Bundle Audit Committee Part 2 28 October 2019

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4	PART 4 ANY OTHER URGENT BUSINESS
4.1	Audit Committee Members to meet with Auditors
4.2	Close Part 2 of the meeting - Date and time of next meeting

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CWM TAF UNIVERSITY HEALTH BOARD

AUDIT COMMITTEE MEETING
28 October 2019

A meeting of the Audit Committee will be held on Monday 28 October 2019 at Ynysmeurig House, Navigation Park, Abercynon. **Part 1** commences at 9.30am, to be followed by **Part 2** at 11.30am.

MR PAUL GRIFFITHS
CHAIR

PART 2 – HOSTED COMMITTEES
(Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC))

AGENDA

PART 1. PRELIMINARY MATTERS

		LEAD / ATTACHMENT
1.1	Welcome and Introductions	Chair/Oral
1.2	Apologies for absence	Chair/Oral
1.3	Declarations of Interest	Chair/Oral
1.4	'Unconfirmed' Minutes of the meeting held on 15 July 2019	Chair **Attachment**
1.5	Action Log	Chair **Attachment**
1.6	Matters Arising not contained within the Action Log	Chair/Oral

PART 2. INTERNAL CONTROL AND RISK MANAGEMENT

2.1	Update on Internal Audit Recommendations Tracker	WHSSC Director of Finance **Attachment**
2.2	WHSSC Corporate Risk Assurance Framework	WHSSC Committee Secretary **Attachment**
2.3	Review of Financial Authorisation Limits	WHSSC Director of Finance **Attachment**
2.4	WHSSC Model Standing Orders	WHSSC Committee Secretary

2.5	EASC Corporate Risk Assurance Framework	**To follow** Chief Ambulance Services Commissioner
2.6	EASC Model Standing Orders	**To Follow** Chief Ambulance Services Commissioner

PART 3. INTERNAL AND EXTERNAL AUDIT

3.1	WHSSC Information Governance	**To follow**
3.2	WHSSC Review of Cardiac Directorate	**Attachment**

PART 4. ANY OTHER URGENT BUSINESS

4.1	Audit Committee Members to meet with Auditors	**Attachment**
4.2	Close of **Part 2** of the meeting – Date and time of next meeting: • 09.00am Monday 13 January 2020	Oral/Chair

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

'UNCONFIRMED' MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 15 JULY 2019, AT YNYSMEURIG HOUSE, ABERCYNON

PART II – HOSTED BODIES

PRESENT

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

IN ATTENDANCE

David Jones	-	Local Counter Fraud Specialist
Dave Thomas	-	Wales Audit Office
Paul Dalton	-	NWSSSP – Head of Internal Audit & Assurance
Emma Samways	-	NWSSSP - Internal Audit & Assurance
Eifion Jones	-	NWSSSP – Internal Audit & Assurance
Mark Thomas	-	Deputy Director of Finance
Gwenan Roberts	-	Head of Corporate Services
Stuart Davies	-	
Kevin Smith	-	Committee Secretary, WHSSC
Jessica Miles	-	Graduate Trainee (Observing)
Kathrine Davies	-	Committee Secretariat

AC/19/027 **WELCOME AND INTRODUCTIONS**

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

AC/19/028 **APOLOGIES FOR ABSENCE**

Apologies for absence were **received** from Gareth Lucy, Stephen Harrhy, Sara Utley, Steve Webster, Robert Williams and Elisabeth Williams.

AC/19/029 **DECLARATIONS OF INTERESTS**

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

AC/19/030 **UNCONFIRMED MINUTES OF THE AUDIT COMMITTEE MEETING HELD ON 1 APRIL 2019**

The minutes of the Audit Committee Part II, held on 1 April 2019, were received and **APPROVED** as an accurate record.

AC/19/031 **ACTION LOG**

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

19/007 – Audit Tracker – Members **NOTED** that an update would be given in item 2.1 on the Agenda.

Members **RESOLVED** to:

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

AC/19/032 **MATTERS ARISING NOT CONTAINED WITHIN ACTION LOG**

AC/19/020 – Audit Tracker – Stuart Davies advised Members that the issues in regards to HRG4+ had now been resolved. Welsh Government had come to an agreement with NHS England and agreed £9.0m for WHSSC and £2/3.0m for Health Boards for Hospital Management. Maria Thomas queried whether this would be the position for next year. Stuart Davies advised that there could be a danger that tariff prices would increase by one to two per cent.

PART 2. INTERNAL CONTROL AND RISK MANAGEMENT

AC/19/033 **AUDIT TRACKER**

Stuart Davies presented the report and advised that 11 reports had been issued with 37 recommendations made. Members **NOTED** that all of the recommendations had reached their target date, 32 recommendations had been achieved and 5 recommendations were outstanding.

Members **NOTED** that work was ongoing in relation to high cost drugs to ensure there were financial restraints and alternative measures with providers to ensure checks were being carried out.

With regard to structural issues, Members **NOTED** that the Board Advisory Group had completed the review of the Framework and this was now effectively closed.

Members **NOTED** that in regard to CAMHS, work was underway to ensure it was safe to increase the capacity within the CAMHS Unit.

Members discussed high cost drugs and how frequently independent validations were carried out. Members were of the opinion that it would be useful to review the justification at a future meeting.

Members **NOTED** that the Policy on PHT had been redrafted and should be ready for approval in September.

Members **RESOLVED** to:

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

AC/19/034 **WHSSC CORPORATE RISK ASSURANCE FRAMEWORK**

Kevin Smith presented the report which provided Members with an update on the WHSSC risk management framework as at 31 May 2019.

Members **NOTED** that the risk management framework for WHSSC as a commissioning organisation had been reviewed during the last year and the new agreed process was being rolled out throughout the organisation and refined. Directorates and/or Commissioning teams were reviewing all risks, including the risks arising out of the Integrated Commissioning Plan 2019-22, and updating the registers to the new template.

Members **NOTED** that since the last report, 4 risks have been removed from the register, namely:

- NC/012 Neurosurgery
- NC/022 Paediatric Neurosurgery
- WC/039 Inherited Metabolic Diseases (IMD)
- WC/041 Paediatric Oncology

There were currently 13 services in escalation.

Members **RESOLVED** to:

- **NOTE** the update provided within the report
- **RECEIVE** assurance that risks were being appropriately assess and managed.

PART 3. ANY OTHER URGENT BUSINESS

AC/19/035 There was no other business to report.

AC/19/036 **DATE OF NEXT MEETING**

Monday 28 October 2019 at 9.00 am

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Paul Griffiths, Chair

.....

Date

Agenda Item Number 1.5

AUDIT COMMITTEE ACTION LOG
From 15 July 2019
(Part 2 – Hosted Bodies)

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS At July 2019
19/007	14/1/2019	Audit Tracker	Interim update to be provided at the next meeting in relation to progress made against CAMHS actions and recommendations	April 2019	WHSCC Director of Finance	**Completed**
19/020	1/4/2019	Audit Tracker	Report to be updated to clearly identify the finding and recommendation, why the recommendation had been delayed and when the recommendation would be addressed	July 2019	WHSCC Director of Finance	**Completed**

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

		Agenda Item	2.1
Meeting Title	**Audit Committee**	Meeting Date	28/10/2019
Report Title	Internal Audit Recommendations Tracker		
Author (Job title)	Financial Accountant		
Executive Lead (Job title)	Director of Finance	~~Public~~ / In Committee	In Committee

Purpose	To provide a progress report on the implementation of internal audit recommendations			
RATIFY ☐	APPROVE ☒	SUPPORT ☐	ASSURE ☐	INFORM ☒

Sub Group /Committee	Audit Committee	Meeting Date	28/10/2019
	Choose an item.	Meeting Date	Click here to enter a date.
Recommendation(s)	Members are asked to: • **Note** the progress achieved in implementing the recommendations made by Internal Audit. • **Approve** the contents of this report.		

Considerations within the report (tick as appropriate)

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

1.0 Situation

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

2.0 Background

The fieldwork for the 2018/19 Plan has now completed and the new plan for 2019/2020 has now started. All reports presented to audit committee have been included in this review.

Regarding internal audit reports issued from April 2017:

- 9 reports have been issued:
- 28 recommendations have been made
- There is only 1 recommendation that has not reached its due date for implementation
- 27 recommendations have been achieved and only one is outstanding.

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

3.0 Assessment

Of the internal audit report on Cardiac Services:

- 3 recommendations were made, of which 2 have been achieved and 1 is progressing but has not yet reached its due date.

4.0 Recommendations

Members are asked to:

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

5.0 Appendices / Annexes

- Audit Recommendations Progress Tracker

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

Legal Implications	There may be an adverse effect on the organisation if arrangements are not put in place to ensure robust and detailed governance arrangements as determined through internal audit assessment

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

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

No.	Recommendation	Priority	Timescale	Lead Director	Owner	Progress	Completed
IA BG 2018 1	**FINDING:** There was a Terms of Reference in place for all of WHSSC's Advisory Groups. However all were overdue for review. · The Wales Renal Clinical Network Board Terms of Reference should be reviewed annually. These were approved by the Joint committee in September 2016, and last reviewed in August 2017. · The NHS Wales Gender Identity Partnership Group Terms of Reference should be reviewed annually, but was last reviewed and approved by the Joint Committee in June 2017. · The All Wales Posture and Mobility Partnership Board Terms of Reference should be reviewed annually. These were last reviewed during 2015, and approved by the Joint Committee in June 2017. **RISK:** There is a risk that governance arrangements are not being properly discharged. There is a risk of ineffective decision making and monitoring. **RECOMMENDATION:** The Terms of Reference for the above advisory groups and the Wales Renal Clinical Network should be reviewed as soon as practicably possible and each year going forward.	MEDIUM	Jan-19	Committee Secretary	Committee Secretary	The Terms of Reference will be reviewed as part of the bi-annual review of the Governance and Accountability Framework, which is scheduled for autumn 2018. **PROGRESS: As at March 2019, This review has now started** **PROGRESS: As at October 2019 - (1) WRCN Revised its terms of reference and these were approved by JC on 14/05/2019. (2) NHSWGIPG - The terms of reference have been reviewed but a decision on the future of the Group is pending therefore no changes were recommended. The Group may be disestablished by JC at its meeting on 12/11/2019.** **PROGRESS: P&M - A decision on the future of the Group is pending following the resignation of the Chair due to a change in their substantive full time role. The main objectives of the group have been realised with significant investment into wheelchair services across Wales and regular performance meetings with the service to ensure equity of access. The Group may be disestablished as a result of this.**	COMPLETED
IA BG 2018 2	**FINDING:** The Mental Health and Learning disabilities Collaborative Commissioning Group did not meet during 2016/17 or 2017/18. Although the Collaborative's new NHS Wales Mental Health Network Board will cover much of the work previously undertaken by the now defunct MHLD Group, the remit of the new MHNB specifically excludes learning disabilities services, which leaves a gap in provision in relation to learning disabilities to the Joint Committee / WHSSC. **RECOMMENDATION:** the MHLD should be formally wound up and removed from the WHSSC governance structure. Consideration should be given to setting up a new advisory group to focus on learning disability services. **RISK:** There is a risk that governance arrangements are not properly discharged. There is a risk of ineffective decision making and monitoring.	MEDIUM	Jan-19	Director of Planning	Committee Secretary	Accepted. This will require an explanatory paper with a recommendation to Joint committee. The explanation will also explore the other areas where there may be gaps in scope between the Mental Health and Learning Disabilities Collaborative Commissioning Group and the Mental Health Network Board. **PROGRESS: As of March 2019, this will be picked up as part of the review of the GAF which is underway.** **PROGRESS: As of October 2019, WHSSC MD has opened a discussion with WG regarding a new learning disability advisory group. WG have established a Task & Finish Group to consider the role of this advisory group. WHSSC MD is writing to influence the terms of reference regarding what WHSSC needs from a learning disability advisory group.**	COMPLETED
IA BG 2018 3	We reviewed the minutes of the last seven Joint Committee meetings held between July 2017 and July 2018 to ensure reports were being regularly received from advisory groups and boards. The All Wales Posture and Mobility Partnership Board had not submitted any reports to the Joint Committee during the period that we reviewed. WE note that the group had met in December 2017, and again in March 2018, but the last report from that group that was submitted to the Joint Committee was in March 2017. There is a risk that governance arrangements are not being properly discharged. There is a risk of ineffective decision making and monitoring. The All Wales Posture and Mobility Partnership Board should be reminded of the requirement to submit a report to the Joint Committee following each advisory group meeting.	MEDIUM	Oct-18	Committee Secretary	Committee Secretary	Accepted. The chair of the All Wales Posture and Mobility Partnership Board will be reminded.	COMPLETED

Welsh Health Specialised Services Committee
Register of Recommendations from the Internal Audit Report on High Cost Drugs
October 2019

No.	Recommendation	Priority	Timescale	Lead Director	Owner	Progress	Completed
IA HCD 2018 1	**FINDING:** No routine validation checks are undertaken by the IPFR team of finance department to ensure that deceased patients are identified. This would minimise the risk of erroneous provision of drugs and services and invoicing A sample of 40 patients was tested from the IPFR team database from across three high cost drug areas that were under review. 6 of these patients were identified as deceased. While our testing confirmed that there was no evidence of "over invoicing" after the date of death, it was noted that the finance department is not proactive in establishing this information and therefore updating its monitoring records. Currently the finance team is reliant on health care providers informing them that a patient is deceased or identifying that an invoice has not been received for a patient for a period of time. However, we note that WHSSC's information team are able to produce a report that lists deceased patients. **RECOMMENDATION:** Periodic validation checks should be undertaken by the finance department to ensure deceased patients are identified and records are updated reducing the risk of erroneous provision of drugs or services and subsequent invoicing. The IPFR team should also be informed of identified deceased patients in order for their records to be updated. **RISK:** There is a risk that services are incorrectly provided and paid for.	MEDIUM	Dec-18	Director of Finance	Director of Finance	**MANAGEMENT RESPONSE:** Finance department to check records for deceased patients and update the IPFR team accordingly. It is accepted that we can implement for high cost patients via the information department on a periodic basis. **PROGRESS: Validation checks for deceased patients are part of a suite of checks undertaken for all services covered under commissioning contract, which will include a number of separately commissioned high cost drugs. Where patients receive ongoing high cost drugs as part of a service commissioned outside the contract process these checks are now undertaken on a regular basis. Since the date of this review there have been 2 such exercises competed where by patient lists are cross matched against the NHS Wales demographic database. Due to the number involved this exercise cannot be undertaken every month. In line with the results of the internal audit testing these exercises have not uncovered any evidence of "over invoicing" either.**	COMPLETED
IA HCD 2018 2	**FINDING**: There are policies in place for the HPN and ERT high cost drugs which are supported by a formal process for periodic review, revision and approval. It is acknowledged that the decision making processes that underpin the commissioning of PHT is supported by use of the NHS England PHT Commissioning Guidance 2014 documentation but there is no WHSSC policy in respect of PHT. **RECOMMENDATION:** WHSSC should produce a policy for commissioning PHT that outlines justification, pre-determination, exclusion criteria and funding approval strategies. **RISK:** There is a risk that services are not appropriately commissioned and provided in line with agreed policies and procedures	LOW	Jan-19	Director of Planning	Assistant Director of Evaluation	**MANAGEMENT RESPONSE:** Accepted that a revised policy is required that either adopts or amends the NHS England one used in practice. **PROGRESS: This recommendation has been superseded by the Internal Audit report on Cardiac Services. PHT is one of the commissioning policies that is to be covered as part of the service specifications and policies review.**	COMPLETED

Welsh Health Specialised Services Committee
Register of Recommendations from the Internal Audit Report on Risk Management
October 2019

No.	Recommendation	Priority	Timescale	Lead Director	Owner	Progress	Completed
IA RM 2018 1	FINDING: The risks included on the Corporate Risk Assurance Framework (CRAF) relate to commissioning, with the Director of Planning assigned as the lead director responsible for all of them. Wider organisational risks relating to areas such as workforce, finance new legislation (General Data Protection Regulations), and BREXIT implications are not formally recorded. However, we acknowledge that these are being assessed by the organisation's Risk Management group. We attended the November 2018 meeting of the Risk Management Group where risks that were not related to commissioning were assigned to lead officers for assessment and scoring. RECOMMENDATION: 1. Management should ensure that the assessment of organisation risks are clearly documented in departmental risk registers where relevant. 2. Any department risk that scores high enough, should be escalated onto the CRAF for ongoing monitoring. RISK: Risks may materialise as monitoring and scrutiny is not appropriately undertaken.	HIGH	Sep-19	Committee Secretary	Committee Secretary	**MANAGEMENT RESPONSE:** Accepted. At the February meeting of the Internal Risk Management Group members provided a progress update on the risks allocated for assessment. The majority of risks presented scored less than 15 and therefore will be monitored through the directorate risk registers. Those scoring over 15 will be escalated to the Corporate Risk Assurance Framework, which will be reviewed and approved by the Corporate Directors group. Assessment of risks is a live process and therefore risks may be escalated and de-escalated through out the year.	COMPLETED
IA RM 2018 2	**FINDING:** The main guidance document within the organisation for risk management is the Integrated Risk Management Framework. We read the framework document and considered how it aligns to current operating practices. We note the following points: •Evidence of approval of the document by the corporate Directors Group could not be obtained. •At the time of our audit fieldwork the Integrated Commissioning Plan (ICP) Risk Management Arrangements section of the framework has not been populated. Given the ICP is a key document for WHSSC, we would expect the arrangements for managing the risks associated with delivery of the plan to be clearly articulated. •The framework makes reference to a Corporate Risk Assurance Framework (CRAF), a Board Assurance Framework (BAF) and a corporate risk register. However, only the CRAF exists and management have acknowledged that the framework needs to be reviewed to reflect this •The risk reporting and escalation chart within the appendices does not align to current practice. **RECOMMENDATION:** 1. The Integrated Risk Management Framework should be reviewed for appropriateness , relevance and completeness. 2. A revised framework should be approved by the relevant committee and evidence of approval recorded in the committee minutes. **RISK:** Risks materialise as the policy is not appropriately applied.	MEDIUM	Jun-19	Committee Secretary	Committee Secretary	**MANAGEMENT RESPONSE:** 1. The Integrated Risk Management Framework has been reviewed and presented to the February meeting of the Internal Risk Management Group for consultation. The comments received during the consultation will be considered, and the framework amended where appropriate. 2. The revised framework will be presented to the Corporate Directors Group **PROGRESS: as at October 2019 The Integrated Risk Management Framework has been revised and it is expected to go to CDGB in November 2019.**	COMPLETED

