Hosted Bodies, Audit, Risk & Assurance Committee

Tuesday 4 August 2026, 09:00 - 10:00

Virtual via Teams

Agenda

09:00 - 09:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Information *Kath Palmer, Committee Chair*

1.2. Apologies for Absence

Information *Kath Palmer, Committee Chair*

1.3. Declarations of Interest

Information *Kath Palmer, Committee Chair*

09:05 - 09:10
5 min

2. CONSENT AGENDA BUSINESS

Discussion *Kath Palmer, Committee Chair*

The Committee Chair will ask if there are any items from the Consent Agenda (item 5) that Committee Members wish to bring forward to the Main Agenda for discussion

09:10 - 09:15
5 min

3. PRELIMINARY BOARD MATTERS

3.1. Action Log

Discussion *Aaron Fowler, Committee Secretary/Deputy Director of Corporate Governance*

2.1 Action Log ARAC HB 4 August 2026.pdf (6 pages)

3.2. Matters Arising not otherwise contained on the Action Log

Discussion *Kath Palmer, Committee Chair*

09:15 - 09:50
35 min

4. STRATEGIC PILLAR: IMPROVING CARE

4.1. Joint Commissioning Committee Strategic Update

Discussion *Juliet Brown, Chief Commissioner, NWJCC*

4.1 NWJCC Strategic Update ARAC HB 4 Aug 2026.pdf (10 pages)

4.2. Joint Commissioning Committee Assurance Framework

Discussion *Aaron Fowler, Committee Secretary/Deputy Director of Corporate Governance*

4.2 NWJCC Risk Mmt and Assurance HB ARAC 4 Aug 2026.pdf (8 pages)
4.2.1 App 1 - Risk Management Procedure Final 2026.pdf (34 pages)
4.2.2 App 2 - JAF Final 2026.pdf (32 pages)
4.2.3 App 3 - JAF Report Template Final 2026.pdf (5 pages)

4.2.4 App 4 - Strategic Risks Final 2026.pdf (11 pages)
4.2.5 App 5 - Risk Appetite Statement Final 2026.pdf (4 pages)
4.2.6 App 6 - Risk Appetite Matrix Final 2026.pdf (2 pages)

4.3. Joint Commissioning Committee Organisational Risk Register

Discussion *Aaron Fowler, Committee Secretary/Deputy Director of Corporate Governance*

4.3 NWJCC Org Risk Register HB ARAC 4 Aug 2026.pdf (10 pages)
4.3.1 App 1 - NWJCC ORR MASTER - May 26 v1.pdf (9 pages)

4.4. Joint Commissioning Committee Audit Tracker

Discussion *Aaron Fowler, Committee Secretary/Deputy Director of Corporate Governance*

4.4 NWJCC Audit Tracker HB ARAC 4 Aug 2026.pdf (7 pages)

4.5. National Imaging Academy Wales Risk Register - to follow

Discussion *Philip Wardle, Academy Director*

4.6. Internal Audit Reports

4.6.1. IA Review - High Cost Drugs

Discussion *Emma Samways, Deputy Head of Internal Audit*

4.6.1 High Cost Drugs - Final ARAC Hosted Bodies 4 Aug 2026.pdf (9 pages)

4.6.2. IA Review - Budget Management - Final

Discussion *Emma Samways, Deputy Head of Internal Audit*

4.6.2 Budget Mmt Final ARAC Hosted Bodies 4 Aug 2026.pdf (12 pages)

09:50 - 09:55
5 min

5. CONSENT AGENDA

5.1. Items for Approval

5.1.1. Unconfirmed Minutes of the Meeting held on 19 May 2026

Decision *Kath Palmer, Committee Chair*

5.1.1 Unconfirmed Minutes 19.05.2026 ARAC HB 4 Aug 2026.pdf (7 pages)

5.2. Items for Noting - tbc

09:55 - 10:00
5 min

6. ANY OTHER URGENT BUSINESS

Discussion *Kath Palmer, Committee Chair*

10:00 - 10:00
0 min

7. DATE AND TIME OF NEXT MEETING

Information *Kath Palmer, Committee Chair*

3 November 2026 at 14:00 pm

HOSTED BODIES AUDIT & RISK COMMITTEE ACTION LOG
FOLLOWING MEETING HELD ON 3 FEBRUARY 2026

OPEN ACTIONS

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT MAY 2026
Agenda Item 3.1	19 May 2026	Action Log	JCC and NIAW to ensure that the committee's specific queries above are responded to in future updates to the Action Log. (JCC re. Right Care, Right Person transport arrangements; and NIAW re. Gateway 5)	August 2026	A. Fowler	Right Care, Right Person – verbal update t be provide in the meeting. NIAW – TN to confirm
Agenda Item 4.1	19 May 2026	NHWJCC Strategic Update	NWJCC to provide an overview of assurance arrangements for NHS 111 and ambulance services, as set out above.	August 2026	A Fowler	Request to defer item to a future ARAC meeting due to annual leave. See below ongoing action – Matter on forward work plan for November.
Agenda Item 4.2	19 May 2026	NWJCC Organisational Risk Register	A Fowler to share the draft JAF with committee members for awareness and feedback	May 2026	A Fowler	Shared with members at 4 August ARAC meeting against Agenda item 4.2
Agenda Item 3.4	3rd February 2026	National Imaging Academy Wales Risk Register	Review the status of the Gateway 5 review for the Imaging Academy, determine if recommendations have been met or if a new review is needed, and update the Committee at the next meeting.	Next meeting	T Norris	**In Progress** **Meeting arranged with WG on 22nd May to discuss action and agree a way forward.**
Agenda item 3.4	13th November 2025	Ambulance Service Commissioner Risk Assurance Update	To provide updates to future meetings on breakdowns of lost hours (handover vs. internal processes), information on the new call categorisation processes and their impact, and an update on the 111 service.	tbc	R Whitehead	Ongoing – A date for submission of a future update remains in discussion between the NWJCC and CTMUHB Corporate Governance teams. On forward work plan for November 2026

COMPLETED ACTIONS

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT AUGUST 2025
Agenda Item 2.1	3rd February 2026	Action Log	Clarify whether responsibility for the national transport solution under the Right Care, Right Person action sits with the JCC or Welsh Government, and provide an update after discussing with the Ambulance Commissioner.	Next meeting	A Fowler	**Closed** The JCC commissions Mental Health Transport from St Johns Cymru to support the transfer of patients accessing mental health services across Wales. This is on receipt of annual funding provided by Welsh Government. The JCC continues to work in partnership with NHS P&I, Welsh Government, WAST and St Johns Cymru supporting the implementation of Right Care, Right Person.
Agenda Item 2.1	3rd February 2026	Action Log	To update the narrative on Risk 68 and keep on the Action Log.	Next meeting	A Fowler	**Closed** Risk 68 has been updated to provide clarity and reflect feedback received – An update on the risk is shared within the JCC Organisational Risk Register Update.
Agenda Item 3.1	3rd February 2026	JCC Strategic Update	To ensure that future updates clearly distinguish between commissioner and provider risks, with more accurate narratives and mitigations.	Next meeting	A Fowler/H. George	**Closed** An updated JCC Strategic Update has been shared. Feedback on the revised approach is welcomed. Details of Provider and Commissioner risks are set out within the Organisational Risk Register Update.
Agenda Item 3.2	3rd February 2026	JCC Organisational Risk Register	Provide a definitive update on mitigations for Risk 92 (Cardiff and Vale frozen JCC-funded posts under women and children) once information is received from the specialist services commissioning team	Next meeting	A Fowler	**Closed** Risk 92 has been de-escalated from the Organisational Risk Register; its score having been reduced from 16 to 12, following changes to recruitment practices that support an expedited process for appointments to be made to funded posts.
Agenda Item 3.3	3rd February 2026	JCC Audit Recommendations Tracker	To provide colour coded RAG ratings for future reports.	Next meeting	A Fowler	**Closed** Recommendation Tracker now incorporates a RAG rating system for each recommendation.
Agenda item 3.2	13th November 2025	JCC Organisational Risk Register	To provide an update on risk 28 business continuity and vacancy rates outside of the meeting.	Next Meeting	A Fowler	**Closed** Risk 28, relating to business continuity has been de-escalated with senior posts now recruited to. As of January 2026, the NWJCC is reporting a vacancy rate of 14.3% down from 30% in June 2025.

Agenda item 3.2	13th November 2025	JCC Organisational Risk Register	To provide an update on risk 28 business continuity and vacancy rates outside of the meeting.	Next Meeting	A Fowler	**Closed** Risk 28, relating to business continuity has been de-escalated with senior posts now recruited to. As of January 2026, the NWJCC is reporting a vacancy rate of 14.3% down from 30% in June 2025.
Agenda item 2.1	13th November 2025	Action Log	To share the update on 'Right Care Right Person' outside of the meeting.	Next Meeting	A Fowler	**Closed** – Update shared with Committee Members by email on the 27th November 2025.
Agenda item 3.2	13th November 2025	JCC Organisational Risk Register	To provide an update on the service costs for risk 68 specialist auditory hearing service outside of the meeting.	Next Meeting	S. Taylor	**Closed** – Whilst the provider is funded to provide a full service and agreed staffing level, staffing difficulties have resulted in funding being provided for posts not yet in place. Due to the lack of progress made against actions monitored through quarterly Service Performance Management meetings, including staffing requirements, the service has been placed into level 3 escalation.
Agenda item 3.4	13th November 2025	Ambulance Service Commissioner Risk Assurance Update	To work with CTM Governance Team on aligning timings of the updates with JCC Board Committee meetings.	tbc	H. George	**Closed** – The NWJCC have re scheduled its Joint Committee and Sub-Committee meetings. The NWJCC Committee Secretary will also attend HB ARAC meetings moving forward to support the alignment of meetings and to agree the appropriate timing of updates in future.
Agenda item 3.4	14th August 2025	Internal Audit Review – Joint Commissioning Committee Financial Arrangements	S Taylor and S May to discuss future standalone reporting to the Hosted Bodies Committee in relation to any breach or waiver to the Standing Orders and Standing Financial Instructions.	Next Meeting	S Taylor & S May	**Closed–** ST has engaged with SM and a standalone report will be shared with the Hosted Bodies Committee for any breach or waiver to the Standing Orders and Standing Financial Instructions will be shared. A request has been shared with NWSSP for this detail, which is presently reported to the CTMUHB ARAC, to be separated for sharing as a standalone item.
Agenda item 3.2	14th August 2025	Joint Commissioning Committee Organisational Risk Register	Director of Commissioning for Ambulance Services & 111 to be invited to a future Committee meeting to provide assurance on the action being taken to meet the changes /targets set by the MAG report affecting the Ambulance service.	Next Meeting	A Fowler and SMT to liaise with lead and confirm attendance with the CTMUHB Meeting Secretariat.	**Closed–** Update to be shared against agenda item 3.4.

Agenda item 3.2	14th August 2025	Joint Commissioning Committee Organisational Risk Register	Updates to risks 55, 68 and 80 to be shared with Members outside the meeting.	Next Meeting	A Fowler and SMT	**Closed-** Updates for risks 55, 68 and 80 are detailed within agenda item 3.2. However, the following up to date position is shared for additional context. Risk 55 – (Neonatal Workforce) – Whilst tough the service remains at escalation level 3 this is not related to its current work force. During the escalation meetings the health board has explained that they have no current concerns with their nursing work force. The risk was reduced from a score of 20 to 12. Risk 68 (C&VUHB Specialist Auditory Hearing service waiting times) – The Specialist Auditory service has been put into escalation level 3. The NWJCC is in the process of setting up the first escalation meeting and the outcome of this process will report into QSOC in December 2025, in addition to the reporting of this risk. Risk 80 – (JACIE accreditation - south Wales CAR T service) – A JACIE accreditation report is expected by the 18th November. Further updates will be shared following that report.
Agenda item 3.2	14th August 2025	Joint Commissioning Committee Organisational Risk Register	Revisit the timelines for producing the risk register for Committee meetings to ensure the latest possible update approved by the Joint Commissioning Committee can be received.	Next Meeting	A Fowler and SMT	**Complete –** Updates are confirmed within the report shared for agenda item 3.2
Agenda item 2.1	14th August 2025	Visibility of significant risks	H George agreed that further updates reports would focus and demonstrate assurance on how risks are being mitigated.	Next Meeting	A Fowler and SMT	**Completed –** Updates are confirmed within the report shared for agenda item 3.2
Agenda item 3.1	14th August 2025	Joint Commissioning Committee Update - Right Care Right Person	H George agreed to seek an update on the latest position and provide a briefing to members outside the meeting.	Next Meeting	A Fowler and SMT	**Completed –** Update shared with Committee members offline via email.
		Joint Commissioning Committee Update - External Adhoc Requests	H George and JCC colleagues to consider the level of risk posed by receiving various external activity / support requests.	Next Meeting	A Fowler and SMT	**Complete –** The level of risk posed by ad hoc support requests is addressed via the JCC's prioritisation and planning work streams which ensure that commissioned activity is prioritised according to risk.

4.2	17 December 2024	JCC Organisational Risk Register	To arrange a meeting between the two Chairs to discuss management of risks and provide assurance back to the next meeting of the Audit, Risk & Assurance Committee	February 2025	Interim Chief Commissioner/ Director of Finance & Information	**Completed** Both Chairs have previously met so a further meeting was not required.
4.4	17 December 2024	Internal Audit Report – Mental Health Quality Commissioning Arrangements	To check if the workshop referred to was held on the 28th November 2024 took place	February 2025	Interim Chief Commissioner/ Director of Finance & Information	**Completed** The workshop did take place.
3.1.1	15 August 2024	JCC Organisational Risk Register	To review risks 40, 57 and 63 that had been reduced and feedback to the Committee. To feedback the comments and observations made today to the Risk Workshop in September 2024.	17 October 2024	JCC Committee Secretary/Associate Director of Corporate Services	**Completed** The risks have been reviewed as follows: • 40 – this related to limited outpatient dialysis in Swansea which has now been has been managed and the risk has been de-escalated, • 57 this related to insufficient theatre beds which has now been has been managed and the risk has been de-escalated, • 63 this related to neurosurgery sustainability which has now been has been managed and the risk has been de-escalated.
2.1	February 2025	JCC Action Log	To review the narrative on risks 65 and 40 on the risk register.	May 2025	JCC Committee Secretary/Associate Director of Corporate Services	**Completed** An update on the risks has been circulated to the Committee via email on the 8.5.25
4.1	17 December 2025	JCC Update	To bring an update to a future meeting of the Committee on the planning and process in relation to the Plan.	February 2025	Interim Chief Commissioner/ Director of Finance and Information	**Completed** Update contained within the JCC Progress Report for the February 2025 meeting.
4.2	15 August 2024	JCC Audit Tracker	To discuss Recommendation 6 with colleagues and provide an update to the Committee on the discussions with Welsh Government.	17 October 2024	Darren Griffiths, Audit Wales	**Completed** An updated was provided to the ARC meting 17 December and all recommendations have been closed.
4.2	17 October 2024	JCC Organisational Risk Register	To review the narrative on the de-escalated Risk 40 – Limited Outpatient Dialysis for patients in Swansea due to the recent issues at the Princess of Wales Hospital. To review Risk 65 – Renal Dialysis across Wales.	17 December 2024	JCC Committee Secretary/Associate Director of Corporate Services	**Completed** Further narrative provided within risk register. The risk has been mitigated by the opening up of twilight sessions to increase capacity until the two new units are open and fully functioning. Unit dialysis capacity pressures across Wales are being managed and monitored through Risk 65 on the risk register with a score of 16.

4.2	17 October 2024	JCC Organisational Risk Register	To provide a detailed focus on the two red Ambulance Risks 71 & 74 for the next meeting of the Committee.	17 December 2024	JCC Committee Secretary/Associate Director of Corporate Services	**Completed** The Ambulance & 111 Commissioning team have undertaken an in-depth piece of work to review and reset the risks for their commissioning portfolio. These were considered by the Senior Leadership Team on 4 November 2024 and are now included in the new JCC Risk Register. Risks 71 and 74 have been replaced by Risk 77
4.3	17 October 2024	National Imaging Academy Wales	To amend the wording in the report in relation to recruitment and re-circulate to members.	November 2024	NIAW Academy Manager	**Completed** Report has been amended and re-circulated.
5.	15 August 2024	Any other Urgent Business	To provide a written update report on the JCC, for future meetings.	17 October 2024	JCC Committee Secretary/Associate Director of Corporate Services	**Completed** Written report on the agenda for December 2024 meeting**.**

Audit, Risk & Assurance Committee Hosted Bodies

NHS Wales Joint Commissioning Committee Strategic Update

Eitem yr Agenda / Agenda Item	**4.1**
Dyddiad y Cyfarfod / Date of Meeting:	04/08/26
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Aaron Fowler, Committee Secretary, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter:	Juliet Brown, Chief Commissioner, NWJCC
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Juliet Brown, Chief Commissioner, NWJCC
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	No Decision Required
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below: Creating Health Sustaining our Future Inspiring People
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	This report provides an update against the delivery of the priorities within the NWJCC Annual Plan 2026-27 and other key matters relating to the NWJCC.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:

Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	The report provides an assurance update on key matters relating to the NHS Wales Joint Commissioning Committee, including: • delivery of the NWJCC Annual Plan 2026/27 • progress with Strategic Reviews and Deep Dives • the Welsh Affairs Committee inquiry into cross-border healthcare • the Welsh Government arbitration outcome on the Cardiff and Vale University Health Board Long-Term Agreement • the Month 3 financial position • planned care performance in specialised services • Directors of Commissioning updates • the work of the Collaborative Commissioning Leadership Group.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The update indicates that the foundations for Annual Plan delivery are in place and that all strategic priority areas made progress during Quarter 1. However, there remain important risks relating to access to data, analytical capacity, provider capacity, workforce constraints, financial sustainability and long waits in some specialised services. The Welsh Affairs Committee evidence session and the LTA arbitration outcome also highlight the importance of clear governance, effective collaboration with providers and commissioners, and robust information-sharing arrangements. While the Month 3 financial position is favourable, continued focus is required to secure best value and maintain a balanced financial plan.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the*	The NWJCC will continue monthly monitoring of delivery confidence across the Annual Plan priorities, with formal quarterly assurance reporting through the Planning, Performance and Finance Sub-Committee and the Joint Committee. Findings from Deep Dives and Strategic Reviews will be tested through CCLG, the August Joint Committee Strategy Session and future Joint Committee meetings, with final reports and recommendations

choices and recommendation(s)being made)	scheduled between September 2026 and January 2027. Further work will also continue on planned care recovery, financial sustainability, advanced therapies, data and analytical capacity, and implementation of the Cardiff and Vale University Health Board LTA arbitration outcome.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	Members are asked to: • **Note** the report.

1. Background / Context

1.1 The purpose of this report is to provide Cwm Taf Morgannwg University Health Board's (CTMUHB) Audit, Risk and Assurance Committee (the Committee) members with an assurance update on key issues relating to the NHS Wales Joint Commissioning Committee (NWJCC).

2. Strategic Insights

2.1 Annual Plan Delivery

The Strategic Reviews and Deep Dives described at the previous meeting are progressing well. Each priority is sponsored by a Health Board (HB) Chief Executive Officer (CEO), a lead NWJCC Director (SRO) and members of the Collaborative Commissioning Leadership Group (CCLG) with support by HB Executives to ensure the necessary input from HBs where required. Each priority has a clear scope/activity brief providing clarity on purpose, scope, deliverables, milestones, intended outcomes, risks, dependencies, leadership and stakeholder engagement, progress will be monitored against these.

Assurance on progress against the Plan at the end of May 2026 was received at the CCLG and the Planning, Performance and Finance (PPF) Sub-Committee in June and July. An overview of progress position across the strategic priority areas as at the end of Quarter 1 was presented at the Joint Commissioning Committee (JC) meeting on 21 July 2026. This included an indication of delivery confidence for the remainder of the year based on emerging risks and planned mitigations.

Members noted:

- That all strategic priority areas had made progress in Quarter 1 with the core foundations for delivery now in place.
- A high-level RAG rating overview of delivery up to the end of June 2026 against the Quarter 1 deliverables for each of the Strategic Priorities.
- An indication of delivery confidence for the remainder of the year for each strategic priority area based on emerging risks and planned mitigations as at end of Quarter 1.

This confidence rating will be closely monitored on a monthly basis and updated in future reporting to ensure transparency across the portfolio in a timely manner.

Key Milestones

The following key milestones have been set for reporting on progress against the Strategic Priorities of the Annual Plan:

- **July - August 2026**: Findings of Deep Dives tested at CCLG ahead of JC workshop (noting caution around Individual Patient Funding Request (IPFR).
- **August 2026**: Workshop on findings of Deep Dives at JC.
- **September 2026**: Final Deep Dive reports and recommendations presented at JC.
- **September 2026**: Mid-year report on initial findings of Strategic Reviews, assessment and recommendations presented to JC.
- **December 2026**: Findings of Strategic Reviews presented and discussed at CCLG and Sub-Committees ahead of final report circulation.
- **January 2027**: Final Strategic Review reports and recommendations formally received, alongside socialisation of the implementation plan, at JC.

Reporting

Formal quarterly reporting on progress against all priorities will include exception reports on issues for escalation as appropriate and be included in the integrated performance report for scrutiny by the PPF Sub-Committee and subsequently to the JC.

2.2 Welsh Affairs Committee into Cross Border Healthcare

The NWJCC Chief Commissioner, Medical Director and Director of Commissioning for Specialised Services attended the UK Parliament's Welsh Affairs Select Committee inquiry into cross-border healthcare on 24 June 2026 to provide evidence on the commissioning and delivery of services accessed by Welsh patients in England. HB CEOs, or their nominated deputies, attended similar sessions on the 23 June 2026.

The evidence presented highlighted the NWJCC's role in commissioning specialist services for the Welsh population, the importance of effective collaboration with English providers and commissioners, and the need for clear governance, accountability and information-sharing arrangements to support safe and equitable cross-border care. The session also provided an opportunity for the NWJCC to explain its developing role as a national commissioning organisation and to respond to issues previously raised by stakeholders regarding access, commissioning arrangements and patient outcomes.

A number of questions were received regarding IPFR but NWJCC colleagues were happy to provide context that, in the last year 35 applications had been received for specialist cross border care, 31 of which were approved. There was a detailed discussion regarding pre-approvals, which highlighted the complexity of our system. These issues are a focus of the IPFR Deep Dive.

2.3 NHS Wales Arbitration – Long-Term Agreement with CVUHB

At the JC's May 2026 meeting it was noted that NWJCC had not yet reached agreement on one LTA. Unfortunately, this was escalated to Welsh Government (WG) for arbitration. WG has determined that the LTA between the NWJCC and Cardiff and Vale University Health Board (CVUHB) must be implemented by the parties, including the decision previously taken by the JC in March 2026 to apply a 2% efficiency reduction to the 2026/27 LTA quantum. Work is being undertaken with CVUHB to take this forward.

2.4 NWJCC Financial Position

The financial position at Month 3 of 2026/27 reported and underspend at Month 3 of £1.3m, against the financial plan, with a year-end forecast underspend of £0.5m. Alongside work to monitor business as usual financial performance the NWJCC is continuing work to identify opportunities to reduce the level of additional income required to achieve a balanced financial plan for the NWJCC in 2026-27. This work is set in the context of driving best value on a system wide level, and that is patient outcome focused. Further updates will be shared as this work progresses and opportunities crystalise.

2.5 Planned Care Performance in Specialised Services

Reducing long waits in specialised services remains a key priority for the NWJCC. While performance has improved in some areas, workforce, capacity and infrastructure constraints continue to create risks against both the 104-week treatment target and the eight-week diagnostic standard. The NWJCC is actively monitoring recovery trajectories and working with providers to support improvement.

There is a significant concern within the Artificial Limb and Appliance Service and Electronic Assistive Technology service, which is breaching the 104-week target. It is anticipated that breaches will continue during 2026/27 even with a focus on provider improvement plans. The Prosthetics and Posture and Mobility Services also have a risk in terms of increasing patient waiting times, this is largely associated with individual patient complexity rather than systemic capacity pressures.

The Southwest Wales Plastic Surgery service has indicated that, 250 patients could breach 104 weeks during 2026/27, this is exclusive of any service growth; recovery plans are being developed.

WG planned care funding has been allocated directly to provider organisations. The NWJCC is engaging with Welsh providers to ensure that these waits are reduced in line with WG direction and the additional funding available. To note, planned care funding has been utilised to support sarcoma pathology outsourcing arrangements, helping to maintain access to specialist diagnostics.

There are currently no waits exceeding 104 being reported for services delivered by English providers.

2.6 Directors of Commissioning Updates

Detailed updates are shared by Directors of Commissioning at the Quality, Safety and Outcomes (QSO) and PPF Sub-Committees. Highlight Reports from each of these Sub-Committee meetings and an overview of the matters discussed are shared at each meeting of the JC and also shared with HB Directors of Corporate Governance for sharing locally. At the JC meeting of the 21 July 2026 the following updates were shared following our Sub-Committee meetings in June and July.

Director of Commissioning for Specialised Services
The Director of Commissioning for Specialised Services reported continued progress in service recovery and performance improvement across a number of specialised services, including the elimination of all 52-week waits within the South Wales Specialist Auditory Implant Device Service, sustained performance in North Wales plastic surgery and increased activity within TAVI services. Significant focus remains on quality, safety and assurance, particularly maintaining JACIE accreditation for Bone Marrow Transplantation and CAR-T services and addressing risks within intestinal failure services. Workforce shortages, capacity constraints and service sustainability continue to present the most significant risks, with enhanced oversight in areas including cardiac surgery, neurosurgery, intestinal failure and ALAS services. The Director also highlighted progress in service innovation and future planning, including expansion of advanced therapies, implementation of the genomics laboratory information management system, development of thrombectomy and functional neurosurgery services, improvements to neonatal pathways and the introduction of all-Wales clinical standards for kidney disease services.

Director of Commissioning for Ambulance Services and National Programmes
The Director of Commissioning for Ambulance Services and National Programmes reported ongoing work to strengthen commissioning assurance arrangements across the portfolio, with revised arrangements expected to be implemented by the end of Quarter 2. Key areas of focus include development of the Future Vision for Non-Emergency Patient Transport Services (NEPTS), establishment of a proposed national NEPTS working group, and work to develop options for future clinical support hub arrangements. Engagement planning is progressing to inform future rural ambulance response proposals, with a programme of public and stakeholder engagement anticipated during 2026. Within national programmes, the director highlighted work on neonatal transport service specifications, major trauma network sustainability and the development of new Sexual Assault Referral Centre commissioning arrangements.

Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups (MHLDVG)
The Director of Commissioning for MHLDVG reported that Caswell Clinic remains subject to Level 3 escalation, though progress continues against the improvement plan and de-escalation will be considered once sufficient assurance has been obtained that actions have been addressed. The director also highlighted a comprehensive review of the Adult Welsh Gender Service to assess alignment with

the latest evidence base and developments across the UK, alongside ongoing work relating to children and young people's gender services. Further priorities include managing the transfer of remaining patients from St Andrews Healthcare, progressing procurement of a new all-Wales digital psychological therapies model, and reviewing future commissioning arrangements for adult eating disorder inpatient services following the closure of the remaining Welsh provider.

At the November JC meeting it was confirmed that agreement had been reached, subject to confirmation of staffing and resource position, for the TSW (Traumatic Stress Wales) service to be transferred to Public Health Wales as host organisation, to sit alongside their Adverse Childhood Experiences' hub. Work remains ongoing to finalise the transfer with NWJCC colleagues working closely with CTMUHB (as the host organisation of the NWJCC) and Public Health Wales to progress the transfer through the finalisation of Transfer of Undertakings processes. Timescales have been significantly longer than originally anticipated due to the complexity of staff contractual arrangements which has required legal advice. CTMUHB received the legal advice in July 2026. This is currently being operationalised to finalise the TUPE process.

Budget allocations to health boards for their commissioned service activity remain with the NWJCC for oversight and ringfencing. Further updates will be shared with the JC as they arise and, in the interim, updates will continue to be reported to the CTMUHB Hosted Bodies Audit, Risk and Assurance Committee as part of the NWJCC's regular Internal Audit recommendation tracker update.

2.7 Collaborative Commissioning Leadership Group (CCLG)

The CCLG met on the 23 June 2026 to consider:

- Annual Plan Delivery - attendees acknowledged the need to strengthen analytical capacity within the NWJCC and access to data to support the strategic priorities and stressed the importance of continued HB lead support to deliver agreed plans.
- Welsh Ambulance Services University NHS Trust Productivity and Efficiency Programme.
- Advanced Therapies and Future Planning – Members received an update on ongoing work to review the options available to the NWJCC for advanced therapies and the growing financial challenge associated with gene therapies and other highly specialised treatments. An options workshop is scheduled with WG colleagues in August.

3. Risks and Opportunities

3.1 Annual Plan Delivery

The main risk reported across the programmes within the NWJCC Annual Plan 2026-27 concerns access to data, data analysis and internal capability to deliver the data analytics required for the large projects. This is an area where support is required from wider HB teams, whilst work is undertaken to build this capacity and capability within the NWJCC's internal teams. Options are being explored

collaboratively within each of the priority areas with a view to increasing capacity to support specific data analysis for these time-limited pieces of work.

3.2 Other Risks

Other risks include delivery risks linked to financial sustainability, provider capacity and long waits in specialised services (with workforce capacity and infrastructure constraints identified).

4. Compliance and Governance

4.1 The NWJCC continues to operate within the governance framework agreed by the seven HBs, with the JC acting collectively on their behalf for delegated commissioning functions. Assurance is provided through the JC, its Sub-Committees, CCLG and the CTMUHB Hosted Bodies Audit, Risk and Assurance Committee. This structure enables scrutiny of delivery, finance, performance, quality, risk and assurance matters before escalation to the JC where required.

The NWJCC will ensure that commissioning assurance arrangements continue to support effective quality governance, patient safety, timely escalation and learning across commissioned services. The organisation is also strengthening its approach to risk appetite, committee assurance and financial grip and control arrangements to support proportionate decision-making in a constrained financial environment.

5. Conclusion

5.1 The report provides an assurance update on key issues relating to the NWJCC, specifically:

- Annual Plan Delivery.
- Welsh Affairs Committee into Cross Border Healthcare
- NHS Wales Arbitration – Long-Term Agreement with CVUHB
- NWJCC Financial Position
- Planned Care Performance in Specialised Services
- Directors of Commissioning Updates
- Collaborative Commissioning Leadership Group

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Choose an item. If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A More Equal Wales
	If more than one applies please list below: A prosperous Wales A resilient Wales A healthier Wales

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Whole-Systems Perspective
	If more than one applies please list below: Culture and valuing people Data to knowledge Leadership Learning, Improvement and Research

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	Choose an item.
	If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Summary of impact: Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Summary of impact:	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Strategic update provided. Quality impact assessments will be undertaken for any element of the NWJCC's work that requires this.	

Cyfreithiol / Legal	**There are no specific legal implications related to the activity outlined in this report**
Enw da / Reputational	**There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report**
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	**There is no direct impact on resources as a result of the activity outlined in this report**

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
NHS Wales Joint Commissioning Committee	21/07/2026	Noted

Audit, Risk & Assurance Committee Hosted Bodies

NHS Wales Joint Commissioning Committee
Risk Management and Assurance Report

Eitem yr Agenda / Agenda Item	**4.2**
Dyddiad y Cyfarfod / Date of Meeting:	04/08/26
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Aaron Fowler, Committee Secretary, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter:	Aaron Fowler, Committee Secretary, NWJCC
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Georgina Galletly, Director of Corporate Planning and Strategy, NWJCC
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	No Decision Required
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below: Creating Health Sustaining our Future
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	This report provides assurance that the appropriate processes and procedures in place for the management of risk aligned with the delivery of the NWJCC Annual Plan 2026-27 and its strategic priorities.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:

Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	Pursuant to Para 10.1 of the NWJCC's Standing Orders, the suite of documents appended to this report provides assurance to the CTMUHB Hosted Bodies Audit, Risk & Assurance Committee ("ARAC") regarding the NWJCC's risk management processes and procedures.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	A Joint Committee Assurance Framework ("JAF") and Risk Appetite Statement has been developed that recognise the risks identified in the NWJCC Annual Plan and strategic priorities for 2026-27 and beyond, alongside a revised Risk Management Procedure ("Procedure"). The Procedure is modelled on the Cwm Taf Morgannwg University Health Board (CTMUHB) Risk Management Strategy but has been tailored to meet the needs of the NWJCC and is designed to provide guidance to all NWJCC staff on the management of both strategic and operational risks within the organisation. The Risk Appetite Statement and Matrix will operate as a tool to inform the treatment and management of the NWJCC's operational and strategic risks moving forward. The JAF will provide the mechanism by which we are able to articulate the NWJCC's strategic risks, how these are being managed/mitigated and where there are gaps in assurance that we need to resolve. The JAF report shared aligns entirely with the CTMUHB iteration of the document, save that the document incorporates the NWJCC's Strategic Objectives.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)*	The suite of risk documents shared will be implemented throughout August and a fully developed JAF will be reported to the JC at its meeting in September 2026, and subsequently to the CTM ARAC.

What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	Members are asked to: • **Note** the report.

1. Situation /Background

1.1 In accordance with the Hosting Agreement ("the HA") between CTMUHB ("Cwm Taf Morgannwg University Health Board") and the NWJCC, the NWJCC has adopted the Risk Management processes of CTMUHB (para. 5.2 of the HA).

1.2 Whilst we will continue to follow the format of CTM's risk management processes there has been a need to tailor these so that they better reflect the operational requirements of the NWJCC as a commissioner organisation.

1.3 As requested by Joint Committee (JC), the Corporate Governance Team reviewed existing risk management processes and undertook work to prepare a new suite of Risk Management procedures and documentation to support the management and review of risk for 2026/27 and beyond.

1.4 Each of the Risk Management and Assurance documents described below were endorsed by the Quality, Safety and Outcomes, and Planning, Performance and Finance Sub-Committees at their scheduled meetings in June 2026 and **approved** by the JC at its meeting on 21st July 2026. This is in accordance with the matters reserved to the JC pursuant to Annex 1 of the NWJCC Standing Orders.

1.5 Assurance regarding the NWJCC's is risk management processes and procedures is provided to the CTMUHB Hosted Bodies Audit, Risk & Assurance Committee ("ARAC") pursuant to Para 10.1 of the NWJCC's Standing Orders.

