Audit & Risk Committee

Tue 17 August 2021, 10:15 - 12:15

Virtually via Microsoft Teams

Agenda

10:15 - 10:20
5 min

1. PRELIMINARY MATTERS

Information *Patsy Roseblade*

1.1. Welcome & Introductions

Information *Patsy Roseblade*

1.2. Apologies for Absence

Information *Patsy Roseblade*

1.3. Declarations of Interest

Information *Patsy Roseblade*

10:20 - 10:25
5 min

2. CONSENT AGENDA

2.1. FOR APPROVAL

2.1.1. Unconfirmed Minutes of the meeting held on 9 June 2021

Decision *Patsy Roseblade*

2.1.1 Unconfirmed Minutes Part 1 Audit Risk Committee 9 June 2021 ARC 17 August 2021.pdf (10 pages)

2.1.2. Unconfirmed Minutes of the In Committee meeting held on 9 June 2021

Decision *Patsy Roseblade*

2.1.2 Unconfirmed In Committee Minutes ARC 9 June 2021 ARC 17 August 2021.pdf (2 pages)

2.1.3. Audit & Risk Committee Annual Report 2020/2021

Decision *Patsy Roseblade*

2.1.3a Audit & Risk Committee Annual Report 2020 2021 ARC 17 August 2021.pdf (3 pages)
2.1.3b Appendix 1 Audit Committee Annual Report 2020 2021 ARC 17 August 2021.pdf (17 pages)

2.1.4. Procurements and Scheme of Delegation Report

Decision *Sally May*

2.1.4a Scheme of Delegation Report ARC 17 August 2021.pdf (6 pages)
2.1.4b Appendix 1 - Request of SoD amendments August ARC 17 Augst 2021.pdf (1 pages)

2.2. FOR NOTING

2.2.1. Forward Work Programme

Information *Patsy Roseblade*

2.2.1 Forward work plan ARC 17 August 2021.pdf (3 pages)

2.2.2. Losses and Special Payments Report

Information *Sally May*

2.2.2a Losses Special Payments Report ARC 17 August 2021.pdf (10 pages)
2.2.2b Report Appendices June 2021 ARC 17 August 2021.pdf (14 pages)

2.2.3. Declarations of Interest and Gifts and Hospitality Report

Information *Georgina Galletly*

2.2.3a - Declarations of Interest and GHS Register - July ARC - Cover paper.pdf (4 pages)
2.2.3b - Appendix 1 - Declarations of Interest Register 1st April 2021 - 28th June 2021 ARC.pdf (5 pages)
2.2.3c - Appendix 2 - Nil Declarations of Interest Return 1st April 2021 - 28th June ARC.pdf (5 pages)
2.2.3d -Appendix 3 - Gifts, Hospitality and Sponsorship Register 1.4.2021-28.6.2021.pdf (1 pages)

2.2.4. ISO14001 External Environmental Audit Report

Information *Gareth Robinson*

2.2.4a ISO14001 Audit Report ARC 17 August 2021.pdf (5 pages)
2.2.4b GBWW231339_C3_SUR3_Customer REPORT - v1 ARC 17 August 2021.pdf (11 pages)

10:25 - 10:30
5 min

3. MAIN AGENDA

Information *Patsy Roseblade*

3.1. Audit & Risk Committee Action Log

Discussion *Patsy Roseblade*

3.1 Part 1 Audit & Risk Committee Action Log ARC 17 August 2021.pdf (2 pages)

3.2. Matters Arising not contained within the minutes or the action log

Discussion *Patsy Roseblade*

10:30 - 11:00
30 min

4. INTERNAL AUDIT

4.1. Internal Audit Progress Report

Discussion *Paul Dalton*

4.1 IA Progress report - August 2021v2 ARC 17 August 2021.pdf (6 pages)

4.2. Internal Audit Review Clinical Audit

Discussion *Paul Dalton*

4.2 IA Clinical Audit Final report_ ARC 17 August 2021.pdf (31 pages)

4.3. Internal Audit Follow Up Review - Facilities

Discussion *Paul Dalton*

4.3 Facilities Directorate Internal Audit Follow-up report Final ARC 17 August 2021.pdf (44 pages)

4.4. Internal Audit Review Vaccinations

Discussion *Paul Dalton*

4.4 IA Mass Vaccinations - Final Internal Audit Report ARC 17 August 2021.pdf (16 pages)

4.5. Internal Audit Review Sunnyside

Discussion *Paul Dalton*

- 4.5 IA CTM Sunnyside Final Report ARC 17 August 2021.pdf (42 pages)

4.6. Draft Internal Audit Review Single Cancer Pathway - Data Integrity

Discussion *Paul Dalton*

- 4.6 Draft Internal Audit Report - Data Quality and Integrity v4 - ISSUE 12.08.21 ARC 17 August 2021.pdf (19 pages)

11:00 - 11:15
15 min

5. EXTERNAL AUDIT

5.1. Audit Wales Audit & Risk Committee Update

Discussion *Sara Utley*

- 5.1 AW CTM AC Update August 2021 ARC 17 August 2021.pdf (10 pages)

5.2. Audit Wales Review - Vaccinations

Discussion *Sara Utley*

- 5.2 AW Vaccination-report-Eng_0 ARC 17 August 2021.pdf (30 pages)

5.3. Audit of Financial Statements Addendum Report

Discussion *Audit Wales*

- 5.3 Audit of Accounts Addendum ARC 17 August 2021.pdf (18 pages)

11:15 - 12:10
55 min

6. INTERNAL CONTROL AND RISK MANAGEMENT

6.1. Post Payment Verification Progress Report

Discussion *Amanda Legge*

- 6.1a PPV Board Committee Report ARC 17 August 2021.pdf (4 pages)
- 6.1b PPV CTMuHB Audit report Oct 20- Mar 21 - Anonymised ARC 17 August 2021.pdf (5 pages)

6.2. Local Counter Fraud Progress Report

Discussion *Matthew Evans*

- 6.2a Local Counter Fraud Update Report ARC 17 August 2021.pdf (2 pages)
- 6.2b Local Counter Fraud Update Report Aug 2021 ARC 17 August 2021.pdf (4 pages)
- 6.2c Appendix 1 - Newsletter Summer 2021 English ARC 17 August 2021.pdf (4 pages)
- 6.2d Appendix 2 - CTM UHB Pre-Employment Checks Exercise ANON ARC 17 August 2021.pdf (11 pages)
- 6.2e Appendix 3 - Counter Fraud Investigations Update.pdf (9 pages)

6.3. Organisational Risk Register

Discussion *Georgina Galletly*

- 6.3a -Organisational Risk Register MB July 2021 to ARC - Cover Paper.pdf (5 pages)
- 6.3b -Org RR Appendix 1 - July 2021 - Current Master Organisational RR - Version 2 21.7.2021.pdf (14 pages)
- 6.3c -Organisational Risk Register - Appendix 2 - Targeted Intervention Ris....pdf (4 pages)

6.4. AW/HIW Follow-Up Review of Quality Governance (May 2021) – Management Action Plan

Discussion *Georgina Galletly*

- 6.4a AW HIW Joint Follow Up Report Mgt Action Plan July 2021 ARC 17 August 2021.pdf (3 pages)
- 6.4b AW HIW Follow Up Management Action Plan ARC 17 August 2021.pdf (28 pages)

6.5. Audit Recommendations Tracker Report

Discussion *Georgina Galletly*

- 6.5a Audit Recommendations Tracker Update Report ARC 17 August 2021.pdf (7 pages)
- 6.5b Internal Audit Tracker ARC 17 August 2021 (Autosaved).pdf (35 pages)
- 6.5c External Audit Tracker ARC 17 August 2021.pdf (12 pages)

12:10 - 12:10
0 min

7. ANY OTHER BUSINESS

Discussion *Patsy Roseblade*

12:10 - 12:10
0 min

8. DATE AND TIME OF NEXT MEETING 4 OCTOBER 2021 AT 2:00PM

12:10 - 12:15
5 min

9. CLOSE OF MEETING

Agenda Item Number: 2.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Audit & Risk Committee held on the 9th June 2021 as a Virtual Meeting via Microsoft Teams

Members Present:

Patty Roseblade	Independent Member (Chair)
Jayne Sadgrove	Independent Member
Ian Wells	Independent Member

In Attendance:

Sara Utley	Audit Wales
Mark Jones	Audit Wales
Steve Stark	Audit Wales
Anthony Veale	Audit Wales
Paul Dalton	NWSSP – Internal Audit & Assurance
Emma Samways	NWSSP – Internal Audit & Assurance
Martyn Lewis	NWSSP – Internal Audit & Assurance (In part)
Kate Eden	Chair, Welsh Health Specialised Services Committee (WHSSC) (In part)
Sian Lewis	Managing Director, WHSSC (In part)
Stuart Davies	Director of Finance, WHSSC (In part)
Jacqui Evans	Committee Secretary, WHSSC (In part)
Christopher Turner	Chair, Emergency Ambulance Services Committee (In part)
Stephen Harrhy	Chief Ambulance Services Commissioner (In part)
Matthew Evans	Head of Local Counter Fraud
Georgina Galletly	Director of Corporate Governance/Board Secretary
Steve Webster	Executive Director of Finance
Hywel Daniel	Executive Director for People (In part)
Owen James	Head of Corporate Finance
Cally Hamblyn	Assistant Director of Governance & Risk
Emma Walters	Committee Governance Manager (Committee Secretariat)

Agenda Item

1.0.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

The 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 by the Chair.

The Chair advised Members that the Health Board had now commenced with the recording of Board Committee proceedings. Members **noted** that recordings would be achieved via Microsoft Teams and were not intended to provide a verbatim account of the meeting. The recording will however aid the meeting

secretariat in ensuring the accuracy of scrutiny related discussions and decisions during such meetings. Members **noted** that the existence of the recording would be temporary and it would be destroyed once the minutes had been confirmed as accurate. Members confirmed that they were content to proceed.

1.2 Apologies for Absence

No apologies for absence were received prior to the meeting.

1.3 Declarations of Interest

No declarations of interest were received prior to the meeting.

2.0.0 CONSENT AGENDA

The Chair asked whether Members wished to move any item on the Consent Agenda to the 'Main Agenda'. No changes to the Consent Agenda were required.

P Roseblade made reference to the ISO14001 External Audit Report at agenda item 2.2.5 and advised that this was an excellent report and asked for her thanks to be extended to the Team for this significant achievement.

P Roseblade requested that the action log was placed on the main agenda for discussion at the next meeting.

Action: Thanks to be extended to Team for achieving the ISO14001 accreditation which was an excellent achievement.

Action: Action Log to be placed on the main agenda for discussion at the next meeting.

2.1 FOR APPROVAL

2.1.1 Unconfirmed Minutes of the Meeting held on the 13th April 2021

Resolution: The minutes were **APPROVED** as a true and accurate record.

2.1.2 Unconfirmed Minutes of the In Committee Meeting held on the 13th April 2021

Resolution: The minutes were **APPROVED** as a true and accurate record.

2.1.3 Unconfirmed Minutes of the meeting held on 17th May 2021

Resolution: The minutes were **APPROVED** as a true and accurate record.

2.1.4 Clinical Audit Forward Plan 2021-2022

Resolution: The Forward Plan for Clinical Audit 2021 – 2022 was **APPROVED**.

2.1.5 Clinical Audit & Effectiveness Policy & Strategy

Resolution: The effectiveness of the Policy & Strategy for Clinical Audit was **APPROVED**.

2.2 FOR NOTING

2.2.1 Action Log

Resolution: The Action Log was **NOTED**.

2.2.2 Audit & Risk Committee Forward Work Programme

The Forward Work Programme was **NOTED.**

2.2.3 Procurement and Scheme of Delegation Report

Resolution: The report was **NOTED**.

2.2.4 Outcome Report – Audit & Risk Committee Effectiveness Survey

Resolution: The report was **NOTED**.

2.2.5 CTMUHB ISO14001 External Audit Report

Resolution: The report was **NOTED**.

3.0.0 MAIN AGENDA

3.1 Matters Arising not considered within the Action Log

There were no further matters arising identified.

4.0.0 ANNUAL REPORT 2020-2021

4.1 CTMUHB – Annual Report including Accountability Report, Remuneration and Staff Report, Performance Report 2020-2021

G Galletly presented Members with the report and advised that Members have had the opportunity to comment on various iterations of the report. G Galletly extended her sincere thanks to C Hamblyn and the wider Team for the work that had been undertaken to prepare the report.

P Roseblade advised that she noted that any changes since the version received in the previous meeting had been referenced within the cover report as requested.

Resolution: The report was **ENDORSED** for Board **APPROVAL.**

4.1.1 Welsh Health Specialised Services Committee (WHSSC) Annual Governance Statement (AGS) 2020-2021

J Evans and S Davies presented Members with the report. Members **noted** that whilst WHSSC did not have a statutory obligation to produce a formal AGS, they do so for their own governance purposes. Members **noted** that the document had been signed by S Lewis, Managing Director yesterday.

P Roseblade confirmed that Members have had the opportunity to comment on previous iterations of the report with a fair amount of scrutiny also undertaken at WHSSC.

Resolution: The report was **NOTED**.

4.1.2 EASC Annual Governance Statement 2020-2021

S Harrhy presented the report which had previously been considered by the Audit & Risk Committee and the Emergency Ambulance Services Committee. P Roseblade welcomed the report which she found to be good practice despite it not being a statutory requirement to produce.

Resolution: The report was **NOTED**.

4.1.3 National Imaging Academy Governance Compliance Statement

G Galletly presented the report and advised that any queries raised would have been addressed prior to the meeting today.

J Sadgrove advised that she welcomed the report and added that it was good governance practice to have received an AGS from each of the hosted organisations.

Resolution: The report was **NOTED**.

5.0.0 ANNUAL ACCOUNTS

5.1 CTMUHB Annual Accounts 2020-2021

S Webster presented the report which identified the changes made in relation to the draft accounts presented previously.

P Roseblade confirmed that the Committee had been given ample opportunity to review the accounts and **noted** that the recommendations made at the May meeting had now been incorporated into the final version.

Resolution: The report was **ENDORSED** for **BOARD APPROVAL**.

5.2 WHSSC & EASC Final Accounts 2020-2021

S Davies presented the report. Members **noted** that following information received from S Harrhy yesterday, regarding the related parties note on page 553, the accounts would need to be amended to reflect that Steve Ham was an Associate Member of EASC and WHSSC, and that Chris Turner was no longer an Independent Member at Cwm Taf Morgannwg UHB.

P Roseblade confirmed that Members have had the opportunity to reviews these accounts prior to the meeting today.

Resolution: Subject to minor amendments, the final audited statements for the financial year ended 31 March 2021 were **ENDORSED.**

5.3 Audit Wales: Audit of the Financial Statement (ISA 260) Report (including the Letter of Representation and Audit Opinion)

A Veale extended his thanks to Finance colleagues for the support they had provided to Audit Wales over the last few weeks.

In presenting the report, M Jones advised that Audit Wales intended to issue unqualified opinions regarding the accounts and confirmed that there were no uncorrected misstatements. Members **noted** that the Health Board would be required to submit final documents by Friday 11 June, with the accounts due to be certified by 13 June 2021. M Jones also extended his thanks to colleagues who had assisted Audit Wales throughout the process.

Members **noted** that in relation to the Senior Clinicians pensions issue referenced within appendix 3 of the report, the Auditor General would be issuing a substantive report on this issue alongside his letter of representation, which would be applicable to all Health bodies, with the exception of Health Education Improvement Wales.

P Roseblade welcomed the comprehensive report and on behalf of the Committee asked for thanks to be extended to the Director of Finance, the Finance Team and Audit Wales for completing this complex piece of work.

Resolution: The report was **NOTED.**

Action: The Committee's thanks to be extended to the Finance Team and Audit Wales colleagues for completing this complex piece of work.

6.0.0 INTERNAL AUDIT

6.1 Internal Audit Progress Report

P Dalton presented the report.

Following a comment made by P Roseblade as to whether Internal Audit were seeking Committee approval to commence a review into Continuing Healthcare, the Committee confirmed they would be happy for Internal Audit to take this piece of work forward.

In response to a comment raised by P Roseblade in relation to the Fire Safety Management Review, it was **agreed** that the completion date identified in the action log needed to be aligned with the date identified within the report.

Resolution: The update was **NOTED.**

Action: Completion date identified in the action log in relation to the Fire Safety Management Review to be aligned with the date identified within the report.

6.2 Internal Audit Review – Targeted Intervention

E Samways presented Members with the report which had been given a Reasonable Assurance rating.

G Galletly extended her thanks to Audit colleagues for this key piece of work which had provided recommendations to enable the process to be strengthened further.

P Roseblade **welcomed** the creation of a centralised file on Admincontrol to enable Senior Responsible Officers and Independent Members to scrutinise the evidence and extended her thanks to colleagues for putting this in place.

In response to a question raised regarding the May 2021 target date for the review of the self-assessment trackers, G Galletly advised that a self-assessment process had been undertaken with Integrated Locality Groups and suggested that this recommendation could be marked as complete, on the basis that risks were now being incorporated into discussions with risks being assessed at every stage of the process.

Resolution: The report was **NOTED**.

Action: Recommendation relating to the review of self-assessment trackers to be marked as completed on the Audit Tracker.

6.3 Internal Audit Review – Digital Response to Covid

M Lewis presented Members with the report which had been given a Reasonable Assurance rating.

J Sadgrove **welcomed** this important report which contained a significant amount of rich information which would help the Health Board to shape how it moves forward. J Sadgrove added that an important point to note was around the potential to exacerbate inequality, which the Health Board would need to address in conjunction with its partners and suggested that consideration could

have been given to surveying service users as well as staff to identify further areas of inequality.

I Wells **welcomed** the report and the management response which he had found to be very comprehensive and added that this would help guide the Health Board on its digital journey.

In response to a comment made by P Roseblade as to whether it was the role of clinical staff to assist patients in using IT or whether there was an alternative method of doing this, M Lewis advised that this was a complicated area and added that there were ambitions in place to get patients more involved in their own care, which would require further discussion with patients during the roll-out.

P Roseblade echoed the comments made by J Sadgrove and I Wells and advised that she found the report to be thorough and easy to understand.

Resolution: The report was **NOTED**.

6.4 Head of Internal Audit Opinion and Annual Report 2020-2021

P Dalton presented the report and advised that Internal Audit would be issuing a Reasonable Assurance opinion for 2020-2021.

P Roseblade extended her thanks to Internal Audit colleagues for the report and the support they had provided throughout the year.

Resolution: The report was **NOTED**.

7.0.0 EXTERNAL AUDIT

7.1 Audit Wales – Audit & Risk Committee Update

S Utley presented the report and advised that fieldwork was about to commence on Phase 2 of the Structured Assessment.

P Roseblade extended her thanks to S Utley for presenting the report.

Resolution: The report was **NOTED**.

7.2 Audit Wales Progress Report – Structured Assessment – Phase 1 Report

S Utley presented the report which highlighted a change in approach. Members **noted** that two recommendations had been made which had both been accepted by management and that monitoring of the response would be undertaken by the Planning, Performance & Finance Committee.

Resolution: The report was **NOTED**.

7.3 Audit Wales National Report – Personal Protective Equipment (PPE)

S Utley presented the report which was a national piece of work which focussed on the procurement and supply of PPE at a national level. Members **noted** that a formal response would now need to be developed by Welsh Government and Shared Services and **noted** that the report contained a couple of recommendations which related to the Health Board which the organisation may wish to consider when developing future plans.

In response to a question raised by I Wells as to whether concerns raised by medical staff about feeling unsafe as a result of inappropriate provision of PPE would be reviewed, S Utley confirmed that this was being considered and added that next steps should be identified within the response from Welsh Government and Shared Services.

P Roseblade **welcomed** the report which she had found to be very comprehensive.

Resolution: The report was **NOTED**.

8.0.0 INTERNAL CONTROL AND RISK MANAGEMENT

8.1 Audit Recommendations Tracker

G Galletly presented the report which provided an update on progress made against Internal and External Audit recommendations.

In response to comments made by J Sadgrove regarding mission drift and ownership of recommendations, G Galletly advised that she would undertake a review of the position outside of the meeting and welcomed any other specific feedback Independent Members may have.

In response to a question raised by I Wells as to whether some Executive Directors had more recommendations than others, for example, the Chief Operating Officer, G Galletly advised that each Executive Lead had a support structure beneath them who would be responsible for providing updates against each area.

P Roseblade commented on the pie chart which identified no red areas and advised that from a scrutiny perspective it would be helpful if a pie chart could be developed which showed progress on each action against the original implementation date and acknowledged that the Committee would understand the slippage in action achieved given the pandemic situation.