IA RM 2018 3	FINDING: WHSSC's risk appetite statement is contained within the Integrated Risk Management Framework. A risk maturity matrix is included as an appendix to the framework and has been used as a guide to set risk appetite. However, the risk appetite statement itself is brief comprising of three statements stating what the organisations appetite is in relation to commissioning risks, fraud, finance, governance and accountability risks. In other organisations we have seen more detailed risk appetite statements, covering a wider range of business areas and descriptions. We could evidence that risk appetite had bee discussed by the Joint committee in January 2018, however, at the time of the audit fieldwork no plans had been made for the annual review. Within the framework, the accountabilities section for the Joint committee states "The Joint Committee is responsible for setting the strategic direction fro risk and over seeing the integrated risk management arrangements across the organisation ". We have been informed by the Corporate governance Manager that this responsibility has been delegated to the Managing Director who sits on the Corporate Directors Group (CDG), who approved the framework and therefore risk appetite. However, we could not be provided with any documentation to support this decision. RECOMMENDATION: 1. In line with the Integrated Risk Management Framework, the organisation should review its risk appetite on an annual basis, with any decision made regarding the risk appetite properly recorded in relevant minutes and the framework updated accordingly. 2. Consideration should be given as to whether the Corporate Directors Group is the correct forum for approving the Integrated Risk Management Framework given that the framework itself states that the Joint committee is responsible for setting the strategic direction for risk	MEDIUM	Jun-19	Committee Secretary	Committee Secretary	**MANAGEMENT RESPONSE**: Partially accepted. 1. The risk appetite statements will be reviewed as part of the refresh of the Integrated Risk Management Framework and then annually following approval of the framework. 2. Management consider the the corporate Directors Group is the correct forum for approval of the risk management framework as the Managing Director has "responsibility for maintaining appropriate governance structures and procedures as well as a sound system of internal control that supports achievement of the Joint committees policies, aims and objectives" this delegation will be made clearer during the forthcoming review of the Scheme od Delegation.	COMPLETED
IA RM 2018 4	FINDING: WE tested a sample of five risks on the CRAF to ensure that movement s in risk scores were justifiable and appropriate. We note that: • Original risk scores are not noted on the CRAF. Where risk scores had m oved it is difficult to identify these changes, furthermore there was no annotation on the CRAF to state what additional controls had been implemented to mitigate the risk and support the lower score. • For 1/5 risks in our sample, an action had not been assigned a lead officer, and an implementation timescale had not been recorded. • For risk WC/38 we note the following action to be completed "Requested business case from C&V to inform 2019/20 IMTP", with a target date of October 2018. However, the report submitted to the Quality and Patient Safety Committee in January 2019 does not give an update on this action. RECOMMENDATION: 1. The CRAF should be kept up to date with information in relation to actions that have taken place, lead officers and timescales. 2. Where risk scores have been amended, reasons should be recorded to demonstrate the reason for the change. 3. Consideration should be given to including original risk scores so that movements over time can be tracked. RISK: Organisation objectives are not fully achieved as risks materialise.	MEDIUM	Jun-19	Committee Secretary	Committee Secretary	**MANAGEMENT RESPONSE:** Noted. As part of the review of the Integrated Risk Management Framework these findings will be considered. However, it must be noted that the premise behind the CRAF is a risk on a page.	COMPLETED

Welsh Health Specialised Services Committee
Register of Recommendations from the Internal Audit Report on Cardiac Services
October 2019

No.	Findings	Recommendation and Risk	Priority	Timescale	Lead Director	Owner	Progress	Completed
IA CS 2019 1	**FINDING:** Service specifications and policies should be in place for each of the cardiac specialities that WHSSC commissions. The service specification defines the core requirements that WHSSC expects providers to have in place, whereas the policy outline WHSSC overall policy for a particular treatment or interventions. In the earlier part of 2018-19, work undertaken by the cardiac services team identified gaps around the specifications and policies in place. Some policies were out of date, while, some areas never had a policy in place. These were reflected in the cardiac annual work plan. We have reviewed the service specifications, policy positions and commissioning policy to ensure areas within cardiac services, which required documentation, had them in place. We identified the following: . At the time of the audit field work 1 out of 6 cardiac service areas that are required to have a policy position did not have one. One missing policy in relation to Everolimus was in draft at the time of the audit fieldwork, and has since been approved and published. In additional, WHSSC were unable to find the cardiac transplant policy. We note that the annual work plan reflects that work is needed in this area. . 2 out of 4 cardiac service areas that are required to have a commissioning policy did not have one that was in date. The outdated policies relate to Cystic Fibrosis (June 2018 review date) and Targeted therapies pulmonary hypertension (February 2014 review date) We acknowledge that these are either on the annual work plan for drafting, or are already in the process of being drafted. . 5 out of 7 cardiac service areas that are required to have a service specification did not have one. Reference is made to ongoing work in these areas as part of the cardiac services annual plan	**RECOMMENDATION:** All areas identified as needing service specifications and/ or a policy should be drafted in line with the timeframes set out in the cardiac services annual plan. **RISK:** There is a risk that value for money and quality of service may not be maximised.	HIGH	Apr-20	Director of Planning	Cardiac specialised services planner	**MANAGEMENT RESPONSE:** The Cardiac commissioning team will review all commissioning policies / policy positions and service specifications that are either out of date or not in place. Where not identified on the work plan we will agree the priority and timescales and document on the work plan. This will be undertaken as a high priority and within 1 month timescales. all policy reviews and service specifications will therefore be drafted in line with the agreed work programme. **PROGRESS: The cardiac commissioning team has reviewed all commissioning policies and has a prioritised list to work through.** **In relation to the cystic fibrosis service specification, this has been drafted with the support of the clinical team and will be circulated for consultation in November.**	
IA CS 2019 2	**FINDING**: There is a risk register specific to cardiac services which is maintained and reviewed on a monthly basis by the specialised planner and assistant planner. Changes made to the risk register are discussed at the cardiac commissioning team meetings. Relevant high scoring risks are reported at a corporate level and relevant directors are consulted when required. We reviewed the risk register and note that it is regularly reviewed and updated, with the last update being 7th June 2019. Our review of the risk within the risk register identified that 6 out of 16 risks which were still open did not have a subsequent review or due date. . 4 out of 16 risks showed control measures as "complete" though they remained as "open" on the register, with no further control measure or future review date for managing the risk. . 1 out of 16 had March 2019 as the review date and no further update provided. . 1 out of 16 had no control measure or review date information recorded against it	**RECOMMENDATION:** For all risks recorded on the register, future review dates should be recorded and updated. **RISK:** Risks might not be identified or effectively managed.	MEDIUM	Oct-19	Director of Planning	Cardiac specialised services planner	**MANAGEMENT RESPONSE:** The risk register has been reviewed and future review dates have been included or risk removed as per agreed process through the cardiac commissioning team.	COMPLETED

No.	Findings	Recommendation and Risk	Priority	Timescale	Lead Director	Owner	Progress	Completed
IA CS 2019 3	**FINDING:** WHSSC has developed generic terms of reference for their commissioning teams. The cardiac services commissioning team meetings currently take place on a six weekly basis whereas the terms of reference suggests meetings should be monthly. The main areas such as performance, information, finance, work plan, quality and patient safety are discussed and reports are presented where required. Minutes, agendas and action plans are produced for each meeting. WHSSC does have a working relationship with the cardiac services network. However, as the terms of reference for the commissioning team meetings are generic, it is difficult to understand the relationship between the cardiac team and the cardiac network and also where responsibilities lie. As such, there is a risk of duplication of effort, or conflicting information being provided.	**RECOMMENDATION:** Management should ensure the terms of reference for the cardiac services commissioning team is reviewed, or an addendum to the current terms of reference is produced that clearly outlines their roles, responsibilities and relationship with the cardiac network, thus providing greater clarity and avoiding potential duplication of work. **RISK:** There is a risk that services are not effectively and efficiently planned and commissioned.	MEDIUM	Oct-19	Director of Planning	Cardiac specialised services planner	**MANAGEMENT RESPONSE:** The terms of reference are generic to all commissioning teams. An addendum to the ToR's will be developed by the cardiac commissioning team for approval by the Corporate Directors Group. This good practice will also be repeated for each of the commissioning teams. **PROGRESS: Terms of Reference have been reviewed by the commissioning teams and updated to reflect current processes and to include an addendum outlining the relationships with the networks. Revised Terms of Reference are to be presented to the Corporate Directors Group on 14th October 2019.**	COMPLETED

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

Report Title	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations over due (Original Date)	Recommendations with a revised due date
Wales Renal Clinical Network Programme Team	January 2017	January 2017	4	4	0	0	0	0
Cancer and Blood Programme Team	February 2017	April 2017	3	3	0	0	0	0
Patient Identifiable Information	March 2017	November 2017	4	4	0	0	0	0
Governance Framework	October 2017	November 2017	3	3	0	0	0	0
Mental Health Programme Team	January 2018	January 2018	2	2	0	0	0	0
Boards & Groups	September 2018	October 2018	3	3	0	0	0	0
High Cost Drugs	September 2018	October 2018	2	2	0	0	0	0
Risk Management 2018	March 2019	April 2019	4	4	0	0	0	0
Cardiac Services	August 2019	October 2019	3	2	1	1	0	0

		Agenda Item	2.2
Meeting Title	Cwm Taf Morgannwg Audit Committee – Part 2	Meeting Date	28/10/2019
Report Title	WHSSC Corporate Risk and Assurance Framework		
Author (Job title)	Business Support Officer		
Executive Lead (Job title)	Committee Secretary	Public / In Committee	In Committee

Purpose	The purpose of this report is to provide Members with an update on the WHSSC risk management framework as at 31 August 2019.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☒	☒

Sub Group /Committee		Meeting Date	Click here to enter a date.
		Meeting Date	
Recommendation(s)	• **Note** the update provided within the report. • **Receive assurance** that risks are being appropriately assessed and managed.		

Considerations within the report (tick as appropriate)

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

1.0 SITUATION

The purpose of this report is to provide Members with an update on the WHSSC risk management framework as at 31 August 2019.

2.0 BACKGROUND

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

2.1 CURRENT PROCESS FOR REVIEW OF RISKS AND ASSURANCE

The risk management framework for WHSSC as a commissioning organisation has been reviewed during the last year and the new agreed process has been rolled out throughout the organisation and refined. Directorates and/or Commissioning teams are reviewing all risks, including the risks arising out of the Integrated Commissioning Plan 2019-22, and updating the registers to the new template.

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

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

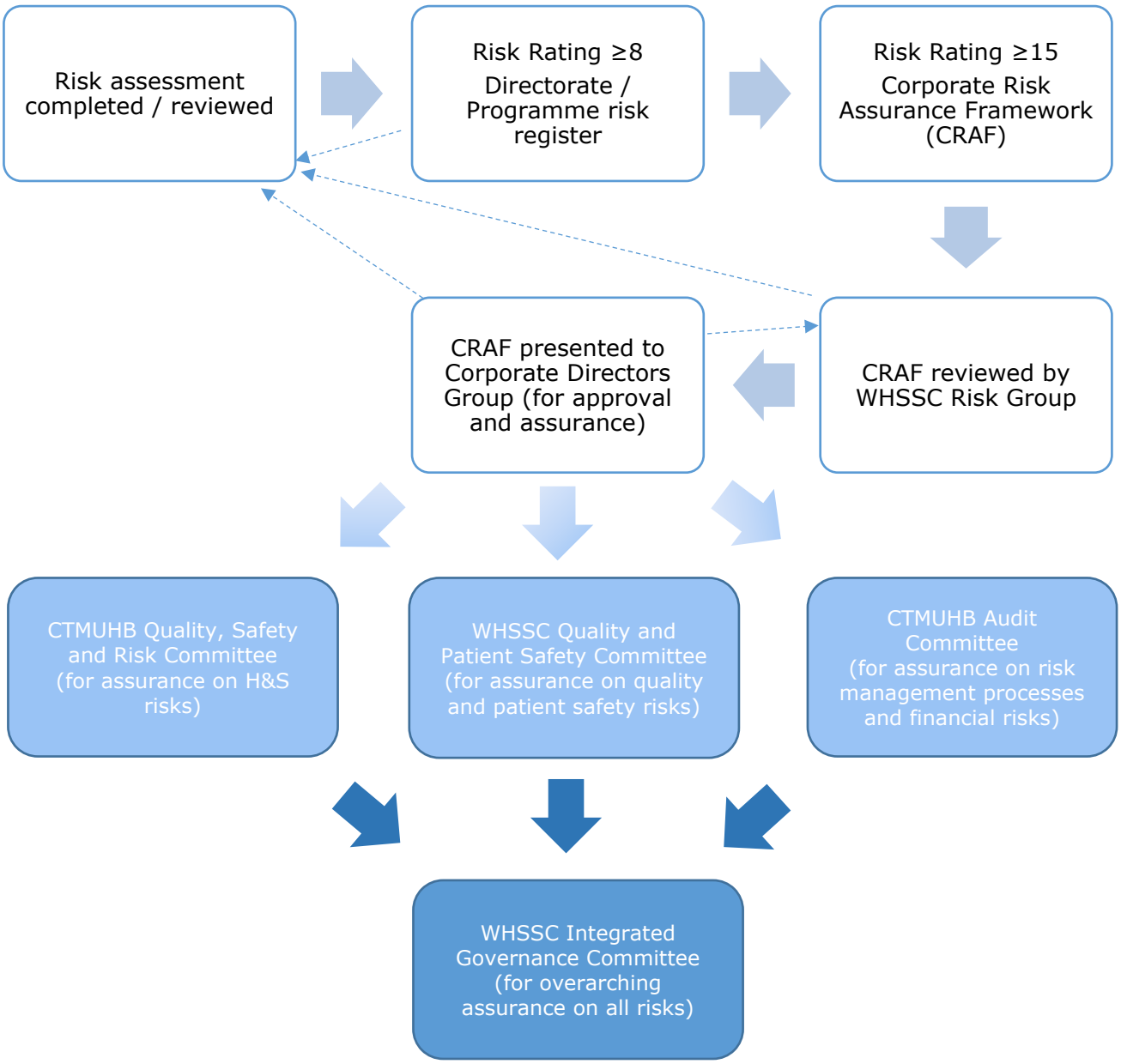
Risks scoring 15 or above in any domain are escalated to the CRAF. All risks within the CRAF are assigned a lead Executive and are aligned to an assuring committee. Each lead Executive is ultimately responsible for the ownership of the assigned risk/s and the reporting of any actions in place to mitigate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

The CRAF is considered at the WHSSC Internal Risk Management Group. This leads to an enhanced focus on risk management generally and an improved level of triangulation between provider performance and risk for commissioning risks.

The CRAF is reported routinely to the WHSSC Corporate Directors' Group, Integrated Governance Committee and the Quality and Patient Safety Committee. The CRAF is also reported into the Cwm Taf Morgannwg UHB Audit and Quality, Safety & Risk Committees.

2.2 REVIEW AND ASSURANCE OF THE CORPORATE RISK AND ASSURANCE FRAMEWORK

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



3.0 3.0 ASSESSMENT

3.1 Work on further developing the CRAF has been undertaken over a number of months and WHSSC Officers have received and acted upon feedback from all committees (as noted above) to whom the CRAF has been presented.

3.2 Members of the WHSSC Integrated Governance and Quality & Patient Safety Committees received a report from the Director of Planning during August 2019, summarising the work undertaken to review the commissioning team risk registers and risk management process and explaining the closure of certain commissioning risks.

3.3 Members of the WHSSC Corporate Directors Group Board received a report from the Committee Secretary during October on the status of non-commissioning risks identified through the Internal Risk Group and charged the Executive leads to ensure that the risk are assessed and rated during the coming weeks. On face value the identified risks look unlikely to score 15 or above and are therefore unlikely to be added to the CRAF.

3.4 The Director of Planning continues to be the designated lead Executive in the case of all risks currently scoring 15 or above and therefore identified on the CRAF. The WHSSC Quality & Patient Safety Committee is the assurance committee for these risks.

3.5 In the meantime the Directorate and Programme risk registers continue to be reviewed monthly – they are 'live' documents.

3.6 As at 1 October 2019, the August Neuro and Chronic Conditions Risk Register had not been updated for the August position. Therefore the data reflected in this report is taken from the July 2019 Neuro and Chronic Conditions Risk Register.

3.7 For the purpose of this report there are 28 risks that attract a rating of 15 or above on the CRAF.

3.8 Since the last report no risks have been added to the register.

3.9 Since the last report, **5** risks have been removed from the register, namely:

- WC/024 Genetics
- CH/020 Lung Cancer
- CH/032 BMT south Wales service: JACIE accreditation
- CH/040 BMT south Wales laboratory capacity
- CH/041 Genetics

3.10 There are currently 12 services in escalation as at August 2019 - detailed in table 1 below:

Table 1. Services in Escalation as at August 2019

Speciality	Level of Escalation	Mitigating action[s]	Movement from previous month
Cardiac Surgery	2	Performance meetings continue bi-monthly with SBMUHB	→
	3	Monthly performance meetings continue with C&VUHB	→
	2	Performance meetings continue bi-monthly with LHCH	→
Thoracic surgery	2	Bi-monthly performance meetings continue with SBMUHB and C&VUHB.	→
Lymphoma Panel	2	Performance meetings are in place with the All Wales Lymphoma Panel (CVUHB and SBMUHB).	→
Plastic Surgery	2	Monthly performance meetings continue with SBMUHB	→
Neurosurgery	2	The service remains at level 2 escalation whilst breaches over 36 weeks are still being reported in relation to a sole consultant undertaking the majority of the urgent tumour work. A locum is in place from early July and the service hopes to clear and maintain zero breaches over 36 weeks by the end of September.	→
Adult Posture & Mobility	2	The BCU Adult service has met the target for complex wheelchairs for the last two months and if this waiting list position remains consistent, will be able to be de-escalated.	→
CAMHS	3	An action plan has been developed with BCUHB and significant improvements to workforce issues have been made in last 3 months.	→
	3	The CAMHS service in South Wales at Ty Llidiard was escalated straight to level 4 following inpatient incident leading to a temporary closure of the unit. Site visit and findings from QAIT report led to unit being reopened to admissions on case by case basis and de-escalated to Level 3 with action plan developed.	→
Paediatric Surgery	2	The service has reported no breaches over 36 weeks for the last 3 months and de-escalation is being considered	→
Paediatric Intensive Care	2	Regular meetings are taking place with the service whilst the recruitment to staff for a seventh bed is undertaken and will continue to take place until the effects of this additional capacity on key performance indicators is known	→
BMT	2	The BMT service in south Wales has recently been placed into level 2 escalation to explore further concerns raised.	→

IVF Shrewsbury	2	The service reported no breaches over 26 weeks against any of the reported targets in June. Following a few months of consistent reporting and achievement of the targets, de-escalation will be considered.	→
Sarcoma	2	WHSSC has arranged weekly input into MDT from surgeon at Royal Orthopaedic. WHSSC is coordinating discussions with health board leads for cancer and radiology to reach an agreement on the diagnostic pathway in south east Wales.	→

4. RECOMMENDATIONS

Members are asked to:

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

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance
Link to Integrated Commissioning Plan	Implementation of the agreed ICP
Health and Care Standards	Safe Care Effective Care Governance, Leadership and Accountability
Principles of Prudent Healthcare	Only do what is needed Reduce inappropriate variation
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and satisfaction)
Organisational Implications	
Quality, Safety & Patient Experience	Robust risk management arrangements are a requisite to the assurance of quality of care, patient safety and the patient experience.
Resources Implications	Some improvement actions may require the application of additional resources.
Risk and Assurance	This report and the CRAF constitute integral elements of WHSSC's risk and assurance arrangements. This work continues to develop.
Evidence Base	The CRAF is based on the extreme risks recorded within the Directorate and Programme risk registers.
Equality and Diversity	There are no equality and diversity implications.
Population Health	There are no immediate population health implications.
Legal Implications	It is essential that there are robust arrangements in place to identify, assess, mitigate and manage risks encountered by WHSSC. Failure to maintain such arrangements may have legal implications.

