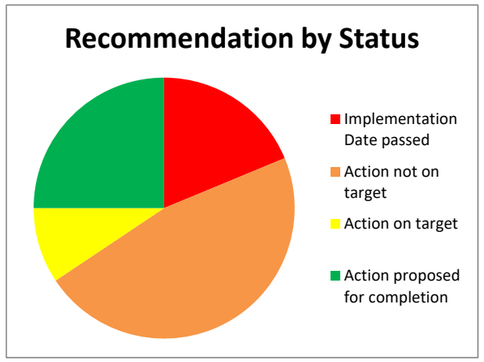
Appendix 1

Cwm Taf Morgannwg

External Audit Recommendations / Action Log - [Month] 2019



Recommendations by Priority & Status					
Priority	TOTAL	Implementation Date passed	Action not on target	Action on target	Actions Completed
High	11	0	6	1	4
Medium/Low	21	6	9	2	4

Progress	
Total Recommendations	
Improving	
No Change	

Recommendations by Executive Lead & Status					
Executive Lead	Total	Implementation Date passed	Action not on target	Action on target	Actions Completed
Director of Corporate Governance	1	0	0	0	1
Director of Finance	3	0	0	2	1
Director of Operations	9	6	3	0	0
Director of Planning & Performance	7	0	4	0	3
Director of Primary, Community & MH	6	0	3	0	3
Director of Public Health	6	0	5	1	0

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Ref	Date added	Issue	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead/Management Lead	Committee /Group	Original Agreed Implementation Date	Revised Implementation Date	Revised Implementation date	Status	Progress	Actions completed	Issues Arising This Period	Next Steps & Expected Milestones
Comparative Picture of Orthopaedic Services (January 2017)															
CPOS 01	Apr-15		Outpatient services: • The ratio of follow-up to new appointments in the Health Board is the second highest in Wales at 2.3 and above the Welsh Government target of 1.9. • DNA rates are above the Welsh Government targets at 8.7 per cent of new appointments and 13 per cent of follow-up appointments. The follow-up DNA rate is the highest in Wales. • The patient cancellation rates are 5.7 per cent and 10.7 per cent for new and follow-up appointments respectively.	High	Follow up pathways are being reviewed as part of the Orthopaedic Planned care programme. Implementation of text and remind service is expected to improve DNA rates. This will be monitored and further action taken if Text & Remind does not generate the improvement anticipated A detailed capacity and demand exercise has been undertaken to confirm baseline numbers of clinics and consistent templates. A revised process is in place to monitor cancellation of clinics outside of 6 weeks	Director of Operations		Jun-15	Sep-16	Feb-21		In Progress		November 2020 Update - Significant work has been undertaken in these areas since 2015 with successes a number of areas especially the text and remind services. Given the UHB's need to respond to covid 19, the level of management focus has not been optimal with the last Outpatient Programme Board held in July 2020. Since then, a Programme Manager has been appointed, who is going to be re-establishing the Planned Care Board which will encompass Outpatients and these issues shortly. Urgent matters are managed through the ILG structures with Senior Managers accountable at Clinical Service Group Meetings on each site. Update will be provided in February 2021.	March 2016 Update - work to date has focussed on new patient pathway. Validation of follow ups is underway, with implementation of the planned care programme arthroplasty pathway planned in the next 6 months. June 2016 update - validation of follow-ups continue with the number of patients waiting past target date reduced by 1000. Clinical agreement needed to implement the recommended arthroplasty follow-up pathway this is in progress. Sept 2016 Update - validation of follow-up patients waiting over target date continues, supported by additional clinics. Arthroplasty follow-up pathway agreed and in place. Jan 2017 - There is a need to evaluate the effect of the Text & Remind Service on DNA rates. Further action is also being taken to address Follow Ups Not Booked, including validation of long waiters. March 2017 - Further action is also being taken to address Follow Ups Not Booked, including validation of long waiters. Further validation of patients on the FUNB list is being undertaken, consutlants are asked to look at clinic letters. August 2017 - Consultants are carrying out virtual clinics in a bid to determine the patients who do actually require a follow up. Steady progress is being made. November 2017 update - Clinical & Non Clinical Validation continues and there is a stronger alignment with the national planned care programme board. Jan 2018 update - Text reminders are having an impact on DNA rates. Partial booking will be rolled out to all FUP appointments in 2018/19. March 2018 update - still in progress
CPOS 05	Apr-15		Day case rates: • The percentage of the recommended orthopaedic procedures undertaken as a day case is below the Welsh Government target for both Prince Charles and Royal Glamorgan hospitals at 65 and 70 per cent respectively.	High	There is no day surgery unit at RGH, but plans are in place to address this in the next 2 years. In PCH there is a capacity shortfall for day surgery theatre space. A review of theatre space across both sites for orthopaedics is needed alongside sub-specialty level capacity planning. This work will be taken forward as part of the Orthopaedic Planned Care programme. In addition, the Directorate plan to centralise urology flexi-cystoscopy procedures at RGH, which would provide additional day theatre space for orthopaedics at PCH	Director of Operations		N/A	Feb-21			In Progress		November 2020 Update - Updates indicate that the improvements have been made in this area (with the WG target rate achieved in January 2018), however the requirement to respond to covid 19 has reduced management focus. A Planned Care Board has been established in the very recent past and theatre efficiency will be an area of work. Urgent matters are managed through the ILG structures with Senior Managers accountable at Clinical Service Group Meetings on each site, then progressing to monthly ILG Meetings with the Director of Operations. An update will be provided in February 2021.	March 2016 Update - Increase in day theatre/day ward capacity at RGH remains dependent on transfer of other services. Plans to centralise urology flexi-cystoscopy have progressed and this is expected to release further day surgery capacity at PCH by the end of the summer 2016. June 2016 Update - The transfer of flexi-cystoscopy sessions to the GUM unit at RGH is planned for October/November 2016 and this will release day theatre space in PCH. Sept 2016 - No further update. Jan 2017 update - fo further progress made. Dependent on wider service changes e.g. ground and first floor scheme PCH. March 2017 - No further progress made. August 2017, ongoing phased plans to move Flexi cystoscopies from PCH to RGH, this includes equipment, staffing and a review of options to utilise this capacity overal are being developed. Currently delays in fully commisioning the Treatment Centre and to plans to convert PCH flexi lists to general anaesthetic lists. Centre opened 10 July 2017. Day case rates are being monitored and will be discussed at CBMs and this will inlcude options to increase the day case rate within current capacity. November 2017 Update - Work being undertaken with Orthopaedic Consultants to improve day of surgery admission. Pilot currently underway. Work across sceduled care to identify cases that are in an inpatient setting that are more appropratley placed in a day case environment. January 2018 - Orthopaedic day case rates have risen above the Welsh Goverment target . March 2018 update - still in progress

