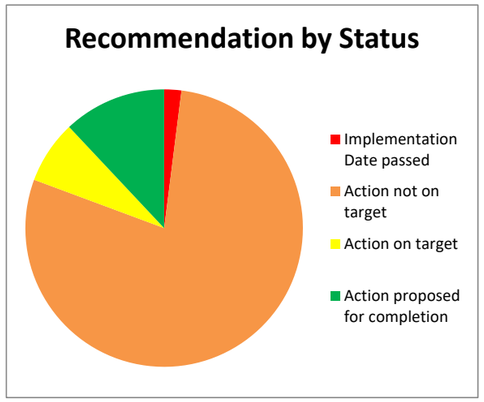
Appendix 1

Cwm Taf Morgannwg

Internal Audit Recommendations / Action Log - [h] 2019



Recommendations by Priority & Status					
Priority	TOTAL	Implementation Date passed	Action not on target	Action on target	Actions Completed
High	**48**	1	40	2	5
Medium	**83**	1	66	5	11
Low	**19**	1	12	4	2

Progress	
Total Recommendations	
New Recommendations	
Improving	19
No Change	4
Declining	

Recommendations by Executive Lead & Status					
Executive Lead	Total	Implementation Date passed	Action not on target	Action on target	Actions Completed
Director of Corporate Governance	**2**	0	2	0	0
Director of Finance	**1**	0	0	0	1
Director of Operations	**69**	0	58	7	4
Director of Primary, Community & MH	**3**	0	0	0	3
Director of Nursing	**8**	1	5	0	2
Director of Planning & Performance	**16**	0	16	0	0
Director of Workforce & OD	**35**	2	29	3	1
Director of Public Health	**3**	0	3	0	0
Medical Director	**13**	0	5	1	7

CTM Internal [date]

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Ref	Date added	Assurance rating	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead/Management Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Revised Implementation date	Status	Progress	Actions completed	Issues Arising This Period	Next Steps & Expected Milestones
Fire Management (June 2018)															
FM 03	May-18	Reasonable	Opportunities will be explored to better capture information, including developing the NWSSP: SES database and improve reporting from Divisions and Directorates. (D)	High	Agreed. The key issue is the absence of meaningful management information and the limitations of a national software system, which results in workarounds being developed. Significant effort is made to ensure that the fire risk assessments are completed adequately; however, the 'Fire Auditing and Reporting System' cannot provide accurate/ up-to-date information for discussion with directorate managers. Noting the limitations of the national system, there are a number of local systems in place as a workaround, however this results in duplication. In the first instance, the issue will be raised with NWSSP: SES to request improvement of the national system, and advise on what action can be taken nationally to address this concern.	Director of Workforce & OD	Head of Health, Safety & Fire	Jun-18				In progress	Ongoing		Update April 2019: A meeting took place with Shared Services Faciities and Estates Services in March 2019 where future options were discussed. An outline case will be developed for the provision of a new system to replace the existing one in 2019. Update July 2019: Despite several communications with NWSSP: SES this project hasn't moved any further beyond an initial scoping meeting. The Health Board continues to request this system is updated to provide the information recommended in this audit. Update October 2019: Despite several communications with NWSSP: SES this project hasn't moved any further beyond an initial scoping meeting. The Health Board continues to request this system is updated to provide the information recommended in this audit. September 2020 Update - This recommendation relies on P332colleagues in Shared Services to update the Fire Management System. They have been chased to update the system, but they have not progressed this work to date.
FM 07	May-18	Reasonable	Fire folders be reviewed on a regular basis and out of date information removed and updated.(O)	Low	Agreed. The files are reviewed on a cyclical basis and this one was due for review in 2018/19.	Director of Workforce & OD	Head of Health, Safety & Fire	Jun-18	Mar-19	Mar-20		In progress			June 2018 update - Fire Officers to undertake an audit of all wards/depts 08/18. September 2018 update - Fire Officers to undertake an audit of all wards/departments 08/18, not completed will be undertaken by 12/18. Updated December 2018 - The Audit of the 400+ Fire folders across the UHB was commenced in 12/18 and is due for completion 03/19. Update April 2019: Due to added resource pressures due to the Bridgend Merger, completion of this audit has been defered until 30 June 2019. Update July 2019: Due to added resource pressures due to the Bridgend Merger and the fire risks that have transferred to CTMUHB following the merger with Bridgend, completion of this audit has been deferred until the end of this financial year. In mitigation, each time a departmental Fire Risk Assessment (FRAs) is reviewed, an assessment on the fire folder is undertaken and information provided to the local manager for that area. As all FRAs are reviewed in no more than a 3 year period, this ongoing review of the folders continues. September 2020 Update - This is still outstanding due to limited resource within the team to undertake the audit. We have another Fire Audit due in the next few months and the auditor will be reviewing this recommendation as part of their audit. It is my belief that the new Audit will supersede this one and new recommendations likely.
Facilities Management (December 2018)															
FM 14	Oct-18	Reasonable	The review of the historical roster templates that are being used should be progressed with revised rosters realigned to meet the current demands of the services at both hospital sites. It should be ensured that suitable systems are in place to accurately capture the work undertaken by the porters, to better inform future roster amendments and to allow monitoring of staff productivity. Rosters should be prepared further in advance in order for staff to know their core shifts and overtime shifts, if any, thus reducing the need for staff to swap shifts if they are unavailable for the overtime they have been allocated. Where there is a need to make use of overtime, efficient use should be made of all available staff.	High	As per the porter redesign and current staff/supervisor/dispatchers organisational change process mentioned at Facilities Finding 6 response. Facilities supported by WF & OD business partners are currently in a period of status quo with staff and trade unions on a number of rota compliance and terms and condition issues. Grievance policy negotiations are ongoing with staff and staff side trade union colleagues. The portertrac system is used to monitor daily porter task activity. However the system is nearly 20 years old is challenging to navigate, is not an end user selfserve system, has to be manually interrogated to extract meaningful reports for effective reporting and does not provide accurate data as it is heavily reliant on accurate input from the porter services duty dispatcher. Facilities is currently developing a Facilities Management (FM) service investment in technology plan which would improve on 24/7 service delivery and address staff transactional management, replacing paper based systems of recording and auditing with software systems. This provides electronic log on duty and tracking of each member of the porter services duty teams shift, carrying out service tasks that can be tasked by end user departments using self-serve direct to each member of the porter team through to log off duty. This system will provide an auditable trace and provides service delivery performance information. We need to invest in FM management software solutions which will bring benefits to the Facilities services environment. The Porter Services re-design currently being taken forward will support the correct management of an efficient rota system across porter services at all sites which includes migration to e-rostering. The re-design scheme will also successfully support integration of the porter security requirement to the working	Director of Operations	Assistant Director of Facilities	Jan-19	Jan-20	Jan-21		Part Completed			Will be fully completed when the Porter redesign scheme is fully implemented. Currently in stage 2 grievance process. Porter redesign includes rota design that will compliment existing staff establishment and support services trends and demands. Porter Trac utilised to support trends for this - July 2019 update Will be fully completed when the Porter redesign scheme is fully implemented. Porter redesign includes rota design that will complement existing staff establishment and support services trends and demands. Porter Trac system will be utilised to support this. Following the service redesign plan phased implementation, staff engagement and consultation phases, some of the Pool Porter Services staff supported by their trade union representatives raised a grievance against the revised rota and some elements of the service change. We are now in the final process of stage 3 grievance at PCH and RGH. The Deputy Director of WF&OD chaired a dispute resolution meeting on the 29 May 19 with Trade unions and the Facilities management team. Progress is being made with agreeing a compliant rota with staff and getting to the final implementation phase. Despite the push back and challenges with this service change scheme, the Facilities management team with support from WF & OD business partners are committed and doing everything they can within OCP process to progress the scheme to completion and deliver on a compliant and a workable and financially sustainable rota. It is anticipated that if agreement can be reached with the latest rotas and following a period of notice that the revised rotas will be put in place in November 2019. October 2019 update - Agreed at the September meeting to extend the completion date to 1 January 2020. June 2020 update: Following final confirmation of pay protection RGH porters new rota commences 23 June 20.
Wellbeing of Future Generations Act (Wales) 2015 (January 2019)															

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WFGA 01	Jan-19	Reasonable	Future Health Board annual reports should provide details on the review and outcome of the progress that has been made during the year towards meeting the agreed Well-being objectives. Whilst the objectives are incorporated into the IMTP process, there should be a clear distinction between setting out the objectives and reporting the progress made in achieving them.	High	Notably, Welsh Government Guidance (Shared Purpose, Shared Future) recognised that "for greatest impact public bodies should ensure that their wellbeing objectives form part of their central planning arrangements, such as a corporate plan or similar organising tool". Accordingly, the Board of CTUHB had determined after detailed consideration of the Core Guidance that it already had an organisational planning processes which was successful, well-embedded and which clinical and non-clinical teams were very familiar with. It therefore agreed on the need to not establish a parallel review and reporting process for the WFG Act. The requirements of the Act would be met via the established mechanism of the UHB's Annual report and this remains the intention. We understand the core purpose of the annual reporting (in whatever format it is done) to be that of allowing public bodies to be transparent about the process and content of review of the well-being objectives and their continuing relevance to the seven national well-being goals. It is the belief of management that these objectives have been achieved for the 2017/18 year through the UHB's annual review and reporting process. As a learning organisation however, we believe there is merit in continuing to review the process to ensure we continue to fulfil the central purpose of the review and annual reporting.	Director of Public Health		Jun-19	Mar-21			In progress			March 2019 update - The Public Health team is looking to recruit to 2 sessions of a Consultant in Public Health role in April whose responsibility will include leading on ensuring future annual reports reflect this guidance. Confirmation will be in the proposed timescale for completion of this task August 2019 Update - We committed to continue reviewing the process of reporting to ensure we demonstrate how we are achieving the central purpose of the WFGA. Addition of capacity in Public Health was achieved as planned but was quickly met with significant demand from the boundary change and this has meant that the review process has been drawn out over a longer period than initially intended in order to accommodate competing priorities for a very limited staffing resource. Ongoing review of the process of reporting however suggests that using the annual report mechanism for CTMUHB continues to be the most efficient and integrated way to report progress on our wellbeing priorities. Importantly, these wellbeing priorities need to be revisited in view of the new CTM organisation. Reporting on progress will need to reflect this change when it happens. Finally, during the year, CTUHB took part in the self-reflection process led by the Future Generations Commissioner for Wales. Her feedback on our self-reflection is embedded. It was helpful feedback on very honest self-reflections on where we are. November 2020 Update - This recommendation remains open and it's completion has been impacted as a result of the Covid 19 Pandemic
WFGA 02	Jan-19	Reasonable	Management should develop a cohesive plan for driving forward the requirements of the WFGA within the Health Board. Key staff should be identified that will assist in embedding the WFGA within the Health Board.	High	The second objective being scrutinised here is that the UHB has taken steps to meet the well-being objectives and that these are clearly identified. Consistent with our earlier response, we believe the UHB has done this through the mechanism of the IMTP. In the IMTP, both clinical and non-clinical Directorates of the organisation set out their plans to achieve the organisation's objectives, including the well-being objectives. The Directorate Managers are named leads on the IMTP plans and naturally have shared responsibility for ensuring the plans are delivered as intended. Having said this, we do recognise that the spirit of the Act is about moving on from a place where the 'sustainable development' (SD) principle is an add-on to one where it is effectively integrated as a means to deciding what our organisational objectives should be. We are not there. So we welcome the potentially helpful suggestions that might help us move faster and further on this path. We recognise that this is going to require organisational culture change at many levels. Every individual needs to be supported to embed SD principles in their work. Ownership at every level and across the organisation is what is needed. Of course the risk in this is that it is not owned by anyone but we believe that embedding it in the established IMTP process mitigates this risk. In pursuance of this recommendation however, the UHB will explore the merit of: ☐ Establishing a WFGA Steering Group ☐ Identifying an independent member to act as 'WFGA Champion'. ☐ Creating designated pages on its internet site detailing the work undertaken in respect of WFGA and highlighting the well-being objectives	Director of Public Health		Jun-19	Mar-21			In progress			March 2019 update - The Public Health team is looking to recruit to 2 sessions of a Consultant in Public Health role in April whose responsibility will include leading on this. Confirmation will be in the proposed timescale for completion of this task August 2019 Update - Addition of capacity in Public Health was achieved as planned. Although these planned actions are in competition with unexpected demands placed on the team by the boundary change, we have considered and ruled out any real benefit from forming a WFGA steering group. Embedding WFGA through the IMTP process and ensuring dispersed ownership remains the most influential way of embedding ownership of the agenda across the organisation. Independent member champion is potentially useful but needs to happen in background of wider Board ownership and drive of the WFGA. We welcome the Audit Committee view on whether it would countenance making a representation to the Board along these lines. The last action on designated pages on the internet remains relevant but merit consideration in light of the new organisational shape. November 2020 Update - This recommendation remains open and it's completion has been impacted as a result of the Covid 19 Pandemic
WFGA 04	Jan-19	Reasonable	The Health Board should consider developing dedicated pages on its internet site detailing its individual responsibilities under the WFGA and clearly highlighting its well-being objectives in order to raise awareness of these objectives.	Low	We accept this recommendation.	Director of Public Health		Jun-19	Mar-21			In progress			March 2019 update - This action is likely to slip because of lack of capacity November 2020 Update - This recommendation remains open and it's completion has been impacted as a result of the Covid 19 Pandemic
Continuing Healthcare (January 2019)															

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CHC 02	Jan-19	Reasonable	Following the publication by Welsh Government of a revised CHC national framework, management should review Health Board procedure documents and forms used in the CHC process to ensure all aspects remain relevant and aligned to the national framework. Consideration should be given to having a single document within the Health Board that signposts users to the relevant guidance such as the framework, the FCP, and to the relevant forms that need completing. Management should also provide refresher training to relevant staff within directorates and extending training to local authority counterparts, to ensure that staff are fully aware of any revisions to the framework and fully understand their responsibilities for the aspects of the process that they are responsible for.	Medium	Welsh Government are in the process of finalising the revised CHC Framework for early 2019. Cwm Taf UHB plan to review all documentation in the line with the new CHC Framework to ensure consistence of application and prevent duplication. A joint training programme between health and social care will be an essential element of embedding the new framework.	Director of Nursing	Lead Nurse for CHC and NHS Funded Nursing Care	01/07/2019	01/10/2019 This should be within three months of implementation of the new framework (due to be published on July 2019).			In progress			March 2019 update - Awaiting publication of new Framework in order to draft policy and organise training programme. March 2020 Update - Welsh Government has confirmed this week that the launch of the new Continuing Healthcare Framework will be delayed from 1 April 2020 until later in the year. November 2020 Update - We are unable to update our paperwork in line with the new CHC Framework until it is launched. We have not been provided with a date from WG as to when this will happen.
CHC 03	Jan-29	Reasonable	A review of the current arrangements for storing patient CHC files should be undertaken. For all patients where funding is in place or an assessment ongoing, a file (preferably electronic) should be held by the CHC team. An electronic copy of the key documents required as part of the decision making process should be provided by directorates and held on file. If documents cannot be centrally saved to file in this way, a checklist should be in place on file indicating where the original copy of these key documents are being held, the date they were completed, and any key decisions.	Medium	Cwm Taf UHB to strengthen quality assurance at directorate level by developing a checklist for each application presented to Clinical Placement Panel. This will be included on the central file and will ensure applications contain necessary documents and then are available and accessible to the central team.	Director of Nursing	Lead Nurse for CHC and NHS Funded Nursing Care	Mar-19				Completed	November 2020 update - We have amended our Financial Sign Off and also have a Quality Assurance Form in use.		March 2019 update - CPP Terms of Reference to be reviewed to ensure quality assurance and scrutiny is understood as part of the CPP's role. New Financial Sign Off being drafted to advise users of the key documentation (Nursing Assessment, Social Work Assessment, Medical Opinion, DST) required for their Unit Panel Application. To encourage users to advise of the date of next review, care co-ordinator, category of care etc.
CHC 05	Jan-19	Reasonable	Management should ensure that copies of nursing assessments and appropriately approved CHC Unit Panel forms are retained on file (preferably electronically) for each year that a person is a CHC patient. Management should ensure that key documentation such as nursing assessments are completed in a timely manner to allow the Unit Panel to approve each year's funding request. Consideration should be given to including in the patient file the date the next nursing assessment is due.	Medium	The quality assurance process and checklist identified in Finding 3 will encompass the recommendation in Finding 5. The central CHC Team to provide training to the directorate teams to identify the importance of annual reviews and approvals.	Director of Nursing	Lead Nurse for CHC and NHS Funded Nursing Care	Mar-19	Jul-19			Completed	November 2020 Update - All assessments received are now stored electronically in a patient folder. Paper Files have a sheet on the front which identifies when the next nursing assessment is due.		March 2019 update - Nursing Team currently reviewing: Checklist to be completed for all Unit Panel Applications Central Filing system and where documentation should be held for easy access. July 2019 update. Terms of reference continue to be relevant for current panel's process. New financial sign off developed in partnerships with directorates will a launch date of July 19 and incorporates a check list for each application.
IT Systems (March 2019)															
IT 01	Feb-19	Reasonable	The organisation should develop an overarching BCP / DR process. This should consider all the systems and use a business impact analysis to prioritise the systems for recovery. The business (Directorates / Departments) should be involved in the process and should be consulted in order to define appropriate RTO / RPOs.	Medium	The organisation will look to develop an overall BCP/DR plan for ICT services. This would require senior management within ICT and the Civil Contingencies Manager to drive this with the co-operation of the various stakeholders within the Health Board. This should be overseen by the Digital Strategy Group. July 2019 Update: Quotes for two suppliers were soliicited and the lower cost supplier has recently been retained to assist with this activity. A detialed plan will be forthcoming once the supplier is on site. We currently estimate to complete this action in October.	Director of Planning & Performance	Assistant Director of ICT	Apr-19	Mar-20	Dec-20		In progress			October 2019 Update - Senior management are in discussions around BCP/DR plans relating to infrastructure and ICT service affecting systems. Incident process flow diagrams are being drafted to provide visibility on the work flow when an incident occurs. This will be reviewed and completed in readiness for DHSSG. June 2020 Update - No Further Progress - Revised completion date of December 2020. August 2020 Update: Distaster Recovery plans have been created for infrastructure services such as DHCP services, on site mail exchnage services and file storage. Initial work has commenced between ICT governance and the Head of Systems to address clinical systems planning. A template has been produced and is to be agreed for all DR plans. The new Cito system has produced a comprehensive DR and BC plans. November 2020 Update - No further progress made since the August update.
IT 02	Feb-19	Reasonable	As part of the review process for DR plans, the identified weaknesses should be addressed, with up to date configurations included, along with all relevant contact names and numbers. The plans should also consider the RTO / RPO needed by the user departments and instructions should be complete. Hard copies of the plans should be stored so they are accessible in the event of network loss.	Medium	Management Respponse: ICT will address the identified weaknesses including contact details and the availability of hardcopy. In addition, ICT will consult with the department regarding their RTO / RPO requirements which will be factored into the updated DR plans.	Director of Planning & Performance	Assistant Director of ICT	Apr-19	Jan-20	Dec-20		In progress			July 2019 Update: This will be part of the review process in Finding 1. October 2019 update - Senior management are reviewing contact names and numbers so they are located on hard copy and digital copy in the event of a major incident. Departments are being communicated with Civil Contingency in terms of user based advise and training in the event of their own DR plans in accordance to ICT service delivery. June 2020 Update - No further progress - revised completion date of December 2020. August 2020 Update - work is progressing as per response for IT01. November 2020 Update - No further progress made since the August update

