB).	→
Paediatric Intensive Care	2	Monthly performance meetings are scheduled to take place with the service.	→
Plastic Surgery	2	Monthly performance meetings continue with ABMUHB	→
Thoracic surgery	2	Monthly performance meetings continue with ABMUHB and C&VUHB.	→
Neurosurgery	2	The Neurosurgery service has been deescalated from a level 3 to level 2, as a result of the improvement in the RTT waiting times since February 2018. Although, the service are still not achieving the 36 week target, monthly meetings are continuing to take place to monitor the situation.	↑
CAMHS	3	An action plan has been developed with BCUHB and significant improvements to workforce issues have been made in last 3 months.	→
	3	The CAMHS service in South Wales at Ty Llidiard was escalated straight to level 4 following inpatient incident leading to a temporary closure of the unit. Site visit and findings from QAIT report led to unit being reopened to admissions on case by case basis and de-escalated to Level 3 with action plan developed.	→
Paediatric Surgery	3	An outcome letter was issued to the HB following the Commissioning Quality Revisit that took place on the 16th of May. The service remains at level 3 of the escalation process and a further re-visit is scheduled to take place on the 24th of October 2018.	→
Bariatric Surgery	3	An assessment of evidence has been undertaken and the bariatric service was de-escalated from level 4 to 3 in April. Bimonthly performance meetings are in place.	→



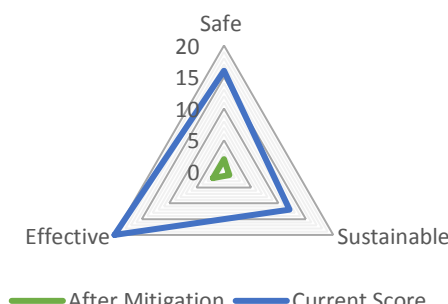
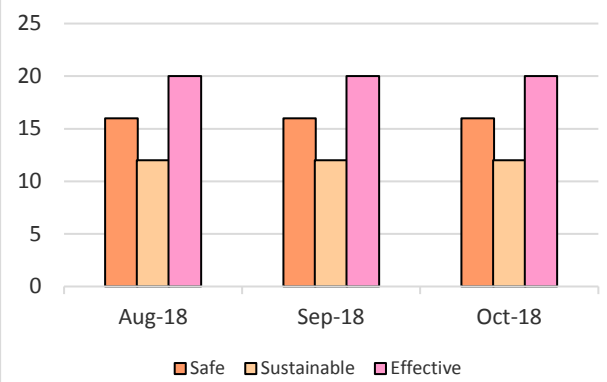
4. RECOMMENDATIONS

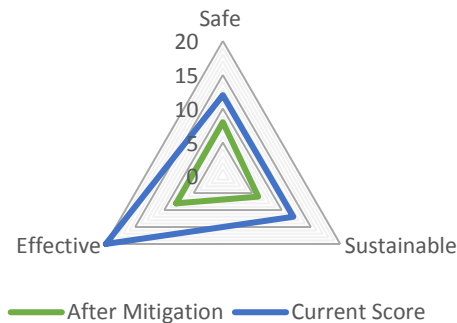
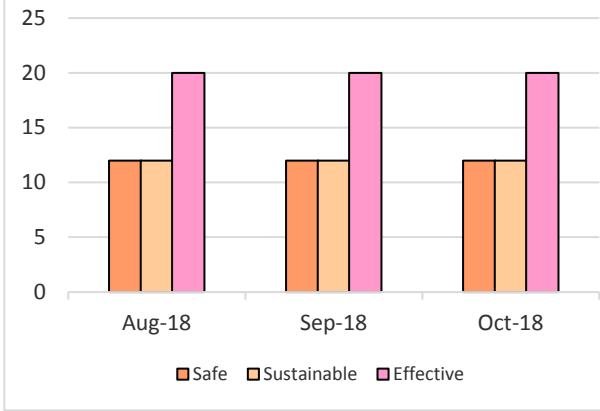
Members are asked to:

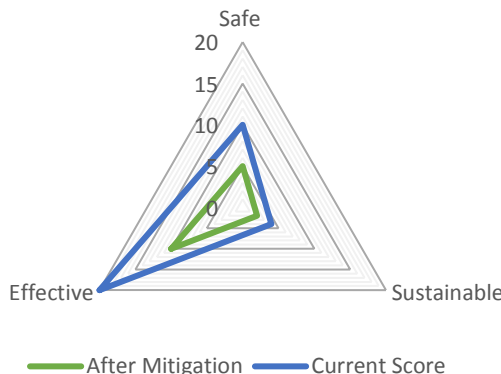
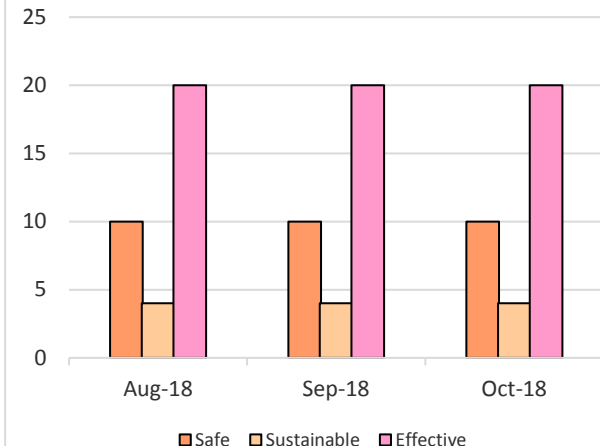
- **Note** the update provided within the report.
- **Receive assurance** that risks are being appropriately assessed and managed.

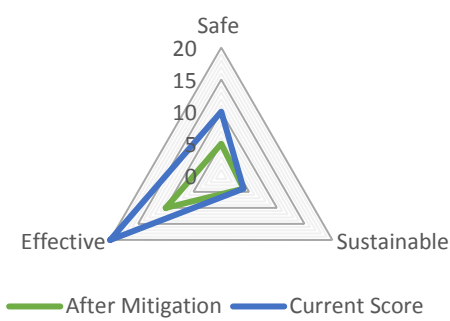
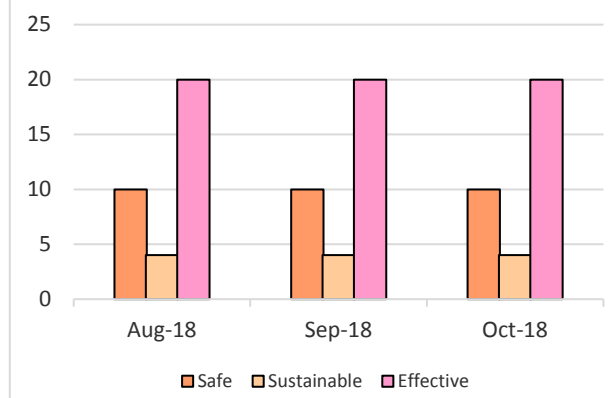


Link to Healthcare Objectives		
Strategic Objective(s)	Governance and Assurance	
Link to Integrated Commissioning Plan	Implementation of the agreed ICP	
Health and Care Standards	Safe Care Effective Care Governance, Leadership and Accountability	
Principles of Prudent Healthcare	Only do what is needed 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
Corporate directors Group Board	04.12.2018	Report noted.

CT/013	CARDIAC ABLATION			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
OCT 2018	Risk: Safe: People with atrial fibrillation have a higher risk of stroke and heart attacks, and they also suffer a considerably poorer quality of life. Access to cardiac ablation for Atrial and Ventricular Tachycardia is far lower in South Wales than in North Wales, England, Scotland, and in 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 are often referred late in the progression of their disease, leading to poorer outcomes and the 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 South 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 South Wales, compared with 102 in North Wales and 113 for England overall. The British Heart Rhythm Society has set a minimum standard of 100 AF ablation pmp.			Date first assessed 05/02/2016 Date last reviewed by Programme / Directorate: Asst. Planning Mgr. 01/11/2018			
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. To be worked through as a recommissioning scheme.		Planning Manager	On-going

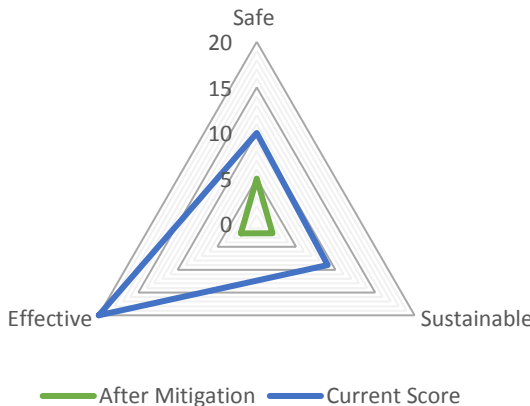
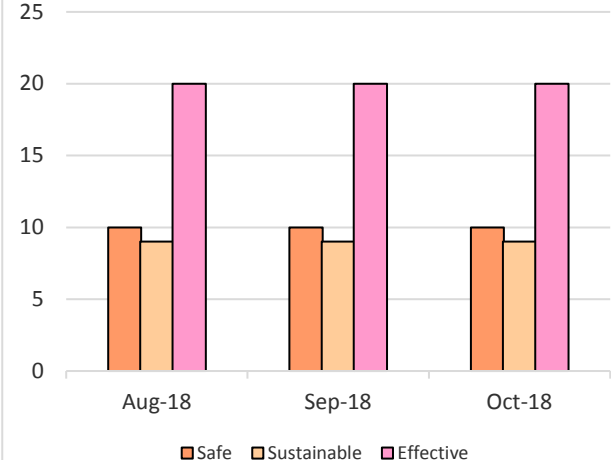
CT/014	INTERVENTIONAL CARDIOLOGY			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
OCT 2018	Risk: Safe: Revascularisation delivery outside the 72 hours increases the risk for patients of having higher risk of future adverse cardiovascular events. Sustainable: 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.			Date first assessed 01/05/2016 Date last reviewed by Programme / Directorate: Asst. Planning Mgr. 01/11/2018			
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

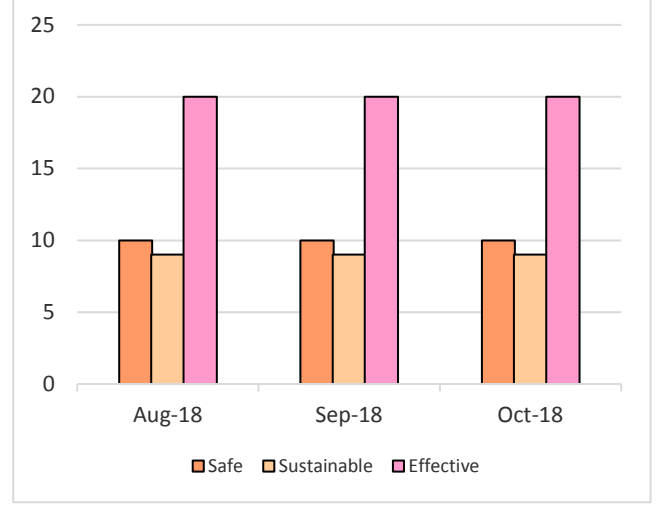
CT/029	Cardiac RTT Reporting Risk: Safe: (1) As part of the DU work, they observed that TAVI waiting lists are not being reported at ABMUHB. Sustainable: N/A. Effective: (2) the Delivery Unit are currently reviewing the application of pathways start dates at tertiary cardiac centres, initial feedback suggests that this may not being robustly implemented currently 3) ABMUHB have excluded certain diagnostics from their cardiac pathways.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 28/07/2017 Date last reviewed by Programme / Directorate: Asst. Planning Mgr. 01/11/2018			
OCT 2018							
Risk Rating				WHSSC Risk Assessment Triangle			
	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

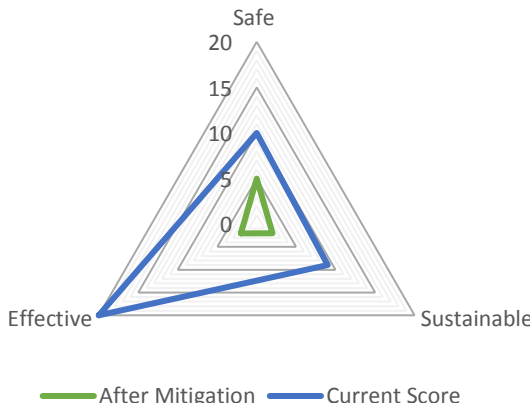
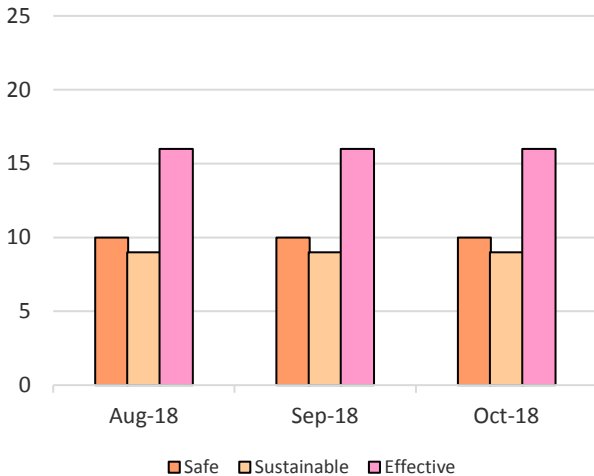
CT/030	Cardiac Surgery Pathway			Director lead: Director of Planning		
OCT 2018	Risk:			Assuring Committee: Quality and Patient Safety Committee		
	Safe: patients are waiting longer surgery, with potential greater risk of mortality.			Date first assessed		
	Sustainable: N/A.			Date last reviewed by		
Effective: The current processes for transferring patients between hospitals is inadequate resulted in patients waiting longer than reported.			Programme / Directorate: Asst. Planning Mgr. 01/11/2018			
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.	Health Boards	Ongoing	