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CPOS 07	Apr-15		Operating theatres: • Orthopaedic theatre utilisation ranges between 80 and 93 per cent across the Health Board. This remains below the Welsh Government target of 95 per cent. • The rates of cancelled operations and cancelled theatre sessions are both high, with 34.7 per cent of lists cancelled at Prince Charles Hospital.	High	At PCH site the planned first floor redevelopment will enable a change in how the specialty manages its capacity with laminar flow and treatment room options. This is linked to lack of theatre capacity highlighted above and trauma/elective split ie. Patients are cancelled but replaced by trauma. The Directorate plan to provide additional day theatre space for orthopaedics at PCH by centralising Urology flexi-cystoscopies at RGH will help support improvements	Director of Operations		Mar-16	Feb-21			In Progress		November 2020 Update - Updates indicate that the improvements have been made in this area with CDs monitoring start and finish times, especially within Ophthalmology. In addition, work is now underway on the changes to the fabric of PCH with the Ground and First Floor project. However, progress has not been optimal – partly as an outcome of the UHB's response to covid 19 – and it is anticipated that this will be resolved via the establishment of a Planned Care Board. Detailed timings are not available on the work programme for the Board, however an update will be provided in February 2021. Urgent matters are managed through the ILG structures with Senior Managers accountable at Clinical Service Group Meetings on each site, then progressing to monthly ILG Meetings with the Director of Operations.	March 2016 Update - As above. June 2016 - No further update. Sept 2016 - No further update. Jan 2017 update - no further progress made. Progress is dependent on wider service changes e.g. ground and first floor scheme PCH, which provides an opportunity to address theatre list allocation, particularly at PCH for elective, day cases and trauma. March 2017 Update - No further progress made. November 2017 Update - Theatre utilisation is being discusssed at ACT and Surgery Recovery meetings. Improved utilisation around productivity is already being initiated in opthalmology. Late satrts and early finishes are monitored through the new qliqsense app enabling CD's to interrogate the data by speciality and inform actions. January 2018 - Work is now underway on improving theatre utilisation rates as part of a programme of work led by Deb Lewis, Assistant Director. This work will be reported to the productivity, Efficiency and Value Board. March 2018 Update - Still in progress
Follow Up Outpatients Not Booked (January 2017)															
R1 Follow Up	Oct-17		Ensure that there is sufficient information on the clinical risks of delayed follow-up outpatient appointments reported to relevant sub-committees so that the Board can take assurance from monitoring and scrutiny arrangements.	Medium/ Low	The original review in 2015 identified that the Health Board needed to broaden the information reported to the Board and is sub committees so that it was aware not only of the volume of delays but also the clinical nature of delays in outpatient follow-up appointments. Since our review the level of scrutiny and focus by the Health Board has increased. There is a clear drive to improve the follow-up position and detailed information is presented in terms of the current performance to Finance, performance and Workforce committee. Quality, Safety and Risk committee has also been scrutinising the performance of the Health Board. However, although the Health Board is targeting its focus on the highest volume areas of follow-up backlog it has not yet produced a risk assessment for follow-up outpatients to determine the clinical conditions where delayed appointments may result in harm. A recent paper to the Quality, Safety and Risk Committee did aim to provide assurance in relation to the clinical risks for patients on the follow-up list, however it did not meet the needs of the committee, and independent members have asked the team to revisit the paper and resubmit it. This is planned for September 2017. The Health Board utilises its Datix system to identify any patients that have come to harm as a consequence of delayed follow up appointments, and these mechanisms are utilised as required. However, despite the lack of a formal assessment of clinical risk, it is clear that within the specialties there is a focus on the clinical areas which can cause the most clinical harm, The Ophthalmology department, for instance, is clear on the conditions which have the most potential for harm and is	Director of Operations						In Progress			January 2018 Update - A senior manager from the COO team is providing focused senior support to improve the position with an initial focus on gastroenterology. Work is underway to support the clinical team to fully understand the backlog position and to review the patients waiting the longest through clinical nurse specialist reviews and virtual clinics initially. Discussion is also ongoing to refine the risk stratification plan in order to provide additional assurance in respect of the management of any known clinical risks. July 2019 update - FUNB work continues with a strong drive and focus from COO and Deputy COO and Board level support for an ongoing resource plan of c. £1m. Full reports have been provided to FWP and QSR committees in the last meeting cycles confirming that the UHB is on trajectory for its intended end of year position of 10k patients on the list (currently about 13k patients on the FUNB list dropping from c.19k patients following Ophthalmology cases outsourcing). Given this performance the Welsh Government has responded to our recent updates and welcomed a bid for performance funding to see if our delivery of a balanced position (due end of 20/21) could be accelerated. In terms of quality, we continue to report every case of harm generated by delays for clinical treatment through the regular FUNB report to QSR committee. Currently, the UHB has the most advanced FUNB position in Wales.