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IT 03	Feb-19	Reasonable	As part of the process for reviewing IT DR plans, contact should be made with departments to ask them to establish their required RTO (the time for which they could acceptably work without the IT service being considered). This process should then push departments into developing their own plans for service provision without IT. The plans should consider varying scenarios covering lengths of outage. e.g. 1hr, 4hr, 1day etc. and also the different aspects of IT e.g. network loss, system loss etc.	Medium	Management Response: The Civil Contingencies Manager to review the BC plans within each Department and put mitigations in place as required, addressing the varying scenarios as recommended.	Director of Planning & Performance	Assistant Director of ICT	Apr-19	Apr-20	Dec-20		In progress			July 2019 Update: ICT, NWIS and the Civil Contingencies Manager ran a half day major incident scenario on 24 June. NWIS are going to provide feedback on the our response which we will use to update the DR plans. Engagement with departments will start in September. Note that the recent loss of a national datacentre has also tested our resilience and the learning from this event will be included in the revised DR plans. October 2019 update - Civil Contingencies Manager has advised that he has asked all Directorates to produce their ICT recovery plans with some Directorates asking for further advice. No completed plans have been received to date. ICT are working with Civil Contingency on meeting with departments to undertake an exercise around their DR plans and to raise awareness on what services ICT deliver in the event of a disaster. June 2020 Update - Due to the current COVID-19 outbreak focus has been placed elsewhere. Within the Datacentres ICT have now had implemented a resilient third room based at PCH to provide resilience for major systems. THis is at the PCH Switchroom which although is on the ground floor at PCH it is in a different fire zone to the main datacentre at PCH. Revised completion date of December 2020. August 2020 Update - Work is progressing as described in IT01. November 2020 Update - No further progress made since the August 2020 update
IT 06	Feb-19	Reasonable	The Health Board should consider putting plans in place to relocate the server rooms to a more stable environment. The Health Board should consider installing fire suppression in the backup room.	Low	Managemetn Response: Replacement of the porta cabin is part of the Health Board's refurbishment of the ground and first floor at PCH which will include fire suppression. Until the refurbishment is complete, the ICT Server team has taken measures to introduce mitigations such as having backup services at the backup site at Blaenavon Data Centre.	Director of Planning & Performance	Assistant Director of ICT	Jun-19	Mar-21			In progress			July 2019 Update: ICT will continue to track the modernisation of PCH and the introduction of a new datacentre. This is not expected in 2019. June 2020 Update - Further work has been carried out on the PCH datacentre which has included a formal structural assessment of the portacabin which has concluded that the structure is safe and stable. The replacement of the main UPS system as well as a backup UPS has been carried out. Due to the ground and first floor refurbishment the backup room at PCH will not have any fire suppression installed. REvised completion date of March 2021. August 2020 Update - The PCH datacentre is structurally safe. There has been installed two main UPS systems for resliiant power supply to the data centre. Due to the ground and first floor refurbishment the back up room at PCH will not have any fire supression installed. November 2020 Update - No further progress made ssince the August 2020 update
Mandatory Training (March 2019)															
MT 01	Feb-19	Reasonable	Management should ensure a plan is developed outlining the target compliance rates that the Health Board is striving to achieve for each level of training and the plans in place in order to help achieve those targets.	High	The recent uploading of higher levels of mandatory training requirements into ESR coupled with new ESR functionality is, for the first time, allowing the production of a detailed TNA and a forecast of required face-to-face training demand. The majority of work required for the production of a training plan based on the information currently held within ESR is already complete. However the impending Bridgend boundary changes will make this information and any plan based on it obsolete on the 1st April 2019. Consequently the analysis of training requirements and the subsequent uploading into ESR undertaken for CTUHB will need to be replicated for all staff transferring from Bridgend County area into the new CTMUHB. Once this work has been undertaken ESR will once again provide a true reflection of the new organisations mandatory training needs. L&D will then work with each of the CSTF mandatory training SMEs to develop a training delivery plan. Each plan will consider; the training demand indicated by ESR against the UHBs capacity to deliver training; agree incremental improvement targets in compliance percentages for each level/competency of all 10 CSTF subjects and rationalise training delivery to ensure that best use is made of available elearning packages to replace face –to-face training delivery. Each plan will be presented to the UHBs CSTF Steering Group for sign off and subsequent monitoring of implementation. L&D are already working with CSTF SMEs to scrutinise and refine the training requirements uploaded into ESR, to reduce the requirement for face to face training and ensure that e-learning is used as the preferred mode of training delivery wherever possible. In tandem with this	Director of Workforce & OD	Learning & Development Manager	Oct-19	Jan-20	Mar-21		Part Completed	Dec 2020 UPDATE: Learning and Development Business Partners introduced Sept 2020 to support ILGs in improving compliance. New Mandatory Training Compliance Improvement Plan agreed by the People and Culture Committee		October 2019 Update - A review of mandatory Training is in the process of being undertaken by the Director of Workforce & OD with a report being presented to January Board (via the Quality & Safety or FPW Committee). This is a substantial piece of work because of the links on the system between the mandatory training links and job competencies on ESR which drive the needs identified for individuals. June 2020 Update - June 2020 update – A review of Core mandatory Training was instigated in January 2020 with a planned completion date of April 2020. Whilst partially completed this work was paused due to Covid 19. July 2020 update - A new Mandatory Training Review Group has been formed. Of the 14 subjects 7 have been reviewed and signed off to date. Meetings are scheduled to review the remaining 7 subjects during the second half of July. Completion date remains at 31 Aug 2020. Dependent upon release from Covid related work and availability of Review Group members along with the 14 mandatory training subject matter leads, the review is being restarted in June 2020 with a proposed completion date of 31 August 2020. Dec 2020 UPDATE: Mandatory Training Compliance Improvement Plan has been agreed an Action Plan is currently beign developed to implement identifed actins to improve complaince

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MT 02	Feb-19	Reasonable	Assurances should be sought that individuals working on behalf of the Health Board, but that are not direct employees, are participating in mandatory training relevant to the role that they are providing. A means of monitoring the training compliance of such staff groups should be put in place. An action plan should be developed in relation to bank staff that includes cleansing the data in ESR and establishing a process to ensure this group of staff participate in training. Monitoring of compliance rates should be undertaken.	High	For agency workers, the UHB's providers manage compliance as part of their contractual obligations. To ensure the UHB is sighted on compliance, at the point of candidate submission the agency is required to submit a number of personnel documents, including a mandatory training certificate. Candidates' documents are reviewed upon presentation. Any gaps in compliance are identified, discussed with the booking department and a risk assessment and a waiver form completed if the level of risk is deemed to be acceptable. For Bank Staff, an action plan is being developed to resolve identified issues, which includes:- • Arrange ESR accounts for all bank workers to access e-learning modules. • Validate and cleansing the staff bank register (commenced). • Validate ESR training records for existing bank staff. Issue of remuneration to be considered as part of this work. • Consider an agreed penalty for non-compliance (e.g. restriction from duties, possible de-registration in line with All Wales Terms of Engagement. • L&D CSTF Strategy to include Bank workers March 2019 progress to date- the ability to receive paper payslips ceased in January 2019. All new starters are immediately set up with NADEX accounts. Validation of the e-system has been completed 360 accounts closed. A Validation of the paper files to be undertaken – due to start mid-March. Bank staff have been contacted to provide evidence of training undertaken outside of CTUHB – this is being received and will be uploaded onto a data load for ESR SBAR is being developed in readiness for Exec	Director of Workforce & OD	Learning & Development Manager	Jan-20	Jan-20	Mar-21		In progress			October 2019 update - see above June 2020 Update - See above July 2020 Update - see above. December 2020 UPDATE: This work has not progressed due to change of senior leadership in the L&D team and other pressures within the team
MT 03	Feb-19	Reasonable	Management should ensure a policy in relation to mandatory training is produced to include relevant information to guide members of staff and managers.	Medium	Since the Core Skills Training Framework (CSTF) was mandated by Welsh Government CTUHB has relied on the accompanying CSTF Manuals to determine training requirements and responsibilities. Elements of these manuals have been "translated" into numerous documents and guides to make their meaning more relevant to CTUHB staff and these are readily available to staff and managers through the UHBs Intranet site. However, the UHB accepts that an overarching Core Mandatory training policy is required to clearly state its stance and to highlight the roles and responsibilities of its staff. A policy will be developed which will be applicable to the new Cwm Taf Morgannwg University Health Board, with a draft ready for consultation in May 2019, which will subsequently run through the Health Board's approval mechanisms.	Director of Workforce & OD	Learning & Development Manager	May-19	Jan-20	Apr-21		In progress			July 2020 Update - see above. DEC 202 Update: This has not progressed partly due to deployment of L&D team during COVID and due to changeover of L&D management team

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MT 04	Feb-19	Reasonable	Management should consider developing action plans for the poorest performing directorates and departments in order to improve compliance rates. The action plans should be the responsibility of directorates / departments to implement but should be developed in conjunction with the Learning and Development department, who can help draw on the practices being used in the better performing directorates / departments such as the administration support utilised in the Estates department.	Medium	The UHB holds directorate management teams to account for their mandatory training compliance through regular Clinical/Corporate Business meetings. Each directorate is supported by a WOD Senior Business Partner who also attends the CBM. Directorate Managers of poorly performing areas will be asked to develop action plans to demonstrate an improved performance trajectory, supported by WOD Senior Business Partners and the Learning and Development Department Directorate management teams will continue to be held accountable for the implementation of plans at routine CBMs. July 2019 update The management response to the action is accurate, in that directorate management teams are held to account for their mandatory training compliance through regular Clinical/Corporate Business meetings. Each directorate is supported by a WOD Senior Business Partner who also attends the CBM. Directorate Managers of poorly performing areas have been asked to develop action plans to demonstrate an improved performance trajectory, supported by WOD Senior Business Partners and the Learning and Development Department. Directorate management teams continue to be held accountable for the implementation of plans at routine CBMs. In that sense, the action as it stands is occurring. I am loathe to say it is complete, however, as compliance remains an issue in a number of areas. I think I would just add in that we intend to review where we are against stat and mand training compliance across the board, and also to ensure the stat and mand training requirements we are recording are accurate (at the request of one of the committees, FP&W I think). Once we have done	Director of Workforce & OD	Learning & Development Manager	Apr-19	Aug-20	Apr-21		In progress	December 2020 UPDATE: Appointment of L&D Business Partners (September 2020.) Approval of Mandatory Training Compliance Improvement Plan by the People and Culture Committee		October 2019 update - see above June 2020 Update - see above July 2020 Update - see above. December 2020 UPDATE: Action Plan currently being developed to implement the wide range of actions identified in the Mandatory Traiing Compliance Improvement Plan
Patient Experience (April 2019) Reasonable Assurance															
PE 03	Apr-19	Reasonable	A more detailed action plan should be developed to support the achievement of the actions outlined under each of the six ambitions. This should include responsible officers and timescales for completion. This will allow easier monitoring of the actions over the life of the Patient Experience Plan.	Medium	The patient experience plan is being revised and will include a detailed implementation plan displaying timescales and leads.	Director of Nursing	Assistant Director of Quality & Safety	Jun-19	Sep-20	Jan-21		In progress			July 2020 Update - see above. November 2020 Update - Due to the changes in structure and the governance teams now being embedded here, a new Patient Experience Plan will need to be pulled together in the new year.
Risk Management (June 2018)															
RM 01 Follow up	Apr-19		It should be ensured that the process described in the cancer risk flow chart is adhered to with departments capturing all relevant cancer risks on Datix, the collated risk register being reviewed at the Cancer Services Strategy and Steering Group and any significant risks escalated to the Cancer Implementation Group. Actions from the Cancer Implementation Group should be disseminated back down to relevant directorates.	High	The following actions were agreed in the Cancer Implementation Group on 13th June 2018: Cancer related risks are documented on the Datix system by individual clinical Directorates. A summary will be collated into a risk register. The Cancer Services Strategy and Steering Group (CSSG) meeting will undertake an initial review of risks identified within this register. Following this, risks will be monitored at each CSSG meeting (held every other month). Any significant (high-rated) risks will be escalated to the Cancer Implementation Group for review. Discussion of these risks will be documented in the meeting action log. Communication and actions will be fed down to the CSSG for dissemination to the relevant clinical Directorate for urgent resolution. Flowchart attached for agreed risk process. The Directorates continue to undertake risk assessments and Datix entry for cancer related risks. Unfortunately CSSG meetings have been cancelled and this item had been scheduled for discussion at the January 2019 meeting. The Cancer Manager – Wayne Jenkins met with the Cancer Clinical Lead, Balan Palanaippan who was recently appointed. The Cancer lead is writing to the Medical Director and Chief Operational Officer regarding the lack of engagement, priority and focus on cancer services within the health board. The Cancer Manager, clinical lead and lead nurse are developing the vision for how cancer services will be managed post 1 April to ensure that focus is provided for cancer services addressing the risk and governance issues across the new HB. Audit note: While we acknowledge the updated management response, we would encourage that through the CSSG cancer risks are monitored and that there is a clear flow of information up to the CIG and down to directorates	Director of Operations		Jul-19	Jun-20	Nov-20		Completed	November 2020 Update - Each service group records their cancer risks on datix and these are dealt with through the normal ILG governance routes. These risks are then collated on a bi monthly basis (for all ILGs) and are reported to the cancer programme board, focusing on any risks of 20 or over. Any particular themes or learning (from a HB perspective) will be discussed here and fed back to the service group. There is also an opportunity to discuss the learning at the cancer services steering group once it is established (first meeting 16h December) – which will have relevant operational representation.		July 2019 update - Following recent discussions regarding changing cancer meeting and reporting structures, there has been established a Cancer Programme Board which meets for the first time on 11th July 2019. The agenda includes risk log for noting all cancer related risks. Within the terms of reference to be ratified at the meeting there will be agreed reporting and escalation clarity. The terms of reference identify cancer related risks as a key priority. • Included in the papers attached are the actions from the Early Cancer Diagnosis Programme Board where the establishment of the overall Cancer Programme Board was agreed. These outline the establishment of clear lines of accountability and processes for escalation of risks as a key action and task the Managers named - Paula Goode, Wayne Jenkins, John Palmer and Mike Dickie to meet to discuss the process for reporting risks through the CBM process – Annie Hughes to arrange. A further update can be provided following the first meeting on the 11th July. October 2019 Update - At the Cancer Programme Board meeting on the 13th September 2019, the following actions were agreed: It was noted that the meeting to discuss risk reporting had been cancelled but an email would be circulated to DMs, ADs and Service Group Managers regarding cancer risks on directorate risk registers and ensuring they are fed into the CPB risk register. Action: Directorates to articulate clinical risks through CBMs which will be fed into the CPB risk log. It was confirmed that an intranet based risk log had been developed to escalate patients who were at risk of breaching the pathway targets. Alongside the individual patient risks identified there is a section for each tumour site to highlight their high level risks, such as staffing issues, capacity challenges etc. Action: Themes regarding risks to be summarised for future meetings. June 2020 Update - Firstly, the structure/forums that are

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RM 02 Follow up	Apr-19		Updated Recommendation - It should be ensured that the process described in the cancer risk flow chart is adhered to with departments capturing all relevant cancer risks on Datix, the collated risk register being reviewed at the Cancer Services Strategy and Steering Group and any significant risks escalated to the Cancer Implementation Group. Actions from the Cancer Implementation Group should be disseminated back down to relevant directorates.	Medium	Updated Management Response - A review of all Directorates Risk Registers has been planned which will capture cancer services from across the organisation. Chris Beadle will lead the work from the Datix system and will work with all Assistant Directors and Directorate Managers.	Medical Director		Dec-19				Completed	November 2020 Update - In relation to the review of Datix and use of information for Directorates on risk, that piece of work was undertaken and is going through further changes in light of our new Organisational Structure and changes that will come about with the introduction of the Once for Wales Incident and Risk Management System. The ILGs are all putting their cancer risk onto Datix, we are also adding in 104 day breaches as part of the harm review process. These are actioned by the ILG. Cancer risks, concerns, complaints and harm reviews for the HB are collated and presented to the Cancer programme bi monthly, in case there are any themes which would lead to HB wide actions/learning.		
RM 03 Follow up	Apr-19		Updated Recommendation - The Ophthalmology risk register should be reviewed and updated. A review of the updated risk register should be a standing agenda item for ENT Heads of Service meetings.	Medium	Updated Management Response - A review of all Directorates Risk Registers has been planned which will capture ophthalmology service. Chris Beadle will lead the work from the Datix system and will work with the Head and Neck Directorate the Assistant Director.	Director of Operations		Jul-19	Sep-20			In progress	31/7/20 New FUNB risk opened 17/9/19 which is reviewed regularly and updated as the opthalmology FUNB work progresses.	31/7/20 Move to ILG structure and COVID	31/7/20 The five health board wide opthalmolgy risks are currently sat on a risk register that has not been allocated to ILGs. The appropriate allocation and urgent review of these risks will have been completed by 14/8/20 and moving forward will be reviewed as part of the ILG Q&S meetings.
Mobile Phones (May 2019) Reasonable Assurance															
MP 01	May-19	Reasonable	The Health Board should introduce a formal policy and procedure that outlines the organisational approach to, and management of, Health Board provided mobile phones.	Medium	Management Response: The Health Board accepts that a policy is needed. ICT will produce the policy, with reference to, and superceding, existing controls and procedures that are in place. July 2019 Update: The draft policy has been produced and will be reviewed and approved at the July DSSG meeting. From there it will be sent to executive catch up for approval.	Director of Planning & Performance	Assistant Director of ICT	Jun-19	Jul-19	Apr-21		In progress			August 2019: Policy was approved at DSSG From there it will be sent to executive catch up for approval. - still pending - Sept 2019 June 2020 Update - No updates received, however, will be reviewed again in line with the new mobile phone contract that is being prepared for tender. July 2020 Mobile signal survey undertaken in collaboration wth looking at the suppliers and how we improve the mobile contract to provide a better service. August 2020 Update - Coverage review underway, and first draft of mobile phone contract released. November 2020 - ICT ITT Specification completed and passed to procurement. Review of survey completed with Vodafone who have agreed to implement changes to try and improve levels of service. Aiming for completion and migration to tender winner before April 2021
MP 02	May-19	Reasonable	Documentation should be stored electronically to allow for easy referral to forms if necessary. This would allow for more historical forms to be accessed easily.	Medium	Management Response: The Health Board has recently procured an electronic document management system for the scanning and storage of medical records. This system can be used for administrative documents as well. However, this is currently outside the scope of the project as funded in the business case (December 2018). ICT will write a proposal for expanding the scope of the project to include corporate documents. July 2019 Update: A project manager has been allocated to this task. Scoping of the activity is now underway and a project brief will be tabled at the September Digital Strategy Steering Group.	Director of Planning & Performance	Assistant Director of ICT	Jul-19	Sep-19	Feb-21		In progress			August 2019 - Project Brief drawn up and circulated to the SRO for agreement. Once finalised it will be discussed at the Project Portfolio Management Board. June 2020 Update - Delays to the DPN project mean that there has been no progress in scannig the documentation. This and other scanning projects are currently on hold. July 2020 Project is progressing looking at the 2 issues of preformance and scanning before UAT commences. August 2020 Update: Position remains the same as June 2020. November 2020 Update - System currently in testing and providing positive responses. Desktop equipment for end users also currently being deployed approximatley 80% complete
Commissioning (May 2019) Reasonable Assurance															
COM 01	May-19	Reasonable	The Health Board should develop a register of the commissioning arrangements it has in place via LTAs and SLAs in order to allow clear and comprehensive oversight and monitoring.	High	Whilst we recognise that there is no Health Board wide register of SLA's and LTA's, we acknowledge the benefits this would bring to the organisation and we will be having further discussion on how best to achieve this. SLA's: Our preferred model for SLA's is that this is held and owned at Directorate Level, to reflect the ownership of the SLA's alongside budgetary and Performance Responsibility of them, with appropriate oversight of the Commissioning and Contracting function. LTA's: With regards to LTA's, all agreements are held centrally by the contracting team and we will develop this further into a LTA register.	Director of Planning & Performance	Assistant Director of Commissioning	Jun-19	Mar-20	Mar-21		In progress			Agreed at the September Audit Committee that the deadline for this recommendation would be extended to 31 March 2020. September 2020 Update - A central repository is in place for all SLA's resulting from the Bridgend Boundary Change, which could be built on. Since the planning departmental restructure there are a number of vacant post and posts that need to be backfilled. I am hopeful that a work programme will be agreed whereby we can hopefully progress these actions. November 2020 Update - This remains on target to be completed in March 2021
COM 03	May-19	Reasonable	The Health Board should implement procedures that outline the compilation, development and active management of LTAs and SLAs and a process that ensures the capture of any currently led directorate managed SLAs with a view to future joint working between the Commissioning Team and directorates to ensure the robust management and monitoring of LTAs and SLAs.	Medium	We recognise the benefit to the wider organisation outside Commissioning and contracting in ensuring consistency of approach to the development and management of SLA's.	Director of Planning & Performance	Assistant Director of Commissioning	Sep-19	Mar-20	Mar-21		Part Completed			October 2019 Update - The 200+ service SLA's developed between SB and CTM have a clear process for compilation, review and management of those SLA's with clear expectations on responsibilities between the Directorates and the commissioning and contracting team. This will be the template for further development into a formal procedure and process document to roll out to cover all SLA's once the SLA register is complete in March 2020. September 2020 Update - A central repository is in place for all SLA's resulting from the Bridgend Boundary Change, which could be built on. Since the planning departmental restructure there are a number of vacant post and posts that need to be backfilled. I am hopeful that a work programme will be agreed whereby we can hopefully progress these actions.

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COM 04	May-19	Reasonable	a) The Commissioning Team should investigate the existence of SLAs that sit outside of their monitoring and scrutiny processes. b) Additionally, the Commissioning Team should meet with the Resuscitation Department to ascertain the review, approval and authorisation process relating to the SLA to ensure compliance with the Health Board's Scheme of Delegation.	Medium	a) Investigation of existence of SLA's: This action will be picked up as part of the process of developing the SLA register under Finding no 1. b) A plan to now bring this into the overall Powys LTA/SLA process and will agenda it for the first meeting of the CQPR of 2019/20 to ensure a wraparound governance process around the SLA.	Director of Planning & Performance	Assistant Director of Commissioning	Part A March 2020 Part B May 2019	Mar-21			Part Completed			October 2019 Update - Partially completed but on target a) The register is being developed and the target date of March 2020 remains b) The resuscitation SLA has been shared with Powys and they are considering whether any amendments are necessary. The financial value has been incorporated into the overall 2019/20 SLA. September 2020 Update - A central repository is in place for all SLA's resulting from the Bridgend Boundary Change, which could be built on. Since the planning departmental restructure there are a number of vacant post and posts that need to be backfilled. I am hopeful that a work programme will be agreed whereby we can hopefully progress these actions.
COM 06	May-19	Reasonable	Future SLAs should include KPIs in respect of contracted service performance activity, quality and patient safety and experience.	Low	The outreach services with Powys relates to CTMHB providing clinical staffing sessions to Powys Teaching Health Board to enable Powys to deliver services to their local population. As Powys is the Provider of these services, the activity, reporting and performance management requirements lie with Powys, therefore any KPI's would need to be developed and monitored by them. We will raise this with Powys Teaching Health Board.	Director of Planning & Performance	Assistsnt Director of Commissioning	Jun-19	Mar-21			In progress			October 2019 Update - Due to capacity issues within the team, this remains an area of development through 2019/20 for consideration for the next round of contracts in 2020/21. September 2020 Update - A central repository is in place for all SLA's resulting from the Bridgend Boundary Change, which could be built on. Since the planning departmental restructure there are a number of vacant post and posts that need to be backfilled. I am hopeful that a work programme will be agreed whereby we can hopefully progress these actions.
Cyber Security (May 2019) Limited Assurance															
CS 03	May-19	Limited	A formal patch management procedure should be developed that sets out the mechanisms for patching / updating all items within the Health Board.	Medium	Formal patching strategy is being put in place and will be submitted to Digital Strategy Steering Group (DSSG) in June. July 2019 Update - Patching Strategy delayed to September DSSG. In the meantime, regular Microsoft patching of servers and desktops is being carried out through the Change Advisory Board	Director of Planning & Performance	Assistant Director of ICT	Jun-19	Aug-20	Dec-20		Part Completed		October 2019: this is partially complete, we are undertaking regular patching, but need to define the formal procedure that covers the approach and the technical areas that are in scope, including their current status. June 2020 Update - A formal patching strategy is being developed and will be submitted to the Digital Strategy Steering Group (DSSG) in Augyst 2020. August 2020 Update - due to pressures of Covid 19 and the resources required for the roll out and ongoing maintenance of Microsoft 365 the timescale has been reset to December 2020. November 2020 - work is continuing in creating the formal procedure.
CS 04	May-19	Limited	A formal, resourced plan for the removal of old software and devices should be established.	Medium	The existing plan will be updated and brought to DSSG for formal approval in June. July 2019 Update - Replacement plan delayed to September DSSG.	Director of Planning & Performance	Assistant Director of ICT	Jun-19	Sep-20	Feb-21		Part Completed			October 2019: This is partially complete: we have provided the detail of the work that needs to be undertaken, but do not yet have the funding in place, which is required both in-year, and over multiple years on a recurring basis. In that respect, we regularly request funding/resources through the IMTP process and, because ongoing annual funding is required, we may find ourselves in a position where we will never be able to close this action? To be able to confirm compliance we also need to develop and maintain a full inventory (CMDB). June 2020 Update - A formal risk analysis and remediation strategy is currently being developed which will be presnted to the DHSSG by September 2020. August 2020 Update - work has commenced within the Infrastructure Team to address the server operating systems to ensure that all servers are on at least Server 2016 operating system. An End User Device Sub Group has been formed and will have its first meeting this month to discuss a strategy of ensuring Windows operating systems are on the most up to date version. The timescale has been set back to November 2020. November 2020 - software mangement wll be addressed by the Working groups. Due to issues with migration to M365 and resources allocated to this has meant that the timescale has slipped to February 2021.