1.6 A fully populated JAF report is currently being prepared and will be shared with the JC in September.

1.7 Attached to this report you will find:

- **Risk Management Procedure** (the "Procedure") – **Appendix 1**
  This document is modelled on the Cwm Taf Morgannwg University Health Board (CTMUHB) Risk Management Strategy but has been tailored to meet the needs of the NWJCC.

- **Joint Committee Assurance Framework ("JAF"), JAF Report Template and Strategic Risks – Appendices 2, 3 and 4**
  The JAF will provide the mechanism by which we are able to articulate the NWJCC's strategic risks, how these are being managed/mitigated and where there are gaps in assurance that we need to resolve.

  The JAF Report template. This is the report format that will be shared with JC to set out the Strategic Risks that the NWJCC is holding and will be used to monitor the risks.

  The Strategic Risks shared were derived from the Annual Plan 2026/27 and subsequently revised following feedback from the NWJCC Senior Leadership Team (SLT), Ian Green (NWJCC Chair) and NWJCC Lay Members.

- **Risk Appetite Statement and Matrix – Appendices 5 and 6**
  The statement and matrix are also incorporated within the Procedure but are separated out for consideration. The risk appetite has been prepared following feedback from the Senior Leadership Team (SLT), Ian Green (NWJCC Chair) and from a workshop held on 16th June 2026 with NWJCC Lay Members.

2. Specific Matters for Consideration

2.1 **Risk Management Procedure**
The Procedure is designed to provide guidance to all NWJCC staff on the management of both strategic and operational risks within the organisation. It aims to:

- Set out respective responsibilities for strategic and operational risk management for the JC and staff throughout the organisation.
- Set out responsibility for Sub Committees, namely the Quality, Safety and Outcomes Sub-Committee ("QSOC"), the Planning, Performance and Finance Sub-Committee ("PPF") and the ARAC
- Describe the procedures to be used in identifying, analysing, evaluating and controlling risks to the delivery of the NWJCC's Annual Plan and strategic priorities for 2026-2027 and beyond.

2.2 Whilst tailored to meet the needs of the NWJCC, the Procedure does not significantly depart from CTMUHB Risk Management procedures, albeit the following specific changes should be noted:

- **Updated Risk Scoring Domains** – (incorporated within the Procedure as Appendix 3): Risk scoring domains have been specifically updated to incorporate a commissioner focus within each area and specifically through the introduction of a specific "Strategic Commissioning" domain. Notwithstanding this, the format and function of the domains continue to align to the CTMUHB iteration. Updates have been informed through review of NHS England risk management processes.

- **Risk Appetite Statement and Matrix** – (incorporated within the Procedure as Appendix 5): As above, this has been updated to incorporate a specific commissioner focus whilst retaining the same overall approach and format to that of CTMUHB. The Risk Appetite Statement and Matrix will operate as a tool to inform the treatment and management of the NWJCC's operational and strategic risks moving forward.

2.3 **Joint Commissioning Assurance Framework ("JAF")**

The JAF is presented in three parts:

- As a standalone Assurance Framework document.
- The JAF Report
- Proposed Strategic Risks

2.4 **The JAF – As a standalone framework document**

The JAF is an integral part of the system of internal control and defines the strategic/principal risks, which impact upon the delivery of the Strategic Objectives of the NWJCC. It also summarises the controls and assurances that are in place for these risks and plans to mitigate them.

Additionally, the JAF identifies and highlights gaps in controls and assurances to support the development of action plans for the closing of gaps and mitigating risk, which is subsequently monitored by the JC for implementation.

The JAF has been designed to provide JC level oversight, and it is intended that, through appropriate utilisation of the JAF, the JC can have confidence that it is providing thorough scrutiny of its role and is able to identify any gaps in assurance and take appropriate action which will support operational and strategic decision making.

The JAF has been prepared specifically for the NWJCC, with CTMUHB not having a similar, specific document. The draft shared has been informed by similar NHS Wales documentation across all Health Boards and adapted to meet the needs of the NWJCC.

2.5 **The JAF Report**

The JAF report shared aligns entirely with the CTMUHB iteration of the document, save that the document incorporates the NWJCC's Strategic Objectives. It will be the used to test and assess the adequacy of the control and assurance mechanisms in place and will describe and score each risk to the achievement of the NWJCC's strategic aims in accordance with the NWJCC Risk Management Procedure.

2.6 **Strategic Risks**

The Strategic Risks, derived from the Annual Plan 2026/27 and subsequently revised following feedback from the Senior Leadership Team (SLT), Ian Green (NWJCC Chair) and from a workshop held on 16th June 2026 with NWJCC Lay Members, will be incorporated within the JAF report.

2.7 **Internal Audit**

It is acknowledged that the NWJCC's approach to risk management is maturing and that the documents referred to above will need to embed within the organisation over the coming months.

Whilst it is considered that positive steps are being taken to achieve this, NHS Shared Services Partnership Internal Audit, have been asked to review the risk management processes to ensure that the NWJCC's approach is appropriate and aligns with best practice. A review is scheduled during Q3 of 2026/27, the outcome of which will be shared with the ARAC for assurance.

3. Conclusion

3.1 The report provides assurance that the NWJCC has appropriate risk management processes and procedures in place for the ongoing management of strategic and organisational risk.

3.2 Specifically, members are asked to:

- **Note** the Procedure
- **Note** the JAF and JAF report
- **Note** the final Risk Appetite Statement and Matrix; and
- **Note** the final Strategic Risks for inclusion within the JAF report.
- Take **Assurance** that the NWJCC has maturing risk management processes in place that will continue to develop following approval of the aforementioned documentation.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Choose an item. Not Applicable The NWJCC was established on 1 April 2024. The NWJCC strategic goals were approved in September 2024. This report is linked to the following NWJCC strategic goals: • Maximise value • ensure quality • reduce duplication • improve equity • population health and facilitate integration

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales A more Equal Wales A Resilient Wales A Wales of Cohesive Communities

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Leadership Learning, Improvement and Research Whole Systems Perspective

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Summary of impact: Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Summary of impact:	If no, please select a reason below. Choose an item.
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	The Risk Management and Assurance documents will be regularly reviewed and do not specifically deal with patient level information i.e. re protected characteristics although all services are required to comply with the Equality Act and Public Sector Equality Duty	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Senior Leadership Team	03/06/2026 and 10/06/2026	Endorsed
NWJCC Lay Members Workshop	16/06/2026	Endorsed
Quality, Safety and Outcome Sub-Committee	29/06/2026	Endorsed
Planning, Performance and Finance Sub-Committee	02/07/2026	Endorsed
NHS Wales Joint Commissioning Committee	21/07/2026	Approved

4.2.1 - APPENDIX 1

NHS Wales Joint Commissioning Committee

Risk Management Procedure 2026/27

Ref:	NWJCC RMP
Document Author:	Assurance and Risk Officer
Executive Sponsor:	Committee Secretary and Associate Director of Corporate Services
Approval / Effective Date:	
Review Date:	
Version:	Final 2026

Target Audience:

People who need to review this document in detail	All Staff with the responsibility for undertaking risk assessments. All staff who approve risks as a risk owner or manager.
People who need to have a broad understanding of this document	All staff.
People who need to know that this document exists	All staff.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:**
	Outcome:
Welsh Language Standard	Yes - If Standard 82 applies you must ensure a Welsh version of this policy is maintained.
Date of approval by Equality Team:	
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care

Approval Route:

Where	**When**	**Why**
CTM UHB Audit & Risk Committee		Endorse for Joint Commissioning Committee Approval
Joint Commissioning Committee		Endorse for Host Body Approval

Disclaimer:
If the review date of this document has passed, please ensure that the version you are using is the most up to date version either by contacting the author or (nwjcc.governance@wales.nhs.uk)

Contents

1. INTRODUCTION

1.1 The NHS Wales Joint Commissioning Committee, hereafter known as "JCC", is an organisation that is committed to supporting the creation of an NHS system fit for the future, with transformed services that join up around the people who use them. Its objectives drive work plans and decisions to enable the JCC to provide all stakeholders with assurance about the internal system of controls.

1.2 The JCC is a joint committee of the seven Health Boards in Wales and hosted by Cwm Taf Morgannwg University Health Board ("CTMUHB"), acting collectively on their behalf. Risk management plays a critical role in helping the JCC understand the impacts and manage the risks associated with its priorities and is fundamental to its success. This procedure sets out key principles that guide how risk management is embedded at all levels and how the JCC will ensure that risk is managed effectively and efficiently.

1.3 Risk is an important feature within the different parts of the NHS systems architecture. Collaborative working can often lead to risks regarding risk ownership and accountability. It is important that there are clear inter-relationships regarding the management and ownership of risks between these elements, acknowledging that organisations across the NHS system may be responsible for implementing the controls and providing assurances for aspects of strategic JCC risks.

1.4 Pursuant to the Hosting Agreement between the JCC and CTMUHB dated 26th September 2024 (and subsequent iterations to be agreed), the JCC adopts the risk assessing and management mechanisms of CTMUHB, details of which can be found here.

1.5 Whilst the JCC adopts the risk assessing policies and procedures of CTMUHB there is a need for the JCC to set out its own risk management processes that relate to the specific functions of the JCC. Such processes are set out within this Risk Management Procedure ("Procedure"), which is also supported by a simple guide that can be found [here – insert link when approved]

1.6 This procedure will be applied to those risks relating directly to the commissioning functions of the JCC undertaken on behalf of the health boards.

1.7 Whilst the procedure outlines the risk management mechanisms for the JCC, the JCC remains aware of the need to work in partnership with each of the seven Health Boards to ensure that it does not substantially deviate from their agreed risk management arrangements.

1.8 The purpose of this procedure is to provide clear instructions on the identification, management and assessment of all risks.

1.9 The JCC is committed to implementing a Joint Committee Assurance Framework ("JAF") that will identify, analyse, evaluate and control the risks that threaten the delivery of its strategic objectives, see Appendix 1, and delivery against its Annual Plan and strategic priorities for 2026–2027 and beyond. It will be considered alongside other key management tools, such as workforce, performance, quality dashboards and financial reports, to give the Joint Committee ("JC") a comprehensive picture of the JCC's strategic risk profile. The JAF can be found [here – insert link when approved]

1.10 The purpose of this Procedure is to provide guidance to all staff on the management of

both strategic and operational risks within the organisation.

1.11 It aims to:

- set out respective responsibilities for strategic and operational risk management for the JC and staff throughout the organisation.
- set out responsibility for Sub Committees, namely the Quality, Safety and Outcomes Sub-Committee ("QSOC"), the Planning, Performance and Finance Sub-Committee ("PPF") and the CTMUHB Hosted Bodies Audit, Risk & Assurance Committee ("ARAC")
- describe the procedures to be used in identifying, analysing, evaluating and controlling risks to the delivery of the JCC's Annual Plan and strategic priorities for 2026-2027 and beyond.

2. SCOPE

2.1 The planning and commissioning of health care services involves risk. The aim of the JCC's activities in respect of this is not to seek to create a risk-free environment, but rather to create an environment in which risks are considered as a matter of course and appropriately identified and controlled or managed.

2.2 The JCC is committed to making risk management a core part of how the organisation runs its activities, making risk an integral part of its planning, delivery and evaluative activities.

2.3 The JCC has a dual role:

- It functions as an organisation with responsibilities for ensuring statutory compliance, overseeing provision and ensuring financial sustainability.
- It functions as an engine of change, with responsibilities to promote joined-up care, innovation, and to deliver improved population health outcomes for the services it commissions.

2.4 The JCC has established a clear process governing the identification and description of risk and for clearly recording how these risks are to be effectively mitigated.

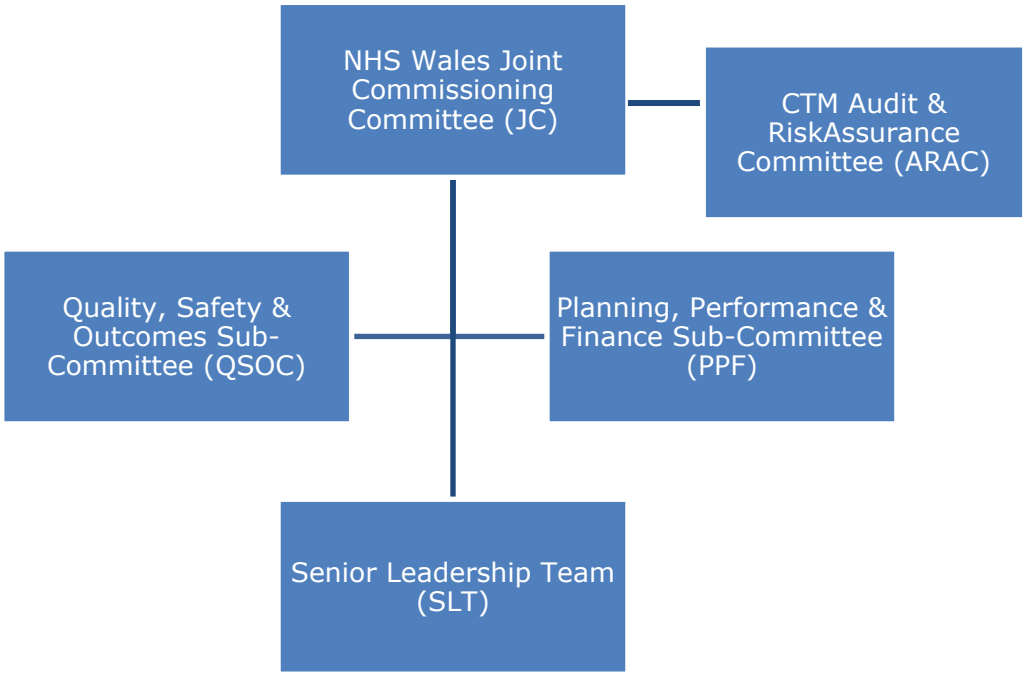
2.5 The procedure covers the management of Strategic and Organisational risks and the process for the escalation of risks for scrutiny and consideration for inclusion on the Organisational Risk Register ("ORR") and JAF.

2.6 **Strategic Risks:** are significant risks that have the potential to impact upon the delivery of strategic objectives, which are reported through the JAF. They are reviewed and monitored by the Senior Leadership Team ("SLT"), Sub Committees and the JC.

2.7 **Organisational Risks**: are risks that are mainly operational in nature and arise from the JCC's day-to-day activities. They are monitored locally through the JCC's directorate teams and when appropriate are reported on the ORR.

2.8 The JCC will seek to take a differential approach to the management of risk, based on the type of risk identified. This is to be linked to the JC's view on risk appetite for the various types of risk, as described in section 4 of this procedure.

3. RISK MANAGEMENT ORGANISATIONAL STRUCTURE



3.1 Roles and Responsibilities

ROLES	RESPONSIBILITIES
Joint Commissioning Committee	Health Board Chief Executives and NWJCC Lay Members share responsibility for the effective management of risk and compliance with relevant legislation. In relation to risk management, the JCC is responsible for: • Articulating the Strategic Objectives/Goals of the JCC. • Articulating the Strategic Risks of the JCC. • Protecting the reputation of the JCC. • Providing leadership on the management of risk. • Approving the risk appetite for the JCC. • Ensuring the approach to risk management is consistently applied. • Ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately. • Reviewing the strategic risks reported through the JAF. • Noting the ORR with risks scored over 15 and those which are novel and/or contentious. • Endorsing risk related disclosure documents. • Approving the JCC Risk Management Procedure, JAF and Risk Appetite Statement on an annual basis.
Senior Leadership Team (SLT)	The SLT undertakes the following duties on behalf of the JCC: • Promote a culture within the JCC, which encourages open and honest reporting of risk with local responsibility and accountability. • Provide a forum for the discussion of key risk management issues within the JCC. • Ensure appropriate actions are applied to strategic risks on the JAF.

ROLES	RESPONSIBILITIES
	• Enable risks which cannot be dealt with locally to be escalated, discussed and prioritised as deemed necessary. • Ensure Directorate Risk Registers are being appropriately rated, and action plans are being agreed and implemented to control them. • Review the risks on the ORR to determine whether they impact upon the JCC's strategic objectives. Typically, these are risks put forward by the directorates with a risk score of 15 or above which may be grouped in nature by service area or deemed appropriate by the SLT to include on the ORR as they are novel or contentious, or unable to be managed locally. • Review the Organisational Risk Register and the JAF prior to its presentation to the JCC. • Review risks identified as scoring 15 and above to ensure that they are assessed on a consistent basis and appropriately reflect the risk to the JCC, as these will inform the risks to achievement of the JCC's strategic objectives reported within the JAF. • Review and monitor the implementation of the Risk Management Procedure, Risk Appetite Statement and JAF on an annual basis. • Ensure that all appropriate and relevant requirements are met to enable the Chief Commissioner to sign the Annual Governance Statement which outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed. • Provide assurance to the JC that there is an effective system of risk management across the Organisation.
Quality, Safety & Outcomes Sub-Committee; and Planning, Performance & Finance Sub-Committee	On behalf of the JC, the sub-committees will have a role to play in ensuring effective risk management in particular they will: • Have responsibility for the review and scrutiny of commissioning risks assigned to them by the JCC. • Receive, monitor and scrutinise risk management and assurance arrangements. • Stimulate discussion to identify any new risks applicable to the JCC. • Ensure that associated quality and/or financial concerns associated with commissioned service risks are appropriately captured within each risk as necessary. • Analyse if there are cross cutting themes and/or risks that need to be captured and escalated to the ORR. • Provide constructive critical challenge on risk scoring, controls and mitigating actions. • Receive updates in terms of actions taken to mitigate the risks and provide feedback and challenge to risk owners on the actions taken and any further action required. • Provide onwards assurance to the JC in relation to risks assigned to them to provide oversight and scrutiny.
CTM Audit, Risk and Assurance Committee ("ARAC") for Hosted Bodies	As a hosted organisation of CTMUHB, the CTM ARAC for hosted bodies has a specific role in relation to the ongoing review of the effectiveness of the JCC Risk Management processes. In relation to risk management, the CTMUHB ARAC shall support and

ROLES	RESPONSIBILITIES
	provide advice to the JCC on the establishment and maintenance of an effective system of internal control and risk management. In particular, the CTM ARAC will seek assurances of: • All risk and control related disclosure statements (in particular the Annual Governance Statement), including information relating to internal audit assessments undertaken, external audits and/or other appropriate independent assurance, prior to endorsement by the JC and/or the JC sub-committees. • The structures, processes and responsibilities for identifying and managing risks facing the JCC. • The JCC's JAF and the adequacy of the scrutiny of risks by the assigned JCC sub-committees. This will be addressed by ensuring all significant risks (i.e. those escalated to the ORR scoring 15 or above or those not able to be managed locally) are assigned to a JCC sub-committee for scrutiny. • Through the Hosting Agreement, the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct and accountability requirements. By identifying and assessing regulatory, legal and code of conduct issues that could have been prevented by more effective management of risk and assurance of controls in place. • The operational effectiveness of policies and procedures, through regular review of policies and procedures, through the Hosting Agreement.
Directorates	Directorates are responsible for risks within their areas of operation and providing assurance to the SLT, via the JCC sub-committees and directorate team meetings on the operational management and any support required in relation to the management of risk. Specifically, each directorate will: • Promote a risk culture which encourages open and honest reporting of risk with local responsibility and accountability. • Use the Local/Directorate Risk Register(s) for recording and reviewing risks. • Ensure that directorate meetings discuss risk, risk management and organisational learning within their area of responsibility on a monthly basis. • Co-ordinate the risk management processes which include risk identification and assessments, and the management of the local and directorate risk registers. • Ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the JCC risk domains and risk scoring matrix contained in this document. • Assure SLT on the management and mitigation of risk for their area. • Provide reports, as required, to the SLT that will contribute to the organisational monitoring and auditing of risk. • Escalate service risks scored 15 and above and any novel or contentious risks that are unable to be managed to the Strategic

ROLES	RESPONSIBILITIES
	Risk Owner for consideration and review at SLT to determine whether they impact on the JCC's strategic objectives. • Contribute to the organisational monitoring and auditing of risk. • Ensure staff attend relevant mandatory and local training programmes. • Ensure the moderation and calibration of risks across the Directorates to avoid duplication, ensure consistency, compliance and alignment with the Risk Management Procedure and ensure shared learning across the JCC. • Review and update existing risks, consider new risks for inclusion and escalate/de-escalate risks as appropriate to the Director assigned as the Strategic Risk Owner for the risk being escalated.

3.2 **Duties of Individuals within the NWJCC Team**

The following table sets out the respective risk management duties and responsibilities for individual staff members.

INDIVIDUALS	DUTIES
Chief Commissioner	The Chief Commissioner as Accountable Officer of the JCC has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management, health and safety, finance, and organisational control and governance. The Chief Commissioner has overall responsibility for: • Ensuring the JCC maintains an up-to-date Risk Management Strategy and JAF endorsed by the JCC. • Promoting a risk management culture throughout the JCC. • Ensuring that there is a framework in place which provides assurance to the JCC in relation to the management of risk and internal control. • Putting in place and maintaining an effective system of risk management and internal control.
Committee Secretary	The Committee Secretary will, with the support of the Assurance and Risk Officer: • Work closely with the JCC Chair, Chief Commissioner, JCC Directors, Director of Corporate Governance at CTMUHB and Chair of the CTMUHB ARC to implement and maintain the Risk Management Strategy and JAF and related processes, ensuring that effective governance systems are in place. • Work with the JCC to develop a shared understanding of the risks to the JCC's strategic objectives. • Develop and communicate the JCC's risk awareness, appetite and tolerance. • Develop and oversee the effective execution of the JAF and ensure effective processes are embedded to rigorously manage the risks therein. • Monitor the action plans and reporting to the JCC and relevant JCC sub-committees.

INDIVIDUALS	DUTIES
Directors	Directors are accountable and responsible for ensuring that their areas of responsibility are implementing this Strategy and related policies. Each Director is accountable for the delivery of their particular area of responsibility and will therefore ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the JCC's strategic objectives. Specifically, they will: • Act as strategic risk owner for risks within their remit including those escalated to the Organisational Risk Register. • Use the Directorate and Organisational Risk for recording and reviewing risk. • Communicate to their staff the JCC's strategic objectives and ensure that the Directorate's individual objectives and risk reporting are aligned to these. • Ensure that a forum for discussing risk and risk management is maintained within their area which will encourage the proactive management of risk. • Co-ordinate the risk management processes which include risk assessments, incident reporting, the investigation of incidents/near misses and the management of the local and directorate risk register. • Ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk scoring matrix contained in this document. • Provide reports to the appropriate JCC sub-committee that will contribute to the monitoring and auditing of risk. • Ensure staff attend relevant mandatory and local training programmes. • Ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting. • Ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post and those key objectives are reflected in the individual performance review/staff appraisal process; and • Ensure that the JAF and the risk management reporting timetable are delivered to the Joint Committee.
All Managers	The identification and management of risk requires the active engagement and involvement of staff at all levels, as staff are best placed to understand the risks relevant to their areas of responsibility and must be supported and enabled to manage these risks, within a structured risk management framework. Managers at all levels of the organisation are therefore expected to take an active lead to ensure that risk management is embedded into the way their directorate/team/area operates. Managers must ensure that their staff understand and implement this Strategy and supporting processes, ensuring that staff attend relevant mandatory and local training programmes.

INDIVIDUALS	DUTIES
	Managers must be fully conversant with the JCC's approach to risk management and governance. They will support the application of this Strategy and its related processes and participate in the monitoring and auditing process.
All Staff	All members of staff are accountable for maintaining risk awareness and identifying and reporting risks as appropriate to their line manager. In addition, they will ensure that they familiarise themselves and comply with all the relevant risk management strategies and procedures for the JCC and attend/complete risk management training as appropriate. They will: • Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the JCC's business. • Report all incidents/accidents and near misses. • Comply with the JCC's incident and 'near miss' reporting procedures. • Be responsible for attending mandatory and relevant education and training events; and • Participate in the risk management system, including the risk assessments within their area of work and the notification to their line manager of any perceived risk which may not have been assessed.

4. RISK MANAGEMENT PROCESS

4.1 Risk Assessment

Each directorate within the JCC needs to identify risks through the completion of risk assessments and ensure that risk assessments are completed and regularly reviewed on an ongoing basis. The JCC Risk Identification and Assessment Form can be found at Appendix 2.

4.2 Organisational Risk Register ("ORR")

The ORR is a record of risks rated 15 which have been determined by the SLT that they may impact upon the JCC's strategic objectives or cannot be managed locally. Typically, these are risks put forward by the directorates with a risk score of 15 or above which may be grouped in nature by service area or deemed appropriate by the SLT to include on the ORR as they are novel or contentious, or unable to be managed locally.

The ORR represents a record of service, quality, commissioning, financial and business risks faced by the JCC during the year.

It sets out the controls which the strategic risk owner and risk lead have or will put in place to effectively mitigate each risk, together with sources of assurance to inform the SLT as to the effectiveness of the controls. It also identifies any areas in which the controls or sources of assurance require improvement to be as effective as possible and sets out actions necessary to secure improvement.

The responsible strategic risk owner and risk lead will take responsibility for the development and implementation of an appropriate risk action plan and ensure progress against this is reported to the relevant JCC sub-committee and SLT for assurance.

4.3 **JCC Risk Assurance Framework**

The JCC's Risk Assurance Framework was approved by the JC on the (insert date following approval).

The JAF will be articulated via a JAF Report presented to the JC that brings together the JCC's strategic objectives and the strategic risks, which may prevent the organisation from achieving its strategic objectives.

The JAF Report identifies the controls in place to manage these risks and any available assurance linked to their effectiveness. It will:

- Incorporate action plans for the strategic risks within the "Mitigating Actions" section which are closely aligned to the gaps in controls and/or assurances.
- Link to key measures of performance and National Priority Measures.
- Align strategic risks to operational risks on the Organisational and Directorate Risk Registers as appropriate.

4.4 The benefits of the JAF include:

- That it is designed specifically for Joint Committee-level oversight.
- It is a structured and evidence-based assessment of the key risks facing the JCC.
- It can be used to shape cycles of business and the work of the JCC and its sub-committees.
- It enables Independent Lay Members to focus their scrutiny and constructive challenge.
- It supports strategic decision-making.

The table below articulates how the JAF differs from the JCC Organisational Risk Register and Local/Directorate Risk Register.

Strategic Risk (JAF)	Corporate (Organisational) Risks	Local (team)/Directorate Risks
• Captured on the Joint Assurance Framework (JAF). • Potential 'high/extreme' risks that may threaten the achievement of the JCC's strategic objectives and key statutory duties. • Proactive identification. • Managed by established control framework and planned assurances. • Long-term (e.g. little movement expected in risk scores). • Will be high/extreme (red) risks by their nature.	• Captured on the Organisational Risk Register (ORR). • 'Live' operational risks which may impact delivery of strategic objectives, wider organisational priorities and/or day to day business delivery. • May be grouped in nature by service area. • May be novel or contentious. • Reactive identification. • Managed by additional mitigations. • Dynamic, short-term (e.g. expected movement in	• Captured on the Local and/or Directorate's Risk Registers. • Operational risks at team and/or directorate level which might impact on the delivery of service or work programme/project objectives. • Reactive identification. • Managed by additional mitigations. • Dynamic, short-term (e.g. expected movement in risk scores). • Will usually be very low to medium (green/amber) risks by their nature. • A risk reaching a high

	risk scores). • Will be high/extreme (red) risks by their nature.	(red) score might prompt review and discussion with the senior leadership team as an emerging risk but will not necessarily result in automatic escalation to the ORR. This reflects the distinction between risks assessed against team and/or directorate level objectives, including project objectives, and those affecting JCC wide strategic objectives. Risks scoring 15 or over can therefore be managed at local directorate/ project level without being reported through the ORR.

4.5 The Joint Committee will monitor and ensure the JAF remains up to date by the following activity:

- Each strategic risk has a Lead Director as the Strategic Risk Owner.
- The Committee Secretary will review the risk score, action plan and current performance with the Lead Director(s) in readiness for reporting to the SLT and onwards to the Joint Committee.
- Each strategic risk has an assigned JCC sub-committee.
- JCC sub-committees will monitor, scrutinise and seek assurances on the strategic risks which they own.
- The Joint Committee should consider annually whether the strategic risks are comprehensive, or if risks need to be added / removed / changed.

The JCC utilises the CTMUHB ARAC to discharge the requirements outlined in the JCC Standing Orders for a sub-committee to cover audit and risk business requirements on behalf of the JCC.

4.6 **Risk Quantification and Escalation & De-escalation**

As part of the risk assessment process risks must be allocated a domain and a risk score which can be obtained using the JCC Risk Domain and Scoring Matrix, found in Appendix 3. Each risk is assessed and scored on the likelihood of occurrence and the severity/impact in the initial assessment (without controls), current (with controls and mitigating actions where gaps in controls are identified), and target risk score (after completion of actions).

The process of risk escalation and de-escalation will be monitored by SLT and the JCC sub-committees, through monitoring new risks hitting threshold scores and being escalated as appropriate and/or current risks having their risk grading reduced so that the risks are appropriately de-escalated from the Organisational Risk Register back to Directorate and/or Local Risk Registers as appropriate.

The score of a particular risk will determine at what level decisions on acceptability of

the risk should be made and where it should be reported. The Joint Committee defines as "High or Extreme" any risk that has the potential to damage the JCC's strategic objectives.

The JCC's 'Risk Management Process – Directorate to Joint Committee Escalation is included at Appendix 4.

4.7 **Risk Appetite**

At its simplest, risk appetite can be defined as the amount of risk that the JCC is prepared to accept in the pursuit of its strategic objectives.

Decisions on accepting risks may be influenced by the following:

- The likely consequences are insignificant.
- A higher risk consequence is outweighed by the chance of a much larger benefit.
- Occurrence is rare.
- The potential financial costs of minimising the risk outweighs the cost consequences of the risk itself.
- Reducing the risk may lead to further unacceptable risks in other ways.

Therefore, a risk with a high numerical value may be acceptable to the JC, but that decision would be taken at an appropriate level following approval of the JCC's Risk Appetite.

The JC will review its risk appetite on an annual basis to ensure that the JCC's 'risk appetite' remains appropriate in the prevailing political, financial and healthcare landscape.

The JCC's Risk Appetite Statement is included at Appendix 5.

4.8 **Risk Treatment**

The risk assessment process involves making a decision about what should be done with each risk. It includes determining appropriate controls and or treatments for the risk, and what level of risk can be tolerated within the organisations risk appetite.

- A **Control** is an existing strategy and process currently in place such as systems, policies, procedures, standard business processes, practices.
- A **Treatment** is an additional strategy/activity we need to develop, and implement should the risk level be unacceptable after controls are applied.

Consideration must be given as to how risks can be controlled or be made less likely to occur. After introducing effective precautions and controls there may still be a certain amount of residual risk remaining.

It is important to remember that if a risk has already occurred then the controls are not working effectively and control mechanisms will need to be reviewed, tightened, and the risk assessment updated.

Where it has been considered that a risk requires further action to reduce the likelihood and/or impact, a mitigating action plan should be devised. The action plan must have an owner; it should be specific to the risk and be SMART (specific, measurable, attainable, relevant and time bound) to evidence how the risk score can be reduced.

There are four options when deciding how to treat a risk and this is known as the 4T approach to risk decision-making.

Following an assessment of the controls and assurance in place for each risk, consideration is given to the risk response:

Risk Response	
Terminate	This is where the activity that could lead to the risk being realised is itself terminated so that the risk can no longer occur.
Transfer	This is where a third party takes on the risk on your behalf. The most common form of risk transference is in insurance, whereby we pay insurance companies a premium to accept (usually a financial) risk on our behalf. This is a rare form of operational risk treatment and so anyone considering this as an option should contact the Strategic Risk Owner for advice. For the JCC, Transfer of a Risk could take place between the JCC to a named provider, who assumes responsibility for the risk following an agreed commissioning decision.
Tolerate	This is where the risk has been assessed, and the Strategic Risk Owner has determined that the risk is acceptable – in other words it is within our risk appetite. Once this decision has been taken, the risk will be kept under regular review to ensure that opportunities to mitigate the risk, or realise opportunities are not lost.
Treat	This is where the risk has been assessed, and the Strategic Risk Owner has determined that it still presents an unacceptable level of exposure and so needs further treatment. Treatment may be in the form of investment in resources, contingency planning or any other action that may help to reduce the risk further.

4.9 **Monitoring and Review**

It is essential to continue to reduce risks to their lowest level practicable through ongoing monitoring and reviewing. It is best conducted through normal day-to-day management. The implementation of a mitigating action plan must be kept under review along with the risk score to measure its effectiveness; if the treatment is not reducing the risk a new treatment plan should be considered.