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R2	Jan-16		Ensure compliance with revised administrative and booking processes across the organisation to avoid unnecessary retrospective validation of patient records.	Medium/ Low	Regular compliance reports will be monitored at the RTTmeetings and Scheduled Care Board, attended by all the appropriate directorate managers. Immediate corrective action will be put in place when necessary to avoid retrospective validation.	Director of Operations		Apr-16				In progress			Sept 2016 Update - Regular compliance reports are being monitored at the RTT meetings and Sceduled Care Board. Jan 17 - The complaince reports have highlighted that adherence to the agreed administrative and booking processes is still not being followed in some areas. Details of the staff who are non compliant is available to the directorate managers in order to implement corrective actions. March 2018 Update - Work continues to improve in this area. As part of the outpatient improvement theme new software has been introduced for clinicians to enable them to record the outcomes of their consultations in real time. Although only rolled out to a small selection of specialities the system has potential to improve recording of patient outcomes which will support the quality of patient data in respect of follow-ups. Performance data is also captured though the Qlik Sense system. This data analytics tool enables directorates and clinicians to interrogate a vast array of data to support day to day management and continuous improvement. September 2018 - The COO presented a proposal to the Executive Board in July outlining the additional resourcing required to address the back log taking a risk based approach and outlining the project plan in place to strengthen and develop performance. For the first phase £200k was agreed and the first stage for ophthalmology has been instigated. Going forward full updates will be included within the Integrated Performance Dashboard. December 2018 update - Much work has been undertaken to cleanse all areas of the waiting lists to ensure no patients are lost to follow up. This has had a negative impact on the FUNB numbers as patients are transferred onto the FUNB lists from other areas of the waiting list. The ICT and medical records team are undertaking training for all staff who fail to outcome appointments appropriately and further work will be undertaken with the outpatient staff. This is an area that will require continous monitoring and action over the forthcoming months. March 2019 In general, positive
R2 Follow Up	Oct-17		Ensure compliance with revised administrative and booking processes across the organisation to avoid unnecessary retrospective validation of patient records.	Medium/ Low	The original review reported that the Health Board was undertaking unnecessary retrospective validation activities and this was an additional pressure on capacity which could be avoided. Unfortunately retrospective validation is still being undertaken by the Health Board. The latest figures reported in April 2017 show that the current volumes of patients without a target date was 1,129, however this is a significant improvement from the same time last year where the volume was 3,509. It remains an area of focus for the Health Board. Work continues to improve in this area. As part of the outpatient improvement theme new software has been introduced for clinicians to enable them to record the outcomes of their consultations in real time. Although only rolled out to a small selection of specialities the system has potential to improve recording of patient outcomes which will support the quality of patient data in respect of follow-ups. Performance data is also captured though the Qlik Sense system. This data analytics tool enables directorates and clinicians to interrogate a vast array of data to support day to day management and continuous improvement.	Director of Operations						In Progress			

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R4	Jan-16		Develop operational arrangements to deal with the backlog in delayed follow-up appointments, in particular, those specialities or clinical conditions where there is likely to be harm to patients who are delayed.	Medium/ Low	Where specialities are identified to have a backlog through the previously described monitoring mechanism, resources will be identified with the directorates to address these. Resources will be directed initially at those specialites where the risk of harm is greatest	Director of Operations		Mar-16				In progress			Sept 2016 Update - Follow up backlogs have been incorporated in their 2016/17 demand and capacity plans for each of the specialties. Directorates have developed plans to provide the additional capacity with changes to clinic templates, additional sessions and the creation of virtual clinics. Improvement trajectories have been developed and these will be monitored through the mechanisms described above. Jan -17 Update - Following a report to the Finance Performance and Workforce Committee on progress, the Committee have requested that directorates focus on the top 10 specialties i.e. those with the largest number of patients past their target date where ongoing delay has an increased potential to result in harm. The specialies are Ophthalmology, ENT, General Medicine, Orthopaedics, Gastroenterology, Gynaecology, Urology, Rheumatology, CAMHS and Respiratory Medicine. An update to the Finace, Performance & Workfroce Committee in May 2017 demonstrating improvement has been requested. March 2017 Update - No further progress made. June 2018 update - A plan is being developed to address the existing backlog on a specialty basis. The programme of work will take 2-3 years and will need to be resourced appropriately. Once the backlog has been reviewed and addressed and sustainable processes and monitoring arrangements are established, the position should be managed within existing demand and capacity plans. September 2018 - The COO presented a proposal to the Executive Board in July outlining the additional resourcing required to address the back log taking a risk based approach and outlining the project plan in place to strengthen and develop performance. For the first phase £200k was agreed and the first stage for ophthalmology has been instigated. Going forward full updates will be included within the Integrated Performance Dashboard. December 2018 update - Plans are developing in all specialities with some areas making more progress than others. In the main the areas with smaller numbers of
R4 Follow Up	Oct-17		Develop operational arrangements to deal with the backlog in delayed follow-up appointments, in particular, those specialities or clinical conditions where there is likely to be harm to patients who are delayed.	Medium/ Low	Our review in 2015 concluded that although the Health Board has plans to develop services within the community, current operational arrangements were having a limited impact on reducing delayed follow-ups and service modernisation would be challenging. Within specialities and directorates there are a range of activities in place to maximise the capacity of the Health Board. We were signposted to new ways of working, for example within Respiratory where a specialist nurse is triaging referrals to identify where patients could be seen by a nurse instead of a consultant, therefore freeing up capacity. Within the Ophthalmology department, community optometrists are being used to provide follow-ups and additional capacity. The range of activities is promising, and shows the commitment of staff within the services to maximise their efficiency. The success of these initiatives is monitored through the regular performance monitoring arrangements in place, and feeds into the demand and capacity plans owned by the services. However, despite these examples of good arrangements there has been less attention given to transformational change to outpatient models. This is recognised within the Health Board, and there is recognition that new ways of working need to be explored and a focus on whole systems change, looking at referral management through to patient discharge	Director of Operations		Mar-16				In Progress			January 2018 update - A senior manager from the COO team is providing focused senior support to improve the position with an initial focus on gastroenterology. Work in underway to support the clinical team to fully understand the backlog position and to review the patients waiting the longest through clinical nurse specialist reviews and virtual clinics initially. Discussion is also ongoing to refine the risk stratification plan in order to provide additional assurance in respect of the management of any known clinical risks. April 2018 Update - A senior manager from the COO team is providing focused senior support to improve the position within a number of key specialties with an initial focus on gastroenterology. Work is underway to support the clinical team to fully understand the backlog position and to review the patients waiting the longest through clinical nurse specialist reviews and virtual clinics initially. Discussions to date have been held with the clinical leads for gastroenterology, cardiology, orthopaedics, ENT surgery and ophthalmology. 70+ patients have been reviewed in gastroenterology and plans are in place for monthly virtual review clinics. Some clinical risk has been identified and whilst the majority of the patients have been discharged a number will require follow up appointments. An extra outpatient clinic is planned for May to pick up a further cohort of the gastroenterology patients. Discussion is also ongoing to refine the risk stratification plan for each speciality in order to provide additional assurance in respect of the management of any known clinical risks. It is clear that a dedicated resource is needed in order to progress the work with each of the specialities and attempts are being made to secure an additional administrative resource.
Discharge Planning (March 2018)															
DP 03	Jan-18		Patient leaflet: Adapt the community hospital patient leaflet so it is relevant for patients staying in acute hospitals, setting out ☐ information about the discharge process, ☐ how the patient and family will be kept informed of the discharge process; ☐ arrangements that the patient may need to make (such as arrange transport); ☐ information about follow-up care; and ☐ the complaints process.	Medium/ Low	A patient information leaflet is already in place and used on the community hospital sites. The UHB will now consider the development of an acute hospital information leaflet.	Director of Operations		Sep-18				In Progress			
Primary Care Services (February 2019)															

