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CAMHS Management Arrangements 05	Feb-21	Limited	1. We agree with the planned approach to identify CAMHS related policies in existence and to review them to ensure consistency across the localities. This work should also ensure relevance and alignment to current legislation and expected working practices. 2. Once updated, the policies should be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews.	High	CAMHS Policy Group newly established, with ToR being developed. All CAMHS policies to be identified, reviewed and standardised to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan will be devised. Policies will be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews.	Chief Operating Officer	Head of Nursing	Mar-21	01/05/2021 August 2021 Now December 2021 Now September 2022 01/12/2022 to support SharePoint development Now March 2023		In progress	February 2023 Update - each area has devised a local index list of SOPs and where required policies, and working through the drafts. Agreed approach for sign off and monitoring via revised Quality Safety and Patient Experience Meeting	March 2021 Update - Update will be available in May 2021. May 2021 Update - CAMHS Policy Group newly established, with ToR developed. All CAMHS policies to be identified, reviewed and standardised to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan will be devised. Policies will be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews. Work delayed due to key staff redeployment due to Covid & HB restructure. Confirmation on the action taken will be confirmed in August 2021. July 2021 Update. CAMHS Policy Group newly established, with ToR developed. All CAMHS policies identified, to be reviewed and standardised to new format to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan devised to ensure rolling programme. Policies will be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews. Work delayed due to key staff redeployment due to Covid & HB restructure. Confirmation on the action taken will be confirmed in August 2021. September 2021. Work on the policy reviews continues, the target date remains December 2021. November 2021 Update - nothing further this month. There has been a change in management arrangements and an update on the work that remains ongoing will be ready for the next meeting. February 2022 Update - no permanent CSG Manager in post. Update will be available for the next meeting. April 2022 – Due to changes in nursing structure and gap in CSG Manager the progress on this action has been delayed. Head of Nursing and CSG Manager will meet in April 2022 to review actions outstanding and make a plan to address the review and publication of policies. June 2022 Update - CSG and Head of Nursing have met and discussed approach. Each LMT has been requested to update current policies and database established. Progress has been made with documents drafted. This will be discussed at Senior Nurse meeting on 14th June with an outline of timescales. August 2022 - This was discussed in the QPSE meeting with the senior nursing team and a number of policies and SOP were brought for review and sign off. Agreement to review which are relevant to go through the HB policy group. October 2022 Update - Local SOPs have been reviewed, one around the use of the age appropriate bed in CTM is being developed with Adult Mental Health and will go through the appropriate HB forums for policy sign off. Plans are being developed HB wide and via the Mental Health care group to develop a SharePoint to hold local SOP and policies. December 2022 Update - CAMHS policy page has been added to the CTM UHB SharePoint page to hold relevant specific CAMHS policies for all staff to access and enables a system for review when required. In addition to the age appropriate bed policy highlighted last month a transition policy has been developed and will be signed off by the MH Care Group. Local management teams are currently pulling together the list of other local standard operating policies and ensuring there is central index for staff to access and system for review.
Concerns 1.2	Feb-22	Limited	A comprehensive set of Standard Operating Procedures should be developed setting out the process to follow from the point a concern or complaint is received though to the provision of a response. The SOP should include concerns from all sources such as those received via the dedicated email accounts, those made in person or issues raised via local MPs or MSs. The responsibilities of the Corporate Concerns Team and the ILGs should be clearly set out.	High	Review the PTR Guidance alongside the CTM structures to identify what Standard Operating Procedures are required and develop and implement to support the new process.	Director of Nursing	Interim Head of Concerns, Redress & Legal	Jun-22	Now September 2022 Now January 2023 Now February 2023		In progress	February 2023 update - Reviews are well in hand, some changes to the proposed operating model will have an effect on some of the SOPs, however these can be changed and ready in line with implementation of the new quality governance structure.	April 2022 Update - On hold until changes to the operating model. June 2022 - Central triage complaints resource identified as part of operating model changes. Once new model is in place. Policies and SOPs will be reviewed and amended in line with the new model. August 2022 Update Work continues on the new Operational model, this incorporates 2 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, with current capacity constraints will be addressed following the implementation of the new operating model. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented. October 2022 update - Complaints Manager and Head of Concerns & Business Intelligence now in post, reviews have now started, however, changes to the operating model will need to be finalised before any changes are made. These should be updated and in place in line with the operating model in January 2023. December 2022 update - Complaints Manager and Head of Concerns & Business Intelligence now in post, reviews have now started, however, changes to the operating model will need to be finalised before any changes are made. These should be updated and in place in line with the operating model in January 2023.
Concerns 3.1	Feb-22	Limited	3.1a A training programme should be developed and rolled out across the Health Board to ensure that staff are suitably trained for the roles they are performing in relation to the Concerns process. 3.1b A training needs analysis should be undertaken in each ILG and for corporate teams to identify the staff that fall into the three levels of training outlined in the Concerns Training Plan. The PADR process could be used in the future to help identify training needs.	High	3.1a CTM Concerns Management training programme to be developed encompassing Putting Things Right, the Once for Wales Concerns Management System and Welsh Risk Pool procedures, more specifically Learning from Events Reports. 3.1b Training Needs Analysis Template to be developed following development of Concerns Management training programme. To be shared with the ILGs for completion and identification of all staff who should receive the training.	Director of Nursing	3.1a Interim Head of Concerns, Redress & Legal 3.1b Interim Head of Concerns, Redress & Legal/ILG Heads of Quality & Safety	3.1a April 2022 3.1b June 2022	Now January 2023 Now February 2023		In progress	February 2023 Update 3.1a - The launch of the new Incident Management Framework and the training which is in place to support this covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. Complaints policies/procedures will be updated in due course in line with the new operating model and changes to PTR following implementation of Duty of Candour. CTM attends the All Wales Duty of Candour Education and Training network. A raft of education and training materials are being developed at an All Wales level. These will be rolled out alongside a complaints training programme. 3.1b - Training Needs analysis will be undertaken on completion of prospectus with the newly formed care groups.	3.1a April 2022 Update - Partially completed in respect of LFERs and Once for Wales CMS. PTR to be completed. 3.1b April 2022 Update - To be developed once training package has been completed. June 2022 3.1a New PTR Training package in process of being developed, in conjunction with the new Incident framework. Elements of training have already been undertaken in respect of LFERs and Once for Wales CMS. Weekly LFER drop in training sessions have been underway for the past 6 weeks, which will assist staff with completion of LFERs. 3.1b Training Needs analysis will be undertaken on completion of prospectus with the newly formed care groups. August 2022 Update 3.1a - The launch of the new Incident Management Framework and the training which is in place to support this covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. 3.1b - Training Needs analysis will be undertaken on completion of prospectus with the newly formed care groups. October 2022 3.1a - The launch of the new Incident Management Framework and the training which is in place to support this covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. Complaints policies/procedures will be updated in due course in line with the new operating model and changes to PTR following implementation of Duty of Candour.
Concerns 6.1	Feb-22	Limited	6.1a A SOP should be developed that documents the quality assurance processes underpinning the end stages of the investigation that lead to the issue of the PTR Concerns Response Letters. The SOP should include who is responsible for quality checking and how quality checks should be documented, including, if deemed necessary, the use of the checklist contained in the policy. Training on the required quality assurance process documented in the SOP should be carried out with relevant staff. 6.1b The Quality Assurance Checklist contained in Appendix 4 of the Concerns Policy should be reviewed and a decision made regarding the expectation for it to be used.	High	6.1a Standard Operating procedure to be developed as part of a suite of SOPs outlined in 1.2 above 6.1b QA checklist to be reviewed at the same time as the SOP is develop	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now September 2022 Now January 2023 Now February 2023		In progress	February 2023 Update 6.1a - A new quality assurance SOP has been developed, an audit programme will commence in February 2023. 6.1b - The QA document contained within Appendix 4, is being revised in line with the new organisational Concerns Policy.	6.1a April 2022 Update - On hold until changes to the operating model. 6.1b April 2022 Update - On hold until changes to the operating model. June 2022 6.1a - A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. 6.1b - will be reviewed in conjunction with Governance teams within the new operating model. August 2022 Update 6.1a - Work continues on the new Operational model, this incorporates 2 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, with current capacity constraints will be addressed following the implementation of the new operating model. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented. 6.1b - QA document will be reviewed in conjunction with Care Group Governance teams within the new operating model. October 2022 6.1a - Work continues on the new Operational model, this incorporates a new Early Resolution team, which includes complaints triage. This should assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints
Concerns 9.1	Feb-22	Limited	9.1a A formalised process should be put in place to ensure there is shared learning from the outcome of concerns, complaints and incidents and also the processes followed when dealing with concerns and complaints. This should include how data will be collected and analysed in or to identify trends and patterns for example across CSGs, ILGs, specialities or by type of concern. Lessons learnt information should then be shared in a consistent way across the Health Board. 9.1b Subsequently, ILGs should ensure they have suitable processes and methods in place for the dissemination of lessons learnt across all of their CSGs.	High	9.1a Regular reports are provided from Datix and monitored via various groups and committees. The quality of information provided will be strengthened with engagement with the RL Datix team. Development of a Learning Framework underway to ensure learning is captured from various avenues and shared across the organisation. 9.1b This will form part of the Learning Framework as per 9.1a and included in the SOPs as per 1.2.	Director of Nursing	9.1a Datix Manager 9.1b AD Nursing & Patient Safety and Interim Head of Concerns, Redress & Legal AD Nursing & Patient Safety and Interim Head of Concerns, Redress & Legal	Jan-22	Now September 2022 Now January 2023		Completed	February 2023 Update 9.1a Various reports are already available and presented at various committees. The Datix team are now producing reports in the new Care Group model whilst maintaining ILG reporting for historic areas. Dashboards are being developed for Care Groups, and training is being rolled out to support key users to be able to run reports and access data "live". The Head of Concerns & Business Intelligence for CTM is co-chair of the All Wales work stream on Data, Business Intelligence and Dashboards. CTM have volunteered to be a pilot site for the Business Intelligence tool within Datix Cymru as part of the Phase 2 roll out. 9.1b The Listening and Learning Framework was launched at a Listening and Learning event in September. As part of this a learning repository is being developed to capture and share learning across the organisation. Learning newsletters are shared across the organisation	9.1a April 2022 Update - Learning Framework has been developed and is in DRAFT form at present. This may need to be revisited following changes to the Operating model. 9.1b April 2022 Update - Learning Framework has been developed and is in DRAFT form at present. This may need to be revisited following changes to the Operating model. June 2022 9.1a - Reports are provided on themes and trends following incidents/complaints and claims. These are presented at various committees. A review of these will be undertaken to ensure that they are fit for purpose and are used to drive improvements The Listening and Learning Framework remains in DRAFT form. A Learning from Events day is planned for July 2022, whereby top themes will be discussed with shared learning from past incidents/complaints. A newsletter is in the process of being devised. 9.1b - this will be reviewed and strengthened and will incorporate the new operating model changes. August 2022 Update 9.1a Various reports are already available and presented at various committees. The Datix team and OfWCMS team will move into the portfolio of the Director of Corporate Governance from 1st August 2022 A review of reports provided by the team will be undertaken in line with the changes to the operating model. Dashboards will be developed where possible to avoid the need to run reports, enabling service areas to view data "live". Engagement with the OfW National Team in respect of the Business Intelligence tool which is due to be rolled out as part of Phase 2 of the OfWCMS (Datix Cymru), will continue to ensure that CTM

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Fire Safety Management 5.1	Feb-22	Limited	Appropriate systems should be developed to allow the production of basic management information in relation to risk assessments.	High	The Health Board will explore the use of the Risk Module in Datix to support the recording and escalation of risks following a Fire Risk Assessment. A Strategic Leadership Group paper will be produced to provide an options appraisal as to how fire risk assessments can be better captured and monitored.	Director for People	Head of Health, Safety and Fire	31/03/2022 30/04/2022	Now November 2022 Now December 2022 Now February 2023		In progress	February 2023 Update: In the interim and whilst waiting for NWSSP Facilities and Estates Services to address the All Wales Fire System, summary data is now available and will be presented to the forthcoming February 2023 Health Safety & Fire sub-committee.	April 2022 Update - NHS Wales Shared Services Partnership: Facilities and Estates are currently reviewing the All Wales software package following concerns raised by all Health Boards and Trusts in Wales. August 2022 Update - whilst work continues within NHS Wales Shared Services Partnership: Facilities and Estates, there are no definitive dates when this work will be completed. CTM is fully involved in this work to help support an all Wales solution to this. Update October 2022 - No further progress with this from colleagues in Shared Services. December 2022 Update - Despite chasing them, no further progress with this from colleagues in Shared Services.
Fire Safety Management 9.1	Feb-22	Limited	ILG reporting could be improved by the inclusion of the issues raised at the observation.	High	ILGs will review their Health, Safety and Fire Group Agendas to ensure this recommendation is addressed. The listed fire information will be required from each Clinical Service Group and provided through their regular reports to the Health, Safety and Fire Group.	Director for People	ILG Director of Operations	May-22	Now January 2023		Completed	February 2023 Update - While the ILG structure is to be disbanded, required elements of reporting were individually evidenced by enhanced reporting addressing other recommendations.	April 2022 Update - Ongoing. August 2022 Update - This recommendation will have to be reviewed further as a result of changes to the Health Board's Operating Model. October 2022 Update - no further update provided against this recommendation. December 2022 Update - no further update provided against this recommendation as new Care Group Operating model is still not available.
Patient Pathway Appointment Management Process Follow Up 1.1	Jun-22	Limited	Management should ensure that the correct data detailed within the outcome reports is produced for each of the Clinical Service Groups, especially where services and therefore data was previously the responsibility of a different ILG.	High	Discussion will be held with colleagues in Performance to ensure that this data is correct for each Service Group and fits in with the new operating model.	Chief Operating Officer	ILG Directors of Operations / Head of Information	Aug-22	Now December 2022 Now January 2023 Now April 2023		In progress	February 2023 Update - a list of the officers on the circulation list has been produced and will be circulated to Service Group Managers in the next month to ensure that the right names are included. This will then be sent back to Performance colleagues.	August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. October 2022 Update - Colleagues within the Information Department have commenced work to transition reports to a site based reporting model (away from ILGs) and will be seeking advice on the Service Grouping that the Organisation required to place over Specialty codes. The change in operating model will slow this process - hence the date has changed to January 2023. December 2022 Update - date for completion remains January 2023.
Patient Pathway Appointment Management Process Follow Up 1.3	Jun-22	Limited	On receipt of the outcome reports, management within the CSGs should ensure that they analyse the data to identify trends such as those staff or departments that are continually failing to input outcome data or making the errors. Appropriate action should be taken including the provision of additional training on the WPAS.	High	ILGs will ensure that they undertake this action.	Chief Operating Officer	ILG Acute Services General Managers	Aug-22	Now December 2022 Now February 2023		In progress	February 2023 Update - a list of the areas where data is not being updated has been produced and some initial conclusions drawn. Once sense checked with colleagues in Performance, this will be reported to Service Groups for training needs to be established and resolved.	August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. October 2022 Update - Report generated regularly for former ILG structure. Steps will be taken to ensure that the recommendation of additional action is taken. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.
Patient Pathway Appointment Management Process Follow Up 1.5	Jun-22	Limited	Given the ongoing problem of outcomes not recorded, management should look to build on the roll out of electronic outcome forms.	High	Consideration will be given by ILGs to roll out electronic outcome forms by September 2022	Chief Operating Officer	ILG Directors of Operations / Head of Information	Sep-22	Now February 2023		In progress	February 2023 Update - no further action to report here. This will be the next area of consideration when the circulation and training is addressed as above.	August 2022 Update - Date remains September 2022. October 2022 Update - no further comment, will be picked up as part of re-focus on this audit. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.

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Patient Pathway Appointment Management Process Follow Up 2.1	Jun-22	Limited	Management should ensure that the correct data detailed within the closed pathway reports is produced for each of the Clinical Service Groups, especially where services and therefore data was previously the responsibility of a different ILG.	High	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	Aug-22	Now December 2022 Now February 2023		In progress	February 2023 Update - as with 1.1 above, a list of the officers on the circulation list will be produced and will be circulated to Service Group Managers in the next month to ensure that the right names are included. This will then be sent back to Performance colleagues when agreed.	August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. October 2022 Update - These reports have been reinstituted as a submission to DHCW and can be made available. Once recipients have been confirmed, the Information Department can discuss method and provide the report regularly to the required audience. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.
Patient Pathway Appointment Management Process Follow Up 2.2	Jun-22	Limited	Management should ensure that closed pathway reports are being sent to the correct staff within each of the Clinical Service Groups to ensure that the patients are put onto an open pathway. In addition, closed pathways reports should be sent on a regular basis to staff within Bridgend ILG, or checks should be made to ensure managers are accessing this data for themselves.	High	ILGs will work with colleagues in Performance to ensure that the appropriate staff are identified.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	Aug-22	Now December 2022 Now February 2023		In progress	February 2023 Update - this will be undertaken in line with the actions planned above.	August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. October 2022 Update - no further comment, will be picked up as part of re-focus on this audit. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.
Patient Pathway Appointment Management Process Follow Up 2.3	Jun-22	Limited	On receipt of the reports, management within the CSGs should ensure that they analyse the data to identify any trends such as those staff or departments that are continually making the errors and closing pathways incorrectly. Appropriate action should be taken including the provision of additional training on the WPAS.	High	ILGs will ensure that they undertake this action	Chief Operating Officer	ILG Acute Services General Managers	Aug-22	Now December 2022 Now February 2023		In progress	February 2023 Update - this will be undertaken in line with the actions planned under 1.3 above.	August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. October 2022 Update - limited action undertaken in this area. There have been conversations on ADT / Outcomes / FUNB transactions timeliness and correctness in recent weeks that are yielding improvement. Further details will be available at the next meeting. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.
Patient Pathway Appointment Management Process Follow Up 2.4	Jun-22	Limited	The Acute Services Manager in each ILG should be provided with the reports for their area to enable them to monitor and have oversight of the errors being made.	High	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	Sep-22	Now February 2023		In progress	February 2023 Update - initial conversations being undertaken as part of this work - some of which is outlined above - indicate that this is happening but a more formal response will be sourced in the next month.	August 2022 Update - Date remains September 2022. October 2022 Update - Report generated regularly for former ILG structure. Steps will be taken to ensure that the recommendation of additional action is taken. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.
POW Theatres Fire Safety Works 1.1	Aug-22	Limited	Management should formulate a Project Board immediately, with appropriate terms of reference and attendance as the accountable body for project delivery (as part of defined project governance).	High	Agreed - This will be put in place to consider the options appraisal. The executive structure and personnel changed across this time. The project involves Health & Safety, Capital, and Strategy & Planning. The role of Senior Responsible Officer was therefore re-allocated. The project is currently being re-appraised. Subsequent to this, and pending the options appraisal to Welsh Government, governance will be further addressed as appropriate for the approved scheme. The CEO has also been in receipt of regular informal briefings from the Project Director.	Director of Strategy & Transformation	Project Director	Immediate	Now November 2022 Now January 2023 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This has been delayed whilst resolving the WG questions over the options appraisal to determine the best way to deliver the works. It is expected that a Project Board will be fully implemented by November. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.

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Digital Operating Model 1.1	Nov-22	Limited	An appropriate steering and ownership governance tier should be established that enables stakeholders to own, steer and oversee the delivery of digital objectives.	High	Accept A new governance and ownership arrangement will be created to align to the Health Board Transformation Change Programme and delivery board created as part of the Care Group Model Implementation.	Director of Digital	Director of Digital	Qtr 3 2022/2023	Propose Qtr 2 2023/2024		In progress	February 2023 Update - Work ongoing re: operational management of digital & data services in alignment with the Care Group model	December 2022 Update - Executive Leadership Group currently utilised for Digital & Data Prioritisation and Approval. Patient Centre Contact Programme created under the Unified Change Board. Extensive engagement has taken place between the Digital & Data team and the Care Groups during the period. Final Digital & Data Governance Group to be confirmed.
Digital Operating Model 2.1	Nov-22	Limited	The Digital Clinical leadership structure should be revised and improved. • The CNIO role should be formalised; and • a network of digital clinical leaders should be established that mirrors the Health Board structure to ensure that each area as a defined leader who can act as a conduit and help embed digital.	High	Accept Digital Clinical Leadership will be developed and formally recognised as part of the Strategic Leadership Group within the Digital & Data Directorate. A new set of roles & capabilities will be identified as part of the new Digital & Data Governance arrangements.	Director of Digital	Director of Digital	Qtr 3 2022/2023	Propose Qtr 2 2023/2024		In progress	February 2023 Update - Work ongoing - new Digital & Data Structure is being finalised	December 2022 Update - As part of the IMTP process, formalisation of a digital clinical group is required. Existing Digital Clinical Leaders are undertaken a benchmarking exercise.
Digital Operating Model 3.1	Nov-22	Limited	As part of the review of the directorate structure, consideration should be given to ensuring that the structure and resources includes: • appropriate digital leadership within the structure; • ongoing change management support; • digital transformation and project resource; and • Office 365 team and support.	High	Accept A Digital Leadership Change Process will be initiated in the Autumn of 2022. A subsequent review of senior management support and related resources will commence in the first half of 2023.	Director of Digital	Director of Digital	Qtr 3 2022/2023 Qtr 4 2022/2023	Now 31 December 2022		In progress	February 2023 Update - Strategic Leadership structure will be finalised in this Qtr as proposed	December 2022 Update - Digital Strategic Leadership consultation period has ended. Work ongoing on finalising the draft Job Descriptions - plan to complete in December 2022
Digital Operating Model 6.1	Nov-22	Limited	The Health Board should ensure that appropriate funding is provided to enable equipment to be kept up to date.	High	Accept Appropriate funding will be identified as part of the IMTP process for a 2023 submission.	Director of Digital	Director of Digital	Qtr 4 2022/2023			In progress	February 2023 Update - Costs for various schemes have now been identified. Prioritisation of programmes of work to be undertaken during February 2023	December 2022 Update - IMTP development will propose required capital and revenue funding to support digital requirements
Radiology Service Review 6.1	Dec-22	Limited	In order for absence to be properly managed and pay not to be affected, comprehensive and accurate documentation in relation to each episode of sickness should be maintained. Management should ensure that self-certification and return to work forms are fully completed in a timely manner following the employee's return. All information contained on self-certification forms, RTW forms and ESR should correspond, and the period of absence should be fully covered by self-certification forms or medical certificates.	High	All superintendents will be advised of the need to maintain comprehensive and accurate documentation in relation to each episode of sickness absence and ensuring that all documentation is completed in a timely manner in line with the Managing Attendance Policy. A request will be made to workforce for Sickness/Absence Management Training.	Chief Operating Officer	Site Superintendent Radiographers	31st December 2022	Now February 2023		In progress	February 2023 Update - Sickness Training Updates are currently being arranged with People's Services for staff on all 3 DGH sites.	