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CS 05	May-19	Limited	The organisation should provide additional resource for a minimum defined period to allow for the data communications team to improve network security.	Medium	Data communications security will be addressed by the new posts discussed in finding 2. .July 2019 Response: See finding 2 above. Additionally, there is an additional, vacant, data comms post, which had been due to be filled in June 2019, but unfortunately the successful candidate withdrew and there were no other appropriate candidates. Now working with the recruitment team to readvertise and recruit.	Director of Planning & Performance	Assistant Director of ICT	Jul-19	Dec-20			In progress			October 2019: the Comms post interviews were set up, but no candidates attended. We therefore had to readvertise the vacancy, so this action is ongoing too. For the Cyber posts, we are awaiting final confirmation that they will be funded by WG. We have a candidate lined up for this final post, from previous related interviews. June 2020 Update - The firewall audit has been received and confirmed as accurate. Work has commenced in addressing the recommendations highlighted in the audit. The Cyber team have received the Cisco implementing Advanced Cisco ASA Security and will be addressing the firewall rules starting in June 2020. August 2020 - work on the updating the software versions on each firewall is now complete along with configuring each firewall as per recommendations. There has been an issue in auditing the rules on each Firewall due to a licensing issue within Solarwinds. The ICT Department have requested a quote from the supplier on the cost of increasing the licenses on Solarwinds to address this issue. November 2020 - The upgrade of the Solarwinds server was not successful. An invesigation with third party support has resulted in the recommendations that the current configuration will need to be moved to a more powerful server and the additional license to build a second 'pollar' server to balance the network load of the main Solarwinds server.
Health and Care Standards (July 2019) - Reasonable Assurance															
HCS 02	Jul-19	Reasonable	Guidance documentation should be in place and made available to all relevant staff on the completion of the self-assessments within the Health Care Management System. Guidance should include a step by step guide to completing the assessment, but also cover areas that have been identified as issues, such as the retention of records to show which samples were used and how samples should be selected (a consistent sample or different one for each question). Additional training should be considered to support the guidance issued.	Medium	We will review the current guidance and amend to ensure we include a more detailed guide to completing the self-assessment. This will be further supported with a week of dedicated walking the wards/areas and speaking to staff. We will explore the opportunity for creating a video to guide staff through the self-assessment process and storing the necessary supporting documents on a SharePoint page.	Director of Nursing	Assistant Director of Quality & Safety	Sep-19	Sep-20	Jan-21		Part Completed			Update March 2020 - The opportunity to develop a video has not been presented itself to date but we do now have a videographer in the communications team so we will liase with them to explore this possibility. As usual the team have made themselves available during the audit period supporting staff and answering queries in a timely manner. November 2020 Update - Guidance amended but probably needs additional review before sharing for next audit period. Documents are shared on a SharePoint page and link provided in e-mail sent to managers Haven't been able to develop the video as yet. Will build into planning timeline for next audit period
HCS 03	Jul-19	Reasonable	Staff should be reminded of the need for the data input into the HCMS to be reviewed and signed off in a timely manner. The review should be undertaken by a Senior Nurse and be someone different to who input the data in the first instance. Consideration should be given to introducing a system of peer reviews amount wards / departments to allow the identification of inconsistencies and sharing of best practice.	Low	We will explore the opportunity for automated notification reminders for staff to sign off their data in line with the expected deadlines. Continue to encourage staff to sign off their data within the timescales identified – this can be achieved during training and highlighted in any guidance documents. We will introduce a programme of peer review for undertaking the 2019 audit. This will take place after the 31st November so that comparisons can be made.	Director of Nursing	Assistant Director of Quality & Safety	Sep-19	Sep-20	Dec-21		Part Completed			Update March 2020 again the automation of notifictions has been discussed and added to the devlopers work plan. However it is worth noting that there is currently a review of the annual audit and the system in terms of its efficacy in providing assurances. A large piece of work is currently being undertaken exploring the use of an aaccrediation framework in place of the HCS audit. We have been unable to achieve a programme of peer review due to competing clinical pressures during the winter months and going forward the COVID-19 pandemic will also affect our ability to achieve this. November 2020 Update - Review of option to provide email notification of sign off process undertaken, but due to national HCMS development priorities not currently achievable. Alternative solution to the HCMS system being investigated through the All Wales Digitisation of Nurse Documentation project. To ensure sign off compliance by ward sister and senior nurse /matrons regular monthly sign off compliance emails circulated by the Clinical Audit & Quality Informatics team (COMPLETE) Sign off compliance and process included in all HCMS training and training material. Peer Review will be incorporated into the planning timeline for the next audit period (COMPLETE)
Directorate Review Surgery Management Arrangements (July 19) - Reasonable Assurance															

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SMA 06	Jul-19	Reasonable	Management should work with consultants to understand what the barriers are to ensuring that job plans are agreed in good time. Actions from this exercise should be implemented to improve job plan sign-off. Management should work with consultants to ensure that job plans are discussed and agreed by all relevant parties ahead of the job planning period. Advice should be sought from other directorates where job plans are completed in a timely manner and a forward work plan should be developed to ensure planning takes place in a timely manner and the CBM should continue to monitor the ongoing status of job plans within the directorate.	High	A plan to undertake consultant job plans that are out of compliance has been developed and this will be monitored through CBM. The major barrier to undertake consultant job plans is Directorate Manager and Clinical Director capacity. The COO has recently agreed an interim Deputy Directorate Manager to increase management capacity in the Directorate.	Director of Operations	Directorate Manager	Ongoing	Feruary 2021			In progress			October 2019 update - Consultant job plans ongoing. Interim deputy directorate manager not in post and directorate capacity remains problematic. June 2020 Update - The job plans are ongoing, further progress was made prior to COVID and work will also be undertaken to reflect the changes in responsibility as the result of the ILG implementation. Progress is dependant on implementing a directorate management structure in the RE ILG Surgical and Anaesthetic Directorate. July 2020 Update - Improvements being made and plans being updated to reflect the ILG structure. November 2020 Update The Clinical Service Group is challenging in terms of size and the number of senior staff to manage the process, however the Manager is working on a timetable to manage the Job Plans. An update will be provided in February 2021. Any urgent job planning matters that cannot wait are managed through the Service Group by the General Manager and the Clinical Director on an ad hoc basis as needed.
Directorate Review Radiology Management Arrangements (July 19) - Reasonable Assurance															
RMA 02	Jul-19	Reasonable	All Radiology specific policies and procedures should be documented in a central record and assigned an 'owner' responsible for ensuring their assigned policies and procedures are maintained up to date. All directorate specific policies and procedures should be made available to all directorate staff via SharePoint.	Medium	Currently moving forward with a new SharePoint site for Radiology – linking with Karl Carpenter (Digital Services Manager) and maintenance of this will be part of the remit of a Superintendent Radiographer post currently being advertised within the Health Board.	Director of Operations	Directorate Manager	Dec-19	Oct-20			In progress			March 2020 Update - Test site created by E-Business team. Awaiting further direction from Directorate. July 2020 Update - Work continues led by Dr Ally Yates, Consultant Radiologist to review all policies and procedures. Radiology has its own 'policy for making policies' based on the Health Board version. As policies are being renewed they are being put in to the new format and agreed although formal governance meetings in Radiology have drifted during Covid. With regard to the Sharepoint site a quick dummy site with some new features was developed but no further progress has been made.
RMA 05	Jul-19	Reasonable	1. Suitable arrangements to cover the Head of Radiology role should be put in place as a matter of urgency. 2. Senior management posts should be included in future succession / workforce plans.	High	1. Agree the previous Head of Radiography has gone on a 2 year secondment. A new Head of Radiography needs to be appointed, this will done via a HR process as part of restructuring required for the new Cwm Taf Morgannwg UHB. 2. Agreed the Quality Lead Role for Radiology is included in our IMTP investment as our number one priority.	Director of Operations	Directorate Manager	Sep-19	Oct-20	Feruary 2021		Part Completed	November 2020 Update Point 1 After a recent round of recruitment into the ILG, a Clinical Director for Radiology has now been confirmed across CTWUHB. A Clinical Service Group Manager for Clinical Support Services has also recently been recruited and supports the group from a managerial perspective. Agreement has just been reached within the ILG to recruit to a HCP Head of Radiology in the next couple of months and is just going through the process of JD, Finance agreement and selection processes. It is anticipated that this post will be an internal only appointment and is in relation to the Senior Superintendent positions		Quality Manager Role approved substantively. Still no progress with the Head of Radiography role due to organisational changes to ILG model. July 2020 update - The 'Head of Radiology' is the Professional Head (a Radiographer) rather than the Directorate/General Manager. We still do not have a formally appointed professional head for Radiology although Paul Johnston has continued to undertake the role. The Quality lead role was approved and advertised with no suitable applicants. It remains a priority but is on hold for discussion regarding management structures with the newly appointed General Manager. November 2020 Update - Point 2 - Reviews around the structure of the senior management and clinical leaders within the CSS CSG took place with the ILG directors in the last two weeks and the proposal is being costing and worked up for agreement. One off funding for an external management consultant to come and look at the workforce structure within pathology has been agreed for 2020/21 and this will be sourced in the next month. The intention of this piece of work is to identify what the structure of pathology needs to look like to be realistic and effective. This piece of work may require some careful mediation and support from WOD is being sourced.
RMA 09	Jul-19	Reasonable	The Directorate should ensure that all staff are provided with the opportunity to undertake their mandatory training. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for noncompliance with a view to providing support where necessary.	Medium	Agree with the findings however would point out that training allocated to staff on ESR has been done poorly and with no consultation with the Directorate. Directorate is in close consultation with Learning & Development but progress is very slow from L&D.	Director of Operations	Directorate Manager	Dec-19	Oct-20			In progress			L&D are still working on this as they are aware of the issue not just in Radiology. July 2020 Update - Mandatory training continues to be reported however learning subjects on ESR are still allocated poorly. This has been raised on a number of occasions as it leads to incorrect statistics regarding the percentages for competency. Most recently raised at our clinical meeting and Workforce taking forward with learning and development.
Retention of Staff Follow Up (October 19) - Limited Assurance															

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RSFU 01	Oct-19	Limited	1. Building on the feedback received from the Nurse Workforce group the objectives recorded in the 'Our Nurse Retention' Strategy and the actions in the Retention Strategy Action Plan should be aligned. All actions outlined in the action plan should contribute to the achievement of an objective. 2. In addition, the strategy and action plan should be aligned to other appropriate leadership and engagement strategies. In addition, both the 'Our Nurse Retention' Strategy and the Retention Strategy Action Plan should be finalised as soon as practically possible.	High	Following discussion with the Interim CEO it has been agreed that a formal Workforce and OD strategy – of which Recruitment and Retention will be a key part, will be developed to support the emergent clinical services strategy (likely to be the last quarter of this year or in to next). Meanwhile the Health Board recognises the key importance of retaining our staff, particularly our nursing staff, and we will use the Nursing Workforce Group as the main vehicle to ensure that actions are agreed, implemented and monitored to agreed deadlines. At a meeting of the Nursing Workforce Group in July, the new Chair (Director of Nursing) determined that revised terms of reference were required to define the overarching purpose of the group, which should include the key activities/subgroups to support a broad range of initiatives, including nurse retention. The terms of reference have subsequently been redrafted and are due for sign off by the Nursing Workforce Group on 10th September 2019. The draft terms of reference confirm that the Group will review the activities of the identified sub-groups as their outputs will provide the initiatives and actions to ensure effective recruitment and retention of the nursing and midwifery workforce. The subgroups are defined as follows: 1. Career Development 2. Nurse Staffing Act 3. Temporary Staffing 4. Rostering Effectiveness 5. Recruitment 6. Health, wellbeing and engagement. Membership and deliverables will be reviewed and monitored by the Nursing Workforce Group.	Director of Workforce & OD	Assistant Director of Workforce & OD	Oct-19	Aug-20	Jan-21		In progress			June 2020 Update - The UHB continues to recognise the importance of retaining our staff, particularly our nursing staff. A sub-group of the Nursing Workforce Group has been set up to focus on retention and all the contributing elements that can support this. This Group was able to meet a few times pre-Covid, but is now on hold until the new normal is able to re-start group meetings in a productive manner. It will also need to be refocused based on the Locality model (also taking in to account the System Groups and Delivery Executives) that has been implemented as of 1 April, which is leading to a restructuring of our senior operational nursing workforce. The Locality model should allow us more opportunity to push the retention agenda forward, as it increases the senior management capacity. The retention strategy will be re-written based on the Locality/System Group/Delivery Executive model and taken to the aforementioned sub group members for discussion. The initial discussion and feedback loops can be done virtually, but sign off will require the Group. Depending on nursing activities and a return to normal business sign off the retention strategy in August 2020. July 2020 update - work on the retention strategy has been interrupted by the Covid-19 response, and the UHB has not yet returned to normal business. The next scheduled Nursing and Midwifery Workforce Group is in September, so the intention is for the Strategy to be taken to that meeting. Establishment of People and Culture Committee was postponed because of Covid, first meeting in July 2020 - this forum will drive the Workforce and OD Strategy. Organisation has now changed its operational structure - the Retention Strategy will be re-drafted in line with the Locality based operating model and submitted to the Nursing and Midwifery Workforce Group for
RSFU 02	October 2019	Limited	1. The changes to the revised exit questionnaire process should be publicised throughout the Health Board as initially intended. 2. The template email should be included as part of the termination form in order to aid the issuing of questionnaires. 3. The Health Board should have a mechanism in place that allows it to ensure and monitor that staff who leave the Health Board are issued with an exit questionnaire by their line manager. 4. A review of those exit questionnaires received to date should be undertaken to ensure any concerns highlighted can be acted upon in a timely manner. Trend analysis can be undertaken as more completed questionnaires are received.	High	1. A revised communication plan will be developed to ensure the exit process is rolled out to all staff groups, including Princess of Wales. 2. The template is a link via the termination form which automatically prompts the individual to complete a questionnaire. This is also being reviewed by the All Wales Hire to Retire ESR group with a view to ESR driving the process. 3. Exit interview outputs are centralised and scrutinised by the HR Business Partners for any concerns to be taken forward. It is not practical for a resource to compare each leaver against the returned exit questionnaire however metrics are run on return rates by Directorate and are fed through to the HRBPs for inclusion in CBMs. 4. As above, the exit questionnaire content is analysed centrally and reported on in the Exec Board and FP&W Board metrics paper.	Director of Workforce & OD	Assistant Director of Workforce & OD	August/September 2019	TBC			Completed	October 2020 Update - Action Completed		June 2020 Update - Communication was released about exit questionnaires – this was to all areas including Princess of Wales/Bridgend. Exit questionnaire results have been included in the WOD Metrics Board report that goes to Management Board/FPW. The aforementioned Board reporting has been put on hold for Covid-19, and it likely to be refocused based on the new structure. Reporting will be aligned to that need when they recommence.
RSFU 03	Oct-19	Limited	1. 'Pulse surveys' or similar should be carried out on a regular basis with nursing staff to assess the opinions of staff and ascertain if they have any concerns in work. 2. Work to progress the leadership development programme in line with the themes that arose from the Health and Wellbeing workshop should take place.	Medium	1. It is important for any pulse surveys undertaken to be evidence based and to be able to provide comparative data. Work is being undertaken for Wales Workforce & OD Directors to review the staff survey with a view to surveying a much smaller number of questions. A report was received and endorsed by WODDs at their July 2019 meeting: "The approach has two main strands which both focus on two way feedback, sharing successes and learning, jointly deciding on any actions that need to be taken, and making space to ensure that these are taken. In essence, it's a check-in to discuss wellbeing: 1)Improve the quality of 1:1 conversations between line managers and their team members by raising the expectation of having a regular conversation with our manager. The conversation should also include how the relationship is progressing between with our manager. In essence it's a regular check-in, wellbeing, role clarity and growth conversation. 2)Using survey results at a team/group level to have a conversation about improving wellbeing and experience in our area of work. The actions we decide upon should be a key part of what we commit to do in our local plans. Initially, whilst the surveys will be every 12 months, the results are just the prompt for our local conversations". The recommended approach is currently with WG for consideration and includes a recommendation for a survey in September 2019. CTM will be able to take a view on options to use questions from a shorter staff survey for periodic pulse surveys. If a clear approach is not forthcoming via Welsh Government, then the Nursing Workforce Group will be consulted on a set of pulse survey questions and the 'waste business areas to be	Director of Workforce & OD	Assistant Director of Workforce & OD	January/March 2020	Dec-20	Jan-21		In progress			1. June 2020 Update - A survey was undertaken in 2019 as part of the 'Let's Talk Culture' work this also repeated the 2018 seven engagement questions, and was used to inform our draft values and behaviour framework. 2. June 2020 Update - A management and leadership programme has been drafted this approach is out for consultation, funding and procurement is yet to be agreed. Will look to implement in 2020. 1. July 2020 - The values and behaviours work was paused for Covid-19, the work to launch the values and behaviours is just restarting. 2. July 2020 - This is progressing, although has experienced a pause for Covid-19. October 2020 Update - The Nursing and Midwifery Workforce Group has not been reinstated by the Director of Nursing due to pandemic. As a result, discussions regarding the content of any planned retention strategy or plan have been put on hold.

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RSFU 04	Oct-19	Limited	Staff should be reminded that PDRs should be undertaken on an annual basis so that ongoing development can be captured to help retain staff including setting key objectives for the following year. Following completion of the pilot scheme, the new PDR form should be rolled out across the Health Board using a planned approach.	Medium	1. Communication via the intranet will be issued to managers reminding them of the importance of undertaking PDRs for staff. 2. Following completion of the pilot scheme the new PDR form will be reviewed and consideration given to any amendments required following feedback. 3. A phased approach for the roll out will be submitted to the Nursing Workforce Group for approval.	Director of Workforce & OD	Assistant Director of Workforce & OD	Jan-20	Dec-20	Mar-21		In progress			June 2020 Update - A revised PDR is currently available on share point however we are looking to update this to incorporate the updated values and behaviours. Expected to be completed by 2020. July 2020 - June update still applies. November 2020 Update - V&B to form part of the discussion within every appraisal (commence Dec 20). Scope best practice processes and paperwork relating to values based appraisal system and related documentation (commence Dec). Design values based guidance and appraisal record documentation for appraiser and appraise (Commence Jan 21)
RSFU 05	October 2019	Limited	When developing the Retention Strategy Action Plan a clear set of initiatives should be included, linked to each of the actions, that will assist in the retention of nurses. Initiatives should have measurable targets attached to them that can be assessed.	Medium	See updated management response 1 – The Nursing Workforce Group will received monthly/bi-monthly updates from the relevant subgroups, measuring their performance.	Director of Workforce & OD	Assistant Director of Workforce & OD	Oct-19	TBC	Jan-21		In progress			June 2020 Update - The UHB continues to recognise the importance of retaining our staff, particularly our nursing staff. A sub-group of the Nursing Workforce Group has been set up to focus on retention and all the contributing elements that can support this. This Group was able to meet a few times pre-Covid, but is now on hold until the new normal is able to re-start group meetings in a productive manner. It will also need to be refocused based on the Locality model (also taking in to account the System Groups and Delivery Executives) that has been implemented as of 1 April, which is leading to a restructuring of our senior operational nursing workforce. The Locality model should allow us more opportunity to push the retention agenda forward, as it increases the senior management capacity. The retention strategy will be re-written based on the Locality/System Group/Delivery Executive model and taken to the aforementioned sub group members for discussion. The initial discussion and feedback loops can be done virtually, but sign off will require the Group. Depending on nursing activities and a return to normal business sign off the retention strategy in August 2020. July 2020 - please see response to RSFU 01. The Nursing and Midwifery Workforce Group has not met during the Covid-19 pandemic, and the next meeting is scheduled for September. Updated will be given as per the agenda. November 2020 Update - The Nursing and Midwifery Workforce Group continues to be stood down during the winter months, due to the COVID19 pandemic. There is no further progress on developing a Retention Strategy however a paper outlining Health Board wide retention strategies, including nurse specifc activities, will be presented to the People and Culture Committee late January 2021.
Data Quality (October 19) - Limited Assurance															
DQ 01	Oct-19	Limited	1. Directorate Managers need to: ☐ Remind consultant, medical and nursing staff of the need to complete outcome forms for all patients seen. ☐ Remind outpatient receptionists of the importance of inputting outcome forms on WPAS in a timely manner. ☐ Remind Medical Secretaries to check that outcomes that have been input on WPAS align to outcomes as per dictated letters. Where necessary additional training should be requested to ensure that all staff are aware of their responsibilities in completing the above steps correctly. 2. Management should engage with the two directorates where the electronic outcome form was trialled to understand why it has been adopted in one area and not in the other. Following the conclusion of this engagement the Health Board should consider trialling the electronic outcome forms within all Directorates. 3. Consideration should be given as to how data can be captured to allow the calculation and monitoring of the proportion of patients whose outcome is not recorded on WPAS.	High	We fully agree with all the recommendations and will incorporate this into our action plan. We intend to secure additional resource to assist in the monitoring and implementation of this action plan. A forum will be set up to oversee this work stream and detailed action plan. A process of 'cashing up' at the end of every clinic is required to ensure clinic and administration staff have processed the patients using the outcome form and WPAS. This process needs to include the initiation of diagnostic tests and request forms being processed to cut down on 'dead time' waits for diagnostics. This process needs to be mandated and managed by the clinic manager. Temporary administration and nursing staff need to undertake mandatory training in cashing up clinics. The Assistant Director of Scheduled Care together with the Assistant Director of Performance and Information will engage with the two directorates where the electronic outcome form was trialled to understand why it has been adopted in one area and not in the other. Following the conclusion of this engagement the Health Board will consider trialling the electronic outcome forms within all Directorates. An appointment with no outcome registered report needs to be circulated in order that administration managers can act on patients who have no outcome, validating the patient's position on the pathway. All staff need to understand the implications of failure to comply. Weekly reports need to be circulated to services including consultants with non-compliance addressed by relevant professional leads.	Director of Operations	Deputy Chief Operating Officer	Mar-20	Feb-21		In progress			December 2020 Update - There has been limited progress in taking action to address the previous recommendations. The onset of Covid-19 clearly impacted on the UHB's ability to deliver elective activity, as it concentrated all its efforts in responding to the pandemic. As a consequence, the UHB lost the momentum it had built up through the establishment of a Planned Patient Flow Project to take forward both the recommendations of the Internal Audit report, as well as the those of the Delivery Unit report arising from their supportive intervention on waiting list management. As has been rightly pointed out by our Internal Audit colleagues, the PID did not make reference explicitly to two of the actions from their report (Findings 4 & 5) and whilst the PPF Project may not have been the right forum for aspects of Finding 4 (temporary secretaries), it should have made explicit reference to the action, especially given the focus on training. Finding 5 (watch list functionality) is not something that the UHB can amend and whilst we were seeking a response from NWIS regarding what might be feasible and over what timescale (current thinking is that this may well not be technically feasible), it is not documented within the PID as it should. IA colleagues have noted that a number of changes have occurred within the Health Board, as a result of turnover and ownership of the agreed actions within the report has not been clearly transferred to individuals now responsible for this area, which is accepted. My WPAS Team are still sending out regular reports to relevant departments requesting errors to be rectified and whilst the volume of errors reduced, this was linked to reduced activity during Covid-19, as opposed to any improvement, as noted by IA colleagues.