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PC 01	Jan-19		The Health Board commissioned the Primary Care Foundation to carry out demand and capacity assessments in GP practices but the take-up from practices has been variable. To maximise value from the commissioned work, the Health Board should centrally analyse and collate the messages from the demand and capacity assessments and share the learning across all practices.	High	Currently this is being undertaken and the outcomes will be shared at Cluster meetings, the Primary Care Strategic Planning Group and reported through to the Primary Care Committee. Numerous practices have implemented changes and this will be captured and shared as a key element of this work.	Director of Primary, Community & Mental Health Services		Dec-18	Mar-20	Mar-21		In Progress			March 2019 update - Delay as a National set of Access Standards have been released and the work needs to be considered in conjunction with this. Bridgend boundary transfer has also an impact and there the work is deferred to end of March 2020. July 2020 Update - Demand and Capacity Took is being commissioned on a national basis as part of the changes to the GMS Contract and introduction of Access Standards. The achievement of this action is now dependent on this as it will be up to date and contemporaneous. Nov 2020: The demand and capacity assessments undertaken by the Primary Care Foundation are now immaterial as demand and the way in which this is managed has signifiantly as a result of Covid-19 pandemic. Many consultations and appointments are undertaken by remote means, e.g. telephone, emails and video as well as face to face. In addition to this access standards have also changed again as a result of National contract negotiations. The national demand and capacity tool will take account of all these changes. The National demand and capacity tool is still being discussed and possibly sourced by Welsh Government and this is awaited.
PC 02	Jan-19		Calculate a baseline position for its current investment and resource use in primary and community care.	High	This work has commenced and will be a crucial element in determining the baseline position for the primary and community element of the Cwm Taf Partnership Transformation Plan.	Director of Primary, Community & Mental Health Services		Mar-19	Mar-20	Mar-21		In Progress			March 2019 update - Bridgend practices now have to be considered as part of the workplan. Deferred for March 2020. July 2020 Update - Deferred for March 2021 as a result of Covid-19 pandemic. Oct 2020 This is being further complicated by the announcement by WG that the transformation funding will be drastically reduced for the period of extension, just a quarter of the funding is being offered. Disussions with WG still taking place.
PC 03	Jan-19		Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	High	The Cwm Taf Partnership Transformation Plan will require that a thorough assessment is made in regard to the impact of investment in primary, community and social care on the whole health and care system. This will require reporting to WG and also through the Regional Partnership Board as well as internal efficiency and productivity arrangements.	Director of Primary, Community & Mental Health Services		Mar-20	Mar-21			Completed	Nov 2020. Action Complete. Andrew Goodall reported in Nov 2019 that investment and shift of services into Primary Care should be reviewed regularly as part of JET mtgs. Addional updates in respect of investment into primary care are provided to Welsh Government on an annual basis as and when requested. This is provided by Finance colleagues. This includes investment from cluster budgets, delivery agreements, and other sources including shift in resources from secondary care. Latest report in respect of primary care funds invested was submitted in October 2020. No requests to date to provide a report to Regional Partnership Board.		Update July 2020 - Delayed as a result of Covid-19 pandemic
PC 04	Jan-19		The Health Board's workforce planning is inhibited by having limited data about the number and skills of staff working in primary care, particularly community dentistry, optometry and pharmacy. The Health Board should develop and implement an action plan for ensuring it has regular, comprehensive, standardised information on the number and skills of staff, from all professions working in all primary care settings.	Medium/ Low	The Health Board through the Oral Health and Eye Care planning arrangements will commence during 2019/20 more detailed work on the workforce issues in Dentistry and Optometry practices. In particular skill mix approaches and professional shortages. The CDS service will have been repatriated and a full workforce analysis and modernisation approach will be undertaken The Cwm Taf Transformation plan places great store on MDT working of which the role of pharmacy and pharmacists is crucial. Workforce planning in this area is key and will be worked through the Transformation Plan	Director of Primary, Community & Mental Health Services		Mar-20	Mar-21			In Progress			Update July 2020 - Delayed as a result of Covid-19 pandemic
PC 05	Jan-19		Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models.	High	The Public Health Local Team have supported the clusters in evaluating a small number of schemes already but not all. In addition to this they have produced a template evaluation framework for clusters. The use of this template needs to be encouraged for all schemes. Detailed evaluation is an essential part of the new transformation plans to demonstrate the impact of the extended MDT team.	Director of Primary, Community & Mental Health Services		Mar-20	Mar-21			Completed	November 2020 Update - Action Complete		July 2020 - Delayed as a result of Covid-19 pandemic
PC 07	Jan-19		Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments.	High	Work has already commenced with this as part of 'know your own team campaign'. A plan for 2018/19 has been produced. Engagement with clusters is essential. Opportunities to engage will be taken via media, press, existing forums and groups and events.	Director of Corporate Governance		Ongoing	Mar-21			Completed	November 2020 Update The large scale transformation funding from WG has enable significant developments in primary care in the last year to enable GP's to have oversight but reduces the need for them to see many people with complex comorbidities so frequently due to more assertive management and support of this group by the extended MDT. The principle of the approach to free up GP time remains core to all PC developments but sufficient progress has been made through transformation to say action completed whilst other work continues.		July 2020 - Delayed as a result of Covid-19 pandemic