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Radiology Service Review 9.1	Dec-22	Limited	In line with Welsh Government and Health Board targets, all staff should participate in a PDR on an annual basis. We acknowledge that the service will always need to prioritise clinical activity, but in order to achieve set targets, the service should develop an action plan outlining a realistic approach to tackle the backlog, prioritising those with future increment dates. Consideration must also be given to developing a sustainable way of maintaining PDR compliance rates once the backlog has been cleared. As part of addressing the backlog, staff should be reminded that it is their PDR and therefore they need to engage in the process and complete any relevant paperwork ahead of the meeting, allowing the actual meeting to be more meaningful and efficient.	High	An action plan will be developed to address the backlog of PDRs and establishing a sustainable system of maintaining PDR compliance in line the with WG and Health Board targets. Robust monitoring arrangements at corporate and at Care Group level will need to be implemented. All staff will be reminded of the importance of having a PDR, including the need for pay progressing, and the need to engage meaningfully in the process.	Chief Operating Officer	Clinical Service Manager Super intendent Radiographer	Jan-23	Now March 2023		In progress	February 2023 Update - The site leads have developed a programme to undertake PDRs. POW are 100% compliant. RGH/PCH staff are working to pay progression dates. The new admin manager is currently undertaking a programme of PDRs. Ongoing due to clinical commitments.	
Radiology Service Review 10.1	Dec-22	Limited	Work should be undertaken to ensure the training requirements and achievements captured in ESR are accurate: • Management should identify if there are staff that have completed higher levels of training yet are not showing as compliant at the lower levels and inform the Learning & Development team, as that may indicate an issue with the set up in ESR that will need resolving. • Management should identify staff that they believe do not need to undertake training at the higher levels identified (or any additional modules). They should follow the appeals process and work with the subject matter leads to determine what is the right level for that role, so that ESR can be amended for the individual and where necessary the wider staffing group. • If management feel staff are professionally	High	The Service will undertake a review of the training requirement and achievements captured in ESR to: • Identify if there are staff that have completed higher levels of training yet are not showing as compliant at the lower levels and inform the Learning & Development team, as that may indicate an issue with the set up in ESR that will need resolving. • Identify staff that they believe do not need to undertake training at the higher levels identified (or any additional modules). They should follow the appeals process and work with the subject matter leads to determine what is the right level for that role, so that ESR can be amended for the individual and where necessary the wider staffing group. • Identify staff are who are professionally qualified above the requirements of any of the ESR modules and liaise with L&D to have this information captured on the ESR records, so that non-completion of the ESR modules does not impact compliance rates.	Chief Operating Officer	Clinical Service Manager Super intendent Radiographers	Mar-23			In progress	February 2023 Update - The Learning & Development Team have been contacted around core competencies. The matter is ongoing with corporate team.	
Radiology Service Review 10.2	Dec-22	Limited	The Clinical Service Group 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 training at higher levels is a Health Board expectation for that role. It should be ensured that all staff are provided with the opportunity to undertake their mandatory training.	High	The Service will remind staff that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role and that staff are provided with the opportunity to undertake their mandatory training. Ongoing support at Executive Level will be required to address role requirements.	Chief Operating Officer	Clinical Service Manager Super intendent Radiographers	Mar-23			In progress	February 2023 Update - Ongoing work is underway to drive core compliance. Unfortunately there are some classroom based courses which are unavailable. Time is being allotted to staff balancing clinical commitments. A Module of the Month is sent to encourage staff to complete training. Ongoing	
Radiology Service Review 11.1	Dec-22	Limited	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.	High	A programme of reviewing consultant job plans has commenced with a target date of completing these by January 2023 and a system is established to ensure that these are reviewed on annual basis	Chief Operating Officer	Clinical Director Clinical Service Manager	Jan-23	Now March 2023		In progress	February 2023 Update - A programme of Job Planning is nearing completion with only 2 outstanding Consultant Job Plans.	
Concerns 1.1	Feb-22	Limited	The concerns policy should be reviewed and updated to accurately reflect the structure, roles, responsibilities and active involvement of the corporate function and the ILGs in respect of the management, investigation and reporting arrangements relating to concerns and complaints.	Medium	Changes will be made to the Concerns Policy and management process in line with the Concerns Improvement project. This will be undertaken via a collaborative process between Corporate and the ILGs and in light of any changes to the Operating Model following the current review.	Director of Nursing	Interim Head of Concerns, Redress & Legal	Jun-22	Now September 2022 Now January 2023 Now February 2023		In progress	February 2023 update - Policy has been reviewed and amended however, some minor changes to the operating model will need to be finalised before any changes are made, along with consideration of Duty of Candour and the changes to PTR. These should be updated and in place in line with the operating model in January 2023.	April 2022 Update - On hold until changes to the operating model. June 2022 - A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. August 2022 Update Work continues on the new Operational model, this incorporates 3 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, with current capacity constraints will be addressed following the implementation of the new operating model. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented. October 2022 update Complaints Manager and Head of Concerns & Business Intelligence now in post, reviews have now started, however, changes to the operating model will need to be finalised before any changes are made. These should be updated and in place in line with the operating model in January 2023. December 2022 update - Complaints Manager and Head of Concerns & Business Intelligence now in post, reviews have now started, however, changes to the operating model will need to be finalised before any changes are made, along with consideration of Duty of Candour and the changes to PTR. These should be updated and in place in line with the operating model in January 2023.
Concerns 3.3	Feb-22	Limited	Records of all training attended in relation to both PTR/Concerns training and Datix Once for Wales Training should be retained.	Medium	Undertake scope on training record management and how this is captured within CTM if it is not retained within ESR Discussion with ESR team to ascertain whether training records can be included on ESR for Concerns Management training. Discussion with Organisational Development regarding retention of training records and how this links to PADRs.	Director of Nursing	Interim Head of Concerns, Redress & Legal	Feb-22	Now December 2022 Now February 2023		Part Completed	February 2023 Update - ESR have confirmed training can be captured on ESR, however resource to update ESR would have to be considered. In the interim period the Central complaints team will be retaining training records.	3.3a April 2022 Update - Discussions ongoing. 3.3b April 2022 Update - Email to ESR team to query whether PTR and further concerns management training records can be stored on ESR. 3.3c April 2022 Update - Email to correspondence in respect of PADRs and training. June 2022 There is no unified way of recording training if it isn't on ESR. Various different methods in place. Consideration for inclusion in PTR training as part of induction. August 2022 Update Engagement with ESR team to ascertain whether training can be captured within ESR. Following the centralisation of quality and safety, a review of training which is not captured on ESR will be undertaken and a consistent method implemented. October 2022 Update ESR have confirmed training can be captured on ESR, however resource to update ESR would have to be considered. Following the centralisation of quality and safety, a review of training which is not captured on ESR will be undertaken and a consistent method implemented. December 2022 Update - ESR have confirmed training can be captured on ESR, however resource to update ESR would have to be considered. Following the centralisation of quality and safety, a review of training which is not captured on ESR will be undertaken and a consistent method implemented.

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Concerns 4.2	Feb-22	Limited	4.2a Management should understand why RTE has not been re-categorising early resolution concerns that were not resolved in the timeframe and take appropriate action to resolve and accurately record in Datix. 4.2b To ensure consistency, a Standard Operating Procedure (SOP) should be in place outlining the process for re-categorising concerns, including who is responsible for performing this task. Training should be provided where necessary.	Medium	4.2a As 4.1 above 4.2b Standard Operating procedure to be developed as part of a suite of SOPs outlined in 1.2 above.	Director of Nursing	4.2a Complaints Manager 4.2b Interim Head of Concerns, Redress & Legal	Apr-22	Now December 2022 Now January 2023 Now February 2023		In progress	February 2023 Update - 4.1b - A review of all Policies and associated SOPs has begun and will incorporate the new operating model and any legislative changes to PTR and Duty of Candour. 4.2a - A review of RTE practice has been undertaken and changes made to ensure consistency across the Health Board, along with benchmarking with NHS Wales colleagues within the Complaints Network. With complaints moving to a centrally managed service, consistency and uniformity will be achievable. 4.2b - Work continues on the new Operational model, this incorporates complaints triage and more support for PALS, which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, current capacity constraints will be addressed following the implementation of the new operating model. Key posts have now been filled. Policies and procedures are in the process of being reviewed.	4.2a April 2022 Update - Complaints Manager not in post. 4.2b April 2022 Update - On hold until changes to the operating model. June 2022 4.1a - Audits will be reinstated when Complaints Manager is in post. Further review will be required once the new operating model is in place and established. 4.1b - A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. August 2022 Update 4.2a - A review of RTE practice has been undertaken and changes made to ensure consistency across the Health Board. 4.2b - Work continues on the new Operational model, this incorporates 3 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, with current capacity constraints will be addressed following the implementation of the new operating model. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented. October 2022 Update 4.1b - A review of all Policies and associated SOPs has begun and will incorporate the new operating model. 4.2a - A review of RTE practice has been undertaken and changes made to ensure consistency across the Health Board. 4.2b - Work continues on the new Operational model, this incorporates 3 complaints triage posts which will assist with managing
Concerns 5.1	Feb-22	Limited	For each concerns investigation undertaken, in the absence of desired Standing Operating Procedures, the process outlined in the Concerns Policy and Procedure documents should be followed. Comprehensive notes and evidence should be added to Datix in a timely manner to support the process followed, the investigation carried out and the lessons learnt. Where aspects of the policy are not being undertaken at all, it should be established if this is due to staff not being aware of this aspect of the process or if the policy is in fact out of date and in relation to current practices.	Medium	To be included in training programme as per 3.1a and 3.1b above	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now December 2022 Now February 2023		Part Completed	February 2023 Update - The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. Training is already taking place since the launch of the new Incident Management Framework. The supporting training covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. Training continues with the implementation of the new Datix Incident reporting module with the importance of updating Datix reinforced.	April 2022 Update - Partially completed in respect of LFERs and Once for Wales CMS. PTR to be completed. June 2022 A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. Training on new policies and SOPs will be included in the training package outlined in 3.1 Audits will be reinstated as outlined in 4.1a when Complaints Manager is in post, this will incorporate any rationale for deviating from policies and SOPs. However, changes to the operating model and centralisation of complaints management should ensure a more unified approach across the organisation. August 2022 Update - The review of Policies and Procedures is due to take place in August and September, taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. However, training is already taking place since the launch of the new Incident Management Framework. The supporting training covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. Training continues with the implementation of the new Datix Incident reporting module with the importance of updating Datix reinforced. October 2022 Update The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a
Concerns 6.2	Feb-22	Limited	Evidence should be retained of CSG management's contribution to the quality checking process of review and oversight of the investigation's outcomes and the draft PTR Concerns Response letters prior to their submission to an ILG Director for sign-off.	Medium	Standard Operating procedure to be developed as part of a suite of SOPs outlined in 1.2 above	Director of Nursing	Interim Head of Concerns, Redress & Legal	Jun-22	Now October 2022 Now December 2022 Now February 2023		In progress	February 2023 Update - The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. Quality assurance and audit programme has been developed and will commence in February 2023, after quality governance model is implemented.	April 2022 Update - On hold until changes to the operating model. June 2022 A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. August 2022 Update This will be completed by the Complaints Manager, supported by the Senior BI and Complaints Manager during the period of August and September, taking into account changes to the operating model. October 2022 Update The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. Quality assurance and audit programme is in the process of being developed. December 2022 Update - The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. Quality assurance and audit programme is in the process of being developed
Concerns 6.3	Feb-22	Limited	A process of retrospectively reviewing the quality assurance processes applied in ILG should be introduced at a corporate level to ensure oversight, challenge and facilitate learning.	Medium	To form part of the rolling corporate concerns management audit programme	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now December 2022 Now February 2023		In progress	February 2023 Update - This has been included into the Quality Assurance and Audit Programme, which commences in February 2023.	April 2022 Update - Complaints Manager not in post. June 2022 Audits will be reinstated as outlined in 4.1a when Complaints Manager is in post. Changes to the operating model and centralisation of complaints management should ensure a more unified approach across the organisation. August 2022 Update This will be included into the Quality Assurance and Audit Programme. Due to be reviewed and updated in August 2022 and rolled out in September 2022. October 2022 Update This will be included into the Quality Assurance and Audit Programme. Due to be reviewed and updated in November 2022. December 2022 Update - This will be included into the Quality Assurance and Audit Programme. There has been some slippage to progress in this area due to shortage of staff within central complaints.
Concerns 6.4	Feb-22	Limited	All ILGs should ensure that the content of their PTR Concerns Response Letters are empathetic, showing concern and explaining with clarity the outcomes and lessons learned arising from the reported complaint. Letters should be independently reviewed and signed by an ILG Director in a timely manner.	Medium	This recommendation should be achieved following development of SOPs, Training and the QA process.	Director of Nursing	Interim Head of Concerns, Redress & Legal	End of June 2022	Now September 2022 Now December 2022		Completed	February 2023 Update - A review of complaint response letters has been undertaken in conjunction with the Communications department and the CEO. The review has focussed on the empathy of letters whilst ensuring they are informative and cover the necessary legislative requirements. Regular QA reviews will take place as part of the audit programme. More consistent, uniform and empathetic letters will be achievable with a centrally managed service.	April 2022 Update - On hold until changes to the operating model. June 2022 Standard templates have been devised and approved in early 2021. Audits will be reinstated as outlined in 4.1a when Complaints Manager is in post, this will incorporate any rationale for deviating from standard template. However, changes to the operating model and centralisation of complaints management should ensure a more unified approach across the organisation. August 2022 Update - A review of compliant response letters has been undertaken in conjunction with the Communications department and the CEO. The review has focussed on the empathy of letters whilst ensuring they are informative and cover the necessary legislative requirements. Regular QA reviews will take place as part of the audit programme. October 2022 Update A review of complaint response letters has been undertaken in conjunction with the Communications department and the CEO. The review has focussed on the empathy of letters whilst ensuring they are informative and cover the necessary legislative requirements. Regular QA reviews will take place as part of the audit programme. December 2022 Update - A review of complaint response letters has been undertaken in conjunction with the Communications department and the CEO. The review has focussed on the empathy of letters whilst ensuring they are informative and cover the necessary legislative requirements. Regular QA reviews will take place as part of the audit programme. These have been shared with the ILG Governance teams
Concerns 7.1	Feb-22	Limited	Clarity should be sought, and information documented with a SOP as to when a case should be closed on Datix and the circumstances for when it can be re-opened. To avoid any confusion, information contained in a SOP and the Concerns Policy should align.	Medium	To be included in the development of SOPs as per 1.2 above	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now September 2022 Now January 2023 Now February 2023		In progress	February 2023 Update - This has been included in the review of Policies and Procedures. This will be incorporated into the training needs analysis and will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented.	April 2022 Update - On hold until changes to the operating model. June 2022 A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. August 2022 Update - The review of Policies and Procedures is due to take place in August and September, taking into account changes to the operating model. October 2022 Update The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. December 2022 Update - The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented.

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Concerns 7.2	Feb-22	Limited	Prior to closing concerns at early resolution stage, some form of quality assurance process should be followed that ensures all aspects of the concern raised by the complainant have been adequately addressed, thus preventing the case being potentially re-opened at a later date. This process should be documented.	Medium	To be included in the development of SOPs and training as per 1.2, 3.1a and 3.1b above	Director of Nursing	Interim Head of Concerns, Redress & Legal	Jun-22	Now September 2022 Now January 2023 Now February 2023		In progress	February 2023 Update - This has been included in the review of Policies and Procedures. This will be incorporated into the training needs analysis and will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. The new triage model will support this requirement.	April 2022 Update - On hold until changes to the operating model. June 2022 A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. Rationale for reopening of complaints is space on Datix, however, this will be regularly monitored. When the new triage process is implemented, with a view to increasing early resolutions and decreasing formal complaints, a balancing measure will be the number of early resolutions moving onto formal complaints. This will be incorporated into the rolling audit programme. August 2022 Update - The review of Policies and Procedures is due to take place in August and September, taking into account changes to the operating model. The way re-opened complaints are recorded within CTM is different and consequently skews data. Once the centralisation of the quality & safety team is implemented, the way complaints are managed will be more consistent in line with new/revised policies and procedures. October 2022 3.1a - The launch of the new Incident Management Framework and the training which is in place to support this covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. Complaints policies/procedures will be updated in due course in line with the new operating model and changes to PTR following implementation of Duty of Candour. 3.1b - Training Needs analysis will be undertaken on completion of prospectus with the newly formed care groups.
Concerns 8.1	Feb-22	Limited	In relation to aged open concerns, it should be ensured comprehensive Datix records are maintained including recording the reason / justification for why the case has remained open and that relevant management are aware of it remaining open.	Medium	Process already in place which includes dashboards, and is monitored via Patient Safety Executive Meeting. The importance of recording regular updates on Datix will be included as part of 3.1a training programme.	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now December 2022		Completed	February 2023 Update - Training is taking place in respect of Datix Cymru and the training which has supported the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any additional training in respect of the new Complaints Policies and Procedures. Training will be required for Duty of Candour implementation and Datix Cymru will be incorporated. A consistent approach to the management of historic concerns will be more achievable in a centrally managed service. Open complaints are regularly monitored via Patient Safety Executive	April 2022 Update - Partially completed in respect of LFERs and Once for Wales CMS. PTR to be completed. June 2022 Process already in place which includes dashboards, and is monitored via Patient Safety Executive Meeting. The importance of recording regular updates on Datix will be included as part of 3.1a training programme. August 2022 Update - Training is taking place in respect of Datix Cymru and the training which has support the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any addition training in respect of the new Complaints Policies and Procedures. October 2022 Update Training is taking place in respect of Datix Cymru and the training which has supported the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any additional training in respect of the new Complaints Policies and Procedures. December 2022 Update - Training is taking place in respect of Datix Cymru and the training which has supported the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any additional training in respect of the new Complaints Policies and Procedures. Training will be required for Duty of Candour implementation and Datix Cymru will be incorporated.
Concerns 8.2	Feb-22	Limited	Where cases remain open beyond 30 days, ongoing progress contact should be maintained with the complainant and evidence of this retained within Datix.	Medium	Will be addressed in the development of the SOPs as per 1.2 and included as part of the training programme as per 3.1a.	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now September 2022 Now February 2023		In progress	February 2023 Update - The revised policies and procedures captures this requirement. The quality assurance new checklist monitors this. Management of this going forward will be more achievable in a centrally managed service.	April 2022 Update - On hold until changes to the operating model. June 2022 4A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. Completion of Datix will be incorporated into the training package. August 2022 Update - Complaints opened over 30 working days are regularly monitor via the weekly data review meeting and the Executive Patient Safety meeting. Updates to patients/family's will be incorporated into the Quality Assurance and Audit Programme being developed in August. Complaints Polices and Procedures are being reviewed in August and September. The centralisation of the quality and safety function with alignment to care groups should ensure a more consistent approach. Findings of the audits will be shared and acted upon, with current capacity constraints will be addressed following the implementation of the new operating model. October 2022 Update Training is taking place in respect of Datix Cymru and the training which has supported the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any additional training in respect of the new Complaints Policies and Procedures. December 2022 Update - Training is taking place in respect of Datix Cymru and the training which has supported the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any additional training in respect of the new Complaints Policies and Procedures.
Concerns 10.1	Feb-22	Limited	CSGs and ILGs should be able to demonstrate through meeting minutes or action notes the level of scrutiny that takes place in relation to concerns data to ensure inactivity is challenged, progress is made, and management are fully sighted on the issues in their area of responsibility.	Medium	10.1a Monthly performance meetings with the ILGs and CGS to continue. 10.1b CSG scrutiny panel to continue. 10.1c Weekly assurance meetings with the CSGs to continue . 10.1d Development of a standard agenda template and standard concerns management template with KPI to ensure consistent scrutiny across all ILGs. 10.1e Director of Corporate Governance to attend ILG Performance Meetings for the purpose of seeking assurance on concerns data.	Director of Nursing	ILG Heads of Quality & Safety	Immediately	Now December 2022		Completed	February 2023 Update - 10.1/10.b/10.c - Various reports are already available and presented at various committees. The Datix team have produced reports in the Care Group format in addition to some historic reporting in the ILG format. Dashboards are being developed for Care Groups, and training is being rolled out to support key users to be able to run reports and access data "live". The Head of Concerns & Business Intelligence for CTM is co-chair of the All Wales work stream on Data, Business Intelligence and Dashboards. CTM have volunteered to be a pilot site for the Business Intelligence tool within Datix Cymru as part of the Phase 2 roll out. The centralisation of the quality and safety function should assist in moving forward in a uniform way in respect of quality and safety. 10.1d - Standardisation of Governance process and various care group specific committees/groups will be undertaken when the new operating model is implemented. 10.1e - The Director of Corporate Governance has held various ad hoc meetings with ILGs, in particular in relation to Learning from Events. The Assistant Director of Concerns & Claims attends a weekly data review meeting whereby Complaints monitoring and management is discussed along with 30 week day compliance, along with LFERs. Lessons are shared across the 3 ILGs	10.1a/10.1b/10.1c April 2022 Update - Performance meetings continue across the ILGs and CSGs. These include review of complaints management, 30 wk day compliance and learning. These may become more standardised when the operational model is reviewed and changed. 10.1d April 2022 Update - This will be developed following review of the Operating model. 10.1e April 2022 Update - The Director of Corporate Governance has held various ad hoc meetings with ILGs, in particular in relation to Learning from Events. The Assistant Director of Concerns & Claims attends a weekly meeting whereby Complaints monitoring and management is discussed along with 30 wk day compliance. Lessons are shared across the 3 ILGs. June 2022 10.1a/10.1b/10.1c - Detailed reports are provided by the Datix team and these are used to monitor performance across ILGs and CSG. Monitoring will have a more uniform approach once changes are made to the operating model. 10.1d - Standardisation of Governance process and various care group specific committees/groups will be undertaken when the new operating model is implemented. 10.1e - The Director of Corporate Governance has held various ad hoc meetings with ILGs, in particular in relation to Learning from Events. The Assistant Director of Concerns & Claims attends a weekly meeting whereby Complaints monitoring and management is discussed along with 30 wk day compliance. Lessons are shared across the 3 ILGs. August 2022 Update - 10.1/10.b/10.c - Various reports are already available and presented at various committees. The Datix team and OfWCMS team will move into the portfolio of the Director of Corporate Governance from 1st August 2022 A review of reports provided by the team will be undertaken in line with the changes to the operating model. Dashboards will be developed where possible to avoid the need to run reports, enabling service areas to view data "live". Engagement with the OfW National Team in respect of the Business Intelligence tool which is due to be rolled out as part of Phase 2 of the OfWCMS (Datix Cymru), will continue to ensure that CTM are abreast of any developments in respect of business intelligence. CTM will volunteer to be part of any pilot work in respect of the new business intelligence tool. The centralisation of the quality and safety function should assist in moving forward in a uniform way in respect of quality and safety. 10.1d - Standardisation of Governance process and various care group specific committees/groups will be undertaken when the new operating model is implemented. 10.1e - The Director of Corporate Governance has held various ad hoc meetings with ILGs, in particular in relation to Learning from Events. The Assistant Director of Concerns & Claims attends a weekly data review meeting whereby Complaints monitoring
Fire Safety Management 4.1	Feb-22	Limited	Management should develop an appropriate medium-term strategy to demonstrate co-ordination of efforts in managing the fire risk.	Medium	The Health Board will develop a medium term strategy for fire safety across its sites.	Director for People	Head of Health, Safety and Fire Head of Capital and Estates ILG Director of Operations	Mar-23			In progress	February 2023 Update - Risks are reported and profiled to Welsh Government at both the Fire Safety Risk Register, and Estates Facilities Performance and Condition report. However, this does not represent a time-phased strategy to address e.g. for expert resource to drive certain actions, or co-ordination with building works. Management comment - Agreed - however, due to limited All Wales capital finance, this has not been prioritised over the last year.	April 2022 Update - Work ongoing. August 2022 Update - no further update provided on this occasion October 2022 - No further update provided on this occasion. December 2022 Update - A new Senior Fire Officer has been appointed following the retirement of the previous post holder. The new Senior Fire Officer came in to post on the 7th November 2022 and has been requested to develop this plan over the coming 2 months.

