CTMUHB Audit & Risk Committee

Wed 16 August 2023, 10:00 - 12:00

Virtually via Microsoft Teams

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Decision *Patsy Roseblade, Committee Chair*

1.2. Apologies for Absence

Discussion *Patsy Roseblade, Committee Chair*

1.3. Declarations of Interest

Discussion *Patsy Roseblade, Committee Chair*

10:00 - 10:00
0 min

2. CONSENT AGENDA

Decision *Patsy Roseblade, Committee Chair*

The Chair will ask if there are any items from the consent agenda (Item 6) that Committee Members wish to bring forward to the Main agenda for discussion

10:00 - 10:00
0 min

3. MAIN AGENDA

3.1. Audit & Risk Committee Action Log

Discussion *Cally Hamblyn, Assistant Director of Governance & Risk*

3.1 Audit & Risk Committee Action Log.pdf (5 pages)

3.2. Matters Arising not contained within the Action log

Discussion *Patsy Roseblade, Committee Chair*

10:00 - 10:00
0 min

4. SUSTAINING OUR FUTURE

4.1. Local Counter Fraud Report

Discussion *Matthew Evans, Head of Local Counter Fraud Services*

4.1a Local Counter Fraud Update Report ARC 16 August 2023.pdf (2 pages)
4.1b Local Counter Fraud Update Report Aug 23 ARC 16 August 2023.pdf (3 pages)
4.1c Appendix 1 Counter Fraud Benchmark Report ARC 16 August 2023.pdf (5 pages)
4.1d Appendix 2 Counter Fraud Investigations Update ARC 16 August 2023.pdf (8 pages)

4.2. Procurement & Scheme of Delegation Report

Discussion *Sally May, Director of Finance*

- 4.2a Procurement & Scheme of Delegation Report - 16 August 2023.pdf (7 pages)
- 4.2b Appendix 1 - Change to the Scheme of Delegation - compensation payments.pdf (1 pages)
- 4.2c Appendix 2 - Amended Charitable Funds FCP August 2023.pdf (19 pages)

4.3. Losses & Special Payments Report

Discussion *Sally May, Director of Finance*

- 4.3a Losses & Special Payments Report -Jul 2023.pdf (10 pages)
- 4.3b Appendices - Losses & Special Payments Report Appendices Jul 23.pdf (9 pages)

4.4. Learning From Events Reports

Discussion *Richard Hughes, Deputy Executive Director of Nursing*

To outline the Impact, process in place to monitor, assessment of impact on Financial Plan in terms of any other penalties likely

- 4.4 Learning From Event (LFER) Report Final v1.3.pdf (5 pages)

10:00 - 10:00
0 min

5. IMPROVING CARE

5.1. Organisational Risk Register

Discussion *Cally Hamblyn, Assistant Director of Governance & Risk*

- 5.1a Organisational Risk Register - July 2023 - ARC Public.pdf (5 pages)
- 5.1b Appendix 1 Organisational Risk Register - July 2023 - ARC - Public....pdf (11 pages)

5.2. Audit Recommendations Tracker

Discussion *Emma Walters, Corporate Governance Manager*

- 5.2a Audit Recommendations Tracker Update Report ARC 16 August 2023.pdf (6 pages)
- 5.2b Appendix 1- Internal Audit Recommendations Tracker August 2023 1 ARC 16 August 2023.pdf (20 pages)
- 5.2c Appendix 2 - External Audit Recommendations Tracker August 2023 ARC 16 August 2023.pdf (5 pages)

5.3. INTERNAL AUDIT

5.3.1. Internal Audit Progress Report

Discussion *Paul Dalton, Head of Internal Audit*

- 5.3.1 CTM -Progress report - August 2023.pdf (7 pages)

5.3.2. Internal Audit Follow Up Review - Facilities Governance

Discussion *Paul Dalton, Head of Internal Audit*

Item withdrawn to be received at the next meeting

5.3.3. Internal Audit Review - Prince Charles Hospital (PCH) Programme Redevelopment

Discussion *Eifion Jones, Internal Audit*

- 5.3.3 IA CTM PCH Combined Final Report issued 24.07.23 ARC 16 August 2023.pdf (16 pages)

5.3.4. Internal Audit Review - Decontamination

Discussion *Paul Dalton, Head of Internal Audit*

- 5.3.4 CTMUB-2223-25-Decontamination- Internal Audit Report FINAL.pdf (20 pages)

5.3.5. Internal Audit Review - National Incident Framework

Discussion *Paul Dalton, Head of Internal Audit*

5.3.5 CTMUHB 22.23 National Incident Framework Final Internal Audit Report_.pdf (21 pages)

5.3.6. Internal Audit Review - Performance Reporting - Integrated Performance Report

Discussion *Paul Dalton, Head of Internal Audit*

5.3.6 IA Performance Reporting - Final v2 ARC 16 August 2023.pdf (17 pages)

5.3.7. Internal Audit Follow Up - Radiology Workforce

5.3.7 CTMUHB 23.24 Follow Up Radiology Workforce Final.pdf (20 pages)

5.4. AUDIT WALES

5.4.1. Audit Wales Update

Discussion *Sara Utley, Audit Wales*

5.4.1 CTMUHB AW Audit Update ARC 16 August 2023.pdf (12 pages)

10:00 - 10:00
0 min

6. CONSENT AGENDA

6.1. FOR APPROVAL

6.1.1. Unconfirmed Minutes of the meeting held on 21 June 2023

Decision *Patsy Roseblade, Committee Chair*

6.1.1 Minutes CTMUHB ARC 21 June 2023 - Unconfirmed.pdf (11 pages)

6.1.2. Unconfirmed Minutes of the In Committee meeting held on 21 June 2023

Decision *Patsy Roseblade, Committee Chair*

6.1.2 Minutes CTMUHB In Committee ARC 21 June 2023 ARC 16 August 2023 - Unconfirmed.pdf (4 pages)

6.1.3. Unconfirmed Minutes of the Extra-Ordinary Audit & Risk Committee 26 July 2023

6.1.3 Minutes CTMUHB Audit Risk Committee ARC 26 July 2023 - Unconfirmed.pdf (4 pages)

6.1.4. Audit & Risk Committee Annual Report

Decision *Patsy Roseblade, Committee Chair*

6.1.4a Audit & Risk Committee Annual Report 2022 2023 ARC 16 August 2023.pdf (2 pages)
6.1.4b Appendix 1 Audit Committee Annual Report 2022 2023 ARC 16 August 2023.pdf (16 pages)

6.1.5. Amendment to the Standing Orders

Decision *Cally Hamblyn, Assistant Director of Governance & Risk*

6.1.5a Amendment to Standing Orders - Model SO's Issued by WG ARC 16 August 2023.pdf (3 pages)
6.1.5b Appendix 1 - Standing Orders (Main Document) - Reviewed July 2023 - Model SOs ARC 16 August 2023.pdf (53 pages)
6.1.5c Appendix 2 - Schedule 5.1 - SRG ToR - Reviewed July 2023 - Model SOs ARC 16 August 2023.pdf (14 pages)

6.2. FOR NOTING

6.2.1. Audit & Risk Committee Annual Cycle of Business

Information *Cally Hamblyn, Assistant Director of Governance & Risk*

6.2.1a Audit & Risk Committee Cycle of Business - Cover Paper ARC 16 August 2023.pdf (2 pages)

6.2.1b Audit Risk Committee Cycle of Business ARC 16 August 2023.pdf (4 pages)

6.2.2. Audit & Risk Committee Forward Work Programme

Information *Cally Hamblyn, Assistant Director of Governance & Risk*

6.2.2 Audit & Risk Committee Forward Work Plan ARC 16 August 2023.pdf (3 pages)

6.2.3. Declarations of Interest and Gifts & Hospitality Report

Information *Cally Hamblyn, Assistant Director of Governance & Risk*

6.2.3a Declarations of Interests and Gifts and Hospitality Report.pdf (3 pages)
6.2.3b Appendix 1 - DOI Spreadsheet - 2023 - 2024.pdf (10 pages)
6.2.3c Appendix 2 - Register of Gifts Hospitality and Sponsorship 2023-24.pdf (4 pages)

6.2.4. Standing Orders Breach Log

Information *Cally Hamblyn, Assistant Director of Governance & Risk*

6.2.4 Breaches to Standing Orders - Aug 23.pdf (3 pages)

6.2.5. Endoscopy JAG Accreditation Closure report - Progress and Associated Risk Mitigation

Information *Gethin Hughes, Chief Operating Officer*

To follow

10:00 - 10:00
0 min

7. CLOSE OUT BUSINESS

7.1. Any Other Business

Discussion *Patsy Roseblade, Committee Chair*

7.2. How Did we Do in this Meeting

Discussion *Patsy Roseblade, Committee Chair*

This provides an opportunity for Committee Members to reflect on the meeting and in doing so may find it helpful to consider the following questions:

Is there anything we should do more or less of?

Have we managed our time well and allowed open and balanced discussion?

Have we considered our values and acted in a way that supports embedding our values across CTM? Have we maintained a strategic focus?

Have we received sufficient assurance from a range of sources?

Has our discussion allowed us to better understand the risks that we are managing that may affect the achievement of our strategic goals?

7.3. Highlight Report to Board

Discussion *Patsy Roseblade, Committee Chair*

Do Members wish to flag any areas for escalation in the Committee Highlight Report to Board

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10:00 - 10:00
0 min

8. PRIVATE/IN COMMITTEE SESSION

Information *Patsy Roseblade, Committee Chair*

The Following items will be discussed at the In Committee Session of the Audit & Risk Committee:

- Medical Variable Pay - Rates agreed above Cap

- Organisational Risk Register - Cyber Security Risks

10:00 - 10:00
0 min

9. DATE AND TIME OF NEXT MEETING - WEDNESDAY 18 OCTOBER AT 10:AM

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 3.1

ACTION LOG – AUDIT & RISK COMMITTEE					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at date papers where circulated)
18/099	8/10/2018	Endoscopy JAG Accreditation Closure report to be presented to a future meeting.	Chief Operating Officer	January 2019 **Revised to:** October 2020 **Ongoing -** Action being led by Director of Operations. This matter is linked to JAG accreditation and updates will be provided to the Committee through the action log at each meeting Now October 2021 Now February 2023 Now April 2023 Now August 2023	**In progress** Review of each site is progressing. Capacity of operational team has been redirected to Planned Care Recovery activity and therefore pace of progress has been impacted. Timeframe readjusted and review date now set for August 2023.
5.3.4	13/02/2023	Internal Audit Review – Medical Variable Pay - Reports outlining the rates that had been agreed above cap to be reinstated and presented to future meetings of the Audit & Risk Committee.	Medical Director	August 2023	**In progress** The Medical Director has confirmed that these reports will be reinstated with the next report presented to the August 2023 meeting.

5.3	19/04/2023	Audit Recommendations Tracker - Hyperlinks to the audit reports to be included against each recommendation to make it simpler for Members to cross reference.	Corporate Governance Manager	21 June 2023 Now 16 August 2023	**Completed** Audit Tracker improvements made. Further work required to include hyperlinks to audit reports within the audit recommendations trackers which will be considered when exploring an automated system.
5.3.2	19/04/2023	Medical Rostering Progress Report – The next update report should report on progress towards a board-wide medical rostering policy underpinned by a single IT system with the aim of providing a single reliable source of information regarding the deployment of the medical workforce. Medics Rostering Policy to be presented to the People & Culture Committee for formal approval.	Medical Director	October 2023	**In progress** Report to be presented to the October 2023 meeting.
4.1.1	21/06/2023	National Fraud Initiative Progress and Outcomes - Future reports to include an opening paragraph which explained the purpose of the national fraud initiative and	Head of Local Counter Fraud	Next report due February 2024	**In progress** The Head of Local Counter Fraud has suggested that the Committee receives bi-annual update son this matter, with the next report to be presented to the

		what the process means for the Health Board			February 2024 Audit & Risk Committee.
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at date papers where circulated)
4.2	21/06/2023	Procurements & Scheme of Delegation Report – Director of Finance to clarify the position in relation the statement made within the Capital Monitoring Financial Control Procedure that any changes over 500k go to the Chief Executive and any changes between 500k and 1m go to the Board.	Executive Director of Finance	16 August 2023	**Completed.** Action Sent to Sally May 26/7/2023
4.3	21/06/2023	Losses and Special Payments Report - Worked example to be included in the next iteration of the report to explain the discounting rate and what this was used Progress report to be presented to the next meeting outlining the steps being taken to address the backlog in Learning From Events reports	Head of Corporate Finance Deputy Director of Nursing	16 August 2023	**Completed** Action Sent to Owen James 26/7/2023 and on agenda for August. On agenda at item 4.4.
5.2	21/06/2023	Audit Recommendations Tracker - Lead officers to be asked for rationale to be	Corporate Governance Manager	16 August 2023	**In Progress** Rationale for changes to

		provided as to why they were proposing a change to the implementation date.		Now date October 2023	implementation dates will be captured in future reports.

completed Actions					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action (as at date papers where circulated)**
4.1	19/04/2023	Local Counter Fraud Report – Future reports to highlight percentage of targeted staff that had attended training sessions.	Head of Local Counter Fraud	21 June 2023	**Completed**
5.3	19/04/2023	Audit Recommendations Tracker - Final column of the trackers to be hidden or truncated. Full version of the document to be uploaded into the documents folder on Admincontrol with a truncated version being included within the papers. Cover report to include a summary of recommendations that were being proposed for closure.	Corporate Governance Manager	21 June 2023	**Completed** Final column now hidden for the purpose of including with the papers for Members. Cover report amended to provide a summary of recommendations being proposed for closure.

4.1	21/06/2023	Local Counter Fraud Report – Report to be shared with the Executive Director for People so that he can consider whether any further action needed to be taken in relation to the process regarding termination forms Links to be made between the Communications Team and Counter Fraud so that a discussion could be held in relation to cascading key messages in relation to timely completion of termination forms	Director of Finance Assistant Director of Governance & Risk	16 August 2023	**Completed** Report shared with the Executive Director for People for consideration **Completed** Email introduction made by the Assistant Director of Governance & Risk
5.1	21/06/2023	Organisational Risk Register – Queries raised in relation to Risks 4908, 4148 and 2987 to be discussed with lead officers outside the meeting	Assistant Director of Governance & Risk	16 August 2023	**Completed.** July iteration of the Organisational Risk Register captures updated positions on these risks.
5.4.1	21/06/2023	Internal Audit Progress Report - Discussion to be held with the Executive Team in relation to timely completion of management responses	Assistant Director of Governance & Risk	16 August 2023	**Completed.** This was raised at the Executive Leadership Group.

AGENDA ITEM
4.1

AUDIT & RISK COMMITTEE

Local Counter Fraud Update Report

Date of meeting	16 August 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Matthew Evans, Head of Local Counter Fraud Services
Presented by	Matthew Evans, Head of Local Counter Fraud Services
Approving Executive Sponsor	Executive Director of Finance & Procurement
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
CFS Wales	Counter Fraud Service Wales
FI	Financial Investigator
LCFS	Local Counter Fraud Specialist
LPE	Local Proactive Exercise
NHS CFA	NHS Counter Fraud Authority

1. SITUATION/BACKGROUND

1.1 The Health Board is required to comply with NHS Counter Fraud Standards. A counter fraud work plan has been agreed for the year setting out work to meet these standards based around four strategic areas. This report updates the Committee on progress against the counter fraud work plan.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The report provides detail on tasks and actions undertaken with the four strategic counter fraud work areas.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 There are no specific key risks or matters for escalation. The report outlines progress and development work in potential risk areas.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	Not required for this report.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

5.1 The Committee is requested to review the report for discussion.

Agenda Item 4.1

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee – 16 August 2023

Counter Fraud Progress Report

Matthew Evans
Head of Local Counter Fraud Services

1. INTRODUCTION

The purpose of this report is to update the Audit Committee on key areas of work undertaken by the Health Board Local Counter Fraud Specialists (LCFS) since the last meeting.

2. BACKGROUND

The following sets out activity under the Key Principles specified within the Fraud, Bribery and Corruption Standards for NHS Bodies (Wales).

3. RESOURCE UTILISATION

AREA OF WORK	Planned Days	Days to Date
Strategic Governance Ensuring that anti-crime measures are embedded at all levels across the organisation	48	21
Inform and Involve Identifying the risks and consequences of crime against the NHS, and raising awareness of these risks amongst NHS staff, stakeholders, and the public.	118	30
Prevent and Deter Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	130	62
Hold to Account Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.	320	87
TOTAL	616	200

4. STRATEGIC GOVERNANCE

The UK Government is currently legislating with intent to establish wide ranging reforms to tackle economic crime and improve transparency over corporate entities. The Economic Crime and Corporate Transparency Bill is currently in final amendment stage having passed Third Reading in both Houses. The Bill, in its current form, will bring in amendments to Proceeds of Crime Act 2002 confiscation and civil recovery powers primarily aimed at cryptocurrency as well as strengthening of anti-money laundering powers.

The Bill will introduce a new offence of 'Failure to Prevent Fraud' this is where a relevant body is guilty of an offence if, in a financial year of the body a person who is associated with the body commits a fraud offence intending to benefit that body or persons connected with the body. This is still subject to amendment but will likely operate in the same context as the existing s.7 Bribery Act 2006 corporate liability offence of Failure of commercial organisations to prevent bribery.

Home Office guidance will be issued upon Bill becoming law and is not expected to be enforced until at least late 2024. The effect of the incoming bill will be assessed for impact on Health Board business.

A benchmarking report of key performance indicators has been produced and is attached at Appendix 1 to this report. The report measures Health Board performance against an all-Wales benchmark average to provide greater context to the information. The report is based on Q1 2023/24 data.

5. INFORM AND INVOLVE

The Communications Team have engaged with the Counter Fraud Team around support to devise a programme of communications activity. In line with this the Counter Fraud Team are developing new ways of engaging with staff and have developed a new blog to reach staff with more informal style communications.

6. PREVENT AND DETER

Work around implementation of managing fraud risk via DATIX is continuing in line with action outlined in Counter Fraud Work Plan to uplift NHS Requirement 3 from Amber to Green. Communications are being arranged to disseminate plans to risk owners before fraud risks are uploaded to the DATIX system. Communications will set out reasoning and expectations of managing these risks locally.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised in Appendix 2 to the report. A summary of basic investigation KPI data is presented at outset of the appendix.

Case information presented is split by between those cases which are currently open and under active investigation by the LCFS; contained in the Open Cases table.

The Pending Cases table reflects those cases where active investigation by the LCFS has concluded, however the case must remain open due to other outstanding actions from third parties such as (but not limited to) disciplinary, professional body enquiries, financial recoveries.

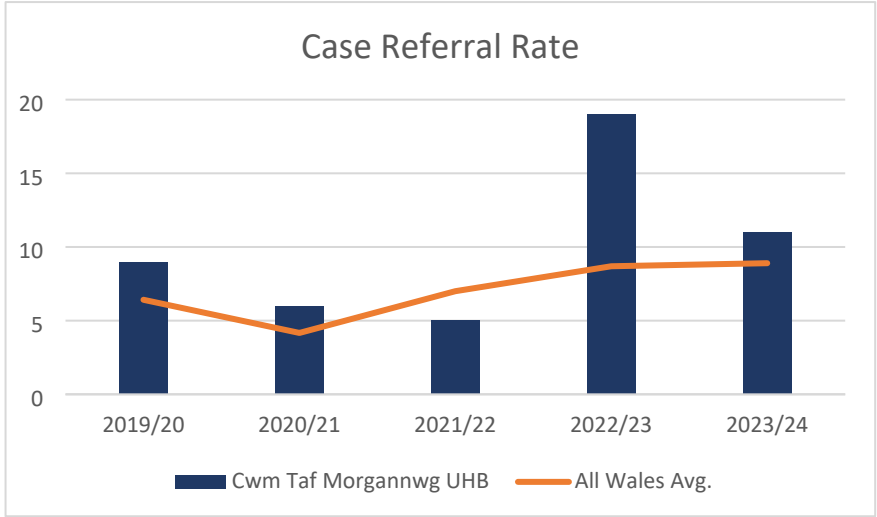
A table of Closed Cases is also presented to review outcomes of investigations.

Item 4.1 – Appendix 1

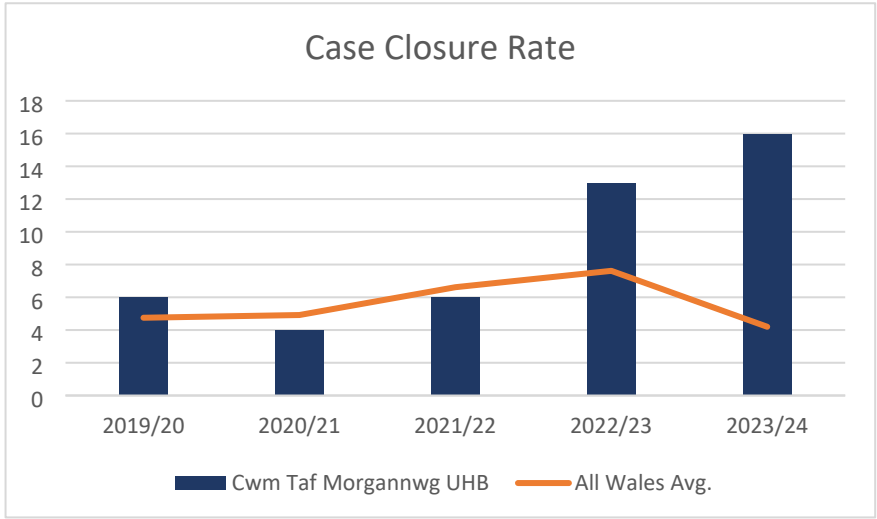
Counter Fraud Benchmark Report

Counter Fraud Benchmarking Statistics – Q1

Case Referral Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	9	6.4
2020/21	6	4.2
2021/22	5	7.0
2022/23	19	8.7
2023/24	11	8.9



Case Closure Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	6	4.8
2020/21	4	4.9
2021/22	6	6.6
2022/23	13	7.6
2023/24	16	4.2



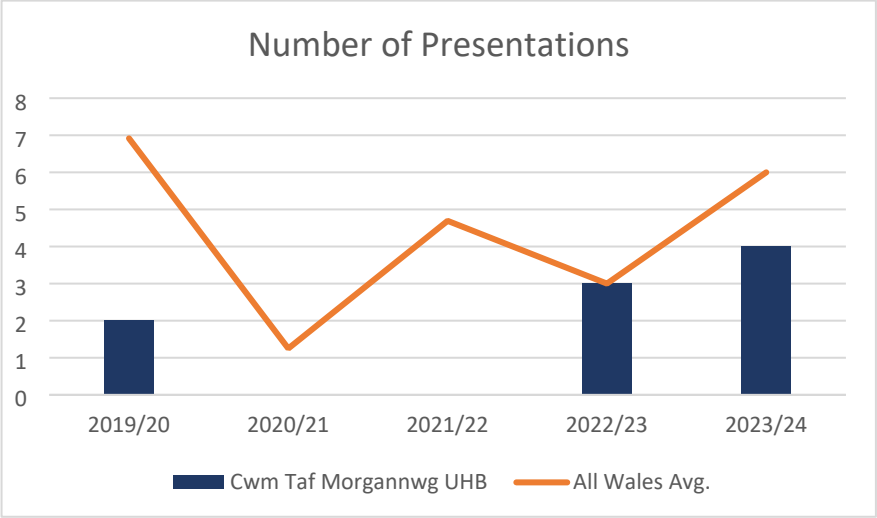
Counter Fraud Benchmarking Statistics – Q1

Investigation Progression Rate	Cases Open at Start of FY	Referrals Received	Cases Closed	Total Cases Open End of Period
2019/20	11	9	6	14
2020/21	18	6	4	20
2021/22	13	5	6	12
2022/23	11	19	13	17
2023/24	13	11	16	8

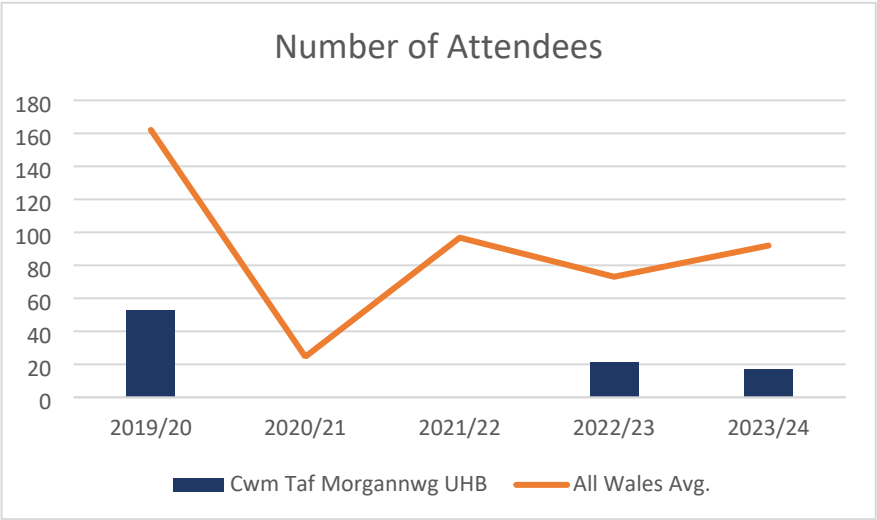
Sanctions	2019/20			2020/21			2021/22			2022/23			2023/24		
	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil
Cwm Taf Morgannwg UHB	0	1	1	0	1	1	1	0	6	0	0	4	0	1	1
All Wales Avg.	0.6	1.4	1.6	0.3	1.0	1.2	0.3	2.3	1.6	0.3	1.4	2.1	0	0.6	0.6
All Wales Total	7	17	19	4	12	14	4	30	21	4	18	27	0	8	8

Counter Fraud Benchmarking Statistics – Q1

Number of Presentations	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	2	7
2020/21	0	1
2021/22	0	5
2022/23	3	3
2023/24	4	6

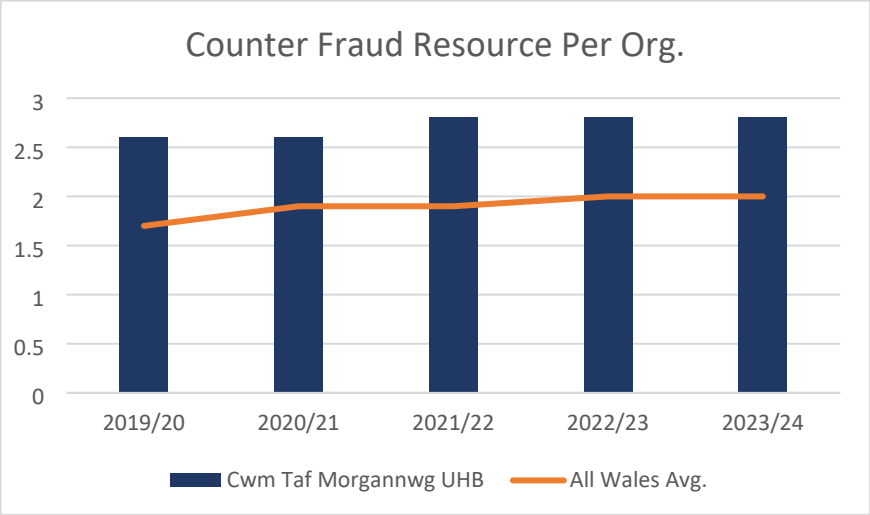


Number of Attendees	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	53	162
2020/21	0	25
2021/22	0	97
2022/23	21	73
2023/24	17	92

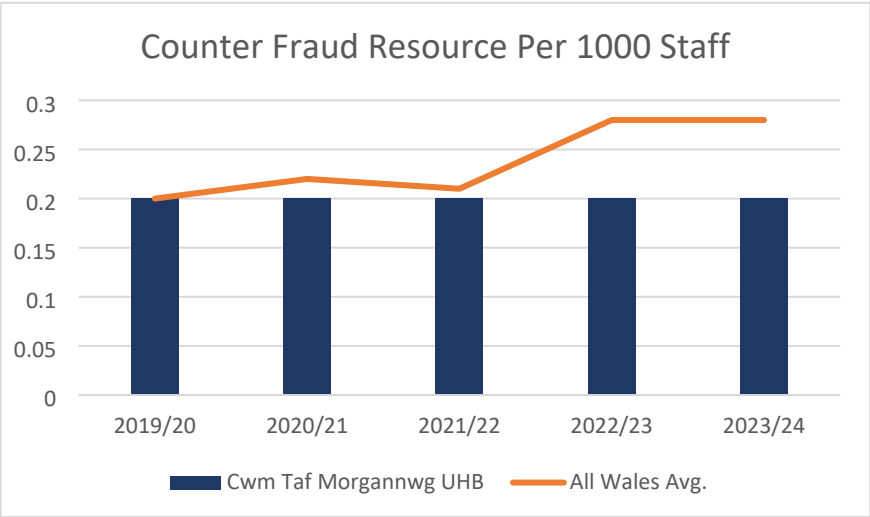


Counter Fraud Benchmarking Statistics – Q1

Counter Fraud Resource Per Org.	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	2.6	1.7
2020/21	2.6	1.9
2021/22	2.8	1.9
2022/23	2.8	2.0
2023/24	2.8	2.0



Counter Fraud Resource Per 1000 Staff	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	0.20	0.20
2020/21	0.20	0.22
2021/22	0.20	0.21
2022/23	0.20	0.28
2023/24	0.20	0.28



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf
University Health Board

Item 4.1 – Appendix 2

Counter Fraud Investigations Update Report

16 August 2023

Summary

The information presented covers the current caseload of the Counter Fraud Team.

Cases being actively investigated by the Counter Fraud Team are listed in the Open Cases table.

Cases in which Counter Fraud Team have concluded their investigation but have third party involvement, such as ongoing internal investigation or investigation by professional body, are listed within the Pending Cases table. These cases remain open on the Counter Fraud Case Management system only for the purposes of recording these outcomes for intelligence purposes.

As cases are closed on the Counter Fraud Case Management system a separate table for Closed Cases will be presented to the Committee to allow review of final outcome of cases.

Case Status

Cases Under Investigation	Cases Pending 3rd Party Outcome	Cases Closed 2023/24
7	0	25

Case Rates

Referrals Received 2023/24	Cases Under Investigation for Over 12 Months
16	1

Sanctions/Outcomes

Criminal Sanctions	Civil Sanctions (Inc. Financial Recovery)	Disciplinary Sanctions
0	0	0

Open Cases			
Reference Number	Date Opened	Allegation	Status
WARO/20/00032	24/01/2020	Alleged theft of petty cash/False representation of employment history and qualifications	The subject appeared at Cardiff Magistrates Court on 20 July and entered a not guilty plea to nine charges. Four of the charges are for fraud by false representation and three are for using a false instrument with intent it be accepted as genuine. There is also a charge of possessing or controlling an article for use in fraud and one charge of unauthorised computer access with intent to commit other offences. The case has been passed to Cardiff Crown Court for trial preparation with next hearing date set for 17 August. The subject resigned their Health Board position whilst disciplinary proceedings were underway. NMC investigation continues and awaits the outcome of the criminal case.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/22/01233	06/09/2022	Overpayment of salary	Enquires have established that subject had a fixed term contract related to Covid recruitment. This should have ended and subject continued to work for Bank. Enquiries have established an overpayment with gross value of £7766.33. An interview has been undertaken and account gained from subject. Following follow up enquiries a second interview was undertaken. During this interview the subject provided account that there was confusion around booking Bank shifts and completion of fixed term contract shifts and there was an honest belief that the shifts they were booking were being split. Subject stated they raised this with their manager at the time and was informed her payslips were correct. This was corroborated by the manager following interview. Assessment of case concluded that subject lacked dishonesty. A civil recovery was agreed and case will be closed once payments commence.
INV/23/01232	10/06/2023	False Overtime Claims	Allegation received via Fraud and Corruption Reporting Line. Staff alleged to be claiming overtime hours on weekends despite finishing work early or not attending at all. Enquiries are being undertaken to corroborate but no individuals named in allegation received. A proactive exercise in this area targeted at named department will be considered if investigation is unable to proceed.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/01232	14/07/2023	Recruitment Concerns	Allegation received via the Fraud and Corruption Reporting Line. Staff member alleged to have employed child in role as well as child's friends. Enquiries being undertaken to verify employment processes undertaken in recruitment of individuals named in allegations.
INV/23/01345	10/07/2023	Nurse Working Without Registration	Subject, a bank worker with the Health Board, is alleged to have been working without professional registration. Matter referred by Head of Nursing. Enquires underway to verify employment processes and revalidation processes utilised in this instance.
INV/23/01440	25/07/2023	Sickness Fraud	Allegation received via Fraud and Corruption Line. Staff member is absent through long term sickness but has been carrying out work on their house posting renovations on social media. Enquiries being undertaken to verify sickness arrangements.
INV/23/01588	01/08/2023	Non-completion of contracted hours	Allegation that staff member has not worked contracted hours with a deficit of 16 hours over 3 weeks. Information received in connection with a disciplinary investigation which is proceeding in parallel. Investigation seeking corroborating evidence of allegation.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
INV/22/01138	18/08/2022	Non-completion of contracted hours and leave fraud	Initial allegation could not be corroborated via digital and locally held records cross referenced against timesheets and leave records. No fraud could be established to the criminal standard.
INV/22/01535	21/10/2022	Timesheet Fraud	Allegation received via the NHS fraud and corruption reporting line. Staff member alleged to be taking more SPA time than other staff and using SPA time to avoid completing additional shifts. Enquiries have uncovered that the subject has a high SPA usage but this is relative based on their part time status. It was established that there is no guidance on SPA allocation for part time vs full time staff and this is being addressed by the Director of Nursing. Assessment of this case has concluded with difficulties in establishing dishonesty and no fraud could therefore be established.
INV/23/00447	06/03/2023	Working Elsewhere Whilst Sick	Allegation highlighted via the National Fraud Initiative. NFI enquiries have established that a member of staff reporting sick to has worked 7 Bank shifts with another Health Board during the sickness absence. Enquiries are being undertaken to collate evidence around the sickness and bank shifts worked. Engagement with manager around sickness dates who stated that the

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
			sickness dates were incorrect. Therefore no working whilst sick fraud established. Due to incorrect ESR information however it appears that the subject has been overpaid approximately 1 month salary. This is being addressed via the normal overpayment recovery procedure.
INV/23/00505	15/03/2023	Overpayment of Salary	A staff member who has now terminated their employment with CTM UHB has been overpaid salary relating to maternity pay for the period 16.02.22. to 16.12.22 Gross £29,636.31. Investigation has been allocated to CFS Wales Financial Investigator to work jointly with LCFS due to criteria for Financial Investigations. Following initial enquiries, it was established that the funds had not been spent. Civil recovery was instigated that resulted in recovery of full amount of overpaid salary.
INV/23/00883	10/05/2023	Overpayment of Salary	Subject has been overpaid maternity pay of net £7565.22. Initial enquiries have established clear guidance issued to subject around expected pay during maternity leave prior to commencement. Further investigation established records of the subject making contact to payroll and disclosing pay issues to management. No dishonesty can therefore be established in case.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
INV/23/00945	17/05/2023	Prescription Fraud	A Health Care Support Worker is alleged to have stolen prescriptions and presented to Pharmacy in attempt to obtain 200 codeine tablets. South Wales Police were leading the investigation who arrested and interviewed subject. Ultimately Police took no further action in this instance. The subject resigned their position at the Health Board.

AGENDA ITEM
4.2

AUDIT & RISK COMMITTEE

PROCUREMENT & SCHEME OF DELEGATION REPORT

Date of meeting	16/08/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Owen James, Head of Corporate Finance
Presented by	Sally May, Executive Director Finance & Procurement
Approving Executive Sponsor	Executive Director of Finance & Procurement
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
		Choose an item.

ACRONYMS	
OJEU	Official Journal of the European Union
FCPs	Financial Control Procedures
SoD	Scheme of Delegation

1. SITUATION/BACKGROUND

1.1 Procurement Matters

The following areas within the Scheme of Delegation (SoD) are reported to the Audit & Risk Committee so that members of the Committee have the opportunity to ask questions or request further information:

a) Engagement off contract of non-medical staff not paid via the payroll. The Director of People and the Head of Procurement would need to confirm agreement prior to any commitment.

b) Waiver of competitive tenders, as authorised by the Director of Finance and Procurement.

c) Contracts requiring Ministerial approval (over £1m)

d) Summary of contracts over £500,000

This report provides details of any such transactions within the period 01.06.23 to 31.07.23.

1.2 Purchase to Pay

In order to comply with the Public Sector Payment Policy, 95% of the number of non-NHS invoices must be paid within 30 days. This report provides an update on the Prompt Payment compliance for 2022-23.

1.3 Scheme of Delegation and Financial Control Procedures

This report provides update to Scheme of Delegations (SoDs) or Financial Control Procedures (FCPs) are reported.

Financial Control Procedures (FCPs) should be reviewed periodically (at least every 3 years) to ensure they are up to date.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Procurement Matters

a) Engagement off contract of non-medical staff not paid via the payroll

There were no engagements or contracts entered into during the period 01.06.23 to 31.07.23.

b) Waiver of competitive tenders, as authorised by the Director of Finance.

Standing Financial Instructions require 4 competitive tenders for supplies of goods and services over £25,000 up to the prevailing OJEU threshold and 5 competitive tenders above OJEU Purchases over £1m require Ministerial approval.

The Scheme of Delegation allows the Director of Finance and Procurement to approve a waiver of the requirement for competitive tenders up to OJEU or other exceptions to tender rules. **Tables A and B** below provides details of such actions during the period 01.06.23 to 31.07.23

Table A – Single Tender Actions 01.06.23 to 31.07.23

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
1673	CAP	Capital Estates	Replace and Upgrade 67 BMS Controllers at RGH	Honeywell Building Solutions	£655,500	a)	19/07/23
1676	CAP	Capital Estates	IPiN Nurse Call System	Wandsworth Group Ltd	£98,512	b)	25/07/23
1665	CAP	Estates	Maintenance work including flooring in SCBU POW for infection Control.	TSF Contractors	£50,746	a)	01/06/23

Reasons for approval:

a) service/work is follow-up, supplier has already undertaken initial work in same area (work undertaken via open competition)

b) Compatibility issue

c) Genuine 1 provider

d) Need to retain particular contractor for real business continuity issues not preferences

Table B - Single Tender Actions- Retrospective

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
1674	Rev	Maintenance	Microscopes Maintenance	Leica	£44,367	a)	19/07/23

c) Contracts requiring Ministerial approval (over £1m)

Reference	Title	Supplier	Value	Date Approval Received
T884	Dental Services Bridgend	Valley Family Dental Services	£5,670,000	13.07.2023

d) Summary of contracts awarded over £500,000

Health Board's must provide a contract summary to Welsh Government for contracts between £500,000 and £1 million prior to the contract being let. This requirement also applies to contracts that are to be let through a mini-competition under a public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. Below is a retrospective summary of contracts awarded between 01.06.23 to 31.07.23:

Reference	Title	Supplier	Value	Date Approval Received
STA1670	BMS upgrade and renewal	Honeywell Building Solutions	£655,500	TBC

2.2 Purchase to Pay (P2P)

The PSPP figures are reported for the first quarter to 30th June 2023.

The Health Board has met its 95% target of paying non-NHS invoices within 30 days to Month 3 2023-24 achieving 97.3% (value 96.7%). This compares to 95.4% (value 94.3%) to Month 3 2022-23.

	0 - 30 Days		Total		%	
	Number	**Value**	**Number**	**Value**	**Number**	**Value**
Apr-23	15,571	38,586,322	16,298	43,991,964	95.5	96.0
May-23	23,465	69,816,166	23,924	76,960,512	98.1	97.9
Jun-23	22,974	35,244,677	23,533	39,126,216	97.6	95.2
YTD	**62,010**	**143,647,165**	**63,755**	**160,078,692**	**97.3**	**96.7**

The NHS invoice position continues to be challenging and shows that 75.4% (number) and 96.7% (value) of invoices were paid within 30 days to month 12 2022-23. (80.9% (number) and 96.6% (value) for the same period in 2021-22).

An escalation process has now been established where the financial accounting team are going to target areas where regular non-payment of NHS invoices within timescales is noticed. If there continues to be delay in payment of invoices this will be escalated to the appropriate Director and Director of Finance.

Scheme of Delegation and Financial Control Procedures (FCPs)

Please see attached at Appendix 1 request to amend the Scheme of Delegation for the approval of compensation payments in regards to personal injury and medical negligence claims. This is to reflect changes in the management and reporting since the departure of the previous Director of Corporate Governance.

A revised Charitable Funds Financial Control Procedure is included for review and approval, all changes are shown through tracked changes. This is to bring the Charitable Fund FCP up to date as per required review dates. The process and funds within the Charity are currently being reviewed and therefore there is likely to be a further update to the FCP once this is complete.

There are a number of other FCPs that are currently under review and have been shared with Senior Managers for comment, these will come to the next Audit & Risk Committee for approval.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 N/A

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Yes – available from Owen James – Head of Corporate Finance
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Ensure sustainability in all that we do, economically, environmentally and socially

5. RECOMMENDATION

The Audit & Risk Committee is asked to:

a) **NOTE** the position on procurement matters for the period 01.06.23 to 31.07.23;

b) **NOTE** the update regarding Purchase to Pay and achievement of PSPP target for the first quarter of 2023/24;

c) **APPROVE** the updated Scheme of Delegation and

d) **APPROVE** revised FP16 – Charitable Funds Financial Control Procedure

Request for changes to the Additional delegations linked to the SFIs

Please return completed form to Owen James - Owen.James2@wales.nhs.uk

SoD Ref.	SoD Page No.	Main Task	Sub Task	Cwm Taf Morgannwg existing		Cwm Taf Morgannwg proposed		Reason for the change	Requested by:	Requested timeframe for implementation
				Limits	Authority delegated to:	Limits	Authority delegated to:			
14. B2	38	Approve compensation payments made under legal obligation	Personal injury and medical negligence claims	i. Up to £25,000	i. Legal Services Manager	i. Up to £25,000	i. Legal Services Manager			
				ii. £25,000 to £75,000	ii. Assistant Director Legal Services and Concerns	ii. £25,000 to £75,000	ii. Assistant Director Legal Services / Assistant Director of Quality & Safety / Deputy Executive Director of Nursing	To provide further appropriate cover for approving claims within the appropriate team	Head of Corporate Finance following discussion with Nigel Downes - Assistant Director of Quality & Safety	Immediate
				iii. £75,000 to £500,000	iii. Director of Corporate Governance	iii. £75,000 to £500,000	iii. Director of Nursing, Midwifery & Patient Care	To reflect change in Director following previous Director of Corporate Governance leaving the HB.	Head of Corporate Finance following discussion with Nigel Downes - Assistant Director of Quality & Safety	Immediate
				iv. £500,000 to £1m	iv. Chief Executive	iv. £500,000 to £1m	iv. Chief Executive			

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

FINANCIAL CONTROL PROCEDURE: CHARITABLE FUNDS

Initiated by:	Director of Finance
Approved by:	Audit & Risk Committee
Date approved:	~~TBC~~16th August 2023
Operational Date:	~~3rd October 2016~~TBC
Version:	~~Two~~v. 3
Date for review:	16th August 2026~~28th of February 2021~~
Distribution:	Executive Directors/Trustees Fundholders

Freedom of Information Status: Open

This policy has been subject to a full equality impact assessment.

CONTENTS

Appendices

1.0 INTRODUCTION

1.1 This procedure details the principles underlying the Cwm Taf Morgannwg University Health Board's system for operating Charitable Funds (also described as Endowment Funds ~~or Non-Exchequer Funds~~) in order to enable the funds to be properly controlled and accounted for. Charitable Funds arise when monies are received in the form of donations, gifts and bequests. The funds are governed by the laws affecting Trustees and Charities.

1.2 The receipt, recording, and the management of all charitable funds shall be in accordance with the Cwm Taf Morgannwg University Health Board's Standing Financial Instructions, Standing Orders and other relevant Financial Control Procedures. Expenditure against any Fund shall be conditional upon:

a. The item being within the objects of the appropriate fund.
b. Delegated limits of approval as determined by the Health Board's Scheme of Delegation

The Cwm Taf Morgannwg UHB is the Corporate Trustee for all of the charitable funds. The individual board members act as the Trustees of the funds.

1.3 Charitable funds are subject to certain legal controls and conditions and they must be accounted separately from ~~exchequer~~ revenue funds. The conditions normally relate to the fund uses and stem from the terms of the original donation or legacy. All funds must be registered with the Charities Commission which has responsibility to ensure any conditions are complied with.

2.0 Creation of New Charitable Funds

2.1 Where possible the setting up of new funds should be avoided, and the monies received will be allocated to existing funds. If there are no suitable funds to meet the donor's wishes, a request to set up a new fund will be submitted to the Chief Executive (CEO) or Director of Finance who will need to approve accordingly.

2.2 The application to the CEO/Director of Finance should be made in writing via the completion of a form (see Appendix A). This should contain the objective/purpose of the fund, source of

donation, the type of purchases that the fund would be used to support, and the proposed delegated fund holders who are responsible for managing the fund and approve expenditure within the Scheme of Delegation.

2.3 The fund name and number will be allocated by the Senior Finance Officer (Charitable Funds), who will inform the requesting officer accordingly.

2.4 The fund holders should ensure that they possess full documentation for each of the funds under their control.

3.0 Donations and Legacies

3.1 Prior to the acceptance of any large donations or any legacy, the Head of Corporate Finance shall assess whether the wishes of the donor can be met. If for any reason the terms cannot be satisfied, then the donation/legacy should be declined. All situations where monies are refused will be with the written authorisation of the CEO. In the case of legacies, legal advice may need to be sought.

3.2 Before large donations/legacies for the purchase of a specific item(s) of equipment/service are accepted, the Head of Corporate Finance, with assistance from capital finance colleagues, shall ascertain whether the use of the donation would generate any revenue costs and if these are within the UHB's approved operational plans.

3.3 The Senior Finance Officer shall assess whether monies received from third parties such as drug companies or other sponsors, should be treated as charitable donations or classified as trading activities, in compliance with the Charity Commission rules.

3.4 All donations must be receipted ~~on a Charitable Funds Collection and Deposit (C&D) Sheet~~, via the ORACLE financial cash receipting system. ~~This can be actioned either within hospital General Offices or in the Finance Department. It is important that exchequer receipts are not recorded on a Charitable Funds C&D Sheet (or vice versa).~~ All receipts for charitable funds will be banked in the Charitable Fund Current Account.

3.5 Where practicable donors will be asked to complete and sign a receipt form with a duplicate being signed and retained by the donor. This form will remove any subsequent misunderstanding

or confusion as to the wishes of the donor. The forms will be held at Hospital ward level and within Hospital General Offices.

3.6 ~~It is preferable that all m~~Monies should be paid into General offices rather than to individuals at ward level. Where this is unavoidable the person in charge should receipt the monies and pay the monies into the General Office at the earliest opportunity. The money should be held in a secure location prior to payment into the General Office.

3.7 The receipt should be completed with details of the donation, e.g. which fund to credit, name of donor, and amount. The coding of the C&D Sheet must be completed at source.

3.8 Where hospital sites have access to the ORACLE Financial System, input shall be done by the Collecting Officer prior to the forwarding of the relevant documentation to the Senior Finance Officer (Charitable Funds)

3.9 For areas without access to the ORACLE Financial System the relevant C&D Sheets must be submitted, at regular intervals, to the Senior Finance Officer (Charitable Funds).

3.10 The donations will be recorded into the Charitable Fund accounting system by the Senior Finance Officer.

3.11 The control over receipt of cash in respect of legacies is the same as that applied to normal donations. However, greater attention must be paid to such bequests, since they may involve large amounts of money and in some cases property.

3.12 All correspondence relating to legacies should be sent **immediately** to the Senior Finance Officer (Charitable Funds), who will then take the appropriate action.

3.13 Donors should be encouraged where practicable to donate via the Health Board's Just Giving site and, for qualifying donations, to make use of Gift Aid provisions (see 4.7 below).

4.0 Fundraising and Gift Aid

4.1 Where external parties propose to undertake fund raising activities on behalf of the Health Board they must be assessed for suitability.

4.2 Details of fundraising activities shall be notified to the Senior Finance Officer (Charitable Funds) so that appropriate accounting records can be maintained. The Senior Finance Officer will supply the fund holder with information on records that need to be completed on income and expenditure for all activities.

4.3 Fundraisers shall be encouraged to use the Health Board's Just Giving website to receive donations, and publicise their appeal.

4.4 Cwm Taf Morganwg UHB is registered with HMRC for Gift Aid. A HMRC number and an account number is maintained, and these details can be provided by the Senior Finance Officer on request.

4.5 A Gift Aid declaration has to made and signed by the donor to benefit the Charity. A copy of the required declaration is attached as Appendix C. After completion, the form should be sent to the Senior Finance Officer who shall collate and obtain reimbursement from the HMRC.

4.6 Alternatively, donors using the Just Giving site may apply for Gift Aid directly through declaring the appropriate information and accepting the relevant conditions.

4.7 **It is important that only UK Income Tax and/or Capital Gains Tax payers are able to claim Gift Aid. All conditions that must be satisfied to qualify for Gift Aid are stated on the declaration form and Just Giving site. It is the donor's responsibility to read these conditions and declare accordingly**.

5.0 ORDER, RECEIPT AND PAYMENT OF GOODS & SERVICES

5.1 Requisitions & Requests for Reimbursement

5.1.1. For all expenditure from a Charitable Fund an electronic requisition on Oracle should be approved by the fund holder or designated signatory authorised by the fund holder. The requisition shall be forwarded to the Charitable Funds Officer ~~Senior Finance Officer~~, where the fund balance will be checked (also taking into account any unpaid orders) ~~and if applicable the requisition marked with "sufficient funds available" and signed and dated~~. If there is found to be "insufficient funds" then the requisition must be return to the f~~F~~und holder stating the reason. Under no circumstances shall a requisition be drawn which would cause the fund to become overdrawn.

5.1.2 If sufficient funds are available and the expenditure is below £5,000 and deemed "non-contentious" (i.e. it is appropriate and compatible with fund objectives), the requisition is forwarded to the Procurement Department for processing of the order. If deemed contentious, this will be discussed in the Charitable Funds committee for approval.

5.1.3 ~~However if the expenditure is deemed contentious, the requisition shall be referred to the CEO or Deputy CEO for approval.~~

5.1.4 ~~All requisitions over £5,000 are referred to the CEO/Deputy CEO for approval, in line with the Scheme of Delegation~~

All requisitions have to be approved in line with the Scheme of Delegation.

5.1.5 Requisitions must be accompanied by a Charitable Fund Expenditure Authorisation Form (Appendix D). This shall include details of any revenue consequences that may arise from the purchase and how those revenue costs are to be funded.

5.1.6 Requests for reimbursement (Appendix E) shall be processed in the same way as requisitions, and in accordance with the Scheme of Delegation.

5.1.7 The Senior Finance Officer is responsible for identifying any purchases that are eligible for VAT Exemption, and complete a VAT exemption certificate (Appendix F). This will be authorised by the Head of Finance and forwarded, along with the requisition, to the Procurement Department. The requisition should be clearly marked "VAT EXEMPT".

5.2 Ordering

5.2.1 Ordering of all items will be carried out by the Shared Services Procurement Department following receipt of a properly authorised requisition.

5.2.2 When a capital purchase is made from Charitable Funds, the Charitable Funds Officers ~~Senior Finance Officer~~ shall liaise with the Capital Finance team to ensure the expenditure is correctly accounted for on the UHB's fixed asset system and Capital Resource Limit.

5.2.3 Statements of need may be requested when purchasing medical equipment to be considered by the Clinical Engineering Department as part of their responsibilities around safety and compatibility of medical equipment.

5.3 Payment for orders raised on ORACLE

5.3.1 For orders that have been raised on the ORACLE system the Requesting officer must ensure that goods or services are receipted when the order is satisfied.

5.3.2 The payment for goods relating to Charitable Fund orders carrying ORACLE order numbers are paid in accordance with the UHB's Financial Control Procedure for Creditor Payments.

5.3.3 Once all the above procedures have been adhered to, a cheque can be raised against the Charitable Fund Account for signing by an authorised signatory in accordance with the bank mandate. All cheques to the value of £20,000 or more must be countersigned by an authorised second signatory.

5.4 Direct reimbursement for expenditure not on ORACLE

5.4.1 The Cash section within the Finance Department shall process any payments, through raising of cheques or Bacs Transfers, for authorised requests for reimbursement (Appendix E).

5.4.2 The Charitable Funds Officer ~~Senior Finance Officer~~ shall be notified of cheque numbers for payments of this nature, which shall be kept on file.

5.4.3 Cheques shall be signed in accordance with the bank mandate and as described in para 5.3 above.

6. REPORTING

6.1 Fund Balances

6.1.1 At the end of each month, all f~~F~~und holders shall be provided with a statement of c~~C~~haritable f~~F~~und b~~B~~alances in order to facilitate management control over their funds. Any anomalies should be reported immediately to the Senior Finance Officer, who will investigate as appropriate and make any necessary corrections.

6.1.2 Funds with nil or small unused balances should be closed or merged. The Senior Finance Officer shall discuss accordingly with the fund holder and obtain approval for such actions.

6.1.3 Fund holders are obliged to ensure that Charitable Funds are used for the purpose intended at the time of donation. Funds should not be allowed to accumulate indefinitely and should be spent as soon as is practicable. The Senior Finance Officer shall periodically request spending plans for particular funds for reporting to ~~Trustees or Audit Committee~~Charitable Funds Committee.

6.2 Management and Statutory Reporting

6.2.1 The Charitable Funds Committee has delegated powers to oversee Charitable Fund matters on behalf of the Trustees. The Head of Finance shall report to each ~~Audit Committee~~Charitable Funds Committee the level of fund balances held, investment performance (see section 7 below) and other governance issues that may be of interest to Trustees in the management of their charitable funds.

6.2.2 A set of annual accounts and an annual report must be prepared at the end of each financial year, externally audited or examined as appropriate in accordance with prescribed thresholds, and approved by Trustees. A full meeting of the Trustees shall be convened once a year to approve the accounts and annual report.

6.2.3 The Annual Accounts and Report must be filed with the Charity Commissioner prior to the 31 January following year-end.

7.0 BANK ACCOUNTS

7.1 Current Account

7.1.1 The Charitable Fund's Current Account balance is monitored daily in order to determine whether outstanding commitments can be satisfied and/or whether cash is available when required.

7.1.2 The Current Account balance should be kept to a minimum. Any surplus cash available should be swept across to an interest bearing Deposit Account in order to generate interest income.

7.1.3 All receipts are deposited in the current account and cheques are drawn against this account. All cheques must be signed,

and the account operated, in accordance with the bank mandate.

7.2 Interest Bearing Deposit Account

Such an account can be used for transfers of cash from the current account to gain interest income. When funds are required to meet outgoing commitments, an appropriate cash transfer can be swept back into the current account.

7.3 Reconciliation of Bank Accounts

At the close of each month, a reconciliation of the bank accounts will be undertaken by the Senior Finance Officer and reviewed by the Financial Accountant. Any reconciling items should be cleared by the following month, or an explanation provided if this was not possible.

8. INVESTMENTS & ADMINISTRATION COSTS

8.1 Investments

8.1.1 Trustees are expected to maximise the investment return on the funds entrusted to them, whilst minimising the risk to the funds themselves.

8.1.2 Funds may be invested in equities, bonds, property etc as directed by Trustees, having due regard to their responsibilities around risk, in order to maximise returns.

8.1.3 The Trustees may appoint investment agents to advise on, and manage investments as required. The Audit Committee shall monitor performance of investment agents and the underlying investments on behalf of the Trustees, and may require the appointed agent to attend meetings as required for this purpose.

8.1.4 In determining the nature of investments to be held, the Audit Committee shall consider any ethical issues that may arise from such investments.

8.1.5 The Trustees will agree an investment policy to act as a guide for making any investments, considering the level of returns expected and the level of risk to be tolerated. This policy will be reviewed periodically and any changes will require Audit Committee approval.

8.1.6 The Head of Corporate Finance, on behalf of the Director of Finance, shall review investments held against the agreed policy and advise on increasing or reducing the level of investment held as appropriate. Any change to the nature of investments will be guided by advice from the appointed agents. The Audit Committee shall be requested to approve any change to either the level or nature of investments held.

8.1.7 The placing of investments, or withdrawal of any investment, shall be authorised by the CEO and Director of Finance.

8.1.8 The value of the investments held shall be regularly reviewed by the Head of Finance, and any increases or fall in values will be charged against a charitable fund revaluation account.

8.1.9 At the end of each financial year, a valuation will be received from the investment agents and accounted for appropriately within the Annual Accounts. A negative revaluation reserve balance at the end of the financial year will need to be apportioned against underlying funds.

8.1.10 A positive revaluation reserve will be carried forward to the following year. This reserve may be distributed across underlying funds should it reach the level prescribed within the investment policy. Any distribution of this capital surplus will require approval by the Director of Finance and Audit Committee.

8.2 Investment Income

8.2.1 ~~Where dividends and interest are paid under the deduction of tax, the Senior Finance Officer will reclaim tax as appropriate.~~

8.2.2 Interest and dividend income will be apportioned to individual funds based on the average fund balance during the period.

8.2.3 Interest and dividends due at the end of each financial year shall be accrued and included in the above apportionment.

8.3 Administration Costs

8.3.1 Where releveant, ~~E~~each fund will be charged an annual administration fee, which will be a share of the total cost of managing the Charitable Funds for that year. The charge will be based on an estimate of the number of hours spent on the Charitable funds by UHB staff and will include a charge for the

proportion of the annual statutory audit fee and any other administrative costs incurred. The apportionment of administration costs over individual funds shall be on the same basis as the apportionment of investment income. Where the funds are unrestricted the recharge for the administration fee and investment income can be charged to an LHB wide general purpose fund. A schedule of the annual administration cost to be charged to charitable funds shall be prepared by the Senior Finance Officer and approved by the CEO.

9 EQUALITY IMPACT ASSESSMENT

Following assessment, this policy is not felt to be discriminatory or detrimental in any way with regard to the following equality strands: Gender; Race; Disability; Age; Sexual Orientation; Religion or Belief; Welsh Language or Human Rights.

APPENDIX A

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

REQUEST FOR A NEW CHARITABLE FUND TO BE SET UP

PROPOSED FUND NAME

SOURCE OF FUNDS:

INITIAL FUND BALANCE

EXPECTED LEVEL OF FUTURE RECEIPTS

DEPARTMENT/WARD

Purpose of Fund ((Please tick relevant box(es)) Patient benefit ☐ Staff benefits ☐ Equipment benefit ☐

Brief Description (Fund Objectives):

FUND HOLDER

Personnel who can authorise expenditure (Signatories)

Name	Title	Signature

PLEASE RETURN COMPLETED FORM TO FINANCE DEPARTMENT
ADMIN BLOCK, DEWI SANT HOSPITAL

Approved
(Director of Finance)

Fund No

Finance Signature

APPENDIX B

Form of Receipt for an Individual Donation

RECEIPT	
Donor's name and address	I..... of .... give to Cwm Taf University Health Board as the Trustees of the Cwm Taf NHS Charitable Fund.
Where the donation is for a **specific purpose**, insert appropriate wording. e.g. to provide extra comforts for the patients in ward x.	the sum of £..... for the general purpose of that Charity. Without imposing any Trust, I desire they use such sum to
If not, this part can be crossed through. The donor should sign and date the receipt. The individual accepting the donation on behalf of the health service body should sign and date the receipt.	.... Donor's signature:..... Date: ..... **RECEIVED WITH THANKS** the sum of £.....for and on behalf of Recipient's signature:..... Date: .....

APPENDIX C

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

giftaid it

Gift Aid Declaration

Name of charity: **Cwm Taf University Health Board**

Please treat as Gift Aid donations:

☐ The enclosed gift of £ _____

Donor's details

Title: _____ Initial(s): _____Surname:

_____

Home address:

_____

_____

Postcode: _____ Date: _____

Signature: _____

I confirm I have paid or will pay an amount of Income Tax and/or Capital Gains Tax for each tax year (6 April to 5 April) that is at least equal to the amount of tax that all the charities or Community Amateur Sports Clubs (CASCs), that I donate to, will reclaim on my gifts for that tax year. I understand that other taxes such as VAT and Council Tax do not qualify. I understand the charity will reclaim 25p of tax on every £1 that I give.

Please notify Cwm Taf ULHB if you:

1. Want to cancel this declaration.
2. Change your name or home address.
3. No longer pay sufficient tax on your income and/or capital gains.

If you pay income tax at the higher rate, you must include all your Gift Aid donations on your Self Assessment tax return if you want to receive the additional tax relief due to you.

Cwm Taf NHS General Charitable Fund, C/O Finance Department, Dewi Sant Hospital, Albert Road, Pontypridd, RCT CF37 1LB
Registered Charity number 1049765

APPENDIX D

Charitable Fund Expenditure Authorisation Form

TO BE ACCOMPANIED BY A COMPLETED NON STOCK REQUISITION)

SECTION A (to be completed by designated officer)

NAME OF FUND: _____ **FUND NO.** _____

EXPENDITURE REQUESTED BY:_____

DESIGNATION: _____

DESCRIPTION OF ITEM/EQUIPMENT TO BE PURCHASED:

_____

COST: _____

REVENUE CONSEQUENCES: _____

_____

WHY IS PURCHASE REQUIRED/WHAT USE WILL BE MADE:

_____

HOW IS IT PROPOSED TO FUND REVENUE CONSEQUENCES:

_____

IS THE PURCHASE VAT EXEMPT: YES/NO/NOT SURE
(Please delete where appropriate). If YES please attach a VAT Exemption Certificate duly completed. If in any doubt signify NOT SURE for Finance Department to process.

(If money has been/will be specifically donated for the above give details of donations)

_____

SIGNED:_____ **DATE:** _____

SECTION B (To be completed by Finance Department)

BALANCE OF FUND BEFORE APPROVAL: _____

VERIFIED BY:_____

DATE: _____

EXPENDITURE AUTHORISED BY: _____

DATE: _____

APPENDIX E

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

Request for reimbursement from a Charitable Fund

SECTION A (to be completed by designated officer)

HOSPITAL: _____

NAME OF FUND: _____ **FUND NO:** _____

REQUESTED BY: _____ **DEPARTMENT:** _____

AMOUNT REQUIRED: _____
(a receipt must be produced where appropriate)

CHEQUE PAYEE: _____

ADDRESS: _____

REASON: _____

_____

_____

_____

SIGNED: _____ **DATE:** _____
AUTHORISED SIGNATORY

SECTION B (to be completed by Finance Department)

BALANCE OF FUND BEFORE APPROVAL: _____

VERIFIED BY: _____ **DATE:** _____

EXPENDITURE AUTHORISED BY: _____ **DATE:** _____

APPENDIX F

VAT EXEMPTION CERTIFICATE

I herby certify that the goods to which this order relates is being purchased with the funds of:

Cwm Taf NHS General Charitable Fund

and/or with voluntary contributions donated by the public and will be donated to (Name of Hospital):

……

Which I believe are:

medical equipment □ sterilising equipment □

scientific equipment □ laboratory equipment □

computer equipment □ refrigeration equipment □

video equipment □

parts or accessories of the equipment indicated above □
repairs or maintenance of the equipment indicated above □

For use solely in: medical research, diagnosis, training or treatment.

I have read the guidance in the Customs and Excise VAT Notice 701/6 and apply for zero-rating of the supply under Group 15, items 5 or 6 of the zero rate Schedule to the VAT Act 1994.

Signed: ……..

Trustee……(Status in Charity)

Date: ……

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
4.3

AUDIT & RISK COMMITTEE

LOSSES AND SPECIAL PAYMENTS 01.04.23 TO 31.07.23

Date of meeting	16/08/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Daxa Varsani – Financial Accountant
Presented by	Sally May - Executive Director of Finance & Procurement
Approving Executive Sponsor	Executive Director of Finance
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
NWSSP – legal services and Risk Pool Stephanie Muir, CTMUHB Assistant Director Claims & Concerns	On-going	NOTED

ACRONYMS	
WRP	Welsh Risk Pool
NWSSP	NHS Wales Shared Services Partnership
VER	Voluntary Early Release
DEL	Departmental Expenditure Limit
L&R	Legal & Risk
PTR	Putting Things Right

CMR	Claims Management Report
LFER	Learning From Events Report
ILG	Integrated Locality Group
CSG	Clinical Service Group
SOP	Standard Operating Procedure
GMPI	General Medical Practice Indemnity
HSE	Health and Safety Executive
AMD	Assistant Medical Director

1. SITUATION/BACKGROUND

1.1 This report advises the Audit & Risk Committee on the losses and special payments made by the University Health Board (UHB) for the four month period from 1 April 2023 to 31 July 2023, as required by in Standing Financial Instruction.

1.2 The Health Board is liable for the first £25k of any Personal Injury or Medical Negligence claim (not including Redress cases), with amounts over this being borne by the Welsh Risk Pool (WRP) managed by the NHS Wales Shared Services Partnership (NWSSP). For any "other" cases such as Employment Matters or Voluntary Early Release (VER) for example, the full cost of the loss is borne by the UHB. Where the WRP would be liable for a reimbursement to the UHB then there will be timing differences between payments being made and any reclaim from the Risk Pool. There is a strict protocol in place for reclaiming from the WRP.

1.3 General Medical Practice Indemnity Scheme (GMPI) was introduced in recent years by the Welsh Government as a state-backed scheme within NHS Wales. Legal and Risk Services and WRP operates this scheme and cases settled under the scheme are presented to WRP for reimbursement.

- Scrutiny of the Learning from Events Report is conducted in the same manner as cases settled under NHS Indemnity or as part of the redress scheme.

- Payments in relation to claims managed under GMPI are made by the defendant Health Board, and reimbursement by the WRP is made to the Health Board.

- No excess in relation to reimbursement of cases settled under the GMPI will apply to the Health Board and all costs incurred are fully reimbursed.

1.4 In accounting for losses on claims, liability is recognised when legal advice states that there is a probability in excess of 50% of the Health Board having to settle. The quantum of the claim, and associated plaintiff costs are therefore recognised as "expenditure" at this point, with the risk pool recovery element also being recognised. Other losses are recognised as and when they arise.

1.5 There is therefore a significant timing issue (which can be several years) between expenditure being recognised within the Health Board's accounts and cash payments being made. Write-off approval action is only required for cash payments. This report highlights:

a) Amounts that have been charged to expenditure for which payments are yet to be made. These amounts are held within the balance sheet as future amounts owing (or owed by the WRP) at the appropriate Balance Sheet date;

b) Amounts charged to expenditure during the current year (together with income from the WRP), and which therefore has a budgetary impact against the Health Board's Revenue Resource Limit; and

c) Cash payments made during the period for which write-off action is required, with details being provided within the appendices.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Standing Financial Instructions require all losses to be reported to the Audit & Risk Committee. This report is therefore a key element of the governance process around losses and special payments.

2.2 The number of claims, both Medical Negligence and Personal Injury, continues to result in significant levels of expenditure. These levels of expenditure are determined case by case and are based on information supplied by Welsh Legal Services.

2.3 Section a, b and c below provide details in regards to amounts that have been charged to expenditure for which payments are yet to be made, budgetary impact against the Health Board's Revenue Resource Limit and the cash payments made during this reporting period.

a) Provision and Creditors as at 31 July 2023

This is shown in table 1 below, together with equivalent figures at the end of the last three financial years.

Table 1

	31.07.23	31.03.23	31.03.22	31.03.21
	£000	£000	£000	£000
	Cumulative	Cumulative	Cumulative	Cumulative
Medical Negligence claims/costs	70,203	72,198	65,127	86,029
Redress Medical Negligence claims/costs	399	385	235	269
Personal Injury claims/costs	805	701	611	436
Recoverable from Welsh Risk Pool	(82,182)	(83,623)	(93,074)	(114,863)
Net claim provision	**(10,775)**	**(10,339)**	**(27,101)**	**(28,129)**
Permanent Injury Benefit	4,002	4,077	6,201	6,320
Net Provision	**(6,773)**	**(6,262)**	**(20,900)**	**(21,809)**
Number of live cases on losses system (LaSPaR)				
	31.07.23	**31.03.23**	**31.03.22**	**31.03.21**
Medical Negligence claims	351	334	299	309
Redress Medical Negligence claims	254	230	213	168
GP Indemnity claims	21	18	7	0
Personal Injury claims	132	129	113	110

Please note the figures disclosed in the above table are cumulative figures as at the relevant reporting period.

Impact of discount rate example:

Changes in the discount rate during the year often have a significant impact on the level of provisions held, especially for permanent injury benefits. At the last Audit & Risk Committee it was requested that a worked example was provided to show the impact of the change of the discount rate. Below shows an example of the rate at 1%; negative 1.3% (as it was at 31/03/22); and 1.7% (as it was at 31/03/2023). It shows two worked examples, showing the impact on the discount rate has on varying forecast remaining lives of claims.