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PC 09	Jan-19		Review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary.	High	Significant support is already given to clusters however they will need to evolve both as part of the strategic direction set by the Welsh Government in A Healthier Wales and to fulfil the expectations and requirements of the transformed model. In addition, a new governance framework has been issued on a national basis and will be used locally as part of the delivery of the transformation plan to support clusters in their maturity.	Director of Primary, Community & Mental Health Services		Mar-20	Mar-21			Completed	November 2020 Update - Action Complete		Update July 2020 - discussions to take place with the 3 ILGs. Clusters have now transferred over as part of the structural reorganisation.
Clinical Coding Follow Up Review															
CCFU 01	Oct-19		Raising the importance of good quality medical records throughout the Health Board;	High	In 2014, we found that the quality of medical records across the Health Board was not of a good standard, with key information required for accurate clinical coding often missing or inappropriately filed. Our work has found that there continues to be issues with the quality of medical records within the Heath Board. In 2018, NWIS produced a report into clinical coding documentation. This review was undertaken as part of ongoing service improvement work to improve the quality of clinical coding data. The primary aim of this review was to assess the quality of the clinical documentation held within case notes. Overall administrative documentation was of good quality, but there were issues with loose paperwork and records being filed out of order. There were also issues with deceased notes and unplanned admissions. The quality of information for coders in the notes was poor. Only half of the clinical entries contained a diagnosis and of these, a third would be unable to be used for coding purposes. This report highlights that there are issues that need to be addressed by the Health Board. In our 2014 report, we noted the re-establishment of the Health Records Committee. The aim of this was to give the necessary focus to the quality of medical records to enable coders to code accurately. However, this Committee was disbanded in August 2017 and we are unaware of any new arrangements in place to monitor and ensure the quality of medical records.	Director of Planning & Performance		Not specified by the Health Board	Oct-20	Feb-21		In progress		November 2020 Update - The completeness of the documentation is the responsibility of multiple staff groups across the hospital sites. Both the content and quality of the record will be improved through the plans to commence digitisation, which have been delayed due to COVID-19 until 20/21. This process will reduce the risk of documents being lost from within the record as they will be scanned and held digitally. However it will not improve the quality of the casenote itself without additional steps being taken prior to digitisation. E-forms will also be introduced to capture information electronically, live at the point of care. These forms will be structured and will require the clinical user to provide answers to mandatory questions and use standard terminology through the use of drop-down menus. This should aid completeness and	Update January 2020 The completeness of the documentation is the responsibility of multiple staff groups across the hospital sites. Both the content and quality of the record will be improved through the plans now being implemented to commence digitisation in November 2019. This process will reduce the risk of documents being lost from within the record as they will be scanned and held digitally. E-forms will also be introduced to capture information electronically, live at the point of care. These forms will be structured and will require the clinical user to provide answers to mandatory questions and use standard terminology through the use of drop-down menus. This should aid completeness and accuracy, as well as legibility of information captured. Digitisation of the critical mass of active patients is expected to take 2 years to complete, but improvements will begin for individual patients from the point of go-live. Rollout of e-form development is planned to commence in April 2020 and this will involve a development programme gradually converting existing paper forms to e-forms. Work will be done to identify those which are highest priority for development, but this is likely to target the highest volume and least complex forms in the first stages. These measures will assist in regards to the completeness of the record and the timely availability of information. Greater focus is needed on every aspect of medical records management, which is clinically led and an organisation wide.
CCFU 02	Oct-19		Clarifying roles and responsibilities for medical records amongst clinical support staff, such as ward clerks and medical secretaries, including filing and general record maintenance	Medium/ Low	The review in 2014 highlighted that the medical records team had responsibility for setting up the record and ensuring that it is stored correctly. These arrangements have continued with medical records retaining responsibility for the movement and storage of files but not the contents. We are not aware of any specific work undertaken to clarify the role and responsibilities for medical records for any other staff.	Director of Planning & Performance		Not specified by the Health Board	Oct-20			Completed	November 2020 Update - Medical Records teams are responsible for filing referral letters and continuation sheets. Responsibility for the maintenance of the Health Record is shared across Medical records Department, ward clerks, outpatient receptionists and Medical Secretaries.		Update January 2020 Medical Records teams are responsible for filing referral letters and continuation sheets. Responsibility for the maintenance of the Health Record is shared across Medical records Department, ward clerks, outpatient receptionists and Medical Secretaries. Greater focus is needed on every aspect of medical records management, which is clinically led and an organisation wide.
CCFU 03	Oct-19		Developing a programme of routine audits of medical records to provide assurance that the quality of medical records is improving;	Medium/ Low	The quality of the patient record has a direct impact on the coders ability to undertake their role. As highlighted previously, work by NWIS into the quality of documentation highlighted concerns with loose paperwork, and the filing of deceased patient records. As part of the annual clinical audit and effectiveness plan, there is currently a Health Board wide audit of the quality of case notes. This audit is looking at documentation in case notes and is aligned to the health records committee, however this committee has been disbanded so we are unsure where the results of this audit are reviewed. The current audit plan shows that this audit was also undertaken last year but there is no record of the report. The results of the current audit are due for publication in March 2019.	Director of Planning & Performance		Not specified by the Health Board	Oct-20			In progress			Update January 2020 The content and the quality of the Health record is the responsibility of all clinical users adding information to the record and this is monitored and reported by the Clinical Audit team. This is emphasised within staff induction programmes where the importance of accurate Health Records and the impact on Clinical Coding is noted. The Management Board have approved additional resource to recruit a Clinical Coding Auditor/Trainer and our stated intent within our IMTP is to take this action forward utilising this much needed resource. November 2020 Update - this audit work was previously undertaken by the Clinical Audit Department. They may be able to provide an update for this purpose. It was reported at the Health Records Committee but may be reported elsewhere as well. The Committee was not responsible for acting on this report.
CCFU 07	Oct-19		Providing support for members of the team to achieve the clinical coding auditor qualification, and the implementation of a local programme of clinical coding audits;	Medium/ Low	In 2014, we found that there was no local programme of clinical coding audit and a lack of a qualified clinical coding auditor within the Health Board meant that this could not be put in place. Since then, the Health Board did support an individual to attain the audit qualification, however they gained promotion into a national role soon after qualifying. The Health Board recognise this gap in their team, have been unable to find a coding course for them to achieve the qualification.	Director of Planning & Performance		Mar-15	Oct-20			Completed	November 2020 Update - Our plan remains to support a member of the team to achieve the auditor qualification. The restriction on this is that you need to be ACC qualified for two years before becoming eligible to study for the qualification. The staff member who will study for this qualification does not fulfil the criteria at present.There was no national profile for such a post, so we have had to submit a job description to the Agenda for Change Team for banding. Once completed, we will advertise and carry out our plan.		Updated January 2020 Our plan is to support a member of the team to achieve the auditor qualification. The restriction on this is that you need to be ACC qualified for two years before becoming eligible to study for the qualification. The staff member who will study for this qualification does not fulfil the criteria at present.