P Roseblade expressed concerns that the implementation date against DQ01 had been revised to May 2021 and suggested that this should be challenged by the Committee as it is a high priority recommendation arising from a limited assurance report. In response, G Galletly advised that she had taken on board

the comments made and added that it is within the Committee's gift to not accept the suggested revision to the target date and to request that this recommendation is marked as red which would keep this as a high priority issue.

Resolution: The report was **NOTED**.

Action: Review to be undertaken of the recommendations which had drifted and the recommendations in which responsibility had been placed on another department to action.

Action: Chart to be developed which showed progress on each action against the original implementation date.

8.2 Organisational Risk Register

C Hamblyn presented the report and advised that this was the version of the report that had been presented to May Board and added that reporting timelines were in the process of being adjusted to ensure the Committees were being presented with the most recent version of the report.

In response to a question raised by I Wells in relation to the risk score remaining at 20 for risk 3826, despite the number of actions that had been undertaken over a long period of time, C Hamblyn advised that the risk was in the process of being reframed by the Interim Chief Operating Officer and Integrated Locality Group (ILG) colleagues.

In response to a comment made by I Wells regarding risk 4565, C Hamblyn advised that the June update would highlight that this risk had now de-escalated as a result of plans that had been put into place. In response to a comment made by P Roseblade as to how the Committee could be assured that the plans had been executed, C Hamblyn advised that whilst the risk is removed from the Organisational Risk Register, the risk still remained on the Digital & Data Committee Risk Register for scrutiny.

In response to a question raised by P Roseblade regarding the lack of progress being made against the fire safety risks, C Hamblyn advised that a Fire Officer was in the process of being recruited and it would be their role to address the outdated risk assessments and undertake the training required. Members **noted** that a discussion on fire safety risks had been recently undertaken at the Health, Safety & Fire Sub Committee. Members **noted** that a review of this risk would also be undertaken as part of the Internal Audit Review into Fire Safety Management.

Resolution: The report was **NOTED**.

8.3 Local Counter Fraud Update

M Evans presented the report.

J Sadgrove **welcomed** the report and encouraged the Counter Fraud Team to liaise with the Health Board's Communications Team to promote the Counter Fraud sharepoint page in order to encourage more visitors.

In response to a question raised by J Sadgrove as to how the Health Board planned to address the overpayments of salary issues, M Evans advised that prevention and deterrent were the key tasks that needed to be undertaken and added that the Local Counter Fraud Team would be happy to support the Health Board in addressing this. S Webster advised that there were issues with the staff termination process which needed to be digitalised and added that a discussion had been held with Internal Audit as to whether a review of the termination process could be incorporated into one of the workforce related audits moving forwards.

P Roseblade **welcomed** the suggestion made in relation to Counter Fraud working within the Health Board's communications team to promote the Counter Fraud Sharepoint page. P Roseblade advised that in relation to overpayment of salaries, staff needed to be made aware of their responsibility to inform of any salary overpayments and that if they continued to receive overpayments this could be considered as theft.

P Roseblade **welcomed** the announcement that G Galletly had now been appointed as the Health Board's new Counter Fraud champion.

Resolution: The report was **NOTED**.

9.0.0 ANY OTHER BUSINESS

No items were identified.

10.0.0 DATE AND TIME OF NEXT MEETING

The next meeting would take place at 10:15am on Tuesday 17th August 2021.

11.0.0 CLOSE

Agenda Item Number: 2.1.2

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Audit & Risk In Committee held on the 9th June 2021 as a Virtual Meeting via Microsoft Teams

Members Present:

Patty Roseblade	Independent Member (Chair)
Jayne Sadgrove	Independent Member
Ian Wells	Independent Member

In Attendance:

Sara Utley	Audit Wales
Paul Dalton	NWSSP – Internal Audit & Assurance
Emma Samways	NWSSP – Internal Audit & Assurance
Georgina Galletly	Director of Corporate Governance/Board Secretary
Steve Webster	Executive Director of Finance
Cally Hamblyn	Assistant Director of Governance & Risk
Emma Walters	Committee Governance Manager (Committee Secretariat)

Agenda Item

1.0.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

The Chair welcomed everyone to the In Committee meeting.

1.2 Apologies for Absence

No apologies for absence were received prior to the meeting.

1.3 Declarations of Interest

No declarations of interest were received prior to the meeting.

2.0.0 MAIN AGENDA

2.1 Audit Wales Report – Financial Control Procedure – Medical Variable Pay – Summary of Authorised Breaches

The Committee received the report which had been placed on the consent agenda. The Committee requested that as they require assurance against this issue this would need to be placed on the main agenda for discussion at future Committee meetings.

Following discussion regarding which Committee needed to scrutinise the position, the Chair suggested that an Executive Team discussion was held to

determine the most appropriate environment in which scrutiny could be undertaken.

Resolution: The report was **NOTED.**

Action: Executive Team discussion to be held to determine the most appropriate environment in which scrutiny of this issue could be undertaken.

3.0 CLOSE

AGENDA ITEM
2.1.3

AUDIT & RISK COMMITTEE

AUDIT & RISK COMMITTEE ANNUAL REPORT 2020-2021

Date of meeting	17/08/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Georgina Galletly, Director of Corporate Governance
Approving Executive Sponsor	Director of Corporate Governance / Board Secretary
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 2020-2021.

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 2020 – March 2021 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 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.
	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 Well-being Objectives	Ensure sustainability in all that we do, economically, environmentally and socially

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 2020-2021

AUDIT & RISK COMMITTEE
ANNUAL REPORT 2020-2021

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 2020-2021.

Whilst I did not become Chair of the Audit & Risk Committee until April 2021, I would like to extend my thanks to Paul Griffiths, the previous Chair of the Committee, for the leadership he provided during his time as Audit & Risk Committee Chair between April 2020 and December 2020 prior to his retirement. I would also like to extend my thanks to Ian Wells, Independent Member, for stepping in to the Chairs role for the February 2021 meeting. I would also like to extend my thanks to Jayne Sadgrove, Maria Thomas and Dilys Jouvenat for the contributions they have made to the Committee during the last year.

I would like to express my sincere thanks to all the officers of the Committee who have supported and contributed to the work carried out and for their commitment 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 July 2020.

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.

Interim Changes to our Board and Committee Framework due to Covid-19

Over the spring period of 2020 the frequency of Board meetings was increased to ensure any business critical matters were received. A reduction in Board Committee meetings was also introduced, which initially applied to all of the Board Committees with the exception of the Audit and Risk Committee and Quality and Safety Committee, as these were felt to have a critical role in scrutinising decisions to ensure actions relating to the pandemic were quality and risk assessed. However the Planning, Performance and Finance Committee resumed its meetings initially in May 2020, to review financial decisions relating to CTMUHB's response to Covid-19.

Over the summer and autumn period of 2020, the remainder of the Board Committees began to meet again as levels of Covid-19 decreased. In response to a Covid-19 infection rate surge in December 2020, a decision was taken to once again stand down the majority of the Board's Committees during January and February 2021. As previously, the Audit and Risk and Quality and Safety Committee continued to meet virtually during that period and there was also a meeting of the Planning Performance and Finance Committee in February 2021 to consider business critical matters that related to finance and the development of the CTMUHB Integrated IMTP.

The stood-down Committees were reinstated from the 1st March 2021.

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 2020-2021 is outlined in table 1 below:

Table 1 – Composition & Membership if the Audit & Risk Committee Apr 2020-March 2021

Name	Period
Members	
Paul Griffiths (Committee Chair & WHSSC Audit lead) Independent Member	Apr 2020 – December 2020
Maria K Thomas Vice Chair / Independent Member	Apr 2020 – March 2021
Jayne Sadgrove Independent Member	Apr 2020 - March 2021
Ian Wells Independent Member	April 2020 – March 2021
Executive Members	

In addition to the members, the following also attended Committee meetings during the 2020-2021:
Director of Corporate Governance / Board Secretary
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 COMMITTEE 2020-2021

During the year, the Committee met on seven occasions, one of which (29 June 2020) was devoted to scrutiny of the Annual Accounts. All meetings were quorate and were well attended as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2020-2021

In Attendance	6 April 2020	15 June 2020	29 June 2020	10 Aug 2020	19 Oct 2020	14 Dec 2020	8 Feb 2020	Total
Committee Members								
Paul Griffiths (Chair of the Committee until December 2020)	✓	✓	✓	✓	✓	✓		**6/6**
Maria Thomas – Vice Chair /Independent Member	Not req.	✓	✓	✓	✓	✓	✓	**6/6**
Jayne Sadgrove – Independent Member	✓	✓	✓	✓	✓	✓	✓	**7/7**
Ian Wells – Independent Member	✓	✓	✓	x	✓	x	✓	**5/7**

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. 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
- Post Payment Verification Annual Report;
- Local Counter Fraud Progress Report;
- Audit Recommendations Tracker Update;
- Procurement and Scheme of Delegation Report;
- Scheme of Delegation Report – Amendments to the Existing Scheme of Delegation;
- Losses and Special Payments report;
- Covid-19 Board and Committees;
- Corporate Governance Arrangements in Response to Covid-19;
- Forward Work Programme;
- Committee Annual Report 2018-2019;
- Amendments to Standing Orders;
- Committee Self-Assessment October 2019 – Improvement Plan Update;
- Risk Management Update;
- Gifts, Sponsorship & Hospitality Form;
- Committee Annual Report 2019/2020;
- Financial Control Procedure – Medical Variable Pay;
- Committee Annual Cycle of Business;
- End of Year Reporting Arrangements;

- Declarations of Interest and Gifts and Hospitality Report

  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. 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.

5. External Audit

Audit Wales provide an Audit Position Statement at each meeting, summarising progress against its planned audit work.

6. Internal Control and Risk Management

The following reports were received for discussion:

- Health Board Risk Management Strategy;
- Organisational Risk Register;
- Covid Response Governance Arrangements;
- Amendment to the Standards of Behaviour Framework Policy – Declarations of Interest;
- Audit Recommendations Tracker Updates;
- Cwm Taf Morgannwg UHB Accountability Report 2019/2020;
- WHSSC Annual Governance Statement 2019/2020;
- EASC Annual Governance Statement 2019/2020;
- Cwm Taf Morgannwg UHB Financial Accounts Report 2019/2020;
- WHSSC & EASC Final Accounts 2019/2020;
- Local Counter Fraud Progress Report;
- Counter Fraud Annual Report 2019/2020;
- Counter Fraud Draft Work Plan 2020/2021;
- Standards of Behaviour – Verbal Update;
- Procurement & Scheme of Delegation Report;
- Consultant Job Planning – Six Monthly Update;
- External Due Diligence review of Field Hospitals – Verbal Update;
- Annual Accounts 2019/2020 Narrative Correction Medical Pay;
- Management Response to Covid Governance Review;
- Covid Assurance – Gateway Report on Field Hospitals;
- Actions arising from Field Hospital Reviews across Wales;
- Covid Assurance – FDU Peer Review of Covid & Resetting;
- Report on Balance Sheet Planning in 2020/2021;

- Clinical Audit Forward Work Programme;
- Financial Control Procedure – Medical Variable Pay;
- Risk Management Improvement Programme Update;
- Committee Self-Assessment Update 2020;
- Declarations of Interest and Gifts and Hospitality Report;
- Update on Balance Sheet Reporting;
- Update on the Welsh Risk Pool Reimbursements/Claims Management Process;
- Clinical Audit Quarterly Update;
- Progress Report – Internal Audit Review into Medical & Dental Rostering

4.2. MAIN AREAS OF AUDIT COMMITTEE ACTIVITY – PART 2 HOSTED BODIES

Welsh Health Specialised Services Committee (WHSSC)	Emergency Ambulance Services Committee (EASC)

As the host organisation, WHSSC and EASC (rely on CTMUHB for its Audit & Risk Committee function.

To support the Audit & Risk Committee requirements for both EASC and WHSCC 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.

Up until December 2020, Paul Griffiths, Independent Member and Chair of the Health Board's Audit & Risk Committee undertook the role of the "Audit Lead" for WHSSC and reported all matters relating to the audit function to the Joint Committee.

The Director of Corporate Governance / Board Secretary for CTMUHB also attends both parts of the meetings.

The WHSSC and the EASC 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 as part of its hosting responsibilities.

The Joint Committee each have approved Governance and Accountability Frameworks including the Standing Orders. These were reviewed and updated during 2020/21.

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 2020/2021, 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

 Yellow	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, 30 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 2020-2021 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 2020-2021 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:

- Wales Audit Office (WAO) Progress Report (at each meeting);
- Annual Audit Enquiries Letter;
- Audit of the Accountability Report and Financial Statements;
- Performance Audit Programme – Verbal Update;
- Effectiveness of Counter Fraud Arrangements;
- Structured Assessment 2020;
- Audit of Accounts Report Addendum;
- Operating Theatre Department Review;
- Annual Audit Report 2020;
- Annual Audit Plan 2021;
- Doing it Differently, Doing it Right – Governance in the NHS during the Covid-19 Crisis

6.2 Approval of the Annual Accounts

A special meeting of the Audit & Risk Committee was convened on 29 June 2020 to scrutinise the 2019-2020 Annual Accounts prior to approval by the Health Board including the letter of representation to Auditors and the Annual Governance Statement. The 2019-2020 Annual Accounts were scrutinised and approved by the Board on 29 June 2020. The meeting also scrutinised the Accounts and Statements for 2019-2020 from the Emergency Ambulance Services Committee (EASC) and the Welsh Health Specialised Services Committee (WHSSC).

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. This process will continue for 2021-2022.

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.

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.

Regular reports were received by the Committee to monitor progress against the agreed Counter Fraud Plan.

The Health Board took the opportunity of the Bridgend Transfer to move to commissioning its Counter Fraud service from Swansea Bay UHB, and at the same time expanded the size of the Counter Fraud team beyond the increase purely needed for the increased size of the organisation. This was to provide increased capacity to meet the growth in demand for investigations and to increase the level of pro-active work. The size of the Counter Fraud team is now fully comparable with that of other large Health Boards.

In 2020/21 the Counter Fraud Team delivered the counter fraud message to 111 staff via face to face presentations and eLearning. Together with Counter Fraud Services (CFS) Wales colleagues counter fraud investigations undertaken on behalf of the Health Board into potential fraud offences resulted in 1 criminal convictions and the application of 5 civil sanctions. This investigation work led to the recovery of £28,993 of Health Board funds.

New Counter Fraud Standards were introduced to commence from April 2021. The new NHS requirements align to the Government Functional Standards: Counter Fraud. The Health Board was required to self-assess on a RAG rated

basis against these new 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, Requirement 6 – Outcome Based metrics, Requirement 8 – Reporting Identified Loss and Requirement 10 – Undertake Detection Activity. Work plan actions have been agreed to improve these areas for 2021/22.

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 & Procurement, 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 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 Annual Governance Statement - During 2020-2021, the Health Board produced its Annual 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 Management Board and the Board Secretary/Director of Corporate Services & 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 2021/22.

10.4 Audit Committee Effectiveness Survey - A Committee Effectiveness Survey was undertaken in 2020-2021 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 2020-2021, 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 Survey Monkey, 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 2021-2022 in respect of:

- The Risk Management Improvement Plan including the new format of the Organisational Risk Register and the outputs from the Board Development session in relation to the risk appetite.
- Reviewing audit outcomes following COVID reviews and ensure actions are taken as a result of learning.
- Clarifying the assurance requirements of its hosted organisations to the CTMUHB through the development of an assurance framework.
- Fully enacting and utilising the Board Assurance Framework.
- Maintaining and strengthening the effectiveness of the Audit Tracker, including seeking and implementing best practice and incorporating further audits in relation to the Delivery Unit and Targeted Intervention.
- Discharging effectively the Board approved Committee Terms of Reference.
- Reviewing the effectiveness of the application of the revised Standing Orders and Scheme of Delegation.
- 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 2020-2021 and Assurance Ratings

	Internal Audit Assignment	Assurance Rating 2018-2019
1	Annual Quality Statement	Substantial
2	Sustainability Reporting	Substantial
3	Estates Directorate – Compliance Review	Substantial
4	Prince Charles Hospital Development Project – Covid 19 related issues	Substantial
5	Prince Charles Hospital Development Project – Validation of Management Actions	Substantial
6	Risk Management	Reasonable
7	Continuous Improvement in response to Targeted Intervention	Reasonable
8	Financial Systems	Reasonable
9	Welsh Risk Pool Claims Process	Reasonable
10	Medical Agency	Reasonable
11	Estates Directorate – Workforce Management Arrangements	Reasonable
12	Estates Directorate – Governance and Risk Management Arrangements	Reasonable
13	Estates Directorate – Performance and Planning Management Arrangements	Reasonable
14	CAMHS Clinical Service Group – Performance and Planning Management Arrangements	Reasonable
15	CAMHS Clinical Service Group – Compliance Review	Reasonable
16	Pathology Directorate Follow Up	Reasonable
17	Digital Response to Covid 19	Reasonable
18	Facilities Directorate – Workforce Follow Up	Reasonable
19	Clinical Audit (Draft)	Reasonable
20	Prince Charles Hospital Development Project - Governance	Reasonable
21	Prince Charles Hospital Development Project – Financial Management	Reasonable
22	Prince Charles Hospital Development Project – Technical Compliance	Reasonable
23	Patient Pathway Appointment Management Process –	Limited

	Progress on the Implementation of Recommendations	
24	IT Service Management	Limited
25	CAMHS Clinical Service Group – Governance and Risk Management Arrangements	Limited
26	CAMHS Clinical Service Group – Workforce Management Arrangements	Limited
27	Head & Neck Directorate Follow Up of Governance Recommendations	Advisory & Non Opinion
28	IT Baseline Review	Advisory & Non Opinion
29	Governance During the Covid 19 Pandemic	Advisory & Non Opinion
30	Covid 19 Governance – Follow Up	Advisory & Non Opinion

	Substantial Assurance Rating	**5**
	Reasonable Assurance Rating	**17**
	Limited Assurance Rating	**4**
	Advisory & Non Opinion	**4**
	Total	**30**

**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 2020-2021 and Assurance Ratings within

The Welsh Health Specialised Services Committee (WHSCC) & the Emergency Ambulance Services Committee (EASC)

	Internal Audit Assignment	Assurance Rating 2019-2020
Welsh Health Specialised Services Committee (WHSCC)		
1	Financial Systems	Substantial
Emergency Ambulance Services Committee (EASC)		
1	Non-Emergency Patient Transport Service – Follow Up	Reasonable

AGENDA ITEM
2.1.4

AUDIT & RISK COMMITTEE

PROCUREMENT & SCHEME OF DELEGATION REPORT

Date of meeting	17/08/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Owen James, Head of Corporate Finance
Presented by	Steve Webster, 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)

This report provides details of any such transactions within the period 01.05.21 to 30.06.21.

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 2021-22.

1.3 Scheme of Delegation and Financial Control Procedures

There are number of proposed changes to the Scheme of Delegation which are highlighted in the report which require approval.

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 01.05.21 to 30.06.21.

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. **Table A** below provides details of such actions during the period 01.05.21 to 30.06.21

Table A – Single Tender Actions 01.05.21 to 30.06.21

STA	Revenue/Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
STA1457	Revenue	Estates	Fire Alarm Maintenance	Morris Churchfield	£57,266	a)	16/03/2021
STA1459	Revenue	Cellular Pathology	Outsourcing; reporting of backlog cases as and when needed by Cellular Pathology	LD Path Ltd	£100,000	a) d)	02/03/2021
STA1468	Revenue	Cardiology	Rental of Vivid S70 Ultrasound system	GE Healthcare	£116,250	d)	04/03/2021

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

STA1459 – LD Path LTD, Outsourcing reporting of backlog of cases for Cellular Pathology

To support the demand in reporting backlog cases within Cellular Pathology a decision was made to outsource, the position was also compounded with the clinical staff shortages. Procurement supported the service in undertaking an EOI (Expression of Interest) through the All Wales (AW) Framework, LD Pathology (non-framework) were also invited as they work extensively in English NHS Trusts. LD Path LTD were successful within the EOI rounds, as they provide a robust governance structure for Clinical staff, no RCPath (Royal College of Pathologist) points, advanced model for digital pathology and provided the best testimonials.

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

Contracting briefing paper for the provision of Endoscopy Procedures via a Mobile unit, was submitted into WG during June 2021. This paper is predicated on the Funding for the mobile unit being made available via WG. To date no update on either funding or feedback on Contract Briefing paper.