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DQ 02	October 2019	Limited	1. Directorate Managers and their teams should review the report of patients recorded as being on a closed pathway to ensure that they are on the correct pathway. Day-case and inpatients should be moved back to an open pathway so that they receive the required treatment on a timely basis. 2. Analysis should be undertaken of the cases where the pathway has been incorrectly closed to identify if they are common to one directorate, department or person. Where necessary, further investigation should be undertaken to why these errors are routinely occurring and further training provided. 3. Consideration should be given to escalating the incorrectly closed pathway reports to ensure Service Group Managers and more senior staff within the Health Board are made aware of the ongoing issue.	High	We are fully in agreement with the recommendations and will incorporate this into the action plan response (see above). Recommend clinic outcome letters are an opportunity to validate patient outcomes, a SOP will detail the actions to be taken to achieve this. Where staff are unable to achieve the required standards, a performance monitoring process will be instigated. Agree there is a need for a regular monitoring report to be tabled at Directorate meetings for improvement purposes.	Director of Operations	Deputy Chief Operating Officer	Mar-20	Feb-21			In progress			December 2020 Update - See above response
DQ 03	Oct-19	Limited	Directorate Managers need to ensure that Medical Secretary training is consistently applied including completion of the Referral to Treatment test. Refresher training should be provided on a regular basis in line with PDR requirements and targeted to those employees who are identified as having a higher numbers of input errors than expected. Where problems remain, consideration should be given to applying the appropriate Workforce and OD policy to manage the situation.	Medium	A performance monitoring tool will be developed to identify areas of focusedintervention with direct performance monitoring for the Directorate teams.	Director of Operations	Deputy Chief Operating Officer	Mar-20	Feb-21			In progress			December 2020 Update - See above response
DQ 04	Oct-19	Limited	Service General Managers together with Directorate Managers should consider reviewing the process for using temporary Secretaries within the Health Board to ensure that all receive WPAS training ahead of commencing in a role.	Medium	Temporary secretaries should not be used to manage Waiting List (WL) data input unless fully trained and long term temps. We will carry out a risk assessment to determine the feasibility of this followed by agreed implementation when feasible. These personnel should be used for letter backlogs and typing. Administration managers must ensure staff are fully trained.	Director of Operations	Deputy Chief Operating Officer	Mar-20	Feb-21			In progress			December 2020 Update - See above response
DQ 05	October 2019	Limited	The process for monitoring patients who are awaiting diagnostic investigation results should be reviewed to ensure all Medical Secretaries are utilising a standard approach that is user friendly and does not restrict access, thus allowing visibility to other staff members.	Medium	A review of this process and guidance will be carried out, potentially with external support to assist and add pace to the review. Consistent guidance and emphasis on use will then be provided. Management teams will ensure that locally held spreadsheets are not replacing the mandatory addition to the formally report QL. Request internal audit re-assessment of this in next year's audit plan.	Director of Operations	Deputy Chief Operating Officer	March/April/May 2020	Feb-21			In progress			December 2020 Update - See above response
Consultant Job Planning (October 19) - Limited Assurance															
CJP 01	October 2019	Limited	1. The Health Board should develop an approach to ensure that all consultants and SAS doctors have an up to date job plan that is reviewed on an annual basis. In developing their approach, the Health Board should consult with consultants, SAS doctors and their line managers to identify the barriers that are currently preventing the timely completion and sign-off of job plans. 2. The Health Board should ensure that there are sufficient resources available so that job plans follow the 'lock down' process where the job plans are not formally signed-off in good time. The Approach should be consistently applied across all sites.	High	1. Job planning does not necessarily require a face to face review if the plan agreed the previous year remains satisfactory. That said personal and organisational objectives need to be agreed for the year and can be signed off if non-contentious. 2. Job plan compliance is a standard agenda item at the Clinical Business Meeting (CBM) held with each directorate. The HR business partners are present at the CBMs to understand what if any barriers there are to job planning. The data is also reported through Finance Performance and Workforce Committee via the Board. 3. We acknowledge that there are many job plans which are out of date and /or not signed-off and this will be addressed by either through refreshed directorate training or Medical Director intervention. 4. Likewise, refreshed training is to be rolled out to Princess of Wales to ensure a consistent approach.	Medical Director	Acting Workforce Operational Lead	Mar-20	Mar-21	Sep-21		In progress			January 2020 Update - Currently there is a gap in training and knowledge of the system in the new areas of CTM. This has started being addressed with training in POW for clinical directors (CD), directorate managers (DM) and assistant directorate managers (ADM) on the 19 December 2019. It has been identified by users of the system, that they feel there is no access to guidance on how to use the system after the training. A standard operating procedure (SOP) will be developed in conjunction with Allocate for users to be able to access when there are questions about how to use the system post training. Allocate have provided a user guide that will be adapted into a CTM specific SOP. There is a need for a spread of responsibility for job planning outside the current CD/DMs tasked with its completion. It is particularly relevant in the areas such as medicine where there is a high amount of medics to job plan for. This is to be supported in the training provided and needs to be factored into each directorates plan on deciding the amount of trained staff needed to have sufficient capacity to meet the demand. July 2020 update - Job planning has been placed on hold for the duration of the Pandemic. We are currently in a situation where very limited job planning activity is being undertaken. This means that compliance is deteriorating. Training was and has been completed in all of the ILGs, though there was very limited engagement even though there was a wide set of staff and medics contacted to let them know the training was being run. An SOP has been developed in conjunction with the guides inside eJP and will be shared with users for comment. The wider spread of responsibility is still desirable, however due to the lack of engagement with the training and the changing structures within the UHB due to the development of the ILGs, it is hard to determine currently who the additional persons involved should be. November 2020 Update - a) The produced job planning compliance report is now distributed via the WOD packs to

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CJP 02	Oct-19	Limited	1. The notes section in the Allocate system should be used to record reasons for deviations from the standard Welsh Government consultant's contract and guidance. For example, where there are more or less than 10 weekly sessions in total, or there are more than 3 weekly SPA sessions. 2. A plan should be developed to ensure all PoW consultants and SAS doctors' job plans are reviewed and updated as soon as is practicably possible to align with the new Health Board's objectives. 3. Staff carrying out job plan reviews should ensure that all SPA activity is sufficiently detailed, that Health Board outcomes are linked to IMTP objectives, and that meaningful Service or Directorate outcomes are recorded in all job plans. This may be achieved by providing tailored training to staff responsible for conducting job plan meetings and reviews. 4. Health Board guidance should be provided detailing how breaks should be factored into timetables.	High	1. Clinical sessions which exceed the contractual norm are relevant as determined by the business area, based on clinical requirements. This will also have implications for continuity and safety of clinical care. The additional sessions are also more cost effective for the Health Board as opposed to agency locums. The reasoning behind additional clinical sessions needs to be clear in the job plan. This will be emphasised as part of the updated training package. 2. As soon as the Health Board's operating model and subsequent objectives agreed, all Health Board objectives will need to be revisited through the annual job planning cycle. In the interim, existing job plans for Doctors in PoW will rollover into the next cycle. 3. The appropriate recording of SPA activity and linking to subsequent Health Board outcomes will be highlighted in the reviewed Health Board training material. 4. The Health Board is very clear about the rest break requirements under EWTD. The reason why breaks are not necessarily included is due to the flexibility required for the individual, as all job plans are variable and negotiated in accordance to service need. The requirement to take rest breaks will be further emphasised in the updated job planning training.	Medical Director	Acting Workforce Operational Lead	Nov-19	Mar-20	Sep-21		In progress			January 2020 Update - Recording of reasons for differences to guideline amounts of direct clinical care and supporting professional activity splits is variable. Differences to guidelines are acceptable and allowed, but training will need to be provided and referenced in the SOP to ensure the reasons for differences are captured in future. There is some historical differences between sites on the split, this will have an agreed approach for all sites from January onwards for new job plans. June 2020 Update - SPA/DCC split guidance – This was developed between medical workforce, Vijay Singh and Sarah Spencer. It is currently awaiting review at the LNC before wider distribution. Due to Covid19 this has stalled due to no LNCs taking place. July 2020 Update - No chnage to the position. September 2020 Update - The Deputy Medical Director and Assistant medical Director revisited the guidance developed by Dr V.Singh. This was matched and referenced against other organisations policies as well as taking royal college guidance into consideration. This has now been brought to final draft in preparation to be taken to the LNC. This will be shared at the next LNC in November before roll out to the UHB. November 2020 Update - a) There has been a delay in full roll out of incorporating all of the Bridgend ILGs job plans into eJP with updated CTM objectives, thus is due to the onset of the pandemic and pausing of job plan reviews with most staff. This will be picked up and moved forwards when business as usual returns to the ILG. b) The operating model for the UHB is now in place and this has been incorporated into the eJP software to match the new structure. c) SPA and DCC guidance has been developed by the AMD for Medical Workforce. This underpins the application of SPA within the job planning process and will be reflected in the notes in eJP. The implementation date should be extended due to
CJP 03	Oct-19	Limited	Staff conducting job planning meetings and annual review meetings should ensure that all job plans include personal outcomes that are sufficiently detailed and measurable, and in line with personal outcomes and targets agreed as part of the annual review process. Progress against personal outcomes should be monitored and recorded in line with the Health Board's guidance.	High		Medical Director	Acting Workforce Operational Lead	Nov-19	Mar-21			In progress			January 2020 Update - The report links the need for personal outcomes to be in the Job plans. This is contrary to what the organisation had seen what Job plans are for. There should be a record of clinical outcomes recorded and referenced, but personal outcomes are for the appraisal and validation process rather than job planning. July 2020 - No change, work has stalled around this due to Covid19. November 2020 Update - Guidance is currently being developed by the AMD for Medical Workforce. No extension needed.
CJP 04	October 2019	Limited	1. An exercise should be undertaken to match the number of sessions from job plans to the payroll for all current consultants and SAS doctors to identify any discrepancies and any potential over or under payments to staff. All discrepancies should be investigated. 2. The current process for updating the payroll with changes to salaries arising from job plan changes should be reviewed to ensure it happens in a timely manner when a plan is signed-off or proxy signed-off. 3. A process should be established for notifying the payroll section of all new job plans and job plan changes for PoW based consultants and SAS doctors. 4. The job planning guidance refers to recording all information in relation to the plan in the e-job plan (Allocate), therefore where plans are created outside of the system, the Allocate system should be updated to reflect this.	High		Medical Director	Acting Workforce Operational Lead	November 2019/April 2019	Feb-20	Dec-20			In progress			January 2020 Update - There is a difference between Allocate and manual Anaesthetics, critical care and theatres (ACT) SAS doctor calculations in regards to session amounts. This is due to ACT using a manual calculation for their sessional data, because there is a belief that Allocates software is not producing the correct data in this area. There are discrepancies between some of the data in the organisation in regards to payments. So a whole organisation review will be undertaken to see how wide spread this is by medical workforce to identify the extent of it. June 2020 Update - Discrepancies in payments/job plans – An organisational review was undertaken. Outside of ACT, only 2 Medics had 'incorrect' salary amounts according to their job plans. ACT has discrepancies due to the Allocate software not calculating the sessional allowance for their work rotas correctly. Allocate have been unable to correct this thus far. July 2020 - No change. Allocate still unable to correct. November 2020 - a) The exercise for matching the sessions against payroll is complete and any discrepancies have been rectified. b) Payroll will only now be informed to change pay for staff with completed and up to date job plans on eJP. The salary is then matched to the session data in eJP. No extension needed.

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CJP 05	Oct-19	Limited	1. Directorates should ensure that all 'Additional Duty' hours are authorised in advance of being worked. Authorisation should incorporate confirmation that a check has been carried out to ensure consultants are not already scheduled (according to the job plan) to work during proposed Additional Duty hours. Furthermore, the check should encompass ensuring that working the additional shift does not mean the consultant is then working 'back to back' shifts or cancelling DCC sessions to undertake the shift. 2. A single standard claim form should be used for ADH claims. Any system utilising electronic claim forms should contain the same data and claimant declarations as manual paper claim forms. Claimants should be required to confirm that they have not cancelled planned DCC sessions to undertake ADH.	High	The Health Board are currently reviewing the ADH process with a view to driving all ADH arrangements through an e-system, as part of the development on an internal locum bank model. This model will address each of the recommendations noted.	Medical Director	Acting Workforce Operational Lead	Apr-20	May-20	Dec-20		In progress			January 2020 Update - There has been a check completed this month on ADH payments and amount of ADH being worked in the organisation. This data is being used to harmonise rates across the HB and to develop a bank system. The standardised ADH rate and bank solution will be in place by the new financial year. June 2020 - An ADH rate card has been produced for all specialties and sites. A sign off process has also been produced. This is still manual in nature though. A project team has been setup to introduce the 'electronic' Medic bank, but due to C19 this has stalled. July 2020 Update - A paper has been submitted to the Management board for approval of the Bank project. A result is being awaited from this to move forwards with. Once agreed and in place, the bank adress all outstanding issues. November 2020 Update - a) An electronic solution to ADH shifts being made available is being implemented within the UHB. This begins its initial roll out in the Bridgend ILG the end of November 2020. This will allow for accurate recording, auditing and allocation of ADHs. This will eventually be the only method that ADHs can be worked, so therefore ensuring there is clear visibility of all future ADHs being undertaken within the UHB. No extension needed.
CJP 07	October 2019	Limited	Checks should be carried out to ensure consultants have a satisfactory job plan in place prior to being awarded additional increments under the Commitment Awards scheme.	Medium	In the former Cwm Taf, Commitment Awards have historically been paid without checking if a satisfactory job plan was in place. In PoW this has always been done in line with the Amendment to the Consultant Contract in Wales. A revised process around Commitment Awards is being introduced and will be communicated across the Health Board. This process will ensure that consultants have a satisfactory job plan in place.	Medical Director	Acting Workforce Operational Lead	Dec-19	Mar-20	Dec-20		Completed	November 2020 Update - The new process for managing CAs has been given approval by the Locality Directors. It meets the audit requirement of not paying CAs automatically (without checking to ensure the 'absence of a satisfactory job plan'). However, it has not been possible to produce as 'e automated' a process as originally desired. It is being implemented with effect from CAs due from February 2021 onwards.		January 2020 Update - Currently commitment awards (CA) for consultants are managed through a purely manual process. It is desirable that we implement an e-solution that removes manual processes and spreadsheets to manage the process. The exact process for CA sign off is being developed currently. Running alongside this is the push to design an Electronic Staff Record (ESR) based solution for the CA tied to the agreed internal process for deciding on whether CAs are approved. June 2020 Update - CA Sign off – The Consultant contract Wales says in Para 5.6 "the appropriate CA will be paid automatically in the absence of an unsatisfactory annual job plan review over the required period". Sign off has been agreed as not automatic for unsatisfactory Job Plans and will be enforced. ESR in its current form cannot host this process without manual intervention and it being not fit for purpose, as there is no functionality built in for CAs. We would have to use the PADR function which is not designed for the CA process and would still require our manual processing and interaction with payroll. Changes to ESR would need to be implemented at a UK wide level and cannot be done just locally. So it will have to remain manual until that can happen, or alternative method is found. July 2020 update- CA sign off has been revisited and a different process held by payroll assuming auto sign off has been put out to comment to the MD, DMD, AMD Workforce and ILGs for comment. Once feedback is received NLT end July. The process can ne in place mid-august 2020. September 2020 Update - Following further discussions with the Medical Director and Locality Directors, a process has been drafted for managing and the giving of Commitment Awards. This is awaiting sign-off at the November LNC.
Pathology Management Arrangements (January 2020) - Reasonable Assurance															
PMA 04	Jan-20	Reasonable	All policies and procedures should be reviewed on a regular basis to ensure that they are current and up to date.	Medium	A review of all Policies and procedures is going to take place as part of the Quality/Governance review within Pathology.	Director of Operations	Directorate Manager	Apr-20	Aug-20	Dec-20		In progress			Documents are currently being reviewed in line with HB policies. June 2020 Update - In Progress: this is monitored through the Pathology Scorecard and progress is being made in most departments. Areas of concern are Hameatology and Blood Bank documents. This issue will be escalated at the next management meeting. Target date has been revised to August 2020. September 2020 Update - Pathology has a significant number of policies and procedures. Review and update of these documents is required to maintain compliance with regulatory and accreditation bodies. Document review is currently monitored through the Pathology Scorecard, and actions are recorded to ensure progress is made. We are currently validating an electronic quality management system that will send email alerts when a document is due for review, this will further improve compliance.