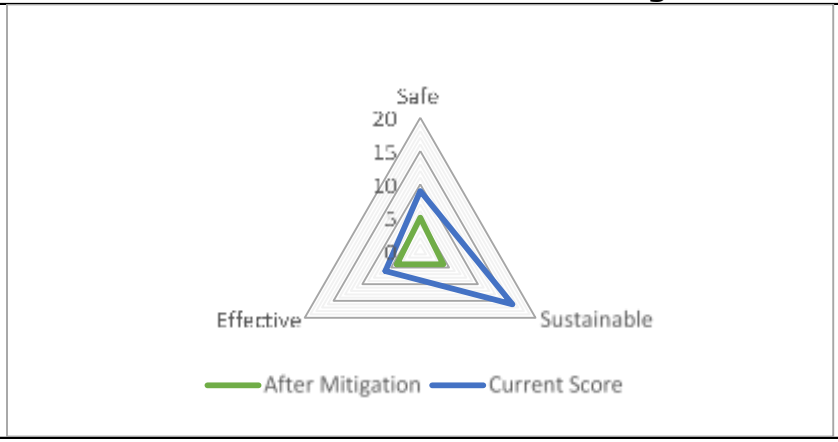
Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**

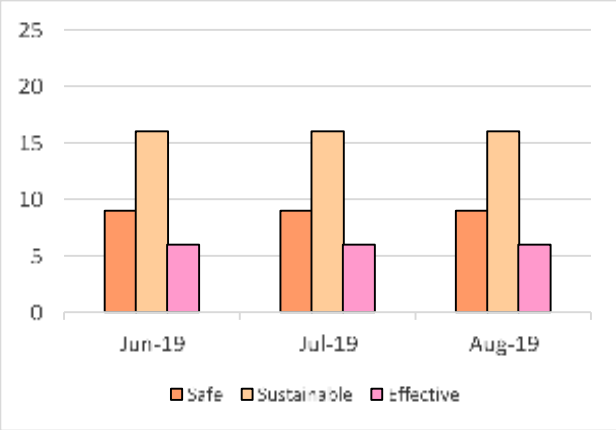
CH/011 AUGUST 2019	**Thoracic Surgery** **Risk:** There is a risk that the current service will not be able to meet the requirement for a dedicated thoracic surgery out of hours rota. This is caused by changes in cardiac and thoracic surgery training and practice (phasing out dual practice / thoracic only out of hours rota). This would lead to the inability to provide a 24/7 rota for thoracic surgery which would mean a safe service could not be sustained.	**Director lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 02/10/2013 **Date last reviewed by Programme/Directorate:** C&B Commissioning 23/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	**5**	**4**	**4**
Current Score	**9**	**16**	**6**

WHSSC Risk Assessment Triangle





Escalation Narrative: Level 2. Bi-monthly performance meetings in place.

Current Control Measures in Place

i) Health Boards agreed the recommendation for a single centre at Morriston Hospital in Nov 2018; ii) Strategic review of the future service model for thoracic surgery is now in the implementation phase led by SBU (work currently being undertaken on the workforce model); iii) CVU: recruitment of substantive third surgeon underway with SBUHB involved in the process; iv) CVU additional theatre list is unlikely to become available but every opportunity to backfill cardiac surgery is taken. v) SBU: arrangements for weekend working in place; vi) Service Level Agreement activity is being delivered in both centres.

Description of further Control Measures Required

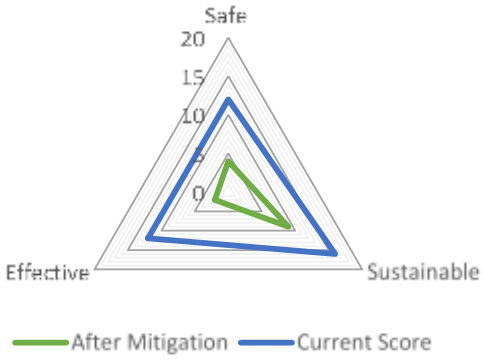
Action	Lead	By when
Implementation of Thoracic Surgery Review Recommendations	Managing Director	01/09/2021
Bimonthly performance meetings with both CV UHB and SB UHB	DoP	Next meetings: CV: 18/09/19 SB: 20/09/19
Develop the consultant thoracic surgeon workforce requirement (to meet future demand, provide 24/7 on call, inc. cover for MTC) and make recommendation to Joint Committee	DoP	Joint Committee 28/07/19
Provide commissioner perspective and input to the Implementation Project Board led by Swansea Bay UHB to support the sustainability of the service through transition to the new centre	DoP	Monthly meetings; next meeting 27/09/19

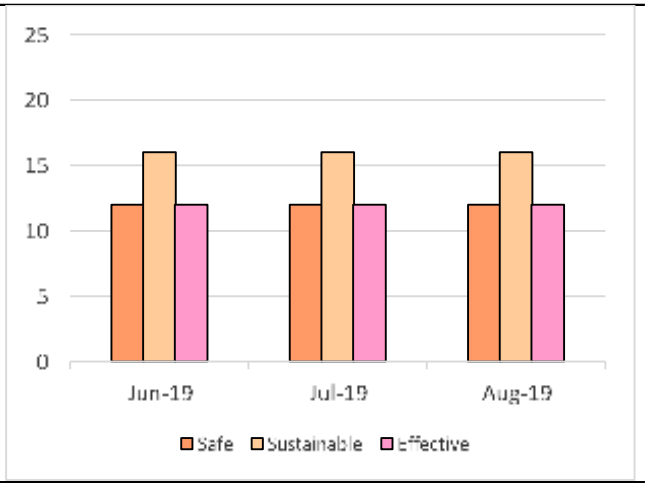
CH/016 AUGUST 2019	**HAEMOPHILIA – Sustainability of the Haemophilia Service at SBUHB** **Risk:** There is a risk that provision of IBD services at Singleton Hospital cannot be sustained. This is caused by difficulty recruiting a haematologist with IBD sub speciality expertise. Cover is being provided on a temporary basis by the Comprehensive Care Centre in CVUHB. This would lead to the loss of specialist IBD service in Swansea Bay UHB and patients needing to travel further for care, increasing pressure on the CCC.	**Director lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed 22/09/2016** **Date last reviewed by Programme/Directorate:** C&B Commissioning 23/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	**4**	**9**	**2**
Current Score	**12**	**16**	**12**

WHSSC Risk Assessment Triangle





Escalation Narrative:

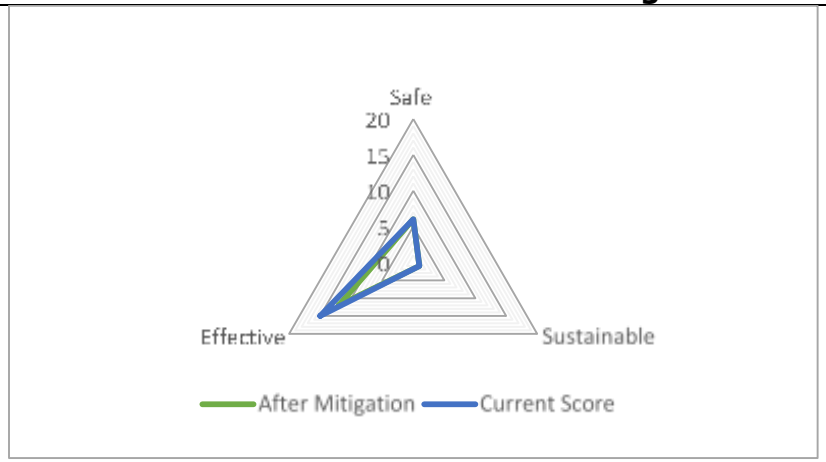
Current Control Measures in Place	**Description of further Control Measures Required**		
	Action	Lead	By when
i) IBD consultants from UHW will continue to attend a monthly clinic on site in SBUHB supported by the senior SpR currently on placement in SBUHB; ii) SBU continues to provide IBD CNS and other allied health professional support for both ad hoc and scheduled clinical work, supported by middle grade and consultant haematologist input from SBU as needed, utilising the more specialised advice and support from UHW as/when required; iii) Funding has been agreed within the WHSSC ICP 2019-20 for the model developed through the IBD project (service model to follow a hub and spoke approach with consultant sessions provided by Cardiff CCC). Interim arrangements are to remain in place until network approach fully adopted.	Hub and spoke model approved in this year's ICP. Consultant sessions to be provided by Cardiff CCC, implementation plan in development.	Planning Manager	April 2019
	To implement the WHSSC ICP scheme for Inherited Bleeding Disorders: review business case and request the release of funding for the south west, south east and mid Wales IBD service development	DoP	Complete
	To establish the IBD commissioning group (inc. providers, commissioners, patients) to monitor implementation and measure the achievement of the objectives for the investment (a sustainable, high quality and equitable service across Wales)	Planning Manager	Meetings to commence Q3

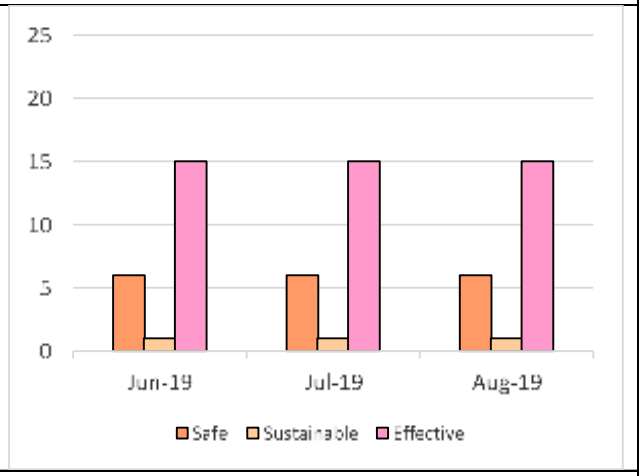
CH/018 AUGUST 2019	**PLASTIC SURGERY** **Risk:** There is a risk of poor patient experience and poor outcome for plastic surgery patients in south Wales. This is caused by failure to achieve the maximum waiting times target with some patients waiting in excess of 52 weeks. This leads to a commissioned service that does not meet waiting times standards and therefore does not provide the required quality of service.	**Director lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 17/03/2014 **Date last reviewed by Programme/Directorate:** C&B Commissioning 23/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	**6**	**1**	**12**
Current Score	**6**	**1**	**15**

WHSSC Risk Assessment Triangle





Escalation Narrative: Level 2. Monthly performance meetings in place.

Current Control Measures in Place

i) Performance management arrangements escalated to monthly executive performance meetings

Description of further Control Measures Required

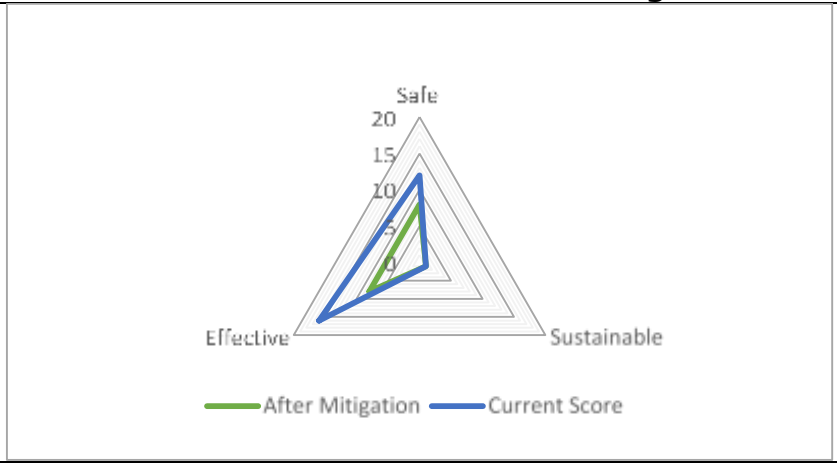
Action	Lead	By when
Monthly performance management meetings	DoP	Next meeting: 23/09/19
Write to SB to detail requirements for an action plan	Planning Manager	April 2019
Revise plastic surgery contract	DoF	Mar-20
Develop commissioning policy to identify those specialised plastic surgery procedures that require the unique skills of plastic surgery	Planning Manager	Mar-20

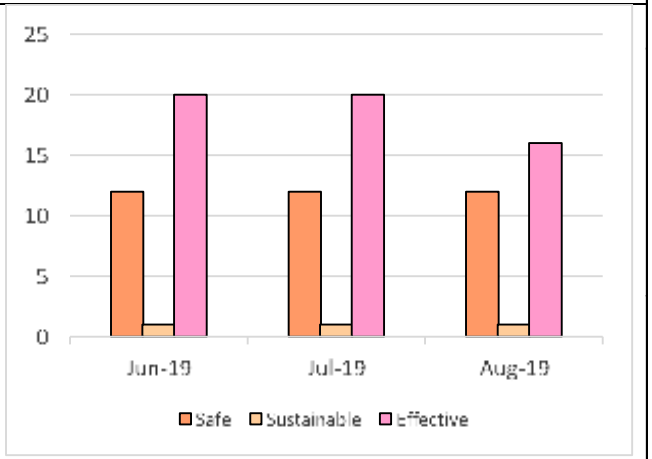
CH/024 AUGUST 2019	**PET – CT POLICY** **Risk:** There is a risk of less than optimal clinical management decisions for patients in Wales and inequity with patients in others parts of the UK. This is caused by relatively limited access to PET-CT under the current commissioning policy. This leads to: - risk of sub-optimal management of cancers excluded by the current commissioning policy; - potential for sub-optimal patient outcomes; - potential that patients receive unnecessary procedures or procedures of limited benefit; - sub-optimal utilisation of scarce healthcare resources The reputation of WHSSC is also at risk as the current PET-CT policy excludes many of the indications included in the NHS England and NHS Scotland policies creating inequity of access across the UK.	**Director lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 01/04/2017 **Date last reviewed by Programme/Directorate:** C&B Commissioning 23/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	**8**	**1**	**8**
Current Score	**12**	**1**	**16**

WHSSC Risk Assessment Triangle





Escalation Narrative: BMT service in escalation (level 2). The patient risks associated with inadequate facilities form part of the reason for escalation.

Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
Patients will continue to be managed via existing diagnostic pathways. As currently, the site specific MDTs will determine best management on the diagnostic and imaging information available.	Update policy with indications agreed for 19/20	ADEEE	complete
	To implement the WHSSC ICP scheme for PET (new indications): request the release of funding	DoP	complete
	To include further development of PET within WHSSC ICP 2020/21	DoP	ICP process from Sept 2019

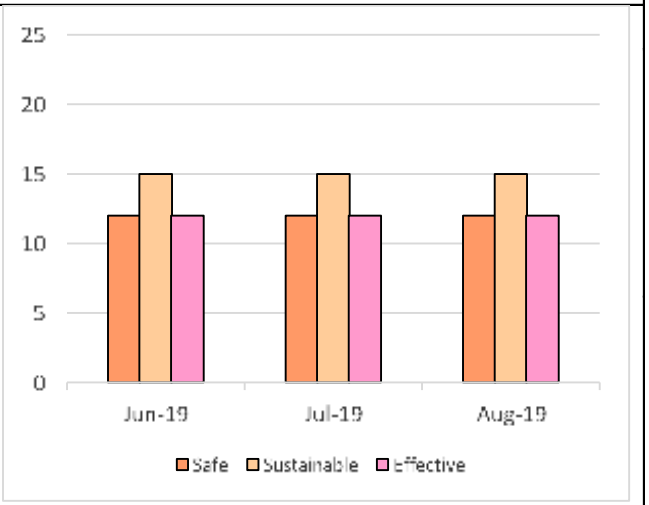
CH/028 AUGUST 2019	**NETs – Sustainability of NETs south Wales service** **Risk:** There is a risk to NET service sustainability in south Wales. This is caused by dependence on a single NET consultant and rising patient demand relative to commissioned capacity. This would lead to: • Clinic capacity insufficient to meet demand (risk to the ability to monitor patients and manage their care appropriately and optimally through timely assessment) and intervention to treat this complex condition; inequity between north and south Wales; • An inability to meet the Task & Finish Group recommendations for the NET services in South Wales would lead to discontent amongst patient groups; • Failure to meet expectations that Welsh Government have made to patient groups; • Potential increase in patient complaints and litigation claims in terms of delay in diagnosis.	**Director lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 01/04/2017 **Date last reviewed by Programme/Directorate:** C&B Commissioning 23/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	3	3	3
Current Score	12	15	12

WHSSC Risk Assessment Triangle





Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
ICP proposal funding was not approved; patients will be prioritised within available capacity according to clinical need.	To support CVUHB to explore alternative means of funding (Welsh Government service improvement funding) outside of the WHSSC process.		