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Fire Safety Management 11.1	Feb-22	Limited	Management should confirm an appropriate timeline to update drawings in respect of compartmentation for all sites.	Medium	Capital and Estates Governance Board will action and provide assurances to the Health, Safety and Fire Sub Committee	Director for People	Head of Capital & Estates	Jun-22	Now December 2022 Now September 2023		Completed	February 2023 Update - Management confirmed that the former CTMUHB Senior Fire Officer has been re-employed within the Estates & Capital Department to carry out a review of all Fire Orientation/Compartmentation plans across the HB and feed info into the HB CAD operator for updating if required. Timelines were confirmed as: • Work already underway at the Royal Glamorgan Hospital - to be completed by end of January 2023. • Survey work commenced in Princess of Wales Hospital (POW) in November 2022 and will be finalised in March 2023. • POW to be followed by Prince Charles Hospital which will take a further 4 months to complete. • Work to Community Hospitals to commence on completion of the District General Hospital sites, with a revised completion target date of September 2023. Management comment - This work will allow the Health Board to have centralised base line fire plans for all the District General Hospital sites that will be utilised for all Passive and Active fire information such as Dampers; cause & effect etc. as well as any other services or operational needs.	April 2022 Update - Work ongoing by the Capital and Estates Team. August 2022 Update - no further update provided on this occasion. Update October 2022 - The Estates Team have appointed a fixed term member of staff to complete this activity. Person started in September 2022 and an update will be provide at the next review to identify a compliance date. Work has started and a GAP analysis is being undertaken to identify any gaps, once the field work has been done a better understanding of timescales can be provided. December 2022 Update - The former CTMUHB Senior Fire Officer has been reemployed to carry out a review of all Fire Orientation/compartmentation plans across the HB and feed information into the HB CAD operator for updating. Royal Glamorgan Hospital will be completed by Jan 2023. Survey work commenced in Princess of Wales Hospital in November 2022 and will be finalized in March 2023 this will be followed by Prince Charles Hospital which will take a further 4 months to complete. This work will allow the HB to have centralised base line fire plans for all the DGH sites that will be utilised for all Passive and Active fire information such as Damper, cause & effect etc. as well as any other services or operational need. Work to the Community Hospitals will commence on completion of the DGH.
Fire Safety Management 12.1	Feb-22	Limited	Management should confirm a process of review of local procedures in respect of each high-risk action addressed.	Medium	Capital and Estates Governance Board will action and provide assurances to the Health, Safety and Fire Sub Committee	Director for People	Head of Capital and Estates	Jun-22	Now December 2022 Now June 2023		Completed	February 2023 Update - Amendment to procedures has been agreed by the Head of Health, Safety & Fire to ensure that high-risk issues identified at risk assessments, are addressed by local procedures.	April 2022 Update - Work ongoing by the Capital and Estates Team. Current Procedure to be reviewed and revised where necessary. August 2022 Update - no further update provided on this occasion. Update October 2022 - The Estates Team have appointed a fixed term member of staff to complete this activity. Person started in September 2022 and an update will be provide at the next review to identify a compliance date. December 2022 Update - The former CTMUHB Senior Fire Officer has been reemployed and is currently reviewing the high risks that are on the Estates risk list, this list will be updated during the next reporting period.
Patient Pathway Appointment Management Process Follow Up 3.1	Jun-22	Limited	Management should establish if staff in the Rhondda Taf Ely and Merthyr Cynon ILGs areas can be provided with the same access to watch lists within WPAS as staff in Bridgend ILG, allowing all staff to be able to view and then monitor each other's watch lists. If this functionality is not available, then our original recommendation should be implemented. A review of the watch list process should be undertaken and following that guidance produced that ensures all Medical Secretaries are using a standard approach that is user friendly and does not restrict access, allowing visibility to other staff members	Medium	This will be addressed by the ILG with colleagues from Performance	Chief Operating Officer	ILG Directors of Operations / Head of Information	Sep-22	Now February 2023		In progress	February 2023 Update - This item will be considered as part of the process for this audit set out above.	August 2022 Update - Date remains September 2022. October 2022 Update - no further comment, will be picked up as part of re-focus on this audit. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.
POW Theatres Fire Safety Works 1.2	Aug-22	Limited	The Health Board should appropriately define and operate project linkage to the Senior Responsible Officer.	Medium	Agreed - This will be put in place to consider the options appraisal. The executive structure and personnel changed across this time. The project involves Health & Safety, Capital, and Strategy & Planning. The role of Senior Responsible Officer was therefore re-allocated. The project is currently being re-appraised. Subsequent to this, and pending the options appraisal to Welsh Government, governance will be further addressed as appropriate for the approved scheme. The CEO has also been in receipt of regular informal briefings from the Project Director.	Director of Strategy & Transformation	Project Director	Aug-22	Now November 2022 Now January 2023 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - Whilst appointments and structures are confirmed this remains outstanding. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.
POW Theatres Fire Safety Works 3.1	Aug-22	Limited	The Health Board should ensure timely completion of contacts.	Medium	Agreed – though in this case, due to the bespoke nature of the contract – a single phase business case, this did not align with the national framework contract stages - requiring additional edit prior to issue. Covid also impacted timely return.	Director of Strategy & Transformation	Project Director	At future contracts	Now January 2023 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - Until a way forward is agreed with WG this will not be required as no new contracts will be let. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.

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POW Theatres Fire Safety Works 4.1	Aug-22	Limited	The Health Board should assess the methodology of awarding direct contracts at design and construction projects.	Medium	Agreed – we will ensure this at future awards. However, in the early stages of this project, we did not want to contractually commit to the full scheme at the outset, until the position had been appraised.	Director of Strategy & Transformation	Project Director	At future contract awards	Now January 2023 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This is a future recommendation at such a time post business case approval. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.
POW Theatres Fire Safety Works 4.2	Aug-22	Limited	The Health Board should confirm how value for money will be assured at the letting of the construction stage award for a Cost Adviser.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be reviewed at the letting of a contract for construction stage post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.
POW Theatres Fire Safety Works 4.3	Aug-22	Limited	The Health Board should ensure appropriate contractual arrangements are in place for the Cost Adviser.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.
POW Theatres Fire Safety Works 6.1	Aug-22	Limited	Upon recommencement of the project, management should utilise Key Performance Indicators in accordance with the contract.	Medium	Agreed. These will be applied as required.	Director of Strategy & Transformation	Project Director	Upon re-engagement with the SCP	Now 2023 Now January 2023 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.
POW Theatres Fire Safety Works 8.1	Aug-22	Limited	Management should ensure appropriate reporting, forecasting and management of project costs, for each project phase, to a project group, accountable for delivery, including overall project reporting of: • contacted sums; • cash flow budgeted to date; • expenditure to date; • forecast out-turn; and • associated variance commentary.	Medium	Agreed. However, profiled costs are provided from the Supply Chain Partner. There is formal cost monitoring in terms of performance against funding to ECMG and monthly reviews of capital costs. Further reporting of the formats suggested will follow as appropriate upon review pending scale of the revised proposal.	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.
POW Theatres Fire Safety Works 9.1	Aug-22	Limited	Pending the outcome of the options appraisal, in the circumstance that Theatres reprovision remains within preferred option, the Project Board should re-assess procurement options to ensure value for money.	Medium	Agreed. This will be undertaken at the future procurement.	Director of Strategy & Transformation	Project Director	At confirmation of the preferred option	Now 2023 Now January 2023 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.

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POW Theatres Fire Safety Works 10.1	Aug-22	Limited	A costed risk register should be regularly maintained and reported, as applicable to the current project phase.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now November 2022 Now January 2023 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be developed and included at business case stage once a preferred option is identified in November. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.
POW Theatres Fire Safety Works 10.2	Aug-22	Limited	Management should actively monitor and report the value of residual risk v remaining contingency.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.
POW Theatres Fire Safety Works 10.3	Aug-22	Limited	Risks should be individually assigned to those best placed to control them, with time parameters for action.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now November 2022 Now January 2023 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be developed and included at business case stage once a preferred option is identified in November. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.
POW Theatres Fire Safety Works 10.4	Aug-22	Limited	An exception report should be published of targeted risk mitigations not achieved.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.
Digital Operating Model 4.1	Nov-22	Limited	The balance between the use of DHCW solutions and development of in house solutions within the operating model should be reviewed to ensure that it matches the needs of the organisation. Consideration should be given to increasing the level of in house development resource in order to provide Health Board specific digital solutions at a pace that suits the Health Board	Medium	Accept Development resources will be considered and proposed as part of subsequent structural reviews. Acknowledgement that any development resource proposal will need to be prioritised against other financial decision points for the Health Board.	Director of Digital	Director of Digital	Qtr 2 2023 / 2024			In progress	February 2023 Update - Ongoing and will be factored into the subsequent structure design for the Digital & Data team	December 2022 Update - Digital development resources will be aligned to the requirements of the IMTP from Care Groups
Digital Operating Model 5.1	Nov-22	Limited	The skills required by the Digital Directorate should be fully defined and mapped to those already in place. A structured training & development plan should be defined to meet skills shortages, alongside the use of temporary staff to meet gaps short term.	Medium	Accept Full review of the capacity and capability required will be completed in 2023 as part of a phased approach to the future target operating model for the Digital & Data Directorate.	Director of Digital	Director of Digital	Qtr 2 2023 / 2024			In progress	February 2023 Update - Work Ongoing	December 2022 Update - Activity to be undertaken once Strategic Leadership roles are finalised

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Digital Operating Model 7.1	Nov-22	Limited	The Health Board should clearly state that minimum digital literacy is a requirement, with provision of training if required.	Medium	Accept Digital literacy to be included within the workforce and organisational development plan as part of the IMTP.	Director of Digital	Director of Digital	Qtr 4 2022/ 2023			In progress	February 2023 Update - Ongoing in alignment with the IMTP	December 2022 Update - Digital Literacy and training initiatives to be outlined within the IMTP
Digital Operating Model 8.1	Nov-22	Limited	The work to restructure support should be finalised, with greater provision of: - fix at first contact; - use of process automation for handling calls; - use of digital champions within services; - a structured SharePoint site; and - how to guides.	Medium	Accept A phased programme of work will be developed alongside the structural review. This programme is likely to run for 12 months.	Director of Digital	Director of Digital	Qtr 3 2023/ 2024			In progress	February 2023 Update - Work ongoing	December 2022 Update - New Digital Service Desk launched in November 2022. Work ongoing to complete how to guides …
Radiology Service Review 6.2	Dec-22	Limited	Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individual's file.	Medium	All superintendents will be advised of the need to maintain accurate documentation of all decision taken including those outside of the Managing Attendance Policy.	Chief Operating Officer	Superintendent Radiographers	31st December 2022	Now February 2023		In progress	February 2023 Update - All Superintendents have been informed of their responsibilities in terms of sickness management. A training update session is in the progress of being arranged with People's Services.	
Radiology Service Review 6.3	Dec-22	Limited	The roll out of electronic staff files across the service should progress with all electronic files fully populated with documentation scanned from hard copy files. Consideration should be given to replicating the Standard Operating Procedure developed in other CSGs (such as CAMHS) in relation to the set up and use of electronic staff files.	Medium	The service will liaise with other recommended CSGs who have implemented areas of good practice based on previous findings to establish a Standard Operating Procedures for the electronic files.	Chief Operating Officer	Clinical Services Manager	31st January 2023	Now March 2023		In progress	February 2023 Update - An electronic staff Personnel File has already been implemented for new staff at RGH and PCH. There is a hybrid system for established staff and a system to scan in legacy documents. Work is underway at POW but the current sickness absence in admin team has delayed progress.	
Radiology Service Review 7.1	Dec-22	Limited	Management should remind staff of the importance of using ESR for requesting and authorising annual leave. Once management are assured that the correct opening balances are captured within ESR, the use of paper records should cease, to prevent confusion and duplication.	Medium	The teams will be encouraged to ensure all leave is recorded on ESR system and if any problems are encountered will escalate to ESR team and Care Group Service Director.	Chief Operating Officer	Clinical Service Group Manager Superintendent Radiographers	30th November 2022			Completed	February 2023 Update - The team at POW have now transitioned over to ESR from paper recording. All leave requests and sickness absence is recorded through ESR and Health Roster. Completed action.	
Radiology Service Review 8.1	Dec-22	Limited	a) A review on the approach to how TOIL is managed across the service should be undertaken to ensure there is some level of consistency (between accruing hours and being paid overtime) and staff are being treated equally, whilst meeting the needs of the service in each area. b) Consideration should be given to the number of hours staff are able to accrue as TOIL, given that resource constraints can impact the ability for staff to take the hours back	Medium	a) A review of the approach to TOIL will be undertaken across the three localities to ensure a consistency of approach. b) An agreement will be established to the maximum number of hours that can be accrued as TOIL considering the impact of the ability to take back hours and the potential impact of the service.	Chief Operating Officer	Clinical Service Manager Site Superintendent Radiographers	Feb-23	Now March 2023		In progress	February 2023 Update - The team have met to review the current HB policy and will implement across Radiology on the 3 sites.	

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Radiology Service Review 8.2	Dec-22	Limited	Where Health Roster is in use, it should be ensured accurate entries and adjustments are made in order for the system to capture meaningful data that staff and management can use to manage TOIL.	Medium	A review of the current systems to record TOIL will be undertaken to establish which system is most effective and applied across the localities.	Chief Operating Officer	Clinical Service Manager Site Super intendent Radiographers	Feb-23			Completed	February 2023 Update - All staff members have been informed to complete the appropriate TOIL form and request permission to build up TOIL in the absence of the Heath Roster being implemented across the 3 sites.	
Radiology Service Review 11.2	Dec-22	Limited	Management should ensure that the recently produced job planning procedure is made available. Once planning meetings have taken place, if there are delays in sign off, the steps outlined in the procedure should be followed, to ensure timely sign off. The CSG should continue to liaise with the Allocate team to ensure the data in the system is accurate, all users have the required access and queries get resolved.	Medium	The hierarchy on Allocate is now a true reflection of the consultant establishment and as job plans are being scheduled access to Allocate is being arranged.	Chief Operating Officer	Clinical Director Clinical Service Manager	Jan-23	Now March 2023		In progress	February 2023 Update - The relevant house keeping has been undertaken with the Allocate Team and all current consultant staff are assigned accordingly. There appears to be an issue with the system where the relevant notification is not being received for sign off by clinician. To be addressed through Allocate Support Team.	
POW Theatres Fire Safety Works 2.1	Aug-22	Limited	The Health Board should confirm that resource requirements are appropriately assessed utilising a detailed resource schedule at the business case stage.	Low	Agreed. The project has been adequately resourced with two internal officers to date. Formal application for resources would be made at a formal business case, and we will look to make appropriate application at that time.	Director of Strategy & Transformation	Project Director	At the business case	Now 2023 Now January 2023 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.
POW Theatres Fire Safety Works 7.1	Aug-22	Limited	The Health Board should obtain advice from NWSSP: Specialist Estates Services in relation to a performance bond for construction works	Low	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.
Radiology Service Review 8.3	Dec-22	Limited	Where paper records remain in use, they should be reviewed and updated to ensure they are fit for purpose and capture all relevant information in format that allows staff and management to manage TOIL effectively.	Low	A review of the current systems to record TOIL will be undertaken to establish which system is most effective and applied across the localities.	Chief Operating Officer	Clinical Service Manager Site Super intendent Radiographers	Feb-23	Now March 2023		In progress	February 2023 Update - All staff members have been informed to complete the appropriate TOIL form and request permission to build up TOIL in the absence of the Heath Roster being implemented across the 3 sites.	
Nurse Agency Usage 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 for People	Head of Corporate Nursing	March 2020/April 2020/August 2020	February 2021 June 2021 Now September 2021 Now December 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - The Bank Policy went to Policy Review Group and was shared for final comment. There were comments on the policy received, that are now being amended in the document to allow it to be re-submitted for the Feb-23 meeting. The actions required in this recommendation have been addressed and included in the policy.	November 2020 Update - The Bank Policy is being updated during December 2020/January 2021. The updated policy will consist of a review and update of all the bank and agency forms. January 2021 update - Policy has been completed and is awaiting review by policy sub groups. APRIL 2021: Amendments came back via policy infrastructure, which will be incorporated into the policy draft for approval. This will be taken through the Health Board's policy group by Jun-21. Revised implementation date provided. July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September. Sept 21 update: Due to inability to get interested parties to agree on the final policy, alongside the cancellation of the last 2 meetings for not being quorate, the policy has not progressed further. The policy is awaiting agreement in partnership to progress to policy group. November 2021 Update - Draft Staff Bank Policy scheduled for Policy Review Group on 18th November 2021. January 2022 Update - Policy sent to policy group for ratification. Apr 2022 – The policy was sent through the ratification route. Comments on the content were made post the policy review group meeting. These comments have been taken away and are actively being worked upon by the Deputy Director of Nursing & the Staff Bank Manager. The Policy will then be resubmitted to the policy group in May, if approved this will then progress to the LPF and be signed off for use in the UHB. June 22 update – The policy has been updated and is progressing through the approval process. August 2022 update – The

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Nurse Agency Usage 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 monitoring issues relating to the quality of service provided by agency staff. If the flowchart is the Heath Boards preferred approach, all Ward Managers should be made aware that in line with the agreed flowchart, incidents are appropriately and consistently recorded on DATIX to allow effective monitoring. 4. Attempts to cross-reference patient experience data and agency usage data should take place with a view to identifying trends. Outcomes should be	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 for People	Head of Corporate Nursing	Aug-20	October 2020 February 2021 June 2021 Now September 2021 Now December 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - The Bank Policy went to Policy Review Group and was shared for final comment. There were comments on the policy received, that are now being amended in the document to allow it to be re-submitted for the Feb-23 meeting. The actions required in this recommendation have been addressed and included in the 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/January 2021. The updated policy will consist of a review and update of all the bank and agency forms. July 2020 Update - Due to outbreak of covid-19 and consequent pressure on staff bank to recruit additional bank workers to support existing and new HB services has meant a delay in starting this policy. January 2021 Update - No further change/update. APRIL 2021: See above for policy amendments. Remaining recommendations delayed due to the pandemic but will be taken forward in the same timeframe as the policy approval. Revised implementation date provided. July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September. Sept 2021 update: Due to inability to get interested parties to agree on the final policy, alongside the cancellation of the last 2 meetings for not being quorate, the policy has not progressed further. The policy is awaiting agreement in partnership to progress to policy group. November 2021 Update - No further update provided. January 2022 Update - Policy sent to policy group for ratification. Apr 2022 – The policy was sent through the ratification route. Comments on the content were made post the policy review group meeting. These comments have been taken away and are actively being worked upon by the Deputy Director of Nursing & the Staff Bank Manager. The Policy will then be resubmitted to the policy group in May, if approved this will then progress to the LPF and be signed off for use in the UHB. June 22 update – The policy has been updated and is progressing through the approval process. August 2022 update – The policy is yet to be ratified. The LPF has not sat since the last audit report return as it was cancelled, to allow for ratification of the policy through the appropriate route. The policy will be taken to the next LPF in September 2022. October 2022 Update - The
Directorate Review Acute Medicine & A&E 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.	Chief Operating Officer	General Manager	Apr-21	01/05/2021 August 2021/April 2022 Now September 2022 Now March 2023		In progress	February 2023 Update - position is unchanged from last report.	RTE ILG January 2021 Update - action has been delayed due to the COVID pandemic and this area will need to be addressed in 2021-22. March 2021 Update - This will be an area for focus in the future – further action will be completed asap. May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a key risk – and both MC and RTE recognise that it will take time to be complete. The CSG Manager in MC has recently sent out information to staff and anticipates an earlier resolution than RTE but it is recognised in both areas. July 2021 Update - no change for RTE and MC ILGs at present however this remains on the agenda. September 2021 Update. No change to report, the target date remains April 2022. November 2021 Update - Target date is April 2022 - nothing further to report. February 2022 Update - the Directorate at MC has established a link with Procurement colleagues to work on this. In RTE, the pressure of work means that there is no update yet and no further action taken. April 2022 Update - Further improvement in MC - the process has started and the anticipated completion is September 2022. June 2022 Update - target remains September 2022, though this will be difficult given the amount of detailed work that will be required within existing staffing profiles. August 2022 Update. For MC, the completion date remains at September 2022. For RTE, this is still an aspiration but not one that the CSG can support at present. October 2022 Update - the situation remains the same, the view of the Directorate is that there is not at present the capacity to complete this task. December 2022 Update - position remains the same in RTE also.
PCH Redevelopment Governance Audit 03	Apr-21	Reasonable	Appropriate arrangements will be made to ensure that vacancies identified within the resource schedule are filled as a matter of priority (O).	High	Agreed. All of the appointments for additional resources are progressing and the Senior Responsible Officer has confirmed that all are permanent positions (Noting that the appointments are for a 5.5 year construction programme and employment rights become permanent due to this duration). Responsibility for the appointments rests with departmental heads to progress these positions with assistance from the Major Projects Unit.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	01/08/2021 Now November 2021 Now May 2022 Now August 2022 Now October 2022 Now March 2023		In progress	January 2023 update - A Band 7 post was advertised until 23rd January. Interviews are scheduled for 6th February. The Deputy Lead Infection Prevention Control Nurse and Decontamination Officer continues to work with the project.	May 2021 Update - One Commissioning Officer in post. 2 Estates posts addressed; Offer made and being processed for Informatics Officer and additional hours granted to part time Officer. 2 Estates post being addressed; applications received with no suitable candidates, being re-advertised. Discussion held with IT about committing resource to project of Contracted member of staff. Discussion held with IPC regarding need to advertise for post. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post. July 2021 Update - Arrangements in place to resource the project requirements. October 2021 - Follow up report received which identified that this recommendation was Partially Implemented. Requirements as specified at the Full Business Case for Phase 2 are currently being reviewed for adequacy. A number of posts have been filled with only two posts remaining – having not been filled following advertisement. November 2021 - Of the two posts that remained to be filled, the Estates Officer post has been awarded and is awaiting confirmation of a start date from the appointee. The IPC post has been advertised twice with no applicants showing interest. The grading of the post is being reviewed. February 2022 update - The remaining Estates Officer will be in post by the end of February 2022. The IPC post is currently being re-advertised one more time at Band 7. If there are no suitable applicants, advertising at a Band 6 will be considered to attract a different profile of candidate. April 2022 Update - The Estates Officer appointment is in post. The IPC post has had no applicants when advertised twice. The job description is being revised before being advertised again. In the meantime, the project is being covered by the Deputy Lead Infection Prevention Control Nurse and Decontamination Officer. June 2022 Update - In light of inability to attract interest in the post, dialogue is to be undertaken with Welsh Government to request that the funding be used to appoint Band 3 nurses to release the Senior Infection Prevention Control Nurse to the project. In the meanwhile, the project is being covered by the Deputy Lead Infection Prevention Control Nurse and Decontamination Officer. August 2022 Update - The post remains unfilled despite repeated advertisements. The project continues to be covered by the Deputy Lead Infection Prevention Control Nurse and Decontamination Officer. October 2022 update - The application date for the IPC post closed on 5/10/22 with interviews scheduled for 17/10/22. In the meanwhile, the project continues to be covered by the Deputy Lead Infection Prevention Control Nurse and Decontamination Officer. December 2022 Update - The most recent post advertisement realised only one candidate being interviewed. However, that candidate proved unsuitable. Discussions have taken place between IPC and Capital and determined that a post of lower grade will be advertised which will enable the Deputy Lead Infection Prevention Control Nurse and Decontamination Officer to be dedicated to the project.
Welsh Language Standards Compliance 04	Oct-21	Reasonable	4.1) Management should review and enhance the reporting and monitoring structures which are currently in place and implement a robust system which provides assurance both to senior management but also provides feedback to the departments and ILGS responsible for implementing Standards. In order to implement this management should consider: • Setting up local Welsh Language Standards working groups within the departments and ILGs which are attended by the key leads from those areas and the Welsh Language Manager, thus allowing localised progress to be given on the status of the action plans and relevant support. • These groups could feed into an overall Welsh Language Group, whose membership should consist of relevant staff from Workforce & Organisational Development along with other areas across the Health Board along with representatives from the local working groups and the Welsh Language Manager. Findings and best practice from ward audits should be shared at this group. • Regular updates against the Standards should be provided to Board, via the People and Culture Committee who are responsible for	High	4.1) The Welsh Language Manager will engage with the ILG SMTs, to determine the feasibility and benefits of establishing local ILG Welsh Language Working Groups and how these would be managed and supported by the Welsh Language Manager. Reporting and monitoring of progress will be strengthened by the requirement for regular compliance reporting, from the nominated Senior ILG leads to the Welsh Language Working Group. The reporting will be further enhanced by having a standard agenda item of "sharing examples of good practice" to assist achievement of compliance in other areas. This information will be provided to the nominated senior ILG lead by the network of ward Welsh Language Champions. The People and Culture Committee when developing its cycle of business for 2022 will incorporate Welsh Language Standards Compliance updates, to be presented and report twice yearly, to provide assurance to the Board.	Director for People	Welsh Language Group Manager/Assistant Director of Workforce/ILG Leads	Oct-21	Now December 2021 Now March 2022 Now May 2022 Now August 2022 Now October 2022 Now December 2022 Now January 2023 Now March 2023		In progress	February 2023 Update - Met with the Exec Dir for People on 30 Jan 2023 to plan and confirm meeting dates for 2023/24 Welsh Language Steering Group. First meeting of the Steering Group will take place on the 15 March 2023 and a programme of dates have been agreed for the rest of the year.	November 2021 Update - A new Welsh Language Committee will meet for the first time in December 2021. Senior leadership will be made aware of their responsibilities in this meeting. Action plans will be distributed and returned to the Welsh Language Manager. Highlight reports and good practice will be shared with the Committee. Formal monitoring and reporting will be via the new Welsh Language Committee to the People and Culture Committee. The first report will be submitted by March 2022 which will co-inside with the writing of the Welsh Language Standards Annual Report. Update Jan 2022 - (4.1) The first meeting of Health Board's Welsh Language Committee was unable to meet in December 2021, due to COVID-19 Service and staff pressures. The meeting has been rescheduled for 17 March 2022. 1.1) The WL Manager contacted senior ILG leads in February and met Bridgend ILG 1.2) A new action plan template document has been created will be dated and version controlled to allow progress to be mapped . June 2022 4.1) The Welsh Language Steering Group arranged for the 17 March 2022 was postponed. The meeting is in the process of being rescheduled. The Welsh Language Services Manager has met with 7 service areas with a further 8 scheduled during May and June to set departmental/service level action plans, and has been invited to RTE ILG governance and business meeting and Senior Nurse Professional Forum in June to progress this work further. The Welsh Language Annual Report is currently being developed and will be presented to the People and Culture Committee in August 2022, prior to being published in September 2022. Welsh Language Standards are now built into People and Culture Committee cycle of business. August 2022 Update - The Terms of Reference for the new Welsh Language Steering Group are currently being revised to reflect the Health Boards New Operating Model and Management Structures. It is anticipated the first meeting of the Welsh Language Steering Group will take place during October 2022. Welsh Language Report etc. for endorsement and approval are being presented to the Executive Leadership Group for endorsement and People and Culture Committee for approval. The Welsh Language Annual Report is currently being scrutinised via this route, in preparation for publication in September 2022. October 2022 update - The Terms of Reference for the Welsh Language Steering Group have been reviewed and amended to reflect the new Operating Model. The first meeting of the WL Steering group has been deferred until December 2022, as some of the key Care Group appointments are still outstanding. The Welsh Language Annual report has been published in accordance with the statutory requirement. December 2022 update - The WL Steering Group has been deferred while some key appointments are still being made within Care Groups. The first meeting will convene in New Year.