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PMA 06	Jan-20	Reasonable	1. The Directorate should ensure that staff are reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that all staff are provided with the opportunity to undertake their mandatory training. 2. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for non-compliance with a view to providing support where necessary.	Medium	1. A plan for the increase of CTSF rates has been produced by each department in response to the UKAS inspection. 2. Monitoring will take place at a departmental level to establish reasons for noncompliance.	Director of Operations	Directorate Manager	Feb-20	Aug-20	Dec-20		Part Completed	June 2020 Update - 2. Complete: core skils are monitored through the Pathology Scorecard, and an action tracker is used wher compliance is not met.		June 2020 Update - 1. In Progress: Staff have been asked to complete core skills training, this has also been encouraged if staff are working from home during the COVID-19 crisis. We are awaiting an update from W&OD to see if there has been a marked improvement. Target date has been revised to August. September 2020 - We are currently not receiving data from HR with regards to core skills compliance. However all service managers are aware that this needs to be progressed in their departments.
PMA 07	Jan-20	Reasonable	Management should work with consultants to ensure that job plans are discussedand agreed by all relevant parties ahead of the job plan period. A forward work plan should be developed to ensure planning takes place in a timely manner and CBM should continue to monitor the ongoing status of job plans within the directorate.	Medium	The directorate will ensure that job plans are reported through the CBM. Dates to be forward planned to ensure that the directorate completes job plans in a timely manner	Director of Operations	Directorate Manager	Immediate & Ongoing	Sep-20	Dec-20		In progress			June 2020 Update - The DM and CD will be working through a work programme to achieve maximum complaince using the e-job planning programme. September 2020 Update - Dates are in the diary for a group job planning meeting with Microbiology Consultants team (28/9/20) and individual Consultants as required will be organised. The Clinical Haematology Consultants job plans are on hold until the service settles after moving back to RGH and PCH in October.
PMA 13	Jan-20	Reasonable	1. Following receipt of the demand and capacity plan from Roche, the Pathology Directorate should ensure that it is validated against any plans developed by the finance team, ahead of the information being utilised within the next IMTP. 2. There should be robust processes in place to independently scrutinise the work of external company whilst they produce the demand and capacity plan on behalf of the directorate and ensuring there are no deemed conflicts of interest.	Medium	1. The D&C work will not be completed in time for submission into the IMTP – it will be included in the plan but will not be complete to inform staffing establishments. 2. There will be support/scrutiny given from a nominated individual (Steve Haynes) who is part of the finance team	Director of Operations	Directorate Manager	Jan-20	Oct-20	Dec-20		In progress			June 2020 Update - 1. In progress: D&C work had been ongoing a bench marking report has been received and the DM/Service Managers will take this forward 2. To be carried out on completion of D&C review. July 2020 Update - we have commissioned and received a Benchmarking report from GK consultancy which presents a 1.5m under resource position compared to other NHS Trusts. To validate this we will need to complete a demand and capacity exercise but at present we have not identified a person and resource available to assist. As we return to normal after COVID then there will be an opportunity to return to this work. September 2020 Update - We have raised with the RTE ILG the need to seek corporate support to complete this task looking ahead. Stephen Haynes was originally allocated from Finance but that option is no longer available. Once area where we are constantly undertaking D & C work is the Covid-19 testing in Microbiology and within Mortuary services in light of the pandemic.
Pathology Compliance (January 2020) - Reasonable Assurance															
PC 01	Jan-20	Reasonable	An inventory of non-capital assets should be developed by Clinical Haematology detailing their assets, which fit under the definition of the inventory as detailed within the FCP. Inventories should be reviewed to ensure that they hold all of the relevant information as laid out in the Health Board's FCP.	Medium	An inventory of non-capital assets will be developed for Clinical Haematology in line with the FCP.	Director of Operations	Directorate Manager	Apr-20	Sep-20	Nov-20		In progress			June 2020 Update - Not Started: on hold due to COVID-19 pressures, target date has been amended to September 2020. September 2020 Update - The Clinical Haematology services will be repatriated from the WWIC to Ward 15 (PCH) and Tirlon Centre (RGH) at the end of September 2020. After a period of settlement we aim to complete this work by the end of October 2020.
PC 03	Jan-20	Reasonable	Whilst it is appreciated that determining the number of tests that will be required to be provided in a year may not be possible, where services are being provided by the Health Board to other health boards in Wales and income is generated as a consequence, SLA's should be in place and approved in line with the Scheme of Delegation.	Medium	SLA's to be developed for work received in line with scheme of delegation.	Director of Operations	Directorate Manager	Apr-20	Sep-20	Dec-20		In progress			SLA's currently in development with assistance of Quality Team. June 2020 Update - In Progress: Departments that generate income are currently developing SLA's, however this is likely not to be compelted bt April due to other comittments relating to COVID -19. Target date has now been amended to September 2020. September 2020 Update - SLA's with C&V and with Harp funeral directors have recently been scrutinised and reviewed. C & V now signed and Harp Funerals ceased.
Digitisation (January 2020) - Reasonable Assurance															
DIG 01	Jan-20	Reasonable	The organisation should seek to increase the level of resource into key areas of the project.	High	Work is now under way to fill the vacant training, testing and system supportroles, via a combination of agency and substantive staff. The individual responsible for the 4 work-streams (Project Manager) has a dual role but this is in two consecutive stages; as project manager prior to go-live, becoming Cito Systems Manager on go-live. The substantive roles being recruited now are the Cito system support staff, working to the Cito Systems Manager. Each of the 4 work-streams has a manager, all of whom report to (or work with) the Project Manager. The majority of the project management work will have been completed by go live, therefore the overlap of project management and system management work is not anticipated to continue beyond the short term	Director of Operations	Programme Manager	Dec-19	Sep-20	Jan-21		In progress	July 2020 Update - Contractors recruited (since terminated). Recruitment commenced - ongoing. Plan for re-engagement of contractors developed, for implementation when we have a confirmed go-live date.	July 2020 Update - Covid disruption to project progression.	July 2020 Update - Shortlisting under way for substantive staff. Go-live decision pending Project Baord August. ECMG approval of revised costs required at August meeting. September 2020 Update Recruitment ongoing for substantive posts; interviews to date have been unsuccessful. Posts revised and interviews are scheduled shortly. External contractors are now funded and will be engaged appropriately before go-live. Project resourced as required. December 2020 Update - 2/12/20. Update:1 Band 4 now in post. Band 6 re-adveertised again; being shortlisted this week. External contractors to be engaged Jan 21 - resourced as required. ILG Clinical and Operational Leads now being engaged, Clinical Assurance Group to be revived

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DIG 01	Jan-20	Reasonable	The organisation should seek to increase the level of resource into key areas of the project.	High	Work is now under way to fill the vacant training, testing and system supportroles, via a combination of agency and substantive staff. The individual responsible for the 4 work-streams (Project Manager) has a dual role but this is in two consecutive stages; as project manager prior to go-live, becoming Cito Systems Manager on go-live. The substantive roles being recruited now are the Cito system support staff, working to the Cito Systems Manager. Each of the 4 work-streams has a manager, all of whom report to (or work with) the Project Manager. The majority of the project management work will have been completed by go live, therefore the overlap of project management and system management work is not anticipated to continue beyond the short term	Director of Operations	Programme Manager	Dec-19	Jan-21			In progress			
DIG 01	Jan-20	Reasonable	The organisation should seek to increase the level of resource into key areas of the project.	High	Clinical Assurance Group – participation by clinical staff remains a challenge, despite attempts to expand this by the Chief Clinical Information Officer and Chief Clinical Nursing Officer. Members who are unable to attend are however sent notes and items under discussion, for information. The new Medical Director is currently being engaged on 16/10/19 and both he and the Chief Operating Officer will be asked to encourage clinical involvement with the project.	Director of Operations	Programme Manager	Oct-19	Jan-21			In progress			
DIG 02	Jan-20	Reasonable	The anticipated go live date should be assessed and restated to an achievable, reasonable date. The project should seek to ensure appropriate resources are provided. Communication should commence, with information on the project being made available to staff on the website.	High	NWIS participation in integration and data migration work is now being provided and this is progressing well. The go-live date has now been re-assessed by the Project Team and Project Board and postponed for two months. The Princess of Wales phase of the project has been deferred for two years, due to clinical concerns about separate ICT systems. This has deferred an element of the project work. These decisions were made with Executive approval (COMPLETED) As outlined above in Finding 1, additional resources are now being sourced for the Project Team, both short-term requirements and substantive staff. As outlined above in Finding 1, communication materials are being developed for imminent publication and dissemination.	Director of Operations	Programme Manager	Oct-19	Aug-20	Feb-21		In progress	July 2020 Update - NWIS support, Comms support achieved.	July 2020 Update - Covid Disruption	July 2020 Update - Plans in place to progress one technical issues resolved an go-live date confrmed. September 2020 Update - Oct 20 Update - Go-live date currently under review due to ongoing technical issues. Decision to set go-live date expected by early November. Resources secured, as above. December 2020 Update - Go-live date currently under review due to ongoing technical issues. Decision to set go-live date expected by early November. Resources secured, as above. Go live expected Feb 21. Comms work ongoing, to be issued shortly. Website under revision, communication to go ut to Champion Users shortly.
DIG 04	Jan-20	Reasonable	The DR process for CITO should be formally set out and tested prior to go live.	Medium	The disaster recovery process is automatic. Cito will be run on 2 servers at PCH,for resilience and load balancing. These are located in different areas of the hospital and have dual power supplies. Back-up tapes are transferred frequently to secure, fire-proof storage at a second site (KHHP). If the PCH servers fail, there is an automatic failover to the RGH server. This also has dual power supplies and back-up tapes. This is described in various documents but will, as recommended, be collated into one document and tested.	Director of Operations	Programme Manager	Dec-19	Sep-20	Jan-21		In progress		July 2020 Update - Covid Disruption	July 2020 Update - Work was ongoing but clinical involvement paused. Re-convene clinical work on business continuity. Complete disaster recovery documentation. September 2020 Update - Work has progressed and is ongoing to document and test the DR process. December 2020 Update; Business Continuity and DR procedures developed further - out for comments by Project Board.
IG Arrangements Community & Mental Health (January 2020) - Reasonable Assurance															
IGCMH 01 (a)	Jan-20	Reasonable	The records management strategy and policy should be reviewed and updated accordingly to incorporate changes in legislation, the impact of the boundary change and the future vision for records management within the Health Board. Once reviewed and approved staff should be made aware of the revised policy and strategy.	High	The Health Board needs to review and implement a current records management strategy with a regular review date. There is an Information Governance policy in place which sets out legal obligations. A revised Records Management Strategy and Policy needs to be developed and approved by the ICT & Information Governance Committee being established in January 2020.	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk Head of Information Governance	Sep-20	Mar-21			In progress			October 2020 Update - The September deadline needs to be pushed back to March 2021 as we have not reviewed / updated the records policy during the last few months due to the COVID position. November 2020 Update - In Progress – policy being drafted benchmarking with other Health Boards in Wales to ensure a consistent approach. Review will be led by the Information Governance Team in conjunction with the Health Records team in relation to patient records. The policy will be received at the Information Governance Group in December and will seek approval by the Digital & Data Committee thereafter.

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IGCMH 06	Jan-20	Reasonable	A) We acknowledge that there is an ongoing all Wales project to develop a national patient information system within the community area. However, the project implementation date for the system, known as the Welsh Community Care Information System (WCCIS), is not clear. As such, the Health Board should look to ensure that a consistent approach is taken to record keeping within Adult Mental Health. B) Staff should be reminded to follow a consistent approach to file management that ensures accuracy and completeness of patient records. C) Where appropriate management should ensure that the individual matters identified in our records testing are addressed.	Medium	An action plan has been created to address specific issues. This risk is on the Directorate risk register and actions to improve the position will be monitored through the related review processes already in place. The development of the Audit check list to address administration systems and processes will include a specific section to review how clinical records are filed. Staff have been informed that where possible, no typing should take place without the clinical file present. Learning from audits pan CTM will report six monthly to the Mental Health Learning from Events Group.	Director of Primary, Community & Mental Health Services	Localities Manager	January 2020/March 2020				Completed	November 2020 Update - Reporting back to LMHPB in January. Action completed.		
IGCMH 07	Jan-20	Reasonable	A) Staff should be reminded to follow a consistent approach to file management that ensures accuracy and completeness of patient records. B) Where appropriate management should ensure that the individual matters identified in our records testing are addressed.	Medium	An action plan has been created to address specific issues. The development of the Audit check list to address administration systems and processes will include a specific section to review how clinical records are filed. Staff have been informed that where possible, no typing should take place without the clinical file present (COMPLETED) A filing rota has been implemented on 04/11/19 to ensure all clinical information is placed in the clinical files as soon as the clinical file is made available to administration staff (COMPLETED) The audit checklist will address whether the clinical file has up to date demographic information, which will be cross referenced with Myrddin. Clinical file audits will address all the clinical information within the file.	Director of Primary, Community & Mental Health Services	Localities Manager	Dec-19				Completed	November 2020 Update - Reporting back to LMHPB in January. Action completed.		
ICGMH 09	Jan-20	Reasonable	A) Staff should be reminded of the importance for timely recording and investigation of incidents. B) When the Health Board's policy is reviewed consideration should be given to introducing guidance to staff for the timely recording and investigating of incidents.	Medium	The GDPR states that IG need to be informed without undue delay and within 72 hours where there is a significant risk to information. Staff are informed at induction and during the classroom IG training that is provided on a monthly basis. We will ensure that all staff are reminded of their obligations in relation to recorded incidents. This will be picked up as part of the Action Plan. Staff have already been reminded of the importance for timely recording and investigation of incidents. E-mail sent to Locality Management Teams (LMTs) along with the flowchart and timescales for processing all incidents on Datix. LMT to monitor compliance. When the Health Board's policy is reviewed consideration should be given to introducing guidance to staff for the timely recording and investigating of incidents (COMPLETED)	Director of Primary, Community & Mental Health Services	Localities Manager	Dec-19				Completed	November 2020 Update - Reporting back to LMHPB in January. Action completed.		
Medical Equipmant and Devices at POW (January 2020) - Reasonable Assurance															
MED POW 01	Febraury 2020	Reasonable	1. Management should ensure the draft Medical Devices policy covers all the relevant aspects as required by the MHRA guidance, is appropriately approved by the relevant Health Board Committee and made available to all relevant staff. 2. Management should ensure that a work plan with time-frames is put in place for the development of a single set of Medical Devices procedures.	Medium	1. This a reflection of Finding 4 in the broader CTM Clinical Engineering audit report. The Medical Devices Policy has been reviewed since the CTM Transition, and is currently in draft form but expected to be verified by the Medical Device Governance Board in early 2020. 2. We migrated to the CTM QMS Medical Device management procedures before the BSI audit in December 2019. Work has also begun on aligning equipment technical information and service procedures, although due to there being over 2,400 active models on the database, with sometimes different models of equipment on each site, this will be an ongoing process, with joint procedures agreed for new models as they are introduced (we're currently replacing most infusion pumps and Philips patient monitors), and selected common items reviewed via senior tem meetings (currently reviewing the T34 syringe pump).	Director of Operations	Assistant Director of Facilities	Early 2020	Sep-20	Apr-21		Part Completed	1. April 2020 Update - Medical Devices Policy approved by Medical Devices Group. Clinical POlicies Working Group and Quality & Safety Committee, published on sharepoint 07/02/2020. Completed		2. April 2020 Update - T34 syringe pumps still currently being reviewed by Medical Electronics Engineering Manager & Head of Clinical Engineering and Clinical Engineering Team. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). July 2020 Update - T34 syringe pumps still currently being reviewed as an ongoing process by Medical Electronics Engineering Manager & Head of Clinical Engineering and Clinical Engineering Team (DW 17/07/2020). 2. September 2020 Update - T34 syringe pump replacement project still an ongoing rollout process by Medical Electronics Engineering Manager & Head of Clinical Engineering and Clinical Engineering Team. WG advised that target date has been amended to reflect this update to 31/03/2021 (DW 28/08/2020).

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MED POW 02	Feb-20	Reasonable	1. At the current time, wards and departments should be reminded of the importance of retaining detailed training records in relation to new equipment purchases, including information on who has attended the training. The Engineering Manager should be informed when training has taken place in order for equipment to be released for use. 2. Consideration should be given to the future method of retaining training records so that there is consistency across the PoW and former Cwm Taf sites. Any system used should facilitate the ability to demonstrate the applicability of training, what training has taken place, the dates training was provided, who attended the training and method of training (in house or manufacturer). 3. Training Needs Analysis forms should be consistently completed across all sites.	Medium	1 & 2) Work has already begun with the medical device trainer Robert Mathews to implement these recommendations on the POWH site asap, and we are liaising with Rob regarding training requirements for equipment currently being installed. Rob is also now in attendance on the POWH site several days a week, with additional training staff being recruited to assist in implementing training requirements expected to be in post shortly. 3) TNA process currently being reviewed with Robert Mathews, with a view to integrating into the installation process at POWH.	Director of Operations	Assistant Director of Facilities	Early 2020	Sep-20	Jan-21		Part Completed	1 & 2. July 2020 Update - B4 Medical Device training co-ordinator in post, now advised of all new medical equipment installions, and overseeing user training prior to issue. Complete (PJ 17/07/2020).		1 & 2 April 2020 Update - B4 training co-ordinator – in post as of 1/04/2020 and currently being allocated duties in relation to implementing recommendations and adding information to TNA plans and ESR. Head of Clinical Engineering has stated that medical device training is not recorded on ESR – it cannot be done at present in a way to be able to get the information back out that would be needed – we have only just had a B4 training co-ordinator start with us yesterday to start to deal with the backlog of recorded manufacturer training on forms and start recording any new manufacturer training on the medical device training database. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 3. April 2020 Update - TNA process still currently being reviewed with Robert Matthews, still with the view to integrate this into the POWH installation process. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 3. July 2020 Update - TNA process still currently being reviewed with Robert Matthews to integrate POWH training requirements (DW 17/07/2020). 2. September 2020 Update - TNA process still currently being reviewed with Robert Matthews to integrate POWH training requirements. WG advised that target date has been amended to reflect this update to 31/12/2020 (DW 28/08/2020).
MED POW 03	Feb-20	Reasonable	1. Management should ensure that the relevant documentation (Statement of Need (SON), Equipment Purchase Approval Form or Capital Purchase form) is fully completed prior to purchases being made and reference numbers are subsequently updated within the medical equipment register. 2. Management should ensure as part of their work to merge the two organisations procedures, that the use of a standardised forms are adopted across all sites and that the procedure states that equipment should not be purchased without a Statement of Need being completed.	Low	1. Completed SONs are held on file for all POWH based medical equipment capital bids as per the previous ABMU system of work, although due to the change of systems after the CTM transition I was unclear as to the reference numbers needed or how to update them to the medical equipment database. However all 2. POWH Capital bid SONs will be updated to the database for the 2020/21 capital year bids. We have been using the CTM SON for all 2019/20 capital bids, although there appears to be more than one version in the system, which will be reviewed for the 2020/21 capital year bids. 3. Local revenue equipment purchases aren't referenced above, but we are still using the single page ABMU equipment purchase approval form for the POWH site, whilst original Cwm Taf areas are using a version of the SON very similar to the capital bid SON, and which appears overcomplicated when compared to the ABMU form. Work is underway to agree a SON for revenue purchases for the 20/21 financial year purchases.	Director of Operations	Assistant Director of Facilities	Apr-20	Sep-20	Jan-21		Part Completed	1. April 2020 Update - Capital bid SON process finalised now following CTM transition and being used with all POWH Capital bid SONs now being added to the correct database for the 2020/21 capital year bids and will be used moving forward. Complete (DW 02/04/2020). 2. April 2020 Update - Capital bid SON process finalised now following CTM transition and being used with all POWH Capital bid SONs now being added to the correct database for the 2020/21 capital year bids and will be used moving forward. Complete (DW 02/04/2020).		3. April 2020 Update - Medical Electronics Engineering Manager and Head of Clinical Engineering currently working with Capital Projects and Procurement leads to develop a SON template for revenue purchases to be used moving forward. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). July 2020 Update - 3. July 2020 Update - New Capital Management Advisory Group (CMAG) group looking into online form, Medical Electronics Engineering Manager and Head of Clinical Engineering will be involved with this process (WG 16/07/2020). 3. September 2020 Update - Capital Management Advisory Group (CMAG) group currently still looking into online form, Medical Electronics Engineering Manager and Head of Clinical Engineering will be involved with this process. WG advised that target date has been amended to reflect this update and that Finance are leading on developing the new form, date amended to 31/12/2020 (DW 28/08/2020).
Medical Equipmant and Devices Follow Up (February 2020) - Reasonable Assurance															
MED FUP 01	Feb-20	Reasonable	The Health Board must be able to ensure that it can demonstrate that staff have been appropriately trained on Medical Equipment and Devices prior to them being used on patients. Prior to new equipment purchases being brought into use in a ward or department, a Training Needs Analysis (TNA) should be completed and where deemed necessary relevant training carried out. Records should be retained of the TNAs and the training provided.	Medium	1. Band 4 Training co-ordinator job advertised and in shortlisting for interview, will appoint as soon as is practicable. Backlog of manufacturer training data will then be updated to training system and new training data will be uploaded immediately when in post. The post holder will also assist with TNA processes. 2. Band 6 Medical Device Trainer post in process on TRAC and will be appointed as soon as is practicable to support the TNA plans for the HB.	Director of Operations	Assistant Director of Facilities	Apr-20	Sep-20	Jan-21		Part Completed	2. September 2020 Update - B6 role now in place. Complete (WG 28/08/2020)		1. April 2020 Update - B4 training co-ordinator – in post as of 1/04/2020 and currently being allocated duties in relation to implementing recommendations and adding information to TNA plans and ESR. Head of Clinical Engineering has stated that medical device training is not recorded on ESR – it cannot be done at present in a way to be able to get the information back out that would be needed – we have only just had a B4 training co-ordinator start with us yesterday to start to deal with the backlog of recorded manufacturer training on forms and start recording any new manufacturer training on the medical device training database. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 2. April 2020 Update - Robert Matthews continuing to implement recommendations and identifying training requirements for equipment currently being installed with Medical Electronics Engineering Manager. B6 trainer advertised – no suitable candidates – to be re-advertised ASAP. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). July 2020 Update - 1. July 2020 Update - Substantial quantity of backlog training records have been updated on to database since staff member in post and is an on going process, started gathering information relevant for Bridgend training requirements but hampered by Covid-19. (WG 09/06/2020). Process still on-going (WG 16/07/2020). 2. July 2020 Update - Following re-advert, interview date set for 18th June 2020. (WG 09/06/2020). Recruitment checks in progress, start date to be agreed once all checks finalised, hopeful of start date of late August or early September (WG 16/07/2020). 1. September 2020 Update - Process still on-going with number of staff per ward per area and their training requirements currently still being collated by the B4 role. Pediatrics, District Nursing and Maternity staff lists have been completed, however due to ward movements during covid this has been delayed for other departments but continues to be collated. WG advised that target date has been amended to reflect this update