2.2 Purchase to Pay (P2P)

The Health Board has failed to meet its 95% target of paying non-NHS invoices within 30 days for the first quarter of 2021-22, achieving only 92.7% (value 90.8%). This compares to 89.4% (value 94.3%) for quarter 1 of 2020-21. The position has improved month on month since Month 1, however, the achievement of the 95% target by the end of the financial year is highly unlikely.

	0 - 30 Days		Total		%	
	Number	**Value**	**Number**	**Value**	**Number**	**Value**
Apr-21	16,593	45,374,647	18,650	50,046,234	89.0%	90.7%
May-21	17,534	32,541,376	18,718	34,390,498	93.7%	94.6%
Jun-21	19,614	38,406,424	20,587	43,616,332	95.3%	88.1%
YTD	**53,741**	**116,322,447**	**57,955**	**128,053,064**	**92.7%**	**90.8%**

The main reason for the underachievement of the target is largely due to Nurse Agency invoices paid outside of the 30 days. This has been identified as due to reduced resource in the department from the beginning of April. It is anticipated a new system for the payment of Nurse Agency invoices will be in place from the autumn, which should improve the payments made within 30 days.

The NHS invoice position shows that 74% (number) and 94.5% (value) of invoices were paid within 30 days for the first quarter of 2021-22. (61.5% (number) and 93.4% (value) for the same period in 2020-21).

Scheme of Delegation and Financial Control Procedures

There have been a number of requests for amendments to the Scheme of Delegation, these are shown in detail in Appendix 1 with changes highlighted in red.

In relation to the amendments of Scheme of Delegation ref 14 B2 - Approve compensation payments made under legal obligation, the changes will affect the job titles within the relevant FCP Losses and Special Payment FP 15. If the proposed amendments are approved these will be updated to reflect the new Scheme of Delegation.

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

3.1 None

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.
	n/a
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 01.05.21 to 30.06.21;
b) **NOTE** the update regarding Purchase to Pay;
c) **APPROVE** the amendments to the Scheme of Delegation in Appendix 1.
d) **APPROVE** (if applicable) update to relevant FCP and SFI to reflect changes to the Scheme of Delegation.

SoD Ref.	SoD Page No.	Main Task	Sub Task	Cwm Taf Morgannwg existing Limits	Cwm Taf Morgannwg existing Authority delegated to:	Cwm Taf Morgannwg proposed Limits	Cwm Taf Morgannwg proposed Authority delegated to:	Reason for the change	Requested by:	Requested timeframe for implementation
7B3	12	**Income, fees and charges and security of cash, cheques and other negotiable instruments**	**Individual NHS Patient treatment charges outside of LTAs and SLAs.**	**Agreement to provide treatment:** **i. up to £5,000** **ii. Between £5,000 and £25,000** **iii. Over £25,000**	**i. Head of Contracting** **ii. Head of Finance (non ILG)** **iii. Deputy Director of Finance**	**Agreement to provide treatment:** **i. up to £5,000** **ii. Between £5,000 and £25,000** **iii. Over £25,000**	**i. Finance Manager - Commissioning & Contracting** **ii. Head of Finance - Financial Planning & Reporting** **iii. Deputy Director of Finance**	**To update Job title.** **To amend error to the change made in April 2020 when job titles were amended to reflect the changes in the organisational structure.**	Andrew.Jones9@wales.nhs.uk	**Immediate**
9A6	17	Contracts for Health Care Services	**Individual Patient Commissionsing Agreements - NHS Providors and non NHS Providors (including European Economic Area applications)**	**unaffected by change**	**unaffected by change**	**unaffected by change**	**unaffected by change**	Remove reference to European Economic Area applications: sub task to read: Individual Patient Commissioning Agreements NHS Providors and non NHS Providors	Andrew.Jones9@wales.nhs.uk	**Immediate**
14B2	38	Disposals and condemnations, losses and special payments	**Approve compensation payments made under legal obligation**	**- Personal injury and medical negligence claims:** **i. up to £5,000** **ii. £5,000 and £20,000** **iii. £20,000 to £500,000** **iv. £500,000 to £1m**	**- Personal injury and medical negligence claims- On receipt of legal advice to pay** **i. Head of Patient Experience** **ii. Assistant Director Quality and Patient Experience** **iii. Director of Nuring*** **iv. Chief Executive**	**- Personal injury and medical negligence claims:** **i. up to £20,000** **ii. £20,000 to £500,000** **iii. £500,000 to £1m**	**- Personal injury and medical negligence claims- On receipt of legal advice to pay** **i. Head of Legal Services & Concerns** **ii. Director of Corporate Governance** **iiii. Chief Executive**	**Change of authority arrangements and limits**	Greg Dix and Georgina Galletly	**Immediate**
6 & 7	10 & 11	**Income, fees and charges and security of cash, cheques and other negotiable instruments; Banking arrangements**	**Various**	**N/A**	**Head of Financial Accounts**	**N/A**	**Head of Corporate Finance**	**Update job title from Head of Financial Accounts to Head of Corporate Finance throughout SoD**	Owen James (Head of Corporate Finance)	**Immediate**
10	19	**Pay expenditure**	**The funded establishment of any department may not be varied without the approval of the Chief Executive or an officer with delegated authority.**	**N/A**	**Director of Finance**	**N/A**	**Officers with delegated authority (provided that the change in funded establishment is in line with a virement of budget approved under 4E)**	**To make the delegation clearer(the current drafting was interpreted as stating that only the Director of Finance can approve changes in funded establishment which is not correct)**	**Director of Finance (following discussion with ILGs and Heads of Finance)**	**Immediate**

AUDIT & RISK COMMITTEE FORWARD WORK PLAN 2021/2022

Meeting	Standing items/Governance	Internal control and risk management	Part II meeting – hosted bodies	Internal control and risk management
17 August 2021 9.30am Virtually via Microsoft Teams	Minutes Action Log Declarations of Interest Forward Work Programme Audit Recommendation Tracker Report Losses and special payments Report Procurements and Scheme of Delegation Report Organisational Risk Register Local Counter Fraud update (to include a review of resource allocation to the Counter Fraud Service) Head of Internal Audit Progress Report Internal Audit Reviews (any limited or no assurance reports require lead director presence) Audit Wales Audit & Risk Committee Update Audit Wales Review Reports (as relevant) Items for information (not normally for discussion) Referrals to other committees Any other urgent business	Declarations of Interest and Gifts & Hospitality Report Audit of Financial Statements Addendum Report (if required) FCP Medical Variable Pay – Summary of all Authorised Breaches (Bi-Monthly Update) **(In Committee)** Post Payment Verification Progress Report Audit & Risk Committee Annual Report	Minutes Action Log Declarations of Interest	Audit Recommendation tracker report WHSSC CRAF update EASC Risk Register Update Receipt of any hosted body internal / external audit report and management responses (WHSSC Governance Review) WHSSC & EASC Model Standing Orders and Standing Financial Instructions

Meeting	Standing items/Governance	Internal control and risk management	Part II meeting – hosted bodies	Internal control and risk management
4 October 2021 2.00pm Virtually via Microsoft Teams	Minutes Action Log Declarations of Interest Forward Work Programme Audit Recommendation Tracker Report Losses and special payments Report Procurements and Scheme of Delegation Report Organisational Risk Register Local Counter Fraud update (to include a review of resource allocation to the Counter Fraud Service) Head of Internal Audit Progress Report Internal Audit Reviews (any limited or no assurance reports require lead director presence) Audit Wales Audit & Risk Committee Update Audit Wales Review Reports (as relevant) Items for information (not normally for discussion) Referrals to other committees Any other urgent business	Post Payment Verification Mid-Year Update Clinical Audit Quarterly Update Reports FCP Medical Variable Pay – Summary of all Authorised Breaches (Bi-Monthly Update) Audit & Risk Committee Terms of Reference Audit & Risk Committee Annual Self-Assessment Progress made in relation to the Review of Risks in CSG's/ILG's – Verbal Update from each ILG 6 Monthly Update on Consultant Job Planning Internal Audit Review into Medical Rostering – Update report on progress	Minutes Action Log Declarations of Interest	Audit Recommendation tracker report WHSSC CRAF update EASC Risk Register Update Receipt of any hosted body internal / external audit report and management responses (WHSSC Governance Review)

Meeting	Standing items/Governance	Internal control and risk management	Part II meeting – hosted bodies	Internal control and risk management
7 December 2021 9.30am Virtually via Microsoft Teams	Minutes Action Log Declarations of Interest Forward Work Programme Audit Recommendation Tracker Report Losses and special payments Report Procurements and Scheme of Delegation Report Organisational Risk Register Local Counter Fraud update (to include a review of resource allocation to the Counter Fraud Service) Head of Internal Audit Progress Report Internal Audit Reviews (any limited or no assurance reports require lead director presence) Audit Wales Audit & Risk Committee Update Audit Wales Review Reports (as relevant) Items for information (not normally for discussion) Referrals to other committees Any other urgent business	Declarations of Interest and Gifts & Hospitality Report FCP Medical Variable Pay – Summary of all Authorised Breaches (Bi-Monthly Update) Audit Wales Annual Audit Report Audit Wales Structured Assessment Report Deep Dive into an ILG Risk Register Legislative Assurance Framework – Development Update	Minutes Action Log Declarations of Interest	Audit Recommendation tracker report WHSSC CRAF update EASC Risk Register Update Receipt of any hosted body internal / external audit report and management responses (WHSSC Governance Review)

AGENDA ITEM
2.2.2

AUDIT & RISK COMMITTEE

LOSSES AND SPECIAL PAYMENTS 01.03.21 TO 30.06.21

Date of meeting	17/08/2021
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 (TBC)
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 Head of Legal Services, Complaints	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

1. SITUATION/BACKGROUND

This report advises the Audit & Risk Committee on the losses and special payments made by the Health Board (HB) for the two month period from 1 March 2021 to 30 June 2021, as required in Standing Financial Instructions.

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 HB. Where the WRP would be liable for a reimbursement to the HB 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.

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.

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)

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.

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.

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 30 June 2021

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

Table 1

	30.06.21	**31.03.21**	**28.02.21**	**31.03.20**	**31.03.19**
	£000	**£000**	**£000**	**£000**	**£000**
	Cumulative	**Cumulative**	**Cumulative**	**Cumulative**	**Cumulative**
Medical Negligence claims/costs (Note 1)	109,867	86,029	102,755	85,516	81,897*
Redress Medical Negligence claims/costs	307	269	438	382	
Personal Injury claims/costs	415	436	459	680	532
Recoverable from Welsh Risk Pool (Note 1)	(125,221)	(114,863)	(129,839)	(115,161)	(99,137)
Net claim provision	**(14,632)**	**(28,129)**	**(26,187)**	**(28,583)**	**(16,708)**
Permanent Injury Benefit	6,313	6,320	6,382	6,252	4,517
Net Provision	**(8,319)**	**(21,809)**	**(19,805)**	**(22,331)**	**(12,191)**
Number of live cases on losses system (LaSPaR)					
	30.06.21	**31.03.21**	**28.02.21**	**31.03.20**	**31.03.19**
Medical Negligence claims	298	309	309	279	230
Redress Medical Negligence claims	179	168	180	202	87
Personal Injury claims	107	110	114	113	97

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

*Medical Negligence claims/costs for the year ended 2019 are inclusive of costs relating to the Redress claims. The costs relating to redress claims for the previous and current years are disclosed on a separate line for additional clarity.

Note 1: At the year-end, £15m of the remaining provision relating to two long-term structured settlement cases were transferred to WRP, with the future periodical payments to the claimants being managed by WRP directly. Giving a reduction in the provision held by the Health Board for the period ending 31st March 2021 compared to the last reported period of 28th February 2021.

The increase in provision for the first quarter of the current financial year predominantly relates to the changes in the estimated settlement values for the three cases, as follows:

1. 05RVEMN0022 (increase of £8.7m). Quantum figures have been reconsidered and increased following receipt of the Claimant's schedule of loss. Estimated costs have increased, as the Health Board were not successful at the liability trial.

2. 20RYLMN0129 (increase of £1.1m). L&RS updated their estimation in May 2021 following receipt of the further expert evidence, and Counsel's advice that this is a complex and high value case so damages and costs have increased.

3. 20RYLMN0198 (increase of £16.8m). Unsupportive expert evidence has been obtained, and on balance, the Health Board will not successfully defend this case but further investigations are ongoing to confirm Health Boards position.

b) Expenditure incurred for the year to 30 June 2021

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 (28.02.2021).

The "other" category mainly consists of payment of retirement gratuities, Employment Matters and voluntary early releases (see appendix 4).

Table 2

	Year to	Year to	Year to	Year ended	Year ended
	30.06.21	**31.03.21**	**28.02.21**	**31.03.20**	**31.3.19**
	£000	**£000**	**£000**	**£000**	**£000**
Medical Negligence claims/costs	25,213	13,110	28,052	18,455	18,300
Redress Medical Negligence claims/costs	107	305	325	367	
Personal Injury claims/costs	146	316	303	557	(405)
Recoverable from Welsh Risk Pool	(25,198)	(12,449)	(27,494)	(18,225)	(16,544)
Net claim expenditure (Note 2)	**268**	**1,282**	**1,186**	**1,154**	**1,371**
Permanent Injury Benefit	(7)	470	432	2,075	1,697
Other	22	609	463	407	306
Total expenditure	**283**	**2,361**	**2,081**	**3,636**	**3,354**

Note 2: The annual budget for net claim expenditure for 2020-21 is £1,169k, there is therefore overspend on claims of £113k as at 31 March 2021. The annual budget for net claim expenditure for 2021-22 is £1,143k (year to date £286k) there is therefore an underspend of £18k.

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.

Welsh Risk Pool charge on late submission of reimbursement claims

As reported previously to the Audit & Risk Committee, the Health Board has been working closely with the colleagues from WRP in resolving the matter relating to the timely submission of the Claims Management Report (CMR's) and Learning From Events Reports (LFER's) for the reimbursement of outstanding monies from WRP.

The WRP Committee meeting was held on 17th March 2021 and it was confirmed that the Committee reviewed the position in relation to the application of a 10% penalty on the reimbursement of cases, which had been submitted outside of the four-month timescale. At the committee, it was confirmed the Health Board have shown improvement and have provided assurances that all outstanding Case Management Reports and associated submission documents have been submitted. As a result, the cases that were subject to the 10% penalty applied from January's meeting have been refunded and no further deductions were made on cases that may have been subject to a 10% penalty in March's meeting.

However, in March 2021, WRP confirmed that the 10% penalty charge applied to the late submission of the cases for the November WRP Committee is a permanent charge. The final value of this penalty charge is £103k and relate to 5 claims. Currently, this charge is reflected in the expenditure figure disclosed within table 2 and appendix 5a and remaining £20k will reported to the next Audit & Risk Committee once appropriate process has been followed in line with the scheme of delegation of duties.

To date, good progress is being made on the WRP reimbursement claims, with £10.2m of WRP reimbursements received in February 2021 and an additional £14.5m received in the first quarter of this financial year. A further £4.3m has been received in July 2021.

Case Management Reports are still being submitted as advised by WRP before the Learning from Events Reports, thus ensuring payments will be made and assuring WRP that the Health Board's Claims Team are following process.

It is proposed that the WRP will reinstate the normal process i.e. the standard 60 working day deadline for submission of an LFER and a six month deadline for submission of further information from 1st October 2021.

This means that the LFERs will require submission before the CMRs.

There are discussions in progress in conjunction with the ILGs as to how this is managed more effectively going forward to ensure timely submission of LFERs and subsequently CMRs.

c) Cash Write-Offs made for the period 1 March 2021 to the 30 June 2021

Table 3a shows the cash impact for financial year 2020-21 and Table 3b up to 30 June 2021 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 1a and 1b.** Redress medical negligence analysis of payments and receipts is now shown separately from medical negligence in **Appendix 2a and 2b.** A similar analysis is provided for personal injury claims in **Appendix 3a and 3b** and Permanent Injury Benefit (PIB) in **Appendix 4a and 4b.**

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 5a and 5b.**

Table 3a

Cash write-offs made during 2020/21

	01.03.21 - 31.03.21 £000	Previously Reported £000	Total 2020-21 £000
Medical Negligence (Appendix 1a)			
Claims	159	7,762	7,921
Costs	1,563	2,442	4,005
Defence Fees	62	608	670
Redress Medical Negligence (Appendix 2a)			
Claims	138	179	317
Costs	2	36	38
Defence Fees	9	54	63
Personal Injury (Appendix 3a)			
Claims	5	276	281
Costs	16	104	120
Defence Fees	14	145	159
Permanent Injury Benefit (Appendix 4a)	101	302	403
Other (Appendix 5a)			
Ex-Gratia	5	57	62
Debt Write Off	1	55	56
Condemnations and Obsolescence	0	268	268
Loss of Cash	120	0	120
Employment Matter	21	83	104
Total	**2,216**	**12,371**	**14,587**
Recovered from Welsh Risk Pool	69	(12,818)	(12,749)
Net Cash Write-Off	**2,285**	**(447)**	**1,838**

Table 3b

Cash write-offs made during 21/22

	01.04.21 - 30.06.21 £000
Medical Negligence (Appendix 1b)	
Claims	**1,072**
Costs	**214**
Defence Fees	**89**
Redress Medical Negligence (Appendix 2b)	
Claims	**44**
Costs	**10**
Defence Fees	**16**
Personal Injury (Appendix 3b)	
Claims	**126**
Costs	**21**
Defence Fees	**20**
Permanent Injury Benefit (Appendix 4b)	**0**
Other (Appendix 5b)	
Ex-Gratia	**20**
Debt Write Off	**0**
Condemnations and Obsolescence	**0**
Ombudsman	**1**
Employment Matter	**0**
Total	**1,633**
Recovered from Welsh Risk Pool	**(14,842)**
Net Cash Write-Off	**(13,209)**

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

None noted.

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

The Audit & Risk Committee is requested to:

- **NOTE** the losses and special payments made for the period 1 March 2021 to 30 June 2021.
- **NOTE** the update in respect of the matter relating to the late submission of the WRP reimbursement claims.