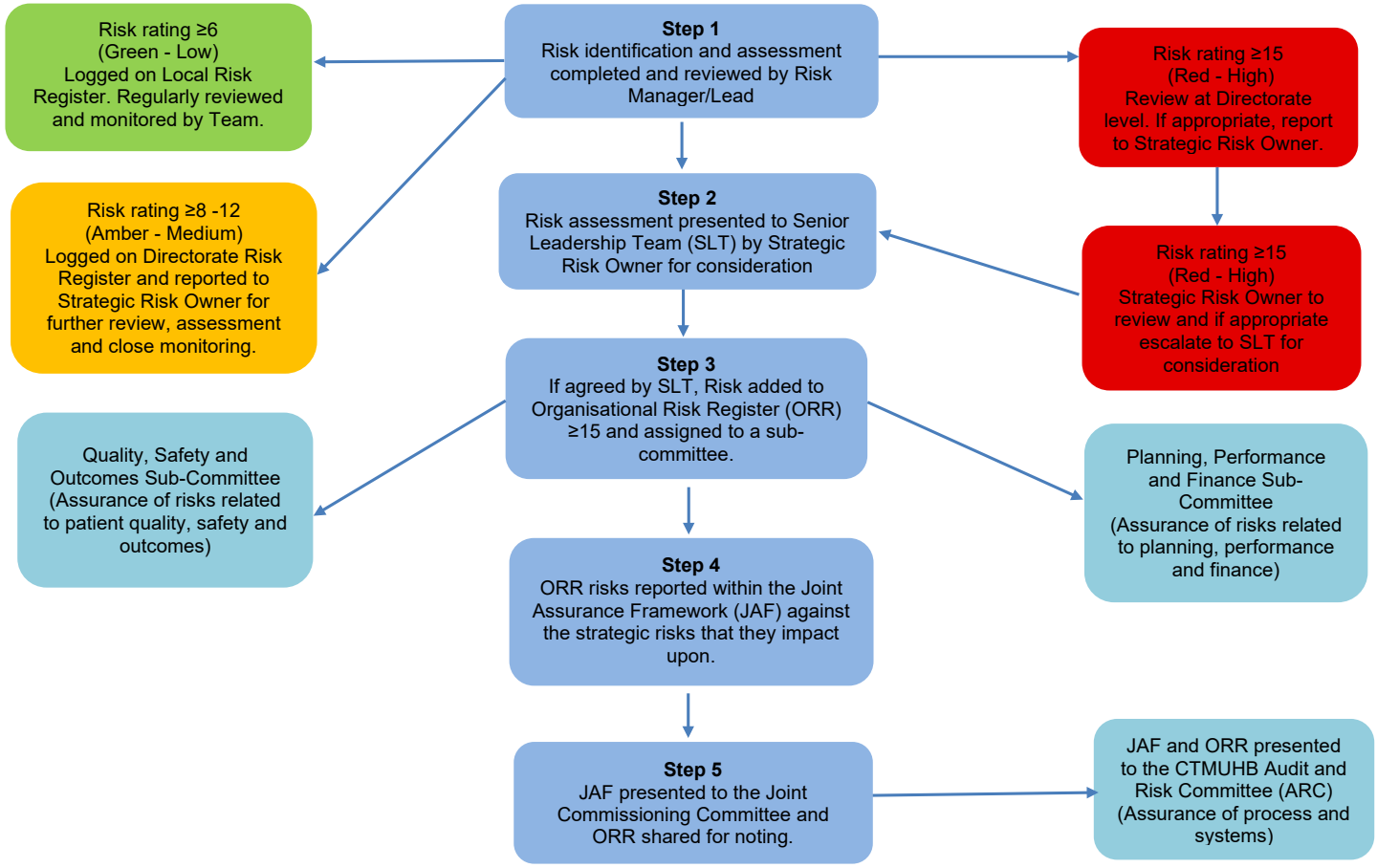
Risk assessments should be reviewed on a regular basis as determined below:

1-6	Low	This type of risk is considered low and should be reviewed and progress on actions updated at least every six months.
8-12	Moderate	This type of risk is considered moderate and should be reviewed and progress on actions updated at least quarterly.
15-25	High	This type of risk is considered high and should be reviewed and progress on actions updated, at least every two months. If scored 20 or above the risk should be reviewed on a monthly basis.

4.10 **Escalation of Risks**

Risks should be reported on the appropriate risk register in order that they can be managed at the appropriate level. Risk escalation supports the established leadership and reporting processes as described at Appendix 4 and illustrated below in Figure 1. Risks will similarly be de-escalated through the process where risk ratings reduce.

FIGURE 1: Risk Escalation Process



5. INFORMATION / SUPPORT

Support and guidance are available from the Corporate Governance Team via nwjcc.governance@wales.nhs.uk

Risk Assessment templates and training information is also available via the following site on SharePoint: http://ctuhb-intranet/dir/HealthandSafety/default.aspx

6. APPENDIX 1 – NHS WALES JOINT COMMISSIONING COMMITTEE VALUES AND STRATEGIC OBJECTIVES

7. APPENDIX 2 - NWJCC RISK ASSESSMENT FORM FOR EMERGING RISKS REQUIRING ESCALATION

RISK ASSESSMENT FORM			
Directorate:			
Service Portfolio:			
Is this risk linked to any of the following: (Service Escalation/ Investment Decision/ Incident/Legal Proceedings/Other (specify))			
Strategic objective: (See Appendix 1)			
Risk domain: (See Appendix 2)			
Risk type: (See Appendix 2)			
Description of risk: Example: **If...** commissioned "specialised" service capacity does not keep pace with increasing demand, **Then...** patients will experience longer waiting times, reduced access to timely support, and poorer patient outcomes, **Resulting in...** • "specialised" service specification standards not being met, • the service potentially having to be placed into escalation, and • alternative service provision having to be secured at additional financial cost to the NWJCC.	**If:**	**Then:**	**Resulting In:**

What is the Initial Risk Score:
This is the risk, considered **without taking account of any controls**. Sometimes called the inherent risk score, this is important as it shows the true severity of the risk should it ever be realised. See **Appendix 3** for Risk Scoring Matrix

Consequence – C		**Likelihood - L**		**Risk Score**	

RISK ASSESSMENT FORM					
Current Control Measures in Place: A control is something that is already in place that has to some extent reduced the likelihood of a risk occurring e.g. service in escalation, governance systems in place such as standing operating procedures, service specifications, policies, additional investment agreed, business/work programmes, alternative commissioning solutions (this might be interim/time-limited), or would reduce the consequence of a risk should it come about e.g. insurance, business continuity plans.					
1. 2. 3.					
With These Current Control Measures the Levels of Risk Are: This is the risk, considered **with any existing controls taken into account**. The current risk score will almost always be lower than the initial risk, and the important point is that the greater the difference between the two scores, the greater the reliance on the control environment					
Consequence – C		**Likelihood - L**		**Risk Score**	
Mitigating Action Plan: An action is something that is intended to be done which, when it is implemented or complete, is expected to reduce the likelihood or consequence of the risk further. Once complete an action may become a new control.					
Action(s) Required		**By Whom?**	**By When?**	**Investment/Cost ? (State actual or estimated if appropriate)**	
1. 2. 3.					
With the Above Controls and Mitigating Actions, the Target Risk Score Will Be: This is the risk score that the Risk Owner, having decided to treat the risk, needs to be actively working towards. The target score is usually lower than the initial score and it must be accompanied by an action plan to achieve the target (Mitigating action that will be taken to reduce the risk)					
Consequence – C		**Likelihood - L**		**Risk Score**	
Target Deadline: Anticipated timescale					
Rationale for risk to be considered: (Set out the case, with any additional details, for why you think the case requires escalation)					

RISK ASSESSMENT FORM	
Risk Assessor(s):	
Date of Risk Assessment:	

THIS SECTION TO BE COMPLETED BY DESIGNATED STRATEGIC RISK OWNER			
Does this risk require capital funding? (Not within NWJCC Control)	Yes ☐ No ☐		
Does this risk require escalation to the Senior Leadership Team (SLT) for consideration?	Yes ☐ No ☐		
Approval Status:			
Strategic Risk Owner:			
Comments / Feedback to Risk Assessor(s):			
Name:		**Date:**	

8. APPENDIX 3 – RISK DOMAINS & SCORING MATRIX

Risk Domains	1. Negligible (1 – 3) Negligible impact on objective/s. Day to day operational challenges.	2. Minor (4 – 6) Minor impact on objective/s. Temporary restriction to business delivery with limited impact on stakeholder confidence.	3. Moderate (8 – 12) Moderate impact on objective/s. Short term failure to deliver key objectives with temporary adverse local publicity.	4. Major (15 – 20) Major impact on objective/s. Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on stakeholder confidence.	5. Catastrophic (25) Catastrophic impact on objective/s. Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence.
Health Inequalities ***Risk Type:*** *Risks that may result in unfair or unavoidable differences in health across different groups within society*	• Negligible risk to communities, with limited impact on health inequalities or disparities	• Minor risk which may lead to noticeable effects on certain populations, leading to minor disparities in access to healthcare services or health outcomes across different groups within society	• Moderate risk which may significantly affect certain populations, resulting in substantial disparities in health status, access to care, or health related quality of life among affected groups	• Major risk which may have a profound impact on certain populations, exacerbating disparities in morbidity, mortality, and overall well-being, with far reaching consequences for affected communities	• Catastrophic threats to certain populations, leading to widespread and severe health crises, overwhelming healthcare systems, and causing significant loss of life and societal disruption
Health Outcomes ***Risk Type:*** *Risks that may result in poor or worsening health outcomes for populations*	• The impact on health outcomes for certain populations are negligible, with only immaterial variations to care or health status observed.	• Minor risk which may lead to noticeable effects on health outcomes, leading to minor disparities in disease management, treatment outcomes, or overall well-being	• Moderate risk which may lead to significant impacts to health outcomes, resulting in disease progression, functional impairment, and health-related quality of life	• Major risk which may lead to profound impact on health outcomes, exacerbating disparities in morbidity, mortality, and life expectancy, with significant implications for health trajectories and long-term prognoses	• Catastrophic threats to health outcomes, leading to severe and potentially life-threatening consequences, overwhelming the ability of certain populations to cope, and causing significant harm to their physical and mental well-being
Legal ***Risk Type****: Risks that may result in successful*	• No impact or negligible impact or	• Breach of statutory legislation	• Single breach in statutory duty	• Enforcement action • Multiple breaches in statutory duty	• Multiple breaches in statutory duty • Prosecution

Risk Domains	1. Negligible (1 – 3) Negligible impact on objective/s. Day to day operational challenges.	2. Minor (4 – 6) Minor impact on objective/s. Temporary restriction to business delivery with limited impact on stakeholder confidence.	3. Moderate (8 – 12) Moderate impact on objective/s. Short term failure to deliver key objectives with temporary adverse local publicity.	4. Major (15 – 20) Major impact on objective/s. Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on stakeholder confidence.	5. Catastrophic (25) Catastrophic impact on objective/s. Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence.
legal challenge and/or non-compliance with regulatory requirements. May include, but not limited to, risks linked to statutory duties, inspections, information governance, data management, general governance and probity	breach of guidance / statutory duty	• Reduced performance rating if unresolved	• Challenging external recommendations / improvement notice	• Improvement notice. • Low performance rating • Critical report	• Complete systems change required • Zero performance rating • Severely critical report
People ***Risk Type:*** *Risks that may result in damage to staff morale, wellbeing and/or adversely impact workforce collaboration and integration. May include, but not limited to, risks linked to human resource issues, business continuity, organisational development, skills mix and staff experience*	Short-term low staffing level that temporarily reduces business quality and delivery (< 1 day)	Low staffing level that reduces business quality and delivery	• Late delivery of key objective / business due to lack of staff • Unsafe capacity or competency levels (>1 day) • Low staff morale • Poor staff attendance for mandatory training	• Uncertain delivery of key objective / business due to lack of staff • Unsafe capacity or competency levels (>5 days) • Loss of key staff • Very low staff morale • No staff attending mandatory training	• Non-delivery of key objective / business due to lack of staff • Ongoing unsafe capacity or competency levels • Loss of several key staff • Staff unable to attend mandatory training on ongoing basis

Risk Domains	1. Negligible (1 – 3) Negligible impact on objective/s. Day to day operational challenges.	2. Minor (4 – 6) Minor impact on objective/s. Temporary restriction to business delivery with limited impact on stakeholder confidence.	3. Moderate (8 – 12) Moderate impact on objective/s. Short term failure to deliver key objectives with temporary adverse local publicity.	4. Major (15 – 20) Major impact on objective/s. Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on stakeholder confidence.	5. Catastrophic (25) Catastrophic impact on objective/s. Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence.
Reputation ***Risk Type:*** *Risks that may result in damage to reputation, poor experience and/or destruction of trust and relations. May include, but not limited to, risks linked to adverse publicity and engagement*	• Rumours • Potential for public concern	• Local media coverage – short-term reduction in public confidence • Elements of public expectation not being met.	• Local media coverage – long-term reduction in public confidence	• National media coverage <3 days well below reasonable public expectations	• National media coverage with >3 days well below reasonable public expectation • MP concerned (questions in the House) • Total loss of public confidence
Resources ***Risk Type:*** *Risks that may result in the organisation, or system, operating outside its resource allocations, poor productivity, inefficiencies, or no return on investment. May include, but not limited to, risks linked to workforce, finance, stability, value for money, procurement and claims*	• Small loss • Risk of claim remote	• Loss of 1-2% of budget • Claim less than £10,000	• Loss of 2-5% of budget • Claim(s) between £10,000 and £100,000	• Uncertain delivery of key objective • Loss of 5-10% of budget • Claim(s) between £100,000 and £1 million	• Non-delivery of key objective • Loss of 10% of budget • Failure to meet specification • Slippage • Loss of contract payment • Claim(s) >£1 million
Social and Economic Development ***Risk Type:*** *Risks relating to decisions or events which may have*	• Minimal or no impact on the environment	• Minor impact on environment	• Moderate impact on environment	• Major impact on environment	• Catastrophic impact on environment

Risk Domains	1. Negligible (1 – 3) Negligible impact on objective/s. Day to day operational challenges.	2. Minor (4 – 6) Minor impact on objective/s. Temporary restriction to business delivery with limited impact on stakeholder confidence.	3. Moderate (8 – 12) Moderate impact on objective/s. Short term failure to deliver key objectives with temporary adverse local publicity.	4. Major (15 – 20) Major impact on objective/s. Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on stakeholder confidence.	5. Catastrophic (25) Catastrophic impact on objective/s. Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence.
favourable social, ethical and/or environmental outcomes					
Strategic Commissioning ***Risk Type:*** *Risks associated with potential threats or uncertainties that may impact the NWJCC's ability to plan and commission services that meet population needs, improve population outcomes, and ensure value for money. Strategic commissioning risks emerge when this process is disrupted or compromised. These risks may affect the NWJCC'S ability to ensure person-centred, equitable, and sustainable care.*	• Negligible disruption to commissioning activities with no impact on service delivery or population outcomes. • Temporary delay in pathway design or contract negotiation.	• Negligible disruption to commissioning activities with no impact on service delivery or population outcomes. • Temporary delay in pathway design or contract negotiation. • Minor misalignment with strategic objectives.	• Moderate disruption to commissioning functions. • Inability to deliver planned service changes or meet transformation targets. • Moderate impact on access, equity, or quality of care.	• Major failure in commissioning processes. • Inability to deliver key services or meet statutory duties. • Major impact on population health outcomes, equity, or financial sustainability	• Catastrophic failure / systemic breakdown in commissioning capability. • Widespread service failure or collapse of strategic programmes. • Catastrophic impact on population health and organisational viability.
Strategy and Operations ***Risk Type:*** *Risks associated with identifying and pursuing strategies / plans*	• Day to day operational challenges • Loss/ interruption of >1 hour	• Temporary restriction to service delivery with limited impact on stakeholder confidence	• Short term failure to deliver key objectives with temporary adverse local publicity	• Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on	• Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of

Risk Domains	1. Negligible (1 – 3) Negligible impact on objective/s. Day to day operational challenges.	2. Minor (4 – 6) Minor impact on objective/s. Temporary restriction to business delivery with limited impact on stakeholder confidence.	3. Moderate (8 – 12) Moderate impact on objective/s. Short term failure to deliver key objectives with temporary adverse local publicity.	4. Major (15 – 20) Major impact on objective/s. Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on stakeholder confidence.	5. Catastrophic (25) Catastrophic impact on objective/s. Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence.
(including risks associated with the establishment of innovative systems and processes to deliver the strategies /plans), which could lead to improvements, opportunities for growth or may contribute positively to the achievement of aims and objectives. May include, but not limited to, risks linked to capacity, demand, service/ business interruption, digital, projects, planning, delivery, commissioning, partnership working and transformation	• Insignificant cost increase / schedule slippage • Key 'political' target is being achieved and impact prevents improvement	• Loss/ interruption of >8 hours • Key 'political' target is being achieved but impact reduces performance marginally below target in the near future or performance currently on target, but there is no agreed plan to meet	• Loss/ interruption of >1 day • 5–10 per cent over project budget • Schedule slippage • Key 'political' goal is marginally below target or is soon projected to deteriorate beyond acceptable limits or there is an agreed plan, but it does not yet meet the rising target	stakeholder confidence • Loss/ interruption of >1 week • Non-compliance with national 10–25 per cent over project budget • Schedule slippage • Key 'political' target not being achieved, and impact prevents improvement, or substantial decline in performance trend.	stakeholder confidence • Permanent loss of service or facility • Incident leading >25 per cent over project budget • Schedule slippage • Key objectives not met • Key 'political' target is not being achieved and the impact further deteriorates the position

RISK SCORING MATRIX

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**

	Rare - This will probably never happen / recur only in very exceptional circumstances. (Not for years)	Unlikely - Do not expect it to happen / recur but it is possible it may do so. (At least annually)	Possible - Might happen or recur occasionally. (At least monthly)	Likely - Will probably happen / recur and it is not a persisting issue. (At least weekly)	Almost certain - Will undoubtedly happen / recur, expected to occur in most circumstances. (At least daily)
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

RISK REVIEW

It is essential to continue to reduce risks to their lowest level practicable through ongoing monitoring and review. It is best conducted through normal day-to-day management. A review must be undertaken whenever there are any changes to the existing risk assessment. Risk assessments should also be reviewed on a regular basis as determined below:

1-6	Low	This type of risk is considered low and should be reviewed and progress on actions updated at least every **six months.**
8-12	Medium	This type of risk is considered moderate and should be reviewed and progress on actions updated at least **quarterly.**
15-25	High	This type of risk is considered high and should be reviewed and progress on actions updated, at least every **two months**. If scored **20** or above the risk should be reviewed on a **monthly** basis.

9. APPENDIX 4 – RISK MANAGEMENT PROCESS DIRECTORATE TO COMMITTEE ESCALATION

CTM training on risk is available to book on ESR please search for course: **110 Risk Management Strategy and Risk Assessment and Training Awareness**.

TASK / ACTIVITY	RISK RATING	RESPONSIBILITY	RISK REGISTER	ESCALATION
Risk Assessment Identify Operational and Strategic risks through the completion of risk identification and assessment, and for ensuring that risk assessments are completed on an ongoing basis.	N/A	Each: It is everyone's responsibility to identify risks however, escalation would be through the: • Directorate Team • Director (Strategic Risk Owner) • Senior Leadership Team	N/A	N/A
Risk Register Use of the Directorate Risk Register to record all risks identified through the Risk Management Process, their Controls, and score and risk treatment/mitigation and generate risk registers.	N/A	Each: • Directorate Team • Director (Strategic Risk Owner)	N/A	N/A

TASK / ACTIVITY	RISK RATING	RESPONSIBILITY	RISK REGISTER	ESCALATION
Management of Local Risks Any risks identified and evaluated as having a low rating, i.e. a score of between one and eight, can be managed locally within the relevant area. These risks can typically be resolved quickly and relatively easily if the correct actions identified, completed and become controls under business as usual. These risks are recorded locally in the local risk register within each area/service e.g. Cardiac, Women & Children, Ambulance and 111 etc. All local risks should be reviewed and updated as per the frequency captured in Section 7 of the Risk Assessment Procedure.	Scored Between 1 – 6 (Green - Low)	Each: • Directorate Team • Directorate Risk Lead • Director (Strategic Risk Owner) **Held and Managed at Local Area/ Service Level** **Reviewed and updated at least every 6 months.**	Local Risk Register	**NO** If it can be managed locally. **YES** If it is felt that the risk can no longer be managed locally and requires more Senior input and support, then it will be first escalated by the risk owner up to the Director (Strategic Risk Owner).
Project Risks Risks identified through the management of individual projects associated with the delivery of the JC Integrated Medium Term Plan (IMTP), will be recorded in the project risk register and managed locally within the Project Management Office (PMO). These risks might score as a high risk i.e. 15 and above, if they are critical to the achievement of a project's objectives, however they will only be escalated and potentially recorded on the Organisational Risk Register if they present a significant financial or business risk to the JCC. Project risks should be reviewed and updated as per the frequency captured in Section 7 of the Risk Assessment Procedure.	Any Score	Each: • PMO • Strategic Project Lead **Held and Managed at Project Level** **Reviewed and updated at least every 6 months.**	PMO Risk Register	**NO** If it can be managed locally. **YES** If it is felt that the risk can no longer be managed at a Project level and requires more senior input and support, then it will be first escalated up through the Strategic Project Lead as appropriate for further review and assessment. A decision on the escalation of a project risk to the ORR should be made by the relevant Director of Commissioning who will submit the risk to SLT for review and consideration for entry onto the ORR.

TASK / ACTIVITY	RISK RATING	RESPONSIBILITY	RISK REGISTER	ESCALATION
Directorate Team Risks Risks identified as having a moderate rating i.e., a score of 8 - 12 are managed at a local level but should also be escalated to Directorate Senior Team for visibility and review. Risks Identified at a Directorate level should be recorded by a relevant Manager on the Directorate Risk Register. Reviewed at least quarterly at the relevant Directorate Team meeting.	Scored Between 8 – 12 (Amber - Medium)	Each: • Directorate Team • Directorate Risk Lead • Director (Strategic Risk Owner) **Held and Managed at Directorate Level** **Reviewed and updated at least quarterly.**	Directorate Risk Register	**NO** If it is scored below 12 and can be managed at Directorate Level **YES** If it is felt that the risk can no longer be managed at Directorate team level and requires more senior input and support, then it will be first escalated up through the Strategic Risk Owner as appropriate for further review and assessment. This might include risks that are considered novel and/or contentious, including services in escalation.

TASK / ACTIVITY	RISK RATING	RESPONSIBILITY	RISK REGISTER	ESCALATION
Directorate/Organisational Risks The Committee Secretary should have sight of the Directorate Risk Registers and ensure that all risks are recorded and being managed as appropriate. Directorate Risk Registers should be monitored at Directorate Team meetings, at least every two months and monthly for risks scored 20 – 25. Risks scored 15 and above, or risks that are novel and/or contentious, including services in escalation, considered for escalation to the Organisational Risk Register, should be reviewed and assessed at Directorate level in the first instance and if considered appropriate reported to the Strategic Risk Owner for further review and escalation to the Senior Leadership Team to determine whether they impact upon the JCC's strategic objectives. Typically, these are risks put forward by the directorates with a risk score of 15 or above which may be grouped in nature by services area or deemed appropriate by the SLT to include on the ORR as they are novel or contentious, or unable to be managed locally.	Scored Between 15 – 25 (Red – High) Or is novel and contentious.	Each: • Directorate Team • Directorate Risk Lead • Director (Strategic Risk Owner) • Senior Leadership Team • JCC Sub-Committees **Held and Managed at Corporate Governance Service Level** **Reviewed and updated at least every two months.**	Organisational Risk Register	**NO** If scored below 15 **YES** If it is felt that the risk can no longer be managed at Directorate level and requires Senior level input and support, then it will be reported for further review and assessment by the Strategic Risk Owner and escalated up to the Senior Leadership Team to consider inclusion to the Organisational Risk Register should they impact on the delivery of the JCC's strategic objectives. These risks will be assigned to the JCC sub-committees for ongoing scrutiny and assurance and presented to the JC for noting. They will remain on the Organisational Risk Register until they are de-escalated following ongoing monitoring and review of the controls and action plans in place to mitigate the risk.

TASK / ACTIVITY	RISK RATING	RESPONSIBILITY	RISK REGISTER	ESCALATION
JAF Risks Risks rated 'high red/extreme' will inform the strategic risks reported through the JAF The Committee Secretary, through the direction of the SLT, will reflect risks 20 and above to inform the JAF. These risks will continue to be reviewed, monthly, by the Strategic Risk Owner and Risk Lead within the Directorate.	Typically, scored 20 -25 (Red – Extreme) but can be scored 15 and above if deemed to be novel or contentious or unable to managed locally and impact on the delivery of the JCC's strategic objectives.	Each: • Directorate Team • Directorate Risk Lead • Director (Strategic Risk Owner) • Senior Leadership Team • JCC Sub-Committees • JCC **Reviewed and updated on a monthly basis.**	Joint Assurance Framework (JAF)	**NO** If scored below 15 and above unless they are deemed to be novel or contentious or unable to managed locally and impact on the delivery of the JCC's strategic objectives. **YES** Risks with a score of 20 and above will be inform the Joint Assurance Framework The JAF will be presented bi-monthly to the JC for approval and to the CTMUHB ARAC, bi-monthly, following sign off by the JC.

10. APPENDIX 5 – NWJCC RISK APPETITE STATEMENT

1. Introduction:

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

The NHS Wales Joint Commissioning Committee ("JCC") should make a strategic choice about the style, shape and quality of risk management and should lead the assessment and management of opportunity and risk. The JCC should determine and continuously assess the nature and extent of the principal risks that the JCC is exposed to and is willing to take to achieve its objectives - **its risk appetite** – and ensure that planning and decision-making reflects this assessment. Effective risk management should support informed decision-making in line with this risk appetite, ensure confidence in the response to risks and ensure transparency over the principal risks faced and how these are managed.[2]
The challenge for the JCC in managing risk is not underestimated, and the intention of the Risk Appetite Statement is to support an informed risk-based decision.

2. The Joint Commissioning Committee has adopted the following **Risk Appetite Matrix:**

Risk Appetite	Description
Averse (None) **(1 – 3)** Avoidance of risk is a key organisational objective	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is a key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimal **(4 – 6)** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.

[1] Government Finance Function – Risk Appetite Guidance Note – August 2021 – V2.0
[2] The Orange Book – Section A

Cautious (7 – 9) Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open (10 -14) Willing to consider all potential delivery options and choose while also providing an acceptable level of reward	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager (Seek) (15 - 20) Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risks)	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

3. The Joint Commissioning Committee's **Risk Appetite Statement:**

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

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

- **Strategic Direction –** the JCC has adopted an **Open** stance, where guiding principles or rules are in place that are receptive to considered risk taking in organisational actions and the pursuit of our priorities. This reflects the uniqueness of the JCC model and provides opportunity to shape the clinical strategy agenda.

- **Health Inequality, Quality, Safety and Outcomes -** the JCC has adopted a **Cautious** stance, with a preference to take decisions that risk an adverse or differential impact on commissioned populations where there is a low degree of inherent risk around patient safety, and the possibility of improved outcomes, and where appropriate controls are in place. Targeting resources to ensure equity of outcome even when this means investing differentially or disinvesting in existing commissioned services and considering options where robust methods for monitoring and measuring impact on outcomes can be established.

- **Financial Stability and Value for Money (VFM) –** the JCC has adopted a **Cautious** stance, being prepared to accept the possibility of limited financial risk with VFM and population outcomes the primary concern for the services commissioned.

- **Innovation and Service Sustainability –** the JCC has adopted an **Open** stance, with a preference to consider some options, including the associated risks, which support the delivery of operational performance targets, with a preference for innovating service delivery, adoption of new technologies and models of service reconfiguration for the benefit of its commissioned population.

- **Governance, Compliance and Statutory Duty –** the JCC has adopted a **Cautious** stance, with a preference to accept the possibility of limited regulatory challenge, seeking to understand where similar actions had been successful elsewhere before taking any decision. The JCC would wish to work towards an **Open** stance as it continues to mature and develop, accepting the possibility of some regulatory challenge as long as it can be reasonably confident around the decisions taken and that challenge would be successful.

- **Confidence, Trust and Reputation** - the JCC has adopted an **Open** stance, being prepared to accept the possibility of some reputational risk provided there is the potential for improved outcomes for stakeholders and the JCC is comfortable with the decisions it has taken.

- **Workforce/People and OD -** the JCC has adopted a **Cautious** stance following the Organisational Change Process (OCP), with a preference to take limited risks with regard to the workforce and whilst the investment of staff development is still in progress. The JCC would wish to work towards an **Open** stance as it continues to develop and mature, with a preference of accepting the possibility of some workforce risk as a direct result from innovation as long as there is the potential for improved recruitment and retention, sustainability and developmental opportunities for staff leading to a healthy experience of work.

- **Data and Information Management –** the JCC has adopted a **Cautious** stance, with a preference to accept the need for operational effectiveness with risk mitigated through careful management, limiting distribution.

4.2.2 – Appendix 2

GIG CYMRU NHS WALES | Cyd-bwyllgor Comisiynu Joint Commissioning Committee

Joint Committee Assurance Framework (JAF) 2026/27

1.0 INTRODUCTION & AIMS

The NHS Wales Joint Commissioning Committee (JCC) is a joint committee of the seven Health Boards in Wales and hosted by Cwm Taf Morgannwg University Health Board (CTMUHB), acting collectively on their behalf. Risk management plays a critical role in helping the JCC understand the impacts of and manage the risks associated with its priorities. This framework sets out key principles that guide how the Joint Committee Assurance Framework will ensure that the risks to its strategic priorities are managed effectively and efficiently.

Risk is an important feature within the different parts of the NHS systems architecture. Collaborative working can often lead to risks regarding risk ownership and accountability. It is important that there are clear inter-relationships regarding the management and ownership of risks between these elements, acknowledging that organisations across the NHS system may be responsible for implementing the controls and providing the assurances for aspects of strategic JCC risks. This Framework will however be applied to those risks relating directly to the commissioning functions of the JCC undertaken on behalf of the health boards.

Pursuant to the Hosting Agreement between the JCC and CTMUHB dated 26th September 2024 (and subsequent iterations thereof), the JCC adopts the risk assessing and management mechanisms of CTMUHB, details of which can be found here.

The JCC was established for the purpose of jointly exercising functions on behalf of NHS Wales, relating to the planning, securing and commissioning of:

- Specialised services for:
  - cancer and blood disorders
  - cardiac conditions
  - mental health, learning disabilities and vulnerable groups
  - neurosciences, and
  - women and children.
  - Welsh kidney network.
- Services where there is agreement between the Local Health Boards that they should be arranged on a regional or national basis
- Emergency medical services
- Non-emergency patient transport services
- Emergency medical retrieval and transfer services
- NHS 111 services
- Sexual assault referral centres, and
- Other services as directed by the Welsh Ministers.

Its role includes overseeing commissioning policy development, supporting regional and inter-Health Board collaboration, and providing strategic leadership on services such as NHS 111, specialist pathways, and other areas of national

significance.

The JCC is committed to the principles of good governance and recognises the importance of effective assurance provided through robust risk management, performance management and clinical escalation processes which are fundamental elements of the organisation's governance framework and system of internal controls.

It is anticipated that the development and implementation of a Joint Committee Assurance Framework will underpin and support the JCC in its role as a commissioner of high quality and safe services from providers (Health boards, Trusts and private sector providers) that deliver value for money and demonstrable positive patient outcomes on behalf of health boards in Wales.

2.0 Purpose of the Joint Committee Assurance Framework (JAF)

The JAF is an integral part of the system of internal control and defines the strategic/principal risks, which impact upon the delivery of the Strategic Objectives of the organisation. It also summarises the controls and assurances that are in place for these risks and plans to mitigate them.

Additionally, the JAF identifies and highlights gaps in controls and assurances to support the development of action plans for the closing of gaps and mitigating risk, which is subsequently monitored by the JCC's Joint Committee (the JC) for implementation.

The JAF has been designed to provide JC level oversight, and it is intended that, through appropriate utilisation of the JAF, the JC can have confidence that it is providing thorough scrutiny of its role and is able to identify any gaps in assurance and take appropriate action which will support operational and strategic decision making.

The effective application of JCC assurance arrangements to produce and maintain a JAF will help the JC to consider collectively the process of securing assurance that promotes good organisational governance and accountability. The JAF and its intended purpose is further described in the JCC Risk Management Procedure (Found here).

The specific benefits include:

- Gaining a clear and complete understanding of the risks faced by the organisation in the pursuit of its strategic objectives, the types of assurance currently obtained, and consideration as to whether they are effective and efficient,
- Identifying areas where assurance activities are not present, or are insufficient for our needs (assurance gaps),
- Identifying areas where assurance is duplicated, or is disproportionate to

the risk of the activity being undertaken (i.e. there is scope for efficiency gains, reduction of duplication of effort and/or a freeing up of resources),
- Identifying areas where existing controls are failing and as a consequence the risks that are more likely to occur,
- The ability to better focus on existing assurance resources, and
- Providing an evidence-base to assist the organisation in the preparation of its annual accountability statement.

3.0 JCC Plans and Strategic Priorities

The JCC has an Annual Plan 2026-27 set within the context of a three-year plan, hereafter referred to as the "Plan".

The Plan sets out the work of the JCC in the short, medium and longer term, to be 'the Centre of Excellence for Collaborative Commissioning' and to 'contribute to the improvement of health and care for the people of Wales'.

It covers the whole range of responsibilities for the JCC in planning and commissioning services for the population of Wales, in line with the NHS Wales Planning Framework, financial guidelines and the JCC's own internal governance framework.

The Plan seeks to balance all statutory and other duties placed on the organisation to commission high quality services on behalf of the 7 Health Boards in Wales. In furtherance of this, the IMTP sets out how the JCC will endeavour to deliver the JCC's 5 Strategic Objectives:

- Maximise Value
- Reduce Duplication
- Facilitate Integration
- Ensure Quality
- Improve Equity and Population Health

The JCC Annual Plan 2026-27 can be found at the following link ( )

4.0 Scope of the Joint Committee Assurance Framework and Key sources of Assurance.

This JAF is relevant to JC members and all employees of the JCC and is informed by the Strategic and Operational plans of the organisation together with the Risk Management, Performance Management and Clinical Escalation Frameworks which apply to all staff, agency staff, contractors brought in to undertake work on behalf of the JCC, students, locums, volunteers, individuals employed on honorary contracts, and other third parties engaged with the organisation in its operational activity. It applies to all activities of the JCC, including those delivered by service providers and contracted parties. The predominant beneficiaries of the JAF will be the JC and its Sub-Committees, which will make use of the JAF as a tool to inform decision making and to support members providing robust scrutiny of JCC activity and performance.

The principal sources of assurance that will inform the JAF will be provided by the JCC:

- Organisational Risk Register and risk management processes – See section 5 for more detail.
- Performance Framework - See section 6 for more detail.
- Clinical Escalation Framework - See section 7 for more detail.

5.0 Risk Management

The planning and commissioning of health care services involves risk. The aim of our activities in respect of this is not to seek to create a risk-free environment, but rather to create an environment in which risks are considered as a matter of course and appropriately identified and controlled or managed.

The JCC is committed to making risk management a core part of how the organisation runs its activities and has established a clear process governing the identification and description of risk and for clearly recording how these risks are to be effectively mitigated.

Whilst the JCC adopts the risk assessing policies and procedures of CTMUHB there is a need for the JCC to set out its own risk management processes that relate to the specific functions of the JCC.

The JCC Risk Management Procedure provides clear instructions on the identification of and management of Strategic and Organisational risks and the process for the escalation of risks for scrutiny and consideration for inclusion on the Organisational Risk Register (ORR) and JAF.

Strategic Risks have the potential to impact upon the delivery of the JCC's Strategic Objectives and are reviewed and monitored by the Senior Leadership Team (SLT) and JC via the JAF.