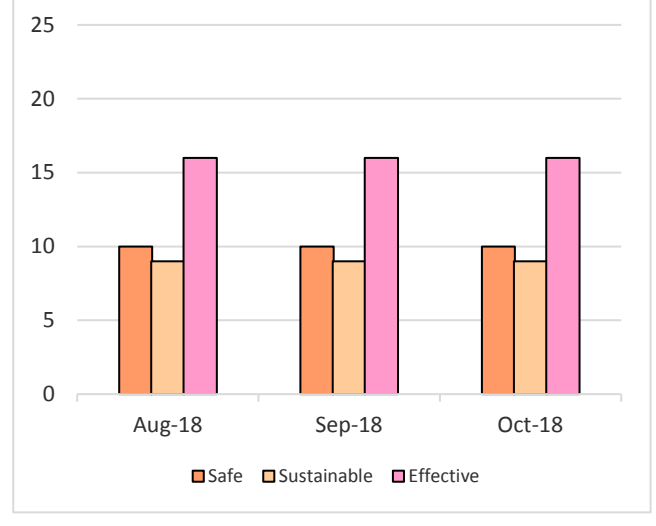
CT/032	ACHD Risk: Safe: inequitable service provision across South Wales. Sustainable: there is a single handed ACHD Consultant based at UHW which results in lack of cover for leave or sickness. Effective: gaps in meeting NHS England CHD Standards for level 2 and level 3 centres.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 23/03/2018 Date last reviewed by Programme/Directorate: Asst. Planning Mgr. 01/11/2018	
OCT 2018					
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	16	16	16		
				25 20 15 10 5 0 Aug-18 Sep-18 Oct-18 Safe Sustainable Effective	
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 to develop 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 in November.	Planning Manager	11/18

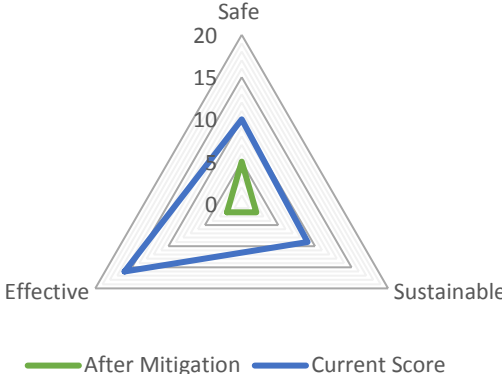
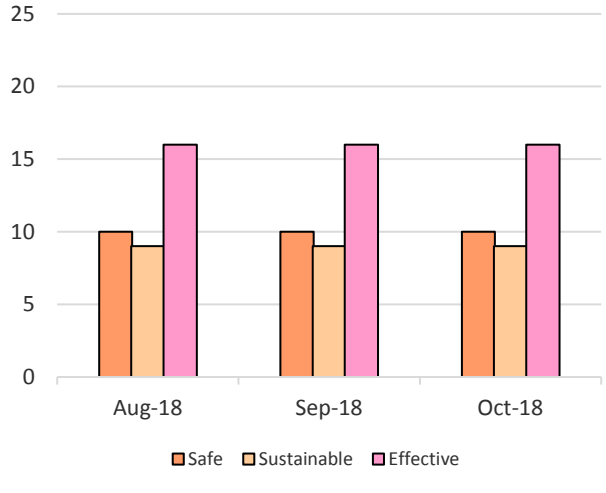
CT/036 (formerly WC/016) OCT 2018	CYSTIC FIBROSIS Risk: Safe: inpatient beds are under increasing pressure, with patients forced to wait extended periods at home placing them at clinical risk or alternatively being admitted to general ward beds with significant infection risks. Sustainable: there is 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.			Director 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. 01/11/2018			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	3	3	3				
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
				Joint Committee approved the funding investment for Phase 1 in July 2018. Phase 2 to be progressed when the capital funding is in place and Phase 1 funding has been implemented.		CVUHB & Planning Mgr.	ONGOING

CT/037 (formerly CT/023)	CARDIAC SURGERY C&VUHB Risk: 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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
OCT 2018				Date first assessed 09/07/2018 Date last reviewed by Programme / Directorate: C&B Commissioning 01/11/2018			
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 Level 3 and a performance quality visit will be scheduled in the Autumn.							
Current Control Measures in Place				Description of further Control Measures Required			
Regular monitoring of data and regular performance management meetings with providers.				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

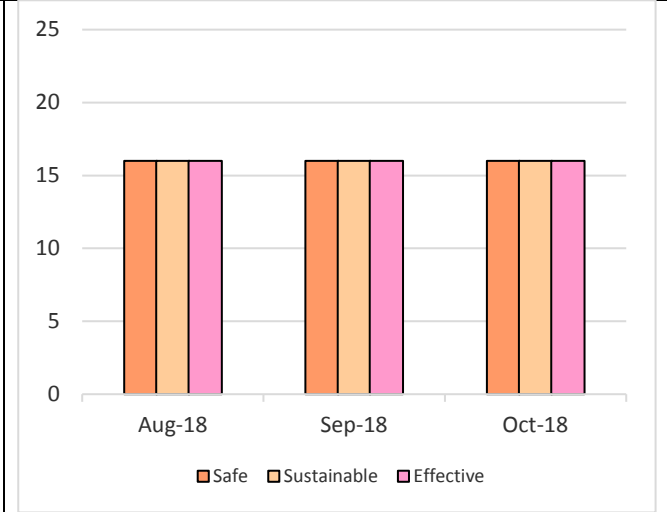


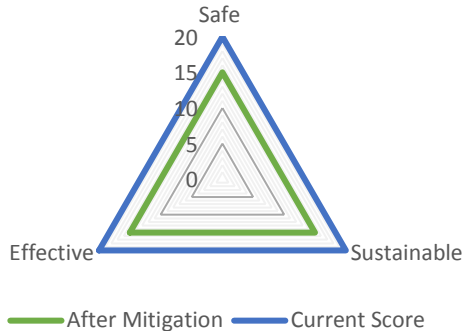
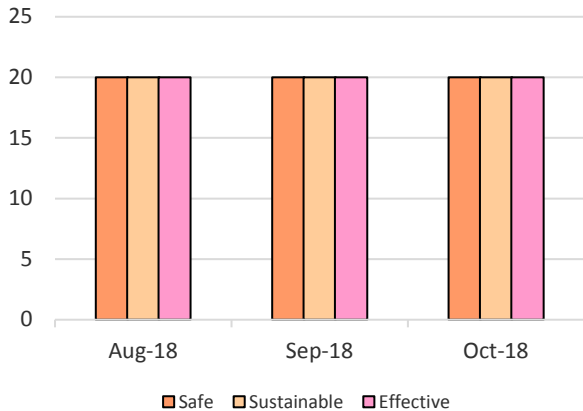
CT/038 (formerly CT/023)	CARDIAC SURGERY ABMUHB Risk: Safe: patients are waiting longer surgery, with potential greater risk of mortality. Sustainable: insufficient capacity for cardiac surgery to be delivered within waiting time standards. Effective: failure to meet Welsh Government RTT targets for cardiac surgery.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
OCT 2018				Date first assessed 09/07/2018 Date last reviewed by Programme / Directorate: C&B Commissioning 01/11/2018			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
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 regular performance management meetings with providers.				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



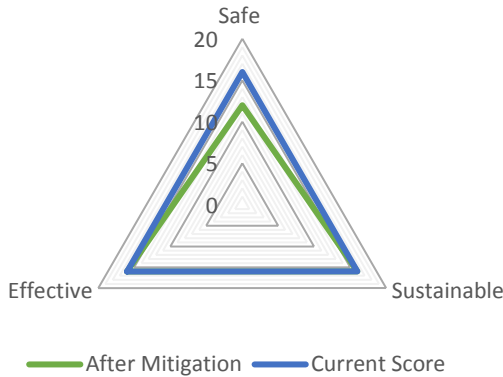
CT/039 (formerly CT/023)	CARDIAC SURGERY LHCH /BCUHB Risk: Safe: patients are waiting longer surgery, with potential greater risk of mortality. Sustainable: insufficient capacity for cardiac surgery to be delivered within waiting time standards. Effective: failure to meet Welsh Government RTT targets for cardiac surgery.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
OCT 2018				Date first assessed 09/07/2018 Date last reviewed by Programme / Directorate: C&B Commissioning 01/11/2018			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
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 regular performance management meetings with providers.				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

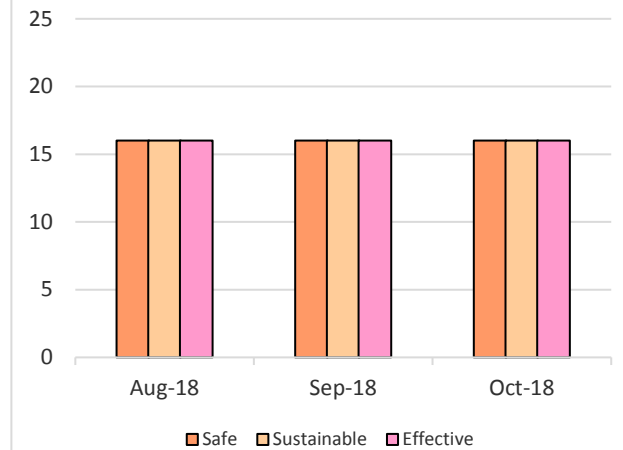
CT/040	PAEDIATRIC CHRONIC HEART DISEASE (CHD) Risk: Safe: inequitable service provision across South Wales. Sustainable: insufficient input from Specialist CHD Cardiologist to outreach clinics. Particularly, in Hwyl Dda University Health Board. Effective: gaps in meeting NHS England CHD Standards for level 2 and level 3 centres.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
OCT 2018				Date first assessed 13/07/2018 Date last reviewed by Programme / Directorate: C&B Commissioning 01/11/2018			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective	Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score			
After Mitigation	4	4	4				
Current Score	16	16	16				
				Aug-18 Sep-18 Oct-18 Safe Sustainable Effective			
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		
SEPT 2018				Date first assessed 10/11/2017 Date last reviewed by 31/10/2018 Programme / Directorate: Carl SHORTLAND		
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective			
After Mitigation	15	15	15			
Current Score	20	20	20			
						
Escalation Narrative: WHSSC/Cwm Taf 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/WHSS C 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.		ABMU/CT/WG	31/12/2018	

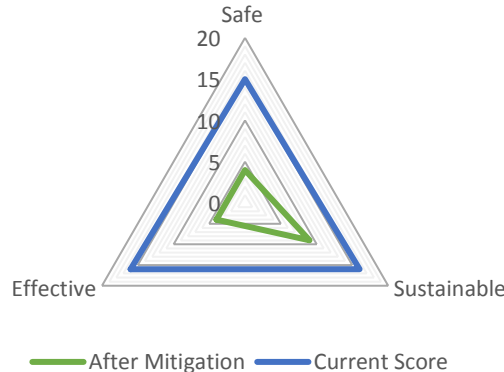
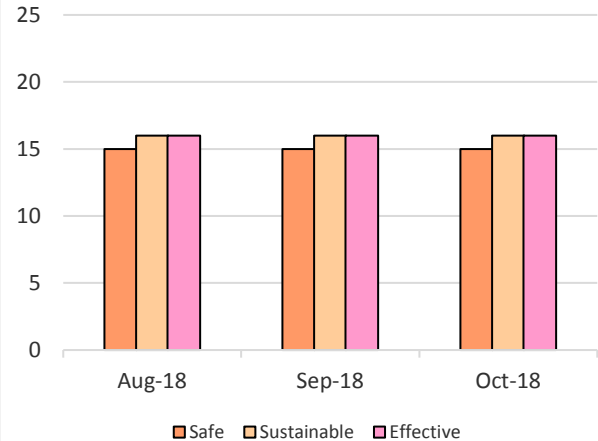
NC/001	SPINAL REHABILITATION Risk: There are significant risks related to delivering a sustainable service that can achieve British Society of Rehabilitation Medicine (BSRM) standards for specialised rehabilitation. Whilst the service is unable to meet staffing levels to the recommended minimum standards 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.	Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee
OCT 2018		Date first assessed 01/05/2014 Date last reviewed by Programme / Directorate: Sp. Planning Mgr. 30/09/2018

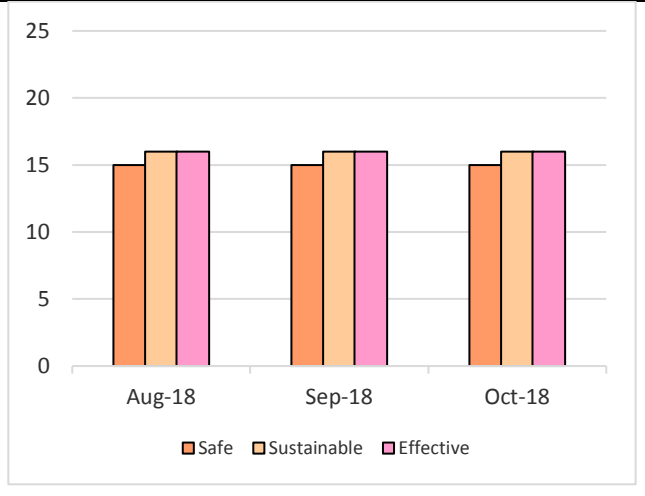
Risk Rating			WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective	
After Mitigation	12	16	16	 Safe 20 15 10 5 0 Effective Sustainable After Mitigation Current Score
Current Score	16	16	16	