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MED FUP 02	Febraury 2020	Reasonable	1. The Health Board must ensure that a Statement of Need is completed, appropriately authorised and forwarded to the Head of Clinical Engineering for review and approval prior to equipment being purchased. 2. The Health Board should ensure that the SON reference is recorded on the RAM system as a matter of course.	Low	1. Clinical Engineering does attempt to ensure a SON is provided for all purchases, however there may be occasions when procurement have placed the order without the necessary checks being made. This is a procedural issue that Procurement need to be able to resolve. It is more of an issue with revenue purchases as buyers need to recognise medical devices descriptions on requisitions to be able to request a SON (April 2020). 2. The SON job reference will be added by Clinical Engineering staff as part of acceptance process, staff are reminded of this, but due to workload and quantities of equipment and the number of fields to add information into, it is inevitable that sometimes it can be missed off. A briefing reminder to all Clinical Engineering staff will be issued (February 2020).	Director of Operations	Assistant Director of Facilities	February 2020/April 2020	Sep-20	Jan-21		Part Completed	2. September 2020 Update - B6 role now in place. Complete (WG 28/08/2020)		1. April 2020 Update - Medical Electronics Engineering Manager and Head of Clinical Engineering currently working with Capital Projects and Procurement leads to develop a SON template for revenue purchases to be used moving forward. Head of Clinical Engineering has stated that this has been made impossible to do with Covid 19 – no SONs for anything being done during this period. Trying to sort a process with Procurement for covid purchases. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 2. April 2020 Update - Medical Electronics Engineering Manager and Head of Clinical Engineering currently working with Capital Projects and Procurement leads to develop a SON template for revenue purchases to be used moving forward. Head of Clinical Engineering has stated that this has been made impossible to do with Covid 19 – no SONs for anything being done during this period. Trying to sort a process with Procurement for covid purchases. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). July 2020 Update - 1 & 2. July 2020 Update - In addition during Covid processes that we had in place were circumvented, so any devices purchased by departments with revenue or capital by procurment tackling the priority challenges of the Covid pandemic will not have SONS or any references associated with them (WG 09/06/2020). New Capital Management Advisory Group (CMAG) group looking into online form, Medical Electronics Engineering Manager and Head of Clinical Engineering will be involved with this process. (WG 16/07/2020). 1. September 2020 Update - Process still on-going with number of staff per ward per area and their training requirements currently still being collated by the B4 role. Pediatrics, District Nursing and Maternity staff lists have been completed, however due to ward movements during covid this has been delayed for other departments but continues to be collated. WG advised that target date has been amended to reflect this update and the amount of work involved to 31/12/2020 (DW 28/08/2020).
MED FUP 03	Feb-20	Reasonable	While we understand that currently, the department does not have the resources to undertake a reconciliation of equipment that has been loaned to wards, consideration should be given to undertaking periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system.	Medium	1. Band 2 Equipment library Job Description is now matched – to be uploaded and advertised on TRAC to appoint staff. This will then enable periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system to be undertaken. 2. Continued use of partial RF-ID system to be utilised with confirmation that data connection to RAM 5000 can be completed. 3. SON to be submitted to Capital for increased RF-ID system coverage for RGH (£244.8K), early indication from Capital is that a more detailed business case will be required as roll out to other sites is also required.	Director of Operations	Assistant Director of Facilities	Apr-20	Sep-20	Apr-21		Part Completed	2. July 2020 Update - Identified costs in IMTP, some work performed by supplier for COVID equipment tracking for mapping sites. Equipment that is tagged will now update 'Last known location' field on RAM each night in background process if within areas with antennae or by using hand held device. Complete (WG 09/06/2020). 1. Role now in place. Complete (WG 28/08/2020)		1. April 2020 Update - B2 equipment library post - advertised – undergoing shortlisting. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 2. April 2020 Update - RF-ID –limited area in use – no further work done - however attempting to obtain further funding through technology funds from Welsh government in meanwhile. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 3. April 2020 Update - RF-ID –limited area in use – no further work done - however attempting to obtain further funding through technology funds from Welsh government in meanwhile. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 1. July 2020 Update - Interviews held. Recruitment checks in progress for successful candidiate (WG 02/06/2020). Start date confirmed as 20/07/2020 (WG 16/07/2020). 3. July 2020 Update - Business case to be developed for submitting to Capital/Finance to support phased approach to implementation on each site, with request from Finance to be revenue neutral. (WG 09/06/2020). 3rd draft of business case paper to be finallised with various options and costs for funding (WG 16/07/2020). 3. September 2020 Update - SON submitted to Capital and DOF on 30/07/2020, awaiting prioritisation and decision on funding. WG advised that target date has been amended to reflect this update, date amended to 31/03/2021 (DW 28/08/2020).
Nurse Agency Usage (April 2020) - Reasonable Assurance															
NAU 01	Apr-20	Reasonable	1. Clarity should be provided as to whether the Staff Bank Policy Induction Checklist (Appendix C) should be completed or the more recently revised 'Ward induction checklist for bank and agency workers'. 2. Ward Managers / the Nurse in Charge should be reminded of the importance to complete the induction checklist to ensure that new agency nurses are appropriately orientated and provided with relevant health and safety overview of the ward they are due to work on.	High	Induction check list to be reviewed and agreed by Heads of Nursing. Ward Managers & Senior Nurses to receive updated check list that must be completed for all new Bank and agency nurses. Updated Bank/Agency Nurse Induction Checklist to be included into the revised Staff Bank policy.	Director of Workforce & OD	Head of Corporate Nursing	March 2020/April 2020/August 2020	Feb-21			In progress			November 2020 Update - The Bank Policy is being updated during December 2020/Januay 2021. The updated policy will consist of a review and update of all the bank and agency forms.

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NAU 02	Apr-20	Reasonable	1. The Bank / Agency Nurse Quality Monitoring Form should be reviewed to ensure it is fit for purpose and provides a suitable means for the routine monitoring of the quality of work provided by agency staff. 2. Ward Managers should be reminded of the need to complete the quality monitoring form and returning it to the Bank office as a means of formally evaluating the performance of agency nurses and aiding and informing any future acceptance or rejection of potential agency nurses in the event of query or concern. 3. The Clinical Incident Reporting for Agency Staff flowchart and the Staff Bank Policy should be reviewed to ensure consistent guidance for managing and	High	Revised Clinical Incident Reporting flowchart to be placed into the Staff Bank Policy. Bank / Agency Nurse Quality Monitoring Form will be reviewed to ensure it is fit for purpose and amendments made for updated policy in August 2020. The cross-referencing of patient experience and agency use data is something that we will look into. In the first instance we will need to see if data in relation to patient experience can be obtained from colleagues in the Health Board and we will look to see if meaningful reports can be produced. In the mean-time we will continue to review specific concerns that have been raised via our routine processes.	Director of Workforce & OD	Head of Corporate Nursing	Aug-20	Oct-20	Feb-21		In progress		July 2020 Update - Due to outbreak of covid-19 and consequent pressure on staff bank to recruit additional bank workers to support exsisting and new HB services has meant a delay in starting this policy.	July 2020 Update - The policy will be written in September 2020, which will coincide with the change in recruitment processes for staff bank workers. Roll out and publication of the policy will be completed by end of October 2020. November 2020 Update - The Bank Policy is being updated during December 2020/Januay 2021. The updated policy will consist of a review and update of all the bank and agency forms.
NAU 03	Apr-20	Reasonable	1. The Staff Bank Policy should be reviewed and updated as necessary to reflect current practice, process and systems in place within the Health Board. The policy should more explicitly reference the engagement and management of agency nurses as opposed to just focussing on Bank staff. 2. Where other relevant policies exist, such as the Rostering Policy, these should be cross-referenced within the Staff Bank Policy. 3. Where procedures are developed to supplement existing policies, reference	Medium	The Staff Bank Policy will require updating to include the Collaborative Bank project which is due to commence in April 2020. The updated version will include appropriate references to the UH Rostering Policy. The updated policy will include: ☐ The updated 'Booking Bank & Agency Nurses - Procedures for Ward Managers' ☐ The new Request for Thornbury Nurses proforma. ☐ The updated e-datix reporting algorithm The following documents will be recirculated to Heads of Nursing.	Director of Workforce & OD		March 2020/April 2020/August 2020	Oct-20	Feb-21		In progress		July 2020 Update - Due to outbreak of covid-19 and consequent pressure on staff bank to recruit additional bank workers to support exsisting and new HB services has meant a delay in starting this policy.	July 2020 Update - The policy will be written in September 2020, which will coincide with the change in recruitment processes for staff bank workers. Roll out and publication of the policy will be completed by end of October 2020. November 2020 Update - The Bank Policy is being updated during December 2020/Januay 2021. The updated policy will consist of a review and update of all the bank and agency forms.
NAU 04	Apr-20	Reasonable	1. A review of the Temporary Nursing & Midwifery Staffing Decision Checklist (Appendix 5) contained within the Roster Policy should take place to ensure all aspects remain relevant. Consideration should be given if the checklist needs to be completed for every shift filled by an agency employee or if one checklist could be completed covering all agency shifts needed on a week's	Medium	Appendix 5 in the Roster Policy will be replaced with the updated 'Booking Bank & Agency Nurses -Procedures for Ward. Heads of Nursing to ensure the checklist is re-circulated to Ward Managers and Senior Nurses emphasising the importance of the completion of the check list for all new bank and agency nurses to the ward areas/department.	Director of Workforce & OD	Head of Corporate Nursing	April 2020/May 2020	Aug-20	Feruary 2021		In progress			Appendix 5 has been sent through to the workforce polict review group for the change to be made to the roster polocu it is in the agenda for the aug meeting. November 2020 Update - The Bank Policy is being updated during December 2020/Januay 2021. The updated policy will consist of a review and update of all the bank and agency forms.
Cyber Security Follow Up (June 2020)															
CSFU 03	Jun-20	Reasonable	**Original Recommendation** - A formal patch management procedure should be developed that sets out the mechanisms for patching / updating all items within the Health Board. **Updated Recommendation** - A formal patching strategy and SOP should be developed for the patching process that sets out the mechanism and processes for this.	Medium	**Original Management Response** - Formal patching strategy is being put in place and will be submitted to Digital Strategy Steering Group (DSSG) in June. **Updated Management Response** - A formal patching strategy and SOP are currently being worked on and should be ready to publish by July 2020.	Director of Planning & Performance	Assistant Director of ICT	Jun-19	Jul-20	Dec-20		In progress			**Current Position** - We note that the process for patching has been amended, with a rota in place for patching of servers. We also note that the Health Board has purchased the Ivanti patch management solution to help improve the patching process. However, at present there is no strategy as stated in the initial management response, and no standard operating procedure (SOP) in place for the patching process. Based on the progress made and the evidence that we reviewed we consider the original recommendation to be partially implemented and have reclassified the remaining elements as Medium priority. July 2020 update - DT & AE drafting patching policy, summary of patching completed but yet to be finalised and produced as SOP. Expected to be finalised by end of August 2020. August 2020 Update - Die to the pressures of Covid 19 and the resources required for the roll out and ongoing maintenance of Microsoft 365, the timescale has been reset to December 2020
CSFU 04	Jun-20	Reasonable	**Original Recommendation** - A formal, resourced plan for the removal of old software and devices should be established. **Updated Recommendation** - The remaining areas of old software should be identified and formally reported to the DSSG / committee, noting where software cannot be easily removed and the associated risk. Linked to this a formal plan for removing /updating old software within the resource constraints should be defined.	Medium	**Original Management Response** - The existing plan will be updated and brought to DSSG for formal approval in June. **Updated Management Response** - A formal risk analysis and remediation strategy is currently being developed which will be presented to the DHSSG by September 2020.	Director of Planning & Performance	Assistant Director of ICT	Jun-19	Sep-20	Nov-20		In progress			**Current Position** - Work to remove old software is part of the general procedures. As new systems are brought on line the older servers are removed so the process is largely led from the bottom up rather than top down and there is no formalised plan to remove old versions of software. We note that old versions of key software such as Java / Windows Server / Windows are still used as they are supporting a vital component of the service and as such the Health Board has removed and updated as much as possible without updating these core applications themselves. We note that there is ongoing work to reduce the risks associated with old software, with older versions of Firefox being removed from desktops. We further note that initial discussions are ongoing over the use of Kapersky to block unofficial and old software within the Health Board. Based on the progress made and the evidence that we reviewed we consider the original recommendation to be partially implemented and the remaining elements remain as Medium priority. August 2020 Update - Work has commenced within the infrastructure team, to address the server operating systems to ensure that all servers are on at least Server 2016 operating systems. An end user device sub group has been formed and will have its first meeting this month to discuss a astrategy of ensuring that Windows operating systems are on the most up to date version. The timescale has been set back to November 2020.

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CSFU 05	Jun-20	Reasonable	**Original Recommendation** - The organisation should provide additional resource for a minimum defined period to allow for the data communications team to improve network security. **Updated Recommendation** - Work should continue to improve the network security of the Health Board. Following the firewall audit, the firewall rules should be amended to increase the security position.	Medium	**Original Management Response** - Data communications security will be addressed by the new posts discussed in finding 2. **Updated Management Response** - The firewall audit has been received and confirmed as accurate. Work has commenced in addressing the recommendations highlighted in the audit. The Cyber team have received the Cisco Implementing Advanced Cisco ASA Security and will be addressing the firewall rules starting in June 2020.	Director of Planning & Performance	Assistant Director of ICT	Jul-19	Jun-20	Dec-20		In progress			**Current Position** - As noted above, resources have been provided for cyber security and one of the posts is within the server team. The current position with the firewall is that the rules have not been changed to restrict access from NHS Wales, however in order to improve the security of the Health Board, a company has been engaged to undertake a firewall audit. The purpose of this is to look at the firewall configuration and rules, which will form the basis of the control moving forward. We note that control over changes to the firewall rules is moving to the cyber security team with training for the cyber security team booked with Cisco in order to do this. The process for changing the firewall rules has been improved with a standard form in place for requests, which are channelled through the cyber team for approval before being discussed and agreed at the Change Advisory Board (CAB). Based on the progress made and the evidence that we reviewed we consider the original recommendation to be partially implemented and the remaining elements remain as Medium priority. July 2020 update: Firewall project to restart in August with gradual handover of firewall rules from Data Comms to Cyber Security Team. Training scheduled between Data Comms Team and Cyber Team to begin handover. We have an additional temporary resource within Cyber Security Team also looking at networking areas and Solarwinds. August 2020 Update - work on the updating of software versions on each firewall is now complete along with configuring each firewall as per recommendations. There has been an isue in auditing the rules on each firewall due to a licensing issues with Solwarwinds. The ICT Department have requested a quote from the supplier on the cost of increasing the licenses on Solwarwinds to address this issue.
PCH Governance (June 2020)															
PCHG 04	Jun-20	Reasonable	Project Board members will be reminded for their responsibility to attend (O).	Medium	Agreed. Terms of Reference have been revisited to confirm the members of the Project Board and the expectation that suitable deputies should be nominated by each member. This should be evidenced at future Project Board meetings	Director of Finance	Deputy Senior Responsible Officer	Aug-20	Oct-20			Completed	November 2020 Update - Confirmation received yesterday from NWSSP-AA that this recommendation "has been closed by Internal Audit – given the specific management action has been taken" and would be grateful if this could be reflected in the audit update		July 2020 Update - Period for sampling agreed to be extended by Audit due to Covid disruption
POW Fire Safety Audit Follow Up Review (June 2020)															
POWFS FU 01	Jun-20	Limited	We would recommend that the monitoring spreadsheet is brought up to date as currently it does not provide a comprehensive monitoring tool.	High	Partially addressed. The adoption of CTMUHB systems will ensure compliance, however work is ongoing to transpose information from legacy systems. Risk assessments are being undertaken/ updated, but limited by available resource.	Director of Workforce & OD	Head of Operational Health, Safety & Fire	Feb-19	Aug-20	Jan-21		In progress			September 2020 Update - Recommendation under review pending 'Review Fire Audit' outcome'. November 2020 Update - The scope of the review has now been agreed. Management have requested that the review is undertaken in Quarter 4 as a result of Covid-19 and staffing pressures. A meeting is being held between Internal Audit and the Director of Corporate Governance in January 2021 to agree the commencement of fieldwork.
POWFS FU 02	Jun-20	Limited	Management should reinstate the bi monthly Fire Subgroup meetings and review the terms of reference to ensure they are current.	High	Partially addressed. Noting the recent restructure within the UHB and Senior Management changes, the Fire Group has not been established. In the interim, fire advisers/ representatives attend the site specific working groups/ meetings.	Director of Workforce & OD	Head of Operational Health, Safety & Fire	Nov-18	Aug-20	Jan-21		In progress			September 2020 Update - Recommendation under review pending 'Review Fire Audit' outcome'. November 2020 Update - The scope of the review has now been agreed. Management have requested that the review is undertaken in Quarter 4 as a result of Covid-19 and staffing pressures. A meeting is being held between Internal Audit and the Director of Corporate Governance in January 2021 to agree the commencement of fieldwork.
POWFS FU 04	Jun-20	Limited	As indicated in 2 above, we would recommend that the Health & Safety Committee Fire Management Subgroup meetings recommence bi-monthly. Fire Advisers should be invited to attend the Subgroup meetings when they recommence.	Medium	Partially addressed. See 2 Above.	Director of Workforce & OD	Head of Operational Health, Safety & Fire	Mar-19	Aug-20	Jan-21		In Progress			September 2020 Update - Recommendation under review pending 'Review Fire Audit' outcome'. November 2020 Update - The scope of the review has now been agreed. Management have requested that the review is undertaken in Quarter 4 as a result of Covid-19 and staffing pressures. A meeting is being held between Internal Audit and the Director of Corporate Governance in January 2021 to agree the commencement of fieldwork.
POWFS FU 05	Jun-20	Limited	We would recommend that reporting to both the Operational Health & Safety Group and the Health & Safety Committee be enhanced to include action taken to address risks identified in risk assessments and risks still to be actioned.	Medium	Outstanding. CTMUHB has been engaged with NWSSP: Specialist Estates Services for a significant period looking to allow the current all Wales FRA system (maintained by SES) to allow improved monitoring/ reporting.	Director of Workforce & OD	Head of Operational Health, Safety & Fire	Mar-19	Aug-20	Jan-21		In progress			September 2020 Update - Recommendation under review pending 'Review Fire Audit' outcome'. November 2020 Update - The scope of the review has now been agreed. Management have requested that the review is undertaken in Quarter 4 as a result of Covid-19 and staffing pressures. A meeting is being held between Internal Audit and the Director of Corporate Governance in January 2021 to agree the commencement of fieldwork.
Head & Neck Compliance (August 2020)															

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HNC 01	Aug-20	Reasonable	1. Staff identified as requiring scheme of delegation training as part of their role should complete the on-line training module in ESR as soon as practically possible. 2. Consideration should be given as to whether any other staff within the directorate would benefit from scheme of delegation training, to ensure there is a consistency in training requests across the directorate.	High	Agreed this will be resolved in the NEW ILG structures The action will be as follows: • The staff requiring scheme of delegation training will be contacted individually and required by the Service Group Manager to complete the training by the end of August 2020. • Advice will be taken from Finance Partners regarding which staff would benefit from scheme of delegation meeting – with a particular focus on band 7 staff. • Issue will be raised in the CSG governance meeting and an email sent to all senior staff in the Directorate (from band 7 up) outlining the paramount	Executive Director of Operations	Service Group Manager	Aug-20				In progress			
HNC 02	Aug-20	Reasonable	Heads of Department within the Head & Neck Directorate should be reminded of the requirement to complete and maintain an inventory of non-capital assets in line with Financial Control Procedure 11, where applicable.	High	Action will be: • The Heads of Service who did not complete the inventories will be contacted individually and required by the Service Group Manager to ensure that they understand the importance of this issue and asked to produce a compliant inventory by the end of September 2020. • Issue will be raised in the CSG Governance meeting and an email sent to all senior staff in the Directorate (from band 7 up) outlining the paramount	Executive Director of Operations	Service Group Manager	Oct-20				In progress			
HNC 03	Aug-20	Reasonable	Given the value of items that pass through the audiology department, management should review the current arrangements for managing stock in all departments and then consider drawing up a desktop procedure for the management of stock, which is applied to all departments. The procedure should cover as a minimum: • Ordering and receipting. • Minimum and maximum stock levels (if practical). • Security and access to stock. • Ongoing spot checks. • Annual stock take.	Medium	Actions will be: • The Service Group Manager will see the Head of Audiology personally to emphasise the importance of this issue – including its financial implications for the Directorate as a whole. • The Head of Audiology will be required to improve this situation as part of his PADR and also asked to identify a plan with milestones.	Executive Director of Operations	Head of Audiology	Sep-20				In progress			
HNC 04	Aug-20	Reasonable	Budget holders should review all budgets with the Finance Business Partner to identify any 'historical' budgets that are no longer applicable and make the necessary adjustments as part of the budget setting process for 2020/2021 financial year.	Medium	Action will be: • Working with Finance Partners, all budget holders will be required to complete reviews of budgets.	Executive Director of Operations	Budget Holders	Oct-20				In progress			
HNC 05	Aug-20	Reasonable	Management should ensure that any additional payments due to staff are correctly recorded and authorised on the monthly pay returns and that all payments are in compliance with Agenda for Change.	Medium	Action will be: • Directorate Support Manager will be required to put in place a system that ensures appropriate payments. This will be audited every three months.	Executive Director of Operations	Service Group Manager	Aug-20				In progress			
HNC 06	Aug-20	Reasonable	All budget holders should be reminded of their responsibility to review all monthly financial information sent to them and contact Finance to rectify any errors.	Low	Actions will be: • Working with Business Partners, meetings will be arranged monthly to review financial reports. They will need to be attended by Heads of Service.	Executive Director of Operations	Service Group Manager	Sep-20				In progress			
Health & Safety Management (Agust 2020)															