Example Permanent Injury Provision

	Example A
Forecast Remaining life	41 years
Payment per year	£10,000

Discount Rate	**1%**	**-1.30%**	**1.70%**
Provision c/f	£334,997	£546,156	£293,527

Difference between -1.3% and 1.7% -£252,629 Saving
Difference between 1% and 1.3% £211,159 Pressure

	Example B
Forecast Remaining life	10 years
Payment per year	£10,000

Discount Rate	**1%**	**-1.30%**	**1.70%**
Provision c/f	£94,713	£107,538	£91,252

Difference between -1.3% and 1.7% -£16,286 Saving
Difference between 1% and 1.3% £12,825 Pressure

- Discount rate is the rate used in the calculation of Net Present Value (NPV)
- This is to reflect the interest they can expect to earn by investing such payments, as well as the effects of tax, expenses and inflation on these returns.
- e.g. inflation rises, the value of future cash flows decreases, leading to a higher discount rate
- Net present value is the value of future cash flows over the life
- An increase in the discount rate reduces the present value and vice versa
- For this provision the discount rate is provided by HM Treasury and applied accordingly
- In 2022/23 there was a big swing in the discount rate from -1.3% to 1.7% which reduced the value of the provision required significantly
- The impact of a change the discount rate is different for each case as example shows a case with 10 years remaining is a lot less value one with 40 years.

b) Expenditure incurred for the year to 31 July 23

This is shown in table 2 below, together with equivalent figures for the last three complete financial years and last reporting period to the Audit & Risk Committee (31.03.2023).

The "other" category mainly consists of payment of retirement gratuities, Employment Matters and voluntary early releases (see appendix 6).

Table 2

	Year to	Year ended	Year ended	Year ended
	31.07.23	**31.03.23**	**31.03.22**	**31.03.21**
	£000	**£000**	**£000**	**£000**
Medical Negligence claims/costs (Note 1)	(437)	17,386	1,945	13,110
Redress Medical Negligence claims/costs	108	711	170	305
GP Indemnity	3	6	1	0
Personal Injury claims/costs	269	822	772	316
Recoverable from Welsh Risk Pool	769	(16,858)	(1,210)	(12,449)
Net claim expenditure (Note 2)	**712**	**2,067**	**1,678**	**1,282**
Permanent Injury Benefit	37	(1,707)	286	470
Other	34	1,427	570	609
Total Net expenditure	**783**	**1,787**	**2,534**	**2,361**

Note 1: Reduction in Medical Negligence expenditure is due to a combination of decrease in overall provision by £2m and payments being made of £1.5m for the first 4 months of this reporting period.

Note2: Performance on the Budget will be reported to the Committee as the year progresses.

c) Cash Write-Offs made for the period 1 April 2023 to the 31 July 2023

Table 3 shows the cash impact to 31 July 2023 of the current financial year. More detail is provided within the Appendices for the current reporting period.

An analysis of medical negligence payments and receipts over cases for the last 4 months is shown in **Appendix 1.** Redress medical negligence analysis of payments and receipts is now shown separately from medical negligence in **Appendix 2.**

GP Indemnity payment is shown on **Appendix 3**. A similar analysis is provided for personal injury claims in **Appendix 4** and Permanent Injury Benefit (PIB) in **Appendix 5.**

Other write-offs relate to ex-gratia payments, employment claim matters, debt write offs and condemnations & obsolescence, which are approved in accordance with the Scheme of Delegation. The ex-gratia payments include gratuities provided to staff on retirement with more than 20 years' service, in line with HR policy, and voluntary early release payments. These are shown in **Appendix 6.**

Table 3

Cash write-offs made during 23/24

	01.04.23 - 31.07.23 £000	Total 2023-24 £000
Medical Negligence (Appendix 1)		
Claims	990	990
Costs	335	335
Defence Fees	232	232
Medical Negligence Totals	1,557	1,557
Redress Medical Negligence (Appendix 2)		
Claims	49	49
Costs	16	16
Defence Fees	28	29
Redress Medical Negligence Totals	93	93
GP Indemnity (Appendix 3)		
Defence Fees	3	3
GP Indemnity Totals	3	3
Personal Injury (Appendix 4)		
Claims	82	82
Costs	45	45
Defence Fees	39	39
Personal Injury Totals	166	166
Permanent Injury Benefit (Appendix 5)	112	112
Permanent Injury Benefit Totals	112	112
Other (Appendix 6)		
Ex-Gratia	31	31
Debt Write Off	0	0
WRP Penalty Charge (Note 3)	17	17
Ombudsman	3	3
Employment Matter	0	0
Other Totals	51	51

Total	**1,982**	**1,982**
Recovered from Welsh Risk Pool	**(671)**	**(671)**
Net Cash Write-Off	**1,311**	**1,311**

Note 3: As reported previously to the Committee, £25k of Penalty Charge was paid in the previous financial year and an additional £17k was paid during this reporting period. As reported below in section 3.1 of this report a separate update report is provided relating to LFERs and WRP Reimbursement process.

WRP Risk Sharing Agreement

The Audit & Risk Committee will be aware that any overspend incurred by the Welsh Risk Pool will need to be shared amongst NHS organisations, and is therefore an additional financial risk to those organisations.

According to the recent WRP forecast £26.5m of overspend is estimated for 23/24, CTM share being £3.5m. This has been included in the Health Boards Forecast.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 A separate detailed report is provided to the Committee in relation to late submission of LFER to WRP and actions being taken by the Health Board to manage and monitor this matter.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The majority of losses and special payments are as a result of things going wrong and where quality, safety or patient experience may therefore have been compromised. Details of medical negligence and personal injury claims are provided quarterly to the Concerns (Claims) Scrutiny Panel who subsequently reports to the Quality, Safety & Risk Committee
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Yes Completed as part of the Financial Control Procedures for Losses & Special Payments (FP 15)
Legal implications / impact	Yes (Include further detail below)
	Losses provided for are informed by legal advice where appropriate based on probability of a successful claim
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	The report highlights the resource impact of losses both in expenditure and cash terms. It also highlights the level of provision within the balance sheet for potential future payments.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 The Audit & Risk Committee is requested to:

- **NOTE** the losses and special payments made for the period 1 April 2023 to 31 July 2023.
- **NOTE** the update in respect of the matter relating to the late submission of the WRP reimbursement claims and the Penalty Charge.

Medical Negligence Payments 01/04/2023 - 31/07/2023							Appendix 1
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
05RRSMN0039	0	4	0	0	4	115	119
09RVEMN0017	10	0	0	0	10	55	65
10RYLMN0014	80	8	175	0	263	1 210	1 473
12RYLMN0004	0	0	100	0	100	77	177
12RYLMN0035	0	12	0	0	12	1 366	1 378
13RYLMN0005	0	1	0	0	1	23	24
13RYLMN0096	0	0	100	0	100	50	150
15RYLMN0049	0	18	75	0	93	265	358
15RYLMN0133	0	0	3	-71	-68	93	25
15RYLMN0199	0	0	0	0	0	3	3
16RYLMN0074	0	0	3	-100	-97	89	-8
16RYLMN0089	0	0	0	-392	-392	417	25
16RYLMN0098	0	0	3	0	3	112	115
17RYLMN0081	-0	1	0	0	0	50	51
17RYLMN0122	0	1	0	0	1	478	479
18RYLMN0068	0	0	3	0	3	281	285
18RYLMN0072	0	4	0	0	4	0	4
18RYLMN0078	0	4	0	0	4	8	13
18RYLMN0106	0	6	0	0	6	13	19
18RYLMN0114	3	1	0	0	4	90	93
18RYLMN0137	0	0	0	0	0	50	50
19RYLMN0030	14	1	0	0	15	69	84
19RYLMN0046	0	0	3	-35	-32	57	25
19RYLMN0079	0	0	0	0	0	1	1
19RYLMN0083	38	1	0	0	39	120	159
19RYLMN0087	-25	1	0	0	-24	113	89
20RYLMN0008	0	1	0	0	1	25	26
20RYLMN0033	0	2	0	0	2	14	16
20RYLMN0035	0	3	0	0	3	25	28
20RYLMN0099	0	4	0	0	4	3	8
20RYLMN0109	65	0	159	0	224	17	241
20RYLMN0112	0	1	0	0	1	5	6
20RYLMN0116	8	3	-20	0	-10	432	422
20RYLMN0125	0	5	0	0	5	5	10
20RYLMN0129	0	9	0	0	9	219	228
20RYLMN0163	0	1	0	0	1	70	71
20RYLMN0164	0	0	0	0	0	9	9
21RYLMN0010	0	6	0	0	6	10	15
21RYLMN0019	0	2	0	0	2	442	443
21RYLMN0020	0	0	0	0	0	48	48
21RYLMN0024	-37	1	0	0	-36	227	191
21RYLMN0034	0	2	0	0	2	3	5
21RYLMN0035	0	2	0	0	2	4	6
21RYLMN0080	0	0	2	0	2	75	77
21RYLMN0098	36	1	25	0	62	11	73
21RYLMN0099	0	0	0	0	0	75	76
21RYLMN0119	0	0	0	0	0	19	19
21RYLMN0134	0	0	19	0	19	1	20
21RYLMN0147	0	1	40	0	41	5	46
21RYLMN0154	0	1	0	0	1	3	4
22RYLMN0012	10	0	10	0	20	48	68
22RYLMN0027	0	3	0	0	3	56	59
22RYLMN0036	0	1	0	0	1	122	123
22RYLMN0053	27	1	0	0	27	5	32
22RYLMN0057	0	3	0	0	3	4	7
22RYLMN0067	0	7	0	0	7	0	7
22RYLMN0070	0	3	0	0	3	2	5
22RYLMN0073	0	3	0	0	3	4	7

Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
22RYLMN0094	9	0	0	0	9	23	32
22RYLMN0096	0	1	0	0	1	2	3
22RYLMN0112	0	5	0	0	5	8	13
22RYLMN0154	0	2	0	0	2	52	54
22RYLMN0157	0	2	0	0	2	4	6
22RYLMN0158	0	1	0	0	1	3	4
22RYLMN0159	0	2	0	0	2	0	2
22RYLMN0161	0	2	0	0	2	5	7
22RYLMN0169	-16	2	0	0	-15	132	118
22RYLMN0182	0	6	0	0	6	3	9
22RYLMN0183	0	1	0	0	1	3	4
22RYLMN0188	15	0	0	0	15	14	29
22RYLMN0191	0	0	0	0	0	0	0
22RYLMN0195	0	2	0	0	2	0	2
23RYLMN0033	0	3	0	0	3	0	3
23RYLMN0034	10	1	0	0	11	34	45
23RYLMN0035	0	0	0	0	0	3	3
23RYLMN0037	23	0	30	0	53	0	53
23RYLMN0038	0	5	0	0	5	0	5
23RYLMN0040	0	10	0	0	10	2	12
23RYLMN0044	0	0	30	0	30	2	32
23RYLMN0046	19	0	7	0	25	2	27
23RYLMN0049	0	0	10	0	10	3	13
23RYLMN0051	0	1	0	0	1	7	8
23RYLMN0065	0	0	17	0	17	0	17
23RYLMN0069	0	1	0	0	1	0	1
23RYLMN0073	0	2	0	0	2	1	3
23RYLMN0074	0	0	15	0	15	0	15
23RYLMN0075	0	0	8	0	8	2	9
23RYLMN0093	0	0	26	0	26	0	26
23RYLMN0094	0	2	0	0	2	0	2
23RYLMN0095	0	1	0	0	1	0	1
23RYLMN0098	0	5	0	0	5	1	6
23RYLMN0100	30	0	55	0	85	0	85
23RYLMN0102	0	2	0	0	2	0	2
23RYLMN0103	0	2	0	0	2	0	2
23RYLMN0116	0	1	0	0	1	0	1
23RYLMN0118	0	3	0	0	3	2	5
23RYLMN0119	0	1	0	0	1	0	1
23RYLMN0122	0	2	0	0	2	0	2
23RYLMN0125	10	0	55	0	65	0	65
23RYLMN0140	0	5	0	0	5	0	5
23RYLMN0141	4	0	5	0	8	0	8
23RYLMN0143	0	4	0	0	4	0	4
23RYLMN0158	0	7	0	0	7	0	7
23RYLMN0161	0	0	25	0	25	0	25
23RYLMN0170	0	4	0	0	4	0	4
23RYLMN0172	0	1	8	0	9	0	9
23RYLMN0197	0	2	0	0	2	0	2
23RYLMN0202	0	2	0	0	2	0	2
23RYLMN0203	0	2	0	0	2	0	2
23RYLMN0220	0	0	0	0	0	0	0
23RYLMN0221	0	1	0	0	1	0	1
23RYLMN0222	0	5	0	0	5	0	5
23RYLMN0235	0	6	0	0	6	0	6
24RYLMN0052	5	0	0	0	5	0	5
Total 01/04/2023 - 31/07/2023	**335**	**232**	**990**	**598**	**959**		
Total						**7 500**	**8 460**

Redress Payments 01/04/2023 - 31/07/2023							Appendix 2
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
18RYLMN0050	0	0	0	0	0	25	25
19RYLMN0105	2	0	0	0	2	3	5
19RYLMN0114	0	0	1	0	1	0	1
20RYLMN0051	0	0	0	0	0	1	2
20RYLMN0079	0	2	0	0	2	4	6
20RYLMN0091	0	0	25	0	25	0	25
20RYLMN0142	2	0	1	0	3	0	3
20RYLMN0147	0	0	0	0	0	0	0
20RYLMN0181	0	0	0	-42	-42	44	2
20RYLMN0183	0	3	0	0	3	0	3
21RYLMN0048	0	0	0	-7	-7	9	2
21RYLMN0091	0	0	0	-5	-5	8	3
21RYLMN0097	0	0	0	0	0	5	5
21RYLMN0139	0	3	0	0	3	0	3
22RYLMN0001	0	0	0	-3	-3	7	4
22RYLMN0024	3	0	0	0	3	7	10
22RYLMN0026	0	7	0	0	7	5	12
22RYLMN0032	0	3	0	0	3	0	3
22RYLMN0125	2	0	0	0	2	23	25
22RYLMN0131	0	3	0	0	3	0	3
22RYLMN0139	0	0	0	0	0	0	0
22RYLMN0141	0	0	11	0	11	0	11
22RYLMN0146	2	0	0	0	2	0	2
22RYLMN0147	0	1	0	0	1	0	1
22RYLMN0196	0	0	0	-1	-1	2	2
23RYLMN0023	0	2	0	0	2	0	2
23RYLMN0026	2	0	6	0	8	14	21
23RYLMN0028	0	0	0	-11	-11	11	0
23RYLMN0087	2	2	4	0	8	0	8
23RYLMN0092	0	0	0	-1	-1	1	0
23RYLMN0114	2	0	0	0	2	4	5
23RYLMN0115	0	0	0	-3	-3	3	0
23RYLMN0169	0	2	0	0	2	0	2
23RYLMN0225	2	0	3	0	4	0	4
Total 01/04/2023 - 31/07/2023	**16**	**28**	**49**	**-73**	**20**		
Total						**175**	**195**

GP Indemnity Payments 01/04/2023 - 31/07/2023							Appendix 3
Case Reference	**Costs £000**	**Defence Fee £000**	**Claims £000**	**WRP reimbursement £000**	**Total £000**	**Previous Write Offs £000**	**Cumulative £000**
23RYLMN0233	0	2	0	0	2	0	2
23RYLMN0234	0	1	0	0	1	0	1
Total 01/04/2023 - 31/07/2023	**0**	**3**	**0**	**0**	**3**		
Total						**0**	**3**

Personal Injury Payments 01/04/2023 - 31/07/2023							Appendix 4
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
18RYLPI0020	0	4	0	0	4	145	149
20RYLPI0022	9	0	0	0	9	6	16
20RYLPI0044	0	2	0	0	2	0	2
20RYLPI0061	25	3	45	0	73	1	74
21RYLPI0006	0	2	0	0	2	0	2
21RYLPI0009	0	5	0	0	5	30	34
21RYLPI0010	0	3	0	0	3	0	3
21RYLPI0018	0	1	10	0	11	0	11
21RYLPI0036	0	0	0	0	0	5	5
21RYLPI0037	0	0	0	0	0	1	1
22RYLPI0002	0	0	0	0	0	1	1
22RYLPI0005	0	0	0	0	0	1	2
22RYLPI0007	5	1	4	0	10	2	12
22RYLPI0014	0	1	0	0	1	1	1
22RYLPI0017	0	0	0	0	0	1	1
22RYLPI0018	0	0	0	0	0	0	1
22RYLPI0020	0	0	0	0	0	1	1
22RYLPI0023	0	0	15	0	15	2	17
22RYLPI0025	0	0	0	0	0	1	1
22RYLPI0035	0	2	0	0	2	10	13
22RYLPI0037	0	0	0	0	0	1	1
22RYLPI0040	0	0	0	0	0	1	1
22RYLPI0041	0	2	3	0	5	2	7
22RYLPI0043	0	0	0	0	0	1	1
23RYLPI0001	0	0	0	0	0	2	2
23RYLPI0002	0	0	0	0	0	1	1
23RYLPI0005	0	0	0	0	0	2	2
23RYLPI0006	0	1	0	0	1	1	2
23RYLPI0007	4	0	2	0	6	1	7
23RYLPI0009	0	0	0	0	0	0	1
23RYLPI0010	0	0	0	0	0	1	1
23RYLPI0011	0	0	0	0	0	1	1
23RYLPI0012	0	1	0	0	1	1	1
23RYLPI0013	0	0	0	0	0	1	1
23RYLPI0015	1	0	0	0	1	1	2
23RYLPI0017	0	-0	0	0	-0	1	1
23RYLPI0021	0	0	1	0	1	1	2
23RYLPI0024	0	0	0	0	0	1	1
23RYLPI0025	0	0	0	0	0	0	0
23RYLPI0026	0	0	0	0	0	1	1
23RYLPI0029	0	0	0	0	0	2	2
23RYLPI0031	0	0	2	0	2	1	3
23RYLPI0033	0	1	0	0	1	0	1
23RYLPI0037	0	2	0	0	2	139	141
23RYLPI0038	0	0	0	0	0	0	1
23RYLPI0040	0	0	1	0	1	0	1
23RYLPI0043	0	1	0	0	1	0	1
23RYLPI0044	0	0	0	0	0	0	1
23RYLPI0052	0	0	0	0	0	0	0
24RYLPI0001	0	0	0	0	0	0	0
Total 01/04/2023 - 31/07/2023	**45**	**39**	**82**	**0**	**165**		
Total						**368**	**533**

Permanent Injury Benefit 01/04/2023 - 31/07/2023

Appendix 5

Laspar Number	In period Payments £000	Previous Write-Offs £000	Cumulative £000
01RRSPI0020	4	245	249
02RVEPI0001	2	69	71
02RVEPI0003	3	179	182
02RVEPI0004	2	123	125
03RRSPI0020	13	876	889
03RVEPI0028	4	268	272
04RRSPI0009	4	238	242
04RRSPI0024	3	166	169
05RRSPI0020	2	82	83
05RRSPI0021	3	197	200
05RVEPI0033	5	302	307
05RVEPI0034	1	89	90
08RVEPI0009	4	195	199
10RYLPI0070	2	111	113
11RYLPI0065	6	254	260
12RYLPI0059	2	77	79
13RYLPI0020	1	40	41
13RYLPI0050	3	149	152
98RVEPI0005	0	7	7
19RYLPI0022	12	329	341
20RYLPI0032	3	43	46
20RYLPI0033	1	18	19
20RYLPI0034	2	29	31
20RYLPI0035	6	85	91
20RYLPI0036	4	59	63
20RYLPI0037	1	20	21
20RYLPI0038	3	48	51
20RYLPI0039	2	36	38
20RYLPI0040	6	89	95
20RYLPI0041	4	60	64
20RYLPI0042	2	29	31
Total 01/04/2023 - 31/07/2023	**112**		
Total		**4 509**	**4 621**

Other Payments 01/04/2023 - 31/07/2023			Appendix 6
Case Reference	**Type**	**Details**	**Amount £000**
24RYLMN0002	Ombudsman	Damages	1,00
24RYLMN0007	Ombudsman	Damages	0,25
23RYLMN0244	Ombudsman	Damages	0,75
24RYLMN0015	Ombudsman	Damages	0,75
24RYLMN0038	Ombudsman	Damages	0,50
24RYLEG0001	Ex-Gratia	Loss of Personal Effects	0,24
24RYLEG0002	Ex-Gratia	Loss of Personal Effects	0,92
24RYLEG0003	Ex-Gratia	Poor Service	0,25
24RYLEG0004	Ex-Gratia	Loss of Personal Effects	2,00
24RYLEG0005	Ex-Gratia	Loss of Personal Effects	0,75
24RYLEG0006	Ex-Gratia	Loss of Personal Effects	0,08
24RYLEG0007	Ex-Gratia	Loss of Personal Effects	0,05
24RYLEG0008	Ex-Gratia	Retirement Vouchers	0,28
24RYLEG0009	Ex-Gratia	Retirement Vouchers	0,20
24RYLEG0010	Ex-Gratia	Retirement Vouchers	0,29
24RYLEG0011	Ex-Gratia	Retirement Vouchers	0,34
24RYLEG0012	Ex-Gratia	Retirement Vouchers	0,21
24RYLEG0013	Ex-Gratia	Retirement Vouchers	0,32
24RYLEG0014	Ex-Gratia	Retirement Vouchers	0,30
24RYLEG0015	Ex-Gratia	Retirement Vouchers	0,21
24RYLEG0016	Ex-Gratia	Retirement Vouchers	0,23
24RYLEG0017	Ex-Gratia	Retirement Vouchers	0,40
24RYLEG0018	Ex-Gratia	Retirement Vouchers	0,24
24RYLEG0019	Ex-Gratia	Retirement Vouchers	0,36
24RYLEG0020	Ex-Gratia	Retirement Vouchers	0,35
24RYLEG0021	Ex-Gratia	Retirement Vouchers	0,21
24RYLEG0022	Ex-Gratia	Retirement Vouchers	0,36
24RYLEG0023	Ex-Gratia	Retirement Vouchers	0,36
24RYLEG0024	Ex-Gratia	Retirement Vouchers	0,31
24RYLEG0025	Ex-Gratia	Retirement Vouchers	0,22
24RYLEG0026	Ex-Gratia	Retirement Vouchers	0,32
24RYLEG0027	Ex-Gratia	Retirement Vouchers	0,30
24RYLEG0028	Ex-Gratia	Retirement Vouchers	0,35
24RYLEG0029	Ex-Gratia	Retirement Vouchers	0,27
24RYLEG0030	Ex-Gratia	Retirement Vouchers	0,35
24RYLEG0031	Ex-Gratia	Retirement Vouchers	0,28
24RYLEG0032	Ex-Gratia	Retirement Vouchers	0,43
24RYLEG0033	Ex-Gratia	Retirement Vouchers	0,34
24RYLEG0034	Ex-Gratia	Retirement Vouchers	0,36
24RYLEG0035	Ex-Gratia	Retirement Vouchers	0,37
24RYLEG0036	Ex-Gratia	Retirement Vouchers	0,21
24RYLEG0037	Ex-Gratia	Retirement Vouchers	0,26
24RYLEG0038	Ex-Gratia	Retirement Vouchers	0,20
24RYLEG0039	Ex-Gratia	Retirement Vouchers	0,27
24RYLEG0040	Ex-Gratia	Retirement Vouchers	0,20
24RYLEG0041	Ex-Gratia	Retirement Vouchers	0,36
24RYLEG0042	Ex-Gratia	Retirement Vouchers	0,20

24RYLEG0043	Ex-Gratia	Retirement Vouchers	0,34
24RYLEG0044	Ex-Gratia	Retirement Vouchers	0,39
24RYLEG0045	Ex-Gratia	Retirement Vouchers	0,27
24RYLEG0046	Ex-Gratia	Retirement Vouchers	0,34
24RYLEG0047	Ex-Gratia	Retirement Vouchers	0,34
24RYLEG0048	Ex-Gratia	Retirement Vouchers	0,04
24RYLEG0049	Ex-Gratia	Retirement Vouchers	0,36
24RYLEG0050	Ex-Gratia	Retirement Vouchers	0,42
24RYLEG0051	Ex-Gratia	Retirement Vouchers	0,36
24RYLEG0052	Ex-Gratia	Retirement Vouchers	0,28
24RYLEG0053	Ex-Gratia	Retirement Vouchers	0,34
24RYLEG0054	Ex-Gratia	Retirement Vouchers	0,35
24RYLEG0055	Ex-Gratia	Retirement Vouchers	0,31
24RYLEG0056	Ex-Gratia	Retirement Vouchers	0,35
24RYLEG0057	Ex-Gratia	Retirement Vouchers	0,35
24RYLEG0058	Ex-Gratia	Retirement Vouchers	0,37
24RYLEG0059	Ex-Gratia	Retirement Vouchers	0,24
24RYLEG0060	Ex-Gratia	Retirement Vouchers	0,25
24RYLEG0061	Ex-Gratia	Retirement Vouchers	0,36
24RYLEG0062	Ex-Gratia	Retirement Vouchers	0,36
24RYLEG0063	Ex-Gratia	Retirement Vouchers	0,35
24RYLEG0064	Ex-Gratia	Retirement Vouchers	0,29
24RYLEG0065	Ex-Gratia	Retirement Vouchers	0,28
24RYLEG0066	Ex-Gratia	Retirement Vouchers	0,27
24RYLEG0067	Ex-Gratia	Retirement Vouchers	0,24
24RYLEG0068	Ex-Gratia	Retirement Vouchers	0,33
24RYLEG0069	Ex-Gratia	Retirement Vouchers	0,31
24RYLEG0070	Ex-Gratia	Retirement Vouchers	0,27
24RYLEG0071	Ex-Gratia	Retirement Vouchers	0,37
24RYLEG0072	Ex-Gratia	Retirement Vouchers	0,35
24RYLEG0073	Ex-Gratia	Retirement Vouchers	0,35
24RYLEG0074	Ex-Gratia	Retirement Vouchers	0,27
24RYLEG0075	Ex-Gratia	Retirement Vouchers	0,31
24RYLEG0076	Ex-Gratia	Retirement Vouchers	0,27
24RYLEG0077	Ex-Gratia	Retirement Vouchers	0,37
24RYLEG0078	Ex-Gratia	Retirement Vouchers	0,25
24RYLEG0079	Ex-Gratia	Retirement Vouchers	0,35
24RYLEG0080	Ex-Gratia	Retirement Vouchers	0,22
24RYLEG0081	Ex-Gratia	Retirement Vouchers	0,34
24RYLEG0082	Ex-Gratia	Retirement Vouchers	0,36
24RYLEG0083	Ex-Gratia	Retirement Vouchers	0,20
24RYLEG0084	Ex-Gratia	Retirement Vouchers	0,28
24RYLEG0085	Ex-Gratia	Retirement Vouchers	0,26
24RYLEG0086	Ex-Gratia	Retirement Vouchers	0,39
24RYLEG0087	Ex-Gratia	Retirement Vouchers	0,34
24RYLEG0088	Ex-Gratia	Retirement Vouchers	0,28
24RYLEG0089	Ex-Gratia	Retirement Vouchers	0,39
24RYLEG0090	Ex-Gratia	Retirement Vouchers	0,39
24RYLEG0091	Ex-Gratia	Retirement Vouchers	0,38
24RYLEG0092	Ex-Gratia	Retirement Vouchers	0,23

24RYLEG0093	Ex-Gratia	Retirement Vouchers	0,27
24RYLLC0001	WRP Penalty	WRP Penalty due to late submission of LFERs (relating to total of 7 cases)	17,50
Total 01/04/2023 - 31/07/2023			**51,33**

AGENDA ITEM
4.4

AUDIT & RISK COMMITTEE

THE LEARNING FROM EVENTS REPORT

Date of meeting	16/08/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Richard Hughes, Deputy Director of Nursing
Presented by	Richard Hughes, Deputy Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Clinical Exec Patient Safety Huddle	07/08/2023	SUPPORTED

ACRONYMS	
CTM	Cwm Taf Morgannwg
LFER	Learning from event and incident report

1. Situation

1.1 Late submission of evidence for learning from event and incident Reports (LFERs) to the Welsh Risk Pool has led to potential financial penalties for the Health Board in CTM. The Audit & Risk Committee is concerned about the impact of these penalties and seeks assurance that appropriate steps are being implemented to prevent future non-compliance.

2. Background

2.1 The Health Board is required to submit timely and accurate evidence of learning from events and incidents to the Welsh Risk Pool, which is crucial for improving patient safety and enhancing the quality of care provided. Failure to comply with submission deadlines has resulted in financial penalties, affecting the Health Board's finances and reputation.

2.2 The Health Board has had initial notification of upcoming adjustments to the current working agreement between Welsh Risk Pool and Health Boards in the management of LFERs. The Health Board is awaiting formal written notification of the terms of engagement.

2.3 There were no financial penalties issued for July 2023 with a number of successful submissions to Welsh Risk Pool. The Assistant Director of Quality and Safety is working with the team and finance colleagues to understand the potential financial risks for September 2023.

2.4 There are a total number of 153 triggered LFERs being processed with submissions being made above the prescribed backlog improvement trajectory.

2.5 At the time of writing, progress is being made against the LFERs required for submission in August 2023 with 9 out of 18 already submitted.

3. Assessment

3.1 Identify the root cause(s) of late submissions, including procedural issues, communication gaps, and resource constraints.

3.2 Assess the current processes for collecting, collating, and submitting evidence to the Welsh Risk Pool.

3.3 Evaluate the impact of financial penalties on the Health Board's budget and resources.

4. Recommendation

Based on the assessment, the following recommendations are proposed:

4.1 Process Improvement:

4.1.1 Collaborate with finance colleagues, and clinical, and care group directors to review and streamline the evidence submission process.

4.1.2 Standard Operating Procedure / Process Map to be completed to establish clear responsibilities and timelines for each step of the submission process.

4.1.3 Implement a robust tracking mechanism to monitor the progress of each submission.

4.1.4 Assistant Director of Quality & Safety, Assistant Director of Concerns & Claims, Head of Legal & Claims, and Heads of Quality & Safety (x3) to regularly meet to review deferred LFERs. The meetings will be structured weekly throughout August 2023, and fortnightly thereafter, until there are no further outstanding deferred LFERs.

4.2 Communication and Awareness

4.2.1 Develop comprehensive guidelines and communication channels to inform relevant staff about the importance of timely submissions and the potential consequences of non-compliance.

4.2.2 Conduct regular training sessions for all staff involved in the evidence submission process.

4.3 Resource Allocation

4.3.1 Collaborate with stakeholder colleagues to allocate sufficient resources, both in terms of personnel and technology, to support timely evidence submissions.

4.3.2 Assess the need for additional staff or outsourcing options during peak submission periods.

4.4 Monitoring and Escalation

4.4.1 Implement a live dashboard, on SharePoint to monitor the progress of evidence submissions in real-time

4.4.2 Defined clear escalation protocols to address any delays or potential issues promptly.

4.4.3 Regularly report on submission status and progress to the Finance and Audit Committee.

4.4.4 Monthly meetings with the Assistant Director of Quality and Safety, Assistant Director of Concerns and Claims, Head of Legal & Claims and Head of Corporate Finance to review the progress tracker in identifying potential financial risks. Potential risks will be outlined in the Patient Care and Safety corporate team's financial risk register for ongoing surveillance, oversight and intervention where required.

4.4.5 Any immediate financial concerns resulting from the monthly meetings will be escalated via the Head of Finance (corporate) to the Deputy Director of Finance and to the Deputy Director of Nursing via the Assistant Director of Quality and Safety.

5. Action

5.1 The Assistant Director of Quality & Safety will coordinate the action plan and ensure its effective implementation.

5.2 Establish a cross-functional team comprising finance colleagues, clinical and care group directors, and relevant stakeholders to execute the plan.

5.3 Develop a timeline for each action and assign responsibilities to team members.

6. Report

6.1 The Assistant Director of Quality & Safety will report the progress and status of the action plan to the weekly Patient Safety Executive Nurse huddle as well as the monthly Patient Care and Safety monthly business meetings. The report will include:

6.1.1 Summary of process improvements made and their impact on the submission timeline.

6.1.2 Details of communication and awareness activities conducted to improve staff compliance.

6.1.3 Information on resource allocation and its contribution to timely submissions.

6.1.4 Overview of the monitoring dashboard and how it aids in identifying and addressing potential delays.

6.1.5 Review of any financial penalties incurred during the reporting period and measures taken to prevent future occurrences.

7. Conclusion

7.1 The action plan aims to address the Audit & Risk Committees concerns regarding potential financial penalties resulting from non-compliance in 'learning from events and incidents' submission to the Welsh Risk Pool. By implementing the recommendations and regularly monitoring progress, the Health Board will enhance its compliance with submission requirements and ensure financial penalties are minimised, thereby safeguarding the organisation's financial stability and reputation while improving patient safety and care quality.

8. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability.
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No
	This document does not refer to a change in policy. A new approach to process has been applied utilising the existing structures within the team.
Legal implications / impact	None to note
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care, creating health, and sustaining our future.

9. RECOMMENDATION

9.1 The Committee are asked to **NOTE** this report.

AGENDA ITEM
5.1

AUDIT & RISK COMMITTEE

ORGANISATIONAL RISK REGISTER

Date of meeting	16th August 2023
FOI Status	Open
If closed please indicate reason	Not Applicable – Public Report
Prepared by	Cally Hamblyn, Assistant Director of Governance & Risk
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Paul Mears, Chief Executive
Report purpose	FOR REVIEW & APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals	Date	Outcome
Service, Function and Executive Formal Review	June/July	RISKS REVIEWED
Operational Management Board	12.7.2023	ENDORSED FOR ELG
Executive Leadership Group	17.7.2023	REVIEW AND EXECUTIVE SIGN OFF RECEIVED
Quality & Safety Committee (Public Session)	25.7.2023	REVIEWED ASSIGNED RISKS

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The purpose of this report is for the Audit & Risk Committee to review and discuss the organisational risk register and consider whether the risks escalated to the Organisational Risk Register are in accordance with the Risk Management Strategy.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Care Groups and Central leads are continuing to review and update their assigned risks taking into account feedback received from Members in relation to scoring, actions with associated timeframes and ensuring timely reviews. This will be a continuous improvement area that Members will hopefully note will evolve over the next 12 months.

2.2 The Operational Management Board now signs off the Organisational Risk Register in terms of Care Group risks prior to submission to the ELG.

2.3 Monthly Risk Management Awareness Sessions (Virtually via Teams) continue. **424** members of staff trained to date. Focussed sessions to discuss risk has also been undertaken with Care Group Leads during June 2023.

2.4 Risks on the organisational risk register have been updated as indicated in red.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 **NEW RISKS**

Diagnostics, Therapies, Pharmacy and Specialties Care Group

- Datix Risk ID 4798 - Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital. Risk reinstated and scored as a 16. Rationale for reinstating is captured in Appendix 1.

- Datix Risk ID 5462 - Adult weight management service - Insufficient capacity to meet demand. Risk scored as a 20.

- Datix Risk ID 5404 - Post Mortem Backlogs in Mortuary. Risk scored as a 16.

- Datix Risk ID 5304 - The Air Handling Unit (AHU) for the pharmacy aseptic production suite. Risk scored as a 16.

Children and Families Care Group

- Datix Risk ID 4928 - Special care baby unit infrastructure does not comply with recommendations. Risk scored as a 15.

- Datix Risk ID 4650 - Ensuring correct establishment for Special Care Baby Unit (SCBU). Risk scored as a 15.

- Datix Risk ID 5364 - Merthyr Cynon Band 6 - Special Community Public Health Nurses (SCPHN's) shortage. Risk scored as a 16.

3.2 **CHANGES TO RISKs**

a) Risks where the risk rating INCREASED during the period

Central Function - Patient, Care and Safety

- Datix Risk ID 4908 - Failure to manage Legal cases efficiently and effectively. Risk re-escalated as risk score increased from a 12 to a 16.

b) Risks where the risk rating DECREASED during the period

Central Function Risks – Medical Directorate

- Datix Risk ID – 4080 - Failure to recruit sufficient medical and dental staff. Risk score reduced from a 20 to a 15.

Central Function Risks – Strategy and Planning

- Datix Risk ID – 5207 - Care Home Capacity. Risk score reduced from a 15 to a 10.

Central Function Risks – Health, Safety & Fire

- Datix Risk ID – 2987 - Fire enforcement order is in place for the ground and first floor PCH due to inadequate fire compartments to prevent spread of fire, smoke and noxious gasses. Risk score reduced from a 15 to a 12.

Central Function Risks – Facilities

- Datix Risk ID 4772 - Replacement of press software on the 13 & 10 stage CBW presses. Risk score reduced from a 15 to a 12.

Central Function Risks – People Services

- Datix Risk ID – 4679 - Absence of a TB vaccination programme for staff. Risk score reduced from a 16 to an 8.

Unscheduled Care Group

- Datix Risk ID – 3826 - Emergency Department (ED) Overcrowding. Risk score reduced from a 20 to a 16.

Rationale for changes captured in Appendix 1.

3.3 **CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER**

Unscheduled Care Group

- Datix Risk ID 4458- Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour

breaches). Risk Closed.

- Datix Risk ID – 3585 - Princess of Wales Emergency Department Hygiene Facilities. Risk Closed.

- Datix Risk ID - 4721 - Shift of the boundary for attendances at the ED. Risk Closed.

All Care Groups

- Datix Risk ID - 4743 - Failure of appropriate security measures / Safety Fencing. Risk Closed.

Diagnostics, Therapies, Pharmacy and Specialties

- Datix Risk ID 3638 - Pharmacy & Medicines Management - Training & Development Infrastructure. Risk Closed.

Rationale for closure captured in Appendix 1.

3.4 **Organisational Risk Register - Visual Heat Map by Datix Risk ID (Risks rated 15 and above):**

Consequence						
	5			4253 3337 4768 3993 4887 4080	5276	
	4				4148 4337 3008 4906 4809 4753 3131 5437 5364 4908 5462 5304 4152 3133 1133 4752 4922 4479 4417 5374 5254 5036 4798 3826	4491 4632 4071 4103 4841 4827 4907 4780 4922 5267 5427 5425
	3					3638 4691 4732 4699 4928 4650 4672 4691 2808 5040 4217
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not applicable for the Risk Register item.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee are asked to:

- **Review** the risks escalated to the Organisational Risk Register at Appendix 1.
- **Consider** whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5425 (Replacing 5153)	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	Financial Stability Risk	Failure to achieve financial balance in 2023/24.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2023/24. Then: The Health Board will not be able to deliver a break-even financial position for 2023/24. Resulting in: Potential deficit in 2023/24 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. Failure to meet statutory financial duty WG not supporting the Health Board's plan Potential cash shortfalls in the latter months of 23/24 Context: The context is that the draft financial plan for 22/23, . This planned deficit is also dependent on the delivery of efficiency savings of £27.3m which is a significant step up in savings compared to recent years.	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to the Executive leadership Group, the Planning, Performance & Finance Committee and the Board.	May 2023: The WG response dated 21 April states that the level of financial deficit in the plan is not an acceptable or supportable position. The requirement is to deliver improvement to delivery of ministerial priorities and the financial plans submitted. A supplementary paper needs to be submitted to WG by 31 May. Update June 2023 - Supplementary paper submitted to WG by the 31st May 2023. Response awaited. Review 31.8.2023.	Planning, Performance & Finance Committee	20	C4xL5	12 C4 x L3	↔	28.04.2023	2.6.2023	31.8.2023
5427 (Replacing 5154)	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	financial Stability Risk	Failure to reduce the planned recurrent deficit of £79.6m at the end of 2023/24.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2023/24. Then: The Health Board will not be able to deliver a break-even financial position for 2024/25. Resulting in: Potential deficit in 2024/25 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. Failure to meet statutory financial duty WG not supporting the Health Board's plan Potential cash shortfalls in the latter months of 24/25	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to the Executive Leadership Group, the Planning, Performance & Finance Committee and the Board.	May 2023: The WG response dated 21 April states that the level of financial deficit in the plan is not an acceptable or supportable position. The requirement is to deliver improvement to delivery of ministerial priorities and the financial plans submitted. A supplementary paper needs to be submitted to WG by 31 May. Update June 2023 - Supplementary paper submitted to WG by the 31st May 2023. Response awaited. Review 31.8.2023.	Planning, Performance & Finance Committee	20	C4xL5	12 C4 x L3	↔	28.04.2023	2.6.2023	31.8.2023
5276	Director of Digital	Central Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	**IF:** the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. **THEN:** operational delivery of pathology services may be severely impacted. **RESULTING IN** potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	A provision will be added to the current legacy contract for a short-term extension until September 2025; this has been agreed in principle but not yet been formally implemented. A set of additional contract milestones to the new system supplier will be included in the contract change notice (CCN) for hosting; the hosting CCN has been agreed subject to Ministerial approval. The LINC programme is working with Health Boards and Trusts to review the new system suppliers revised delivery plan. On the 13th June 2023, NHS Wales and the software company jointly agreed to end the contract for the implementation of a Laboratory information management system. This decision was made on the basis of the current and future requirements of the pathology service in Wales. Both parties remain committed to managing the transition out of this project in the best interests of patient outcomes in Wales. CTM Local Deployment Group met on the 29th June 2023 to ensure that there is adequate CTM representation on any newly formed work groups established to discuss forward plans for future ALL Wales LIMS. Review 31.08.2023.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	05.07.2023	31.08.2023
4922	Director of Corporate Governance Interim - Executive Director of Nursing	Central Support Function - Quality Governance (Compliance)	Assistant Director of Governance & Risk	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Covid-19 Inquiry Preparedness - Information Management	IF: The Health Board doesn't prepare appropriately for the Covid-19 enquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues.	The Covid-19 Inquiry Working Group are monitoring a number or preparedness risks such as: - Retention and Storage of information, emails and communication - Capturing reflections of key decision makers prior to any departure from the Health Board - Organisational Member. The Health Board has a Covid-19 Inquiry CTM Preparedness Plan which is monitored via the Covid-19 Inquiry Working Group. The Board and Quality & Safety Committee received a detailed update on the preparedness progress at their respective meetings in March 2022 and September 2022. The Assistant Director of Governance & Risk is the first point of contact for any Inquiry contact and the Executive Director of Nursing is the Interim Senior Responsible Officer (SRO).	Update June 2023 - The Health Board has successfully appointed to the Covid-19 Information Manager position who commenced on the 30th May 2023. The priority activity will be the development of a Timeline and starting the archiving of information to a central repository. The likelihood of this risk will be revisited once the new post holder is embedded an initial assessment of the Health Boards preparedness has been undertaken. Review 31.8.2023.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	23.11.2021	04.07.2023	31.08.2023
4780	Executive Director for People	Central Support Function -Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Patient Handling Training	If there are no Trainers available to provide patient handling training Then all new starters need to be on restricted duties. Organisational compliance is affected. Training response to Incidents such as W156305 cannot be achieved. Manual Handling Training staff resource is not sufficient for new HB. Current establishment of two Trainers to approx. 7000 patient handling staff makes compliance with regulatory requirements unachievable. Resulting in breach of Health & Safety Law, particularly MHOR 1992, LOLER 1998, PUWER 1998, H&S at Work Act. Non-compliance with Organisational mandatory training requirements. Enforcement action from the HSE.	Two Band 3 Training Assistants continue to deliver Inanimate Load Handling Training so staff groups such as Admin & Clerical are not at risk. The current Training Post for Bridgend is vacant, new Trainer commencing employment 31st August 2021. Trainer in post at Tonteg is on LTS (Long Covid). Manual Handling Advisor picking up training where possible which is impacting on their ability to function within their role.	Mitigating action is to increase the establishment within the Manual Handling Team by at least one extra Trainer, one extra Assistant and another Risk and Safety Officer. July 2023 - Funding for Business case has been approved. Full case to be presented to the Executive Leadership Group for final sign off. Once signed off additional staff will be appointed. Timeframe for review 30.09.2023.	Health Safety & Fire Sub Committee	20	C4 x L5	4 C2xL2	↔	06.08.2021	04.07.2023	30.09.2023
4827	Executive Director for People	Central Support Function -Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Lack of Lead for Face Fit Training along with Face Fit Trainers	If the organisation fails to appoint and provide a fully qualified face fit testing lead and suitable number of Face Fit Testers. Then there is a potential for staff to be exposed to airborne viruses e.g. Covid, flu, etc; Resulting in lack of assurance that the risk is being adequately managed at a local and Board level further resulting in a high risk of prosecution by the Health and Safety Executive.	Departmental Trainers have been trained but not in the numbers required by the organisation. Many of those trained during the first phase has now returned to substantive posts and are unable to undertake this role. Also may now be out of compliance for annual review of practice. Single H&S Coordinator is taking up this role on a part-time basis but this is inadequate for the requirements due to the commitments of his substantive post and the demands/size of the organisation. Departmental trainers are in post across the organisation but not all are able to fulfil this role either due to returning to busy substantive roles or being out of compliance of their annual review. Despite posts being added to Trac, it has become apparent that there is no funding available in the UHB to support this work. Discussions are underway between the Director for People and the Deputy Director of Nursing. No clear plan available to address this risk currently.	SBAR completed outlining the requirements regarding Fit Testing. July 2023 - Business case has now received funding for the corporate provision of FIT Testing. Full business case is to be represented to Executive Leadership Group for formal sign off prior to appointing staff into posts. Agreement for Care Group Nurse Directors to identify trainers to be trained and Assistant Director Health, Safety and Fire to train the trainers. Agreement of financial mechanism, review of resource plan required. Deputy Executive Nurse Director has written to executives on the proposed approach with the aim of implementing a recruitment strategy by the end of July 2023. Review 30.09.2023	Health Safety & Fire Sub Committee	20	C4xL5	9 C3xL3	↔	01.02.2021	04.07.2023	30.09.2023
4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	Update July 2023 - The financial Planned Care Recovery package agreed in June 2023 and the schemes are now in motion which is resulting in a positive impact on backlogs and ongoing demand. The Health Board has trajectories in place for planned and cancer targets which is monitored weekly by the Planned Care Director and their wider team. Clinical strategy work is ongoing which will serve to strengthen the Health Boards ability to create more capacity within the system. The Health Board is also starting to look at a Demand Management Plan as currently referrals to CTM are higher than pre-Covid levels. In order to sustain performance the Health Board needs to tackle this issue along with Primary Care colleagues and in this regard have produced a heat map to identify those practices that the Health Board needs to work collaboratively with as a priority. In addition the Six Goals Plan was agreed in June 2023 and the plans to increase Same Day Emergency Care (SDEC) plans across CTM are in motion. The Health Board is now focussing on its outcome matrices to ensure it captures investment return effectively. The risk will be further reviewed on the 31.8.2023.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	13.7.2023	16.6.2023	31.8.2023

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4071	Chief Operating Officer All Integrated Locality Groups Linked to RTE 5039 / 4513	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer Pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three sites are working to maximising access to ASA level 3+4 surgery on the acute sites. HB working to ensure haematological SACT delivery capacity is maintained. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigours monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update June 2023 - Action plan in response to Welsh cancer patient experience survey finalised. Roll out of Canisc replacement piloting with the Breast MDT. Implementation of weekly performance meetings with highlight report to COO weekly. Action plans developed for high risk challenged areas - Gynaecology, Lower GI, & endoscopy with support from the DU to implement required changes.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	19.06.2023	31.08.2023
4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**IF**: The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WL1 clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	July 2023 Update: Cataract and General - Performance continues to improve with additional internal activity at weekends. Cardiff & Vale UHB continue to support with capacity for stage 1 and 4 activity for cataracts. Currently there are 559 patients >104 weeks RTT. This position continues to decrease. The regional work is progressing with the option appraisal complete and business case submitted. Validation work continues routinely in tandem with the booking of weekend work and RTT rules. Glaucoma and Macula - The Care group are focussing on the high risk sub services with specific action plans for the services. Business cases are in development, resource will be required to support follow up waiting list review and mitigation in Glaucoma. Focused piece of work being undertaken to review the macular FUNB patients with a key focus on: • Securing additional hours for consultant hours to review each individual case and prioritise clinic appointments accordingly. • Additional weekend clinic appointments in July 23 • Additional nursing posts being advertised as part of PCR funding to meet the demand for harm reviews and appoint a family liaison officer to support the increased reporting and RCA investigations. • HIW action plan being reviewed to ensure timely actions and reviews Next review 31.8.2023	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	13.7.2023	31.08.2023
4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	**IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM **THEN:** avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care **RESULTING In:** higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. • ToR and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Board briefing to ensure all sighted to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CTM input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	Update July 2023 -The 2023 version of the National Clinical Guideline for Stroke for the United Kingdom and Ireland (April 2023) has been published. Ongoing work across CTM UHB and the wider region to assess current services against the guidelines and identify any gaps. - Regional working continues to progress between CTM UHB and Cardiff and Vale UHB in development of the South Central Wales Stroke Delivery Network. Communications and Engagement Plan in place and phase 1 of the engagement scheduled to commence in July 2023 with the distribution to all patients who have experienced a stroke and been under the care of one of the South Central Wales Health Boards, within the last year. This will give the Programme Board insight in to the lived experience of service users and help establish a baseline position of experiences of care. -The NHS Wales Executive Delivery Unit has identified that patients are self-presenting to emergency departments in units who are both specialist stroke centres and emergency departments in hospitals that do not specialise in stroke. The Delivery Unit has, therefore, established an all-Wales review of self-presenters in stroke care, which aims to establish whether the practices and processes in each Health Board are appropriate for timely stroke care and to make quality improvement recommendations. -Stroke Operational Group Meeting established with first meeting at the end of July with the intention to establish specific work streams for improvement of services and approaches. - The pathway between RGH and PCH with the ring-fencing of an additional bed has been implemented. It is the expectation that there will be improvement over the coming months as this is embedded. -lack of resources for implementation of AI software (£20K per annum) which will limit CTMUHB to provide timely thrombectomy and extend thrombolysis to wake up strokes and 9 hours, as per the new national stroke guidelines.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	11.05.2021	11.6.2023	31.07.2023
5462	Executive Director of Therapies and Health Sciences.	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Adult weight management service - Insufficient capacity to meet demand	If there is insufficient capacity within the adult weight management service to meet the demand Then patients will not be offered timely intervention in line with the All Wales Weight Management Pathway. The current waiting list is over 6 years. Resulting in missed opportunity to support activated patients who want support with their weight. Patients will live with over weight or obesity for longer and will be at high risk of a range of obesity related long term conditions such as developing or worsening type 2 diabetes, long term MSK, CVD and some cancers.	People are offered the lowest intervention required in line with the Health Weight Healthy Wales pathways. Those that are waiting are being supported with 'waiting well' signposting. Digital opportunities are being explored to maximise efficiencies within pathways as well as maintaining communication with patients to manage expectations on waiting list times. Existing services, both within the Health Board and with community partners are being maximised and integrated within pathways.	This is a new service in early stages of development and delivery. Optimisation of capacity is supported by continuous review of pathway design (Timeframe July 2023). Capacity and Demand is being closely monitored (Timeframe August 2023).	Quality & Safety Committee People & Culture Committee	20	C4xL5	8 - (C4xL2)	New Risk to Organisational Risk Register - Escalated July 2023	07.06.2023	08.06.2023	31.07.2023
4664	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Ransomware Attack resulting in loss of critical services and possible extortion	**IF**: The Health Board suffers a major ransomware attack. **Then**: there could be potential data loss and subsequent loss of critical services. **Resulting in**: Catastrophic service loss to all clinical and business services adversely impacting on population health management, patient care, business continuity, health and wellbeing of staff, organisational relationships, substantial financial risk and the UHB's other routine and improvement work - culminating in a culture of mistrust of the Health Board and all things digital leading to the likelihood of the opportunities that present from digital transformation being less likely to be achieved.	Details captured in Private Audit & Risk Committee as business sensitive								
4907	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively	**If**: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager	Update July 2023: New operating model in respect of quality, safety and governance almost fully implemented. Claims handler post awaiting approval. New systems and processes, including escalation developed and implemented to assist with effective management of cases.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	02.11.2021	03.07.2023	31.08.2023

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5267 (Capturing risks 4106 and 4157 which are now closed)	Executive Nurse Director / Deputy Chief Executive	Centre Support Function - Patient Care & Safety - Nursing	Deputy Executive Director of Nursing	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses	**IF:** the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage & Health Care Support workers (HCSW's) **Then:** The Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff. **Resulting in:** The potential for disruption to the continuity and of patient care and risk of suboptimum team communication due Potential to impact on patient safety and staff wellbeing. Financial implications of continue high use of agency cover (includes registered nurses and HCSW's) Please note - this risk is an amalgamation of two previous risks i.e., 4106 and 4157, these have been closed with a narrative to state this combined new risk has been created.	Proactive engagement with HEIW Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues. • Close work with university partners to maximise routes into nursing • Retire and return strategy to maintain skills and expertise • Dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act; this has now been rolled out to all wards within CTMUHB. • Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board • Regular review by Birth Rate Plus, overseen by maternity Improvement Board • Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends • Targeted approach to areas of specific concern reported via finance, workforce and performance committee The HCSW agency shift requests will follow the same type of forms and sign off from December 2022. Nurse Roster Policy now approved, ratified and implemented in December 2023. This includes KPIs which will allow monitoring of effective roster management. Automated nursing agency invoicing system implemented within the Health Board by the Bank office team - rosters must be locked down daily to enable the system to work- provides more rigor to roster management at ward/ department level.	Update July 2023 - "Coffee mornings" have been held for spouses of CTM UHB employees to undertake an assessment of eligibility to apply for the registered nurse adaptation process. The evaluation of data following the coffee morning activity is underway to inform the adaptation programme for international nurses. CTM have project plans around recruitment, retention and attraction, linked in to the Health Education Improvement Wales Retention Toolkit. Focussed activity is underway in terms of Nurse Bank to ensure that there are an appropriate number of nurses / trained staff available to meet the demands. CTM is working closely with the University of South Wales to support their international student nurse recruitment and are exploring mentorship arrangements and pastoral care in conjunction with CTM's existing international nurse cohort. Mobile recruitment fairs have been undertaken which have been collaborative events across all sites resulting in students coming into CTM, where Students have not taken up these opportunities the data is being evaluated to understand the reasons for their decision not to join CTM. Practice Facilitator Nurses are supporting the third year consolidation nurses in their career development and through the streamlining process. Corporate Nursing colleagues are working with the People Services and Communication and Engagement Teams to share information with Senior Nurse Teams in order to raise awareness of streamlining to support recruitment and ensure vacancy opportunities are promoted Face to Face sessions with the Student Academy's (Bridgend and Merthyr College to date) have been held to attract students into the nursing profession. Engagement events within the community continue. CTM are linked into the National Band 4 workforce activity underway on a National basis. The outcomes of these activities will be considered with a view to assessing the likelihood score for this risk in its next review at the end of August 2023.	Quality & Safety Committee	20	C4xL5	C4xL3	↔	25.10.2022 (It should be noted that although the new reframed risk opened in October 2022 the previous iterations of this risk - Datix ID 4106 and 4157 were opened on the 01.06.2015 and 01.01.2016 respectively)	13.7.2023	31.8.2023
3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Continue to implement actions identified in the control measures. Action plans are in the process of being reviewed so a timescale will follow once the review has been undertaken by the lead. June Update: Improvement plans in place as part of the Six Goals improvement programme however this programme is not yet in implementation stage. Targeted improvement trajectories in place for the USC group relating to 4 hour ambulance delays and patients waiting over 12 hours within the department which will improve overcrowding. This remains an ongoing risk for all 3 sites and will be reviewed regularly as implementation of targeted improvement takes place. Risk score reviewed by the USC Care Group in June and initial consequence score of a 5 was considered too high and therefore risk scoring reviewed utilising the Health Boards risk scoring domain matrix.	Quality & Safety Committee	16 ↓ 20	C4xL4	12 (C4xL3)	↓ Risk score decreased from a 20 to a 16 in July 2023	24.09.2019	26.06.2023	31.08.2023
4908	Executive Nurse Director / Deputy Chief Executive	Central Function - Patient, Care and Safety	Assistant Director Quality & Safety	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Legal cases efficiently and effectively	If: The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads New operating model in respect of quality, safety and governance almost fully implemented. New systems and processes, including escalation, implemented to assist to effectively manage cases.	Update July 2023 New operating model in respect of quality, safety and governance almost fully implemented. Claims Claims Handler post still awaiting approval and sickness absence within the team has re-escalated this risk. Review 31.8.2023.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	Risk Re-escalated to the Organisational Risk Register July 2023	02.11.2021	04.07.2023	31.08.2023
5304	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Environmental / Estate / Infrastructure	The Air Handling Unit (AHU) for the pharmacy aseptic production suite	The AHU is over 20 years old and is at risk of malfunction. If: the air handling unit malfunctions Then: the aseptic unit will not be able to function Resulting in: patients not being able to receive certain drug therapies.	The room pressures are being monitored on a daily basis. The estates department maintain the AHU regularly. Monthly in-house QC testing of air quality provided by AHU. 6 monthly external testing of air quality provided by AHU. Contingency plan in place if the AHU does malfunction.	AHU to be independently assessed by an external expert from NWSSP. Timeframe end of July 2023.	Quality & Safety Committee	16	C4xL4	4 (C4xL1)	New Risk to Organisational Risk Register - Escalated July 2023	29.11.2022	11.07.2023	31.08.2023
5404	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Post Mortem Backlogs in Mortuary	IF: the Coronial service fails to ensure consultant Pathologist capacity to undertake post mortems to meet the increasing demand across the Health Board region. THEN: There will be delays in performing and reporting autopsies. RESULTING IN: * Mortuary capacity breaches * Inability to store deceased appropriately including long term freezer storage of which the Health Board only has 8 spaces. *deterioration of deceased due to length of stay leading to poor experience for the bereaved and complaints *Failure of the Health Board to provide a quality Bereavement service to the population. * Families not being able to view loved ones due deteriorating condition of the deceased due to prolonged storage *Non-compliance with HTA regulatory requirements and current WG bereavement framework principles *Reputational damage *Reliance on additional contingency storage creating financial risk for the Health Board	Additional contingency storage in place. Weekly situation meetings with Coroner's Office to assess current situation. Short term use of Locum pathologist by service provider commissioned by the Coroner's Office using our current supporting APT resource whilst Pathologist on leave.	Escalation mechanism for high level discussion with Coroners services: Exec support needed with discussion around future management of the increase in demand for PM's by the Coroners service. Timeframe 31.7.2023.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	New Risk to Organisational Risk Register - Escalated July 2023	13.04.2023	03.07.2023	23.07.2023
5437	Director of Digital	Central Support Function - Digital & Data Function	Assistant director of therapies and health science	Improving Care	Core Business, Business Objectives, Environmental & Estates Impact and Projects Including systems and processes, service and business interruption	Dual deployment at CTM of both RISP and LINC Programme Systems	If: There is no change to the current implementation plans of both the RISP and LINC Programmes solutions then there will be a deployment overlap at CTM. Then: Necessary workforce deployment resource, including IT expertise, will need to be shared between deployments. Resulting In: Sharing of limited resource needed to deploy products within specified timeframe, which could result in errors or delayed implementation. Any delays to implementation threatens the ability to provide pathology and radiology services both locally and nationally.	Escalated to Executive Leadership Group. Raised at National Imaging Programme Board.	Update July 2023 – At this time, draft implementation plans for both the LINC and RISP Programme indicate that there will be some element of a deployment overlap at CTM. This has been articulated to both programmes on several occasions. Review: 30.09.2023	Digital & Data Committee	16	C4xL4	4 (C4xL1)	↔	14.04.2023	06.07.2023	30.09.2023
4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.	**If** the therapy services (physiotherapy, speech and language therapy, dietetics, occupational therapy) continue to not be at the recommended staffing levels according to national level requirements (GPICs), **Then:** the critical service will be unable to meet the need of patients requiring therapy, **Resulting in:** significant negative impact on patient outcomes, ability to recover from critical illness and length of stay in critical care unit and consequently in hospital longer than needed.	Currently staff stretch to cover and prioritise patient need as much as possible. During winter pressures have tried in the past to recruit locums but availability still remains an issue for some services and not sustainable. Sighted within HB Critical Care Board as significant gap and within peer review response.	Discussions with all 3 critical care units regarding repurposing of funds to develop SLT posts. Nursing leaders aware and case being taken to next Operational Management Board. Three separate organisational critical care risks for workforce (medical, therapies, pharmacy) on Risk Register. Single combined risk has been drafted. Risk reinstated as considered not to align with 5214 in terms of the AHP workforce risk. Update: Following discussion with wider MDT this AHP critical care workforce risk was agreed to remain separate rather than combined with the medical/nursing workforce risk as the mitigations available to medical and nursing workforce were not applicable AHP workforce gaps, as these relate to non-funding rather than recruitment challenges. No progress in attaining additional funding for AHP workforce. Further update 27.6.23 - The lack of SLT service has triggered a Duty of Candour response in relation to a patient safety incident, which has led to progress in relation to SLT funding, and ability to commence recruitment. Gaps in funding other AHPs remain.	Quality & Safety Committee	16	C4xL4	C4xL2	↔	20.08.2021	27.6.2023	31.8.2023
3131	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Mortuary Capacity	**IF:** There is insufficient Mortuary capacity across the Health Board, including bariatric capacity **THEN**: the Health Board will be unable to accommodate any increases in deaths (due to seasonal pressures, pandemics, general increases in service demand), and may exceed capacity in the event of Mortuary closure or refrigeration failure, or funeral directors/undertakers being unable to collect bodies or move bodies between sites due to adverse weather. **RESULTING IN:** bodies not being placed in storage that is in compliance with HTA licencing standards, No capacity for bariatric bodies, leading to HTA reportable incidents, complaints and reputational damage.	Mortuary capacity log is in operation and informs the pathology scorecard for monthly reporting (average, max and min). Business continuity plan is in place to move bodies around the sites to ensure capacity is maintained within the HB. This relies on the Health Boards contracted funeral director to move the bodies in an appropriate and dignified manner. Mortuary staff are trained to complete the mortuary capacity log on a daily basis and to ensure the business continuity plan is executed in the event of likely capacity issues. Nutwell units in use at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) "Real time" capacity white board installed in both mortuaries so porters/APTs can visualise quickly capacity issues. Private ambulance with a dedicated driver, now in use between sites. 4X4 vehicle so can be used during inclement weather (within reason). Can transport up to 4 deceased per journey, in a dignified manner.	Update June 2023: - Submit paper to HTA board regarding releasing deceased on MES certificate. By releasing deceased following MES certificate this will improve flow of deceased. Reviewed following further scrutinisation of relevant guidance, which suggests this might be appropriate for urgent releases recognizing risk. Timeframe 31.7.2023. - Review processes to encourage collection by Funeral Directors. Explore options to reduce length of stay of the deceased and engagement with stakeholders. Timeframe 31.7.2023.	Quality & Safety Committee	16	C4xL4	C3xL2	↔	05.03.2018	23.6.2023	31.8.2023

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5036 Link to RTE 5155	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Service Director - Diagnostics, Therapies, Pharmacy and Specialties Care Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Pathology services unable to meet current workload demands.	IF: Pathology services cannot meet current service demands. THEN: - there will be service failure - there will be continued delays in reporting of Cellular Pathology results - failure to provide OOH services required for acute care - inadequate support and accommodation for Clinical Haematology cancer patients - increased turnaround times for provision of results including timely autopsies - increased pressure on existing staff - inadequate training provision throughout - inability to repatriate services from Bridgend. RESULTING IN: 1. Failure to meet cancer targets and national cancer standards 2. Anxiety for patients waiting for delayed results 3. Unsuspected cancer cases being missed in the backlog potentially leading to patient harm. 4. Delays in the reporting of critical results and issue of blood products OOH leading to patient harm 5. failure to meet the standards required for provision of autopsy reports for the ME service 6. Clinical incidents due to errors and poor training. 7. Poor compliance with legislation and UKAS standards (that are mandated by the HB and Welsh Government). 8. Reputational damage and adverse publicity for the HB. 9. Continued inequity of services provided to CTM patient population. 10. Suboptimal care for Haematology cancer patients	1. Triaging of patient samples (into urgent & routine) as they arrive into Cellular Pathology. 2. Outsourcing of routine Cellular Pathology backlog to an external laboratory (LDPATH) 3. Expansion of Cellular Pathology into POCT training room. 4. Capital bids being progressed for ageing equipment. 5. All Wales LINC programme for implementation of Pathology LIMS and downstream systems. 6. Use of locums throughout all departments. 7. Advertisement and recruitment for vacant posts 8. Use of overtime to cover OOH services. 9. Business case to increase capacity of CNS support for Clinical Haematology patients. A Cellular Pathology Recovery Plan paper has been submitted to the Executive team for review - end of May 2022	Blood Bank Capacity Plan Due date 1.12.2022 Demand & capacity review Due Date 31.07.2023 Workforce redesign Due date 31.07.2023 Dedicated Pathology IT resource Due Date 31.7.2023 Accommodation review Due Date 31.07.2023 Novation of Equipment to the Managed Service Contract Due date 3.7.2023 Update April 2023 - Risk score reduced to 16 to reflect current position, this is dependent upon ongoing review and continued investment from the HB.we have consciously reduced the risk to 16 as we have had funding to year end to continue the outsourcing and there is a tentative commitment for a significant amount to continue the outsourcing through 2023-24 which we are comfortable that it allows us to reduce the risk on that basis. We will keep this under review and should the situation change we will update the risk register and adjust the risk assessment appropriately. Update July 2023 - position remains unchanged from that reported in April 2023. No change to score or mitigation.	Quality & Safety Committee	16	C4 x L4	6 (C3xL2)	↔	02.03.2022	07.07.2023	30.09.2023
5254	Executive Nurse Director / Deputy Chief Executive	Centre Support Function - Quality Governance - Concerns and Claims	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour	**If**: The Health Board is unable to meet the increased work demand in respect of the implementation of Duty of Candour **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * New incident framework developed * Engagement with the All Wales Duty of Candour Network to discuss implementation of the Duty * Reports run on predicted case numbers * Request to the All Wales Duty of Candour Network that an impact assessment is undertaken	Update July 2023 Robust incident triage process now in place, managed by the Heads of Quality & Safety. Currently the impact of Duty of Candour is manageable within current resources. The operational model is currently not fully implemented. Awaiting approval for claims officer post to be advertised, which will assist in addressing the current Redress backlog and will manage any new redress cases identified via the Duty of Candour process.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	03.07.2023	31.08.2023
5374	Executive Director of Strategy & Transformation	Central Function - Environmental Sustainability	Deputy Director of Strategy and Transformation	Sustaining Our Future	Environment /Estate/ Infrastructure	Fulfilling our environmental and social duties	**IF:** the health board's decisions fail to reflect our values or consider the long term environmental or social impact **Then:** we will not fulfil our socio-economic duty, our Wellbeing of Future Generations objectives or our value based healthcare principles **Resulting in:** negative environmental and social impacts and loss of trust and confidence among stakeholders	• Integrated Medium Term Planning Process aligned to the seven Welsh wellbeing goals and five ways of working. • 'CTM 2030' delivery focusses on community developments, employment and local procurement where possible. • CTM becoming established as an Anchor Organisation. • Decarbonisation Action Plan • Established a CTM Decarbonisation Group which will have oversight and delivery of CTM's decarbonisation agenda • 'CTM 2030' seeks to ensure that services take account of the impact on the environment • All-Wales approach to sustainable procurement • Green CTM Staff Forum • Fleet emissions reduction programme and trial of electric vehicles • Tree planting initiatives • Waste management – elimination of landfill for foodstuffs • Use of less environmentally impactful anaesthetic gases	Update June 2023 - No change to mitigation or risk score. Build environmental and social impact sections into health board project paperwork/cover sheets to ensure these have been considered as part of decision making processes - Mitigation Timeframe June 2024.	Population Health & Partnerships Committee	16	C4xL4	8 (C4xL2)	↔	21.2.2023	21.6.2023	31.10.2023
4479	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Infection, Prevention and Control	Deputy Lead Infection Prevention Control Nurse & Decontamination Officer,	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No Centralised decontamination facility in Princess of Wales Hospital (POWH)	**If:** there is no centralised decontamination facility in POWH **Then:** there are a number of areas undertaking their own decontamination via automated/manual systems. **Resulting In:** possible mismanagement of the decontamination processes/near misses/increased risk of infection/litigation risks and non compliance with national guidance/best practice documents. The hospital site is at risk of losing their JAG accreditation in Endoscopy if plans to centralise decontamination is not progressed. There is no dirty - clean flow for procedure room 2 in endoscopy. There is some decontamination equipment in HSDU that needs replacement. The decontamination equipment in Urology is at the end of it's life and there are regular service disruptions due to failed weekly water testing results.	Monthly audits undertaken in all decontamination facilities in POWH by the lead endoscopy decontamination officer and results shared at local decontamination meetings. AP(D)support available on site. Monthly ILG decontamination meetings take place where all concerns are escalated to the HB Decontamination Committee meeting. SOPs is place Water testing carried out as per WHTM guidance Maintenance programme in place for decontamination equipment 07/10/2021 - In view of aging Urology washer disinfectors, urology service managers to liaise with APDs to initiate/ agree a service contract for maintenance and servicing of equipment with an external.	The planning application for the centralised decontamination unit has been approved by Bridgend County Borough Council and the tender has been shared with 5 companies. Update 30/6/23 - Capital planning are in a position to develop the business case for WG however, awaiting Executive steer on future plans for decontamination. Ongoing concerns with Urology decontamination equipment in POW, care delivery group informed and awaiting a response. Review 31.8.2023.	Quality & Safety Committee	16	C4xL4	2 C1xL1	↔	30.12.2020	30.06.2023	31.08.2023
1133	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; **Then:** the Health Board will be unable to deliver safe, high quality services for the local population; **Resulting in:** compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site. September 2022 Review by Nurse Director for Unscheduled Care: Currently 6.3 wte ANPs in post with 3 new trainees commencing. Advert for locum Consultant in progress Ad-hoc locum for middle grade to cover for absences and planned leave	Update June 2023 - Medium term and substantive plans for workforce requirements and innovations to be worked through as part of the six goals board and advanced practice board. New target score of 8. New review date 30/09/23	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4 x L4	8 (C4xL2)	↔	20.02.2014	26.06.2023	30.09.2023
3008	Chief Operating Officer	Children and Families Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk of injury due unavailability of opportunities to train and maintain compliance with Manual handling training.	**If:** There is a lack of manual handling training there is the risk of potential injury to a member of staff or injury to the patient. **Then:** There are a number of clinicians who have not had the opportunity to meet the requirements for manual handling training. **Resulting In:** Potential harm being caused to both staff and patients.	1. Staff are aware of the risks associated with manual handling. 2. All staff have been informed to consider the ergonomics of the environment that this activity is being undertaken. 3.Appropriate equipment is available in the clinical areas or on request from the MH team e.g. pat slides, slide sheets, hoists. 4. Manual Handling risk assessments are incorporated into the admission bundles 5. The training group are planning training for clinical staff with the manual handling department - current position that this can not be supported 6. Ask other HB`s their MH requirements SBUHB online training package to be shared. 7. Directorate will Seek out any opportunities for online updating to support current practice 8. 2 registered nurses to undertake train the trainer and initially cascade to community midwifery staff, commencing Sept 2022. 9. Staff member identified to action monthly module B training to facilitate improvement in knowledge and skills- agreed 11.10.22 10. In agreement with MH team 2 midwives to undertaken 5 day TTT course for manual handling in July. Meeting arranged with MH team to arrange bespoke 3 hour course for all midwives to be implemented 2023/2024 for 100% compliance in 12 months.	Organisational plan for compliance training. Update April 2023 - Risk reviewed. Bespoke training module in development and ready for roll out 2023. Risk score will be adjusted once numbers trained increases. Update June 2023 - risk reviewed by AD Health, Safety & Fire 27.6.2023 - No Changes made.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	01.05.2017	27.6.2023	31.08.2023
3133	Chief Operating Officer	Central Support Function -Facilities	Governance and compliance manager, Facilities	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	~~Due to capacity issues to deal with Covid-19 staff not attending medical gas safety training and courses being rescheduled.~~ Poor compliance with Medical Gas Safety Training .	**If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	The current risk rating will remain the same, as there has not been any significant increase in attendance on the Medical Gas training courses., across CTM. Medical Devices Training have promoted said course on SharePoint and by emailing ward managers/lead nurses, however attendance remains low. The training department are actively liaising with Swansea Bay medical device training and BOC, to establish an E-learning package, to try and increase course accessibility. Next review 3 months. (DG 27/06/2023).	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	28.06.2023	30.09.2023