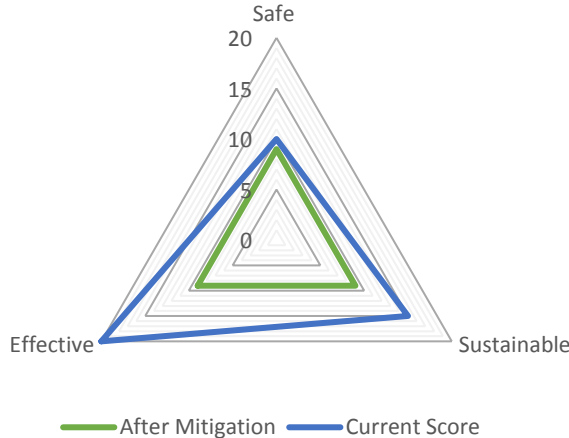
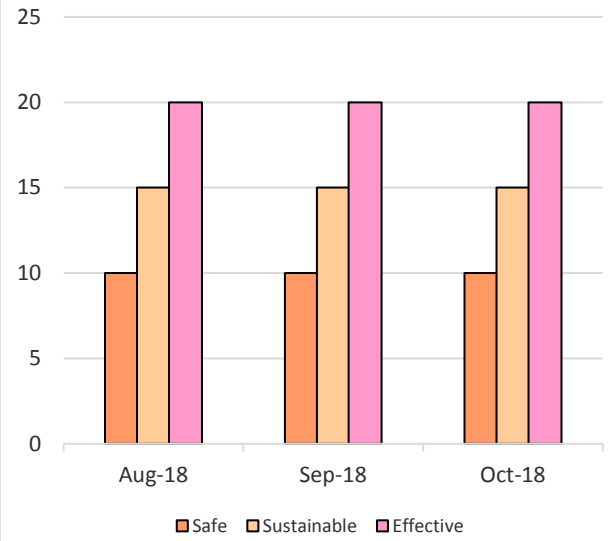


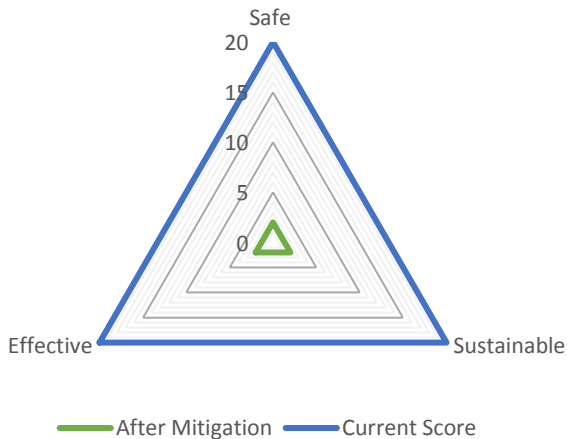
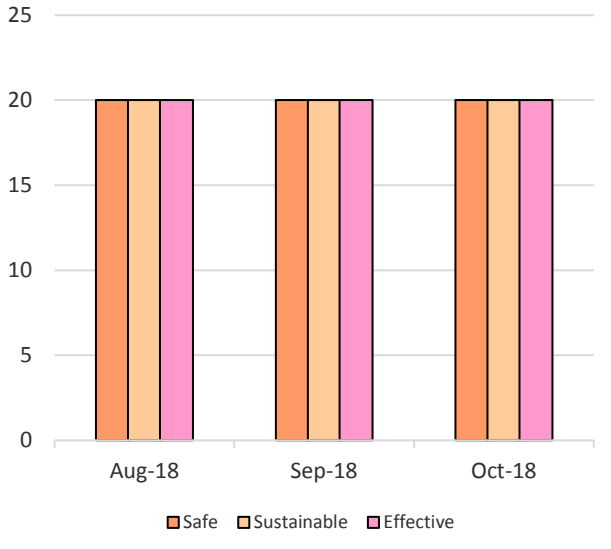
Escalation Narrative:

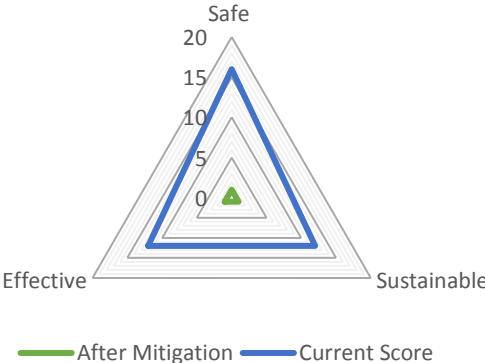
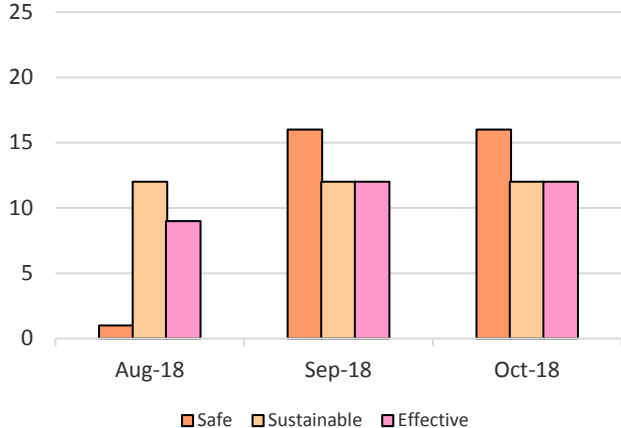
Current Control Measures in Place	Description of further Control Measures Required		
A proposal to address the immediate staffing concerns was submitted for inclusion in the 2017-20 ICP. Similarly to the majority of proposals submitted, funding was not allocated to this proposal and the risk remains.	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.	Planning Manager	01/10/18

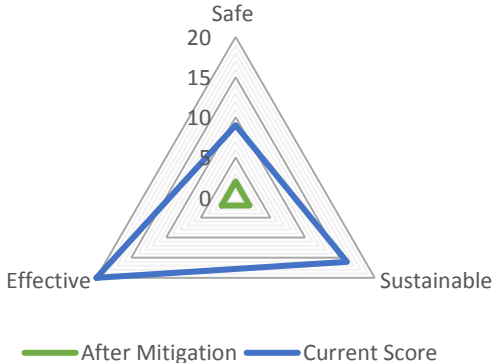
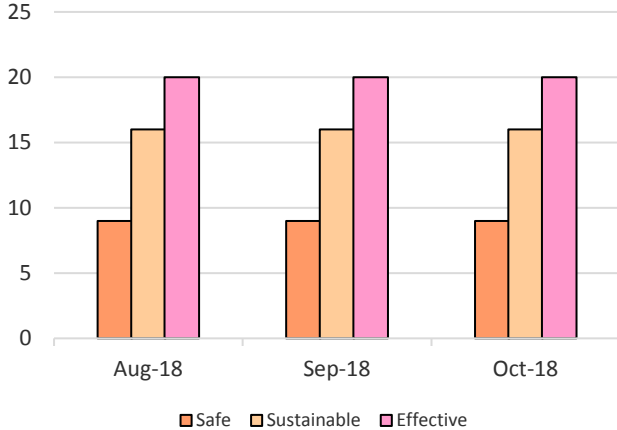
NC/010	NEURO REHABILITATION Risk: Patients not receiving their full potential due to lack of appropriate staff to support their rehabilitation.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
OCT 2018				Date first assessed 25/04/2017 Date last reviewed by Programme / Directorate: Sp. Planning Mgr. 30/09/2018			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
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.		Planning Manager	31/10/18

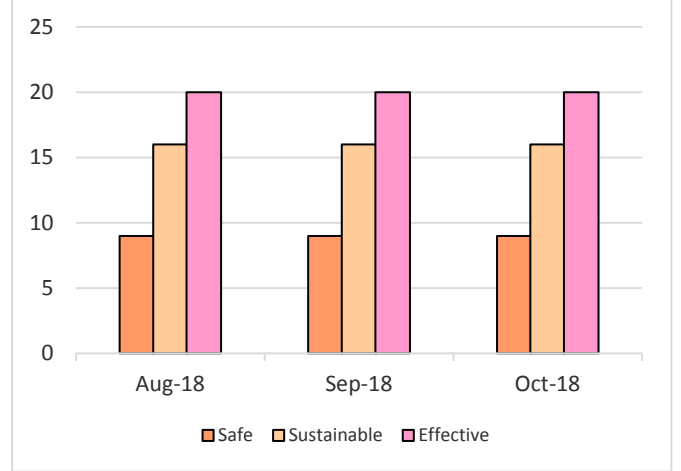


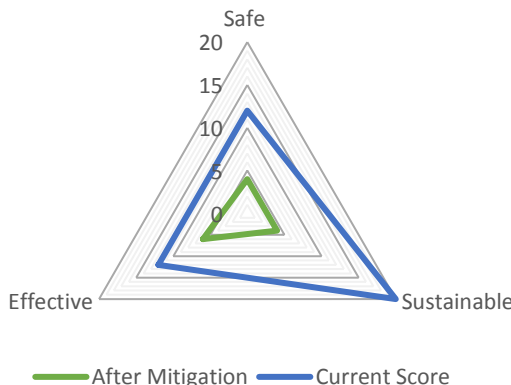
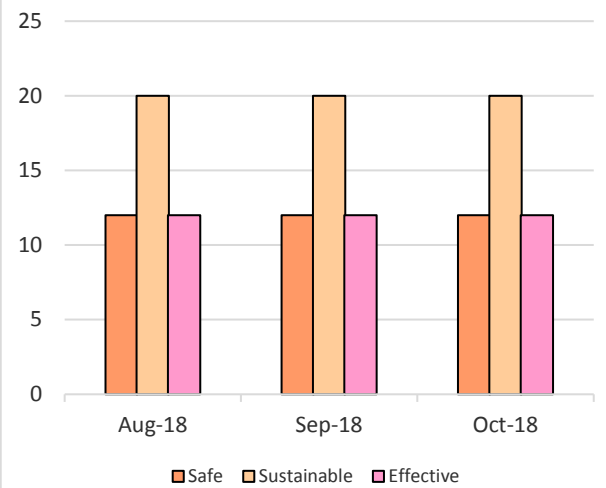
NC/012	NEUROSURGERY RTT Risk: Patients waiting in excess of the agreed waiting times for Neurosurgery.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee		
OCT 2018				Date first assessed 01/03/2017 Date last reviewed by Programme / Directorate: Sp. Planning Mgr. 30/09/2018		
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

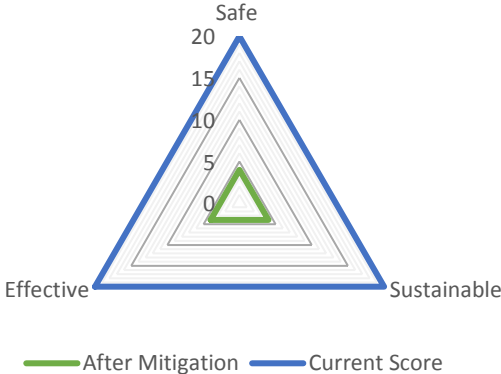
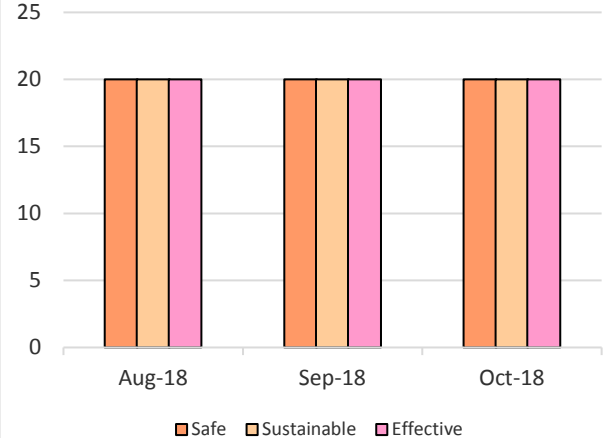
NC/014	INTERVENTIONAL RADIOLOGY Risk: Interventional Radiology - Ability of Cardiff & Vale University Health Board to deliver the Interventional Radiology service at University Hospital Wales. A member of the clinical team has resigned. This will increase the pressure on the interventional radiology service, and will also have an impact on other services, and WHSSC will be undertaking work to quantify this impact.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
OCT 2018				Date first assessed 01/03/2017 Date last reviewed by Programme / Directorate: Sp. Planning Mgr. 30/09/2018			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	2	2	2				
Current Score	20	20	20				
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

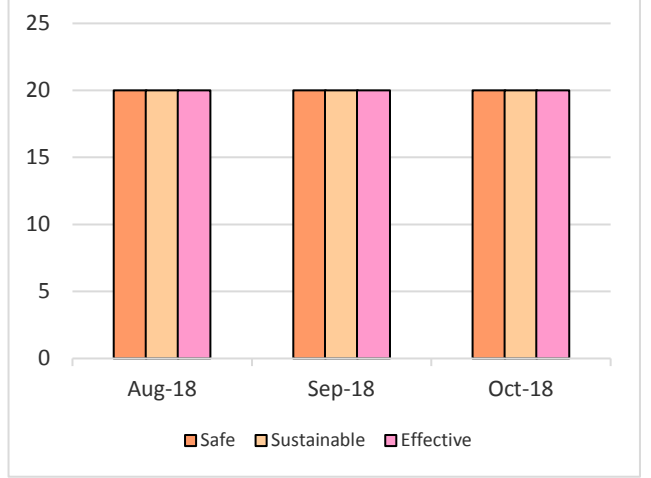
NC/022	PAEDIATRIC NEUROSURGERY Risk: NHS England are due to publish the outcomes of their commissioning through evaluation for Selective Dorsal Rhizotomy (SDR) in Spring 2018. There is the potential for a change in policy in light of the reported outcomes that could mean SDR becomes a commissioned service. 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.			Director 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. 30/09/2018		
OCT 2018						
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective			
After Mitigation	1	1	1			
Current Score	16	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