Organisational Risks are mainly operational in nature and arise from the JCC's day-to-day activities and are monitored by operational teams, and when considered to be extreme (scoring 15/25 or above), they are escalated to the SLT for review and to determine if they impact upon the JCC's strategic objectives and necessitate inclusion on the ORR, which is monitored by the SLT, JCC Sub-Committees and the JC. These risks may be grouped in nature by services area, or where deemed appropriate by the SLT, for inclusion on the ORR as they are novel or contentious, or unable to be managed locally.

The Organisational Risks detailed within the ORR will inform the risks to achievement of the JCC's strategic objectives reported within the JAF. This escalation mechanism will ensure that strategic decision making, and mitigation of risk is informed by the operational risks that the organisation is holding.

Links to the JCC's Risk Management Procedure is detailed at **Appendix 1.**

6.0 Performance Framework

The JCC Performance Framework provides a mechanism for the JCC to report upon NHS Wales service performance across multiple specialties commissioned by the JCC. It focuses on key indicators such as waiting times, activity levels, incident trends, and overall performance. The insights are intended to support evidence-based decision-making and promote equitable, high-quality care across Wales.

To complement available reports, an interactive Power BI dashboard is also available which offers drill-down features and year-on-year comparisons, to enable detailed consideration to be given to performance trends and areas where additional assurance may be needed. Click this link to explore the dashboard: Interactive Performance Report

Commented [AF1]: To be checked for most up to date data.

Additionally, the JCC's performance reporting provides an overview of commissioned services that are in escalation and the current escalation level they are at. This detail, when combined with reported organisational risks will inform the population of the JAF and allow JC members to focus their attention on the area's most in need of assurance to support strategic decision making.

An overview of the JCC Performance Framework is attached as **Appendix 2.**

7.0 Clinical Escalation Framework

The quality of care and experience that patients and their families receive is central to the commissioning of healthcare services. Quality is everyone's business and all JCC staff strive to ensure that quality and patient-centred services are at the heart of commissioning.

The JCC Nursing and Quality team have put in place a JCC Escalation Process which provides a clear methodology for the identification and management of providers issues and the actions required to find a joint resolution, which will inform the JAF and seek to provide assurance to Health Boards and the public that the JCC continues to commission high quality clinical care.

The escalation process is not a punitive one, but a means by which problems are identified as early as possible with the aim that support and partnership working will lead to an improvement in the service commissioned.

Routine Monitoring is the term used to report on all commissioned services where there are no identified concerns around the service being delivered. Where there are performance concerns and there is lack of available assurance in terms of improvement, there is an escalation process in place. This process is structured to allow engagement with providers, local and regional commissioners and regulators where necessary. It is a system whereby there is continuous service improvement or decommissioning/outsourcing of services if necessary.

This process is described in more detail in Appendix 3 however, in summary, the process is aligned to a tiered approach similar to the Welsh Government approach (NHS Wales Escalation and Intervention Arrangements 2014) so that Health Boards are familiar with terminology when receiving assurance reporting from the JCC:

- Routine Monitoring
- Escalated Monitoring
- Escalated Intervention
- Escalated Measures
- Decommissioning/Outsourcing.

All services in escalation are reported to the Quality, Safety and Outcomes Sub-Committee (QSOC) via the JCC Commissioning Team Reports and a summary of the services in escalation is submitted with the QSOC Chair's report to the JC. This in turn is circulated to each of the seven LHBs and incorporated within the JAF to provide a full operational view of the services commissioned by the JCC.

The JCC Clinical Escalation Framework can be found at **Appendix 3.**

8.0 The JCC's Appetite for Risk

The JC recognises that risk is inherent in the commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that the organisation understands and is aware of the risks it is prepared to accept in the pursuit of its aims and objectives.

Risks throughout the organisation will be managed within the JC's risk appetite, or where this is exceeded and cannot be tolerated, action will be taken to reduce the risk. The JC has limited appetite to risks that materially impact on its ability to commission safe services; or risks that could result in the organisation being non-compliant with UK law, healthcare legislation, or any of the applicable regulatory frameworks in which the JCC operates.

The JC has greatest risk appetite in the pursuance of innovation and the challenge of current working practices and financial risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

Commented [ME2]: To be updated when the risk appetite has had final consideration and been approved by the JC.

The JCC's Risk Appetite Statement sets out the JC's strategic approach to risk-taking by defining its risk appetite thresholds. It is a live document that is regularly reviewed and modified, so that any changes to the organisation's strategy, objectives or its capacity to manage risk are properly reflected. The JCCs risk appetite statement can be found within the JCC Risk Management Procedure and is available from nwjcc.governance@wales.nhs.uk.

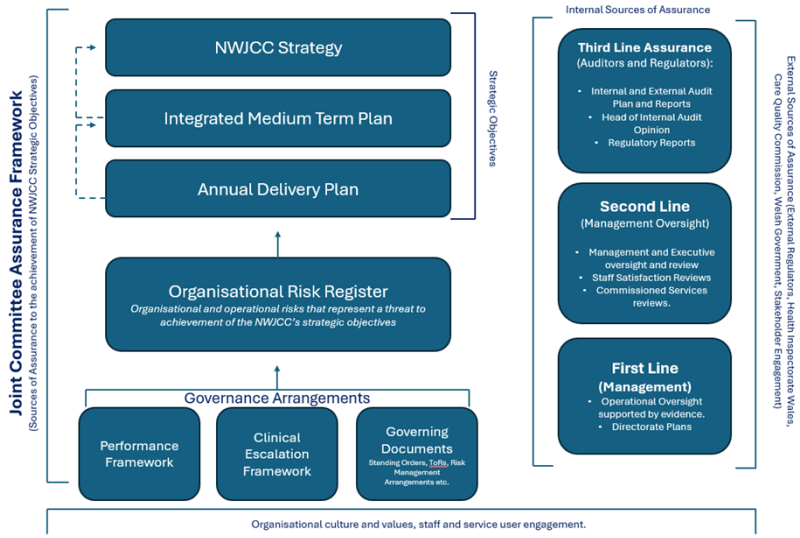
9.0 The Joint Committee Assurance Framework

The JAF is designed to provide the JC with:

1. a systematic and coherent picture of the assurances in place to support the delivery of the organisation's strategic objectives. It essentially maximises the links between assurance, performance management and risk management,
2. an overview of assurance in relation to its governance framework, and
3. the opportunity to undertake thematic reviews of assurance to support the JC in its role. For example, a thematic review of 'equitable service provision across Wales'.

The JAF includes the integration of the Three Lines of Defence (assurance) model. More details can be seen in section 10.

The key components of the JAF in so far as it supports the achievement of the JCC's Strategic Objectives can be seen in the diagram below:



There are six steps to supporting the development of the JAF:

1. Identify key objectives
2. Identify key risks to the delivery of objectives
3. Identify key controls in place to ensure delivery of objectives and manage/mitigate risks
4. Identify sources of controls, their adequacy and operation
5. Assess gaps in controls and gaps in assurance
6. Develop JC action plans to address gaps in controls and assurance.

The quality of assurance received by the JC is a key enabler as regards to the JC's ability to effectively determine the best use of its resources and the effective achievement of its strategic objectives. The JAF articulates the level of assurance required by the JC for each element, identifies gaps in controls and/or assurance and provides structured assurance in relation to risks which are being managed effectively and objectives that are on track to be delivered.

Scrutiny of the quality of assurances received is the responsibility of all Committee Members and assessment of the effectiveness of internal controls and assurances will be a continuous process. As part of the development of the JAF, a review of assurance effectiveness will be undertaken.

The JC's clinical escalation and integrated performance management frameworks help to identify and escalate emerging patterns of poor performance and risk in health services commissioned by the JCC. Through this process, risks may be identified for recording in local or directorate risk registers

or the Organisational Risk Register, dependent upon the level and type of risk. The JAF contributes to the whole system of governance of the JCC which is summarised below within the JCC Accountability Map found here.

10. The role of the 'Three Lines of Defence' in providing assurance

Different sources and types of assurance have different strengths and are best used in different ways. Therefore, the JAF plays a key role in seeking an optimum mix of assurance. The 'Three Lines of Defence' model advocated by H. M. Treasury can help in this respect.

First line of defence (assurance) – operational management
The first line of defence includes the overall risk management systems and control frameworks. It also incorporates the controls over operational processes and outputs. This stage includes controls over day-to-day transactions and periodic controls, for example cut-off procedures at the month or year-end, as well as procedures such as commissioned service inspections where these are a regular part of operations. Day-to-day management supervision, for example approval of large transactions, is also part of this stage.

Assurance is given by the knowledge and commitment of the staff operating the controls.

The benefits provided by the first line of defence are that the staff operating the controls know the business and workflow and should be aware of where controls are potentially weak. Building more controls in at this stage can also mean that mistakes are less likely to happen and can be more easily rectified. Effective day-to-day controls relating to information provision should mean that the information provided in external reports and to external auditors is likely to be more reliable.

The main weakness of the first line of defence is lack of independence, that the controls are being implemented by the same staff who are responsible for the operations to which the controls relate. They are effectively certifying their own work (self-review).

Second line of defence (assurance) – management oversight
The second line of defence relates to review by management or specialists that is separate from day-to-day operations. It includes risk and compliance reviews, financial controls over operational departments and oversight of operations by the JC.

The second line of defence introduces a degree of independence and objectivity, as the reviewers are not staff and managers who are operationally responsible for the areas being reviewed. However, the reviewers are still part of the same management team, working with those being reviewed.

Third line of defence (assurance) – audit and regulators (adapted for JCC framework)
Internal and External audit is the third line of defence. The effectiveness of audit will depend on the extent of its terms of reference. These could be wide-ranging, covering operational efficiency and effectiveness, compliance and reliability of reporting. As well as looking at systems overall, audit can also focus on specific risks, particularly risks which the first two lines of defence identify gaps in assurance or control. Audit's role is also valuable if there are changes affecting the first two lines of defence, or changes in organisational structures, reporting processes and information systems.

Audit work has the significant benefit of being undertaken by staff who are independent and separate from line management, who are not involved in operational work and, in the case of the JCC, are not employees of the organisation. Auditors' independence is strengthened by being able to report directly to the JC and the CTMUHB Hosted Bodies Audit, Risk and Assurance Committee (ARAC) and being able to discuss issues with the JC and ARAC without operational management being present where required.

The services commissioned by the JCC are also regulated by a number of regulators including Health Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW), as well as being subject to a number of other compliance and legislative requirements by Welsh Government and other Commissioners, for example the Welsh Language Commissioner and the Future Generations Commissioner. All regulators will also be considered as the third line of defence.

**NB – in other sectors internal and external audit are separated into the third and fourth line of defence, mainly due to internal audit being employees of the organisation. For the purpose of the JCC JAF, internal and external audit have been combined into the third line of defence given the JCC does not employ any auditors.*

11. JAF Reporting Process.

The JAF will test and assess the adequacy of the control and assurance mechanisms in place and will describe and score each risk to the achievement of the JCC's strategic aims in accordance with the JCC Risk Management Procedure.

In considering the assurance provided and controls in place for each risk, the JAF will set out the following detail:

- Control Measures in place
- Sources of Assurance
- Gaps in Controls and Assurance (with actions to mitigate); and
- Linked risks detailed within the ORR.

Gaps in controls or assurance identified by the JAF, will be assigned to the JCC SLT for review and for recommendations to be made to the JC in relation to how those gaps can be closed.

The ORR and JAF is reviewed by the SLT and the JCC's Sub Committees in advance of presentation to the JC. At each JC meeting the JC will receive a copy of the JAF for review and a copy of the ORR for noting and to inform scrutiny of the JAF.

A copy of the JAF Report Template is attached as **Appendix 4.**

Appendix 1

JCC Risk Management Resources:

- **JCC Risk Management Procedure (add link)**
- **JCC Risk Management Simple Guide (add link)**

Appendix 2.
Performance Assurance Framework – *Measuring What Matters*

Document Control

Document Author:	Director of Finance & Value/Committee Secretary
Director Lead:	Chief Commissioner
Approved by:	Joint Commissioning Committee (NWJCC)

1. Purpose

This Performance Assurance Framework sets out how the NHS Wales Joint Commissioning Committee (NWJCC) will obtain assurance on the **performance** of services commissioned on behalf of NHS Wales Health Boards.

The framework:

- Supports NWJCC in discharging its **delegated statutory commissioning responsibilities.**
- Establishes a **consistent, proportionate and transparent approach** to performance oversight.
- Strengthens commissioner–provider and commissioner–Health Board relationships.
- In the longer term provides ambition to move beyond activity-based measures towards **outcomes.**
- Aligns with Welsh Government priorities and national outcomes frameworks.

2. Context and Background

Historically, performance assurance has relied heavily on:

- Contractual KPIs and service specifications.
- Welsh Government Delivery and Outcomes Framework measures.
- Periodic reporting to PPF and Joint Committee.

While these remain important, they do not in isolation provide sufficient assurance on:

- Sustainability and resilience of services.
- Value and affordability across the system.

This framework therefore **resets and strengthens** performance assurance arrangements, reflecting:

- Lessons learned from the predecessor Committees.
- Increasing financial and operational grip and control.
- The need for stronger system-level commissioning leadership.
- Priorities and activities linked to the work plan of the JCC team.

3. Commissioner Relationships

3.1 Relationship with Health Boards
The NWJCC acts on behalf of Health Boards but also requires assurance that commissioned services align with:

- Local population needs.
- Health Board strategic intentions.
- Regional and national transformation priorities.

To support this:

- **Annual commissioner-to-Health Board executive discussions** will be undertaken, agreed with individual Health Boards and will be focused on:
  - Strategic priorities and risks.
  - Demand management and pathways.
  - Future commissioning intentions.
- Insights from these discussions will inform:
  - NWJCC strategy.
  - Commissioning intentions.
  - Development of IMTP For the JCC including prioritisation and spending decisions.

4. Performance Assurance Measurement

Performance assurance will be based on a **balanced set of measures**, recognising that no single indicator provides sufficient assurance.

4.1 Measurement Principles
The NWJCC will have a focused lens on commissioning services established role and approach identified through the Joint Committee with considering to:

- Measure **what matters to patients and the system..**
- Balance **activity, cost, quality and outcomes.**
- Use quantitative and qualitative intelligence particularly in the context of nationally agreed data submissions for targets measured nationally.
- Apply proportionality based on risk, value and strategic importance.
- Remain flexible to align with any **new Welsh Government mandated frameworks.**
- Care across the patient pathways and system impact.

1. **Quantitative**
2. **Process**
3. **Outcome**
4. **Qualitative (experience and narrative)**

These are applied to:

- Patients referred.
- Patients undergoing treatment.
- Patients waiting for treatment.
- Patients diverted to alternative treatments.

(See Appendix 2A)

5. Performance Assurance Process

As services move beyond pandemic recovery, the NWJCC will operate a **clear, structured and risk-based assurance process**.

Key features include:
- Regular, structured Commissioner–Provider engagement.
- Clear escalation routes for non-delivery of contracted values.
- Integration of quality, finance and operational intelligence.
- Alignment with Annual Plan delivery.

Where services are commissioned from England, NWJCC will:
- Continue to use NHS England specialist commissioning intelligence.
- Supplement this with NWJCC-specific assurance where required.

6. Contract Segmentation and Assurance Intensity

6.1 High-Value or Strategically Significant Contracts (> ~£40m or strategically critical)

- Annual Executive-to-Executive meetings (Planning, Finance, Clinical leadership as a minimum).
- Bi-monthly SLA / performance meetings.
- Enhanced monitoring where services are in escalation.
- Forward-looking discussion aligned to ICP development.

6.2 Medium-Value Contracts (~£10m–£40m)
- Bi-annual SLA / performance meetings.
- Escalation meetings where required.
- Targeted engagement on delivery risks and future plans.

6.3 Lower-Value Contracts (< ~£10m)
- Annual SLA / performance meeting.
- Exception-based escalation.
- Proportionate assurance approach.

6.4 Themed or System Deep Dives
The NWJCC will periodically undertake deep dives on:

- Specific clinical specialties.
- Cross-border pathways.
- Geographic or Health Board-specific issues.

These will supplement, not replace, routine assurance.

7. Reporting Arrangements

Performance information will be reported through a clear governance route:

- **Joint Health Board Committee (NWJCC):** Bi-monthly
- **Planning, Performance and Finance (PPF):** Bi-monthly
- **Executive Collaborative Commissioning Leadership Group:** Bi-Monthly

Reporting will focus on commissioned services where data is collated nationally and therefore quality checked nationally through Digital Healthcare Wales triangulated to local contracting and service level intelligence using:

- Exception and risk-based assurance.
- Trends and emerging issues.
- Financial and quality interdependencies.
- Impact on patients and system sustainability.

8. Roles and Responsibilities

8.1 Joint Health Board Committee (NWJCC)

- Sets strategic direction and priorities.
- Seeks assurance on performance, quality, outcomes and value.
- Drives a culture of continuous improvement and accountability.

8.2 Chief Commissioner / Accountable Officer

- Overall accountability for performance, governance and assurance.
- Reports to the Joint Committee.
- Delegates operational responsibility as appropriate.

8.3 Director of Finance & Information

- Oversees performance reporting.
- Leads development and maintenance of the Framework.
- Lead responsibility for financial performance and affordability.
- Integration of financial and activity intelligence.
- Assurance on value for money and financial sustainability.

8.4 Director of Planning / Performance

- Oversees performance reporting and escalation in the context of organisational delivery against the Annual Plan.

- Leads the development and maintenance of Workforce reporting.
- Ensures alignment with national and local priorities including Ministerial Priorities.

8.5 Director of Nursing and Quality

- Assurance on quality, safety and patient experience.
- Integration of quality intelligence into performance reporting.
- Leads the services in escalation framework including criteria for improvement.

8.6 Medical Director

- Clinical leadership and professional accountability.
- Oversight of clinical outcomes and standards.
- Ensures alignment with national developments and local policy updates.

8.7 Commissioning Teams

- Day-to-day performance monitoring.
- Development and tracking of improvement plans.
- Relationship management with providers and management of delivery including recovery actions.

8.8 All Staff

- Contribution to performance improvement.
- Ownership of quality, value and outcomes within their remit.

Appendix 2A – Performance Assurance Measures (NWJCC)

Scope	Quantitative	Process	Outcomes	Qualitative
Patients referred	Referral volumes, waiting lists	Prioritisation processes	Contact with patients	Patient experience
Patients treated	Activity	Compliance with clinical guidelines	Mortality, readmissions, PROMs	PREMs
Patients waiting	Waiting list size	Waiting list management	Emergency admissions, outcomes	PREMs
Patients diverted	Alternative pathway activity	Policy compliance	Outcomes, LOS, readmissions	PREMs

Appendix 3

JOINT COMMITTEE ASSURANCE FRAMEWORK

ESCALATION & DE-ESCALATION PROCESS

for Commissioned Services

Document Author:	Director of Nursing & Quality
Executive Lead:	Director of Nursing & Quality
Approved by:	Joint Commissioning Committee
Issue Date:	
Review Date:	
Document No:	

The Joint Commissioning Committee Escalation and De-escalation Framework (the Framework) sets out the approach to escalation and intervention where there are matters of concern that need to be addressed. It provides the parameters of how the Joint Commissioning Committee will work with commissioned providers and relevant stakeholders to address these. Escalation should not be viewed as a punitive process but a means by which support, and intervention can be provided to improve commissioned services.

The Framework process provides a clear methodology to address identified concerns as early as possible. It aims to ensure that providers/organisations understand the reporting mechanisms and the actions required to support services by ensuring that potentially serious issues are addressed effectively and in a timely matter.

De- escalation is equally as important in order to recognise the actions taken to improve services, enable the wider sharing of any lessons learnt and ensure there is sustained improvement built into the monitoring process thereafter.

Quality must be the central factor in strategic decision making and act as the foundation for our thinking, in the commissioning and delivery of services. It is central in our engagement with partners, service users, and the Duty of Quality in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 ("the 2020 Act") domains of the Health and Care Quality Standards 2023 enable and create the opportunity for defining areas for improvement and the actions required.

The following principles underpin the JCC Escalation and De-escalation Framework and build on the principles described in the NHS Wales Oversight and Escalation Framework (2024):

- **Creating an improvement culture**: Through all Service Level Agreements and contractual arrangements developing a culture of high performance and accountability will aid the monitoring and potential need to escalate where necessary.
- **Transparency and engagement**: JCC will be transparent regarding the stage of the process and engage with the providers and work in partnership with them to identify the next steps and the timescales/ actions involved.
- **Delivery focus**: The approach will always focus on delivering improvement and sustainability of services.
- **Proportionality and balance**: The framework arrangements will seek to ensure that interventions and actions are proportional to the scale of the risk and that a balance between challenge and support is maintained. Working in partnership with

shared agreed actions is seen as key driver to aid the process.

- **Clear lines of accountability**: A robust scheme of delegation and quality assurance arrangements will ensure that the Board, Chairs and Accountable Officers identify responsible officers for deliverables who will then interface with the oversight approach.
- **Earned autonomy**: delivery against plans and agreed trajectories will earn greater levels of autonomy. As organisations deliver against target expectations, frequency and intensity of oversight arrangements will be reviewed. Conversely greater levels of support and quality assurance interventions will be in place where required and could be assessed as part of organisational escalation.
- **Effective governance:** Assurance around the later stages of escalation and any negotiated contractual realignment imposed on provider organisation will be detailed and addressed with the provider. They will be reported through the JCC reporting structures outlined in the document.

1. ESCALATION AND INTERVENTION OPERATIONAL PROCESS

The following section sets out the process to review commissioned services and the steps in the escalation and de-escalation process in both identifying and responding to serious issues affecting Commissioned services. The process reflects how information will be exchanged in a timely manner, the triggers and prompts for escalation/intervention, reporting lines and levels of responsible individuals/teams. Escalation supports and builds on information sharing and performance management. It aims to manage risks and operates within the Commissioning Assurance Framework to compliment the suite of documents.
In order to provide consistency, the escalation steps are aligned to a tiered approach similar to the Welsh Government (NHS Wales Escalation and Intervention Arrangements 2024)

Whilst the LEVELS are clearly defined depending on the severity of the issue the starting point can be at any stage of the process.

2. STAGES/LEVELS OF ESCALATION

- LEVEL 0 ROUTINE ARRANGEMENTS is the term used to report on all Commissioned services where there are no identified concerns around the service being delivered. Routine monitoring involves performance management against service specification, KPI, patient experience and performance outcomes. Where there are performance concerns and there is lack of available assurance in terms of improvement, there will be a need to introduce the steps in escalation. This process is structured to demonstrate engagement with providers and evidence of the quality in commissioned services.

- LEVEL 1 AREA OF CONCERN is the term used if there is a potentially emerging concern impacting on service delivery. Concern may be triggered by analysis of serious incidents, a single event or combination of factors. This is essentially a fact-finding

exercise whereby evidence is gathered, analysed and discussed by the relevant Commissioning team If there are emerging issues or concerns the commissioning team will need to explore how these are taken forward the level of impact of these on patient outcomes.

The enquiry will lead to one of the following possible outcomes:

1. No further action is required; routine arrangements will continue. Decisions need to be logged and recorded by the commissioning team for future reference if required.
2. Escalation to a higher-level dependent on the severity of the findings.

- LEVEL 2 ENHANCED MONITORING is a pro-active response to put effective processes in place to drive improvement and aid early intervention. Findings from the above should be shared with the provider for consideration and comment. At this stage there should be jointly agreed objectives between the provider and commissioner to address the issues identified and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include:
  - Provider performance meetings
  - Triangulation of data with other quality indicators
  - Advice from external advisors
  - Monitoring of any action plans

A risk assessment should be undertaken and logged on the Commissioning Team Risk Register if a commissioning risk is identified and reported in the Quality Safety Outcome Commissioning Team report if deemed necessary.

Enhanced monitoring will lead to one to the following possible outcomes:

1. Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to routine monitoring.
2. If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to escalate to Level 3 Targeted intervention.

- LEVEL 3 TARGETED INTERVENTION will be initiated if there is a need for greater scrutiny, monitoring and reporting of emerging concerns. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. The decision to move to level 3 will be decided by the Commissioning Team and agreed by the relevant Commissioning Director and the Medical/Nurse Director if there are patient safety issues identified. The NWJCC Senior Leadership Team will be informed of decision and a NWJCC Executive Lead identified. The NWJCC will formally notify the provider and request the nomination of an Executive Lead from a provider perspective.

An initial meeting will be set up as soon as possible dependent on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue, but the meetings should ideally comprise of the following personnel as a minimum:

- Chair (JCC Executive Lead)
- Executive Lead from provider Health Board/Trust
- Associate Medical Director - Commissioning Team
- Senior Planning Lead – Commissioning Team
- Assistant Director of Nursing/ Head of Quality
- Clinical representative from provider Health Board/Trust
- Management representative from provider Health Board/Trust

An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions, any changes or progress made in the escalation level agreed. Minutes and updated action places will be shared for future monitoring. Consideration of entry on the risk register if a commissioning risk is identified and reported in line with the NWJCC risk management process.

Reporting will be through commissioning team to QSOC Committee, and the escalation trajectory (Appendix 3a) commenced and updated accordingly. It may be appropriate to report to Welsh Government and an Early Warning Notification submission made if appropriate.

Targeted intervention will lead to one to the following possible outcomes:

1. If there is ongoing concern relating to patient care and safety with no clear progress, then further escalation will be required to Level 4.
2. If there is sufficient evidence that improvement has been achieved then the service could be de-escalated to level 2 with the need to demonstrate sustained improvement.

- **LEVEL 4 SPECIAL MEASURES** If services have been unable to demonstrate evidence of improvement or an immediate patient safety issue is identified a number of actions need to be considered. This stage will require escalation and involvement of the NWJCC Chief Commissioner and CEO from the provider organisation. Both Quality Patient Safety and Outcomes Committee and Joint Committee should be cited on the level of escalation and potential consequences. The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue:
    1. De-commissioning of the service/ Suspension from the mental Health Framework
    2. Outsourcing from an alternative provider. This may be permanent or temporary
    3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider.

Involvement with Welsh Government and LLAIS is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making.

Please section 6 below for a tabular overview of the escalation levels for commissioned services.

3. ESCALATION TRAJECTORY

The escalation trajectory must be commenced at Level 3 or above (Template Appendix 1). In addition to the Levels described above the framework has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level. See diagrammatic illustration below:

Level of escalation reducing / improving position

Level of escalation unchanged from previous report

Level of escalation increasing / worsening position

Following each escalation meeting based on the outcome the commissioning team needs to consider the position and update the escalation trajectory accordingly. This intervention will also aid the decision-making progress and direction in which the service is making or not. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and enable accurate reporting.

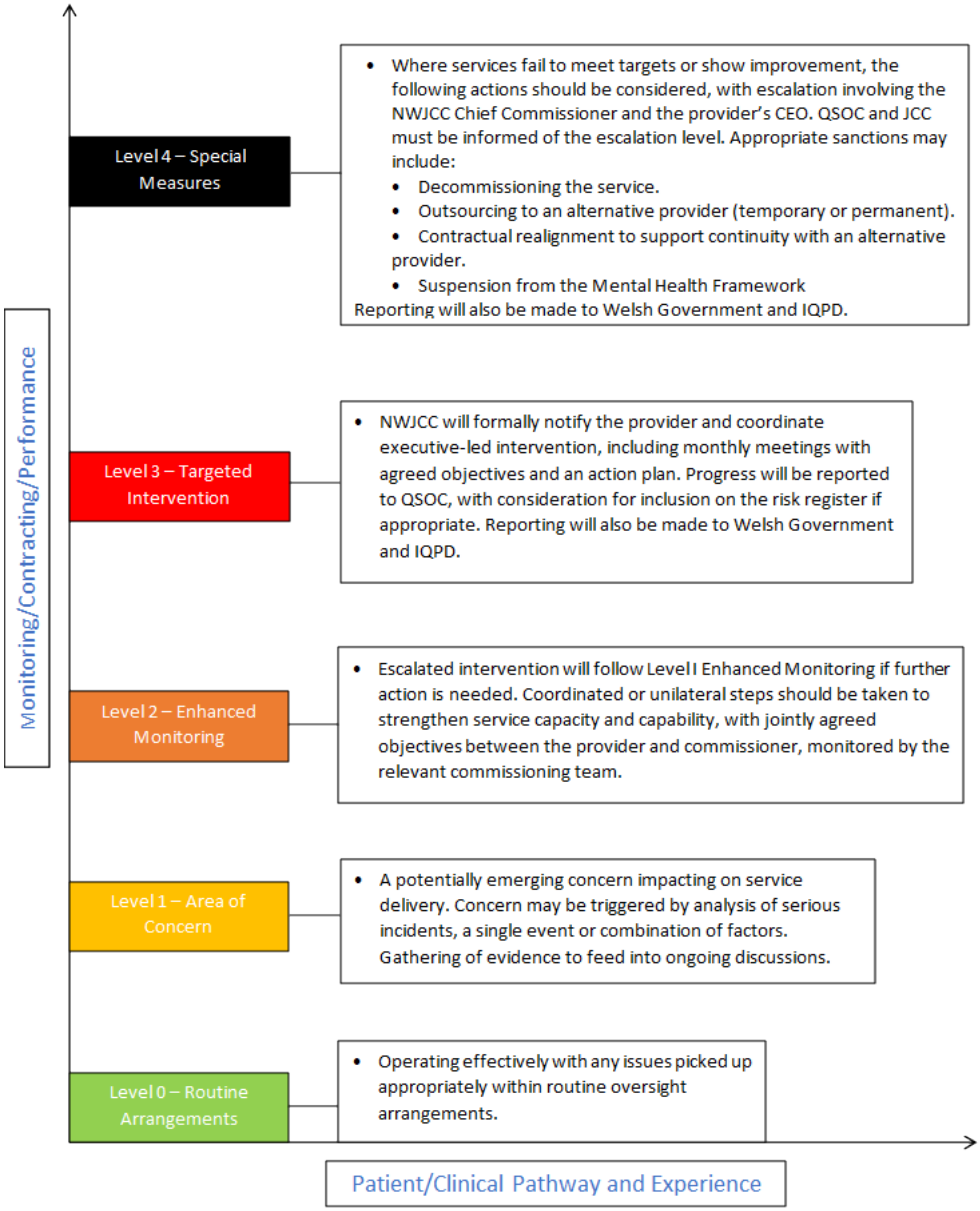
4. REPORTING

All services in escalation are reported through to the Quality Patient Safety and Outcomes Sub-Committee via the Commissioning Team Directorate report. For services in Level 3 or above a separate escalation trajectory will also be shared with the Sub-Committee. All updates to the trajectory will be made in red for ease of reporting. A summary of services in Escalation (Level 3 or above) will be submitted with the Chairs report to the Joint Commissioning Committee and then through to the seven Health Boards.

5. AUDITING THE PROCESS

It is equally important the process is reviewed and audited at the end of an escalation period to ensure that any lessons learnt are shared. This includes feedback from the relevant provider in terms of how helpful or not the process has been in terms of addressing the concerns. This will be undertaken by the relevant commissioning team and done in partnership with the provider.