Medical Negligence Payments 01/03/2021 - 31/03/2021							Appendix 1a
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
05RVEMN0022	0	0	0	0	0	533	533
10RYLMN0065	0	3	0	0	3	61	65
11RYLMN0068	0	0	-39	0	-39	64	25
13RYLMN0005	0	0	0	0	0	10	11
13RYLMN0125	60	0	0	0	60	183	243
13RYLMN0131	200	0	0	0	200	69	269
14RYLMN0214	0	0	-29	0	-29	54	25
15RYLMN0079	225	0	0	0	225	874	1,099
15RYLMN0104	0	1	0	0	1	53	55
15RYLMN0109	350	0	0	0	350	4,011	4,362
15RYLMN0167	0	1	0	0	1	10	11
15RYLMN0171	0	1	0	0	1	493	494
15RYLMN0203	40	0	0	0	40	1	41
16RYLMN0002	175	1	0	0	176	31	207
16RYLMN0010	30	0	0	0	30	91	120
16RYLMN0073	0	3	0	0	3	47	50
16RYLMN0138	140	0	0	0	140	905	1,045
16RYLMN0144	0	2	0	0	2	6	8
17RYLMN0012	0	1	0	0	1	2	2
17RYLMN0022	80	6	0	0	86	663	749
17RYLMN0056	30	0	0	0	30	94	124
17RYLMN0070	0	0	-8	0	-8	107	99
17RYLMN0071	31	0	0	0	31	57	88
17RYLMN0073	0	0	1	0	1	87	88
17RYLMN0093	0	3	0	0	3	464	467
17RYLMN0095	48	2	0	0	49	249	298
17RYLMN0123	0	0	0	69	69	-30	39
17RYLMN0126	0	0	-3	0	-3	28	25
18RYLMN0031	0	5	0	0	5	16	21
18RYLMN0033	0	0	0	0	0	22	22
18RYLMN0058	0	0	16	0	16	146	162
18RYLMN0064	0	8	0	0	8	12	20
18RYLMN0066	0	0	23	0	23	43	65
18RYLMN0099	0	2	0	0	2	1	2
18RYLMN0106	0	1	0	0	1	3	4
19RYLMN0006	25	0	0	0	25	316	341
19RYLMN0021	0	2	0	0	2	3	5
19RYLMN0034	30	8	200	0	238	12	250
19RYLMN0056	80	0	0	0	80	241	321
19RYLMN0085	0	0	0	0	0	12	12
20RYLMN0024	0	-1	0	0	-1	1	0
20RYLMN0026	20	0	0	0	20	29	49
20RYLMN0027	0	0	0	0	0	4	4
20RYLMN0030	0	0	0	0	0	0	0
20RYLMN0035	0	-0	0	0	-0	128	128
20RYLMN0100	0	1	0	0	1	0	1
20RYLMN0112	0	0	0	0	0	1	2

Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
20RYLMN0165	0	2	0	0	2	3	5
20RYLMN0170	0	3	0	0	3	0	3
20RYLMN0200	0	2	0	0	2	4	6
21RYLMN0022	0	1	0	0	1	2	3
21RYLMN0030	0	1	0	0	1	0	1
21RYLMN0032	0	1	0	0	1	0	1
21RYLMN0059	0	1	0	0	1	2	3
Total 01/03/2021 - 31/03/2021	**1,563**	**62**	**159**	**69**	**1,853**		
Total						**10,220**	**12,072**

Medical Negligence Payments 01/04/2021 - 30/06/2021							Appendix 1b
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
05RRSMN0039	0	0	0	-415	-415	465	50
05RVEMN0022	0	12	250	-482	-220	533	313
06RRSMN0037	42	2	0	0	44	56	100
08RVEMN0013	0	0	0	-4,973	-4,973	4,998	25
10RYLMN0065	0	0	0	0	0	61	62
12RYLMN0004	0	0	0	-1,320	-1,320	1,870	550
12RYLMN0037	0	2	0	0	2	50	52
13RYLMN0005	0	1	0	0	1	10	11
13RYLMN0096	0	0	350	-404	-54	454	400
13RYLMN0125	55	5	0	0	60	183	243
13RYLMN0157	0	0	0	-5	-5	30	25
14RYLMN0006	0	0	0	-1	-1	26	25
14RYLMN0198	0	0	0	-256	-256	310	53
14RYLMN0200	0	0	0	-891	-891	1,265	374
15RYLMN0049	65	0	0	0	65	86	151
15RYLMN0078	0	0	0	-31	-31	56	25
15RYLMN0079	-120	6	0	-824	-938	874	-64
15RYLMN0109	0	1	0	-1,493	-1,491	4,011	2,520
15RYLMN0130	0	1	0	0	1	6	7
15RYLMN0133	0	1	0	0	1	96	96
15RYLMN0152	0	1	0	0	1	25	26
15RYLMN0171	0	0	0	-468	-468	493	25
16RYLMN0010	3	0	0	0	3	91	94
16RYLMN0073	0	1	20	0	21	47	68
16RYLMN0078	0	0	0	-962	-962	987	25
16RYLMN0090	0	0	0	-3	-3	28	25
16RYLMN0098	0	0	0	0	0	115	115
16RYLMN0104	0	0	0	-85	-85	110	25
16RYLMN0115	0	0	0	-15	-15	40	25
16RYLMN0116	0	0	0	-90	-90	115	25
16RYLMN0131	0	0	0	-37	-37	62	25
16RYLMN0138	0	0	0	-855	-855	905	50
16RYLMN0144	0	1	0	0	1	6	7
16RYLMN0145	0	0	0	-9	-9	34	25
16RYLMN0203	0	1	0	0	1	2	3
17RYLMN0012	0	0	49	0	49	2	51
17RYLMN0022	0	2	0	0	2	663	665
17RYLMN0037	0	0	0	-3	-3	28	25
17RYLMN0038	0	0	0	-43	-43	68	25
17RYLMN0050	0	0	1	0	1	2	3
17RYLMN0054	8	0	0	0	8	1	9
17RYLMN0061	0	0	0	-93	-93	118	25
17RYLMN0063	0	0	0	-5	-5	30	25

17RYLMN0070	0	0	8	-82	-74	107	33
17RYLMN0073	0	0	0	-63	-63	87	24
17RYLMN0095	0	0	0	-199	-199	249	50
17RYLMN0096	0	0	0	-88	-88	113	25
17RYLMN0120	66	0	0	0	66	121	187
17RYLMN0123	0	2	0	-14	-11	-30	-42
17RYLMN0150	0	0	0	-26	-26	51	25
17RYLMN0157	0	3	0	0	3	69	72
18RYLMN0020	0	0	0	-53	-53	78	25
18RYLMN0030	0	1	0	0	1	4	5
18RYLMN0031	0	2	0	0	2	16	18
18RYLMN0033	0	2	0	0	2	22	25
18RYLMN0058	0	0	0	-121	-121	146	25
18RYLMN0064	0	3	0	0	3	12	16
18RYLMN0066	11	1	0	0	12	43	55
18RYLMN0076	0	3	0	0	3	1	4
18RYLMN0079	0	0	0	-1	-1	26	25
18RYLMN0085	0	3	0	0	3	8	11
18RYLMN0093	0	1	0	0	1	7	7
19RYLMN0006	10	0	0	0	10	316	326
19RYLMN0017	0	0	0	-21	-21	50	29
19RYLMN0047	0	2	20	0	21	0	21
19RYLMN0061	5	0	0	0	5	0	5
19RYLMN0081	31	0	100	0	131	34	165
19RYLMN0084	0	0	0	-28	-28	53	25
20RYLMN0004	0	-2	0	0	-2	2	0
20RYLMN0008	0	0	260	0	260	57	317
20RYLMN0017	0	0	0	-98	-98	123	25
20RYLMN0026	1	0	0	0	1	29	30
20RYLMN0027	0	1	0	0	1	4	5
20RYLMN0033	0	1	0	0	1	0	1
20RYLMN0035	0	0	0	0	0	128	128
20RYLMN0112	0	0	0	0	0	1	2
20RYLMN0126	3	0	0	0	3	53	55
20RYLMN0129	0	4	0	0	4	7	11
20RYLMN0163	0	1	0	0	1	0	1
20RYLMN0170	0	2	0	0	2	0	2
20RYLMN0198	0	2	0	0	2	3	5
20RYLMN0201	0	0	14	0	14	5	19
21RYLMN0007	9	1	0	0	10	41	51
21RYLMN0023	0	2	0	0	2	0	2
21RYLMN0025	27	0	0	0	27	11	38
21RYLMN0059	0	1	0	0	1	2	3
21RYLMN0063	0	3	0	0	3	4	7
21RYLMN0065	0	0	0	0	0	1	1
21RYLMN0080	0	1	0	0	1	0	1
21RYLMN0113	0	0	0	0	0	0	0

21RYLMN0118	0	1	0	0	1	0	1
21RYLMN0130	0	2	0	0	2	0	2
21RYLMN0133	0	1	0	0	1	0	1
21RYLMN0147	0	1	0	0	1	0	1
21RYLMN0148	0	5	0	0	5	0	5
21RYLMN0157	0	3	0	0	3	0	3
Total 01/04/2021 - 30/06/2021	**214**	**89**	**1,072**	**-14,558**	**-13,183**		
Total						**21,468**	**8,285**

Redress Payments 01/03/2021 - 31/03/2021							Appendix 2a
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
19RYLMN0018	0	0	19	0	19	4	23
20RYLMN0093	2	0	9	0	10	0	10
20RYLMN0117	0	0	24	0	24	2	26
20RYLMN0130	0	0	-6	0	-6	10	4
20RYLMN0150	0	0	0	0	0	0	0
21RYLMN0052	0	0	18	0	18	0	18
21RYLMN0102	0	0	0	0	0	1	1
14RYLMN0189	0	0	-0	0	0	2	2
18RYLMN0124	0	0	-0	0	0	4	4
19RYLMN0013	0	0	10	0	10	4	14
19RYLMN0113	0	1	0	0	1	19	20
19RYLMN0116	0	1	0	0	1	4	5
19RYLMN0124	0	0	0	0	0	4	4
20RYLMN0063	0	0	25	0	25	3	28
20RYLMN0065	0	5	0	0	5	0	5
20RYLMN0071	0	1	0	0	1	0	1
20RYLMN0082	0	0	5	0	5	1	6
20RYLMN0136	0	0	9	0	9	4	13
20RYLMN0159	0	0	5	0	5	1	6
21RYLMN0044	0	0	20	0	20	0	20
21RYLMN0105	0	0	0	0	0	0	1
21RYLMN0112	0	0	0	0	0	0	0
Total 01/03/2021 - 31/03/2021	**2**	**9**	**138**	**0**	**149**		
Total						**62**	**210**

Redress Payments 01/04/2021 - 30/06/2021							Appendix 2b
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
17RYLMN0028	0	0	0	-1	-1	3	2
17RYLMN0142	0	0	0	0	0	8	8
18RYLMN0039	0	0	0	-1	-1	3	2
18RYLMN0096	0	0	0	-5	-5	8	3
19RYLMN0012	0	5	0	0	5	0	5
19RYLMN0018	2	0	-1	0	1	4	5
19RYLMN0036	0	0	0	-1	-1	3	2
19RYLMN0055	0	0	0	-5	-5	5	0
19RYLMN0072	0	3	0	0	3	0	3
19RYLMN0099	2	0	0	0	2	4	6
19RYLMN0101	0	0	0	-23	-23	25	2
19RYLMN0123	0	0	0	0	0	9	9
20RYLMN0056	0	0	1	0	1	0	1
20RYLMN0062	0	0	0	-1	-1	1	0
20RYLMN0076	0	0	0	-9	-9	10	0
20RYLMN0078	0	0	0	-2	-2	4	2
20RYLMN0083	0	0	0	0	0	0	0
20RYLMN0093	0	0	0	-9	-8	0	-8
20RYLMN0105	0	0	0	-5	-5	6	2
20RYLMN0117	2	0	0	0	2	2	3
20RYLMN0130	0	-0	0	0	-0	10	10
20RYLMN0133	2	0	0	0	2	0	2
20RYLMN0150	0	0	-0	0	-0	0	-0
20RYLMN0151	0	0	0	0	0	0	0
20RYLMN0154	2	3	0	0	4	0	4
20RYLMN0190	0	0	0	-3	-3	3	0
20RYLMN0191	0	2	0	0	2	0	2
20RYLMN0194	0	0	0	-4	-4	4	0
21RYLMN0048	0	2	0	0	2	0	2
21RYLMN0052	2	0	3	0	5	0	5
21RYLMN0085	0	0	0	-1	-1	1	0
21RYLMN0091	0	1	0	0	1	0	1
21RYLMN0092	0	0	19	0	19	0	19
21RYLMN0096	0	0	2	0	2	0	2
21RYLMN0102	0	0	0	0	0	1	1
21RYLMN0108	0	0	0	0	0	0	0
21RYLMN0111	0	0	20	0	20	0	20
21RYLMN0126	0	0	1	0	1	0	1
22RYLMN0023	0	0	0	0	0	0	0
Total 01/04/2021 - 30/06/2021	**10**	**16**	**44**	**-70**	**-0**		
Total						**114**	**114**

Personal Injury Payments 01/03/2021 - 31/03/2021							Appendix 3a
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
16RYLPI0004	0	1	0	0	1	14	15
16RYLPI0010	0	0	-3	0	-3	28	25
18RYLPI0007	0	1	0	0	1	0	1
18RYLPI0010	10	0	0	0	10	25	35
18RYLPI0025	0	2	0	0	2	0	2
20RYLPI0002	0	3	0	0	3	10	12
20RYLPI0003	0	4	0	0	4	5	9
20RYLPI0007	0	0	0	0	0	0	0
20RYLPI0020	0	1	0	0	1	0	1
20RYLPI0031	0	1	0	0	1	3	4
20RYLPI0043	0	0	5	0	5	0	5
20RYLPI0045	0	-0	0	0	0	3	3
20RYLPI0062	0	1	0	0	1	0	1
21RYLPI0010	0	0	0	0	0	0	0
21RYLPI0014	6	0	0	0	6	2	8
21RYLPI0015	0	0	0	0	0	0	0
21RYLPI0032	0	0	3	0	3	0	3
Total 01/03/2021 - 31/03/2021	**16**	**14**	**5**	**0**	**35**		
Total						**89**	**124**

Personal Injury Payments 01/04/2021 - 30/06/2021							Appendix 3b
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
18RYLPI0010	0	1	0	0	1	25	26
20RYLPI0058	0	1	0	0	1	3	4
16RYLPI0019	0	0	0	-5	-5	30	25
18RYLPI0006	0	0	0	-45	-45	70	25
18RYLPI0027	0	1	6	0	6	0	6
21RYLPI0009	0	1	1	0	2	0	2
21RYLPI0027	1	1	1	0	3	0	3
21RYLPI0042	0	0	20	0	20	0	20
16RYLPI0004	0	0	25	0	25	14	39
17RYLPI0002	0	0	0	-9	-9	34	25
17RYLPI0017	0	0	0	-53	-53	78	25
17RYLPI0025	4	0	0	0	4	2	7
18RYLPI0007	0	0	60	0	60	0	60
18RYLPI0020	0	1	0	0	1	1	1
19RYLPI0007	0	0	0	-43	-43	68	25
19RYLPI0014	0	0	0	-58	-58	91	32
20RYLPI0057	1	1	0	0	2	1	2
20RYLPI0064	0	0	2	0	2	0	2
21RYLPI0032	6	2	0	0	8	0	8
18RYLPI0002	8	0	6	0	14	0	15
18RYLPI0032	0	1	0	0	1	0	1
19RYLPI0009	0	1	0	0	1	0	1
19RYLPI0021	0	1	0	0	1	0	1
20RYLPI0013	0	1	0	0	1	0	1
20RYLPI0047	0	1	0	0	1	0	1
21RYLPI0006	0	0	0	0	0	0	0
21RYLPI0012	0	1	0	0	1	0	1
21RYLPI0016	0	0	3	0	3	0	3
21RYLPI0030	0	1	0	0	1	0	1
21RYLPI0036	0	1	0	0	1	0	1
21RYLPI0037	0	1	0	0	1	0	1
21RYLPI0039	0	0	0	0	1	0	1
21RYLPI0040	0	1	0	0	1	0	1
21RYLPI0041	0	0	0	0	0	0	0
21RYLPI0043	0	0	0	0	0	0	0
21RYLPI0044	0	0	0	0	0	0	0
21RYLPI0045	0	0	2	0	2	0	2
22RYLPI0001	0	0	0	0	0	0	0
22RYLPI0002	0	0	0	0	0	0	0
22RYLPI0003	0	0	0	0	0	0	0
Total 01/04/2021 - 30/06/2021	**21**	**20**	**126**	**-214**	**-46**		
Total						**416**	**371**

Permanent Injury Benefit 01/03/2021 - 31/03/2021

Appendix 4b

Laspar Number	In period Payments £000	Previous Write-Offs £000	Cumulative £000
01RRSPI0020	3	213	217
02RVEPI0001	2	54	56
02RVEPI0003	3	156	158
02RVEPI0004	2	107	109
03RRSPI0020	12	765	777
03RVEPI0028	3	238	242
04RRSPI0009	4	205	209
04RRSPI0024	3	139	142
05RRSPI0020	1	69	70
05RRSPI0021	3	169	172
05RVEPI0033	5	258	263
05RVEPI0034	1	76	77
08RVEPI0009	3	166	169
10RYLPI0070	2	94	96
11RYLPI0065	5	206	212
12RYLPI0059	2	61	62
13RYLPI0020	1	31	32
13RYLPI0050	3	120	123
98RVEPI0005	0	6	6
19RYLPI0022	11	233	243
20RYLPI0032	3	18	21
20RYLPI0033	1	8	9
20RYLPI0034	2	12	14
20RYLPI0035	5	37	42
20RYLPI0036	4	25	29
20RYLPI0037	1	9	10
20RYLPI0038	3	21	24
20RYLPI0039	2	15	18
20RYLPI0040	6	38	44
20RYLPI0041	4	26	29
20RYLPI0042	2	12	14
Total 01/03/2021 - 31/03/2021	**101**		
Total		**3,587**	**3,688**

Permanent Injury Benefit 01/04/2021 - 30/06/2021

Appendix 4b

Laspar Number	In period Payments £000	Previous Write-Offs £000	Cumulative £000
01RRSPI0020	0	217	217
02RVEPI0001	0	56	56
02RVEPI0003	0	158	158
02RVEPI0004	0	109	109
03RRSPI0020	0	777	777
03RVEPI0028	0	242	242
04RRSPI0009	0	209	209
04RRSPI0024	0	142	142
05RRSPI0020	0	70	70
05RRSPI0021	0	172	172
05RVEPI0033	0	263	263
05RVEPI0034	0	77	77
08RVEPI0009	0	169	169
10RYLPI0070	0	96	96
11RYLPI0065	0	212	212
12RYLPI0059	0	62	62
13RYLPI0020	0	32	32
13RYLPI0050	0	123	123
98RVEPI0005	0	6	6
19RYLPI0022	0	243	243
20RYLPI0032	0	21	21
20RYLPI0033	0	9	9
20RYLPI0034	0	14	14
20RYLPI0035	0	42	42
20RYLPI0036	0	29	29
20RYLPI0037	0	10	10
20RYLPI0038	0	24	24
20RYLPI0039	0	18	18
20RYLPI0040	0	44	44
20RYLPI0041	0	29	29
20RYLPI0042	0	14	14
Total 01/03/2021 - 31/03/2021	**0**		
Total		**3,688**	**3,688**

Other Payments 01/03/2021 - 31/03/2021 **Appendix 5a**

Case Reference	Type	Details	Amount £000
21RYLBD0047	Bad Debts	Bad Debt Write Off	0.28
21RYLBD0048	Bad Debts	Bad Debt Write Off	0.08
21RYLBD0049	Bad Debts	Bad Debt Write Off	0.04
21RYLBD0050	Bad Debts	Bad Debt Write Off	0.03
21RYLBD0051	Bad Debts	Bad Debt Write Off	0.08
21RYLEG0150	Ex-Gratia	Loss of Personal Effects	0.19
21RYLEG0151	Ex-Gratia	Loss of Personal Effects	0.71
21RYLEG0152	Ex-Gratia	Loss of Personal Effects	0.18
21RYLEG0153	Ex-Gratia	Loss of Personal Effects	0.06
21RYLEG0154	Ex-Gratia	Loss of Personal Effects	0.08
21RYLEG0155	Ex-Gratia	Loss of Personal Effects	0.13
21RYLEG0156	Ex-Gratia	Retirement Gratuity	0.34
21RYLEG0157	Ex-Gratia	Retirement Gratuity	0.39
21RYLEG0158	Ex-Gratia	Retirement Gratuity	0.27
21RYLEG0159	Ex-Gratia	Retirement Gratuity	0.36
21RYLEG0160	Ex-Gratia	Retirement Gratuity	0.34
21RYLEG0161	Ex-Gratia	Retirement Gratuity	0.20
21RYLEG0162	Ex-Gratia	Retirement Gratuity	0.22
21RYLEG0163	Ex-Gratia	Retirement Gratuity	0.21
21RYLEG0164	Ex-Gratia	Retirement Gratuity	0.23
21RYLEG0165	Ex-Gratia	Retirement Gratuity	0.43
21RYLEM0002	Employement Matter	Employement Matter	1.09
21RYLEM0006	Employement Matter	Employement Matter	20.00
21RYLLC0002	Loss of Cash	Mislaid Audiology Equipuipment	6.72
21RYLLC0003	Loss of Cash	WRP 10% Penalty	83.26
21RYLLC0004	Loss of Cash	Contract Penalty	30.62
21RYLMN0156	Ombudsman	Damages/Compensation	0.25
Total 01/03/2021 - 31/03/2021			**146.78**