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CCFU 11	Oct-19		Raising awareness of the clinical coding process adopted by the Health Board through training sessions for medical staff, as well as attendance at appropriate meetings such as audit sessions;	Medium/ Low	In 2014, we highlighted there was limited clinical engagement in clinical coding. Since then, the Health Board has attempted to raise awareness of clinical coding by attending sessions some sessions clinical staff, for example recent engagement with ENT consultants but the extent to which this has happened has been limited and adhoc. Staff capacity within the coding team has been identified as the main reason.	Director of Planning & Performance		Not specified by the Health Board	Oct-20			Completed	November 2020 Update - The Clinical Coding Manager has been working with a number of specialties in order to improve the Information that is used for coding. The Clinical Coding Manager is also looking at new digital ways of improving the quality of information available for coding purposes, such as through utilising Discharge Advice Letters (DALs) and making use of new data sources, such as information from LIMS, which we have used to indicate the source of infection for Covid-19 cases. This is a task that will never end, in that there will always be a need to interact with the medical and clinical staff, though we are committed to continuing with our efforts and attending medical induction sessions whenever we can, both now and in the future.		Update January 2020 The Clinical Coding Manager is currently working with Gastroenterology, Haematology and Obstetrics, to improve the Information that is used for coding. The Clinical Coding Manager has also attended the MTED user group meetings to try to improve the quality of information on the Discharge Advice (DAL) At present due to the high volume of trainee Clinical Coders and the limited number of qualified Clinical Coders we have to deliver targets, visiting clinical areas regularly is a challenge. We do however encourage such engagement, since it is beneficial to both parties and there are enthusiastic clinical staff who are keen to understand the differences between clinical terminology which they use daily and clinical coding classifications, which they are less familiar with and come across less frequently. We will look to increase this interaction as we take forward our plans for improving the service.
CCFU 13	Oct-19		Encouraging clinical coding staff to engage clinicians in the validation process and to visit clinical areas.	Medium/ Low	An identified model of good practice is to engage clinicians in the validation process. However, staff are reporting issues with accessing clinicians because it is time consuming and they often do not get a reply. The coding team however have established a single point of contact in ENT for coding queries, but this appears to be the only arrangement that is in place. Where engagement occurs elsewhere, this appears to be reactive to concerns about the quality of coding. For example, cardiology approached the coding team when they were receiving data which did not match what they were expecting. This discussion has however provided an opportunity to raise the importance of good quality case notes to support the coding process.	Director of Planning & Performance		Not specified by the Health Board	Oct-20			In progress			Update January 2020 We are optimistic with the role out of i Compare CHKS, that this will further raise awareness to Clinical Staff of the importance of Clinical Coding. We also raise awareness of Clinical Coding through the Junior Doctors Induction programme. At present, we are also engaging with Clinical Staff via the National Audit Programmes for Heart Failure Dementia and Stroke, where during this process clinically coded data is validated by Clinicians and Senior Coding Officers. November 2020 Update - We continue to have a high volume of trainee Clinical Coders, with our qualified Clinical Coders and supervisors supporting them in the workplace. The availability of training sessions has also reduced, meaning a greater level of support is required locally. This makes visiting clinical areas regularly is a challenge. We do however encourage such engagement, since it is beneficial to both parties and there are enthusiastic clinical staff who are keen to understand the differences between clinical terminology which they use daily and clinical coding classifications, which they are less familiar with and come across less frequently. We will look to increase this interaction as we take forward our plans for improving the service. We remain optimistic with the role out of CHKS iCompare, that this will further raise awareness to Clinical Staff of the importance of Clinical Coding. We also raise awareness of Clinical Coding through the Junior Doctors Induction programme. We continue to engage with clinical staff via the National Audit Programmes.
CCFU 14	Oct-19		Providing short briefing material which clearly sets out the implications of poor clinical coding (reflecting timeliness, completeness and accuracy) on key performance indicators;	Medium/ Low	The Health Board has maintained its surveillance of its coding performance, and both completeness and accuracy feature as part of the Health Board's key performance indicators which are reported to Board. The detail and benchmarking information in these have improved since our last review. The information highlights the backlog and the actions being taken. However, the report does not explicitly highlight the impact the backlog has on the quality of data. The results from our board member survey identified that 87% of those responding said they would find it helpful to have more information on clinical coding and the extent to which it affects the quality of key performance information. Since our previous work, the Health Board has had considerable churn of Independent Members who may benefit from training on clinical coding	Director of Planning & Performance		Not specified by the Health Board	Oct-20			In Progress			Update January 2020 Clinical Coding performance continues to be reported via the Performance Dashboard Report, reflecting the coding position for the past 12 Months. Timeliness Completeness and Accuracy taken from CHKS i Compare are also key indicators that are reported each month within the organisation benchmarked against the Welsh peer group.. There is an accompanying narrative outlining the actions and any issues affecting the production of clinical coding. November 2020 Update - Clinical Coding performance continues to be reported via the Performance Dashboard Report, reflecting the coding position for the past 12 Months. Timeliness Completeness and Accuracy taken from CHKS iCompare are also key indicators that are reported each month within the organisation benchmarked against the Welsh peer group. There is an accompanying narrative outlining the actions and any issues affecting the production of clinical coding. The monthly Performance Dashboard has been transformed, with further developments planned. Using this new format, there will be further detail provided on the depth of clinical coding and its impact on key performance information. Following the January Audit Committee meeting, it was arranged for two independent members to visit the Department. However the date of the visit coincided with the onset of Covid-19 in March and so had to be postponed. Whilst the invitation remains open, it is likley that it will not be appropriate for it to be accepted no earlier than 2021/22.
Structured Assessment 2019															