6. ESCALATION LEVEL CHARTS



Appendix 3A – Escalation Trajectory Report

NWJCC Director Lead:
Provider Director Lead:
Commissioning Team:
Date of Escalation:
Date last reviewed by Commissioning Team:
Date Last reported to Quality Safety Outcome Committee:

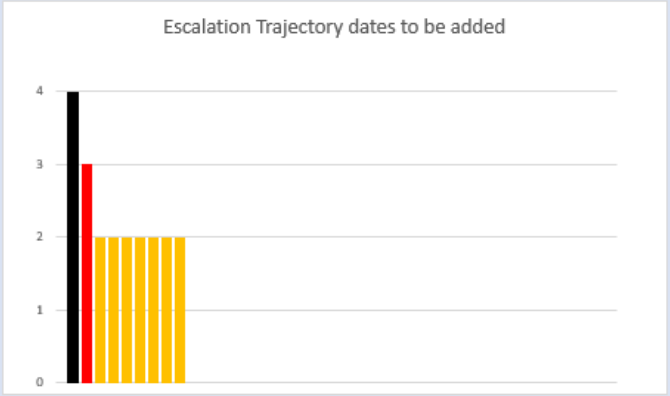
Service in Escalation:

Current Escalation Level

Escalation Trend Level

Trend	Rationale	Current Trend Level
↑	Level of escalation reducing / improving position	
↔	Level of escalation unchanged from previous report	
↓	Level of escalation increasing / worsening position	

Escalation Trajectory:



Escalation History:

Date	Escalation Level

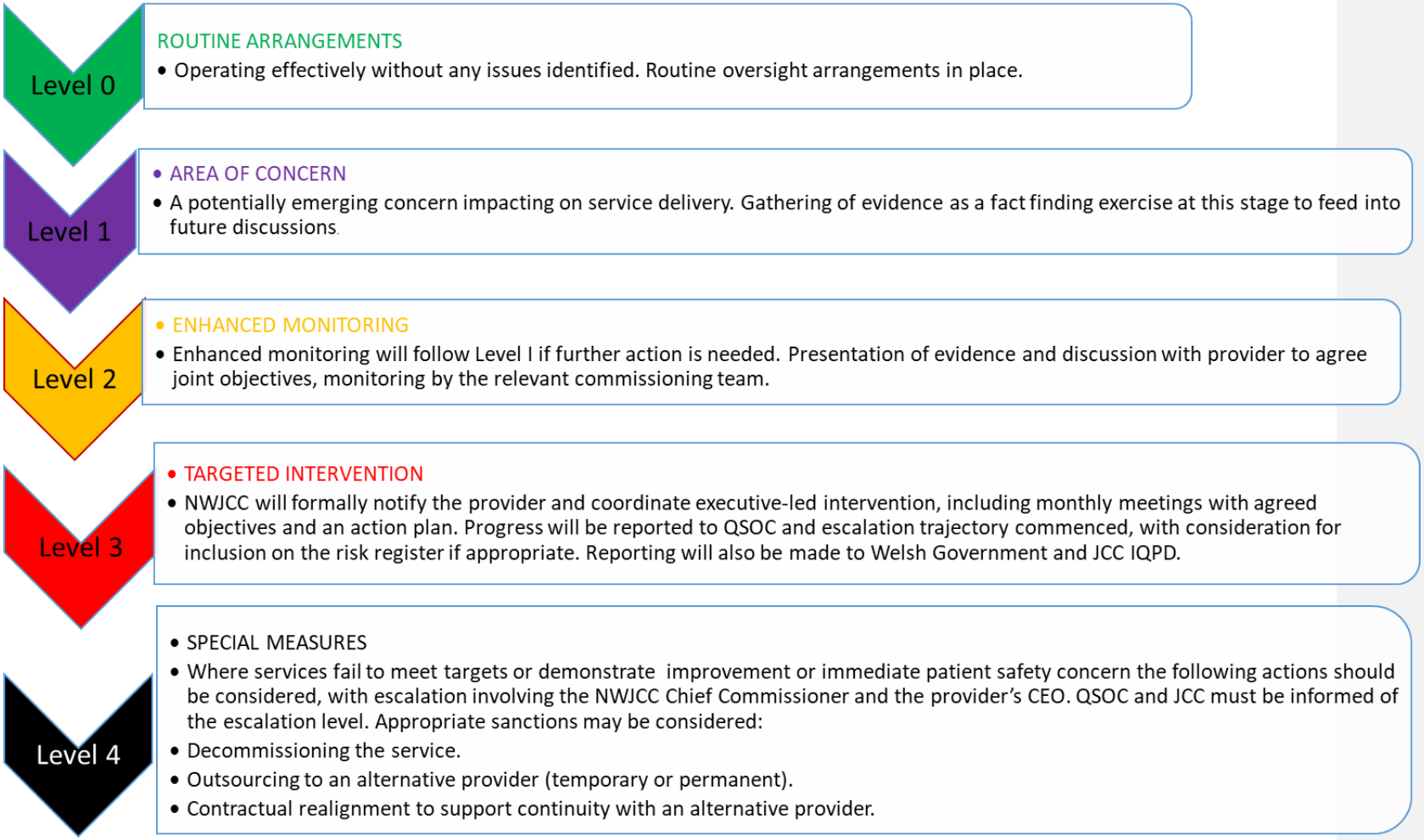
Rationale for Escalation Status: Patient/Safety

Background Information:

Actions & Risks Arising:

Key updates/Actions:

Action	NWJCC Lead	Action Due Date	Completion Date


Level 0
ROUTINE ARRANGEMENTS
• Operating effectively without any issues identified. Routine oversight arrangements in place.
Level 1
• AREA OF CONCERN
• A potentially emerging concern impacting on service delivery. Gathering of evidence as a fact finding exercise at this stage to feed into future discussions.
Level 2
• ENHANCED MONITORING
• Enhanced monitoring will follow Level I if further action is needed. Presentation of evidence and discussion with provider to agree joint objectives, monitoring by the relevant commissioning team.
Level 3
• TARGETED INTERVENTION
• NWJCC will formally notify the provider and coordinate executive-led intervention, including monthly meetings with agreed objectives and an action plan. Progress will be reported to QSOC and escalation trajectory commenced, with consideration for inclusion on the risk register if appropriate. Reporting will also be made to Welsh Government and JCC IQPD.
Level 4
• SPECIAL MEASURES
• Where services fail to meet targets or demonstrate improvement or immediate patient safety concern the following actions should be considered, with escalation involving the NWJCC Chief Commissioner and the provider's CEO. QSOC and JCC must be informed of the escalation level. Appropriate sanctions may be considered:
• Decommissioning the service.
• Outsourcing to an alternative provider (temporary or permanent).
• Contractual realignment to support continuity with an alternative provider.

Appendix 4
Joint Committee Assurance Framework Template Report

NWJCC – JOINT COMMITTEE ASSURANCE FRAMEWORK REPORT
Section 1 – Summary

Risk no	Strategic Goal	Strategic / Principal Risk	Lead(s) for this risk	Assurance committee	Current score	Scoring Trajectory	Risk Treatment
1.	Maximise Value 						
2.	Ensure Quality 						
3.	Reduce Duplication 						
4.	Improve Equity and Population Health 						
5.	Facilitate Integration 						

Section 2 Strategic Risk Heat Map

Current risk scores in **black**

Target risk scores in ***grey italic***

Consequence						
	5		*A,B,C,D,E*		**A,B,C,D,E**	
	4					
	3					
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

SECTION 3 – STRATEGIC RISKS

Strategic Goal(s):		Risk score **TBC**
Strategic Risk: TBC		
If ...	***Then*** ...	***Resulting in*** ...

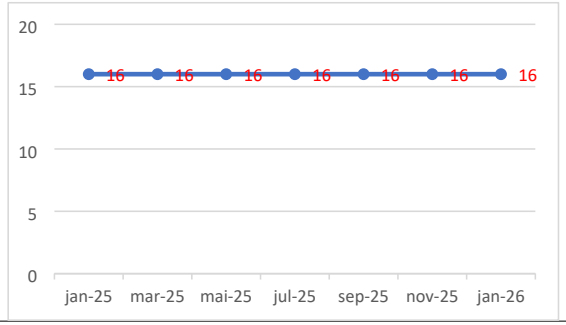
Risk Lead	•	Assurance committee	

	Consequence	Likelihood	Score
Initial			
Current			
Target			
Risk Appetite	*TBC*		

Risk Score Trend this Period:

TBC

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	

Current Control Measures
Current Control Measures Cont.
Sources of Assurance (Internal and External)

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)

Linked National Priority Measures
E.G. Access to Timely Planned Care • Number of patients waiting more than 104 weeks for treatment; • Number of patients waiting more than 36 weeks for treatment; • Percentage of patients waiting less than 26 weeks for treatment;

Current Performance Highlights		
Were there any significant incidents affecting this strategic Risk this period:		
Associated Risks escalated to the Organisational Risk Register		
Risk Reference:	**Risk Title:**	**Current Risk Score:**

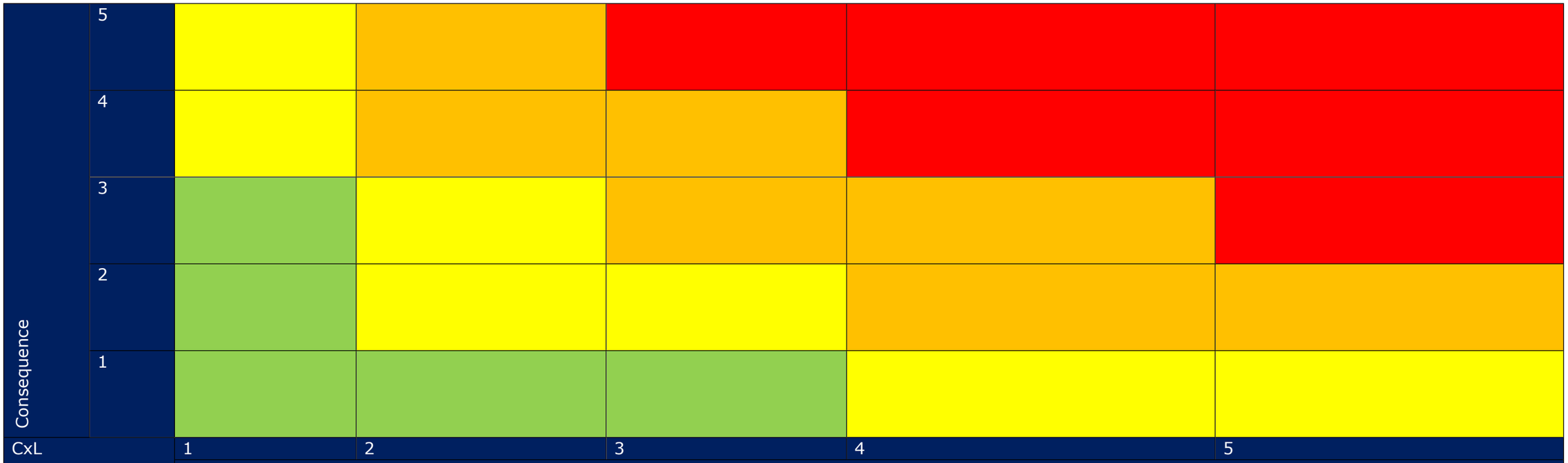
4.2.3 - APPENDIX 3 – SECTION 1. JOINT COMMITTEE ASSURANCE FRAMEWORK (JAF) REPORT

Risk no	Strategic Objective	Strategic Risk	Strategic Risk Owner(s)	Assurance committee	Current score	Scoring Trajectory	Risk Appetite	Risk Treatment
1.	• Maximise Value • Facilitate Integration  See page [ ]	Financial Sustainability and Affordability	TBC	• Planning, Performance & Finance Sub-Committee • Joint Commissioning Committee • CTM Audit, Risk & Assurance Committee	**TBA (C x L)**	TBA	TBA	TBA
2.	• Maximise Value • Ensure Quality • Improve Equity and Population Health  See page [ ]	Quality, Safety and Outcomes	TBC	• Quality, Safety & Outcomes Sub-Committee • Joint Commissioning Committee • CTM Audit, Risk & Assurance Committee	**TBA (C x L)**	TBA	TBA	TBA
3.	• Maximise Value • Ensure Quality • Improve Equity and Population Health • Facilitate Integration  See page [ ]	Service Sustainability, Fragility and Equity of Access	TBC	• Quality, Safety & Outcomes Sub-Committee • Joint Commissioning Committee • CTM Audit, Risk & Assassurance Committee	**TBA (C x L)**	TBA	TBA	TBA
4.	• Maximise Value • Ensure Quality • Reduce Duplication • Facilitate Integration  See page [ ].	Data Quality, Analytical Capacity and Contract Management	TBC	• Planning, Performance & Finance Sub-Committee • Joint Commissioning Committee • CTM Audit, Risk & Assurance Committee	**TBA (C x L)**	TBA	TBA	TBA
5.	• Maximise Value • Reduce Duplication • Facilitate Integration  See page [ ]	Commissioning Boundaries and Accountability	TBC	• Planning, Performance & Finance Sub-Committee • Joint Commissioning Committee • CTM Audit, Risk & Assurance Committee	**TBA (C x L)**	TBA	TBA	TBA

Risk no	Strategic Objective	Strategic Risk	Strategic Risk Owner(s)	Assurance committee	Current score	Scoring Trajectory	Risk Appetite	Risk Treatment
6.	• Maximise Value • Ensure Quality • Improve Equity and Population Health • Facilitate Integration  See page [ ]	Ambulance Commissioning Model	TBC	• Senior Leadership Team • Joint Commissioning Committee • CTM Audit, Risk & Assurance Committee	**TBA (C x L)**	TBA	TBA	TBA

SECTION 2. STRATEGIC RISK HEAT MAP

Current risk scores in **black**
Target risk scores in ***grey italic***



SECTION 3 – STRATEGIC RISKS

Strategic Objective(s):		Risk Score: **(TBD)**
Strategic Risk:		
If…	***Then…***	***Resulting in…***

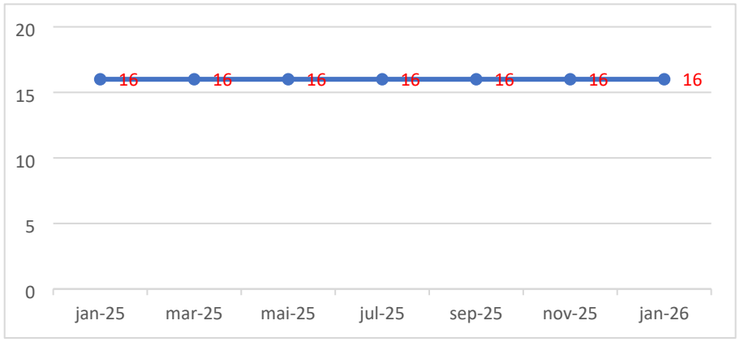
Risk Lead	TBC	Assurance Committee(s)	

	Consequence	Likelihood	Score
Initial			
Current			
Target			
Risk Appetite			

Rationale for assessment of risk score:
Including where risk score remains unchanged and for any changes

Risk Score Trend this Period:

Risk Score Trajectory:



Risk Treatment Assessment:
i.e. Treat, Tolerate, Transfer etc.

Example - Treat – [Action to be taken:]

Current Control Measures

Sources of Assurance (Internal and External)

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)

Linked National Priority Measures

Current Performance Highlights
Were there any significant incidents affecting this strategic risk this period:
Associated Risks escalated to the Organisational Risk Register

Risk Reference:	Risk Title:	Current Risk Score:

4.2.4 - APPENDIX 4

Strategic Risks 2026/2027

SR1 – Financial Sustainability and Affordability

SLT Owner: [TBC]

There is a risk that the NWJCC is unable to maintain financial balance because the plan is delivered within a no investment settlement, with recurrent underlying cost pressures, high-cost medicines growth and reliance on Commissioner and Provider efficiency savings that may not be fully deliverable, resulting in an inability to deliver financial balance in year and will impact on the planning for a balanced IMTP for the period 2027/28 – 2029/30.

Strategic objectives impacted:

- Maximise Value
- Facilitate Integration

Principal causes:

- 1.11% uplift insufficient to meet unavoidable demand and inflation
- Recurrent underlying deficit and legacy cost pressures
- Dependence on provider CIPs and commissioner contributions
- Growth in high-cost medicines and specialised activity

Key impacts:

- Failure to deliver a balanced plan in-year
- Increased pressure on Health Boards' IMTPs
- Reduced headroom for service sustainability and transformation

Key controls:

- Robust financial planning and MoSCoW prioritisation
- Quality Impact Assessments for investment and disinvestment decisions
- Collaborative savings programmes with providers
- In-year financial monitoring and escalation

Key assurances:

- Joint Committee financial reports
- Planning, Performance & Finance Committee oversight
- External audit and Welsh Government assurance processes

Gaps / residual issues:

- Limited flexibility within no investment framework
- Delivery risk associated with recurrent savings
- Exposure to in year volatility (e.g. medicines, demand surges)

SR2 – Quality, Safety and Outcomes

SLT Owner – [tbc]

There is a risk that patient populations will not have timely access to high quality, safe and effective services within the NWJCC's commissioning portfolio, or within new or emerging service areas, due to the 2026/27 Annual Plan being delivered in a no-investment context, with insufficient inflationary cover, rising demand and service fragility, resulting in poorer access and worse patient outcomes.

Strategic objectives impacted:

- Ensure Quality
- Improve Equity & Population Health
- Maximise Value

Principal causes:

- No-investment planning context
- Insufficient inflationary cover
- Rising demand and complex case mix
- Workforce and provider fragility

Key impacts:

Reduced access to services and poorer access patient outcomes
- Failure to deliver standards and improvement
- Increased inequity, escalation and reputational risk

Key controls:

- Clinically led prioritisation
- Quality and Equality Impact Assessments
- Duty of Quality and escalation arrangements
- In-year financial and contract monitoring

Key assurances:

- QSO Sub-Committee scrutiny
- PPF Sub-Committee oversight
- Joint Committee performance and risk reporting
- Provider and patient assurance information

Gaps / residual issues:

- Limited in-year flexibility
- Deferred resilience and improvement investment
- Dependence on wider system capacity

SR3 – Service Sustainability, Fragility and Equity of Access

SLT Owner – [TBC]

There is a risk that fragile, highly specialised, nationally commissioned, and locally provided services become unsustainable or are unable to provide equitable access across Wales due to workforce shortages, constrained capacity, geographical variation and limited capital investment, resulting in service disruption, delays to care, unequal access and poorer patient outcomes.

Strategic objectives impacted:

- Ensure Quality
- Improve Equity & Population Health
- Facilitate Integration
- Maximise Value

Principal causes:

- Persistent workforce fragility and reliance on small specialist teams
- Capacity not keeping pace with demand
- Geographical variation in service distribution and resilience
- Constrained estate and capital investment
- Interdependencies with non-NWJCC commissioned pathways

Key impacts:

- Delays to care and increased waiting times
- Unequal access to specialist services across Wales
- Increased reliance on independent sector and cross-border provision
- Poorer patient experience and outcomes

Key controls:

- Fragile services monitoring and escalation
- Strategic service reviews and deep dives
- Population needs-led commissioning and pathway review
- Equity and Quality Impact Assessments
- Provider engagement and contractual levers

Key assurances:

- Quality, Safety & Outcomes Sub-Committee reports
- Provider performance and escalation reports
- Equity analysis and patient experience intelligence
- Joint Committee oversight of fragile services and access risks

Gaps / residual issues:

- Limited ability to invest in resilience
- Capital constraints outside NWJCC control
- System-wide workforce shortages
- Limited capacity to address unwarranted variation quickly

SR4 – Data Quality, Analytical Capacity and Contract Management

There is a risk that poor data quality, inconsistent coding and limited analytical capacity undermines the NWJCC from effectively contract managing commissioned services, resulting in weak oversight, delayed intervention and unmanaged quality, activity and financial risk.

Strategic objectives impacted:

- Maximise Value
- Ensure Quality
- Reduce Duplication
- Facilitate Integration

Principal causes:

- Inconsistent provider data submissions and variable data quality
- Inconsistent clinical coding and limited dataset standardisation
- Insufficient analytical capacity and performance intelligence
- Limited ability to triangulate quality, activity, outcome and finance data

Key impacts:

- Reduced ability to identify, challenge and manage provider underperformance
- Weak contract management and limited leverage over activity, quality and cost
- Poorer commissioning decisions, forecasting and prioritisation
- Unmanaged quality, performance and financial risk

Key controls:

- Minimum Data Set development and standardised reporting requirements
- Performance dashboards, exception reporting and deep dives
- Data quality requirements embedded in contracting and provider review meetings
- Strengthened analytical support for contract and performance management

Key assurances:

- Provider performance and contract monitoring reports
- Planning, Performance and Finance Sub-Committee scrutiny
- Audit and assurance reviews of data quality and reporting

Gaps / residual issues:

- Time lag to improved data maturity and consistency
- Dependence on provider systems, coding and reporting discipline
- Residual gap in analytical capacity and specialist intelligence

SR5 – Commissioning Boundaries and Accountability

SLT Lead – [TBC]

There is a risk that unclear commissioning boundaries between NWJCC and Health Boards will lead to gaps in accountability and unmanaged system risk, resulting in duplication, omission of services or delayed mitigation of pressures.

Strategic objectives impacted:

- Maximise Value
- Reduce Duplication
- Facilitate Integration

Principal causes:

- Evolving role of NWJCC
- Services not formally delegated but interdependent
- Inconsistent understanding across the system

Key impacts:

- Increased system risk
- Delayed decision-making
- Inefficient use of resources

Key controls:

- Clear articulation of inclusions and exclusions
- Governance and accountability frameworks
- Engagement with Health Boards

Key assurances:

- Joint Committee decisions and records
- Health Board feedback and alignment

Gaps / residual issues:

- Ongoing system complexity
- Emerging services and technologies

SR6 – Ambulance Commissioning Model

SLT Lead – [TBC]

Without NHS Wales system wide improvements across service areas, including, but not limited to Ambulance Handover, delivery of preventative care in the community and other areas to increase ambulance availability, there is a risk that that the NWJCC's commissioned ambulance service capacity will not deliver its intended outcomes resulting in the requirement for additional and/or alternative commissioning models that may create recurrent cost pressures for Health Boards and reduce the ability to fund other commissioning priorities.

Strategic objectives impacted:

- Ensure Quality
- Maximise Value
- Facilitate Integration
- Improve Equity & Population Health

Principal causes:

- Persistent handover delays and poor system flow
- Insufficient whole-system progress on urgent and emergency care improvement
- Constrained NHS Wales funding and limited Health Board affordability

Key impacts:

- Requirement to revise the ambulance commissioning model
- Potential requirement for significant additional ambulance workforce capacity
- Additional recurrent funding pressure on Health Boards
- Reduced affordability for other commissioning priorities
- Continued performance, quality and public confidence risk

Key controls:

- National handover improvement oversight and escalation
- Joint planning with WAST and Health Boards on demand and capacity
- Scenario modelling for ambulance workforce and funding implications
- Financial escalation through NWJCC and NHS Wales planning processes

Key assurances:

- Joint Committee performance, finance and risk reports
- Planning, Performance and Finance Sub-Committee scrutiny
- Urgent and emergency care performance reporting
- WAST and Health Board assurance reporting on improvement delivery

Gaps / residual issues:

- Limited leverage over whole-system flow drivers outside NWJCC control
- Uncertain affordability of any recurrent paramedic expansion
- Risk of cost shunting to Health Boards without resolving root causes

4.2.5 - APPENDIX 5

Joint Commissioning Committee

Risk Appetite Statement 2026/2027

1. Introduction:

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

The NHS Wales Joint Commissioning Committee ("JCC") should make a strategic choice about the style, shape and quality of risk management and should lead the assessment and management of opportunity and risk. The JCC should determine and continuously assess the nature and extent of the principal risks that the JCC is exposed to and is willing to take to achieve its objectives - **its risk appetite** – and ensure that planning and decision-making reflects this assessment. Effective risk management should support informed decision-making in line with this risk appetite, ensure confidence in the response to risks and ensure transparency over the principal risks faced and how these are managed.[2]

The challenge for the JCC in managing risk is not underestimated, and the intention of the Risk Appetite Statement is to support an informed risk-based decision.

[1] Government Finance Function – Risk Appetite Guidance Note – August 2021 – V2.0
[2] The Orange Book – Section A

2. The Joint Commissioning Committee has adopted the following **Risk Appetite Matrix:**

Risk Appetite	Description
Averse (None) **(1 – 3)** Avoidance of risk is a key organisational objective	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is a key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimal **(4 – 6)** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious **(7 – 9)** Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open **(10 -14)** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager (Seek) **(15 - 20)** Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risks)	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

3. The Joint Commissioning Committee's **Risk Appetite Statement:**

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

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

- **Strategic Direction –** the JCC has adopted an **Open** stance, where guiding principles or rules are in place that are receptive to considered risk taking in organisational actions and the pursuit of our priorities. This reflects the uniqueness of the JCC model and provides opportunity to shape the clinical strategy agenda.

- **Health Inequality, Quality, Safety and Outcomes -** the JCC has adopted a **Cautious** stance, with a preference to take decisions that risk an adverse or differential impact on commissioned populations where there is a low degree of inherent risk around patient safety, and the possibility of improved outcomes, and where appropriate controls are in place. Targeting resources to ensure equity of outcome even when this means investing differentially or disinvesting in existing commissioned services and considering options where robust methods for monitoring and measuring impact on outcomes can be established.

- **Financial Stability and Value for Money (VFM) –** the JCC has adopted a **Cautious** stance, being prepared to accept the possibility of limited financial risk with VFM and population outcomes the primary concern for the services commissioned.

- **Innovation and Service Sustainability –** the JCC has adopted an **Open** stance, with a preference to consider some options, including the associated risks, which support the delivery of operational performance targets, with a preference for innovating service delivery, adoption of new technologies and models of service reconfiguration for the benefit of its commissioned population.
- **Governance, Compliance and Statutory Duty –** the JCC has adopted a **Cautious** stance, with a preference to accept the possibility of limited regulatory challenge, seeking to understand where similar actions had been successful elsewhere before taking any decision. The JCC would wish to work towards an **Open** stance as it continues to mature and develop, accepting the possibility of some regulatory challenge as long as it can be reasonably confident around the decisions taken and that challenge would be successful.

- **Confidence, Trust and Reputation** - the JCC has adopted an **Open** stance, being prepared to accept the possibility of some reputational risk provided there is the potential for improved outcomes for stakeholders and the JCC is comfortable with the decisions it has taken.

- **Workforce/People and OD -** the JCC has adopted a **Cautious** stance following the Organisational Change Process (OCP), with a preference to take limited risks with regard to the workforce and whilst the investment of staff development is still in progress. The JCC would wish to work towards an **Open** stance as it continues to develop and mature, with a preference of accepting the possibility of some workforce risk as a direct result from innovation as long as there is the potential for improved recruitment and retention, sustainability and developmental opportunities for staff leading to a healthy experience of work.

- **Data and Information Management –** the JCC has adopted a **Cautious** stance, with a preference to accept the need for operational effectiveness with risk mitigated through careful management, limiting distribution.

4.2.6 - APPENDIX 6 - NWJCC RISK APPETITE MATRIX 2026/2027

Risk Appetite Level → / Risk Category ↓	Risk Domain and Strategic Objectives Alignment	Averse (None) (1 – 3) Avoidance of risk is a key organisational objective	Minimal (4 – 6) Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential	Cautious (7 – 9) Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential	Open (10 -14) Willing to consider all potential delivery options and choose while also providing an acceptable level of reward	Eager (Seek) (15 - 20) Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risks)
Strategic Direction	**Risk Domains:** • All **Strategic Objectives:** • All	We have guiding principles or rules in place that largely maintain the status quo and seek to limit risk in organisational actions and the pursuit of our priorities. Our strategic objectives are rarely refreshed.	We have guiding principles or rules in place that typically minimise risk in organisational actions and the pursuit of our priorities.	We have guiding principles or rules in place that allow considered risk taking in organisational actions and the pursuit of our priorities.	We have guiding principles or rules in place that are receptive to considered risk taking in organisational actions and the pursuit of our priorities.	We have guiding principles or rules in place that welcome considered risk taking in organisational actions and the pursuit of our priorities. Our strategic objectives are reviewed and refreshed dynamically.
Health Inequality, Quality, Safety and Outcomes **(CTMUHB – Cautious)**	**Risk Domains:** • Health Outcomes • Health Inequalities • Strategic Commissioning **Strategic Objectives:** • Improve Equity and Population Health • Reduce Duplication	We have no appetite for risks that impact the health, safety and well-being of our commissioned population or for decisions that may have an uncertain impact on health outcomes.	Our appetite for risk taking is limited to where there is a minimal impact on the health, safety and well-being of our commissioned population. We will avoid anything that may impact on health outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	We are prepared to take decisions that risk an adverse or differential impact on the quality and safety of our commissioned population where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. We will target our resources to ensure equity of outcome even when this means investing differentially or disinvesting in existing commissioned services. We will consider options where we know we can establish robust methods for monitoring and measuring impact on outcomes.	We believe that sustainably addressing a wide range of inequalities requires us to concentrate on addressing the broader determinants of health and investment in primary prevention. This requires a long-term, collaborative approach that may result in a short to medium-term impact on quality, safety and health outcomes with potential for longer-term rewards. We support innovation.	We will pursue opportunities to commission collaboratively to address the broader determinants of health. We will pursue innovation wherever appropriate. We are willing to take decisions on quality, safety and health outcomes where there may be higher inherent risks but the potential for significant longer-term gains.
Financial Sustainability and Value for Money **(CTMUHB – Cautious)**	**Risk Domains:** • Resources • Strategic Commissioning **Strategic Objectives:** • Maximise Value	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM and population outcomes are our primary concern for the services we commission.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM and population outcomes for the services we commission with price not the overriding factor.	We will invest for the best possible return for the services we commission and accept the possibility of increased financial risk.
Innovation and Service Sustainability	**Risk Domains:** • Strategy and Operations **Strategic Objectives:** • Ensure Quality • Maximise Value	We have no appetite for decisions that may have a negative impact on current service delivery or operational performance targets for the services we commission.	We are only willing to accept decisions that may have a limited impact on current service delivery or operational performance targets for the services we commission.	We will take decisions that may have an impact on current service delivery or operational performance targets for the services we commission, provided the adoption of new models of service where similar actions have been successful elsewhere.	We will consider some options, including the associated risks, which support the delivery of operational performance targets, with a preference for innovating service delivery, adoption of new technologies and models of service reconfiguration for the benefit of our commissioned population.	We will pursue innovation in service delivery, adoption of new technologies and models of service reconfiguration for the benefit of our commissioned population.

Risk Appetite Level → / Risk Category ↓	Risk Domain and Strategic Objectives Alignment	Averse (None) (1 – 3) Avoidance of risk is a key organisational objective	Minimal (4 – 6) Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential	Cautious (7 – 9) Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential	Open (10 -14) Willing to consider all potential delivery options and choose while also providing an acceptable level of reward	Eager (Seek) (15 - 20) Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risks)
Governance, Compliance and Statutory Duty **(CTMUHB – Cautious)**	**Risk Domains:** • Legal **Strategic Objectives:** • Maximise Value • Facilitate Integration	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident, we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.
Confidence and Trust **(CTMUHB – Cautious)**	**Risk Domains:** • Reputation **Strategic Objectives:** Facilitate Integration	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.
Workforce/People and OD **(CTMUHB – Cautious)**	**Risk Domains:** • People **Strategic Objectives:** • Ensure Quality • Maximise Value • Facilitate Integration	We have no appetite for decisions that could have a negative impact on workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for the workforce but could improve the skills and capabilities of staff. We recognise that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.
Data and Information Management **(CTMUHB – Cautious)**	**Risk Domains:** • Strategy and Operations **Strategic Objectives:** • Facilitate Integration	We will lock down data & information and have tightly controlled access with high levels of monitoring.	We will minimise the level of risk due to potential damage from disclosure.	We will accept the need for operational effectiveness with risk mitigated through careful management, limiting distribution.	We will accept the need for operational effectiveness in the distribution and sharing of information.	We will minimise the level of controls with data and have information openly shared.

Target Risk Score: This provides the **risk tolerance score** for each of the different types of risks and therefore, **the target risk score**, which should sit within the tolerance score determined by the JCC for the stated category of risk. The strategic risk owner should consult the JCC's risk appetite statement to ensure the target score is appropriate and within the tolerance values of what the JCC is willing to take.

Audit, Risk & Assurance Committee Hosted Bodies

NHS Wales Joint Commissioning Committee Organisational Risk Register

Eitem yr Agenda / Agenda Item	**4.3**
Dyddiad y Cyfarfod / Date of Meeting:	04/08/26
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Aaron Fowler, Committee Secretary, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter:	Aaron Fowler, Committee Secretary, NWJCC
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Georgina Galletly, Director of Corporate Planning and Strategy, NWJCC
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	No Decision Required
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below: Creating Health Sustaining our Future
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	This report provides assurance that the appropriate governance arrangements are in place for the management of risk aligned with the delivery of the NWJCC Annual Plan 2026-27 and its strategic priorities.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:

Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	As required by the Terms of Reference for the Hosted Audit and Risk Assurance Committee ("the Committee"), this report is shared to provide assurance to the Committee that appropriate governance arrangements are in place for the management of risk by the NWJCC.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The NWJCC Organisational Risk Register ("ORR") details risks scoring 15 or above and/or those that cannot be managed locally across the NWJCC through adopted risk management processes. Each of the high/extreme risks recorded within the ORR are assigned to one of the NWJCC Sub-Committees to be reviewed, and for assurance to be provided that risks are being appropriately mitigated, with robust actions in place for their ongoing management. In addition to Sub-Committee scrutiny the NWJCC SLT reviews the ORR on a bi-monthly basis alongside any new emerging risks to assess whether they impact upon the delivery of the NWJCC strategic objectives and Annual Plan and therefore deemed appropriate to be reported through the ORR. There are currently 13 risks with a score of 15 or above being reported on the ORR which are subject to scrutiny and challenge by the processes referred to above.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being*	The NWJCC will continue bi-monthly monitoring and management of the ORR. Work will continue with the Directorate Teams to ensure the approach to risk reporting and management is embedded. Further review of the controls and mitigating actions will be a focus in the coming months. A Joint Committee Assurance Framework ("JAF") and Risk Appetite Statement has been developed that recognises the risks identified in the NWJCC Annual Plan and strategic priorities for 2026-27 and beyond,

made)	alongside a revised Risk Management Procedure. These will be implemented throughout August and a fully developed JAF will be reported to the JC at its meeting in September 2026, and subsequently to the CTM ARAC.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	Members are asked to: • **Note** the report.

1. Situation /Background

1.1 As required by the Terms of Reference for the Hosted Audit and Risk Assurance Committee ("the Committee"), this report is shared to provide assurance to the Committee that appropriate governance arrangements are in place for the management of risk by the NWJCC.

1.2 In accordance with the Hosting Agreement ("the HA") between CTMUHB and the NWJCC, the NWJCC has adopted the Risk Management provisions of CTMUHB (para. 5.2 of the HA). To this end, the NWJCC has developed an NWJCC Organisational Risk Register ("ORR") which details those risks scoring 15 (out of 25) or above and/or those that cannot be managed locally across the NWJCC through adopted risk management processes. This process mirrors the risk management process adopted by CTMUHB, as set out within the CTMUHB Risk Management Strategy.

1.3 Each of the high/extreme risks recorded within the ORR are assigned to one of the NWJCC sub-committees (Quality, Safety & Outcomes Sub-Committee ("QSOC") and the Planning, Performance & Finance Sub-Committee ("PPF")) to be reviewed, and for assurance to be provided that risks are being appropriately mitigated, with robust actions in place for their ongoing management. Additionally, each sub-committee provides onwards assurance, via Sub-Committee Highlight Reports, to the NWJCC Joint Committee (the "JC") regarding the management of risk.

1.4 As previously reported, work has been undertaken to develop a Joint Committee Assurance Framework ("JAF") and Risk Appetite Statement that recognises the risks identified in the NWJCC Annual Plan and strategic priorities for 2026-27 and beyond. Following appropriate consultation with the NWJCC Senior Leadership Team ("SLT"), the NWJCC Chair and Lay Members, the QSOC and PPF Sub-Committees throughout June 2026, the JAF, Risk Appetite Statement and Risk Management Procedure was approved by the JC at its meeting on 21st July 2026 and is shared with the ARAC for noting under Agenda Item 4.2.

1.5 The narrative within this report, and the appended ORR, is intended to provide assurance to the Committee that the aforementioned processes are operating effectively and support the ongoing management of risk by the NWJCC.

2. Specific Matters for Consideration

2.1 In addition to the local review of risk by operational teams, the following reviews of the ORR have been undertaken at JC and Sub-Committee meetings since the update shared with the Committee in May 2026:

- **Quality Safety and Outcomes Sub-Committee**

29 June 2026
The QSOC undertook a review of all patient quality, safety and outcome related risks within the ORR that will be presented to the JC at its meeting of the 21 July 2026. This meeting was attended by three NWJCC Lay Members, apologies were given for the appointed CEO lead for the Sub-Committee.

The QSOC Highlight Reports presented to the JC can be found at **Appendices 1a and 1b.**

- **Planning, Performance and Finance Sub-Committee**

2 July 2026
The PPF undertook a review of all planning, performance and finance related risks within the ORR that will be presented to the JC at its meeting of the 21 July 2026. This meeting was attended by three NWJCC Lay Members, apologies were given for the appointed CEO lead for the Sub-Committee.