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CHC and FNC 8.0	Feb-22	Reasonable	formalised reporting structure should be put in place that allows the monitoring and scrutiny of CHC data to take place at varying levels within the Health Board, and to facilitate management in being able to make informed decisions around the delivery of the service and care packages provided.	High	CURRENT REPORTING MECHANISMS • In light of the current review of the Health Board's operating model, it is agreed that CHC reporting and monitoring will be included as part of this review and will incorporate any reporting management tool identified by Welsh Government in the new framework. • Prior to the review of the operating model, CHC / FNC will be a standing agenda item on monthly Community Service Group performance meeting agendas. Reporting to Health Board Quality and Safety Committee and Planning, Performance and Finance Committee will commence.	Chief Operating Officer	Lead Nurse for CHC and NHS Funded Care	May-22	Now July 2022 Now October 2022 Now December 2022		Completed	February 2023 Update - Following a recent report that was presented to Quality & Safety Committee it has been agreed that going forward an Annual Report will be submitted to this Committee. Also, all Escalating Concerns will be reported through the Primary Community Care Group Highlight Report and all MH Hospitals on AWF that are receiving additional monitoring will be reported through the MHLD Care Group Highlight Report.	April 2022 Update - No update this month due to sickness of Lead Nurse. Anticipated that there will be more to report at the next meeting. June 2022 Update. This is subject to ongoing development with a pivot table being worked on. Ongoing work to consider how this will be cascaded in new operating model alongside Finance. August 2022 Update - paper to go to Board to progress in September 2022. October 2022 Update - Paper went to Quality & Safety Committee in September 2022. Actions required following Committee. The team are working through these to strengthen reporting across the organisation and the new operational model. November 2022 Update - Team continue to work through actions from Quality & Safety Committee to strengthen reporting. Reportable data has been identified and admin are currently reviewing best way to present information concisely. Await new operational model to finalise plans for reporting.
Overtime & Additional Hours 5.0	May-22	Reasonable	The functionality available in Health Roster to monitor compliance with the various Working Time Regulations requirements should be used to ensure staff are not in breach of regulations. For those areas not using Health Roster, managers should routinely monitor the hours and working patterns of staff to ensure they are not in breach of WTRs. To do this effectively, they should be aware which staff have opted out of the WTRs and therefore know the upper limit of hours to be worked in a week.	High	The UHB will turn on the Health Roster functionality to block book bank / agency workers to work any non-WTR compliant shifts. The revised Overtime Policy will set out the line manager's responsibility to routinely monitor the hours and working patterns of their staff, to ensure compliance with WTRs, when Health Roster is not used. The Policy will also require the manager to check whether their staff who regularly work overtime have completed a WTR Opt-Out Form. The Overtime Policy will be cross referenced with the WTR Policy	Director for People	Head of Workforce Productivity and E-Systems Assistant Director of Policy, Governance and Compliance	July 2022 November 2022	Now January 2023 Now March 2023		In progress	February 2023 Update - The revised draft Overtime Policy incorporates the management actions agreed. The required system settings to ensure Working Time Regulations compliance are activated as required by the audit.	August 2022 Update - The Overtime Policy will be reviewed by the Workforce Policy Review Group in September 2022. The review will take into consideration the internal audit recommendations. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated. December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 People Policy Review Group.
Welsh Risk Pool Claims 1.3	Jun-22	Reasonable	To prevent future issues arising, management should ensure all staff are aware of the requirement to capture learning information in Datix at the point of investigation, in order to support the administrative process for reimbursement and to allow appropriate learning to be shared in good time.	High	Staff to be reminded of importance of updating Datix Cymru for all incidents and concerns, using various methods such as management discussions, Datix Cymru training programme, patient safety discussions.	Director of Nursing	Assistant Director of Patient Safety/Assistant Director of Concerns & Claims/Care Group Leaders	Jun-22	Now January 2023		Completed	February 2023 Update - Training is taking place in respect of Datix Cymru and the training which has support the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any additional training in respect of the new Complaints Policies and Procedures. Capturing learning is a key focus of the new Incident Management Framework and associated training. The Listening and Learning Framework was launched at a Listening and Learning event in September. As part of this a learning repository is being developed to capture and share learning across the organisation.	August 2022 Update Training is taking place in respect of Datix Cymru and the training which has support the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any addition training in respect of the new Complaints Policies and Procedures. Capturing learning is a key focus of the new Incident Management Framework and associated training. Listening and Learning Framework in draft format, due to be rolled out in September 2022. Inaugural Learning from Events Day to be undertaken in September. October 2022 Update Training is taking place in respect of Datix Cymru and the training which has support the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any additional training in respect of the new Complaints Policies and Procedures. Capturing learning is a key focus of the new Incident Management Framework and associated training. The Listening and Learning Framework was launched at a Listening and Learning event in September. As part of this a learning repository is being developed to capture and share learning across the organisation. December 2022 Update - Training is taking place in respect of Datix Cymru and the training which has support the launch of the
Financial Systems 8.1	Jun-22	Reasonable	Management should ensure that staff responsible for approving requisitions and processing purchase orders are aware of the correct procurement process as stated in the Requisition of Goods and Services FCPO and the All-Wales No PO No Pay policy.	High	Procurement will increase the training and cascade information relating to the No PO No Pay policy. We will identify the areas of retrospective ordering, implement a plan and ensure bespoke training to these areas.	Director of Finance	Head of Procurement	Jul-22	Now August 2022 Now November 2022 Now January 2023 Now March 2023		In progress	February 2023 update : - As part of the Finance Delivery Unit AW P2P group, the No PO policy approach within HBs is being developed as best practice within the HB, and internal communication to Directorates is being strengthened and re-issued Jan 2023 - All FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. CTM systems ensuring training undertaken prior to giving Oracle access to new users, and refresher training being developed. As part of the Finance Delivery Unit AW P2P group,(SRO - DOF Swansea Bay) the No PO policy and exemption list is being reviewed together with a Communications plan through an AW Task & Finish group. Outline paper with planned approach approved by AW P2P group 17th November. CTM already undertaking focused P2P training, Facilities and Estates completed, identifying further areas as part of No PO review (Top 3 monthly with systems). Further lunch and learn sessions being scheduled monthly to target Non compliant areas.	August 2022 Update - All FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. As part of the Finance Delivery Unit AW P2P group, the No PO policy approach within HBs is being developed as best practice within the HB, and internal communication to Directorates is being strengthened and re-issued by Oct 2022. October 2022 Update - All FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. CTM systems ensuring training undertaken prior to giving Oracle access to new users, and refresher training being developed. As part of the Finance Delivery Unit AW P2P group,(SRO - DOF Swansea Bay) the No PO policy and exemption list is being reviewed together with a Communications plan through an AW Task & Finish group. Outline paper with planned approach going to AW P2P group 17th November. CTM already undertaking focused P2P training, Facilities and Estates completed, further lunch and learn sessions being scheduled monthly to target Non compliant areas. December 2022 update : - As part of the Finance Delivery Unit AW P2P group, the No PO policy approach within HBs is being developed as best practice within the HB, and internal communication to Directorates is being strengthened and re-issued by Jan 2023 - All FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. CTM systems ensuring training undertaken prior to giving Oracle access to new users, and refresher training being developed. As part of the Finance Delivery Unit AW P2P group,(SRO - DOF Swansea Bay) the No PO policy and exemption list is being reviewed together with a Communications plan through an AW Task & Finish group. Outline paper with planned approach approved by AW P2P group 17th November. CTM already undertaking focused P2P training, Facilities and Estates completed, further lunch and learn sessions being scheduled monthly to target Non compliant areas.
Medical Records Management 4.2	Nov-22	Reasonable	A formal reporting process for health records should be established which includes key performance indicators such as, but not limited to: - Number of records provided - Percentage of records available at point of need - Number untracked / missing records.	High	Agreed Performance report to be created as part of routine service provision.	Director of Digital	Director of Digital	Qtr 3 2022/2023	Now January 2023		Completed	February 2023 Update - Propose to close - routine report now in place	December 2022 Update - Work ongoing. New Head of Clinical Administration commenced role in November 2022 and now developing a suite of metrics for the Medical Records function - to be reported to the Digital & Data Committee from January 2023

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Medical Records Management 7.1	Nov-22	Reasonable	The retuned files should be monitored and a record kept of errors in files, and the source of the files. These errors should be reported to the clinical service areas, noting that there is a professional requirement on staff to ensure appropriate record keeping and requesting that all staff ensure that file quality is maintained.	High	Agreed Standard Operating Procedure to be developed for reporting quality issues with the paper record.	Director of Digital	Director of Digital	Qtr 3 2022/2023			Completed	February 2023 Update - Medical Records action plan and monitoring activities now in place	December 2022 Update - As part of Medical Records review in November 2022, SOP for reporting quality issues has been identified and in development
ICTM Quality Improvement Team 1.2a and 1.2b	Dec-22	Reasonable	1.2a A review of the approach for capturing project initiation information in relation to proposed projects should be undertaken. Where possible a consistent approach, that is not burdensome on staff, yet contains enough detail to allow meaningful initiation decisions to be made, should be adopted. The current 'plan on a page' template could be considered for this but should be reviewed to ensure necessary information is included, especially in relation to benefits and risks and where possible the cost and resource implications. 1.2b The procedural guidance mentioned in 1.1 should set out the criteria of what is deemed small scale and 'safe to fail'. The guidance should sit alongside the 'plan on a page' template to help staff make informed decisions regarding the size and risk associated with their QI project and encouraging them to seek the support and advice of the QI team if they feel their project falls outside the criteria.	High	As part of the response to this audit we will produce an overarching set of procedures and guidance which will incorporate this recommendation. To support this we have already reviewed our procedures in line with the recommendations of this audit. The plan on a page format has been altered to ensure it covers the areas outlined in the audit and a new 'project initiation' form has been created to capture the required details. The project workbook is being used for our pressure damage work and its use will be reviewed and spread as appropriate. Training has been altered to include specific advice on what is deemed safe-to-fail and this will be incorporated into the guidance.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Dec-22	Now January 2023		Part Completed	February 2023 Update - 1.2a Completed - plan on a page has been reviewed and a version produced that can be integrated into the LifeQI record. 1.2b Procedural guidance is in draft form for completion in January 2023.	
iCTM – Quality Improvement Team 1.4	Dec-22	Reasonable	Procedural guidance for use by the QI team in relation to the projects they are directly involved in delivery should be developed and should include, but not be limited to: initiating a project; recording the key elements of a project such as the rationale, expected benefits and outcomes, estimated costs, staff resource requirements and risks; obtaining approval; monitoring and reporting projects. Furthermore, consideration should be given to using the project workbook currently being trailed as the mechanism for capturing QI project information. The workbook should be reviewed and tailored to meet the needs of the Health Board.	High	As part of its response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation. The success of 'project workbook' will be reviewed following its use on our Community Acquired Pressure Ulcer project alongside other tools being developed by the Change Hub with a view to adopting a standard approach. A new form has been created to help us properly assess incoming requests for support in line with the audit recommendations.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Dec-22	Now January 2023		In progress	February 2023 Update - Procedural guidance is in draft form for completion in January 2023. The new form is being used to asses new pieces of work as described. The Project Workbook is being used for the Community Acquired Pressure Ulcer collaborative and is under review to assess its suitability for other projects.	
iCTM – Quality Improvement Team 5.1	Dec-22	Reasonable	Management should develop and document processes for Project Leads to follow to allow identification and assessment of project risks, in order to determine if projects are low risk and therefore suitable to progress as Life QI projects. A risk log should be created for each project and reviewed throughout the project to ensure that potential risks, including those that may jeopardise the success of the project, or outweigh its benefits are identified and managed.	High	We are working closely with our Corporate Risk Management Team to implement this recommendation and incorporate a risk assessment and register into our procedural guidance.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery/ Assistant Director of Governance & Risk	Dec-22			Completed	February 2023 Update - Risk management training has been held with the Corporate Risk Management Team and risk management process agreed. Risk will be a monthly agenda item on management team meetings and Datix will be used to generate a risk log as per organisation guidance.	
iCTM – Quality Improvement Team 5.2	Dec-22	Reasonable	We note that Risk Management training has been provided to the Change Hub team. This training should be rolled out to the QI team in order facilitate them in developing their own risk register.	High	We are working closely with our Corporate Risk Management Team are organising this training to ensure it is part of our induction process and regularly updated.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery/ Assistant Director of Governance & Risk	Dec-22			Completed	February 2023 Update - Risk management training has been held with the Corporate Risk Management Team and risk management process agreed. Risk will be a monthly agenda item on management team meetings and Datix will be used to generate a risk log as per organisation guidance.	

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Radiology Service Review 3.1	Dec-22	Reasonable	a) Due to the volume of policies and procedures that require reviewing, a plan should be developed with clear objectives, targets and responsible officers to ensure that all are reviewed and disseminated to staff in a timely manner. Once a list of all existing policies and procedures has been created, work needs to progress collectively across all localities to determine what needs to be updated, deleted, or amalgamated, while also recognising that some policies are site specific. b) Going forward, a policy and procedure register should be maintained identifying the document owner and the review dates in order to make it easier to keep them up to date.	High	a) A review of all policies and procedures will be scheduled and responsible officers identified to oversee the process of updating, deleting or amalgamating. A formal circulation list for review of any policies / procedures has been developed. A Radiology adapted Policy for the Management and Authorisation of Radiology documents has been drafted for ratification on 1 December 2022. b) A policy and procedure register is established and maintained to identify the owner and review dates. Investigation to try and automate reminders for policy review via SharePoint underway.	Chief Operating Officer	Senior Superintendents Clinical Leads Superintendent Radiographers Clinical Leads Health & Safety Leads	June 30th 2023			In progress	February 2023 Update - a) A review of all policies and procedures is an ongoing programme of work. A formal circulation list for review of any policies / procedures has been developed. A Radiology adapted Policy for the Management and Authorisation of Radiology documents has been drafted for ratification on 1 December 2022.	
Radiology Service Review 5.2	Dec-22	Reasonable	A risk management monitoring structure should be established, ensuring that the risk register is a standing agenda item for relevant committees or groups. Lower scoring and more localised risks should be monitored at the localised departmental meetings, with the moderate and higher scoring risks, along with oversight of the whole risk register considered at Quality Improvement & Governance Group and where appropriate, reported to the ILG Radiology Performance Review Group. There should be a clear escalation process between the groups.	High	As described above a risk management monitoring system will be established with the Quality Improvement & Governance Group having oversight of the register and an escalation process for moderate and high risks.	Chief Operating Officer	Clinical Lead for Quality and Governance Senior Superintendents	31st December 2022			Completed	February 2023 Update - Risk Managing is a standard item on the Radiology Business meeting agenda. The service has implemented a monthly Risk Management meeting following the Business Meeting. All departmental risks are also discussed or escalated via the Radiology Quality, Improvement and Governance Meeting quarterly. Completed.	
Radiology Service Review 12.1	Dec-22	Reasonable	A detailed workforce plan should be developed by the CSG in conjunction with their Workforce Business Partner that incorporates both the current workforce situation, plus longer-term plans in relation to areas such as known retirements.	High	The Service Group now sits in the Diagnostic and Therapies Care Group since September 2022 and the Care Group Director and Medical Director will work with the teams to advise of the workforce plan required for the IMTP/Annual Plan for 2023/24. On receipt of this advice the Service Group will work with the Workforce Business Partners to articulate the current workforce issues and medium and longer term plans.	Chief Operating Officer	Care Group Service Director Care Group Medical Director	30th November 2022	To be confirmed		In progress	February 2023 Update - Work has been developed within the IMTP framework to address this. Draft IMTP submitted December 2022.	
Radiology Service Review 15.1	Dec-22	Reasonable	Staff who engage medical agency staff should be familiar with the requirements set out in the Medical Variable Pay Financial Control Procedure and ensure that they can demonstrate the rates that will be paid to agency staff and the appropriate authorisation where rates exceed the WG pay cap.	High	There are two individuals who engage medical agency staff in the Service. The Interim Radiology Service Manager (RGH and PCH) and the Superintendent Radiographer (POW) These individuals provide cross cover for each other.	Chief Operating Officer	N/A				Completed		
Directorate Review Radiology Management Arrangements 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.	Chief Operating Officer	Directorate Manager	Dec-19	October 2020 March 2021 June 2021 August 2021 Now December 2021 Now September 2022 Now April 2023		Completed	February 2023 Update - Recommendation has now been superseded as a result of the Radiology Service Review	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. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - A test site was set up in March 2020 and the process of reviewing all policies started in June 2020 led by Dr Ally Yates. The appointment of the Head of Radiography post will take place imminently and this will aid implementation. A plan outlining expected completion dates will be worked on by the meeting in June 2021. Covid-19 has meant that this process has lost momentum. May 2021 Update - A test site was set up in March 2020 and the process of reviewing all policies started in June 2020 led by Dr Ally Yates. The appointment of the Head of Radiography post will take place imminently and this will aid implementation - this post is going out for advertisement in July 21. A plan outlining expected completion dates will be worked on by the meeting in June 2021. Covid-19 has meant that this process has lost momentum. July 2021 Update - Process underway to update and amalgamate all policies from two distinctive ones to a whole HB approach, with the potential for some local discretion. Regarding updated policies, yes all updated policies will be available on SharePoint. In addition POW have developed an app for use by SpRs with all policies and help available on their mobile phones. Pilot in POW due to start with August new intake and expect to roll out for next rotation. September 2021 Update. Nothing further to add - target date remains December 2021. November 2021 Update - as a consequence of staff sickness there will be no update this quarter - it will be available for the next meeting. February 2022 Update - as a consequence of staff sickness there will be no update this quarter - it will be available for the next meeting. April 2022 Update - Nothing further to report for this meeting. Issue will be chased up in the coming month. June 2022 Update – New senior management support in the service. All procedures and policies have been reviewed and in shared folders. Full governance structure and review re-established across CTM from July 2022. Work continues for service usable SharePoint page with the superintendent leading. August 2022 Update. The new Interim CSGM has been asked for a response. It is anticipated that progress will be reported at the next meeting. October 2022 Update - the Directorate is in the process of re-invigorating this recommendation. In addition, it is likely that after a follow up audit, a new Radiology report with a new recommendation about this is about to be produced, superseding this one. December 2022 Update - The Directorate has started working with Corporate IT on building a new SharePoint site which will be used as the document repository and regular weekly meetings are taking place to progress. Agreement has been reached for the Policy for 'Management and Authorisation of Policies etc. in Radiology and work is starting to address policies in a logical / clinically prioritised order.