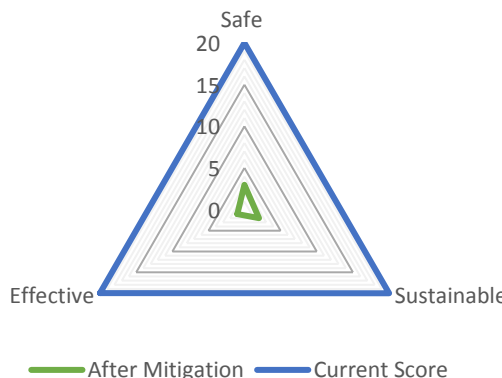
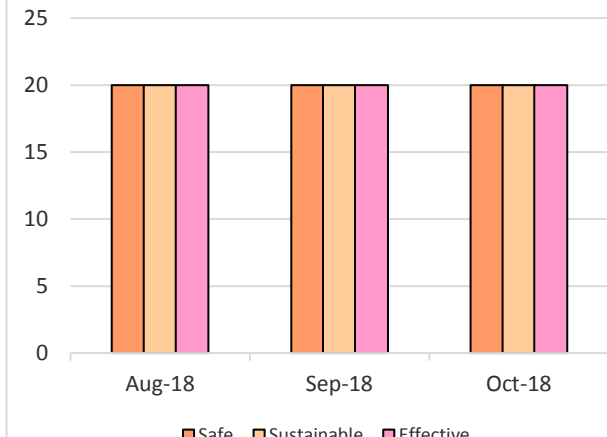
NC/023	NEURO-ONCOLOGY Risk: Delays in Neuro-oncology treatment due to the cancellation of MDT meetings if not all members are available or suitable cover in place. Inequitable care for patients in the North and the South and only 22% of patients are seen by a Clinical Nurse Specialist.			Director lead: 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. 30/09/2018			
OCT 2018							
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



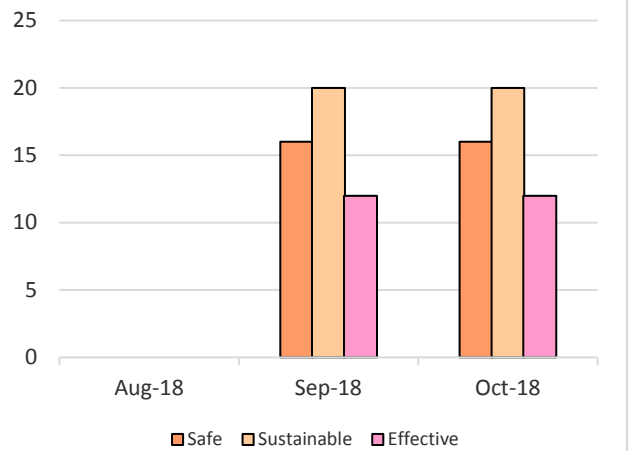
NC/026	Posture & Mobility - Prosthetics			Director lead: Director of Planning			
OCT 2018	Risk: Current arrangements are not conducive to ensuring a consistent and equitable service for the War Veterans and Civilians who require access to the BCU Prosthetics Service. Staffing levels and non-pay funding 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.			Assuring Committee: Quality and Patient Safety Committee			
Date first assessed 03/07/2017							
Date last reviewed by Programme / Directorate: Sp. Service Planner 30/09/2018							
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.		Planning Manager	31/10/18

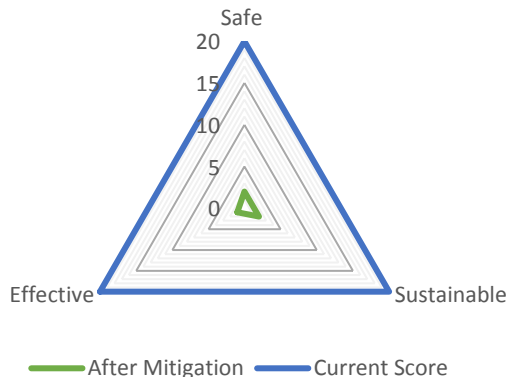
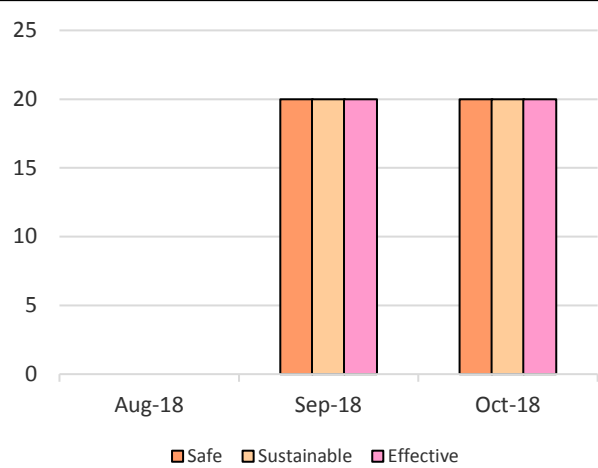
NC/028	ALAS ALTERNATIVE AUGMENTATIVE COMMUNICATION Risk: If no further funding is made available for equipment then patients will be assessed but will not be able to receive the equipment recommended to them. As patients’ needs change over time this also reduces the effective use of staff time.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee		
OCT 2018				Date first assessed 01/09/2017 Date last reviewed by 30/09/2018 Programme / Directorate: AAC		
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective			
After Mitigation	4	4	4			
Current Score	20	20	20			
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	Lead	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.	Planning Manager	01/08/18
				Further discussions with Welsh Government	Planning Manager	31/10/2018

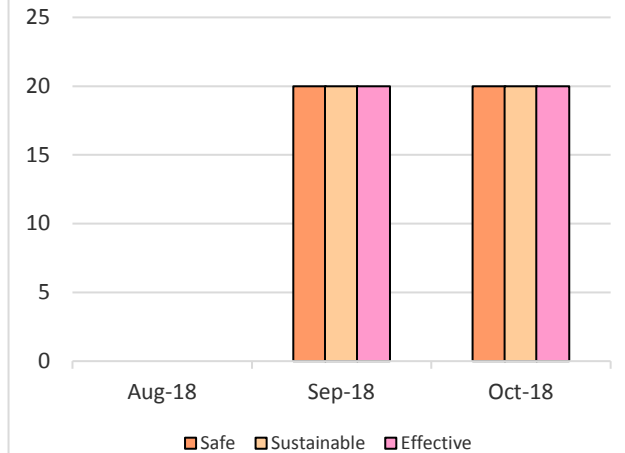


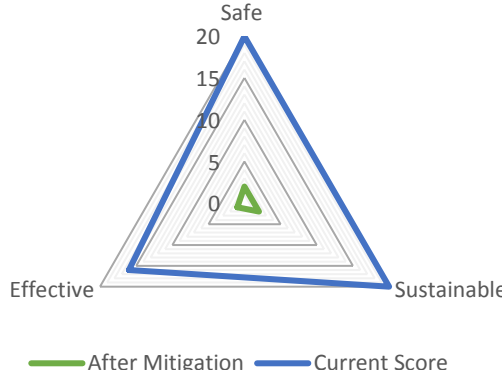
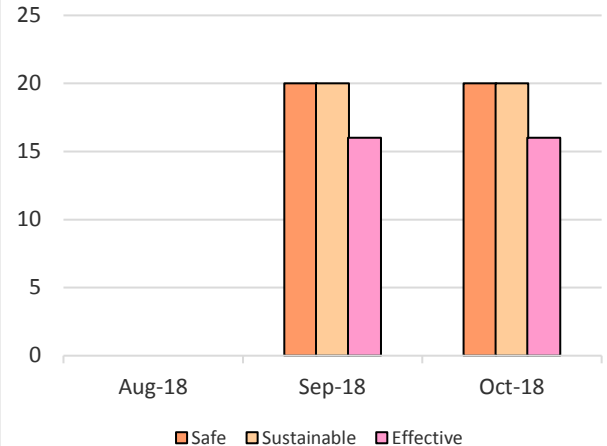
NC/029	Neurosurgery Spinal Monitoring Risk: The Development of the Complex Spinal Surgery pathway policy and service specification highlighted the shortfall in spinal cord monitoring. There is currently only 1 member of staff who is trained to undertake this role. However, the member of staff is employed 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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee		
OCT 2018				Date first assessed 07/11/2017 Date last reviewed by Programme / Directorate: AAC 30/09/2018		
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective			
After Mitigation	3	2	1			
Current Score	20	20	20			
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	09/18

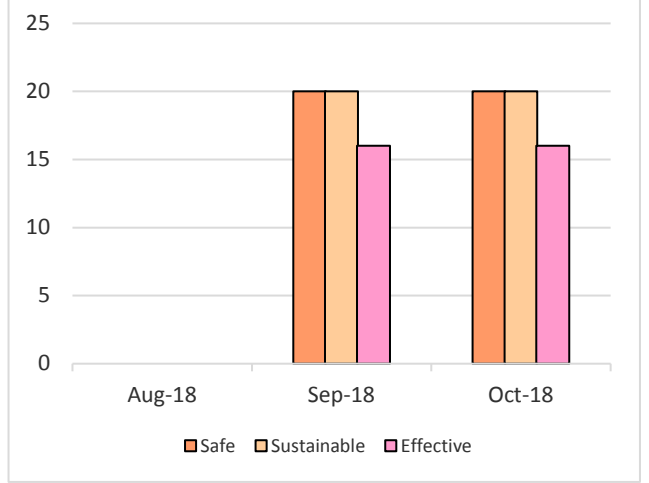
NC/031	Ketogenic Diet Risk: The service was originally provided by North Bristol NHS Trust (NBT) but ceased when Paediatric Services in Bristol were consolidated into University Hospitals Bristol NHS Trust. Individual cases are currently funded through the IPFR system Current practices rely on the availability 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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee																		
OCT 2018				Date first assessed 15/01/2018 Date last reviewed by Programme / Directorate: Neuro 31/10/2018																		
Risk Rating				WHSSC Risk Assessment Triangle																		
	Safe	Sustainable	Effective	Safe Sustainable Effective After Mitigation Current Score		<table border="1"><thead><tr><th>Category</th><th>Aug-18</th><th>Sep-18</th><th>Oct-18</th></tr></thead><tbody><tr><td>Safe</td><td>16</td><td>16</td><td>16</td></tr><tr><td>Sustainable</td><td>20</td><td>20</td><td>20</td></tr><tr><td>Effective</td><td>1</td><td>12</td><td>12</td></tr></tbody></table>	Category	Aug-18	Sep-18	Oct-18	Safe	16	16	16	Sustainable	20	20	20	Effective	1	12	12
Category	Aug-18	Sep-18	Oct-18																			
Safe	16	16	16																			
Sustainable	20	20	20																			
Effective	1	12	12																			
After Mitigation	2	2	1																			
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		Lead	By when															
				Scheme to be submitted for ICP 19-22.		Planning Manager	31/10/18															

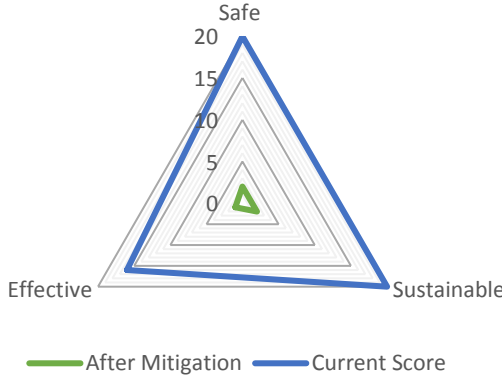
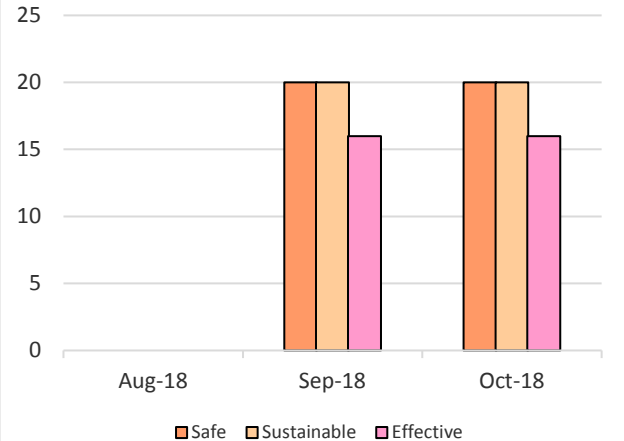


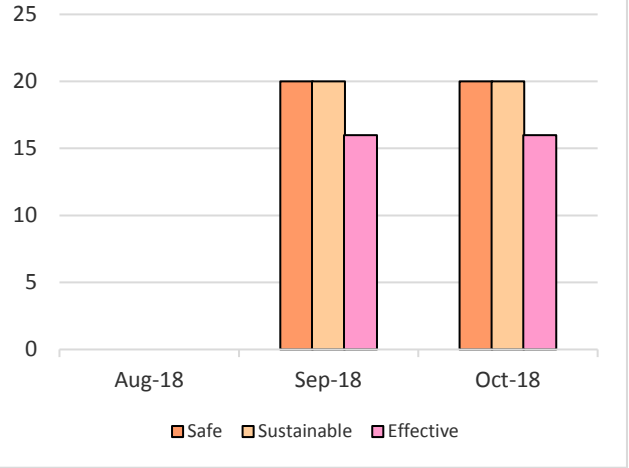
NC/032	Thrombectomy 1 Risk: Neuroradiology - Service Development - Lack of Neuro-interventional Consultants and the ongoing recruitment difficulties at the Cardiff centre to provide a robust 24/7 service.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee																		
OCT 2018				Date first assessed 01/04/2018 Date last reviewed by Programme / Directorate: Neuro 31/10/2018																		
Risk Rating				WHSSC Risk Assessment Triangle																		
	Safe	Sustainable	Effective	 — After Mitigation — Current Score																		
After Mitigation	2	2	1																			
Current Score	20	20	20																			
 <table border="1"><thead><tr><th>Category</th><th>Aug-18</th><th>Sep-18</th><th>Oct-18</th></tr></thead><tbody><tr><td>Safe</td><td>0</td><td>20</td><td>20</td></tr><tr><td>Sustainable</td><td>0</td><td>20</td><td>20</td></tr><tr><td>Effective</td><td>0</td><td>20</td><td>20</td></tr></tbody></table>							Category	Aug-18	Sep-18	Oct-18	Safe	0	20	20	Sustainable	0	20	20	Effective	0	20	20
Category	Aug-18	Sep-18	Oct-18																			
Safe	0	20	20																			
Sustainable	0	20	20																			
Effective	0	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															