The PPF Highlight Reports presented to the JC can be found at **Appendices 2a and 2b.**

- **Joint Committee Meeting – 21 July 2026**

The JC undertook a review of the ORR as of the 31 May 2026. This meeting was attended by all NWJCC Lay Members, Health Board Chief Executives and NWJCC operational leads. Feedback received by the Committee has been incorporated within updates shared.

2.2 Commissioning Directorates continue to manage, and review reported risks at an operational level and refer extreme risks to the Corporate Governance Team (CGT) for scrutiny.

2.3 Following review by the CGT, the ORR and any emerging risks are reviewed by the SLT to ensure that the risks detailed within the ORR remain appropriate, and to consider whether emerging risks are suitable for addition to the ORR taking into consideration the potential impact of the risk on the NWJCC, the risk score and its description.

2.4 In addition to Sub-Committee scrutiny the NWJCC SLT reviewed the January and March ORR and emerging risks at its meetings of the 18 February 2026 and 22 April 2026. Within these reviews it was acknowledged that operational teams had taken steps to implement the JC's direction that risks should be described so that they set out the operational and system-based commissioning risks that the NWJCC is holding, rather than the operational provider risks to be held by Health Boards.

2.5 It is acknowledged that further improvement will continue to be targeted over the coming months as the new approach beds in and teams become more familiar with the style and expectations of the JC in the effective reporting and management of risk. Following feedback at QSOC and PPF, effort will be focussed on ensuring that risk controls and actions are appropriately defined and updated.

3. Key Risks / Matters for Escalation

3.1 NWJCC Risk Profile

As of 31 May 2026, there are **13** risks with a score of 15 and above (high risks) on the NWJCC Organisational Risk Register, see **Appendix 3**. A summary of these risks is outlined below.

3.2 For ease of reference, the text in red font are the updates provided for the month(s) of April and May 2026, since the last report was received. The text in white font, on the overarching NWJCC Risk Dashboard highlights those risks where there has been movement for the same period.

3.3 **Commissioning Risks -** There are **11** risks open with a risk score of 15 and above:

- Ambulance Services x 1 (new re-described risk)
- Cancer and Blood x 2
- Cardiac x 1
- Neurosciences x 5
- Welsh Kidney Network x 1
- Women and Children x 1

3.3 A summary of the changes that have taken place since the last report to the Committee are outlined below:

Table 1 – Commissioning Risk Profile – As of 31 May 2026

Commissioning Risk Activity	Movement to ORR between April and May 2026 (inc.)
New Commissioning Risks	One new risk has been added. • Risk 96 - Delivery and sustainability of safer, quality, valuable, integrated and more equitable Commissioning - Capacity - Emergency Ambulance Service (EMS) This new risk replaces Risk 78 (previously assigned to QSOC) which now better describes the impact to the JCC from a commissioner perspective and was considered by SLT on 17th June 2026 and subsequently agreed for

Commissioning Risk Activity	Movement to ORR between April and May 2026 (inc.)
	inclusion on the ORR. The new risk has been assigned to the PPF sub-committee for scrutiny and assurance as it largely relates to service delivery and commissioned capacity. During review at PPF Sub-Committee the risk description was challenged and the version shared with the JC, subsequently ARAC, reflects feedback shared to ensure that the risk accurately reflects the potential impact on patients.
Escalated Commissioning Risks	No risks have been escalated.
De-escalated Commissioning Risks	Two risks have been de-escalated: • Risk 77 - Commissioning of sufficient Emergency Ambulance Services capacity This risk has been reviewed as part of ongoing work to review Ambulance Service risks. Within this review a decision had been made to refresh and reword the risk description, and to reduce the rating from 15 to 12, leading to a de-escalation from the ORR. On review the consequence score has been reduced from 5 (Catastrophic) to 4 (Major) on the basis that with the improvements noted, it is unlikely there would be a rapid catastrophic manifestation. The likelihood score has also been reduced from 4 (likely) to 3 (possible). Similarly, the target score of 10 has been revised to 8 to reflect the above changes. The NWJCC Annual Plan 2026/27, Ambulance Services Strategic Review findings, coupled with a full understanding of the impact of the provider Phase 2 ambulance performance framework changes introduced in December 2025 will continue to inform further work in this area and specifically the re-assessment of demand and capacity requirements moving forward. Further progress on reduction of handover delays to 2018/19 commissioned levels also support a reduction in this risk. Additionally, handover has seen monthly improvements and based on an assumption of continuing improvements in this area, the rationale for the reduction in likelihood score is supported.

Commissioning Risk Activity	Movement to ORR between April and May 2026 (inc.)
	• Risk 91 - Hereditary Anaemias Service - Capacity in south Wales Following approval of funding in the 2026/27 Annual Plan, a business case has been requested from CVUHB which will ensure the sustainability of the service and meet the NWJCC service specification. A timeline for the receipt of the business case is awaited. The business case will be scrutinised by the Cancer and Blood commissioning team before approval for funding release to CVUHB is sought. The Cancer and Blood commissioning team has reviewed the risk and agreed that the commissioning risk has reduced due to a provision of funding being included in the Annual Plan.
New Emerging Commissioning Risks	Six new emerging risks have been highlighted. • Paediatric Neurology Service provision for South Wales (Women & Children) • Paediatric Radiology Service at CVUHB (Women & Children) • Failure of specialised Audiology service at CVUHB (Neurosciences) • Artificial Limb and Appliance Centre (ALAC) Electronic Assistive Technology Service Waiting Times at CVUHB (Neurosciences) • Single Handed Consultant -National Acute Porphyria Service at CVUHB (Neurosciences) • Single Handed Surgeon - Cerebrospinal Fluid Disorders at the Neurosurgery Service at CVUHB (Neurosciences) Following consideration of the above emerging risks at SLT on 17th June 2026, SLT have asked that these should be re-considered in accordance with the JCC scoring matrix. The SLT acknowledged that the escalation of these risks had been contributed to by funding decisions made within the annual plan and would need to be carefully monitored moving forward. Whilst these risks have not been added to the ORR, they will be managed through the Directorate Risk Register and re-escalated as necessary. As part of the review of these risks, consideration will be given to whether there is scope for these risks to continue to be managed locally and reflecting their cumulative risk to the NWJCC as a risk within the ORR, that ultimately aligns to the proposed fragile services strategic risk to be reported upon within the Joint Committee Assurance Framework.

Commissioning Risk Activity	Movement to ORR between April and May 2026 (inc.)
Closed Commissioning Risks	One risk has been closed. • Risk 78 - Utilisation of Emergency Ambulance Capacity Risk 78 predominantly mitigated the risk from a Provider perspective. A refreshed risk has been prepared that more appropriately describes and mitigates against the risk from a commissioner perspective. The new risk has been assigned to the PPF sub-committee for scrutiny and assurance as it largely relates to service delivery and commissioned capacity.

3.5 **Corporate/Organisational Risks –** There are here are **2** risks open with a risk score of 15 and above:

- Finance x 1
- Medical x 1

3.6 A summary of the changes that have taken place since the last report to the Committee are outlined below:

Table 2 – Corporate/Organisational Risk Profile – As of 31 May 2026

Corporate Risk Activity	Movement to ORR between April and May 2026 (inc.)
New Corporate Risks	No new risks have been added.
Escalated Corporate Risks	No risks have been escalated.
De-escalated Corporate Risks	No risks have been de-escalated.
Emerging Corporate Risks	No emerging risks were highlighted.
Closed Corporate Risks	No risks were closed.

4. Conclusion

4.1 The report provides an assurance that the NWJCC has appropriate risk management processes and procedures in place for the ongoing management of organisational risk.

5. Assessment

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Choose an item. Not Applicable

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals**	A Healthier Wales A more Equal Wales A Resilient Wales A Wales of Cohesive Communities

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Data to Knowledge Leadership Learning, Improvement and Research Whole Systems Perspective

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable

Asesiad Effaith **Impact Assessment**		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Summary of impact: Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Summary of impact:	If no, please select a reason below. Choose an item.

Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	The Risk Register is regularly reviewed and does not specifically deal with patient level information i.e. re protected characteristics although all services are required to comply with the Equality Act and Public Sector Equality Duty
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Senior Leadership Team	17/06/2026	Approved for Committee Approval 21/07/2026
Quality, Safety and Outcomes Sub-Committee	29/06/2026	Endorsed for Committee Approval on the 21/07/2026
Planning, Performance and Finance Sub-Committee	02/07/2026	Endorsed for Committee Approval on the 21/07/2026
NHS Wales Joint Commissioning Committee	21/07/2026	Approved on the 21/07/2026

Risk Dashboard (Risks Graded 15 and Above) - May 2026

LIKELIHOOD (L)	CxL	1 - Negligible	2 - Minor	3 - Moderate	4 - Major	5 - Catastrophic
		CONSEQUENCE (C)				
	1 – Highly Unlikely					
	2 – Unlikely					**91 Hereditary Anaemias service - capacity in south Wales - Risk DE-ESCALATED from 15 to 10 in May 2026**
	3 – Likely				**77 Commissioning of sufficient Emergency Ambulance Services capacity - Risk DE-ESCALATED from 15 to 12 in May 2026**	**80** JACIE accreditation - south Wales CAR T service **81** JACIE accreditation - south Wales BMT service
	4 – Highly Likely				**61** Obesity surgery at Salford Royal Hospital waiting times **65** Renal dialysis capacity across Wales **68** Specialist Auditory Implant Device Service' CVUHB - **82** Neuro-rehabilitation service at SBUHB **87** Commissioning of Acute Neurosurgery Therapy MDT at CVUHB **89** Paediatric Neurology Service provision for North Wales **95** Neuro-rehabilitation services at C&VUHB	**78 Utilisation of Emergency Ambulance capacity - Risk CLOSED in May 2026** **88** Commissioning of 24/7 South Wales Thrombectomy Service **96 - Delivery and sustainability of safer, quality, valuable, integrated and more equitable Commissioning - Capacity - Emergency Ambulance Service (EMS) - New Risk added May 2026**
	5 – Almost Certain			**84** Financial Break-even 2025/26	**94** High-cost medicines	

JCC RISK REGISTER - RISKS WITH SCORES >15

Risk Ref	Risk Title	Revised Risk Descriptor (by Commissioning Team)	Provider Risk Indicator	Provider Risk Indicator Link	Strategic Risk Owner	Commissioning Team/ Directorate	JCC Strategic Objective	NWJCC Risk Domain	Provider/s	Controls in place	Action Plan	Assuring Committees / Sub-Committees	Rating (current) (C x L)	Rating (Target) (C x L)	Trend	Risk Opened	Last Reviewed
													C L	C L			
61	**Obesity surgery for the population of North Wales**	**If...**the JCC is unable to secure an alternative provider for obesity surgery for the North Wales population **Then...**patients from Betsi Cadwaladr University Health Board (BCUHB) and North Powys will be unable to access the surgery they require, or the need to travel a distance to receive their surgery. This would lead to fragmented care and extended delays for BCUHB patients, worsening an already deteriorating waiting list position. **Resulting in...** • the potential for poorer population outcomes and inequity of service provision across Wales. • alternative service provision from another provider being at a potential increased financial cost to the JCC, and • the JCC being open to reputational risk and potential litigation			Director of Commissioning for Specialised Services	Cardiac	**Improve equity and population health:** ensure that people are able to access the right service when they need it whoever they are, wherever they live	Health Inequalities Strategic Commissioning Resources	BCUHB/Salford Royal Hospital	• Director oversight in place, action plan and task finish group established to manage the required change.	• The SBUHB proposal and costs have been agreed in principle by the Health Board Executives; the business case proposal was recommended for approval by the Health Board's Performance and Finance Committee on the 20 May. Formal sign off by the Health Boards Executive Board is expected week commencing 8 June. A number of meetings have already taken place with the WIMOS team, Northern Care Alliance (NCA), and Betsi Cadwaladr University Health Board to discuss and agree the process of moving patients. This process has included the communications required for patients and liaison with Llais, and this has included the development of a letter and a FAQ sheet for patients. • Continue process to identify a new provider for Obesity surgery for North Wales population. **Update May 2026 -** The risk score remains unchanged. A reduction in the score is contingent upon the approval (anticipated week commencing 8 June 2026) and implementation of the business case.	• Joint Commissioning Committee • Planning, Performance & Finance Sub-Committee • Senior Leadership Team • CTMUHB Audit & Risk Committee	16 4 4	4 4 1	⟷	des-23	mai-2026
65 WKN18	**Renal Dialysis Capacity across Wales**	**If...**the number of patients requiring dialysis continues to grow annually at a rate of 3-4% (or higher based on some projections) **Then...**the demand will exceed current commissioned capacity across Wales for both unit-based and home dialysis, and there will be delays or limits on the number of patients accessing home dialysis, as the growing demand exceeds the capacity of the nursing workforce to provide timely training and ongoing monitoring. **Resulting in...** • the need to commission additional capacity, at financial risk to the NWJCC, to avoid population harm • Increased pressure on the commissioned NEPTS service to transport a greater number of patients to and from dialysis session 3 times per week at a financial risk to the JCC			Director of Commissioning for Specialised Services	Welsh Kidney Network	**Ensure quality:** with a commissioning approach that is fostered in a quality management system, provide quality outcome, evidence based service specifications for commissioned services and monitor delivery against these	Strategic Commissioning Resource	BCUHB, CVUHB, SBUHB	• Value in Health Care funding secured to increase the number of transplant and home dialysis patients • Monitoring through provider WKN meetings through the WKN commissioning performance dashboard • Additional capacity provided in Welshpool and through the new Bridgend Dialysis Unit will be monitored through provider meetings • A focus on increasing home therapies and transplant will increase capacity in the units, although a percentage of patients will return to unit dialysis for respite or due to kidney transplant failure, which needs to be accounted for when assessing capacity pressures • The following strategic Prevention workstreams are expected to have a medium/long term effect, led by the WKN Clincial Prevention Lead: - All Wales Community Healthcare Pathway for referrals for Chonric Kidney Disease have been agreed and introduced into Primary Care - Regional actions plans have been developed and introduced for increasing patient numbers for home dialysis and transplantation, monitored through the WKN Regional performance meetings • National Primary Care CKD optimisation project approved as a mandatory component of the new GMS contract for all GP practices in Wales £4.5m budget. Educational webinar to completed to supported by regional workshops and implementation. Target metrics have been developed by DHCW and EMIS searches • CKD e-learning module for primary care focusing on prevention, screening and optimisation for early CKD - CPD-approved is now live, awaiting a report on the level of uptake by cluster areas	Prevention workstream medium/long term effect: • Community Cardiorenal clinic pilot being developed in SBUHB - start date to be confirmed Commissioned services: • A focus on increasing home therapies and transplant will increase capacity in the units, although a percentage of patients will return to unit dialysis for respite or due to kidney transplant failure, which needs to be accounted for when assessing capacity pressures • Commission a distinct piece of work on Demand and Capacity Modelling, The HEOR presentation was provided to WKN Network Board meeting 24/09/25 on the demand, Further workshops to be held with the regional providers (x3) to go through the regional detail - This session took place on 10th December 2025 with further refinement required by end of January 2026 • Full workforce analysis with Regions and bench marking to quantify the various staffing costs per session by Quarter 4 2025/26 This action will now be picked up in the WKN Deep Dive review in 2026/27. • Monitor the variation between the 1.77% uplift applied as part of the IMTP Foundation plan and the projected 3.7% growth for dialysis across Wales - Qtr 4 2025/26 • Development of action plans for increasing capacity to include opening of Twilight • Risk will form part of the IMTP plan for 2026/2027 • Deep dive review to include projecting the inflationary costs requirement and projected growth for 2026/27 • Development of a report with recommendations and next steps to deliver system value and improve efficiency and sustainability **Update for May 2026 -** Risk reviewed and risk remains unchanged, awaiting Care Closer to Home submissions from Regions for NWJCC Foundation plan funding allocation.	• Joint Commissioning Committee • Welsh Kidney Network Board • Quality & Patient Safety Sub-Committee • Senior Leadership Team • CTMUHB Audit & Risk Committee	16 4 4	8 4 2	⟷	jan-24	mai-2026
68 NCC064	**Specialist Auditory Implant Device Service' CVUHB**	**If...**CVUHB South Wales Specialist Auditory Implant Device Service continues to experience staffing shortages, high sickness absence, poor staff morale and ongoing funding pressures within the specialist Audiology, while the service remains at escalation level 3 **Then...**South Wales patients requiring a Cochlear Implant or Bone Conduction Hearing Implant (BCHI) will be unable to access the Specialist Service within the national standard waiting times target, with the potential for poorer population outcomes and inequity of service provision between the South and North Wales service **Resulting in...**the potential need to seek an alternative provider at an increased financial cost and reputational impact to the NWJCC			Director of Commissioning for Specialised Services	Neurosciences	**Improve equity and population health:** ensure that people are able to access the right service when they need it whoever they are, wherever they live	Strategic Commissioning Resources Reputation	CAVUHB	• The service is at Level 3 of the NWJCC Escalation Framework wef October 2025	• As a result of lack of progress in improving performance and meeting waiting time targets, the service was put into level 3 of the NWJCC Escalation Framework in October 2025. • Following escalation meetings to date, some assurance has been provided in terms of improving waiting times with a target of 52 weeks to be met by March 2026. • Contract re baselining discussions have begun to ensure sustainable and efficient resource allocation to deliver activity levels to agreed quality standards. • A number of quality related issues raised and staff wellbeing concerns. Due to the impact on the quality of service delivery this risk was re-escalated in January 2026. The next executive level escalation meeting was scheduled for late April 2026. There will be a focused discussion to address accurate baselining of the contract, to ensure delivery against ontracted quality and activity, and adequate staffing is in place. This will aim to fully support performance and quality whilst meeting and sustaining waiting time targets. **Update for May 2026 -** the risk has been reviewed, the impact on staff has been noted and the additional operational manager the HB have put in place to mitigate the risk; the scoring remains the same.	• Joint Commissioning Committee • Planning, Performance and Finance Sub-Committee • Senior Leadership Team • CTMUHB Audit & Risk Committee	16 4 4	8 4 2	⟷	mar-25	mai-2026
80 CB12	**JACIE certification south Wales CAR T service**	**If...**CVUHB does not achieve JACIE certification for its CAR-T service due to facilities not meeting standards **Then...**pharmaceutical companies will withdraw their approvals for CVUHB to administer their products and there will be no CAR-T service in Wales for the NWJCC to commission leading to: • patients having to travel further for treatment at a certified centre; • an increased risk of patients not receiving treatment in a timely manner • risk of poorer patient outcomes and adverse impact on patient and family experience **Resulting in...** significant increase in costs to the JCC and NHS Wales due to commissioning additional services in England and an inability to deliver against the strategic intention of ATMP delivery in Wales therefore damaging the reputation of the JCC and NHS Wales	Bone Marrow Transplant/2 010-1102	https://cavuhb.nhs.wales/files/board-and-committees/board-2025-26/2025-11-27-board-papers-bundle-pdf/ Page 360 and 361	Director of Commissioning for Specialised Services	Cancer & Blood	**Ensure quality:** with a commissioning approach that is fostered in a quality management system, provide quality outcome, evidence based service specifications for commissioned services and monitor delivery against these	Strategic Commissioning Resources Reputation	CVUHB	• The NWJCC continues to work with providers to ensure that services are being delivered to previously agreed service specifications, or where this is not possible that assurance is provided that appropriate mitigations are in place, including stringent infection control measures	• In conjunction with the provider, to advise Welsh Government on the implications for the service and patients if JACIE certification is not achieved. • Continue to meet with the service on a regular basis to monitor progress - next meeting 5th June 2026 **Update for May 2026 -** JACIE report received by CVUHB on 8th January deferring their final decision with regards to recertification pending CVUHB's submission of their corrective actions by 8th July. It is noted that there is acceptance that deficiencies requiring longer-term solutions (such as construction) are not expected to be complete by the deadline, they expect the plans for such corrections to be included with the response with as much detail as possible. An action list has been drawn up by the service in order to provide a response to JACIE by the deadline. CVUHB expects to have complied with all the standards which do not require further investment. Submission of a proposal to address areas highlighted by JACIE report as requiring staff is expected from the health board. The Cancer & Blood commissioning team has reviewed the score using the JCC domains and risk scoring matrix and the scoring remains unchanged.	• Joint Commissioning Committee • Quality, Safety & Outcomes Sub-Committee • Senior Leadership Team • CTMUHB Audit & Risk Committee	15 5 3	5 5 1	⟷	mai-25	mai-2026
81 CB13	**JACIE certification - south Wales BMT service**	**If**... CVUHB does not achieve JACIE certification for its BMT service due to facilities not meeting standards **Then**...a commissioning decision will need to be made by NWJCC to either commission from a non-certified centre (CVUHB) or from certified centres in NHS England meaning that: • either patients will receive treatment from a centre which does not meet national standards or the NWJCC service specification, or • there is an increased risk of patients not receiving treatment in a timely manner leading to poorer patient outcomes and experience due to complex pathways with multiple providers requiring significant coordination and administration **Resulting in**... If continuing to commission from CVUHB: Patients receiving treatment from a centre which is deemed not to reach national standards or the NWJCC service specification. If outsourcing: significant increase in costs and administration to the JCC and NHS Wales due to commissioning additional services in England	Bone Marrow Transplant/2 025-2601	https://cavuhb.nhs.wales/files/board-and-committees/board-2025-26/2025-11-27-board-papers-bundle-pdf/ Page 360 and 361	Director of Commissioning for Specialised Services	Cancer & Blood	**Ensure quality:** with a commissioning approach that is fostered in a quality management system, provide quality outcome, evidence based service specifications for commissioned services and monitor delivery against these	Strategic Commissioning Resources Legal	CVUHB	• The NWJCC continues to work with providers to ensure that services are being delivered to previously agreed service specifications, or where this is not possible that assurance is provided that appropriate mitigations are in place, including stringent infection control measures	• In conjunction with the provider, to advise Welsh Government on the implications for the service and patients if JACIE certification is not achieved. • Continue to meet with the service on a regular basis to monitor progress - next meeting 5th June 2026 **Update for May 2026 -** JACIE report received by CVUHB on 8th January deferring their final decision with regards to recertification pending CVUHB's submission of their corrective actions by 8th July. It is noted that there is acceptance that deficiencies requiring longer-term solutions (such as construction) are not expected to be complete by the deadline, they expect the plans for such corrections to be included with the response with as much detail as possible. An action list has been drawn up by the service in order to provide a response to JACIE by the deadline. CVUHB expects to have complied with all the standards which do not require further investment. Submission of a proposal to address areas highlighted by JACIE report as requiring staff is expected from the health board. The Cancer & Blood commissioning team has reviewed the score using the JCC domains and risk scoring matrix and the scoring remains unchanged.	• Joint Commissioning Committee • Quality, Safety & Outcomes Sub-Committee • Senior Leadership Team • CTMUHB Audit & Risk Committee	15 5 3	5 5 1	⟷	mai-25	mai-2026

Risk Dashboard (Risks Graded 15 and Above) - May 2026

Risk Ref	Risk Title	Revised Risk Descriptor (by Commissioning Team)	Provider Risk Indicator	Provider Risk Indicator Link	Strategic Risk Owner	Commissioning Team/ Directorate	JCC Strategic Objective	NWJCC Risk Domain	Provider/s	Controls in place	Action Plan	Assuring Committees / Sub-Committees	Rating (current) (C x L)	Rating (Target) (C x L)	Trend	Risk Opened	Last Reviewed
82 NCC057	**Neuro-rehabilitation service at SBUHB**	**If...**the NWJCC is unable to support the investment required to recruit to the multi-disciplinary staffing establishment at the SBUHB Inpatient Neuro-rehabilitation Unit to meet the minimum BSPRM standards **Then...**specialist neuro-rehabilitation at the Unit will be compromised or lost **Resulting in...** • the potential for poorer population outcomes for South West Wales • inequity of service provision • and the JCC being open to reputational risk and potential judicial review of decisions linked to service investment • placing the service into escalation and the potential need to seek an alternative provider at an increased financial cost			Director of Commissioning for Specialised Services	Neurosciences	**Improve equity and population health:** ensure that people are able to access the right service when they need it whoever they are, wherever they live	Strategic Commissioning Resources Reputation	SBUHB	• Recommendations to mitigate the current risks and medium to longer term staffing requirements by recruiting and maintaining a well-resourced and competent multidisciplinary team. • SBUHB have reduced the number of Neuro-rehabilitation inpatient beds from 14 to 10 beds in the short term whilst recruitment gaps are resolved. • Information re: delayed admissions/discharges shared with the JCC • Half yearly Performance meetings with the service in place.	• JCC drafted a specialised rehabilitation strategy, the unit is to be included in this project. The strategy has been paused for review in 25/26. • A performance meeting with the NPT Rehabilitation Service was held on the 22nd of September 25 and quarterly meetings with the NWJCC and NPT Rehabilitation Service have been arranged, these meetings continue to monitor the position. **Update for May 2026** - this risk has been reviewed and no change to the scoring in this reporting period.	• Joint Commissioning Committee • Quality, Safety & Outcomes Sub-Committee • Senior Leadership Team • CTMUHB Audit & Risk Committee	16 4 4	8 4 2	⟷	apr-25	mai-2026
84	**Financial break-even 2026/27**	**If...**the NWJCC overspends against the agreed Annual Plan 2026/27 **Then...**the Health Boards will have to include the relevant amounts in their own financial reporting **Resulting in...**unexpected overspends/restriction of JCC/HB services to patients/breaching HB statutory financial requirements. If this happens there is a risk that the JCC financial position will have a detrimental impact on individual Health Board financial positions leading to potential reputational damage to the JCC			Director of Finance & Value	Finance & Value	**Maximise Value:** through our expertise and advice, determine where resources are best focussed and prioritised to inform choices that support the improvement of patient outcomes and commission appropriate services where value is demonstrated	Strategic Commissioning Resources	N/A	• Financial performance monitored and reported to LHBs on a monthly basis providing key variance analysis in a timely manner to allow LHBS to make their own financial provisions or to take mediating actions to manage their demand. • Business partner arrangements with monthly directorate team meetings • Internal budget management regime updated in tandem with the scheme of delegation. • Bi-monthly CCLG and collaborative commissioning group meetings. • Bi-monthly Joint Committee meetings to discuss key variances from plan, formulate plans to manage demand where possible and to provide LHBS with sufficient information and financial forecasts to be able to make their own financial provisions in advance.	• Continuation of discussion with Welsh Government and Health Boards • SLT prioritising the work plan aligned to the risk based foundational plan and strategic priorities. **Update for May 2026** - Continued monitoring of strategic sustainability and efficiency to ensure a break even position, with a view to go further and reduce commissioner contributions. Currently the NWJCC is in dispute with C&VUHB in respect of their provider LTA which is currently in the arbitration process with Welsh Government. At month 2 there does not appear to be any financial risk to break even, except in the instance of arbitration being found against the NWJCC.	• Joint Commissioning Committee • Planning, Performance & Finance Sub-Committee • Senior Leadership Team • CTMUHB Audit & Risk Committee	15 3 5	9 3 3	⟷	apr-25	mai-2026
87 NCC059	**Commissioning of Acute Neurosurgery Therapy MDT at CVUHB**	**If...**the NWJCC is unable to provide funding to address the insufficient commissioned establishment for the Neurosurgery Therapy MDT at Cardiff & Vale University Health Board **Then...**there is a risk of delay to acute therapy service provision for patients on the acute neurosurgery pathway, the potential for poorer population outcomes for South Wales and inequity of service provision compared to North Wales **Resulting in...** The JCC being open to reputational risk and potential judicial review of decisions linked to service investment			Director of Commissioning for Specialised Services	Neurosciences	**Improve equity and population health:** ensure that people are able to access the right service when they need it whoever they are, wherever they live	Health Inequalities Resources Reputation	CVUHB	• Continue to monitor the position at the quarterly Neurosciences Performance Meeting. • Acute Neurosurgery therapies was approved in the ICP 24/25.	• Commissioning team to clarify if the funding release can proceed in 25/26 which will be dependent on the ICP for 26/27. **Update for May 2026** - the risk has been reviewed and the scoring remains the same	• Joint Commissioning Committee • Planning, Performance & Finance Sub-Committee • Senior Leadership Team • CTMUHB Audit & Risk Committee	16 4 4	8 4 2	⟷	jul-25	mai-2026
88	**Commissioning of 24/7 South Wales Thrombectomy Service**	**If...**the JCC is unable to commission a 24/7 mechanical thrombectomy service on behalf of South Wales Health Board's and their populations **Then...**there is a risk of continued inequity of access to services between patients in South Wales and South Powys, compared to those in North East Wales and North Powys who have access to a 24/7 Mechanical Thrombectomy Service and the potential for poorer population outcomes in South Wales and South Powys **Resulting in...** • the JCC being open to significant reputational risk and potential judicial review of decisions linked to service provision	No risk for Thrombectomy on CVUHB Risk Register or BAF - From the provider's perspective, it delivers to its current contract.	N/A	Director of Commissioning for Specialised Services	Neurosciences	**Improve equity and population health:** ensure that people are able to access the right service when they need it whoever they are, wherever they live	Health Inequalities Legal Reputation	CVUHB	• Four phase investment plan for the provision of a 24/7 service in place with CVUHB. Business case received from CVUHB 4 phase plan to provision of 24/7 service. • Ongoing discussions with North Bristol Hospital Trust (NBHT) being held regarding service provision.	• JCC were awaiting a business case from CAVUHB by end of September 2025. CVUHB advised that they were not in a position to submit a revised business case to expedite the 4 phase plan (agreed with Joint Committee in 2024) to mitigate the risk of lack of 24/7 access. The NWJCC continue to discuss the 24/7 service provision with North Bristol Hospital Trust • JCC to continue to meet Cardiff service regularly as required (currently fortnightly) to monitor activity. • A deep dive into Mechanical Thrombectomy provision has been included as a strategic priority for 26/27 and aims to conclude by Q3 to update a way forward for this service and addresing this risk in the long term. **Update for May 2026 -** the risk has been reviewed and the scoring remains the same	• Joint Commissioning Committee • Quality, Safety & Outcomes Sub-Committee • Senior Leadership Team • CTMUHB Audit & Risk Committee	20 4 5	8 4 2	⟷	jul-25	mai-2026
89 P/21/28	**Paediatric Neurology Service provision for North Wales**	**If...**neurology services in Alder Hey NHSE remain under resourced **Then...**North Wales paediatric patients will not have access to the full range of specialised Paediatric neurology services with the potential for poorer population outcomes in North and inequity of access between North Wales and South Wales **Resulting in...** • the JCC being open to significant reputational risk and potential judicial review of decisions linked to service provision • the need to re-commission Paediatric Neurology services for North Wales at a potential financial consequence to the JCC			Director of Commissioning for Specialised Services	Women & Children	**Improve equity and population health:** ensure that people are able to access the right service when they need it whoever they are, wherever they live	Health Inequalities Strategic Commissioning Resource Reputation	Alder Hey	• Continue regular SLA perfomance meetings with Alder Hey to discuss JCC commissioned services.	• The next SLA meeting, scheduled for the 19th March 2026, will discuss the continued reduced service due to work force constraints. Members of the commissioning team will be attending in person and confirmation of consultation start date, full service capacity and plan to mitigate any backlog caused from lack of resource. **Update for May 2026 -** Paediatric Neurology was discussed in the Alder Hey SLA meeting on the 19th March. The Alder Hey team have recruited and have a member of the team on a phased return. They were reviewing job plans therefore the service is still limited but are hoping to be able to deliver a comprehensive service in the future. Meeting held on the 27th May between Alder Hey and BCUHB, with JCC in attendance. Alder Hey confirmed that they will be commencing tertiary paediatric neurology via a MDT for the population of North Wales. They have agreed the lead consultants who will cover the 3 main hospitals. Discussions are ongoing but they hope to commence the MDT sessions as soon as final arrangements have been agreed. The risk score will be reviewed when Aldr Hey has committed to a start date, until that time the risk score remains unchanged.	• Joint Commissioning Committee • Quality, Safety & Outcomes Sub-Committee • Senior Leadership Team • CTMUHB Audit & Risk Committee	16 4 4	8 4 2	⟷	jul-25	mai-26
94	**High-Cost Medicines**	**If...**Medicine costs increase by a predicted 30% plus inflation due to geo-political pressures and inflation **Then...**the JCC's expenditure could increase by circa £39m **Resulting in...**significant financial pressures for the organisation which will impact on our ability to achieve financial targets and/or savings. Additionally this will impact on our ability to deliver our Foundational Plan or future IMTP plans			Medical Director	Medical Directorate	**Maximise value –** through our expertise and advice, determine where resources are best focussed and prioritised to inform choices that support the improvement of patient outcomes and commission appropriate services where value is demonstrated	Resources	ALL	• Whilst we do not have any control over the organisations responsible for this risk, financial mitigations could be put in place within our commissioning plans for the future.	• Make representations and lobby key stakeholders - ABPI, Welsh Government • Review all medicines commissioned to ensure they all remain appropriate for JCC commissioning **Update for May 2026 -** The Medical team has reviewed the risk using the JCC domains and risk scoring matrix and the risk remains unchanged	• Joint Commissioning Committee • Planning, Performance & Finance Sub-Committee • Senior Leadership Team • CTMUHB Audit & Risk Committee	15 3 5	9 3 3	⟷	nov-25	mai-2026
95	**Neuro-rehabilitation services at C&VUHB**	**If...**The JCC does not provide funding to increase the commissioned establishment to meet the minimum BSPRM standards **Then...**The service will not have the staffing levels required to respond to the patient needs (complexity) that change over time meaning potentially poorer outcomes for the patient population **Resulting in...** • CVUHB being unable to take patients with more complex needs or admit new patients in line with demand thereby not fulfilling their contractual obligations • Financial implications for both the JCC and CVUHB and the need to consider the re-commissioning of services (bed closures)			Director of Specialised Services	Neurosciences	**Maximise value –** through our expertise and advice, determine where resources are best focussed and prioritised to inform choices that support the improvement of patient outcomes and commission appropriate services where value is demonstrated	Strategic Commissioning Resources	CAVUHB	• CVUHB have successfully recruited to the commissoned staffing establishment, however still remain below the minimum standards for the British Society Physical Rehabilitation Medicine. • JCC receiving and monitoring performance and repatriation delay information • Performance reporting and oversight via Risk Assurance and Recovery meetings, SLA meetings and to Management Group and JCC	• JCC to continue meeting quarterly with the C&VUHB team to understand the risks • The concerns raised by the Rehabilitation team will be addressed in the Rehabilitation Strategy which is currently paused for review in 25/26. **Update for May 2026** - the risk has been reviewed and the scoring remains the same	• Joint Commissioning Committee • Quality, Safety & Outcomes Sub-Committee • Senior Leadership Team • CTMUHB Audit & Risk Committee	16 4 4	8 4 2	⟷	jan-26	mai-2026