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HSM 01	Aug-20	Reasonable	1) It should be ensured that training data in relation to PoW and another Bridgend based staff is input into ESR and included in any performance data reported. 2) Where compliance rates are low in particular areas, management should work to understand what the barriers are that stop staff completing the training. In addition, advice should be sought from those areas that are performing well in order for best practice and ideas to be shared. 3) All Executive Directors should undertake training to the level required as part of their role and ESR records should be updated accordingly. 4) Consideration should be given to the Violence and Aggression training report submitted to the Security and Violence Operational Group and the need for additional resources to meet the current training gap.	High	Actions to address each item are listed below. 1. It should be ensured that training data in relation to PoW and another Bridgend based staff is input into ESR and included in any performance data reported. At the time of audit Cwm Taf Morgannwg University Health Board (CTMUHB) was in the process of aligning ESR Competency data between the old Cwm Taf University Health Board and the Bridgend region of Abertawe Bro Morgannwg University Health Board. The work is now completed and all Competencies at Level 1 have now migrated on to the ESR system for staff in the Bridgend region and performance data is reported. 2. Where compliance rates are low in particular areas, management should work to understand what the barriers are that stop staff completing the training. In addition, advice should be sought from those areas that are performing well in order for best practice and ideas to be shared. Statutory and Mandatory Training has previously been monitored via Directorate Clinical/Corporate Business Meetings within the Health Board. This monitoring will continue and form part of the improvement work of the newly established Integrated Locality Groups (ILGs). A group has recently been established under the Director of Nursing to review the current training requirements for all Statutory and Mandatory Training for all Nurses employed within the UHB. This will help identify the main	Director of Workforce & OD	Head of Health, Safety & Fire	Mar-21				Part Completed			This work is currently on hold due to the current Covid-19 epidemic and a completion time is not currently predictable.
HSM 02	Aug-20	Reasonable	The Health and Safety policy should be reviewed and where necessary updated to reflect any changes required due to the merger between Cwm Taf and Princess of Wales Hospital, and to reflect the current Health and Safety reporting arrangements within the Health Board.	Medium	In April 2019 the Bridgend region of the former Abertawe Bro Morgannwg University Health Board merged with Cwm Taf University Health Board. Each organisation had in place their own individual Health and Safety Polices and under TUPE arrangements it was decided to allow the organisation 12 months to align these policies. A newly drafted Health and Safety Policy for Cwm Taf Morgannwg University Health Board has been developed. The Policy once approved will be signed by the Chief Executive communicated to all staff through the Health Board's Intranet Training and via regular update training.	Director of Workforce & OD	Head of Health, Safety & Fire	Sep-20				In progress			
HSM 03	Aug-20	Reasonable	Management should review the Health and Safety Co-ordinator resource and the alignment of work in order to ensure sufficient coverage of the service areas.	Medium	In light of the recent structural changes implemented within Cwm Taf Morgannwg UHB, a review of Health and Safety Coordinator support to each new Integrated Locality Group has been undertaken. It is planned to have 2 Health and Safety Coordinators in each new ILG. There is a current deficiency for 1 Health and Safety Coordinator post in the Bridgend ILG and this is currently being considered through a business case.	Director of Workforce & OD	Head of Health, Safety & Fire	Aug-20				In progress			
HSM 04	Aug-20	Reasonable	The Health and Safety Department should liaise with the Directorate Managers for their assigned areas of the Health Board to identify key individuals who have the responsibility for Health and Safety within that directorate. Once identified the Health and Safety team can work with these individuals or their nominate representatives to ensure they are aware of their responsibility to be compliant with the Health and Safety Policy.	Medium	In light of the recent structural changes implemented within CTMUHB, a review of Health and Safety Coordinator support to each new Integrated Locality Group has been undertaken. For all of the Health and Safety Coordinators they will be required to support areas/services in the new ILGs that they may not have previously. As part of the new ILG structures the Health and Safety Coordinators will attend local Service Group Governance Groups as well as the ILG Health, Safety & Fire Group. This will allow clear working relationships for both the responsible officers of the ILGs and the respective Health and Safety Coordinators.	Director of Workforce & OD	Head of Health, Safety & Fire	Sep-20				In progress			
HSM 05	Aug-20	Low	The pathway on the intranet to the Health and Safety Policy should be made easier in order to ensure easy access for all staff.	Low	The New CTMUHB Health and Safety Policy (once ratified) will be placed under the Risk Management Policies section of the Health Board's intranet pages. A link to this will also be provided clearly on the Health Board's Health and Safety Webpages.	Director of Workforce & OD	Head of Health, Safety & Fire	Sep-20				In progress			

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HSM 06	Aug-20	Low	The templates currently being used to undertake annual Health and Safety reviews should be reviewed to ensure they are accurately reflecting the Health and Safety issues within each department.	Low	The Health and Safety Team are developing an audit package for use across the CTMUHB. The package will provide assurance to ILGs and the Board that policies and procedures are being followed in all Service Group Wards and Departments. Once completed, the audit package will be presented to the Health, Safety and Fire Committee for approval.	Director of Workforce & OD	Head of Health, Safety & Fire	Jan-21				In progress			
Directorate Review Acute Medicine & A&E (July 2020)															
DRAM 01	Aug-20	Reasonable	A detailed review of all risks currently recorded on DATIX should be undertaken in order to ensure all entries are accurate, remain relevant and have been consistently scored. Where possible a more streamlined register should be in place that facilitates comprehensive monitoring of at least the high scoring risks at the CBM and QSRGG.	Medium	The establishment of the Integrated Locality Groups has prompted a thorough review of the risk registers for each of the clinical service groups. The CSG are now focused on one acute site and the register should therefore be smaller and easier to manage, with regular review of the risks via the governance groups. This work has started but not yet completed due to delays in appointments to the ILG supporting structures.	Executive Director of Operations	General Manager	Sep-20	Dec-20			In progress			November 2020 Update - The establishment of the Integrated Locality Groups prompted a thorough review of the risk registers for each of the clinical service groups. The RTE ILG Clinical Services Group for Medicine is now focused on one acute site and the register is smaller and easier to manage, with regular review of the risks via the governance groups. This work started in April 2020 and is now nearing completion although it should be noted that there were delays due to the impact of the COVID pandemic and timing of key appointments to the supporting structure.
DRAM 02	Aug-20	Reasonable	Following the review of the risk register, there should be clear evidence of review and monitoring of at least all high scoring risks at the CBM and QSRGG.	Medium	The risk register for each site will be reviewed and updated for each acute site by September 2020 as per finding 1. Once this work is completed the process for review and monitoring will be established via the ILG and service group governance structures.	Executive Director of Operations	General Manager	Sep-20	Dec-20			In progress			November 2020 Update - The risk register for the Medicine CSG, once completed as set out above, will be subject to regular review and monitoring via the ILG and service group governance structures.
DRAM 03	Aug-20	Reasonable	1. The Health Board Executive Team should review the contents of the current draft version of the CBM terms of reference with a view to updating content particularly around business and membership and to ensure the format of the meetings will work with the new operating model. The revised Terms of Reference should then undergo a formal approval process for use in all CBMs as soon as possible. 2. Officers who form the core membership of both the CBM and the QSRGG should attend at each meeting or send a representative where appropriate. This ensures that key messages can be cascaded to all relevant teams within the directorate. 3. The terms of the reference for the QSRGG should be reviewed, updated and finalised. The review should include a review of the structure diagram outlining the key groups in the directorate, to ensure it captures all groups with the correct group names.	Medium	1. Each ILG has put in place revised governance arrangements and the CBM are no longer part of the model. The newly established governance arrangements have been subject to robust review and discussion with the executive directors (COMPLETED) 2 & 3 The format of the governance groups is now being reviewed to ensure that it is aligned to the ILG model. Once membership has been agreed, attendance will be monitored to ensure that the groups are quorate. The reviews will capture the supporting structure on each acute site.	Executive Director of Operations	ILG Directors/ General Manager	Sep-20	Dec-20			Part Completed	Action 1 has been completed		
DRAM 04	Aug-20	Reasonable	1. A review of the policies and procedures saved to the intranet should be undertaken to ensure there is a central repository of all documents and all documents that are listed are still relevant, with all out of date policies reviewed and updated where necessary. 2. Where there are common policies across a number of departments, to avoid duplication and possible inconsistencies, consideration should be given to having a set of directorate wide policies with one copy saved and clear information on the lead area for the policy including who is responsible for reviewing and updating the policy.	Medium	The review of policies and procedures needs to be undertaken on each acute site and it is acknowledged that this is an area of concern with focussed attention needed over the next 6 months. There also needs to be clear guidance from the ILG on the process for the approval of policies and procedures in the new operating model.	Executive Director of Operations	ILG Directors/ General Manager	September 2020/December 2020				In progress			November 2020 Update - The planned review has been delayed due to the COVID pandemic and the timely appointment to the CSG supporting structure.
DRAM 05	Aug-20	Reasonable	1. Management should ensure that all outstanding staff that have yet to complete a Declaration of Interest or Nil Return, do so in line with the Health Board's Standards of Behaviour Policy. 2. The directorate management team should consider how the information contained on declarations for their staff are reported within the directorate for appropriate consideration	Medium	The process for annual declarations of interest returns is manged via the corporate services team and the clinical services groups will need regular reports in order to address this area of concern. Once received the information should be discussed via the established governance groups.	Director of Corporate Governance/ Board Secretary	General Manager	Aug-20				In progress			November 2020 Update - Revised Electronic process now in place and regular reports will be presented to the Audit & Risk Committee

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DRAM 06	Aug-20	Reasonable	1. Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period. 2. Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Directorate Manager and Clinical Director in order to resolve any problems in a timely manner and ensure plans get signed off.	High	This area of concern is acknowledged and it is accepted that the consultant job planning process will now be easier to manage via each ILG. Each of the CSG general managers needs to ensure that a plan is in place to reach 100% compliance as quickly as possible.	Executive Director of Operations	General Manager	Nov-20	Dec-20			In progress			November 2020 Update - The RTE ILG position for medicine has been subject to review over the last 6 months and a plan is in place to reach 100% compliance as quickly as possible. Current compliance is set out below: - 50 Consultants = 32 completed, 5 scheduled for the next two weeks, 6 relate to the ED and are subject to discussion with the workforce team re annualised job plans and the Allocate system, 1 long term sick leave, 1 maternity leave and 5 other e.g. leaving, retire & return, new consultant, C&V employee, dispute. 13 SAS Doctors - 1 completed, 2 scheduled for the next two weeks, 8 relate to A&E and 2 are on long term sick leave.
DRAM 07	Aug-20	Reasonable	In line with Health Board targets, all staff should be subject to a PDR on an annual basis with copies of PDRs accessible should managers be absent.	Medium	It is acknowledged that every member of staff should have an up to date PDR in place and this will need to be addressed by the CSG general managers and other members of the leadership team such as the Senior Nurses on each of the acute sites	Executive Director of Operations	General Manager & Senior Nurses	Dec-20	Dec-20			In progress			November 2020 Update - The position is monitored via the monthly ILG performance review meetings although it must be acknowledged that this has been difficult during the COVID pandemic.
DRAM 08	Aug-20	Reasonable	1. All information contained on self-certification forms, RTW forms and ESR should correspond. Comprehensive and accurate documentation in relation to each episode of sickness should be maintained to allow the proper management of sickness within the directorate and accurate reporting. 2. It should be ensured that self-certification and return to work forms are fully completed in a timely manner following the employee's return.	Medium	It is acknowledged that this position is not acceptable and this will need to be addressed by the CSG general managers and other members of the leadership team such as the Senior Nurses on each of the acute sites.	Executive Director of Operations	General Manager & Senior Nurses	Dec-20				In progress			November 2020 Update - The position is monitored via the monthly ILG performance review meetings although it must be acknowledged that this has been difficult during the COVID pandemic.
DRAM 09	Aug-20	Reasonable	The directorate should ensure that all staff record their mandatory training in ESR and all staff are provided with the opportunity to undertake their mandatory training. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for non-compliance with a view to providing support where necessary.	Medium	It is acknowledged that every member of staff should be provided with the opportunity to undertake their mandatory training and this will need to be addressed by the CSG general managers and other members of the leadership team such as the Senior Nurses on each of the acute sites.	Executive Director of Operations	General Manager & Senior Nurses	Dec-20				In progress			November 2020 Update - The position is monitored via the monthly ILG performance review meetings although it must be acknowledged that this has been difficult during the COVID pandemic.
DRAM 10	Aug-20	Reasonable	Staff should be reminded of the importance for rotas to be produced and approved in a timely manner and the need for wards to operate at template staffing levels.	Medium	This is accepted as poor practice and reminders will be issued to all staff within the Clinical Service Groups.	Executive Director of Operations	Senior Nurses Medicine	Jul-20				Completed	November 2020 Update - Reminders have been issued to all staff within the Clinical Service Group.		
DRAM 11	Aug-20	Reasonable	1. All relevant records (paper and electronic) in relation to annual leave should be accurately completed and retained to ensure managers are aware of leave that has been granted and prevent staff taking more leave than they are entitled to. 2. The annual leave entitlement recorded on paper records or other systems should be reconciled to ESR at the start of each year to ensure opening balances are correct. Where necessary any differences should be investigated, including the variations identified during our testing.	Low	This is accepted as poor practice and reminders will be issued to all staff within the Clinical Service Groups.	Executive Director of Operations	Senior Nurses Medicine	Jul-20				Completed	November 2020 Update - reminders have been issued to all staff within the Clinical Service Group.		
DRAM 12	Aug-20	Reasonable	Management should ensure that the directorate's demand and capacity plan is updated on a periodic basis to reflect any issues that arise for any of the specialties. The updated plan should then be formally reviewed at the CBMs.	Medium	Demand and capacity planning remains a challenge for each of the service groups and further action is needed to ensure that robust plans are in place and subject to regular review. It should however be noted that the establishment of the ILG operating model and the COVID-19 pandemic response has delayed progress in this area during 2020. It will now need to be a priority to ensure that we fully understand the position and the actions needed to return to normal working and	Executive Director of Operations	ILG Directors/ General Manager	Sep-20	Dec-20			In progress			
DRAM 13	Aug-20	Reasonable	An inventory of non-capital assets should be developed for each department within the directorate, detailing their assets, which fit under the definition of inventory as detailed within the Financial Control Procedure.	High	It is accepted that this area needs attention and this will need to be prioritised by the CSG general managers during 2020-21 once supporting staffing structures are in place.	Executive Director of Operations	General Manager	Apr-21				In progress			

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DRAM 14	Aug-20	Reasonable	1. Management should ensure that all staff are aware of the contents of Patients Property and Money Financial Control Procedure and their responsibilities to comply with it. Consideration should be given to some form of monitoring to ensure compliance. 2. In the meantime, a separate property book should be obtained for use in the major injury unit and disclaimers should be present within wards and departments to make it clear to patients about their responsibility for personal possessions.	High	This is accepted as poor practice and communication will be sent to all wards and departments to outline the required actions to ensure compliance with the Financial Control Procedure.	Executive Director of Operations	Senior Nurses Medicine	Jul-20	Apr-21			In progress			November 2020 Update - Communication has been sent to all wards and departments (July 2020) to outline the required actions to ensure compliance with the Financial Control Procedure. This area remains a challenge and the position has been exacerbated during the COVID pandemic with increased patient movement between wards in line with the IPC guidelines.
DRAM 15	Aug-20	Reasonable	1. Staff identified as requiring scheme of delegation training as part of their role should complete the on-line training module within ESR as soon as practically possible. 2. Consideration should be given as to whether any other staff within the directorate would benefit from Scheme of Delegation training to ensure there is consistency in training	Medium	This action will need to be picked up once the supporting staffing structures are in place on each of the acute sites and budgetary responsibilities have been clarified.	Executive Director of Operations	General Manager	Sep-20	Jan-21			In progress			
Medical & Dental Rostering (July 2020)															
MDR 01	Aug-20	Limited	The Health Board should continue to move to using a single medical and dental rostering system that would allow efficiencies in usage, especially where links can be made to other Health Board systems such as consultant job planning. This will also enable the Workforce Development team to provide consistent support across the Health Board.	High	Allocate Health Roster has now been rolled out for the whole of the UHB with the exception of ACT and PoW ED. In particular, the rollout was extended to Princess of Wales (PoW) medics during April and May. ACT currently use a separate rostering product called CLW and have for many years. This is also the case in a number of Health Boards and Trusts as the rostering features have been specifically designed for Anaesthetic rosters. Historically, and prior to the transfer on 1 April 2020 POW Emergency Department have used a separate rostering product. For ED POW and ACT to move over to Health Roster, the additional functionality needed would require the purchase of 2 additional modules from Allocate. The 2 modules are Medic on Duty (MOD) and Activity Manager (AM). In addition, this would require further discussions with Consultants and directorate colleagues as their current processes are considered to be perfectly suitable and adequate for their rostering arrangements and would not be a priority. The link of eJob Planning to health roster is the ultimate gold standard and is fully supported. For this to be possible it requires the purchase of the additional e-rostering products, to allow for the interface and indeed for all business areas to be using the Activity manager. In order to roll out Activity Manager effectively, the rostering team would be required to revisit all ILGs to ensure Health Roster is being used effectively for	Executive Director of Workforce & OD	Head of Workforce Productivity & E-Systems	June 2020/December 2020				In progress			
MDR 02	Aug-20	Limited	1) The current project plan should be reviewed and updated so an accurate plan can be put in place with achievable timeframes for the roll out of the HealthRoster system to medical and dental staff. 2) An analysis of the resource requirements needed to roll out the rostering system to all medical and dental areas, whilst also providing support to those areas (including nursing) that are already using the system, should be carried out. 3) There should be a process of ongoing monitoring and review of the project plan to ensure it remains a current, live document, with delays around roll out escalated as necessary.	High	A programme board has been discussed and agreed with the Medical Director, Finance Director and W&OD Director to ensure oversight of the Rostering project. Rostering forms one strand of the Medical Efficiency programme which will be monitored through highlight reports a PID and Project Plan. Within the rostering project plan, the resource, time requirements and milestones will be set. A live record of the project will be maintained and presented to the programme board to demonstrate progress against the plan.	Executive Director of Workforce & OD	Head of Workforce Productivity & E-Systems	September 2020/October 2020				In progress			
MDR 03	Aug-20	Limited	1) Management should ensure that the Medics User Group is set up as HealthRoster starts to be implemented within each of the departments to ensure that the Workforce Rostering Team is receiving feedback on the system and to help to resolve any issues ahead of roll out to other areas of the Health Board. 2) Where feedback is received from departments, a process should be in place to capture this feedback and ensure it is acted	Medium	A medics user group is no longer considered to be the most appropriate forum for discussing generic issues. Moreover, given the current ILG structure, it is more appropriate for ILG leads to be identified as super users, who in turn would provide constructive feedback to the rostering lead. The super users would need to be identified in each business area.	Executive Director of Workforce & OD	Head of Workforce Productivity & E-Systems	Nov-20				In progress			

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MDR 04	Aug-20	Limited	1) The Health Board should develop a rostering policy specific to medical and dental staff. To ensure consistency and no conflict or duplication, consideration should be given to any other related policies and future financial control procedures such as medical variable pay. The policy should also give clear guidance on the alignment between the roster development process, consultant job plans and service demands. 2) The current set of HealthRoster 'how to' guides should be reviewed to ensure they are comprehensive and can be used in all areas of the Health Board as HealthRoster is rolled out. It should be ensured that any procedures or guides created align to the roster policy and cover both the use of the system to create rosters and the use of the system by medical and dental staff to manage their time. For example, booking annual leave and making amendment requests. 3) For areas where the roll out of HealthRoster is not imminent, separate 'how to' guides on that system should be developed. The guides should include the step by step process for creating the rosters and also guides for users of the system, allowing consistency during unexpected periods of absence.	High	A rostering policy will be developed in a collaboration with the ILGs to ensure they are bought into the guidance. Sitting alongside this a separate 'medical establishment' project which will identify the funded posts in each of the ILGs. This is critical to inform the true and accurate development and recording of rosters. There are user guides on how use Health Roster within the Allocate Health Roster system so further guidance would not be relevant. If there is a requirement to refine this guidance, following feedback from Super Users, only then will the Allocate guidance be further developed.	Executive Director of Workforce & OD	Head of Workforce Productivity & E-Systems	Sep-20				In progress			
MDR 05	Aug-20	Limited	Annual leave and sick leave should be recorded on Health Roster which interfaces with ESR for Consultants and Middle Grade staff, thus allowing sickness to be managed appropriately.	High	The addition of PoW (excluding ED and ACT) to Health Roster has already moved a significant way towards achieving consistent recording of absences. The next phase however is to meet with each business area to ensure absences are being recorded on the system, which in turn feeds into ESR. There is a reliance on directorate colleagues in the ILGS to administer the system however regular checks and reporting may also expose where the data is not being inputted. This would be an ongoing exercise and could not be a one-off meeting with the directorate rota administrators and would be reliant on additional rostering	Executive Director of Workforce & OD	Head of Workforce Productivity & E-Systems	Sep-20				In progress			
MDR 06	Aug-20	Limited	Management should ensure that there are processes in place for monitoring the rosters including reviewing aspects such as ensuring medical and dental staff are undertaking the correct hours and working in line with the job plans.	High	The monitoring of hours worked against the planned rota is the responsibility of the Directorate and Roster managers. Workforce will provide KPI data to the Directorates through the ILG Medical Workforce Efficiency meetings setting out time frames for requesting leave, sickness data and study leave. The comparison of agreed job plans against rota is again a matter for the ILG Directorates as noted above.	Executive Director of Workforce & OD	Head of Workforce Productivity & E-Systems	Nov-20				In progress			
MDR 07	Aug-20	Limited	1) While the current systems remain in use, each department should have enough members of staff with the relevant skills and knowledge to prepare rosters and provide training to roster users where applicable. The Health Board should be clear as to who within departments are best placed to produce rosters, so that resources are used effectively. 2) As plans are taken forward to roll out HealthRoster to more areas, users of the system should be provided with training relevant to their needs, including re-training on elements of the system such as recording annual leave and oncall roster if roll out is going to be incremental. Enough staff within each team should be trained on roster creation to ensure suitable levels of cover and consistency during periods of absence.	Medium	The ILGs are responsible for identifying the relevant resource to administer rosters. If in turn the ILG resource requests additional training, this will be provided however as part of the comprehensive revisit of all other areas of the UHB, training will be given to colleagues where the system is not utilised. Every area (excluding ACT and PoW ED) that has been introduced to Heath Roster has been trained on the use of the system. This has also taken place with the PoW roll out. Everyone who has received training in PoW has been recorded in eRostering. The eRostering team will compile a comprehensive list of all staff trained in roster creation for Medics and ensure there is enough representation in each area.	Executive Director of Workforce & OD	Head of Workforce Productivity & E-Systems	Nov-20				In progress			
MDR 08	Aug-20	Limited	1) Management should ensure that on granting annual and study leave to staff, that consideration is taken to ensure there is enough Consultants in place to cover all shifts and they are not all granted leave at the same time. 2) The process for requesting and approving annual and study leave should be clearly set out in departmental procedure notes so that all are clear on the expectation of the department.	Medium	A policy has recently been finalised covering study leave entitlements across CTM. This clarifies how much is available and how to record it via the Health Roster system. This policy is awaiting ratification by the LNC. Once all areas are using Health Roster fully, rules can be set on the roster to ensure the correct amount of staff are permitted to be off per day/Week.	Executive Director of Workforce & OD	Head of Workforce Productivity & E-Systems	Nov-20				In progress			