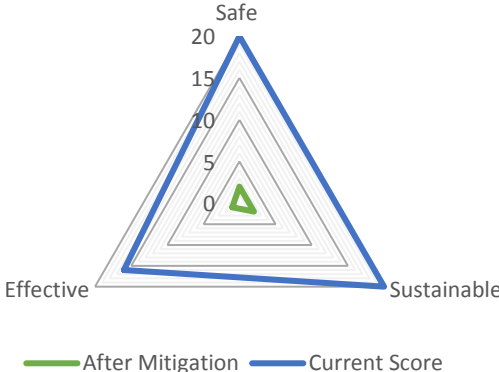
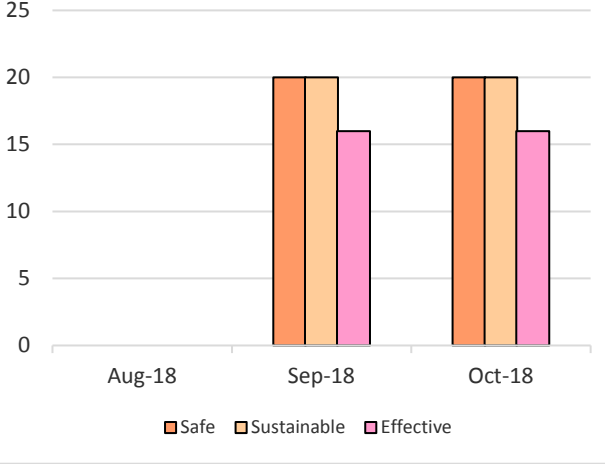


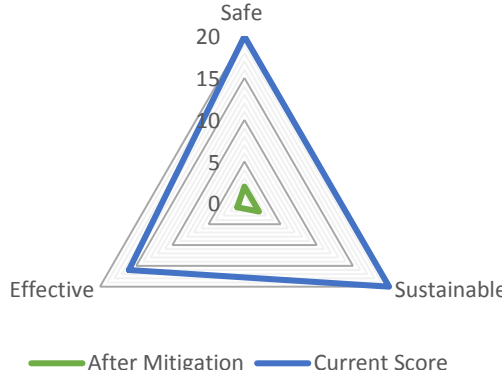
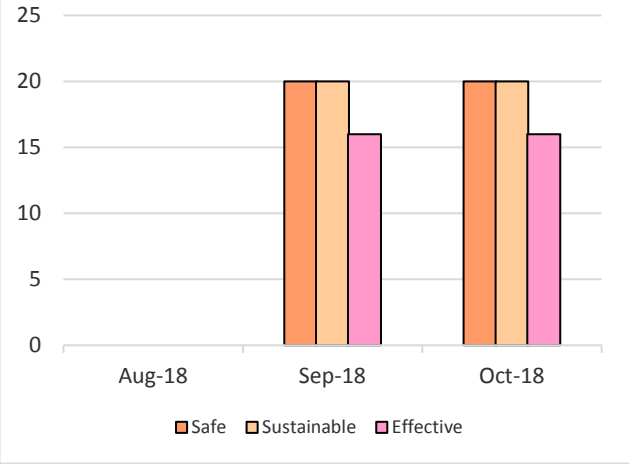
NC/033	Thrombectomy 2 Risk: Neuroradiology - Service Development - Bed Capacity at the Cardiff centre particularly with the development of the Major Trauma Centre			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee																		
OCT 2018				Date first assessed 01/04/2018 Date last reviewed by Programme / Directorate: Neuro 31/10/2018																		
Risk Rating				WHSSC Risk Assessment Triangle																		
	Safe	Sustainable	Effective	 Safe Effective Sustainable — After Mitigation — Current Score																		
After Mitigation	2	2	1																			
Current Score	20	20	16																			
 <table border="1"><thead><tr><th>Category</th><th>Aug-18</th><th>Sep-18</th><th>Oct-18</th></tr></thead><tbody><tr><td>Safe</td><td>0</td><td>20</td><td>20</td></tr><tr><td>Sustainable</td><td>0</td><td>20</td><td>20</td></tr><tr><td>Effective</td><td>0</td><td>16</td><td>16</td></tr></tbody></table>							Category	Aug-18	Sep-18	Oct-18	Safe	0	20	20	Sustainable	0	20	20	Effective	0	16	16
Category	Aug-18	Sep-18	Oct-18																			
Safe	0	20	20																			
Sustainable	0	20	20																			
Effective	0	16	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															

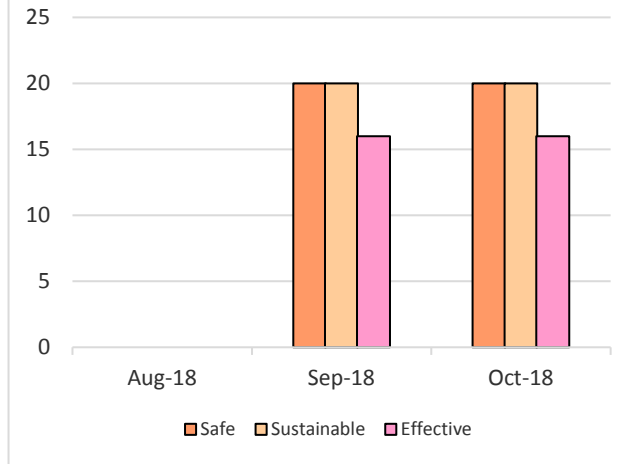


NC/034	Thrombectomy 3 Risk: Neuroradiology - Service Development - Rapid access to appropriate imaging (Non contrast CT scan and CT Angiogram as a minimum)			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
OCT 2018				Date first assessed 01/04/2018 Date last reviewed by Programme / Directorate: Neuro 31/10/2018			
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			
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.				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

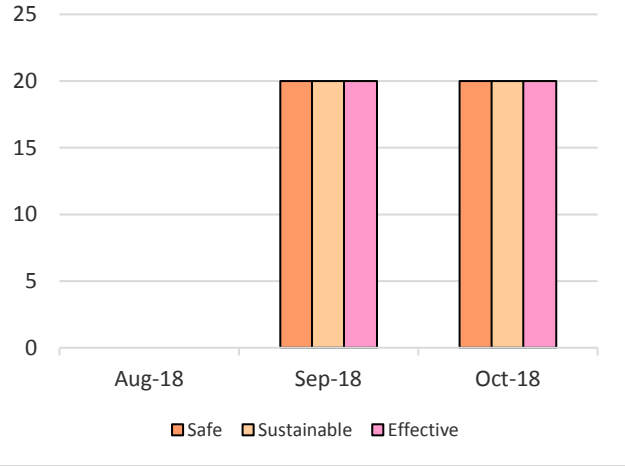


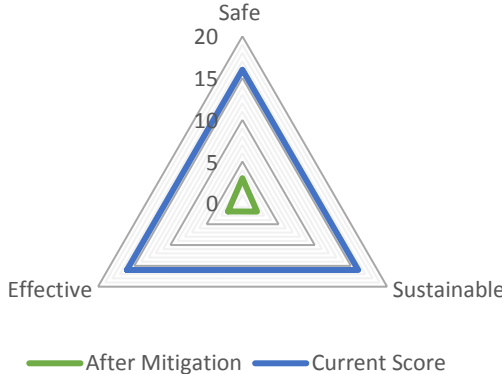
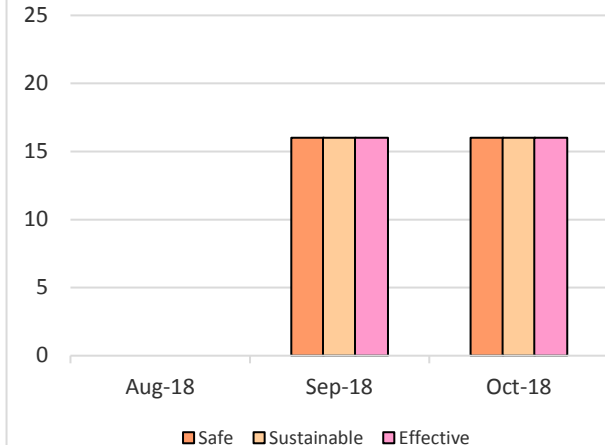
NC/035	Thrombectomy 4 Risk: Neuroradiology - Service Development - Safe and rapid transport to the specialist centre for patients who have been identified for this clinical treatment.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
OCT 2018				Date first assessed 01/04/2018 Date last reviewed by Programme / Directorate: Neuro 31/10/2018			
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			
Discuss and agree an operational process with WAST to meet the demand.				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

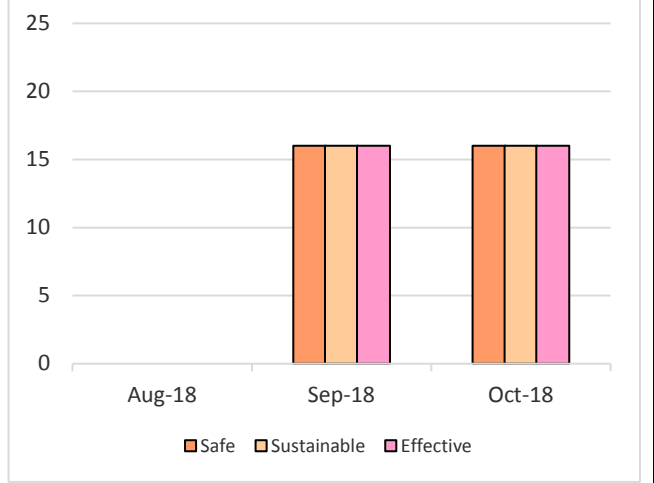
NC/036	Thrombectomy 5 Risk: Neuroradiology - Service Development - Post operative care			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
OCT 2018				Date first assessed 01/04/2018 Date last reviewed by Programme / Directorate: Neuro 31/10/2018			
Risk Rating				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

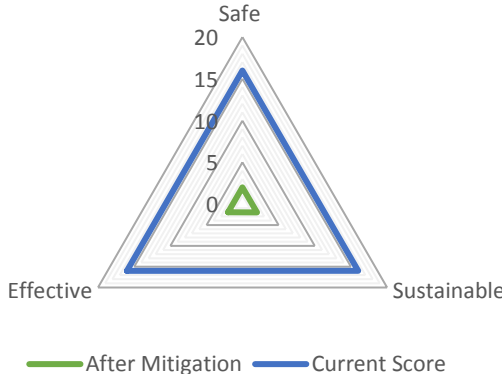
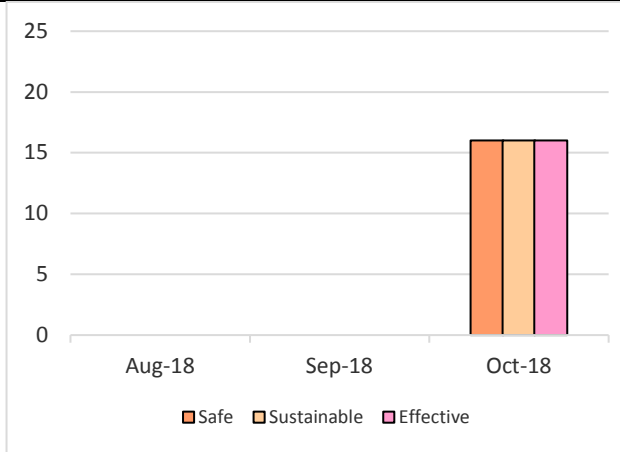


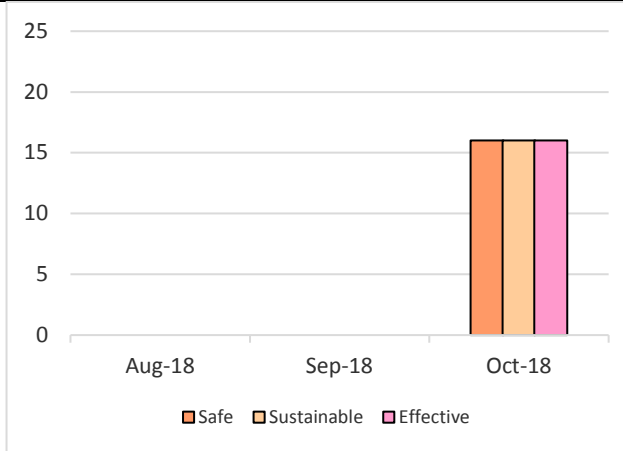
NC/038	MAJOR TRAUMA Risk: Neurosurgery - Major Service Development. Development of a major trauma network for the South Wales population. To provide a more robust approach to the management of severely injured patients with life threatening conditions in the South Wales region. Inequity of the service and delivering a sustainable service.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
OCT 2018				Date first assessed 01/04/2017 Date last reviewed by Programme / Directorate: Neuro 31/10/2018			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective	Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score			
After Mitigation	9	9	9				
Current Score	20	20	20				
25 20 15 10 5 0 Aug-18 Sep-18 Oct-18 Safe Sustainable Effective							
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
To identify the resources required and set up a Project Board for the development of the service.				Action		Lead	By when
				Development of a Project Board and appointment to key posts to manage the project.		Acting Director of Planning	On-going