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4148	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Quality & Patient Safety)	Assistant Director Quality, Safety & Safeguarding	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non-compliance with Deprivation of Liberty Safeguards (DoLS)legislation and resulting authorisation breaches	**IF:** the Health Board fails to adequately resource the DoLS Team to address the backlog of authorisations and adequately manage a timely and effective response to new authorisations. **Then:** the Health Board will be unlawfully depriving patients of their liberties and failing to comply with the DoLs legislation **Resulting in**: the rights, legal protection and best interests of patients who lack capacity potentially being compromised. Potential reputational damage and financial loss as a result of any challenge by the ombudsman or litigation.	During February 2023 review of this risk the control measures have been revisited and streamlined. - Hybrid approach to the management of authorisations which includes the ability to offer a virtual format if necessary, although face to face is the preferred mechanism. - An action plan will be overseen by the Deputy Head of Safeguarding to monitor the management of the backlog. - Welsh Government have agreed to a change of use of current 22/23 funding to appoint an agency to clear the current backlog. This agency includes Best Interest Assessors and section 12 Doctors to undertake assessments. - The current backlog is reviewed regularly to ensure that urgent authorisations are prioritised. - A further part time and full time Best Interest assessor were appointed in December 2022, their induction is now complete and they are fully integrated into the DoLS team.	The Health Board has received confirmation that the Welsh Government will be offering funding to address backlogs in authorisations, to provide training in the MCA and prepare the implementation of the Liberty Protection Safeguards. This will be offered in three stages. CTMUHB have already succeeded in securing a £123,000, this has been used to extend the Best Interest Assessor and the Practice Facilitator roles. There will also be a three day Best Interest Assessor post going out to audit in May 22. It is anticipated that the Health Board will need to apply for further funding throughout the year to address any backlog and plan to implement the LPS. - The implementation of the change in legislation with regards the Liberty Protection Safeguards will improve the Health Boards compliance however the date of implementation is still awaited. The Code of Practice is currently out for consultation. - The DoLs Team are meeting with leads within the Locality Groups to work with CSGs to progress the action plan in order to enhance the awareness of the MCA, the risks associated with DoLs authorisations and timely review required and reporting compliance. This work has commenced within YCC and YCR. There are plans to extend this work throughout CTMUHB. Update June 2023 - Recurrent Welsh Government funding has been approved to continue to reduce the DoLS backlog and further strengthen Mental Capacity Act awareness. Procurement are sourcing an agency to complete authorisations through tender. Once an agency is agreed and contracts confirmed they will be utilised to address the backlog. The backlog has already been reduced through the appointment of two further BIA and performance management. Review 31.8.2023.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01/10/2014	04.07.2023	31.08.2023
4152	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	**If:** there is a backlog of imaging and reduced capacity **Then:** waiting lists will continue to increase. **Resulting in** delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	WLIs are being undertaken by consultants to reduce reporting backlogs, this is part of the work agreed via Planned Care Recovery (PCR) funding. Use of fixed term locum staff to help relieve pressure from vacancies. Overtime payments have been made in line with agreed PCR schemes for sessions to help reduce backlogs. Weekend scanning sessions being provided and added lunchtime lists as overtime being run. Re-vetting of referrals against BMUS guidance, review of pathways/criteria, increased productivity per scanner. Close monitoring of USC waiting times and working collaboratively with Cancer Business Unit and other colleagues. There is an ongoing review of capacity plans for the whole service but without additional investment the WG target will not be met. PCR funding bid for 2 biochemists - FITT testing - new vetting criteria Update July 2023 - The referral pathway for lower gastrointestinal (GI) investigations has been modified following national guidance and FIT testing. This is ensuring the patients are receiving the correct investigation at the start of the pathway. Referral criteria for non-obstetric ultrasound scans have been updated to include national guidance. This ensures scanning only when clinically indicated. Next review due 31.8.2023.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	7.7.2023	31.08.2023
4337	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Integrating Patient Records across the Health Board	**If:** The Health board does not have a unified electronic health and care record and systems which are integrated across the organisation and with our primary and social care providers **Then:** The Health board will be unable to deliver safe, high quality, clinically and cost effective care to patients **Resulting In:** Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan and the requirement for sub-optimal manual processes	**Key Controls** 1. SBUHB Service Level Agreement 2. Bridgend disaggregation and the one-CTM aggregation plan 3. NHS Wales Control Agreement and data sharing agreements 4. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. 5. National ePR programme and systems **Gaps in Control** The full business case for the Bridgend / old-CT integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. SBUHB have no process in place to incorporate the needs of Bridgend users in their developments. There is insufficient discretionary capital funding available to support delivery of the aggregation plan There is no data item integration with GP systems Numerous delays in NHS Wales progressing open architectural approach Strategic approach to becoming an anchor organisation to encourage SMEs not developed, resulting in challenges in proceeding with small agile developments Discipline of organisation in keeping to the supported application platforms is being challenged - in particular staff are keen to exploit the opportunities presented by the MS365 platform however there are no resources available to support, train or integrate this platform within the EPR architecture	Integrate Bridgend ICT Systems within CTM - Work ongoing, estimated 2 years from April 2023 Additional Funding for ICT Integration of Bridgend - WPAS funding for resource, workstream started Nationally led. estimated timescales arrive at 2025. No change to mitigation or risk score. Next review due 28.7.2023.	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	24.3.2023	28.07.2023
4809	Executive Director for People	Central Support Function - Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Non Compliance with Mandatory Violence and Aggression Training	training review was undertaken to identify HB violence and aggression training requirements. Following review the HB is unable to achieve full compliance on any training module. This is due to a lack of training resource within the Health Safety and Fire Team. If the training is not delivered, then the organisation will not be compliant with mandatory Violence and Aggression Training. Restraint training is mandatory for inpatient acute services for Mental Health and CAMHS. Training is delivered by inpatient staff and the Health Safety and Fire Personal Safety Advisor. If there is insufficient training resource available then the organisation will be unable to maintain compliance on annual refreshers. If the PSA is unable to deliver key aspects of their role due to the high demand for violence and aggression training delivery then advice to clinical areas is greatly reduced. Resulting in non compliance of mandatory training and a risk of injuries to both staff and patients and possible claims.	Personal Safety Advisor delivers training modules with some support from part time trainers within Mental Health and CAMHS. However there is insufficient resource to ensure compliance within the entire organisation. Trained tutors available from clinical areas. The PSA regularly has to support training due to ward based trainers unable to be released to deliver. This role is not currently included in their job description which has resulted in some trainers resigning from delivering, hence compounding the lack of training resource. The availability of the PSA to offer personal advice to clinical areas is greatly reduced due to the excessive training requirement.	Module D PMVA Training Provision / Programme Delivery - Timeframe 28.07.2023. Addition training needs to be acquired to meet the increasing demand as highlighted in the Training Needs Analysis. The present training programme will not meet specified compliance targets. Timeframe 31.08.2023	Health Safety & Fire Sub Committee	16	C4 x L4	9 C3xL3	↔	31.08.2021	05.06.2023	31.08.2023
4906	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to provide evidence of learning from events (Incidents and Complaints)	**If:** The Health Board is unable to produce evidence of learning from events. **Then:** the Health Board will be unable to recoup any costs from Welsh Risk Pool for personal injury or clinical negligence claims made against the Health Board. **Resulting in**: Risk to quality and patient safety with potential for further claims as learning and improvement will not have taken place. Financial impact to the Health Board	Controls are in place and include: * Monitored and reported through the weekly Executive Quality & Safety meeting. * Regular engagement and meetings with the Executive team to assist in gathering of learning. Improvement plan implemented by WRP with monthly targets to submit the backlog. * Learning From Event Report (LFER) Standard Operating Procedure devised and disseminated * LFER 'How to Guide' devised and disseminated * Ad-hoc training available on request. * Internal targeted monitoring in place.	Update July 2023: The new operational model review in respect of quality, safety & governance has ensured that the facilitation of LFERs sits within the Care Group Governance Teams, with Patient Safety Improvement Managers taking a lead of facilitation. LFER status is regularly reviewed in the weekly Patient Safety, Complaints and Legal Services data meeting, weekly Executive Patient Safety Meeting and Quality & Safety Committee. The business intelligence team have developed reports and dashboards. WRP are no longer accepting incomplete LFERs and therefore this will drive better and more timely completion of LFERs. Penalties have recently been realised. Letter from Medical Director outlining the importance of engagement in the quality and safety agenda has been distributed.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	3.7.2023	31.08.2023
4417 (Linked to Risk IDs 4706 and 4703)	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services & Primary, Community & Mental Health)	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Management of Security Doors in All Hospital Settings	Following several serious incidents following patients absconding from clinical areas, the HSE have issue an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions: In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action. IF: the Health Board do not comply with the notice. THEN: the Health Board may be subject to prosecution by the HSE RESULTING IN: Large Fines and poor publicity.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding. A document has been circulated from Estates which outlines procedures around how and where staff should be reporting failures in doors.	Update from MHLD Care Group - July 2023 - A further review of the Risk is underway to ensure that lessons have been learnt from the Bridgend review, shared and actioned appropriately across all sites with a view to de-escalating this risk.	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	↔	30.09.2020	5.7.2023	30.09.2023
5364	Chief Operating Officer	Children and Families Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Merthyr Cynon Band 6 - Special Community Public Health Nurses (SCPHN's) shortage	IF we are unable to recruit SCPHN School Nurses into vacant caseloads. THEN there will not be enough SCPHN's to deliver the School Nursing Framework and Welsh Government priorities. In addition increased pressure on existing staff. RESULTING IN – the school nursing service being unable to fulfil all of its statutory obligations to safeguarding, optimise immunisation uptake rates, support CYP with their emotional health and compliance with the CMP. It is also predicted that there will be increased levels of staff sickness and impact on recruitment and retention of staff.	Vacancies to be advertised as required. Development of a SCPHN SN bank Team Leader and CNS safeguarding to support staff to ensure safeguarding statutory duties are met. Plan in place to prioritise, Immunisations, CMP, SEHS. Where possible, Team Leader to protect SCPHN time to hold drop in sessions within schools. Vacant caseload policy has been activated. Letter send to Directors of Education and Head Teachers regards reduced SN service capacity. Development plan in place for junior staff to complete SCPHN training and ensure succession planning of future SCPHN workforce. Cross cover support from School Nursing staff across the HB. Extra hours have been offered throughout the team. Team leader review workforce capacity as required and escalate to Senior Nurse when required. Skill mix approach by MC team to deliver school nursing service Senior Nurse to escalate to senior management as required	Due to a national shortage of SCPHN students qualifying across Wales, all vacant SCPHN posts will be recruited into at every opportunity. Band 5 development plan, to support succession planning and future of SCPHN workforce Timeframe: 21.7.2023	Quality & Safety Committee People & Culture Committee	16	C4xL4	8 C4xL2	New Risk to Organisational Risk Register - Escalated July 2023	03.02.2023	20.06.2023	31.08.2023

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4671	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Lack of a resilient and performant Digital Network Infrastructure and Assets	**IF**: The Health Board suffers regular local and/or national network issues and/or outages to critical clinical and business systems or performance issues in accessing and using systems. **Then:** there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated. **Resulting in**: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: Loss of information integrity and accessibility as multiple copies of clinical records. Threat of malware being introduced on to the network from unmanaged data, systems and software. Possible breaches to the GDPR, safeguarding and information governance risks. Mistrust by staff of the ICT systems and services they are using	Details captured in Private Audit & Risk Committee as business sensitive								
4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs -Improving induction and development of new doctors	These are risks that will continue due to the National workforce availability. The Health Board will need to tackle these issues in a variety of ways – there is no one solution. This approach will encompass – recruitment, job planning (compliance and standardisation), regular establishment monitoring, new ways of working (MDT and expanding alternative roles), ADH spend and national rate cards, managing attendance. All of these impact on the workforce and are part of the Medical Workforce Productivity Programme agenda. As the Health Board now has a planned stepwise programme it is dealing with the matter with more clarity and direction. Key Updates from MWPG: - Proposed paper for localised CTMUHB Rate Card to be presented to exec team for approval (May '23) - Milestones agreed as realistic and achievable (Apr '23) - Interface with Care Groups for benefits realisation in development (May '23) - Work underway with Care Group managers to ensure job plans have standardised approach (May '23) - Medical Recruitment strategy being finalised (May '23) Whilst the uncontrollable national medical workforce recruitment issues continue, the MWPG has now been re-established with realistic and achievable targets. With a senior workforce now fully engaged with accountability for achieving the targets with the Care Groups, the overall score has been reflected. The likelihood of this risk has now been reduced to a score of 3.	Quality & Safety Committee People & Culture Committee	15 ↓ 20	C5 x L3	10 (C5xL2)	↓ Risk Score Reduced July 2023	01.08.2013	17.5.2023	31.8.2023
4928	Chief Operating Officer	Children and Families Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Special care baby unit infrastructure does not comply with recommendations.	The current neonatal unit infrastructure is based on a dated footprint that does not comply with current recommendations. (Health Building Note 09-03:Neonatal Units, DoH, 2013) IF the unit remains the same as it is now the ability to provide safe patient care will be compromised. THEN as well as patient care being effected we will continue to fail IPC audits and medicines management audits. We will not be able to provide the best possible care for the families on the unit and staff morale will continue to suffer. RESULTING IN long term damage to the patient experience, staff wellbeing and the predicted future of the unit.	In order to mitigate the ongoing situation all available areas of the ward have been utilised to support patient safety. An extra cubicle has been created by moving the ward managers office to a family room. Storage for equipment has been temporarily sought in the parent accommodation. The patient areas have been moved around to try to ensure space between cots is optimised.	Update June 2023:Meetings to be convened with capital colleagues.Latest IPC audits to be highlighted.	Quality & Safety Committee	15	C3xL5	C3xL3	New Risk to Organisational Risk Register - Escalated July 2023	01.12.2021	20.06.2023	31.08.2023
4650	Chief Operating Officer	Children and Families Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ensuring correct establishment for Special Care Baby Unit	IF: the current staffing levels are maintained as minimum BAPM level of staffing requirement THEN: safe staffing of the unit will not comply with WTE directive. Also there will be an increase in the use of overtime/ bank/ agency to cover shift patterns. RESULTING IN: a core staffing deficit of 2.45 wte NNEB, as per BAPM requirements.	Care Group are currently running a roster that aims to maintain 4 staff (3 registered and 1 nursery nurse)on each shift by utilising bank and overtime when available. Ward manager/Practice development Nurse also steps in to cover short fall when needed. Shifts are managed depending on patient acuity and skill mix.	Continue to utilise bank and overtime shifts when needed. Continue to work collaboratively with paediatric staff if support is needed. Acknowledging the shortfall and filling the vacancy will ensure the use of overtime and bank is reduced and give staff confidence in the staffing levels.	Quality & Safety Committee	15	C3xL5	C3xL3	New Risk to Organisational Risk Register - Escalated July 2023	19.05.2021	20.06.2023	31.08.2023
2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring RESULTING IN: a core staffing deficit of 2.45 wte NNEB, as per BAPM requirements.	The service is operating as efficiently as possible e.g. enhanced roles for SLT/CNS/Pharmacist. Pathways have been reviewed e.g. ADOS's limited to only those cases where clinically necessary. Clinical Lead role created to support this (as below). Recurrent funding agreed at Planned Care Board 25/08/2022 and successfully appointed 1.0 wte Psychiatrist (clinical lead role, Uplift from 8a to 8b 0.6 wte Pharmacist, 1.0 wte Band 3 admin & 0.6 wte Band 3 HCSW - appointed Nov 22 Meetings with National Lead for Values Based and Prudent Health Care taken place to look at modelling of the service. Bids have been submitted through successive IMTPs and previously against new WG funding sources for the ND service. Internal working group in place to repatriate SLA from Swansea Bay so that a local service can be developed WG funding (£12m) announced for ND services - health, education and third sector. SBARS being developed to bid for funding to enhance provision moving forwards. WLI agreement following Neurodivergence Improvement Programme funding via RPB until end of March 2023 to address longest waiters achieved no patients to be waiting over 104 weeks at end of March 2023. WLI agreed to continue April 2023 onwards to maintain current wait times whilst additional funding is being agreed through regional partnership board to develop a pan CTM model.	Improvement in waiting times with no children waiting >104 weeks. additional funding agreed through regional partnership board so the service model is being referred. Meetings scheduled to bid for funding via Regional Partnership Board. Timeframe 29.9.2023	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	05.07.2023	31.07.2023
3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2021. Need to plan for drop in theatres to mitigate work commencing	Update June 2023 -options for decant remains under strategic review and is proposed for discussion at Improving Care Board on 27th June. If this is the agreed way forward this will be discussed at a formal review with Welsh Government, likely to be late July. If approved then the contractor can be re-engaged and works commence on procuring the decant solution and developing the design for the theatre department works for inclusion in a business case. Further funding will need to be applied for to develop the business case. Once approved then the decant will need to be installed. Likely to require a further extension on the Fire enforcement notice which is due to expire on 31st December 2023.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	20.06.2023	31.08.2023
4672	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Access to a complete, integrated, and coded medical record.	**IF:** The Health Board is not able to record information accurately and reliably, with complete and up to date information **Then:** the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete **Resulting in:** Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc.	**Operational controls:** Coding key performance indicators covering productivity, demand and backlog robustly monitored Digitised Patient Notes programme board monitors scanning times, adherence of contractor to terms and quality of staff in maintaining a record DHCW annual coding quality audit. Coding Improvement and transformation plan established incorporating additional trained coding capacity, coding at source, use of data captured in other systems and e-forms implemented. Natural language programming resource deployed and outputs of programme being validated. Tactical - EPR programme with deployment of snomed-CT onotology server, WCP & E-forms etc. **Tactical controls:** Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme . **Gaps in controls** Scanning time of outpatient activity to digitise the record is at 51 days cf maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards Digital solutions not yet using snomed-CT/ structurally coded data Information and Technical Standards not being followed with national body favouring document rather than data exchange Vast amounts of clinical information stored in disparate spreadsheets not visible to central medical record or available to patients or system leaders (including value based healthcare) Digital transcription programme unsupported & unsupported from march 23	Update June 2023 - Day forward scanning has reduced from previous reported 51 days to within the agreed 48 hour turn around due to a focus by our external provider (GBS) moving from legacy note scanning to day forward. Current contract only funded until Sep 2023 and business case currently being developed for the continuation of the project past this point. Risk if no further funding is awarded/ business case approved from Sep 23 further delays may become realised due to the capacity of the in-house CTM scanning department.	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	16.6.2023	30.09.2023
4732	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of orthogeriatrician as NICE guidance and KPI1 NHFD	IF: If we do not have this specialist service THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality. RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too.	The already stretched on call medical team are contacted for ad hoc advice. There is no COTE service and no specialist advice available	Update 26 June 2023 - Orthogeriatrician service model is being reviewed and CTM as part of the trauma and orthopaedic reconfiguration of service. New review date 30/09/23.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	30.06.2021	26.6.2023	30.09.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5040	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Projects Including systems and processes, Service /business interruption	Digital Healthcare Wales (DHCW interdependencies	**IF:** The Health Board can not integrate new applications into its digital architecture in a timely fashion **Then:** there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend aggregation and the deployment of the new Emergency Department system) not being delivered **Resulting in:** delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: 1. Loss of information integrity and accessibility as multiple copies of clinical records. 2. Failure and delay of digital system deployments (e.g. WEDS) 3. Possible breaches to the GDPR, safeguarding and information governance risks. 4. Mistrust by staff of the ICT systems and services they are using 5. Money being wasted.	A Myrddin strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome SLAs are in place between DHCW and NHS Wales organisations, however their futility has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months Gaps in controls: WG have agreed some funding for the PAS element, however the DHCW IMTP continues to be a top down decision process rather than one being based on HB (user / customer) needs - driven in part by demand overwhelming their capacity (much of which is either Covid born or results from the significant overrun in establishing a minimum viable product to replace CanISC) and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying vacancies in critical areas with no capacity to cover the work from within. As a consequence programme to digitise the Emergency Department processes and records has been suspended. Data acquisition from DHCW products is a curates egg, some new APIs are being made available to standards, however latest PAS offering is via csv download, presenting challenges to adoption of standards within certain areas. UHB still awaiting availability of access to key HB data such as radiology and tests results.	National Data Resource Programme has accelerated plan to open up the architecture, with API management procured for all of Wales. National Funding received from WG for PAS integration work to create a second team supporting data migration. CTMUHB appointment process has commenced. WG funding for £7m awarded to support PAS integration 24/8/22 UPDATE 28/10 ICT Risk meeting - no further update October 22 - National Data Resource Programme has accelerated plan to open up the architecture, with API management procured for all of Wales & implementation date set for Jan 23 - will be limited in nature. National Funding received from WG for PAS integration work to create a second team supporting data migration. CTMUHB & DHCW appointment process has commenced. Included within this is a post for PAS integration developer.	Digital & Data Committee	15	C3xL5	9 C3xL3	↔	07.02.2022	22.10.2022	02.12.2022
3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	1. Process in place for clinical teams to access information via local authority and health board teams. 2. Clinical teams will only use historical information as part of their current risk assessment and if this is not available they will judge the risk accordingly. 3. WCCIS Programme Board establishment for CTM will be finalised by the 30th June 2021, Merthyr and Cynon CGS Lead will Chair this group. The Chair of this group will report to the Senior Responsible Officer. The Task and Finish Groups established and aligned to this Programme board. 4. Local Authority have recently developed reports for Mental Health which identifies practitioner caseloads, admissions and discharges and care plan for compliance. 5. Deployment order in place for all existing WCCIS mental health staff users 6. Community Drug and Alcohol Team in Bridgend have now moved over to WCCIS, early implementation learning continues to take place. 7. WCCIS Regional Working Group now has a representative from the Health Board to maintain pace of delivery for WCCIS mental health rollout. 8.CTM have set up a Project Board in partnership to prepare for implementation of WCCIS 9. Project manager has been recruited. This role is leading on the development and implementation plan. 10. Business Case identifying additional ICT resource to progress the disaggregation process developed and awaiting approval. Workforce capacity impacts on programme deliverables. Patient Safety Controls: • CSG's have undertaken initial review and rationalised staff access to all information systems to understand the presenting need for access. • CSG's have introduced mechanisms to monitor and control access to FACE/WCCIS/W Drive to ensure prudent access to patient information. • Each clinical team has at least one staff member with resources and training to access information in line with agreed permissions to ensure ease of access to available information from all systems. • RTE lead nurse will lead pan CTM MDT working group to develop consistent approach to clinical record keeping and monitor ongoing IG process/ workstreams (Meeting date in November to be confirmed).	1. A Business Case has been developed which identifies additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. Business Case pending approval. 2. Director of Digital, CTMUHB undertaking a review to understand if WCCIS remains the best solution to progress for CTMUHB in general and for Mental Health specifically. WCCIS "go-live" at ABUHB in August 2022. Lessons learnt group is attended by CTUHB Project Manager. 3. Options Appraisal completed with plans to present to the ELG on the 7th November 2022 with a view to progress to full Business Case. A service improvement and learning team is being established and the role of this team will be to develop robust oversight and mitigations in relation to record keeping until such time and integrated system is available. Update July 2023 - : A further review of this Risk is underway aligned to the new WCCIS Programme Board. A new Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme.	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	05.07.2023	30.09.2023
4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer Director of Primary Care and Mental Health Services Rhondda Taf Ely Locality	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed.	1. Discussions to commence with Welsh Government in relation to the inpatient environment. 2. A scoping document case to be prepared and submitted to Welsh Government -COMPLETE scoping Document submitted and agreement to commence a Strategic Outline Business Case received. 3. Develop a strategic outline business case. Timescale March 22 currently scoping the configuration of a future focused mental health unit - paused due to pandemic 4. If the strategic outline business case is accepted, progress to the development of an outline then a full business case. 5.work paused due to pandemic. Resource to be identified to progress business case process 6. A Quality Improvement Programme in relation to inpatient care is being developed and a workstream in relation to therapeutic environments is being established with the aim of optimising the patient experience. Inaugural workshop to take place early 2023. 7. Recruitment has taken place for Assistant Director of Strategic Transformation and this role will lead a range of strategic programmes including recommencing a new capital business case for a new Mental Health Unit. COMPLETE Update July 2023 - MHLD Care Group : A further review of this Risk is underway to separate the two key issues. The ligature risk and actions have been managed however the wider environmental issues of the unit remain. It is proposed that the risk is therefore restructured to reflect this residual risk which will be held by the Care Group Health & Safety, Fire & Capital Group. Review 30.09.2023.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	05.07.2023	30.09.2023
4699	Director of Digital	Central Support Function - Digital & Data (Information Governance)	Chief Information Officer	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Failure to deliver a robust and sustainable Information Governance Function	**IF:** The Health Board is not able to legally share the business and patient sensitive information for which it is a data controller and which it is required to shared for the delivery of care **Then:** There will be a loss of trust and confidence in the Health Board from its patients, population, staff and 'care providing partners' and thus will not have the information required to provide safe, high quality and effective care and to make informed evidenced based decisions. **Resulting in**: Poor outcomes for our population, a loss of reputation for our organisation, substantial delays in improving services, inability to collaborate regionally or deliver integrated care services.	**Key Controls:** - Adoption and implementation of All Wales IG and Data protection policies, - Continual improvement and progress made in mitigating non delivery of legislation (CLDC, DPA etc) - Mandatory training in Information Governance with auditing functionality (such as NIIAS) built in to monitor compliance, - Accessible but robust data protection process for new and existing data sharing arrangements (DPIA procedures) - Joint data controllership arrangements with DHCW + WASPI -Professional (clinical) training and approach to maintain an accurate and timely medical record **Gaps in Controls:** 1. Shortfall in trained IG professionals 2. Inability to legally stipulated timescales for Freedom if Information and Subject Access Requests	Cyber and Data Protection Improvement Plans being taken forward. - Timeframe: Quarterly updates Response to ICO audit recommendations being managed on a prioritised and smart basis (aligned to other improvement areas) Benchmarking with other organisations in Wales undertaken. Procedures and requirement to initiate all programmes being enhanced to meet legal requirement of privacy by design Update June 2023 - successful recruitment exercise in June 2023 and a Head of Information Governance has been appointed with a start date circa September 2023. Risk score currently remains unchanged and will be reviewed at the end of September.	Digital & Data Committee	15	C3xL5	12 C3xL4	↔	18.06.2021	04.07.2023	30.09.2023
4217	Executive Director of Nursing & Midwifery Infection Control	Central Support Function - Infection, Prevention and Control	Lead Infection, Prevention and Control Nurse	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No IPC resource for primary care	**If** there is no dedicated IPC resource for primary care. **Then:** the IPC team is unable to provide an integrated whole system approach for infection prevention and control. **Resulting In:** non compliance with the reduction expectations set by WG. A significant proportion of gram negative bacteraemia, S.aureus bacteraemia and C.Difficile infections are classified as community acquired infections.	Liaise with specialist services in primary care e.g.. bowel and bladder service IPC team investigate all preventable community acquired S.aureus and gram negative bacteraemia and share any learning with the IPC huddles arranged in primary care to look at community acquired. Update August 2021: the IPC team is working collaboratively with the bowel and bladder service to investigate all preventable urinary catheter associated bacteraemia. Any learning points/ actions is being shared with community teams. Work in progress to start/reintroduce RCAs/IPC huddles for community acquired C.Difficile cases.	A strategic review is planned to determine what is required to provide an integrated whole system approach for IPC. Update June 2023 - position remains as statement above.	Quality & Safety Committee	15	C3xL5	6 C3xL2	↔	16/07/2020	28.6.2023	31.08.2023

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
5207	Executive Director of Strategy & Transformation	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Care Home Capacity	**If:** the rising costs of delivering care in private facilities drives a number of providers to cease trading. **Then:** there will be a loss of capacity within the system. **Resulting in:** exacerbated delays in hospital flow, an impact on wait times and increased admission to hospital for displaced patients. Patient experience will be impacted due to increased hospital stays. There will also be a longer term impact on residential care opportunities.	Multi Agency Operational Group established that effectively risk assesses the homes and manages any emergent contractual/ provider/ safeguarding issues, we wonder if this is forward looking enough in the current context. Local Authorities have regular contact with Care Homes to assess any challenges that they are facing and will intervene as appropriate based on risk and circumstances.	Via the Regional Partnership Board and other partnership meetings questions will continued to be escalated to seek assurance. Reports on specific incidents will be taken to Planning, Performance & Finance Committee. Care Providers will continue to engage with Welsh Government to escalate their concerns around the current position. CTMUHB is working with Care Inspectorate Wales (CIW)and the local authorities to understand the implications of the HB providing care services either as a provider in its own right or in partnership with a local authority Update June 2023 -Risk reduced as the situation has not escalated as anticipated last summer. Consider again at next review point. Review 31.10.2023.	Quality & Safety Committee Planning, Performance & Finance Committee	10 ↓ 15	5	Central Planning Function propose for de-escalation as the situation has not escalated as anticipated last summer. Consider again at next review point - 31.10.2023.
2987	Executive Director of Strategy & Transformation	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire enforcement order is in place for the ground and first floor PCH due to inadequate fire compartments to prevent spread of fire, smoke and noxious gasses	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Fire Enforcement Order. An action plan and target dates for the 1st and ground floor areas at PCH is available and is subject to available finance for completion. Phase 1b of the wider programme has been completed and the UHB has now achieved remediation for physical fire issues identified in the FEN in the majority of the new Pharmacy, Dining Room and Kitchen areas at PCH which opened in January 2021. This has tackled the higher risk for fire areas of the old kitchens and improved the fire stopping below ITU as well as reducing the overall volume of area remaining in the FEN to be remediated (remediated c2000m2 of c18000m2). In addition the UHB secured Welsh Government approval in October 2020 for the Phase 2 FBC, in the sum of £220m, which will see progressive improvement of the majority of the remaining G&FF areas to be remediated for fire over the next 5 and a half years. As a reminder these works are progressive due to the need to balance them against maintaining service delivery as best as we are able and are intended to be supplemented (to run concurrently with final years of the Phase 2) by a final Phase 3 business case intended to address the final physical accommodation areas included within the FEN	Ground and first floor Phase 2 major project approved by WG to address the fire notification on PCH. In progress with completion due 2026 / 27. Annual reviews as to remediation progress are held with SWF&RS and the Health Board is required to evidence continued progression in the shortest timescale. If satisfied SWF&RS issue an annual extension letter against the FEN. The current extension runs to the 31/07/23. The Phase 2 programme has now reached a point where c 6000m2 of FEN accommodation has been handed to the contractor (Apr 2023) to be remediated, having now decanted these areas to alternate fire compliant accommodation. 04/07/2023 - Updated by Assistant Director Health, Safety & Fire . Risk scoring has been amended appropriately (reduced from a 15 to a 12) as this risk is in the process of reducing as further works on the site are completed.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	12 ↓ 15	6	04/07/2023 - Updated by Assistant Director Health, Safety & Fire . Risk scoring has been amended appropriately as this risk is in the process of reducing as further works on the site are completed.
4772	Chief Operating Officer	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Replacement of press software on the 13 & 10 stage CBW presses	**If:** The 10 & 13 stage Lavatec presses have old software control systems, and are both vulnerable to failure. Following a fault developing and a recent maintenance call out it was identified that the 10 stage press is working intermittently caused by a software problem. **Then**: If the 10 Stage press control system fails the consequence of not purchasing the software replacement would result in the laundry service being unable to produce to full capacity and reduced to around 55%. If the Stage 10 press control system software fails then it could also impact on the Stage 13 press. The consequence of both presses failing and not purchasing the software replacement would result in the laundry service being unable to process any laundry which will result in all CTMUHB laundry being outsourced to commercial laundries. The costs will be significantly higher than those incurred in-house. **Resulting In:** •Potential of service failure due to existing system. •Potential of CTM sites being without bedding and linen at existing volumes and turnaround times. •Potential increased costs resulting from having to outsource laundry processing to commercial laundries in the event of equipment failure.	The All - Wales Laundry review continues, and at the current time, it is likely that services will be provided from CTM laundry until at least 2024. After this time, the equipment could be moved and rehoused elsewhere to continue to support CTM and the All-Wales Laundry agenda. Previous IMTP submissions have included as a priority £375K for a replacement automated sorting and roll cage washer/dryer system at the laundry. The software that controls system for the CBW forms an integral part of the current press. Benefits of equipment being replaced: •Reduced risk of service failure and therefore improved confidence in continued production. •Easier to diagnose and put right any mechanical defects. The Laundry is being monitored remotely by the system supplying company. There is a robust contingency plan in place we are able to continue with a normal service until these issues are resolved. We also have the ability to call upon the other L4 region production units. The contingency plan provides for a 5 day full service with ability to call on the other L4 within the All	June 2023 - Health Board is now ready for the installation of the software upgrade to the 13-stage press. Prior to the software upgrade, specialist engineering work is required. This work has been requested and we are waiting for confirmation of when the engineers will attend site. The upgrade is anticipated to be completed before the end of August The risk score has been reviewed and the score has reduced to a risk rating 12 – moderate risk due to the robust contingency plans in place and the work now being scheduled for the 2nd week in August. There is no IPC impact associated with this risk.	Quality & Safety Committee Planning, Performance & Finance Committee	12 ↓ 15	4	The risk score has been reviewed and the score has reduced to a risk rating 12 – moderate risk due to the robust contingency plans in place and the work now being scheduled for the 2nd week in August.

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
4679	Executive Director for People (Executive Lead for Occupational Health)	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Absence of a TB vaccination programme for staff	**If:** the Health Board is not providing TB vaccination to staff **Then**: Staff and patients are at risk of contracting TB **Resulting in**: Failure to comply with the Department of Health and Social Care guidance and lack of confidence in the service	The 'fitness letter' issued by Occupational Health to the appointing line manager following an employee health clearance highlights vaccination status. Screening for latent TB for new entrants and offering T spot testing to assess positive or negative.	Update for May 2023 - A new process has been mapped which needs to be ratified with the Occupational Health Dr provision, Specialist Respiratory Nurse Team and Pharmacy before training and implementation of TB screening can take place. A meeting is being arranged to progress. Update July 2023 - process has been ratified by OH Doctor and two OH nurses have undergone training. Pharmacy have confirmed vaccines are available to order. Prioritisation of at risk groups to be confirmed and then clinics can commence	Quality & Safety Committee People & Culture Committee	8 ↓ 16	8	Proposed for de-escalation and then closure as process in place and ratified. Closure of the risk to follow once clinics have commenced.

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
4458	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches.)	**If:** the Health Board fails to deliver against the Emergency Department Metrics **Then:** The Health Boards ability to provide safe high quality care will be reduced. Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. **Resulting In:** A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls. Compromised safety of patients, potential avoidable harm due to waiting time delays. Potential of harm to patients in delays waiting for treatment.	Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protections Schemes Implemented within ILG's. Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	The Unscheduled Care Improvement Board will monitor progress on the programme on a monthly basis. Given the decrease in compliance for 12 and 4 hour waits, it is impossible to outline progress at this point. It is anticipated that the work of the Urgent Care Improvement Group will be able to report some improvement in the coming months. Review 26.06.2023 - to combine with risk 3826.	Quality & Safety Committee Planning, Performance & Finance Committee	Jul-23	The Unscheduled Care Group propose that this risk is captured within Datix ID 3826 - Emergency Overcrowding and recommend this risk is closed.
3585	Chief Operating Officer.	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Princess of Wales Emergency Department Hygiene Facilities	**If:** the toilet and shower facilities are not increased within the Emergency Department. **Then:** at times of increased exit block the facilities are insufficient for the needs of the patients in the department. **Resulting In:** Poor patient experience, complaints and further concerns raised from the Community Health Council have repeatedly flagged this issue on visits to the department.	There are additional toilet facilities in the radiology department that mobile patients can be directed to however staff do whatever they can within the constraints that they have. Additional facilities being explored as part of departmental capital works.	Additional facilities being explored as part of departmental capital works. There is a capital plan for improvement works in ED. The improvements will be – 1. NIV cubicle, 2. Creation of a second patient toilet, 3. Improvement to HDU area, 4. Relocation of Plaster Room, 5. Creation of 2 paediatric bays with adjoining paediatric waiting room, 6. Redesign of waiting room and reception desk. Prior to the Covid pandemic, improvements 2-6 were planned, but the creation of an NIV cubicle has taken priority. The plans are in the process of being signed off for all areas but there is no confirmed start date yet. There was / is potential for delays in sourcing materials by contractors and we need to consider the need to keep contractors as safe as possible from any Covid contact. Patient numbers are now increasing daily but we are restricting visitors and relatives attending with patients (unless required as carers etc). We have also developed a remote waiting room for patients who can safely wait in their cars. This will help to mitigate the footfall in the department when the capital work commences. Update June 2023 - The disabled access toilet is now open. This has been deescalated and will be closed.	Quality & Safety Committee	Jul-23	The Unscheduled Care Group propose that this risk is closed as The disabled access toilet is now open.
4721	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Shift of the boundary for attendances at the ED.	IF: the current boundary change to redirect emergency cases from the lower Cynon Valley to the Royal Glamorgan Hospital is not reviewed: THEN: patients will continue to be admitted to a hospital further from their home RESULTING IN: increased pressure on the medical teams to manage an increased patient cohort, lack on continuity of care with follow up arrangements closer to home	Boundary change currently subject to review to understand the impact across CTM.	Boundary change currently subject to review to understand the impact across CTM. Update April 2022 - Meeting to be convened between M&C and RTE clinicians to agree way forward. For discussion at Execs 25th April. Review 30.06.2022. No change to mitigation or risk score. Update June 2023 - Risk reviewed, 4 patients attend a day with an additional 2 qualified nurses to manage. A full nursing establishment to be undertaken and this risk should now be de-escalated and closed.	Quality & Safety Committee	Jul-23	The Unscheduled Care Group propose that this risk is closed as risk reviewed, 4 patients attend a day with an additional 2 qualified nurses to manage. A full nursing establishment to be undertaken and this risk should now be de-escalated and closed.
3638	Executive Medical Director	Inspiring People	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Pharmacy & Medicines Management - Training & Development Infrastructure	**IF:** the planned HEIW led changes to the education and training of pharmacists and pharmacy technicians with increased numbers of trainees across both primary and acute care are fully implemented **Then:** the there will be insufficient capacity within the medicines management team to provide the required training, supervision and management of the planned trainees. **Resulting in:** a lack of appropriately qualified pharmacy professionals to meet future service demands in all sectors and particularly in hard to recruit to ILGs such as Merthyr where we have established a "grow our own" model. This can impact the primary care sustainability MDT model. Also a reduction in reputation of a HB that has a very high level of % qualifying and a reduction in future applicants. Current capacity is overstretched and a robust education, training and development infrastructure is needed to meet these demands for specialist & advanced practitioners in primary and secondary care.	This CTM Pharmacy issue that has stalled at various times in the past which has added to delay. Initially started in 2018 as an SBAR propose increase training capacity in order to meet the demand. Included in IMTP and prioritised as number one priority, as part of the PRIMARY CARE pacesetter for education and development in primary care academic hubs and was successful. This element of the ed/tr will be implemented in 2018 for 3 years with evaluation. As such is in place and continues to run. Funding approved for primary care lead pharmacist - commenced in post April 2019.SBAR for Nov CBM on new technician training requirements. Progress and evaluate primary care pacesetter plan to increase training infrastructure to inform business case to continue funding and scale up. SECONDARY CARE elements were not supported in the IMTP prioritisation process	Update July 2023 - DTPS Care Group have proposed this risk for closure due to the new structure established and that Education and Training (ET) has been incorporated into Job Planning. The education and training and workforce development team within the pharmacy department consists of an acute site Head of Pharmacy, who is responsible for developing the workforce development strategy, and the necessary education and training to deliver this. The principal pharmacist will support the development of the strategy, and will lead on project delivery. The remainder of the ET team will be engaged in service provision, project delivery and support of education and training of medical, nursing and allied staff, the pharmacy team, students and undergraduates. The whole pharmacy workforce is expected to engage in the education and training, and this will be achieved through use of job planning software, as suggested in the HEIW strategic pharmacy workforce plan, and expectations set within job descriptions and managed through PADRs, and 121s. The strategic vision for the workforce development for the CTM pharmacy team will aim to be completed, and launched by April 2024.	People & Culture Committee	Jul-23	Update July 2023 - DTPS Care Group have proposed this risk for closure due to the new structure established and that Education and Training (ET) has been incorporated into Job Planning. See update in column H.

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
4743	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure of appropriate security measures / Safety Fencing	**If:** there is a failure in security measures. **Then:** there is an increased likelihood of patients having unrestricted and inappropriate access on the site. **Resulting In:** absconding events and possible harm to the patient or members of the public	The risk of absconding, and self harm/ suicidal ideation for Mental Health and CAMHS patients is risk assessed on admission and reviewed regularly thereafter. Works programme to review and renew physical barriers such as door locks and restricted window access to limit unauthorised ingress and egress from Mental Health and CAMHS units are in situ. High risk patients are escorted when outside the units Absconding patient policy in place Some fencing is in place in the areas concerned, however, it is aged and fails to provide an adequate barrier.	July 2023 - ongoing capital works project is the completion of the ligature proof fencing in the car park stairwells which completed last year.	Quality & Safety Committee	Jul-23	Confirmation received from the Acute Services General Manager that works are complete so this risk can be closed.

AGENDA ITEM
5.2

AUDIT & RISK COMMITTEE

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Date of meeting	16/08/2023

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Emma Walters, Head of Corporate Governance & Board Business
Presented by	Emma Walters, Head of Corporate Governance & Board Business
Approving Executive Sponsor	Chief Executive

Report purpose	FOR NOTING

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

ACRONYMS	
NWSSP	NHS Wales Shared Services Partnership

1. SITUATION/BACKGROUND

1.1 The main purpose of this report is to present an update to the Audit & Risk Committee on reported progress of Audit report recommendations in the revised format.

1.2 The scope of this report relates to both internal and external audit review recommendations.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Internal Audit (NWSSP)

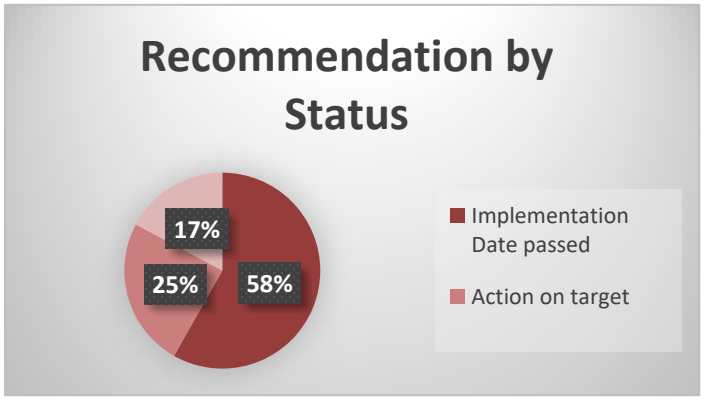
2.1.1 Since the last meeting the following changes and updates are noted:

- **3 NEW** Internal Audit Reviews have been added to the Audit Recommendations Tracker:
  - Welsh Risk Pool Claims – Eight recommendations;
  - Follow Up Review: Concerns – Seven recommendations;
  - Arrangements for Managing Service Level Agreements – Five recommendations;

- **21** Internal Audit recommendations have been completed and are proposed for **CLOSURE**, these are:
  - Concerns 1.1, 1.2 and 3.1;
  - Concerns Follow Up Review 4.2, 4.3 and 8.0;
  - Clinical Service Group & Integrated Locality Group Quality Assurance 3.0 and 5.0;
  - Financial Systems 03;
  - ICTM Quality Improvement Team 3.2;
  - Medical Variable Pay 4.1;
  - Radiology Service Review 1.1, 13.1, 6.1, 6.2, 6.3 and 8.1;
  - Risk Management (2021) 03;
  - Welsh Risk Pool, 1.2, 3.1 and 4.1.

2.1.2 **Current Position**

The tables below provide a summary of the current position in relation to Internal Audit Recommendations, noting that the proportion of red status recommendations has deteriorated to 58% compared to the June position which was at 30%.



Recommendations by Priority & Status				
Priority	**TOTAL**	Implementation Date passed	Action on target	Actions Completed
High	**33**	23	5	4
Medium	**75**	41	22	12
Low	**15**	7	3	5

Recommendations by Executive Lead & Status				
Executive Lead	**Total**	Implementation Date passed	Action on target	Actions Completed
Director of Corporate Governance	**2**	1	0	1
Director of Finance	**20**	10	9	1
Chief Operating Officer	**34**	27	1	6
Director of Nursing	**22**	9	1	12
Director of Digital	**5**	0	5	0
Director for People	**11**	3	8	0
Director of Strategy & Transformation	**19**	13	6	0
Medical Director	**9**	8	0	1

Implementation Date Extended by					
Priority	**TOTAL**	More than 24 Months	18-24 Months	12-18 Months	6-12 Months
High	**16**	1	1	10	4
Medium	**47**	8	10	13	16
Low	**7**	1	2	2	2

2.2 External Audit (Audit Wales)

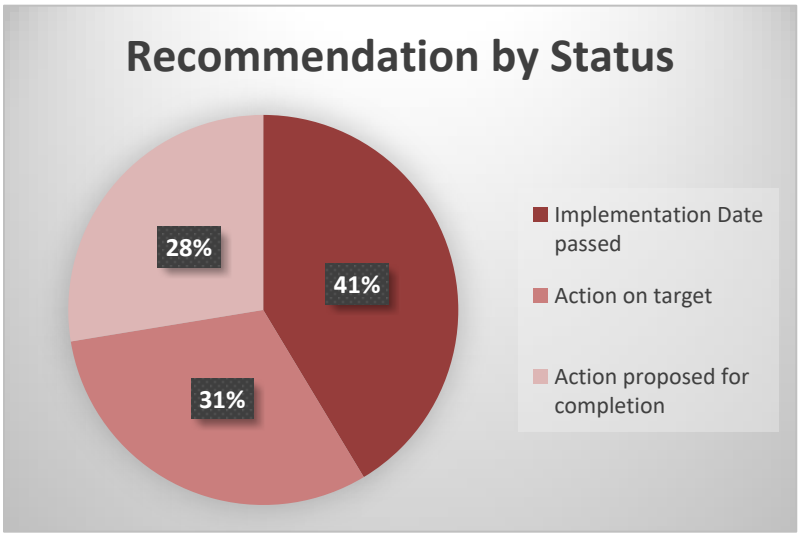
2.2.1 Since the last meeting the following changes and updates are noted:

- **1 NEW** new External Audit Review has been added to the Audit Recommendations Tracker:
    - Orthopaedic Services in Wales Tackling the Waiting List Backlog – three recommendations.

- **8** external audit recommendations have been completed and are proposed for **CLOSURE**, these are:
    - Audit Wales/Healthcare Inspectorate Wales Joint Follow Up Review R10.1, R10.4, R11.6 and R14.5;
    - Structured Assessment 2022 R6, R7 and R10;
    - Transformational Leadership Programme Board – Baseline Governance Review R3.

2.1.3 Current Position

The tables below provide a summary of the current position in relation to External Audit Recommendations. You will note that the percentage of recommendations whereby the implementation date has now passed has improved slightly to 41% compared to the 42% reported to the June 2023 meeting.



Recommendations by Priority & Status				
Priority	**TOTAL**	Implementation Date passed	Action on target	Actions Completed
High/Medium/Low	**21**	12	9	8

Recommendations by Executive Lead & Status				
Executive Lead	**Total**	Implementation Date passed	Action on target	Actions Completed
Director of Corporate Governance	**3**	1	0	2
Director of Strategy & Transformation	**11**	8	2	1
Chief Operating Officer	**3**	0	3	0
Director of Finance	**3**	0	0	3
Director of Digital	**1**	0	1	0
Director of Nursing	**5**	2	1	2
Director for People	**2**	1	1	0
Medical Director	**1**	0	1	0

Implementation Date Extended by					
Priority	**TOTAL**	More Than 24 Months	18-24 Months	12 - 18 Months	6 -12 Months
High/Medium/Low	**11**	1	3	6	1

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 As outlined in section 2, the audit tracker will continue to be updated with a targeted focus on actions where the implementation date has passed

3.2 Steps have been taken to seek updates from Management leads in relation to outstanding internal and external audit recommendations which are classed as high/medium/low priority.

4 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Robust internal processes aligned with a strong governance framework is essential to ensuring patients experience the greatest possible levels of safety and quality.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required
Legal implications / impact	Yes (Include further detail below)
	There may be an adverse effect on the organisation if CTMUHB does not fully implement learning and improvements identified as part of Audit arrangements.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5 RECOMMENDATION

5.1 The Audit & Risk Committee are being asked to **NOTE** the report and **AGREE** the assurances provided particularly in relation to closed recommendations.

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Ref	Date added	Assurance rating	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead/Management Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates during this period/Latest Update	Update provided for Previous meeting
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 Now May 2023 Now July 2023		Completed	August 2023 Update - Recommendation superseded by Follow Up Review. Propose to close. New audit by Internal Audit along with action plan presented at Quality & Safety Committee in July 2023. SOP completed and approved by the Executive Team in July 2023.	June 2023 Update: A full set of Standard Operating Procedures for the Management of Complaints have been developed. These have been shared at the weekly executive catch up, the team and with Internal Audit as part the review of the previous audit. These procedures reflect the centralisation of the complaints and a clear process of escalation. The overarching Concerns policy has been drafted and following consultation will be presented to the Q&SC (July 2023) for approval.
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 Now May 2023 Now September 2023		Completed	August 2023 Update - Recommendation superseded by Follow Up Review. Propose to close. New audit by Internal Audit along with action plan presented at Q&S in July 2023	June 2023 Update: Updated action reflected in updated internal audit report: Training Needs Analysis to be developed and sent to all Care Groups to identify staff which require training. Once the training needs analysis has been completed, this will inform the training programme. This will be developed and be an ongoing rolling programme for the Health Board. Discussions to be held with Learning and Development to ascertain the best method to capture this training on an ongoing basis. The delay in the recruitment of new staff has been impacted and delayed due to the revised Operating model.
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 Now June 2023 Now October 2023		In progress	August 2023 Update - limited progress has taken place. There will be a further update at the next meeting.	June 2023 Update - work continues. Meeting planned with Audit and the Care Group in June 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 Now June 2023 Now October 2023		In progress	August 2023 Update - limited progress has taken place. There will be a further update at the next meeting.	June 2023 Update - work continues. Meeting planned with Audit and the Care Group in June 2023.
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 Now June 2023 Now October 2023		In progress	August 2023 Update - limited progress has taken place. There will be a further update at the next meeting.	June 2023 Update - work continues. Meeting planned with Audit and the Care Group in June 2023.
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 Now June 2023 Now October 2023		In progress	August 2023 Update - limited progress has taken place. There will be a further update at the next meeting.	June 2023 Update - work continues. Meeting planned with Audit and the Care Group in June 2023.

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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 Now June 2023 Now October 2023		In progress	August 2023 Update - limited progress has taken place. There will be a further update at the next meeting.	June 2023 Update - work continues. Meeting planned with Audit and the Care Group in June 2023.
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 Now June 2023 Now October 2023		In progress	August 2023 Update - limited progress has taken place. There will be a further update at the next meeting.	June 2023 Update - work continues. Meeting planned with Audit and the Care Group in June 2023.
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 Now June 2023 Now October 2023		In progress	August 2023 Update - limited progress has taken place. There will be a further update at the next meeting.	June 2023 Update - work continues. Meeting planned with Audit and the Care Group in June 2023.
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 Now April 2023 Now June 2023 Now September 2023		In progress	August 2023 Update - Draft TORs have been created and membership developed. Currently a meeting date is being confirmed and it is expected that invites will be sent imminently for a date in Late August/ early September. During this time information on a final option is being developed for a discussion on the decant options which will be the focal point of the first project Board meeting.	June 2023 Update - An options paper for the decant has been developed and is undergoing strategic review prior to submission to and discussion with WG. The next review with SWFRS is 19th June and they will expect the HB to have a confirmed decant option to be reviewed with WG. Once this has been agreed the business case will need to be redrafted and the Project Board meetings can commence. In preparation of this draft Agenda and TOR have been drafted just waiting for confirmation of approved decant solution
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	August 2023 Update - This recommendation is on track for completion by Quarter 2 2023/2024	June 2023 Update: On track. New Digital Strategic Leadership being recruited to. These will enable support for new Governance model
Radiology Service Review 6.1	des-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 Now April 2023 Now August 2023		Completed	August 2023 Update - in-house F2F bespoke sickness absence training delivered by People's Services 06/07/23. 16 staff attended and trained. Now complete.	June 2023 update - RGH sickness training delivered to five members of staff, three outstanding. Coordination of dates challenging with clinical responsibilities.

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Radiology Service Review 9.1	des-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 Now May 2023 Now August 2023 Now October 2023		In progress	August 2023 Update - significant improvement noted at PCH with increased compliance from 39% up to 66%. The team have booked and planned PDRs around incremental dates. All managers have been asked to review and ensure all dates are reflected accurately on ESR. It has been noted that some staff are lacking confidence in completing the new PDR document prior to the planned PDR. Staff are encouraged to engage in the process and work through the document with their line manage during the PDR or seek support prior to the PDR. Ongoing	June 2023 Update - small increase in compliance. Compliance has improved in RGH/POW. Work to be undertaken with PCH team.
Radiology Service Review 10.1	des-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 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.	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	Now May 2023 Now August 2023 Now October 2023		In progress	August 2023 Update - Two members of staff have been assigned responsibility to review all Radiology staff core competencies as a focussed piece of work. They will liaise with learning and development. Module of the month is promoted through the Staff Newsletter, reports regularly circulated to Superintendents.	June 2023 Update. Manual handling training was cancelled by the manual handling team in May 2023. Training has been rescheduled for June 2023. Contact with Safeguarding team around Safeguarding Adults Level 3 competency and relevance to Radiology Staff.
Radiology Service Review 10.2	des-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	Ongoing Now October 2023		In progress	August 2023 Update - Two members of staff have been assigned responsibility to review all Radiology staff core competencies as a focussed piece of work. They will liaise with learning and development. Module of the month is promoted through the Staff Newsletter, reports regularly circulated to Superintendents.	June 2023 - No update received against this recommendation for the June submission
Medical Variable Pay 1.1	feb-23	Limited	1.1a A review of the Medical Variable Pay Financial Control Procedure and the Medical Agency Locums Standard Operating Procedure should be undertaken. From considering the findings from the audit report and reviewing current processes, both documents should be updated to reflect the processes and controls that staff should be adhering to when engaging medical agency staff. 1.1b Updated copies of the updated FCP and SOP should be accessible to all staff and staff should be made aware of their existence. 1.1c Consideration should be given to providing training to relevant staff to raise awareness of the FCP and SOP and ensure staff are clear on the correct processes to be followed.	High	1.1a The Financial Control Procedure (FCP) and Standard Operating Procedure (SOP) will be reviewed immediately and updated in line with recommendations within this report. They will then go through a ratification process to ensure this is also compliant with the Health Board's scheme of delegation and in place policy and procedures. Both the FCP and SOP were due to be reviewed at the start of this audit, however this was delayed to ensure the recommendations contained in this audit could be incorporated into both documents. The June target date is used as the FCP will have to go through a ratification process. 1.1b Both the FCP and SOP will be hosted on the agency intranet page, also available from the People Directorate on request and issued by Retinue to current users. Every time a new area is added to the system, all staff with access to book agency workers will be issued with the documents, along with training on how to use the system. 1.1c All areas using the agency booking system will be provided with refresher training. A training plan will be developed and provided to all existing users, once the new FCP and SOP are in place. A record will be kept of what areas have had this training and when	Medical Director	Assistant Medical Director/Head of Workforce Productivity & E-Systems	1.1a and 1.1b June 2023 1.1c August 2023	Now October 2023		In progress	July 2023 update - FCP agreed, now awaiting Executive Leadership Group sign off for rate card	June 2023 update - Awaiting FCP changes from finance colleagues
Medical Variable Pay 3.1	feb-23	Limited	3.1a The process for authorising payments that exceed the WG cap rates should be reviewed, with suitable authorisation taking place to approve higher value payments. 3.1b The FCP and SOP should be updated to reflect the correct process to be followed and should provide greater clarity on the cost elements that need to be included when determining if a rate exceeds guidance rates. There should be consistent use of terminology across the FCP, SOP and Retinue system.	High	3.1a The process for payments exceeding the WG cap rates will be fully reviewed as part of the development of the new FCP and SOP. The recommendations of this audit will be incorporated into the FCP and SOP. 3.1b The new FCP and SOP will fully address and unify the inconsistent terminology used currently, to reduce any confusion going forwards. The documents will also clearly set out the authorisation process required for rates that exceed WG cap rates. The process for requesting above WG cap rates will also be included in the refresher training to all areas using agency workers.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & E-Systems	jun-23	Now October 2023		In progress	July 2023 update - FCP agreed, now awaiting Executive Leadership Group sign off for rate card	June 2023 update - Awaiting FCP changes from finance colleagues
Medical Variable Pay 3.2	feb-23	Limited	Approval of higher rate payments should be retained in a suitable format that allows future reference if needed.	High	All authorisation of higher rates payments will be recorded fully and provided on request. The way this is captured and accessible for audit will be included in the FCP and SOP for future reference.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & E-Systems	jun-23	Now October 2023		In progress	July 2023 update - FCP agreed, now awaiting Executive Leadership Group sign off for rate card	June 2023 update - Awaiting FCP changes from finance colleagues

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Medical Variable Pay 4.1	feb-23	Limited	It should be ensured that suitable processes are in place and adhered for engaging agency staff on a longer-term basis, or for extending any placements thus making them longer term. Prior to authorising longer-term placements, it should be confirmed that recent efforts to recruit into the post have been made and that plans for future recruitment attempts are in place, to prevent ongoing reliance on the agency locum. Where there is a need to extend existing placements, it should be ensured that a review of the current post holder and any alternative agency staff is carried out to ensure the Health Board is achieving value for money and the best fit person is used.	High	The recommendations of this action will be included in the FCP and SOP. Setting out a clear process for extending agency workers placements, that ensure the recommended considerations are taken and recorded, before offering an extension. Training will be provided to all areas on how and when this process is to be used, to ensure the Health Board gets the correct balance between value for money and the correct person for the role.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & E-Systems	aug-23			Completed	July 2023 update - DE policy is now in place in Care Groups	June 2023 update - Direct Engagement report written. Medical Workforce Manager to review and discuss at Medical Workforce Productivity Programme meeting.
Medical Variable Pay 6.1	feb-23	Limited	6.1a The process for seeking CSG Manager approval to use agency staff to cover roster gaps should be reviewed to ensure that agency use is appropriate. 6.1b The FCP and SOP should be updated to reflect the correct process to be followed.	High	6.1a A process for authorisation will be clearly defined and communicated via the new FCP and SOP. How to undertake this process and ensure authorisation is gained, will be incorporated into the training provided to all areas using agency staff. 6.1b The recommendations and subsequent processes developed will be included in the FCP and SOP.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & E-Systems	aug-23	Now October 2023		In progress	July 2023 update - FCP agreed, now awaiting Executive Leadership Group sign off for rate card	June 2023 update - As per new FCP. Awaiting FCP changes from finance colleagues
Reasonable Offer Process 4.1	apr-23	Limited	Training in relation to application of waiting time adjustments should be provided to all booking staff to ensure they are fully aware of and complying with the relevant RTT rules.	High	An audit of the `all users with WPAS compliance' report to take place and training arranged for identified staff	Chief Operating Officer	Director of Operations Planned Care & Head of Clinical Administration Transformation	aug-23	Now December 2023		In progress	August 2023 Update - Training is available to all staff from the PAS team and RTT manager with recent training sessions held with speciality staff in POW. Online training material available to all staff via SharePoint.	June 2023 Update - audit very recent, target date remains August 2023.
Reasonable Offer Process 5.1	apr-23	Limited	A review of the approach to data validation to ensure compliance with the Waiting List Management SOP and RTT rules should be undertaken. A pro-active, consistent and independent approach should be adopted regardless of whether the booking has been made by a central booking team or the speciality themselves. The Waiting List Management SOP should be updated to reflect the validation process. Ongoing data validation work should be used to identify trends in errors to allow training to be targeted on certain aspects of the process or to certain teams / specialities. Where there are persistent errors in specialities consideration should be given as to whether it is appropriate for that service to retain managing its own bookings, or if the process should revert to one of the central booking teams.	High	5.1.1 - Identification of WPAS reports to allow for identification of compliance. 5.1.2 - Development of process to escalate where processes are not being followed consistently, sharing training documents/ SOP to support improvements	Chief Operating Officer	Director of Operations Planned Care & Head of Clinical Administration Transformation	July 2023 August 2023	Now December 2023		In progress	August 2023 Update - 5.1.1 identification of compliance reports have not yet been identified as RTT rules are numerous and reporting on individuals and their application of the rules is complex. 5.1.2 Where examples of non RTT compliance are identified (recent example of patients ROTT process) these are escalated through the CSG management functions for action and training needs assessments.	June 2023 Update - audit very recent, target date remains August 2023.
SLA Arrangements 1.0	jun-23	Limited	To aid the Health Board in achieving more efficient use of resources, a consistent approach for entering into SLA agreements should be adopted. Guidance should be in place to provide clarity on the roles and responsibilities of the central commissioning team in supporting service managers when SLAs are set up. The development of procedures, guidance and templates should be completed, approved and made available to all staff. Communication with staff should take place, to ensure staff are aware of the Health Board's desired approach and prevent the use of localised procedures and approaches that may not comply with the Scheme of Delegation or allow value for money to be achieved.	High	A project team has been set up to develop the guidance required for development of SLAs. This includes Strategy and Transformation, Finance (Commissioning) leads and will include Procurement and Care Group representatives as the work progresses. This group will: • Develop guidance for the development of SLAs. • Provide templates for SLAs and service specifications. • Ensure all SLAs currently in place are recorded on the register of agreements and have Strategy, Commissioning and Care Group (service) leads. This guidance will be supported by a clear structure of governance supported by meetings with each Care Group to manage and monitor SLAs. Progress already made includes: • A checklist for the development and changes to SLAs has been drafted. • A revised SLA template is being tested for a current SLA development	Director of Strategy & Transformation	Assistant Director of Transformation and project team	sep-23				August 2023 Update - no update has been provided on this occasion	
SLA Arrangements 2.0	jun-23	Limited	Data in the register of agreements should be checked to confirm its accuracy and completeness. • Once the current completeness and accuracy of the register of agreements has been confirmed, procedures will need to be put in place to ensure that changes are promptly notified so that it remains accurate and up to date. • The register of agreements should be checked before setting up an SLA agreement with a provider to ensure that multiple SLAs are not set up with the same provider for the same service and that no issues have been identified which would suggest that setting up the SLA agreement should not proceed. The columns for end date and review date in the register of agreements should be regularly used to identify when periodic reviews are due and whether they have been completed on schedule.	High	The register of agreements will be reviewed by a process of sharing with all corporate and service (Care Groups) teams for review and supported by a structure of meetings between the Strategy and Transformation Team (Commissioning leads) and the Care Groups to manage and monitor SLAs. All third sector SLAs have been reviewed and the register will be updated to reflect the latest status.	Director of Strategy & Transformation	Assistant Director of Transformation supported by the Commissioning Manager and Planning Assistant	aug-23				August 2023 Update - no update has been provided on this occasion	

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SLA Arrangements 5.0	jun-23	Limited	Adequate data should be obtained in line with SLA requirements to allow effective performance, quality and financial monitoring of the SLA to take place. The supporting data should be provided in sufficient time before SLA reviews are scheduled to occur so that it can be properly considered at the review. Evidence and supporting data should be retained of the SLA review process.	High	Please refer to action four above, which confirms that information requirements and review frequency will be determined with Care Groups. The capacity of the Strategy and Transformation team's commissioning function has been a limiting factor in the robust development of processes. A Commissioning Support Officer vacancy is being considered by the organisation's scrutiny panel. This post will lead on organisation of the administration of the register of agreements and the meetings with Care Groups. A Head of Commissioning job description has been developed and has been sent for Agenda for Change banding. This post will be recruited to on a fixed-term basis while the Head of Planning post is vacant due to secondment. Should this role provide successful, every effort will be made to structure the team to retain this function, however this will be dependent upon the team budget.	Director of Strategy & Transformation	Assistant Director of Transformation and Commissioning Manager	sep-23				August 2023 Update - no update has been provided on this occasion	
Concerns 1.1	feb-22	Limited+C29: D29	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		Director of Nursing	Interim Head of Concerns, Redress & Legal	jun-22	Now September 2022 Now January 2023 Now February 2023 Now May 2023 Now July 2023		Completed	August 2023 Update - Recommendation superseded by Follow Up Review. Propose to close. New audit by Internal Audit along with action plan presented at Q&S in July 2023	June 2023 Update: The overarching Concerns policy has been drafted and following consultation will be presented to the Q&SC (July 2023) for approval.
Fire Safety Management 2.1	feb-22	Limited	Local procedures will be reviewed and updated within specified review periods - and associated uniform approval arrangements applied.	Medium	Agreed A review is in progress to align and standardise procedures.	Director for People	Head of Health, Safety & Fire	mar-22	jun-24		In progress	August 2023 Update - Due to staff absence it has not been possible to obtain an update for this submission	June 2023 - No update received against this recommendation for the June submission
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	Now June 2023		In progress	August 2023 Update - Due to staff absence it has not been possible to obtain an update for this submission	June 2023 - No update received against this recommendation for the June submission
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 Now June 2023 Now October 2023		In progress	August 2023 Update - limited progress has taken place. There will be a further update at the next meeting.	June 2023 update - work continues. Meeting planned with Audit and the Care Group in June 2023.
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 Now June 2023 Now March 2024		In progress	August 2023 Update - Once the business case is approved, updated contracts will be required for the SCP, Project Manager and Supervisor - all governed by Designed for Life principles. Also a contract for the Cost advisor will be required. It is anticipated that these will be standard Stage 4 construction contracts and therefore can be issued and signed immediately. Until this point the current bespoke contract arrangements remain in place. In terms of timing, the case remains under strategic review for discussion at the Project Board. Once a preferred option is internally approved this can be discussed with WG and the business case work recommenced. It is anticipated that a business case will be at least 16 weeks in development as costs must be tendered and therefore unlikely to be completed until at least February 2024. It is hoped that this will have a swift approval and turnaround by WG	June 2023 Update - Still in progress pending confirmation of the approved decant way forward as outlined in point 1.1

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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 Now June 2023 Now March 2024		In progress	August 2023 Update - Project remains under strategic review - options to be discussed at Project Board which is being scheduled for the end of August/beginning of September, once this has happened this can be discussed with WG. Currently there are no contracts to enter it, this recommendation is noted as a future requirement when the construction phase becomes live and contracts are entered into. As this is a D&L scheme then most contracts are prescribed under that framework, including Project manager so this would only refer to contracting for a cost advisor for the balance of the scheme which will be undertaken once the business case is approved.	June 2023 Update - Once the decant solution has been agreed and approved by WG the SCP can be re-engaged to develop the business case. The contract may require review depending on the preferred solution
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 Now June 2023 Now March 2024		In progress	August 2023 Update - As mentioned above the cost advisor in post is contracted until Business case approval. A planned competitive process is planned for the stage of business case scrutiny to let the contract for the cost advisor without delay once the business case is approved	June 2023 Update - Once the decant option is confirmed the arrangements around appointing the cost advisor for the final construction stage can be confirmed to ensure value for money
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 Now June 2023 Now March 2024		In progress	August 2023 Update - This links into the response and timeline for the above and will be addressed when the contract falls to be renewed with a competitive process.	June 2023 Update - please see point above that this will be addressed in conjunction with point 4.2
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 Now September 2023		In progress	August 2023 Update - As mentioned above post an agreed strategic review and way forward with WG, the SCP and PM will be re-engaged and the formal performance review mechanisms will be re-enacted under the contract	June 2023 Update - As agreed as soon as project recommences and the SCP is re-engaged
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 Now June 2023 Now September 2023		In progress	August 2023 Update - Formal cost reporting templates have been developed and agreed for utilisation upon commencement of work by the SCP and PM. These will be formally reported at Project Board as well as reported via ECMG in terms of in year CRL performance and risks to the total capital allocation.	June 2023 Update - Agreed, once the decant solution is confirmed and the SCP re-engaged, standard cost reporting and forecasting will commence and templates are developed in readiness for this
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 Now June 2023 Now October - December 2023		In progress	August 2023 Update - The business case process will ensure value for money - once recommenced this will be an integral part of the case once the preferred option is developed for the single stage business case	June 2023 Update - Agreed, to be reviewed once the decant option is selected

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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 Now June 2023 Now September 2023		In progress	August 2023 Update - As above this will be developed in a risk workshop once the preferred option is confirmed both internally and with WG for the single business case	June 2023 Update - This will be developed once the preferred decant solution is agreed with WG. Paper currently under strategic review
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 Now June 2023		In progress	August 2023 Update - no update has been provided on this occasion	June 2023 Update - Actions as above as this cannot be actioned until works recommence.
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 Now June 2023 Now September 2023		In progress	August 2023 Update - As detailed above, this will be undertaken on re-commencement of the project in conjunction with the review and update of the risk register	June 2023 Update - will be undertaken on re-commencement of the project in conjunction with the review and update of the risk register
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 Now June 2023 Now September 2023		In progress	August 2023 Update - As detailed above, this will be undertaken on re-commencement of the project in conjunction with the review and update of the risk register	June 2023 Update - as above in line with the re-commencement of the project and review of the register
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	August 2023 Update - This recommendation is on track for completion by Quarter 2 2023/2024	June 2023 Update: New Strategic Leadership roles are in process of being recruited to. £2m allocated to digital. This is now being proportioned to cover all critical resource needs. Compliance roles (IG & Cyber) have been prioritised.
Radiology Service Review 6.2	des-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 Now May 2023 Now August 2023		Completed	August 2023 Update - Two members of staff have been assigned responsibility to review all Radiology staff core competencies as a focussed piece of work. They will liaise with learning and development. Module of the month is promoted through the Staff Newsletter. Reports are regularly circulated to Superintendents.	June 2023 Update - RGH training delivered to five staff, three outstanding. Coordination of dates challenging with clinical responsibilities.