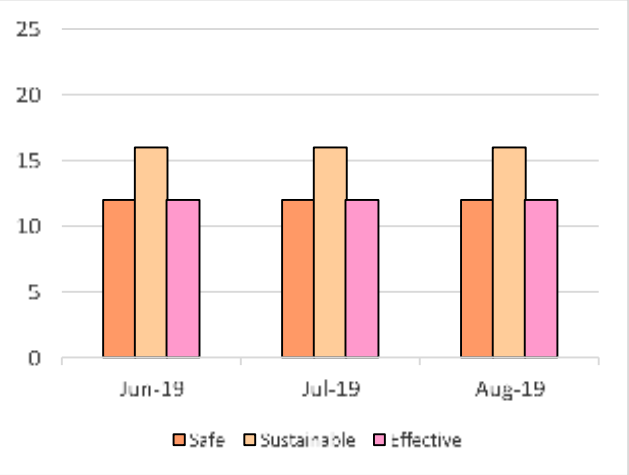
CH/033 AUGUST 2019	**HAEMOPHILIA – Sustainability of service at BCUHB** **Risk:** There is a risk that provision of IBD services at Bangor Hospital cannot be sustained. This is caused by difficulty recruiting a haematologist with IBD sub speciality expertise. No on-site specialist haemophilia consultant cover at present. This would lead to the loss of specialist IBD service in Bangor and patients needing to travel further for consultant care.	**Director lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** **Date last reviewed by Programme/Directorate:** C&B Commissioning 23/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	**4**	**9**	**4**
Current Score	**12**	**16**	**12**

WHSSC Risk Assessment Triangle





Escalation Narrative:

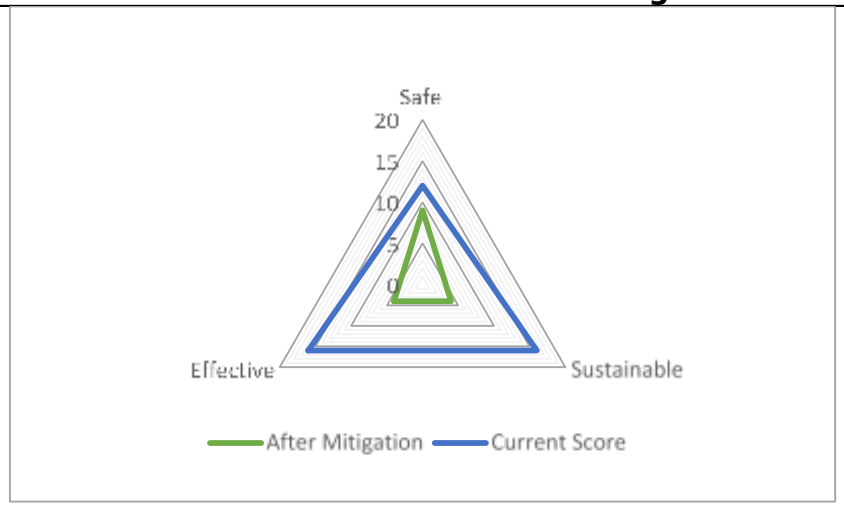
Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
i) Additional outreach clinic from Liverpool held at YGC for patients from Bangor; ii) Nurse led service with telephone support from Liverpool; iii) Hub and spoke model recommended outcome of formal review- funding approved in ICP.	To implement the WHSSC ICP scheme for Inherited Bleeding Disorders: review business case and request the release of funding for the north Wales IBD service development	DoP	Management Group on 28.11.19
	To establish the IBD commissioning group (inc. providers, commissioners, patients) to monitor implementation and measure the achievement of the objectives for the investment (a sustainable, high quality and equitable service across Wales)		Meetings to commence from Q3

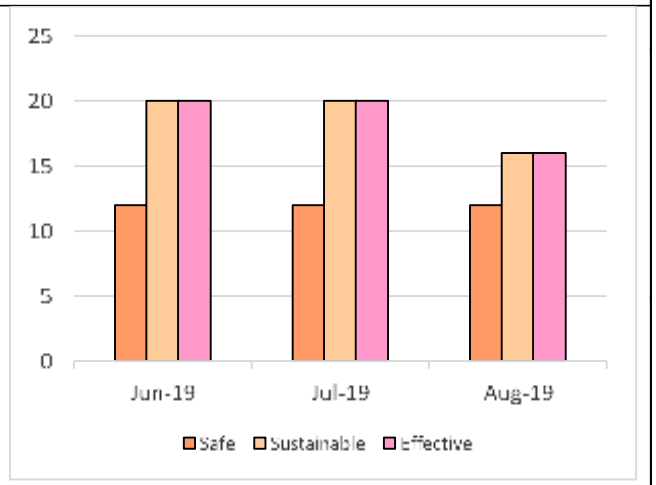
CH/036 AUGUST 2019	**SARCOMA** **Risk:** Sustainability of south Wales soft tissue sarcoma service (single CNS for patients in south west Wales) Sustainable provision of CNS support	**Director lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 28/09/2018 **Date last reviewed by Programme/Directorate:** C&B Commissioning 23/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	**9**	**4**	**4**
Current Score	**12**	**16**	**16**

WHSSC Risk Assessment Triangle





Escalation Narrative: Sarcoma is currently at escalation level 2.

Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
Requirement for flexible working between SW and SE CNS is included in CNS recruitment process.	To support SBUHB taking forward the recruitment of an additional CNS	Planning Manager	

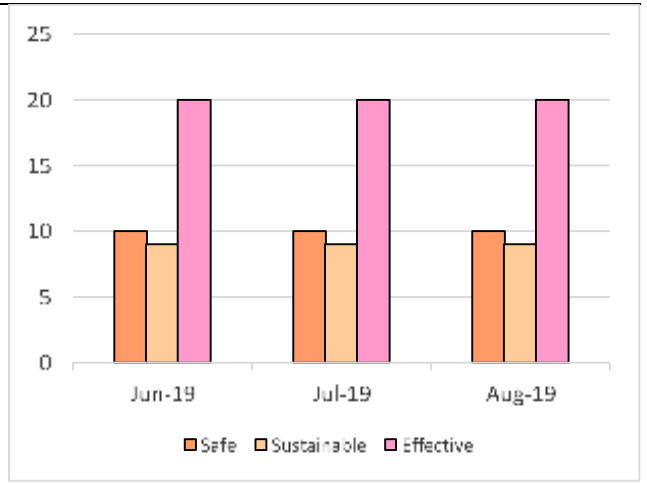
CT/037 (formerly CT/023) AUGUST 2019	**CARDIAC SURGERY C&VUHB** **Risk:** There is a risk of patients waiting in excess of the agreed waiting times for Cardiac Surgery which could result in their condition deteriorating whilst on the waiting list or having poorer outcomes	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed 09/07/2018** **Date last reviewed by Programme/Directorate:** C&B Commissioning 30/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	**5**	**2**	**2**
Current Score	**10**	**9**	**20**

WHSSC Risk Assessment Triangle





Escalation Narrative: The service has been escalated to Stage 3 and a performance quality visit has been scheduled for the 19th February.

Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
Regular monitoring of data and monthly meetings with C&VUHB.	Implementation of performance management arrangements, with providers to ensure delivery of contracted levels of operating.	Planning Manager	On-going
	Implement findings of DU review of PSDs when complete.	Planning Manager	08/17
	Ensure that diagnostics are not excluded as part of Cardiac pathways.	CVUHB	Complete
	A WHSSC Commissioning Quality Visit took place on the 19th February. The Health Board is producing an action plan to address the issues. A follow up meeting will be arranged for October	WHSSC / CVUHB	Oct 20

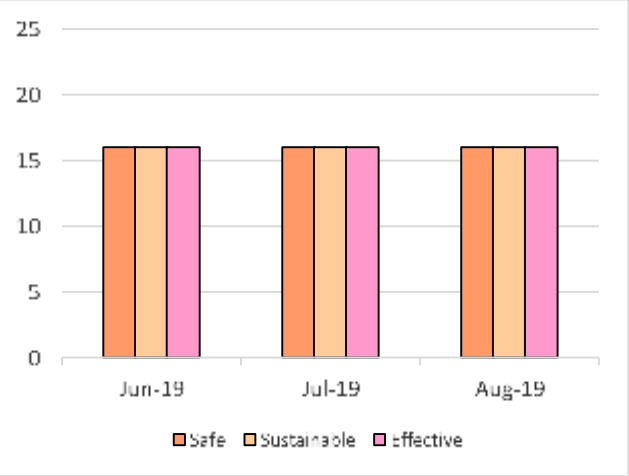
CT/040 AUGUST 2019	**PAEDIATRIC CHRONIC HEART DISEASE (CHD)** **Risk:** Children are waiting in excess of the agreed waiting times for cardiology follow up which has the risk of their condition deteriorating whilst on the waiting list or poorer outcomes	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed 13/07/2018** **Date last reviewed by Programme/Directorate:** C&B Commissioning 30/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	4	4	4
Current Score	16	16	16

WHSSC Risk Assessment Triangle





Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
Paediatric CHD risk highlighted as part of the business case submitted by C&VUHB in 2016. Funding was provided for C&VUHB Paediatric Cardiology to address RTT further business case awaited to address the regional service.	C&VUHB Consultants are undertaking additional clinics to support and manage the risk from long waiting times.	C&VUHB	On-going
	C&VUHB to submit a business case for inclusion in this year's ICP planning cycle.	C&VUHB	09/19
	Additional clinics being undertaken	C&VUHB	On-going

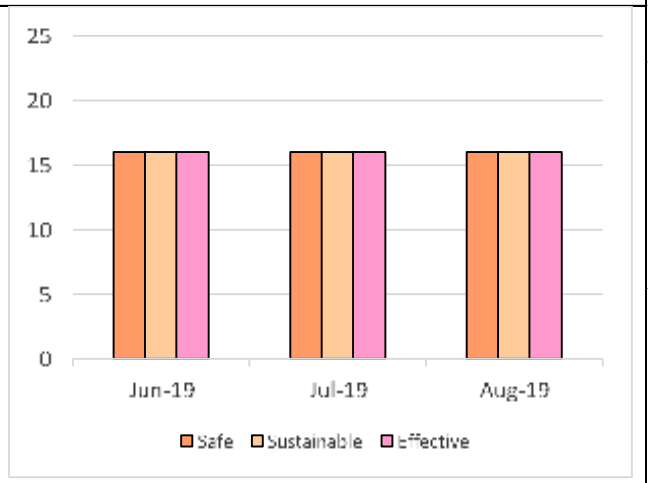
CT/032 AUGUST 2019	**ACHD – Sustainability of the Adult Congenital Heart Disease Service** **Risk:** There is a risk that Adult patients with CHD are not receiving equitable and timely care due to lack of appropriate staff to support their needs. This could result in deterioration of condition.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed 23/03/2018** **Date last reviewed by Programme/Directorate:** Asst. Planning Mgr. 30/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	**4**	**4**	**4**
Current Score	**16**	**16**	**16**

WHSSC Risk Assessment Triangle





Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
Phase 1 of the investment in ACHD fully implemented all staff are in post. Medical and nursing staff undertaking additional clinics to meet demand.	C&VUHB are currently developing Phase 2 of the investment business case taking into consideration the gaps in meeting the NHS England Standards.	CVUHB	11/18
	The proposal for investment in Phase 2 has been developed and is being taken forward to the ICP 2019-20 prioritisation process. Funding has been approved in principle with further work required around the priority of funding of schemes agreed within the ICP.	Planning Manager	10/19

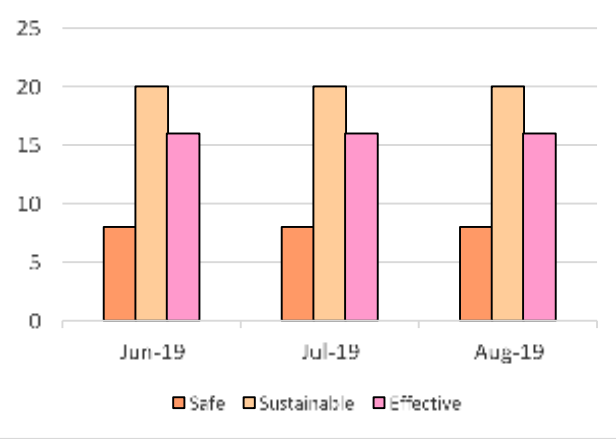
CT/036 (formerly WC/016) AUGUST 2019	**CYSTIC FIBROSIS** **Risk:** There is a risk that patients with CF will not be able to access inpatient care in a timely manner due to insufficient numbers of beds. This could result in patients' condition deteriorating.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed 17/03/2017** **Date last reviewed by Programme/Directorate:** Asst. Planning Mgr. 30/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	3	3	3
Current Score	8	20	16

WHSSC Risk Assessment Triangle





Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
•Capital business case under development by C&VUHB for additional inpatient beds. •Phase 1 of the CF investment for MDT and part year effect of the Premixed IV Antibiotic Service approved in July 2018. •ICP funding for Phase 2 cannot be progressed until the capital case and timeline has been provided by the Health Board/Welsh Government. •The additional MDT staffing proposal and the full proposal for the IV service will be considered through the ICP 2020/21 planning and investment cycle.	Capital business case submitted to WG by C&VUHB.	C&VUHB	ONGOING
	Proposal for enhancing service in order to manage growing patient cohort submitted to 2017/18 ICP prioritisation process. However funding was not approved.	Planning Mgr.	Complete
	Presented to Management Group re: risk in Sept 17 and further work was required by C&VUHB to gain support for revenue and capital business case.	Planning Mgr.	Complete
	The business case information for Phase 2 was outstanding from the Health Board for the ICP 19/20 CIAG/MG prioritisation process. There has been several meetings with senior colleagues in C&VUHB to progress this and it has been agreed that this information would be submitted to WHSSC by 28th November for further consideration of in year funding. A paper was submitted to MG in January 2019 with further information has been requested particularly because of the limited amount of ICP funding available. Funding has now been released for additional staff to support satellite clinics and the provision of a home IV service which will support the in-patient capacity issues. Review implementation progress in January 2020	CVUHB & Planning Mgr.	January 202C

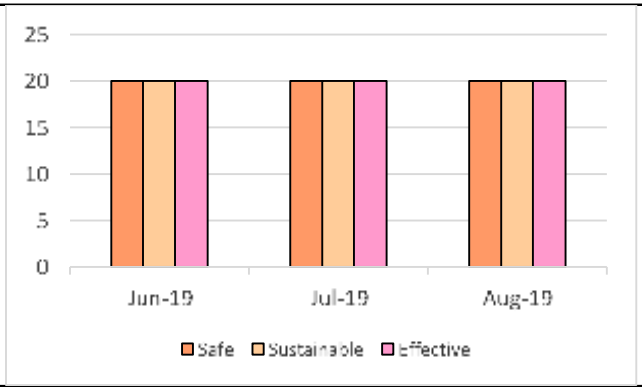
MH/108 AUGUST 2019	**CAMHS Risk:** Ty Llidiard Capacity Issues. Reduced ability to manage funded capacity & case mix following a series of serious incidents and a sentinel event at the unit. Changes to environmental have been delayed extending revised operating arrangements.	**Director lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 10/11/2017 **Date last reviewed by** 12/08/2019 **Programme/Directorate:** Carl SHORTLAND

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	**15**	**15**	**15**
Current Score	**20**	**20**	**20**

WHSSC Risk Assessment Triangle





Escalation Narrative: Service is at Level 3 escalation and WHSSC/Cwm Taf are holding regular action planning meetings. Review of estate environment completed and funding secured from WG but progress delayed due to LHB changes. All admissions to unit continue to be risk assessed on individual needs basis.

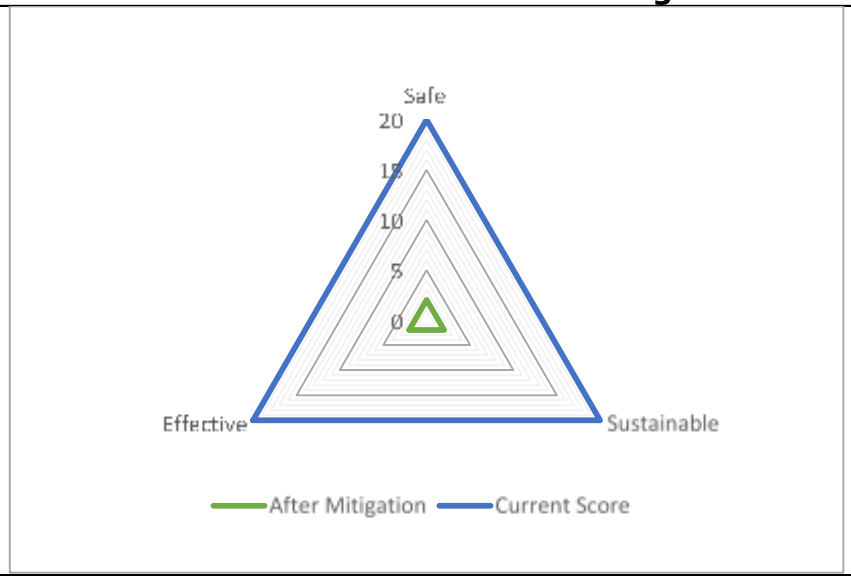
Current Control Measures in Place	**Description of further Control Measures Required**		
	Action	Lead	By when
Unit temporarily closed to new admissions pending quality review by Quality Assurance & Improvement Team. Individual risk assessments updated and shared with patients LHBs. Service placed into stage 4 escalation by WHSSC with enhanced monitoring and support arrangements. Service de-escalated to level 3 following receipt of QAIT report with all issues incorporated into wider summary action plan.	Audit Visit & Report	QAIT	w/c 26/03/2018
	Stage 4 Escalation	WHSSC DoN	De-escalated following receipt an evaluation of QAIT review and feedback with Cwm Taf at Visit o 5th April
	Stage 3 Escalation. Commissioning Quality Visit completed & regular action planning meetings being held.	CTUHB DPCMH/WHSSC DoN	On-going
	National capital funding identified by Welsh Government to address environment issues in audit report to enable unit to operate in line with specification/contract.	ABMU/CT/WG	30/09/2018
	Delays in capital works due to HB issues including boundary changes have been escalated to CTUHB DPCMH. Initial meeting to review contract/specification held at end of December.	WHSSC/ DoN	31/12/2018
	Further meeting arranged for February but capital issue unlikely to be resolved before transfer of Bridgend services to Cwm Taf UHB in April	WHSSC/ DoN	28/02/2019
	Meeting to discuss number of serious incidents held with LHB and progress reported with environment changes with completion expected by end of June 19.	Cwm Taf/ WHSSC	30/04/2019
	Review group has been established and has held 2 meetings to date to consider best use of estate and develop service specification for enhanced care service	Cwm Taf/ WHSSC	31/07/2019

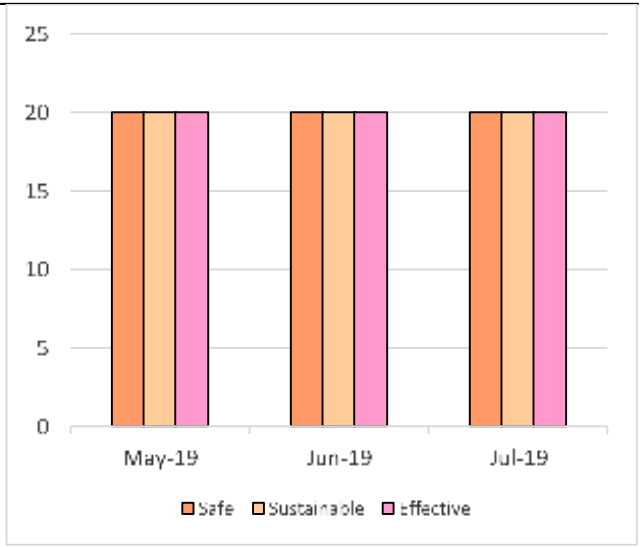
NC/014 JULY 2019	**RADIOLOGY - INTERVENTIONAL RADIOLOGY** **Risk:** There is a risk to patients of not being able to receive INR treatment locally due to the south Wales service only having one Interventional Neuro Radiologist.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 01/03/2017 **Date last reviewed by Programme/Directorate:** Sp. Planning Mgr. 01/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	2	2	2
Current Score	20	20	20

WHSSC Risk Assessment Triangle





Escalation Narrative:

Current Control Measures in Place

Supporting arrangements have been put in place with North Bristol NHS Trust to provide INR treatment when the sole south Wales INR Consultant is unavailable.