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Medical Equipment and Devices Follow Up 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.	Chief Operating Officer	Assistant Director of Facilities	Apr-20	September 2020 April 2021 July 2021 Now March 2022 Now September 2022 Now January 2023 Now July 2023		Part Completed	February 2023 Update - There are continued issues with network connectivity on the POW site which remains unresolved and is therefore holding up progress on POW site. K1 to K2 migration project initiated 18/01/2023 for utilising the existing passive system and transfer medical equipment over to the newer platform. DG has discussed options for utilising new active tags with the new platform and establish if current Wi-Fi infrastructure can support the new tag technology. This would simplify expansion UHB wide. (Still awaiting confirmation of specs required) DG developing a new SON in anticipation of the technology being a possibility to use as it could reduce the capital request. Based on the above update, the target date has been moved to 31/07/2023 (WG 25/01/2023).	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 candidate (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 finalised 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). 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) January 2021 Update - Additional hand-held devices have now been ordered and delivered. Further work is in progress by the supplier to implement the site mapping for the devices to be functional on PCH and POW sites. Further purchase orders are to be submitted for additional works and installation, presentation to be provided at next CMAG and ECMG in February 2021 for planning of future phase rollout. Total cost is £654K (WG 25/01/2021). March 2021 Update - 1 & 2. July 2020 Update - B4 Medical Device training co-ordinator in post, now advised of all new medical equipment installations, and overseeing user training prior to issue. Complete (PJ 17/07/2020). 3. January 2021 Update - New B6 medical device trainer now in post, with all new equipment purchases being referred to Rob Matthews prior to installation. Complete (PJ 06/11/2020). 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. May 2021 Update - For phase 1 equipment has arrived but further work is needed for implementation such as addressing Wi-Fi connectivity issues at POW, addressing new ICT issues with scanning large amounts of equipment in one area via handhelds, mapping locations into the system at PCH, and final installation of oxygen cylinder tracking and bed store equipment at RGH. This work is scheduled to begin in May / June 2021. Due to this the target date has been moved to 31/07/2021. It should be noted that now in place is that any new equipment is now being tagged as part of the RF-ID system and this will continue moving forward. (PJ WG 12/05/2021). 3. July 2021 Update - Wi-Fi connectivity issues at POW are now resolved. ICT issues with scanning via handhelds has been resolved. Mapping locations is no longer viable under current circumstances with ward moves etc. Department lists will be used instead on Version 2 of software. Fixed reader points have been installed at RGH for extended coverage for oxygen cylinder tracking and bed store equipment. Supplier awaiting approval for remote access (to update and set system up to Version 2 of software and database) from ICT. Access issues for the tracking system on Citrix at POW need to be resolved with ICT. Quote received to apply fixed reader points to fully cover RGH site as next phase and will now be submitted to Capital for funding. Lead member from Clinical Engineering has now left the organisation, which has made planning and implementing the above works difficult. Based on the above updates, the target date has been moved to 31/03/2022. (WG DW 20/07/2021). 3. September 2021 Update - Supplier still awaiting approval for remote access (to update and set system up to Version 2 of software and database) from ICT. Access issues for the tracking system on Citrix at POW still being resolved with ICT. Quote received to apply fixed reader points to fully cover RGH site as next phase and submitted to Capital for funding, awaiting decision. (DW WG 20/09/2021). 3. November 2021 Update - CITRIX issue resolved at POW. Remote access issue resolved for supplier to install V2 software for BOC cylinder project. Other ICT anti-virus problem now affecting the system and is under investigation by ICT and Clinical Engineering to replicate and resolve to ensure reliable functionality. The additional quote did not get submitted as key member of staff supporting project left organisation, so it would not be viable to submit without the project / technical support to ensure a successful expansion project. There are other capital replacement schemes which have Clinical Engineering involvement and are higher in risk that are being progressed instead pending submission of an updated bid with
Nurse Agency Usage 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 should be made to the overarching policy and if necessary, the policy should be updated to reflect the existence of the procedure. 4. Senior Nurse Management across the Health Board should ensure the dissemination and awareness of the recently developed procedure for booking bank and agency nurses for use by Ward Managers and the Thornbury authorisation and approval pro forma.	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. ☐ The updated The updated 'Booking Bank & Agency Nurses -Procedures for Ward Managers' ☐ The new Request for Thornbury Nurses proforma. ☐ The updated e-datix reporting algorithm Heads of Nursing to ensure all the documents listed above are circulated to Ward Managers and Senior Nurses.	Director for People		March 2020/April 2020/August 2020	October 2020 February 2021 June 2021 Now September 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - The Bank Policy went to Policy Review Group and was shared for final comment. There were comments on the policy received, that are now being amended in the document to allow it to be re-submitted for the Feb-23 meeting. The actions required in this recommendation have been addressed and included in the 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/January 2021. The updated policy will consist of a review and update of all the bank and agency forms. July 2020 Update - Due to outbreak of covid-19 and consequent pressure on staff bank to recruit additional bank workers to support existing and new HB services has meant a delay in starting this policy. Jan 21 update - Policy has been completed and is awaiting review by policy sub groups. APRIL 2021: See above for policy amendments. Remaining recommendations delayed due to the pandemic but will be taken forward in the same timeframe as the policy approval. Revised implementation date provided. July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September. Sept 2021 update: Due to inability to get interested parties to agree on the final policy, alongside the cancellation of the last 2 meetings for not being quorate, the policy has not progressed further. The policy is awaiting agreement in partnership to progress to policy group. November 2021 Update - No further update provided. January 2022 Update - Policy sent to policy group for ratification. Apr 2022 – The policy was sent through the ratification route. Comments on the content were made post the policy review group meeting. These comments have been taken away and are actively being worked upon by the Deputy Director of Nursing & the Staff Bank Manager. The Policy will then be resubmitted to the policy group in May, if approved this will then progress to the LPF and be signed off for use in the UHB. June 22 update – The policy has been updated and is progressing through the approval process. August 2022 update – The policy is yet to be ratified. The LPF has not sat since the last audit report return as it was cancelled, to allow for ratification of the policy through the appropriate route. The policy will be taken to the next LPF in September 2022. October 2022 Update - The policy has had to be stalled due to changes needed to the agency booking process required by the Nurse Productivity Programme Board. This renewed process is currently with nursing leadership to approve, which is a part of the bank policy. Once this has been approved, the policy will then progress through the route to ratification. December 2022 - The policy has been completed was sent to the Policy Review Group in November. Unfortunately the meeting was not quorate, however, the policy has been shared with the group members, for final review via comments. Then potential sign off will be achieved on the 15th December, at the next Policy Review Group prior to the final stages of the governance route.
Nurse Agency Usage 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 rota. 2. The importance of completing the checklist should be reiterated to the Nurse in Charge as means of supporting and substantiating the decision to use agency nursing.	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 for People	Head of Corporate Nursing	April 2020/May 2020	August 2020 February 2021 June 2021 Now September 2021 Now December 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - The Bank Policy went to Policy Review Group and was shared for final comment. There were comments on the policy received, that are now being amended in the document to allow it to be re-submitted for the Feb-23 meeting. The actions required in this recommendation have been addressed and included in the policy.	Appendix 5 has been sent through to the workforce policy review group for the change to be made to the roster policy it is in the agenda for the aug meeting. November 2020 Update - The Bank Policy is being updated during December 2020/January 2021. The updated policy will consist of a review and update of all the bank and agency forms. Jan 21 update - Policy has been completed and is awaiting review by policy sub groups. APRIL 2021: The Rostering Policy has been updated and is currently in the system for approval. A new Rostering Group has been established with Senior Nurses to ensure appropriate and consistent rostering practice across the Health Board. The Rostering Policy will be approved within the same timeframe as the Bank Policy. A revised implementation date has been provided. July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September. Sept 2021 update: Due to inability to get interested parties to agree on the final policy, alongside the cancellation of the last 2 meetings for not being quorate, the policy has not progressed further. The policy is awaiting agreement in partnership to progress to policy group. November 2021 Update - No further update provided. Feb 2022 Update - Policy sent to policy group for ratification. Apr 2022 – The rostering policy is being reviewed at the next policy group in April 2022. Comments on the content can be made up to 2 weeks after this meeting. If there are none received, it will progress to the LPF and achieve final sign off for use in the UHB. June 22
Directorate Review Acute Medicine & A&E 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.	Chief Operating Officer	ILG Directors/ General Manager	September 2020/December 2020	01/04/2021 Now April 2022 Now December 2022 Now February 2023		Part Completed	February 2023 Update - position remains unchanged.	November 2020 Update - The planned review has been delayed due to the COVID pandemic and the timely appointment to the CSG supporting structure. RTE ILG January 2021 Update - The planned review has been delayed due to the COVID pandemic and the timely appointment to the CSG supporting structure. March 2021 Update - Final timing for the completion of this work will be reported by the end of April 2021. May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a key risk for old policies –and this will be a challenging piece of work to undertake with all the other priorities. Both Directorates do, however, confirm that the new policies that were developed as a result of changes involving covid 19 have been stored in one place and are accessible. July 2021 update. For RTE and MC ILG, no change – remains a key risk area. Will be addressed when capacity allows. September 2021 Update - This remains a key risk and represents a significant amount of work in an area where capacity is stretched. No further action to report, but it remains an issue about which the Service Group is aware. November 2021 Update - no action to report - deadline remains April 2022. February 2022 Update - the Directorate has started a task and finish group to review all policies and procedures and will update them pan CTM if they are organisation wide – support on this from corporate team and policies will be taken month by month through policy group chaired by a Consultant member of the medical staff. Given the size of the task the Directorate says that it will need a year for this to be complete. April 2022 Update - For MC, a monthly task and finish group is in place as part of the ED Improvement Programme. The aim is to review policies and procedures and the Directorate is updating its intranet page. So - for MC, complete. June 2022 - nothing further to add this month, will be pursued for August 2022 for RTE where it remains outstanding and is a challenging area for the CSG. August 2022 Update. For MC, this continues to be included in the Improvement Work underway - so complete. For RTE, this remains a task that the CSG cannot resource adequately. October 2022 Update - position unchanged. Directorate feels that there is not the resource to complete this task appropriately. December 2022 Update - no change within the RTE area as a result of inadequate resources to complete this piece of work.

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Risk Management 2021 03	Feb-21	Reasonable	Whilst we acknowledge that compiling a Training Needs Analysis is a new task that has been included on the Risk Management Improvement Plan, Management need to ensure that all departments and staff are provided with training on the new Risk Management Strategy, and the use Datix to record risks, as soon as possible. This will help ensure consistency of approach across the organisation.	Medium	A training needs analysis will be undertaken early in 2021. In the interim monthly risk training sessions via Microsoft Teams has been scheduled with an open invite for staff across ILG's to attend.	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk	Apr-21	01/07/2021 Now October 2021 Now December 2021 31.12.2021 - Module 1 Training. Module 2, 3 and TNA 31.3.2022 Now April 2022 Now October 2022 Now 31 December 2022		In progress	February 2023 Update - A small cohort of the OFW Task and Finish Group met with the OFW Datix Team on the 6th December to receive an update on progress. Suggestions on further improvements were put forward and a further update meeting is scheduled for 2023. In the meantime monthly training continues with sessions booked throughout 2023. The revised Risk Assessment Procedure was approved in December 2022 which mandates the use of Datix for all risks irrespective of scoring. This has been promoted through the Staff Newsletter along with the training.	Update March 2021 A revised date is requested as the Assistant Director of Governance & Risk is now part of a small Task and Finish Group with other NHS Organisations in Wales to develop a risk training needs analysis that ensures a consistent approach across NHS Wales and avoids duplication. A first draft of a TNA has been developed and will be shared with the Health Board in due course. The training packages to support the TNA are being worked through by the group. Update May 2021 Training Needs Analysis currently being finalised within the Task and Finish Group. Will be shared with the Health Board once the training packages that align have been developed. Update July 2021 - Training Needs Analysis completed and will be shared across the Health Board one the training packages that align to the TNA have been developed. Level 1 Training Package- draft being shared with ELearning colleagues w/c 26th July 2021 to start development of ESR module. Level 2 - Training package development to commence August 2021. September 2021 Update - The Training Needs Analysis is complete, however, the Assistant Director of Governance & Risk is working with peers across NHS Wales to develop Level 1 - 3 Risk Training packages available on the ESR E-Learning platform. Level 1 is currently with ELearning Teams to finalise and Level 2 development has been commenced. An extension to the implementation date is requested to allow for the launch to coincide with the training packages being made available on E-Learning on an All Wales Basis. The Health Board is working with All Wales colleagues to ensure a consistent approach to risk is adopted and transferable across Wales. November 2021 Update - In Progress: Training Needs analysis complete launch of this will be in conjunction with the completion of the following modules. Module 1 Risk Training – developed and with Learning Management System (LMS) Team to finalise and upload to the LMS. Timescale: 31.12.2021. Module 2 – Risk Management in Practice Module 3 – Board Member Risk Awareness Module 2 development will commence in December 2021 and Module 3 - thereafter for completion by the end of March 2022. The TNA will be issued once all modules are complete. The Risk Community in Practice meet on a monthly basis with All Wales representatives progressing the training programmes as a cohesive group to ensure consistency across Wales in the approach to risk management. The monthly risk training will continue until the above is in place. Update January 2022 The TNA and development of an All Wales Risk Management Training package has been placed on hold whilst the Once For Wales Risk Management Module is finalised. The rationale for this decision is to ensure that any training developed is aligned to the new module that staff will be expected to use. The Health Board is represented on the Once For Wales Monthly Meetings and the more regular task and finish group meetings. In the meantime, risk management training continues within the Health Board with monthly sessions being held virtually over Teams. April 2022 Update - The implementation of the Once For Wales Risk Module within the Health Board is anticipated circa October 2022, with two pilot sites going live from the 1st April 2022. The All Wales Training Modules are being developed to align with the new approach and timescales. The TNA has been finalised and Module 1 of the training is in draft. Progress is monitored via the OFW Risk Module Meetings and the All Wales Risk Community of Practice for which the Assistant Director of Governance & Risk is a member. In the meantime, monthly Risk Sessions remain in place throughout 2022 run by the Assistant Director of Governance & Risk and
Financial Systems 03	Apr-21	Reasonable	1. As part of the ongoing review of the Charitable Funds FCP the inconsistencies between the FCP and Scheme of Delegation should be resolved, and updates made where processes and appendices have been amended. 2. Consideration should be given to introducing tolerance levels, below which finance can approve variations in payment values, as opposed to requiring fund holder authorisation. 3. Relevant staff should be made aware of the revised FCP and old copies of forms removed from circulation.	Medium	Agreed, FCP needs to be reviewed in line with the Scheme of Delegation and updated.	Director of Finance	Head of Corporate Finance	Jun-21	01/08/2021 Now November 2021 Now December 2021 Now March 2022 Now June 2022 Now August 2022 Now October 2022 Now January 2023 Now April 2023		In progress	February 2023 Update - FCP has now been updated and will be circulated for review and comment ready for April Audit & Risk Committee.	July 2021 Update - Charitable Funds have recently been moved onto the Oracle system which allows for greater consistency of governance and controls, these are currently being bedded in and reviewed. The FCP needs to be updated to reflect these changes. September 2021 Update - New Model Standing Financial Instructions are to be adopted by the board in October. Following this will require review of the full suite of FCPs, including Charitable Funds FCP. This has started and will be completed in the next couple of months. November 2021 Update - The Model Standing Financial Instructions are due to be approved by the Board on the 25th November 2021. The review of FCPs and SoDs is currently being undertaken and will be brought to the next Audit Committee for endorsement to the Board. January 2022 Update - The Model SFIs have now been approved. Work is ongoing to update the FCPs for Charitable Funds, in line with the move onto the Oracle system. This has been delayed due to audit of the Charitable Funds accounts, but will be a priority in the next month. April 2022 Update - This still requires updating. A review is currently being undertaken on the governance arrangements of the Charitable Funds which will impact on the FCP. June 2022 Update - The Charitable Funds FCP is currently being updated following the audit of the accounts which has further delayed the update. August 2022 Update - This still isn't completed. This should hopefully be updated when we update FCPs following the change in Scheme of Delegation update due to the restructure. This will be a significant piece of work. Hope to complete by October 2022. October 2022 Update - We have engaged with internal audit to discuss the changes to the forms which are included within the FCP and are in discussion with ICT on how we can make better use of digital signatures for forms. The Oracle process has given an opportunity to simplify the authorisation of expenditure process, which will significantly change the FCP and form. This is a continued piece of work which
Sunnyside Health & Wellbeing Centre 01	Aug-21	Reasonable	Management should confirm revised governance arrangements via a Project Execution Plan including: • effective cost management; • contractual relationships, values and payment arrangements; • committee reporting of project risks; • scheduled outputs from sub-groups for scrutiny; and • stakeholder engagement.	Medium	The Health Board will work with the external project manager to develop a Project Execution Plan to be signed off at the Project Board, this will provide a formalised single record of all of the above criteria which have been approved separately by Project Board.	Director of Finance	Head of Capital	Sep-21	Now January 2022 Now 31 March 2022 Now May 2022 Now August 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - the PEP is being drafted however there have been delays in the same due to the administration of the contractor. It was anticipated the completion contract would have been issued by this time however due to internal process at Linc Cymru this has been delayed to the end of September, as a result the PEP will not be completed until the new contractor is know and this is not likely to be until December 2021 at the earliest. November 2021 Update - the PEP will be drafted however there have been delays in the same due to the administration of the contractor. It was anticipated the completion contract would have been issued by this time however due to internal process at Linc Cymru this has been delayed to mid November. As a result the PEP will not be completed until the new contractor is known and this is not likely to be until late January 2022 at the earliest. January 2022 Update The tender process has been extended at contractors request. The tender process closes on 9th Feb and will need a ca 3 week evaluation process. At that stage the revised costs will need to go back to WG for re-approval. Therefore it has been proposed to change the review date to 31 March 2022 when contractor, costs and timeline should be clearer to inform the contents of the PEP. April 2022 Update - ongoing however focus has been on the new contractor appointment and whether a disaggregated tender process will be required as this will completely change the way that reporting and contractual management lines work within the PEP. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 2022 Update - there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction
Sunnyside Health & Wellbeing Centre 04	Aug-21	Reasonable	Management should ensure that individual cost provisions within the works information are reported to understand charges and adjustments to provisional sums.	Medium	The updated reporting template includes a section detailing provisional sums and contingencies and tracks through the release of provisional sums into actual costs, as well as all contingency items, these will be reported monthly to Project Board as part of the financial template. However there will need to be a further tender and revised provisional sums with the letting of a contract for completion therefore an extended target date is provided to ensure the most up to date information is captured	Director of Finance	Senior Project Manager	Mar-22	Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - Remains in progress to be agreed with the new contractor when appointed. November 2021 Update - Remains in progress to be agreed with the new contractor when appointed. Update 31.01.22 the tender process has been extended at contractors request. The tender process closes on 9th Feb and will need a ca 3 week evaluation process. At that stage the revised costs will need to go back to WG for re-approval. Therefore it has been proposed to change the review date to 31 March 2022 when contractor, costs and timeline should be clearer to inform the report contents. April 2022 Update - With no contractor appointed as yet and no confirmed revised tender sum this is difficult to implement extended to give time for possible further tender and contractor appointment. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 2022 Update - there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023
Sunnyside Health & Wellbeing Centre 05	Aug-21	Reasonable	Management should ensure provision of project manager and cost adviser reports, in support of the Welsh Government Dashboard return.	Medium	These will be included as required as soon as the project recommences, and a new contractor is appointed. This is likely to take at least a further 3-4 months hence the longer target date.	Director of Finance	Senior Project Manager	Jan-22	Now March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - Remains in progress to be agreed with the new contractor when appointed. November 2021 Update - Remains in progress to be agreed with the new contractor when appointed. January 2022 Update The tender process has been extended at contractors request. The tender process closes on 9th Feb and will need a ca 3 week evaluation process. April 2022 Update - With no contractor appointed as yet and no confirmed revised tender sum this is difficult to implement extended to give time for possible further tender and contractor appointment. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 2022 Update - there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment

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Blue - Action

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	Status	Progress	Updates during this period/Latest Update	Previous Updates
Sunnyside Health & Wellbeing Centre 07	Aug-21	Reasonable	Management should obtain documentation to which the client is entitled under the contract, including collateral warranties, and a copy of the construction performance bond, and confirm assurances provided at the latter.	Medium	These are available and will be supplied by the developer.	Director of Finance	Senior Project Manager	Sep-21	Now November 2021 Now January 2022 Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - There have been delays in obtaining all of this due to the priority being the completion contract works these are in hand to be provided by the time of the next meeting. November 2021 Update - Remains in progress to be provided by the new contractor when appointed. January 2022 Update The tender process has been extended at contractors request. The tender process closes on 9th Feb and will need a ca 3 week evaluation process. At that stage the revised costs will need to go back to WG for re-approval. Therefore it has been proposed to change the review date to 31 March 2022 when contractor, costs and timeline should be clearer to inform the report content. April 2022 Update - Awaiting to ensure that the tender will proceed in current format or whether separate continuation arrangements and contracts will be made. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023
Sunnyside Health & Wellbeing Centre 10	Aug-21	Reasonable	Management should be provided with proposed contact variations and monitoring to facilitate timely Health Board scrutiny, in accordance with entitlements under the contract.	Medium	This will be provided when the project restarts and all design works are completed.	Director of Finance	Senior Project Manager	No Date Identified	01/03/2022 Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - To be completed and agreed with new contractor on appointment. November 2021 Update - To be completed and agreed with new contractor on appointment. January 2022 Update The tender process has been extended at contractors request. The tender process closes on 9th Feb and will need a ca 3 week evaluation process. At that stage the revised costs will need to go back to WG for re-approval. Therefore it has been proposed to change the review date to 31 March 2022 when contractor, costs and timeline should be clearer to inform the report content. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new
Sunnyside Health & Wellbeing Centre 11	Aug-21	Reasonable	The Health Board require the developer to remind the contractor of its contractual obligations to formally notify of any delays (and their associated time/cost impact within the contractual time frames).	Medium	With the original contractor there was confidence that much of the time could be recovered and therefore no formal application had been made. Clearly with the current contractor going into administration there will need to be a new contractor appointment. The Health Board will ensure that the need for a contractual. notification of future delays is communicated to the new contractor.	Director of Finance	Senior Project Manager	Mar-22	Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - To be completed and agreed with new contractor on appointment. November 2021 Update - To be completed and agreed with new contractor on appointment. January 2022 Update - as per the above notes this can only be done post contractor appointment which has delayed due to tender period extensions and confirmed need for WG re-approval. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023
Sunnyside Health & Wellbeing Centre 12	Aug-21	Reasonable	A costed risk register should be regularly maintained and reported to facilitate monitoring of the build.	Medium	A fully costed capital risk register is in existence and will continue to be kept up to date as risks are realised or not throughout the project, however this will be revisited with decision on process for and appointment of a new contractor.	Director of Finance	Head of Capital	Nov-21	Now March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - In progress and development - risk of some slippage due to delays in the tender for the completion contract but all steps are being taken to ensure this is completed by November. November 2021 Update - To be completed and agreed with the Employers Agent once new contractor has been appointed. January 2022 Update - see notes above for revised timeline. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023
Sunnyside Health & Wellbeing Centre 13	Aug-21	Reasonable	Management should actively monitor and report the value of residual construction cost risks v remaining contingency.	Medium	This is picked up in the appendix to the standard Highlight Report discussed in action 2.	Director of Finance	Head of Capital	Sep-21	Now March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - One off exercise done to date but this will not be actively monitored until construction works recommence. November 2021 Update - One off exercise done to date but this will not be actively monitored until construction works recommence. January 2022 Update - see notes above for revised timeline. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be
Sunnyside Health & Wellbeing Centre 15	Aug-21	Reasonable	The Health Board should obtain engrossed and signed copies of all relevant developer adviser contracts in accordance with entitlements to inform of potential liabilities and costs, and report relevant implications to appropriate groups/committees.	Medium	This cannot be fully achieved without the appointment of a new contractor. The Health Board will ensure that all contracts have been received and filed centrally. The new contractor contract will be provided by the developer on signature .	Director of Finance	Project Leader	Sep-21	Now January 2022 Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - Contracts for all save for the new contractor are complete - for the new contractor this will not be delivered until 2022. November 2021 Update - Contracts for all save for the new contractor are complete - for the new contractor this will not be delivered until 2022. January 2022 Update - see notes above for revised timeline. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be
Sunnyside Health & Wellbeing Centre 18	Aug-21	Reasonable	Management should obtain signed lease agreements with relevant parties at the earliest opportunity.	Medium	The Primary Care lead will continue to work with NWSSP Specialist Estates Services to ensure that the lease is signed off as soon as possible.	Director of Finance	Primary Care Estates and Development Manager	Jan-22	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - Ongoing with GPs partners however new contract and revised cost is required now to finalise this. November 2021 Update - Ongoing with GPs partners however new contract and revised cost is required now to finalise this. January 2022 Update - this will be delayed until after the new contractor costs and timeline is known. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as

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Yellow - Action
Green - Action
Blue - Action