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Radiology Service Review 6.3	des-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 Now May 2023 Now August 2023		Completed	August 2023 Update - SOP now rolled out across all sites. SOP finalised 06/07/23. Complete.	June 2023 Update - work has commenced in POW. All new staff have an E Personnel Folder and work is underway scanning legacy information on to the shared drive.
Radiology Service Review 8.1	des-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 Now May 2023 Now August 2023		Completed	August 2023 - SOP developed on management of TOIL for the Radiology department. Clarity has now been provided to all Superintendents. TOIL is currently managed via the Health Roster and paper format in Bridgend until the team are transferred on to the Health Roster.	June 2023 Update - Local Radiology Policy to be drafted and ratified.
Medical Variable Pay 2.1	feb-23	Limited	2.1a The process for using non-direct engaged medical locums should be reviewed to ensure suitable controls, scrutiny, challenge and authorisation is in place going forward. 2.1b The FCP and SOP should be updated to reflect the correct process to be followed, and staff should be made aware of the correct processes and the additional cost implications of using non-direct engaged staff.	Medium	2.1a The process around non-direct engagement booking will be fully reviewed. Any identified shortcomings, along with the recommendations of this audit, will be rectified and added to the SOP and FCP. 2.1b Staff will be provided with the new FCP and SOP. They will also be provided with training on how to apply these to this particular part of the audit. The training will be recorded centrally, to ensure every area using the system is up to date with their responsibilities relating to it. Part of this training will be conveying the importance of direct engagement (DE) bookings and the financial benefit to the Health Board.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & E-Systems	jun-23	Now August 2023		In progress	July 2023 update - DE document written and shared with Care Groups	June 2023 Update - DE policy written demonstrates a clear escalation policy in place for care groups. For discussion at Medical Workforce Productivity Programme meeting.
Medical Variable Pay 2.2	feb-23	Limited	The Health Board should resume previous work undertaken with Retinue to encourage agency locums to switch to being directly engaged.	Medium	All current agency workers being used by the organisation will be reviewed for their DE status. Any that are not being engaged through DE will be approached to switch. Retinue will be required to offer up DE candidates in the first instance if available, as well as encourage non-DE agency workers seeking to work in Cwm Taf Morgannwg to switch to DE. This will become a constant process of analysis and identification of non-DE workers in the Health board, which will allow the organisation to target and reduce DE use.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & E-Systems	jun-23	Now August 2023		In progress	July 2023 update - DE document written and shared with Care Groups	June 2023 Update - DE policy written demonstrates a clear escalation policy in place for care groups. For discussion at Medical Workforce Productivity Programme meeting.
Medical Variable Pay 5.1	feb-23	Limited	Following the implementation of any actions arising from the Medical Productivity Board, the future reporting and monitoring requirements, in relation to medical variable pay, should be agreed and the FCP updated accordingly.	Medium	Finance currently provide comprehensive reports to the Care Groups detailing medical spend. This reporting will continue to happen and any additional requirements recommended by the Medical Productivity Board (MPB) will be added to this financial dataset. The FCP will be updated to reflect the recommendations from the MPB as soon as they are communicated.	Medical Director	Assistant Director of Finance/ Assistant Medical Director/Head of Workforce Productivity & E-Systems	jun-23	Now October 2023		In progress	July 2023 update - Plan to discuss breaches at Medical Productivity Board. FCP has been updated but awaiting rate card approval at Executive Leadership Group	June 2023 - DE policy written demonstrates a clear escalation policy in place for care groups. For discussion at Medical Workforce Productivity Programme meeting.
Reasonable Offer Process 1.1	apr-23	Limited	As we continue to move away from a pandemic environment, the Health Board should review its approach to the provision of reasonable appointment offers and the subsequent management of waiting lists, in light of any additional WG guidance issued during the course of the pandemic. The Waiting List Management Standard Operating Procedure should be reviewed, updated and appropriately approved. Previous versions of the Waiting List Management Standard Operating Procedure should be removed from the Health Board's intranet site and only the current version published.	Medium	Standard Operating Procedures to be reviewed and updated with approval at OMB and Executive Leadership Group. Once approved, the SOP will be published and issued to all booking teams. Previous versions of the SOP will be removed from the intranet and kept in a historical record.	Chief Operating Officer	Director of Operations Planned Care/Head of Clinical Administration Transformation	End April 2023	Now August 2023 Now October 2023		In progress	August 2023 Update - WL SOP previous version has been requested to be removed via E Business Team. Awaiting outcome of OMB decision.	June 2023 - audit very recent, target date now August 2023.

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Reasonable Offer Process 2.1	apr-23	Limited	We recommend that the Health Board review and revise the training arrangements in place for appointment booking staff in the Bridgend booking team and those that are working directly within specialities, to ensure that they have consistent training, with access to the same level of support and training currently being provided to the booking team based in Merthyr/Rhondda.	Medium	A review of the booking process in Bridgend will be carried out and a training compliance plan for Bridgend developed.	Chief Operating Officer	Head of Clinical Administration Transformation	End April 2023	Now August 2023 Now October 2023		In progress	August 2023 Update - There are a mix of direct and partial booking being utilised across the site with more direct booking due to the nature of patient referrals, Urgent/ USC. Not all services are booked from within core team and the services outside of main function have been identified to ensure consistent access to training material when approved. Weekly stakeholder meeting established with SME from Information and operational booking managers to review current training materials and implementation of audit recommendations	June 2023 - audit very recent, target date now August 2023.
Reasonable Offer Process 2.3	apr-23	Limited	Consideration should be given to the current approach of having some bookings managed centrally and some managed within specialities, to ensure that the chosen approach does not place the Health Board at greater risk of having inconsistent approaches, errors in application of the RTT rules and over-reliance on key individuals. (We acknowledged that instigating data validation checks will need to take place first to allow relevant information to be available on non-conformance.)	Medium	A review of the structures in Bridgend will take place. A plan for an organisational restructure with a standardised approach will be developed.	Chief Operating Officer	Director of Operations Planned Care/Head of Clinical Administration Transformation	End June 2023	Now August 2023 Now October 2023		In progress	August 2023 Update - Future consideration following organisational change through summer 23/autumn 2023	June 2023 - audit very recent, target date now August 2023.
Reasonable Offer Process 3.1	apr-23	Limited	The Health Board should perform a training needs assessment of staff responsible for booking appointments and arrange for refresher training on the application of the Waiting List Management SOP/RTT rules, specifically in relation to reasonable offers and the required audit trail within WPAS.	Medium	A training needs assessment and compliance sign off will take place post implementation of the agreed SOP. Refresher training to be organised where required for staff identified.	Chief Operating Officer	CSGMs & for all operational/booking team managers/Head of Clinical Administration Transformation	aug-23	Now October 2023		In progress	August 2023 Update - An update will be available when the status of the SOP has been confirmed.	June 2023 - audit very recent, date remains August 2023.
SLA Arrangements 3.0	jun-23	Limited	When SLAs are agreed the documentation should be completed to include the details of the lead contact for the Health Board. SLAs should be signed on behalf of the Health Board as the commissioning body and by the provider before the start of the period to which it applies to confirm agreement with its terms and conditions.	Medium	The guidance to be developed, as described in the response to action one will include clarity on processes for signing and storing of agreements.	Director of Strategy & Transformation	Assistant Director of Transformation and project team	sep-23				August 2023 Update - no update has been provided on this occasion	
SLA Arrangements 4.0	jun-23	Limited	SLAs should be reviewed in line with timeframes set out within them and the spreadsheet register kept up to date with renewal dates.	Medium	The meetings to be initiated with Care Groups as described in the actions above and the updating of the register of agreements will include the required performance information for each agreement and frequency of reporting, with the officers responsible for review to be identified.	Director of Strategy & Transformation	Assistant Director of Transformation and Commissioning Manager	sep-23				August 2023 Update - no update has been provided on this occasion	
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 Now September 2023		In progress	August 2023 Update - This will be included in the business case scheduled for completion over the autumn once the preferred option is defined	June 2023 Update - see above, this will be addressed on scheme re-commencement as part of the business case process.

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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 Now June 2023 Now September 2023		In progress	August 2023 Update - as previously noted this will be undertaken once the options paper is approved at executive level	June 2023 Update - as previously noted this will be undertaken once the options paper is approved at executive level
Reasonable Offer Process 2.2	apr-23	Limited	Further consideration be given to the sharing of training materials, checklists and guidance between Merthyr/Rhondda and Bridgend staff.	Low	In line with 2.1, checklist and guidance will be standardised.	Chief Operating Officer	Head of Clinical Administration Transformation	End April 2023	Now August 2023 Now October 2023		In progress	August 2023 Update - All material has recently been reviewed and updated with this being made available on SharePoint to all staff. This has also been communicated via RTT meetings.	June 2023 - audit very recent, target date now August 2023.
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 Now June 2023 Now December 2023		In progress	August 2023 Update - position remains unchanged while being reviewed by Care Group.	June 2023 - position remains unchanged, new Service Group Manager started in post very recently.
Overtime & Additional Hours 5.0	mai-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 Now August 2023		In progress	August 2023. - The Overtime Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.	June 2023 Update - The Overtime Policy has been consulted on and comments and amendments noted, actioned as appropriate. The revised version will follow the ratification process and be presented to the People and Culture Committee in August 2023 for approval.
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 Now September 2023 Now End of March 2024		In progress	August 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, Completion by Sept 2023. 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 local monthly P2P CTM group, plan in place and being monitored monthly. CTM already undertaking focused P2P training, Facilities and Estates completed, identifying further areas as part of No PO review (Top 3 monthly with systems). What does good Procurement session held with Care groups within Operational Management board 12th July 2023. Further lunch and learn sessions being scheduled from Sept 2023 as part of Procurement Engagement plan to target Non compliant areas.	June 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, Completion by Sept 2023. 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 local monthly P2P CTM group, plan in place and being monitored monthly. 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 from June 2023 as part of Procurement Engagement plan to target Non compliant areas.
Radiology Service Review 3.1	des-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	Now August 2023 Now October 2023		In progress	August 2023 Update - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager to manage this work stream. A management structure including support for the governance role has been submitted to the Executive Board for approval.	June 2023 - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager to manage this work stream. A management structure including the governance role has been submitted to the executive board for approval.

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Radiology Service Review 12.1	des-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	Now August 2023 Now December 2023		In progress	August 2023 Update - Second Phase of planning ongoing and will not be operational until August 2023. HEIW will be supporting the workforce planning going forward to inform next IMTP.	June 2023 - Second Phase of planning ongoing and will not be operational until August 2023.
Welsh Risk Pool 2.1	jun-23	Reasonable	Management should ensure that required documentation is submitted to the WRP within the specified timeframes, appropriately recorded on Datix Cymru, and monitoring takes place to ensure compliance with this requirement.	High	In respect of LFER's a new process and SOP is being drafted to ensure timely submission of LFER's. In respect of CMR's there is a process that currently picks up on upcoming CMR's. The process around monitoring CMR's will be solidified by the new dashboard which will allow a more robust monitoring process. Individuals who have missed deadlines will be reminded of importance of CMR deadlines and provided with additional training & support.	Director of Nursing	Head of Claims & Inquest	jun-23	Now September 2023		In progress	August 2023 Update Standard Operating Procedure for LFERs drafted. Whilst escalation is taking place this needs formalising to ensure a consistent approach. SOP is out for consultation and will be ratified imminently. CMRs and LFERs are already monitored via the weekly reporting process. Further development of dashboard will ensure that appropriate staff have easy access to this data. Dashboard development forms part of the work plan for Business Intelligence Team, which is well underway. Staff remained of work deadlines and prioritisation. Heads of Quality & Safety meet regularly with the Legal and Claims team to review progress against outstanding and deferred LFERs.	
Bridgend Transfer of Informatics Services Follow Up 1.1	apr-23	Reasonable	Consideration should be given to requesting that services fully quantify the impact of the lack of integration on the delivery of services and service change, with monitoring with reporting at an appropriate committee.	High	Bridgend disaggregation is reported to every Digital & Data Committee. This reporting will be reviewed to ensure it covers integration, service delivery and service change. The programme is currently developing a template which will assess the impact of any of the repatriation. The template is planned to be completed by June 2023.	Director of Digital	Director of Digital / Assistant Director of ICT	Qtr. 2 2023/2024			In progress	August 2023 Update - This recommendation is on track for completion by Quarter 2 2023/2024	June 2023 Update: Issue raised at Joint Management Group and escalated to Joint Executive Group. Action Ongoing.
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	August 2023 Update - no update has been provided on this occasion	June 2023 Update – the current RF-ID tracking system migration is currently in progress by Clinical Engineering, Kinsetsu and UHB ICT, this work is continuing with various information being sanitised and updated for new server which has been installed. ICT infrastructure issues are still restricting/expanding use of system in POW, until the specified SBUHB de-segregation work is completed and fully tested, this will remain an issue (for a number of cross UHB medical device linked projects). Phase 1 of ICT de-segregation is completed with phase 2 and 3 to be completed in next couple of months. Pharmacy are on board with expanding use of system as soon as migration and infrastructure work is completed as there are financial benefits in ability to track CD size cylinders due to the rental costs and lost cylinder charges applicable. Deputy Head Of Clinical Engineering has formulated a bid to expand use of the passive system to support Pharmacy and also by use of new active tag technology exploring costs and infrastructure requirements for active tags which reduce the quantity of passive aerials required for medical equipment tracking as they can in part use existing Wi-Fi infrastructure in place with reduced modification costs where needed. Costs will have to be funded via capital, however we are working with CTM innovation/R & D department to investigate possible technology funding sources. Due capital constraints and how funds are prioritised, any further development will be on hold until funding can be secured. Due to the above a target date remains 31/07/23 .
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 Now June 2023		Part Completed	August 2023 Update - no update has been provided on this occasion	June 2023 - position remains unchanged, new Service Group Manager started in post very recently.
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 Now 31 October 2023		Completed	August 2023 Update - COMPLETE Propose to close. A Risk Management Training Needs Analysis has been developed and approved by Executive Leadership Group on the 17th July 2023. This provides an overview of options for staff in terms of training on the risk management strategy within the Health Board and the use of Datix. It is acknowledged that the TNA will require review once the OFW Risk Module is in place but as of yet the implementation date is not known and therefore this interim approach has been adopted.	June 2023 Update - This recommendation is paused as the Health Board continues to wait the implementation of the new OFW Risk Module on Datix to ensure that the Training Needs Analysis aligns with the new system and process. The implementation date continues to be undetermined. The OFW Team Senior Management and Datix Senior Management are meeting w/e 19th May to discuss options with a further meeting of the All Wales OFW Task and Finish Group meeting after that to consider the next steps. A more detailed update should be available at the next meeting.
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		Completed	August 2023 Update - Revised FCP brought to August Committee for review and approval	June 2023 Update - no further update to provide in relation to this recommendation

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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 Now July 2023 Now September 2023		In progress	August 2023 Update - As per the June update, the Tender process has concluded with only one return and the tender evaluation report is expected imminently. Once received this will need to form the basis of an updated Full Business Case to be submitted to WG by September. Once this is approved, the contract can be entered into and the PEP updated for this information	June 2023 Update - The tender process remains ongoing and therefore the PEP can not be continued until a contractor appointment is confirmed and funded. This will not be known until Late July early August 2023 once returns have been submitted and analysed. Once this occurs an application will be made to WG for funding. Once the funding is confirmed as approved a PEP can be presented to Project Board
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 Now July 2023 Now September 2023		In progress	August 2023 Update - As noted above, the tender has just closed and the report is awaited. Once received and the business case completed this level of reporting and oversight can commence.	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed
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 Now July 2023 Now December 2023		In progress	August 2023 Update - The re-commencement of actual works is likely to not take place before the winter due to the need for an updated business case and WG approval process	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed
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 Review July 2023 but could be later depending on timings of approvals Now November 2023		In progress	August 2023 Update - Once the contract can be let then this will be made available to the HB but due to the need for a revised business case this is not expected to be until the end of the year	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed
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 Now September 2023 Now November 2023		In progress	August 2023 Update - As mentioned above this can not be made available until the contract for the construction is let and this is agreed with the new contractor	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed
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 Now September 2023 Now November 2023		In progress	August 2023 Update - As above, this will be raised with the new contractor once appointed	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed
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 Now September 2023		In progress	August 2023 Update - This will be updated on submission of the revised FBC and then will be subject to monthly review and updates therefore in conjunction with the main contractor once appointed	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed
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 Now September 2023		In progress	August 2023 Update - As noted above, this can not be applied until the contractor is appointed	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed
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 Now September 2023		In progress	August 2023 Update - As above, with the need for a revised business case this wont be until later in the year once a formal appointment can take place	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed

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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 Now October 2023		In progress	August 2023 Update - Once the development timeline is known, and costs are understood these discussions can be refreshed with the primary care contractors and negotiations and drafting undertaken	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed
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 Now September 2023		In progress	August 2023 Update - This remains Ongoing	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed
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 Now July 2023 Now September 2023		In progress	August 2023 Update - This will be refreshed for the revised FBC	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed
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 Now July 2023 Now September 2023		In progress	August 2023 Update - As noted above, to form part of the revised FBC	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed
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	mai-22	Now August 2022 Now October 2022 Now December 2022 Now April 2023 Now June 2023		In progress	August 2023 Update - no update has been provided on this occasion	June 2023 Update - Finance element not completed, will be chased for the next update.
Overtime & Additional Hours 1.1b	mai-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 Now August 2023		In progress	August 2023. - The Overtime Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.	June 2023 Update - The Overtime Policy has been consulted on and comments and amendments noted, actioned as appropriate. The revised version will follow the ratification process and be presented to the People and Culture Committee in August 2023 for approval.
Overtime & Additional Hours 1.2	mai-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 Now August 2023		In progress	August 2023. - The Overtime Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.	June 2023 Update - The Overtime Policy has been consulted on and comments and amendments noted, actioned as appropriate. The revised version will follow the ratification process and be presented to the People and Culture Committee in August 2023 for approval.
Overtime & Additional Hours 2.1	mai-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 Now August 2023		In progress	August 2023. - The Overtime Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.	June 2023 Update - The Overtime Policy has been consulted on and comments and amendments noted, actioned as appropriate. The revised version will follow the ratification process and be presented to the People and Culture Committee in August 2023 for approval.

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Overtime & Additional Hours 2.2	mai-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 Now August 2023		In progress	August 2023. - The Overtime Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.	June 2023 Update - The Overtime Policy has been consulted on and comments and amendments noted, actioned as appropriate. The revised version will follow the ratification process and be presented to the People and Culture Committee in August 2023 for approval.
Overtime & Additional Hours 3.0	mai-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 Now August 2023		In progress	August 2023. - The Overtime Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.	June 2023 Update - The Overtime Policy has been consulted on and comments and amendments noted, actioned as appropriate. The revised version will follow the ratification process and be presented to the People and Culture Committee in August 2023 for approval.
Overtime & Additional Hours 4.0	mai-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 Now August 2023		In progress	August 2023. - The Overtime Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.	June 2023 Update - The Overtime Policy has been consulted on and comments and amendments noted, actioned as appropriate. The revised version will follow the ratification process and be presented to the People and Culture Committee in August 2023 for approval.
Consultant Job Planning Follow Up 5.1	mai-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	des-22	Now April 2023 Now August 2023 Now October 2023		In progress	August 2023 - Although not formally confirmed yet, it seems that there will not be an all Wales rate card issued in the near future. Therefore, a proposal for a CTM rate card will be presented to Executive team in August 2023 with a proposed October 2023 implementation date.	June 2023 Update - Although not formally confirmed yet, it seems that there will not be an all Wales rate card issued in the near future. Therefore, a proposal for a CTM rate card will be presented to Executive team in June 2023 with a proposed summer launch date.
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 Now May 2023 Now July 2023 Now September 2023		In progress	August 2023 Update Staff were reminded of the importance of completing all required fields in Datix Cymru during the weekly team meeting. All Claims Investigation Officers have been asked to ensure the Datix Cymru Record is up to date when reviewing their cases. A draft checklist has been developed outlining the current stages and requirements for closing records. This needs to be tested on Datix Cymru. A SOP to support the training has been developed, further guidance regarding stages is in the process of being completed. Monthly audits will commence when guidance and training has been completed. An audit tool is being drafted. Baseline validation exercise of open claims currently being undertaken. Feedback being provided to the Claims Team Manager.	July 2023 Update: The overarching Concerns policy has been drafted and following consultation will be presented to the Q&S Committee in July 2023 for approval. LFER Improvement plan is ongoing, with a trajectory to reduce deferred LFERS. Dashboards to be implemented to allow live monitoring of LFERs The SOPs in respect of LFERs (including new escalation process) have been drafted and are to be agreed before presenting to the Q&S Committee for approval.
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	des-22	Now January 2023 Now February 2023 Now May 2023 Now July 2023 Now September 2023		In progress	August 2023 Update - Standard Operating Procedure for LFERs drafted. Whilst escalation is taking place this needs formalising to ensure a consistent approach. SOP is out for consultation and will be ratified imminently. CMRs and LFERs are already monitored via the weekly reporting process. Further development of dashboard will ensure that appropriate staff have easy access to this data. Dashboard development forms part of the work plan for Business Intelligence Team, which is well underway. Staff remained of work deadlines and prioritisation. Heads of Quality & Safety meet regularly with the Legal and Claims team to review progress against outstanding and deferred LFERs.	June 2023 Update: The Legal services SOP for managing Claims and Redress has been drafted and following consultation will be presented to the Q&S Committee (July 2023) for approval. This includes the operating procedures in relation to financial limits.

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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	01/09/2023 (aligned to AW T&F exemption list review)		In progress	August 2023 update - Alternative methods of payments will be reviewed as part of AW PO exemption list T&F group by Sept 2023. AW T&F group being led by Head of Corporate finance and Head of Procurement.	June 2023 update - Alternative methods of payments will be reviewed as part of AW PO exemption list T&F group by Sept 2023. AW T&F group being led by Head of Corporate finance and Head of Procurement.
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	Now September 2023		In progress	August 2023 Update - Refer to the update provided for 7.1. Retrospective review being undertaken as part of AW P2P T&F group completion Sept 2023. Further training needs are being identified through local P2P group monthly	June 2023 Update - Refer to the update provided for 7.1. Retrospective review being undertaken as part of AW P2P T&F group completion Sept 2023. Further training needs are being identified through local P2P group monthly
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	Now May 2023 Now June 2023 Now September 2023		In progress	August 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 Sept 2023. Stretched resource and increased demands on Savings engagement has delayed completion of CTM share point. NWSSP Buyers toolkit completed but awaiting sign off by NWSSP prior to implementation. On completion - communication will be cascaded through CTM finance systems updates to HB.	June 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 June 2023. Stretched resource and increased demands on Savings engagement has delayed completion of CTM share point. NWSSP Buyers toolkit completed but awaiting sign off by NWSSP prior to implementation. On completion - communication will be cascaded through CTM finance systems updates to HB.
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	des-22	Now January 2023 Now May 2023 Now September 2023		Completed	August 2023 Update - the outcome of Phase 2 of the Operating model is awaited. Following which the OCP process will commence, it is anticipated that this will be completed within 8 weeks. The completion of the OCP will allow for alignment of the actions detailed in the Quality Framework to be aligned accordingly supporting the Care Group quality and safety structure.	June 2023 Update: Care Group Q&SC are embedding within the new operating model and following phase 2 of the OCP the newly developed CSG will replicate the care group Q&SC structure
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 Now June 2023 Now September 2023		In progress	July 2023 - Delays due to ensuring formatting was correct. Now scheduled for discussion at LNC meeting scheduled to take place on Tuesday 12th September 2023	June 2023 Update - For discussion at LNC meeting scheduled to take place on 13th June 2023 for noting and implementation.

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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 Now October 2023		In progress	August 2023 Update - SOP has been signed off and an implementation plan has been developed to move files to electronic system. All therapies files are now stored electronically with the other areas being progressed in the next few months. As highlighted in the previous report, there is an agreed process around where staff paper files are held and how they can be accesses if line managers are not in work, which addresses the initial concern from the audit	June 2023 Update - SOP has been shared at CAMHS Quality, Safety and Patient Experience meeting and no comments received. It has been shared with HR colleagues and the SOP will be formally signed off at next CAMHS meeting at the end of June. Teams have been asked to develop an implementation plan for moving to the electronic records and this will be done in a phased approach. In the interim there is an agreed process around where staff files are held and how they can be accessed if staff members are not in work, which addresses the initial concern from the audit.
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	August 2023 Update - This recommendation is on track for completion by Quarter 2 2024/2025	June 2023 Update: Proposals being developed. New standardised procedure for booking patients moving across Health Board has been developed. Further work required for a comprehensive suite of procedures.
Radiology Service Review 1.1	des-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 Now April 2023 Now August 2023		Completed	August 2023 Update - Radiology Team actions complete. New meeting structure from 11/08/23 with DTPS Care Group Directors. Template has been provided for this performance meeting. Radiology issues are now reported/ escalated through the Operational Management Board Monthly or through Quality, Safety and Patient Experience meetings by the Care Group Directors.	June 2023 - Radiology Team actions complete. ToR for monthly Radiology Performance meeting to be provided by executive team.
Radiology Service Review 2.1	des-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 Now April 2023 Now August 2023 Now October 2023		In progress	August 2023 update - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager. A management structure including the governance role has been submitted to the executive board for approval. Changes to current monthly Radiology Performance meetings discussed and new structure. Executive team to update.	June 2023 - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager. A management structure including the governance role has been submitted to the executive board for approval. Changes to current monthly Radiology Performance meetings discussed and new structure. Executive team to update.
Radiology Service Review 2.2	des-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	des-22	Now March 2023 Now May 2023 Now August 2023 Now October 2023		In progress	August 2023 Update - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager to manage this work stream. A management structure including the governance role has been submitted to the executive board for review in Phase 2.	June 2023 - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager to manage this work stream. A management structure including the governance role has been submitted to the executive board for approval.

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Radiology Service Review 4.1	des-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	Now October 2023		In progress	August 2023 Update - Request made for list of Radiology staff who would need to have signed the DOI is complete. If incomplete the Care group will encourage individuals to complete asap.	June 2023 - No update received against this recommendation for the June submission
Radiology Service Review 13.1	des-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 better articulated to determine what is actually an action, with the action log for that meeting capturing the required	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 Now April 2023 Now August 2023		Completed	August 2023 Update - New performance meeting structure in place from 11/08/23 led by Care Group Directors and inviting Deputy COO- Template completed with all recommended areas covered. Also clear escalation slide included for every meeting.	June 2023 - ToR to be sought from executive team
Board Awareness of Digital	apr-23	Reasonable	Training sessions that have already been delivered at Board Development sessions should be revisited as part of the 2023 Board members training and development schedule. Board members are encouraged to proactively familiarise themselves with training topics to aid their ability to lead the digital agenda and enable digital transformation.	Medium	In partnership with the Corporate Governance team, we will ensure regular board development sessions to include topics such as Cyber, Data Visualisation and awareness of the latest digital developments.	Director of Digital	Director of Digital	des-23			In progress	August 2023 Update - This recommendation is on track for completion by December 2023	June 2023 Update: Board development sessions being planned. eWhiteboards has been added to the list alongside Digital Patient Contact. Planned for later in the year
Welsh Risk Pool 1.1	jun-23	Reasonable	1.1a Management should reiterate to staff the importance of ensuring accurate data in relation to the closure is captured in Datix for all closed cases. 1.1b Regular monitoring of the 'stages' within Datix should be carried out to ensure compliance and that no 'blanks' are being reported	Medium	1.1a Staff will be reminded of importance in next meeting in respect of closure. A check list will be developed to support staff in the completion of Datix at all stages of process. This information will included in the Standard Operating Procedures for the closing of records. A refresher training session will be provided to the Claims Team in relation to Datix Cymru by the Business Intelligence Team. A monthly audit of closed claims will be undertaken by the Business Intelligence Team. Feedback from this audit will be presented to the Health Board Datix Management and shared with the Claims Team with actions for improvement identified where required. 1.1b In addition a regular (minimum of monthly) data validation exercise and audit of open claims will be completed. Feedback from this exercise will be shared with the Claims Team and recurring issues escalated to the Senior Team.	Director of Nursing	Head of Claims & Inquest Legal services Manager Head of Concerns & Business Intelligence	jun-23	Now September 2023		In progress	August 2023 Update Staff were reminded of the importance of completing all required fields in Datix Cymru during the weekly team meeting. All Claims Investigation Officers have been asked to ensure the Datix Cymru Record is up to date when reviewing their cases. A draft checklist has been developed outlining the current stages and requirements for closing records. This need to be tested on Datix Cymru. A SOP to support the training has been developed, further guidance regarding stages is in the process of being completed. Monthly audits will commence when guidance and training has been completed. An audit tool is being drafted. Baseline validation exercise of open claims currently being undertaken. Feedback being provided to the Claims Team Manager.	
Welsh Risk Pool 1.2	jun-23	Reasonable	1.2a The 'closure' section within the SOP should be reviewed and updated with clear guidance on what the stages are for closed cases in Datix. 1.2b Consideration should be given to providing additional training to staff to ensure they understand all aspects of the process.	Medium	1.2a The relevant section of the Standard Operating Procedure will be reviewed to ensure that it clearly outlines all requirements associated with the closure of claim file, including the Datix Cymru components. 1.2b The updated Standard Operating Procedure will be shared with all staff and training will be provided at the next team day following update. This will include training on the Datix Cymru System.	Director of Nursing	Head of Claims & Inquest Legal services Manager Head of Concerns & Business Intelligence	jun-23			Completed	August 2023 Update - Review of Standard Operating Procedure completed. Joint training session were provided on the team day on 06.07.23	

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Welsh Risk Pool 2.2	jun-23	Reasonable	Management should ensure that staff are aware of accurately recording date information within Datix to allow the calculation of target dates and monitoring.	Medium	Staff will be reminded of the importance of accurately recording date information on Datix Cymru and ensuring it is reflected on documents submitted to WRP. The recording of LFER information will be included in the audit and data validation programme described in action 1.1b.	Director of Nursing	Legal services Manager Head of Concerns & Business Intelligence H	jun-23	Now September 2023		In progress	August 2023 Update Staff were reminded of the importance of completing all required fields in Datix Cymru during the weekly team meeting. All Claims Investigation Officers have been asked to ensure the Datix Cymru Record is up to date when reviewing their cases. Validation of LFER is completed as part of the production of the weekly report. A cross reference of all deferred LFERs against WRP information was completed at the beginning of July 2023. Audit programme of new, closed and ongoing claims planned for September 2023.	
Welsh Risk Pool 4.1	jun-23	Reasonable	4.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 4.1b Consideration should be given to providing additional training to staff to ensure they understand all aspects of the process.	Medium	4.1a The relevant section of the SOP will be reviewed and updated as recommended. 4.1b The updated SOP will be shared with all staff and offer of training will be provided at the next team day following update.	Director of Nursing	Head of Claims & Inquest Legal services Manager	mai-23			Completed	August 2023 Update The SOP has been revised and shared with staff. Training took place on the 10.07.23	
Concerns Follow Up Review 3.1	jun-23	Reasonable	3.1a Once the Concerns Policy and SOP have been finalised, the training needs analysis work should be completed in order to identify the training requirements across the Health Board, including refresher training for those that may have previously completed training on previous policies and processes. 3.1b A training programme should be put in place to deliver the identified concerns training requirement. 3.1c A decision should be made on the best method for capturing concerns training attendance, that allows management the ability to review and monitor attendance going forward.	Medium	3.1a Training Needs Analysis to be developed and sent to all Care Groups to identify staff which require training 3.1b Once the training needs analysis has been completed, this will inform the training programme. This will be developed and be an ongoing rolling programme for the Health Board 3.1c Discussions to be held with Learning and Development to ascertain the best method to capture this training on an ongoing basis.	Director of Nursing	Head of Concerns & Business Intelligence	3.1a August 2023 3.1b October 2023 3.1c October 2023			In progress	August 2023 Update -A training needs analysis is currently being undertaken. The Internal Audit for Complaints and Incident Management both include recommendations for the undertaking a training needs analysis. A joint approach will be adopted to develop a training strategy for the investigation of concerns (complaints & incidents) that will identify the levels of training that are required i.e. awareness, management review, complex concern / RCA investigation training.	
Concerns Follow Up Review 4.1	jun-23	Reasonable	The information within the draft Early Resolution SOP in relation to re-classification of cases to PTR status should be reviewed to provide greater clarity on the exact timeframe and process to be followed.	Medium	Early Resolution SOP to be reviewed in line with the updated PTR Guidance, with more clarity around timeframes and process.	Director of Nursing	Concerns Manager	jun-23	Now September 2023		In progress	August 2023 Update - Standard Operating Procedure has been reviewed, with timescales and expectations outlined. Further update will be required following release of updated Putting Things Right Guidance. Awaiting updated guidance from the NHS Executive,	
Concerns Follow Up Review 4.2	jun-23	Reasonable	Regular monitoring should be undertaken of cases that remain open and classified as Early Resolution, to ensure they do not remain open indefinitely while waiting for a response. Responses should be chased up frequently for those cases that are open longer, and where necessary a decision should be made to re-classify as a PTR case if the context is appropriate.	Medium	Monitor already occurs on a regular basis. However, in addition quality assurance audits will be undertaken on a minimum of a monthly basis.	Director of Nursing	Concerns Manager	June 2023 and ongoing			Completed	August 2023 Update - Early Resolution Complaints are followed up on a weekly basis where a response has not been received. Monthly management review of cases which remain open past 5 days with a view to re-classification where appropriate	
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 Now June 2023		Part Completed	August 2023 Update - Due to staff absence it has not been possible to obtain an update for this submission	June 2023 - No update received against this recommendation for the June submission

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Ref	Date added	Assurance rating	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead/Management Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates during this period/Latest Update	Update provided for Previous meeting
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 Now September 2023		In progress	August 2023 Update - This remains ongoing	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed
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 Now September 2023		In progress	August 2023 Update - This remains ongoing	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed
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 Now June 2023 Now October 2023		In progress	August 2023 Update - Following updated guidance from the NHS executive and the implementation of Duty Of Candour, a review of the incident Management Framework is being undertaken. The Framework will outline the requirements for management of incidents and all related externally reportable incidents. The Framework will link to the training strategy and needs analysis currently being undertaken. It will also outline the Datix Cymru actions required. It is anticipated the revised framework will be implemented from 01.10.23	June 2023 Update: phase one is in progress with phase two as outlined in last month's update to then take place within the care groups. The objective is still on target for June 2023 completion.
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	des-22	Now January 2023 Now May 2023 Now June 2023		Completed	August 2023 Update - Integrated Quality report presented to the respective Governance forums	June 2023 Update: phase one is in progress with phase two as outlined in last month's update to then take place within the care groups. The objective is still on target for June 2023 completion.
iCTM – Quality Improvement Team 3.2	des-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	Now April 2023 Now June 2023		Completed	August 2023 Update - Action Complete	June 2023 Update: Faculty post only recently recruited to so framework will be updated June 2023
Welsh Risk Pool 3.1	jun-23	Reasonable	The reasons for not being able to access all information saved to Datix should be identified and attempts made to resolve the issue.	Low	The Staff member has been identified and the issue will be raised with IT. This will be followed up by the Legal Services manager to ensure this issue is swiftly resolved Issues in relation to accessing the documents within Datix (Web or Cymru) will be addressed by the Business Intelligence Team. A reminder will be issued to escalate system issues to the Business Intelligence Team as thev arise.	Director of Nursing	Legal services Manager Head of Concerns & Business Intelligence He	jun-23			Completed	August 2023 Update - This was an internal IT issue which has now been resolved. Staff have been reminded of the importance of raising any functionality issues with Datix Cymru at the earliest opportunity.	
Concerns Follow Up Review 1.1	jun-23	Reasonable	1.1a The concerns SOP should be revisited ahead of approval to ensure all sections are populated and reference is made to other relevant SOPs / supplementary documents. Consideration should be given to re-naming the SOP and removing the reference to 'written' concerns only. 1.1b The revised Concerns Policy and Standard Operating Procedures should be formally approved and made available to staff. The concerns pages on the CTM internet site should also be updated with the revised policy and the previous version removed.	Low	1.1a The Concerns SOP will be reviewed in line with the recommendation above and will be renamed and written concerns will be explained. 1.1b The various SOPs/policy will be made available on SharePoint for all staff to access once approval has been received in Quality & Safety Committee in July 2023.	Director of Nursing	Head of Concerns & Business Intelligence	1.1a May 2023 1.1b August 2023	Now September 2023		In progress	August 2023 Update - A review of the Concerns Policies and Procedures has been undertaken, along with all underpinning Standard Operating Procedures. These have been strengthened to support robust triage and escalation where comments remain outstanding. The Concerns Policy & Procedure was scheduled to be approved at the July Quality & Safety Committee, this has been deferred to September due to the impending release of updated PTR guidance and the review of the incident management Framework following revised National Incident Guidance from the NHS Executive. The Health Board's Concerns Share Point pages are being reviewed to ensure they are to update and accurate information is available to support staff involved in the management of concerns.	
Concerns Follow Up Review 4.3	jun-23	Reasonable	Consideration should be given to enhancing the Quality Assurance /Audit checklist and SOP by including steps for capturing the outcomes and actions arising from the audits, that can be used for future identification or trends, patterns and training needs.	Low	Quality assurance checklist and SOP to be reviewed and Audit template developed to ensure findings and actions/learning is captured and actioned.	Director of Nursing	Concerns Manager	jun-23			Completed	August 2023 Update -Quality Assurance Checklist has been reviewed and approved. Complaints audit tool for new cases developed and implemented from 03.07.23. Complaints audit tool for closed cases developed and to be implemented from 17.07.23	
Concerns Follow Up Review 8.0	jun-23	Reasonable	Consideration should be given to revising the concerns policy and SOP to give an indication of the regularity that contact should be made with complaints for cases that remain open beyond 30 days.	Low	Concerns Policy and SOP will be reviewed and updated to include frequency of contact for complaints open beyond 30 working days.	Director of Nursing	Concerns Manager	jun-23			Completed	August 2023 Update - The need to ensure monthly updates either by phone, email or letter is provided to all complainants where the response is over 30 working days is included in the Standard Operating Procedure. A review of all holding letter requirements are undertaken on a weekly basis and completed by the administration team.	
Concerns Follow Up Review 9.0	jun-23	Reasonable	Once the Assistant Director of Quality & Safety has commenced in post, the terms of reference for the Shared Listening and Learning Forum should be reviewed and formally agreed for use.	Low	Listening and Learning Forum TOR to be reviewed.	Director of Nursing	Assistant Director of Quality & Safety	jun-23	Now October 2023		In progress	August 2023 Update - The Shared Listening & Learning Forum including its terms of reference is currently under review in light of the operating model changes and to ensure we have an increase in Clinical Engagement from across the health board at each of the quarterly forums	
Board Assurance Framework 1.1	apr-23	Substantial	Consideration should be given to ensuring the BAF captures the key statements that the Health Board has set out for each strategic goal within the IMTP, and the link to the associated control/s and assurance report/s or the gap in control and mitigating action.	Low	The Assistant Director of Governance & Risk in conjunction with the Strategic Risk owner will review the narrative in the BAF to align to the Health Board's key statements as set out in the IMTP.	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk & Strategic Risk Owners	31.07.2023	Now October 2023		In progress	August 2023 Update - Due to capacity within the Team this element of the BAF review has been delayed as focus has been targeted towards risk scoring rationale and risk treatment options. Request an extension to the end of October 2023.	June 2023 Update - In Progress The Interim Head of Corporate Governance & Assurance is reviewing the BAF in conjunction with planning leads.

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				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									

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Ref	Date added	Recommendation	CTM Focussed Review/ National Review	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Update provided for Previous meeting
Audit of Accounts Addendum 2020/2021 02	aug-21	The Health Board should review its governance and procedures in place for the appointment of senior officers, and as part of the review ensure that it fully understands the extent of WG's delegated authority to the Health Board, and importantly, the decisions that WG has not delegated. The Health Board should ensure that minutes, particularly those of the Remuneration Committee, are clear. For example, minutes should make a clear distinction between when the Remuneration Committee has approved (or rejected) a business case; and when it has endorsed (or not endorsed) a business case that then needs the approval of the WG. In respect of retire and return cases, the Health Board should ensure that it has appropriate procedures in place for the consideration and approval/ rejection of business cases. The Health Board should record the process contemporaneously and provide accurate information to the payroll department.	CTM Focussed Review	There is a context to the DoTHS delay, for example, which is that the situation was novel, and required Welsh Government banding for a new joint role, which took some time.	Director for People		Immediate	Now August 2022 Now October 2022 Now December 2022 Now March 2023 Now August 2023		In Progress	August 2023. - The new NHS Pension Scheme Benefit Flexibilities Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.	June 2023 Update - In partnership with Trade Union colleagues, a new "NHS Pension Scheme Benefit Flexibilities Policy" has been drafted. This new policy will go to the Local Partnership Forum in June 2023, to be endorsed to be approved by the People and Culture Committee in August 2023. The Policy will apply to all employee's requesting to take their pension benefits, who wish to request to retire and return (including Executive Directors). The process will require the employee's manager to meet with them to discuss their request and provide in writing the decision along with the objective business reasons for either approving or declining the application.
Audit Wales/HIW Quality Governance Follow Up Review R2.3	aug-21	The Health Board needs to take a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically; a- The BAF reflects the objectives set out in the current IMTP and the Health Board's quality priorities b- The risk management strategy reflects the oversight arrangements for the BAF, the quality and patient safety governance framework and any changes to the management of risk within the Health Board c- The quality and patient safety governance framework must support the priorities set out in the Quality Strategy and align to the values and behaviours framework	CTM Focussed Review	The Health Board's overarching quality priorities published within the IMTP/Annual Plan for 2020-23 are as follows: • Strengthened focus on quality on strategic planning; • Individuals' voices are better heard; • Shared learning and continuous quality improvement; • Risk better articulated, shared and mitigated; • Strengthened two-way 'point of service delivery' to Board sight; and • Extensive review and improvement of the management of concerns and serious incidents. Review of the Quality Governance Framework to reflect the developed quality strategy and enhanced governance processes within ILG's . The revised framework will provide improved granular detail in respect of ILG governance that wasn't available at the previous refresh in November 2020. System testing through attendance at CSG/ILG Q&PSE governance meetings will be introduced for evidence/assurance that the framework is embedded.	Director of Nursing		des-21	01/03/2022 Now June 2022 Now December 2022 Now May 2023 Now June 2023 Now October 2023		Part Completed	August 2023 Update - awaiting outcome of phase 2 of the Operating model. The OCP process will be completed within the next 8 weeks-this will allow for substantive aligning of the actions detailed in the framework to be aligned accordingly.	June 2023 Update: Quality & Safety agenda shared amongst the clinical care group directors, the heads of nursing role is currently under review as part of phase 2 of operating model - Partial Complete
Audit Wales/HIW Quality Governance Follow Up Review R6.1	aug-21	There needs to be sufficient focus and resources given to gathering, analysing, monitoring, and learning from patient experience across the Health Board. This must include use of real-time patient feedback.	CTM Focussed Review	Health Board purchased CIVICA (captures population feedback using a patient insight software platform)	Director of Nursing		jul-21	Now December 2021 Now July 2022 Now March 2023 Now December 2023		In Progress	August 2023 Update - The funding agreement process for CIVICA has been concluded. The workforce and implementation plan is now being actioned. An analysis of the CIVICA Patient Experience feedback 2022/23 has been completed and will be presented to Q&SC in September 23	June 2023 Update- Governance and the performance paper submitted. Awaiting response from finance on Civica funding and to move funding to Value Based Healthcare (VBHC). Patient Experience feedback for 2022/23 via CIVICA system has been developed and will be presented at a future Quality & Safety Committee. Care Groups actively use feedback to enhance clinical care.
Audit Wales/HIW Quality Governance Follow Up ReviewR8.6	aug-21	The Health Board needs to clarify accountabilities and responsibilities for quality and patient safety within directorates. This must include a review of the Heads of Nursing role in relation to site management and quality and patient safety.	CTM Focussed Review	Quality Governance Framework to reflect enhanced governance processes	Director of Nursing		des-21	01/03/2022 Now June 2022 Now December 2022 Now January 2023 Now May 2023 Now June 2023 Now October 2023		Part Completed	August 2023 Update - Quality & Safety agenda shared amongst the clinical care group directors, awaiting outcome of phase 2 of the Operating model the OCP process will be completed within next 8 weeks-this will allow for substantive aligning of actions detailed in the framework to be aligned accordingly	June 2023 Update - Quality & Safety agenda shared amongst the clinical care group directors, the heads of nursing role is currently under review as part of phase 2 of operating model - Partial Complete
Audit Wales/HIW Quality Governance Follow Up Review R10.1	aug-21	The Health Board must ensure there are clear and comprehensive risk management systems at directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers. This must be reflected in the risk strategy.	CTM Focussed Review	Risk Training: including the development of a Training Needs Analysis (TNA) in line with All Wales developments, dissemination of the TNA across the Health Board, new risk training programmes which are aligned to the new TNA.	Director of Corporate Governance	Assistant Director of Governance & Risk	okt-21	Now December 2021 Now April 2022 Now October 2022 Now 31 December 2022 Now 31 March 2023 Now 31st October 2023		Completed	August 2023 Update - COMPLETE Propose to close. A Risk Management Training Needs Analysis has been developed and approved by Executive Leadership Group on the 17th July 2023. This provides an overview of options for staff in terms of training on the risk management strategy within the Health Board and the use of Datix. It is acknowledged that the TNA will require review once the OfW Risk Module is in place but as of yet the implementation date is not known and therefore this interim approach has been adopted.	June 2023 Update - This recommendation is paused as the Health Board continues to wait the implementation of the new OFW Risk Module on Datix to ensure that the Training Needs Analysis aligns with the new system and process. The implementation date continues to be undetermined. The OFW Team Senior Management and Datix Senior Management are meeting w/e 19th May to discuss options with a further meeting of the All Wales OFW Task and Finish Group meeting after that to consider the next steps. A more detailed update should be available at the next meeting.
Audit Wales/HIW Quality Governance Follow Up Review R10.4	aug-21	The Health Board must ensure there are clear and comprehensive risk management systems at directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers. This must be reflected in the risk strategy.	CTM Focussed Review	An efficient risk management process which is seen as efficient and not cumbersome – linked to the new Once For Wales Risk Management System.	Director of Corporate Governance	Assistant Director of Governance & Risk	apr-22	Now October 2022 Now 31 December 2022 Now 31 March 2023 Now 31 October 2023		Completed	August 2023 Update - Propose to close. The implementation of the OfW Risk Management Module has been delayed with the implementation date to be confirmed. There is a robust Service to Board escalation process in place which is clearly aligned to the Risk Management Strategy and the Board Assurance Framework. Once the new OfW System is available the suite of risk documents will be updated to align with any changes in process / methodology.	June 2023 Update - The implementation date of the OFW Risk Module continues to be undetermined. The OFW Team Senior Management and Datix Senior Management are meeting w/e 19th May to discuss options with a further meeting of the All Wales OFW Task and Finish Group meeting after that to consider the next steps. A more detailed update should be available at the next meeting.

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Audit Wales/HIW Quality Governance Follow Up ReviewR11.6	aug-21	The oversight and governance of DATIX must be improved so that it is used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a directorate or corporate level, and formal mechanisms to identify and share learning.	CTM Focussed Review	Review all backlog incidents to eliminate duplicates and ensure correctly identified/categorised.	Director of Nursing		okt-21	Now 31 August 2022 Now December 2022 Now January 2023 Now May 2023 Now July 2023		Completed	August 2023 Update - The implementation of Duty Of Candour on the 01.04.23 has introduced an additional layer of scrutiny which includes a process of corporate review. The Quality & Safety Team review all patient safety incidents for accuracy and appropriate escalation. In addition all Health & Safety related incidents are reviewed by the Health & Safety Team. A consolidation exercise of Nationally Reportable Incidents has been completed. Validation of incidents which have triggered Duty Of Candour during quarter 1 2022/2023 has been undertaken. A dashboard has been developed to support this process on a weekly basis.	June 2023 Update: The Business Intelligence Manager will be commencing on the 12.06.23. A key priority following this will be to implement the validation and audit programme. In addition a 12 month programme of work has commenced to develop dashboards that provide real time information at all levels of the organisation.
Audit Wales/HIW Quality Governance Follow Up Review R14.5	aug-21	The Health Board must develop a stronger approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken in the Princess of Wales hospital.	CTM Focussed Review	Implementation of PREMS and CIVICA system to gather data on patient experience to inform learning and service enhancement and improvement. Project has been initiated and Project Manager appointed.	Director of Nursing		sep-21	Now December 2021 No revised date for completion provided - currently in discussion Now March 2023 Now June 2023		Completed	August 2023 Update -The funding agreement process for CIVICA has been concluded. The workforce and implementation plan is now being actioned. The learning from the fundamentals of Care audit which has been completed in POW has been taken and included in the wider Nursing & Midwifery work through the use of AMaT - An analysis of the CIVICA Patient Experience feedback for 2022/23 has been completed and will be presented to Q&SC in September 23 Each Care Group presents a highlight report to the Q&SC on a bi-monthly basis which takes into consideration integrated learning.	June 2023 Update- CIVICA-Governance and the performance paper submitted. Awaiting response from finance on CIVICA funding and to move funding to VBHC
Audit Wales/HIW Quality Governance Follow Up Review R7.7h		There needs to be improved visibility and oversight of clinical audit and improvement activities across directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning.	CTM Focussed Review	Undertake audit of compliance against Royal College of Anaesthesia (RCOA) Standards (ACSA process) identify and develop standards to meet with RCOA recommended GPICS (set standards by RCOA for Anaesthetic services) baseline and inform continuous improvement programmes and improve compliance against the standards.	Medical Director		jul-24			In progress	August 2023 Update - No further progress has been made since the update provided in June 2023	June 2023 Update - The ACSA process is more in depth and time consuming than was originally understood. Like all good accreditation processes if they were easy they would not be worth the doing, and this one involves looking at all aspects of clinical care. However due to clinical pressures the ACSA processes on the 3 sites have not progressed at the pace we would have wished. The teams will continue to work on them but completion in 2024 is not realistic. The Planned Care Group will continue to monitor the process.
Equality Impact Assessments R4	nov-22	Reviewing public bodies' current approach for conducting EIAs: While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.	National Review	CTM UHB welcomes the report's recommendations for a national approach to clarifying the scope of the duty to impact assess policies and practice and developing guidance for integrated impact assessment. CTM UHB is currently reviewing the EIA process, in line with the findings of this report, and the guidance available from the EHRC and the Practice Hub. As such work has commenced on benchmarking against other NHS organisations. Quality Assurance measures are also being designed to monitor EIAs, as well as monitor the impact of the decisions in the context of the PSED. In addition, further staff guidance and policies will be developed to ensure that the EIA process is both robust and informed. Consideration will be given, as part of the review, to determine whether the EIA forms part of a wider integrated impact assessment.	Director for People	EDI Practitioner	mar-23	Now May 2023 Now July 2023 Now October 2023		In Progress	August 2023 - New ED&I Lead started in post and is undertaking a final review of the EQIA process, including guidelines and monitoring, as it has to sit within the Operational Plan following the Strategic Equality Plan consultation which ended 14th July. There is a need to pause and review if it is fit for purpose. This will land within the next 4 to 8 weeks. This will also link in with the current organisational review of the development of Policies being undertaken by the Corporate Governance and Risk Dept. Public Health Wales are currently undertaking an All Wales review of the EQIA procedure together with developing an All Wales digital approach. The ED&I Lead is a member of the All Wales Equality Leaders Group, which will feed in to this review and will update as it moves along.	June 2023 Update - Our new Head of Organisational Development and Inclusion has started in post and needs to review the new digital form and comment on the proposed process. Meeting arranged for w/c 29.05.23. A new digital form has been developed and IT are adding in 'behind the scene' controls to ensure that it does what it needs to do. Learning and Development have completed the video to go alongside this and the guidance document needs to be finalised. Subject to testing, the new process will go live July 2023.
Transformational Leadership Programme Board – Baseline Governance Review R1	des-22	Strategic planning and applying the sustainable development principle Our work found opportunities for the TLPB to strengthen its planning arrangements and demonstrate how it is acting in accordance with the sustainable development principle (as set out in the Well-being of Future Generations (Wales) Act). The principle should be integral to the TLPB's thinking and genuinely shaping what it does by: a) taking a longer-term approach to its planning beyond five years, b) ensuring greater integration between the long-term plans of the four statutory bodies of the TLPB, and c) improving involvement of all members of the TLPB to ensure an increased voice for non-statutory partners and a better understanding of the purpose of the RPB more generally.	CTM Focussed Review	Agreed. Although the sustainable development principle is a fundamental consideration in all decision making, this will be made more explicit in reports to TLPB and RPB going forward. Transition to a new delivery plan has been completed and work will continue to integrate the long term plans of the four statutory bodies improve involvement of non-statutory partners	Director of Strategy & Transformation	Head of Regional Collaborative Unit	31 March 2023	Now 31 March 2024		In Progress	August 2023 Update - The Health and Social Care Regional Integration Fund (the RIF) is a 5-year fund to deliver a programme of change from April 2022 to March 2027. The RIF builds on the learning and progress made under the previous Integrated Care Fund (ICF) and Transformation Fund (TF) and seeks to create sustainable system change through the integration of health and social care services. Key features and values of the Fund include; • A strong focus on prevention and early intervention • Developing and embedding national models of integrated care • Actively sharing learning across Wales through communities of practice • Sustainable long-term resourcing to embed and mainstream new models of care • Creation of long-term pooled fund arrangements • Consistent investment in regional planning and partnership infrastructure The RIF is a key lever to drive change and transformation across the health and social are system and in doing so will directly support implementation of several key pieces of policy and legislation over the longer term.	June 2023 Update - No update received on this occasion
Transformational Leadership Programme Board – Baseline Governance Review R3	des-22	Performance Management The outcomes and performance framework was still being finalised at the time of our review. The TLPB needs to finalise and implement the framework, ensuring it contains quantitative and qualitative measures that will enable the RPB to demonstrate outcomes and impact.	CTM Focussed Review	Agreed. Work is ongoing in relation to the performance framework in support of the new delivery plan and this will also need to reflect changes arising from the population needs assessment	Director of Strategy & Transformation	Head of RCU	30 September 2022			Completed	August 2023 Update - Framework completed and endorsed by RPB. Framework being used to shape national RIF performance framework. CTM piloted new performance framework for quarter 4. Performance presented to Adult board and Leadership Team meetings on 22nd May.	June 2023 Update - No update received on this occasion
Transformational Leadership Programme Board – Baseline Governance Review	des-22	Risk Management Our work found areas of risk management that need to be improved, particularly in relation to regional workforce planning. The TLPB should strengthen regional risk management arrangements by improving the identification and prioritisation of shared risks and ensuring mitigating actions are robust and clearly articulated	CTM Focussed Review	Agreed. Within the new governance structure there will be an integrated resources group which will be tasked to develop the risk management framework.	Director of Strategy & Transformation	Chair TLPB	31 March 2023	Now 31 March 2024		In Progress	August 2023 Update - Further Faster will establish a comprehensive community care model ensuring a full range of preventative and early intervention services are available locally. This will involve new delivery structures, moving the workforce and creating new roles so that, for example, community first responder services, more therapy and reablement workers, enhanced domiciliary care roles, community nursing and allied health professionals are the priorities for service and workforce development. Building on successful models service specifications will be developed nationally upon which to benchmark and model regional delivery. Risk registers are maintained centrally and reported to Leadership Board.	June 2023 Update - No update received on this occasion
Transformational Leadership Programme Board – Baseline Governance Review R5	des-22	Regional Commissioning Unit Our work found that the lack of capacity within the RCU was leading to some delays in progressing actions. The work of the RCU is crucial to the continuing success of the TLPB. The TLPB needs to consider how it can build capacity and maximise resources to support the TLPB and minimise overreliance on a small team.	CTM Focussed Review	Agreed. Additional infrastructure has been agreed to support dementia work and NEST framework and capital. Additional capacity will also be identified from partner organisations to support the programme delivery.	Director of Strategy & Transformation	Head of RCU	31 December 2022	Now December 2023		In Progress	August 2023 Update - Additional Infrastructure for Capital had been agreed regionally and scope for further programme management linked to IRCF funding to support business case development and Community hub infrastructure. Partnership Leadership Team tasked with developing robust model for community services within which Programme management requirements to be identified. To deliver the integration agenda at pace a Director for Integration post has been agreed at Chief Executive level between the health board and Local Authorities. RCTCBC have agreed to host the post on a two-year fixed term. The grading for the post will need to reflect the expectation of the role. In addition to the Director role consideration has been given to existing infrastructure that can be realigned to support as well as top slicing additional infrastructure and wider RIF resource. External Consultant short term capacity has also been considered however determined that local knowledge of existing service configuration is critical.	June 2023 Update - No update received on this occasion

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Ref	Date added	Recommendation	CTM Focussed Review/ National Review	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Update provided for Previous meeting
Transformational Leadership Programme Board – Baseline Governance Review R6	des-22	Use of Resources Improving the health and social care outcomes of the region will require efficient and effective use of combined resources. Our work found that there had been some limited examples of pooled budgets and other arrangements for sharing resources. The TLPB needs to explore more innovative ways of sharing and pooling core	CTM Focussed Review	Agreed. The development of the RIF delivery plan is only one funding stream and TLPB recognises that we will need to align core budgets, for example around children with complex needs. This will be addressed through the planning cycle in advance of 2023/24	Director of Strategy & Transformation	Chair TLPB	31 March 2023	Now 31 March 2024		In Progress	August 2023 Update - Welsh Government officials are currently working to review Part 2 and Part 9 Codes of Practice (Social Services and Wellbeing Act 2014) which will further strengthen partnership arrangement and collaborative service delivery (Consultation planned Autumn 2023). As part of the amendments to codes of practice the duty to co-operate will be established as lying equally on Local Authorities and Health Boards and the role of the RPB as a key vehicle through which that duty should be exercised. Furthermore within chapter 5, pooled funds positioned more clearly within joint commissioning context and greater flexibility given in relation to pooling resources at Regional, sub-regional pan cluster, cluster and individual levels.	June 2023 Update - No update received on this occasion
Transformational Leadership Programme Board – Baseline Governance Review R7	des-22	Regional workforce planning Like many parts of the public sector, the region is experiencing significant workforce challenges. The TLPB needs to consider how it can facilitate a regional and strategic approach to addressing these challenges and to help it deliver its priorities	CTM Focussed Review	Agreed. Regional workforce development arrangements exist through SCWDP Board workforce development group and work is underway to strengthen links with RPB and Health	Director of Strategy & Transformation	Chair TLPB	31 March 2023	Now 31 March 2024		In Progress	August 2023 Update - One of the four quadruple aims outlined in the document, 'A Healthier Wales: Our Plan for Health and Social Care', is to have a motivated and sustainable health and social care workforce that delivers a truly seamless system of health and care, and calls for a fundamental shift in our understanding of who constitutes the workforce, and how we support the contribution that each individual makes. Requiring not only 'greater parity of esteem' between health and social care professionals, but also recognising and supporting the vital role played by the informal workforce of unpaid carers and of volunteers. To support new models of care, health and social care services must strengthen the support, training, development and services available to the workforce, with a focus on building skills across a whole career and supporting their health and wellbeing. New seamless models of health and care that emerge, require a clear and coherent approach to developing and planning the whole workforce. To meet this need, WG commissioned Health Education and Improvement Wales (HEIW) and Social Care Wales (SCW) to develop a long-term workforce strategy, in partnership with NHS and Local Government, the voluntary and independent sectors, as well as regulators, professional bodies, and education providers. The workforce strategy aims to address the Parliamentary Review's call for joint regional workforce planning. The workforce strategy also identifies dynamic leadership will be needed to instigate change, empower others and lead by example, as well as create conditions for continuous innovation and improvement, to drive up the quality and value of services.	June 2023 Update - No update received on this occasion
CTMSB SLA Review R3	feb-23	Our work identified that service users and patients' needs are not routinely assessed when variations to agreements are made, and we have seen no evidence of the use of quality impact assessments. The health boards should implement a process for conducting impact assessments when making changes to the way in which services are delivered for the Bridgend population.	CTM Focussed Review	Changes in patient flows and impact on patients is addressed in the cessation paperwork and is always discussed as part of the disaggregation discussions. Equality Impact Assessments have started to be completed for the cessation of the Clinical Capacity SLAs in NPTH as the changes will impact on patient flow and access to services. However, there is not enough corporate resource to complete a detailed impact assessment for each SLA cessation and in most cases the impact is not necessary as there is no change in patient flow. The Community Health Councils are kept up to date on all cessations and detailed engagement is undertaken where changes will affect patient flow.	Director of Strategy & Transformation	Assistant Director of Strategy (SB) & Assistant Director of Transformation (CTMUHB)	nov-22			In Progress	August 2023 Update - An update has not been provided against this recommendation on this occasion	June 2023 Update - No update received on this occasion
CTMSB SLA Review R4	feb-23	Our work identified that there was no clear link between the risk registers managed by the commissioning and contracting group to the health board risk registers. The health boards should review the risk management process associated with the transition so that risks are linked and reflected in individual health board corporate risk registers.	CTM Focussed Review	Clinical risk matrix has been developed and is completed as part of the disaggregation process. The risk score is highlighted to Joint Management Group and Joint Executive Group through the slide deck. However, the risk register for the programme needs to be reviewed and there needs to be a stronger link between the risk register for the programme and the corporate risk registers. Process to be developed outlining how service risks are linked with the CTMU and SBU risk registers.	Director of Strategy & Transformation	Head of Strategic Commissioning (SB) & Assistant Director of Transformation (CTMUHB)	mar-23			In Progress	August 2023 Update - An update has not been provided against this recommendation on this occasion	June 2023 Update - No update received on this occasion
Structured Assessment 2022 R1	apr-23	Improving administrative governance arrangements We found opportunities for the Health Board to improve its administrative governance arrangements to enhance public transparency and support Board and committee effectiveness. The Health Board, therefore, should: a) publish the agendas of private Board and committee meetings; b) publish the papers for all public Board, committee, and advisory meetings on its website in a timely manner; c) update report cover sheets to enable authors to better link their reports to the requirements of the Well-being of Future Generations (Wales) Act 2015; and d) update presentation cover sheets to enable authors to summarise the information sufficiently and capture the relevant risks and issues.	CTM Focussed Review	a) In the exceptional circumstances where the Health Board is required to hold a Private Board meeting or Board Committee it will endeavour to highlight the agenda items covered on the Public Agenda for transparency. b) Due to capacity constraints within the Corporate Governance Function it is accepted that the timely publishing of papers maybe impacted. Discussions are underway with the Web Development Team to consider if they can provide interim support over the next 3-6 months. c) Cover reports will be reviewed to incorporate requirements of the WBFG Wales Act. d) Presentation cover sheets to be reviewed to ensure authors sufficiently reflect key risks and issues.	Director of Corporate Governance	Assistant Director of Governance & Risk	a) 30th April 2023 - Complete b) 31st August 2023 31.10.2023 - Part 2 of action. c) 30th June 2023 31.10.2023 d) 30th June 2023- Complete			In Progress	August 2023 Update A) Complete. Public agendas now include a section indicating the topics discussed at closed sessions where appropriate. B) Agenda bundles for all Board and Board Committees are published in a timely manner on the Website. Further work is required in terms of Advisory Groups and this will be explored and may require further support to leads in this area. It is anticipated that the pace of change for the Advisory Groups may take longer than originally assessed and a revised implementation date of 31.10.2023 is proposed. c) An extension to this action is required as the team would wish to incorporate the activity around the Duty of Quality in its review of cover papers and this is being explored with other Health Boards for consistency. d) Complete. Presentation cover sheets continue to be quality assured to ensure key risks and issues are considered. Communication and Engagement colleagues are reviewing the Presentation template and this will therefore be revisited again at this point.	June 2023 Update - a) Complete Board and Board Committee agendas will now include a section capturing the occasions where a Private meeting was held and the topics covered. b) The Interim Head of Corporate Governance & Assurance is undertaking a review of the website to identify where there are gaps. Agenda Bundles are being uploaded as an interim measure. The Web Development Team have kindly agreed to support the team. c) Cover reports under review in respect of this recommendation and the requirements under the new Duty of Quality. d) Presentations Templates under review in light of the changes also identified in 'c' above as well as ensuring key risks and issues are captured.
Structured Assessment 2022 R3	apr-23	**Strengthening performance management arrangements** The Health Board has a number of longstanding performance challenges across many areas in both planned care and urgent and emergency care, resulting in it being escalated to enhanced monitoring from routine arrangements under Welsh Government's Escalation and Intervention Arrangements. The Health Board, therefore, should ensure its performance management and reporting arrangements are appropriately focused on the key challenges it faces in both planned care and urgent and emergency care, especially where performance in those areas is comparatively worse than other Health Boards in Wales.	CTM Focussed Review	The Health Board continues to work to improve the Integrated Performance Reporting to the Board. The lay out, content and specifically the narrative throughout the report to Board is constantly being refined and updated to ensure the Board has the right information at the right time. In addition steps have been taken to ensure that the Board Committees receive the performance information relevant to their remit. However the Health Board recognises that given the nature of its business and its complexities that this remains a very large report and it can be challenging to identify the most significant issues. The Health Board is holding a workshop with Board Members in Spring 2023 to develop an approach that enables a greater visibility of the most important indicators whilst still presenting all other metrics in a timely fashion for openness and accountability. Whilst creating opportunities for members to select the "most important indicators" will enable the Board to align measures to strategic priorities etc., the Executive Leads will also draw the Board's attention to areas of concern and/or where performance is comparatively worse than other Health Boards in Wales.	Director of Strategy & Transformation (Performance Framework) Chief Operating Officer (Operational Performance) Director of Digital (Performance Information)		30th September 2023 The workshop with Board Members is scheduled for Quarter 1 – 2023-2024.			In Progress	August 2023 Update - An update has not been provided against this recommendation on this occasion	June 2023 Update - No update received on this occasion
Structured Assessment 2022 R4	apr-23	**Establishing measurable outcomes for strategic priorities** Whilst the Health Board has made positive progress in developing a long-term vision, strategic goals, and strategic priorities for the organisation, the new strategy (CTM 2030) lacks clear and measurable outcomes. The Health Board, therefore, should seek to articulate outcomes for each strategic priority, what success would look like, and how it will measure and report progress. In doing so, it should consider the relationship between the goals of the Population Health Strategy and the wider strategic goals and public health 'life course' approach set out in CTM 2030.	CTM Focussed Review	We agree that this work needs to progress. The ongoing work of the Strategy Groups and the CTM 2030 steering group is to set out clearly the measurable improvements to be delivered. Most of these relate to pre-existing measures set out in the Quadruple Aims. Each lead for a "strategy chapter" are responsible for identifying the measurable outcomes for their "chapter". In addition, work has already commenced to align the strategy group work to the goals and measures set out within the Population Health Management plan. We will continue to work to ensure that the thread between these aspects is more visible.	Director of Strategy & Transformation		30th June 2023 Now September 2023			Part Completed	August 2023 Update - This work has been completed for the Living Well Strategy Group and the Ageing Well/Dying Well Strategy Group. The work is still in progress for the Starting Well and Growing Well Strategy Groups.	June 2023 Update - Work has been completed in regards to aligning the population health goals and the strategy groups. This is now being used to support the development of measures and outcomes for each group which is developing well. To note, this may not be completed by the end of June but will be completed summer 2023.
Structured Assessment 2022 R5	apr-23	**Enhancing arrangements for monitoring delivery of corporate plans and strategies and reporting progress to the Board** We found opportunities for the Health Board to enhance its arrangements for monitoring the delivery of corporate plans and strategies, and reporting progress to the Board. The Health Board, therefore, should enhance its arrangements by ensuring: a) plans and strategies contain clear summaries of key actions / deliverables, timescales, and measures to support effective monitoring and reporting; b) plans and strategies provide greater detail on which Executive Directors are responsible for the delivery of key actions / deliverables to enable appropriate accountability; and c) reports are aligned to performance reports to enable the Board to assess the extent to which the implementation of key actions / deliverables is having a positive impact on Health Board performance.	CTM Focussed Review	a) All plans and strategies will contain an executive summary setting out this information. As set out above, work is ongoing around outcome measures. b) Executive Directors are clear on their responsibilities for delivery so we will ensure this is more visible. c) Reports will be reviewed to ensure they provide the Board with sufficient information to assess the impact of implementation of key actions and deliverables on the Health Board's Performance.	Director of Strategy & Transformation		30th June 2023			In Progress	August 2023 Update - No further update for this month	June 2023 Update - a) this message has been disseminated and will be put into place moving forward with the development of plans b) this is clear on all board papers and portfolios have been agreed by execs c) there is still further work to be done in line with this as we set out our performance monitoring approach