Other Payments 01/04/2021 - 30/06/2021 Appendix 5b

Case Reference	Type	Details	Amount £000
22RYLBD0001	Bad Debts	Bad Debt Write Off	0.35
22RYLEG0001	Ex-Gratia	Loss of Personal Effects	0.10
22RYLEG0035	Ex-Gratia	Loss of Personal Effects	0.10
22RYLEG0036	Ex-Gratia	Loss of Personal Effects	2.00
22RYLEG0037	Ex-Gratia	Loss of Personal Effects	0.19
22RYLEG0038	Ex-Gratia	Loss of Personal Effects	0.02
22RYLEG0048	Ex-Gratia	Loss of Personal Effects	0.29
22RYLEG0055	Ex-Gratia	Loss of Personal Effects	1.50
22RYLEG0056	Ex-Gratia	Loss of Personal Effects	0.14
22RYLEG0002	Ex-Gratia	Retirement Gratuity	0.29
22RYLEG0003	Ex-Gratia	Retirement Gratuity	0.36
22RYLEG0004	Ex-Gratia	Retirement Gratuity	0.23
22RYLEG0005	Ex-Gratia	Retirement Gratuity	0.29
22RYLEG0006	Ex-Gratia	Retirement Gratuity	0.34
22RYLEG0007	Ex-Gratia	Retirement Gratuity	0.44
22RYLEG0008	Ex-Gratia	Retirement Gratuity	0.24
22RYLEG0009	Ex-Gratia	Retirement Gratuity	0.32
22RYLEG0010	Ex-Gratia	Retirement Gratuity	0.34
22RYLEG0011	Ex-Gratia	Retirement Gratuity	0.34
22RYLEG0012	Ex-Gratia	Retirement Gratuity	0.35
22RYLEG0013	Ex-Gratia	Retirement Gratuity	0.54
22RYLEG0014	Ex-Gratia	Retirement Gratuity	0.80
22RYLEG0015	Ex-Gratia	Retirement Gratuity	0.37
22RYLEG0016	Ex-Gratia	Retirement Gratuity	0.24
22RYLEG0017	Ex-Gratia	Retirement Gratuity	0.30
22RYLEG0018	Ex-Gratia	Retirement Gratuity	0.27
22RYLEG0019	Ex-Gratia	Retirement Gratuity	0.44
22RYLEG0020	Ex-Gratia	Retirement Gratuity	0.24
22RYLEG0021	Ex-Gratia	Retirement Gratuity	0.27
22RYLEG0022	Ex-Gratia	Retirement Gratuity	0.41
22RYLEG0023	Ex-Gratia	Retirement Gratuity	0.34
22RYLEG0024	Ex-Gratia	Retirement Gratuity	0.29
22RYLEG0025	Ex-Gratia	Retirement Gratuity	0.22
22RYLEG0026	Ex-Gratia	Retirement Gratuity	0.22
22RYLEG0027	Ex-Gratia	Retirement Gratuity	0.30
22RYLEG0028	Ex-Gratia	Retirement Gratuity	0.30
22RYLEG0029	Ex-Gratia	Retirement Gratuity	0.24
22RYLEG0030	Ex-Gratia	Retirement Gratuity	0.04
22RYLEG0031	Ex-Gratia	Retirement Gratuity	0.54
22RYLEG0032	Ex-Gratia	Retirement Gratuity	0.36
22RYLEG0033	Ex-Gratia	Retirement Gratuity	0.20
22RYLEG0034	Ex-Gratia	Retirement Gratuity	0.38
22RYLEG0039	Ex-Gratia	Retirement Gratuity	0.27
22RYLEG0040	Ex-Gratia	Retirement Gratuity	0.32

22RYLEG0041	Ex-Gratia	Retirement Gratuity	0.38
22RYLEG0042	Ex-Gratia	Retirement Gratuity	0.20
22RYLEG0043	Ex-Gratia	Retirement Gratuity	0.42
22RYLEG0044	Ex-Gratia	Retirement Gratuity	0.34
22RYLEG0045	Ex-Gratia	Retirement Gratuity	0.31
22RYLEG0046	Ex-Gratia	Retirement Gratuity	0.43
22RYLEG0047	Ex-Gratia	Retirement Gratuity	0.43
22RYLEG0049	Ex-Gratia	Retirement Gratuity	0.26
22RYLEG0050	Ex-Gratia	Retirement Gratuity	0.29
22RYLEG0051	Ex-Gratia	Retirement Gratuity	0.47
22RYLEG0052	Ex-Gratia	Retirement Gratuity	0.36
22RYLEG0053	Ex-Gratia	Retirement Gratuity	0.36
22RYLEG0054	Ex-Gratia	Retirement Gratuity	0.25
22RYLMN0004	Ombudsman	Damages/Compensation	0.25
22RYLMN0006	Ombudsman	Damages/Compensation	0.50
Total 01/04/2021 - 30/06/2021			**21.40**

AGENDA ITEM
2.2.4

AUDIT & RISK COMMITTEE

DECLARATIONS OF INTERESTS, GIFTS, SPONSORSHIP, HOSPITALITY & HONORARIA

Date of meeting	17/08/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lynn Hudson, Corporate Services Support Officer Karl Carpenter, Digital Services Manager
Presented by	Georgina Galletly, Director of Corporate Governance
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Management Board	07.07.2021	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 Management Board.

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 and 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 An email to all Board Members requesting the annual Declarations of Interest was sent on the 10 May 2021. All returns have been received. Board Members compliance – 100%.

2.3 An email was issued to 1,341 members of staff (included all Consultants and Workforce – Bands 8a and above). To date we have received 263 returns equalling a 20% return rate. It should be noted that a further 114 returns have been received in this period, however, they are awaiting manager approval which is currently being followed up by the Corporate Governance Team.

2.4 In summary there have been:

- **263** new declarations of interest received and entered on the Declarations of Interest Register for the period 1st April 2021 – 28 June 2021.

  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 28 June 2021 as follows:

- Appendix 1 – Declarations of Interest received 1.4.2021 – 28.6.2021
- Appendix 2 – Nil declarations received 1.4.2021 – 28.6.2021
- Appendix 3– Gifts, Hospitality and Sponsorship Declarations received 1.4.2021 – 28.6.21.

  It should also be noted that donations received by the public in response to the Covid-19 pandemic have not been captured as previously agreed by the Audit & Risk Committee and Board.

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

3.1 Please refer to the register for the Declarations of Interest Register Declaration included at Appendix 1 and the Gifts, Hospitality and Sponsorship at Appendix 2.

3.2 During 2021, when the pressure and challenges faced by the Covid-19 pandemic ease, the Health Board will relaunch its approach to Gifts, Hospitality & Sponsorship and Declarations of Interest sharing the new forms and new dedicated SharePoint pages.

3.3 The following additions have been added to appendix one since it was the report was received at the Management Board on the 21st July 2021:

- Marcus Longley confirmation of the Financial Benefits now included with declaration.
- Jonathan Arthur confirmation of the Financial Benefits now included with declaration.
- Stuart Hackwell confirmation of the Financial Benefits now included with declaration.

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
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	No (Include further detail below)

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	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 The report is open to the Audit & Risk Committee for **REVIEW** and to examine any entries on the register in full.

Declarations of Interest Received 1st April 2021 - 28th June 2021

Created	Full Name	Position	Declarations	Period of Involvement	Financial Benefits/In Kind
28/06/2021	Sharon Richards	Associate Member, Chair of the Stakeholder Reference Group	Chief Officer at Voluntary Action Merthyr Tydfil. Ensuring connectivity between the University Health Board and the voluntary and community sector.	VAMT since 18/1/97 and as Chief Officer since 1/10/20	Nil.
26/06/2021	Linda Prosser	Executive Director of Strategy & Transformation	1) Director, Altyn Tep Ltd. 2) Spouse is Director Altyn Tepe Ltd.	1) Nov 2019 to date 2) Nov 2019 to date.	1) Yes. 2) Yes
18/06/2021	Patsy Roseblade	Independent Member - Finance & Audit	Non-Executive Director of Tennis Wales	2020 - 2024	Voluntary.
16/06/2021	Clare Conaty	Optometrist lead for Glaucoma and ODTC services	My husband is Director of Robert E Lloyd Optometrists.	2013 to present	Nil
15/06/2021	Louise Blow	Health Care Support Worker (HCSW)	Mother is OPD Staff at YCR.	N/A	N/A
15/06/2021	Andrea Stone	Team Lead Physio	Working in private physiotherapy clinic. One2One Therapy, Dragon's Court, Bridgend Industrial Estate, Bridgend.	15 years and on-going.	Nil
14/06/2021	James Hehir	Independent Member Legal	1) Non Executive Director, Llandarcy Park Ltd. 2) Trustee Neath Port Talbot Contact Centre. 3) Vice Chairman, Neath Port Talbot Group of FE Colleges. 4) Solicitor of the Supreme Court. 5) Honorary Vice President, West Glamorgan Magistrates Association. 6) Associate member, magistrates Association. 7) Patron Neath YMCA.	1) 14/6/2018 ongoing. 2) 1/5/2007 ongoing. 3) 29/3/2006 ongoing. 4) 14/2/1984 to 31/8/2016. 5) 16/10/2017 life time appointment. 6) 1/6/1993 ongoing. 7) April 2015 ongoing.	Nil for all declarations.
14/06/2021	Yasmin Francis Ford	Clinical Specialist MSK	Hoping to start as a Bank Physiotherapist (Nuffield Hospital).	Commencing July 21 for 7 hours per week.	Not yet commenced.
10/06/2021	Keiron Montague	Independent Member - Community	Director of Trivallis Ltd.	2019 to date	Currently working with the RPB on delivery of ICF Funded Projects, this may include new projects in the coming year.
10/06/2021	Dilys Jouvenat	Independent Member - Third Sector	1) Chair of RCT Citizens Advice. 2) Trustee Newport Citizens Advice. 3) Possible conflict if RCT Citizens Advice are involved in delivery projects for the Health Board.	1) June 2015 to date. 2) March 2020 to date.	Nil.
10/05/2021	Greg Dix	Executive Director of Nursing, Midwifery & Patient Care.	1) Visiting Professor - University of South Wales 2020. 2) Associate Professor - University of Plymouth 2015. 3) Husband works for the Health Board as Population Testing Office Manager.	1) 2020 to date. 2) 2015 to date.	Nil.
10/05/2021	Nicola Milligan	Independent Member - Local Authority.	1) Board Member, Royal College of Nursing in Wales. 2) Vice Chair, Royal College of Nursing in Wales.	1) January 2016 - December 2020. 2) 1 January 21 to 31 December 2022.	Nil.
10/05/2021	Maria Thomas	Vice Chair.	1) Director of Winchfawr Investment. 2) Justice of the Peace. 3) Executive Member Macmillan Cancer Support Merthyr. 4) Trustee Safer Merthyr Tydfil. 5) Chair of Governors, Gwaun Farren School. 6) Executive Member of St John's Eye Hospital Jerusalem. 7) Member of the Order of St John Cymru Wales. 8) Vice Chair St John Council, Cardiff & Vale.	1) 2005 to present. 2-8) 15 years approx.	Nil for all declarations.
09/06/2021	Ian Wells	Independent Member ICT, IG & Digital	1) 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 to date.	Nil.
07/06/2021	Mrs. Elisabeth Williams	Finance Manager - Financial Accounts	1) Director of husband's company - CPM21 Ltd. 2) Spouse - Director CPM21 Ltd	1) From 1/8/2016 2) From 13/3/2012	1) No transactions between CTM & CPM21 Ltd. 2) No transactions between CTM & CPM21 Ltd.
04/06/2021	Stephen Webster	Executive Director of Finance	Currently on the Board of WWIC (Wound Innovation Ltd).	March/April 2021	Nil

Created	Full Name	Position	Declarations	Period of Involvement	Financial Benefits/In Kind
04/06/2021	Kenneth Emmanuelle	Consultant Obstetrician & Gynaecologist	1) Director, General medical Healthcare Ltd. 2) Spouse - Director, General medical healthcare Ltd.	1) From 2016. 2) From September 2016	1) Yes financial benefits. 2) Yes financial benefits.
02/06/2021	Sophie Hughes	MSK B6 Physiotherapist	Owner of self employed Veterinary Physiotherapy business - SoPhysio.	Since May 2021.	Confirmation being sought by the Corporate Governance Team.
28/05/2021	Philip Bell	Physiotherapist	Part time (8 hrs p/w) employee of Medic Mentor Ltd - provides mentorship and online training to prospective students looking to train in healthcare roles (age 16-18).	Since January 2021.	Monthly BACS payment.
26/05/2021	Leah Salter	Family and Systemic Psychotherapist	I am a co-director for the centre for systemic studies (cic) a not for profit community interest company offering family therapy and systemic training	2 years	Nil.
25/05/2021	Ruth Alcolado	Deputy National Clinical Director, Urgent and Emergency Care, NHS Wales	Consultancy work, University Hospitals Plymouth.	6 days over 6 months.	Invoiced for work undertaken as required.
24/05/2021	Jaydeep Shar	Consultant Orthopaedic Surgeon.	1) I have private company (KALRAV Ltd) for private medical and medico legal Work. I am Director in the company.	Since May 2018.	1) Lease car from NHS Fleet Solutions.
24/05/2021	Georgina Galletly	Director of Corporate Services	1) Governor of Marshfield Primary School. 2) Brother is a Director of Architecture, Microsoft Consulting Services.	1) 2018 to date.	Nil.
20/05/2021	Jonathan Arthur	Head of Audiology	Honorary Lectureship at Swansea University	Ongoing.	Nil.
19/05/2021	Gemma Cartwright	Clinical Lead Musculoskeletal Physiotherapist	Employment Bank staff Nuffield Healthcare.	Bank	Employment
19/05/2021	Christopher Hodcroft	Consultant in Acute Medicine	I sit on the Council of the Society of Acute Medicine as their representative for Wales. This position is unremunerated.	August 2017 to present.	Nil
19/05/2021	Rutton Hilloowalla	Consultant	Provide sedation services at a private fertility clinic in Cardiff once or twice a month.	Since 2018.	Paid as per the number of cases sedated.
19/05/2021	Philip White	Independent Member Local Authority	1) The Clever Green Portal Company Ltd. 2) Director, Whitedge Renewables. 3) Director, CNEG Ltd. 4) Chair of Governors Nanyffyllon Primary School. 5) Governor, Maesteg Comprehensive School.	1) 4/4/18 to date. 2) 1/6/12 to date. 3) Feb 2020. 4) 2017 to date. 5) 2017 to date.	Nil for all declarations.
18/05/2021	Kelly Mitchem	Consultant Clinical Biochemist	1) Synlab. 2) Pura. Undertake Consultant Clinical Biochemist duties/services for Synlab Laboratory Services, Abergavenny and Pura Diagnostics, Gloucester. Involves providing clinical advice and information when required, and assisting with IQC/EQA queries.	1) Since 2016 2) Since October 2019	Yes financial transactions. No benefits in kind.
18/05/2021	Neeraj Saxena	Consultant	1) Director of Saxena Pain Management Ltd. 2) Equity Funds (non substantial) 3) Private practice in anaesthesia, pain medicine, aesthetics and medicolegal work.	1) 4 years 2&3) Clarity being sought by the Corporate Governance Team.	1) Limited liability company for private practice.
17/05/2021	Stuart Martin Hackwell	Integrated Locality Group Director for Rhondda/Taf Ely	1) Spouse Partner of Taff's Well Medical Centre GP Practice	1) 18 years	CTM contract the practice for Primary Care services via a GMS contract
17/05/2021	Richard Johnson	Director of Acute Care/Consutlant Surgeon	1) Healbay Ltd. - ownership. 2) Spouse - Healby Ltd. 3) Trustee, Ogmore Commers Association. 4) Trustee, Endeavour Charity Bridgend.	1) 15 years 2) 15 years 3) 20 years 4) 3 years	1) To manage private practice income. 2) To manage private practice income. 3) Nil 4) Nil.
17/05/2021	David Huw Davis	CSGL SACT Consultant Anaesthetists	1) Director, H&J Medical Ltd. 2) Fisher-Pykel. Undertaken in own time, or annual leave if taken in working time. 3) Baxter Healthcare. Undertaken in own time, annual leave if taken in working time.	1) 2010 2) 2020 3) 2020-2021	1) Annual dividend. 2) Honorarium for panel member. 3) Honorarium for presenting at IFAD/FOAM2020.
17/05/2021	Gareth MacGillivray Brown	Consultant	1) Director of Gareth Brown Urology Ltd., Private Limited company. 2) Spouse - Director of Gareth Brown Urology Ltd.	1) 2019	1) Nil 2) Nil
14/05/2021	Samuel Fishpool	ENT Consultant	Director, Oxford Medical Innovations Ltd.	Since 11 February 2018	N/A
14/05/2021	Angela Davies	Primary Care Therapist	I offer private counselling appointments in the evenings. I rent a room from counselling service in Bridgend.	2-3 evenings per week, maximum of 4 hours per week.	Payment from each client is taken depending on the service offered, ie psychotherapy or EMDR. I have an accountant who handles all relevant tax returns on my behalf.
14/05/2021	David Rees Price	Consultant Anaesthetist/Clinical Service Director for Anaesthetics/Theatres for M&C ILG	Local Authority Appointed School Governor, Durand Primary School, Caldicott, Monmouthshire	2018 to present.	None
14/05/2021	Eugene Tabiowo	Consultant in Acute Medicine	Secretary to Focused Acute Medicine Ultrasound (FAMUS) committee group	Since 2018 to date.	Nil

Created	Full Name	Position	Declarations	Period of Involvement	Financial Benefits/In Kind
13/05/2021	Paul Mears	Chief Executive Officer	1) Drake Consultancy Services Directorship. 2) Owner of Drake Consultancy - previous company is no longer operating as company is dormant.	1) May 2018 to present. 2) May 2018 to present.	1) Previous consultancy now dormant. 2) Nil.
13/05/2021	Jayne Sadgrove	Independent Member University	1) Senior Professional Fellow, Cardiff University. 2) Director, Cardiff Union Services Ltd. 3) Trustee and Vice Chair of Board, Cardiff University Students Union. 4) Trustee, The Escape Route. 5) Lay Member, Advisory Committee for magisterial appointments. 6) Son is employee of Cardiff University School of Healthcare Sciences. 7) Spouse: Director and CEO, Home Study Courses Ltd., 8) Spouse: Owner, Home Study Courses Ltd.	1) May 2019 ongoing. 2) June 2019 ongoing. 3) June 2019 ongoing. 4) 2012 ongoing. 5) 2019 ongoing. 6) 1995 ongoing. 7) 1995 ongoing.	1 - 5 Nil 6) CEO's salary.
13/05/2021	Andrea Croft	Senior ANP Anticoagulation	1) Trustee, Thrombosis UK.	10 years	Nil
13/05/2021	Omar Alex Pemberton	Consultant anaesthetist	Member of Council of Society of Anaesthetists of Wales (previously Honorary Secretary 2013-2019).	October 2019 to present	Nil.
13/05/2021	Rosalind Oliver	Salaried PCSU GP	1) Self employed management consultant (though mostly for churches). 2) Consultant governor for SE Wales Regional Education Consortium. 3) Elder of City Church Cardiff, Chair of School Governors, LLandaff City Church in Wales primary school.	1) 2019 to present 2) 2020 to present 3) 2010	1) None for CTM 2) None for CTM 3) None - voluntary
13/05/2021	Janet Mary Gilbertson	Head of Clinical Education	1) Company Director, Mosaic Leadership Ltd. 2) 25% ownership share Mosaic Leadership Ltd.	1) 17.11.2020 2) 17.11.2020	1)Company is currently dormant. As soon as trading commences I will update. 2) Company is currently dormant.
13/05/2021	Gareth Robinson	Chief Interim Officer	Non Executive Director for Queen Alexandria College, Harborne.	3 years	Nil.
13/05/2021	Avril Tucker	Pharmacy Team Leader	Standing committee member of the NICE 'Management of Common Infections' Prescribing Guidelines Committee	December 2016 ongoing	Nil.
12/05/2021	Marcus Longley	Chair	Board Member, Professional Standards Authority for Health & Social Care.	May 2017 Duration of role extended to May 2025.	The PSA role is remunerated as a Public appointment.
12/05/2021	David Grant Williams	Advanced Clinical Practitioner	1) Co-Director of Trauma Nursing Limited. 2) Independent expert witness providing advice to the course in matters of criminal/civil negligence in respect of Emergency Nursing. 3) Consultancy and educational provision to other NHS Trusts in UK	1) 2002 to present. 2) 1995 to present. 3) 2002 to present.	1) Not for profit organisation involved with disseminating trauma education to nurses around the UK and Eire. In directing and co-ordinating courses in Bridgend, we receive 2 free places for ED nursing staff to undertake the course. 2) Fees are paid for my expert opinion in accordance with the Civil Procedure Rules and contractual arrangements with instructing firms of solicitors. I have my own personal insurance for this work. 3) Occasionally undertake private consultancy/teaching to NHS Trusts in the UK in respect of emergency care and end of life care.
12/05/2021	Leslie Robert Ala	Consultant Acute Physician	1) School Governor. 2) Independent Professional Advisor in Medicine for Public Service Ombudsman of Wales.	1) Since 2018. 2) Since 2018	1) Voluntary no pay. 2) Sessional pay.
12/05/2021	Gareth Jordan	Clinical Director Primary care and Localities	1) Training Programme Director GP Training HEIW, Gwent and South Powys Scheme.	1) Since February 2020 onwards.	1) Salaried role for HEIW.
12/05/2021	Majd Al Shamaa	Consultant	Case Manager/Student Advisor, My Medic, Cardiff University School of Medicine Institute of Medical Education, College of Biomedical and Life Sciences.	Since 2012	Voluntary.
12/05/2021	Marc Penny	Director of Improvement	Company Director - Marc Penny Consultancy Ltd.	3 years	Dividend.
12/05/2021	Brian Hawkins	Chief Pharmacist Medicines governance	Adviser to Health ombudsman for Wales	Commenced 2016	Payment received for report undertaken in 2017.
12/05/2021	Sian Mary Lewis	Dietetic Operational Lead	External Examiner for Cardiff Metropolitan University for MSc Dietetics & MSc Advanced Dietetic Practice.	2019 to present.	Pre paid for work undertaken in own time.
12/05/2021	Shawn Halpin	Locum Consultant Neuroradiologist	1) Cardiff Neuroradiology Ltd. 2) Spouse/Partner/Family Member - Cardiff Neuroradiology Ltd.	10 Years. 10 years.	Private Medical Income.