Description of further Control Measures Required

Action	Lead	By when
Informal arrangements in place with North Bristol to provide support. Additional WLI planned for Aug 18. No further WLI's have been identified. Waiting times are increasing. Monitoring the position via the Neurosurgery Performance meeting.	Planning manager	Ongoing
Interviews for 3rd Consultant Radiologist held and appointed. 3rd Consultant Radiologist to start in October 19	Planning Manager	Ongoing
Appointed 3rd Consultant Radiologist to commence in October 19	Planning Manager	30/10/2019

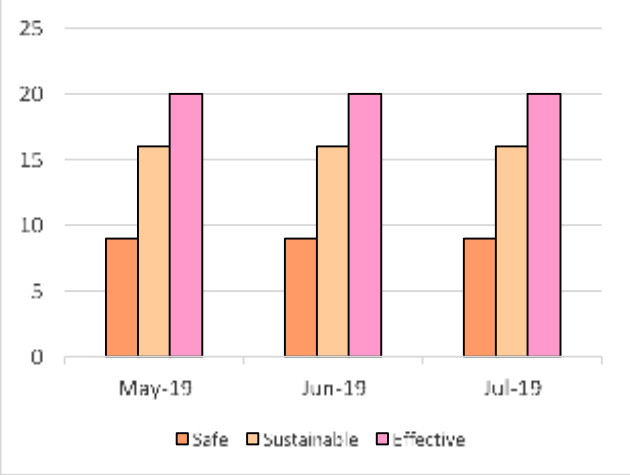
NC/023 JUNE 2019	**NEUROSURGERY – NEURO-ONCOLOGY** **Risk:** There is a risk to patients of a delay in Neuro-oncology treatment due to the cancellation of MDT meetings if not all members are available or suitable cover in place and of not receiving the most optimum treatment available to lack of Radiological input. Inequitable care for patients in the North and the South with only 22% of patients are seen by a CNS.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 05/04/2017 **Date last reviewed by Programme/Directorate:** Sp. Planning Mgr. 01/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	2	2	2
Current Score	9	16	20

WHSSC Risk Assessment Triangle





Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
Funding to address the serious concerns raised in the peer review has been allocated within the 2019-22 ICP and will be released to the service by the end of Sept 2019 to allow for recruitment.	Scheme submitted for ICP but not agreed for funding in 2018-21. Discussed at management group workshop 6/9/18.To be considered as part of the ICP 19-22 planning process.	Planning Manager	31/10/18
	Proforma to be completed by Mid Oct 18. Rated 11th in the Prioritisation process. To be included in the ICP 19-22.	Planning Manager	31/06/2019
	Funding of £150k has been set aside for the development of this scheme. A planned approach to delivering the scheme will be developed.	Planning Manager	31/03/2019

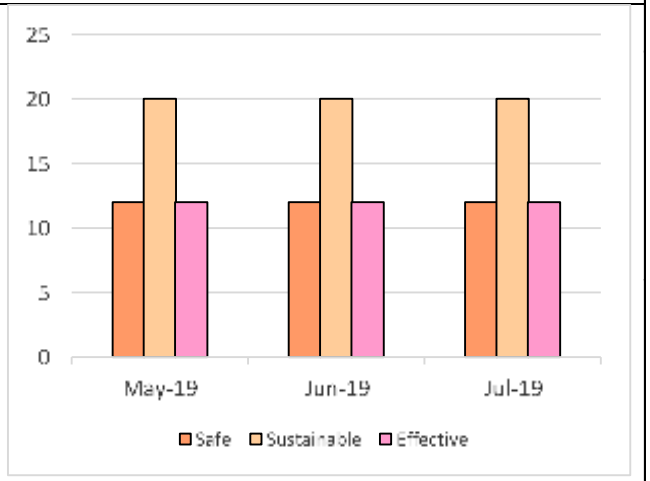
NC/026 JULY 2019	**Posture & Mobility – Swansea Bay & BCU - Prosthetics** **Risk:** There is a risk that civilian patients requiring are not receiving equitable access to the Prosthetics service due to the priority given to War Veterans. This is due to staffing levels and non-pay funding not being increased to meet the expected KPIs for War Veterans.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 03/07/2017 **Date last reviewed by Programme/Directorate:** Sp. Service Planner 01/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	**4**	**4**	**6**
Current Score	**12**	**20**	**12**

WHSSC Risk Assessment Triangle





Escalation Narrative:

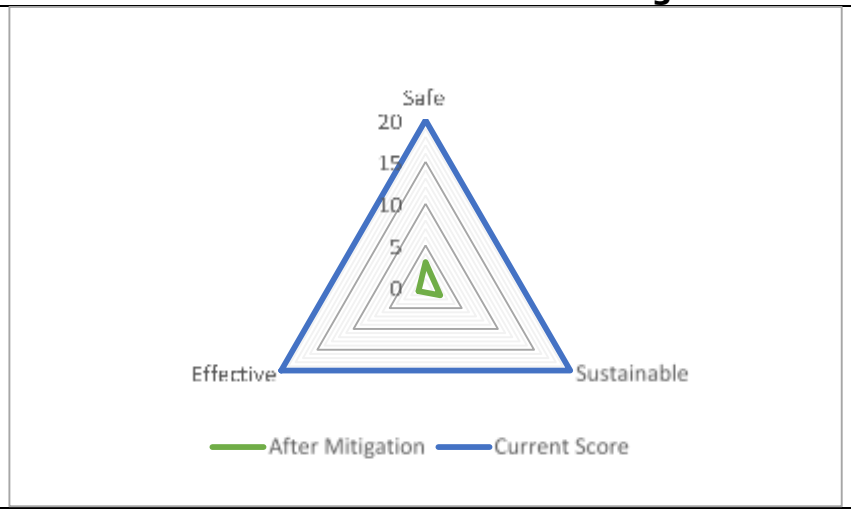
Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
Service are working increased overtime hours to meet the current levels of demand and as a consequence are significantly overspending against the budget. WHSSC are meeting regular with the prosthetic service to kept up to date of any new and emerging issues as well as current performance. A proposal to address the staffing and non pay shortfalls was submitted for inclusion in the 2019-22 ICP but funding was not allocated to this proposal and will need to be re-considered in the 2020-23 ICP process.	Scheme submitted for ICP but not agreed for funding in 2018-21. To be included in the ICP 19-22. Policies are in the process of being updated. Rated 6th in the prioritisation process.	Planning Manager	31/03/19

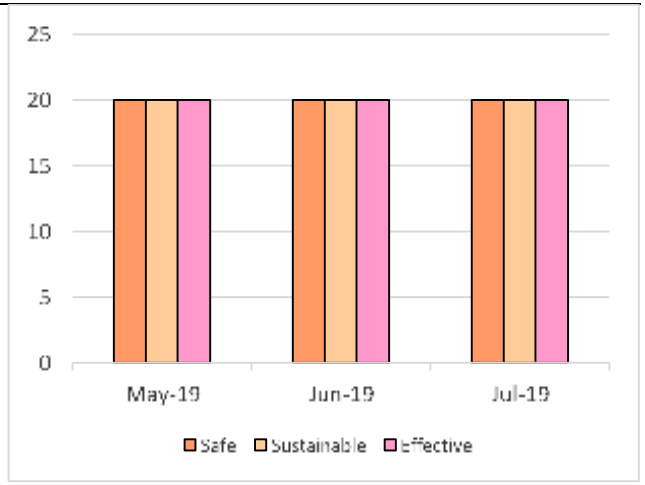
NC/029 JULY 2019	**Neurosurgery - Spinal Monitoring** **Risk:** There is a risk that with only one member of staff trained to undertake intr-operative spinal monitoring that patients are not receiving optimal treatment and are also receiving inequitable care with those treated in England where spinal monitoring is provided routinely, in line with national standards.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 07/11/2017 **Date last reviewed by Programme/Directorate:** AAC 01/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	**3**	**2**	**1**
Current Score	**20**	**20**	**20**

WHSSC Risk Assessment Triangle





Escalation Narrative:

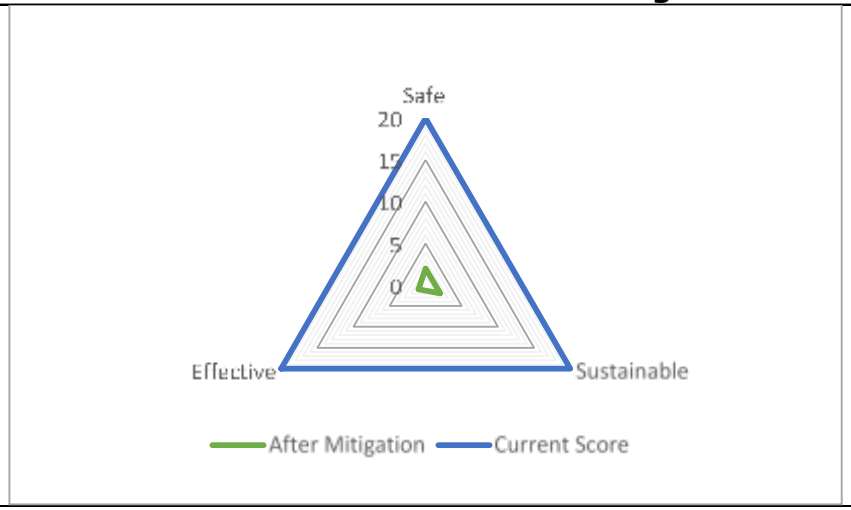
Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
WHSSC is working with the provider to understand how they are reporting this risk and if it is a funding shortfall that is responsible for this monitoring not being provided.	Scheme will need to be submitted for the 2019-22 ICP.	Planning Manager	Ongoing

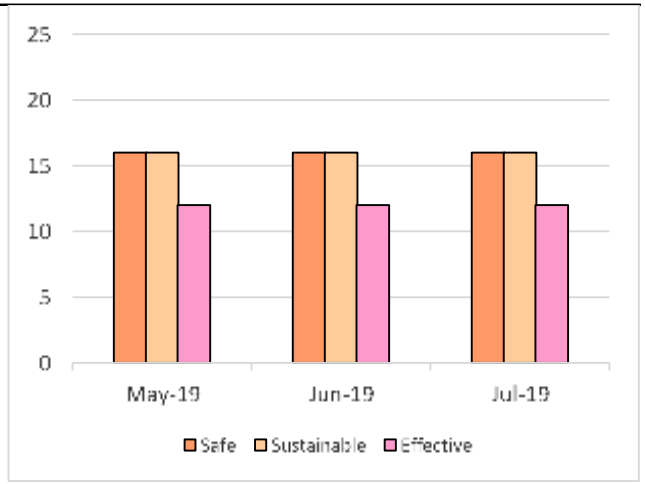
NC/031	**Ketogenic Diet – PAEDIATRIC NEUROLOGY** **Risk:** There is a risk that patients are not able to implement the Ketogenic Diet effectively due to lack of support from staff following the change of model when the service was transferred between providers and also that there is another cohort of patients not accessing the diet due to the distance to the specialist centre in Bristol. By not implementing the Diet effectively patients have a greater risk of not being able to control their Epilepsy and in the worst case scenarios, this has resulted in a Critical Care admission.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee
JULY 2019		**Date first assessed** 15/01/2018 **Date last reviewed by Programme/Directorate:** Neuro 01/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	**2**	**2**	**1**
Current Score	**16**	**16**	**12**

WHSSC Risk Assessment Triangle





Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
It was agreed as part of the development of the 2019-22 ICP that the service should be repatriated to the Children's Hospital of Wales and effectively staffed.	Scheme submitted for ICP 19-22.	Planning Manager	Ongoing
	Proforma to be completed by Mid Oct 18. Rated 17th in the Prioritisation process. To be included in the ICP 19-22.	Planning Manager	31/06/2019

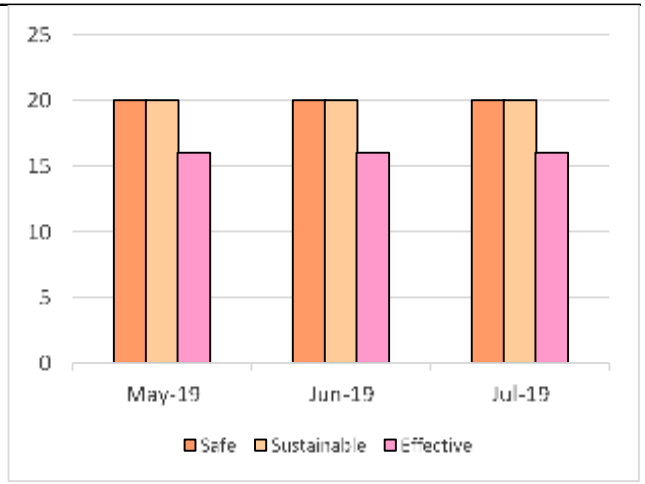
NC/035 JULY 2019	**Thrombectomy - Neuroradiology - Service Development - Transport** **Risk:** Patients are at risk at not being able to access Thrombectomy treatment in NHS England until transport to repatriate patients following treatment is identified.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 01/04/2018 **Date last reviewed by Programme/Directorate:** Neuro 01/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	2	2	1
Current Score	20	20	16

WHSSC Risk Assessment Triangle





Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
No current controls. WHSSC Managing Director is chasing EASC for written confirmation that they will repatriate Thrombectomy patients by private ambulance.	Project Initiation Document and Service Specification completed and will be submitted to the weekly Corporate Directors meeting for discussion (Oct 18)	Planning Manager	On-going
	Proforma to be completed by Mid Oct 18. Was not prioritised in the Prioritisation process as WG/ JC had already agreed to support this service with a separate funding stream.	Planning Manager	31/06/2019

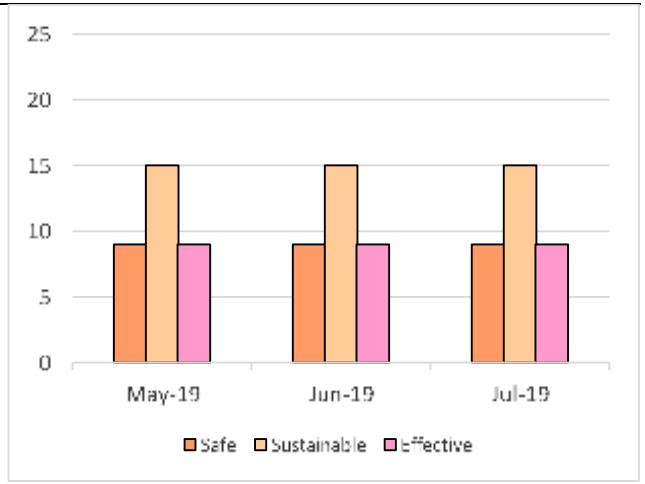
NC/041 JULY 2019	**Posture and Mobility Service - Discontinued Wheelchairs - North Wales Service** **Risk:** There is a risk to patients' safety if their obsolete model of wheelchair breaks down and they have a long wait for an appropriate replacement due to the requirement to build the wheelchair to meet their specific needs. Such waits could be detrimental to a patient's health as chairs are specifically built around their physical needs such as cushioned to improve their posture for respiratory difficulties and prevent pressure sores. Lack of an appropriate wheelchair could also render patients housebound, reducing their independence and potentially having a huge effect on a patient's mental health which could increase the number of primary care contacts they have.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 24/04/2017 **Date last reviewed by Programme/Directorate:** Neuro 01/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	4	6	4
Current Score	9	15	9

WHSSC Risk Assessment Triangle





Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
Funding to for a planned wheelchair replacement programme has been allocated within the 2019-22 ICP and will be released to the service once a business case is received from BCUHB.	Scheme submitted IC 19-22 agreed	Planning Manager	On-going
	Proforma to be completed by Mid Oct 18. Rated 4th in the prioritisation process. To be included in the ICP 19-22 Plan.	Planning Manager	31/06/2019
	Awaiting Business Case		

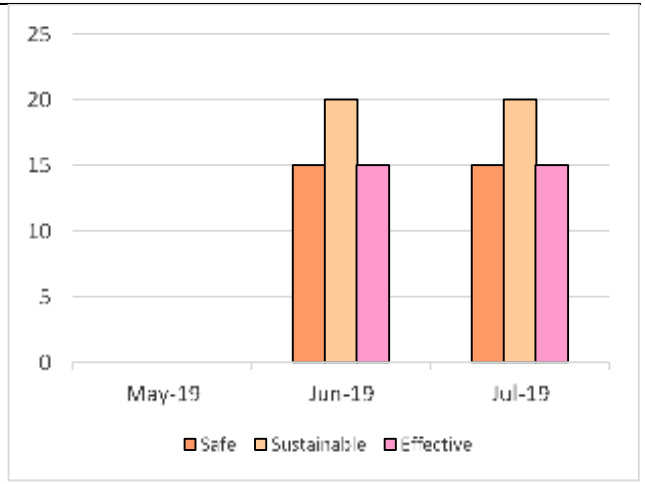
NC/043 JULY 2019	**Intestinal Failure - Availability of Home Parental Nutrition** **Risk:** There is a risk that patients who are already prescribed home parental nutrition are being hospitalised due to the HPN company suspending production of HPN due to an MHRA notice. There is a risk to patients who are suitable but yet to access HPN that they are unable to be prescribed it resulting them only being able to access treatment in a hospital environment.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 31/07/2019 **Date last reviewed by Programme/Directorate:** Neuro 01/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	**0**	**0**	**0**
Current Score	**15**	**20**	**15**

WHSSC Risk Assessment Triangle





Escalation Narrative:

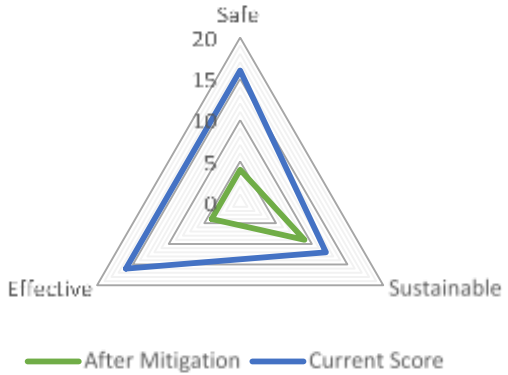
Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
Where possible local providers are making up HPN for patients or patients are being hospitalised where this is not possible. WHSSC Nurse Director is involved with daily calls with NHS England and Welsh Government who are trying to put solutions in place until the private company production issues are resolved.			

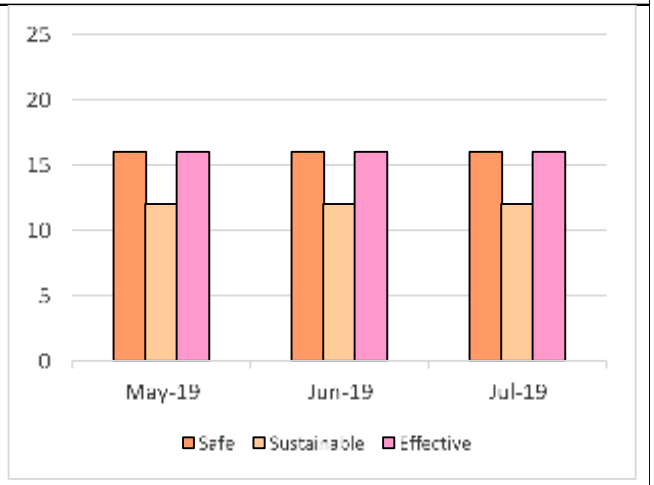
NC/010 JULY 2019	**NEURO REHABILITATION** **Risk:** There is a risk that patients within the neuro rehabilitation setting are not receiving their full potential due to lack of appropriate staff to support their rehabilitation.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 25/04/2017 **Date last reviewed by Programme/Directorate:** Sp. Planning Mgr. 01/08/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	4	9	4
Current Score	16	12	16

WHSSC Risk Assessment Triangle





Escalation Narrative:

Current Control Measures in Place

Funding to address the most concerning of staffing deficits and provide an MDT Co-ordinator to allow the service to input data into the national UKROC database was approved in June 2019.