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	Status	Progress	Updates during this period/Latest Update	Previous Updates
Sunnyside Health & Wellbeing Centre 19	Aug-21	Reasonable	Management should confirm an agreed service model with measurable outcomes for front line and support services.	Medium	The Bridgend Integrated Locality Group (ILG) will link with the Primary Care team over the service model and support functions. This will be developed during the construction period for the site and given that the completion is likely to slip to late 2/23 the target is to complete in order that any financial consequences are picked up in Integrated Medium Term Plan (IMTP) planning cycles.	Director of Finance	Bridgend ILG Community Lead	Mar-22	Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - Ongoing. November 2021 Update - Ongoing. January 2022 Update - remains ongoing as programme remains unclear until contractor appointment. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment
Sunnyside Health & Wellbeing Centre 20	Aug-21	Reasonable	Objectives at the business case should be measurable.	Medium	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	Director of Finance	Head of Capital	Jan-22	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - Ongoing. November 2021 Update - Ongoing. January 2022 Update - may need to be tied in with new contractor appointment. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023
Sunnyside Health & Wellbeing Centre 21	Aug-21	Reasonable	Management should review and confirm project objectives based on only measurable outcomes within a Benefits Realisation Plan.	Medium	Please see response above .	Director of Finance	Head of Capital	Jan-22	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - Ongoing. November 2021 Update - Ongoing. January 2022 Update - as per BRP. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023
Welsh Language Standards Compliance 06	Oct-21	Reasonable	6.1) The importance of compliance with the Welsh Language Standards should be reiterated to all staff, and the implications of non-compliance should be considered for inclusion on departmental and ILG risk registers and subsequent monitoring. 6.2) The risk register should be reviewed to ensure the controls listed as being in place and the action marked as completed are an accurate reflection of the findings made during the audit review.	Medium	6.1) The Welsh Language Manager will develop regular communications to remind all staff of their responsibilities and the importance and benefits of complying with the Welsh Language Standards. These communications will be distributed to staff via a range of communications media, including social media. 6.2) The nominated senior ILG leads on the Welsh Language Working Group should discuss with department managers, the inclusion of non-compliance with the Standards on their departmental registers, to assist with the monitoring of progress and completion of outstanding actions. 6.3) The Welsh Language Manager will review the actions on the current Workforce and OD and Health Board Risk Registers to ensure that they are up to date and include the risks identified in this audit report. 6.4) The nominated ILG senior members of the Welsh Language Working Group will have responsibility for adding relevant and appropriate non-compliance issue to the ILG risk registers, which are monitored by the respective SMTs.	Director for People	Welsh Language Manager/ILG Leads/Head of Policy, Compliance and Agenda for Change	January 2022/October 2021	Now March 2022 Now June 2022 Now August 2022 Now October 2022 Now December 2022 Now January 2023 Now March 2023		In progress	February 2023 Update - Met with the Executive Director for People on 30th Jan 2023 to plan and confirm meeting dates for 2023/24 Welsh Language Steering Group. First meeting of the Steering Group will take place on the 15 March 2023 and a programme of dates have been agreed for the rest of the year.	November 2021 Update - The Risk Register has been updated. Although the risk register has been updated. The senior leadership of the ILGs have not received communication or action plans as the new Welsh Language Committee hasn't met. This means there is no progress with ILGs monitoring their compliance and updating their own risk registers. Jan 2022 update 6.1) A short communication plan will be written by the recently appointed Welsh Language Manager, including resources to share regarding the Welsh Language Standards i.e. videos and graphics to promote understanding of them. This will be discussed in a meeting arranged with the Asst Director of Communications and Engagement on 3 February 2022. 6.2) The inclusion of Welsh Language risks on the ILG Risk Registers will be an agenda item all forthcoming Welsh Language Committee meetings, with effect from 17 March 2022. 6.3) The Welsh Language Risk Register has been reviewed and appropriate risks added, including the findings of this audit. 6.4) The inclusion of Welsh Language risks on the ILG Risk Registers will be a standing agenda item on the new Welsh Language Committee, which is scheduled for 17 March 2022. 6.1) Regular communications are drafted and sent via staff updates with SharePoint reviewed regularly. 6.2) Departmental risk registers will be added to once weaknesses are identified through action planning 6.4) The inclusion of Welsh Language risks on the ILG Risk Registers will be a standing agenda item on the new Welsh Language Steering Group, which was scheduled for 17 March 2022 but new date to rescheduled June 2022 Actions points 6.1, 6.3 and 6.4 have been completed previously. December 2022 update - The WL Steering Group has been deferred while some key appointments are still being made within Care Groups. The first meeting will convene in New Year. 6.2) The inclusion of Welsh Language risks on the ILG Risk Registers will be an agenda item all forthcoming Welsh Language Committee meetings, which is in the process of being arranged. August 2022 Update - Work has continued to remind managers and staff of their Welsh Language responsibilities. This is picked up during routine department audits by the Welsh Language Team and in the bespoke departmental action plans. The identified Welsh Language WOD risks are reviewed and progress noted at the WOD Business Transformation SMT meeting. October 2022 Update - the revised ToR for the WL Steering Group confirms that the membership will comprise of senior Care Group leads who will be responsible for addressing non-compliance issues, monitor progress and ensure outstanding actions are completed and the outcomes reported back to the Steering Group. This process will commence following the first meeting of the WL Steering Group.
CHC and FNC 1.1	Feb-22	Reasonable	1.1a Existing procedure documents and assessment forms, including those that are in draft format, should be reviewed and updated to reflect the revised WG CHC framework and any changes as a result of the new operating model in place within the Health Board. 1.1b Once finalised, management should ensure that they are accessible to all relevant staff and that staff are using the most up to date versions of the forms.	Medium	1.1a The CHC team are awaiting the release of the new Welsh Government CHC Framework, launch date due in February 2022 with an implementation date of 01.04.2022. All existing documentation and assessment forms will be reviewed and updated to reflect the revised WG CHC Framework, in readiness for implementation. 1.1b The CHC team will ensure that all reviewed, updated documents, following the implementation of the WG CHC framework in April 2022, will be accessible for all staff via the designated CHC page on the CTMUHB intranet site, to ensure staff are using the most current version of the forms.	Chief Operating Officer	Lead Nurse for CHC and NHS Funded Care	Apr-22	Now July 2022 Now September 2022 Now December 2022		Completed	February 2023 Update - All existing documentation and assessment forms have been reviewed and updated to reflect the revised WG CHC Framework. 1.1b Dedicated CHC Page on CTMUHB Intranet has been set up and will continue to be updated throughout 2023 as necessary. CHC Page on CTMUHB Internet site also set up.	April 2022 Update - No update this month due to sickness of Lead Nurse. Anticipated that there will be more to report at the next meeting. June 2022. The work to align the documentation with the new CHC Framework commenced in March and will be completed by end of June. There are weekly working group meetings to address the various aspects of the new CHC Framework to ensure that the process is compliant and transparent making transition from the old to new Framework is smoother for all our staff and patients. The working documents and associated processes will be uploaded onto CTM UHB Intranet Site by mid July. August 2022 Update. All documentation has been finalised and distributed to the teams. Discussion has taken place with Comms to put onto the intranet site by September 2022. October 2022 Update - A meeting has been arranged with the communication team to agree the webpage. All documents available and ready for upload. December 2022 update: Admin have met with the communication team and both internet and intranet pages have now been created, Documents have begun to be published to both. Further documents to be added shortly. The intranet will facilitate quick and easy information sharing for members of staff. Pertinent documents (e.g. New appeals and disputes protocol) to be shared with relevant stakeholders, e.g. Local authorities. Communication team will show admin how to update the intranet so that any further amendments can be made quickly in future.
CHC and FNC 1.2	Feb-22	Reasonable	1.2 A terms of reference for the Clinical Service Group Panels and Integrated Locality Groups panels should be put in place to set out the roles of each panel, their decision-making responsibilities and membership and quoracy arrangements. When developing the ILG panels terms of reference, consideration should be given to decision making powers of the panel when they are making funding decisions on behalf of another ILG for cases where the individual does not reside in their ILG area.	Medium	1.2 • Clinical Service Group Terms of Reference are in draft and are to be finalised by March 31st 2022, to include decision-making responsibilities, membership and quoracy arrangements. • Integrated Locality Group Unit Panel Group Terms of Reference will be reviewed and updated in line with the CSG ToR above and will be approved by March 31st 2022.	Chief Operating Officer	Lead Nurse for CHC and NHS Funded Care	Mar-22	Now July 2022 Now October 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - ToR still in draft will be finalised by March 2023.	April 2022 Update - No update this month due to sickness of Lead Nurse. Anticipated that there will be more to report at the next meeting. June 2022 Update. Terms of Reference have been updated, reviewed and are awaiting final sign off. August 2022 Update - no change. Further update at the next meeting. October 2022 Update - Terms of Reference that had been previously agreed, need to be re-reviewed in light of new operating model. December 2022 Update - Await new operating model. Terms to be reviewed in light of this once received.

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CHC and FNC 1.3	Feb-22	Reasonable	1.3 The CHC Financial Control Procedure should be reviewed by the finance team in conjunction with the CHC team and updated to reflect current processes and set up within the Health Board.	Medium	1.3 The Finance Team will review the Financial Control Procedure (FCP) in line with any changes identified in the new CHC Framework. The updated FCP will be an agenda item at the Audit Committee and a further review date agreed.	Chief Operating Officer	Finance Manager CHC/Finance Manager Commissioning and Contracting	May-22	Now August 2022 Now October 2022 Now December 2022 Now April 2023		In progress	February 2023 Update - CHC Finance Team are currently drafting Financial Control Procedure and will liaise with CHC Team to confirm when completed. Should be within the month.	April 2022 Update - No update this month due to sickness of Lead Nurse. Anticipated that there will be more to report at the next meeting. June 2022. Colleagues from Finance have been approached to provide an update on the new Finance Control Procedure. August 2022 Update - response awaited from Finance. October 2022 Update - As a consequence of sickness this remains an outstanding issue, but Finance colleagues are aware and are working on it. December 2022 Update - As a consequence of sickness this remains an outstanding issue, but Finance colleagues are aware and are working on it.
Digital Strategy	Apr-22	Reasonable	3.1. Work should continue to ensure benefits are fully defined within business cases, along with a baseline position and a process for benefits realisation. 3.2 Consideration should be given to defining an overall benefits position for the Digital Strategy.	Medium	All moderate to major digital developments now require a business case and are subject to a degree of scrutiny which incorporates not only the anticipated benefits but the process by which these benefits will be measured and actions taken where there is limited delivery. In regards to overall benefits measuring, the UHB is committed to ensuring that this is incorporated within the WG digital and data strategy and that there is alignment to the Value Based Health Care Programme. In addition to this, the Health Board is currently reviewing its operating model and there is an opportunity to re-align and strengthen the relationship and ways of working between major digital developments and the change hub where the majority of capacity for programme and project management, service change and benefits management. This review is planned to be complete by the end of September 2022	Director of Digital	Director of Digital	Qtr 3 2022/2023	Now Qrtr 4 2022/2023		In progress	February 2023 Update - Structure will be finalised by end of Qtr 4 2022/2023. 12 month post will be appointed to support service change and benefits realisation under a new Assistant Director of Digital Transformation	June 2022 Update - Operating model phase 1 nearing completion, 2nd stage yet to commence. August 2022 - new operating model and proposed digital operating model to be completed by September 2022. October 2022: Current Strategic Leadership tier has been proposed and is under consultation. This is due to complete in early November 2022 and therefore on track for completion within Qtr 3 2022/2023. Benefits Realisation processes will be embedded into a new Digital Transformation function - subject to completion of the consultation. December 2022 Update - Strategic Leadership Structure to be completed by end of December 2022 - proposal to appoint a new Assistant Director of Digital Transformation who will have benefits realisation within the portfolio
Overtime & Additional Hours 1.1b	May-22	Reasonable	Given the time and events that have passed, a reminder should be issued to all senior managers in relation to the Overtime and Additional Hours Policy, including the authorisation process to follow if payments outside of AfC are necessary.	Medium	The Workforce Policy Review Group will ensure that this is included in the policy and that the current and future versions of the Overtime Policy are shared with the managers within the UHB. The current policy is available via the intranet. Further communications will be sent out in the Staff Bulletin and via the ILG Heads of Workforce briefing, with the senior management Team and cascaded to managers on their email distribution lists.	Director for People	Head of Workforce Productivity and E-Systems / Assistant Director of Policy, Governance and Compliance	Jun-22	Now November 2022 Now January 2023 Now March 2023		In progress	February 2023 Update - First draft of policy complete, seeking clarification on NWSSP recording process in respect of overtime worked which is not recorded in Health Roster. The guidance to support managers with NWSSP process needs to be written to form an appendix of policy. The policy will go out for consultation to be brought back to Feb Policy Review Group.	August 2022 Update - The Overtime Policy will be reviewed by the Workforce Policy Review Group in September 2022. The review will take into consideration the internal audit recommendations. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated. December 2022 - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group.
Overtime & Additional Hours 1.2	May-22	Reasonable	Procedure documents in relation to overtime should be developed and made available to those areas that do not currently use Heath Roster. The procedure should cover key points such as how overtime is captured and any prior authorisation required, and the checking and authorisation process that managers should follow. A standardised claim form should form part of the procedure.	Medium	There currently is guidance contained in the Overtime Policy directing managers on overtime use and application. The WPRG will undertake to review this policy to ensure that it is fit for purpose and reflects the requirement of the audit recommendation.	Director for People	Assistant Director of Policy, Governance and Compliance	Nov-22	Now January 2023 Now March 2023		In progress	February 2023 Update - The revised draft Overtime Policy incorporates the management actions agreed.	August 2022 Update - The Overtime Policy will be reviewed by the Workforce Policy Review Group in September 2022. The review will take into consideration the internal audit recommendations. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated. December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group.
Overtime & Additional Hours 2.1	May-22	Reasonable	The value and practicality of using the overtime authorisation checklist should be reviewed. Consideration should be given to alternative approaches for capturing the justification and authorisation of overtime in advance of it being worked. For example, in some instances, it may be more efficient to have one justification checklist completed and approved per department but reviewed periodically.	Medium	The Overtime Policy review will be undertaken by the Workforce Policy Review Group (WPRG), in partnership with local trade union colleagues and key stakeholders. The revised Overtime Policy will set out the new, more practical approach for capturing the justification and authorisation of overtime in advance of it being worked in accordance with the Audit recommendation. Provision will be made within the revised Overtime Policy to address both circumstances i.e. consistent use of overtime and occasional use, ensuring that clear guidance is provided on how to manage both in Health Roster and outside of Health Roster.	Director for People	Assistant Director of Policy, Governance and Compliance	Nov-22	Now January 2023 Now March 2023		In progress	February 2023 Update - The revised draft Overtime Policy incorporates the management actions agreed.	August 2022 Update - The Overtime Policy will be reviewed by the Workforce Policy Review Group in September 2022. The review will take into consideration the internal audit recommendations. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated. December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group.
Overtime & Additional Hours 2.2	May-22	Reasonable	If the approach to using the overtime authorisation and justification checklist is to be consistently used in the future, then the information being captured should be reviewed and scrutinised in order to understand the underlying reasons for use of overtime and to aid the development of plans to address those issues.	Medium	The revised Overtime Policy will outline the responsibility of the Workforce Efficiency Team to regularly review and analyse the overtime authorisation and justification checklist data to provide the UHB with intelligence on the reasons for overtime, which will assist the organisation to review and development the Workforce Plan to address the identified issues. The Workforce Efficiency Team will explore alternative more practical approaches for capturing the justification and authorisation of overtime in advance of it being worked in accordance with the Audit recommendation. This work will be undertaken in parallel with the review of the Overtime Policy, to ensure this process is reflected within. The new process will form the basis of a clear and auditable overtime justification and authorisation process.	Director for People	Assistant Director of Policy, Governance and Compliance /Head of Workforce Productivity and E-Systems	Nov-22	Now January 2023 Now March 2023		In progress	February 2023 Update - The revised draft Overtime Policy incorporates the management actions agreed. Overtime booked via the eSystems team (Health Roster) captures the reason for why the shift has been booked, when and who authorised it. This is the case for every shift undertaken, such as 'sickness'.	August 2022 Update - This work is being progressed by the Head of Workforce Efficiency and E-Systems. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated. December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group.

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Overtime & Additional Hours 3.0	May-22	Reasonable	A standardised claim form for capturing overtime and additional hours should be in place, that incorporates the requirement for individuals to confirm the hours they have worked, and for management to authorise the claim ahead of input on pay return. Claim forms also need to be clear about the need to capture time net of breaks.	Medium	A single standardised claim form, for the use in all non-health roster areas will be developed by the WPRG and contained within the Overtime Policy, for all areas of the UHB to access and use. The form will be based on the standardised NWSSP Payroll form for overtime and additional hours claims, which will contain information on the shift worked, the date, time, rate of pay and who has approved and authorised the payment. Once the Overtime Policy is reviewed and ratified all former UHB overtime forms in circulation and use will be withdrawn (removed from SharePoint etc.) and Payroll instructed to only accept and process the new standard form for payment.	Director for People	Head of Workforce Productivity and E-Systems	Nov-22	Now January 2023 Now March 2023		In progress	February 2023 Update - As part of the policy development we are developing a standardised claim form using NWSSP payroll template to be used when overtime is not recorded on Health Roster.	August 2022 Update - The Overtime Policy will be reviewed by the Workforce Policy Review Group in September 2022. The review will take into consideration the internal audit recommendations. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated. December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group.
Overtime & Additional Hours 4.0	May-22	Reasonable	Now that all Covid related agreements for payment of higher overtime rates have concluded, a review of payroll data should be carried out to identify departments that are continuing to pay staff outside of the AfC terms and conditions. Payroll codes set up specifically for such payments should be closed to prevent usage. Where it identified that payments outside AfC remain, discussions should be held with the departments to ascertain the reasons why. If necessary, the appropriate procedure should be followed to obtain authorisation in line with the scheme of delegation to continue with such payments.	Medium	Review of Payroll Overtime enhancement codes undertaken by Head of Workforce Productivity and e Systems with an NWSSP Payroll manager to ensure all non AfC payroll codes are closed immediately. The revised overtime policy will set out that all overtime and enhanced payments will be paid only in accordance with AfC. Should a department wish to deviate from these arrangements a discussion must take place with Executive Director for People.	Director for People	Head of Workforce Productivity and E-Systems Assistant Director of Policy, Governance and Compliance	July 2022 November 2022	Now January 2023 Now March 2023		In progress	February 2023 Update - The revised draft policy now confirms that all overtime and enhanced payments will only be paid in accordance with A4C and any deviation must be approved by the Exec Director for People. Payroll will only process enhanced payments if prior approval has been given by the UHB. Health Roster can only allow enhanced payments if this is turned on for areas. This can only be allowed centrally and at the instruction of the Director for People.	August 2022 Update - The Overtime Policy will be reviewed by the Workforce Policy Review Group in September 2022. The review will take into consideration the internal audit recommendations. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated. December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 People Policy Review Group.
Consultant Job Planning Follow Up 3.1	May-22	Reasonable	The new e-job planning guide should be updated to reflect the Health Board's position in respect of the recording of personal outcomes within job plans, and also the recording of Health Board, service or directorate outcomes. The Health Board should ensure that the revised job planning training materials include appropriate guidance on the recording of outcomes within job plans, in line with the e-job planning guide.	Medium	Development of and management of outcomes in job plans is a priority area of work for the Medical Director's team. This work has been assigned to the Assistant Medical Director (AMD) for Workforce to complete the framework of how this will be achieved. This will then be incorporated into the suggested documentation and training.	Medical Director	AMD for Workforce	Sep-22	Now December 2022		Completed	February 2023 Update - The SPA document has been approved between Medical Workforce, the BMA and the Local Negotiating Committee (LNC). It has been distributed to the Consultant workforce and relevant managers. A Job Planning workshop is planned for the 26th January to discuss the SPA document and job planning.	June 2022 Update - In progress - on target for September 2022 completion. July 2022 update - Current Job planning process already has outcomes in the form of a division of work between Direct Clinical Care (DCC) and Supporting Professional Activities (SPA). The contractual position states having a DCC: SPA split of 7:3. In practice this varies with different departments and for different individuals. The average split for CTM is around 7.5-8 DCC activities and 2.5-2 SPAs. An agreement with the LNC has been reached but is awaiting final ratification, regarding the tariff for various SPA activities, bringing objectivity and equality across the 3 ILGs. (The last 2 LNC meetings got cancelled due to unavoidable circumstances). The DCC undertaken already has specific outcomes regarding the time (when) and site (where) the activity is undertaken. Some departments record the time that the SPA activity is undertaken on site, whereas some departments do not. There is recognition that one SPA activity can be contractually undertaken at home and that some SPA activities cannot have a fixed time in the week to undertake it. The workforce department is working towards having a greater detail in the level of outcomes both for DCC and SPA, but that requires improvement in data access and training of CDs and managers undertaking the job planning. It is envisaged that once the clinical leads in the new structure are appointed, the process for having more detailed outcomes in job planning can be prioritised. October 2022 Update - no update provided against this recommendation on this occasion. December 2022 Update – The BMA representatives have now withdrawn approval for the previous documentation shared, wanting
Consultant Job Planning Follow Up 5.1	May-22	Reasonable	Residual work in relation to the principals of the ADH rate card and its subsequent approval should be completed.	Medium	A paper discussing the principles on which a rate card will be developed has been submitted to Director of People. Agreement of these principles will then result in the engagement of interested parties to develop the rate card.	Director for People	Director for People	Dec-22	Now April 2023		In progress	February 2023 Update - An all Wales approach has now developed a rate card. The work is now in its final stages, with all the Health Boards undertaking a cost assessment based on the proposed ADH rates for Wales. There is a meeting scheduled for the 1st week of February where the implementation date will be discussed and set. The implementation date has been estimated as 1st of April 2023, however this will be revised after the meeting in Feb-23.	August 2022 Update - The first meeting of the 'the unified transformation portfolio' sat on the 20th July. The work for the development of the rate card has been folded into the Medical Workforce productivity work stream. The rate card development and delivery has therefore been incorporated into the PID for the medical workforce productivity. October 2022 Update – The rate card development is now one of the work streams identified in the Medical Productivity Programme. The development of a rate card is being led by the Interim Unscheduled Care Group Medical Director, a task and finish group is being formed and further information on the work stream will be shared in due course. December 2022 Update - This work has expanded further than our own Health Boards boundaries. There is now a national group that has met numerous times to decide and recommend a unified approach across Wales for rates paid for ADHs. Antony Gibson, the local lead for the rate card development is a member of this group, along with the AMD for Workforce and the Head of Workforce Productivity & E-Systems. This group will have a recommendation for rates finalised in December 2022. This recommendation will go to Welsh Government for comment, ratification and then implementation if approved.
Welsh Risk Pool Claims 1.1	Jun-22	Reasonable	Management should ensure that required documentation is submitted to the WRP within the specified timeframes and monitoring takes place to ensure compliance with this requirement.	Medium	1.1a Legal Services SOPs to be reviewed and updated. 1.1b Monitoring process to be implemented in respect of deadlines for various paperwork submissions. 1.1c Spot check audit to be undertaken bi-monthly on paperwork submissions against deadlines i.e. CMRs, LFERs etc.	Director of Nursing	Legal Services Manager	1.1a Dec 2022 1.1b June 2022 1.1c August 2022	Now February 2023		In progress	February 2023 Update - 1.1a Some Legal Services SOPs have been reviewed and updated. Some are still in progress of being reviewed. 1.1b LFERs are regularly monitored via reports/trackers and dashboards. Datix Cymru has been updated to enable better tracking of red/amber deferred cases. These are regularly monitored via weekly data review meetings and Executive Patient Safety meetings. 1.1c Spot check audits undertaken by the Legal Services Manager Regular engagement with Welsh Risk Pool. LFER improvement plan devised, prioritising as appropriate, between legacy cases and new cases, as well as high value claims. £12.4 million has been approved by WRP for reimbursements in the last few months. LFERs have been given as a key responsibility for PSIM within the new operating model.	August 2022 Update 1.1a Legal Services SOP in progress of being reviewed. 1.1b LFERs are regularly monitored via reports/trackers and dashboards. Datix Cymru has been updated to enable better tracking of red/amber deferred cases. These are regularly monitored via weekly data review meetings and Executive Patient Safety meeting. 1.1c Spot check audits undertaken by the Legal Services Manager Regular engagement with Welsh Risk Pool. LFER improvement plan devised, prioritising as appropriate, between legacy cases and new cases, as well as high value claims. Date for submission of cases deferred over 6 months set for end of September. October 2022 Update 1.1a Legal Services SOP in progress of being reviewed. 1.1b LFERs are regularly monitored via reports/trackers and dashboards. Datix Cymru has been updated to enable better tracking of red/amber deferred cases. These are regularly monitored via weekly data review meetings and Executive Patient Safety meeting. 1.1c Spot check audits undertaken by the Legal Services Manager Regular engagement with Welsh Risk Pool. LFER improvement plan devised, prioritising as appropriate, between legacy cases and new cases, as well as high value claims. Date for submission of cases deferred over 6 months set for end of September.