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Ref	Date added	Recommendation	CTM Focussed Review/ National Review	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Update provided for Previous meeting
Structured Assessment 2022 R6	apr-23	**Strengthening financial management arrangements** We identified the need for the Health Board to improve its arrangements for containing expenditure and delivering savings. The Health Board, therefore, should review its arrangements to ensure there is sufficient grip and challenge at all levels of organisation on expenditure and savings delivery.	CTM Focussed Review	Finance review meetings are held with all of the Care Groups on a monthly basis and with other functions on a bi-monthly basis. These meetings cover savings delivery, expenditure variances plus action plans to improve the overall control environment. These processes will be reviewed to ensure that they are sufficiently robust in terms of containing Health Board expenditure and delivering planned savings. Within the draft, Internal Audit Plan for 2023-2024 it is proposed that Internal Audit will undertake a review of budgetary control at a localised level.	Director of Finance		30th September 2023			Completed	August 2023 Update - This recommendation is proposed for closure in light of the update provided in June 2023	June 2023 Update - Strengthened accountability agreements cascaded from CEO to Directors and Care Groups. Finance review meetings scheduled with all of the Care Groups on a monthly basis and with other functions on a bi-monthly basis. These meetings cover savings delivery, expenditure variances plus action plans to improve the overall control environment. These processes will be subject to review after Q1 to ensure that they are sufficiently robust in terms of containing Health Board expenditure and delivering planned savings. Within the Internal Audit Plan for 2023-2024 it is proposed that Internal Audit will undertake a review of budgetary control at a localised level.
Structured Assessment 2022 R7	apr-23	**Strengthening financial controls** Whilst the Health Board's financial control procedures are generally effective, we identified opportunities to strengthen some controls and update the information available on the Health Board's website. The Health Board should: a) review the delegated upper financial limit for the Chief Executive; b) ensure there is a clear process in place for the Board to review and approve capital programmes and projects; and c) ensure out-of-date financial control procedures are removed from its website and replaced with the current versions.	CTM Focussed Review	a) The Health Board will undertake a review of the Chief Executives upper financial limit. This will form part of the review of the Health Board's Standing Financial Instructions being led by the Head of Corporate Finance. b) Capital approvals are managed through the Executive Capital Management Group (ECMG) which meets monthly and approves all new schemes and adjustments to approved capital schemes. ECMG is Chaired by the Director of Finance and the Director of Strategy and Transformation and Chief Operating Officer are also members. Since the removal of the Capital Programme Board the reporting for the capital programme and all business cases are reported through Planning, Performance and Finance Board Committee prior to being reported at the Board. It is proposed that quarterly capital reporting is reinstated through Planning, Performance & Finance (PPF) Committee and to the Board to cover updates on the capital programme and major projects. Business case over £1M will be brought through the PPF and Board Agenda prior to approval to Welsh Government dependent on project progression and Board Agendas. c) A review of all the outdated Financial Control Procedures is underway.	Director of Finance		a) 30th September 2023 b) 30th June 2023 c) 31st December 2023 (Qtr. 3)			Completed	August 2023 Update - This recommendation is proposed for closure in light of the update provided in June 2023	June 2023 Update - a) Reviewed So &SFIs and confirmed upper limit for contracts is consistent with model Sos and SFIs. Contract in excess of £1m require WG Ministerial approval CLOSED b) Quarterly Capital reports included on PPF agenda c) FCP review ongoing
Structured Assessment 2022 R9	apr-23	**Maximising the benefits of digital technologies and solutions** There is limited capacity within the Health Board to fully deliver its digital transformation agenda. The Health Board, therefore, should seek to set out in its refreshed Digital Strategy how it indents to overcome staffing and funding challenges to fully exploit the benefits offered by digital technologies and solutions.	CTM Focussed Review	The themes identified in the existing Digital Strategy continue to be aligned to the NHS Wales Digital Strategy and are embedded and will continue to evolve with the CTM2030 strategy in relation to digital activity. The Health Board has performed an analysis and identified a minimum set of resources (staff and capital/revenue) required over the next 3 years. Aligned to this work, during 2022 the Health Board completed a functional map of services required from a Digital and Data perspective. The next stage in the process is to align staffing resources to the functions, which will be achieved by following organisational change process. For significant Digital and Data changes (i.e. projects/programmes) the Health Board has developed a process of creating business cases to support service transformation. These business cases indicate the resources (staffing & Infrastructure) required to implement service change and ensure ongoing provision of support services to sustain change. The Health Board is committed to adopting all National Digital developments, where appropriate, and has invested heavily in the deployment of these products across the Health Board. The current strategy is to continue to operate in this manner and ensure it maximises resources efficiently and effectively.	Director of Digital		31st December 2023 (Qtr. 3) Qtr. 1 – Business Case for Patient Centred Contact. Qtr. 2 – Business Case for e-prescribing. Ongoing as National Digital Developments are released.			In Progress	August 2023 Update - An update has not been provided against this recommendation on this occasion	June 2023 Update: During the months of May and June 2023 - recruitment is taking place for two new Assistant Directors within the Digital & Data Directorate. From here the structural design of the Digital & Data Directorate will evolve further.
Structured Assessment 2022 R10	apr-23	**Strengthening Board-level oversight of estates issues and risks** There is currently insufficient Board-level oversight of the condition of the estate and other significant related risks. The Health Board, therefore, should: a) ensure there is regular reporting on estates-related performance indicators and risks to the Planning, Performance, and Finance Committee; b) update the committee's Terms of Reference to reflect these responsibilities; and c) establish a clear process for ensuring appropriate cross-referral of issues with the Quality and Safety Committee, which oversees health and safety matters.	CTM Focussed Review	On publication of Welsh Government's annual Estates, Facilities Performance Management System data, the findings are reported to the Planning, Performance and Finance (PPF) Committee. The report includes the Health Board's performance measured against the national estates key performance indicators which are Physical Condition, Statutory and Safety compliance, fire safety, functional suitability and space utilisation. In addition the report includes the estates operational planned and reactive performance data for statutory and mandatory jobs and also captures helpdesk request data, the reported data is compared against previous years so that trends can be analysed. The report also includes the organisations energy performance and Carbon Dioxide (CO2) emissions which is measured and reported against the Welsh Government performance targets. At all of the Health Board's Health, Safety and Fire Sub Committees there is a standard agenda item for an Estates Safety and Compliance report and a fire safety report. These reports cover the critical infrastructure systems such as high and low voltage electricity, medical gases, ventilation and water. The Estates and Capital Directorate has its own risk register which is reported quarterly to the Estates / Capital Governance Board, the risks identified with a score above 15 are subsequently reported to Corporate Governance for inclusion on the Health Board's Organisational Risk register. The Health Board is also considering its approach to developing an Estates Strategy within the Health Board and how this will align with other key strategic documents and plans. The Planning, Performance & Finance Committee Terms of Reference will be reviewed to reflect the responsibility to receive Board level oversight of estates issues. The Health Board has a defined Committee Referral process which will be used if there are matters considered at either the PPF Committee or HS&F Sub Committee that require consideration at the Quality & Safety Committee. The HS&F Committee will also ensure any estates issues will be notified to the Q&S Committee through the Committee Highlight Report.	Director of Finance		In accordance with the Committee Cycle of Business for the PPF Committee and Health, Safety and Fire Sub Committee – Circa April / May 2023.	Now October 2023		Completed	August 2023 Update - This recommendation is proposed for closure in light of the update provided in June 2023	June 2023 Update - Revised date to reflect expected publication of Estates and Facilities Performance Management System data.
Review of Orthopaedic Services R3	jun-23	The Getting It Right First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to: a) ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and b) ensure that clear action plans are in place to address the things that get in the way of improvement.	National Review	The Health Board will undertake the following in order to maintain oversight and scrutiny and ensure action plans are in place: • Ensure that prehab services are improved by setting up a Prehabilitation Service to ensure patients are medically optimised for surgery. Both digital and face to face options to be considered. • The GIRFT implementation will be included in the reconfiguration programme and updated through the Improving Care Board • Increase the capture of PREMs and PROMS data, digitally captured via MyMobility and through the HB website wherever possible. RGH does not have a system for PROMS or PREMS. Old CTM PCH only had funding and support from Clinical Audit and no funding or support was agreed by the HB. Would need a commitment to roll out MyMobility HB wide • Improve rehabilitation pathways with increased Therapies support. The HB is looking at centralising Trauma and Elective surgery and ensuring the appropriate services are available on these sites. • Implement an Orthogeriatric Service on both trauma sites to ensure management of patient pathways and rehabilitation needs. There will be a focus on early discharges from acute sites. This timing of this will depend upon funding availability. • Introduce a FLS service to prevent repeat fractures –timing will depend upon funding. • Actively consider the provision of a seven day service including Therapies service to ensure earlier discharges and increased throughput. • Consider seven day Theatre working when possible (longer term aim). • Increase clinician engagement • Updated GIRFT action plan to be created with new CD and monitored through the reconfiguration programme. • Weekly Orthopaedic Reconfiguration Group ongoing. All key stakeholders are fully involved.	Chief Operating Officer	COO / Planned Care Director/ Clinical Restart Manager/DTS Director/USC Care Director/ Planned Care Medical Director	Various Dates from between May 2023 - April 2024			In Progress	August 2023 Update - An update has not been provided against this recommendation on this occasion	
Review of Orthopaedic Services R4	jun-23	Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to: a) ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and b) ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.	National Review	The Health Board will undertake the following in order to ensure the recommendations are achieved: • The fragility of a small CMATS team was recognised within physiotherapy. Since the merger with Bridgend the UHB has invested training and development into the band 7 clinical specialist team in order to increase the number of staff working at the advanced practice level, to meet the demand across CTM. • In PCH, CMATS is undertaken via digital referrals (started April 22). Referrals are received centrally and then pooled out within sub specialties, Nurse led, Consultant led and AHPs • A full workforce and demand and capacity analysis is being undertaken through the regional and local reconfiguration work • The UHB now has FCP clinicians across all GP clusters except Merthyr Cynon and there are clear pathways in place for patients to transition from primary care into secondary care. The clinicians working within the primary care settings are working at advanced practice level.	Chief Operating Officer		No target date for completion identified			In Progress	August 2023 Update - An update has not been provided against this recommendation on this occasion	

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Review of Orthopaedic Services R5	Jun-23	There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to: a) ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level; b) ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and c) put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.	National Review	The Health Board will undertake the following in order to ensure the recommendations are achieved: • Within POWH, PREMS and PROMs data is currently being captured electronically for all arthroplasty patients and utilising the MyMobility applications AI system, patients with anticipated poorer outcomes are having enhanced Therapies input digitally. There is at present no system for PROMS or PREMS within the "old CT" part of the UHB, with PCH having some help from Clinical Audit. Changes would require a commitment to roll out MyMobility HB wide. • Within POWH, all Arthroplasty patients are enrolled on the MyMobility application to provide prehab for all patients awaiting surgery to try and minimise the harm caused by delays and ensure patients are medically optimised. There is at present no system for PROMS or PREMS within the "old CT" part of the UHB, with PCH having some help from Clinical Audit. Changes would require a commitment to roll out MyMobility HB wide. • Single Clinical Director Leadership required to establish performance structure and review of current services. • Weekly performance reviews that monitor waiting list volumes and actions being taken to address and recover the position • Action plan development with singe CD for performance and governance structure across CTMUHB	Chief Operating Officer	COO / Planned Care Director/Medical Group Director/ Clinical Director	From April 2023 to April 2024			In progress	August 2023 Update - An update has not been provided against this recommendation on this occasion	

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee Internal Audit Progress Report

August 2023

NWSSP Audit and Assurance Services

Contents

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

1 Introduction

1.1 This progress report provides the Audit & Risk Committee (the 'Committee') with the current position of the work undertaken by Internal Audit as at **8 August 2023**. This report provides information on the status of progress of our reviews.

1.2 We report the progress made to date against individual assignments along with details regarding the delivery of the plan and any required updates.

2 Reports Issued

2.1 Since the June meeting of the Committee five reports have been finalised, a further three reports have been issued in draft, and we have ongoing fieldwork in relation to six reviews. A summary of the position of the finalised reports, including a summary of number of recommendations, is provided below in Table 1.

Table 1 – Summary of finalised reports

Assignments	High	Medium	Low	Total	Assurance rating
Integrated performance reporting (2022/23)	1	2	-	3	Reasonable
National Incident Framework (2022/23)	1	5	-	6	Reasonable
Decontamination (2022/23)	-	4	1	5	Reasonable
PCH Combined report (2022/23)	-	5	-	5	Reasonable
Radiology Workforce - follow up	2	2	1	5	Reasonable

3 Delivering the Plan

3.1 Our agreed performance indicators are agreed during planning. We will report these from the next Audit and Risk Committee.

4 Feedback

4.1 Our final reports are issued with a post audit questionnaire, which is our way of getting feedback on the audit process so that we can look to make improvements. In 2022/23 we have issued the questionnaires in relation to the finalised reports, and have received seven responses.

4.2 In 2023/24 we will be asking for post audit questionnaire using a MS forms document, which we hope make it easier for the Health Board to provide us with feedback.

5 Other activity

Meetings

5.1 We continue to meet regularly with the officers of the Health Board, Counter Fraud, and Audit Wales colleagues.

Appendix A – 2023/24 Programme of work

Table 2: Core programme of work for Q1 and Q2

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
22	Follow up – Radiology – workforce	Reasonable	Q1	Final	Y	N	-
19	IT Infrastructure	Reasonable	Q1	Draft	Y	-	Draft report issued 28.07.23
4	Estates Assurance / condition	Limited	Q1	Draft	Y	-	Draft report issued w/c 07.08.23
3	Performance management of 4-hour target	-	Q1	WIP	-	-	Fieldwork started 21.06.23
7	Deprivation of Liberty Safeguards (DoLS)	-	Q2	WIP	-	-	Fieldwork started 17.07.23
-	Arrangements for financial savings	-	-	WIP	-	-	Brought forward from 2022/23
-	Interventions Not Normally Undertaken (INNU)	-	-	WIP	-	-	Brought forward from 2022/23

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
2	Gastro-intestinal pathway	-	Q1	Planned	-	-	Draft brief issued to COO for approval 31.07.23
6	Management of controlled drugs	-	Q2	Planned	-	-	Brief agreed and planned to start late summer
9	Adult mental health – CSG review	-	Q2	Planned	-	-	Brief agreed and planned to start late summer
18	IT Service Management	-	Q2	Planned	-	-	Plan to start fieldwork in August
5	Charitable funds	-	~~Q2~~ Q3	Planning	-	-	Request by DoF to start later in year
1	Leadership and management development	-	~~Q1~~ Q3	Planning	-	-	Moved to Q3 as internal development ongoing. Scoping meeting booked 30.08.23
8	Finance - Budgetary controls	-	Q2	Planning	-	-	Scoping meeting 08.08.23 cancelled and rescheduled to September
23	Follow up – medical variable pay	-	Q2	-	-	-	Note the completion date of management actions

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
							have been revised to later in year

Table 3: Status of PCH plan 2023/24

This table sets out the position of our work relating to the Prince Charles Hospital development that was outstanding at the time of the previous meeting of the committee.

Assignment	Status	Assurance	Notes
Financial management	Planning	-	Brief has been issued
Quality – Site supervisor role	Planning	-	Brief has been issued

Table 4: Hosted bodies programme of work – Q1 and Q2

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
1	WHSSC – Integrated commissioning plan (ICP)	-	Q1	WIP	-	-	Fieldwork started 25.07.23
2	WHSSC – Welsh Kidney Network	-	Q2	Drafting report	-	-	Fieldwork concluding

PCH Programme Redevelopment
Final Internal Audit Report

July 2023

Cwm Taf Morgannwg University Health Board

NWSSP Audit and Assurance

Contents

Review reference:	SSU_CTMUHB_2223_06,08 & 09
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Management response received:	20/07/23
Final report issued:	24/07/23
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Sally May, Director of Finance
Distribution:	Tim Burns, Assistant Director of Strategic & Operational Planning Jeremy Holifield, Responsible Officer, Prince Charles Hospital Construction Programme Bill Rogers, Programme Director Rosie Cavill, Head of Capital
Committee:	Audit & Risk Committee

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

Acknowledgement

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

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Executive Summary

Purpose

This report summarises a series of audits undertaken to review the delivery and management arrangements in place to progress the PCH Redevelopment Programme.

Overall Audit Opinion and Overview

The audit found that most of the internal controls operated as intended and that programme performance was subject to robust challenge/ scrutiny.

At the time of the review the programme continued to progress well against the original timescales – with only minor delays experienced given the extent and intrusive nature of the works being undertaken.

A potential £1m overspend was being reported, however this was offset by remaining client contingencies of £4.6m. This overspend was largely attributed to the VAT reclaim interim assessment by HMRC being less than that originally estimated by the VAT adviser – albeit this interim assessment could be revised upward between now and completion of the programme.

With circa 70% of the client contingency having been consumed midway through the programme, there is a real risk that contingency may be fully consumed prior to the completion of the scheme.

The cost position has been widely reported internally and externally to both Welsh Government and NWSSP: Specialist Estates Services – with several strategies being considered to manage the position. However, at the time of reporting no additional funding had been secured.

An additional cost pressure was that remaining high risks were assessed at a value of £3.7m (total identified risks were estimated at £9.7m) – which would fully consume the remaining client contingency, in the unlikely event that they all materialised. It is acknowledged that several options had been identified to offset the risk within the current overall approved sum.

Reasonable assurance has been determined at each of the areas examined at this time to reflect the adequacy of the internal control arrangements in place and compliance with the same. Whilst the project is currently within the approved funding envelope, it is recognised that the emerging risks outlined above could materially impact the outturn position and will require ongoing management focus and dialogue with Welsh Government. These issues will be subject to further audit scrutiny in 2023/24.

Further recommendations are provided within **Appendix A**.

Report Classification

Due to the wide range of areas covered in this review, we do not provide an overall assurance opinion. Instead, we have provided separate assurance opinions for each of the areas reviewed.

Assurance Summary [1]

	Assurance Area	Assurance
1	Programme Performance	Reasonable
2	Governance Arrangements	Reasonable
3	Community Benefits	Reasonable
4	Change, Risk & Contingency Management	Reasonable

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
Governance Review				
1.1	The Planning, Performance and Finance committee will receive a regular update/ assurance on the PCH Refurbishment Programme.	2	Operation	Medium
Community Benefits				
2.1	A timeline will be agreed for the reintroduction of monitoring of those community benefits suspended during the covid pandemic.	3	Operation	Medium
2.2	A joint exercise should be undertaken with the Supply Chain Partner to agree the focus of community benefit efforts for the remainder of the programme.	3	Operation	Medium
Change, Risk & Contingency Management				
3.1	Appropriate resource should be committed to resolving the 'open' changes as a matter of priority.	4	Operation	Medium
4.2	The remaining financial values and risk scores at the risk register should be reviewed for adequacy/ accuracy.	4	Operation	Medium

1. Introduction

2.1 The Prince Charles Hospital Phase 2 ground and first floor works has been developed with six sections of works, with a total approval of £220m (which includes an allowance of £23m for inflation) and completion anticipated in June 2026.

2.2 This audit originated from the 2021/22 integrated audit plan for the Prince Charles Hospital (PCH) Redevelopment, agreed with management and approved by the Audit Committee. The audit focused on:

- **Area of Assurance 1:** Whether the programme achieves its original key delivery objectives and that governance, risk management and internal controls are working effectively.
- **Area of Assurance 2:** The programme inter-links with the existing governance structures of the Health Board.
- **Area of Assurance 3:** The establishment, tracking and achievement of Community Benefits at the Programme.
- **Area of Assurance 4:** The arrangements to effectively manage the Change, Risk and Contingency positions at the Programme.

2.3 The potential risks considered in this review included:

- There are weaknesses in the controls in place, impacting the achievement of the overall objectives.
- There is insufficient or inadequate information to adequately inform management.
- There is no management action to control matters, or proposed action is inadequate.

2. Detailed Audit Findings

Area of Assurance 1: Programme Performance

2.4 At a programme/ project audit, levels of assurance are determined on whether the programme/ project achieves its original key delivery objectives and that governance, risk management and internal control within the area under review are suitably designed and applied effectively.

2.5 When assessing progress against the original delivery objectives, the following was evidenced:

Time

2.6 The following is a summary of the current programme position:

Table 1:

	Contract Completion Date	Anticipated Completion Date
Section 1	23/12/21	31/03/22
Section 2	01/06/22	05/12/22
Section 3	28/03/24	22/04/24
Section 4	15/05/25	17/11/25
Section 5	19/06/26	05/08/26
Section 6	20/03/23	21/03/23
Overall	**19/06/26**	**05/08/26**

2.7 Noting the significance and intrusive nature of the works, the current reported delay is not considered material and has been largely attributed to additional asbestos removal.

Cost

2.8 The following extracts were taken from the latest cost report:

Table 2:

	BJC Approval (£)	Forecast Costs (£)
Target Cost	129,789,879	128,885,731
PMIs		15,988,673
Anticipated Variations		5,364,321
	129,789,879	**150,238,725**
Health Board Fees	8,651,054	9,191,088
Non-Works	653,284	757,249
Equipment	10,083,636	10,138,636
Contingency	11,722,071	4,601,956
Provisional sums	11,802,000	142,000
VAT	33,736,948	34,406,059
VAT reclaim	-11,976,611	-11,054,695
Gain share		904,148
Inflation (inc. VAT)	22,925,761	19,063,175
Total Cost	**217,388,022**	**218,388,341**

2.9 The current reported position outlines an overspend of a circa £1m, however this is offset by £4.6m of client contingency remaining.

2.10 The three areas of concern are:

- Circa 70% of contingency had been consumed compared with 40% of progress against programme. This position and associated risk had been reported extensively both internally within the UHB and to Welsh Government – but remained a risk.

  Additional reporting of changes to NWSSP Specialist Estates Services had been introduced as an additional line of challenge/ accountability. Furthermore,

expenditure on contingency in 2022/23 was £500k less than the anticipated £3m expenditure, suggesting a reducing rate of consumption of contingency.

- The VAT reclaim assessment at the Full Business Case was based on the VAT advisor's assessment at 34.18%. The current interim VAT reclaim assessment was 31.08% - which will impact negatively on the overall budget (as outlined above). This was an interim assessment and may increase in the future but remains a risk at the time or reporting.
- The financial implication of 'high' risks at the risk register was estimated at £3.7m (of total risk remaining of £9.7m), which could fully deplete the available client contingency in the unlikely event that they all materialise (see **Area of Assurance 4** below).

2.11 The risk to the outturn cost position outlined above should be noted.

Quality

2.12 Issues of quality and performance are regularly discussed at the Programme Board, having been an issue at the inception of the programme. There were no significant quality and performance issues to note at the time of the current review.

2.13 **Reasonable assurance** has been determined in respect of programme performance, however the risks outlined should be noted.

The following sections of the report further outline the key observations that have contributed to the above – matters which require management attention.

Area of Assurance 2: Governance Review

2.14 The programme had clear performance reporting lines into the Executive Capital Management Group and ultimate accountability to the Planning, Performance and Finance Committee. Separately, we also observed reporting on key risks to the Health, Safety & Fire Sub-committee and Quality & Safety Committee.

2.15 Regular narrative reporting was observed on key issues, risks and performance at the Executive Capital Management Group, with issues escalated as required to the Planning, Performance and Finance Committee.

2.16 Previously, quarterly reports were routinely presented to the Planning, Performance and Finance Committee providing an update on project progress against key performance objectives. In the period of review, these reports were not produced with regularity – with reliance placed on the information contained within the Director of Finance's returns to Welsh Government. It was agreed that these quarterly update reports would be reintroduced (**MA 1.1**).

2.17 During the period of review, no significant changes were observed that were outside of the delegated authority of the Programme Board.

2.18 Noting that the programme was fully integrated within the reporting/ accountability structure of the organisation, **reasonable assurance** was determined.

Area of Assurance 3: Community Benefits

2.19 The Well-being of Future Generations Act and corresponding Welsh Procurement Policy Notes require all projects to outline and monitor the delivery of community benefits and social value.

2.20 The PCH Redevelopment Programme was let under the NHS Building for Wales 3 Framework i.e. at a time when the standard contract documentation did not include details in relation to community benefits. The Supply Chain Partner has voluntarily adopted the national key performance indicators and was regularly reporting on progress against the same to the Programme Board.

2.21 Considerable progress had been reported against the targets, with 5 of the 22 KPIs reporting compliance of 100% or above.

2.22 Monitoring of 9 of the KPIs had been put on hold due to the impact of Covid. Accordingly, it has been recommended that a timeline and approach is agreed for the reintroduction and achievement of the suspended targets (**MA 2.1**).

2.23 The Supply Chain Partner also undertook additional initiatives that were reported to the Programme Board.

2.24 Noting that the programme was mid-way through its delivery, it would be opportune to jointly review, with the Supply Chain Partner, which of the activities and additional initiatives have generated the most significant benefits – to agree a focus/ approach to maximise the benefit to the immediate local community for the remainder of the programme (**MA 2.2**).

2.25 Noting the performance to date and the additional initiatives undertaken by the Supply Chain Partner, **reasonable assurance** has been determined.

Area of Assurance 4: Change, Risk & Contingency Management

2.26 Changes continued to be processed in accordance with contractual requirements. Internal approvals were recorded via the PIF process introduced by the Deputy SRO. No approval issues were observed from our sample. It was further noted that changes over £50k were now being reported to NWSSP Specialist Estates Services for additional scrutiny, challenge and assurance (recognising the anticipated cost pressures).

2.27 The status of changes was reported regularly to the Programme Board. At the time of the review, 20% (197 in total) of instructions remained 'open'. Prudently, the associated estimated costs were included within the current forecast outturn cost, however these require prompt resolution, as many will be outside contractual timeframes for resolution, weakening the negotiation position of the University Health Board (**MA 3.1**).

2.28 A costed risk register was maintained and regularly reported to the Programme Board. Cira £3.3m of risk has been mitigated/ removed since Full Business Case approval, with £9.7m of risk remaining - £3.7m of those identified as High Risk. At the time of review, a number of potential options to mitigate the risks were identified within the available funding envelope e.g. gain share, reduced inflation.

2.29 Client contingency currently stands at £3.6m (adjusted down to recognise the current forecast overspend of £1m). The Project Update report currently reports this position to the Project Board. Noting the potential significant impact of high risks, it is also recommended that the costs and risk scores are assessed for adequacy/ accuracy to inform reporting (**MA 4.1**).

2.30 Noting that internal controls are operating as intended, a **reasonable assurance** is determined.

Appendix A: Management Action Plan

Matter Arising 1: Planning, Performance and Finance Committee Reporting			Impact
The Planning, Performance and Finance Committee has responsibility for monitoring performance against the capital resource limit and delivery of the overall capital programme. The committee regularly receives the Director of Finance monitoring returns, which includes details of the in-year expenditure on capital projects (including the PCH Refurbishment Programme). However, reporting against the overall programme, budget and programme objectives in the period of review was not observed. The committee should be receiving a regular update/ assurance on the programme noting its significant value and importance.			Potential risk of: • The Planning, Performance and Finance Committee is not assured on the latest position of the programme.
Recommendations			**Priority**
1.1	The Planning, Performance and Finance committee will receive a regular update/ assurance on the PCH Refurbishment Programme.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Agreed. In line with Audit Wales recommendation regular reporting will be provided to the Planning, Performance & Finance Committee and the Board.	August 2023	Director of Finance/ Head of Capital

Matter Arising 2: Community Benefits Strategy	Impact
The PCH Refurbishment Programme was progressed under the NHS Building for Wales 3 framework. At that time, the community benefits requirements were not detailed within the standard contractual documentation as standard. Nonetheless, the Supply Chain Partner has voluntarily adopted the national key performance indicators in relation to community benefits. At the time of the audit, considerable progress was observed at the more significant key performance indicators e.g., Jobs created (224%), community events (300%), School engagement (212%) However, nine of the indicators had been suspended due to the impact of the Covid pandemic as follows: o Labour Force – Percent of workforce from postcode; o Supply Chain Initiatives – 60% spend in Wales per project; o Supply Chain Initiatives – number and type of materials produced in Wales; o Supply Chain Initiatives – Value of materials; o Supply Chain Initiatives – Volume of materials; o Supply Chain Initiatives – Percent Welsh subcontractors per project; o Supply Chain Initiatives – Number of supply chain engagements per project; o Environmental – Amount of waste produced tonnes/ £m; and o Complete the WG measurement tool. While recognising this may have been appropriate at the time, a timeline should be agreed for the reintroduction and achievement of these indicators. At the time of the audit, the Supply Chain Partner had been monitoring and reporting community benefits for a period of 28 months. It was evident that certain initiatives achieved greater benefit than others, and that certain initiatives generated greater local community benefits than others. It is therefore recommended that a joint review be undertaken with the Supply Chain Partner to focus effort during the	Potential risk of: • The Programme not generating community benefit or social value.

remainder of the programme on those initiatives that generate greatest benefit to the immediate local community.			
Recommendations			**Priority**
2.1	A timeline will be agreed for the reintroduction of monitoring of those community benefits suspended during the covid pandemic.		**Medium**
2.2	A joint exercise should be undertaken with the Supply Chain Partner to agree the focus of community benefit efforts for the remainder of the programme.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Agreed. A recent appointment within Supply Chain Partner has seen an improved engagement on community benefits.	August 2023	Responsible Officer PCH Programme
2.2	Agreed. A meeting will be arranged to discuss future opportunities and focus.	August 2023	Responsible Officer PCH Programme

Matter Arising 3: Monitoring Changes	Impact
Several changes had been instructed at the programme, which would be expected of a programme of intrusive works: **New in month / Raised / Closed / Open** Project Managers Instructions (PMI): 3 / 463 / 364 / 99 Compensation Events (CE): 3 / 360 / 280 / 80 Early Warnings Notifications (EWN): 1 / 123 / 112 / 11 Contractor Notification of CE: 1 / 34 / 27 / 7 **Total: 8 / 980 / 783 / 197** Accordingly, 20% (or 197) of changes remained 'open' at the time of review: ○ Only 52 of the 197 changes had an been costed with an associated cost of circa £6.112m; and ○ Only 41 of the 197 changes had been dated, with 40% of those being older than 3 months. Delaying the agreement of changes can reduce the negotiation position of the Health Board. These should be resolved as a priority.	Potential risk of: • Costs not agreed prior to works commencing.

Recommendations		Priority
3.1	Appropriate resource should be committed to resolving the 'open' changes as a matter of priority.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
3.1	Agreed. The status of changes will be reviewed for accuracy in the first instance, and management efforts focused on resolving those longer standing changes.	August 2023	Responsible Officer PCH Programme

Matter Arising 4: Contingency Management			Impact
The latest risk register (Updated October 2022) outlined risks had reduced from £13,076,433 to £9,733,332 since the programme progressed on site – a reduction of circa £3.3m. Of the remaining risks, £3,672,683 related to 'high' risk issues. If these risks were to materialise, they would fully consume the remaining contingency of £3.6m (reduced for the current forecast overspend of £1m). This is highlighted within the narrative of the Progress Update Report presented to the Project Board. At the time of the audit, the Project Manager's report indicated that following the recent review of risks 'a review of the financial implications will be undertaken'. This review should focus on the methodology applied to scoring each risk – with particular emphasis on the probability of each risk (a probability risk of 5 being certain to occur).			Potential risk of: • Client contingency is largely consumed by materialised risks.
Recommendations			**Priority**
4.1	The remaining financial values and risk scores at the risk register should be reviewed for adequacy/ accuracy.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Agreed. The risk register was recently reviewed but will be reviewed with consideration of the recommendation prior to being circulation.	August 2023	Responsible Officer PCH Programme

Appendix B: Assurance Opinion and Action Plan Risk Rating

Audit Assurance Ratings

We define the following levels of assurance that that the project achieves its key delivery objectives and that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Decontamination
Final Internal Audit Report

August 2023

Cwm Taf Morgannwg University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Contents

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Auditors:	Paul Dalton – Head of Internal Audit Emma Samways – Deputy Head of Internal Audit Andrea Calise – Principal Auditor
Executive sign-off:	Greg Dix – Executive Director of Nursing, Midwifery & Patient Care
Distribution:	Richard Hughes – Unscheduled Care Group Nurse Director Bethan Cradle – Lead Infection Prevention and Control Nurse Sarah Morgan – Deputy Lead Infection Prevention and Control Nurse & Decontamination Officer
Committee:	Audit & Risk Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

Executive Summary

Purpose

The review aimed to provide assurance that there are effective arrangements and processes in place to manage the current decontamination services across the Health Board whilst proposed future developments are put in place.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- The Health Board's decontamination policy requires updating.
- The decontamination procedures in place at a local level (units/departments) vary widely in terms of their content/quality.
- There is not a dedicated Microbiologist (Decontamination) for the PoW site.
- There is a need to implement a schedule/programme of site audits to assess/evaluate the local decontamination arrangements.

Other recommendations / advisory points are within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Assurance summary[1]

Objectives		Assurance
1	Policies and Procedures	Reasonable
2	Roles and Responsibilities	Reasonable
3	Decontamination Training	Substantial
4	Governance Arrangements	Substantial
5	Monitoring Arrangements	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	The Decontamination Policy (CTM wide) is out of date	1	Design	Medium
2	Standard of quality/content of Decontamination Procedures require improvement	1	Design	Medium
3	Lack of dedicated Microbiologist (Decontamination) for PoW site	2	Design	Medium
5	Schedule/programme of audits be put in place to assess/evaluate the decontamination arrangements	5	Operation	Medium

1. Introduction

1.1 Our review of decontamination arrangements has been completed in line with the 2022/23 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Decontamination is a term used to describe a range of processes including cleaning, disinfection and sterilisation. These processes remove or destroy contamination and prevent infectious agents or other contaminants reaching a susceptible body site in sufficient quantities to cause infection or any other harmful response.

1.3 The Health Board has a legal obligation under the Health and Safety at Work Act (1974) and a duty to ensure that: the decontamination of all re-useable medical devices follows recognised guidelines; and that they are compliant with the current national standards, legislation and recognised guidance documents.

1.4 Systems should be in place to ensure reusable medical devices are appropriately decontaminated prior to use, and that the risks associated with decontamination facilities and processes are adequately managed. Processes apply equally to equipment that is owned, rented or on loan. These processes should protect, as far as reasonably practical, the health, safety and welfare of staff, patients and those recipients who are involved in inspection, service, repair or transportation of medical devices or equipment.

1.5 The Health Board provides acute services through the three main hospitals, Prince Charles, Royal Glamorgan and Princess of Wales (PoW). These facilities provide a broad range of medical and surgical treatments and interventions. The Hospital Sterilisation and Decontamination Units (HSDU) provide a reprocessing service for Reusable Invasive Medical Devices (RIMDs), more commonly known as surgical instrumentation. The scope for this audit did not focus on the decontamination arrangements in place for the HSDU as these arrangements are already under a scrutiny programme through accreditation providers (JAG, SGS, IHEEM).

1.6 In 2021, at the Health Board's request, an independent strategic review of the decontamination service was undertaken by the Specialist Estates Services (SES) from NHS Wales Shared Services Partnership (NWSSP). The review covered the Health Board's existing facilities, engineering infrastructure, equipment, operational management, and services used to decontaminate medical devices. The purpose of the review was to help inform and shape the more detailed work necessary to develop a long-term strategy for the modernisation of the Health Board's decontamination provision.

1.7 The SES report was presented to the Executive team summarising the decontamination issues and concerns that had been identified across the service, and the recommendations for future service improvements. One concern arising from the review was the risk of the PoW hospital site losing its Joint Advisory Group (JAG) accreditation status if there were further delays in progressing the central decontamination scheme at PoW. We understand that since the SES report was published, JAG accreditation was awarded in Endoscopy and not Urology. At the

time of our fieldwork, the Health Board has had a strategic outline case for the PoW hospital centralisation scheme approved by Welsh Government, and they are in the process of developing a full business case to help secure funding for the work. Furthermore, concerns have been escalated with regards to the ageing equipment/infrastructure in Urology and infrastructure in HSDU.

1.8 The potential audit risks considered as part of this review were as follows:

- Patient and staff safety compromised if decontamination is not carried out appropriately.
- Reputational damage through increased publicity if action is taken against the Health Board where decontamination failures occur.
- Financial costs incurred if action is taken against the Health Board.
- Loss of JAG (on GI Endoscopy) accreditation at the PoW site if work to progress a central decontamination facility fails to progress.

2. Detailed Audit Findings

Objective 1: Accessible policies and procedures are in place at both a Health Board and localised level that reflect national guidance.

2.1 We read and reviewed the Health Board's decontamination policy, which was developed in 2017. The policy has adopted best practice guidance as set out by Welsh Government in its health circular on the decontamination of medical devices and makes reference to the latest Welsh Health technical memorandums relating to decontamination. However, the policy was scheduled for review in 2020, but this did not happen due to other priorities during the pandemic. Whilst the policy is readily available on the Health Board's intranet, through our testing we found that generally staff were not aware of its existence. **(Matter Arising One – Medium Priority)**

2.2 In addition to the overarching decontamination policy, there are several local Standard Operating Procedures in place for units and departments that manage decontamination. Our review of a sample of these procedures identified that both the quality and content varied. For example, some procedures had been approved by the Local Decontamination Group and they provided context to decontamination linking to the CTM overarching decontamination policy and set out comprehensive information relating to the type of equipment, decontamination method to be used, step-by-step guidance, staff responsibilities. However, other procedures only set out the basic steps of the decontamination method. **(Matter Arising Two – Medium Priority)**

Conclusion:

We have provided Reasonable Assurance for this objective. While the Health Board has a decontamination policy, it is due for a review. We also found that localised procedures need to be reviewed to ensure that they have an appropriate level of detail.

Objective 2: The roles and responsibilities of staff in relation to decontamination are set out, with named individuals appointed to key posts.

2.3 The Health Board identifies the managerial/lead responsibilities in relation to the decontamination arrangements within the decontamination policy.

2.4 We met with staff to confirm that the key decontamination roles and positions had been appointed to named individuals. We note:

- Until recently the operational decontamination lead role was exclusively assigned to the Deputy Lead Infection Prevention Control Nurse & Decontamination Officer. As such, the Health Board did not have a dedicated post to focus specifically on decontamination. However, we acknowledge that the appointed decontamination officer is now in post and reporting to the Deputy Lead Nurse for IPC and Decontamination. We understand that the officer's responsibilities will include visible leadership across the Health Board, providing specialist advice to clinical and non-clinical areas in relation to decontamination issues and ensuring an integrated approach is in place within the Health Board, which will include risk management, surveillance and audit.
- Prince Charles and Royal Glamorgan sites have a dedicated Decontamination Microbiologist however PoW site does not. The Microbiologist (Decontamination) is designated by management to be responsible for advising the user and management on microbiological and infection prevention aspects of the decontamination of reusable surgical instruments. We acknowledge that the Decontamination and IPC Committee is aware of this issue and has raised a risk within the Decontamination and IPC Risk Register. The Lead IPCN and Deputy Lead IPCN/Decontamination lead are currently in the process of requesting the Health Board for additional resources to establish a dedicated Microbiologist at PoW. **(Matters Arising Three – Medium Priority)**

Conclusion:

We have provided Reasonable Assurance for this objective. Our findings conclude that whilst the roles and responsibilities of staff in relation to decontamination are set out, with named individuals appointed to key posts, the Health Board has only recently (June 2023) appointed a Decontamination Officer (CTM Wide) and does not have a dedicated Microbiologist (Decontamination) in place for the Princess of Wales site.

Objective 3: Staff are suitably trained to perform their duties. Adequate resources and structures are in place to allow delivery of the services.

2.5 The Health Board provides acute services through the three main hospitals, Prince Charles, Royal Glamorgan and Princess of Wales. These facilities provide a broad range of medical and surgical treatments and interventions. Decontamination services across these sites are divided into three distinct streams:

- Sterile service departments (SSDs) – for cleaning and sterilization of surgical equipment and accessories.

- Endoscope decontamination – for cleaning and disinfection of channelled flexible endoscopes.
- Community dental services (CDS) decontamination and sterilization – for cleaning of dental surgical instruments.

2.6 In addition to the above, there are local decontamination arrangements within units and departments across the Health Board which undertake decontamination of medical devices which include non-channelled scopes.

2.7 We tested a sample of units and departments that are responsible for managing their own decontamination arrangements, across the three acute sites to review the decontamination training arrangements in place. We found that:

- Decontamination training for staff is managed locally by the relevant Ward/Unit manager. Provision of training is undertaken by the relevant medical device/decontamination manufacturers.
- Decontamination training records were held locally within each of the units and departments that we tested.

Conclusion:

We have provided Substantial Assurance for this objective. We are satisfied that there are robust systems and controls in place to ensure that staff are suitable trained to perform their duties in relation to decontamination.

Objective 4: Governance arrangements are in place to ensure oversight of decontamination matters including the monitoring of decontamination risks.

2.8 The quarterly Decontamination Committee meetings consists of both operational and clinical leads for decontamination from across the Health Board, including representatives from estates, specialised services, health and safety and procurement. The committee directly reports into the Infection Prevention and Control Committee (IPCC) and to the Quality and Safety Committee. The purpose of the Decontamination Committee is to provide assurance to the IPCC that the Health Board has effective systems in place across all localities to achieve its objectives, complying with all internal and external monitoring, surveillance and reporting arrangements in accordance with Welsh Health Technical Memoranda (WHTM), and decontamination national guidance.

2.9 The Decontamination Committee also provides leadership and direction to the Care Groups, to ensure that a structured approach to the decontamination and safe use of medical devices prior to use, and that risks associated with decontamination facilities and processes are highlighted and adequately managed.

2.10 Local Decontamination Groups are in place for PoW, Prince Charles and Royal Glamorgan sites. They meet at least monthly with meetings chaired by the operational lead for decontamination with representation from the service representatives from the relevant site. The purpose of the group is to monitor compliance of the decontamination facilities, equipment and training through the monthly submissions of Quality Assurance Tools by units and departments that manage decontamination locally. Following each meeting a report on the

actions/risks identified and decisions agreed is presented to the next available Decontamination Committee.

2.11 We note that the Terms of Reference for the Local Decontamination Group needs to be updated as it was due for review in August 2021. **(Matter Arising Four – Low Priority)**

2.12 We confirmed that there are robust arrangements in place for monitoring decontamination risks. Both clinical and operational leads for decontamination are required to identify, assess and report any risks through the Local Decontamination Groups. If the risk requires escalation this is done through reporting into the Decontamination Committee.

Conclusion:

We have provided Substantial Assurance for this objective. We confirmed that there are suitable governance arrangements in place to ensure oversight of decontamination matters through the Decontamination Committee and the site-specific Local Decontamination Groups.

Objective 5: Monitoring arrangements exist to ensure the service is operating in accordance with procedures. Plans are in place to address issues of non-conformance that are identified.

2.13 The decontamination policy requires units and departments that manage decontamination locally to confirm they comply with the policy through an audit process. To address this point departments have been self-assessing their arrangements and facilities and submitting a monthly report to the relevant Local Decontamination Group. We reviewed the latest monthly Quality Assurance tool reports for all three sites and confirmed that the reports happen in a timely manner. The Quality Assurance Tools submissions for Bridgend, are reviewed and checked by the lead officer for Endoscopy Decontamination. The officer also undertakes visits to assess and evaluate the unit and department's decontamination arrangements. However, currently, there is no programme of audits in place to independently assess the decontamination arrangements and facilities for the units and departments that perform localised decontamination in Merthyr and Rhondda localities. **(Matter Arising Five – Medium Priority)**

2.14 In September 2021, SES in conjunction with Health Board representatives within the Health Board, formed a working party to provide a strategic overview of the Health Board's existing facilities, engineering infrastructure, equipment, operational management and services used to decontaminate medical devices. The report made a number of findings and recommendations, which were shared with the Strategic Leadership Board in April 2022. We can confirm that the Health Board is monitoring the progress of implementation within its governance structure. We have listed below the key highlights of the report and provided a brief update on each:

- The Health Board is in discussions with WG and an agreement for a single-stage joint Outline Business Case is under development for a centralised decontamination unit at PoW site.

- The 2018 national survey (endoscope decontamination services) identified concerns at Prince Charles Hospital and Royal Glamorgan Hospital for using manual cleaning systems (chemical wipes) only for decontamination of several medical devices, including non-channelled endoscopes (nasendoscopes) and certain ultrasound probes/transducers. Our site visits noted that such systems are still in place.
- Local decontamination facilities supporting community dental premises are generally in poor condition, with units often lacking appropriate environmental controls. Recommendations have been put forward to the Health Board to explore the transfer of community dental services decontamination activities to accredited Sterile Service Units. We are aware that a small number of clinics have transferred decontamination services to HSDU at POW and there are plans to progress this further.
- The current operational decontamination lead role has had a wide remit with a great number of defined responsibilities and is a shared resource within the Infection Prevention and Control team. We note that the funding has been approved and role assigned with a dedicated Decontamination Officer (CTM wide) which was appointed in June 2023.

Conclusion:

We have provided Reasonable Assurance for this objective. We note that there are controls currently in place to monitor the adequacy and effectiveness of the decontamination arrangements through the Quality Assurance Tools process. We note the Quality Assurance Tools are currently self-assessments led by the individual areas and there is scope to implement a schedule/programme of individual site audits to evaluate/assess the decontamination arrangements in place.

Appendix A: Management Action Plan

Matter Arising 1: Decontamination policy out of date (Design)	**Potential Impact**
The Health Board's decontamination policy was due for review by the Decontamination Group in 2020, but this did not happen due to the operational pressures faced by the Health Board during the Covid-19 Pandemic. While the policy aligns with the latest national decontamination guidance and best practice, it does not cover the following arrangements: • Quality Assurance Tools – There is currently a process in place whereby departments/wards that manage decontamination locally, undertake a monthly self-assessment of their decontamination arrangements and provide a report to the Lead/Deputy Infection Prevention Control Nurse & Decontamination Officer. We note that this is good practice, however these arrangements are not set out within the 'monitoring' section of the decontamination policy. • The role of the Local Decontamination Groups (See Objective 4 for further information). • The role of the Decontamination Officer (role started in June 2023). • We note that the governance arrangements, as set out within the decontamination policy, reflect the Health Board's 'Integrated Locality Group' operating model. The policy should be reviewed and revised to consider the impact of the Health Board's recently implemented 'Care Group Delivery Model'. Our fieldwork identified that generally there appears to be a lack of awareness of the existence of the decontamination policy.	• Patient and staff safety compromised if decontamination is not carried out appropriately. • Reputational damage through increased publicity if action is taken against the Health Board where decontamination failures occur.

	Recommendations	**Priority**
1	The decontamination policy should be reviewed and updated to reflect the most up to date guidance and practices. The revision should ensure that the updated policy reflects the current decontamination monitoring arrangements, the roles and responsibilities of Decontamination Officer and the role and purpose of the Local Decontamination Groups. The policy should also reflect the impact of the Health Board's new operating model. Once revised and approved, the policy should be made available to relevant staff.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1a	Update the Decontamination of Reusable Medical and Surgical Devices Policy (IPC 27).	Sept 2023	Deputy Lead IPCN/Decontamination Lead
1b	Present the updated policy to the appropriate oversight committee for ratification.	Oct 2023	
1c	Implementation of the updated policy to include appropriate team briefing and advisory support.	Nov 2023	

Matter Arising 2: Quality of localised decontamination procedures (Design)	**Potential Impact**
The decontamination policy states that where medical devices are decontaminated locally, there should be adequate standard operating procedures (SOPs) in place to provide guidance to staff on the decontamination processes to follow. We selected a sample of units/departments that perform decontamination locally and reviewed the SOPs in place. We identified that the quality and content of decontamination SOPs in place at a local level varied widely across the Health Board. For example, 'The Decontamination of Trans-Oesophageal Ultrasound Probes used for interventional procedures in Cardio-Respiratory Department' was, very comprehensive and had been approved by the Local Decontamination Group at PoW in May 2023, whereas other SOPs have very limited information.	• Patient and staff safety compromised if decontamination is not carried out appropriately. • Reputational damage through increased publicity if action is taken against the Health Board where decontamination failures occur.

Recommendations		**Priority**
2	A review of locally held decontamination procedures should be carried out to ensure standardised approach to the quality, content and approval.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.a	Audit tools for approval in the next Decontamination Committee meeting (see action 5.1).	Sept 2023	Deputy Lead IPCN/Decontamination lead
2.b	Audit programme to be carried out across all appropriate areas within CTM to inform local SOP status and revisions where required (see action 5.2).	July 2024	Deputy Lead IPCN/Decontamination lead
2.c	All local SOPs are to have been reviewed and ratified for ongoing implementation.	September 2024	Deputy Lead IPCN/Decontamination lead

Matter Arising 3: Lack of dedicated microbiologist at Princess of Wales site (Operation)	**Potential Impact**
The Welsh Health Technical Memorandums (WHTM) 01-01 Decontamination of Medical Devices (Part A through to Part D) recognise the role of the Microbiologist (Decontamination) as a functional responsibility. The Microbiologist is defined as a person designated by Management to be responsible for advising the user on microbiological aspects of disinfecting and sterilising medical devices. They should be defined as the person responsible for advising the user on the microbiological aspects of handling, washing, disinfecting and sterilising used medical devices. The Health Board has recognised the Microbiologist (Decontamination) functional role within the overarching Decontamination Policy. Whilst there is a dedicated Microbiologist (Decontamination) in post for Prince Charles and Royal Glamorgan site, there is not one in post dedicated to PoW. We acknowledge that the Decontamination/IPC Committee is aware of this risk and has captured it within the Decontamination/IPC Risk Register. We are also aware that the IPC Lead Nurse and Deputy Lead Nurse/Decontamination Officer is in the process of requesting additional resources from the Health Board to instate a dedicated Microbiologist (Decontamination) for the PoW site.	• Patient and staff safety compromised if decontamination is not carried out appropriately. • Reputational damage through increased publicity if action is taken against the Health Board where decontamination failures occur.

Recommendations		**Priority**
3	Arrangements be put in place to ensure that there is a dedicated Microbiologist (Decontamination) in place for Princess of Wales site as soon as practically possible.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
3a	Escalation to the Deputy Medical Director and escalated to the last IP&C Committee meeting (11/07/23).	July 2023	Lead IPC Nurse
3.b	Multi-stakeholder meeting to discuss the current arrangements with active service level agreements, Public Health Wales and CTM to inform the programme of work required to reach an appropriate substantive outcome.	September 2023	Deputy Medical Director and Deputy Director of Nursing

3.c	Outcome report and appropriate plan from stakeholder engagement to be presented to IPC Committee meeting.	October 2023	Deputy Medical Director

Matter Arising 4: Local Decontamination Group ToRs (Design)	**Potential Impact**
The Terms of Reference for the Local Decontamination Groups (Bridgend/MTC/RTE) were first developed in August 2020 and were due for their annual review in August 2021. The ToRs currently state that the Senior Nurse/Deputy Head of Nursing is to Chair each meeting however we noted that Chair role has been undertaken by the Deputy Lead IPC Nurse/Decontamination Officer,. Furthermore, we note that as agreed by the Decontamination Committee in February 2023, the Decontamination Officer (CTM Wide) once in post should be the nominated Chair for the Local Decontamination Groups. We note that the Decontamination Officer is now in post and will chair future meetings. The ToRs for the Local decontamination Groups need to be amended.	• Patient and staff safety compromised if decontamination is not carried out appropriately. • Reputational damage through increased publicity if action is taken against the Health Board where decontamination failures occur.

	Recommendations	**Priority**
4	The Terms of Reference for the Local Decontamination Groups should be reviewed and revised (where applicable) and presented to the Decontamination Committee for overall approval.	**Low**

	Agreed Management Action	**Target Date**	**Responsible Officer**
4a	Update the terms of reference for the local decontamination meetings in CTM.	August 2023	Deputy Lead IPCN/Decontamination lead
4.b	Updated and agreed terms of reference to be presented to the Decontamination Committee for discussion and ratification.	Sept 2023	Deputy Lead IPCN/Decontamination lead
4.c	Present reviewed and agreed local decontamination terms of reference to IPC Committee for noting.	October 2023	Deputy Lead IPCN/Decontamination lead

Matter Arising 5: Quality Assurance Tools (Design)	**Potential Impact**
As part of the Quality Assurance Tool, departments/units that perform localised decontamination must self-assess their decontamination arrangements/facilities monthly. As part of the Quality Assurance Tools, units/departments must provide assurance on the following themes: • Medical Devices being used that require localised decontamination and report on any issues; • The decontamination process in place; • Decontamination records held and traceability system in place; • Compliance with Decontamination Training; • Estates related issues and medical devices maintenance/servicing; • Decontamination incident reporting. We note that the Quality Assurance Tools submitted by Units/Departments within Bridgend site are independently checked/reviewed by the Lead for Endoscopy Decontamination. There is no independent checking/assessment in place for the Quality Assurance Tool submissions at the Merthyr and RTE sites.	• Patient and staff safety compromised if decontamination is not carried out appropriately. • Reputational damage through increased publicity if action is taken against the Health Board where decontamination failures occur.

Recommendations		**Priority**
5	A schedule/programme of independent decontamination audits be implemented to evaluate and assess the decontamination facilities/arrangements across the Health Board. The outcome of these audits be summarised into a report for presentation to the Decontamination Committee so that appropriate actions can be taken.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
5a	Decontamination audit tools are currently being developed. Three audit tools will be taken to the next Decontamination Committee meeting for approval. Decontamination audit programme to commence.	Sept 2023	Deputy Lead IPCN/Decontamination Officer

5.b	Audit program to review decontamination facilities/arrangements across the Health Board to inform all appropriate future governance.	June 2024	Deputy Lead IPCN/Decontamination Officer

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

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

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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National Incident Framework
Final Internal Audit Report

August 2023

Cwm Taf Morgannwg University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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Committee:	Audit & Risk Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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

Executive Summary

Purpose

The review sought to provide assurance that there were effective arrangements and processes in place for the application of the Welsh Government national patient safety incidents reporting policy.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- The incident management framework needs to be reviewed in light of the May 2023 NHS Executive Guidance and HB changes.
- Identification of investigating staff that require Root Cause Analysis (RCA) training.
- Evidence not always in place within Datix to support compliance with the framework.
- Action plan not monitored following submission to the Delivery Unit (DU).
- Some key stages and processes within the incident reporting cycle falling behind expectation and reasonable timelines.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	The Incident Management Framework aligns to WG policy and DU guidance.	Reasonable
2	Incidents are identified, captured, investigated, quality assured, approved and responded to.	Reasonable
3	Appropriate actions and learning form events takes place.	Reasonable
4	Monitoring and reporting takes place.	Substantial
5	Incidents are reported within the required timeframes.	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Policy and procedures need to be updated	1	Design	Medium
2	Training required	1	Operation	Medium
3	Evidence to support adherence to the framework to be retained	2	Operation	Medium
4	Outcome from lessons learnt and action plan review	3	Operation	Medium
5	Timeliness of undertaking NRI reviews	5	Operation	High

1. Introduction

1.1 Our audit of the Incident Management Framework was undertaken in line with the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board ('CTMUHB' or 'the Health Board').

1.2 The effective application of appropriate incident management policies and procedures are critical to ensuring both patient safety and operating efficiency of public sector organisations. NHS Wales organisations should maintain policies and procedures setting out the required actions for staff and independent members to follow when they identify a potential risk, or an incident has occurred.

1.3 In June 2021, an NHS Wales National Incident Reporting Policy implementation guidance document (Phase 1) was produced by the NHS Wales Delivery Unit (DU). The document applies to all NHS Wales organisations. The guidance was developed following the issue of the National Patient Safety Incidents Reporting Policy from Welsh Government (WG). The guidance replaces the serious incident section of the Putting Things Right guidance; most notably removing the term 'serious incident' from the policy. The revised approach places a greater focus on maximising learning opportunities at all levels of incident.

1.4 Whilst the DU guidance provides NHS Wales' responsible bodies with the operational detail of how reporting should occur to support implementation of the WG national Incident Reporting Policy, localised procedures are also required. As such, the CTMUHB Incident Management Framework (the 'framework') was launched June 2022. The framework guides staff in making decisions, highlighting the investigation system and future learnings that should be applied to areas within the Health Board.

1.5 The relevant lead for this review was the Executive Director of Nursing, Midwifery & Patient Care.

1.6 The potential risks considered in this review were:

- Non-compliance with relevant legislation.
- Patient harm or poor patient experience.
- Financial loss if action is taken against the Health Board.
- Reputational damage with decreased public confidence.

1.7 Our audit testing has focused on Nationally Reportable Incidents (NRIs) that occurred after April 2022.

2. Detailed Audit Findings

Objective 1: The Health Board has an Incident Management Framework which aligns to the WG policy and Delivery Unit guidance. The framework is accessible to staff and training has taken place where necessary.

2.1 National incident reporting in NHS Wales changed in June 2021, with the production of phase 1 National Patient Safety Incident Reporting Policy by Welsh

Government (WG). Following the publication of the policy, the Delivery Unit (DU) developed guidance for all NHS Wales bodies to use. This was adopted by the Health Board while further work was carried out to establish how it could safely manage the transition and ensure there was a consistency of approach and oversight of incidents meeting the new criteria. In May 2022 the CTMUHB Incident Management Framework was produced, and it was formally launched in June 2022.

2.2 Our review of the Health Board Incident Management Framework found that in the main it aligns to the WG policy and DU guidance. We identified a few areas within the DU guidance that are not clear within the framework, such as setting out the reporting lines into relevant committees and the Board. ***(Matter Arising 1 – Medium Priority)***

2.3 In May 2023, the NHS Wales Executive published a revised National Incident Policy and Guidance document. Due to the timing of our fieldwork, any changes as a result of this revised policy were not included in the current framework. The Health Board framework will need to be reviewed and updated to reflect the revised guidance. ***(Matter Arising 1 – Medium Priority)***

2.4 While the Health Board's intranet includes the Incident Management Framework and associated appendices, the documents are not easily accessible as a 'search' links to a previous version of the framework. This is the same for the 'A-Z listing' within the webpage. ***(Matter Arising 1 – Medium Priority)***

2.5 The central patient safety team have a series of Standard Operating Procedures (SOPs) for use when processing notifications that they receive. These include:

- early warnings notifications SOP;
- locally reportable incidents notification and closures SOP;
- nationally reportable incidents closures SOP; and
- pressure damage combined notification and closure SOP.

A number of the SOPs require updating to reflect the revised operating model in the Health Board, and to remove reference to staff that are no longer in post. ***(Matter Arising 1 – Medium Priority)***

2.6 There are two specific training modules for staff involved with the framework. These are:

- Datix training on how to report an incident within the system – up to three training sessions week were provided when the new system was rolled out and there continues to be weekly training sessions available and training for new users.
- Root Cause Analysis (RCA) training, for managers who undertake investigations of incidents.

2.7 The framework requires that at least one member of an investigation team is RCA trained. We tested a sample of 17 investigations and found for 11 we no member

of the investigations team had undertaken RCA training in the last two years. ***(Matter Arising 2 – Medium Priority)***

2.8 We note that a training needs analysis has been drafted which covers 'Concerns and Incident Reporting awareness' and 'Understanding the process for managing concerns and undertaking RCA training'. Once finalised, management will have a list of staff that require training.

Conclusion:

2.9 The Health Board has a detailed Incident Management Framework in place with supplementary appendices and SOPs. These are based on WG policy and DU guidance. The documents will need to be reviewed to ensure that recent changes to the Health Board's operating model and NHS Wales Executive guidance, are incorporated. The Health Board needs to continue to train staff to ensure compliance with the framework and accurate use of Datix. We have provided ***Reasonable Assurance*** against this objective.

Objective 2: Patient safety incidents are identified and captured, investigated, quality assured, approved and responded to within required timeframes.

2.10 Incidents are logged onto Datix. In April 2022, the Health Board moved to a new Datix system as part of an All-Wales initiative. As a result, incidents that remained open in the old system had to be migrated to the new system.

2.11 When initially logged on Datix incidents are assessed as either: no harm; low harm; moderate harm; severe harm; or death. Investigations into reported incidents are managed by the governance team within each of the former Integrated Locality Groups (ILGs), led by the Heads of Quality & Safety. Depending on the level of harm, staff are allocated responsibility for managing and investigating the incident case. For example, a low harm case is managed by a Ward Manager, while significant cases, whilst still investigated within the localities, will have more involvement from the central patient safety team.

2.12 The central team also has responsibility for:

- forwarding the Nationally Reportable Incidents (NRIs) to the Delivery Unit.
- checking for accuracy, adequacy and completeness of NRI notification forms, though they are not required to undertake any sign off.
- monitoring incidents relating to never events. They are also involved in their investigation.
- attending meetings where teams require support regarding the uniqueness of a reported incident.

2.13 There are a number of stages mapped out in the framework that need to be followed to ensure incidents are captured, investigated, quality assured and approved, with evidence retained in Datix. Actions include completing immediate 'make-safes', where necessary conducting rapid review meetings, completing NRI notification forms and informing the central patient safety team, generating reports and action plans following conclusion of investigations, scrutiny by a quality

assurance panel, Executive approval of a closure bundle of documents and notification to the Delivery Unit.

2.14 Using a report of NRI cases opened between April 2022 and February 2023, we tested a sample of 17 incidents from across Community Services and Surgery, Anaesthetics, Theatres & Critical Care CSG, to confirm the process undertaken in relation to meetings, investigations, approvals and quality review. We saw:

- Evidence of immediate 'make-safe' actions taking place in all cases.
- Lessons learnt and action plans were in place for incidents where the investigation had been completed.
- All pressure damage and fall incidents were reported to the pressure and fall scrutiny panels.
- All NRI forms were approved by the Executive Director, or their deputy.

2.15 However, our testing identified a number of exceptions including a lack of evidence that a rapid review meeting took place where necessary, minutes from the Scrutiny Panel and Quality Assurance Panel meetings not always being present on Datix (though in most cases we could evidence from other sources that the meetings had taken place), and Root Cause Analysis reports were not always present on Datix. Our testing in relation to timeframes has been reported on under objective 5. ***(Matter Arising 3 – Medium Priority)***

Conclusion:

2.16 The Incident Management Framework provides detail on the process to be followed when incidents occur, and our sample testing has confirmed that the process was followed. However, on some occasions documentation or information was not present to support each stage in the process. We have provided ***Reasonable Assurance*** against this objective.

Objective 3: Appropriate actions are undertaken from the 'learning from the event' and 'outcome' reports and learning is shared across the Health Board.

2.17 We have established that a number of mechanisms are in place to allow the sharing of learning across the Health Board.

2.18 On a monthly basis the central patient safety team produces a newsletter providing information such as staff incident related training dates, key patient safety learning and actions, urgent safety briefings and safety alerts. Data in relation to NRIs and LRIs and themes are also included.

2.19 From September 2022 listening and learning events have taken place approximately every six months. We saw that key themes and trends from high profile incidents are discussed.

2.20 Our testing has confirmed that for nearly all completed investigations in our sample, the lessons learnt had been captured, and in all cases, action plans were in place. In most cases we saw evidence of actions being implemented. We note that for the small number of cases where we could not confirm if all actions had

been implemented, this may be due to the incident being closed in Datix ahead of full implementation. We understand that the Health Board has expressed an interest in using the dedicated action plan module available in Datix to allow the ongoing monitoring of action plans. ***(Matter Arising 4 – Medium Priority)***

2.21 A learning repository has been set up on the Health Board's intranet and is accessible to staff. This continues to develop and we understand that lessons learnt will be in one system allowing information to be analysed by theme.

Conclusion:

2.22 The Health Board has in place a number of mechanisms to capture and then share learning from NRIs and wider. The current Datix set up makes it more difficult for action plans relating to NRIs to be followed up and monitored once the incident has been closed in Datix. We have provided ***Reasonable Assurance*** against this objective.

Objective 4: Monitoring (including the identification of themes) and reporting takes place at appropriate forums within the Health Board, with escalation where necessary.

2.23 The Health Board monitors and reports incidents in a number of ways. Every two months a patient safety quality dashboard, is taken to the Health Board's Quality and Safety Committee. Prior to the change in the operating model, the dashboard included appendices provided by each locality. However, now overarching data on the NRIs and Locally Reportable Incidents is presented and granulated information on topics such as pressure damage incidents and falls.