Description of further Control Measures Required

Action	Lead	By when
Scheme submitted for ICP but not agreed for funding in 2018-21. Resubmitted for 2019-22 funding agreed. Cardiff and Vale to submit a business case	Planning Manager	01/09/2019
Proforma completed Oct 18. Rated 15th in prioritisation process. Funding agreed ICP 19-22	Planning Manager	30/06/2019
£150k agreed funding ICP 19-22 to fund outreach service and coordinator.	Planning Manager	30/06/2019

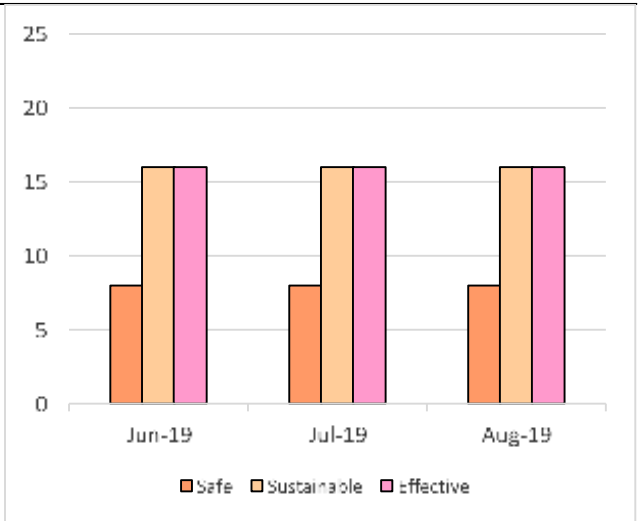
WC/015 AUGUST 2019	**CLEFT LIP & PALATE (CLP)** **Risk:** Lack of resource for full MDT of CLP service. There is a risk that patients do not have access to the full MDT. This is caused by insufficient commissioning of the service and may lead to patients not having access to the MDT when required.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 17/03/2017 **Date last reviewed by Programme/Directorate:** KM 09/09/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	3	2	2
Current Score	8	16	16

WHSSC Risk Assessment Triangle





Escalation Narrative:

Current Control Measures in Place	**Description of further Control Measures Required**		
	Action	Lead	By when
Funding release paper approved at MG in June 19. Funding release paper sent to the service. Risk rating to be reduced when the service commence the implementation of the scheme. Recruitment of staff is in progress.	Proposals for enhancing the full Multi-Disciplinary Team and to increase operating capacity taken through 2018/19 Integrated Commissioning Plan prioritisation process but not approved. Seek funding in future ICPs.	Planner	On-going
	Service to continue to maximise delivery within existing resource	Planner	On-going
	Regular dialogue with the service to monitor performance. Implementation of the scheme Funding release to MGT June 2019. Policy and Service Specification to be completed.	DGW Policy and Implementation LK	06/19
	Meeting planned with both networks for North And South Wales		OUTSOURCING OF Morriston PATIENTS AGREED. RTT work to commence Sept 2019

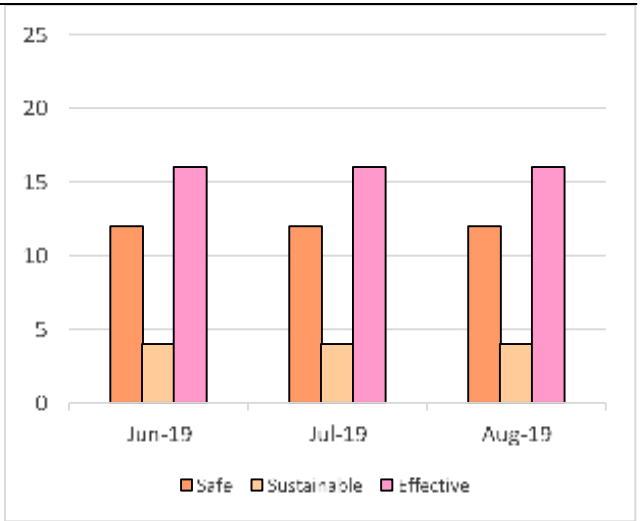
WC/018 AUGUST 2019	**NEONATAL TRANSPORT** **Risk:** Lack of 24/7 dedicated Neonatal transport in South Wales. The risk is that babies who require transfer to another unit for a higher level of care during out of hours, will not have access to a neonatal transport team. This is caused by the fact that the commissioning of the neonatal transport service in South Wales is for Monday to Sunday 8am to 8pm. This may lead to neonates being cared for in appropriate area, where the necessary skills or equipment are not available or the patient being transferred out of Wales.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 26/04/2017 **Date last reviewed by Programme/Directorate:** KM 09/09/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	**12**	**4**	**12**
Current Score	**12**	**4**	**16**

WHSSC Risk Assessment Triangle





Escalation Narrative:

Current Control Measures in Place	**Description of further Control Measures Required**		
	Action	Lead	By when
Service review will be starting 3rd July 2019 with external experts in the service. Meeting with key stakeholders is to take place on 31st July. The expert panel will produce a service review report by the end of August 2019. Paper to be prepared for MG outlining the options.	Action plan to be developed with network following recommendations within the case note review	Planner	02/19
	Development of governance lead for the service	Planner	02/19
	JC agreed to full review of current neonatal service model to take place throughout 2019/20.	Planner	03/19
	A meeting has been arranged for 4th April 2019 to agree a set of SMARTA actions following the recommendations of the case note review.		07/19

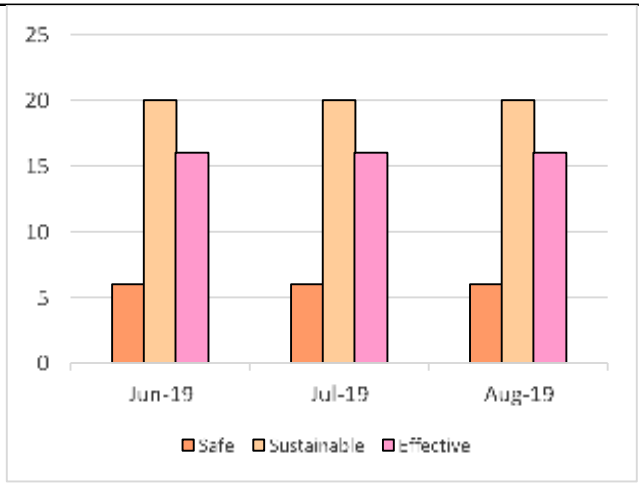
WC/020 AUGUST 2019	**PAEDRIATRIC ENDOCRINOLOGY** **Risk:** Inequitable service for Endocrinology patients in Wales. The risk is the inequity of the Paediatric Endocrinology service in South Wales. This is caused by the implementation of the national standards. This may lead to patients not having access to a comprehensive Paed Endocrinology service.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 25/04/2017 **Date last reviewed by Programme/Directorate:** KM 09/09/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	3	3	3
Current Score	6	20	16

WHSSC Risk Assessment Triangle





Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
Funding release paper approved at MG in June 19. Funding release paper sent to the service. Risk rating to be reduced when the service commence the implementation of the scheme. Recruitment of staff is in progress.	Prioritisation taken place, the scheme is identified within the ICP	Planner	03/2019
	Resource map the funding to WHSSC. WHSSC Finance lead to meet with Cardiff to agreed baseline for transfer.	Finance Manager	03/2019
	Service specification ready to be put on website once service has been approved for funding through the ICP	Planner	03/2019
	James Leaves to discuss transfer of services with CM at CVUHB. Paper being written for CDG in relation to funding		05/19

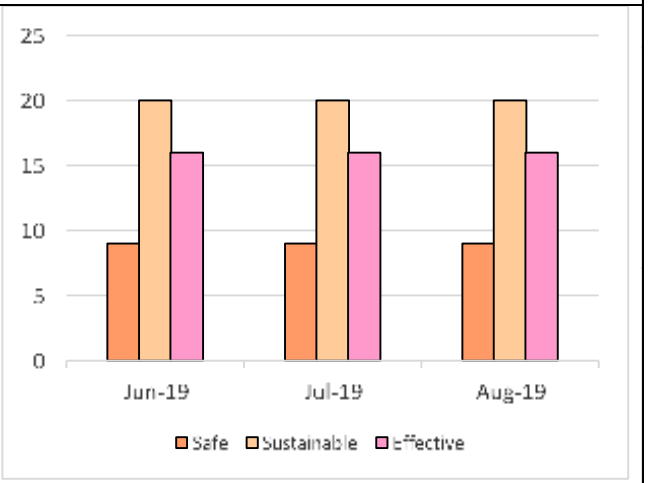
WC/022 AUGUST 2019	**PAEDIATRIC RHEUMATOLOGY** **Risk:** Limited and unsustainable Paediatric Rheumatology service in South Wales. The Paediatric Rheumatology service in South Wales is currently delivered by an adult Rheumatologist that is due to retire within the next few years (no precise date as yet). It is very unlikely that their replacement will take on paediatric services therefore leaving a significant gap in service in South Wales. Further, the current service does not meet standards and has been identified by the National Rheumatoid Arthritis Association as an outlier within the UK. There is a risk to patients that they cannot currently access a full MDT and that the limited service that they can access is at risk when the Consultant currently delivering the service retires.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 24/04/2017 **Date last reviewed by Programme/Directorate:** KM 09/09/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	2	2	2
Current Score	9	20	16

WHSSC Risk Assessment Triangle





Escalation Narrative:

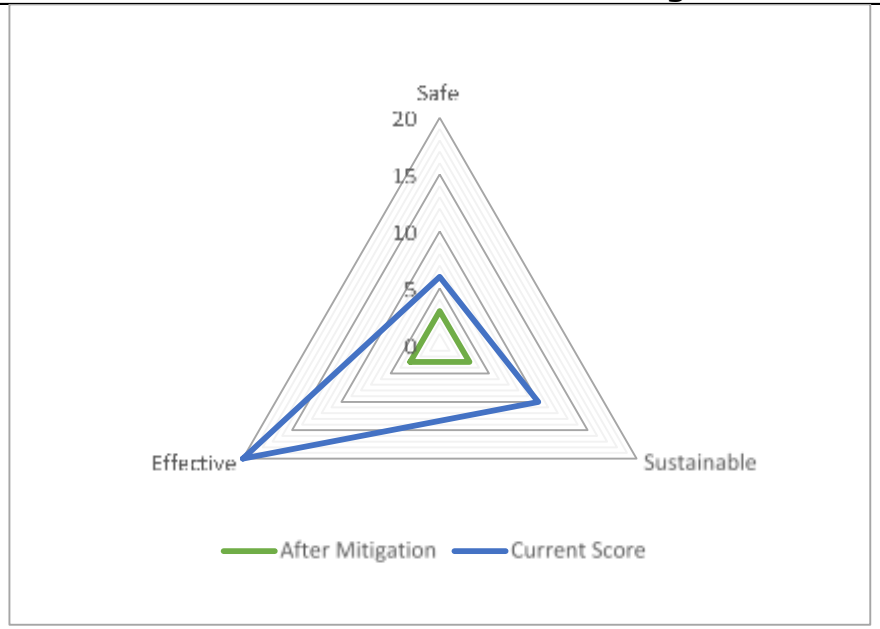
Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	TBC
Funding release paper approved at MG in June 19. Funding release paper sent to the service. Risk rating to be reduced when the service commence the implementation of the scheme. Recruitment of staff is in progress.	Planning Team currently working on service specification	Acting DoP	03/2019
	WHSS Team to include commissioning proposal in 2019/20 ICP	Acting DoP	03/2019
	5/3/19 -Commissioning Team meeting. Business Case to be submitted by C&V by August 2019. Implementation of the scheme will take place from September 2019. A service specification will be submitted to the May 19 Policy Group meeting.	PW , C&V , LK/DGW	Service Spec May 2019. Business Case - Aug 2019. Implementation Sept 2019
	Funding release paper to June MGT Board		June 2019

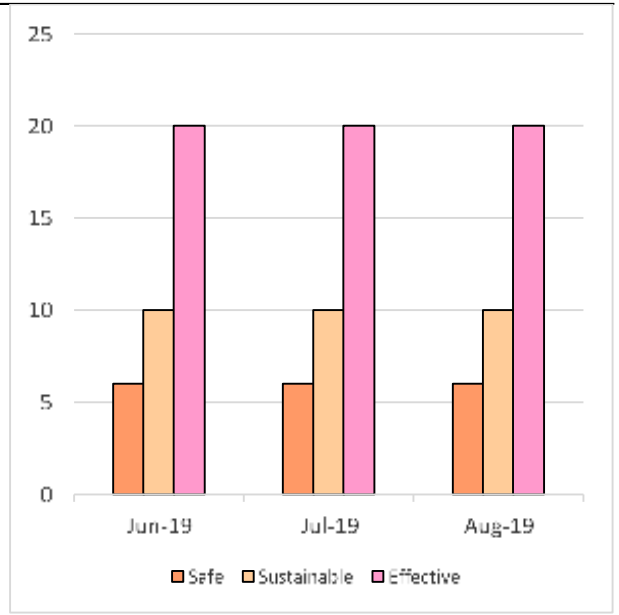
WC/029 AUGUST 2019	**CLEFT LIP & PALATE WAITING TIMES** **Risk:** Significant waiting times for adult patients waiting for revisional surgery. There is a risk adult CLP patients referred to the South Wales service will not be treated in a timely manner. This is caused by insufficient funding leading to an allocated lack of theatre sessions. This is leading to inequitable treatment of patients in the following areas adults compared to paediatrics and South Wales compared to North Wales Impacting on the quality of care and patient experience.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 17/03/2017 **Date last reviewed by Programme/Directorate:** KM 09/09/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	3	3	3
Current Score	6	10	20

WHSSC Risk Assessment Triangle





Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
Funding release paper approved at MG in June 19. Funding release paper sent to the service. Risk rating to be reduced when the service commence the implementation of the scheme which will start in Sept 19.	Business case has been prioritised as part of the ICP process, awaiting confirmation of the plan	Planner	03/2019
	Implementation of the scheme is to take place from June 2019. The service are preparing a Business Case. Service Specification to be completed by end of April 2019.	Planner and Asst. Planner	LK/DGW
	A meeting is planned for May 2019		05/19

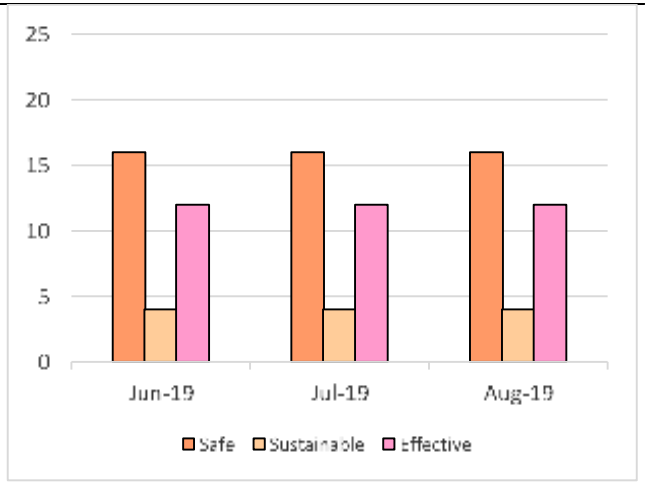
WC/037 AUGUST 2019	**NEONATAL TRANSPORT** **Risk:** Governance and subsequence safety issues with the 12 hour Neonatal Transport service. The current service is provided by three HB's on a one in three rota. The three providers are ABMU/C&V/ABU. It has become evident through carrying out a case note review that there are significant gaps in documentation kept and there is no clear governance lead which poses significant safety and effective risks. Due to the volume of the service the risk to sustainability is low.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 23/07/2018 **Date last reviewed by Programme/Directorate:** KM 09/09/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	**4**	**4**	**4**
Current Score	**16**	**4**	**12**

WHSSC Risk Assessment Triangle





Escalation Narrative:

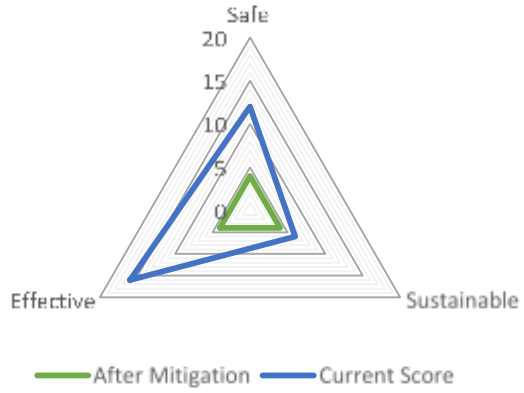
Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
SMATA action plan has been produced and shared with the Neonatal transport service. WHSSC to monitor the actions and request updates from the service. Next meeting 17/7/19.	Draft ToR for review following meeting with potential reviewer, shared with network for comment awaiting response	Planner	03/19
	Discussion with network to explore and develop the role of the transport sub-group	Planner	03/19

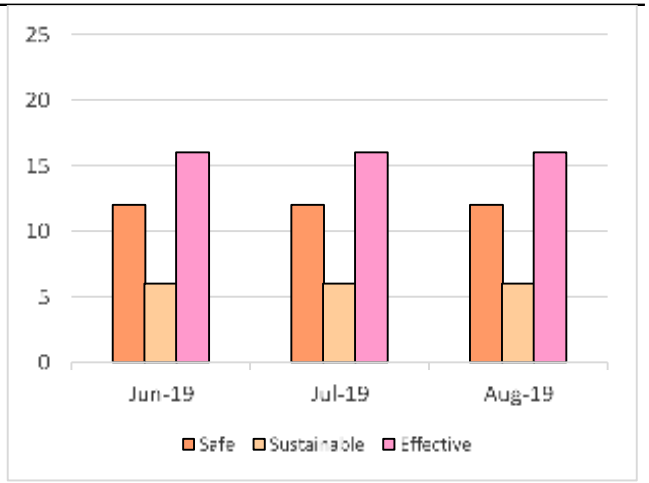
WC/038 AUGUST 2019	**BAHA AND COCHLEAR** **Risk:** BAHA and Cochlear replacement and maintenance policy for South Wales Patients. The BAHA and Cochlear service for south Wales patients is managed centrally by C&V however patients are managed at both Bridgend Hospital and UHW. Currently there is no maintenance or replacement policy for south Wales patients. There are limited numbers within the contract for upgrades and maintenance to take place however this does not align with the average life of an implant which is 6 years. There is therefore risk to patients' wellbeing and quality of life that cannot have their implant upgraded/maintained as there is no policy in place.	**Executive lead:** Director of Planning **Assuring Committee:** Quality and Patient Safety Committee **Date first assessed** 23/07/2018 **Date last reviewed by Programme/Directorate:** KM 09/09/2019

Risk Rating

	Safe	Sustainable	Effective
After Mitigation	4	4	4
Current Score	12	6	16

WHSSC Risk Assessment Triangle





Escalation Narrative:

Current Control Measures in Place	Description of further Control Measures Required		
	Action	Lead	By when
Funding agreed as part of the prioritisation process for 2019/22. Awaiting a business case from the service to inform a paper to be submitted to MG for funding release approval.	Business case has been prioritised as part of the ICP process, awaiting confirmation of the plan	Planner	03/19
	Funding release paper to Management Group.	Planner	June 2019
	Workshop to be held with all HBs in South Wales who provide BAHA / cochlear services. Benchmarking the service with other providers to take place in August and Sept.		July 2019

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

		Agenda Item	2.3
Meeting Title	**Audit Committee**	Meeting Date	28/10/2019
Report Title	Review of Financial Authorisation Limits		
Author (Job title)	Financial Accountant		
Executive Lead (Job title)	Director of Finance	~~Public~~ / In Committee	In Committee

Purpose	In light of the increasing need to send invoices to the Cwm Taf Chief Executive for authorisation, the financial limits of the DOF and MD need to be reviewed and, if appropriate, increased.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☒	☒	☐	☐

Sub Group /Committee	Audit Committee	Meeting Date	28/10/2019
	Choose an item.	Meeting Date	Click here to enter a date.
Recommendation(s)	Members are asked to: • **Approve** the request to increase the individual financial authorisation limits of the DOF and MD.		