Risk Ref	Risk Title	Revised Risk Descriptor (by Commissioning Team)	Provider Risk Indicator	Provider Risk Indicator Link	Strategic Risk Owner	Commissioning Team/ Directorate	JCC Strategic Objective	NWJCC Risk Domain	Provider/s	Controls in place	Action Plan	Assuring Committees / Sub-Committees	Rating (current) (C x L)	Rating (Target) (C x L)	Trend	Risk Opened	Last Reviewed
96 (Replaces Risk 78)	**Delivery and sustainability of safer, quality, valuable, integrated and more equitable Commissioning - Capacity - Emergency Ambulance Service (EMS)**	**If...** the NWJCC provider, WAST (Welsh Ambulance Services University NHS Trust), is unable to utilise the Emergency Ambulance Service capacity planned for, secured and commissioned by the NWJCC (based on system assumptions (e.g. demand, alternative and community pathways, handover delays) due to Provider and/or NHS Wales system-wide inefficiencies **Then...** Health boards populations will not receive the pre-hospital emergency care they require leading to **Resulting in..** patient harm and deteriorating patient experience and the NWJCC being exposed to reputational harm and potential financial consequences attributed to commissioning mitigations to improve the utilisation of Emergency Ambulance Service capacity, it being acknowledged that, in the prevailing operational circumstances, the commissioning of additional capacity alone will not mitigate current inefficiencies.	WAST Risk 223 QUEST *Trust inability to reach Patients in the Community. Causing patient harm and death.*	https://ambulance.nhs.wales/files/trust-board-papers/papers-27-november-2025/ Agenda Item 10	Director of Commissioning for Ambulance Services and National Programmes	Ambulance Services and National Programmes	**Facilitate Integration:** through effective engagement and collaboration, provide the key mechanism to support regional and national integration for commissioning services for the people of Wales	Strategic Commissioning Health Outcomes Resources Reputation	WAST NEPTS NHS 111 WALES EMRTS	• NWJCC EAS (WAST) commissioning forum • JCC system/health boards touchpoints (plan to be instated) • Strategic review on Ambulances (provider) • NWJCC annual plan - planning / forecasting current and future demand (increase/decreases) • Commissioning Intentions 26/27 specific to the provider to deliver against non-cash releasing productivity gains (2%) • Joint demand & capacity reviews • NWJCC strategic review, and a more evidenced based Commissioning approach (framework) • Regularly reviewed performance, and in collaboration with HB's • NWJCC continued conversations with Committee - Ongoing (Joint agreed acceptance of tolerance for commissioning of current 6.000 hours or when required JCC to provide options) • Monitoring for Assurances; WAST IMTP service improvement delivery 2026/2027-29 - Ongoing e.g. WAST culture change programme, areas outlined inc. Workforce; sickness absence challenges and monitoring provider service improvements e.g. meal breaks	• Forecasting population for Commissioning (deprivation metrics) - Q3 2026 • JCC Assurance - Regular (weekly) monitoring of utilisation, UHP and performance reporting inc % provision - Ongoing • Agree Provider targets (notification if exceeds threshold for escalating) - Q2 2026 **Update for May 2026** - This new risk replaces Risk 78 (previously assigned to QSOC) which now better describes the impact to the JCC from a commissioner perspective and was considered by SLT on 17th June 2026 and subsequently agreed for inclusion on the ORR. The new risk has been assigned to the PPF sub-committee for scrutiny and assurance as it largely relates to service delivery and commissioned capacity.	• Joint Commissioning Committee NWJCC • Planning, Performance & Finance Sub-Committee PPF • Senior Leadership Team SLT • CTMUHB Audit & Risk Committee ARAC	**20** **5** **4**	**10** **5** **2**	New Risk Added May 2026	mai-26	mai-2026

JCC RISK REGISTER FOR DE-ESCALATED RISKS >15

Risk ID	Risk Title	Risk Description	Strategic Risk owner	Strategic Objective	NWJCC Risk Domain	Controls in place	Action Plan	Assuring Committees	Rating (Current)	Rating (Target)	Month De-escalated	De-escalation Rationale
91 CB15	**Hereditary Anaemias Service - Capacity in south Wales**	**If...** commissioned capacity in the south Wales hereditary anaemias service is not increased in order to meet increasing demand (doubling of patient population in last 5 years) **Then...**patients may not be seen in a timely way or in accordance with the quality standards of the service specification with the potential for poorer patient outcomes and experience and an adverse impact on the wellbeing of staff in the service including: • delays in access to timely clinic review • inability to provide timely review of emergency admissions • lack of capacity to deliver timely access to red cell exchange transfusions • lack of medical cover particularly in the adult service (dependence on a single consultant) • delays in access to psychology support • lack of social work support placing pressure on and diverting the work of CNSs • lack of capacity to deliver specialist obstetric support for a growing number of pregancies affected by haemoglobinopathies **Resulting in...**An NWJCC commissioned service that is not sustainable, resilient, safe or of high quality and the NWJCC being open to reputational risk and potential judicial review of decisions linked to service investment.	Director of Commissioning for Specialised Services	**Ensure quality:** with a commissioning approach that is fostered in a quality management system, provide quality outcome, evidence based service specifications for commissioned services and monitor delivery against these	Strategic Commissioning Resources Legal	• The NWJCC continues to work with providers to ensure that services are being delivered to previously agreed service specifications, or where this is not possible that assurance is provided that appropriate mitigations are in place, including clinical prioritisation plans and workforce planning to maximise the level of service provided.	• Obtain more detail from the service in CVUHB on what would be required for a more sustainable service. In progress. • Seek to understand increase in demand in more depth by asking Liverpool service if they have seen a similar trend. In progress. • Propose as a "Must do" in the 2026-29 IMTP Planning Process - ~~awaiting outcome~~ COMPLETE. Funding approved within the Annual Plan. • Request business case to address service sustainability. COMPLETE	• Joint Commissioning Committee • Quality, Safety & Outcomes Sub-Committee • Senior Leadership Team • CTMUHB Audit & Risk Committee	**10 (C5 x L2)**	**10 (C5 x L2)**	mai-26	Following approval of funding in the 2026/27 Annual Plan, a business case has been requested from CVUHB which will ensure the sustainability of the service and meet the NWJCC service specification. A timeline for the receipt of the business case is awaited. The business case will be scrutinised by the Cancer & Blood commissioning team before approval for funding release to CVUHB is sought. The Cancer & Blood commissioning team has reviewed the risk and agreed that the commissioning risk has reduced due to a provision of funding being included in the Annual Plan.
77	**Commissioning of sufficient Emergency Ambulance Services capacity**	**If...** NWJCC provider, WAST (Welsh Ambulance Services University NHS Trust) and the wider NHS system is able to eradicate, or significantly reduce emergency medical ambulance service inefficiencies and the capacity planned for, secured and commissioned by the NWJCC, based on system assumptions, becomes insufficient **Then...** the capacity will not be sufficient to meet the pre-hospital emergency care needs of the population leading to patient harm and deteriorating patient experience **Resulting in...**the JCC being exposed to significant reputational and financial risk due to the need to commission additional capacity.	Director of Commissioning for Ambulance Services and National Programmes	**Facilitate Integration:** through effective engagement and collaboration, provide the key mechanism to support regional and national integration for commissioning services for the people of Wales	Strategic Commissioning Resource Reputation	•The NWJCC have commissioned ambulance services capacity in-line with the 2019 ambulance services demand and capacity review. In addition to the 2019 demand and capacity review, the NWJCC and Welsh Government have commissioned additional ambulance service capacity, to respond to the changing demands for ambulance services. •Historical establishment of the clinically led National Improvement Delivery Group (1st July 2025) to reduce ambulance handover delays of which the JCC was an active participant • Investment in additional ambulance service capacity by pass through of previous 2024/25 uplift •NWJCC Strategic Review currently taking place •Plan for Forecasting and Modelling with a focus on Population Health need and deprivation (Health Board level)	• Assurance from the ambulance commissioning framework evaluation • Investment in additional ambulance service capacity by pass through of previous 2024/25 uplift • Completion of Demand and Capacity reviews - findings considered as part of 2026/27 IMTP plan development • Assessment of implications of Manchester Arena Inquiry submission by the ambulance service undertaken • Continued monitoring of performance for Commissioning Assurance, against the Number of lost hours due to handover delays (this has historically reduced and seen an improving trend.	• Joint Commissioning Committee • Planning, Performance & Finance Sub-Committee • Senior Leadership Team • CTMUHB Audit & Risk Committee	**12 (C4 x L3)**	**8 (C4 x L2)**	mai-26	This risk has been reviewed as part of ongoing work to review Ambulance Service risks. Within this review a decision had been made to refresh and reword the risk description, and to reduce the rating from 15 to 12, leading to a de-escalation from the ORR. On review the consequence score has been reduced from 5 (Catastrophic) to 4 (Major) on the basis that with the improvements noted, it is unlikely there would be a rapid catastrophic manifestation. The likelihood score has also been reduced from 4 (likely) to 3 (possible). Similarly, the target score of 10 has been revised to 8 to reflect the above change. The NWJCC Annual Plan 2026/27, Ambulance Services Strategic Rreview findings, coupled with a full understanding of the impact of the provider Phase 2 ambulance performance framework changes introduced in December 2025, will continue to inform further work in this area and specifically the re-assessment of demand and capacity requirements moving forward. Further progress on reduction of handover delays to 2018/19 commissioned levels also support a reduction in this risk. Additionally, handover has seen monthly improvements, and based on an assumption of continuing improvements in this area, the rationale for the reduction in likelihood score is supported.

JCC RISK REGISTER FOR CLOSED RISKS >15

Risk ID	Risk Title	Risk Description	Strategic Risk Owner	Strategic Objective	Risk Domain	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
78	**Utilisation of Emergency Ambulance Capacity**	**If...**the capacity commissioned by the NWJCC is not utilised for its intended purpose **Then...**Health boards and their populations will not receive the services they require **Resulting in...**patients not receiving a timely emergency ambulance response, increasing the risk of harm, disability and death	Director of Commissioning for Ambulance Services and 111	**Ensure quality:** with a commissioning approach that is fostered in a quality management system, provide quality outcome, evidence based service specifications for commissioned services and monitor delivery against these	Safety & Well-being - Patients/ Staff/ Public Quality/ Complaints/ Assurance/ Patient Outcomes	• Implementation of Welsh Government ambulance handover targets for health boards • NWJCC collaborative working with health boards and WAST to reduce conveyance to Emergency Departments • Establishment of the clinically led National Improvement Delivery Group on 1st July 2025 to reduce ambulance handover delays of which the JCC is an active participant	• The Ministerial Advisory Group report into NHS Wales Performance and Productivity (Recommendation 13) recommends Urgent action should be taken to reduce ambulance handover delays at emergency departments by implementing a national improvement programme, supported by real-time data, operational standards, and accountability mechanisms. JCC are working collaboratively to support implementation of this recommendation and support a weekly operational discussion regarding national ambulance handover performance with Welsh Government and NHS Wales Performance & Improvement including taking a lead on the development of a performance dashboard. • Increase the number of patients managed at Step 2 of the ambulance commissioning framework • Investment in additional ambulance service capacity by pass-through uplift • Developing of productivity improvement plan aligned to the 5 step ambulance pathway - maximising efficiency of commissioned capacity early 2026 • Introduction of rapid clinical screening from December 2024, to clinically optimise dispatch decisions • Phased introduction of Remote Integrated Care Service (RICS) in Q4, providing consistency for 111 and 999 to remotely clinically assess patients via a single point and appropriately refer patients to a direct pathway (where available). This ensures ensuring patients can access the right response first time. • Accelerated design events planned took place during August/September 2025 to improve handover delays further.	• Joint Commissioning Committee • Quality, Safety & Outcomes Sub-Committee • Senior Leadership Team • CTMUHB Audit & Risk Committee	mai-26	Risk 78 has been held previously and predominantly mitigates the risk from a Provider perspective and a refreshed risk has been prepared that more appropriately describes and mitigates against the risk from a commissioner perspective. The new risk will be held and managed by the directorate going forward, reflecting the impact to the NWJCC.

NWJCC Risk Domains

Risk Domains	1. Negligible (1-3) Negligible impact on objective/s. Day to day operational challenges.	2. Minor (4-6) Minor impact on objective/s. Temporary restriction to business delivery with limited impact on stakeholder confidence.	3. Moderate (8-12) Moderate impact on objective/s. Short term failure to deliver key objectives with temporary adverse local publicity.	4. Major (15-20) Major impact on objective/s. Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on stakeholder confidence.	5. Catastrophic (25) Catastrophic impact on objective/s. Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence.
Health Inequalities Risks that may result in unfair or unavoidable differences in health across different groups within society	• Negligible risk to communities, with limited impact on health inequalities or disparities	• Minor risk which may lead to noticeable effects on certain populations, leading to minor disparities in access to healthcare services or health outcomes across different groups within society	• Moderate risk which may significantly affect certain populations, resulting in substantial disparities in health status, access to care, or health related quality of life among affected groups	• Major risk which may have a profound impact on certain populations, exacerbating disparities in morbidity, mortality, and overall well-being, with far reaching consequences for affected communities	• Catastrophic threats to certain populations, leading to widespread and severe health crises, overwhelming healthcare systems, and causing significant loss of life and societal disruption
Health Outcomes Risks that may result in poor or worsening health outcomes for individuals or populations	• Health outcomes for certain populations are negligible, with only immaterial variations to care or health status observed	• Minor risk which may lead to noticeable effects on health outcomes, leading to minor disparities in disease management, treatment outcomes, or overall well-being	• Moderate risk which may lead to significant impacts to health outcomes, resulting in disease progression, functional impairment, and health-related quality of life	• Major risk which may lead to profound impact on health outcomes, exacerbating disparities in morbidity, mortality, and life expectancy, with significant implications for health trajectories and long term prognoses	• Catastrophic threats to health outcomes, leading to severe and potentially life-threatening consequences, overwhelming the ability of certain populations to cope, and causing significant harm to their physical and mental well-being
Legal Risks that may result in successful legal challenge and/or non-compliance with regulatory requirements. May include, but not limited to, risks linked to statutory duties, inspections, information governance, data management, general governance / probity, compliance and safeguarding	• No impact or negligible impact or breach of guidance / statutory duty	• Breach of statutory legislation • Reduced performance rating if unresolved	• Single breach in statutory duty • Challenging external recommendations / improvement notice	• Enforcement action • Multiple breaches in statutory duty • Improvement notice • Low performance rating • Critical report	• Multiple breaches in statutory duty • Prosecution • Complete systems change required • Zero performance rating • Severely critical report
People Risks that may result in damage to staff morale, wellbeing and/or adversely impact workforce collaboration and integration. May include, but not limited to, risks linked to human resource issues, organisational development, skills mix and staff experience	• Short-term low staffing level that temporarily reduces business quality and delivery (<1 day)	• Low staffing level that reduces business qualiyt and delivery	• Late delivery of key objective / business due to lack of staff • Unsafe capacity or competency levels (>1 day) • Low staff morale • Poor staff attendance for mandatory training	• Uncertain delivery of key objective / business due to lack of staff • Unsafe capacity or competency levels (>5 days) • Loss of key staff • Very low staff morale • No staff attending mandatory training	• Non-delivery of key objective / businessdue to lack of staff • Ongoing unsafe capacity or competency levels • Loss of several key staff • Staff unable to attend mandatory training on ongoing basis
Reputation Risks that may result in damage to reputation, poor experience and/or destruction of trust and relations. May include, but not limited to, risks linked to adverse publicity and engagement	• Rumours • Potential for public concern	• Local media coverage – short-term reduction in public confidence • Elements of public expectation not being met	• Local media coverage – long-term reduction in public confidence	• National media coverage with <3 days well below reasonable public expectations	• National media coverage with >3 days well below reasonable public expectation • MP concerned (questions in the House) • Total loss of public confidence
Resources Risks that may result in the organisation, or system, operating outside its resource allocations, poor productivity, inefficiencies, or no return on investment. May include, but not limited to, risks linked to workforce, finance, stability, value for money, procurement and claims	• Small loss • Risk of claim remote	• Loss of 1-2% of budget • Claim less than £10,000	• Loss of 2-5% of budget • Claim(s) between £10,000 and £100,000	• Uncertain delivery of key objective • Loss of 5-10% of budget • Purchasers failing to pay on time • Claim(s) between £100,000 and £1 million	• Non-delivery of key objective • Loss of 10% of budget • Failure to meet specification • Slippage • Loss of contract/ payment by results • Claim(s) >£1 million
Social and Economic Development Risks relating to decisions or events which may have favourable social, ethical and/or environmental outcomes	• Minimal or no impact on the environment	• Minor impact on environment	• Moderate impact on environment	• Major impact on environment	• Catastrophic impact on environment

Strategic Commissioning Risks associated with potential threats or uncertainties that may impact the NWJCC's ability to plan and commission services that meet population needs, improve population outcomes, and ensure value for money. Strategic commissioning risks emerge when this process is disrupted or compromised. These risks may affect the NWJCC'S ability to ensure person-centred, equitable, and sustainable care.	• Negligible disruption to commissioning activities with no impact on service delivery or population outcomes. • Temporary delay in pathway design or contract negotiation.	• Negligible disruption to commissioning activities with no impact on service delivery or population outcomes. • Temporary delay in pathway design or contract negotiation. • Minor misalignment with strategic objectives.	• Moderate disruption to commissioning functions. • Inability to deliver planned service changes or meet transformation targets. • Moderate impact on access, equity, or quality of care.	• Major failure in commissioning processes. • Inability to deliver key services or meet statutory duties. • Major impact on population health outcomes, equity, or financial sustainability	• Catastrophic failure / systemic breakdown in commissioning capability. • Widespread service failure or collapse of strategic programmes. • Catastrophic impact on population health and organisational viability.
Strategy and Operations Risks associated with identifying and pursuing strategies /plans (including risks associated with the establishment of innovative systems and processes to deliver the strategies /plans), which could lead to improvements, opportunities for growth or may contribute positively to the achievement of aims and objectives. May include, but not limited to, risks linked to capacity, demand, service/ business interruption, digital, projects, planning, delivery, commissioning, partnership working and transformation	• Day to day operational challenges • Loss/ interruption of >1 hour • Insignificant cost increase / schedule slippage • Key 'political' target is being achieved and impact prevents improvement	• Temporary restriction to service delivery with limited impact on stakeholder confidence • Loss/ interruption of >8 hours • Key 'political' target is being achieved but impact reduces performance marginally below target in the near future or performance currently on target, but there is no agreed plan to meet	• Short term failure to deliver key objectives with temporary adverse local publicity • Loss/ interruption of >1 day • 5–10 per cent over project budget • Schedule slippage • Key 'political' goal is marginally below target or is soon projected to deteriorate beyond acceptable limits or there is an agreed plan, but it does not yet meet the rising target	• Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on stakeholder confidence • Loss/ interruption of >1 week • Non-compliance with national 10–25 per cent over project budget • Schedule slippage • Key 'political' target not being achieved, and impact prevents improvement, or substantial decline in performance trend.	• Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence • Permanent loss of service or facility • Incident leading >25 per cent over project budget • Schedule slippage • Key objectives not met • Key 'political' target is not being achieved and the impact further deteriorates the position

Risk Scoring Matrix

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

NWJCC STRATEGIC OBJECTIVES
Maximise value – through our expertise and advice, determine where resources are best focussed and prioritised to inform choices that support the improvement of patient outcomes and commission appropriate services where value is demonstrated
Ensure quality – with a commissioning approach that is fostered in a quality management system, provide quality outcome, evidence based service specifications for commissioned services and monitor delivery against these
Reduce duplication – use value based health principles to reduce variation to identify and maximise opportunities for collaborative commissioning in Wales
Improve equity and population health - ensure that people are able to access the right service when they need it whoever they are, wherever they live
Facilitate integration - through effective engagement and collaboration, provide the key mechanism to support regional and national integration for commissioning services for the people of Wales

Audit, Risk & Assurance Committee Hosted Bodies

NHS Wales Joint Commissioning Committee Audit Tracker

Eitem yr Agenda / Agenda Item	**4.4**
Dyddiad y Cyfarfod / Date of Meeting:	04/08/26
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Aaron Fowler, Committee Secretary, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter:	Aaron Fowler, Committee Secretary, NWJCC
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Georgina Galletly, Director of Corporate Planning and Strategy, NWJCC
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	No Decision Required
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below: Creating Health Sustaining our Future Inspiring People
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	This report provides an update against the delivery of the NWJCC audit programme.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:

Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	The report provides an update to the CTMUHB ARAC for hosted bodies on progress with implementing internal and external audit recommendations for the NWJCC. Internal audits completed in 2025-26 covered: • Finance Systems – Reasonable • Traumatic Stress Wales – Limited • Individual Patient Funding Requests – Substantial. Progress has been made against audit recommendations, with all Financial Arrangements recommendations achieved, no recommendations arising from Individual Patient Funding Requests, and several Traumatic Stress Wales recommendations remain outstanding.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The key assurance issue remains Traumatic Stress Wales, which received a Limited Assurance rating and has outstanding recommendations linked to hosting and staff employment arrangements. The proposed TUPE transfer to Public Health Wales is complex and remains the main risk, although legal advice has been received and regular discussions between CTMUHB and PHW are continuing. The report also confirms that NWJCC has no current external audit involvement and that completed recommendations are being removed from the tracker to maintain focus on outstanding actions.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the*	ARAC members are asked to note the progress reported through the Audit Recommendations Tracker, including the proposed completion of the Financial Arrangements recommendation and the ongoing assurance arrangements for Traumatic Stress Wales.

choices and recommendation(s)being made)	CTMUHB and PHW will continue to progress the TUPE transfer, with completion hoped for by the end of October 2026. Future ARAC updates will include the outcome of completed internal audits on Budget Management and High-Cost Drugs, alongside the agreed 2026-27 audit programme covering Contract Monitoring Arrangements, Escalation Process, Risk Management and Strategic Planning.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	Members are asked to: • **Note** the report • Take an **assurance** on the progress against the audit programme • **Note** the ongoing discussions regarding the Traumatic Stress Wales service • **Note** the planned audit programme for 2026-27.

1. Background / Context

1.1 The purpose of this report is to provide the Cwm Taf Morgannwg University Health Board (CTMUHB) Audit, Risk and Assurance Committee (ARAC) for hosted bodies with an update on progress in respect of the implementation of recommendations from internal and external audits.

1.2 Since 1 April 2024, in accordance with the NHS Wales Joint Commissioning Committee (NWJCC) Standing Orders and the Hosting Agreement with CTMUHB, the NWJCC utilises the CTMUHB ARAC to discharge the requirement to have a sub-committee to cover the audit and risk aspects of Joint Commissioning Committee (JC) business.

1.3 Audits play an important independent role in providing the JC and the ARAC with assurance over the internal controls, systems and processes that are in place, and to ensure that they are sufficiently comprehensive and operating effectively. Therefore, it is essential that recommendations from both internal and external audits are implemented in a timely way. All reports from audits undertaken across NWJCC services are logged and monitored through the NWJCC Audit Tracker.

2. Internal Audit

2.1 Summary of Audits Undertaken in 2025-26

The following reviews have been completed by Internal Audit:

Audit Theme	Quarter	Assurance Rating
Finance Systems	4	**Reasonable**
Traumatic Stress Wales	4	**Limited**
Individual Patient Funding Requests	4	**Substantial**

Progress towards implementing Internal Audit recommendations is set out in the table below.

Audit Theme	Recommendations			
	Made	**Achieved**	**Not Yet Due**	**Outstanding**
Financial Arrangements	7	7	0	0
Traumatic Stress Wales	9	3	6	6
Individual Patient Funding Requests	No recommendations made.			

In addition to the above, internal audits have been undertaken on the following and will be presented at a future ARAC meeting:

- Budget Management
- High-Cost Drugs

Members are asked to note the following regarding the Internal Audit Reports on Financial Arrangements and Traumatic Stress Wales with further updates provided in **Appendix 1**:

- *IA FA 2024 Recommendation 3*
  It is proposed that this recommendation is completed, the agreed action was to (i) undertake a review of recurring payments to ensure all remain appropriate, with new and appropriately approved purchase orders raised where necessary and (ii) for a process to be introduced as part of regular monitoring and reporting that allows spend to be monitored to ensure values are not exceeded. However, as this is an ongoing process that will be embedded into day-to-day tasks, there is no natural end date. This work has already started and is expected to continue indefinitely. The update provided against this recommendation confirms that the reporting process is now in place and has been incorporated into the monitoring and reporting cycle.

- *IA TSW 2025 Recommendations 1-7*
  Discussions continue to progress on the hosting arrangements. Complexities surrounding staff employment arrangements has required legal advice to clarify the staff subject to the TUPE process. Legal advice was received in July 2026. CTMUHB (as the host organisation of the NWJCC) and Public Health Wales (PHW) continue to meet on a regular basis to progress the transfer. It is hoped the TUPE transfer will be complete by the end of October 2026. Assurance regarding the ongoing management of the TSW service in the interim will continue to be provided to CTMUHB via the Hosted Bodies ARAC and the Audit Recommendations Tracker.

Update against outstanding and in-progress recommendations are detailed in the attached Audit Recommendation Tracker – **Appendix 1**. As previously described, audit recommendations agreed as completed have been removed from the next meeting's Audit Recommendations Progress Tracker to ensure a focus on ongoing recommendations.

2.2 Summary of Planned Audits for 2026-27

Following discussions with colleagues from the NHS Wales Shared Services Partnership's (NWSSP) Internal Audit team, the following reviews have been agreed with Internal Audit for completion during 2026-27:

Audit Theme	Quarter	Assurance Rating
Contract Monitoring Arrangements	Q1	TBC
Escalation Process	Q2	TBC
Risk Management	Q2/3	TBC
Strategic Planning	Q3	TBC

2.3 External Audit

The NWJCC is not involved in any external audits at present.

3. Risks and Opportunities

3.1 The main risk relates to the transfer of Traumatic Stress Wales service to PHW. This process is complex and involves staff employment arrangements. Legal advice has been received from CTMUHB as the host organisation. CTMUHB and PHW continue to meet on a regular basis to progress the transfer. It is hoped the TUPE transfer will be complete by the end of October 2026.

4. Compliance and Governance

4.1 The main compliance and governance matters include:

- The CTMUHB ARAC provides audit and risk oversight for the NWJCC, in line with the NWJCC Standing Orders and the Hosting Agreement with CTMUHB.
- The implementation of audit recommendations in a timely manner is a key governance matter and is presented through the NWJCC Audit Tracker.
- The Limited Assurance rating for the TSW internal audit resulted in recommendations relating to governance issues such as hosting arrangements and staff employment arrangements.
- The programme of planned audits for 2026–27 will ensure that assurance is provided across key governance and compliance areas.

5. Conclusion

5.1 The report provides an assurance update on the progress made in respect of the implementation of recommendations from internal and external audits including:

- Summary of Audits Undertaken in 2025-26.
- Summary of Planned Audits for 2026-27.
- External Audits.

6. Assessment

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Choose an item. If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals**	A More Equal Wales If more than one applies please list below: A prosperous Wales A resilient Wales A healthier Wales

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Whole-Systems Perspective If more than one applies please list below: Culture and valuing people Data to knowledge Leadership Learning, Improvement and Research

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	Choose an item. If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Summary of impact: Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Summary of impact:	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Update against the delivery of the NWJCC audit programme provided. Quality impact assessments will be undertaken for any element of the NWJCC's work that requires this.	
Cyfreithiol / Legal	**There are no specific legal implications related to the activity outlined in this report**	
Enw da / Reputational	**There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report**	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	**There is no direct impact on resources as a result of the activity outlined in this report**	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**

High Cost Drugs

Internal Audit Report

2025/26

Joint Commissioning Committee

Reasonable Assurance

Contents

Review Reference	JCC-2526-01
Fieldwork	April-June 2026
Executive Sign Off	9 July 2026
Audit Committee	4 August 2026
Executive Lead	Dr Iolo Doull, Medical Director
Audit Team	Paul Dalton, Head of Internal Audit
	Emma Samways, Deputy Head of Internal Audit

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Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

Our audit of the processes for the managing of specialised high cost drugs was undertaken as part of our 2025/26 Internal Audit work for the Joint Commissioning Committee (NWJCC).

In 2018 the Welsh Government and Welsh Health Specialised Services Committee (now the NWJCC) invested in the purchase of the 'Blueteq High Cost Drugs' system for NHS Wales. The system is an electronic prior approval system for high cost drugs and has been used by NHS England for many years. Its roll out in Wales commenced in 2020. Phase one, led by the NWJCC, involved implementing the system for all of the specialist high cost drugs it commissions.

Phase two is being led by the All Wales Therapeutics and Toxicology Centre and has a target completion of March 2027. It involves implementing the system for all eligible high cost drugs prescribed by health boards and Velindre NHS Trust. The overarching aim of the system is to provide greater clinical and financial governance in relation to the high cost drugs.

The Blueteq system contains criteria for prescribing forms for various high cost drugs based on National Institute for Health and Care Excellence (NICE) and All Wales Medical Steering Group (AWMSG). As the drugs recorded in the system have been pre-approved for use, clinicians who are able to demonstrate that their patients meet the required criteria are able to prescribe these treatments without the need for approval panels. For those drugs not currently set up within the Blueteq system, the extant prior approval process is followed, with requests managed by the patient care team.

Overview

We have concluded reasonable assurance on this area. The following matters requiring management attention:

- The 'Blueteq Form Development' Standard Operating Procedure (SOP) is in draft.
- The Patient Care team do not have a SOP for the pre-approved high cost drug requests they process.
- Detailed information in relation to high cost drug activity and spend is not provided to health boards, nor is it reported internally within the NWJCC.
- The data captured in Blueteq is not used for monitoring potential similar alternatives for patients or to highlight patients reaching a certain age where criteria or requirements for their high cost drugs change.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

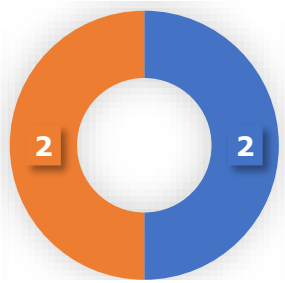
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Appropriate process and controls are in place for setting up new high cost drugs within the Blueteq system and for making amendments to the criteria for any existing drugs.	1	**Reasonable**
2	There are appropriate process and controls in place for the prescribing of high cost drugs that are not available via the Blueteq system and managed by the Patient Care Team via a prior approval route.	2	**Reasonable**
3	Invoices received in relation to high cost drugs are reconciled to agreed commitments, with variations challenged. Spend on high cost drugs is routinely monitored and reported on.	3	**Reasonable**
4	Regular reports from the Blueteq system are generated and monitoring is undertaken.	4	**Reasonable**

Management Actions

1	3
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

Choose an item.

Choose an item.

Choose an item.

Findings & Agreed Action Plan

Objective 1: Appropriate process and controls are in place for setting up new high cost drugs within the Blueteq system and for making amendments to the criteria for any existing drugs.	Reasonable

Overview / Summary of Observations

The Medicines Optimisation Team has a draft Standard Operating Procedure (SOP) that outlines how the team develops, makes amendments to and removes drug prescribing forms for NWJCC commissioned high-cost medicines that are recorded on the Blueteq system. We understand that the draft SOP is scheduled to be presented at the June 2026 Quality, Safety and Outcomes committee (QSOC) for review and approval.

At the time of our review, we were unable to obtain a report from the Blueteq system of additions, amendments and removal of forms. As such, our testing to ensure compliance with the process set out on the SOP was limited to small number of additions that had been recently added to the system. We saw evidence confirming that the setup of the drug forms aligned to the SOP, including obtaining specialist clinical input and set up within the system by appropriate staff. As amendments are infrequent, these were not tested.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Draft Blueteq Form Development SOP** The SOP for 'Blueteq Form Development' is in a draft, although we understand it will be finalised following approval by QSOC in June 2026. The current version does not capture the owner of the SOP, a review date, or a version control log for recording amendments.	Drug forms are inappropriately set up within Blueteq that are not aligned to NICE guidance, resulting in reputational damage, financial loss and potentially patient harm.	**Agreed Action:** The draft Blueteq Form Development SOP will be updated to include a version control log, ownership and future review frequency. The SOP will be submitted to QSOC for approval and then made available to all relevant staff.
			Expected Evidence of Implementation: Updated and approved Blueteq Form Development SOP
		Medium Priority	**Officer:** Angharad Lawson, Lead Medicines Optimisation Pharmacist **Target Implementation Date:** October 2026
	Theme: Policies & Procedures	Control Design	

Objective 2: There are appropriate process and controls in place for the prescribing of high cost drugs that are not available via the Blueteq system and managed by the Patient Care Team via a prior approval route.	Reasonable

Overview / Summary of Observations

Clinician requests to prescribe high cost specialist drugs that have not been set up in the Blueteq system are managed by the Patient Care team. There is a process for managing, reviewing and approving funding for pre-approved high-cost drugs requested by health boards outside the Blueteq system, which are integrated into financial management arrangements. However, our fieldwork confirmed that these processes are not documented in a SOP.

Our testing of a sample of funding requests found that all applications were reviewed, documented and approved by officers in an appropriate role. All were processed with clinicians typically notified of the outcome decision within a few working days of the request being received by the team. We also saw that funding commitments were accurately recorded in order for the finance team facilitate invoice processing and monitoring.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Absence of SOP for pre-approved drugs processes** The Patient Care team process all requests for high cost drugs that are not available by the Blueteq system. Whilst the team have a standard process, this is not documented in a SOP.	Drugs are prescribed that are not aligned to NICE guidance resulting in reputational damage, financial loss and potentially patient harm.	**Agreed Action:** A Standard Operating Procedure (SOP) will be created for the processes relating to pre-approved drugs, managed outside of the Blueteq system by the Patient Care team.
			Expected Evidence of Implementation: An approved SOP for the pre-approved drugs process managed by the Patient Care team.
		Medium Priority	**Officer:** Oliver Harness, Senior IPFR Manager - Patient Care Team
	Theme: Policies & Procedures	Control Design	**Target Implementation Date:** December 2026

Objective 3: Invoices received in relation to high cost drugs are reconciled to agreed commitments, with variations challenged. Spend on high cost drugs is routinely monitored and reported on.	Reasonable

Overview / Summary of Observations

Processes are in place to ensure the finance department is informed on a monthly basis of new high-cost drug commitments arising from both Blueteq and the pre-approved drug requests managed by the Patient Care team. We saw evidence of reconciliations between invoiced expenditure and authorised cost commitments, with activity accurately tracked on a finance commitments spreadsheet to ensure spend does not exceed approved limits. Where there are variances between invoice values and agreed funding commitments, the finance department work with the Medicines Optimisation team, and Patient Care team to resolve issues.