Created	Full Name	Position	Declarations	Period of Involvement	Financial Benefits/In Kind
12/05/2021	Suzanne Scott-Thomas	Clinical Director and Head of Medicines management	1) Chair of Royal Pharmaceutical Society Welsh pharmacy Board. 2) Director Coedrath caravan Park Ltd. 3) Sister is professor and Director of Dementia Research Unit Cardiff University	1) 6 years. 2) 7 years.	1) Nil. 2) Nil.
12/05/2021	John Geen	Consultant Clinical Scientist and Assistant Director for Research & Development	1) Visiting Professor of Clinical Science, University of South Wales 2) Honorary Professor of Clinical Biochemistry, Cardiff Metropolitan University,	1) 2012 to present. 2) 2019 to present.	1) Nil. 2) Nil.
12/05/2021	Lisa Curtis-Jones	Associate Member	Statutory Directors of Social Services (Chief Officer) in Merthyr Tydfil.	April 2016 ongoing	ICT/Transformation funding to Local Authorities through the Regional Partnership Board.
12/05/2021	Rachel Criddle	Macmillan Clinical Psychologist	1) Private practice (psychological therapy) at R & R Consulting Centres in Cardiff. I do not see patients or staff from the Cwm Taf Morgannwg UHB area to avoid a potential conflict of interest.	2 hours a week, 2 clients - 1 hour each.	1) Fee for therapy from client.
12/05/2021	Tom Powell	Innovation Manager	Director: Healthcare Diagnostic Solution Ltd.	Since 2015	N/A
11/05/2021	Mel Jehu	Independent Member Community	1) Independent Member (Vice Chair) South Wales Police Crime Panel. 2) Chair (Standards Committee) Rhondda Cynon Taff Council. 3) Trustee, Cancer Aid, Merthyr Tydfil. 4) Trustee, Safe Merthyr Tydfil. 5) Trustee Standards Committee, South West Wales Fire Service. 6) Wife is employed in CTMUHB in a part time trole as Lymphoedema Nurse since 2012 and prior to that Breast Care Specialist Nurse.	1) 2012 to date. 2) 2012 to date. 3) 2010 to date. 4) 2008 to date. 5) 2014 to date.	1) Attendance fee. 2) Attendance fee. 3) Voluntary no financial gain 4) Voluntary no financial gain. 5) Attendance fee.
11/05/2021	Valerie Joan Wilson	Director of Midwifery, Gynaecology and Integrated Sexual Health	1) Director of Limited Company. 2) Spouse - Director of Limited Company.	1) 2013 to date. 2) 2016 to date.	1 & 2) Nil in last financial year and to date in current.
11/05/2021	Duncan Thain	Pharmacist Team Leader - Quality Assurance	1) Viking Therapeutics 2) Abbvie Pharmaceuticals 3) Spectrum Pharmaceuticals	1) 4 years. 2) 2 years. 3) 7 months	Shares
11/05/2021	Rhys Roberts	Lead Nurse	1) My wife is an employee of Malinko Health Care Solutions Ltd and operates as an Implementation Consultant for their scheduling software tool. CTMUHB has procured this software for use within the District Nursing service. Whilst I lead on Malinko implementation and use within the DN Service, I am not involved in any promotional or contractual dealings with the company as a result of this conflict of interests.	1) Wife has worked for Malinko for approx 1 year.	1) CTMUHB procure the Malinko tool for use within the DN service.
11/05/2021	Hayley Pugh	Deputy Manager for Primary Care/Programme Manager for prison healthcare	Treasurer for Waun Wen Lyndsey Leg Club	2 years	None
11/05/2021	Anthony Cadogan	Pharmacist Team Leader	Wife is a Consultant Physician at CAVUHB	N/A	N/A
11/05/2021	Zoe Brewster	Assistant Head of Physiotherapy	Sister is an OT in CTMUHB	N/A	N/A
11/05/2021	Grant Williams	Advanced Clinical Practitioner (Emergency Medicine)	1) Co-director of Trauma Nursing Ltd. 2) Independent expert witness providing advice to the course matters of criminal/civil negligence in respect of Emergency nursing. This is outside my contract of employment and I decline instructions if there is a conflict of interest. 3) Consultancy and educational provision to other NHS Trusts in UK. I occasionally undertake private consultancy/teaching at NHS Trusts in the UK in respect of emergency care and end of life care.	1) 2002 to present. 2) 1995 to present. 3) From 2002 to present.	This is a not-for profit organisation involved with disseminating trauma education to nurses around the UK and Eire. In directing an coordinating course in Bridgend, we receive 2 free places for ED nursing staff to undertake the course. 2) Fees are paid for expert opinion in accordance with the Civil Procedure Rules and contractual arrangements with instruction firms of solicitors. I have my own personal indemnity insurance for this work. 3) This is a private contractual arrangement with fees dependent upon the work involved and travel expenses.
11/05/2021	Nick Lyons	Medical Director	Wife works as a Respiratory Physiotherapist at Royal Glamorgan Hospital.	N/A	N/A
10/05/2021	Fiona Jenkins	Executive Director Therapies & Health Sciences (Interim)	Executive Director of Therapies and Health Sciences, Cardiff & Vale University Health Board.	2019 to date	Salaried.
10/05/2021	Kelechi Nnoaham	Executive Director of Public Health	1) Wife is employed by Cwm Taf Morgannwg University Health Board. 2) Honorary Professorship in Public Health with Plymouth University. 3) Honorary Professorship in Public Health with Cardiff University.	2) March 2014 to date. 3) February 2021 to January 2026.	Nil.
08/05/2021	David Pemberton	Consultant in Trauma & Orthopaedics	1) Director/Shareholder, Quality of Life Ltd. (make waterproof cast coverings). No link with the Trust or anyone. 2) MAC, Chair of Nuffield Cardiff & Vale.	1) Over 5 years 2) Over 7 years	1) Nil. Not make a profit since insurrection. 2) Nil.

Declarations of Interest Received 1st April 2021 - 28th June 2021

Created	Full Name	Position	Declarations	Period of Involvement	Financial Benefits/In Kind
29/04/2021	Bethan Phillips	Consultant Clinical Psychologist	1) Private Psychological Therapy Practice. 2) Governor, Ysgol Mynydd Bychan.	1) 2010 2) April 2021	Nil.
29/04/2021	Bethan Jones	Psychological Wellbeing Practitioner	I volunteer for Shout, which is a charity that runs a text crisis service. My role involves supporting texters in crisis using an alias.	4 months ongoing.	None voluntary
13/04/2021	Kay Henry	Staff Nurse	I will be carrying out Microsclerotherapy and Desobody , Desoface. The company name will be Khaeshetics.	May 2021 - 2 days per month privately	Yes.

Received	Name	Position
05/05/2021	Dr Iyad Al-Muzaffar	Consultant Neonatal Paediatrician
11/05/2021	Alexandra Marie Thomas	Virology Operational Manager
11/05/2021	Steffan Gwynne	Deputy Clinical Service Group Manager
11/05/2021	Phil Walters	Head of ICT Programme & Projects
11/05/2021	Stewart John Duncan	Deputy Clinical Service Group Manager - Surgery, Anaesthetics, Critical Care, Theatres
11/05/2021	Bethan Jayne Thomas	Pharmacist
11/05/2021	Philip Stephen Lewis	Head of Nursing
11/05/2021	Andrew John Francis	Civil Contingencies and Business Continuity Manager
11/05/2021	Donna Seldon	Senior Nurse ED
11/05/2021	Stuart Williams	Improvement Manager
11/05/2021	Mike Davies	Clinical Co-ordinator T&O
11/05/2021	Martin Davies	Head of Pharmacy Community and Integrated Services
11/05/2021	Paul Harrison	Head of workforce Productivity and eSystems
11/05/2021	Rachael Gdesis-Evans	Principal Occupational Therapist
11/05/2021	Sian Jenkins	Assistant Finance Director
11/05/2021	Chris Ball	Head of ICT Infrastructure
11/05/2021	Sue Holroyd	Assistant Director of Finance - M&C ILG
11/05/2021	Marie Evans	Head of Planning and Commissioning Adulthood System Group
11/05/2021	Chrystelle Walters	Senior Nurse
11/05/2021	Cally Hamblyn	Assistant Director of Governance & Risk
11/05/2021	Amanda Powell	Clinical Services Group Manager Medicine
11/05/2021	Kellie Jenkins-Forrester	Once for Wales Project Manager
11/05/2021	Martine Randall	Head of Urgent Primary Care
11/05/2021	Stuart Baines	Clinical specialist Radiographer
11/05/2021	Alison Lagier	Community Service Group Manager
11/05/2021	Collette Jones	Superintendent Radiographer
11/05/2021	Aaron Jones	Senior Performance & Quality Manager
11/05/2021	Fiona Wood	Head of Nursing
11/05/2021	Kathryn Greaves	Head of Midwifery, Gynaecology and Integrated Sexual Health MC ILG
11/05/2021	Clare Wright	Strategic Lead for Employee Wellbeing and Experience
11/05/2021	Gail Clack	Interim Head of Nursing CYP/CAMHS
11/05/2021	Richard James Knowles	Regional Facilities Manager - Bridgend
11/05/2021	Bronwyn Baldwin	Deputy Directorate Manager
11/05/2021	Gavin Evan Owen	Clinical Service Group Manager - Surgery, Anaesthetics, Critical Care, Theatres
11/05/2021	Kimberly Dunn	Primary Care Manager
11/05/2021	Paul Crank	Team Leader - Community Vaccination
12/05/2021	Claire Northwell	Head of Information Governance/DPO
12/05/2021	Fran Hipkiss	Senior Nurse

Received	Name	Position
12/05/2021	Julie Ann Welling	Interim Senior Nurse Merthyr & Cynon ILG
12/05/2021	Stephen James	National Workforce Lead 111/UPC Programme
12/05/2021	Deborah Harris	Head of Nursing
12/05/2021	Cath Granelli	Senior Nurse
12/05/2021	Paul Chilcott	Head of Server Management
12/05/2021	Bernard Michael Carter	Senior Projects Manager
12/05/2021	Michelle Hurley-Tyers	Assistant Director of OD & Wellbeing
12/05/2021	Rhian Searle	Senior Nurse
12/05/2021	Paul Edward Jones	Engineering Manager
12/05/2021	Anna Louise Cartlidge- Llewellyn	Senior Nurse for Surgery
12/05/2021	Marc Phillips	Superintendent Radiographer
12/05/2021	Elizabeth Jenkins	EDI Manager
12/05/2021	Janet Louise Bevan	Principal Occupational Therapist
12/05/2021	Amanda Jayne Smith	Nurse Colposcopist
12/05/2021	Hugh Pascoe	Cardiac Physiologist
12/05/2021	Pauline Griffiths	Senior Nurse
12/05/2021	Claire Masters	Facilities Business Manger
12/05/2021	Jennifer Torkington	Cardio-Respiratory
12/05/2021	Richard Haydn Lewis	Chief Cardiac Physiologist
12/05/2021	Rose-Marie Louise Cavill	Head of Capital
12/05/2021	Sarah Long	Cluster Pharmacist
12/05/2021	Richard Davies	Clinical Haematology Service Manager
12/05/2021	Chris Urquhart	Deputy Head of Workforce & OD
12/05/2021	Jo lines	Lead nurse
12/05/2021	Hilary Mott	Assistant Head of Physiotherapy
12/05/2021	Kim Christine Palmer	Senior Clinical Nurse Specialist Eating Disorders Band 8a
12/05/2021	Suzanne Priest	Clinical Service Group Manager
12/05/2021	Lee Leyshon	Assistant Director Engagement and Communications
12/05/2021	Paul Johnston	Superintendent Radiographer
12/05/2021	Joanne Santos-Matthews	Principal Occupational Therapist
12/05/2021	Jeff Chard	Linen Services Manager
12/05/2021	Tim Burns	Assistant Director - Capital and Estates
12/05/2021	Rhian Beynon	Research and Development Manager
12/05/2021	Catherine Hinkin	Senior Nurse
12/05/2021	Rachel Hannah Heycock	Multi-disciplinary Quality Improvement Manager
12/05/2021	Georgina Dawn Southam	Finance Manager - Systems
12/05/2021	David Jones	Consultant Intensivist
12/05/2021	Iyad Al-Muzaffar	Consultant neonatal Paediatrician

Received	Name	Position
12/05/2021	Sara de Vries	Consultant pathologist
12/05/2021	Angela Bell	Interim Assistant Director of Therapies and Health Science
12/05/2021	Catharina Hermina Maria Bisseling	Consultant
12/05/2021	Natalie Potter	Therapies Covid rehab hub strategic lead/Macmillan clinical specialist dietitian.
12/05/2021	Richard Hugh Jones	Consultant Anaesthetist
12/05/2021	Rani Nagrani	Consultant Gynaecologist
12/05/2021	Caren Hobrough-Harris	Echo Service manager
12/05/2021	Stacey James	Dietetic Operational Lead
12/05/2021	Irina cozma	Specialty Doctor Ophthalmology
12/05/2021	Ruth Williams	Respiratory Consultant
12/05/2021	Dr Charles L Thomas	Consultant Dermatologist
12/05/2021	Anna Lewis	Respiratory Consultant
12/05/2021	Dr Gautam Das	Consultant Physician and Endocrinologist
12/05/2021	Dr Vikram Sinha	Consultant Anaesthetist
12/05/2021	Jason Butcher	Consultant Anaesthetist
12/05/2021	Lisa A Williams	Consultant Trauma and Orthopaedic Surgeon
12/05/2021	Madelaine Ann Nina Najjar	Deputy Head of Service
12/05/2021	Dr Rachel Ann Hooper	Speciality Doctor Dermatology
12/05/2021	Alice Reed	Head of Nutrition & Dietetics
12/05/2021	Mark Deacon	Head of Orthoptics & Optometry Services
12/05/2021	William Rogers	Programme Director PCH
12/05/2021	Tammy Payne	Blood Transfusion Service Manager
12/05/2021	Rhian Rhys	Consultant Radiologist
12/05/2021	Robert Hugh Slade	Finance Manager
12/05/2021	Neeta Tailor	Consultant Anaesthetist
12/05/2021	Philip Evans	Consultant Physician
12/05/2021	Emily Payne	Paediatric consultant
13/05/2021	Ben Durham	Lead Nurse For Professional Practice and Quality Assurance
13/05/2021	Jeremy Morgan Holifield	Responsible Officer for Prince Charles Hospital Construction Programme
13/05/2021	Pathi Venkat Raja Rao	Special Doctor - Trauma & Orthop
13/05/2021	Jeyashree Natarajan	Consultant Paediatrician
13/05/2021	Emma Brierley	Lead specialist pharmacist
13/05/2021	Bev Woods	Pharmacist
13/05/2021	christina Morgan	Senior Nurse
13/05/2021	Rachel Hood	Specialty Doctor
13/05/2021	Richard Thomas	Head of Informatics
14/05/2021	Ceri Wilson	Senior Nurse
14/05/2021	Karen Wright	Clinical Lead Physiotherapist

Received	Name	Position
14/05/2021	Gillian Timm	Pharmacy team Leader education and training
14/05/2021	Vanessa Hayward	Head of Speech & Language Therapy
14/05/2021	Nader Naguib	Consultant
14/05/2021	Latha Srinivasa	Consultant Anaesthetist
14/05/2021	James Robert Chambers	Primary Care and Community Estate Development Manager
14/05/2021	Elizabeth Johnson	Band7/8a Radiographer
14/05/2021	Brian Jenkins	Anaesthetics Consultant
15/05/2021	Jasmeet Sethi	Senior Clinical Fellow
16/05/2021	Judith Chidgey	SLT Professional Manager
17/05/2021	Sali Curtis	Professional Manager for Adult Speech & Language Therapy
17/05/2021	Sharon Donovan	Superintendent Radiographer/Site Manager in Radiology
17/05/2021	Charlotte Pearce	Pharmacist
17/05/2021	Sally Ann Price	Consultant Physician
17/05/2021	Dr Damien Cremin	Consultant Anaesthetist
17/05/2021	Philip Brumwell	Consultant Pathologist; Clinical Service Director - Pathology
17/05/2021	Paula Claire Williams	Consultant Cardiologist
17/05/2021	Shenehnoor Tarique	Consultant General Internal Medicine and Respiratory Medicine
17/05/2021	Tarek Saleh	Consultant Anaesthetist
17/05/2021	Sunil Joseph	Consultant Psychiatrist
17/05/2021	John Richard Jones	Senior Dentist/Educational Supervisor
17/05/2021	Rachel Owen	Lead Nurse Unscheduled Care
18/05/2021	Dinah Jones	CDS Manager
18/05/2021	Humphrey Okuonghae	Consultant Paediatrician
18/05/2021	Bronwyn Sheila Roane	Principal Occupational Therapist for Children and Young People
18/05/2021	Sarah Lewis-Simms	Deputy Head Occupational Therapist
18/05/2021	Katie Innes	Interim Clinical Service Group Manager
18/05/2021	Nichola Elliott	Administrative Officer
18/05/2021	Clare Price	Departmental Clerical Officer
18/05/2021	Osama Hussein	Consultant radiologist
19/05/2021	Julie Hays	Lead ANP
19/05/2021	Gary Sullivan	Locum Consultant Psychiatrist
19/05/2021	Cheryl Hucker	Head of Quality and Safety
19/05/2021	Cher Thomas	Pharmacist
19/05/2021	Nia Meleri Morris	CAMHS Consultant Psychiatrist
19/05/2021	Dr Gareth David	Paediatric Clinical Psychologist
19/05/2021	Sophie Haddon	Pharmacist
20/05/2021	Vonda Price	Pelvic Health Physiotherapist
20/05/2021	Caitlin Kristina Ebbehoj	Pelvic Health Physiotherapist

Received	Name	Position
20/05/2021	Catrin Mair Bowen	Physiotherapist
20/05/2021	Meryl Wiltshire	Senior Nurse
20/05/2021	Melanie Marchetti	Senior Nurse
20/05/2021	Paul Neill	Respiratory Physician
20/05/2021	Fiona Thomas	Clinical Service Group Manager Mental Health
20/05/2021	suzanne Marie Rees	Senior Nurse Sexual Health and Community Gynaecology
24/05/2021	Owen James	Head of Corporate Finance
24/05/2021	Claire Collins	Clinical Lead Pharmacist YM@H team
24/05/2021	Deborah Cairns	Consultant
24/05/2021	Martin Keith Smart	Consultant Oral Surgeon
24/05/2021	Kath McGrath	Assistant Director of USC - NCCU
24/05/2021	Hywel Daniel	Executive Director of People
26/05/2021	stephanie O'Neill	Mental health nurse- single point of access
26/05/2021	Harry Hunt	Clinical Director
26/05/2021	Laura Parry	Mental Health Nurse Practitioner
26/05/2021	Deborah Matthews	Head of Nursing
27/05/2021	Bethan Morris	Physiotherapist
27/05/2021	Azelle Gerry	Senior Nurse Vaccinations and Immunisations
28/05/2021	Laura Bevan	Team Lead Physiotherapist
28/05/2021	Victoria Hover	physiotherapist
28/05/2021	Aideen Evans	Physiotherapy Clinical Lead for Primary Care
28/05/2021	Sian McCarthy	Clinical Specialist Physiotherapist
28/05/2021	Craig Lewis	Physiotherapist
28/05/2021	Senarath Gamage	Physiotherapist
28/05/2021	Senarath Gamage	Physiotherapist
28/05/2021	Owen Tomos Jones	Physiotherapist
01/06/2021	Lynne Millar-Jones	Consultant
02/06/2021	Catherine Roberts	Director of Operations
04/06/2021	Christine Dowle	Speech & Language Therapist
05/06/2021	Debbie Ruth Davies	Head of Physiotherapy Services
07/06/2021	Dolina Morris	Professional Manager Paediatric Physiotherapy
07/06/2021	Rebecca Goode	Executive Business Manager
09/06/2021	Clare Williams	Executive Director of Planning & Performance (Interim)
14/06/2021	Cheryl Davies	Deputy Head of Nursing Unscheduled Care
17/06/2021	Poonamallee Govindaraj	Consultant Paediatrician
24/06/2021	Eleanor Morris	Consultant Radiologist

Appendix 3 – Gifts, Sponsorship, Hospitality and Honoraria Register – Period 1 April 2021 – 28 June 2021

Date Submitted	Name	Designation/ Department	Department	Provided by / From	Date Received	Details	Reason	Gift, Hospitality and/or Sponsorship	Accepted or declined
15/04/21	Lorraine Davies	Cwm Taff Morgannwg- Wound Clinic	Cwm Taff Morgannwg- Wound Clinic	Patient	14/4/21	Thank you card handed to a member of staff and was not opened until later when it was realized that £50 in cash was inside. Contact was made with the patient to thank them for the generous gift and advise the position on acceptance of cash. The patient advised that she was unable to get out to buy a thank you gift and stressed that she would like the money to be used to buy teas and coffee etc for the clinic team. Advice was sought from Corporate Governance and the Finance Team where it was agreed that the £50 will be taken into Maesteg Hospital & will be credited to the Maesteg General Purpose Fund & detailed for the wound clinic etc to use as per the patients wishes.	See Details Column	£50 cash	**Accepted**

AGENDA ITEM
2.2.4

AUDIT & RISK COMMITTEE

CTMUHB ISO14001 EXTERNAL AUDIT REPORT

Date of meeting	17/08/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	David Williams, Facilities Governance & Compliance Manager
Presented by	Russell Hoare, Assistant Director OSS (Facilities)
Approving Executive Sponsor	Chief Operating Officer
Report purpose	FOR NOTING

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

ACRONYMS	
EMS	Environmental Management System
CTMUHB	Cwm Taf Morgannwg University Health Board

1. SITUATION/BACKGROUND

1.1 ISO 14001:2015 is the international environmental standard that specifies requirements for controlling those aspects of an organisation that have a significant impact on the environment, through an effective Environmental Management System (EMS). It is a requirement of Welsh Government that all Health Boards in Wales are accredited to ISO 14001:2015. The accreditation is on a three

year cycle with surveillance audits every year for Cwm Taf Morgannwg University Health Board (CTMUHB) to ensure that we maintain compliance.