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Welsh Risk Pool Claims 2.1	Jun-22	Reasonable	Procedures should be in place that provide staff with clear guidance on how to process claims, especially the dates that are to be used in relation to the 'Decision to Settle' and 'Final Payment', and the circumstances of when these dates should be updated in Datix. Guidance should also cover the other issues we identified including the correct process for capturing financial transactions in Datix and the process that should be followed if a claim is dismissed when taken to court.	Medium	2.1 Legal Services SOPs to be reviewed and updated and staff to be retrained where appropriate. 2.2 SOP to be devised to assist staff through the financial process if a claim is dismissed.	Director of Nursing	Legal Services Manager	Dec-22	Now January 2023 Now February 2023		In progress	February 2023 Update - 2.1 Legal Services SOPs in process of being reviewed. 2.2 Financial SOP to be developed	August 2022 Update 2.1 Legal Services SOPs in process of being reviewed. 2.2 Financial SOP to be developed. October 2022 Update 2.1 Legal Services SOPs in process of being reviewed. 2.2 Financial SOP to be developed December 2022 Update - 2.1 Legal Services SOPs in process of being reviewed. 2.2 Financial SOP to be developed
Financial Systems 1.1	Jun-22	Reasonable	Guidance notes / desktop procedures should be developed to provide more detailed explanations on the budgetary control and virement processes to be followed to ensure compliance with the FCP.	Medium	An updated process document will be put in place for virements to ensure consistency and understanding across the Health Board.	Director of Finance	Head of Corporate Finance	Jul-22	Now January 2023		Completed	February 2023 Update - Discussions have taken place with the management accounts team and an updated process note is being implemented.	August 2022 Update - All FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. October 2022 Update - Need to review the appropriateness of the review of virements. Virements are done in line with Scheme of Delegation. December 2022 Update - Process still being reviewed
Financial Systems 6.2	Jun-22	Reasonable	In order to mitigate any form of error, virement journals being signed off by both the preparer and reviewer.	Medium	We will update the requirements of review/sign off as part of the updated process.	Director of Finance	Head of Corporate Finance	Jul-22	Now October 2022 Now January 2023		Completed	February 2023 Update - Discussions have taken place with the management accounts team and an updated process note is being implemented.	August 2022 Update - This will be updated in line with the update of FCP. October 2022 Update - Need to review the appropriateness of the review of virements. Virements are done in line with Scheme of Delegation. December 2022 Update - Process still being reviewed.
Financial Systems 8.2	Jun-22	Reasonable	In cases where it is appropriate, management should explore the use of alternative mechanisms for raising orders and paying invoices, for example the use of 'call off' orders.	Medium	As above, we will identify the areas where retrospective orders are raised and review alternative mechanisms for order or payment.	Director of Finance	Head of Procurement	Mar-23			In progress	February 2023 update - Alternative methods of payments will be reviewed within the NO PO/Retrospective order review by March 2023 alongside the PO exemption list	August 22 update - Alternative methods of payments will be reviewed within the NO PO/Retrospective order review by March 2023. October 2022 update - Alternative methods of payments will be reviewed within the NO PO/Retrospective order review by March 2023. December 2022 update - Alternative methods of payments will be reviewed within the NO PO/Retrospective order review by March 2023 alongside the PO exemption list
Financial Systems 8.3	Jun-22	Reasonable	Where a retrospective order is deemed appropriate, staff should be encouraged to complete the notes section of Oracle explaining the reason for use of a retrospective order, including details of who requested the goods or service to be procured.	Medium	Where retrospective orders are deemed acceptable, further training will be given to end users to ensure notes are completed within Oracle	Director of Finance	Head of Procurement	Mar-23			In progress	February 2023 Update - Refer to the update provided for 7.1. Retrospective review being undertaken as part of AW P2P T&F group, and further training needs will be identified by March 2023 No PO policy and exemption list being progressed through AW P2P and Finance academy. NO PO policy letters issued to HB in December 2022.	August 2022 Update - Refer to the update provided for 7.1. October 2022 - Retrospective review being undertaken as part of AW P2P T&F group, and further training needs will be identified by March 2023. December 2022 Update - Refer to the update provided for 7.1. October 2022 - Retrospective review being undertaken as part of AW P2P T&F group, and further training needs will be identified by March 2023

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Financial Systems 8.4	Jun-22	Reasonable	Documentation to support all orders should be retained made available if required	Medium	Documentation will be made available via SharePoint.	Director of Finance	Head of Procurement	Mar-23			In progress	February 2023 Update - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant P2P information including virtual training guides by March 2023.	August 2022 - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant P2P information including virtual training guides by March 2023. October 2022 Update - Remains the same as the update provide in August 2022. December 2022 - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant P2P information including virtual training guides by March 2023.
Financial Systems 9.1	Jun-22	Reasonable	As sending individual letters to staff when it is identified they are non-compliant with the policy is time consuming, consideration should be given to alternative methods of ensuring departments that are persistently non-compliant are made aware, with support and training provided in an attempt to prevent ongoing non-compliance.	Medium	Training on No PO and retrospective orders will be made available to respective areas. Non Compliance letters will still be issued.	Director of Finance	Head of Procurement	Jul-22	Now October 2022 Now March 2023		In progress	February 2023 Update - as per December update.	Aug-2022 update - Non compliance letters are being issued in relation to retrospective orders. As above the No PO policy approach is being reviewed within the FDU AWP2P forum and messaging is being strengthened to both HB and Supplier by October 2022. Best practice approach also being developed within FDU AW P2P. October 2022 - AW P2P T&F group work delayed and approach being presented to AW P2P group and SRO 17th November. Training/Lunch and learn sessions continuing and retrospective letters still being issued. Retrospective order review for priority areas being identified by March 2023. December 2022 update - Non compliance letters are being issued in relation to retrospective orders. As above the No PO policy approach is being reviewed within the FDU AWP2P forum and messaging is being strengthened to both HB and Supplier by January 2023 Best practice approach also being developed within FDU AW P2P. AW P2P T&F group work delayed and approach approved by AW P2P group and SRO 17th November. Training/Lunch and learn sessions continuing and retrospective letters still being issued. Retrospective order review for priority areas being identified by March 2023
Risk Management 2022 04	Aug-22	Reasonable	Management should ensure that for those risks highlighted, a review is undertaken as soon as practicable and the Datix system updated. Management should ensure that staff are reminded of the requirement to review and update risks in Datix in line with the timescales detailed in the Health Board guidance.	Medium	Risk Leads will be asked to ensure that Datix is updated to reflect the updates on the risks identified as being passed their review dates. Reminders to ensure risks are regularly updated will be included in the CTM Staff update and more prominently on the Risk Intranet Pages. Messaging will also continue via the training and regular meetings with risk leads.	Director of Corporate Governance	Assistant Director of Governance & Risk	Sep-22	Now 31 January 2023		Completed	February 2023 Update - The revised Risk Assessment Procedure was approved in December 2022 which clearly articulates the system and processes for the Management of Risk within the Health Board. Training continues throughout 2023 via monthly risk awareness sessions where messaging in terms of these themes are reiterated. A workshop is scheduled with the Executive Team in January 2023 to review the risks on the Organisational Risk Register and address the common feedback themes. In the call for risk updates common feedback themes are raised with risk leads.	October 2022 Update - The initial management action has now been superseded as the Executive Leadership Group approved the "Guiding principles for Quality Governance Accountability Arrangements during the transition to the new Operating Model", at its meeting on the 12th September 2022 For the purposes of these principles, the ELG have identified the period of 'transition' to end on 31st January 2023. This includes the realignment of all open ILG Legacy Risks and establishing a workshop to review risks on the Organisational Risk Register in light of the new model. December 2022 Update - On track: The Assistant Director of Governance & Risk, along with the Chief Operating Officer and/or Deputy Chief Operating Officers, has started to meet with Care Groups during October and November to review risks in terms of alignment to the new Care Group Model. The Organisational Risk Register will continue to be updated to reflect the changes being made as a result of this activity. Monthly risk training continues to reiterate the need for timely review. The consultation on the revised Risk Assessment Procedure has just concluded and this procedure has further clarified the Health Boards stated timescales for review based on the risk scoring. This Procedure is planned for approval in December 2022. The recent Staff Newsletter (November 2022) raised awareness in terms of the review of the risk assessment procedure, training dates and the dedicated risk pages on SharePoint which all support this recommendation.
CSG & ILG Quality Assurance 1.4	Aug-22	Reasonable	A review of the quality monitoring arrangements for Surgery CSG within Merthyr Cynon ILG should be undertaken to establish if the remit of the Surgery Governance Group and wider Acute Service Patient Safety Governance Group are able to provide the same level of quality monitoring and assurance that can be provided from a dedicated Quality and Safety Group for the CSG. If necessary, consideration should be given to having a dedicated Surgery Quality and Safety Group in line with other CSGs.	Medium	The health board is in transition period of adopting a new operating model. The current framework (Nov 2020) describes quality governance arrangements within the current model of Integrated Locality Groups (ILG's), including a template for Quality, Safety & Patient Experience (QSPE) meetings, terms of reference, frequency, agenda and more recently common quality measures. It is recognised that this clear direction was not extended to the Clinical Service Group (CSG) structure, which was very much in its early stages of development in 2020. This assurance audit was requested to explore the governance interface in relation to CSG, ILG and Health Board assurance, escalation and risk. This has been a very helpful activity in reaffirming the need to apply a standardised framework to CSGs for good governance and assurance from service point to Board line of sight. This granular governance will be articulated through the revised Quality & Patient Safety Framework and embedded within the new Care Group operating model.	Director of Nursing	Assistant Director Quality & Safety	Dec-22	Now January 2023		In progress	February 2023 Update - no update provided on this occasion	October 2022 update-The health board continues to make changes in respect of its new operating model which includes quality governance and patient safety arrangements for CSG's and the Care Groups they sit within. Each Clinical Service Group will have a standardised assurance framework in place to describe how floor to board assurance is articulated within services, as well as standardised tools for annual work plans, quality assurance of incident management & investigation, Terms of Reference/Agenda for Quality, Patient Safety & Patient Experience Meetings and arrangements to share learning. Upward reporting and monitoring through to the Care Group will be based on agreed quality indicators, informed by work plans and a common reporting framework. These arrangements will be articulated in the revised Quality & Safety Framework due for publication in December 2022. December 2022 Update - Care Group governance structures are being developed, The Children and Families Care Group are holding its first meeting on 1.12.22 with representation from both Clinical Service Groups. Structures being reviewed to ensure the golden thread between patient care, Planned Care Quality & Safety meeting and upwards reporting into Operational Management Board
CSG & ILG Quality Assurance 3.0	Aug-22	Reasonable	All ILG Quality and Safety Groups and their constituent CSGs should establish annual quality assurance work plans that will allow focus, monitoring and reporting on their relevant quality issues and objectives in a targeted manner.	Medium	Response as in 1.1; The health board is in transition period of adopting a new operating model. The current framework (Nov 2020) describes quality governance arrangements within the current model of Integrated Locality Groups (ILGs), including a template for Quality, Safety & Patient Experience (QSPE) meetings, terms of reference, frequency, agenda and more recently common quality measures. It is recognised that this clear direction was not extended to the Clinical Service Group (CSG) structure, which was very much in its early stages of development in 2020. This assurance audit was requested to explore the governance interface in relation to CSG, ILG and Health Board assurance, escalation and risk. This has been a very helpful activity in reaffirming the need to apply a standardised framework to CSG's for good governance and assurance from service point to Board line of sight. This granular governance will be articulated through the revised Quality & Patient Safety Framework and embedded within the new Care Group operating model. In addition, the requirement of annual work plans for Clinical Service Groups will be re-established and monitored through the new Care Group model governance system. Progress against CSG annual plans will be upwardly reported by Care Groups to Quality and Safety Committee on a yearly basis.	Director of Nursing	Assistant Director Quality & Safety Care Group Nurse Directors	Dec-22	Now January 2023		In progress	February 2023 Update - no update provided on this occasion	October 2022 update-The health board continues to make changes in respect of its new operating model which includes quality governance and patient safety arrangements for CSG's and the Care Groups they sit within. Each Clinical Service Group will have a standardised assurance framework in place to describe how floor to board assurance is articulated within services, as well as standardised tools for annual work plans, quality assurance of incident management & investigation, Terms of Reference/Agenda for Quality, Patient Safety & Patient Experience Meetings and arrangements to share learning. Upward reporting and monitoring through to the Care Group will be based on agreed quality indicators, informed by work plans and a common reporting framework. These arrangements will be articulated in the revised Quality & Safety Framework due for publication in December 2022. December 2022 Update - Care Group governance structures are being developed, Planned Care held it's first meeting on 22.11.22 with representation from all 3 Clinical Service Groups - Surgery CSG structures being reviewed to ensure the golden thread between patient care, Planned Care Quality & Safety meeting and upwards reporting into Operational Management Board. There are already service wide assurance groups in place for maternity, gynaecology and integrated sexual health. The Care Group is working to align CYP accordingly however CYP already regularly hold Quality and Safety meetings. Both service groups will actively participate in the Children and Families Care Group QPSE Meetings from 1.12.22. Maternity and Neonates have developed a floor to board escalation framework which was updated and approved at Health Board Quality and Safety Committee in September 2022. Work is underway within the Care Group to now align the framework and ensure CYP are included.

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CSG & ILG Quality Assurance 4.0	Aug-22	Reasonable	It should be ensured that going forward there is Surgery CSG representation at the PCH Acute Services Patient Safety and Governance Group. Consideration should be given to reviewing the terms of reference for the ILG Quality, Patient Safety and Experience Group to include representatives from the CSGs so that quality matters for those areas can be discussed in greater detail.	Medium	Notwithstanding the pending changes to the operating model, this finding has been relayed to the Nurse Director of Merthyr Cynon ILG who is chair of the ILG QPSE group for corrective actions. This will also be highlighted in the Merthyr Cynon ILG quality and patient safety legacy document in preparation for the change in the operating model.	Director of Nursing	Merthyr Cynon ILG Nurse Director	Sep-22	Now October 2022 Now January 2023		In progress	February 2023 Update - no update provided on this occasion	October 2022 update-The handover document is being finalised and will be completed by end of October 2022. The unscheduled care Director of Nursing is working closely with the planned care Director of Nursing during this phase until formal handover has been completed. December 2022 Update - PCH Surgery CSG are actively participating in the Planned Care Quality & Safety meeting which has met for the first time.
Medical & Dental Rostering Follow Up Review 3.1	Aug-22	Reasonable	The draft Medics Rostering Policy should be further reviewed to remove any legacy references to the Nursing Rostering Policy. Feedback should then sought from the appropriate groups and approval obtained from the appropriate committee ahead of making the policy available to all relevant staff.	Medium	The draft has been reviewed substantially and is now complete. The policy has been submitted to the Medical Workforce Sustainability Group (MWSG) for review. This will be set as an agenda item for the next meeting and then progress through the formal Health Board route to ratification.	Medical Director & Director for People	Head of workforce productivity and E-Systems	Nov-22	Now February 2023 Now March 2023		In progress	February 2023 Update - The policy is awaiting review at the LNC. The next LNC is not until March 2023, so the policy will not be ratified until after this. This is however reliant on it passing the committee with no alteration required.	October 2022 Update - no update provided against this recommendation on this occasion. December 2022 update – The MWSG has not met since the policy was completed. The MWSG has now been disbanded as a formal group. The policy will now go through the Policy Review Group, and then progress to the LNC.
Medical & Dental Rostering Follow Up Review 3.2	Aug-22	Reasonable	For areas where the full roll out of Health Roster is not imminent, separate 'how to' guides on the local system used should be considered. 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.	Medium	How to guides will be developed by ACT & ED for use of their respective systems.	Medical Director & Director for People	ACT Manager & Roster manager ED Manager & Roster manager	Nov-22			Completed	February 2023 Update - In terms of the Health Roster Systems, Allocate do provide guides and there is a tutorial in the system; we also train multiple people in the areas so that any issues like absence are less disruptive, In terms of the other systems by ACT and ED, they have local connections with their providers so we do not have any guides or control other these,	October 2022 Update - no update provided against this recommendation on this occasion. December 2022 Update - How to guides are yet to be developed or shared by Anaesthetics or Emergency Department (ED) colleagues.
Medical & Dental Rostering Follow Up Review 4.1	Aug-22	Reasonable	Management should ensure that the Study Leave policy is approved and circulated within the Health Board.	Medium	Discussion around agreeing a Health Board wide policy is still ongoing between the Medical Director and the BMA. This is due to the differences between provision for study leave contained in the previous Cwm Taf and Swansea Bay policies. Agreement needs to be reached between the involved parties, to allow for the new policy to progress and be ratified through the formal UHB policy route.	Medical Director & Director for People	Medical Director	Nov-22	Now December 2022 Now March 2023		In progress	February 2023 Update - Further meeting to be scheduled with BMA to discuss approach and confirm agreement	October 2022 Update - On track for completion November 2022. December 2022 update - The MD is in active talks with the BMA to come to solution to the differences in study leave entitlements. The former Cwm Taf policy and the Swansea Bay policy have some fundamental differences that ideally need to be harmonised across the whole of Cwm Taf Morgannwg University Health Board. This is not in the gift of the Health Board to do unilaterally, it needs to be agreed in partnership.
CAMHS Workforce Follow Up Review 2.1	Aug-22	Reasonable	a) The SOP in relation to the set up and use of electronic staff files should be finalised. b) All current electronic files should be fully populated with documentation scanned from hard copy files. c) The roll out of electronic staff files to all other areas of the CSG should commence.	Medium	a) A SOP is being drafted by the Swansea Bay CAMHS locality Senior Nurses on the set up and use of electronic staff files and will be taken to the Quality, Patient Safety and Experience meeting for review and discussion prior to sign off. b) Swansea Bay CAMHS locality Senior Nurses will ensure all current electronic files will be fully populated with the documentation from the hard copy files c) CTM CAMHS locality will commence the roll out of electronic files following sign off of the SOP to approach and any learning from the Swansea Bay CAMHS team	Chief Operating Officer	a) Senior Nurses for Swansea Bay CAMHS locality b) Senior Nurses for Swansea Bay CAMHS locality c) Head of Nursing and Senior Nurses for each locality	a) End of October 2022 b) End of September 2022 c) End of November 2022	Should all be complete by November 2022 Now January 2023 Now March 2023		In progress	February 2023 Update - SOP has been drafted and circulated for comment prior to sign off.	October 2022 Update - nursing electronic files in Swansea Bay CAMHS have been fully populated with the documentation from the hard copies. A draft SOP has been developed and will be discussed with teams in October prior to sign off. December 2022 Update - All nursing electronic files in SB CAMHS have been fully populated with the documentation from the hard copies. SOP has been developed but requires review in CAMHS Quality, Safety and Patient Experience meeting which was cancelled in October due to limited attendance with next date in January 2023.

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Medical Records Management 1.1	Nov-22	Reasonable	The responsibilities of the Health Records departments across the Health Board should be standardised. Linked to this the procedures operating within each site should be standardised as much as possible, given the limitations imposed by digitisation.	Medium	Accept There are challenges to standardising the operational procedures of the Health Records teams due to the variances between the digital systems used within the Princess of Wales and the rest of the Health Board. It should also be noted that some of the Health Records personnel within the Health Board are not under the direct responsibility and accountability of the Director of Digital. The Health Board has devised a programme of work to standardise the PAS in use across the Health Board. This programme is planned until the Autumn of 2024. Process will be aligned as practically possible prior to the completion of the programme.	Director of Digital	Director of Digital	Qtr 2 2024/2025			In progress	February 2023 Update: Ongoing - will be aligned to the next iteration of the Care Group structure	December 2022 Update - Scoping and implementation work ongoing
Medical Records Management 2.1	Nov-22	Reasonable	Work should start to identify records which could immediately be destroyed when the moratorium relating to the infected blood inquiry ends. These records should be moved to an alternate location.	Medium	Partial Agreement Identification of records to be destroyed can commence and complete by end of Qtr 3 2022/2023. The Health Board is currently reviewing its estate, with a view to reducing some of its existing facilities. An alternative location would need to be procured. This cannot be resolved quickly due to continued financial pressures for the Health Board. An alternative location cannot be procured within the existing financial envelope of the Health Board. Audit Note – We recognise the limitations to space and agree with the approach to identify the relevant records.	Director of Digital	Director of Digital	Qtr 3 2022/2023	Now March 2023		Completed	February 2023 Update: Records have been identified and process underway / Propose to close	December 2022 Update - Work underway - plan to complete by end of QTR4 2022/2023
Medical Records Management 6.1	Nov-22	Reasonable	The underlying reason for failures should be established and corrected to prevent future issues. The progress of scanning and any issues should be reported within the structure referred to in MA4	Medium	Agreed Underlying Issue to be identified and reported.	Director of Digital	Director of Digital	Qtr 3 2022/2023			Completed	February 2023 Update - Underlying causes identified / resources required to rectify some of the key issues / decisions will need to be made in alignment of priorities for the Health Board. Actual action complete - propose to close	December 2022 Update - To be completed with the Medical Records review report from November 2022
ICTM Quality Improvement Team 1.1	Dec-22	Reasonable	Procedural guidance should be developed that set out the difference between projects that the QI team are involved in delivering and projects where the team operate in a supportive role.	Medium	As part of the response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation. This will be supported by a documented and recorded approval process for projects we agree to support.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23			In progress	February 2023 Update - Procedural guidance is in draft form for completion in January 2023. Project approval will be incorporated as an agenda item in the monthly project group.	
iCTM – Quality Improvement Team 1.3a, 1.3b and 1.3c	Dec-22	Reasonable	1.3a A decision should be made regarding which QI projects the QI team expect to see recorded on the Life QI system and the instances where projects do not need to be recorded. Whilst we acknowledge that capturing QI projects on the Life QI system is outside of the control of the QI team, the procedural guidance should include the QI team's expectations of staff in relation to using the system. 1.3b The benefits of capturing all QI information in one place should also be emphasised as part of the guidance. 1.3c Consideration should be given to each project captured on the Life QI system having a unique reference number to allow ease of reference going forward.	Medium	We will review our use of LifeQI as a repository for project information. While it may be suitable for this purpose a separate database hosted centrally may be a more appropriate response. However we will review the guidance that supports LifeQI and support the recommendations elsewhere in this report about ensuring a more consistent approach to how it is used. We will develop a reference number system that links to whatever database solution is devised.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Mar-23			Completed	February 2023 Update - Use of LIFEQI has been reviewed. Projects will be monitored at the monthly 'Project Review' group. Reference numbers will be used as requested.	

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iCTM – Quality Improvement Team 2.1	Dec-22	Reasonable	A comprehensive central record should be maintained of all improvement activity carried out by the QI team. This should include a unique project reference number and the status of each project or programme and the date it was approved.	Medium	We are developing a solution which will be based either on use of the existing LifeQI system or a new centrally held database.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23	Now February 2023		In progress	February 2023 Update - All improvement projects will be captured on LifeQI.	
iCTM – Quality Improvement Team 2.2	Dec-22	Reasonable	All Improvement projects should be aligned to the organisation's strategic aims and objectives, and this should be captured within project documentation.	Medium	As part of its response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation. Life QI and other software will be adapted to facilitate this.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23			In progress	February 2023 Update - We are aligning all projects either to the goals of CTM 2030 - the LHBs long term strategy, or toward the goals of the national Safe Care Collaborative. In addition, scrutiny at the monthly project group will allow us to ensure projects are aligned to organisation goals.	
iCTM – Quality Improvement Team 3.1	Dec-22	Reasonable	The QI Faculty Framework should be reviewed. The review should cover the effectiveness of the operation of the framework since its implementation, and re-alignment to the new Care Group structure currently being implemented across the Health Board.	Medium	As part of its response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation. A review of the Faculty Framework is underway but will be dependent on the roll out of the new organisation structure which is still in progress.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23	Now February 2023		In progress	February 2023 Update - Faculty Framework has been reviewed and a new model in development.	
iCTM – Quality Improvement Team 4.1	Dec-22	Reasonable	Where possible performance measures and / or indicators should be drawn up and recorded for all improvement projects to allow easier monitoring of success during and at the conclusion of a project.	Medium	The nature of improvement and our approach to nurturing improvement skills as opposed to direct involvement in project may make this difficult to implement for every project. However we will include this in our new procedural guidelines and where possible include it within the scope of improvement projects.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23			In progress	February 2023 Update - Procedural guidance is in draft form for completion in January 2023.	
iCTM – Quality Improvement Team 4.2	Dec-22	Reasonable	To facilitate wider sharing of information and the lessons and good practice arising from improvement projects, the QI team should liaise with Project Leads to remind them of the importance of keeping the Life QI system updated with progress on their projects and against any performance measures and / or indicators on a regular basis.	Medium	As part of its response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation. Clearer guidance on the use of LifeQI and the accountability associated with receiving a license will be part of this guidance.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23			In progress	February 2023 Update - Procedural guidance is in draft form for completion in January 2023.	