2.24 More locally, each former ILG holds a regular governance meeting, where an incidents tracker is reviewed. Weekly reports analyse incidents by theme, by harms and near misses. In addition, there are weekly meetings between the Heads of Quality and Safety from the localities and the lead for business intelligence. Detailed information on a range of patient safety matters including NRIs is presented along with an 'at a glance' report which provides a visual summary.

2.25 Executive led weekly patient safety meetings are also held, to which issues from the previous weekly meeting are escalated.

2.26 There is a quarterly shared listening & learning forum which is chaired by the Executive Director of Nursing, Midwifery and Patient Care, and includes a director representative from each locality. The forum:

- oversees the Health Board's framework for listening to and learning from quality and patient/staff related concerns and experiences, to ensure it is consistent with the requirements and standards set for NHS bodies in Wales;
- discusses information from the learning and sharing from different parts of the Health Board, internal newsletters and learning from external organisations.

2.27 The DU also generates quarterly dashboards at an all-Wales and Health Board level that includes data on the number of NRIs the Health Board has reported, analysed

across months, severity and location. The purpose of this reporting is to ensure good governance both on the part of the DU, responsible for the national reporting process, and individual organisational governance responsibilities in complying with the published policies and guidance.

Conclusion:

2.28 The Health Board has a structure in place that provides effective mechanisms for monitoring from a localised level up to the Quality and Safety Committee of the Board. The regularity of monitoring at a local level allows for the prompt escalation of cases where necessary. We have provided ***Substantial Assurance*** against this objective.

Objective 5: Relevant incidents, including nationally reportable incidents, are reported within the required timeframes in accordance with the national reporting requirements.

2.29 We analysed the time taken for our sample of 17 incidents to progress through the incident lifecycle. We compared the time taken against the target timeframes set out in the Incident Management Framework. We saw all 'make-safes' were within the first 72-hour target, and all had the investigation phase completed within 12 working days from the date the investigation was started. However, we also saw a number of instances where the time taken to complete some actions, far exceeded the target timeframes. For example, the time taken for an investigation to start once it had been reported, and the time taken for the NRI notification forms to be approved by localities.

2.30 The time taken for incidents to be closed on Datix after the investigation was completed varied considerably, from between 11 days to over one year. The approach to closing incidents on Datix may be inconsistent, as some incidents are closed when all actions related to the action plan have been closed, whilst others were closed on Datix at earlier stages of implementation of the action plan. This links the point raised in paragraph 2.20. ***(Matter Arising 5 – High Priority)***

Conclusion:

2.31 The processes are well defined within the framework. However, the importance of service areas taking a proactive approach to the documentation and timeliness of the incident reporting process is key. Embedding this into training sessions would help mitigate the matters we have identified. While the timeliness of the majority of the incident reporting stages that we tested were appropriate, we identified some stages within the incident reporting process that were longer than the expected and established timelines. We have provided ***Reasonable Assurance*** against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Update of policy and procedures (Design)	**Potential Impact**
The Incident Management Framework was launched June 2022. The new framework and associated documents are on the Health Board's intranet pages but they are not easy to find. We searched for 'incident management' on the intranet, which linked to the previously published incident reporting policy, guidance and investigation documents are found. Similarly, the previous policy is listed in the risk management policy section of the intranet. Furthermore, the A-Z section has an 'Incident Reporting' page, but again links to the old policy. The new framework and guidance can be found in the 'Quality Governance and Patient Safety' section of the A-Z. We are aware that since the Incident Management framework was launched, there have been changes to the operating model, with a move away from Integrated Locality Groups to Care Groups. These changes are yet to be reflected in the policy. Similarly, from our review of the Standard Operating Procedures we note they reference individuals that are no longer in post. The NHS Wales National Incident Reporting Policy Implementation guidance document (Phase 1) sets out the requirement for clear lines of reporting to relevant committees and the Board. Although our review of the monitoring and reporting of incidents has identified that the Board and relevant committees are sighted on this information, the Incident Management Framework does not make reference to how reporting will take place. In May 2023 the NHS Wales Executive published a revised National Incident policy and guidance document. Changes required as a result of this new guidance will need to be captured in any updates to the framework.	Non-compliance with the most relevant legislation. The Health Board received notification of the NHS Executive National Incident updated policy in May 2023. A task and finish group has been implemented to review the Health Boards current Incident Investigation Framework

Recommendations		**Priority**
1.1	Management should ensure all out of date guidance documents are removed from the intranet and only relevant policies and procedures are made available.	**Medium**

1.2	The Incident Management framework should be reviewed and updated where necessary to take account of the Health Boards new operating model, the recently published updated guidance and incorporate information on reporting processes.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	All policies and procedures relating to Incident & Concerns Management will be uploaded to SharePoint and previous versions removed.	01.10.23	Head of Concerns & Business Intelligence Clinical Lead for Serious Incidents
1.2	The Health Board's Incident Management Framework to be reviewed in line with the recommendation, duty of Candour requirements and agreed proposal to remove reference to the Locally Reportable Incident Proforma.	01.10.23	Head of Concerns & Business Intelligence Clinical Lead for Serious Incidents

Matter Arising 2: Training (Operation)	**Potential Impact**
A training programme is in place covering both Datix training on how to report an incident, and Root Cause Analysis (RCA) training used when investigating incidents. The Incident Management Framework states that at the investigation stage, at least one member of the investigation team must be RCA trained. From the sample of 17 cases reviewed we identified from Datix the name/s of the investigators. In 11/17 cases, we could not confirm that at least one person involved in the investigation had undertaken RCA training in the last 2 years. We acknowledge that some staff have been in post many years and are experienced and may have undertaken training previously. However, there remains a risk that staff who are not fully trained are undertaking investigations. Given WG's revised approached to incident reporting and the HB's revised Incident Management Framework and approach to shared learning, it is important to ensure all staff are fully trained on the most up to date practices and approaches. We are aware from other audit work that a training needs analysis has been drafted. This covers 'Concerns and Incident Reporting awareness' and 'Understanding the process for managing concerns and undertaking RCA training'. It is our understanding that once the training needs analysis is finalised, managers within the Care Groups will be asked to identify the staff in their areas that require training and at what level.	Non-compliance with relevant legislation.

Recommendations		**Priority**
2.1	The draft training needs analysis should be finalised and staff in Care Groups should be requested to identify who needs to attend incident management training and RCA training. As part of the process of identifying staff training needs, consideration should be given to if refresher training on Datix is required.	**Medium**
2.2	In the meantime, it should be ensured that at least one member of the investigation team on cases is RCA trained.	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
2.1	A training strategy to be developed which outlines all levels of training in relation to Incident and Concerns Management for different staff groups across the Health Board. This will include a reference to Datix Cymru requirements. Following approval of the Strategy, a training need analysis will be undertaken and a training Programme established.	01.11.23	Clinical Lead for Serious Incidents Head of Concerns & Business Intelligence
2.2	Ensure that a member of the Investigation Team has received the appropriate RCA Training. Remind Care Group Leads of the requirement to include one appropriately RCA trained member in the Investigation Team. Undertake checks during the Quality Assurance Process to confirm the requirement has been fulfilled. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible care group.	01.09.23	Clinical Lead for Serious Incidents

Matter Arising 3: Evidence to support adherence to the framework (Operation)	**Potential Impact**
From our analysis of NRIs reported between April 2022 and February 2023, we undertook detailed testing of a sample of 17 cases from Community Services (ten cases) and Surgery, Anaesthetics, Theatres & Critical Care (seven cases). Our testing looked to evidence the key stages in the 'incident lifecycle' including investigation, quality assurance and approval process. As a result of some of our sample being at the different stages within the incident reporting process, some of the tests undertaken were not applicable. The following exceptions from the whole process were made: • 6/10 had no information in relation to the Rapid Review meeting. While we note that in certain circumstances these meetings may not be required, in the six cases identified it was not clear if the meeting was needed. • 2/17 incidents did not have a proposed investigation timeline stated on the NRI notification form. • 9/13 scrutiny panel minutes were not on Datix. However, we confirmed the panel meeting dates from other documentation. It was not clear on what the expectations were to save panel minutes to Datix. • 9/12 quality assurance panel minutes were not on Datix. Again, it was not clear on what the expectations were to save panel minutes to Datix. • 7/11 RCA reports were not on Datix. • 3/10 closed incidents had no Delivery Unit reference number entered on Datix. We also identified that the quality assurance checklist is a key document which highlights information around the tools and approaches used to evidence that incident went through the due process. From our sample of 17 cases the checklist was not always completed adequately. For instance, questions in relation to if investigators were RCA trained, or if investigation analysis tools were used, routinely had a 'yes' response, but no details of the relevant investigator or the tool/s used were not recorded.	Patient harm or poor patient experience.

Recommendations		**Priority**
3.1	Management should ensure all documentation in relation to NRIs is appropriately completed with relevant documentation saved to Datix. This includes:	

	• Evidence of rapid review meetings taking place or confirmation that one was not required. • NRI forms capturing the proposed investigation timeline which will allow future monitoring and reporting to take place. • The quality assurance checklist recording all relevant information such as who the RCA training investigators are, as opposed to just ticking that someone is RCA trained. • All relevant fields within Datix completed as required. • Copies of the RCA report saved to Datix. • A consistent approach to the saving of panel minutes to Datix, giving consideration to if a panel reviews more than one case, the data protection implications of saving the full set of minutes to individual Datix records.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
3.1	Reminder to be sent to all Care Groups of the need to ensure that all documentation has been uploaded to Datix Cymru. Datix Cymru Incident Management Training to include the requirement to upload all documentation to Datix Cymru. The quality assurance process will include a check that ensures all required documentation has been uploaded. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible Care Group.	01.09.23	Head of Concerns & Business Intelligence Clinical Lead for Serious Incidents

Matter Arising 4: Review of lessons learnt and action plans (Operation)	**Potential Impact**
We tested the same sample of 17 cases to confirm that for completed investigations lessons learnt had been documented and follow up action plans were in place. While all expected action plans were in place, for 3/14 we could not evidence that work had been undertaken to implement actions. Furthermore, it is not clear how subsequent follow up work and documented updates are undertaken on action plans following submission to the DU, at which point all documentation is saved in a PDF format to Datix. We understand that Datix has a module that could be used for capturing action plans and ongoing monitoring. This would allow for more timely closing of cases as opposed to having to wait for the majority of actions to be implemented, yet still allow the action plans to be updated as work to implement them takes place.	Patient harm or poor patient experience. Reputational damage where lessons are not learnt and similar incidents occur.

	Recommendations	**Priority**
4.1	Further work should be carried out to explore the option of accessing the action plan module in Datix, thus allowing the NRI to be closed in Datix more timely following completion of the investigation, yet still allowing the monitoring of the implementation of actions. Whilst this option is explored, it should be ensured that the action plans saved to Datix are adequately completed with evidence of actions taken to date and if necessary, a process for following up on actions following submission of the paperwork to the NHS Wales Executive (formerly the DU.)	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
4.1	Ensure that all required staff have access to the actions module and appropriate training is provided. This will be linked to the implementation of the revised Incident Management Framework. The quality assurance process will include an assessment to confirm that an action plan has been developed and upload to Datix Cymru. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible care group.	01.10.23	Head of Concerns & Business Intelligence

Matter Arising 5: Review of timeframes of incidents reported (Operation)	**Potential Impact**
For our sample of 17 cases we reviewed the time taken to undertake key aspects of the process and compared these to the timeframes set out in the framework. As we note in matter arising 3, due to the stage the case is at in the incident lifecycle, some testing was not relevant to some of the incidents in our sample. Our findings are as follows: • 6/10 had no evidence of a rapid review meeting. For the four where there was evidence, 1/4 was outside the 3-day target. • 2/17 cases the time taken for the incident to be reported after it occurred was 13 and 35 working days. Given that rapid review meetings should take place within 3 days, we would expect the initial reporting of incidents to have taken place timelier in these instances. • 5/16 cases an investigation did not start until more than 17 working days after it was initially reported, with the longest taking over 3 months to start. • 14/16 took longer than the 7 day target to get the NRI notification approved by the ILG. • 5/10 took over 100 working days for the incident to be closed on Datix after it was reported. While there is no target timeframe, the framework requires the investigation team to estimate a timescale for completion, based on the nature and complexity of the incident. In 4/5 of these cases the predicted timescale was 60 working days and in the remaining case the timescale had not been recorded on the notification form. • 9/10 took between one month and one year to close the investigation in Datix after the investigation was completed. The long timeframes for this may be attributed to the fact that some incidents are only closed upon implementation of all actions in their action plans, whereas others are closed irrespective of action plan completion. We also note that the date that 'make-safe' action is taken is not captured in Datix. While we saw this information within other documentation, and confirmed that all actions happened with in the 72-hour timeframe, the lack of a Datix field to capture this information makes it more difficult for the Health Board to monitor compliance with the make-safe target.	Financial loss if action is taken against the Health Board. Reputational damage with decreased public confidence.

Recommendations		Priority
5.1	Management should ensure that incidents are processed within the expected timeframes as stated in the policy and framework, or within a reasonable timeframe. Management should review the key parts of the process where significant delays are occurring with a view to understanding any reasons behind the delay and revising or refining approaches to help reduce the delays. There should be an agreed mechanism in place for ongoing monitoring and reporting of the key stages within the incident life cycle.	**High**
5.2	In order to allowing monitoring and ensure compliance with the 72-hour timeline placed in changing the new incident to 'make safe', the make safe date should be captured within Datix.	**Low**

Agreed Management Action		Target Date	Responsible Officer
5.1	A process for providing and monitoring data in relation to the timescales for reviewing, investigating and closing of incidents on a weekly basis to be established. Information in relation to Incident Management Timescales to be included as part of the Care Group dashboard development work currently being undertaken. The information will be presented to the Care Group Quality & Governance Meetings and the Weekly Patient Safety Executive Meeting.	01.09.23	Head of Concerns & Business Intelligence
5.2	An audit programme of new, open and closed incidents to be implemented to ensure that all required fields are completed in the required timescales. Feedback from the audits will be presented to the Care Group Quality & Governance Meetings and the Weekly Patient Safety Executive Meeting.	01.10.23	Head of Concerns & Business Intelligence

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

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

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Performance Reporting – Integrated Performance Report

Internal Audit Report

July 2023

Cwm Taf Morgannwg University Health Board

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

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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

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

Executive Summary

Purpose

The overall objective of the audit was to provide assurance on the effectiveness of the Health Board's performance reporting arrangements with particular reference to the Integrated Performance Report.

Overview

The matters requiring management attention include:

- The draft Performance Framework needs to be reviewed and updated to reflect current WG guidance, the Health Board's structure and provide a clearer understanding of how performance will be monitored across the Health Board.
- The report compilation process should be strengthened.
- The content of the Integrated Performance Report should be reviewed.

Other recommendations are within the detail of the report.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 2017/18

Assurance summary[1]

Objectives		Assurance
1	Appropriate governance arrangements in relation to monitoring performance are in place.	Reasonable
2	Robust systems and processes exist to capture and validate performance information.	Limited
3	Performance reporting is effective to allow appropriate decisions to be made and actions taken.	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Draft Performance Management Framework to be reviewed.	1	Design	Medium
2	Performance report compilation process to be strengthened.	2	Operation	High
3	Content of Integrated Performance Framework to be reviewed.	3	Operation	Medium

1. Introduction

1.1 Our review of Performance Management and Reporting was completed in line with the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Effective performance monitoring and reporting is integral to the Health Board's overall management and assurance arrangements. Performance reports should provide accurate, reliable, complete and timely management information, and assurances to senior management and Independent Members on the attainment of targets and overall performance, in order to provide a sound basis for decision making and maintaining accountability. Performance reporting should focus on continuous improvement and delivering improved outcomes, highlighting when action is required to meet expected outcomes aligned to health board strategies and ministerial priorities.

1.3 In recent months the Health Board has reviewed its Integrated Performance Report (the 'dashboard') and performance information reporting, resulting in a revised report format that is now presented to the Board and its committees.

1.4 The Health Board is in the process of implementing its new Care Group model. As such, our review has focused on the dashboard reporting that gives an organisation wide view of performance to the Board.

1.5 The potential risks considered in this review were as follows:

- Inappropriate assurances provided and reputational damage caused if inaccurate or incomplete performance information is presented.
- Services fail to meet performance measures due to ineffective monitoring and governance arrangements.
- Poor decisions made, or corrective action not taken where information is lacking.

2. Detailed Audit Findings

Objective 1: Appropriate governance arrangements in relation to monitoring performance are in place, which includes a framework, and links to both Welsh Government and Health Board objectives.

2.1 Each month the integrated performance report is reviewed by the Strategic Leadership Group. For months where there is a Planning, Performance and Finance (PP&F) committee or Board meeting, the performance report is included on the agenda. A Standard Operating Procedure (SOP) is in place in relation to preparing the report.

2.2 In January 2022 the Health Board developed a draft Performance Management Framework. While many of the principles set out in the framework are in place, it appears that it has not been formally approved. It is our understanding that the

framework will be redrafted in 2023, incorporating findings from our review as appropriate. **(Matter Arising 1)**

2.3 The draft framework appropriately outlines the Health Board's intentions in relation to performance management, including the objectives of its performance framework, how a culture of performance improvement will be developed, and the roles and responsibilities of officers and committees across the Health Board. However, some processes, such as 'earned autonomy', where the degree of scrutiny is linked to performance, have not been taken forward. While the draft framework sets out the existing assurance structure and escalation route, recent changes to the Health Board structure will need to be considered when it is updated. **(Matter Arising 1)**

2.4 The draft framework also needs to be updated to capture the requirements of the new Welsh Government (WG) performance framework as currently an older delivery framework is referenced. The updated WG framework has introduced new performance measures, while other measures are no longer used. Since the completion of our fieldwork, we have been made aware that an update WG framework is due for publication by the end of June 2023. **(Matter Arising 1)**

2.5 The draft framework captures both the Health Board's four strategic objectives, as set out in its IMTP, and the Ministerial priority measures. There are over 250 key performance metrics in the draft framework, each listed as being linked to either a Health Board objective or a Ministerial measure.

2.6 We compared the draft framework to the performance measures in the 2022/23 WG delivery framework, but the link between the 76 performance measures, set out as part of the WG quadruple aims, and the performance metrics listed in the draft framework was not clear, nor was the link to IMTP trajectories as required by Welsh Government **(Matter Arising 1)**

2.7 The draft performance framework references meetings where performance against key metrics is monitored, including the dashboard report that is taken to Board. However, not all of the 250 metrics listed in the framework are reported in the dashboard, and it is not clear where the other metrics are reported. **(Matter Arising 1)**

2.8 Some parts of the draft framework need to be clearer. For example, the escalation and assurance structure diagram reference the Audit and Risk Committee and the Quality and Patient Safety Committee, yet the 'roles and responsibilities' section of the framework does not identify their role in monitoring performance. **(Matter Arising 1)**

Conclusion:

2.9 The Health Board has a draft Performance Framework which sets out its performance monitoring intentions. The Health Board's key strategic aims and WG priorities are incorporated in the framework. However, the framework needs to be updated to align it to the forthcoming WG framework and the Health Board's new care group model. Furthermore, the Health Board needs to be clear how it decides

which metrics will be reported in the dashboard. We have provided Reasonable Assurance against this objective.

Objective 2: Robust systems and processes exist to capture and validate performance information, including checks for completeness and accuracy, and supporting narrative information.

2.10 A Standard Operating Procedure (SOP) is in place in relation to preparing the integrated performance report. However, the draft framework is not clear which performance metrics should be included in the report, or how the 'RAG' rating should be applied in the scorecard contained within the report. **(Matter Arising 2)**

2.11 Each month the integrated performance report is prepared, predominantly by one individual. Other staff are not routinely involved in the compilation of the report so if the preparer is absent, there is a risk that timely performance information may not be available to help decision making. **(Matter Arising 2)**

2.12 The SOP outlines the key sources of information for each section of the integrated performance report. Data is obtained from a number of sources internally, by relevant departments and for the scorecard element of the report, extraction from the WG Planning Delivery & Performance website, having previously been uploaded by departments within the Health Board. We understand that data validation should be undertaken by departments before it is uploaded to the WG Planning Delivery & Performance website. Other data and narrative is sourced from key individuals within the Health Board. The SOP requires that 'all available data published should be checked and balanced to the working data held internally, and any discrepancies investigated.' We note that data that is provided internally from the information team is supplied by various members of the team who we understand apply data standards and methodology. We note that the Performance Monitoring Manager and the lead for Data Intelligence and Compliance within the Digital & Data Directorate provide scrutiny to the performance report, some elements of which are reliant on their existing understanding and knowledge of the data sets. **(Matter Arising 2)**

2.13 This current process for bringing together the data from the various sources and preparing the report is manual. **(Matter Arising 2)**

2.14 As part of the validation process prior to publishing, the draft report should be reviewed by the lead for data intelligence and compliance ahead of sign off by the Executive Director of Strategy & Transformation. This allows for the narrative data provided by data owners, and other data and information contained in the report, to be triangulated to ensure consistency. A corporate reporting timetable exists and therefore the dates that the draft report is to be provided to the lead for data intelligence and compliance for review are documented. However, beyond this, we were informed that there is no formal timetable scheduling the stages of report compilation, such as deadlines for gathering performance data and obtaining narratives from data owners. As such reliance is placed on the Performance Monitoring Manager's knowledge of when to request information from individuals.

Without a formal detailed timetable, the meeting reporting deadlines could be missed if key staff are absent and dates are not known in advance.

2.15 We understand that there have been occasions where the timing of the reporting has meant that a full review has not been possible by the accountable Executive for Performance. **(Matter Arising 2)**

Conclusion:

2.16 The Health Board has a process to capture and report performance data in its Integrated Performance report. However, the current approach relies on the specialised knowledge of a small team of individuals to create the report and sense check the data. We found that whilst procedural guidance is in place, it is not sufficiently detailed and would benefit from a more detailed timetabled approach. We have provided Limited Assurance against this objective.

Objective 3: Performance reporting is effective to allow appropriate decisions to be made and actions taken, including timeliness and consistency.

2.17 The monthly performance reports are reviewed at the Strategic Leadership Group, and for months where there is a PP&F Committee or Board, reports are submitted to these meetings. However, as noted above, while the reports are prepared in time for the meetings, we understand that sometimes there is insufficient time for the reports to be fully scrutinised by the lead Executive ahead of publishing. **(Matter Arising 3)**

2.18 While the performance report includes narrative information which provides context to the metrics, and in most cases includes the plan to help improve performance, the report appears to be long and lacking a consistent structure. **(Matter Arising 3)**

2.19 We compared the November 2022 performance report to the WG NHS Performance Framework and identified that a number of the quadruple aim measures were not reported. While we acknowledge that some measures may not be relevant to the Health Board, or may have annual data points, most should be relevant. We also note that the eight operational measures outlined in the NHS Performance Framework 2022/23 document are not reported in the integrated performance report. We acknowledge that there are often in-year changes to what WG requires the Health Board to report on and the performance report therefore ends up being a dynamic report to reflect this. **(Matter Arising 3)**

2.20 We reviewed the performance report taken to the February 2023 PP&F Committee and note a more streamlined approach. Previous reports included metrics on the four themes of Quality, People, Access (Performance) and Finance. The revised report focused on the Performance and Finance themes. As such, no Quality or People metrics were reported, nor was there information for a number of metrics relating to WG quadruple aims one, three and four. Whilst we have seen 'Quality' performance metrics reported to the Quality and Patient Safety Committee, due to committee timings we have not been able to confirm if all the 'People' metrics will be reported to the People and Culture Committee. **(Matter Arising 3)**

2.21 The Board meeting continues to receive information on all four themes and all of the WG quadruple aims giving an integrated overview of performance of the Health Board. Whilst a streamlined approach to reporting within committees may create a more user-friendly report, management must ensure that key metrics have appropriate scrutiny through a committee, ahead of reporting to the Board. **(Matter Arising 3)**

Conclusion:

2.22 The Integrated Performance Report provides a platform for performance to be reported, interrogated and actions to be taken. However, not all WG metrics appear to be reported and the current format may mean that key messages are not clearly identified. We understand that work to revise the report has already started. We have provided Reasonable Assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Draft Performance Management Framework to be updated (Design)	**Impact**
In January 2022 the Health Board developed a draft Performance Management Framework. The framework has remained in draft and has not been widely circulated. The performance management structure within the draft framework is not clear. We note: • At points, the framework document refers to it being a strategy which will not include a list of KPI to allow future flexibility. However, the framework also sets out over 250 key performance metrics that have either been aligned to Ministerial performance measures or the Health Board's four strategic aims. It is not clear how these align to the WG delivery framework, how it is determined which of the 250 metrics are to be captured in the monthly performance dashboard, or the link to IMTP trajectories. • The draft framework needs to be updated to reflect the most recent NHS Wales Performance Framework & Guidance, which includes updated performance metrics under the quadruple aims. The updated WG framework also includes eight specific 'operational measures', but these are not referenced in the performance framework. • The framework needs to be updated to reflect the Health Board's new care group model as it currently references the previous Integrated Locality Group model. • Reference is made to the roles and responsibilities of some of the Board committees, but not all, and the escalation and assurance structure between committees. However, the governance arrangements and links to the listed performance metrics are not clear. For example, the responsibility for gathering, reviewing and monitoring performance data to determine if it is 'off trajectory', and needs escalation. We acknowledge that the Health Board has delayed updating the draft framework until after our audit work has been completed.	Potential risk of: • Inappropriate assurances provided and reputational damage caused if inaccurate or incomplete performance information is presented; • Services fail to meet performance measures due to ineffective monitoring and governance arrangements; • Poor decisions made, or corrective action not taken where information is lacking.

Recommendations		**Priority**
1.1	The draft performance management framework should be reviewed to ensure:	**Medium**

	• There is alignment to the most up to date Welsh Government Performance Framework, ensuring all metrics and measures outlined are accurate and there is link the IMTP trajectories required by WG • Greater clarity is provided on how the framework will be applied in practice, including how reporting against metrics will take place. • Listed metrics can be clearly linked to source requirements e.g. WG quadruple aims, other national indicators, internal indicators. • The roles and responsibilities of all Health Board Committees is set out including how those roles relate to one another. • Reference is made to the revised operating model and therefore reporting structure within the Health Board. Following the completion of the review, the framework should be appropriately approved and made available to relevant staff.	

Agreed Management Action		Target Date	Responsible Officer
1.1	The Health Board needs to formalise a Performance Framework. This review will consider the points listed above.	QTR 4 2023 / 2024	Executive Director of Strategy & Transformation / Director of Digital

Matter Arising 2: Integrated Performance report compilation (Operation)	**Impact**
We reviewed the process for generating the monthly integrated performance report and identified: • The Standard Operating Procedure (SOP) is not detailed in relation to certain stages in the process. For example, the SOP states that the performance report is a 'dynamic' document, suggesting different metrics may be reported each month, dependant on performance. Whilst a list of core measures and indicators is embedded within the SOP, there is no information on the discretion to be exercised, or for determining what should be reported each month. • The process for compiling the monthly report is manual, with data and narrative information collated from several sources. Currently, work to prepare the report is predominantly undertaken by one member of staff. • There is no formal detailed timetable setting out the stages for producing the report. Although we understand the staff member compiling the report has their own timetable of when to contact data owners. We note that at times there has been insufficient time for the Executive Director of Strategy & Transformation to perform a thorough review and triangulation of data ahead of the report being published to meet reporting deadlines. • While the validation of data prior to inclusion in the report should be undertaken at source prior to it being submitted by data owners, the SOP requires data to be 'checked and balanced' and 'discrepancies investigated'. However, the SOP is not clear how this process should be undertaken.	Potential risk of: • Inappropriate assurances provided and reputational damage caused if inaccurate or incomplete performance information is presented; • Services fail to meet performance measures due to ineffective monitoring and governance arrangements

Recommendations		**Priority**
2.1	The Standard Operating Procedure for preparing the performance report should be enhanced to fully set out the process for preparing the report. It should include more comprehensive information on how it is determined, which performance measures are to be reported on, how data should be checked for accuracy and completeness and a detailed monthly timetable for production that allows sufficient time for Executive review.	**High**

2.2	A review of the process for compiling the performance report should be undertaken in an attempt to move away from a manual, resource intensive approach to a more automated one, that will allow more time for interrogation and validation of the data.	
2.3	It should be ensured that a number of staff are proficient in preparing the performance report to avoid over reliance on one individual.	

Agreed Management Action		Target Date	Responsible Officer
2.1	A review of the Standard Operating Procedure will be undertaken to ensure it comprehensively covers the activities required.	QTR 3 2023/2024	Director of Digital
2.2	A review of the process for compiling the report will be undertaken to ensure all opportunities have been taken to minimise manual burden.	QTR 3 2023/2024	Director of Digital
2.3	A number of the team are already included in the preparation of the performance report. A review of the existing capacity to support the performance report will be undertaken.	QTR 3 2023/2024	Director of Digital

Matter Arising 3: Structure and content of the Integrated Performance Report (Operation)	**Impact**
The November 2022 Integrated Performance report was 51 pages in length and not in a standard format across the document. Our review identified the following points: • The concept of a scorecard with the Quality, People, Access (Performance) and Finance quadrants at the start of the report, allows for an integrated picture the Health Board performance against key metrics to be presented. However, it is not clear to the reader why the series of metrics under each of the quadrants has been selected and if they are linked to one of the WG quadruple aim metrics or an internal Health Board metric. Furthermore, the opening paragraph of the report references 29 performance measures in the scorecard, yet there are 32 RAG rated metrics listed in the scorecard, plus another 18 metrics reported without a RAG rating. • We compared the information contained in the report against the WG NHS Performance Framework. The framework outlines 84 performance measures set out under the quadruple aims that all health boards should report where applicable. We identified 20 measures that did not feature in the report, while some were not relevant to the Health Board, or may have annual data points, it was not clear why they had were excluded. We also note that the Health Board does not appear to report against all of the eight operational measures outlined in the NHS Performance Framework. • The report includes sections that provide more detailed information on key metrics from each of the four quadrants, but the reason why these metrics are reported in more detail is not clear. • The final section of the report is a summary of key risks and matters. Whilst there is a detailed summary of the 'Quality' quadrant, the reader of the 'Performance' quadrant is referred back to the detail within the report, and for the 'People' quadrant there is no information. Information relating to the 'Finance' quadrant is contained in finance performance updates reported separately at Board meetings. As such, this lack of consistency means that it is difficult to see where they may be interconnected issues. We note that until recently the Integrated Performance Report taken to Board was presented to the PP&F Committee. The draft Performance Framework states that the PP&F committee should be scrutinising and reviewing (performance) to a level of depth and detail that is not possible in Board meetings. However, we note that the PP&F Committee focused on the performance and finance quadrants of the scorecard and report, with wider discussion on quality and people metrics to be held in other committee meetings.	Potential risk of: • Inappropriate assurances provided and reputational damage caused if inaccurate or incomplete performance information is presented; • Poor decisions made, or corrective action not taken where information is lacking.

The February 2023 Integrated Performance Report taken to PP&F committee was a more streamlined report. The scorecard had been removed, only quadruple aim two was reported and there were no metrics in relation to people or quality. Whilst we acknowledge that this is in an attempt to make the report more focussed, it needs to be ensured that other Health Board Committees receive relevant metrics and the Health Board is reporting on all that it is required to report on.		
Recommendations		**Priority**
3.1	It should be ensured that current versions and future iterations of the Integrated Performance Report include all relevant WG metrics that the Health Board is required to report on, as set out in the WG Performance Delivery framework.	**Medium**
3.2a	We acknowledge that work has already commenced to review the format of the Integrated Performance Report. As part of that review process, the views of stakeholders should be sought, and consideration given to alternative reporting formats such as an interactive dashboard in order to make the report more user friendly.	
3.2b	Consideration should be given to: • Cross referencing the performance being reported on to either the relevant Health Board strategic aim and/or the relevant WG quadruple aim. It should be clear to the reader why the metrics reported on are included. • Including clear information pertaining to the most high-risk areas to ensure these are discussed and acted on appropriately and in good time.	
3.3	The reporting arrangements for the component parts of the Performance Report should be reviewed to ensure all aspects are being reported on and respective committees are aware of their responsibilities in relation to reporting. Consideration needs to be given as to how an integrated / Health Board wide view of performance will be achieved if performance monitoring is going to be undertaken in constituent parts.	

Agreed Management Action		Target Date	Responsible Officer
3.1	Review the presentation of the Integrated Performance Report, recognising the dynamic nature of the report and the need to respond to metrics and ministerial priorities. The report will continue to provide all metrics whether as an appendices' or in the main body of the report.	QTR 3 2023 / 2024	Director of Digital
3.2a 3.2b	Review presentation and layout of the report as appropriate to the requirements of the Board. As 3.2a	QTR 3 2023 / 2024	Director of Digital
3.3	As part of the performance report review, consideration will be taken for all component parts.	QTR 3 2023 / 2024	Director of Digital

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Follow-up: Radiology Workforce
Final Internal Audit Report

August 2023

Cwm Taf Morgannwg University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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Committee:	Audit and Risk Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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

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

Executive Summary

Purpose

Our review has followed up on the workforce recommendations made in our 2022 Radiology Service audit. We have sought to ensure that for recommendations deemed to be implemented by management, suitable actions have been taken. We have also considered if adequate progress has been made against those recommendations that remain open.

Overview of findings

We identified six matters arising in our original review, which included five high, six medium and one low priority recommendations.

From our meetings with staff, our review of documentation, and undertaking sample testing we have confirmed that one recommendation has been fully implemented, and there is ongoing work to implement the remaining five recommendations.

Since our original review, the CSG has carried out absence management training at both the PoW and RGH sites and has started setting up electronic staff folders. The CSG has increased its number of completed consultant job plans, and the Allocate system now shows the correct consultant establishment.

However, further work is needed to bring the PDR and mandatory training rates in line with Welsh Government and Health Board targets. We note that there continues to be some inconsistencies in the management of time off in lieu (TOIL) across each site.

Follow-up Report Classification

		Trend
Reasonable 	**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.	

Progress Summary[1]

	Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Absence Management	High		High
2	Annual Leave	Medium		Closed
3	TOIL	Medium		Medium
4	PDRs	High		High
5	Mandatory Training	High		Medium
6	Consultant Job Plan	High		Low

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 Our follow-up review of the Radiology Clinical Service Group (CSG) workforce recommendations was completed in line with the 2023/24 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Our original Radiology CSG review was finalised in October 2022. We issued a 'limited' assurance rating in relation to the workforce management area, and identified six high or medium priority matters arising, with 12 recommendations across the six matters. During 2022/23 the Audit and Risk Committee has monitored the progress made implementing the management actions.

1.3 In February 2023 the Health Board's recommendations tracker showed that management actions had been taken to close parts of the recommendations, and work had progressed on the remaining recommendations, with a revised implementation date of May 2023.

1.4 Our review looked to ensure that suitable actions have been taken for the closed recommendations and that adequate progress is being made against those that remain open.

1.5 The risks considered during our review were:

- Reduced service provision / additional costs due to inappropriate or unauthorised absence.
- Staff performance is not effectively assessed and addressed.

2. Findings

2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	5	-	5	-
Medium	6	3	3	-
Low	1	1	-	-
Total	**12**	**4**	**8**	**-**

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**. Where action is ongoing we have re-assessed the priority rating for the recommendation and revised these where appropriate.

2.3 For the recommendations that have been closed or partially closed, management have taken action to address the matters arising in our original report. This includes:

- Absence management training has been provided to management at RGH and PoW.
- The rollout of electronic staff folders has begun, and a standard operating procedure is being drafted.
- PoW are now requesting and approving annual leave through ESR.
- PoW have developed and implemented a new TOIL form.
- Progress has been made to tackle the issues around the correct allocation of mandatory training of staff. This is currently with Learning and Development to resolve.
- The number of consultant job plans has improved since our original audit and the Allocate system has been 'cleansed' to ensure that the data in the system is correct.

2.4 The actions listed above have either resulted in the recommendation being categorised as implemented, or partially implemented. Three of the five recommendations originally categorised as High priority, now have a residual priority rating of Medium or Low.

Appendix A: Management Action Plan

Previous Matter Arising 6: Absence Management (Operation)			
Original Recommendation			Original Priority
6.1	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, return to work (RTW) forms and ESR should correspond, and the period of absence should be fully covered by self-certification forms or medical certificates.		**High**
6.2	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**
6.3	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 (SOP) developed in other CSGs (such as CAMHS) in relation to the set up and use of electronic staff files.		**Medium**
Management Response		Target Date	Responsible Officer
6.1	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.	31st December 2022	Site Superintendent Radiographers
6.2	All superintendents will be advised of the need to maintain accurate documentation of all decision taken including those outside of the Managing Attendance Policy.	31st December 2022	Superintendent Radiographers

6.3	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.	31st January 2023	Clinical Service Manager

Current findings	Residual Risk
Absence management training has been provided to most staff at RGH and all PoW staff. We understand that the training arranged at PCH was subsequently cancelled. In place of this training, the absence management policy was shared with all staff at PCH and some in house training was provided. Our original audit predominately identified issues with the absence management records for staff based at PCH. As such we tested five periods of absence at PCH to establish if improvements had been made. Our work focused on the retention of documents and management of sickness episodes. For 4/5 of the absences we reviewed, the dates recorded on Health Roster did not align to either the self-certification or RTW documents. We note one instance where the absence resulted in a management review 'prompt' being met, but there was no evidence of the action taken by management. The roll out of electronic staff folders has begun and the Superintendent Radiographer at RGH is in the process of completing a SOP for use across the CSG. PoW have liaised with RGH and have set up the folders in a consistent way, and are planning to scan sickness episodes onto the electronic folders going forward. PCH have electronic folders set up for each staff member, but these are in a different format to the other sites, and paper folders are still used to manage sickness episodes. We understand that their intention is to make changes to the electronic folders following the agreement of the new SOP. **Conclusion:** Whilst we recognise that some actions have been taken to address the original recommendations there are still issues with the management of sickness at PCH, which may be linked to the lack of formal training. The completion of the Electronic Folders SOP needs to be finalised and agreed with management.	Sickness is not properly recorded resulting in incorrect pay. Sickness is not properly managed resulting in additional costs as shifts have to be covered by agency or bank staff. Sickness is not well managed so effecting staff wellbeing.

New Recommendations		Priority
1.1	Training in relation to the Managing Attendance Policy should be re-arranged for PCH staff, in order for those staff who are responsible for absence management to fully understand the policy and apply the correct processes when managing the absence of staff.	**High**

1.2	The draft electronic staff folders SOP should be completed and finalising as soon as possible and rolled out across all sites to ensure consistency in approach.	**Medium**

Management Response		Target Date	Responsible Officer
1.1	06/07/2023 – Sickness Absence training in person was delivered by People's Services. 16 staff attended the bespoke training which discussed the policy, recording of dates and information as well as when to move staff through stages of sickness and navigation through the resources. 2 from PCH, 11 from RGH and 3 from POW attended. Register obtained for audit purposes. Two Superintendents at PCH has been assigned sickness management responsibility for the whole department. The full episode of sickness will be quality checked for compliance by the Senior Superintendent who covers RGH/PCH.	06/07/23 Completed	Bronwyn Baldwin - Radiology Clinical Service Group Manager
1.2	Now rolled out across all sites. SOP finalised 06/07/23.	06/07/2023 Completed	Bronwyn Baldwin - Radiology Clinical Service Group Manager

Previous Matter Arising 8: Time off in Lieu (Operation)			
Original Recommendation			Original Priority
8.1	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**
8.2	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**
8.3	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**
Management Response		Target Date	Responsible Officer
8.1	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.	February 2023	Clinical Service Manager Site Superintendent Radiographers
8.2	A review of the current systems to record TOIL will be undertaken to establish which system is most effective and applied across the localities.	February 2023	Clinical Service Manager Site Superintendent Radiographers
8.3	A review of the current systems to record TOIL will be undertaken to establish which system is most effective and applied across the localities.	February 2023	Clinical Service Manager Site Superintendent Radiographers

Current findings	Residual Risk
Health Roster is used to manage TOIL at RGH and PCH. At these sites the level of TOIL hours accrued remains minimal as we understand staff are paid instead. During our original audit we identified a number of PCH staff, mostly non-shift workers, for whom Health Roster had been incorrectly set up, which effected their accumulated additional hours. Action to correct this has yet to be taken. PoW continue to manage TOIL using paper forms as the department is not using Health Roster. A new TOIL form has been created that addresses the issues identified in our original audit. In addition, a record of the number of hours each person has accrued is maintained and monitored by one of the Superintendent Radiologists. Cases that exceed 37.5 hours are highlighted and these staff are encouraged to use the TOIL before requesting annual leave. Although the TOIL form has been updated there are no specific guidelines outlining the agreed process. The Health Board Overtime Policy states that if additional hours are required to be worked, then alternative options to the payment of overtime should always be considered first, for example, TOIL. The policy also states that staff who, for operational reasons, are unable to use TOIL within three months must be paid in accordance with Agenda for Change terms and conditions. Our follow up work has identified that there continues to be inconsistent approaches to working additional hours across the CSG, with some sites allowing staff to be paid for the work, and others allowing TOIL to be accrued. Furthermore, consideration does not appear to have been given to establishing a maximum number of hours that staff are able to accrue. **Conclusion:** Although some improvements have been made to address the original recommendations, including more comprehensive paper records at PoW, having a consistent approach to the treatment of additional hours and TOIL does not appear to have been addressed.	Time is inappropriately accrued and taken off causing an impact on the provision of the service or the need to backfill shifts with bank / agency staff.

	New Recommendations	Priority
2.1	a) A review should be undertaken on the approach to how TOIL is managed across the service to ensure they are in line the Health Board Overtime Policy and that there some level of consistency across site (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 also be given to the number of hours staff are able to accrue as TOIL. This needs to be applied across all sites and reflected on the TOIL form (where used) so that everyone is aware of the agreed process.	**Medium**

2.2	Management at PCH need to liaise with the Service Improvements Systems Administrator within Workforce Development to ensure that the roles within Health Roster are set up correctly to allow for additional hours to be properly captured.	**Medium**

Management Response		Target Date	Responsible Officer
2.1	SOP developed on management of TOIL for the Radiology department. Clarity has now been provided to all Superintendents. TOIL is currently managed via the Health Roster and paper format in Bridgend until the team are transferred on to the Health Roster.	10/07/2023 Complete	Sharon Donovan, Paul Johnston, Collette Jones, Marc Phillips, Alex Wallace - Site Superintendent Radiographers
2.2	Contact made with Roster team on 08/06/23. Issues with accruals addressed as some staff members contracted hours were not accurately reflected.	08/06/23 Complete	Marc Phillips - Site Superintendent Radiographer

Previous Matter Arising 9: Personal Development Plans (Operation)		
Original Recommendation		Original Priority
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**
Management Response	Target Date	Responsible Officer
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.	January 2023	Clinical Service Manager Super intendent Radiographers
Current findings		**Residual Risk**
We compared the number of outstanding PDRs in May 2023 to the July 2022 data from our original audit. Overall compliance for the CSG has increased by 11% to 54%. For PCH and RGH the percentage of outstanding reviews have remained similar to the levels at the time of our original audit. PCH has 71% (56 people) with an out-of-date PDR, and RGH has 44% (51 people). We note that both departments have a plan to address their PDR compliance rates, but they are yet to see any significant improvement. However, PoW has seen a significant improvement over the last year, moving from 75% outstanding to currently 23% outstanding (19 people). We note that 'reminders' have been sent out to departmental superintendents at PoW to address outstanding appraisals.		Staff performance is not effectively assessed and addressed.

Conclusion: Whilst there has been an improvement in compliance rate at one site, the compliance rate at the remaining two key sites has not improved and a large number of PDRs remain outstanding. We have seen evidence of the plans management have put in place to address the PDR issue, although these are yet to have an impact.			
New Recommendation			**Priority**
3	In line with Welsh Government and Health Board targets, all staff should participate in a PDR on an annual basis. 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**
Management Response		**Target Date**	**Responsible Officer**
3	Current compliance as at 10/07/23: • POW 82.5% • RGH 60.8% • PCH 66% Significant improvement noted at PCH with increased compliance from 39%. The team have booked and planned PDRs around incremental dates. All managers have been asked to review and ensure all dates are reflected accurately on ESR. It has been noted that some staff are lacking confidence in completing the new PDR document prior to the planned PDR. Staff are encouraged to engage in the process and work through the document with their line manage during the PDR or seek support prior to the PDR.	Ongoing	Sharon Donovan, Paul Johnston, Collette Jones, Marc Phillips - Site Superintendent Radiographers Alex Wallace – Radiographer Alyson Berbillion – Radiology Admin Manager

Previous Matter Arising 10: Mandatory Training (Operation)			
Original Recommendation			Original Priority
10.1	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 qualified above the requirements of any of the ESR modules then they should 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.		**High**
10.2	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**
Management Response		Target Date	Responsible Officer
10.1	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	March 2023	Clinical Service Manager Super intendent Radiographers

	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.		
10.2	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.	March 2023	Clinical Service Manager Super intendent Radiographers

Current findings	**Residual Risk**
The Superintendent Radiologist at RGH has liaised with Learning and Development staff and other colleagues within the Health Board to resolve the issues around the ESR training modules allocated to individuals. At the time of our follow up audit, work is ongoing, but modules that may not be necessary are still allocated to staff members and non-completion of these ESR modules are still impacting on compliance rates. However, overall CSG compliance rates for the core skills modules have improved by 11.03% to 63.4% since our original audit. There has also been over 30% increase in compliance rates for specific modules; Information Governance and Safeguarding Children. During our original audit, 8/10 core skills modules had compliance rates below 60%, whereas only 2/10 now fall into that category. 'Module of the month' was introduced, where focus is placed on a training module with low compliance rates and staff are encouraged to complete the training. This has helped improve rates for certain modules, and some sites also targeted specific staff with low compliance. We understand that RGH continue to struggle to release staff to carry out mandatory training, due to service pressures, and all Service leads report issues with access to classroom-based courses. **Conclusion:** Whilst efforts have been made to address the underlying issues of the allocation of learning modules in ESR, this is yet to be resolved and has not been looked at across the CSG. Although, compliance rates for level one training have improved.	Staff performance is not effectively assessed and addressed.

New Recommendations		Priority
4.1	Management at RGH should continue to liaise with the Learning and Development team to ensure the suggested amendments to learning profiles are implemented on ESR. It should be determined if similar exercises to refine learning requirements are required for staff at the PCH and POW sites.	**Medium**
4.2	The CSG 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.	**Medium**

Management Response		Target Date	Responsible Officer
4.1	Two members of staff have been assigned responsibility to review all Radiology staff core competencies as a focussed piece of work. They will liaise with learning and development.	01/09/2023	Ian Mcilquham - Superintendent Radiographer Quality and Governance
4.2	Module of the month is promoted through the Staff Newsletter, reports regularly circulated to Superintendents.	Ongoing	Bronwyn Baldwin - Radiology Clinical Service Group Manager

Previous Matter Arising 11: Consultant Job Plans (Operation)			
Original Recommendation			Original Priority
11.1	Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period.		**High**
11.2	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**
Management Response		Target Date	Responsible Officer
11.1	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.	January 2023	Clinical Director Clinical Service Manager
11.2	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.	January 2023	Clinical Director Clinical Service Manager
Current findings			**Residual Risk**
Consultant Job Plan compliance rates have improved from our original audit: • At the time of our fieldwork PCH had one consultant job plan awaiting 'second sign off', at which time they will be 100% compliant. • RGH had 16/19 plans in place (84% compliant). Three plans remained outstanding but were at a sign off or further discussion stage. • PoW had 3/8 plans in place (33% compliant). The remaining five consultants have had a job planning meeting but are yet to sign their job plan as they have raised queries. We understand that these queries are being worked through with management.			Disputes may arise between the Health Board and Consultants where signed contracts are not in place. Splits between clinical sessions and personal development sessions are not in line with WG guidance, leaving the Health Board with a deficit in capacity.

The Allocate system has been amended to show the correct consultant establishment for Radiology and management are following the Health Board procedure. **Conclusion:** Although we recognise that the CSG has improved its compliance with the number of consultant job plans completed and signed off, there are still a number of plans, particularly in PoW, that are outstanding and need to be resolved.			
New Recommendations			**Priority**
5	Work should continue to resolve the issues raised with the five Consultant job plans within PoW.		**Low**
Management Response		**Target Date**	**Responsible Officer**
5	Current compliance POW: • 7 signed off • 1 awaiting 1st sign off • 1 expired but booked – date arranged for 20/09	End September 2023	Bronwyn Baldwin - Radiology Clinical Service Group Manager, Christopher Goodwin – Consultant Radiologist

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure. **Follow up:** All recommendations implemented and operating as expected
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

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

Archwilio Cymru
Audit Wales

Audit and Risk Committee Update – Cwm Taf Morgannwg University Health Board

Date issued: August 2023

Document reference:3313A2023

This document has been prepared for the internal use of Cwm Taf Morgannwg University Health Board as part of work performed / to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

About this document

1 This document provides the Audit and Risk Committee with an update on our current and planned accounts and performance audit work at Cwm Taf Morgannwg University Health Board.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work and	Executive Lead	Focus of the work	Current status	Planned date for consideration
2022-23 Performance Report, Accountability Report and Financial Statements	Executive Director of Finance and Director of Corporate Governance	The statutory audit of the Health Board's 2022-23 Performance Report, Accountability Report and Financial Statements, which are prepared and audited in accordance with the Welsh Government's 2022-23 'Manual for Accounts' guidance.	We are currently undertaking this audit.	The Audit and Risk Committee considered the audited document on 26th July and the Board approved it on 27th July. The Auditor General certified it on 28th

				July and it was then laid by the Senedd.
2022-23 Charity Account.	Executive Director of Finance	The statutory audit of the Health Board's Charitable Funds Accounts.	Audit work not yet started	December 2023 / January 2024

Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Review of Unscheduled Care	Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work will include an examination of the actions being taken by	Drafting	To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow. We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs.		
Joint Review Follow up (Local work 2022)	Chief Executive	This work will examine the Health Board's progress in implementing the recommendations made in the Joint Review Report from 2019.	Clearance	To be confirmed
All-Wales thematic on workforce planning arrangements	Executive Director of People	This review will assess the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Fieldwork	To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Primary Care Services - Follow-up Review (Local Work 2023)	Chief Operating Officer	In 2018, we conducted a review of primary care services, specifically considering whether the Health Board was well placed to deliver the national vision for primary care as set out in the national plan. We made several recommendations to the Health Board. This work will follow-up progress against these recommendations.	Fieldwork	To be confirmed
Structured Assessment 2023 – Core	Executive Director of Corporate Governance	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2023 Structured Assessment work will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.	Fieldwork	To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Structured Assessment 2023 – Deep Dive	Executive Director of Corporate Governance	In addition to the core structured assessment work described above, we will also review certain arrangements at NHS bodies in more depth. This year, we will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Planning	To be confirmed

Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. We have not published any relevant examinations or studies since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
Digital Inclusion in Wales and Key questions for public bodies	March 2023
Orthopaedics Services in Wales – Tacking the Waiting list backlog	March 2023

Additional information

7 Exhibit 4 provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided.

8 There are no relevant Audit Wales consultations currently underway.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Annual Report and Accounts	June 2023

Audit Wales
1 Capital Quarter
Tyndall Street
Cardiff CF10 4BZ Tel: 029 2032 0500

Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales
We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Agenda Item Number: 2.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Audit & Risk Committee held on the 21 June 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

Patsy Roseblade	Independent Member (Chair)
Jayne Sadgrove	Health Board Vice Chair
Carolyn Donoghue	Independent Member
Ian Wells	Independent Member

In Attendance:

Sara Utley	Audit Wales
Mark Jones	Audit Wales
Paul Dalton	NWSSP – Internal Audit & Assurance
Emma Samways	NWSSP – Internal Audit & Assurance
Sally May	Executive Director of Finance
Owen James	Head of Corporate Finance (In part)
Cally Hamblyn	Assistant Director of Governance & Risk
Matthew Evans	Head of Local Counter Fraud
Gethin Hughes	Chief Operating Officer (In part)
Emma Walters	Corporate Governance Manager (Secretariat)

1.0.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

P Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted. Members **noted** that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members **noted** that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.

The Committee Chair advised that at the end of the meeting, she would be seeking Members views as to how the meeting went.

The Committee Chair advised that it had been suggested and agreed that agenda item 2.2.3 CTMUHB ISO14001 Certification Progress Report would be discussed within the main agenda.

1.2 Apologies for Absence

No apologies for absence have been received

1.3 Declarations of Interest

No declarations of interest were received prior to the meeting.

2.0.0 CONSENT AGENDA

2.1 FOR APPROVAL

2.1.1 Unconfirmed Minutes of the Meeting held on 19 April 2023

Resolution: The minutes were **APPROVED** as a true and accurate record.

2.1.2 Unconfirmed Minutes of the In Committee Meeting held on the 19 April 2023

Resolution: The minutes were **APPROVED** as a true and accurate record.

2.2 FOR NOTING

C Donoghue made reference to item 2.2.3 and the statement made on page 6 of the report that '*The Facilities team responsible for the ISO 14001 contract have been reminded of the importance of ensuring that this contract does not lapse and to prevent a reoccurrence'*. C Donoghue advised that she felt that this statement needed to be strengthened as it was evident that a strong action plan had now been established. The Committee Chair advised that this comment would be considered during the discussion held on this item which had now been moved to the main agenda.

2.2.1 Audit & Risk Committee Annual Cycle of Business

Resolution: **The Annual Cycle of Business was NOTED.**

2.2.2 Audit & Risk Committee Forward Work Programme

Resolution: The Forward Work Programme was **NOTED.**

3.0.0 MAIN AGENDA

GOVERNANCE

2.2.3 CTMUHB ISO14001 Certification Progress Report
[This agenda item was removed from the Consent Agenda]

S May presented the report and advised that the report was due to be presented to the April meeting of the Committee, however, it was delayed as further work was required to ensure the report reflected the current position. Members noted that the Health Board's certification had lapsed as of July 2022 and a request

had been made to the Facilities Team to gather learning as to why this lapse had occurred. Members noted that further work was required in relation to escalation processes as this issue had not been escalated to either S May or G Hughes and Members noted that further work was required in relation to timeliness and proactive management of contracts, particularly within Facilities.

G Hughes advised that the position the Health Board had found itself in was unacceptable and added that a review had been undertaken of the arrangements in place for maintaining an accurate and up to date register of activity requiring external validation. Members noted that a contract monitoring register had now been established within Facilities which would be reviewed periodically by the Chief Operating Officer to ensure it was being robustly managed and adhered to. G Hughes advised that this process would be reviewed as part of the ongoing support being provided to Facilities management across a range of areas.

Members noted that certification had now been received following a phase 2 audit that had recently been undertaken, with positive feedback being received from the external auditors, with no major or minor improvements identified and areas of good practice highlighted.

J Sadgrove extended her thanks to S May and G Hughes for the update and advised that she agreed with the comments made that they had found this report to be unacceptable. J Sadgrove added that the updates received had now provided with her with the assurance required and welcomed the introduction of a contracts register which would be monitored regularly. J Sadgrove extended her thanks to G Hughes for undertaking routine checks in relation to the register and added that the next step would be to ensure these routine checks are owned by the function.

In response to a question raised by the Committee Chair as to whether medical equipment maintenance programmes were being managed by Facilities and therefore would fall under the same process, G Hughes advised that whilst some aspects would be covered by Facilities, a number of contracts for equipment were being held within service areas. Members noted that a significant amount of work was required in this area, with particular focus on larger contracts. Members noted that a piece of work also needed to be undertaken in relation to equipment libraries within the Health Board to provide further levels of assurance. Members noted that as part of the Phase two changes within the Operating Model it is anticipated that the management of Clinical Engineering, which currently sits within the Facilities Hub, would move into the Diagnostics, Therapies, Pharmacy and Specialties Care Group.

The Committee Chair made reference to a software tool that was previously managed by Information Governance that covered all contracts within a Health organisation and commented as to whether this could be utilised within the Health Board. S May advised that this was an area that requires overall improvement and service areas needed to maintain ownership of all their contractual arrangements and note that the role of procurement is in a supporting /advisory capacity.

Resolution: The report was **NOTED.**

3.1 Audit & Risk Committee Action Log

C Hamblyn presented Members with the action log.

In relation to Action Log reference 18/099, I Wells sought assurance as to the level of confidence in achieving the timeframe of August given that the item had been deferred on a number of occasions. G Hughes advised that a Project Initiation Document was being presented to the Board in July which would outline what actions needed to be taken moving forwards in order to achieve accreditation. Members noted that timescales for completion would also be included within the report. G Hughes confirmed that this report would also be presented to the August Audit & Risk Committee.

In relation to action log reference 5.3.2 which related to Medical Rostering, J Sadgrove advised that she wanted to record that the reason why this had been added to the action was to address the specific question as to why the Health Board have two departments who were using different rostering systems. J Sadgrove advised that the reasons for being interested in this was that the organisation needed to have an overall view of how medical resource was being utilised and added that whilst the organisation was operating with different systems the information was not available in an easily accessible way. J Sadgrove questioned how the organisation could get to a position where it has an effective and efficient process to review the use of its people resources in the most expensive category area. Following discussion, it was agreed that the narrative against this action would be updated.

G Hughes agreed with the comments made by J Sadgrove and advised that to be able to record and view this activity is vitally important. G Hughes advised that clarity was required regarding expectations in relation to job plans and productivity within job plans and added that this formed part of the work that D Hurford was leading on in relation to the Quality Assurance process in relation to consultant job plans.

In relation to action log reference 5.3, which related to the audit recommendations tracker, the Committee Chair advised that she had requested hyperlinks to be added from the cover report to the audit tracker as opposed to hyperlinks to the audit reports. C Hamblyn advised that this was work in progress.

Resolution: The Action Log was **NOTED**.

Action: Narrative against action log reference 5.3.2 to be updated to reflect the comments made by J Sadgrove.

3.2 Matters Arising not contained within the Action Log

There were no further items identified.

4.0.0 SUSTAINING OUR FUTURE

4.1 Local Counter Fraud Report

M Evans presented the report and highlighted the key matters for Members attention.

J Sadgrove welcomed the report and advised that she was pleased to see the ongoing increasing maturity of the function. J Sadgrove welcomed the benchmarking report which showed where attention needed to be directed to in relation to increasing counter fraud awareness and also welcomed the preventative exercise which was clearly risk based.

J Sadgrove made reference to a statement made on page five of the report which advised that there was currently no plan to modify the process for submitting termination forms as a result of two departments needing to be notified, Payroll and IT services. J Sadgrove questioned whether this was the right decision to make and questioned whether a different approach could be taken to manage the financial risk more proactively. M Evans advised that a risk assessment and action plan would be developed in relation to this and agreed that some changes need to be made in this area. S May advised that she would ensure the Executive Director for People has sight of this report so that he can consider whether any further action needed to be taken in relation to termination forms.

The Committee Chair made reference to the e-learning modules which had been referenced within the benchmarking report and sought clarity as to whether this would form part of the mandatory training moving forwards. M Evans advised that whilst e-learning was not mandatory at present, this had been explored in the past and added that this would be something that the Team would be happy to explore again in the future.

The Committee Chair made reference to the overpayment of salaries and sought clarity as to whether any particular departments had been identified who may benefit from additional training in relation to salary overpayments. Members noted that there was not one area that seemed to be performing worse than others, with issues being distributed across a wide range of departments. M Evans advised that he would be happy to track any hot spot areas moving forwards.

The Committee Chair questioned whether there was an opportunity here for the Communications Team to cascade some key messaging to ensure that termination forms were being completed in a timely manner and advised of the need to demonstrate that fraud was being taken seriously within the Health Board. C Hamblyn agreed to introduce M Evans to S Blackburn, Director of Communications, Engagement & Fundraising to discuss this further and whether this could be built into the staff newsletter moving forwards.

Resolution: The report was **NOTED.**

Actions: Report to be shared with the Executive Director for People so that he can consider whether any further action needed to be taken in relation to the process regarding termination forms

Links to be made between the Communications Team and Counter Fraud so that a discussion could be held in relation to cascading key messages in relation to timely completion of termination forms

4.1.1 National Fraud Initiative progress and outcomes.

M Evans presented the report and highlighted the key matters for Members attention. The Committee Chair advised that for future reports it would be helpful if an opening paragraph could be included to outline the purpose of the National Fraud Initiative explaining the process and scope. M Evans advised that he would be happy to include this information in future iterations of the report.

Resolution: The report was **NOTED.**

Action: Future reports to include an opening paragraph which outlines the purpose of the National Fraud Initiative explaining the process and scope.

4.2 Procurements and Scheme of Delegation Report

S May presented Members with the report and highlighted the key matters for Members attention. The Committee Chair advised that she was pleased to see that only one single tender waiver had been included on this occasion.

C Donoghue made reference to section 5.2.3 within the Capital Monitoring Review Financial Procedure and sought clarity on the statement made that any changes over 500k go to the Chief Executive and any changes between 500k and 1m go to the Board. S May agreed to review this and provide confirmation outside the meeting as to the correct process.

Resolution: The report was **NOTED** and the Financial Control Procedure for Capital Monitoring was **APPROVED** subject to further clarification being provided by the Director of Finance in relation to authorisation levels.

Action: Executive Director of Finance to clarify the position in relation the statement made within the Capital Monitoring Financial Control Procedure that any changes over 500k go to the Chief Executive and any changes between 500k and 1m go to the Board.

4.3 Losses & Special Payments Report

S May presented Members with the report and highlighted the key matters for Members attention.

The Committee Chair sought clarity as to whether Members felt content that they understood the significance of the discounting rate and what this was used for and suggested an explanation regarding this along with an example of how this is used would be helpful. O James advised that he would be happy to include a worked example of this in the next iteration of the report and added that this mainly related to Clinical Negligence Claims. M Jones also advised that Audit Wales undertakes an audit of the Welsh Risk Pool Clinical Negligence cases, largely on behalf of Velindre University NHS Trust, with the recent audit highlighting some positive observations with no issues of concern raised.

The Committee Chair made reference to the Welsh Risk Pool no longer accepting blank Learning From Events forms, the impact this may have and the fact that nothing had been contained within the financial plan regarding possible future penalties. The Committee Chair questioned whether given the number outstanding, were the Health Board likely to receive future penalties. S May advised that whilst this was possible, the Patient Care & Safety Team were working to address this and have provided assurances that the Team are on track to address the backlog. The Committee Chair advised that she remained concerned regarding the backlog of cases.

Following discussion, it was agreed that a request would be made to the Patient Care & Safety Team for a progress report to be presented to the August meeting of the Committee outlining the steps being taken to address the backlog. Members were assured that this matter was being discussed and monitored weekly at the Executive Led Patient Safety meetings.

Resolution: The report was **NOTED.**

Actions: Worked example to be included in the next iteration of the report to explain the discounting rate and what this was used

Progress report to be presented to the next meeting outlining the steps being taken to address the backlog in Learning From Events reports.

5.0.0 IMPROVING CARE

5.1 Organisational Risk Register

C Hamblyn presented the report and provided an update against the key matters for Members attention. Members noted that the organisational risk register is now received at the Operational Management Board meetings, with regular discussions also being undertaken with Care Groups in relation to their risks.

The Committee Chair made reference to risk 4908 and questioned whether it was reasonable to reduce the risk score given the discussion held in relation to the Welsh Risk Pool no longer accepting blank LFER forms and given that the Internal Audit had given a limited assurance rating to this area in particular in their review of the Welsh Risk Pool. C Hamblyn agreed to share this feedback with G Dix, Deputy Chief Executive / Executive Director of Nursing and his Team.

The Committee Chair made reference to Risk 4148 which related to Deprivation of Liberties Standards compliance and sought clarity whether funding had been approved or not as this had not been made clear. The Committee Chair added that if funding had been approved there appeared to be a suggestion that it would take two months to clear the backlog of cases. C Hamblyn agreed to seek confirmation from G Dix regarding the queries raised and advised that she would provide the Committee with an update.

In response to a query raised by the Committee Chair regarding Risk 2987 and why the consequence of this risk had changed, C Hamblyn agreed to provide an update on this in future reports.

Resolution: The report was **REVIEWED**.

Action: Queries raised in relation to Risks 4908, 4148 and 2987 to be discussed with lead officers outside the meeting

5.2 Audit Recommendations Tracker

E Walters presented the report and highlighted the key matters for the attention of the Committee.

C Donoghue advised that she found the report to be much improved and clearer to work through. C Donoghue noted that there were a few areas where updates had not been received on this occasion and advised that she would welcome updates on these areas at the next meeting, particularly in relation to Financial Systems and Radiology.

I Wells also agreed that he found the report to be much improved. I Wells made reference to some of the implementation dates that had been identified and questioned whether some of the dates identified were realistic. Following discussion, it was agreed that moving forwards lead officers would be asked for rationale to be provided as to why they were proposing a change to the implementation date.

Resolution: The report was **NOTED**.

Action: Lead officers to be asked for rationale to be provided as to why they were proposing a change to the implementation date.

5.3 AUDIT WALES

5.3.1 Audit Wales Audit & Risk Committee Update

S Utley presented the report and highlighted the key points for Members attention.

Resolution: The report was **NOTED**.

5.3.2 Audit Wales Forward Work Programme 2023-2026

S Utley presented the report and advised Members that this was the first time that Audit Wales had produced a forward work programme regarding the value for money studies that Audit Wales would be working on through 2023-2026.

Resolution: The report was **NOTED**.

5.3.3 Audit Wales National and Local Report Orthopaedic Services - to include the Local Management Response

S Utley presented the report and highlighted the key points for Members attention. Members were reminded that the report was presented to the April meeting without the management response. Members noted that the management response had now been received and was being shared with Committee Members alongside the review. G Hughes advised that he had welcomed the report and highlighted the key matters contained within the management response.

The Committee Chair recognised that Physiotherapy had been highlighted as an area which was exceptionally good and that Radiology had been recognised as an area which was an outlier in terms of performance. G Hughes advised that positive engagement was in place with Physiotherapy and added that the introduction of extended scope practitioners and first contact practitioners was a really important development. In relation to Radiology, G Hughes advised that there were challenges in this area, particularly in relation to MRI scanning and added that the development of the Llantrisant Health Park would help to address some of the capacity issues in the longer term. Members noted that work was also being undertaken with Aneurin Bevan and Cardiff & Vale University Health Board's to explore regional opportunities in the short to medium term.

Resolution The report was **NOTED**.

5.3.4 Audit Wales CTMUHB Detailed Audit Plan 2023

M Jones presented the report and highlighted the key points for Members attention. Members were reminded that the outline audit plan was shared with Members at the April 2023 meeting.

Resolution: The report was **NOTED**.

5.4 INTERNAL AUDIT

5.4.1 Internal Audit Progress Report

P Dalton presented the report and highlighted the key points for Members attention.

J Sadgrove made reference to the turnaround times in relation to management responses which had worsened over the last couple of years and advised that she would welcome an improvement in this area in relation to timeliness of management responses being received. P Dalton advised that he had included more granularity in relation to this performance measure within each individual review and added that he would be happy to continue to provide this information into 2023/2024.

The Committee Chair requested that C Hamblyn discusses this matter further with the Executive Team. C Hamblyn advised that whilst she had discussed this previously with the Executive Team, she would undertake a further discussion with Executive Colleagues at the next Executive Leadership Group and would also share the report with them for awareness.

Resolution: The report was **NOTED**.

Action: Discussion to be held with the Executive Team in relation to timely completion of management responses

5.4.2a Internal Audit Review – Welsh Risk Pool

E Samways presented the report and advised that an overall rating of reasonable assurance had been given. Members noted that there was one area of limited assurance which related to the completion of Learning From Events forms.

Resolution: The report was **NOTED.**

5.4.2b Internal Audit Follow Up Review – Concerns

E Samways presented the report which had been allocated a reasonable assurance rating following the limited assurance rating previously given. Members noted that management were fully accepting of the findings.

Resolution: The report was **NOTED.**

5.4.2c Internal Audit Review – SLA Arrangements

E Samways presented the report which had been allocated a Limited Assurance rating. Members noted that management were fully aware of the issues identified and had accepted the recommendations made. The Committee Chair advised that the Committee recognised that by taking a risk based approach to the audit plan this would inevitably result in Limited Assurance audit reports being received and clearly identified where attention needed to be focussed.

Resolution: The report was **NOTED.**

6.0.0 ANY OTHER BUSINESS

The Committee Chair extended her thanks to C Donoghue who was attending her last meeting of the Audit & Risk Committee. Members noted that G Hopkins, Independent Member would become a member of the Committee from July 2023 onwards.

6.1 How Did we do in This meeting

The Committee Chair asked Members to share any feedback as to how they felt the Committee went today outside the meeting.

6.2 Items Discussed at In Committee

Members noted that the following items were discussed at the In Committee session held earlier today:

- Draft Annual Report 2022-2023;
- Draft Annual Accounts 2022-2023;
- Organisational Risk Register – Cyber Security Risks.

6.3 Committee Highlight Report to Board

Members noted that this would be drafted by the Committee Secretariat outside of this meeting.