Considerations within the report (tick as appropriate)

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

1.0 Situation

The financial limits of the Level 1 and Level 2 directors of WHSSC remain unchanged from those inherited from HCW in 2010. Under the financial limits policy and scheme of delegation, all WHSSC Directors have an individual financial limit of £300k which gives them the authority to commit WHSSC to any single high cost IPFR request up to this limit. In addition to this, the Level 1, Managing Director and Level 2, DOF, have the ability to commit the organisation to Long Term Contractual Agreements and to authorise the monthly cash payments against these contracts.

However in the years since 2010, the number, nature and value of invoices and payments processed by WHSSC have changed significantly but without any corresponding review of the underlying scheme of delegation.

2.0 Background

Since WHSSC was created in 2010, the number of high cost, non contract exclusions has increased, along with the number of individual extremely high cost IPFR treatments, such as Proton Therapy, Intestinal Transplants, ECMO, severe Burns, all of which individually regularly exceed the financial limits of the top tier Directors as set out in the financial limits policy. Looking forward, the new gene therapy treatments and the cancer CAR-T treatments coming on line in 2019-20 through the ICP approved by Joint Committee will each require individual non contract invoice payments in excess of £500k each.

Currently, as set out in the financial limits policy any invoice or payment request in excess of the individual director limit of £300k, has to be forwarded to the Cwm Taf Morgannwg Chief Executive to be authorised for payment.

3.0 Assessment

The appendix attached shows the number and value of invoice payments made over the last 18 months which exceeded the individual limit of both the WHSSC Managing Director and the WHSSC Director of Finance and would have needed the Chief Executive authorisation before payment could be actioned.

This is not only in compliance with the WHSSC Financial Limits Policy and Financial Control Procedures, but is also a requirement Cwm Taf Morgannwg place on their cashiers team through their own governance processes. It needs to be borne in mind that the number and frequency of such invoices is expected to increase.

In order to reduce the evident future need to send increasing numbers of authorisation requests to the Cwm Taf Morgannwg Chief Executive and to ensure that processing delays are kept to a minimum, it is recommended that the individual financial limits of the Level 1 and Level 2 directors are increased to £750k.

Under the terms of the WHSSC SFI's and Financial Control Procedures, this request requires the formal approval of the WHSSC Audit Committee to be implemented.

4.0 Recommendations

Members are asked to:

- **Approve** the request to increase the individual financial authorisation limits of the DOF and MD to £750k.

5.0 Appendices / Annexes

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	**None**
Health and Care Standards	Governance, Leadership and Accountability Choose an item. Choose an item.
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production Choose an item. Choose an item.
Institute for HealthCare Improvement Triple Aim	Reducing the per capita cost of health care Improving Patient Experience (including quality and Satisfaction) Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	A strong financial governance framework is essential to ensuring patients experience the greatest possible levels of safety and quality in the services commissioned by WHSSC Informed decisions within the environment of a clear financial governance framework are more likely to impact favourably on the quality, safety and experience of patients and staff.
Resources Implications	None
Risk and Assurance	Delays in obtaining authorising signatures could place WHSSC in breach of its PSPP targets and could result in arbitration proceedings though Welsh Government. Delays relating to LTA payments could be considered a breach in the payment terms contained within LTA agreements.
Evidence Base	Invoices received and payments made over 18 months. WHSSC financial limits policy, Standing Financial Instructions and Financial Control Procedures.
Equality and Diversity	No Impact.
Population Health	No Impact.
Legal Implications	Delays in obtaining authorising signatures could place WHSSC in breach of its PSPP targets and could result in arbitration proceedings though Welsh Government. Delays

	relating to LTA payments could be considered a breach in the payment terms contained within LTA agreements.

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

Invoices over WHSSC director limits April 2018 - Sept 2019

Provider	Date of invoice	Invoice number	£ Value	Detail
ABERTAWE BRO MORGANNWG UNIVERSITY LHB	03/04/2018	3160464	333,900.00	Recharge of Eculizumab costs Q4 2017/18
CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD	04/04/2018	469366	397,798.00	Ivacaftor Adult Qtr 4
CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD	04/04/2018	469365	3,777,299.41	WHSSC Year End Settlement 17/18
VELINDRE NHS TRUST	14/05/2018	1071434	437,394.00	NICE Month 12 Adjustment 17-18
ABERTAWE BRO MORGANNWG UNIVERSITY LHB	30/07/2018	3164781	1,112,365.00	Main LTA Provider Performance Settlement for 2017/18
CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD	03/08/2018	476593	503,097.00	Adult Ivacaftor April to June 2018
CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD	24/10/2018	481512	366,660.00	Eculizumab for Patients MR and KP
CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD	31/10/2018	481946	464,655.00	Adult Ivacaftor Quarter 2
CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD	29/01/2019	487340	329,636.00	Renal Dialysis ISP Inflation 2018/19
BETSI CADWALADR UNIVERSITY LOCAL HEALTH BOARD	05/03/2019	399964	338,085.63	Recharge for Immuno Suppressants and Valanciclovir Reimbursement
CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD	07/03/2019	489617	1,000,000.00	Year End Settlement - Partial Provider over performance
CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD	07/03/2019	489618	1,626,000.00	Year End Settlement - Month 10 commissioner settlement
ABERTAWE BRO MORGANNWG UNIVERSITY LHB	07/03/2019	3173966	500,000.00	Payment on account against M11 Provider LTA performance
BETSI CADWALADR UNIVERSITY LOCAL HEALTH BOARD	07/03/2019	400071	2,906,000.00	Commissioner over-performance month 11 forecast out-turn 18-19
VELINDRE NHS TRUST	25/03/2019	1080591	1,214,839.00	NICE Drugs Adjustment Month 12
ABERTAWE BRO MORGANNWG UNIVERSITY LHB	01/04/2019	3175420	321,300.00	Recharge of Eculizumab costs for Q4 2018/19
SWANSEA BAY UNIVERSITY HEALTH BOARD	02/04/2019	3175438	714,101.00	Core LTA Performance 18/19
CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD	03/04/2019	492051	325,105.00	Main ERT Year End Settlement 2018/19
CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD	03/04/2019	492058	1,237,981.00	WHSSC LTA Year End Settlement 2018/19 Developments
CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD	03/04/2019	492057	331,164.00	WHSSC LTA Year End Settlement 2018/19 Renal
CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD	03/04/2019	492056	3,339,634.00	WHSSC LTA Year End Settlement 2018/19 - LTA, Renal Baseline, Genetics Baseline and Comms Aids Baseline
SWANSEA BAY UNIVERSITY LOCAL HEALTH BOARD	04/04/2019	3175482	387,573.00	Commissioner Under-Performance 2018/19
CWM TAF UHB	17/05/2019	4940	484,000.00	Charges in respect of 2018/19 LTA Settlement
CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD	26/07/2019	497987	358,615.00	Migalastat - Quarter 1 April - June 2019
CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD	26/07/2019	497992	466,326.00	Ivacaftor Quarter 1 April - June 2019 ADULT
CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD	26/07/2019	497997	456,120.00	Eculizumab - Haematology Quarter 1 April - June 2019

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

		Agenda Item	2.4
Meeting Title	Audit Committee	Meeting Date	28/10/2019
Report Title	Review and update of WHSSC Governance and Accountability Framework		
Author (Job title)	Corporate Governance Manager		
Executive Lead (Job title)	Committee Secretary	Public / In Committee	In Committee

Purpose	This report explains proposed changes to be made to the WHSSC Governance and Accountability Framework, including the WHSSC Standing Orders and Associated Documents.			
RATIFY ☐	APPROVE ☐	SUPPORT ☒	ASSURE ☐	INFORM ☒

Sub Group /Committee This links to additional information provided on last page	Corporate Directors Group Board	Meeting Date	07/10/2019
	Choose an item.	Meeting Date	Click here to enter a date.
Recommendation(s)	Members are asked to: • **Note** the content of this report; • **Support** the amended WHSSC Standing Orders and Associated Documents being taken forward for approval by the Joint Committee and, as appropriate, by the seven Welsh Local Health Boards.		

Considerations within the report (tick as appropriate)

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

1. SITUATION/INTRODUCTION

1.1 The WHSSC Governance and Accountability Framework, which comprises the WHSSC Standing Orders and certain associated documents, has been reviewed in the context of the new Model Standing Orders issued by Welsh Government under Welsh Health Circular 2019 027 in September 2019.

1.2 This report provides the Audit Committee with an explanation of the key proposed changes and seeks support for the amended WHSSC Standing Orders and associated documents being taken forward for approval by the Joint Committee and, as appropriate, by the seven Welsh Local Health Boards (LHBs).

2. BACKGROUND

2.1 It is necessary to ensure that Local Health Board's (LHBs), Trust, WHSCC and EASC Model Standing Orders (SOs) are kept up to date and take account of any developments. Whilst individual organisations are responsible for review of their respective documents they are informed by Model SOs issued using the Welsh Ministers power of direction in accordance with Sections 12(3) and 19(1) of the National Health Service (Wales) Act 2006. In September 2019 the Welsh Government issued revised Model Standing Orders for LHBs, Trusts and the Welsh Health Specialised Services Committee. Model SOs for the Emergency Ambulance Services Committee (EASC) were issued for the first time.

2.2 Following receipt of the revised Model SOs the WHSS Team has reviewed the WHSSC SOs. The WHSSC SOs are incorporated as Schedule 4.1 of the LHBs' SOs.

2.3 Model SOs and Reservation and Delegation of Powers for LHBs, Trusts and WHSSC were first issued in 2009 in accordance with the Welsh Ministers powers of Direction. Revised model documents were subsequently issued in 2012 and 2014.

2.4 NHS organisations in Wales are required to review their SOs annually. Some organisations have held off undertaking a review in expectation of issue of updated Model SOs.

2.5 There have been a number of changes to legislation which require changes in the governance arrangements within NHS organisations such as the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015. It is necessary for the Model SOs to reflect these changes.

2.7 In November 2018 the Minister issued a direction to LHBs regarding changes to the voting arrangements for WHSSC and EASC. This latest review incorporates these changes.

2.8 Welsh Government also issues Model Standing Financial Instructions (SFIs). The SFIs are incorporated within Schedule 2 of the SOs and will have effect as if incorporated directly into the SOs. The timing of their review traditionally has coincided with the review of the Model SOs. On this occasion the Model SFIs are being reviewed on a different timeline. A Task and Finish Group has been established to take this work forward with the involvement of a representative of the Board Secretaries and Director of Finance Peer Groups.

2.9 In addition to the WHSSC SOs and SFIs, the WHSSC Governance and Accountability Framework comprises (1) a Memorandum of Agreement that defines the governance arrangements for the Joint Committee and the agreed roles and responsibilities of the Chief Executives of the LHBs as individual members of the Joint Committee, (2) a Hosting Agreement that outlines what the accountability arrangements and resulting responsibilities mean for Cwm Taf Morgannwg UHB (as the host organisation) and the Joint Committee, and (3) a Memorandum of Agreement known as the Joint Committee Business Framework that sets out a framework so that members of the Joint Committee and sub committees/ sub groups have a clear understanding of the decision making process (together the Associated Documents).

3. CHANGES TO THE GOVERNANCE AND ACCOUNTABILITY FRAMEWORK

3.1 The WHSS Team undertook reviews of the WHSSC SOs and the Associated Documents that were considered by the Joint Committee in January 2018 and May 2019. The Joint Committee noted that the recommended amendments were factual and minimal or automatically incorporated by direction of the Welsh Ministers. The amendments proposed as a result of these reviews were approved by the Joint Committee. On advice received from Welsh Government and particularly in anticipation of the issue of revised Model SOs, the amendments were not forwarded to the LHBs for their approval; however this latest review incorporates those amendments to the extent that they are still applicable.

3.3 The latest proposed amendments are also factual and minimal or automatically incorporated by direction of the Welsh Ministers and, in particular, include references to the current names of the LHBs, the current title of the Minister and changes that reflect the new voting arrangements directed by the Minister in November 2018.

3.4 The latest proposed amendments will be considered further by the WHSSC Integrated Governance Committee at its meeting scheduled for 29 October 2019.

4. RECOMMENDATION

4.1 Members are asked to:

- **NOTE** the content of this report; and
- **SUPPORT** the amended WHSSC Standing Orders and Associated Documents being taken forward for approval by the Joint Committee and, as appropriate, by the seven Welsh Local Health Boards.

5. Appendices/ Annexes

None.

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	Scheme of Delegation
Health and Care Standards	Governance, Leadership and Accountability Choose an item. Choose an item.
Principles of Prudent Healthcare	Only do what is needed Choose an item. Choose an item.
Institute for HealthCare Improvement Triple Aim	Choose an item. Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	Ensuring accuracy of the Standing Orders will provide risk control for the WHSSC.
Resources Implications	No additional financial impact has been identified with the amendment to the Governance and Accountability Framework.
Risk and Assurance	There may be an adverse effect on the organisation if arrangements are not put in place to manage the governance arrangements within WHSSC.
Evidence Base	The Standing Orders are based on the model Standing Orders for WHSSC issued by Welsh Government.
Equality and Diversity	Ensuring a robust accountability and governance framework will have a positive impact on equality and diversity.
Population Health	Ensuring a robust accountability and governance framework will have a positive impact on the workforce.
Legal Implications	There may be an adverse effect on the organisation if arrangements are not put in place to manage the governance arrangements within WHSSC.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	07/10/2019	Noted and supported.
Choose an item.		

Welsh Health Specialist Services Committee

Information Governance Review

Internal Audit Report

October 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Opinion and key findings

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTMU-1920-47
Report status:	Internal Audit Report
Fieldwork commencement:	21 August 2019
Fieldwork completion:	10 October 2019
Draft report issued:	14 October 2019
Management response received:	18 October 2019
Final report issued:	18 October 2019
Auditors:	Murray Gard – Principal Auditor Emma Samways – Deputy Head of Internal Audit
Executive sign off:	Kevin Smith – Committee Secretary & Head of Corporate Services
Distribution:	Helen Tyler – Corporate Governance Manager
Committee:	Audit Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

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

Disclaimer notice - Please note:

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

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1. Introduction and Background

Our review of the Welsh Health Specialised Services Committee (the 'Committee' or 'WHSSC') Information Governance arrangements was completed in line with the 2019/20 Internal Audit Plan.

Information Governance is a framework, which supports how organisations and individuals manage the way information is handled. It applies to sensitive and personal information of employees, patients and service users, and to information related to the business of the organisation. It is about setting a high standard for the management of all information and giving organisations the tools to achieve that standard. The ultimate aim is to demonstrate that the organisation can be trusted to maintain the confidentiality and security of both personal and business information, by helping individuals to be consistent in the way they handle it.

Several legal requirements, standards and guidance apply to information handling, including but not limited to:

- General Data Protection Regulation (2018);
- Freedom of Information Act (2000);
- Public Records Act (1958) and
- Caldicott Principles.

The relevant lead for the review was the Committee Secretary.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the management of Information Governance. The review sought to provide assurance to the Audit Committee that risks material to the system's objectives are managed appropriately. The areas that the review sought to provide assurance on are:

- The Committee has appropriate Information Governance structures, assigned roles and responsibilities, policies and procedures in place that ensures Information Governance is embedded within WHSSC.
- Information Governance incident management systems are in place with breaches reported appropriately.
- All staff have received appropriate training in Information Governance.

The scope of the audit was limited due to Cwm Taf Morgannwg University Health Board (CTMUHB) hosting WHSSC and therefore being their data controller and holder of the Information Asset Register. Our testing in relation to the Information Asset Register has been undertaken in our Cwm Taf Morgannwg Records Management review.

3. Associated Risks

The potential risks considered in the review were as follows:

- Non-compliance with regulations leading to potential financial or reputational impact if policies and guidance are not available.
- Inappropriate access to information or loss of information if staff are not aware of their information governance responsibilities due to a lack of training.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

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

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

We identified that overall there are suitable arrangements and processes in place for information governance management. Suitable reference is made to information governance in corporate documentation, and information governance has been identified as a risk on the risk register. We note that this risk would normally be monitored by the Internal Risk Group, but this group has not met since May 2019.

The scope of the audit was limited due to Cwm Taf Morgannwg University Health Board (CTMUHB) hosting WHSSC and are therefore their data controller and as such hold the Information Asset Register.

CTMUHB are currently in the process of transferring their information governance systems including the data held for WHSSC. As a result, the information assets register, which is a 'live' register, is not being used until the migration has taken place in November 2019. Following the migration,

there will be a data cleansing exercise to ensure the correct information is recorded. WHSSC will have to contribute to this exercise to ensure the accuracy of the information stored in relation to its systems.

Our review identified the requirement in CTMUHB's records management policy for all host bodies to have their own procedures on records management. WHSSC are in the process of refining a draft version ahead of approval.

Our testing of recording potential information governance incidents in Datix, and the subsequent investigation of them, highlighted that action was not always being taken in a timely manner.

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

5. Assurance Summary

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

Assurance Summary					
1	Policies and procedures			✓	
2	Incident reporting			✓	
3	Information Governance training				✓

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

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weaknesses in the system design/ control for information governance.

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weaknesses in the operation of the designed system/control for information governance.

6. Summary of Audit Findings

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

Objective 1: The Committee has appropriate Information Governance structures, assigned roles and responsibilities, and policies and procedures in place that ensures Information Governance is embedded within WHSSC.

We note the following areas of good practice:

- WHSSC has a corporate manual that references information governance issues.
- Performance information relating to aspects of information governance, for example Freedom of Information and Subject Access Requests are reported on a monthly basis through the Organisation Performance Report to the Corporate Directors Group Board.

We identified the following findings:

- The Internal Risk Group has not met since May 2019, and the action log has not been kept up to date in the interim period.
- The WHSSC draft records management policy requires approving and disseminating to all staff.

Objective 2: Information Governance incident management systems are in place with breaches reported appropriately.

We note the following areas of good practice:

- The Datix system is used to record all incidents. The system has various 'drop downs' for recording incidents into different categories; one of which being 'breach of confidentiality / information security'.
- Incident reporting forms a key section of the corporate procedures, and this references information governance breaches.
- In the absence of the Cwm Taf Morgannwg Information Governance Board meeting, we were informed by the Corporate Governance Manager that any information governance incidents were highlighted in the WHSSC Corporate Director Group Catch up meetings that are held weekly, however these meetings are informal and not minuted.