1.2 In July 2021, CTMUHB had its final surveillance audit of the three year cycle. Following completion of the audit, CTMUHB has successfully retained the ISO 14001:2015 accreditation for all healthcare sites, with two minor non-conformities raised.

1.3 The attached ISO14001 external audit report and accompanying cover report highlight this result and provide further details of the audit findings for the committee to note.

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

2.1 Following completion of the audit, CTMUHB has successfully retained the ISO 14001:2015 accreditation for all healthcare sites, with two minor non-conformities raised. Details of these minor non-conformities, together with actions, target dates and progress to mitigate are provided below.

Source	Type	Summary of Non Conformance	Action	Responsibility	Target Date	Closed Date	Status	Progress to mitigate
Ext Audit	Minor	7.5 - EMS Document Control Log. The EMS Document control log has not been maintained in full. Log is currently at Version 5 for the OCP (Operating Control Procedures) and the Operating Control. Procedure is at Version 7 verified by log entry and hard copy procedure. Documented information required by the environmental management system shall be controlled to ensure control of changes.	Review Document Control Log and update to correct version if applicable	Governance & Compliance Manager	04/07/2022 (By next external audit)		Partially closed	Immediate Action - Document Control Log reviewed and OCP version corrected during audit - Completed. Follow-Up Action - Undertake an internal audit of the Document Log to ensure all document versions are included and referenced correctly - Ongoing. (DW/RE 19/07/2021)
Ext Audit	Minor	8.1 - Operational Control, Prince Charles Hospital. During the Site Tour of external areas and Waste containers it was observed that litter and an unmarked plastic bottle containing fluid next to a surface water drain had not been cleared up. Unused paint pots were also observed not locked away in external lock up, stacked on the top of the lock up.	Maintain Schedule of litter picking activities as per PPM	Estates / Facilities / MCV ILG	04/07/2022 (By next external audit)		Partially closed	Immediate Action - Additional litter pick requested and undertaken during the audit - Completed. - Unmarked plastic bottle checked and liquid was water used by the waste team to wash hands. Estates Manager at PCH has agreed to install a hand sanitation station next to the temporary waste hold at PCH - Ongoing. - Used paint pots have been removed and disposed of, unused paint piots have now been locked away in the external lock-up. Also PCH Facilities / Estates corridor has

								been cleared of unused equipment during audit - Completed. Follow-Up Action - Maintain Schedule of litter picking activities as per PPM and ensure that the PPM incorporates all required areas on sites - Ongoing. - Look at potential of implementing a site inspection log that managers can use to note any issues and then raise via Estates and Facilities Help Desks - Ongoing. (DW/RE 19/07/2021)

2.2 Notable high points by the auditor at the audit de-brief were:

2.2.1 Continued very good performance and monitoring in energy and carbon reduction, sustainable travel and waste (recycling, clinical, food etc.).

2.2.2 The organisation has demonstrated awareness of all compliance and applicable legislation and have arrangements in place to monitor any amendments.

2.2.3 Raised once again that the teamwork and approach to EMS processes very good and ISO14001:2015 was found to be well embedded within the organisation at all levels.

2.2.4 Great to see the Sustainability agenda being taken forward at CTMUHB from an Executive level.

2.2.5 Internal Communications methods are in place and effective, and where they are received from interested parties they are reported, reviewed and investigated. Actions identified are suitably addressed and actioned within defined timescales.

2.2.6 Praise given to the environmental initiatives that have been implemented by CTMUHB (e.g. Continued roll-out of LED lighting, continued progress with EV fleet vehicle installation, grounds and gardens biodiversity initiatives such as 'no-mow areas', Central Production Unit and minimising food waste etc.). Recommended that this good work should be communicated more through the organisation communication streams where possible.

2.2.7 Good contractor control, maintenance and record keeping practices from Estates regarding FGas, boiler, legionella, air handling units etc.

2.2.8 Overall, staff provided tremendous support to the audit process, from acute sites to the smallest of health centre premises audited.

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

3.1 It is a requirement of Welsh Government for all Health Boards in Wales to achieve ISO14001:2015 accreditation for Environmental Management. The accreditation is on a three year cycle with surveillance audits every year for CTMUHB to ensure that we maintain compliance.

3.2 CTMUHB is one of the largest employers within the local area. In delivering our role as a health care provider we acknowledge our responsibility to maintain a high level of environmental performance, to conform to our compliance obligations and to set and fulfil our environmental objectives with an emphasis on continual improvement.

3.3 All staff and in particular all managers at all levels must be aware of and fully support our environmental responsibilities.

3.4 CTMUHB has successfully retained the ISO 14001:2015 accreditation for all healthcare sites, with two minor non-conformities raised to action and close by the next external audit (scheduled for July 2022). Details of these minor-non-conformities are included above.

3.5 By maintaining our certification to the ISO 14001:2015 environmental standard we can demonstrate and reaffirm the Health Board's commitment to minimise the impact of our activities upon the environment.

3.6 For more information visit the CTMUHB Environmental Hub on Sharepoint at http://ctuhb-intranet/dir/Facilities/Env/_layouts/15/start.aspx#/default.aspx

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)
	Report notifies the committee of ISO14001 audit result only, no EIA required.
Legal implications / impact	Yes (Include further detail below)

	It is a requirement of Welsh Government that all Health Boards in Wales are accredited to ISO 14001:2015.
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

5.1 The committee is requested to **NOTE** the result of the ISO14001:2015 audit and the findings within the accompanying audit report.

CERTIFICATION

AUDIT REPORT: CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

VISIT TYPE:	**SURVEILLANCE - 3**
CONTRACT NUMBER:	**GB/WW/231339**

BE THE BENCHMARK

EXECUTIVE SUMMARY
The audit was carried out partially on site and by remote auditing using the ICT tools indicated in the audit plan and the use of The audit was conducted using a process-based audit focusing on the organisations,aspects, risks and objectives required by the standard. A sampling process, was used based on the information available at the time of the audit. The audit methods used were interviews and reviews of documents and records. This was a V3 Surveillance audit that reviewed both management and operational activities for ISO 14001-2015. There were two non-conformances raised during the audit and a satisfactory corrective action plan was discussed. These are summarised within the report. The sites were generally of a high standard with excellent record and documented evidence provided. The Health Boards have challenging times and the EMS continues to improve and with the drive of the Sustainability agenda it will be interesting to see how this is integrated into the EMS at the next audit (Visit1 Re certification). The overall integration of the EMS across sites could me more consistent its approach to daily housekeeping inspections and EMS,communication methods. Good examples of this were viewed at the Princess of Wales site. Based upon the evidence viewed the auditor's recommendation is that certification is continued. Congratulations!

SGS DELIVERING OFFICE:	SGS United Kingdom Ltd.
ORGANIZATION NAME:	Cwm Taf Morgannwg University Health Board
HEAD OFFICE:	Prince Charles Hospital Mountain Ash, Merthyr Tydfil, CF47 9DT, United Kingdom
REPRESENTATIVE:	Russell Hoare

AUDIT CRITERIA			
STANDARD	**ACCREDITATION**	**ACCREDITED SGS OFFICE**	**NO. OF EFFECTIVE EMPLOYEES /STANDARD**
ISO 14001:2015	UKAS	SGS United Kingdom Ltd.	13035

CERTIFICATION SCOPE
The management of environmental aspects associated with the provision of healthcare and clinical services at the following sites: • Prince Charles Hospital • Royal Glamorgan Hospital • Community Hospitals, Health Centres & Clinics Rheoli agweddau amgylcheddol mewn perthynas â darparu gofal iechyd a gwasanaethau clinigol yn y safleoedd canlynol: • Ysbyty'r Tywysog Siarl • Ysbyty Brenhinol Morgannwg • Ysbytai cymunedol, canolfannau iechyd a clinigau

SITES COVERED BY CERTIFICATION SCOPE		
ADDRESS SITE 1	**NO. OF STAFF**	**NO. OF SHIFTS**
Aberfan Clinic Cotteral Street, Aberfan, CF48 4QU, United Kingdom	10	1
ADDRESS SITE 2	**NO. OF STAFF**	**NO. OF SHIFTS**
Ysbyty Cwm Rhondda , Partridge Road , Lwynypia, CF40 2LU, United Kingdom	600	1

ADDRESS SITE 3	NO. OF STAFF	NO. OF SHIFTS
Dewi Sant Hospital Albert Road, Pontypridd, CF37 1LB, United Kingdom	50	1
ADDRESS SITE 4	**NO. OF STAFF**	**NO. OF SHIFTS**
Pontypridd H.C. Bridge Street, Pontypridd, CF37 4PF, United Kingdom	15	1
ADDRESS SITE 5	**NO. OF STAFF**	**NO. OF SHIFTS**
Porth Dental Teaching Unit Leith House, Pontypridd Road, Porth, CF39 9PH, United Kingdom	30	1
ADDRESS SITE 6	**NO. OF STAFF**	**NO. OF SHIFTS**
Ystrad Clinic Trefalgar Terrace, Ystrad, CF41 7RG, United Kingdom	15	1
ADDRESS SITE 7	**NO. OF STAFF**	**NO. OF SHIFTS**
Princess of Wales Hospital Coity Road, Bridgend, CF31 1RQ , United Kingdom	2195	1
ADDRESS SITE 8	**NO. OF STAFF**	**NO. OF SHIFTS**
Royal Glamorgan Hospital Ynysmaerdy, Llantrisant, CF72 8XR, United Kingdom	3000	1
ADDRESS SITE 9	**NO. OF STAFF**	**NO. OF SHIFTS**
Ysbyty Cwm Cynon New Road, Mountain Ash, CF45 4BZ, United Kingdom	600	1
ADDRESS SITE 10	**NO. OF STAFF**	**NO. OF SHIFTS**
Tonypandy H.C. , DeWinton Field, CF40 2LE, United Kingdom	6	1
ADDRESS SITE 11	**NO. OF STAFF**	**NO. OF SHIFTS**
Hirwaun Medical Centre High Street, Aberdare, Hirwaun, CF44 9SL, United Kingdom	4	1
ADDRESS SITE 12	**NO. OF STAFF**	**NO. OF SHIFTS**
Central Processing Unit , Units 21-22, Caemawr Industrial Estate, Treorchy, CF42 6EJ, United Kingdom	50	1
ADDRESS SITE 13	**NO. OF STAFF**	**NO. OF SHIFTS**
Pine Wood House High Street, Treorchy, CF42 6AE, United Kingdom	20	1
ADDRESS SITE 14	**NO. OF STAFF**	**NO. OF SHIFTS**
Ynyswen Clinic Ynsywen Road, Treorchy, CF42 6ED, United Kingdom	15	1
ADDRESS SITE 15	**NO. OF STAFF**	**NO. OF SHIFTS**
Cwm Gwyrdd Medical Centre , High Street, Gilfach Goch, CF39 8TJ, United Kingdom	10	1

ADDRESS SITE 16	NO. OF STAFF	NO. OF SHIFTS
Rhondda Mental Health Clinical Day Services (Trealaw) Brynteg Terrace, Trealaw, CF40 2PD, United Kingdom	25	1
ADDRESS SITE 17	**NO. OF STAFF**	**NO. OF SHIFTS**
Ysbyty George Thomas Cwmparc Road, Treorchy, Rhondda, CF42 6YG, United Kingdom	300	1
ADDRESS SITE 18	**NO. OF STAFF**	**NO. OF SHIFTS**
Glanrhyd Hospital Tondu Road, Bridgend, CF31 4LN, United Kingdom	210	1
ADDRESS SITE 19	**NO. OF STAFF**	**NO. OF SHIFTS**
Aberdare Health Centre High Street, Aberdare, CF44 7DD, United Kingdom	10	1
ADDRESS SITE 20	**NO. OF STAFF**	**NO. OF SHIFTS**
Pontypridd & District Hospital Y Bwthyn, Hospital Road, Pontypridd, CF37 4AL, United Kingdom	25	1
ADDRESS SITE 21	**NO. OF STAFF**	**NO. OF SHIFTS**
Carnegie Clinic Brithwaunydd Road, Trealaw, CF40 2UH, United Kingdom	35	1
ADDRESS SITE 22	**NO. OF STAFF**	**NO. OF SHIFTS**
Treharris Primary Care Resource Centre Fox Street, Treharris, CF46 5HE, United Kingdom	10	1
ADDRESS SITE 23	**NO. OF STAFF**	**NO. OF SHIFTS**
Tonteg Church Road, Tonteg, Pontypridd, CF38 1HE, United Kingdom	50	1
ADDRESS SITE 24	**NO. OF STAFF**	**NO. OF SHIFTS**
Ynysmuerig House Unit 3 Navigation Park, Abercynon, CF45 4SN, United Kingdom	150	1
ADDRESS SITE 25	**NO. OF STAFF**	**NO. OF SHIFTS**
Pontypridd Mental Health Clinical Day Services (Maritime) Woodland Terrace, Maesycoed, Pontypridd, CF37 1DZ, United Kingdom	25	1
ADDRESS SITE 26	**NO. OF STAFF**	**NO. OF SHIFTS**
Dinas Isaf Industrial Estate West Williamstown, Rhondda, CF40 1PY, United Kingdom	50	1
ADDRESS SITE 27	**NO. OF STAFF**	**NO. OF SHIFTS**
Keir Hardy Health Park , Aberdare Road, Merthyr Tydfil, CF48 1BZ, United Kingdom	100	1

ADDRESS SITE 28	NO. OF STAFF	NO. OF SHIFTS
Ferndale Medical Centre High Street, Ferndale, CF43 4XX, United Kingdom	6	1
ADDRESS SITE 29	**NO. OF STAFF**	**NO. OF SHIFTS**
Maesteg Hospital Neath Road, Maesteg, CF34 9PW, United Kingdom	83	1
ADDRESS SITE 31	**NO. OF STAFF**	**NO. OF SHIFTS**
Tylorstown Surgery Ferndale Road, Tylerostown, CF43 3HB, United Kingdom	10	1
ADDRESS SITE 32	**NO. OF STAFF**	**NO. OF SHIFTS**
Llwyn-Yr-Eos Clinic Main Road, Church Village, Pontypridd, CF38 1RN, United Kingdom	10	1
ADDRESS SITE 33	**NO. OF STAFF**	**NO. OF SHIFTS**
Prince Charles Hospital Mountain Ash, Merthyr Tydfil, CF47 9DT, United Kingdom	3000	1
ADDRESS SITE 34	**NO. OF STAFF**	**NO. OF SHIFTS**
Linen Services , Heol Draw, Upper Church Village, Pontypridd, CF38 1UR, United Kingdom	90	1
ADDRESS SITE 35	**NO. OF STAFF**	**NO. OF SHIFTS**
Talbot Green H.C. , Heol-y-Gyffraith, Talbot Green, CF72 8AJ, United Kingdom	6	1

AUDIT TEAM COMPOSITION AND AUDIT INFORMATION	
AUDIT TEAM LEADER	Nick Johnson
ANY OTHER ACCOMPANYING PERSON (NAMES & ROLES)	None
AUDIT DATE(S)	19 Jul 2021

1. AUDIT OBJECTIVES

The objectives of this audit/visit are, for the scope of certification:

Determination of the conformity of the client's management system, or parts of it, with audit criteria;

Determination of the ability of the management system to ensure the client meets applicable statutory, regulatory and contractual requirements (NOTE: A management system certification audit is not a legal compliance audit.);

Determination of the effectiveness of the management system to ensure the client can reasonably expect to achieving its specified objectives;

As applicable, identification of areas for potential improvement of the management system.

CONSIDERATIONS:

The scope of the audit, dates and places where audit activities were conducted are identified in the audit plan (any changes are identified in the audit report).

This audit report contains a summary of the capability of the management system to meet applicable requirements and expected outcomes.

This report is confidential, and distribution is limited to the audit team, audit attendees, client representative, the SGS office and may be subject to Accreditation Body, Certification Scheme owners or any other Regulatory Body sampling in line with our online Privacy Statement which can be accessed at www.sgs.com/en/privacy-at-sgs.

Audits use a sampling process, based on the information available at the time of the audit. The audit methods shall include, but are not limited to, interviews, observation of activities and review of documentation and records.

2. SUMMARY AND CONCLUSIONS

CONCLUSIONS

The audit team recommends that, based on the results of this audit, the management system certification be :

Continued.

Continued certification is conditional to satisfactory processing of non conformities.

AUDIT SUMMARY

• The organization has demonstrated effective implementation of a management system and documentation that conforms with audit criteria.

• The management system is effective with regard to achieving the organization´s objectives and the intended results of the applicable standard(s).

Number of nonconformities identified:2 minor(s)

• Nonconformance was not identified at the previous audit.

• Certification scope is appropriate.

• Audit objectives have been fulfilled.

• Audit plan was followed.

• Audit programme is adequate.

• Any issues resolved.

N/A

3. PREVIOUS FINDINGS

The results of the last audit of this system have been reviewed, in particular to assure appropriate correction and corrective action has been implemented when non-conformities (or Stage 1 findings) were identified. When the management system has not adequately addressed non-conformity (or Stage 1 finding) identified during previous audit activities, the specific issue has been raised in the non-conformity section of this report.

4. NON-CONFORMITIES

NON-CONFORMITY	Nº 1 / 2	Minor	
PROCESS	Operational Control-Prince Charles	**DATE RAISED**	19 Jul 2021
STANDARD	ISO 14001:2015	**CLAUSE**	7.5.3
DESCRIPTION	The EMS Document control log has not been maintained in full. Log is currently at Version 5 for the OCP (Operating Control Procedures) and the Operating Control Procedure is at Version 7 verified by log entry and hard copy procedure.Documented information required by the environmental management system shall be controlled to ensure control of changes (e.g. version control).		

NON-CONFORMITY	Nº 2 / 2	Minor	
PROCESS	Operational Control-Prince Charles	**DATE RAISED**	19 Jul 2021
STANDARD	ISO 14001:2015	**CLAUSE**	8.1
DESCRIPTION	During the Site Tour of external areas and Waste containers it was observed that litter and an unmarked plastic bottle containing fluid next to a surface water drain had not been cleared up.Unused paint pots were also observed not locked away in external lock up stacked on the top of the lock up.		