7.0.0 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Wednesday 26 July 2023. Members noted that this was an Extra-Ordinary meeting to discuss and endorse the Annual Report and Annual Accounts.

8.0.0 CLOSE

Agenda Item Number: 2.1.2

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Audit & Risk In Committee held on the 21 June 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

Patsy Roseblade	Independent Member (Chair)
Ian Wells	Independent Member
Carolyn Donoghue	Independent Member
Jayne Sadgrove	Vice Chair/Independent Member

In Attendance:

S Utley	Audit Wales
M Jones	Audit Wales
Paul Dalton	NWSSP – Internal Audit & Assurance
Emma Samways	NWSSP – Internal Audit & Assurance
S May	Executive Director of Finance, CTMUHB
O James	Head of Corporate Finance, CTMUHB
J Evans	Committee Secretary and Associate Director of Corporate Services, Welsh Health Specialised Services Committee
S Davies	Director of Finance, Welsh Health, Specialised Services Committee
J Leaves	Assistant Director of Finance, Welsh Health Specialised Services Committee
S Spill	Independent Member, Welsh Health Specialised Services Committee
Stephen Harrhy	Chief Ambulance Services Commissioner, Emergency Ambulance Services Committee (EASC)
Philip Wardle	Academy Director, National Imaging Academy for Wales
Tracy Norris	Academy Manager, National Imaging Academy for Wales
Cally Hamblyn	Assistant Director of Governance & Risk
Wendy Penrhyn-Jones	Head of Corporate Governance & Board Business
Emma Walters	Corporate Governance Manager (Secretariat)

1.0.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

P Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted.

1.2 Apologies for Absence

Apologies were received from Gwenan Roberts, Committee Secretary EASC / Deputy Director Corporate National Collaborative Commissioning Unit (NCCU).

1.3 Declarations of Interest

No declarations of interest were received prior to the meeting.

2.0.0 DRAFT ANNUAL REPORT 2022-2023

2.1 CTMUHB – Draft Annual Report including Accountability Report, Remuneration and Staff Report, Performance Report 2022-2023

C Hamblyn presented Members with the report. Members made reference to some minor points of detail which would be shared with C Hamblyn outside the meeting.

Resolution: The report was **NOTED**.

2.2 WHSSC Draft Annual Governance Statement 2022-2023

J Evans presented the report. Members highlighted some errors contained in appendix one which would be addressed outside the meeting.

Resolution: The report was **NOTED.**

2.3 EASC Draft Annual Governance Statement 2022-2023

S Harrhy presented the report and advised that EASC were not identifying any governance controls or issues within the statement.

Resolution: The report was **NOTED.**

2.4 National Imaging Academy Governance Compliance Statement

P Wardle presented the report and extended his thanks to C Hamblyn and W Penrhyn-Jones for their help in producing the document.

Resolution: The report was **NOTED.**

2.5 National Collaborative Commissioning Unit Annual Governance Compliance Statement for 2022-2023

S Harrhy presented the report and advised that the report had been discussed at internal governance processes within the Unit.

Resolution: The report was **NOTED.**

2.6 Draft - Head of Internal Audit Opinion and Annual Report 2022-2023

P Dalton presented the report. Members noted that a draft opinion of "Reasonable Assurance" was being proposed and noted that a final version of the report would be presented to the July Extra-Ordinary Audit & Risk Committee for endorsement prior to subsequent Board approval.

Resolution: The report was **NOTED.**

3.0.0 DRAFT ANNUAL ACCOUNTS

3.1 CTMUHB Draft Accounts 2022-2023 - **Draft Subject to Final Audit Review**

S May presented the report which highlighted the key risks within the financial year. Members noted that a number of misstatements had been identified which had been shared with Audit Wales.

Resolution: The report was **NOTED.**

3.1.1 CTMUHB Audit Enquiries Letter

C Hamblyn presented the report which had been jointly produced with Finance and Counter Fraud colleagues and had been shared with Audit Wales.

Resolution: The report was **NOTED.**

3.2 WHSSC and EASC Draft Accounts 2022-2023

J Leaves presented the report and advised that no significant findings had been identified to date with a few minor amendments required prior to submitting the final version of the accounts.

Resolution: The report was **NOTED.**

3.2.1 WHSSC Audit Enquiries Letter

S Davies presented the report and advised that there were no major concerns to note.

Resolution: The report was **NOTED.**

3.2.2 EASC Audit Enquiries Letter

S Harrhy presented the report and advised that there were no issues to highlight at present.

Resolution: The report was **NOTED.**

3.3 Audit Wales: Audit of the Financial Statements (ISA 260) Report (Including the Letter of Representation and Audit Opinion) - Verbal Update

M Jones provided a verbal update and advised that the audit was on target for completion of the fieldwork during week commencing 3 July 2023. Members noted that the audit would remain ongoing until the point of certification which was Friday 28 July.

Resolution: The update was **NOTED.**

4.0.0 ANY OTHER BUSINESS

The Committee Chair extended her thanks to S Davies who was attending his last regular meeting of the Audit & Risk Committee prior to retirement. The Committee Chair extended her thanks for the significant contribution he had made and extended her best wishes for the future. S Davies extended his thanks to the Committee for all of their support over the last 12 years.

4.1 Organisational Risk Register - Cyber Security Risks

C Hamblyn presented the report and a discussion was held in relation to the Cyber Security risks.

Resolution: The report was **NOTED**.

5.0.0 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Wednesday 26 July 2023.

6.0.0 CLOSE

Agenda Item Number: 2.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Audit & Risk Committee Approval of Accounts held on the 26 July 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

Patsy Roseblade	Independent Member (Committee Chair)
Ian Wells	Independent Member
Jonathan Morgan	Health Board Chair

In Attendance:

Paul Mears	Chief Executive Officer
Mark Jones	Audit Wales
Steve Stark	Audit Wales
Paul Dalton	Head of Internal Audit & Assurance
Sally May	Executive Director of Finance
Owen James	Head of Corporate Finance
Stuart Davies	Welsh Health Specialised Services Committee (WHSSC) Director of Finance
Helen Tyler	Head of Corporate Governance, WHSSC
Steve Spill	Independent Member, WHSSC
Chris Turner	Interim Chair of EASC
Stephen Harrhy	Chief Ambulance Services Commissioner
Cally Hamblyn	Assistant Director of Governance & Risk
Philip Wardle	Academy Director, National Imaging Academy for Wales
Tracy Norris	Academy Manager, National Imaging Academy for Wales
Emma Walters	Corporate Governance Manager (Committee Secretariat)

Agenda Item

1.0.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

P Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items.

1.2 Apologies for Absence

Apologies for absence had been received from:

- Jayne Sadgrove, Independent Member;
- Geraint Hopkins, Independent Member;
- Jacqui Evans, Committee Secretary and Associate Director of Corporate Services, WHSSC
- Gwenan Roberts, Committee Secretary EASC / Deputy Director Corporate NCCU

1.3 Declarations of Interest

No declarations of interest were received prior to the meeting.

2.0.0 ANNUAL REPORT 2022-2023

2.1 CTMUHB – Annual Report including Accountability Report, Remuneration and Staff Report, Performance Report 2022-2023

C Hamblyn presented the report and advised that the Committee were being asked to **ENDORSE** the report for onward submission to the Board for approval.

2.1.1 WHSSC Annual Governance Statement 2022-2023

H Tyler presented the WHSSC Annual Governance Statement and advised that no changes had been made following its presentation to the Audit & Risk Committee meeting held on 16 May 2023.

In response to a question raised by I Wells as to why the update in relation to the Specialist Implant Hearing Device Service had not been included in this report, H Tyler confirmed that this had not been included as the outcome had not been reported to Joint Committee until May 2023 which was outside this reporting period, which was 1st April 2022-31st March 2023.

2.1.2 Emergency Ambulance Services Committee (EASC) Annual Governance Statement 2022-2023

S Harrhy presented the EASC Annual Governance Statement and advised that no changes had been made following its presentation to the Audit & Risk Committee meeting held on 16 May 2023. S Harrhy noted that it had been an incredibly challenging year in relation to ambulance handover delays and added that all staff had worked incredibly hard to try to improve the position. S Harrhy advised that Cwm Taf Morgannwg in particular had undertaken some exemplary work in relation to improving ambulance handover delays and added that he wanted to express his thanks publicly for this achievement.

The Committee Chair extended her thanks to S Harrhy for recognising the positive contribution Cwm Taf Morgannwg had made to the position and reminded Members that the Committee was responsible for all Health Board's in Wales and not just Cwm Taf Morgannwg.

2.1.3 National Collaborative Commissioning Unit (NCCU) Annual Governance Statement 2022-2023

S Harrhy presented the NCCU Annual Governance Statement and confirmed that the Governance statement had been reviewed via NCCU internal governance

processes and added that there were no specific issues he wanted to draw attention to.

2.1.4 National Imaging Academy Governance Compliance Statement 2022-2023

P Wardle presented the National Imaging Academy Governance Compliance Statement and advised that no changes had been made following its presentation to the Audit & Risk Committee meeting held on 16 May 2023. P Wardle extended his thanks to Members of the Corporate Governance Team for the support they had provided.

2.1.5 Head of Internal Audit Opinion and Annual Report 2022-2023

P Dalton presented the report and advised that no significant changes had been made to the report following its presentation to the Audit & Risk Committee on the 16 May 2023. Members noted that the overall opinion remained as "Reasonable Assurance".

The Committee Chair advised that a reasonable assurance was really pleasing for the Health Board and added that whilst there had been some limited assurance reviews received, this demonstrated that the right areas were being audited and that a risk based approach was being taken.

3.0.0 ANNUAL ACCOUNTS

3.1 CTMUHB Annual Accounts 2022-2023

S May presented the report and advised that the report identified the main changes that had been made since the draft accounts were presented to Audit & Risk Committee on the 16 May 2023. S May made Members aware that the Health Board had not met a number of its financial duties within this financial year as it had not achieved a break even position or an approved Integrated Medium Term Plan.

3.2 WHSSC and EASC Final Accounts 2022-2023

S Davies presented the report and advised that the draft accounts were presented to the Audit & Risk Committee on the 16 May 2023. S Davies thanked his team and colleagues within Cwm Taf Morgannwg Health Board for the support they provided in producing the accounts.

3.3 Audit Wales: Audit of the Financial Statements (ISA 260) Report (including the Letter of Representation and Audit Opinion)

M Jones presented the report and advised the Committee that Audit Wales intended to issue an unqualified audit opinion. M Jones set out the process that would be followed following subject to approval being provided by the Board at its meeting on 27 July 2023.

Resolution: Following consideration of all reports, the Audit & Risk Committee agreed to **ENDORSE** the onward submission of the Annual Report and Annual Accounts for 2022/2023 to the Board for Approval. The Committee also agreed to **ENDORSE** the Signing of the Letter of Representation at the Board.

4.0.0 ANY OTHER BUSINESS

The Committee Chair extended her thanks to S Davies for all the support he had provided to the Committee over the last few years and wished him all the very best in his retirement. S Davies also extended his thanks to Members of the Committee and his Team for their support and added that he was looking forward to retirement.

5.0.0 DATE AND TIME OF NEXT MEETING

The next meeting would take place at 10:00am on Wednesday 16 August 2023.

6.0.0 CLOSE

AGENDA ITEM
6.1.4

AUDIT & RISK COMMITTEE

AUDIT & RISK COMMITTEE ANNUAL REPORT 2022-2023

Date of meeting	16/08/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	ENDORSE FOR BOARD APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Under Standing Order 10.2.3, each Committee of the Board is required to submit an annual report *"setting out its activities during the year and detailing the results of a review of its performance".*

1.2 This annual report from the Audit & Risk Committee details the activities and performance for the Committee for the reporting period 2022-2023.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The Committee Annual Report at Appendix 1, summarises the key areas of business activity undertaken by the Committee from April 2022 – March 2023 and highlights some of the key issues which the Committee intend to give further consideration to over the next 12 months.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Please refer to Appendix 1 for the full detail contained within the report.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not applicable for this report.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee are being asked to **ENDORSE FOR BOARD APPROVAL** the Committee Annual Report.

Appendix 1

Audit & Risk Committee

Committee Annual Report 2022-2023

AUDIT & RISK COMMITTEE
ANNUAL REPORT 2022-2023

1. FOREWORD

I am pleased to be able to commend to you this annual report, which has been prepared for the attention of the Board and reviews the work of the Committee for the financial year 2022-2023.

I would also like to take this opportunity to extend my thanks to Ian Wells, Independent Member, for stepping in to the Chairs role for the meeting held on 14 June 2022.

I would like to recognise the significant commitment of all the officers of the Committee who have supported and contributed to the work carried out and for their continued dedication in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by the Internal Audit team at the NHS Wales Shared Services Partnership (NWSSP), by Audit Wales and Local Counter Fraud Services.

Going forward, the Committee intends to continue to pursue a full programme of work covering a wide range of topics and subject areas as part of its long term aim to help further strengthen the governance arrangements of the Health Board.

Patsy Roseblade
Chair of the Audit & Risk Committee
Cwm Taf Morgannwg University Health Board (CTMUHB)

2. INTRODUCTION

The Committee's business cycle runs from the closure of the Annual Accounts in one financial year to the next. This reflects its key role in the development and monitoring of the Governance and Assurance framework for Cwm Taf Morgannwg University Health Board (CTMUHB), which culminates in the production of the Accountability Report including the Governance Statement.

The Terms of Reference for the Committee were reviewed and were formally approved by the Board in May 2023.

Members will be aware that all papers relating to the Committee (unless closed or 'in-committee') are available on the Health Board website.

This report sets out the role and functions of the Audit & Risk Committee and summarises the key areas of business undertaken during the year. In addition, the report sets out some of the key issues, which the Committee will be focussing on over the next few years.

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 ROLE

The role of the Committee is to advise and assure the Board on whether there are effective arrangements in place – through the design and operation of the Health Board system of assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

The Organisation's system of internal control has been designed to identify the potential risks that could prevent Cwm Taf Morgannwg UHB achieving its aims and objectives. It evaluates the likelihood of the risks being realised, considers the impact should they occur, and seeks to manage them efficiently, effectively and economically. Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, the assurance framework may be strengthened and developed further.

The Committee's Terms of Reference are reviewed annually and are included within the Standing Orders for the Cwm Taf Morgannwg UHB.

3.2 MEMBERSHIP

The membership of the Audit & Risk Committee comprises of four Independent members, enabling the Committee to provide appropriate scrutiny and assurance to the Board independently of the management decision-making processes.

A summary of the Independent membership during 2022-2023 is outlined in table 1 below:

Table 1 – Composition & Membership if the Audit & Risk Committee Apr 2022-March 2023

Name	Period
Members	
Patsy Roseblade (Committee Chair) Independent Member	April 2022 – March 2023
Jayne Sadgrove Vice Chair/Independent Member	April 2022 - March 2023
Ian Wells Independent Member/ WHSSC Audit Lead (until Nov 2022)	April 2022 – March 2023
Carolyn Donoghue Independent Member	April 2022 – March 2023
Executive Members In addition to the members, the following also attended Committee meetings during the 2022-2023:	
Director of Corporate Governance / Board Secretary (the Assistant Director of Governance & Risk was in attendance from November 2022 following the departure of the Director of Corporate Governance/Board Secretary from the Health Board in November 2022)	
Executive Director of Finance & Procurement	
Representatives of Internal Audit & Assurance (NHS Wales Shared Services Partnership)	
Representatives of External Audit (Audit Wales)	
Local Counter Fraud Specialist (LCFS)	
Health Board Chair and Chief Executive (Accounts meeting only)	
Chair and Managing Director of NHS Wales Specialised Services Committee	
Chief Ambulance Services Commissioner	
Other Executive Directors and senior staff as required for specific agenda items.	

3.3 ATTENDEES

The Committee's work is informed by reports provided by Audit Wales, Internal Audit, Local Counter Fraud Services and CTMUHB personnel. Although they are not members of the Committee, auditors and other key personnel are expected to attend each meeting of the Audit & Risk Committee. Invitations to attend the Committee meeting are also extended, where appropriate and on an 'ad hoc' basis, to specific staff when reports which relate to their specific area of responsibility are being discussed by the Audit & Risk Committee.

3.4 ATTENDANCE AT AUDIT & RISK COMMITTEE 2022-2023

During the year, the Committee met on eight occasions, one of which (18 May 2022) was devoted to scrutiny of the Draft Annual Accounts and one of which was devoted to the Approval of the Annual Accounts (14 June 2022). All meetings were quorate and were well attended as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2022-2023

In Attendance	28 April 2022	18 May 2022	14 June 2022	23 June 2022	22 Aug 2022	24 Oct 2022	12 Dec 2022	13 Feb 2023	Total
Committee Members									
Patsy Roseblade Committee Chair/Independent Member	✓	✓	x	✓	✓	✓	✓	✓	**7/8**
Jayne Sadgrove – Independent Member	✓	✓	✓	✓	✓	✓	x	✓	**7/8**
Ian Wells – Independent Member/Committee Vice Chair	✓	✓	✓	x	✓	✓	✓	✓	**7/8**
Carolyn Donoghue – Independent Member	✓	✓	x	✓	✓	✓	✓	✓	**7/8**

4. AUDIT COMMITTEE BUSINESS

The Audit & Risk Committee provides an essential element of the Health Board's overall assurance framework. It has operated within its Terms of Reference in accordance with the guidance contained within the NHS Wales Audit Committee Handbook.

As a result of the Covid-19 Pandemic, a Consent agenda approach was adopted across all Board and Committee meetings during 2020 and has continued to be used since. This enabled a number of reports to be received by Members for approval/noting, with an opportunity provided to Members to raise questions against these items in advance of the meeting.

The Audit & Risk Committee agenda broadly followed a standard format, comprising of specific sections, which are outlined below:

4.1 Main Areas of Audit & Risk Committee Activity – Part 1

The agenda for each meeting followed a standard format, broken down into the following 6 main parts:

1. Preliminary Matters

This included the apologies for absence, welcome and introductions and declarations of interest.

2. Consent Agenda for Approval/Noting

The following written reports were received by the Audit & Risk Committee and considered accordingly:

- Unconfirmed Minutes;
- Action Log;
- Committee Annual Cycle of Business;
- Forward Work Programme;
- Amendment to the Standards of Behaviour Framework Policy – Declarations of Interest Form;
- Declarations of Interest & Gifts and Hospitality Report;
- Clinical Audit Annual Plan and Clinical Audit Annual Report;
- Audit Wales – Annual Audit Enquiries Letter Response;
- Audit & Risk Committee Annual Report;
- Audit & Risk Committee Terms of Reference;
- Audit & Risk Committee Effectiveness Self-Assessment;
- Annual Report Timetable 2022-2023.

It is important to note any member of the committee can request that an item planned for the consent agenda can be moved to the main agenda for discussion.

3. Main Agenda

4. Sustaining Our Future

The following reports were received for discussion:

- Local Counter Fraud Report;
- Counter Fraud Annual Report;
- Counter Fraud Annual Self Review;
- Counter Fraud Draft Work Plan;
- Procurement and Scheme of Delegation Report;
- Post Payment Verification Annual Report and End of Year Update;
- Draft Annual Report and Draft Annual Accounts 2021-2022;
- Losses and Special Payments Report;
- The National Fraud Initiative in Wales 2020-2021: National Fraud Initiative (NFI) Self-Appraisal Checklist;
- Medical Rostering Six Monthly Progress Report.

5. Improving Care

The following reports were received for discussion:

- Audit Recommendations Tracker;
- Consultant Job Planning – Six Monthly Progress Reports;
- Organisational Risk Register;
- Internal Audit – Prince Charles Hospital Redevelopment Programme Integrated Audit Plan 2022-2023;
- Annual Internal Audit Plan and Internal Audit Charter;
- Draft Annual Report and Annual Accounts 2021-2022.

Also received under this section were reports from:

- **Internal Audit**

NHS Wales Shared Services Partnership are the appointed Internal Auditors to the Health Board and provide an update on progress against the internal audit annual plan of business at each meeting together with finalised reports for each area that was subject to audit.

Each report contained an assessment on the level of assurance provided. Follow-up action was agreed for recommendations raised, which informed future audit plans.

- **External Audit**

Audit Wales provide an Audit Position Statement at each meeting, summarising progress against its planned audit work.

4.2. MAIN AREAS OF AUDIT COMMITTEE ACTIVITY – PART 2 HOSTED BODIES

The organisations hosted by the Health Board are the Welsh Health Specialised Services Committee (WHSSC), the Emergency Ambulance Services Committee (EASC) and the National Imaging Academy for Wales (NIAW).

In December 2021, the Audit & Risk Committee Part 2 Hosted Bodies, approved the CTMUHB Hosting Assurance Framework, which captured the reporting requirements in relation to hosting where it is stated that the Health Board will convene an Audit & Risk Committee not less than four times a year, to consider matters relating to the hosted organisations.

Regular, standing agenda reporting to the CTMUHB Audit & Risk Committee for Hosted Organisations include;

- Internal and External Audit Plans
- Internal and External Audit Reports with completed management action plans
- Progress reports against audit recommendations (Audit Tracker) NB - to be highlighted to Joint Committee and/or Lead Sponsor if progress is deemed unsatisfactory
- Assurance Framework Report and Risk Register
- Compliance and activity governed by CTMUHB Standards of Behaviour Policy (i.e. Declarations of Interest, Gifts & Hospitality)
- Single Tender Actions
- Breach or waivers to Standing Orders and/or Standing Financial Instructions

To support the Audit & Risk Committee requirements for EASC, WHSCC and the NIAW the Health Board's Audit & Risk Committee is separated into two parts, specifically Part 1 for Health Board business and Part 2 for the Hosted bodies. The relevant officers attend for the relevant components of the meeting.

The Director of Corporate Governance / Board Secretary for CTMUHB also attends both parts of the meetings. The CTMUHB Director of Finance also commenced attending the Hosted Bodies part of the meeting from February 2023.

The WHSSC, EASC and NIAW share the same External and Internal Audit teams and Local Counter Fraud Services (LCFS) with CTMUHB. All these factors enable CTMUHB to take necessary assurances from the hosted bodies, particularly in relation to the Accounts and the Annual Governance Statement and vice-versa for areas carried out by CTMUHB on behalf of WHSSC/EASC/NIAW as part of its hosting responsibilities.

4.3. WORK/ACTION LOG

In order to monitor progress and any necessary follow up action, in line with recognised 'house style' templates a work log is maintained to capture all agreed actions from the Audit & Risk Committee and Joint Committees. This provides an essential element of assurance both to the Committee and from the Committee to the Board.

5. INTERNAL AUDIT - OVERALL SUMMARY

In overall terms for the year 2022/2023, the Head of Internal Audit opinion provided **Reasonable Assurance** to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the following assurance domains:

- Corporate Governance, risk and regulatory compliance;
- Strategic Planning, performance management and reporting;
- Financial governance and management;
- Clinical governance quality and safety;
- Information governance and security;
- Operational service and functional management;
- Workforce management;
- Capital and estates management.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit & Risk Committee throughout the year. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements
- The result of audit assignments that have been issued in draft to the organisation before the issue of this opinion, but have yet to be reported to the Audit & Risk Committee.
- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module
- Other assurance reviews, which impact on the Head of Internal Audit opinion including audit work performed at other organisations

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

In total, 33 audit reviews were reported to the Audit & Risk Committee during the year.

A breakdown of the internal audits results presented to the Audit & Risk Committee and the Board in 2022-2023 is presented at **Appendix 1** for information.

A breakdown of the Audit results for the Hosted Bodies presented to the Audit & Risk Committee and the Board in 2022-2023 is presented at **Appendix 2** for information.

A number of follow up audits were also undertaken within key assurance areas, a list of which is detailed in appendix 1 & 2, together with the respective assurance ratings.

6. EXTERNAL AUDIT

6.1 Audit Wales Audit Wales provide a progress report at each meeting, covering both probity and performance audits. The audit strategy, audit letters and statements of responsibilities were received and the ISA260 report was approved as part of the Accounts approval process.

The following performance reports and management responses were also discussed during the year, with attendance from UHB Officers where considered appropriate:

- Audit Wales Audit & Risk Committee Update (at each meeting);
- Audit Wales Audit Plan 2022;
- Audit Wales Audit of Accounts Report Addendum;
- Making Equality Impact Assessments more than just a tick box exercise;
- Review of Commissioning and Contracting Arrangements (CTM & Swansea Bay);
- Transforming Leadership Partnership Board Baseline Governance Review;
- Audit Wales Review - Ysbyty Cwm Cynon Minor Injuries Unit.

6.2 Approval of the Annual Accounts

A meeting of the Audit & Risk Committee was convened on 14 June 2022 to scrutinise the 2021-2022 Annual Accounts prior to approval by the Health Board including the letter of representation to Auditors and the Annual Governance Statement. The 2021-2022 Annual Accounts were scrutinised and approved by the Board on 14 June 2022. The meeting also scrutinised the Accounts and Statements for 2021-2022 from the Health Board's hosted organisations as appropriate.

7. PRIVATE MEETING WITH AUDITORS

In line with recognised good practice a private meeting between Audit Committee members, Internal Audit, External Audit and the Local Counter Fraud Specialist can be held as and when required. This provides an opportunity for free and frank discussion. The Audit & Risk Committee Chair also meets privately with Internal Audit and External Audit on occasions. This process will continue for 2023-2024.

8. LINKS WITH OTHER COMMITTEES

8.1 Other Sub Committees

The Audit & Risk Committee has close links with the Quality & Safety Committee and other Committees of the Board. Through either specific meetings or the regular Independent Member meetings there is an opportunity for Committee Chairs to support the work of each of the Committees they Chair, share learning and avoid duplication. All Committee Chairs have access to Committee Highlight Reports to the Board.

During 2022-2023, a Committee Referral process continued to be adopted for all Committees where the following three questions were posed by the Committee Chair for each referral request:

- What are you referring?
- Why are you referring it?
- What is the outcome that you are anticipating for this referral?

The Chair of the Audit & Risk Committee provided a report to the Board after each meeting via the Committee Highlight Report.

9. LOCAL COUNTER FRAUD SERVICES

The work of the Local Counter Fraud Services is undertaken to help reduce and maintain the incidence of fraud (and/or corruption) within CTMUHB to an absolute minimum. Work is undertaken in accordance with Welsh Government Directions to NHS Bodies on Counter Fraud Measures with adoption of Government Functional Standards: Counter Fraud NHS Requirements with which the Health Board is expected to comply.

Regular reports were received by the Committee to monitor progress against the agreed Counter Fraud Plan.

The Health Board commissions its Counter Fraud service from Swansea Bay UHB via Service Level Agreement. The Health Board maintains an accredited counter fraud specialist resource of 2.6 FTE. This is in line with comparable sized Health Board's within NHS Wales.

The Counter Fraud Team received 34 new referrals for investigation in 2022/23 with 10 investigations carried over from 2021/22. 31 investigations were closed in 2022/23 which resulted in the application of 12 civil sanctions. This investigation work led to the recovery of £63,070 of Health Board funds and an overall identified fraud prevention figure of £134,257.

A review of compliance with Government Functional Standards: Counter Fraud NHS Requirements is undertaken annually. The Health Board was required to self-assess on a RAG rated basis against these Standards across 12 requirement areas. The Health Board achieved an overall Green rating following

review with improvement identified as required in relation to Requirement 3 – Risk Assessment which was assessed as Amber rated and Requirement 1b - Accountable individual which was rated Red due to a lack of nominated Fraud Champion, following the departure of the Director of Corporate Governance during this self-assessment period. Work plan actions have been agreed to improve these areas for 2023/24 and Green ratings are anticipated at the next review.

As part of its work, the Counter Fraud Department has a regular annual programme of raising fraud awareness within the Health Board for which a number of days are then allocated and included as part of an agreed Counter Fraud Work-Plan which is signed off, by the Health Board's Executive Director of Finance, on an annual basis.

In addition to this and in an attempt to promote an Anti-Fraud Culture within the Health Body, a quarterly newsletter is produced which is then made available to all staff on the Health Board's Intranet and all successful prosecution cases are also publicised in order to obtain the maximum deterrent effect. The Counter Fraud Team also deliver awareness sessions to staff, both general awareness aimed at all staff and bespoke sessions based on risks faced by staff assessed to be in roles at a higher level of potential exposure to fraud.

10. ASSURANCE TO THE BOARD

The Audit & Risk Committee provides an essential element of the overall governance framework for the organisation and has operated within its Terms of Reference and in accordance with the guidance contained in the NHS Wales Audit Committee Handbook.

10.1 Internal Control & Risk Management - In addition to the audit reports received by the Committee during the reporting period, a wide range of internally generated 'governance' reports/papers were produced for consideration by the Audit & Risk Committee.

10.2 Governance Statement - During 2022-2023, the Health Board produced its Governance Statement, which explains the processes and procedures in place to enable the Health Board to carry out its functions effectively. The Statement was produced following a review of CTMUHB's governance arrangements undertaken by the Board with the support of and the Board Secretary/Director of Corporate Governance. The Statement brings together all disclosures relating to governance, risk and control for the organisation.

10.3 Tracking of Audit Recommendations

The Committee has increased the focus on tracking the implementation of agreed audit recommendations and the clarity of reporting of this, which achieved improvement during the year and laid the foundations for the further improvements now being made in 2023/2024.

10.4 Audit Committee Effectiveness Survey - A Committee Effectiveness Survey was undertaken in 2022-2023 to obtain feedback from Committee members on potential areas for development.

The statements used in the survey were devised in accordance with the guidance outlined within the NHS Audit Committee Handbook.

11. CONCLUSION AND FORWARD LOOK

The Audit & Risk Committee in discharging its scrutiny and assurance role on behalf of the Board considers that on the basis of the risk based work completed by the Committee during 2022-2023, that there are effective measures in place **and that there are no outstanding issues that the Audit & Risk Committee wishes to bring to the attention of the Board.**

The Directors have been held to account and have responded positively in dealing with any concerns raised by the Auditors and the Audit & Risk Committee.

This Annual Report will be supplemented by the annual self-assessment process, which will be undertaken via Microsoft Office Forms, which reviews the individual and collective function of the Committee against the NHS Audit Committee Handbook best practice guidance and helps to inform the work of the Committee going forward.

The Committee is committed to continuing to develop its function and effectiveness and intends seeking further assurance in 2023-2024 in respect of:

- The Risk Management Strategy and the embedding to the Board Assurance Framework
- Reviewing audit outcomes and ensure actions are taken as a result of learning.
- Continue to strengthen the Audit Tracker process to incorporate further quality related audits and inspections and explore the implementation of an automated system
- Discharging effectively the Board approved Committee Terms of Reference.
- Increased reporting in relation to Declarations of Interest forms for the organisation.
- Ensuring all parties discharge their responsibilities appropriately as outlined within the Audit Charter.
- Continue to strengthen processes and resources in place to prevent and respond to fraud activity.

Appendix 1

List of Internal Audits Undertaken within Cwm Taf UHB 2022-2023 and Assurance Ratings

	Internal Audit Assignment	Assurance Rating 2022-2023
1	Staff wellbeing	Substantial
2	Board Assurance Framework	Substantial
3	PCH – Validation of management actions	Substantial
4	PCH – 1B Final Account	Substantial
5	Medical records management	Reasonable
6	Board awareness of digital	Reasonable
7	iCTM – Quality improvement team	Reasonable
8	Cyber security	Reasonable
9	Follow up – Fire safety	Reasonable
10	Follow up – CAMHS workforce management	Reasonable
11	Follow up – Bridgend transfer of Informatics services	Reasonable
12	Follow up – Single cancer pathway data quality and integrity	Reasonable
13	Radiology Service review – Governance arrangements	Reasonable
14	Radiology Service review – Risk management	Reasonable
15	Radiology Service review - Planning and performance	Reasonable
16	Radiology Service review – Compliance with Financial Control Procedures (FCP)	Reasonable
17	Performance reporting – Integrated performance report	Reasonable
18	Welsh risk pool claims	Reasonable
19	Follow up – Concerns	Reasonable
20	National incident framework (Draft)	Reasonable
21	Decontamination (Draft)	Reasonable
22	PCH - governance (Draft)	Reasonable
23	PCH - Change, risk and contingency (Draft)	Reasonable
24	PCH – Community benefits (Draft)	Reasonable

25	PCH – Programme performance (Draft)	Reasonable
26	Radiology service review – Workforce management	Limited
27	Digital operating model	Limited
28	Medical variable pay – Agency costs	Limited
29	Reasonable offer process	Limited
30	Arrangements for managing SLAs	Limited
31	Follow up - Facilities systems – (Draft)	Limited
32	Annual Governance Statement	Advisory & Non Opinion
33	Decarbonisation	Advisory & Non Opinion

	Substantial Assurance Rating	**4**
	Reasonable Assurance Rating	**21**
	Limited Assurance Rating	**6**
	Advisory & Non Opinion	**2**
	Total	**33**

**NB – the above does not include the internal audit ratings for the reviews undertaken for the hosted bodies.*

Appendix 2

List of Internal Audits Undertaken 2022-2023 and Assurance Ratings within

The Welsh Health Specialised Services Committee (WHSCC) & the Emergency Ambulance Services Committee (EASC)

	Internal Audit Assignment	Assurance Rating 2022-2023
Welsh Health Specialised Services Committee (WHSCC)		
1	WHSCC – Quality unit	Substantial
2	WHSSC – Neurosciences and long term conditions	Substantial
Emergency Ambulance Services Committee (EASC)		
1	EASC – Ambulance handover improvement arrangements	Substantial

AGENDA ITEM
6.1.5

AUDIT & RISK COMMITTEE

AMENDMENT TO STANDING ORDERS: MODEL STANDING ORDERS REVIEW JULY 2023

Date of meeting	16th August 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Cally Hamblyn, Assistant Director of Governance & Risk
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	ENDORSE FOR BOARD APPROVAL

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

ACRONYMS	
CHC	Community Health Council
CTM	Cwm Taf Morgannwg
SO's	Standing Orders

1. SITUATION/BACKGROUND

1.1 The Cwm Taf Morgannwg University Health Board Standing Orders form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Boards Standards of Behaviour Policy is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

1.2 All Health Board members and officers must be aware of the SOs and, where appropriate, should be familiar with their detailed content.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Welsh Government have recently issued revised model Standing Orders for adoption by Health Boards. The main changes are to reflect the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and the change from CHC to Llais.

2.2 These amendments supersede those issued in accordance with the Welsh Health Circulars numbered WHC 2020/011 and 2021/010. A new WHC will be published to confirm this.

2.3 The Board is required to incorporate and adopt this latest review into CTM's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions (which form part of the Standing Orders) as appropriate.

2.4 The WHSSC and EASC Standing Orders form Schedule 4.1 and 4.2 of the Health Board Standing Orders and once endorsed through the Joint Committee arrangements will be received by CTM's Health Board.

2.5 The changes are highlighted in red in Appendices 1 and 2.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Once approved, the Standing Orders will be uploaded to SharePoint and the Health Board's Internet site.

3.2 The Standing Orders will be further strengthened in year as and when required.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Compliance with the SO's support robust quality governance arrangements.
Related Health and Care standard(s)	Governance, Leadership and Accountability
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required.
Legal implications / impact	No
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee is asked to **ENDORSE FOR BOARD APPROVAL** the amendments to the Health Board's Standing Orders as outlined in section two of this report.

Standing Orders

Reservation and Delegation of Powers

For Cwm Taf Morgannwg University Health Board

Adopted from the Model Standing Orders and Standing Financial Instructions issued by Welsh Government in April 2021

Date approved:	Pending
Approved by:	Health Board
Review date:	Annual
Version:	5
Responsible Director:	Director of Corporate Governance/Board Secretary
Distribution:	Board Members All staff
FOI Status:	Open

Foreword

These Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards (LHBs) in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs LHBs must ensure they are made in accordance with directions as may be issued by Welsh Ministers.

These SOs are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of decisions reserved to the Board; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the LHB.

These documents form the basis upon which the LHB's governance and accountability framework is developed and, together with the adoption of the LHB's Values and Standards of Behaviour framework known as the Standards of Behaviour Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Board Secretary will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements within the LHB.

Further information on governance in the NHS in Wales may be accessed at: https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.

Contents

The following Schedules which support the Standing Orders are held separately to this main Standing Orders Document. These are:

- **Schedule 1 Scheme of Reservation and Delegation of Powers**
- **Schedule 2 Key Guidance Instructions and Other Related Documents**
- **Schedule 2.1 Model Standing Financial Instructions for LHB's**
- **Schedule 3 Board Committee**
- **Schedule 4 Joint Committee Arrangements**
- **Schedule 5 Advisory Group Terms of Reference**

Section A – Introduction

Statutory framework

~~The Cwm Taf Morgannwg Local Health Board (the LHB) is a statutory body that was established on 1st June 2009 and became operational on the 1 October 2009 under **The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778)**, "the Establishment Order". The Establishment Order was amended in 2019 to reflect the Local Health Boards (Area Change) (Wales) (Miscellaneous Amendments) Order 2019 which changed the areas of Cwm Taf University Local Health Board and Abertawe Bro Morgannwg University Local Health Board and also changed their names. The principal local government area of Bridgend transferred from Abertawe Bro Morgannwg University Local Health Board and forms part of the area of Cwm Taf University Local Health Board from 1 April 2019 onwards. Abertawe Bro Morgannwg University Local Health Board was renamed Swansea Bay University Local Health Board and Cwm Taf University Local Health Board was renamed Cwm Taf Morgannwg University Health Board. The Amendments giving effect to these changes were made to the Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 and the Local Health Boards (Constitution, MeHPFmbership and Procedures) (Wales) Regulations 2009.~~

i) On 1 April 2019 following the transfer of the principal local government area of Bridgend from Abertawe Bro Morgannwg University Local Health Board to Cwm Taf University Local Health Board as a result of the **Local Health Boards (Area Change) (Wales) Miscellaneous Amendments) Order 2019** Abertawe Bro Morgannwg University Health Board was renamed Swansea Bay Local Health Board/Cwm Taf University Local Health Board was renamed Cwm Taf Morgannwg University Local Health Board.

ii) The principal place of business of the LHB is – Ynysmeurig House, Navigation Park, Abercynon, CF45 4SN

iii) All business shall be conducted in the name of Cwm Taf Morgannwg University LHB, and all funds received in trust shall be held in the name of the LHB as a Corporate Trustee.

iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales)

Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how LHBs are governed and their functions.

v) Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made **the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779)** ("The Constitution Regulations") which set out the constitution and membership arrangements of LHBs, which includes a requirement for LHBs to make SOs for the regulation of its proceedings and business including provision for the Boards suspension.

vi) Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHB's statutory functions are set out in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511).**

vii) **The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of specialised and tertiary services and for the purpose of jointly exercising those functions will establish the Welsh Health Specialised Services Committee ("WHSSC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made the **Welsh Health Specialised Services Committee (Wales) Regulations 2009 (S.I. 2009/3097)** which make provision for the constitution and membership of the WHSSC including its procedures and administrative arrangements.

viii) **The Emergency Ambulance Services Committee (Wales) Directions 2014 (2014/8)** as amended by the **Emergency Ambulance Services (Wales) Amendment Directions 2016 (2016/8)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance services and for the purpose of jointly exercising those functions will establish the Emergency Ambulance Services Committee ("EASC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014/566)** which make provision for the constitution and membership of the EASC including its procedures and administrative arrangements.

ix) In addition to directions the Welsh Ministers may from time to time issue guidance which LHBs must take into account when exercising any function. However in some cases the relevant function may be contained in other legislation. In exercising their powers LHBs must be clear about the statutory basis for exercising such powers.

x) As a statutory body, the LHB has specified powers to contract in its own name and to act as a corporate trustee. The LHB also has statutory powers under sections 194 and 195 of the NHS (Wales) Act 2006 to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

xi) The **National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-being (Wales) Act 2014 (2014).**

xii) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes the NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trusts and, for the purpose of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

xiii) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

xiv) Further duties and powers placed on health boards in relation to co-operation and partnership with local authorities and other partners in Wales are set out in the **Social Services and Well-being (Wales) Act 2014**. This Act establishes the legal framework for meeting people's needs for care and support and imposes general and strategic duties on local authorities and LHBs in order to effectively plan and provide a sufficient range and level of care and support services. The **Partnership Arrangements (Wales) Regulations 2015 (2015/1989),** made under Part 9 of the **Social Services and Well-being (Wales) Act 2014** set out the arrangements made and provides for LHBs and local authorities to pool funds for the purpose of providing specified services**.**

Guidance on the provisions of Part 9 can be found at https://gov.wales/sites/default/files/publications/2020-02/part-9-statutory-guidance-partnership-arrangements.pdf

xv) The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (the 2020 Act) makes provision for:

Ensuring NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality);

- Ensuring NHS bodies and primary care services are open and honest with patents, when something may have gone wrong in their care (the Duty of Candour);
- The creations of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

Local Health Boards will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/duty-candour-statutory-guidance-2023

xvi) The **Well-being of Future Generations (Wales) Act 2015** also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

xvii) The Welsh Language (Wales) Measure 2011 makes provision with regards to the development of standards of conduct relating to the Welsh language. These standards replace the requirement for a Welsh Language Scheme previously provided for by Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of Local Health Boards. The Local Health Board will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

xviii) LHBs are also bound by any other statutes and legal provisions which govern the way they do business. The powers of LHBs established under statute shall be exercised by LHBs meeting in public session, except as

otherwise provided by these SOs.

NHS framework

xix) In addition to the statutory requirements set out above, LHBs must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that are expected at all levels of the service, locally and nationally.

xx) Adoption of the principles will better equip LHBs to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.

xxi) The overarching NHS governance and accountability framework incorporates these SOs; the Schedules of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework*; the Health and Care Quality Standards 2023, ~~*Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Framework~~, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/

xxii) The Welsh Ministers, reflecting their constitutional obligations and legal duties under the **Well-being of Future Generations (Wales) Act 2015,** have stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

xxiii) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/ Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Local Health Board Framework

xxiv) Schedule 2 provides details of the key documents that, together with these SOs, make up the LHB's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.

xxv) LHBs will from time to time agree and approve policy statements which apply to the LHB's Board members and/or all or specific groups of staff employed by Cwm Taf Morgannwg University LHB and others. The decisions to approve these policies will be recorded in an appropriate Board minute and, where appropriate, will also be considered to be an integral part of the LHB's SOs and SFIs. Details of the LHB's key policy statements are also included in Schedule 2.

xxvi) LHBs shall ensure that an official is designated to undertake the role of the Board Secretary (the role of which is set out in paragraph xxxiii below).

xxvii) For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SOs 1.1.2 refers.

Applying Standing Orders

xxviii) The SOs of the LHB (together with SFIs and the Values and Standards of Behaviour Framework – the Standards of Behaviour Policy will, as far as they are applicable also apply to meetings of any formal Committees established by the LHB, including any Advisory Groups, sub-Committees, joint-Committees and joint sub-Committees. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs and further details on joint-Committees may be found in Schedule* 4.

xxix) Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Board Secretary, who will ask the Audit and Risk Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and LHB officers have a duty to report any non-compliance to the Board Secretary as soon as they are aware of any circumstance that has not previously been reported.

xxx) **Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

Variation and amendment of Standing Orders

xxxi) Although these SOs are subject to regular, annual review by the LHB, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Board Secretary shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with regulation 15 of the Constitution Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;
- The proposed variation or amendment has been considered and approved by the Audit and Risk Committee and is the subject of a formal report to the Board; and
- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

xxxii) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the LHB shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Board Secretary and, where appropriate the Chief Executive or the Director of Finance (in the case of SFIs).

xxxiii) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SOs when interpreting any term or provision covered by legislation.

The role of the Board Secretary

xxxiv) The role of the Board Secretary is crucial to the ongoing development and maintenance of a strong governance framework within LHBs, and is a key source of advice and support to the LHB Chair and other Board members. Independent of the Board, the Board Secretary acts as the guardian of good governance within the LHB. The Board Secretary is responsible for:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of LHB business through meetings of the Board, its Advisory Groups and Committees;
- Ensuring that Board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Board acts fairly, with integrity,

and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the LHB's compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers;

As advisor to the Board, the *Board Secretary's* role does not affect the specific responsibilities of Board members for governing the organisation. The Board Secretary is directly accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal responsibilities.

xxxv) Further details on the role of the Board Secretary within Cwm Taf Morgannwg University LHB, including details on how to contact them, are available on the Cwm Taf Morgannwg website (Board Members - Cwm Taf Morgannwg University Health Board (nhs.wales)

Section B – Standing Orders

1. THE LOCAL HEALTH BOARD

1.0.1 The LHB's principal role is to ensure the effective planning and delivery of the local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.

1.0.2 The LHB was established by the **Local Health Boards (Establishment and Dissolution) (Wales) Order 2009** (S.I. 2009/778) and most of its functions are contained in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009** (S.I. 2009/1511). The Establishment Order was amended in 2019 to reflect the Local Health Boards (Area Change) (Wales) (Miscellaneous Amendments) Order 2019 which changed the areas of Cwm Taf University Local Health Board and Abertawe Bro Morgannwg University Local Health Board and also changed their names. The principal local government area of Bridgend transferred from Abertawe Bro Morgannwg University Local Health Board and forms part of the area of Cwm Taf University Local Health Board from 1 April 2019 onwards. Abertawe Bro Morgannwg University Local Health Board was renamed Swansea Bay University Local Health Board and Cwm Taf University Local Health Board was renamed Cwm Taf Morgannwg University Health Board. The Amendments giving effect to these changes were made to the Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 and the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. The LHB must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.

1.0.3 To fulfil this role, the LHB will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Local Health Board

1.1.1 The membership of the LHB shall be no more than 24 members comprising the Chair, Vice Chair, non-officer members (appointed by the Minister for Health and Social Services), Associate Members, the Chief Executive (appointed by the Board with the involvement of the Chief Executive, NHS Wales) and officer members (appointed by the Board).

1.1.2 For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance. Officer and non-officer

members shall have full voting rights. Associate Members do not have voting rights.

Officer Members [to be known as Executive Directors]

1.1.3 A total of 9 (including the Chief Executive), appointed by the Board, whose responsibilities include the following areas: Medical; Finance; Nursing; Primary Care and Community and Mental Health Services; Strategic and Operational Planning; Workforce and Organisational Development; Public Health; Therapies and Health Science. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.

Non Officer Members [to be known as Independent Members]

1.1.4 A total of 9, appointed by the Minister for Health and Social Services, including: an elected member of a local authority whose area falls within the LHB area; a current member or employee of a Third Sector organisation within the LHB area; a trade union official; a person who holds a post in a University that is related to health; and five other Independent Members who together have experience and expertise in legal; finance; estates; Information Technology; and community knowledge and understanding.

1.1.5 In addition to the eligibility, disqualification, suspension and removal provisions contained within the Constitution Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales.

Associate Members

1.1.6 A total of 4 associate members may be appointed to the Board. They will attend Board meetings on an ex-officio basis, but will not have any voting rights.

1.1.7 No more than three Associate Members may be appointed by the Minister for Health and Social Services. This may include:

- Director of Social Services (nominated by local authorities in the LHB area)
- Chair of the Stakeholder Reference Group
- Chair of the Healthcare Professionals' Forum

1.1.8 The Board may appoint an additional Associate Member to assist in carrying out its functions, subject to the agreement of the Minister for Health and Social Services.

Use of the term 'Independent Members'

1.1.9 For the purposes of these SOs, use of the term 'Independent Members' refers to the following voting members of the Board:

- Chair
- Vice Chair
- Non Officer Members

unless otherwise stated.

1.2 Joint Directors

1.2.1 Where a post of Executive Director of the LHB is shared between more than one person because of their being appointed jointly to a post:

i) Either or both persons may attend and take part in Board meetings;
ii) If both are present at a meeting they shall cast one vote if they agree;
iii) In the case of disagreement no vote shall be cast; and
iv) The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

1.3.1 Independent Members and Associate Members appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed but may not hold office as a member or associate member for the same Board for a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.3.2 Any Associate Member appointed by the Board will be for a period of up to one year. An Associate member may be re-appointed if necessary or expedient for the performance of the LHBs functions. If re-appointed they may not hold office as an Associate Member for the same Board for a total period of more than four years. Time served includes time as a Ministerial appointment (if relevant) which need not be consecutive and will still be counted towards the total period even where there is a break in the term. An Independent or Associate Member appointed by the Minister for Health and Social Services who has already served the maximum 8 years as a Ministerial appointment to the same Board will not be eligible for appointment by the Board as an Associate Member.

1.3.3 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.4 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are

applicable, as specified in Schedule 2 of the Constitution Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.5 The LHB will require Board members to confirm in writing their continued eligibility on an annual basis.

1.4 The Role of the LHB Board and responsibilities of individual members

Role

1.4.1 The principal role of the LHB is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the LHB's performance across all areas of activity.

Responsibilities

1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business, and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.

1.4.4 LHBs shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".

1.4.5 Associate Members, whilst not sharing corporate responsibility for the decisions of the Board, are nevertheless required to act in a corporate manner at all times, as are their fellow Board members who have voting

rights.

1.4.6 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the LHB within the communities it serves.

1.4.7 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

1.4.8 The Chair shall work in close harmony with the Chief Executive and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

1.4.9 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed.

1.4.10 In addition to their corporate role across the breadth of the Board's responsibilities, the Vice-Chair has a specific brief to oversee the LHB's performance in the planning, delivery and evaluation of primary care, community health and mental health services ensuring a balanced care model to meet the needs of the population within the LHB's area.

1.4.11 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the LHB. They are the appointed Accountable Officer for the LHB and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

1.4.12 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the LHB, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF LHB FUNCTIONS

2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.

2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i) Schedule of matters reserved to the Board;
ii) Scheme of delegation to committees and others; and
iii) Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of these SOs.

2.0.3 Subject to Standing Order 4, the LHB retains full responsibility for any functions delegated to others to carry out on its behalf.

2.1 Chair's action on urgent matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

2.1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

2.2 Delegation of Board functions

2.2.1 The Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2.(i)) to Committees and others, setting any conditions and restrictions it considers necessary and following any directions or regulations given by the Welsh Ministers. These functions may be carried out:

i) By a Committee, sub-Committee or officer of the LHB (or of another LHB or Trust); or

ii) By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
iii) Jointly with one or more bodies including local authorities through a joint-Committee, sub-Committee or joint sub-Committee.

2.2.2 The Board may agree and formally approve the delegation of specific executive powers to be exercised by Committees, sub-Committees, joint-Committees or joint sub-Committees which it has formally constituted.

2.3 Delegation to officers

2.3.1 The Board may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 LHB Committees

3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the LHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

Use of the term 'Committee'

3.1.2 For the purposes of these SOs, use of the term 'Committee' incorporates the following:

- Board Committee
- joint-Committee
- sub-Committee

- joint sub-Committee

unless otherwise stated. The Board's Advisory Groups are referred to separately.

3.2 Joint Committees

3.2.1 The Board may, and where directed by the Welsh Ministers must, together with one or more LHBs or NHS Trusts or the local authorities operating within the LHB's area, appoint joint-Committees or joint sub-Committees. These may consist wholly or partly of the LHB's Board members or Board members of other health service bodies or of persons who are not LHB Board members or Board members of other health service bodies. Any such appointments must be made in accordance with the Board's defined requirements on membership (including definition of member roles, powers and terms and conditions of appointment) and any directions given by the Welsh Ministers.

3.2.2 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others on its behalf. The Board shall wherever possible determine, in agreement with its partners, that its joint-Committees hold meetings in public unless there are specific, valid reasons for not doing so.

3.2.3 The Board shall establish, as a minimum, the following joint-Committees:

- The Welsh Health Specialised Services Committee (WHSSC).
- The Emergency Ambulance Services Committee

Joint Committee Standing Orders, terms of reference and operating arrangements

3.2.4 The Board shall formally approve SOs or terms of reference and operating arrangements for each joint-Committee established. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal; role, responsibilities and accountability; and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships and accountabilities with others (including the LHB Board its Committees and Advisory Groups);
- Any budget, financial and accounting responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.2.5 In doing so, the Board shall specify which aspects of these SOs are not

applicable to the operation of the joint-Committee, keeping any such aspects to the minimum necessary. The detailed SOs or terms of reference and operating arrangements for those joint-Committees established by the Board are set out in Schedule 4.

3.3 Sub-Committees

3.3.1 A Committee appointed by the Board may establish a sub-Committee to assist it in the conduct of its business provided that the Board approves such action. Where the Board has authorised a Committee to establish sub-Committees they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

3.4 Committees established by the LHB

3.4.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety;
- Audit;
- Information governance;
- Charitable Funds;
- Remuneration and Terms of Service; and
- Mental Health Act requirements.

3.4.2 In designing its Committee structure and operating arrangements, the Board shall take full account of the need to:

- Embed corporate standards, priorities and requirements, e.g., equality and human rights across all areas of activity; and
- Maximise cohesion and integration across all aspects of governance and assurance.

3.4.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others (including the Board its Committees and Advisory Groups)
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.4.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the Committee, keeping any such aspects to the minimum necessary.

3.4.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the LHB Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the LHB Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the LHB.

3.4.6 Executive Directors or other LHB officers shall not be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated LHB officers shall, however, be in attendance at such Committees, as appropriate. The only exception to this position is the Charitable Funds Committee where all Board Members form the Corporate Trustee.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

3.5 Other Committees

3.5.1 The Board may also establish other Committees to help the LHB in the conduct of its business.

3.6 Confidentiality

3.6.1 Committee members and attendees must not disclose any matter dealt with by or brought before a Committee in confidence without the permission of the Committee's Chair.

3.7 Reporting activity to the Board

3.7.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their activities. Committee Chairs' shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4. NHS WALES SHARED SERVICES PARTNERSHIP

4.0.1 From 1 June 2012 the function of managing and providing Shared

Services to the health service in Wales was given to Velindre University NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261) ("the Shared Services Regulations") require the Velindre NHS Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations (as amended) prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.

4.0.4 These arrangements necessitate putting in place a Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs and Trusts setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre University NHS Trust but will be a shared responsibility of all NHS bodies in Wales.

4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

5.0.1 The LHB has a statutory duty to take account of representations made by persons and organisations who represent the interests of the communities it serves, its officers and healthcare professionals. To help discharge this duty, the Board may and where directed by the Welsh Ministers must, appoint Advisory Groups to the LHB to provide advice to the Board in the exercise of its functions.

5.0.2 The LHB's Advisory Groups include a Stakeholder Reference Group, Healthcare Professionals' Forum and Local Partnership Forum. *The membership and terms of reference for these groups are set out in Schedule 5.*

5.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Terms of reference and operating arrangements

5.1.1 The Board must formally approve terms of reference and operating arrangements for the Advisory Groups. These must establish the governance arrangements and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships with others (including the LHB Board, its Committees and Advisory Groups) as well as other relevant local and national groups);
- Any budget and financial responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.1.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the Advisory Group, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements are set out in Schedule 5.

5.1.3 The Board may determine that the Advisory Group shall be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the Board approves such action.

5.2 Support to the Advisory Groups

5.2.1 The LHB's Board Secretary, on behalf of the Chair, will ensure that the Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the LHB and others;
- Ensuring the provision of secretariat support for Advisory Group meetings (for specific arrangements relating to Local Partnership Forum see Schedule 5.3, paragraph 1.7.1);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the Advisory Group accords with the governance and operating framework it has set.

5.3 Confidentiality

5.3.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

5.4 Advice and feedback

5.4.1 The LHB may specifically request advice and feedback from the Advisory Groups on any aspect of its business, and they may also offer advice and feedback even if not specifically requested by the LHB. The Groups may provide advice to the Board:

- At Board meetings, through the SRG and CAG Chair's participation as Associate Members;
- In written advice;
- In any other form specified by the Board.

5.5 Reporting activity

5.5.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.5.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

5.5.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

5.6 THE STAKEHOLDER REFERENCE GROUP (SRG)

Role

5.6.1 The SRG's role is to provide independent advice on any aspect of LHB business. This may include:

- Early engagement and involvement in the determination of the LHB's overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the LHB's operations on the

communities it serves.

5.6.2 The SRG provides a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the LHB, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the LHB's decision making.

5.6.3 The SRG's role is distinctive from that of Community Health Councils (CHCs), who have a statutory role in representing the interests of patients and the public in their areas. The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the LHBs area.

5.6.4 It does not cover those stakeholders whose interests are represented within the remit of other Advisory Groups established by the LHB, e.g., the Healthcare Professionals' Forum and Local Partnership Forum.

5.6.5 In addition to the provisions above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

5.7 Relationship with the Board

5.7.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.

5.7.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings.

The SRG's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

5.7.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the SRG.

5.7.4 The Board's Chair shall put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation.

5.8 Relationship between the SRG and others

5.8.1 The Board must ensure that the SRG's advice represents a balanced, co-ordinated stakeholder perspective from across the local communities served by the LHB. The SRG shall:

- Ensure effective links and relationships with other advisory groups, local and community partnerships and other key stakeholders who do not form part of the SRG membership;
- Ensure its role, responsibilities and activities are known and

understood by others; and
- Take care to avoid unnecessary duplication of activity with other bodies/groups with an interest in the planning and provision of NHS services, e.g., Regional Partnership Boards.

5.9 Working with Llais ~~Community Health Councils~~

5.9.1 The SRG shall make arrangements to ensure designated Llais ~~CHC~~ members receive the SRG's papers and are invited to attend SRG meetings.

5.9.2 The SRG shall work together with Llais ~~CHC~~ within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.

Refer to Schedule 5.1 for detailed Terms of Reference and Operating Arrangements

5.10 THE CLINICAL ADVISORY GROUP (CAG)

Role & Scope

5.10.1 The CAG will:

- Act as the clinical voice within CTMUHB.
- Work with and alongside Management Board and Executives and will be the representative voice of all clinical groups across the Health Board advising on clinical services and care.
- Provide a balanced, multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery.
- Facilitate engagement and debate amongst the wide range of clinical interests within CTMUHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the CTMUHB's decision making.

5.10.2 The role of CAG does not include consideration healthcare professional terms and conditions of employment.

5.11 Terms of reference and operating arrangements

5.11.1 In addition to the provisions in 5.2.1 above the Board must set out, the relationships and accountabilities with others, as well as the National Professional Advisory Group.

5.12 Relationship with the Board

5.12.1 The CAG's main link with the Board is through the CAG Chair's membership of the Board as an Associate Member.

5.12.2 The Board may determine that designated Board members or CTMUB officers shall be in attendance at Advisory Group meetings. The CAG's Chair may also request the attendance of Board members or CTMUHB officers, subject to the agreement of the CAG Chair.

5.12.3 The Board shall determine the arrangements for any joint meetings between the CTMUHB Board and the CAG.

5.12.4 The Board's Chair shall put in place arrangements to meet with the CAG Chair on a regular basis to discuss the CAG's activities and operation.

5.13 Rights of Access to the LHB Board for Professional Groups

5.13.1 CTMUHB Chair, on the advice of the Chief Executive and/or Director of Corporate Governance (Board Secretary), may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

i) Where the CAG recommends that a matter should be presented to the Board by a particular healthcare professional grouping, e.g., due to the specialist nature of the issues concerned; or

ii) Where a healthcare professional group has demonstrated that the CAG has not afforded it due consideration in the determination of its advice to the Board on a particular issue.

5.13.2 The Board may itself determine that it wishes to seek the views of a particular healthcare professional grouping on a specific matter, in accordance with Standing Order 7.5.7.

5.14 Relationship with the National Professional Advisory Group

5.14.1 The CAG Chair (or CAG Vice-Chair) will not necessarily be a member of the National Professional Advisory Group and this is a position approved by the Board as variation to the model Standing Orders. CTMUHB will however, ensure at least one member of the CAG is a member of the National Professional Advisory Group who will act as the formal link between the two Groups.

Refer to Schedule 5.2 for detailed Terms of Reference and Operating Arrangements

5.15 THE LOCAL PARTNERSHIP FORUM (LPF)

Role

5.15.1 The LPF's role is to provide a formal mechanism where the LHB, as employer, and trade unions/professional bodies representing LHB

employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the LHB - achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the LHB's workforce.

5.15.2 It is the forum where the LHB and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

5.16 Relationship with the Board and others

5.16.1 The LPF's main link with the Board is through the Executive members of the LPF.

5.16.2 The Board may determine that designated Board members or LHB staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Board members or LHB staff, subject to the agreement of the LHB Chair.

5.16.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the LPF's staff representative members.

5.16.4 The Board's Chair shall put in place arrangements to meet with the LPG's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

5.16.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

Refer to Schedule 5.3 for detailed Terms of Reference and Operating Arrangements

6. WORKING IN PARTNERSHIP

6.0.1 The LHB shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers, e.g., the development of population assessments and area plans.

6.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the LHB through:

- The LHB's own structures and operating arrangements, e.g., Advisory Groups; and
- The involvement (at very local and community wide levels) in

partnerships and community groups – such as Regional Partnership and Public Service Boards – of Board members and LHB officers with delegated authority to represent the LHB and, as appropriate, take decisions on its behalf.

6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. This includes "Partnership Arrangements" established under the direction of Regional Partnership Boards and under which the LHB may carry out any of the specified functions on behalf of the partnership body and may established pooled funds for specified purposes. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working-–-implications-for-health-boards-and-NHS-Trusts.pdf

6.0.4 The Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

~~**6.1 Community Health Councils (CHCs)**~~

~~6.1.1 The **Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010** (S.I. 2010/288) (as amended) and the **Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010** (S.I. 2010/289) place a range of duties on LHBs in relation to the engagement and involvement of CHCs in its operations.~~

~~6.1.2 In discharging these duties, the Board shall work constructively with the CHCs working jointly within the LHB's area by ensuring their involvement in:~~

- ~~The planning of the provision of its healthcare services;~~
- ~~The development and consideration of proposals for changes in the way in which those services are provided; and~~
- ~~The Board's decisions affecting the operation of those healthcare services that it has responsibility for~~

~~and formally consulting with those CHCs working jointly within the LHB's area on any proposals for substantial development of the services it is~~

~~responsible for.~~

~~6.1.3 The Board shall ensure that each relevant CHC is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.~~

~~*Relationship with the Board*~~

~~6.1.4 The Board may determine that designated CHC members shall be invited to attend Board meetings.~~

~~6.1.5 The Board shall make arrangements for regular joint meetings between the CHC members and the Board, to be held not less than once every three calendar months and ensuring attendance of at least one third of the Board's members.~~

~~6.1.6 The Board's Chair shall put in place arrangements to meet with the relevant CHC Chair(s) on a regular basis to discuss matters of common interest.~~

6.2 The Citizen Voice Body for Health and Social Care, Wales (to be known as Llais)

6.2.1 Part 4 of the Health **and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on LHBs in relation to the engagement and involvement of Llais in its operations.

6.2.2 The 2020 Act places a statutory duty on the LHB to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

6.1.3 The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

6.1.4 The 2020 Act also places a statutory duty on the LHB to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. The LHB must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant).

6.1.5 The Code of Practice on Access to Premises and Engagement with Individuals can be found at

https://www.gov.wales/code-practice-llais-accessing-premises-and-engaging-people

6.1.6 In discharging these duties, the Board shall work constructively with Llais to ensure both organisations are able to discharge their duties. They will ensure their involvement in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for service change and the way in which those services are provided;
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and

- Engaging, formally consulting and working jointly within the LHB's area on any proposals for substantial development or change of the services it is responsible for, in line with the Guidance on Changes to Health Services in Wales 2023.

  The Guidance on Changes to Health Services can be found at https://www.gov.wales/guidance-changes-health-services

6.1.7 The Board shall ensure that Llais is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

6.1.8 The Board may determine that a designated Llais representative(s) shall be invited to attend Board meetings.

The Board shall ensure arrangements are in place for regular meetings between LHB officers and regional representatives of Llais.

6.1.9 The Board's Chair shall put in place arrangements to meet with the Regional Director and relevant representatives of Llais on a regular basis to discuss matters of common interest.

7. MEETINGS

7.1 Putting Citizens first

7.1.1 The LHB's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The LHB, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;

- The selection of accessible, suitable venues for meetings when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested or required) and in electronic formats;
- Requesting that attendees notify the LHB of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g., Disability Discrimination Act, as well as its Communication Strategy and provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011 .

7.1.2 The Chair will ensure that, in determining the matters to be considered by the Board, full account is taken of the views and interests of the communities served by the LHB, including any views expressed formally to the LHB, e.g., through the SRG or Llais ~~CHCs~~.

7.2 Annual Plan of Board Business

7.2.1 The Board Secretary, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

7.2.2 The plan shall set out the arrangements in place to enable the LHB to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh languages, where appropriate.

7.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.

7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be published on the organisations website.

Annual General Meeting (AGM)

7.2.5 The LHB must hold an AGM in public no later than the 31 July each year [Note: no later than 30 September 2023 for year 2022/2023]. At least 10

calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) on the LHB's website.

The notice shall state that:

- Electronic or paper copies of the Annual Report and Accounts of the LHB are available, on request, prior to the meeting; and
- State how copies can be obtained, in what language and in what format, e.g. as Braille, large print, easy read etc.

7.2.6 The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of the annual accounts and funds held on trust accounts, and may also include presentation of other reports of interest to citizens and others.~~,~~

7.2.7 A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

7.3 Calling Meetings

7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.

7.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Board members, then those Board members may themselves call a meeting.

7.4 Preparing for Meetings

Setting the agenda

7.4.1 The Chair, in consultation with the Chief Executive and Board Secretary, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the LHB. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.

7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Board Secretary, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least 10 calendar days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Board Secretary, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.

7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

7.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

7.4.7 Except for meetings called in accordance with Standing Order 7.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- On the LHB's website, together with the papers supporting the public part of the Agenda; as well as
- Through other methods of communication as set out in the LHB's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the LHB shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

7.5.1 The LHB shall encourage attendance at its formal Board meetings by the public and members of the press as well as LHB officers or representatives from organisations who have an interest in LHB business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility.

7.5.2 The Board and its committees shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67)."

7.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.

7.5.4 The Board Secretary, on behalf of the Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

7.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

7.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Board, its Committees and Advisory Groups

7.5.7 The Board will decide what arrangements and terms and conditions it feels

are appropriate in extending an invitation to observers to attend and address any meetings of the Board, its Committees and Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Board will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the LHB, (whether directly or through the activities of bodies such as The LHB must hold an AGM in public no later than the 31 July each year Llais ~~CHCs~~ and the LHB's Advisory Groups representing citizens and other stakeholders) and to demonstrate openness and transparency in the conduct of business.

Chairing Board Meetings

7.5.8 The Chair of the LHB will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and vice-chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Board Secretary. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

7.5.10 At least six Board members, at least three of whom are Executive Directors and three are Independent Members, must be present to allow any formal business to take place at a Board meeting.

7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

7.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Board member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count

towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes.

Dealing with motions

7.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Board Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).

7.5.14 **Proposing a formal notice of motion –** Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.

7.5.16 **Amendments -** Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.

7.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e., the substantive motion.

7.5.18 **Motions under discussion –** When a motion is under discussion, any Board member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Board member may not be heard further;
- The Board decides upon the motion before them;

- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

7.5.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

7.5.20 **Withdrawal of motion or amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Chair.

7.5.21 **Motion to rescind a resolution –** The Board may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Board members.

7.5.22 A motion that has been decided upon by the Board cannot be proposed again within six months except by the Chair, unless the motion relates to the receipt of a report or the recommendations of a Committee/Chief Executive to which a matter has been referred.

Voting

7.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted. Associate Members may not vote in any meetings or proceedings of the Board.

7.5.24 In determining every question at a meeting the Board members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of the community and healthcare professionals within the LHB's area. Such views will usually be presented to the Board through the Chairs of the LHB's Advisory Groups and the Llais ~~CHC~~ representative(s).

7.5.25 The Board will make decisions based on a simple majority view held by the Board members present. In the event of a split decision, i.e., no majority view being expressed, the Chair shall have a second and casting vote.

7.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

7.6 Record of Proceedings

7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulation 2018, and the LHB's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

7.7.1 All Board members (including Associate Members), together with members of any Committee or Advisory Group established by or on behalf of the Board and LHB officials must respect the confidentiality of all matters considered by the LHB in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework - Standards of Behaviour Policy or legislation such as the Freedom of Information Act 2000, etc.

8. VALUES AND STANDARDS OF BEHAVIOUR

8.0.1 The Board must adopt a set of values and standards of behaviour for the LHB that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the LHB, including Board members, LHB officers and others, as appropriate. The framework adopted by the Board is the Standards of Behaviour Policy which will form part of these SOs.

8.1 Declaring and recording Board members' interests

8.1.1 ***Declaration of interests –*** It is a requirement that all Board members must declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to

influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Values and Standards of Behaviour Framework - Standards of Behaviour Policy and their statutory duties under the Constitution Regulations. Board members must notify the Chair and Board Secretary of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

8.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Board Secretary will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Board Secretary. However, the onus regarding declaration will reside with the individual Board member.

8.1.3 ***Register of interests –*** The Chief Executive, through the Board Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.

8.1.4 The register will be held by the Board Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Board members. The Board Secretary will also arrange an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.