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SA 2019 04	Feb-20		Change management We found that the Health Board has a significant programme of work to develop and implement the Integrated Healthcare Strategy, and strategic transformation plans within directorates. The Health Board should evaluate the capacity within the Programme Management Office to ensure it is sufficient to effectively support service transformation projects.	High	As detailed in the CTM Organisational Improvement Plan, the on-going development, and full establishment of 'Improvement CTM' will enhance change management capacity alongside further recruitment to project management to ensure more rounded programme management capacity in the organisation. On-going recruitment of project managers and identification of staff who already have bronze/silver/gold IQT training will strengthen the capacity across the organisation and are creating a more coherent approach to align our Bevan Fellowships and Exemplars with organisational transformation objectives.	Director of Public Health		Full Est. by April 2023/ December 2020				In Progress			July 2020 Update - We are on track for that date – we've made first appointment (AMD QI) and will now, pending a conversation we're bringing to Monday Exec, made further appointments
SA 2019 07	Feb-20		A range of benchmarking is used for planning, service improvement and efficiency work, but scope exists to extend the information used in respect of costs. The Health Board should progress its development and use of costing so that it better informs financial planning and management.	Medium/ Low	The Health Board has in recent years used costing information to benchmark performance and inform service planning through: • Use of the UK wide Patient Costing Benchmarking tool, allowing comparison of unit cost and cost driver information with a range of English providers. • Inclusion of cost information in the internal clinical variation tool. • Use of patient level costs to inform currencies for inter Health Board Funding Flows. • Development of a Commissioning activity Tool to understand internal variation from a population health perspective. • Support of specific pathway redesign projects. It has been our experience that it has been hard to develop service engagement around benchmarking of fully absorbed unit costs – more so in the Welsh environment where tariff-based payments and Service Line Reporting are not operational. In pursuit of technical efficiency therefore the approach has moved towards benchmarking the factors that underpin variation in unit cost: • Cost Drivers – indicating how efficiently well we are using our capacity • Cost Base – identifying potential savings in the delivery of that capacity – through workforce, procurement etc. The recent focus of the costing function has been to identify opportunity from cost driver efficiency particularly in respect of patient flow, theatres and outpatients – making use of CHKS and internal information sources. Moving forward the development and use of costing information will be developed in the context of the National Efficiency Framework developed by the Finance Delivery Unit which	Director of Finance		Mar-21				In Progress			
Implementing the Wellbeing and Future Generations Act															
IWFG 01	Feb-20		Begin to explore the potential for long-term funding prior to completion of the pilot, so that momentum can be sustained in the event of a successful outcome.	Medium/ Low	The Health Board recognises this is a challenge. Funding has been agreed for 2020/21 from the Early Years Pathfinder grant. This is a pilot, the outcomes of which will need to be considered by the PSB and WG to determine if there is value taking this work forward in the long-term across CTM and Wales. If the pilot is successful and accepted as a more effective mechanism to target support, the longer term future role out and delivery will need to be discussed with Welsh Government, in the context of Cwm Taf Morgannwg as well as any benefit to other regions of Wales.	Director of Public Health		Feb-20	Nov-20	Mar-21		In Progress			July 2020 Update - The potential for long term funding of this work post-pilot has been discussed in context of wider population health management work for which longer term funding had been secured. The principles and goals are similar and it makes sense to integrate them. The medium-long term outlook for funding of this work however looks bleak in light of the pressures COVID-19 has placed on WG and HB finances. November 2020 Update - This work has been delayed as a result of Covid-19 Pressures
IWFG 02	Feb-20		Continue gathering evidence on the causes of vulnerability to inform the model over time.	Medium/ Low	This is a resource intensive commitment at a local level. It was intended to be a one off piece of work to inform the pilot. There is no capacity locally to take this forward. It will be shared with the Early Years Pathfinder programme and the F1000Ds network. If it is considered beneficial to update it nationally, periodically, it would be agreed at a future date. Public Health Wales could potentially take a lead on this as a once for Wales approach.	Director of Public Health		TBA	Nov-20	Mar-21		In Progress			July 2020 Update - Despite the challenges of COVID-19, progress has been made with this aspect. We have successfully engaged SAIL to do the analysis as they had most of the data needed. SAIL are also doing review of the evidence base to inform the weighting of the risk factors to contribute to the score for the vulnerability profiling. They will validate that with risk factors and outcomes for children in the Wales and RCT data they hold from 2000. Also we have a KESS 2 student co-sponsored by Swansea Uni and CTMUHB comparing the Flying Start method of directing resources to the most in need with the Vulnerability Profile scoring to see which one best identifies those most in need of support. Despite different ways of working, the HB and its partners have made progress on aspects of the work recognising the need to overcome barrieirs through mutual understanding. November 2020 Update - This work has been delayed as a result of Covid-19 Pressures.