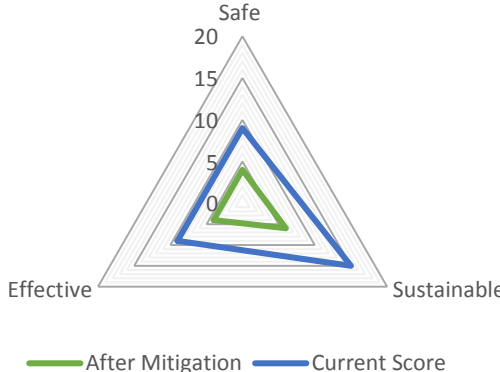
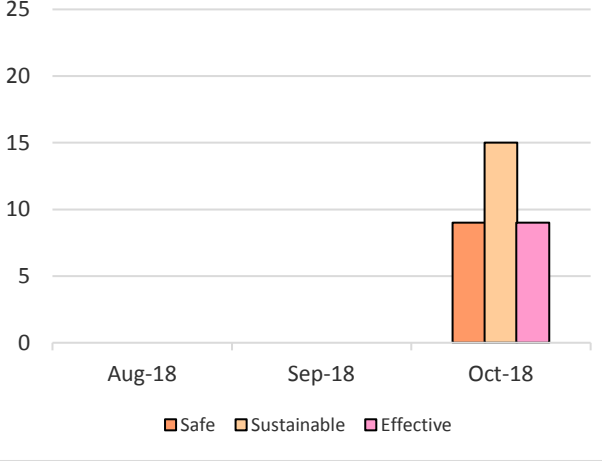


NC/039	NEUROSURGERY Risk: Neurosurgery – SDR – Development of SDR surgery. Inequity for Welsh patients as they do not have access to surgery as English children.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
OCT 2018				Date first assessed 05/10/2018 Date last reviewed by Programme / Directorate: Neuro 05/11/2018			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	3	2	2				
Current Score	16	16	16				
							
Escalation Narrative:							
Current Control Measures in Place				Description of further Control Measures Required			
Funding release proforma to be taken to Management Group this month recommending it to be included in the ICP 19 -22				Action		Lead	By when
				Scheme will need to be submitted for the 2019-22 ICP		Planning Manager	On-going

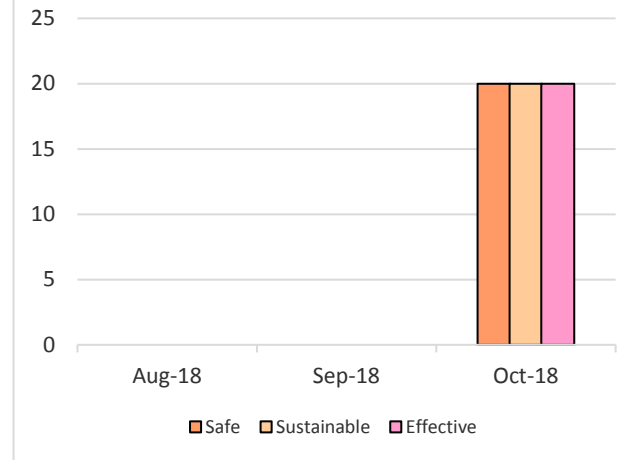


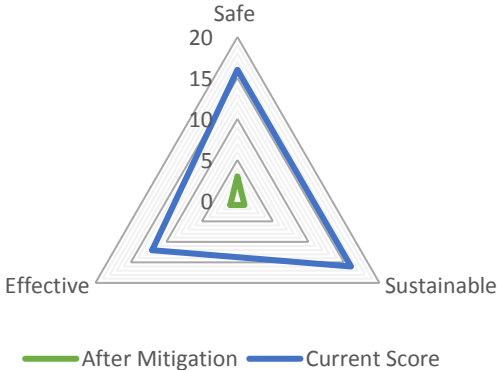
NC/040	Neurosurgery - Paediatrics Risk: Effective - Waiting times for Paediatrics to receive a MRI is outside of the standard. An inequitable service between North and South Wales. The Provider risk for this service is high, as currently there is staff funding for three days of 7.5 hours of scanning. 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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
OCT 2018				Date first assessed 12/10/2018 Date last reviewed by Programme / Directorate: Neuro 05/11/2018			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	2	2	2				
Current Score	16	16	16				
							
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

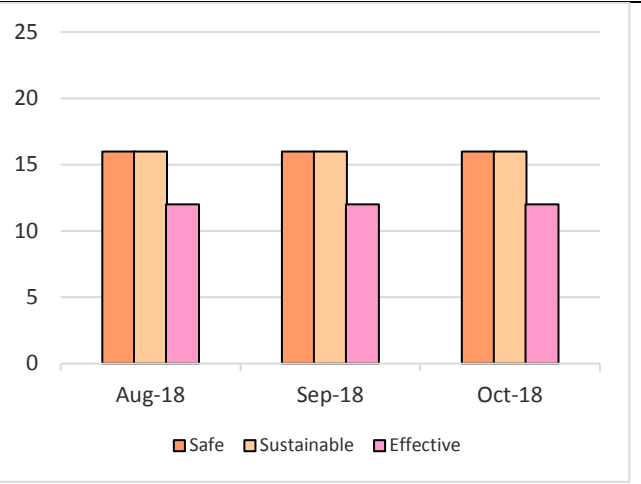


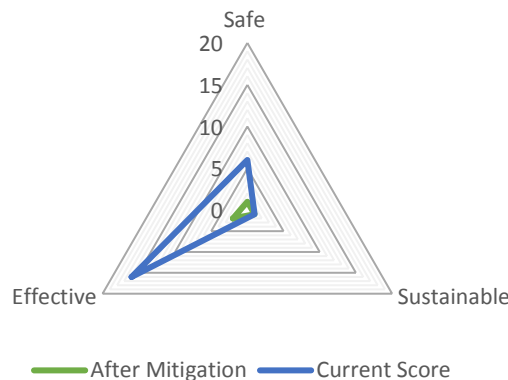
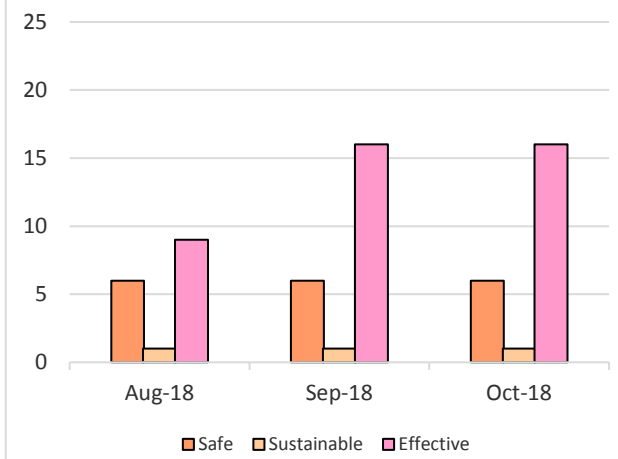
NC/041	Posture and Mobility Service - Discontinued Wheelchairs - North Wales Service			Director lead: Director of Planning	
OCT 2018	Risk: Long waits and the requirement to build the wheelchair to meet the specific needs of the patient could impact on patient safety.			Assuring Committee: Quality and Patient Safety Committee	
				Date first assessed 24/04/2017	
				Date last reviewed by Programme / Directorate: Neuro 05/11/2018	
Risk Rating				WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective		
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
					By when On-going

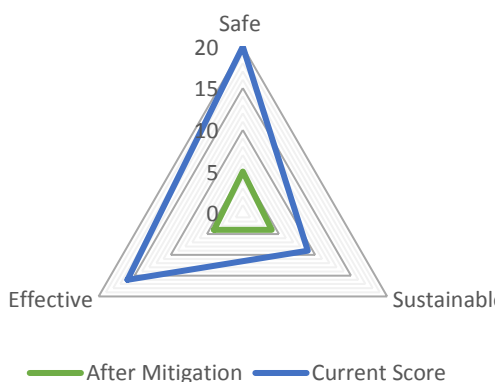
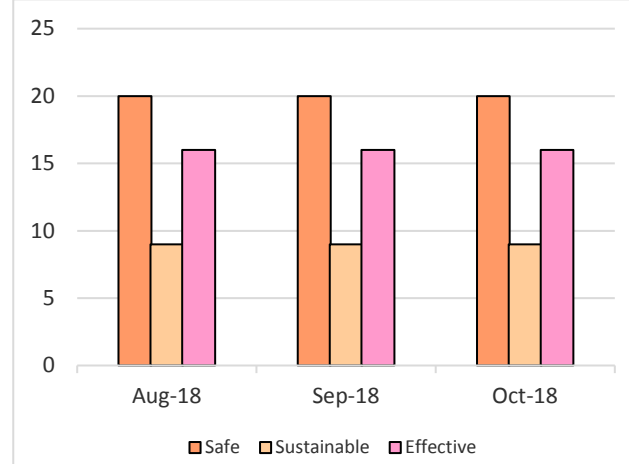
NC/042	Major Trauma Risk: Revenue requirement to support the implementation of major trauma network for the South Wales population. Safe: To provide a more robust approach to the management of severely injured patients with life threatening conditions in the south Wales region. Sustainable: To support 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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee			
OCT 2018				Date first assessed 18/10/2018 Date last reviewed by Programme / Directorate: Neuro 18/10/2018			
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective	Safe 20 15 10 5 0 Effective Sustainable — After Mitigation — Current Score		25 20 15 10 5 0 Aug-18 Sep-18 Oct-18 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			
To identify the resources required and include it within the ICP 19-22				Action		Lead	By when
				Scheme will need to be submitted for the 2019-22 ICP.		Acting Director of Planning	On-going

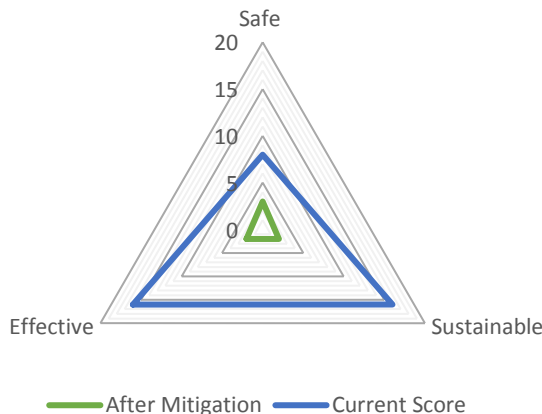
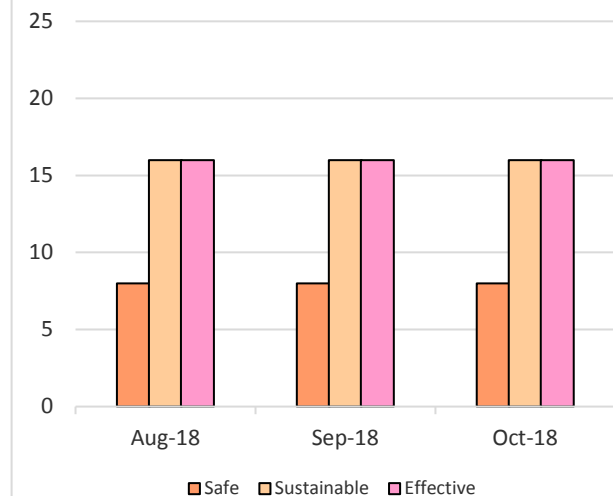


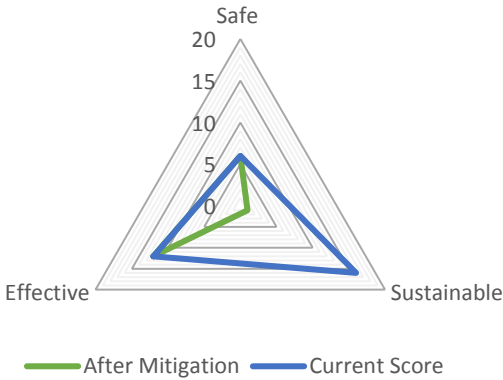
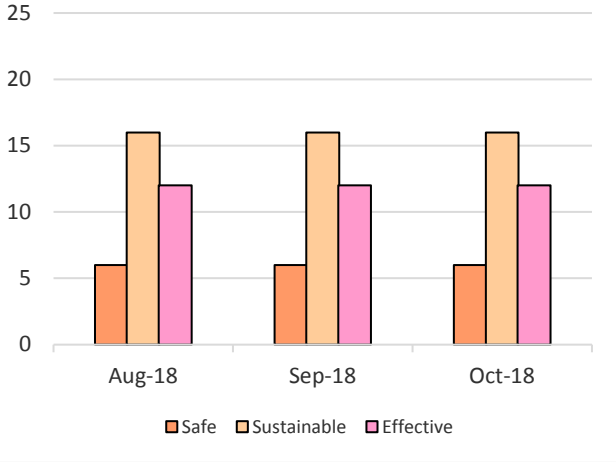
WC/008	FETAL MEDICINE Risk: Currently Fetal medicine services for patients in South Wales, with the exception of ABU patients, are treated at the University Hospital of Wales. There are currently a number of risks to the sustainability and safety of the service in particular there are a significant waits, 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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 07/07/2016 Date last reviewed by Programme / Directorate: KM 04/10/2018			
OCT 2018							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	3	1	1	 Safe Effective Sustainable — After Mitigation — Current Score			
Current Score	16	16	12				
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
				WHSSC work with C&V to develop scheme for potential in year solution to address capacity issues.		Planner	10/18
				Develop case to address longer term capacity difficulties for consideration within the 2019/20 plan.		Planner	10/18
				Resource map funding from HB's to WHSSC.		Finance Manager	12/18