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iCTM – Quality Improvement Team 4.3	Dec-22	Reasonable	Monitoring of the projects captured on the Life QI system should be carried by the QI team so they can maintain an oversight of the current status of projects and either remind project owners of the importance of keeping the system up to date or determine if they are in need of support from the QI team to progress the project. Monitoring of Life QI information will also enable the QI team to provide the IIB with periodic updates on data such as the number of live projects, topics and themes, completed projects and their outcomes and lessons for sharing.	Medium	As part of its response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation. More specifically members of the team will be assigned specific responsibilities around the monitoring of projects and we will incorporate a monthly review of projects on Life QI within our wider QI faculty structure.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23			Completed	February 2023 Update - Projects will be monitored monthly at the Project Review Group.	
Radiology Service Review 1.1	Dec-22	Reasonable	The Terms of Reference for all groups and committees should be reviewed to ensure they are up to date and relevant, including information such as purpose and remit of the group, attendees and quoracy arrangements, frequency of meetings and arrangements for rescheduling.	Medium	Due to the HB restructure, the previous Radiology Performance Meeting Forum has been stood down and replaced with a weekly Care Group Radiology Performance Review. ToR to be sourced from the Executive Office to reflect attendees, quoracy and frequency of the meetings while the care group structure beds in. A Radiology Quality, Improvement & Governance Structure Meeting has been arranged to update the governance meeting arrangements, reporting structure and review of ToR on 9/11/2022.	Chief Operating Officer	Executive Office Clinical Service Manager Senior Superintendents Clinical Lead for Quality and Governance Health and Safety Leads	31 December 2022 9 November 2022	Now March 2023		In progress	February 2023 Update - A standardised ToR is in the process of being implemented for all meeting groups. The Radiology Quality, Improvement and Governance Chair and management have met to finalise the ToR for QI&G and the first new meeting took place on 25/01/23, with vice chair appointed.	
Radiology Service Review 2.1	Dec-22	Reasonable	a) Where scheduled quarterly meetings fail to take place, to prevent large time gaps, consideration should be given to rearranging the meeting, as opposed to waiting to next scheduled quarterly meeting. b) To prevent Quality Improvement & Governance group meetings being cancelled when the Chair is not available, a Vice-Chair should be appointed.	Medium	a) The service management team have scheduled quarterly meetings from December 2022 through to April 2024. The Radiology Quality, Improvement & Governance Structure Meeting arranged on 9 November 2022 will address the quoracy structure and appointment of Vice Chair to ensure that the meetings are not cancelled unless there is not quorate. In the event of a cancelation the members will review the agenda to assess whether there are any urgent matters that require action and re arrange the meetings as necessary. b) The Terms of Reference for the Quality & Governance Group will be reviewed and updated on 9 November 2022. This will identify a Vice Chair for the meetings.	Chief Operating Officer	Clinical Service Manager Clinical Lead for Quality and Governance Senior Superintendents Health and Safety Leads	30-Nov-22	Now March 2023		In progress	February 2023 Update - A standardised ToR is in the process of being implemented for all meeting groups. The Radiology Quality, Improvement and Governance Chair and management have met to finalise the ToR and the first new meeting took place on 25/01/23. A Vice Chair has been appointed to oversee meetings in absence of Chair. March 2023.	
Radiology Service Review 2.2	Dec-22	Reasonable	Consistent approaches to monitoring and governance arrangements should be in place across the localities. Where groups exist that operate on a locality basis, standardised terms of reference should be in place.	Medium	The Terms of Reference for all existing groups will be reviewed to ensure that there is a standardised approach.	Chief Operating Officer	Clinical Service Manager	Dec-22	Now March 2023		In progress	February 2023 Update - A standardised ToR is in the process of being implemented for all meeting groups.	
Radiology Service Review 2.3	Dec-22	Reasonable	It should be ensured that action logs generated after meetings are followed up at future meetings, to confirm that work has been undertaken and the action closed or carried forward.	Medium	A review of the action log will be a standing item on all meeting agendas. This is currently in operation for the Radiology Quality, Improvement & Governance Meetings. The new Care Group Performance Review produces an action log following the meeting, which can be evidenced.	Chief Operating Officer	Clinical Service Manager Executive Office	Completed			Completed		

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Radiology Service Review 3.2	Dec-22	Reasonable	Consideration should be given to having a standard agenda item during the Radiology Management Team Business Meeting in relation to policies and procedures, to ensure that all staff are aware of what is due for review and to ensure that there is consistent communication in relation to new policies or policy updates following changes in legislation or guidance.	Medium	The Radiology Management Team Business Meeting agenda will be changed on the 17th October 2022 to ensure that is a standing item relating to policies and procedures to review and ratify.	Chief Operating Officer	Clinical Services Manager	Completed			Completed		
Radiology Service Review 4.1	Dec-22	Reasonable	a) Acknowledging that for 2022/23 the Standards of Behaviour Policy has been amended, and less categories of staff will be required to make a return, relevant staff within Radiology should be reminded of the relevance of the policy and the requirement to comply with it and complete an annual return. Where individuals fail to make a return, managers should continue to prompt staff to do so. b) Management should work with the Committee team to identify any gaps in the declaration of interest reporting.	Medium	a) The register of the declaration of interest information is maintained by the Corporate Service Department and submissions are registered and updated through this Department. A request for any outstanding declaration of interest will be made to the Corporate Services Department to identify those individual where these are outstanding and the relevant staff will be prompted to complete. b) A system of review will be agreed with the Corporate Services Department.	Chief Operating Officer	Corporate Services Manager/Clinical Service Manager	31st December 2022			In progress	February 2023 Update - no update provided on this occasion	
Radiology Service Review 5.1	Dec-22	Reasonable	When risks are reviewed within Datix, the narrative in the 'controls in place' or notes section should be updated for changes since the previous review.	Medium	A review of the risk register will be undertaken to establish those that can be closed and a regular review of the Datix and the controls in place scheduled into monthly meetings. Advice will be taken from the newly centralised corporate Governance Team in relation to management of the Risk Register.	Chief Operating Officer	Superintendent Radiographers Clinical Service Manager Care Group Service Director	30th November 2022			Completed	February 2023 Update - Risk Management is a standard item on the Radiology Business meeting agenda. The service has implemented a monthly Risk Management meeting following the Business Meeting. All departmental risks are also discussed or escalated via the Radiology Quality, Improvement and Governance Meeting quarterly. Completed.	
Radiology Service Review 13.1	Dec-22	Reasonable	To allow more effective monitoring, improvements should be made to the data and reporting format of information taken to the Performance Review meetings, including: • Having a level of consistency in the data so that management can differentiate between the data of the constituent services within the CSG. Similarly, where necessary the breakdown of data across localities should be in place. • Performance data on areas such as workforce and quality should be presented at every meeting. • Where performance targets are included, it should be clear if the target is an internal CSG one. Any Health Board and Welsh Government targets should also be included and reported against to allow comparisons to other CSGs. • IMTP priority updates and actions should be	Medium	A new system of Performance Review across the Care Group has now been established with weekly meetings with the Chief Operating Officer and monthly Business Meetings. The exact format of the Business Meetings has yet to be finalised but it is anticipated that they will: • Have a level of consistency and accuracy in the data so that management can differentiate between the data of the constituent services within the CSG and plan to address gaps. • Report Performance data on areas such as workforce and quality and risks at every meeting. • Include any Health Board and Welsh Government targets and trajectories towards achieving them. • Include any IMTP priorities and actions in the wider health board IMTP.	Chief Operating Officer	Care Group Director	31st December 2022 Now March 2023			In progress	February 2023 Update - There is no formal agenda for the monthly performance meeting. Following receipt of the ToR, this will enable the department to follow an agenda or inform expectations for reporting consistently. Ongoing.	
Radiology Service Review 14.1	Dec-22	Reasonable	A review of the format of the CRES information presented during the Performance Review meetings should be undertaken, to ensure the data is more meaningful and easier to interpret. Details about the CRES schemes that have been identified in the relation to the overall target, and progress and likelihood of achieving each scheme should also be presented.	Medium	A review of the format of the CRES information presented during the Performance Review meetings will be undertaken, to ensure the data is more meaningful and easier to interpret.	Chief Operating Officer	Finance Business Partner Clinical Service Manager	31st December 2022 To be confirmed			In progress	February 2023 Update - The current Performance Meeting does not cover CRES. CRES discussions are held at Care Group level with Director of Finance and Care Group senior team.	

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Radiology Service Review 15.2	Dec-22	Reasonable	Consideration should be given to having a single point of contact within Radiology for managing the engagement of medical agency staff. This should allow a more co-ordinated approach to agency usage and reduce the risk of non-compliance with the FCP, errors with payments and financial records and potentially greater opportunity for agency staff to be utilised across multiple sites as demand fluctuates.	Medium	There are two individuals who engage medical agency staff in the Service. The Interim Radiology Service Manager (RGH and PCH) and the Superintendent Radiographer (POW) These individuals provide cross cover for each other.	Chief Operating Officer	N/A				Completed		
Health & Safety Management 06	Aug-20	Reasonable	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 for People	Head of Health, Safety & Fire	01/01/2021 Now 31 May 2022	01/07/2021 Trial Audit on Social Distancing completed August 2021. New completion date for audit package to be suitable for H&S Audits 31/01/2022 Now May 2022 Now September 2022 Now February 2023		Part Completed	February 2023 Update - The Health Safety and Fire Team have completed their second Organisational Audit and results will be provided to the Health, Safety and Fire Sub Committee in February 2023.	APRIL 2021: An audit tool is being developed, taking learning from the social distancing audit tool developed. The package itself is developed, and by July we will have determined the key areas to be examined via the audit tool. This will be complete and ready to use by the end of July. A revised implementation date has been provided. July 2021 - Audit Package currently undergoing further testing due so some reporting issues on the AMaT system. SEPTEMBER 2021: The above audit findings were presented as a draft to the last Health, Safety and Fire Committee in September 2021. There are still some issues with the audit package producing an Executive summary of the audit undertaken. The Health, Safety and Fire Team are in further discussions with the Clinical Audit Team and AMaT to resolve this. Whilst awaiting this system fix an audit programme is being set up and will be rolled out once the system fixes have been completed. November 2021 - No further update provided. April 2022 Update - Health & Safety Team has been working closely with Clinical Audit colleagues to determine whether the AMaT system could be used to capture audit information. The Team were now working towards a revised target date of end of May 2022 to complete this recommendation. April 2022 Update - Health & Safety Team has been working closely with Clinical Audit colleagues to determine whether the AMaT system could be used to capture audit information. The Team were now working towards a revised target date of end of May 2022 to complete this recommendation. August 2022 Update - Following several other issues which had to be resolved with AMaT the Health and Safety Team will be undertaking a management audit of a selection of wards/departments throughout the month of September. Update October 2022 - First audit commenced in September 2022 and a selection of Wards and Departments have been highlighted to be audited. Audit results will be presented to the next Health, Safety and Fire Sub Committee. December 2022 Update - First audit commenced in September 2022 and a selection of Wards and Departments have been highlighted to be audited (x30). Audit results will be presented to the next Health, Safety and Fire Sub Committee in February 2023.
Financial Systems 06	Apr-21	Reasonable	Management may want to consider creating a procedure, as it will help strengthen efficiencies, deliver best practice and more importantly it will provide added support should the department have new staff working in that area.	Low	Agreed. A manual for the fixed asset register will be created.	Director of Finance	Finance Manager	Sep-21	Now September 2022 Now November 2022 Now December 2022		In progress	February 2023 Update - no update provided on this occasion	July 2021 Update - Action on target to be completed by September 2021. September 2021 - No further update. November 2021 - No further update provided. January 2022 Update - Due to changes in post and the significant pressure on the team as a result of IFRS implementation and preparation for the new quinnquennial revaluation this has been unable to be addressed. It is proposed that this is picked up post the year end audit process over the summer of 22/23 post IFRS 16 adoption. April 2022 - No further update to report. August 2022 Update - A user manual for the Fixed Asset register is in progress, we have started working on it but it is not yet complete. October 2022 Update - Implementation date remains November 22. December 2022 Update - A draft version has been completed and is being checked through, this will now be completed during December 2022.
Sunnyside Health & Wellbeing Centre 09	Aug-21	Reasonable	Performance of relevant parties should be monitored appropriately	Low	As above although there will be a delay with the appointment of a new contractor.	Director of Finance	Senior Project Manager	Sep-21	Now January 2022 for Contractor only Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - Complete for advisors but will not be complete for contractor until a new contractor is appointed. November 2021 Update - ongoing, awaiting contractor appointment. January 2022 Update - this has been further delayed as a result of a need to extend the tender period. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023
Sunnyside Health & Wellbeing Centre 17	Aug-21	Reasonable	Management should instigate a process for formal review and sign-off of any further design changes with relevant parties.	Low	The Health Board already has in places processes for sign off of design by users and this process will be used in this scheme moving forward (also to be detailed in the Project Execution Plan).	Director of Finance	Senior Project Manager	Nov-21	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - Ongoing. November 2021 Update - to be completed this month. January 2022 Update - although technically this has been agreed it can not be fully implemented until the new contractor is back on site and appointed which will be at least March. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023
Financial Systems 6.1	Jun-22	Reasonable	In line with the Scheme of Delegation, management should ensure authorisation is sought and retained prior to virements being input on Oracle.	Low	Agreed, as per action 1, an updated process will be developed	Director of Finance	Head of Corporate Finance	Jul-22	Now October 2022 Now January 2023		Completed	February 2023 Update - Discussions have taken place with the management accounts team and an updated process note is being implemented.	August 2022 Update - Will be updated in line with the update of FCP. October 2022 Update - Need to review the appropriateness of the review of virements. Virements are done in line with Scheme of Delegation. December 2022 Update - Process still being reviewed alongside Ref 1.1 and 6.2
Risk Management 2022 05	Aug-22	Reasonable	Management should consider the use of Datix for capturing all risks, this would allow for a consistent approach throughout the Health Board and provide greater effectiveness of monitoring.	Low	The ability to maintain a consistent approach to recording low level risks will be considered with a suggestion to align with the implementation of the new All Wales Risk Module on Datix where low level risks can be added to the system without generating the more detailed steps higher level risks require.	Director of Corporate Governance	Assistant Director of Governance & Risk	Oct-22	Now 31 December 2022 Now 31 March 2023		In progress	February 2023 Update - A small cohort of the OFW Task and Finish Group met with the OFW Datix Team on the 6th December to receive an update on progress. Suggestions on further improvements were put forward and a further update meeting is scheduled for 2023. In the meantime monthly training continues with sessions booked throughout 2023. The revised Risk Assessment Procedure was approved in December 2022 which mandates the use of Datix for all risks irrespective of scoring. This has been promoted through the Staff Newsletter along with the training.	October 2022 Update - This recommendation has been aligned to the implementation of the Datix Cymru Risk Module the implementation of the new module has been delayed. Progress is monitored via the OFW Risk Module Meetings which is next due to meet in October 2022 where a further update on timescales will be received. Furthermore, the current risk training encourages risk owners to include all risks to the Datix System and this will be reflected in the next iteration of the Risk Management Procedure. December 2022 Update - This recommendation is dependent on the implementation of the OFW Risk Module as the intention is that the training will include how to undertake a risk assessment utilising the risk module on Datix. The pace of implementation on the new module has slowed and therefore the work in this activity has not been progressed. A meeting has been scheduled in early December with a small cohort of risk leads across NHS Wales and the OFW System Lead to undertake some work on the progress of the module developments. A further update will be available following this meeting with a greater insight into an anticipated implementation date. In the meantime the revised Risk Assessment Procedure which is planned for approval in December 2022 mandates the use of Datix for all risks irrespective of scoring. The Risk Management Training also captures the Health Boards position on mandating the use of Datix for risk

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CSG & ILG Quality Assurance 1.1	Aug-22	Reasonable	The terms of reference for the CSG Service Group Performance Review (SGPR) meetings should be reviewed and updated where necessary, including amending the frequency of meetings if deemed appropriate. CSGs should endeavour to hold their SGPR meetings in line with the frequency agreed in the terms of reference.	Low	The health board is in transition period of adopting a new operating model. The current framework (Nov 2020) describes quality governance arrangements within the current model of Integrated Locality Groups (ILG's), including a template for Quality, Safety & Patient Experience (QSPE) meetings, terms of reference, frequency, agenda and more recently common quality measures. It is recognised that this clear direction was not extended to the Clinical Service Group (CSG) structure, which was very much in its early stages of development in 2020. This assurance audit was requested to explore the governance interface in relation to CSG, ILG and Health Board assurance, escalation and risk. This has been a very helpful activity in reaffirming the need to apply a standardised framework to CSGs for good governance and assurance from service point to Board line of sight. This granular governance will be articulated through the revised Quality & Patient Safety Framework and embedded within the new Care Group operating model.	Director of Nursing	Assistant Director Quality & Safety	Dec-22	Now January 2023		In progress	February 2023 Update - no update provided on this occasion	October 2022 update-The health board continues to make changes in respect of its new operating model which includes quality governance and patient safety arrangements for CSG's and the Care Groups they sit within. Each Clinical Service Group will have a standardised assurance framework in place to describe how floor to board assurance is articulated within services, as well as standardised tools for annual work plans, quality assurance of incident management & investigation, Terms of Reference/Agenda for Quality, Patient Safety & Patient Experience Meetings and arrangements to share learning. Upward reporting and monitoring through to the Care Group will be based on agreed quality indicators, informed by work plans and a common reporting framework. These arrangements will be articulated in the revised Quality & Safety Framework due for publication in December 2022. December 2022 Update - Quality & Safety Framework first draft expected December 2022
CSG & ILG Quality Assurance 2.0	Aug-22	Reasonable	Quality governance training should be provided to all relevant staff in the ILGs and their constituent CSGs to ensure a sound understanding of quality assurance principles and practices	Low	The Health Board launched a new Patient Safety Incident Management Framework and Toolkit in June 2022. This describes the responsibilities of colleagues in managing patient safety issues from an initial incident and investigation through to complaints, redress, inquests and claims. In July 2022, the Health Board also launched a rolling programme of patient safety investigation training, which includes good governance in relation to quality and patient safety, Datix and patient experience. The training also introduces the important concepts of psychological safety, human factor errors and safety thinking. Attendance is recorded on the Health Board's Electronic Record System, which ensures that those undertaking incident investigations are appropriately, and consistently trained to improve standards and performance. Bespoke Datix training has been rolled out by the Datix Management Team following the adoption of the Once for Wales incident module, and is ongoing. The corporate team have initiated good governance training in relation to assurance report writing and preparedness for Boards and Committees as well as Risk Management Awareness Training. Training sessions are supported by the Health Board's Communication channels, Intranet SharePoint system where further information and assistance for colleagues is signposted by the Patient Care and Safety site. A further opportunity to raise awareness and understanding of the quality assurance principles and practice to the wider workforce will be the publication of the Quality and Patient Safety Framework.	Director of Nursing	Assistant Director Quality & Safety	The nature of this action is ongoing; however, the new structure will provide an opportunity to target CSGs. Quality & Patient Safety Framework December 2022	Now January 2023		In progress	February 2023 Update - no update provided on this occasion	October 2022 update-As previously identified the Patient Safety Incident Management Framework and Toolkit describes the responsibilities of colleagues in managing patient safety issues from an initial incident and investigation through to complaints, redress, inquests and claims. The rolling programme of patient safety investigation training, which includes good governance in relation to quality and patient safety, Datix and patient experience continues on a monthly basis. Bespoke Datix training sessions are being offered CSG's and departments by the Datix Management Team following the adoption of the Once for Wales incident module. The corporate team have continued good governance training in relation to assurance report writing and preparedness for Boards and Committees as well as Risk Management Awareness Training. A further opportunity to raise awareness and understanding of the quality assurance principles and practice to the wider workforce will be the publication of the Quality and Patient Safety Framework in December 2022 which will articulate how CSGs provide assurance through standardised frameworks, systems and processes. To date approx. 70 people have been trained to maximise patient safety, understand putting things right legislation and undertake investigations. Sessions will continue to run monthly from November. As the organisational change takes place, the vision is for the all governance teams across the care groups to support with delivering this training. December 2022 Update - As previously identified the Patient Safety Incident Management Framework and Toolkit describes the responsibilities of colleagues in managing patient safety issues from an initial incident and investigation through to complaints, redress, inquests and claims. The rolling programme of patient safety investigation training/ RCA training which includes good governance in relation to quality and patient safety & Datix and patient experience has a rolling training programme every 6- 8 weeks due to room booking availability across all 3 sites. To date approx. 80 people have received training. As the organisational change takes place, the vision is for the all governance teams across the care groups to support with delivering this training. Further training is being scoped with the claims team as feedback from medical colleagues is more training is required around identifying breach of duty. Bespoke Datix training sessions are being offered to CSG's and departments by the Datix Management Team following the adoption of the Once for Wales incident module. The corporate team have continued good governance training in relation to assurance report writing and preparedness for Boards and Committees as well as Risk Management Awareness Training. A further opportunity to raise awareness and understanding of the quality assurance principles and practice to the wider workforce will be the publication of the Quality and Patient Safety Framework in December 2022 which will articulate how CSGs provide assurance through standardised frameworks, systems and processes.
CSG & ILG Quality Assurance 5.0	Aug-22	Reasonable	For clarity, each CSG should consider mapping out its quality assurance reporting and oversight arrangements from the CSG up to the ILG Quality and Safety Group.	Low	This will be actioned through the new Quality and Patient Safety Framework as detailed in earlier agreed management actions.	Director of Nursing	Assistant Director Quality & Safety	Dec-22	Now January 2023		In progress	February 2023 Update - no update provided on this occasion	October 2022 update-This has been responded to within earlier updates in relation to the new Quality & Safety Framework. December 2022 Update - Quality & Safety Framework first draft expected December 2022
iCTM – Quality Improvement Team 3.2	Dec-22	Reasonable	The updated faculty framework document should be formally approved with the date of approval and issue recorded on the document.	Low	As part of its response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Mar-23			In progress	February 2023 Update - Procedural guidance is in draft form for completion in January 2023.	
PCH Phase 1b Final Account 1.1	Nov-22	Substantial	The remaining subcontractor statements of final account will be obtained, and assurances provide to the UHB that these reconcile with the amounts claimed by the Supply Chain Partner.	Low	Agreed	Director of Finance	Senior Responsible Officer	Nov-22	Now March 2023		Completed	January 2023 update - Since the time of making the recommendation the majority of sub-contractor accounts have been formally acknowledged as signed off. Those remaining constitute a small risk in monetary terms and are largely for service or supply contracts rather than works. This information has been shared with NWSSP Audit Service, who are content that this risk can be closed.	December 2022 Update - Statements of final account are being sought for the outstanding accounts.