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IWFG 03	Feb-20		The Health Board and its partners have different ways of working and need to work together to recognise those differences in order to overcome any barriers they may present.	Medium/ Low	This is well recognised. One of the key areas is to try to get consistency of approach across 3 LA areas when requesting/commissioning of services from the UHB. There have been discussions to highlight the need for consistency in the provision of Maternity and Health visiting services so that staff are not requested to provide different services in different areas. Also acknowledgement of different IT software systems in different LA's. This has led us to look at whether SAIL could be used to overcome this issue. The joint working in pilots like this presents the opportunities to recognise differences, learn together and build trust across the system. For example, different organisations have different capacities and experience in undertaking analysis. For this reason, the multi-agency group agreed that Rhondda Cynon Taf would pilot this project as they had a bigger team with experience in profiling children and young people at risk of not being in education, employment or training (NEET). It was agreed that all local authorities would be on the Steering Group so that the learning and barriers could be explored jointly.	Director of Public Health		Mar-21				In progress			July 2020 Update - This is ongoing and I am not sure there's an endpoint I can clearly describe as this is an abiding challenge of partnership working. November 2020 Update - This work has been delayed as a result of Covid-19 Pressures.
IWFG 05	Feb-20		Plan a follow-on system-wide engagement event to inform people about progress to date and to pave the way for the next phase of development, ensuring that it includes people with appropriate technical and governance expertise.	Medium/ Low	This is would add value and help communication and consideration will be given to this later in the pilot. Two qualitative involvement projects are planned to inform the next phase of this pilot: • Pregnant women, parents of young children and wider public views on data sharing for this purpose. • Political leaders and senior staff of partner organisations for views on sharing data for this purpose and any concerns or barriers to implementation. This will be picked up through the Vulnerability Profiling work stream.	Director of Public Health		Jun-20	Mar-21			In Progress			July 2020 Update - This work has had to be deferred to the end of the financial year, when the COVID response is hopefully over. November 2020 Update - This work has been delayed as a result of Covid-19 Pressures.
IWFG 06	Feb-20		Included in the report but not in the management response Paragraph 10: No evidence of progress on Corporate Arrangements	Medium/ Low	This is a recognised need within the Health Board and consideration will be given to this. The findings of this audit will be reported back through the Audit Committee of the Health Board to consider the findings, opportunities to strengthen corporate assurance and oversight and respond accordingly. The Committee meets quarterly and the report will go to the next available Committee upon receipt by the Health Board. Any actions identified will be monitored through the Audit Committee. In recognition of the partnership context of this work stream, it will also be reported back to the Cwm Taf and Bridgend Public Services Boards and the Children and Young People's Sub Group of the Cwm Taf Morgannwg Regional Partnership Board. Any actions identified will be reported upon through these mechanisms also. Work is underway to explore how the corporate arrangements for WbFG within CTMUHB can be strengthened. This will include clarity around the assurance, Governance and oversight as well as incorporating the legislation into planning processes.	Director of Public Health		Jun-20	Nov-20	Mar-21		In Progress			July 2020 Update - A paper will be submitted to the Exec and Management Board to consider resourcing of WFGA co-ordination. This would align with practice elsewhere. this paper, currently in draft, and which has been delayed by the COVID-19 outbreak, explores how the corporate arrangements for WbFG within CTMUHB can be strengthened. It offers clarity around the assurance, Governance and oversight of the integration of the legislation into planning processes in CTMUHB. November 2020 Update - This work has been delayed as a result of Covid-19 Pressures.
Effectiveness of Counter Fraud Arrangements															
CFA 01	Oct-20		Implement mandatory counter-fraud training for some or all staff groups.	Low	Counter Fraud will be Included within the Health Board's induction training more distinctly than it is now. Additionally, there are a range of options from face to face delivery of training to mandatory counter fraud e-learning to apply to sections of staff at higher risk of fraud that can be explored to supplement the established programme of awareness work undertaken by the Health Board's Counter Fraud Team.	Director of Finance		Mar-21				In progress			
CFA 02	Oct-20		Implement consistency in the recording and monitoring of economic fraud risk in line with the Health Board's risk management policy and strategy.	Low	Fraud risk will be managed in line with the Health Board's risk management framework; utilising established policy, procedure and systems. This will enable effective management of risk by the risk owners with specialist support from the Counter Fraud Team.	Director of Finance		Sep-20				Completed	November 2020 Update - We are now working under this procedure and Counter Fraud Team have been trained on use of risk management procedure and completion of risk assessments as part of day to day counter fraud work.		

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