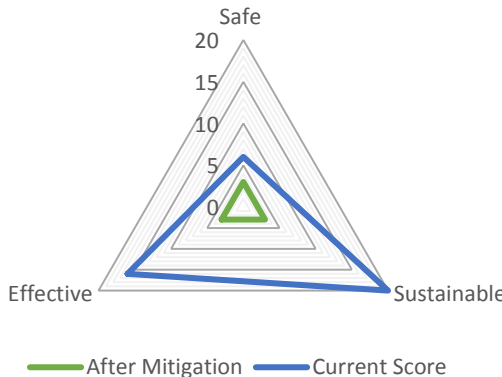
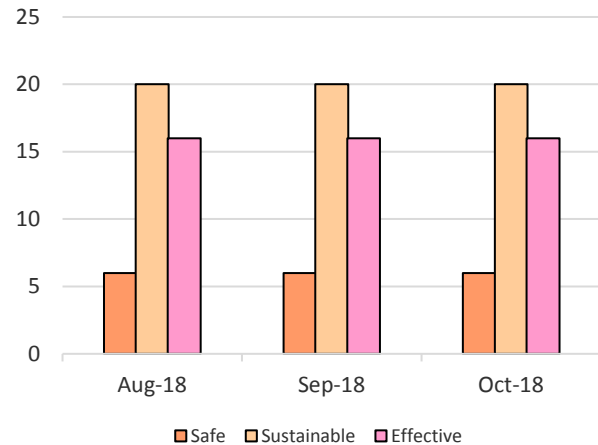


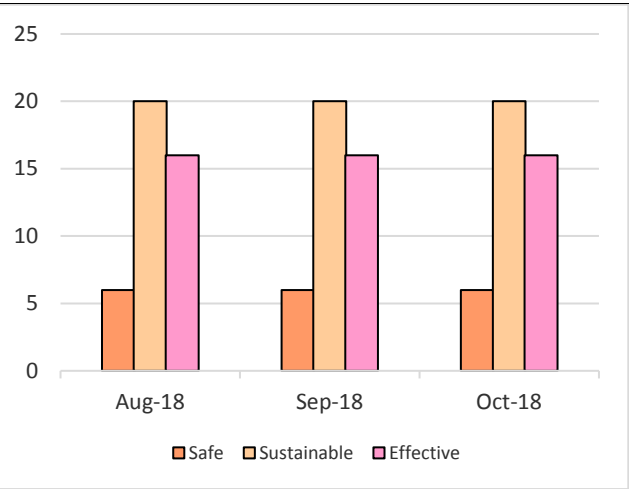
WC/009	IVF Risk: Waiting Times to commence IVF - Patients requiring fertility treatment in North Wales access services from Liverpool and Shrewsbury. Patients in Shrewsbury despite being seen for their first appointment within 26 weeks they are waiting significant periods of time before commencing actual 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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 07/07/2016 Date last reviewed by Programme / Directorate: KM 18/11/2018			
OCT 2018							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective	 Safe Effective Sustainable — After Mitigation — Current Score		 Aug-18 Sep-18 Oct-18 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
				Shrewsbury is in the process of being placed in escalation Stage II, letter sent on the 28/11/18			

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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 12/01/2017 Date last reviewed by Programme / Directorate: KM 04/10/2018			
OCT 2018							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	5	4	4				
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
				PIC review commenced in 2018/19		Planner	12/2018
				Assessment of the Business Case submitted by the HB, meeting scheduled to discuss queries and detail.		Planner	10/2018
				Monthly meetings with provider to monitor demand and activity.		Planner	Ongoing

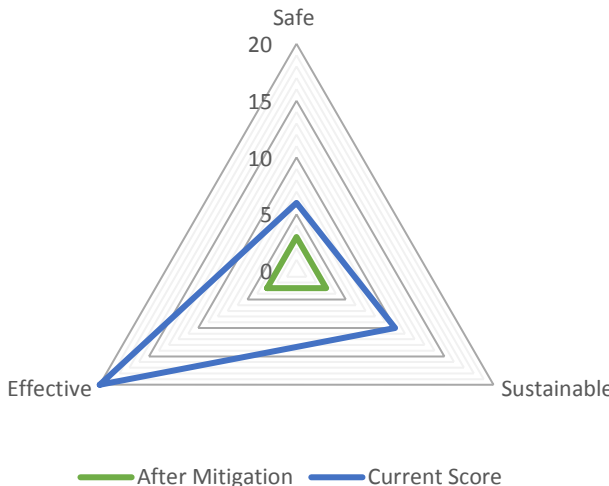
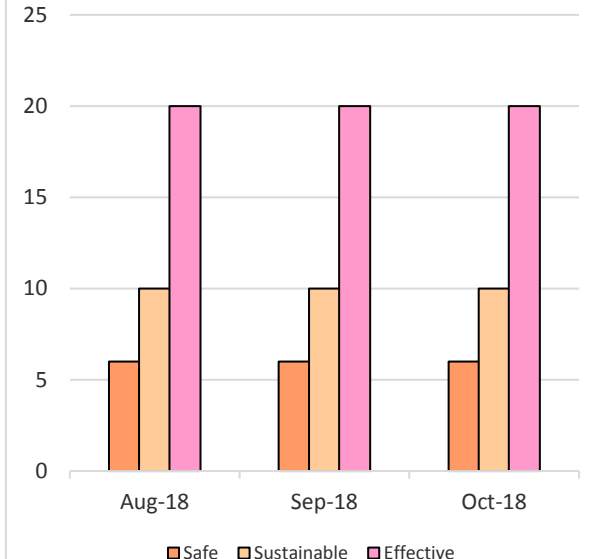
WC/015	CLEFT LIP & PALATE (CLP) Risk: Lack of resource for full MDT of CLP service: The Cleft Lip and Palate service for patients in South and West Wales is delivered at Morriston Hospital. Currently there are significant capacity shortfalls in the full MDT and sustainability issues due to likely retirements, 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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 17/03/2017 Date last reviewed by Programme / Directorate: KM 04/10/2018			
OCT 2018							
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
				Management Group workshop to take place to demonstrate the impact on patients		Planner	09/18

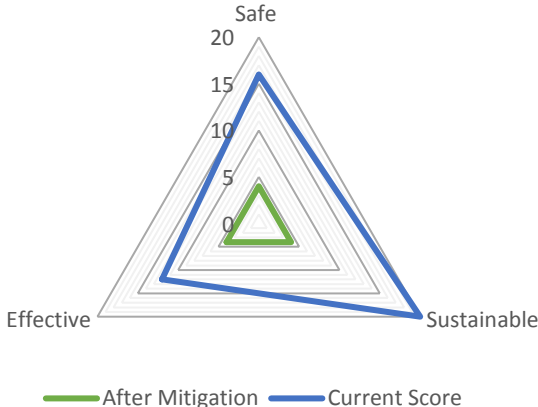
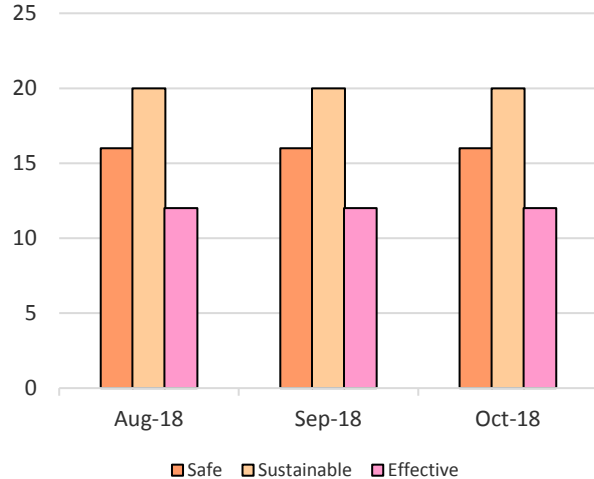
WC/019	BAHA AND COCHLEAR Risk: Significant waiting times (over 52 weeks) for BAHA and Cochlear implants in South Wales for adults. The BAHA and Cochlear service for south Wales patients is managed centrally by C&V however patients are managed at both Bridgend Hospital and UHW. Adult patients are waiting 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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 25/04/2017 Date last reviewed by Programme / Directorate: KM 04/10/2018		
OCT 2018						
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
			Funding to meet 26 week RTT has been agreed, implementation of funding		Planner	10/18
			Regular dialogue with service to monitor achievements against 26 week RTT		Planner	03/19

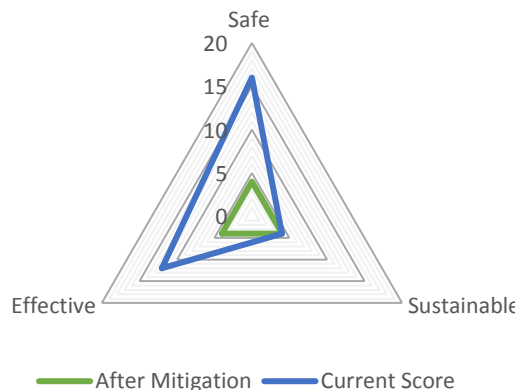
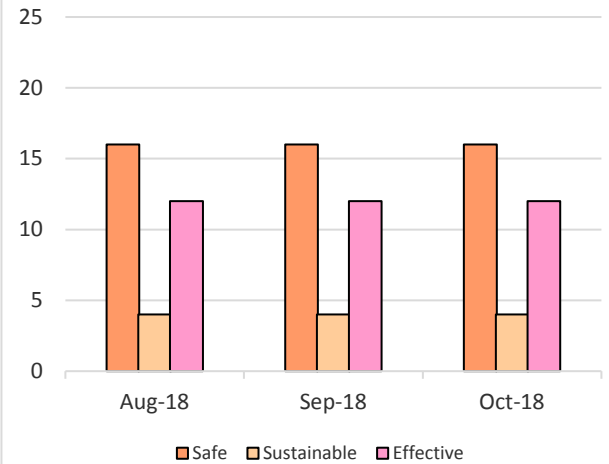
WC/020	PAEDRIATRIC ENDOCRINOLOGY Risk: Inequitable service for Endocrinology patients in Wales. Paediatric Endocrinology services are delivered in Alder Hey for North Wales patients, Cardiff and Vale for South and West and Bristol for patients from the East. WHSSC has overall commissioning responsibility 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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee		
OCT 2018				Date first assessed 25/04/2017 Date last reviewed by Programme / Directorate: KM 04/10/2018		
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective			
After Mitigation	3	3	3			
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
			Collate formal consultation responses prior to publication.		Planner	10/2018
			Understand financial contribution made by all HBs for their current arrangements.		Finance Manager	10/2018
			Undertake needs assessment and develop proposals for submission in the 2019/20 Integrated Commissioning Plan process.		Planner	10/2018

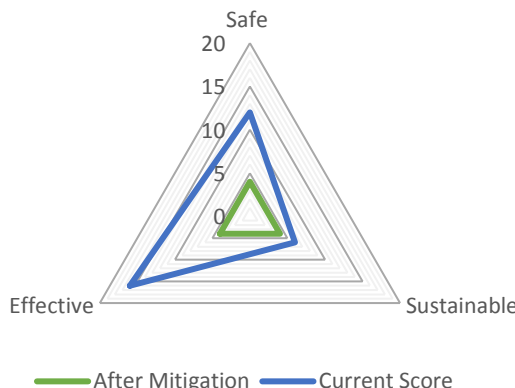
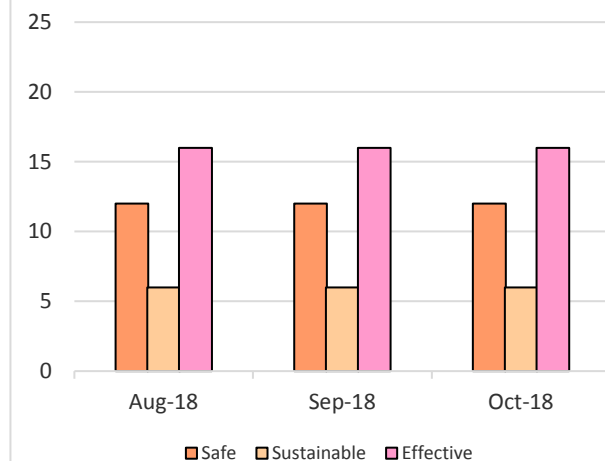


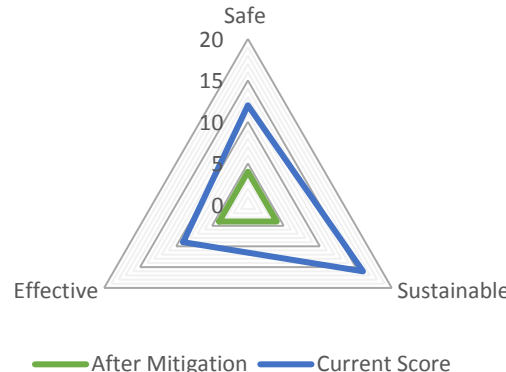
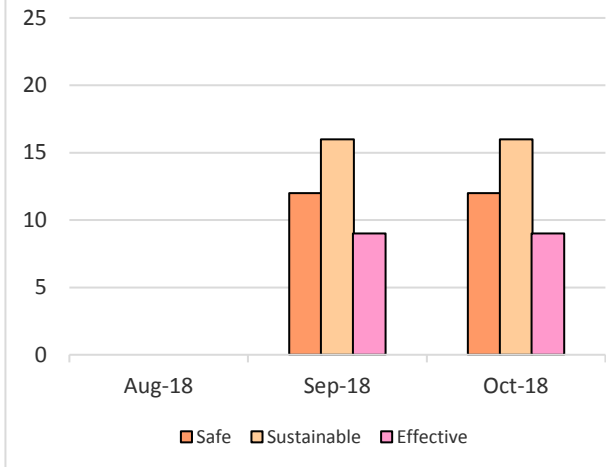
WC/022	PAEDIATRIC RHEUMATOLOGY Risk: Limited and unsustainable Paediatric Rheumatology service in South Wales. The Paediatric Rheumatology service in South Wales is currently delivered by an adult Rheumatologist that is due to retire within the next few years (no precise date as yet). It is very unlikely 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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 24/04/2017 Date last reviewed by Programme / Directorate: KM 04/10/2018																		
OCT 2018																						
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	9	20	16																			
<table border="1"><thead><tr><th>Category</th><th>Aug-18</th><th>Sep-18</th><th>Oct-18</th></tr></thead><tbody><tr><td>Safe</td><td>9</td><td>9</td><td>9</td></tr><tr><td>Sustainable</td><td>20</td><td>20</td><td>20</td></tr><tr><td>Effective</td><td>16</td><td>16</td><td>16</td></tr></tbody></table>							Category	Aug-18	Sep-18	Oct-18	Safe	9	9	9	Sustainable	20	20	20	Effective	16	16	16
Category	Aug-18	Sep-18	Oct-18																			
Safe	9	9	9																			
Sustainable	20	20	20																			
Effective	16	16	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	10/2018																
			WHSS Team to include commissioning proposal in 2019/20 ICP		Acting Director of Planning	10/2018																