We identified the following finding:

- Our sample testing of information governance incidents raised in Datix identified instances relating to the timeliness of inputting the issue, and with investigations starting once input.

Objective 3: All staff have received appropriate training in Information Governance.

We note the following area of good practice:

- As at August 2019 WHSSC had an overall compliance rate of 85.71% for the information governance mandatory training module. This exceeds the Welsh Government target of 85%.

We identified the following findings:

- At the time of our fieldwork, the medical and dental staff group had not achieved the 85% compliance target for the information governance.
- WHSSC has not undertaken an information governance training needs analysis to identify the level of training required by staff group.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**2**	**2**	**4**

Finding 1 – Information Governance Risks (Operating effectiveness)	Risk
An Internal Risk Group has been established to review risks within WHSSC. During our Risk Management audit in March 2019, we identified that there was no terms of reference for this group, and this remains the case at the time of this review. An information governance risk has been identified, assessed and is recorded on the risk register. However, information such as mitigation actions and lead officers have not been recorded. We understand that this is partly due to the group not meeting since May 2019 due to staff turnover, and the office relocation. As a result, it was not clear if the action log generated following the last meeting has been worked upon, as it has not been taken to any group for monitoring or provision of updates. We by the Corporate Governance Manager were informed that updates to the actions are currently being 'chased' by the corporate team. We understand that the Internal Risk Group will reconvene before the end of the calendar year in order to carry on their role in reviewing risks.	The Health Board does not have appropriate policies and procedures in place covering information governance to appropriately manage the processes.
Recommendation 1	**Priority level**
1. The Internal Risk Group should be reconvened as soon as possible to allow risks to be routinely monitored, and actions arising from the meetings to be monitored and updated.	**Medium**

2. A terms of reference outlining the remit of the Internal Risk Group should be drafted and approved.	
Management Response	**Responsible Officer/ Deadline**
Accepted. The Internal Risk Group is scheduled to meet on 22nd October 2019 with the following meeting planned to be held prior to end of January 2020. The Action log will be updated with progress noted against the actions. Work on reviewing and monitoring departmental risks will be led by Executives and an update on progress will be taken to the Corporate Directors Group Board meeting in November 2019. It is anticipated that the group will need some time to re-establish and progress matters but it is anticipated that within 6 months (by April 2020) we will be able to provide a positive progress report on the work of the Internal Risk Group. A draft terms of reference will be drafted for the Internal Risk Group and circulated in advance of the 22nd October meeting for consideration. The output will be taken to Corporate Directors Group Board for approval by the end of January 2020.	Committee Secretary/Corporate Governance Manager 1. January 2020. 2. January 2020.

Finding 2 - Incident Reporting (Operating effectiveness)	Risk
The Datix system is used to record incidents. The system has various 'drop down' menus for apportioning the incidents into differing categories, one of which being 'breach of confidentiality / information security'. For the period April 2018 to March 2019, five incidents were recorded on Datix under the heading 'breach of confidentiality / information security'. We reviewed the timelessness of recording and investigating these incidents and note the following: • For 3/5 incidents there were delays between two and three weeks from when the incident occurred to it being recorded on Datix, with no explanation recorded of why there had been a delay. • 1/5 incidents there was a delay of approximately two weeks from the incident being recorded on Datix to an investigation being started. • In two further incidents we identified that the investigation had started before being recorded on Datix. These were both cases where there was a delay in inputting the incident on Datix.	Non-compliance with regulations including the General Data Protection Regulations.
Recommendation 2	**Priority level**
1. Staff should be reminded of the importance of recording incidents in Datix in a timely and accurate manner and that subsequent investigations should commence in a timely manner.	**Medium**

2. Consideration should be given to monitoring the timescales for inputting and investigating incidents on Datix in order to establish if additional guidance and training is needed.	
Management Response	**Responsible Officer/ Deadline**
Accepted. The Corporate Governance Manager has made contact with the Cwm Taf Morgannwg Datix team to request written guidance, which can be issued to staff as a reminder on how to use Datix to record all incidents. Once received this will be sent to all staff as a reminder of the importance of recording incidents on the Datix system. Any staff that require more than written guidance will be offered a one to one briefing with the Corporate Governance Manager. The Corporate Governance Manager will monitor timescales for inputting and investigating incidents on Datix over the next 9-12 months. Once a sufficient number of incidents have been logged and reviewed a decision will be taken on whether any additional training is required.	Corporate Governance Manager 1. January 2020 2. October 2020

Finding 3 -Procedures (Operating effectiveness)	Risk
As WHSSC are hosted by Cwm Taf Morgannwg University Health (CTMUHB) Board, they act as the data controller for WHSSC. WHSSC also uses the Health Board's information governance and records management policies. CTMUHB's records management policy requires directorates, including hosted bodies, to have their own operational processes for the management of paper as well as any electronic records. WHSSC currently has a draft records management policy. We were informed by the Corporate Governance Manager that the draft policy will be presented to Corporate Directors Group Board for approval in the forthcoming months.	WHSSC does not have appropriate policies and procedures in place covering information governance to appropriately manage the processes.
Recommendation 3	**Priority level**
The draft records management policy should be formally approved and distributed to all staff, ensuring all staff are aware of it and understand the content of it.	**Low**
Management Response	**Responsible Officer/ Deadline**
Accepted. The draft records management policy is currently being reviewed by the Corporate Governance Manager who is new in post. Along with reviewing WHSSC internal guidance the Corporate Governance Manager will also review Cwm Taf	Corporate Governance Manager March 2020

Morgannwg guidance to ensure a consistent approach. Once the policy has been approved by the Corporate Directors Group Board it will be sent to all staff. Any staff that require more than written guidance will be offered a one to one briefing with the Corporate Governance Manager.	

Finding 4 – Information Governance Training (Operating effectiveness)	Risk
Welsh Government sets a target of 85% compliance for the core statutory and mandatory training modules, one of which is information governance. As at August 2019 WHSSC has an overall compliance rate for the information governance module of 85.71%. The only staff group to not achieve the 85% compliance target was Medical and Dental staff, who achieved a 71.43% compliance rate. The online training module only provides a basic overview of information governance. Our review did not identify if WHSSC had undertaken any additional training needs analysis to determine if more detailed training around information governance is required for differing staff groups within the organisation.	Staff are not aware of their information governance responsibilities due to a lack of training.
Recommendation 4	**Priority level**
1. Staff should be reminded of the importance of completing all online training modules that form the core skills training framework on a timely basis. 2. Consideration should be given to undertaken a training needs analysis on the level of information governance training required for each staff group within WHSSC.	**Low**

Management Response	Responsible Officer/ Deadline
Accepted in part. As the WHSSC compliance for the IG core statutory and mandatory training modules is above the Welsh Government target and as the Managing Director frequently issues reminders to all staff to undertake all statutory and mandatory training, this Recommendation is already being met. The Corporate Governance Manager has made contact with Cwm Taf Morgannwg IG Manager to discuss what additional IG training is available. This issue will inform consideration of a needs analysis when the IG risk assessment is reviewed.	Corporate Governance Manager 1. Completed 2. March 2020

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

Cardiac Services Review

Welsh Health Specialised Services Committee

Internal Audit Report

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTMU-1920-48
Report status:	Final Internal Audit Report
Fieldwork commencement:	17 June 2019
Fieldwork completion:	11 July 2019
Draft reports issued:	22 July and 2 August 2019
Management response received:	9 August 2019
Final report issued:	12 August 2019
Auditors:	Olubanke Ajayi Olaoye (Senior Internal Auditor) Emma Samways (Deputy Head of Internal Audit)
Executive sign off:	Sian Lewis (Managing Director)
Distribution:	Karen Preece (Director of Planning) Andrea Richards (Specialised Services Planning Manager)
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

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

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1. Introduction and Background

A review of Cardiac Services at the Welsh Health Specialised Services Committee ('WHSSC' or the 'organisation') was completed in line with the 2019/20 Internal Audit plan.

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

WHSSC is managed through functional directorates (patient care, medical, planning, finance and corporate services), which integrate through six multidisciplinary programme commissioning teams and networks, one of which being the cardiac programme. Cardiac services provides commissioned services for areas including:

- Cardiac Surgery
- Adult Congenital Heart Disease
- Paediatric Congenital Heart Disease
- Specialised Cardiology Services
- Bariatric Surgery
- Cystic Fibrosis

The NHS Wales Health Collaborative Team was established in 2015 and provides support to health boards in the delivery of services that require an all Wales focus. A number of clinical networks make up the collaborative, one of which is the Cardiac Network. The network consists of clinical and managerial representatives from the health boards, commissioners and key strategic partners from across Wales, forming a strategic leadership group, with the aim of delivering the priorities set out in the 'Heart Conditions Delivery Plan'. As such, there is a need for good working relationships between cardiac programme lead staff at WHSSC and those working for the Cardiac Network.

The relevant lead for the assignment is the Managing Director.

2. Scope and Objectives

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

- Adequate governance arrangements are in place for the service including a designated lead, defined team structure, management group and reporting into the Joint Committee.

- An approved annual service plan is in place for the programme team that aligns with the overall Integrated Commissioning Plan (ICP) for Specialised Services for Wales 2019-22 and has consideration for the work being undertaken by the cardiac network.
- Up to date evidence based service specifications are in place and cardiac services are planned against specialised service policies.
- Formal service agreements / contracts have been appropriately agreed with providers and robust procedures are in place to monitor and report on activity, financial performance and quality outcomes.
- Annual budgets for the programme are agreed and regularly reported and reviewed. Variances are identified and investigated and remedial action is taken where required.
- A programme risk register is in place and progress towards managing key risks is regularly monitored, updated and reported. High level risks are communicated and appropriately escalated within WHSSC.

3. Associated Risks

The potential risks considered in this review were as follows:

- Services are not effectively planned and commissioned.
- Value for money and quality of service may not be maximized.
- Budgets are not effectively monitored and managed.
- Risks are not identified or effectively managed.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context. The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Cardiac Services is a reasonable assurance.

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

Cardiac Services has appropriate governance arrangements in place with Cardiac Commissioning team meetings taking place regularly. There is a clear line of reporting into the Corporate Directors Group, Management Group and the Joint Committee. However, the governance arrangements could be strengthened with the introduction of a terms of reference for the Cardiac Commissioning Team meetings, in order for their remit and responsibilities to be clearly defined.

Processes are in place to facilitate the planning of Cardiac Services. The internal work plan is used as a medium to meet with the goals and targets set within the Integrated Commissioning plan.

An annual budget is set and monitoring of the financial position is carried out during the year. The Service Level Agreements (SLA) relating to Cardiac Services was appropriately signed and dated by the service providers and WHSSC.

We found that some of the Cardiac service specialist areas should have either a service specification and / or a policy in place to outline WHSSC's

approach to commissioning that service and requirements of the provider. For a number of the specialities the specifications or policies were not in place, however, we acknowledge that a future date for their development had documented in the current Cardiac Service annual work plan.

We found that key risks are reviewed within the Cardiac Services team and escalated within the organisation where required. We note that at the time of our review, the risk register included some notes which should be actioned at the next Cardiac Services team meeting.

5. Assurance Summary

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

Assurance Summary					
1	Governance arrangements			✓	
2	Annual service plan				✓
3	Service specifications and policies			✓	
4	Service agreements / contracts				✓
5	Budgets monitoring				✓
6	Programme risk register			✓	

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

Design of Systems/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the system control/design for Cardiac Services.

Operation of System/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the operation of the designed system/control for Cardiac Services.

6. Summary of Audit Findings

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

Objective 1: Adequate governance arrangements are in place for the service including a designated lead, defined team structure, management group and reporting into the Joint Committee.

We note the following areas of good practice:

- There is an Associated Medical Director appointed to cover Cardiac Services and there are defined leads responsible for specific functions (such as Finance, Information and Quality) within Cardiac Services.
- Cardiac Commissioning Team meetings take place on a regular basis and cover key areas including performance, finance, quality and patient safety, updates on the Cardiac network, and updates on the Cardiac work plan.
- Cardiac Services are discussed at the various levels and groups within the WHSSC.

We identified the following finding:

- The Cardiac Commissioning team meeting has no terms of reference.

Objective 2: An approved annual service plan is in place for the programme team that aligns with the overall Integrated Commissioning Plan for Specialised Services for Wales 2019-22 and has consideration for the work being undertaken by the Cardiac network.

We note the following area of good practice:

- There is a work plan in place for Cardiac Services which aligns with the ICP for 2019-22.

We did not identify any findings under this objective.

Objective 3: Up to date evidence based service specifications are in place and Cardiac services are planned against specialised service policies.

We note the following areas of good practice:

- There is a policy group which meets every month. They ensure there are internal governance arrangements for the management and implementation of all policies and a methodology and templates have been produced to help standardise the drafting of polices. These are used by Cardiac Services.
- There is a policy process methodology which is a process that is followed in the preparation of policies.

- There are templates in place to fit various categories of policies such as commissioning templates and non-routine templates.

We identified the following finding:

- Some areas within Cardiac Services which require a service specification, policy position or commissioning policy, did not have one in place.

Objective 4: **Formal service agreements / contracts have been appropriately agreed with providers and robust procedures are in place to monitor and report on activity, financial performance and quality outcomes.**

We note the following area of good practice:

- All five SLAs relating to Cardiac Services were in place and the agreements had been signed by the relevant parties.

We did not identify any findings under this objective.

Objective 5: Annual budgets for the programme are agreed and regularly reported and reviewed. Variances are identified and investigated and remedial action is taken where required.

We note the following areas of good practice:

- In January 2019, as part of the ICP the 2019/20 budget was signed and approved by the Joint Committee.
- On the third day of each month the Finance lead for Cardiac Services sends Financial Risk Sharing tables to Welsh Government and the providers (HBs), which details the budgets, actual costs to date, and the allocation of cost variances to each of the health boards.

We did not identify any findings under this objective.

Objective 6: A programme risk register is in place and progress towards managing key risks is regularly monitored, updated and reported. High level risks are communicated and appropriately escalated within WHSSC.

We note the following areas of good practice:

- Cardiac Services has an up to date risk register in place with all risks described and scored.
- The risk register is reviewed on a monthly basis as part of the Cardiac Commissioning Team meetings. This also feeds into, and is reported at, the Quality Patient and Safety Committee but this depends on the level of risk. There is a risk assessment for each of the identified risks this details the risk and the control measures that are in place.

We identified the following finding:

- Our review of the risk register identified that the register includes some risks that did not have future review dates or actions recorded.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**2**	**0**	**3**

Finding 1: Policy documents (Control design)	Risk
Service specifications and policies should be in place for each of the cardiac specialities that WHSSC commissions. The service specification defines the core requirements that WHSSC expects providers to have in place, whereas the policy outlines WHSSC's overall policy for a particular treatment or intervention. In the earlier part of 2018/19, work undertaken by the Cardiac Services team identified gaps around the specifications and policies in place. Some policies were out of date, while some areas never had a policy in place. These were reflected it the Cardiac annual work plan. We reviewed the service specifications, policy positions and commissioning policy to ensure areas within Cardiac services, which required documentation, had them in place. We identified the following: • At the time of the audit field work 2/6 Cardiac Service areas that are required to have a **policy position** did not have one. One missing policy in relation to Everolimus was in draft at the time of the audit fieldwork, and has since been approved and published. In addition, WHSSC were unable to find the Cardiac Transplant policy. We note that the annual work plan reflects that work is needed in this area. • 2/4 Cardiac Service areas that are required to have a **commissioning policy** did not have one that was in date. The outdated policies relate to Cystic Fibrosis (June 2018 review date), and Targeted Therapies Pulmonary Hypertension (February 2014 review date). We acknowledge that these are	Value for money and quality of service may not be maximised.

either on the annual work plan for drafting, or are already in the process of being drafted. • 5/7 Cardiac Service areas that are required to have a **service specification** did not have one. Reference is made to ongoing work in these areas as part of the Cardiac Services annual plan.	
Recommendation 1	**Priority level**
All areas identified as needing service specifications and /or a policy should be drafted in line with the timeframes set out in the Cardiac Services annual plan.	**High**
Management Response	**Responsible Officer/ Deadline**
The Cardiac Commissioning Team will review all Commissioning Policies/ Policy Positions and Services Specifications that are either out of date or not in place. Where not identified on the work plan we will agree the priority and timescales and document on the work plan. This will be undertaken as a high priority and within the 1 month timescales. All policy reviews and service specifications will therefore be drafted in line with the agreed work programme.	Andrea Richards - Specialised Services Planning Manager September 2019 – to identify missing policies / specifications. April 2020 – to draft missing policies / specifications.

Finding 2: Risk register (Operating effectiveness)	Risk
There is a risk register specific to Cardiac Services which is maintained and reviewed on a monthly basis by the Specialist Planner and Assistant Planner. Changes made to the risk register are discussed at the Cardiac Commissioning team meetings. Relevant, high scoring, risks are reported at a corporate level and relevant directors are consulted when required. We reviewed the risk register and note that it is regularly reviewed and updated, with the last update being 7 June 2019. Our review of the risks within the risk register identified that 6/16 risks which were still open did not have a subsequent review or due date. • 4/16 risks showed control measures as 'complete' though they remained as 'open' on the register, with no further control measure or future review date for managing the risk. • 1/16 had March 2019 as the review date and no further update provided. • 1/16 had no control measure or review date information recorded against it.	Risks are not identified or effectively managed.
Recommendation 2	**Priority level**
For all risks recorded on the risk register, future review dates should be recorded and updated.	**Medium**

Management Response	Responsible Officer/ Deadline
The Risk Register has been reviewed and future review dates have been included or risk removed as per agreed process through the Cardiac Commissioning team	Andrea Richards - Specialised Services Planning Manager. Completed

Finding 3: Cardiac Services Commissioning Team terms of reference (Control design)	Risk
WHSCC has developed generic terms of reference for their commissioning teams. The Cardiac Services Commissioning Team meetings currently take place on a six weekly basis, whereas the terms of reference suggests meetings should be monthly. The main areas such as performance, information, finance, work plan, quality and patient safety are discussed and reports are presented where required. Minutes, agendas and action plans are produced for each meeting. WHSSC does have a working relationship with the Cardiac Services Network. However, as the terms of reference for the commissioning team meetings are generic, it is difficult to understand the relationship between the Cardiac team and the Cardiac Network, and also where responsibilities lie. As such, there is a risk of duplication of effort, or conflicting information being provided.	Services are not effectively and efficiently planned and commissioned.
Recommendation 3	**Priority level**
Management should ensure the terms of reference for the Cardiac Services Commissioning team is reviewed, or an addendum to the current terms of reference is produced that clearly outlines their roles, responsibilities and relationship with the Cardiac network, thus providing greater clarity and avoiding potential duplication of work.	**Medium**

Management Response	Responsible Officer/ Deadline
The Terms of Reference are generic to all Commissioning Teams. An addendum to the TOR's will developed by the Cardiac Commissioning Team for approval by the Corporate Directors Group. This good practice will also be repeated for each of the Commissioning Teams.	Andrea Richards - Specialised Services Planning Manager September 2019 Karen Preece – Director of Planning October 2019 (CDG sign off)

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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