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MDR 09	Aug-20	Limited	Management should ensure when they are producing the rosters that the SPAs and DCC session align to the agreed job plans.	Medium	If the Medic on Duty and Activity Manager modules are purchased and integrated into the process, this can automate the upload of the Job Plan into HealthRoster. This will demonstrate whether or not there is a reflection of the agreed job plan. However, this does need to be enforced and managed by each of ILG management teams, not by Workforce. ILG management will need to ensure that actual job plans reflect what is shown on the Roster.	Executive Director of Workforce & OD	Head of Workforce Productivity & E-Systems	Dec-20				In progress			
MDR 10	Aug-20	Limited	Where changes are made to rosters an audit trail should be place to show the amendments and the reason for the change on the roster.	Medium	HealthRoster provides various ways to audit changes to the roster. 1. Notes can be added to shifts. 2. If rosters are approved you can then run a roster stats report to show how much of the roster has been changed. 3. A unit audit report can be run to show in depth all changes that have happened on the roster. Once all business areas are using HealthRoster for their rosters, any subsequent changes will be visible as noted above as opposed to being recorded on separate spreadsheets.	Executive Director of Workforce & OD	Head of Workforce Productivity & E-Systems	Nov-20				In progress			
Head & Neck Management Arrangements (August 2020)															
HNMA 01	Aug-20	Limited	1. The Health Board Executive Team should review the contents of the current draft version of the CBM terms of reference with a view to updating content particularly around business and membership and to ensure the format of the meetings will work with the new operating model. The revised Terms of Reference should then undergo a formal approval process for use in all CBMs as soon as possible. 2. In the mean-time, Clinical Business Meetings should be held monthly wherever possible. Officers who form the core membership of the CBM should be in attendance or send a representative where appropriate. 3. Officers who form the core membership of the Directorate Integrated Governance Business Meeting should attend each meeting or send a representative where appropriate. This ensures that key messages can be cascaded to all relevant teams within the directorate.	High	The Directorate does not have the final word on the cancellation of CBMs and does not organise them. The new ILG arrangements will over-ride the current CBM system. Performance review meetings and Quality Patient Safety meetings are established in the new ILG format approved by the Executive team in the inaugural performance review with the CEO in June 2020.	Executive Director of Operations	ILG Leads	Jul-20				In progress			
HNMA 02	Aug-20	Limited	1. The Directorate should ensure that a central database is created that records all applicable policies and procedures for all departments that constitute the Head & Neck Directorate. The database should include as a minimum the name of policy/procedure, applicable department, lead person, approval date, review date and committee/meeting responsible for formally approving policy if applicable. 2. Management should also ensure that the information is accessible to all applicable staff including agency workers.	High	The Service Group Manager will work with the Heads of Department to ensure that a dedicated page is established on the intranet site. Thought will be given to nominating a number of more junior staff to come up with proposals and lead the process and develop a communication plan.	Executive Director of Operations	Management Team Ophthalmology	No Date Indentified				In progress			
HNMA 03	Aug-20	Limited	Monitoring of risks recorded in DATIX should be undertaken and appropriately reported to ensure action is taken in a timely manner within the Clinical Business Meeting or the Directorate Integrated Governance Business Meeting.	High	The UHB is undertaking a full review of risk registers across the Board and it is anticipated that this will improve the position significantly. There has been a significant piece of work undertaken on the risks in Ophthalmology, clinically lead and supported by the internal Patient Quality and Safety team. This work has also been shared with Welsh Government as part of the "no surprises" process. Further, this issue will be highlighted to the Bridgend ILG when it takes over management responsibility for this service. The new TOR for the MC ILG patient safety meeting receives a report to include the current risk register high level risks and	Executive Director of Operations	ILG's	No Date Indentified				In progress			

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HNMA 04	Aug-20	Limited	The Directorate should review all risks currently recorded on DATIX to ensure that all information is accurate and up to date. The Directorate should also ensure that appropriate processes are implemented to ensure that risks are regularly reviewed, including when risk handlers are absent from work for extended periods of time.	Medium	The UHB is undertaking a full review of risk registers across the Board and it is anticipated that this will improve the position significantly. Further, this issue will be highlighted to the Bridgend ILG when it takes over management responsibility for this service. The Directorate Management team responsible for the risk register have ensured any outstanding work has been completed and through the weekly meetings with Patient care and safety business partners will also ensure there is action undertaken on new risks in readiness for a supported handover of services.	Executive Director of Operations	Management Team	Sep-20					In progress			
HNMA 05	Aug-20	Limited	Management should ensure that all outstanding staff that have yet to complete a Declaration of Interest do so.	Medium	The Service Group Manager will seek the names of these individuals from colleagues at YMH and ensure that they return the appropriate information asap.	Executive Director of Operations	Service Group Manager	Sep-20				In progress			
HNMA 06	Aug-20	Limited	1. All episodes of sickness should be recorded on ESR. Comprehensive and accurate documentation in relation to each episode of sickness should be maintained to allow the proper management of sickness within the directorate and accurate reporting. 2. It should be ensured that self-certification and return to work forms are fully completed. 3. All information contained on self-certification forms, RTW forms and ESR should correspond. 4. Absence management prompts should be monitored and where periods of absence result in a prompt being breached, the appropriate action should be taken.	High	Working with colleagues in WOD the Directorate will start an education programme for all staff management issues – with joint workshops as has happened in other areas (for example, Mental Health). This will start a journey for the Directorate towards compliance. Since receipt of the report the detail has been shared with the Heads of Service and improvements have been made which will be qualified if a re-review takes place. Further, this issue will be highlighted to the Bridgend ILG when it takes over management responsibility for this service.	Executive Director of Operations	Service Group Manager	Oct-20				In progress			
HNMA 07	Aug-20	Limited	1. In line with Health Board targets, all staff should be subject to a PDR on an annual basis. 2. PDR documentation should be fully completed, with meaningful objectives agreed by the manager and employee. The document should be signed by both parties and ESR with the date the PDR took place. 3. Copies of PDRs can be accessed to be undertaken in Manager's absence.	High	The report has been shared with all Heads of Services and improvements have been made in the specialty area of Dental Services. The new management arrangements for the RTE ILG are in the process of being resolved and in line with the new workforce performance management ILG structure, the detailed improvements will be made. Further, this issue will be highlighted to the Bridgend and RTE ILG when it takes over management responsibility for this service.	Executive Director of Operations	Service Group Manager	Oct-20				In progress			
HNMA 09	Aug-20	Limited	The Directorate should ensure that all staff record their mandatory training in ESR and all staff are provided with the opportunity to undertake their mandatory training. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for non-compliance with a view to providing support where necessary.	Medium	This has been raised with the Heads of Service. The new management arrangements for RTE ILG are in the process of being resolved and in line with the new workforce performance management ILG structure, the detailed improvements will be made Further, this issue will be highlighted to the Bridgend ILG when it takes over management responsibility for this service.	Executive Director of Operations	Service Group Manager	Oct-20				In progress			
HNMA 10	Aug-20	Limited	1 Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period. 2 Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Directorate Manager and Clinical Director to resolve any problems in a timely manner and ensure plans get signed off.	Medium	The management team agree with this recommendation, and the lack of compliance has been as a result of COVID restrictions. The Clinical Director and the Service General Manager will work to complete this work by the end of September 2020.	Executive Director of Operations	Clinical Director/ Service General Manager	Sep-20				In progress			
HNMA 11	Aug-20	Limited	1. All relevant records (paper and electronic) in relation to annual leave should be accurately completed and retained to ensure managers are aware of leave that has been granted and prevent staff taking more leave than they are entitled to. 2. The annual leave entitlement recorded on paper records or other systems should be reconciled to ESR at the start of each year to ensure opening balances are correct. Where necessary any differences should be investigated, including the variations identified during our testing.	Low	Working with colleagues in WOD the Directorate will start an education programme for all staff management issues – with joint workshops as has happened in other areas (for example, Mental Health). This will start a journey for the Directorate towards compliance. Further, this issue will be highlighted to the Bridgend ILG when it takes over management responsibility for this service.	Executive Director of Operations	Service Group Manager	Oct-20				In progress			

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HNMA 13	Aug-20	Limited	Workforce Reporting within the Directorate Integrated Governance Business Meetings should be expanded to provide information on a departmental level. This would allow any areas of concern to be highlighted and the Directorate could then determine what action needs to be undertaken and responsible officer.	Medium	The Heads of Service have the reports for their areas and understand the HR issues in their departments. The Heads of Department will work with Business Partners to improve the situation.	Executive Director of Operations	Heads of Service & Business Partners	Nov-20				In progress			
HNMA 14	Aug-20	Limited	Management should ensure that all relevant correspondence/documentation relating to the IMTP process is retained if future access is required.	Low	The Service Group Manager will ensure that this is in place in the next round of IMTP planning and submission.	Executive Director of Operations	Service Group Manager	Dec-20				In progress			
Annual Quality Statement (August 2020)															
AQS20 01	Oct-20	Substantial	Consideration should be given that at any future public external stakeholder events held should be supported by attendance records that helps the Health Board gather information on areas such as demographics and stakeholder representation.	Low	We will engage with our communications colleagues and ensure that we have attendance record for any future public external stakeholder events. Our intention going forward will be to provide significantly greater emphasis on public participation and engagement in developing the AQS to facilitate greater co-production of the statement for 20-21. We have been very successful this year in engaging with partner agencies and the third sector whereby their contributions have been invaluable.	Director of Nursing	Senior Nurse Professional Standards & Quality Improvement/ Assistant Director Quality, Safety & Safeguarding	Sep-20				In progress			
AQS20 02	Oct-20	Substantial	All data submitted from departments should be checked to their original source for validity and accuracy prior to their inclusion within the AQS.	Low	The original source of any data used will be validated at the point of receiving it. This will be incorporated into the AQS timeline. It is certainly expected practice for any information, data or intelligence to be robustly verified and evidenced prior to use in any UHB report.	Director of Nursing	Senior Nurse Professional Standards & Quality Improvement/ Assistant Director Quality, Safety & Safeguarding	Sep-20				In progress			
Pathology Directorate Follow Up Review (Managerial Arrangements) (October 2020)															
PDFU 01	Oct-20	Reasonable	**Updated Recommendation** 1. The Rhondda and Taf Ely ILG Quality, Safety, Risk and Experience (QSRE) Group's ToR should be approved as soon as possible. A ToR should be drafted and approved for the Service Group Performance Review as soon as practicably possible. 2. The Pathology Quality Manual should continue to be brought up to date following the review of the ToRs of the various groups/ committees within the directorate. The manual should also refer to the Service Group Performance Review meeting both within the ToR section and the	Medium	1. Quality, Safety, Risk and Experience Group's ToR to be finalised at ILG level once the structure is finalised. ToR for the Service Group Performance Review meetings to be drafted and finalised once the structure is finalised. 2. Pathology Quality Manual to be updated to included CSG performance review.	Director of Operations	Locality Nurse Director/Locality Director of Operations/Pathology Quality Manager	October 2020/November 2020/December 2020				In progress			
PDFU 03	Oct-20	Reasonable	**Updated Recommendation** - The directorate should continue to monitor and review the risk register to ensure all risks are reviewed and updated by the set review date.	Medium	**Updated Management Response** - Pathology Risk Register will be reviewed as part of the RTE ILG risk review process. A peer review group is going to be established to look at risk scoring, and guidance to be provided on frequency of review	Director of Operations	Pathology Quality Manager	Dec-20				In progress			
PDFU 04	Oct-20	Reasonable	**Updated Recommendation** - All policies and procedures should be reviewed on a regular basis to ensure that they are current and up to date.	Low	**Updated Management Response** - There are a significant number of policies and procedures within Pathology, document review is monitored monthly through the Pathology scorecard and significant improvements have been made. Pathology will be implementing an electronic quality management solution within the next few months, this will automatically alert staff when documents are due for review, which should result in further improvements. There will also be a visual metrics dashboard which will show the status of document review for each	Director of Operations	Service Leads	Jan-21				In progress			
PDFU 05	Oct-20	Reasonable	**Updated Recommendation** - Managers should ensure all staff receive a PDR on an annual basis. Where necessary an action plan should be developed, and consideration given to obtaining assistance from other departments within the directorate to ensure compliance rates can be improved.	High	**Updated Management Response** - 1. Service managers to provide an action plan with target dates for completion of outstanding PDRs. 2. Compliance at 9/9/20 is 56.3%.	Director of Operations	Service Managers	Oct-20				In progress			
PDFU 06	Oct-20	Reasonable	**Updated Recommendation** - The Directorate should ensure all staff are reminded (and provided with support when needed) to complete core module training in line with Welsh Government's expectations. When reasonably practicable (following the Covid-19 crisis) staff should be afforded the opportunity and time to complete mandatory training.	Low	**Updated Management Response** - Managers to provide time to complete mandatory training for staff wherever possible to improve compliance.	Director of Operations	Service Managers	Ongoing				In progress			

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PDFU 07	Oct-20	Reasonable	**Updated Recommendation** - When consultant job plans are re-established following the Covid-19 crisis, the Directorate should ensure these are completed in a timely manner. A control system should be established to ensure Consultant Job Plans are reviewed prior to expiration and monitoring should take place at an appropriate group within the directorate.	Medium	**Updated Management Response** - Review of overdue consultant job plans to take place. A system will be developed to alert consultants when job plans are due for review.	Director of Operations	Clinical Service Group Manager	Nov-20				In progress			
PDFU 08	Oct-20	Reasonable	**Updated Recommendation** - Management should ensure that TOIL documentation is accurately completed, and the hours are recorded correctly.	Low	**Updated Management Response** - All departmental managers now complete weekly staff returns forms which are forwarded to a central point for review. The staff returns form includes hours worked, A/L and TOIL, all information is now recorded centrally.	Director of Operations		Completed				Completed			
PDFU 09	Oct-20	Reasonable	**Updated Recommendation** - It should be ensured that RTW forms are fully completed, including details of previous sickness episodes, to determine if the current absence has resulted in a prompt being hit. Where a prompt has been hit a record should be made of the action taken, including if no action is taken, with an explanation as to why discretion was applied in this instance.	Medium	**Updated Management Response** - Managers to ensure that sickness continues to be appropriately monitored and managed within their service areas.	Director of Operations	Service Managers	Ongoing				In progress			
Medical Agency Usage (October 2020)															
MAU 01	Oct-20	Reasonable	1. The Medical Agency Locums Operational Guideline document should be reviewed to ensure that it is appropriate, comprehensive and incorporates references to the supplementary flow charts and guidance notes in existence. It should be ensured that all documents align with one another and that the users are able to understand the process from the information documented. 2. Following a review of the guidelines, management need to ensure that staff are reminded of the guidelines so that they are aware of the process that needs to be followed.	High	The current guidelines will be reviewed and updated in line with the newly developed financial control procedure (FCP). All flow charts and process maps will be cross referenced throughout the document. All ILGs and rota co-ordinators will be contacted with the revised guidance including a link to share point for all documents.	Medical Director	Assistant Director of Workforce Productivity & Efficiency	Dec-20				Completed	November 2020 Update - The Medical Agency Standard Operating Procedure (SOP) has been updated to ensure all guidelines replicate the processes outlined within the Financial Control Procedure (FCP). All process maps have been updated in line with any changes. The updated Medical Agency SOP will be re-issued to all staff alongside the FCP following Management Board sign-off on 3rd December. In addition, the updated SOP, FCP and process maps will be uploaded 3rd December, onto the Medical Agency SharePoint page and medical staff will be signposted to these documents.		
MAU 02	Oct-20	Reasonable	Whilst the principle of using Whatsapp to approve rates above the pay cap to allow for speedy decisions is understood, such decisions should be supported by appropriate documentation. This will allow a comprehensive audit trail back to the individual who have been paid higher rates and ensure information is available should the messages or the Whatsapp group itself be deleted. Furthermore, the Whatsapp route should only been followed where there is an urgent need for a decision, as opposed to bookings being made weeks in advance. Following the Health Board's ongoing review of the pay cap approvals process, which involves ILG Directors, the process documents and guidelines should be updated to reflect these changes.	High	As stated above due to the newly developed FCP the rate approval is now part of this document. All agency rates up to 25% will be authorised by the Integrated Locality Director and any rate over 25% of the cap rate will require authorisation from the Medical Director. The WhatsApp group will still be used in order to expedite the decision making process. In order to allow an audit trail, each week an excel spreadsheet of all authorisations will be downloaded from the Retinue Bridge system. This will then be sent to the relevant 'authoriser' and saved within the Workforce drive to act as a record of all authorised shifts for each locality. The operational guidelines will be updated and a process map developed.	Medical Director	Assistant Director of Workforce Productivity & Efficiency	Dec-20				Completed	November 2020 Update - A WhatsApp group is administered by workforce for initial authorisation of any 'urgent bookings' where there are breaches. This will be fully documented by workforce as evidence of any decision making. A summary via an excel spreadsheet of all authorised breaches will be sent to each ILGD on a weekly basis. The spreadsheet will provide a breakdown of the hourly rate, the name of the doctor, length of placement and the reason why the doctor has been engaged. These will be recorded centrally within Workforce in addition to sharing with the ILG's. The first rate breach reports will be issued in January 2021. Each ILGD will be responsible for authorising any escalated Bank/Agency rates up to 25% above the standard rate, any rates above 25% will require authorisation from the MD/DCSO. Rate authorisation process maps have been developed and are part of the FCP. The Medical Agency SOP has also been updated to reflect this process change. The launch date of the Medical Bank has been delayed until 07.12.20 due to the challenge of communicating the roll out remotely. In addition the FCP won't be signed off at Management Board until 3rd December. The updated Medical Agency SOP will be re-issued to all staff alongside the FCP (once approved). In addition the updated SOP, FCP and process maps will be uploaded onto the Medical Agency SharePoint page and staff will be signposted to it. This will be completed on 3rd December.		
MAU 03	Oct-20	Reasonable	The departments need to work with Retinue to ensure that they are not being provided with medical agency staff to work back to back shifts. Consideration should be given to appropriate gaps in working patterns so that agency medics do not work excessive hours in short periods of time which could be a risk to the safety of patients.	High	While unsafe working hours need to be monitored by the directorates, the flexibility required by the ILGs requires our booking system to be agile without the need to reset each EWTD breach. The Workforce Team will speak with each ILG to consider the appropriateness of switching the system on through Health Roster for long term bookings.	Medical Director	Assistant Director of Workforce Productivity & Efficiency	Dec-20				Completed	November 2020 Update - Following consultation with ILG Directors, it was determined that a flat should be set at 72 hours, for the maximum number of hours to be worked, including resident on-call. Any time-sheets over 72 hours will require escalation to the Clinical Service Group Manager, prior to authorisation of the time-sheet. The Standard Operating procedures will be updated to include this requirement.		

CTM Internal [date]

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MAU 04	Oct-20	Reasonable	Now that there is less reliance on agency staff at RGH A&E, management should consider if the process of not having a second (budget holder) approver remains appropriate. The operating guidelines should provide greater clarity on the first and second approver process including who should be undertaking these approvals and the reasons for them. If it is deemed in certain areas that these controls are not required, the guidelines should make this clear.	Medium	The newly developed FCP states that all rota gaps must be identified using the Health Roster system and shifts to be filled via ADHs or agency locums must be approved by the Clinical Service Group Manager (CSGM). This approval also confirms the gaps are for posts that are within the agreed funded establishment. Therefore the Clinical Service Group Manager (CSGM) will act as the second approver and the rota co-ordinator will remain as the first approver. This is a requirement throughout each locality across all specialities. The operational guidance will be updated to reflect this change.	Medical Director	Assistant Director of Workforce Productivity & Efficiency	Dec-20				Completed	November 2020 Update - The FCP states that all rota gaps must be identified using the Health Roster system and shifts to be filled via ADHs or agency locums must be approved by the Clinical Service Group Manager (CSGM). This approval also confirms the gaps are for posts that are within the agreed funded establishment. The CSGM is to have sight of all of the gaps within the roster. By authorising the roster they are essentially authorising that the service groups can go out to bank and agency to fill the vacancies. This is referred to as the 2nd approver within the guidance. The FCP will be issued CTM wide in early December, falling in line with the Medical Bank launch in Bridgend on 7th December. Therefore, all Clinical Service Groups across the UHB will be required to adhere to the new processes, this includes A&E RGH. The updated Medical Agency SOP will be re-issued to all staff alongside the FCP (once approved). In addition the updated SOP, FCP and process maps will be uploaded onto the Medical Agency SharePoint page and staff will be signposted to it. This will be completed on 3rd December.		
MAU 05	Oct-20	Reasonable	In line with the guidelines, staff should be reminded that waivers should only be granted in certain circumstances. If it is felt appropriate that waivers could be granted for additional aspects of the pre-employment process, then the guidelines should be updated appropriately.	Medium	The guidance will be updated to make it clear regarding authorisation for the sign off of a waiver and ensuring it is clear which documents can be waived. Regarding the DBS certificates outstanding for the two individuals noted above, one has now been sent to the auditors. The other doctor has been unable to find their original DBS certificate and therefore Retinue have provided the DBS letter which was provided by the agency. The DBS letter states that there are no convictions recorded. As per the framework standards Retinue would only request a copy of the full certificate if any convictions had been noted.	Medical Director	Assistant Director of Workforce Productivity & Efficiency	Dec-20				Completed	November 2020 Update - The compliance process within the Medical Agency Standard Operating Procedure (SOP) has been updated. The SOP states that waivers can only be issued for a CV gap, references and mandatory training. If there are any requests for waivers for any other documents then approval will be required from the Locality Director. The updated Medical Agency SOP will be re-issued to all staff alongside the FCP (once approved). In addition the updated SOP, FCP and process maps will be uploaded onto the Medical Agency SharePoint page and staff will be signposted to it. This will be completed on 3rd December.		
MAU 06	Oct-20	Reasonable	Following the review of required attendees for the Scrutiny Group, it should be ensured that the remit of the group is clear, there are regular meetings taking place and all relevant staff are in attendance.	Low	The Scrutiny group structure and cohort is currently being revised to ensure it falls in line with the new locality based structures. Representation will be sought from each ILG from a director (or nominated deputy), finance, procurement, workforce and speciality perspective. Current talks are ongoing as to whether to hold three separate meetings per locality or one CTM meeting. A new terms of reference will be developed for this meeting, it has been agreed that this will be chaired by the Medical Director or Deputy Medical Director in their absence.	Medical Director	Assistant Director of Workforce Productivity & Efficiency	Feb-21				In progress		November 2020 Update - Discussions around the structure of the Scrutiny group going forward are yet to be finalised. Revised terms of reference will be finalised in January 2021.	