8.1.5 In line with the Board's commitment to openness and transparency, the Board Secretary must take reasonable steps to ensure that the citizens served by the LHB are made aware of, and have access to view the LHB's Register of Interests. This may include publication on the LHB's website.

8.1.6 ***Publication of declared interests in Annual Report –*** Board members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in the LHB's Annual Report.

8.2 Dealing with Members' interests during Board meetings

8.2.1 The Chair, advised by the Board Secretary, must ensure that the Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the LHB and the NHS in Wales.

8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Board Secretary before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.

8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:

i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;
ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;
iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;
iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.

8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.

8.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the Board.

8.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Board Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

8.2.7 ***Members with pecuniary (financial) interests –*** Where a Board

member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

8.2.8 The Constitution Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

8.2.9 ***Members with Professional Interests -*** During the conduct of a Board meeting, an individual Board member may establish a clear conflict of interest between their role as a LHB Board member and that of their professional role outside of the Board. In any such circumstance, the Board shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Board Secretary.

8.3 Dealing with officers' interests

8.3.1 The Board must ensure that the Board Secretary, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of LHB officers' interests in accordance with the Values and Standards of Behaviour Framework.

8.4 Reviewing how Interests are handled

8.4.1 The Audit and Risk Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

8.5 Dealing with offers of gifts[2], hospitality and sponsorship

8.5.1 The Values and Standards of Behaviour Framework - Standards of Behaviour Policy approved by the Board prohibits Board members and LHB officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

8.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or LHB officer who is offered a gift, benefit or hospitality which may or may

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[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.
[2] The term gift refers also to any reward or benefit.

be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Board member or LHB officer. Failure to observe this requirement may result in disciplinary and/or legal action.

8.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Board Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:.

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the LHB;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the LHB; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

8.5.4 A distinction may be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

8.6 Sponsorship

8.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual,

department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

8.6.2 All sponsorship must be approved prior to acceptance in accordance with the **Values and Standards of Behaviour Framework** Standards of Behaviour Policy and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

8.7.1 The Board Secretary, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to LHB officers working within their Directorates.

8.7.2 Every Board member and LHB officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused. The Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.
- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

8.7.4 Board members and LHB officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the LHB ;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,

[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

8.7.5 The Board Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the LHB to be submitted to the Audit and Risk Committee (or equivalent) at least annually. The Audit and Risk Committee will then review and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the LHB is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board.

9.0.2 Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1. Register of Sealing

9.1.1 The Board Secretary shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealing's shall be presented to the Board at least bi-annually.

9.2 Signature of Documents

9.2.1 Where a signature is required for any document connected with legal proceedings involving the LHB, it shall be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the LHB any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has delegated appropriate authority.

9.3 Custody of Seal

9.3.1 The Common Seal of the LHB shall be kept securely by the Board Secretary.

10. GAINING ASSURANCE ON THE CONDUCT OF LHB BUSINESS

10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of LHB business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit and Risk Committee (or equivalent).

10.0.3 Assurances in respect of the services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the LHB.

10.0.4 Assurances in respect of the functions discharged by WHSSC and EASC shall achieved by the reports of the respective Joint Committee Chair, and reported back by the Chief Executive. Reference should be made to paragraph 3.2 above regarding the governance arrangements which should be agreed for each of the Joint Committees.

10.0.5 Arrangements for seeking and providing assurance in respect of any other services provided on behalf of or in association with the LHB shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

10.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

10.1.2 The Board shall set out the relationship between the Head of Internal Audit (HIA), the Audit and Risk Committee (or equivalent) and the Board. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;

- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

10.2 Reviewing the performance of the Board, its Committees and Advisory Groups

10.2.2 The Board shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

10.2.3 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

10.2.4 The Board shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Board Development Programme, as part of an overall Organisation Development framework; and
- The Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles.

10.3 External Assurance

10.3.1 The Board shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the LHB's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

10.3.2 The Board may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

10.3.3 The Board shall keep under review and ensure that, where appropriate, the LHB implements any recommendations relevant to its business made by the Welsh Government's Audit, the Senedd Cymru/Welsh Parliament's Public Accounts Committee and other appropriate bodies.

10.3.4 The LHB shall provide the Auditor General for Wales with any assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

11. DEMONSTRATING ACCOUNTABILITY

11.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the communities it serves and other stakeholders, including its officers and healthcare professionals.

11.0.2 The Board shall, in publishing its strategic and operational level plans, set out how those plans have been developed taking account of the views of others, and how they will be delivered by working with their community and other partners.

11.0.3 The Board shall also facilitate effective scrutiny of the LHB's operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

11.0.4 The Board shall ensure that within the LHB, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

12. REVIEW OF STANDING ORDERS

12.0.1 An equality impact assessment has been undertaken and found that as an administrative document, there is no *direct* impact on the health of the population, the addressing of inequalities in health or the delivery of services. However, it does clearly impact on how Cwm Taf Morgannwg UHB makes its decisions.

12.0.2 These SOs shall be reviewed annually by the Audit and Risk Committee, which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

Appendix 1

Six Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation
- adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees

Appendix 2

Code of Conduct

A code of conduct for meetings sets ground rules for all participants:

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid 'put downs' of views or points made by colleagues
- Respect a colleague's point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation
- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views
- No 'side-meetings' to take place
- Respect the Chair
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the LPF member.

Appendix 3

List of Recognised Trade Unions/Professional Bodies referred to as 'staff organisations' within these Standing Orders

- British Medical Association (BMA)
- Royal College of Nursing (RCN)
- Royal College of Midwives (RCM)
- UNISON
- UNITE
- GMB
- British Orthoptic Society
- Society of Radiographers
- British Dental Association
- Society of Chiropodists and Podiatrists
- Federation of Clinical Scientists
- Chartered Society of Physiotherapy (CSP)
- British Dietetic Association
- British Association of Occupational Therapists (BAOT)

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Schedule 5.1

Stakeholder Reference Group

Terms of Reference and Operating Arrangements

THE STAKEHOLDER REFERENCE GROUP (SRG)

1.1 Role

1.1.1 The SRG's role is to provide independent advice on any aspect of LHB business. This may include:

- Early engagement and involvement in the determination of the LHB's overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the LHB's operations on the communities it serves.

1.1.2 The SRG provides a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the LHB, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the LHB's decision making.

1.1.3 The SRG's role is distinctive from that of Llais ~~Community Health Councils (CHCs)~~, who have a statutory role in representing the interests of patients and the public in their areas. The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the LHBs area.

1.1.4 It does not cover those stakeholders whose interests are represented within the remit of other Advisory Groups established by the LHB, e.g., the Healthcare Professionals' Forum and Local Partnership Forum.

1.1.5 In addition to the provisions in 1.1.3 above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

1.2 Membership

1.2.1 The membership of the SRG, including the approval of nominations to the Group; the appointment of Chair and Vice Chair; definition of member roles, powers and terms and conditions of appointment (including remuneration and reimbursement) will be determined by the Board, taking account of the views of its stakeholders.

1.2.2 There shall be no minimum or maximum requirement in terms of membership size. In determining the number of members, the Board shall take account of the need to ensure the SRG's size is optimal to ensure focused and inclusive activity.

1.2.3 Membership must be drawn from within the area served by LHB, and shall ensure involvement from a range of bodies and groups operating within the communities serviced by the LHB. Where the Board determines it appropriate, the LHB may extend membership to individuals in order to represent a key stakeholder group where there are not already formal bodies or groups established or operating within the area and who may represent the interests of these stakeholders on the SRG.

1.2.4 In determining the overall size and composition of the SRG, the Board must take account of the:

- Demography of the areas served by the LHB;
- Need to encourage and reflect the diversity of the locality, to incorporate different ages, race, religion and beliefs, sexual orientation, gender, including transgender, disability and socio-economic status. Where appropriate, the LHB shall support positive action to increase representation;
- Balance needed in both the range of difference stakeholders and the geographical areas covered, taking particular care to avoid domination by any particular stakeholder type or geographical area;
- Design and operation of the partnership/stakeholder fora already influencing the work of the LHB at local community levels;
- Need to complement, and not duplicate the work of Llais ~~CHCs~~; and
- Need to guard against the over involvement of particular stakeholders through their roles across the range of partnership/stakeholder arrangements in place.

1.2.5 The Board shall keep under review the size and composition of the SRG to ensure it continues to reflect an appropriate balance in stakeholder representation.

1.2.6 A minimum of one third of members which includes the SRG Chair or Vice

Chair, plus an appropriate senior officer of the LHB must be present to ensure the quorum of the SRG. Meetings shall be held no less than quarterly, and otherwise as the Chair of the SRG deems necessary. The Director of Corporate Governance / Board Secretary, on behalf of the health board's Chair, will ensure that the SRG is properly equipped to carry out its role by arranging the provision of advice and support to members on any aspect related to the conduct of their role.

1.2.7 If a meeting is not quorate, this will be noted in the minutes, however the meeting will continue to ensure members are able to receive relevant updates in a timely manner. If the meeting content requires advice to be provided to the health board, all absent members will receive details of the discussion and information to provide their comments to ensure a full membership response.

1.3 Member Responsibilities and Accountability:

The Chair

1.3.1 The Chair is responsible for the effective operation of the SRG:

- Chairing Group meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Group business is conducted in accordance with its agreed operating arrangements; and
- Developing positive and professional relationships amongst the Group's membership and between the Group and the LHB's Board and its Chair and Chief Executive.

1.3.2 The Chair shall work in close harmony with the Chairs of the LHB's other advisory groups, and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Group in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.3 As Chair of the SRG, they may as an Associate Member of the LHB Board. The Chair is accountable for the conduct of their role as Associate Member on the LHB Board to the Minister, through the LHB Chair. They are also accountable to the LHB Board for the conduct of business in accordance with the governance and operating framework set by the LHB.

The Vice Chair

1.3.4 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing Chair resumes their duties or a new chair is appointed, and this deputisation includes acting in the role of Associate Member of the LHB Board.

1.3.5 The Vice Chair is accountable, through the SRG Chair to the LHB Board, for their performance as Vice Chair, and to their nominating body or grouping for the way in which they represent their views at the SRG.

Members

1.3.6 The SRG shall function as a coherent Advisory Body, all members being full and equal members and sharing responsibility for the decisions of the SRG.

1.3.7 All members must:

- Be prepared to engage with and contribute fully to the SRG's activities and in a manner that upholds the standards of good governance – including the values and standards of behaviour – set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the SRG within the communities it represents.

1.3.8 SRG members are accountable, through the SRG Chair to the LHB Board for their performance as Group members, and to their nominating body or grouping for the way in which they represent the views of their body or grouping at the SRG.

1.3.9 Members are encouraged to provide and invite a deputy to attend in their absence to ensure a wide representation at meetings.

1.3.10 In circumstances where the SRG is providing feedback to the Board on a particular issue and not all members or their representatives were able to attend relevant SRG meeting, the SRG secretariat will (at the request of the SRG Chair/Vice Chair) contact members by email to provide an opportunity for those not present to contribute by a given deadline**.**

1.4 Appointment and terms of office

1.4.1 Appointments to the SRG shall be made by the Board, based upon nominations received from stakeholder bodies/groupings. The Board may seek independent expressions of interest to represent a key stakeholder group where it has determined that formal bodies or groups are not already established or operating within the area that may represent the interests of these stakeholders on the SRG.

1.4.2 The nomination and appointment process shall be open and transparent, and in accordance with any specific requirements or directions made by the Welsh Ministers. The appointments process shall be designed in a manner that meets the communication and involvement needs of all stakeholders eligible for appointment;

1.4.3 The Board Secretary, on behalf of the Chair of the LHB, will oversee the process of nomination and appointment to the SRG.

1.4.4 Members shall be appointed for a period specified by the Board, but for no longer than 3 years in any one term. Those members can be reappointed but may not serve a total period of more than 5 years consecutively. The Board may, where it considers it appropriate, make interim or short term appointments to the SRG to fulfil a particular purpose or need.

1.4.5 The ***Chair*** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration by the LHB Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. The appointment as Chair shall be made by the Minister, but it shall not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

1.4.6 The Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Chair has ended.

1.4.7 The ***Vice Chair*** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration and appointment by the LHB Board. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board. In the SRG Chair's absence, the Vice Chair shall also perform the role of Associate Member on the LHB Board. The appointment of the Vice Chair is therefore also on the basis of the conditions of appointment for Associate Members set out in the Regulations.

1.4.8 The Vice Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Vice Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Vice Chair has ended.

1.4.9 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the SRG Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The SRG Chair will advise the Board in writing of any such cases

immediately.

1.4.10 The LHB will require SRG members to confirm in writing their continued eligibility on an annual basis.

1.5 Resignation, suspension and removal of members

1.5.1 A member of the SRG may resign office at any time during the period of appointment by giving notice in writing to the SRG Chair and the Board.

1.5.2 If the Board, having consulted with the SRG Chair and the nominating body or group, considers that:

- It is not in the interests of the health service in the area covered by the SRG that a person should continue to hold office as a member; or
- It is not conducive to the effective operation of the SRG

it shall remove that person from office by giving immediate notice in writing to the person and the relevant nominating body or group.

1.5.3 A nominating body or group may request the removal of a member appointed to the SRG to represent their interests by writing to the Board setting out an explanation and full reasons for removal.

1.5.4 If an SRG member fails to attend any meeting of the Group for a period of six months or more, the Board may remove that person from office unless they are satisfied that:

i) The absence was due to a reasonable cause; and
ii) The person will be able to attend such meetings within such period as the Board considers reasonable.

1.5.5 Before making a decision to remove a person from office, the Board may suspend the tenure of office of that person for a limited period (as determined by the Board) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the Board suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

1.6 Relationship with the Board

1.6.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.

1.6.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The SRG's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

1.6.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the SRG.

1.6.4 The Board's Chair shall put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation.

1.7 Relationship between the SRG and others

1.7.1 The Board must ensure that the SRG's advice represents a balanced, co-ordinated stakeholder perspective from across the local communities served by the LHB. The SRG shall:

- Ensure effective links and relationships with other advisory groups, local and community partnerships and other key stakeholders who do not form part of the SRG membership;
- Ensure its role, responsibilities and activities are known and understood by others; and
- Take care to avoid unnecessary duplication of activity with other bodies/groups with an interest in the planning and provision of NHS services, e.g., Regional Partnership Boards.

1.8 Working with Community Health Councils

1.8.1 The SRG shall make arrangements to ensure designated Llais ~~CHC~~ members receive the SRG's papers and are invited to attend SRG meetings.

1.8.2 The SRG shall work together with Llais ~~CHC~~ within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.

1.9 REVIEW

These Terms of Reference shall be reviewed annually by the Group and submitted to the Board for approval

APPENDIX 1

Cwm Taf Morgannwg University Health Board

Stakeholder Reference Group (SRG) Member

Role Description & Personal Specification

Aim of role

- To represent a defined stakeholder body or grouping, e.g. patient, carer etc, who have an interest in, or whose own role and activities may be impacted by the decisions of Cwm Taf Morgannwg University Health Board (LHB).

Accountability

- You are accountable, through the SRG Chair, to the LHB for your performance as a Group member.
- It is expected that if you resign, that you notify both the Chair and the relevant electing and/or (if applicable) the nominating body, e.g. County Voluntary Council, Local Authority etc.

Responsible to:

The SRG Chair.

Time commitment

A minimum of six meetings per annum, of approximately two hour's duration.

Term of Office

- No longer than three (3) years in any one term. Members can be reappointed but may not serve a total period of more than five (5) years consecutively. Those people who are nominated need to declare if they take on a different role within their nominating organisations (if this applies to the member in question) which affects their ability to represent the views of the organisation/specialist interest group they represent at the SRG.

Key working relationships

- To work closely with the SRG Chair.
- Wherever possible, SRG members should attend the local community groups they represent or other relevant Fora to maintain good working relationships and gather views from stakeholders.
- Where appropriate, SRG members should maintain good working relationships with the LHB, local and community partnerships and other key stakeholders who do not form part of the SRG membership.

Role

You will be expected to:

- Regularly commit to the meetings of the SRG.
- Represent your specialist interest group or organisation at SRG meetings.
- Express opinions clearly and allow others to express theirs.
- Share responsibility for the recommendations of the SRG with other members.
- Promote the work of the SRG in the community it represents.
- Undertake appropriate induction and development training identified by the SRG Chair or LHB.

Key tasks

- Meaningfully engage in the meeting in relation to your special interest group or organisation.
- Suggest ways in which the LHB could better engage with your special interest group or organisation.
- Engage with and contribute fully in SRG activities, accepting responsibility to share workload with other members where identified and completing tasks to set timescales.

Remuneration

SRG members are not paid.

Cwm Taf Morgannwg University Health Board

Stakeholder Reference Group (SRG) Member

Personal Specification

All SRG members will be required to demonstrate the following qualities:

Commitment

- A commitment to the work of the SRG, believing in its purpose and functions.
- Reliable, punctual and professional in attendance and conduct at meetings.
- Willingness to participate in the continuing development of the SRG.
- Compliant with the terms and conditions of the appointment.

Attitude and Approach

- Respectful and appreciative of the contribution that others make.
- Welcoming and encouraging towards people from different backgrounds who may bring with them different opinions and perspectives.
- Sensitive, diplomatic and tactful in dealing with others.
- Flexibility in approaching complex problems and issues.
- Willing to learn new information and contribute to solving problems.

Skills and Experience

- A current connection to the nominating group, body you are representing at the SRG or special interest group, e.g. patient, carer etc.
- Ability to work as part of a team.
- Experience of dealing with confidential issues.
- Ability to consider reports and other documentation and contribute to discussion and decisions.

APPENDIX 2 SRG CHAIR ROLE DESCRIPTION & PERSON SPECIFICATION

Cwm Taf Morgannwg University Health Board

Stakeholder Reference Group (SRG) Chair

Role Description

Aim of role

- To ensure the effective operation of the SRG as a coherent Advisory Body, developing positive and professional relationships between the SRG, Cwm Taf Morgannwg University Health Board (LHB) and its Chair and Chief Executive.

Accountability

- As Chair of the SRG, you will be appointed as an Associate Member of the LHB. You will be accountable for the conduct of your role as Associate Member to the Minister, through the LHB Chair.
- You are required to sign the Official Secrets Act as directed by the Minister.
- You are also accountable to the LHB for the conduct of business in accordance with the governance and operating framework set by the LHB.

Responsible to:

- The LHB Chair.

Time Commitment

- A minimum of six SRG meetings, six LHB Board meetings and six Board Development sessions per annum, with other related meetings as required.

Term of Office

- The Chair's Term of Office shall normally be for a period of up to two years, with the ability to stand as Chair for an additional year.
- You may remain as a member of the SRG after your appointment as Chair has ended for the remainder of your term.

Key Working Relationships

- LHB Chair, Chief Executive and Board Secretary.
- Lead Executive for SRG, management support and secretariat.
- SRG members and LHB members
- HB's other Advisory Groups and Committees
- Local and community partnerships and other key stakeholders who do not form part of the SRG membership.

Role

You will be expected to:

- Chair SRG meetings.
- Attend meetings of the LHB, providing advice on behalf of the SRG where appropriate.
- Report regularly to the HB on SRG activities.
- Work with the HB to maintain a strong SRG membership.
- Promote the work of the SRG within the community it represents.
- Undertake appropriate induction and development training identified the LHB.

Key tasks

- Lead the SRG to provide a forum to facilitate full engagement and active debate amongst stakeholders from across the LHB area.
- Provide formal feedback to the SRG from the Health Board meetings.
- Aim to reach and present a cohesive and balanced stakeholder perspective to inform the LHB's decision making, this will include the provision of:
  - Advice on specific service proposals prior to formal consultation.
  - Feedback on the impact of LHB operations within the community.
  - Early stakeholder engagement and involvement for our LHB when it is shaping its overall strategic direction.
  - Casting vote on decisions will remain with the Chair.

Remuneration

The SRG Chair is not a paid role.

Cwm Taf Morgannwg University Health Board

Stakeholder Reference Group (SRG) Chair

Personal Specification

As SRG Chair, you will be required to demonstrate the following qualities:

Commitment

- A commitment to the work of the SRG, believing in its purpose and functions.
- Reliable, punctual and professional in attendance and conduct at meetings.
- Willingness to participate in the continuing development of the SRG and LHB.
- Compliant with the Terms and Conditions of the appointment.

Attitude and Approach

- Ready to develop positive working relationships with others.
- Respectful and appreciative of the contribution that SRG members make.
- Welcoming and encouraging towards people from different backgrounds who may bring with them different opinions and perspectives.
- Sensitive, diplomatic and tactful in dealing with others.
- Flexibility in approaching complex problems and issues.
- Willing to learn new information and contribute to solving problems.

Skills and Experience

- Experience of leading programmes of work and people.
- Ability to analyse complex information, collate views and develop concise reports.
- Ability to influence and be persuasive.
- Ability to work as part of a team.
- Experience of dealing with confidential issues.

Eligibility exemptions

- Statutory nominated members and members in attendance are NOT eligible to run for Chair.

AGENDA ITEM
6.2.1

AUDIT & RISK COMMITTEE

AUDIT & RISK COMMITTEE CYCLE OF BUSINESS

Date of meeting	16/08/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The Audit & Risk Committee should, on annual basis, receive a Cycle of Business which identifies the reports which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Committee is effectively carrying out its role.

1.2 The Cycle of Business covers the period 1 January 2023 to 31 December 2023.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The Cycle of Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and Committee business.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Please refer to **Appendix 1** – Audit & Risk Committee Cycle of Business for further detail.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore ensuring good governance within the Trust can support quality care.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	Not required.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee is asked to **NOTE** the Committee Cycle of Business.

Audit & Risk Committee

Cycle of Business

(1st January 2023 – 31st December 2023)

The Audit & Risk Committee should, on annual basis, receive a cycle of business which identifies the reports which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Audit & Risk Committee is effectively carrying out its role.

The Cycle of Business covers the period 1st January 2023 to 31st December 2023.

The Cycle of Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business.

The principal role of the Committee is set out in the Standing Orders – Schedule 3.1.

The Committee is an independent member committee of the Board and has no executive powers, other than those specifically delegated in the Terms of Reference. The Committee will function in accordance with the NHS Audit Committee Handbook.

The Committee will also consider issues in respect of the roles and responsibilities of organisations hosted by the CTMUHB on behalf of NHS Wales as appropriate. These are the Welsh Health Specialised Services Committee, the Emergency Ambulance Services Committee and the National Imaging Academy. The meeting will be split into two parts with Cwm Taf Morgannwg University Health Board business and hosted organisations business discussed and recorded separately.

The purpose of the Committee is to advise and assure the Board on whether effective arrangements are in place – through the design and operation of the Health Board system of risk and assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

Audit & Risk Committee Cycle of Business (1st January 2023 – 31st December 2023)

Item of Business	Executive Lead	Reporting period	Jan 2023	Feb 2023	Mar 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Consent Agenda														
Minutes of the previous Meeting	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Audit & Risk Committee Annual Cycle of Business	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Committee Forward Work Programme	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Audit & Risk Committee Annual Report	Director of Corporate Governance	Annually								✓				
Audit & Risk Committee Annual Self-Assessment	Director of Corporate Governance	Annually												✓
Audit & Risk Committee Terms of Reference	Director of Corporate Governance	Annually				✓ Amends required								
Declarations of Interest and Gifts & Hospitality Report	Director of Corporate Governance	Quarterly				✓				✓				✓
Clinical Audit Annual Plan	Medical Director	Annually				✓								
Clinical Audit Annual Report	Medical Director	Annually												✓
Governance														
Action Log	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Annual Financial Accounts	Director of Finance	Annually						✓ (draft accounts)	✓ Extra ordinary meeting					
Accountability Report (Including the Governance Statement)	Director of Corporate Governance	Annually						✓ (draft report)	✓ Extra ordinary meeting					
Annual Review of the Risk Management Strategy / Board Assurance Framework	Director of Corporate Governance	Annually				✓								
Sustaining our Future														
Losses & Special Payments Report	Director of Finance	Quarterly		✓				✓		✓				✓

Item of Business	Executive Lead	Reporting period	Jan 2023	Feb 2023	Mar 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Procurements & Scheme of Delegation Report	Director of Finance	All Regular meetings		✓		✓		✓		✓		✓		✓
Local Counter Fraud Report	Director of Finance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Counter Fraud Annual Report	Head of Local Counter Fraud	Annually				✓								
Counter Fraud Annual Self Review	Head of Local Counter Fraud	Annually				✓								
Counter Fraud Draft Work plan	Head of Local Counter Fraud	Annually				✓								
National Fraud Initiative Progress and Outcomes	Head of Local Counter Fraud	Bi-Annually from June 2023 onwards						✓						
Post Payment Verification Annual Report	Post Payment Verification Manager	Annually				✓								
Post Payment Verification Mid-Year Update	Post Payment Verification Manager	Annually										✓		
Improving Care														
Audit Recommendations Tracker	Director of Corporate Governance	All regular meetings		✓		✓		✓		✓		✓		✓
Organisational Risk Register	Director of Corporate Governance	All regular meetings		✓		✓		✓		✓		✓		✓
Consultant Job Planning	Medical Director	Bi-Annually				✓						✓		
Medical Rostering	Medical Director	Bi-Annually				✓						✓		
Internal Audit Progress Report	Head of Internal Audit	All Regular Meetings		✓		✓		✓		✓		✓		✓
Internal Audit Annual Audit Plan	Head of Internal Audit	Annually				✓								
Internal Audit Reviews	Head of Internal Audit	All regular meetings		✓		✓		✓		✓		✓		✓
Head of Internal Audit Opinion and Annual Report	Head of Internal Audit	Annually							✓ Extra ordinary meeting					
Audit & Risk Committee Update	Audit Wales	All regular meetings		✓		✓		✓		✓		✓		✓

Item of Business	Executive Lead	Reporting period	Jan 2023	Feb 2023	Mar 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Audit Wales Review Reports (as relevant)	Audit Wales	All regular meetings		✓		✓		✓		✓		✓		✓
Audit Wales Annual Audit Report	Audit Wales	Annually				✓								
Audit Wales Audit Plan 2022	Audit Wales	Annually				✓								
Audit Wales Audit of the Financial Statements (ISA 260) Report (Including the letter of representation and Audit Opinion)	Audit Wales	Annually							✓ Extra ordinary meeting					
Structured Assessment	Audit Wales	Annually				✓								
Audit of Financial Statements Addendum Report (if required)	Audit Wales	Annually								✓ Defer to Oct		✓		
Hosted Bodies														
WHSSC Internal Audit Recommendations Tracker	WHSSC Director of Finance	All regular meetings		✓		✓		✓		✓		✓		✓
WHSSC Corporate Risk Assurance Framework including the risk register.	WHSSC Committee Secretary/Head of Corporate Services	All regular meetings		✓		✓		✓		✓		✓		✓
WHSSC Governance Statement	WHSSC Committee Secretary/Head of Corporate Services	Annually						✓ (draft report)	✓ Extra ordinary meeting					
EASC Risk Register	Chief Ambulance Services Commissioner	All regular meetings		✓		✓		✓	✓ Extra ordinary meeting	✓		✓		✓
EASC Governance Statement	Chief Ambulance Services Commissioner	Annually						✓ (draft report)	✓ Extra ordinary meeting					
WHSSC & EASC Annual Accounts	WHSSC/EASC	Annually						✓ (draft accounts)	✓ Extra ordinary meeting					
National Imaging Academy for Wales Hosted Compliance Statement.	Director of the National Imaging Academy	Annually						✓ (draft report)	✓ Extra ordinary meeting					
National Imaging Academy for Wales Risk Register	Director of the National Imaging Academy	Bi-Annually		✓		✓						✓		

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 6.2.2

AUDIT & RISK COMMITTEE – FORWARD WORK PLAN				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Proposed approach suggested by the Director of Corporate Governance	Additional Item	Endoscopy JAG Accreditation Closure report - Progress and Associated Risk Mitigation	Chief Operating Officer	13 February 2023 – Deferred to 19 April 2023 as per action log update. **Deferred to August 2023 as per action log update.**
Email Request from the Assistant Director of Governance & Risk	Additional Item	A National Review of Consent to Examination & Treatment Standards in NHS Wales - Final Welsh Risk Pool Report - March 2023	Medical Director	21 June 2023 – Now deferred to 16 August 2023 as the report was not finalised in time for the June meeting. **Now Deferred to the October 2023 meeting following presentation to the September 2023 Quality & Safety Committee**
Request received from the Assistant Director of Governance & Risk	Additional Item	Standing Orders Breach Log	Assistant Director of Governance & Risk	16 August 2023 – **On agenda**

Agenda Item 6.2.2

AUDIT & RISK COMMITTEE – FORWARD WORK PLAN				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Request made at the June Audit & Risk Committee for a report to come forward	Additional Item	Learning From Events Report – Impact, process in place to monitor, assessment of impact on Financial Plan in terms of any other penalties likely	Deputy Director of Nursing	16 August 2023 – **On agenda**
Email request received from the Assistant Director of Governance & Risk	Additional Item	Amendment to the Standing Orders	Assistant Director of Governance & Risk	16 August 2023 – **On agenda**

Completed				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Advised at the meeting held on 12 December 2022 that this report would be presented to the June 2023 meeting	Additional Item	National Fraud Initiative progress and outcomes.	Local Counter Fraud Specialist	**Completed** Received at the meeting held on 21 June 2023. Reports to be received bi-annually by the Committee. Added to the Annual Cycle of Business
Email request received from the Facilities Governance & Compliance Manager on 3 February 2023	Additional Item	CTMUHB ISO14001 Certification Progress Report	Chief Operating Officer	**Completed** Report received at the meeting held on 21 June 2023

AGENDA ITEM
6.2.3

AUDIT & RISK COMMITTEE

DECLARATIONS OF INTERESTS, GIFTS, SPONSORSHIP, HOSPITALITY & HONORARIA

Date of meeting	16/08/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Philippa Peake-Jones, Interim Head of Corporate Governance and Assurance
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	FOR NOTING

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

ACRONYMS	
DOI	Declarations of Interest

1. SITUATION/BACKGROUND

1.1 In accordance with the requirements of the Health Board's Standing Orders and Standards of behaviour Framework Policy, a report is required to be received by the Audit & Risk Committee as a standing agenda item which will detail the Declarations of Interest, Gifts, Hospitality and Sponsorship

etc. activities approved within each Health Board. A similar report will also be considered by the Strategic Leadership Group.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The form in the Standards of Behaviour Framework policy or online via SharePoint should be used to declare interests and/or seek approval for receiving hospitality/sponsorship/gifts and this should help or prevent the omission of crucial information that the authorising officer requires making an informed decision on approval or rejection. The authorised signatories should also be scrutinising the declarations prior to authorisation, in order to ensure the correct information is captured on the form before it is submitted to the Corporate Governance Team.

2.2 In early May 2023 an email to all Board Members requesting their annual Declarations of Interest was sent. As at July 2023, 13 returns had been returned and approved a further five have been returned and are awaiting approval and three remain outstanding. Since the last report, in year amendments have been received by Board Members which have been reflected in red in Appendix 1. This exercise will be repeated in May 2023 for the 2023-2024 reporting period.

2.3 An email was issued in May 2023 to 746 members of staff (included all Consultants, Very Senior Managers, Board Members and Staff at Band 8d and Band 9). To date we have received 313 returns equalling a 42% return rate. It should be noted that some of the returns received in this period may have been received from individuals that did not receive the targeted email as there is an onus on all employees to declare interests. This exercise will be repeated in May 2024 for the 2024-2025 reporting period.

2.4 In summary there have been:

- 313 new declarations of interest received and entered on the Declarations of Interest Register for the period 1 April 2023 – 30 June 2023.
- 1 new entry on the Gifts, Hospitality and Sponsorship Register.

2.5 The appendices to this report include the new entries received up to the 31 July 2023 as follows:

- Appendix 1 – Declarations of Interest received 1 April 2023 – 30 June 2023.
- Appendix 2 – Gifts, Hospitality and Sponsorship Declarations received 1 April 2023 – 30 June 2023.

2.6 The Declaration of Interest Register and Gift Hospitality and Sponsorship Register for the financial year 2022-2023 is available upon request.

2.7 The advice from the Interim Head of Information Governance is any information published on the register, which is then published in the public domain, excludes first and last names and includes job titles only. This has been actioned in terms of the appendices to this report.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Please refer to the register for the Declarations of Interest included at Appendix 1 and the Gifts, Hospitality and Sponsorship register at Appendix 2.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The Register and Declaration of Interests is the method by which the Health Board safeguards against conflict or potential conflict of interest where private interests and public duties of members of staff do not concur. The Health Board must be impartial and honest in the conduct of its business and must ensure that employees remain beyond suspicion at all times.
Related Health and Care standard(s)	Governance, Leadership and Accountability
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered required in the box below.
	Not required.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The report is open to the Audit & Risk Committee are asked to:

- **REVIEW** and to examine any entries on the register in full.

Received	Full Name	Designation	Declarations	Period of Involvement "From"	Period of Involvement "To"	Financial Benefits/In Kind	In Year Amendments (Narrative Detail)	In Year Amendments Date Received
14.03.2023	Jonathan Morgan	Chair	Director of Insight Wales Consulting Limited (100% Share Ownership: Insight Wales Consulting Limited)	2011	Present	Dividend		
14.03.2023	Jonathan Morgan	Chair	Associate with Practice Solutions Limited	2011	Present	Consultant fee		
14.03.2023	Jonathan Morgan	Chair	Wife employed as a Welsh Government Lawyer	2010	Present	Salaried		
08.05.2023	Dilys Jouvenat	Independent Member	Chair RCT Citizens Advice	8 years	Period of Involvement "To"	Financial Benefits/In Kind		
08.05.2023	Dilys Jouvenat	Independent Member	Trustee Newport Citizens Advice	2 years	To date & continuing	None		
08.05.2023	Dilys Jouvenat	Independent Member	Trustee South East Wales Citizens Advice Consortium	1 year	To date & continuing	None		
08.05.2023	Dilys Jouvenat	Independent Member	Trustee Interlink	6 months	To date & continuing	None		
03.05.2023	Dom Hurford	Exec Medical Director	NIL	N/A	To date & continuing	None		
20.05.2023	Hywel Daniel	Exec Director for People	NIL	N/A	N/A	N/A		
23.05.2023	Jayne Ann Sadgrove	Vice Chair	Director, Cardiff Union Services Ltd	2019	Present	None		
23.05.2023	Jayne Ann Sadgrove	Vice Chair	Spouse/Partner - Director Home Study Course	1995	Present	None		
12.05.2023	Linda Prosser	Executive Director Strategy and Transformation	Director Altyn Tepe Ltd	Since 2019	Present	Yes		
12.05.2023	Linda Prosser	Executive Director Strategy and Transformation	Spouse/Partner - Director Altyn Tepe Ltd	Since 2019	Present	Yes		
20.04.2023	Nicola Milligan	Independent Member	Board Member Royal College of Nursing Wales	Since 2016	Present	Nil		
09.05.2023	Paul Mears	Chief Executive	Director Drake Consultancy Services LTD (dormant Company)	mai-18	Present	Nil		
09.05.2023	Paul Mears	Chief Executive	Spouse/Partner - Director Drake Consultancy Services LTD (dormant Company)	mai-18	Present	Nil		
18.05.2023	Carolyn Anne Donoghue	Independent Member	Welsh Wound Innovation Centre - Chair	9 years	Present	Payment for each board meeting		
18.05.2023	Carolyn Anne Donoghue	Independent Member	Independent Governor University West of England	2 years	Present	None		
18.05.2023	Carolyn Anne Donoghue	Independent Member	Magistrate - Newport Bench	3 years	Present	None		
18.05.2023	Carolyn Anne Donoghue	Independent Member	Chair South East Wales Student Mental Health	3 years	Present	Consultancy fee - hourly rate		
31/7/23	Stuart Morris	Director of Digital	Chair of Governors for Penyfai Primary School, Bridgend	2017	Present	None		
12/7/23	Greg Dix	Executive Director of Nursing, Midwifery & Patient Care / Deputy CEO	Trustee - Royal College of Nursing Foundation	sep-21	Present	Voluntary role, travel / accommodation paid for by the charity		
12/7/23	Greg Dix	Executive Director of Nursing, Midwifery & Patient Care / Deputy CEO	Board Director - Welsh Wound Innovation Centre	jan-22	Present	No financial or benefits in kind		
12/7/23	Greg Dix	Executive Director of Nursing, Midwifery & Patient Care / Deputy CEO	Visiting Professor, University of South Wales	2020	Present	None		
12/7/23	Greg Dix	Executive Director of Nursing, Midwifery & Patient Care / Deputy CEO	Associate Professor, University of Plymouth	2015	Present	None		
04.08.2023	Gethin Hughes	Chief Operating Officer	School Governor and Trustee Ditcham Park School	7 Years		None		
04.08.2023	Gethin Hughes	Chief Operating Officer	Wife is Parliamentary Assistant to Natasha Ashgar MS	Since 7.8.23	Present			
09.05.2023	Sally Ann May	Executive Director of Finance	Cousin is Director of DECIPHER; Professor in Social Interventions and Health, Cardiff University Ongoing Salaried position	Ongoing		Salaried		
			Cousin is Regional Sales Manager South West Arthrex Ltd Ongoing Salaried position	Ongoing		Salaried		
			Cousin is Partner, Knight Frank Project and Building Consultancy Ongoing Salaried position	Ongoing		Salaried		
26/7/23	Lisa Curtis-jones	Independent Member	Statutory Director of Social Services in Merthyr Tydfil	2016	Present	Member of the Regional Partnership Board (RPB) – RIF funding to local authorities through RPB.		
	Mel Jehu	Independent Member	Independent Member (Vice Chair) South Wales Police Crime Panel.	2012 to date	Present	Attendance Fee		
	Mel Jehu	Independent Member	Chair (Standards Committee) Rhondda Cynon Taff Council.	2012	Present	Attendance Fee		
	Mel Jehu	Independent Member	Trustee, Safe Merthyr Tydfil.	2008	Present	Voluntary no financial gain		
	Mel Jehu	Independent Member	Independent Member - Merthyr Tydfil County Borough Council Standards Committee	24.02.2022	Present	Attendance Fee		

Received	Full Name	Designation	Declarations	Period of Involvement "From"	Period of Involvement "To"	Financial Benefits/In Kind	In Year Amendments (Narrative Detail)	In Year Amendments Date Received
	Mel Jehu	Independent Member	Deputy Lord Lieutenant for Mid Glamorgan	01.09.2021	Present	No remuneration or benefits in kind		
	James Hehir	Independent Member	Non-Executive Director, Llandarcy Park Ltd.	14.06.2018	Present	None		
	James Hehir	Independent Member	Trustee Neath Port Talbot Contact Centre.	01.05.2007	Present	None		
	James Hehir	Independent Member	Vice Chairman, Neath Port Talbot Group of FE Colleges.	29.03.2006	Present	None		
	James Hehir	Independent Member	Solicitor of the Supreme Court.	14.02.1984	31/8/2016.	None		
	James Hehir	Independent Member	Honorary Vice President, West Glamorgan Magistrates Association.	16.10.2017	life time appointment.	None		
	James Hehir	Independent Member	Associate member, magistrates Association.	01.06.1993	Present	None		
	James Hehir	Independent Member	Patron Neath YMCA.	apr-15	Present	None		
	Ian Wells	Independent Member	Director of the Wales Institute of Digital Information which undertakes research with Digital Health and Care Wales/NHS Wales Informatics Service in collaboration of University of Wales Trinity St David and the University of Wales. Research projects also undertaken for various health boards including CTM.	3 days per week from 1/2/20	Present	Nil financial transactions or benefits in kind.		
07.08.2023	Patsy Roseblade	Independent Member	NED Tennis Wales	2020	Present	Voluntary		

Targeted DOI Request Sent	Designation	Declarations	Period of Involvement "From"	Period of Involvement "To"	Financial Benefits/In Kind
6.4.23	Adult weight management service- Department Professional Lead	Nil	Not applicable	Not applicable	
11.4.23	Senior Applied Psychologist	Nil	Not applicable	Not applicable	
11.4.23	Chief of Staff	Director General Medical Healthcare Limited	2016		
12.4.23	Radiographer	Partner a Director of General Medical Healthcare Limited	2016		
12.4.23	HCSW	Nil	Not applicable	Not applicable	Not applicable
16.4.23	Consultant Anaesthetist	Nil	Not applicable	Not applicable	Not applicable
17.4.23	Consultant Surgeon	Nil	Not applicable	Not applicable	Not applicable
17.4.23	consultant radiologist	Nil	Not applicable	Not applicable	Not applicable
17.4.23	Consultant Community Paediatrician	Nil	Not applicable	Not applicable	Not applicable
17.4.23	Consultant Gastroenterologist	Nil	Not applicable	Not applicable	Not applicable
17.4.23	Locum Consultant Psychiatrist	Nil	Not applicable	Not applicable	Not applicable
17.4.23	ADI ICT	Nil	Not applicable	Not applicable	Not applicable
17.4.23	Nurse Director	Nil	Not applicable	Not applicable	Not applicable
17.4.23	CONSULTANT PAEDIATRICIAN	Nil	Not applicable	Not applicable	Not applicable
17.4.23	Consultant Histopathologist	Head Sports Therapist at Rugby Clup	3 Years		Voluntary
17.4.23	Assistant Director of Governance & Risk	Company Director Kalrav Limited	Since 2018		None
17.4.23	Deputy Medical Director	Wife is joint Company Director	Since 2018		
17.4.23	Consultant	Works privately as a Physiotherapist for Weston House college, part of Bridgend College. This is a specialist unit for young adults with physical disabilities. This secondary employment is term time only and is a commitment of 3 hours a week.	Term time Only, annually - 3 hours a week max		Paid secondary employment
17.4.23	Consultant Gynaecologist	Director General Medical Healthcare	Since 2016		Dividend
17.4.23	Head of Capital	Spouse Co-director of General Medical Healthcare	Since 2016		Dividend
17.4.23	Deputy Director of Planning (Primary Care)	Co-director of Cardiac Health Diagnostics (CHD)	About to start		Financial Benefit
17.4.23	Consultant Surgeon	Spouse Co-director of Cardiac Health Diagnostics (CHD)	About to start		Financial Benefit
17.4.23	CONSULTANT (CAMHS)	Medical Advisor for Welsh Hearts Charity	Since 2015		Nil
17.4.23	ICU consultant - long term locum	Private Medical Practice with Vale Hospital	Since 2015		Financial Benefit
17.4.23	Director of Operations, Children and Families Care Group	Private Medical Practice with Spire and Vale Hospitals	Since 2005		Financial Benefit
17.4.23	Consultant Anaesthetist	Nil	Not applicable		Not applicable
17.4.23	Medical consultant	Nil	Not applicable		Not applicable
17.4.23	Head of Health Psychology Service	Director at Gaur Limited & Spouse Soma Gaur	Since 2015		Dividend
17.4.23	Medical Secretary	Nil	Not applicable		Not applicable
17.4.23	Principal Clinical Psychologist	Director at A Hassan LTD & Husband a partner in the same	Since May 2022		Financial Benefit
17.4.23	Consultant Surgeon	Astra-Zenica Shares	15 Years		Dividend
17.4.23	Assistant Director of Communications & Engagement	Abbvie Advisor Honoraria	2 Years		Paid for Advisor role (one off) and lecture
17.4.23	Haematology Consultant	Nil	Not applicable		Not applicable
17.4.23	Assistant Director - Capital and Estates	Sophie Lewis Physiotherapist	3 years		
17.4.23	Deputy Director of Strategy and Partnerships	Nil	Not applicable		Not applicable
17.4.23	Assistant Psychologist	Nil	Not applicable		Not applicable
17.4.23	Director of Nursing for Planned Care	Nil	Not applicable		Not applicable

Targeted DOI Request Sent	Designation	Declarations	Period of Involvement "From"	Period of Involvement "To"	Financial Benefits/In Kind
17.4.23	Consultant Paediatrician	My sister works in IT in Velindre Trust	Since 2014		
17.4.23	Assistant Finance Director, USC & Children and Families Care Groups	Carry out occasional private work			0 hours contract
17.4.23	Consultant Community Paediatrician	Nil	Not applicable		Not applicable
17.4.23	Assistant Director of Finance - Planned Care and DT&S	WRU - Casual Contractor S&C Coach	2022-		Financial Transactions
17.4.23	Locum T&O Consultant	Owner of Podiatry Practice			No financial payments received
17.4.23	Consultant Psychiatrist; Clinical Service Group Director, Mental Health, Merthyr Cynon ILG	Nil	Not applicable		Not applicable
18.4.23	Assistant Director of OD & Wellbeing	Nil	Not applicable		Not applicable
18.4.23	ENT Consultant	Nil	Not applicable		Not applicable
18.4.23	Critical Care Psychology Team Manager	Occasional dance instructor (unpaid, once/monthly)	April 2022 - June 2023		None. Unpaid/volunteered.
18.4.23	Paediatric Clinical Psychologist	Wife - Emma James (Director of Nursing, Unscheduled Care)	Married since 2014		
18.4.23	Consultant Physician	Volunteer committee member (secretary) on the British Dietetic Association Oncology group Volunteer committee member on a social running group	2018-present 2019-present		Nil Nil
18.4.23	Clinical Director of Pharmacy and Medicines Management	Honorary Research Fellow role at Cardiff University. I have an NHS Locum Consultant role in Aneurin Bevan University			The honorary contract confers no financial benefit. I am paid for my NHS Locum role through a salary as usual.
18.4.23	consultant radiologist	Guest lecturer for Cardiff University	Yearly		Paid personally / special leave granted by health board
18.4.23	consultant orthogeriatrics	Completed level 3 sports massage diploma, will consider private work in the future.			None currently
18.4.23	consultant	lecturing in Cardiff met university for a social care course.			no payment
18.4.23	Strategic Lead for Employee Experience and Wellbeing	Private Practice	Resumed 04/2023		Salaried
18.4.23	Consultant Oral and Maxillofacial Surgeon	N/A	Not applicable	Not applicable	Not applicable
18.4.23	Consultant Psychiatrist	I hold the title of honorary lecturer for the university of Cardiff	current		No financial or other benefits. I teach medical students rotating through their Dermatology placement.
18.4.23	Radiographer	I hold the title of Honorary lecturer for the University of Cardiff	current		No financial transactions or Benefits. I am involved in medical students on their placements at Princess of Wales Hospital.
19.4.23	Director of Midwifery & Nursing, Children & Families Care Group	honorary title - Senior Professional Fellow, Cardiff University	2019- 2023-		None
19.4.23	consultant in T &O	My son Edward Donoghue is employed by Seating Matters a company which supplies clinical seating to healthcare organisations.	1 year	3 years	None
19.4.23	Interim deputy medical director for acute services	Nil	Not applicable		Not applicable
19.4.23	Consultant in Palliative Medicine	None	Not applicable	Not applicable	Not applicable
19.4.23	Consultant EM	Wife works for Cardiff and vale UHB	20+ years	2016	Paid work
19.4.23	Physiotherapist b6 rotational	Nil	Not applicable	Not applicable	Not applicable
19.4.23	Consultant Physician	Host of the Aural Apothecary podcast - a podcast about medicines, improvement and prescribing.	Ongoing		Unpaid but previously has led to paid speaking engagements and expenses paid invited to conferences. These are done on own time.
19.4.23	Consultant	Declaring secondary employment/private aesthetics practice.	January 2023 ongoing		Private Ltd Company. (HanAesthetics Ltd)
20.4.23	Assistant Psychologist	Nil	Not applicable	Not applicable	Not applicable
21.4.23	Consultant Old Age Psychiatrist	Nil	Not applicable	Not applicable	Not applicable
21.4.23	Consultant	Nil	Not applicable	Not applicable	Not applicable
21.4.23	Consultant Radiologist	Nil	Not applicable	Not applicable	Not applicable
21.4.23	Medicines Management Support Officer	Nil	Not applicable	Not applicable	Not applicable
22.4.23	Clinical Lead GPOOH	Nil	Not applicable	Not applicable	Not applicable

Targeted DOI Request Sent	Designation	Declarations	Period of Involvement "From"	Period of Involvement "To"	Financial Benefits/In Kind
24.4.23	Care Group Service Director	Nil	Not applicable	Not applicable	Not applicable
24.4.23	Consultant O&G	Nil	Not applicable	Not applicable	Not applicable
24.4.23	Consultant acute medicine	Nil	Not applicable	Not applicable	Not applicable
24.4.23	Nurse Director USC	Nil	Not applicable	Not applicable	Not applicable
24.4.23	Consultant Pathologist	Nil	Not applicable	Not applicable	Not applicable
24.4.23	Radiographer	Nil	Not applicable	Not applicable	Not applicable
25.4.23	Consultant - anaesthesia	Nil	Not applicable	Not applicable	Not applicable
25.4.23	Consultant Radiologist	Nil	Not applicable	Not applicable	Not applicable
26.4.23	Consultant Ophthalmology	Nil	Not applicable	Not applicable	Not applicable
26.4.23	Travel expenses for attending Meeting Sponsor G Roach Bayer	Nil	Not applicable	Not applicable	Not applicable
26.4.23	Consultant Community Child Health	Nil	Not applicable	Not applicable	Not applicable
26.4.23	Acute Services General Manager	Nil	Not applicable	Not applicable	Not applicable
26.4.23	Clinical Psychologist	Nil	Not applicable	Not applicable	Not applicable
2.5.23	Clinical Director for Growing Well strategy group	Nil	Not applicable	Not applicable	Not applicable
3.5.23	HCSW	Nil	Not applicable	Not applicable	Not applicable
5.5.23	Pharmacy Technician	Nil	Not applicable	Not applicable	Not applicable
5.5.23	Pharmacy Technician - Band 4	Nil	Not applicable	Not applicable	Not applicable
6.5.23	Consultant	Nil	Not applicable	Not applicable	Not applicable
9.5.23	ENT Consultant	Nil	Not applicable	Not applicable	Not applicable
9.5.23	Accuracy Checking Pharmacy Technician	Nil	Not applicable	Not applicable	Not applicable
9.5.23	physiotherapy Health care support worker	Nil	Not applicable	Not applicable	Not applicable
10.5.23	Independent Member	Nil	Not applicable	Not applicable	Not applicable
10.5.23	Executive Director of Therapies and Health Science	Nil	Not applicable	Not applicable	Not applicable
11.5.23	Pharmacy Assistant	Nil	Not applicable	Not applicable	Not applicable
11.5.23	pharmacy technician	Nil	Not applicable	Not applicable	Not applicable
11.5.23	Pharmacy Technician	Nil	Not applicable	Not applicable	Not applicable
11.5.23	Medicines Management Pharmacy Technician	Nil	Not applicable	Not applicable	Not applicable
18.5.23	Consultant Child LD Psychiatrist	Nil	Not applicable	Not applicable	Not applicable
19.5.23	Project Manager	Nil	Not applicable	Not applicable	Not applicable
22.5.23	Advance Pharmacist NICE and HCD Medicines	Nil	Not applicable	Not applicable	Not applicable
25.5.23	Academy Administrator	Nil	Not applicable	Not applicable	Not applicable
30.5.23	NICE Co-ordinator	Nil	Not applicable	Not applicable	Not applicable
1.6.23	District nurse	Nil	Not applicable	Not applicable	Not applicable
1.6.23	Head of SLT	Nil	Not applicable	Not applicable	Not applicable
1.6.23	Consultant Neonatologist	Nil	Not applicable	Not applicable	Not applicable
1.6.23	Radiographer	Nil	Not applicable	Not applicable	Not applicable
1.6.23	HCSW	Nil	Not applicable	Not applicable	Not applicable
2.6.23	Deputy Ward Manager	Nil	Not applicable	Not applicable	Not applicable
2.6.23	HCSW	Nil	Not applicable	Not applicable	Not applicable

Targeted DOI Request Sent	Designation	Declarations	Period of Involvement "From"	Period of Involvement "To"	Financial Benefits/In Kind
5.6.23	Therapies Clinical Quality Manager	Nil	Not applicable	Not applicable	Not applicable
6.6.23	Dietitian	Nil	Not applicable	Not applicable	Not applicable
6.6.23	Clinical Specialist Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
6.6.23	Clinical Specialist Physiotherapist in Palliative Care	Nil	Not applicable	Not applicable	Not applicable
7.6.23	Therapies administration manager	Nil	Not applicable	Not applicable	Not applicable
7.6.23	Clinical Lead Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
7.6.23	Band 7 Physiotherapist Team lead	Nil	Not applicable	Not applicable	Not applicable
7.6.23	Head of Podiatry and Orthotics	Nil	Not applicable	Not applicable	Not applicable
7.6.23	Admin	Nil	Not applicable	Not applicable	Not applicable
7.6.23	Deputy Head of Podiatry and Orthotics	Nil	Not applicable	Not applicable	Not applicable
7.6.23	MSK PODIATRIST	Nil	Not applicable	Not applicable	Not applicable
8.6.23	Physiotherapy Assistant	Nil	Not applicable	Not applicable	Not applicable
8.6.23	Rotational Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
8.6.23	Health Care Support Worker (Band 3)	Nil	Not applicable	Not applicable	Not applicable
8.6.23	Band 7 Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
8.6.23	Band 4 HCSW	Nil	Not applicable	Not applicable	Not applicable
9.6.23	Head of Occupational Therapy Services	Nil	Not applicable	Not applicable	Not applicable
9.6.23	Principal Occupational Therapist - Adult Mental Health	Nil	Not applicable	Not applicable	Not applicable
9.6.23	Clinical Lead Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
9.6.23	Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
9.6.23	Clinical Lead Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
9.6.23	Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
9.6.23	HCSW	Nil	Not applicable	Not applicable	Not applicable
9.6.23	Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
9.6.23	Band 6 Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
9.6.23	Band 5 Rotational Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
12.6.23	Team lead physiotherapist	Nil	Not applicable	Not applicable	Not applicable
12.6.23	Neuro rehab rotational band 6 physiotherapist	Nil	Not applicable	Not applicable	Not applicable
12.6.23	Assistant Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
12.6.23	B6 rotational inpatient physiotherapist	Nil	Not applicable	Not applicable	Not applicable
12.6.23	Physiotherapy Health Care Support Worker	Nil	Not applicable	Not applicable	Not applicable
12.6.23	Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
12.6.23	Dietetic Professional Manager -Public Health	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Senior Public Health Practitioner	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Deputy Head of Service - Nutrition and Dietetics	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Public Health Dietetic Assistant Practitioner	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Public Health Dietetic assistant practitioner	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Specialist Public Health Dietitian	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Professional Manager Acute SLT	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Head of adults SLT	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Department Professional Manager	Nil	Not applicable	Not applicable	Not applicable

Targeted DOI Request Sent	Designation	Declarations	Period of Involvement "From"	Period of Involvement "To"	Financial Benefits/In Kind
13.6.23	Specialist Dietitian	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Project Support Officer	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Professional Manager SLT in community	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Public Health Dietetic Assistant Practitioner	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Head of Nutrition and Dietetics	Nil	Not applicable	Not applicable	Not applicable
13.6.23	BAND 6 SPECIALIST ADULT WEIGHT MANAGEMENT DIETITIAN	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Public Health Dietetic Support Worker	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Clerical Support Officer	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Departmental Administrative Officer	Nil	Not applicable	Not applicable	Not applicable
14.6.23	Public Health Dietetic Administrator	Nil	Not applicable	Not applicable	Not applicable
14.6.23	Public Health Dietetic Assistant Practitioner	Nil	Not applicable	Not applicable	Not applicable
14.6.23	Band 6 Neuro Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
14.6.23	Head of Children's Speech and Language Therapy	Nil	Not applicable	Not applicable	Not applicable
14.6.23	Physiotherapy Assistant	Nil	Not applicable	Not applicable	Not applicable
14.6.23	Public Health Administration and Clerical Officer	Nil	Not applicable	Not applicable	Not applicable
14.6.23	Highly Specialist Public Health Dietitian	Nil	Not applicable	Not applicable	Not applicable
14.6.23	Public Health Dietetic Assistant Practitioner	Nil	Not applicable	Not applicable	Not applicable
15.6.23	Public Health Dietetic Support Worker	Nil	Not applicable	Not applicable	Not applicable
15.6.23	Highly Specialist Public Health Dietitian	Nil	Not applicable	Not applicable	Not applicable
16.6.23	physiotherapy clinical lead	Nil	Not applicable	Not applicable	Not applicable
18.6.23	HCSW	Nil	Not applicable	Not applicable	Not applicable
19.6.23	Specialist Oncology Dietitian	Nil	Not applicable	Not applicable	Not applicable
19.6.23	Dietitian	Nil	Not applicable	Not applicable	Not applicable
19.6.23	Orthotic Services Administrator	Nil	Not applicable	Not applicable	Not applicable
19.6.23	Physio Assistant Practitioner	Nil	Not applicable	Not applicable	Not applicable
19.6.23	Dietetic Professional Manager - Acute Services	Nil	Not applicable	Not applicable	Not applicable
19.6.23	Dietetic Administration and Clerical Officer	Nil	Not applicable	Not applicable	Not applicable
19.6.23	Diabetes Specialist Dietitian	Nil	Not applicable	Not applicable	Not applicable
19.6.23	Physiotherapy Assistant Practitioner	Nil	Not applicable	Not applicable	Not applicable
20.6.23	Professional Lead SLT	Nil	Not applicable	Not applicable	Not applicable
20.6.23	Clerical Officer	Nil	Not applicable	Not applicable	Not applicable
20.6.23	Generic Therapy Assistant Practitioner	Nil	Not applicable	Not applicable	Not applicable
20.6.23	Generic Therapy Assistant Practitioner	Nil	Not applicable	Not applicable	Not applicable
21.6.23	Rotational Band Five Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
21.6.23	Team Lead Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
21.6.23	Clinical Specialist (B7) Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
21.6.23	Band 6 Static MSK physiotherapist	Nil	Not applicable	Not applicable	Not applicable
21.6.23	Band 6 Static Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
21.6.23	Physiotherapist	Nil	Not applicable	Not applicable	Not applicable

Targeted DOI Request Sent	Designation	Declarations	Period of Involvement "From"	Period of Involvement "To"	Financial Benefits/In Kind
21.6.23	Band 7	Nil	Not applicable	Not applicable	Not applicable
21.6.23	Staff Nurse	Nil	Not applicable	Not applicable	Not applicable
21.6.23	Major Trauma Rehab Coordinator	Nil	Not applicable	Not applicable	Not applicable
21.6.23	Major trauma rehab coordinator	Nil	Not applicable	Not applicable	Not applicable
21.6.23	Clinical Lead MSK Outpatient Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
21.6.23	HCSW	Nil	Not applicable	Not applicable	Not applicable
22.6.23	Physiotherapy Assistant	Nil	Not applicable	Not applicable	Not applicable
22.6.23	Band 6 Rotational Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
22.6.23	Band 6 secondment	Nil	Not applicable	Not applicable	Not applicable
22.6.23	Physio	Nil	Not applicable	Not applicable	Not applicable
22.6.23	Clinical Specialist Physio	Nil	Not applicable	Not applicable	Not applicable
22.6.23	HCSW	Nil	Not applicable	Not applicable	Not applicable
22.6.23	Staff Nurse	Nil	Not applicable	Not applicable	Not applicable
22.6.23	RGN	Nil	Not applicable	Not applicable	Not applicable
23.6.23	Band 7 PH Physio	Nil	Not applicable	Not applicable	Not applicable
23.6.23	Pelvic Health Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
23.6.23	Pelvic Health Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
23.6.23	PHYSIOTHERAPIST	Nil	Not applicable	Not applicable	Not applicable
23.6.23	PH Physio	Nil	Not applicable	Not applicable	Not applicable
23.6.23	HCSW	Nil	Not applicable	Not applicable	Not applicable
26.6.23	Band 6 Specialist Paediatric Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
26.6.23	Physiotherapy Assistant Practitioner	Nil	Not applicable	Not applicable	Not applicable
26.6.23	Paediatric Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
26.6.23	Principal Occupational Therapist	Nil	Not applicable	Not applicable	Not applicable
26.6.23	Clinical Specialist Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
26.6.23	A&C	Nil	Not applicable	Not applicable	Not applicable
26.6.23	clerical officer	Nil	Not applicable	Not applicable	Not applicable
26.6.23	Band 6 Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
26.6.23	Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
26.6.23	Staff Nurse	Nil	Not applicable	Not applicable	Not applicable
27.6.23	Clinical Lead ED Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
27.6.23	Staff Nurse	Nil	Not applicable	Not applicable	Not applicable
28.6.23	Highly Specialist Podiatrist, acute foot	Nil	Not applicable	Not applicable	Not applicable
28.6.23	Speech & Language Therapist	Nil	Not applicable	Not applicable	Not applicable
28.6.23	community staff nurse	Nil	Not applicable	Not applicable	Not applicable
28.6.23	Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
28.6.23	Physiotherapist (junior)	Nil	Not applicable	Not applicable	Not applicable
29.6.23	Rotational Inpatient Band 6 Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
29.6.23	CTM UHB	Nil	Not applicable	Not applicable	Not applicable

Targeted DOI Request Sent	Designation	Declarations	Period of Involvement "From"	Period of Involvement "To"	Financial Benefits/In Kind
29.6.23	clinical specialist physiotherapist	Nil	Not applicable	Not applicable	Not applicable
29.6.23	Band 3 Admin Roster Support	Nil	Not applicable	Not applicable	Not applicable
29.6.23	physiotherapy assistant	Nil	Not applicable	Not applicable	Not applicable
29.6.23	Advanced Pharmacist in Surgery	Nil	Not applicable	Not applicable	Not applicable
29.6.23	Dietitian	Nil	Not applicable	Not applicable	Not applicable
29.6.23	Specialist Dietitian	Nil	Not applicable	Not applicable	Not applicable
29.6.23	Band 4 Physiotherapy Assistant Practitioner	Nil	Not applicable	Not applicable	Not applicable
29.6.23	Band 6 specialist paediatric physiotherapist	Nil	Not applicable	Not applicable	Not applicable
29.6.23	Paediatric Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
29.6.23	Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
10.5.23	Assistant director of improvement culture capability and delivery, Patient Care & Safety	Nil	Not applicable	Not applicable	Not applicable
12.6.23	Consultant Child and Adolescent Forensic Psychiatrist	Nil	Not applicable	Not applicable	Not applicable
12.6.23	Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Physiotherapy Assistant Practitioner	Nil	Not applicable	Not applicable	Not applicable
13.6.23	Therapy Assistant Practitioner	Nil	Not applicable	Not applicable	Not applicable
14.6.23	Band 6 Neuro Rotational Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
14.6.23	Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
16.5.23	Consultant Cardiologist	Nil	Not applicable	Not applicable	Not applicable
16.5.23	Physiotherapy Team Lead Community, @Home and Reablement Services	Nil	Not applicable	Not applicable	Not applicable
16.6.23	Macmillan AHP Lead	Nil	Not applicable	Not applicable	Not applicable
17.4.23	Deputy Chief Operating Officer	Nil	Not applicable	Not applicable	Not applicable
17.5.23	Consultant Obstetrician and Gynaecologist	Nil	Not applicable	Not applicable	Not applicable
17.5.23	Consultant Obstetrician and Gynaecologist	Nil	Not applicable	Not applicable	Not applicable
18.4.23	Consultant Surgeon	Nil	Not applicable	Not applicable	Not applicable
18.4.23	Consultant	Nil	Not applicable	Not applicable	Not applicable
18.4.23	Consultant	Nil	Not applicable	Not applicable	Not applicable
18.5.23	Consultant Histopathologist	Nil	Not applicable	Not applicable	Not applicable
19.6.23	Highly Specialist Weight Management Dietitian	Nil	Not applicable	Not applicable	Not applicable
19.6.23	Dietitian	Nil	Not applicable	Not applicable	Not applicable
19.6.23	Deputy Head of Nutrition	Nil	Not applicable	Not applicable	Not applicable
2.5.23	Consultant orthopaedic Surgeon	Nil	Not applicable	Not applicable	Not applicable
2.5.23	Consultant orthopaedic Surgeon	Nil	Not applicable	Not applicable	Not applicable
2.5.23	Consultant in Public Health	Nil	Not applicable	Not applicable	Not applicable
20.6.23	Speech and Language Therapist	Nil	Not applicable	Not applicable	Not applicable
21.6.23	Specialist MSK Physiotherapy	Nil	Not applicable	Not applicable	Not applicable
21.6.23	Physiotherapy Practicioner	Nil	Not applicable	Not applicable	Not applicable
21.6.23	Podiatrist	Nil	Not applicable	Not applicable	Not applicable
21.6.23	Clinical Pharmacist	Nil	Not applicable	Not applicable	Not applicable
22.6.23	Physiotherapist	Nil	Not applicable	Not applicable	Not applicable

Targeted DOI Request Sent	Designation	Declarations	Period of Involvement "From"	Period of Involvement "To"	Financial Benefits/In Kind
23.5.23	Consultant Physician	Nil	Not applicable	Not applicable	Not applicable
23.5.23	Consultant Physician	Nil	Not applicable	Not applicable	Not applicable
23.6.23	Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
23.6.23	Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
24.5.23	Consultant Dermatologist	Nil	Not applicable	Not applicable	Not applicable
26.4.23	Consultant Cardiologist	Nil	Not applicable	Not applicable	Not applicable
26.4.23	Consultant Cardiologist	Nil	Not applicable	Not applicable	Not applicable
26.4.23	Consultant Cardiologist	Nil	Not applicable	Not applicable	Not applicable
26.4.23	Consultant Cardiologist	Nil	Not applicable	Not applicable	Not applicable
26.4.23	Consultant Cardiologist	Nil	Not applicable	Not applicable	Not applicable
26.6.23	Clinical Director for Therapies	Nil	Not applicable	Not applicable	Not applicable
26.6.23	Specialist Paediatric Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
26.6.23	Specialist Paediatric Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
26.6.23	Community Clinical Specialist Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
29.6.23	None	Nil	Not applicable	Not applicable	Not applicable
30.5.23	Consultant in Public Health Medicine	Nil	Not applicable	Not applicable	Not applicable
5.5.23	Staff Nurse	Nil	Not applicable	Not applicable	Not applicable
7.6.23	Band 7 Physiotherapist in ESD	Nil	Not applicable	Not applicable	Not applicable
7.6.23	Band 5 Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
7.6.23	Physio Tech	Nil	Not applicable	Not applicable	Not applicable
7.6.23	Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
7.6.23	Band 3 Physiotherapy Assistant	Nil	Not applicable	Not applicable	Not applicable
7.6.23	Assistant Head of Physiotherapy	Nil	Not applicable	Not applicable	Not applicable
8.6.23	Team Lead Physiotherapist Acute Stroke	Nil	Not applicable	Not applicable	Not applicable
8.6.23	Band 7 Physiotherapist	Nil	Not applicable	Not applicable	Not applicable
8.6.23	Extended Scope Podiatrist - Orthopaedics	Nil	Not applicable	Not applicable	Not applicable
9.6.23	Band 6 rotational physiotherapist	Nil	Not applicable	Not applicable	Not applicable
9.6.23	Clinical Specialist Inpatient Neuro	Nil	Not applicable	Not applicable	Not applicable

Date Declaration Made	Date Received by Corporate Governance	Name	Designation / Department
18.04.2023	19.04.2023	Suzanne Hardacre	Director of Midwifery

Provided by / From	Date Received
12th June 2023	16th June 2023

Details
Conference attendance at International Confederation of Midwives – Bali, Indonesia Sponsored by Welsh Government, Office of the Chief Nurse - Annual leave is required £800 (fees were paid in 2019, conference postponed due to COVID-19)

Gift/Hospitality and or Sponsorship	Accepted or Declined
Sponsorship	Accepted and supported by Gregg Dix

AGENDA ITEM
6.2.4

AUDIT & RISK COMMITTEE

STANDING ORDER BREACHES

Date of meeting	16/08/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Philippa Peake-Jones, Interim Head of Corporate Governance and Assurance
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Under section 7.1 Preparing for Meetings as stated in the Standing Orders, it is noted that under the section of "Notifying and Equipping Board Members":

*"Board members shall be sent an Agenda and a complete set of supporting papers at least **10 calendar days before** a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired."*

1.2 In practice most Health Boards publish papers electronically 7 days prior to the Meeting. The 10 day notice was drafted when papers were sent out in hard copy, however, given that the Standing Orders have not changed and are unlikely to do so in the near future the Audit & Risk Committee should note that all Board Meeting publications are in breach of the 10 day publication period.

1.3 Further scrutiny of the Standing Orders will be undertaken and any other Breaches will be reported in future updates to the Audit & Risk Committee.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The Committee is asked to note that papers are published 7 days in advance rather than 10 as stated in the Standing Orders, however, the Board continues to fulfil its role and meet its responsibilities through the conduct of the meeting with the 7 day publication period.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 No further information to note.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not applicable for the Standing Order Breach item
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Sustaining our Future

5. RECOMMENDATION

The Committee are asked to:

- **Note** that papers are published 7 days in advance rather than 10 as stated in the Standing Orders.

- **Note** that the publication of papers is likely to continue to breach the 10 day publication and continue as 7 days electronic publication.