On a monthly basis, health boards are provided with financial data as part of the risk sharing table reports. However, financial activity on high cost drugs, both via Blueteq and pre-approved drugs is amalgamated with Individual Patient Funding Request (IPFR) spend. As such, health boards are not provided with a breakdown of their spend on specialist high cost drugs, although we understand this information can be provided if requested by a Health Board.

Whilst an annual High Cost Drugs report is presented to the Joint Commissioning Committee, the report focuses on activity and not spend and there is no other regular periodic reporting on spend within NWJCC.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Monitoring high cost drugs expenditure** On a monthly basis the health boards receive financial data though the risk sharing tables. Whilst this information includes spend on high cost drugs, detailed information is not available as spend is amalgamated with IPFR spend. There is no supplementary, granular reporting in respect of high cost drugs activity to health boards which would provide them with an analysis of those drugs prescribed by their clinicians on a monthly basis. Furthermore, no regular reporting of high cost drug spend takes place within the NWJCC.	Lack of oversight and monitoring of total spend on high cost drugs, resulting in a lack of opportunity for Health Boards or managers to understand and challenge the financial costs.	**Suggested Action:** A number of lines within the monthly JCC risk-share tables relate to high-cost drug expenditure in specific areas, including Vertex cystic fibrosis therapies, Eculizumab, enzyme replacement therapies, NICE-approved high-cost drugs commissioned through Cardiff and Swansea University Health Boards, Asfotase Alfa, haemophilia products, and Advanced Therapy Medicinal Products (ATMPs). The remaining drug expenditure is distributed across multiple other lines within the reporting tables; however, these values are comparatively small in relation to the principal high-cost drug categories identified above. With around 200 individual risk-share lines contributing to the monthly risk-share schedules, each supported by separate datasets, producing a fully consolidated monthly position would be a resource-intensive exercise requiring additional staffing capacity. As a more proportionate short-term solution, the existing High Cost Drugs report will be enhanced to include expenditure information alongside activity data, providing stakeholders with a more comprehensive and timely view of performance.

			The Information Team will work with Health Board with Pharmacy colleagues to explore how relevant contract monitoring data could be aligned and incorporated to support this enhanced reporting approach.
			Expected Evidence of Implementation: Reports of high cost drug activity and expenditure data provided to Health Board Pharmacy Leads and within JCC.
		High Priority	**Officer: Alex Thomson, Head of Information**
	Theme: Reporting	Control Design	**Target Implementation Date:** December 2026

Objective 4: Regular reports from the Blueteq system are generated and monitoring is undertaken	Reasonable

Overview / Summary of Observations

The Medicines Optimisation Support Manager has developed a BI dashboard based on data held within the Blueteq system. The dashboard is used within the team to monitor information such as number of requests by health board, numbers of each type of intervention per year and status of requests such as approved, treatment complete and declined.

From our review of the Blueteq system and through our meetings with the Medicines Optimisation team we have identified:

- Reporting on gaps in patient data is not a requirement as key patient data is recorded in mandatory fields within Blueteq, and requests cannot progress where information is absent.
- Continuation forms are required one year following initial prescribing. Every two months reports are run highlighting those patients whose initial approval was a year ago and require a continuation form. Where clinicians have not completed a continuation form on time, a freeze is placed on funding and contact is made with the clinician to resolve.
- A very small number of NWJCC commissioned drugs patients reaching a certain age will require a new Blueteq form due to minor changes in the criteria or requirements associated with their drugs. We understand that whilst it is possible to produce reports with this information, these are reports not produced and as such data is not provided to clinicians/ health boards. However, we understand that currently only one type of drug is impacted when a patient turns 18 years old.
- Bio-similar drugs are drugs that are a highly similar copy to a reference or original product. MHRA guidance states that bio-similar drugs are interchangeable with original products and so the most cost effective drug should be used. However, no data is generated from the Blueteq system that would allow the identification of patients that may be eligible to switch to a more cost effective bio-similar drug.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Blueteq reporting** The Blueteq system has the functionality to run a number of reports that can be shared with health boards about their patients. Reports are not currently run and shared in relation to: • patients reaching a certain age where criteria or requirements for their high cost drugs change and new forms are needed. • patients potentially eligible for switching to a similar product/best value bio-similar drug.	Lack of ongoing monitoring, with payments made that are not in line with agreed commitments, resulting in financial loss.	**Agreed Action:** Consideration will be given to the production of reports from the Blueteq system that periodically provide information relating to patients reaching a certain age where criteria or requirements for their high cost drugs change, and those patients that are potentially eligible to be prescribed a similar cost effective biosimilar drug. **Expected Evidence of Implementation:** Reports from Blueteq.
		Medium Priority	**Officer:** Owen Campbell (Medicines Optimisation Support Manager) to produce the reports\ Angharad Lawson (Lead Medicines Optimisation Pharmacist) to review reports and liaise with relevant clinical teams **Target Implementation Date:** December 2026
	Theme: Reporting	Control Operation	

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Joint Commissioning Committee. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Budget Management

Final Internal Audit Report

2025/26

NHS Wales Joint Commissioning Committee

Reasonable Assurance

Contents

Review Reference	JCC-2526-04
Fieldwork	March - April 2026
Executive Sign Off	26 June 2026
Audit Committee	4 August 2026
Executive Lead	Stacey Taylor, Director of Finance and Value
Audit Team	Paul Dalton, Head of Internal Audit
	Emma Samways, Deputy Head of Internal Audit

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Executive Summary

Purpose

Our audit of the budget management process was completed as part of our 2025/26 Internal Audit work for the Joint Commissioning Committee (JCC).

The JCC is a Joint Committee of the seven health boards in Wales, acting collectively on their behalf. The JCC was established in April 2024 in response to the findings of an independent review, commissioned by Welsh Government. The JCC replaced the Emergency Ambulance Services Committee (EASC), the Welsh Health Specialised Services Committee (WHSSC), and the National Collaborative Commissioning Unit (NCCU), assuming responsibility for the services previously commissioned by these bodies.

The JCC's Chief Commissioner is accountable for managing a commissioning budget of around £1.3 billion. This budget is not a separate Welsh Government allocation; it is a pooled budget made up of contributions from the seven health boards.

Overview

We have concluded reasonable assurance on this area. The matters requiring management attention are:

- Governance documents require reviewing to ensure they remain up to date.
- Notable differences and document control issues exist between the February 2026 and May 2025 versions of the Scheme of Delegation. These discrepancies may lead to confusion regarding authorisation limits and responsibilities.
- The budget-setting and budget management process are not documented with reliance on key staff. The Budgetary Control FCP is outdated and does not set out key roles and responsibilities.
- There were inconsistencies in the budget baseline and early financial reporting. Reconciliation of the ledger and risk tables has not been completed as required.
- Budget virements lacked documented approvals, often referred to incorrect accounting periods, with significant delays in inputting to Oracle.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- The Standing Financial Instructions should be reviewed to ensure they remain current and align to recent changes made to the Standing Orders.
- Financial updates were not regularly shared at the CCLG. Between August 2025 and April 2026 this information was shared twice.
- Appendix B of the Month-End procedure FCP includes the 2025/26 calendar. While it is currently presented as an example, consideration should be given to updating this annually so that it reflects the current years reporting calendar.

Scope & Assurance Summary

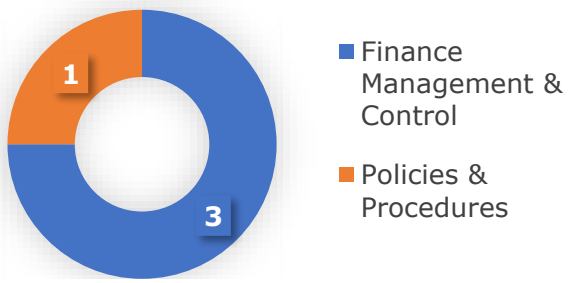
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The organisation has Standing Orders (SO) and Standing Financial Instructions (SFI) in place with delegated limits set out in a Scheme of Delegation (SoD).	1	**Reasonable**
2	Procedures for budget setting and budget management are in place, including processes for calculating Health Board contributions	2,3,4	**Limited**
3	Budget holders are aware of their responsibilities and support is provided to help them fulfil their roles	2	**Reasonable**
4	Timely financial information is available to budget holders, JCC management, Members, Health Boards and Welsh Government.	3	Substantial
5	Where variances are identified, plans are formulated at an appropriate level to manage the variance.	-	**Substantial**

Management Actions

1 High Priority

3 Medium Priority

Themes



Risk Types

Financial Loss

Findings & Agreed Action Plan

Objective 1: The organisation has Standing Orders (SO) and Standing Financial Instructions (SFI) in place with delegated limits set out in a Scheme of Delegation (SoD).	**Reasonable**

Overview

The JCC's financial governance framework is supported by a hierarchy of documents. The Standing Orders (SOs) and the Standing Financial Instructions (SFIs) set out the overarching financial control requirements. These are supplemented by an 'Additional Delegations' (Scheme of Delegation) document, to clarify and tailor delegated authorities for the JCC operating model. A 'Delegated Authorisation Matrix' defines approval limits by role and expenditure type. Based on our review, there is appropriate alignment between the SOs, SFIs, delegation documents and operational application.

We note that the SOs were reviewed and updated in October 2025. While the SFIs are appended to the SOs there does not appear to have been a corresponding review of the SFIs to assess whether updates were necessary following the changes to the SOs.

The Delegated Authorisation Matrix was approved by the JCC in May 2025, although at the time of our fieldwork an updated version was in use. We note some differences between the versions and have been unable to identify approval of the changes **(Key Finding 1)**

	Key Findings	Risk & Impact	Agreed Management Action
1	**Discrepancies in the Scheme of Delegation** We compared the 'Delegated Authorisation Matrix' approved by the JCC in May 2025 to the more recent version in use (February 2026). We noted some discrepancies: • The February 2026 version indicates that the Chief Commissioner can sign off on the Annual Financial Plan and Service Level Agreements, but this authority is not in the May 2025 document. • The May 2025 version allows the Medical Director to authorise up to £750,000 for emergency activity under IPFR requests and other non-contract payments. This is not in the more recent version. • The Director of Planning's financial limit for committee running costs has been reduced in the more recent version from £75k to £50k. • Approval of payroll study leave has been removed from all tier 2 directors in the more recent version.	Decision being taken outside approved authority levels or being inappropriately withheld.	**Agreed Action:** The 'Delegated Authorisation Matrix' will be reviewed by Head of Financial Accounting & Governance and Committee Secretary to ensure it accurately reflects the authorisations agreed by the JCC. Where operational needs have changed, appropriate approval will be sought to amend the matrix. The matrix will be updated to include a glossary of symbols, and be version controlled. Care will be taken when converting the document between Excel, Word or PDF formats that elements are not lost or inaccurately presented. **Expected Evidence of Implementation:**

	We also noted that in the February 2026 version does not contain a glossary explain the symbols are used, and the document has no version control.		Updated Delegated Authorisation Matrix
		Medium Priority	**Officer:** Rachel Wetherill, Head of Financial Accounting and Governance
	Theme: Finance Management & Control	Control Design	**Target Implementation Date:** 31 July 2026

Objective 2: Procedures for budget setting and budget management are in place, including processes for calculating Health Board contributions.	**Limited**

Overview

The approach to budget-setting, including calculation of Health Board contributions and budget management is primarily delivered through established financial tables and spreadsheets that act as the core working documents. While detailed process knowledge is held by a small number of key individuals, including senior finance staff, there is no documented procedure for developing the annual budget. Reliance is placed on their experience and shared understanding to prepare the budget, explain how figures are developed, how finance tables are constructed, and how data flows from planning through to approval and uploaded into Oracle. We understand that financial tables are typically rolled forward from the prior year and adapted to reflect changes agreed with senior stakeholders, meaning continuity is dependent on working documents and staff expertise, rather than a formalised, documented method. **(Key Finding 2)**

The JCC uses excel spreadsheet risk sharing tables as its main financial management tool rather than relying exclusively on data and reports from the Oracle financial system. The risk sharing tables, underpin budget setting, monitoring, and reporting. They contain the operational detail of the JCC's finances, whereas Oracle has less detail recorded. There is currently no documented procedure relating to the compilation and maintenance of the risk-sharing tables.

Whilst a Financial Control Procedure (FCP) setting out month end processes has recently been developed; there is no overarching FCP for budgetary control, although we note a legacy budgetary control FCP exists from WHSSC, but this does not appear to be used.

The financial information approved by the JCC in March 2025 as part of their Foundation Plan should be recorded in Oracle and the risk sharing table to create the opening budget positions. All three data sets should reconcile to confirm accuracy of initial set up. Our reconciliation between the approved 'financial tables' in the plan and the opening budget in the risk sharing table identified several inconsistencies. **(Key Finding 4)**

Virement forms are used to capture the entries for inputting the approved budget and for recording the authorisation of any ongoing movements to the agreed plan ahead of inputting into Oracle and the risk sharing tables. Our testing of a sample of budget virements identified some instances where incorrect accounting periods had been recorded on virement forms, some virements that had been processed without documented approval and entries that were not uploaded to Oracle in a timely manner. **(Key Finding 3)**

A budget reconciliation spreadsheet lists the entries included on the virement forms to show the movement from the approved starting budget for each cost centre. On a monthly basis the revised budget values should be reconciled to the risk sharing tables and to the Oracle system. Our testing found variances. Including one virement that was recorded on the reconciliation but was never present on the virement form. **(Key Finding 4)**

We tested a sample of reporting lines from the January 2026 risk sharing table to determine the origin of the source information and confirm accuracy. In all cases the calculations were accurate.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Budget setting and monitoring procedures** The JCC does not have a documented method for budget setting. The approach, which includes the development of financial	Budgets are prepared inconsistently, key	**Agreed Action:** A finance-owned budget-setting and Risk Sharing management standard operating procedure (SOP) will be developed by the

	tables, and the flow of figures from planning through to approval and upload is embedded in working documents and is reliant on the knowledge of key individuals. There is no documented procedure for the compilation and ongoing maintenance of the monthly risk sharing table, which is the key financial document shared internally with commissioning leads and externally with health boards for budget monitoring. A documented timetable for setting the 2025/26 budget was not in place, although the process was included as part of broader planning activities. While we understand that a more structured timetable was developed for 2026/27 planning, we have not seen this document. The Budgetary Control FCP relates to WHSSC. It is therefore out of date and does not reflect current roles, including the responsibilities of commissioning leads as budget holders, and does not clearly define the roles and responsibilities of Finance Business Partners.	assumptions or control steps are not applied or evidenced, and errors are not detected in a timely manner.	Head of Financial Planning and the Assistant Director of Finance that documents (as a minimum): • Roles and responsibilities. • The end to end process and budget setting timetable. • How the risk sharing tables are structured, populated, reviewed and updated. The procedure will be supported by a user guide for the main spreadsheets/ tables and will be reviewed and updated annually as part of the budget cycle. Training and handover materials will be created to reduce key-person dependency. A review of the budgetary control Financial Control Procedure (FCP) will be undertaken by the Head of Financial Accounting and Governance, the Head of Financial Reporting & Business Partnering and the Assistant Director of Finance to ensure it is up to date, links to the existing SFIs and accurately reflects current organisation arrangements including: • Reflect current budget holder roles, including Commissioning Leads. • Define Finance Business Partners' responsibilities and support. The Head of Financial Accounting & Governance will ensure that updated FCP will be approved through the appropriate governance route (Audit & Risk Committee) and communicated to budget holders and finance teams, with the document location publicised on the intranet.
			Expected Evidence of Implementation: A budget-setting and Risk Sharing management SOP and user guide. Updated Budgetary Management FCP
		High Priority	**Officers:** Sandra Tallon/Kendal Smith/Rachel Wetherill/Joel Tofton
	Theme: Policies & Procedures	Control Operation	**Target Implementation Date:** 31 July 2026
3	**Budget virement process** The JCC does not use the Oracle system for financial reporting but uses risk sharing tables instead. However, virement forms provide the audit trail of the authorisation and reasoning for budget changes, both within Oracle and the risk sharing tables.	Inaccurate and untimely processing of budget virements increases the risk that the ledger does	**Agreed Action:** The Assistant Director of Finance and/or Head of Financial Reporting & Business Partnering will ensure that virement forms are accurately populated and appropriately authorised in line with the scheme of delegation. Whilst the JCC does not use

	The process for completing and authorising virement forms is set out on the form itself and the scheme of delegation. Our testing of a sample of five budget virements forms to verify completeness, authorisation and correct input identified: • 3/5 virements had the wrong accounting period recorded on the form. The same forms lacked information regarding the date of upload and the identity of the person responsible for uploading, as such we are unclear if they have been uploaded to Oracle. • 0/5 had been authorised in line with the scheme of delegation. • 2/5 virements relating to the opening budget were requested in May 2025 but were not uploaded to Oracle until November 2025. We also note one instance where the virement was retrospectively completed as it was requested in February 2026 but related to transactions listed in a budget reconciliation for August 2025. Our testing indicates that virement forms have been populated to reflect decisions already made and reflected in risk sharing tables.	not reflect approved budget decisions resulting in inaccurate reporting.	Oracle as its primary financial record, opening budgets will be reflected in Oracle with ongoing adjustments to the plan also reflected in Oracle in a timely manner. The virement forms will provide a clear audit trail to amendments made in the risk sharing tables to opening budgets. **Expected Evidence of Implementation:** Virement forms that are fully and accurately completed. Oracle reports showing budget upload at start of year.
		Medium Priority	**Officers**: Sandra Tallon- Assistant Director of Finance/Joel Tofton - Head of Financial Reporting & Business Partnering **Target Implementation Date:** 31 July 2026
	Theme: Finance Management & Control	Control Operation	
4	**Inconsistent opening budget baseline and early reporting** Our testing to confirm that the foundation plan and the month 1 risk sharing tables reconciled identified variances for the savings target and for one health board's opening budget. It was month 4 before the risk sharing table reconciled to approved plan plus any later agreed movements. As such, any reporting up to that date, including the month 2 report to the JCC, will have included these inaccuracies. We reviewed the budget reconciliation spreadsheet. Our comparison of the month one sub-total to the risk sharing tables found variances. This included entries that were recorded on the reconciliation, but were never present on the virement form, implying that a reconciliation was not performed. As noted in finding 3, we identified that the first two virement forms for the year were not signed off until November 2025,	Inaccurate or inconsistent budget baselines and delayed financial report alignment heighten the risk of poor in-year decisions, reduced transparency, and unnecessary risk-sharing disputes.	**Agreed Action:** The Assistant Director of Finance and Head of Financial Reporting & Business Partnering will implement the Finance Month-end Procedures timetable requirement by completing the monthly reconciliation between the Oracle ledger/budget and the risk sharing tables by the fifth working day, with sign-off retained and exceptions escalated

	meaning that the opening budget was not set up in Oracle until that date. As such there cannot have been any reconciliations between Oracle, the approved plan and the risk sharing tables prior to that date. In the absence of using Oracle, the excel spreadsheet risk sharing tables are the primary source of financial information. There is a risk linked to manual input of information and data integrity. Timely reconciliation of data is therefore essential.		
			Expected Evidence of Implementation: Monthly reconciliation records
		Medium Priority	**Officers**: Sandra Tallon- Assistant Director of Finance/Joel Tofton - Head of Financial Reporting & Business Partnering
	Theme: Finance Management & Control	Control Operation	**Target Implementation Date:** 31 July 2026

Objective 3: Budget holders are aware of their responsibilities and support is provided to help them fulfil their roles.	**Reasonable**

Overview

The SFIs define the roles, accountability and responsibilities of budget holders, including financial control expectations, compliance requirements, and non-pay expenditure duties. However, they are intended to be read in conjunction with the Scheme of Delegation and FCPs for full operational understanding. As such, these processes are reliant on users accessing multiple supporting documents, including the budgetary control FCP, which has been identified under key finding two as out of date. We also note that the FCP does not reflect current roles, including the responsibilities of commissioning leads as budget holders, and does not clearly define the roles and responsibilities of finance business partners. **(See Key Finding 2)**

The finance structure includes three designated finance business partners: one assigned to ambulance and 111 service; one to specialised services; and another to mental health services. The finance business partners provide formal reports and advisory support to the commissioning leads (budget holders). They also serve as the main finance contact and help clarify financial positions and risks across services. They present monthly updates, address variances, and flag concerns.

We met with one commissioning lead who confirmed their responsibilities in relation to overseeing spend and providing finance reports in relation to their area.

Objective 4: Timely financial information is available to budget holders, JCC management, members, health boards and Welsh Government.	**Substantial**

Overview

The SFIs outline reporting requirements, including presenting the financial position to the JCC, submitting monthly monitoring returns to Welsh Government, and sharing the monthly financial status with all seven local health boards. Additional forums such as the Collaborative Commissioning Leadership Group (CCLG) and the Planning, Performance and Finance committee (PPF) also review the financial position at their bi-monthly meetings. Our findings show that, for the most part, the financial position was reported as required. However, the CCLG only received financial updates twice between August 2025 and April 2026. We understand this is due to IMTP updates being presented at the December 2025 and February 2026 meetings.

The 'Finance Month-End' FCP dated November 2025 details a schedule for month-end processes, highlighting key deadlines and responsibilities. The FCP incorporates a monthly checklist indicating which tasks should be completed from working day 1 to 9 according to the reporting timetable. For 2025 /26 a calendar was developed with specific dates and actual time deadlines; however, this is now out of date.

Our testing confirmed that month-end tasks were completed in accordance with the timetable, with the exception of the reconciliation of Oracle budgets to the risk sharing tables. **(See Key Finding 3)**

The finance business partner for specialised services attends monthly meetings with each commissioning lead (budget holder), presenting financial updates via Power BI reports tailored for their area. In addition to these meetings, there is ongoing monitoring which ensures budget holders receive timely financial information.

Our review of the JCC minutes from November 2025 to January 2026 confirmed financial oversight, with prompt scrutiny of an in-year overspend and forecast deficit identified in November 2025. The minutes show challenge, decision making, and ongoing monitoring, providing evidence that financial pressures are actively managed.

Objective 5: Where variances are identified, plans are formulated at an appropriate level to manage the variance.	**Substantial**

Overview

The SFIs set clear expectations for budget holders to investigate variances using activity, workforce, and financial information, and to develop proportionate plans to address adverse variances. We found that these expectations are operating in practice with overspends relating to commissioned services identified through monthly budget monitoring. Explanations are obtained for adverse or material variances and these may be supported by deep-dives and bespoke analysis. These are discussed with commissioning teams and services, with an escalation process in place where required, including referral through management groups to the JCC as necessary. Corrective actions and recovery plans are developed, and progress is overseen through ongoing monthly monitoring and governance challenge.

Our testing confirmed that, where variances had been identified, they had been appropriately reported and considered.

Appendix A

Assurance Opinion

	**Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

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

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the NHS Wales Joint Commissioning Committee. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Agenda Item	5.1.1

Unapproved Minutes of the Hosted Audit, Risk & Assurance Committee

Date and Time of Meeting	Tuesday 19th May 2026 at 9:00a.m. – 10:00a.m
Venue	Via Microsoft Teams

Members Present	Patsy Roseblade	Independent Member, CTMUHB (Committee Chair)
	Carolyn Donoghue	Independent Member, CTMUHB
	Kath Palmer	Vice Chair, CTMUHB
	Dilys Jouvenat	Independent Member, CTMUHB
In Attendance	Aaron Fowler	Committee Secretary/Deputy Director of Corporate Services - NWJCC
	Emma Samways	Deputy Head of Internal Audit, Audit & Assurance Services, NHSSSP
	Emma Walters	Head of Corporate Governance & Board Business, CTMUHB
	Gavin Owen *Item 3.1 only*	Deputy Director of Commissioning for Ambulance and NHS 111, NWJCC
	Huw George	Chief Commissioner – NWJCC
	Louise Stait	Interim Assistant Director of Governance & Risk CTMUHB (Minutes)
	Mark Jones	Finance Lead – Audit Wales
	Nathan Couch	Audit Wales - Audit Manager (Performance)
	Nia Roberts	Lay Member, NWJCC
	Owen James	Head of Corporate Finance – CTMUHB
	Paul Dalton	Head of Internal Audit, Audit & Assurance Services, NHSSSP
	Sally May	Executive Director of Finance – CTMUHB
	Stacey Taylor	Director of Finance & Information - NWJCC
	Tracy Norris	National Imaging Academy for Wales
Meeting Observers	Maxine Evans	Assurance and Risk Officer - NWJCC

Agenda Item	Meeting Business
1.	**PRELIMINARY MATTERS**
1.1	**Welcome and Introductions**
	P Roseblade, Committee Chair welcomed everyone to the meeting. The format of the proceedings in its virtual form was also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny-related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.
1.2	**Apologies for Absence**
	Apologies had been received from: • Kathy Mason – Independent Member, CTMUHB • Rhys Goode – Independent Member, CTMUHB • Gareth Watts, Director of Corporate Governance, CTMUHB
1.3	**Declarations of Interest**
	None identified.
2.	**CONSENT AGENDA**
2.1	P Roseblade reminded Members that the agenda had been reformatted to include consent agenda items at the end of the agenda. She asked if there were any items from the consent agenda (Item 5) that the Committee Members wished to bring forward to the main agenda for discussion. There were no items Members wished to bring forward**.**
3.	**PRELIMINARY BOARD MATTERS**
3.1	**Action Log**
	A Fowler presented the Action Log and provided updates on progress against outstanding actions. In relation to Right Care, Right Person transport arrangements, Members noted that the current position did not yet provide sufficient clarity regarding responsibility or a confirmed long-term solution. It was acknowledged that interim arrangements were in place, however further work was required to clarify the overall approach and provide assurance to the Committee. S Taylor advised that the matter could be progressed through forthcoming discussions with Welsh Government, including consideration of funding arrangements, with a further update to be provided. The Committee agreed that the action should remain open pending this clarification. In response to question about the action to provide mitigations for Risk 92 (Cardiff and Vale frozen JCC-funded posts under women and children), A Fowler clarified that revised arrangements had streamlined recruitment, reducing vacancy levels and contributing to the de-escalation of the risk, although the issue had not been fully resolved and would continue to be monitored through contractual and quality assurance processes. H George confirmed that the

	position had stabilised following a period of organisational transition, with vacancies now reflecting normal turnover. Members were satisfied that the verbal update provided sufficient assurance, noting that the issue reflected a broader organisational position rather than an isolated service concern, and the action was agreed for closure. In response to questions about the National Imaging Academy Wales action (Re. Gateway 5), T Norris advised that a meeting had been arranged with Welsh Government to review the position, noting that circumstances had progressed since the original review and that a clearer direction for next steps would be established following this discussion. The Committee requested that future updates on this action provide greater clarity to link the issue, actions and proposed closure, to support oversight and assurance. Members also noted updates in relation to other actions, including commissioning risks and workforce-related issues, and were advised that these were being progressed through existing governance and contract management arrangements. Where appropriate, actions were agreed for closure on the basis of the updates provided.
Resolution:	The Committee **NOTED** the updates to the Action Log and **AGREED** the proposed closures, with the exception of actions where further clarification and assurance were required.
Action:	JCC and NIAW to ensure that the committee's specific queries above are responded to in future updates to the Action Log. (JCC re. Right Care, Right Person transport arrangements; and NIAW re. Gateway 5)
3.2	**Matters Arising Not Captured on the Action Log**
	No further business was identified.
4.	**STRATEGIC PILLAR: IMPROVING CARE**
4.1	**Joint Commissioning Committee Strategic Update**
	H. George presented the routine update from the Joint Commissioning Committee, noting that the report had been reformatted to strengthen its focus on assurance, including clearer articulation of key issues, financial performance and strategic priorities. The report outlined key developments including the year-end financial position, delivery of the Annual Plan, progress on strategic priorities, and early work to strengthen governance, including development of a Joint Assurance Framework. Members welcomed the revised format and the focus on assurance, particularly the emphasis on strategic priorities and system-wide transformation, noting the pace and scale of work underway. Discussion focused on assurance arrangements for commissioned services, including NHS 111 and ambulance performance. It was noted that performance, risks and mitigations are monitored through established JCC governance

	processes, including performance, quality and finance sub-committees and formal Joint Committee oversight. However, Members sought greater clarity on how these arrangements provide assurance to Health Boards and to the Committee. The Committee noted ongoing work to clarify roles and responsibilities across organisations, including Welsh Government and system partners, particularly in relation to performance management and reporting. G. Owen (Deputy Director of Commissioning) was invited to provide further context on ambulance services and NHS 111. He advised that key risks relate to system-wide pressures on ambulance capacity, particularly handover delays, and confirmed that work is ongoing to further define the commissioning role, responsibilities and mitigating actions, alongside wider system improvement activity. The Committee requested that a clear overview of assurance arrangements for NHS 111 and ambulance services should be brought to a future meeting, setting out governance structures, roles and reporting mechanisms to support the Committee's understanding of assurance. Subsequently, ongoing updates would be incorporated into routine reporting. It was noted that, whilst the JCC's role is focused on commissioning, it also contributes to wider system action and oversight through established governance arrangements and partnership working. P Roseblade sought assurance regarding attendance and representation at JCC sub-committees, noting references to Chief Executive absences and the use of deputies. It was confirmed that this had been identified through committee effectiveness reviews, with actions being developed to strengthen resilience and ensure appropriate senior representation, recognising the wider demands on Chief Executives across NHS Wales. K. Palmer asked whether the annual review of the JCC hosting agreement was on track; A Fowler confirmed that it was. He noted that no significant changes were anticipated, with the focus on refining supporting arrangements and resolving operational matters and financial contributions. H George added that progress had been made in addressing legacy HR issues, with the position now largely stabilised, and expressed his thanks to Hayleigh Jones for her outstanding support in resolving these matters.
Resolution:	The report was **NOTED**.
Action:	NWJCC to provide an overview of assurance arrangements for NHS 111 and ambulance services, as set out above. LS to convey H George's thanks and praise to H Jones.

4.2	**Joint Commissioning Committee Organisational Risk Register**
	A Fowler presented the Organisational Risk Register (ORR), noting that it includes risks scoring 15 and above, reflecting high and extreme risks escalated from commissioning directorates and legacy predecessor organisations. Members were advised that the ORR is subject to regular review through established governance arrangements, including the Senior Leadership Team and relevant sub-committees, with onward assurance provided to the Joint Committee. The Committee noted that, as at 1 April 2026, there were 15 risks recorded on the ORR, predominantly commissioning risks, with a smaller number of corporate risks relating to finance and high cost medicines. Members considered the changes to the risk profile since the previous report, including newly identified risks, risk escalations, de-escalations and closures, and noted the ongoing work to refine risk descriptions to better reflect commissioning risks rather than provider-level risks. Discussion focused on the clarity of risk narratives and the robustness of mitigating actions, with Members seeking further assurance that actions clearly demonstrate how risk exposure will be reduced, including in the short term where appropriate. Members also highlighted the importance of ensuring risks remain current and aligned to the evolving financial and strategic context, including the impact of the transformation programme. The Committee noted the anticipated development of the Joint Committee Assurance Framework (JAF), which is expected to further strengthen the alignment between strategic priorities, risk management and assurance reporting. The Committee acknowledged that further work is ongoing to improve the consistency, quality and clarity of risk reporting, particularly in relation to controls and action plans.
Resolution:	The Committee: • **NOTED** the report and the detail contained within the NWJCC Organisational Risk Register as of 1st April 2026 • Took **ASSURANCE** that the NWJCC had appropriate risk management processes and procedures in place for the ongoing management of organisational risk.
Action:	A Fowler to share the draft JAF with committee members for awareness and feedback.
4.3	**Joint Commissioning Committee Audit Tracker**
	A Fowler presented the report, outlining progress against the implementation of internal audit recommendations and providing an overview of the audit programme.

	Members noted the position in respect of completed and outstanding recommendations, including ongoing work relating to Finance Systems and Traumatic Stress Wales, where a number of recommendations remain in progress. Members considered the update on Traumatic Stress Wales (TSW) and noted the ongoing complexity associated with the transfer of the service between organisations. The Committee sought further assurance regarding the continuity of the service during this transition, and requested a more detailed update to support oversight of progress and risks. It was agreed that a further update would be provided, including through the Chief Commissioner's report.
Resolution:	The Committee: • **NOTED** the report • **TOOK ASSURANCE** on progress against the audit programme.
Action:	NWJCC to include an update on TSW via the Chief Commissioner's Report.
4.4	**National Imaging Academy Wales – Risk Register** T. Norris presented the report, outlining the current National Imaging Academy Wales (NIAW) risk register. Members noted that the risk profile comprises one high risk relating to the commissioned number of Clinical Radiology Specialist Trainees, and two moderate risks relating to delivery confidence following the Gateway Review and the Radiology Informatics System Procurement (RISP) project. The Committee noted the potential impact of these risks on workforce capacity, delivery of strategic objectives, and wider stakeholder confidence, alongside the mitigating actions in place and ongoing engagement with key partners including Welsh Government and Health Education and Improvement Wales.
Resolution:	The report was **NOTED.**
Action:	None
5.	**CONSENT AGENDA**
5.1	**ITEMS FOR APPROVAL**
5.1.1	**Unconfirmed Minutes of the Meeting held on 3rd February 2026**
Resolution*:*	The Minutes were **APPROVED**
5.2	**ITEMS FOR NOTING**
	No items identified on this occasion.
6.	**ANY OTHER URGENT BUSINESS**
	No further business was identified. The Chair formally recorded her thanks to H George for his leadership of the Joint Commissioning Committee and his support to the Committee, and wished him well for his retirement.
7.	**DATE AND TIME OF THE NEXT MEETING**
	4th August 2026 at 14:00 pm.