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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 17/03/2017 Date last reviewed by Programme / Directorate: KM 04/10/2018		
OCT 2018						
Risk Rating				WHSSC Risk Assessment Triangle		
	Safe	Sustainable	Effective			
After Mitigation	3	3	3			
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
				Ongoing discussions with the service to develop case further for 2019/20 Integrated Commissioning Plan	Planner	10/2018
				Management Group workshop to take place to demonstrate the impact on patients	Planner	10/2018

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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 01/08/2017 Date last reviewed by Programme / Directorate: KM 04/10/2018			
OCT 2018							
Risk Rating				WHSSC Risk Assessment Triangle			
	Safe	Sustainable	Effective				
After Mitigation	4	4	4				
Current Score	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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 23/07/2018 Date last reviewed by Programme / Directorate: KM 04/10/2018			
OCT 2018							
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 Terms of Reference for review following meeting with potential reviewer.		Planner	10/18
				Analysis of returns following letter seeking expressions of interest from all three providers for the governance lead.		Planner	10/18

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.			Director lead: Director of Planning Assuring Committee: Quality and Patient Safety Committee Date first assessed 23/07/2018 Date last reviewed by Programme / Directorate: KM 18/11/2018			
OCT 2018							
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
				Letter to be issued to Chief Operating Officer setting out WHSSC expectations		Planner	10/18
				Meeting to be arranged with corporate team in UHW to discuss way forward.		Planner	10/18
				This scheme has been assessed through the prioritisation process and is currently being considered through the IMTP development			

WC/039	INHERITED METABOLIC DISEASES (IMD)– PAEDIATRIC SERVICES			Director lead: Director of Planning	
OCT 2018	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.			Assuring Committee: Quality and Patient Safety Committee	
				Date first assessed 04/10/2018	
				Date last reviewed by Programme / Directorate: KM 04/10/2018	
Risk Rating				WHSSC Risk Assessment Triangle	
	Safe	Sustainable	Effective		
After Mitigation	4	4	4		
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
			Requested business case from C&V to inform 2019/20 IMTP.		By when
			Planner		10/2018

Non-Emergency Patient Transport Service - Follow-up of Baseline Position Review

Final Report

2018/19

Emergency Ambulance Services Committee

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A

Dashboard Assessment

Review reference:	CT1819.44
Report status:	Final
Fieldwork commencement:	12 September 2018
Fieldwork completion:	13 November 2018
Draft report issued:	21 November 2018
Management response received:	22 November 2018
Final report issued:	26 November 2018

Reviewers: Paul Dalton, Emma Samways, Ken Hughes

Executive sign off: Stephen Harrhy, Chief Ambulance Service Commissioner

Distribution: Julian Baker, National Collaborative Commissioning Lead

James Rodaway, Head of Commissioning & Programme Management

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.

Please note:

This report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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

1. Introduction and Background

A baseline position review for the provision of Non-Emergency Patient Transport Services (NEPTS) across NHS Wales was undertaken by Internal Audit in January 2016. This follow-up review was requested by the Chief Ambulance Service Commissioner (CASC) who is the lead Executive Director for the review.

Following the 2013 strategic review of Welsh Ambulance Services (McClelland) a business case was produced by the project board that considered the future of NEPTS in Wales.

One of the recommendations of the business case was that the existing NEPTS commissioning arrangements and responsibilities were transferred from the nine commissioning organisations to a single body, this being the Emergency Ambulance Service Committee (EASC). EASC, who on behalf of NHS Wales, will hold the Welsh Ambulance Services NHS Trust (WAST) accountable to deliver against the standards, requirements, performance and quality indicators contained within a new Service Level Agreement.

To clearly set out the expectations on health organisations, and to provide assurance to EASC for the commissioning and delivery of NEPTS, a Quality and Delivery Framework ('the framework') has been developed.

To help facilitate the transfer arrangements and the development of the framework, in 2016/17 EASC requested a range of information from the nine transferring organisations plus WAST to provide a baseline of the NEPTS activity position across Wales at that time.

Our 2016/17 review of the progress with the transfer of responsibilities for NEPTS from health boards and other health bodies to WAST found that there was still much work to do to clarify robust spend and activity figures for NEPTS.

The transfers from health bodies is being undertaken on a phased approach. Health boards and trusts have been prioritised in terms of the number of providers they currently use, and whether these are already covered by formal contracts. In July 2018 Cardiff & Vale University Health Board (C&VUHB), who use a small number of providers and who currently have contracts in place to cover this activity, were the first to transfer their commissioning arrangements with the other health boards and trusts due to transfer in the subsequent 18 months.

WAST have produced an action plan and progress against agreed actions is monitored by the EASC Delivery Assurance Group.

2. Scope and Objectives

The overall objective of our review was to provide EASC with an updated position of the information received from the ten organisations at the time of our audit fieldwork as at October 2018, to ensure that this was being provided in line with the agreed action plan so that the phased transfers can be delivered.

The areas that we intended to cover in our review were:

- variations in approach across current activity;
- gaps in current practice; and
- opportunities for improvements to current arrangements.

However, as there has not been further gathering of baseline data, we were unable to assess the variations in approach across current activity or gaps in current practice. Therefore, our review has focussed on the progress towards completion of the framework for NEPTS, and the associated schedules. To do this we reviewed the latest version of the draft framework document and analysed of the information submitted to EASC. The review did not involve any interviews with health board or trust staff, or any testing or validation of current procedures.

3. Associated Risks

The potential risk to WAST considered in this review is as follows:

- That the transfer of commissioning arrangements and responsibilities fails to happen within agreed timescales and / or fails to deliver the perceived benefits identified in the business case.

KEY FINDINGS

4. Executive Summary

Responsibility for commissioning NEPTS formally transferred to EASC in April 2016. A key part of the work to facilitate the transfer was to establish a baseline position of existing NEPTS activity across Wales. Consequently EASC requested a range of information from the nine transferring organisations and WAST. The initial request for information was made by EASC in April 2016, and this was followed up by a second request towards the end of 2016/17.

Once the baseline data had been received, the next step in the process was to develop a Quality and Delivery Framework for NEPTS using the NEPTS Workbook ('the workbook'). The workbook is structured around the CAREMORE® approach for collaborative commissioning and focuses on Care standards, Activity, Resource Envelope, Model of care, Operational arrangements, Review of performance and Evaluation.

The framework includes, in the form of schedules under each of the seven CAREMORE® components, details of local operational arrangements for each organisation. The schedules are drawn up based on various sources of information such as that provided in the baseline assessment returns, the NEPTS business case, NEPTS Ministerial Statement and WAST's existing plans and IMTP.

In the table below we have provided a summary of the current position in developing the schedules against the identified goal in each of the CAREMORE® areas of the framework. This shows that while the desired goals have largely been achieved, not all of the required workbook schedules have yet been completed. A more detailed analysis of each area is provided in section 5 of this report.

We note that whilst a number of schedules remain incomplete, the transfer of some organisations has gone ahead. The original planned 'Go Live' date for the framework was April 2017, but there has been slippage in the timetable, and the first organisation (Cardiff & Vale UHB) did not transfer its commissioning arrangements until July 2018. This was followed by Velindre NHST in September 2018. The most recent timetable will see the next organisation, Betsi Cadwaladr UHB, due to transfer by the end of December 2018, and the last organisation (Cwm Taf UHB) by the end of September 2019.

Summary assessment of current position

CAREMORE® AREA	GOAL	CURRENT POSITION (October 2018)
Care Standards	Define care standards for NEPTS to meet.	Care Standards for NEPTS have now been defined for WAST, or any agent appointed to deliver services by WAST.
Activity	Know and understand demand and capacity requirements.	A Baseline Assessment was undertaken to record NEPTS activity by WAST and the transferring organisations. Activity descriptors have been developed for each of the five steps contained within the patient care pathway for NEPTS.
Resource Envelope	Identify total resources which might be utilised and affected.	Resource Management Descriptors have been documented for each step of the patient care pathway. The cost of providing the service has also been mapped against the 5 step model and a WAST capital plan for the 5 year period 2018/19 to 2022/23 has been drawn up.
Model of Care	Define model(s) of care across a NEPTS patient care pathway.	A 'Model of Care' has now been produced based on the five step patient care pathway.
Operational Arrangements	Mechanisms are established to ensure effective delivery of the framework.	A schedule has been prepared that outlines how the NEPTS Quality & Delivery Framework links into the IMTP process through Commissioning Intentions.
Review of Performance	Detail the on-going performance metrics, management and improvements.	The desired outcomes and measures for the five steps of the patient care pathway within the the NEPTS Quality and Delivery Framework have been documented.

CAREMORE® AREA	GOAL	CURRENT POSITION (October 2018)
		A NEPTS Activity and Performance Report has also been prepared for the period April to June 2018.
Evaluate	Define methods and outcomes as criteria for judging benefits from the framework.	The schedules previously developed for evaluation have been superseded by three new schedules that are not yet complete.

5. Detailed Findings

We have reviewed each of the seven elements of CAREMORE® and the progress against the production of Schedules under each key component, which are being used to develop the Quality and Delivery Framework for NEPTS. Our assessment is based on discussions with, and documentation provided by, the National Collaborative Commissioning Unit as at September and November 2018.

5.1 Care Standards

This section of the workbook requires the production of one schedule (C1) which had been fully completed. Care Standards for NEPTS had been defined for WAST, or for any agent appointed to deliver services on behalf of WAST. These are split between service and core requirements. Compliance with the care standards will be monitored through production of a NEPTS Activity and Performance report.

5.2 Activity

The final framework requires the production of the Activity Descriptors schedule (A1). This details the descriptors which have been developed for each of the five steps contained within the patient care pathway. This schedule is complete.

The R2 (Review of Performance) data repository will contain the metrics to measure activity outlined in schedule A1. This will enable performance reporting by each transferring organisation and will include patient and staff experience measures.

5.3 Resource Envelope

This section of the workbook requires the production of three schedules (RE1 - RE3) which have all been completed.

Resource Management Descriptors for each step of the patient care pathway has been defined in schedule RE1. An Income, Expenditure, Savings and Reinvestment Plan for 2018/19 had been completed in Schedule RE2. Schedule RE3 detailed the WAST Capital Plan for the 5 year period 2017/18 to 2021/22.

5.4 Model of Care

This section of the workbook required the production of two schedules (M1 & M2) both of which had been completed at the time of our review.

Schedule M1 details a standardised 5 step 'Model of Care' based on the patient care pathway.

M2 is a 'wiring diagram' for NEPTS and details the booking process which has been tailored to each health board and trust by region. We understand that this will be updated to an All Wales process once all health boards and trusts have transferred.

5.5 Operational Arrangements

This section of the workbook required the production of four schedules (O1 - O4) of which two had been completed at the time of our review (O1 and O4).

Schedule O1 is a process flowchart that outlines how the framework links into the IMTP process via Commissioning Intentions.

Schedule O4 had also been completed. This is a reference schedule and contains links to the WAST IMTP table 1a and 1b that detail how the framework will be updated to ensure continuous improvement of the service and the framework itself.

However, schedules O2 (Application of the Model of Care) and O3 (Extant Policies, Protocols, Pathways) were still to be completed. These schedules set out the relevant services for each transferring organisation that WAST has responsibility for under the framework.

5.6 Review of Performance

This section of the workbook required the production of two schedules (R1 and R2) of which only R1 had been completed at the time of our review.

Schedule R1 (Performance Measurement Descriptors) describes the performance measures that will give assurance against delivery of the care standards for each step of the patient care pathway.

Schedule R2 is a data repository and sets out the performance reporting mechanisms and frequency that WAST will utilise in support of the Quality and Delivery Framework. It is a reference schedule compiled from data contained in Schedules A1, RE1 and R1, set in the context of the Care

Standards Schedule (C1). This will enable performance reporting on an all Wales or individual organisation level. A draft schedule had been prepared at the time of our review, but it had not been completed.

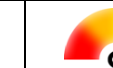
5.7 Evaluate

This section of the workbook requires the production of three schedules (E1 - E3). However, none of these had had been completed at the time of our review.

When completed Schedule E1 will contain the mixed methods that will be used to evaluate service change initiatives; Schedule E2 will be the Evaluation Programme for the CAREMORE® Quality and Delivery Framework and will be delivered by Swansea University; Schedule E3 will reference all the completed evaluation reports for service changes since the NEPTS Quality and Delivery Framework went live.

Conclusion

In the table below we provided a subjective assessment of the progress against the production of schedules under each of the key components that are being used to develop the framework for NEPTS.

Care Standards	Activity	Resource Envelope	Model of Care	Operational Arrangements	Review of Performance	Evaluate
						

Good progress has been made in developing the workbook schedules for each of the seven CAREMORE® components, and although some schedules are incomplete the first version of the NEPTS Quality & Delivery Framework has been drafted. This is due to be signed off by the Emergency Ambulance Services Committee and WAST during November 2018.

While the transfer of arrangements from health boards and trusts to WAST has not happened in line with the original timelines, this process has now commenced and work should continue to ensure the completion of all schedules and the transfer of the remaining health bodies in a timely manner.

APPENDIX A

Key to Dashboard Assessment

	There is no progress towards the production of schedules under the components of CAREMORE®.
	There is limited progress against the production of schedules under the components of CAREMORE®.
	There is good progress against the production of schedules under the components of CAREMORE®.
	All schedules have been completed.