FOR MINOR NON-CONFORMITIES Corrective Actions to address identified minor non-conformities including a cause analysis shall be documented on an action plan. Where actions are deemed to be satisfactory, they will be followed up at the next scheduled visit.	
Action plan reviewed by the Auditor and are satisfactory, To follow up at the next scheduled visit. (or)	☑
Send Action plan to SGS for review (within 90 days). To follow up at the next scheduled visit. (or)	☐
To follow at the next scheduled visit. No need to send action plan.	☐

Non-conformities detailed here shall be addressed through the organization's corrective action process, in accordance with the relevant corrective action requirements of the audit standard and shall include actions to analyse the cause of the non-conformity and prevent recurrence, and complete records maintained.

Deadlines indicated may need to be reduced when there is a more restrictive requirement, e.g. certificate expiry.

5. OBSERVATIONS AND IMPROVEMENT OPPORTUNITIES

Not applicable

6. SPECIFIC REQUIREMENTS

Any significant changes?

No

No changes since last audit which was delayed due to COVID

Are certification claims accurate and in accordance with SGS guidance and is the organisation effectively controlling the use of certification documents and marks?

Yes

7. AUDIT TRAILS

SITE 33		
PROCESS	**PROCESS OWNER**	**AUDITOR**
Context of the Organisation	D Williams	Nick Johnson
SUMMARY		
The organisation has determined their internal and external issues, their interested parties and their needs and expectations. The scope includes the applicability of the management system and the boundaries. the organisation has established, implemented, maintained and continually improved its management system.No change since last audit.		
PROCESS	**PROCESS OWNER**	**AUDITOR**
Aspects and Impacts	D Williams	Nick Johnson
SUMMARY		
All aspects and reasonably foreseeable hazards have been identified, with the aspects and consequential risks evaluated.Appropriate control measures are in place, together with suitable monitoring.		
PROCESS	**PROCESS OWNER**	**AUDITOR**
Internal Audit/Non Conformance and Corrective Action	D Williams	Nick Johnson
SUMMARY		
An audit programme is in place with audits conducted on time. The reports are completed satisfactorily showing objective evidence and impartiality.Spoke about continual improvement of the EMS with own departmental auditors being internally trained. Non Conformance and Corrective action monitored and actioned quickly.		
PROCESS	**PROCESS OWNER**	**AUDITOR**
Management Review	D Williams/R Hoare	Nick Johnson
SUMMARY		
The Management Review is carried out at defined intervals, is attended by Top Management and addresses all inputs and outputs of the standard viewed at previous audit.		
PROCESS	**PROCESS OWNER**	**AUDITOR**
Compliance Obligations and Evaluation	D Williams	Nick Johnson
SUMMARY		
The organisation has demonstrated awareness of all compliance and applicable legislation and have arrangements in place to monitor any amendments.Full evaluation of compliance takes place at periodic intervals and the results recorded with any actions identified.		
PROCESS	**PROCESS OWNER**	**AUDITOR**
Operational Control-Prince Charles	D Williams	Nick Johnson
SUMMARY		
Operational Control at the site was generally seen to be generally effective.It was noted that waste areas have been moved due to busy contractor works were being carried out and this has contributed to some housekeeping issues and risk of pollution to the environment-See NCR1.		
PROCESS	**PROCESS OWNER**	**AUDITOR**
Objectives	D Williams	Nick Johnson

PROCESS	PROCESS OWNER	AUDITOR
Objectives	D Williams	Nick Johnson
SUMMARY		
The organisation has in place measurable objectives, established for all functions and levels, with programmes and action plans that are being adhered to.		

PROCESS	PROCESS OWNER	AUDITOR
Communication/internal and external	D Williams	Nick Johnson
SUMMARY		
Internal Communications methods are in place and effective, and where they are received from interested parties they are reported, reviewed and investigated. Actions identified are suitably addressed and actioned within defined timescales.		

SITE 27		
PROCESS	**PROCESS OWNER**	**AUDITOR**
Operational Control and Key Processes-Kier Hardy	D Williams	Nick Johnson
SUMMARY		
Operational Control was seen to be effective at Kier Hardie with excellent housekeeping and and a sound knowledge of Waste Management processes internally and externally shown by Gaynor Davies.		

SITE 2		
PROCESS	**PROCESS OWNER**	**AUDITOR**
Operational Control-YCR Key Processes	D Williams	Nick Johnson
SUMMARY		
Operational Control was carried out remotely and records and documents were sent in good order and compliant. All records sampled and processes seen were found to effectively trained and controlled.		

SITE 12		
PROCESS	**PROCESS OWNER**	**AUDITOR**
Operational Control-Central Processing Unit	D Williams	Nick Johnson
SUMMARY		
Operational Control and Key Processes on site were seen to be very effective. CPU has an excellent standard and upkeep of minimal environmental impact.Process approach and Leadership and Commitment to initiatives to continually improve the EMS were sampled throughout.		

SITE 25		
PROCESS	**PROCESS OWNER**	**AUDITOR**
Operational Control-Pontyprydd-MHC	D Williams	Nick Johnson
SUMMARY		
Operational Control was seen to be effective at the site.The has low impact potential and everything including documentation and records sampled were compliant.One incident in 2018 showed EMS effective in controlling spillage and Emergency Preparedness.		

SITE 13		
PROCESS	**PROCESS OWNER**	**AUDITOR**
Operational Control-Pinewood House	D Williams	Nick Johnson
SUMMARY		
All areas sampled were effectively controlled in a low impact potential site.Awareness shown of maintenance schedule by estates during tour.All records of servicing obtained beforehand with no issues.		

SITE 7		
PROCESS	**PROCESS OWNER**	**AUDITOR**
Operational Control-Princess of Wales	Gareth Brown	Nick Johnson
SUMMARY		
Operational Control at the site was seen to be of excellent standard with areas of positive Biodiversity.The site has many good initiatives and is a fine example of how the EMS is continuing to improve.		

8. ADDITIONAL COMMENTS

Not applicable

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WHEN YOU NEED TO BE SURE

AUDIT & RISK COMMITTEE ACTION LOG
FOLLOWING MEETINGS HELD ON 9 JUNE 2021

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT August 2021
18/099	8/10/2018	Endoscopy JAG Accreditation	Closure report to be presented to a future meeting.	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	Interim Chief Operating Officer	**In progress** One of the key reasons for not obtaining JAG Accreditation related to capacity issues. A proposal looking to address the capacity issues has been submitted to Welsh Government. JAG were due to undertake a revisit again this year but have not been able to as a result of COVID. The other issue where JAG accreditation cannot be provided is associated with the ingress and egress and as such we do not have a definitive position from JAG. We are actively pursuing acquiring more capacity and are awaiting JAG dialogue in regard to the built environment, with a date yet to be received from JAG.
20/070	16/06/2020	Internal Audit Review – Princess of Wales Hospital Fire Safety – Follow Up Review	Executive Lead to be invited to attend a future meeting to discuss the content of the report. Committee Chair to consider the most appropriate time for a discussion to take place.	October 2020 **Revised to:** April 2021 Now October 2021	Director for People	**In progress** Fieldwork has now commenced. It is hoped that a report will be available for the October 2021 meeting of the Committee
4.2	13/04/2021	Internal Audit Review – IT Service Management	Position in relation to finding 8 to be reviewed and reported back to the Digital & Data Committee as to how widespread the systematic issues were and whether any learning needed to be shared across Wales.	July 2021	Director of Public Health	**In progress** This will be discussed and reviewed at the July meeting of the Digital & Data Committee
4.7	13/04/2021	Internal Audit Review – Governance Arrangements During Covid 19 Follow Up – Advisory Review	Closure report for the Gold, Silver, Bronze Command Decisions Log to be shared with Committee members if required.	June 2021	Director of Corporate Governance	**Completed** Closure report has now been shared with Committee colleagues.

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT August 2021
4.11	13/04/2021	Internal Audit Review – Prince Charles Hospital Technical Compliance	Explanation to be given in future management responses as to why a recommendation had been agreed and what action was to be taken, as opposed to simply stating 'agreed'.	June 2021	Executive Directors	**In progress** This will be taken forward by the Executive Directors
2.2.1	09/06/2021	Action Log	Action log to be placed on the main agenda for discussion at the next meeting	August 2021	Director of Corporate Governance	**Completed** Action log has now been placed on the main agenda for discussion
2.2.5	09/06/2021	CTMUHB ISO14001 External Audit Report	Thanks to be extended to Team for achieving the ISO14001 accreditation which was an excellent achievement.	June 2021	Chief Operating Officer	**Completed** The Committees thanks have been extended to members of the Facilities Team.
5.3	09/06/2021	Audit Wales: Audit of the Financial Statement (ISO 260) Report	The Committee's thanks to be extended to the Finance Team and Audit Wales colleagues for completing this complex piece of work.	June 2021	Director of Finance	**Completed** The Committee's thanks has been extended
6.1	09/06/2021	Internal Audit Progress Report	Completion date identified in the action log in relation to the Fire Safety Management Review to be aligned with the date identified within the report.	October 2021	Director of Corporate Governance	**In progress** Fieldwork has now commenced. It is hoped that a report will be available for the October 2021 meeting of the Committee
6.2	09/06/2021	Internal Audit Review – Targeted Intervention	Recommendation relating to the review of self-assessment trackers to be marked as completed on the Audit Tracker.	June 2021	Director of Corporate Governance	**Completed** Audit tracker has been updated
8.1	09/06/2021	Audit Recommendations Tracker	Review to be undertaken of the recommendations which had drifted and the recommendations in which responsibility had been placed on another department to action.	October 2021	Director of Corporate Governance	**In progress** Session booked in with ILGs in August to go through Audit Tracker. Improvement should therefore be realised in the subsequent report to the October Audit & Risk Committee meeting.
8.1	09/06/2021	Audit Recommendations Tracker	Chart to be developed which showed progress on each action against the original implementation date.	August 2021	Director of Corporate Governance	**Completed** Charts now included in the latest iteration of the report.
2.1 In Committee	09/06/2021	Medical Variable Pay – Summary of Authorised Breaches	Executive Team discussion to be held to determine the most appropriate environment in which scrutiny of this issue could be undertaken.	August 2021	Director of Corporate Governance/ Director of Finance	**In progress** Report continues to be presented to Audit & Risk Committee in the form of a closed report.

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee Internal Audit Progress Report

August 2021

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 Institute of Internal Auditors.

Acknowledgement

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit & Risk Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cwm Taf Morgannwg University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1 Introduction

1.1 This progress report provides the Audit & Risk Committee (the 'Committee') with the current position regarding the work undertaken by Internal Audit as at **9 August 2021**. 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 plans and any required updates.

2 Reports Issued

2.1 Since the June meeting of the Committee five reports have been finalised, three are in draft, and we have ongoing fieldwork in five areas.

2.2 Due to changes in executives, the pandemic, and the need for responses from a number of sources, we agreed with management that the single cancer pathway draft report that was issued in June should be taken to committee to provide members with sight of the matters identified. The finalised report with management responses will be brought to the next committee.

2.3 A summary of the reviews that have been reported is provided below in Table 1.

Table 1 – Summary of reports issued

Assignment	**Assurance rating**
Clinical audit 20/21	Reasonable
Facilities directorate (workforce arrangements) – follow up 20/21	Reasonable
Management of capital – Sunnyside Health& Wellbeing centre project	Reasonable
Single cancer pathway: data quality and integrity (Draft)	Limited
Mass vaccination programme	Substantial
WHSSC – Cancer and blood services	Substantial

3 Delivering the Plan

3.1 We have completed our programme of work for 2020/21 and have ongoing work for the 2021/22 plan. The detail of the scheduling and progress of the audit work is outlined in the assignment status schedule, which is included at Appendix A.

Table 2: Status of 2020/21 reviews

Assignment	Status	Assurance	Notes
Clinical audit	Final	Reasonable	-
Facilities directorate – workforce follow up	Final	Reasonable	-

Table 3: 2021/22 reviews – planned for Q1 and Q2

Assignment	Status	Assurance	Notes
Annual Governance Statement	Complete	N/A	No formal report.
Management of capital – Sunnyside Health& Wellbeing centre project	Final	Reasonable	-
Vaccinations	Final	Substantial	-
Single cancer pathway: data quality and integrity	Draft	Limited	Issued In draft 24.06.21. Due to change in executives and the number of people needing to give a response has taken longer than expected.
Fire safety management	Draft	Limited	Draft report issued 27.07.21
Integrated locality group (ILG)	Draft	Reasonable	Draft report issued 27.07.21
Welsh Language Act	WIP	-	-
Concerns	WIP	-	-

Assignment	Status	Assurance	Notes
CAMHS – follow up	WIP	-	This is the follow up of a limited assurance report that was issued in 2020/21. Focus is on the governance, risk and workforce recommendations made in our directorate review.
Bridgend transfer of IT	WIP	-	Fieldwork on going.
Continuing healthcare	WIP	-	Additional review requested by management.
Digital strategy	Planning	-	Brief has been agreed.
Recruitment and retention of staff	Planning	-	Held discussions with management. This will be an advisory review to support management with the implementation of its updated process.
Overtime and expenses	Planning	-	Had initial planning meeting 20.05.21.
Financial systems – budgetary control	Planning	-	Had planning meeting. Brief being drafted.
Innovation and improvement	Planning	-	Meeting with executive lead on 11.08.21
Implementation of the operating model	Planning	-	Have held initial discussion with executive lead.

Table 4: Status of hosted bodies 2021/22 reviews

Assignment	Status	Assurance	Planned Timing	Notes
WHSSC – Cancer & Blood services	Final	Substantial	-	-

Assignment	Status	Assurance	Planned Timing	Notes
EASC – governance	Planning	-	Q2	Brief agreed 09.08.21

Clinical audit

Internal Audit Report

Cwm Taf Morgannwg University Health Board

2020/21

June 2021

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference:	CTMU-2021-14
Report status:	Internal Audit Report
Fieldwork commencement:	9 April 2021
Fieldwork completion:	7 May 2021
Draft report issued:	21 May 2021 & 26 May 2021
Management response received:	4 June 2021
Final report issued:	11 June 2021
Auditors:	Lucy Jugessur, Internal Audit Manager Emma Samways, Deputy Head of Internal Audit
Executive sign off:	Nick Lyons, Medical Director
Distribution:	Dom Hurford, Interim Deputy Medical Director Mark Townsend, Head of Clinical Audit & Quality Informatics

	Natalie Morgan-Thomas, Deputy Head and lead Nurse for Clinical Effectiveness
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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1. Introduction and Background

Our review of Clinical Audit was completed in line with the 2020/21 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board'). The relevant lead for the review is the Medical Director.

The Healthcare Quality Improvement Partnership (HQIP) defines clinical audit as *"a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes."*

Its purpose is to engage all healthcare professionals in systematic evaluation of their clinical practice against standards and to support and encourage improvement in the quality of treatment and care. Additionally, it provides information for patients and the public on the quality of specific healthcare services being provided locally and nationally.

Each year the Health Board produces a Clinical Audit Forward Plan that sets out the national audits from the National Clinical Audit and Outcome Review Plan (NCAORP) in which they must participate. As stated in the annual plan, it is essential that these audits are treated as priorities and that appropriate resource is provided to support them. Clinical audit outcomes are an integral part of the Health Board's continuous improvement programme of work and assurance framework.

The clinical audit process within the Health Board operates on a tiered system:

- Tier 1– National audits – set out in the NCAORP
- Tier 2 – Organisation Priority audits – identified though incidents or Patient Safety Alerts
- Tier 3 & Tier 4 – local speciality clinical audits

In December 2019 the Health Board approved a number of funding bids aimed at strengthening the Clinical Audit and Quality Informatics department's ability to monitor compliance against the forward plan and improve data quality across all national audits. Funding was used to support a number of new posts, which have all been recruited to, and procure the Clinical Audit & NICE (National Institute for Health and Care Excellence) management system.

At the onset of the Covid-19 pandemic, Welsh Government advise was that all clinical audit data collection should be suspended to allow clinically qualified staff to be mobilised to the frontline. The Welsh Government later revised this guidance as they acknowledged that a blanket ban on all clinical audit work may have unintended consequences. The delayed 2020/21 plan has had one national audit removed and a national Covid-19 audit included. We understand that the clinical audit plan for 2021/22 will be taken to a committee for approval in the summer of 2021.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to Clinical Audit. Our review sought to provide assurance to the Health Board's Audit and Risk Committee that risk material to the system's objectives are managed appropriately.

The areas that the review sought to provide assurance on are:

Roles, Responsibilities and Resources

- There is a nominated lead clinician with responsibility for clinical audit across the whole organisation.
- Clinical leads for clinical audit and quality improvement are in place at an ILG level, with dedicated time for this activity.
- There are resources in place for the management and administration of the audit programme both at corporate and ILG levels.
- Relevant staff have been appropriately trained in both undertaking audits and the information governance requirements and in the use of the clinical audit system and using it to monitor data in real time.

Programme Planning

- There is a Health Board agreed approach to clinical audit that links to its strategic aims.
- There is a planned programme of clinical audit, which has been appropriately approved and in line with the Health Board's clinical audit approach.
- Arrangements are in place to engage clinicians, managers and service users/patients during the development of the programme, and to ensure Health Board priorities and risks are considered alongside national requirements.
- Audit proposals are registered, reviewed and approved in accordance with the Health Board's approach to ensure that each has clear improvement aims and objectives and a named lead responsible for delivery.
- Documented procedures are in place to ensure a consistent approach to clinical audit activity and achievement of the audit criteria.

Programme Delivery & Board Assurance

- Progress against the planned programme is reported and monitored effectively at both a corporate and ILG level, with use made of real time data from the system.
- Arrangements are in place to ensure that the outcomes of all planned audits are appropriately reported, providing assurance or identifying action where improvement is required.

- Arrangements are in place to ensure action is agreed and implemented, and improved outcomes achieved.
- Identified risks are given consideration as to where they are recorded and monitored.

3. Associated Risks

The risks considered in the review were as follows:

- Financial penalties are imposed on the Health Board where there are failed targets for 'must do' national audits.
- Clinical audit plan is not completed as resources are not available.
- Clinical issues materialise if risks are not identified due to monitoring and governance arrangements not being in place.
- Patient harm due to healthcare not meeting quality standards.
- Quality issues with service delivery not identified.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

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

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

Since our previous audit review in 2017/18, significant developments have taken place within the Clinical Audit Department that have contributed to a greatly improved control environment. Changes include the purchasing of a clinical audit & NICE compliance monitoring system (AMaT), the recruitment of additional staff, restructuring around the new Integrated Locality Group (ILG) model, and producing a Clinical Audit & Effectiveness Policy & Strategy.

Roll out of the AMaT system started in April 2020, with 2020/21 seen as a transition year. All clinical audits should be recorded on the AMaT system from April 2021. Despite the pandemic, some training has been provided to staff on the use of the AMaT system. However, we found that there are a considerable number of staff that are registered on the system, that have yet to be trained. Whilst the system appears intuitive, and a number of documented procedures are in place, training is likely to be needed for some of those already registered to use the system.

Roles and responsibilities in relation to clinical audit are clearly defined, with the Executive Medical Director having overall responsibility. A Deputy Assistant Medical Director for Clinical Audit was appointed in January 2021 to oversee the clinical audit and clinical effectiveness functions. There are Clinical Auditor Manager roles to provide direct support to the ILGs.

While there is a draft Clinical Audit & Effectiveness Policy & Strategy (the 'policy'), which has been used since April 2020, at the time of our fieldwork it had not been approved by the Audit & Risk Committee.

The Health Board Clinical Audit Forward Plan 2020/21 lists the tier 1 national and tier 2 priority audits. The plan identifies all of the clinical audit projects from the National Clinical Audit and Outcome Review Plan for 2020/21. All tier 3 and tier 4 clinician speciality audits form part of the ILG clinical audit programmes. These local audits are held electronically on the AMaT system to ensure consistency in the format and recording of the clinical audit data. Although there has been a Health Board wide plan and ILG plans in place for 2020/21, these plans had either not been approved at the start of the 2020/21 year, or at all. We understand that the impact of the pandemic on clinician time and relevant meetings being able to take place has had a direct impact on the approval of plans.

Similarly, the delay in setting up governance meetings within the new ILG structure and the lack of regular meetings due to the pandemic, has meant the monitoring and performance reporting of progress against the national and local clinical audit plans has not happened in line with the draft policy. However, weekly update reports have been circulated to key individuals in the ILGs on the national audits and where monitoring reports have been presented at Board committees, these show that the majority of national audits have had data gathered in line with required timescales. We acknowledge that there has been less activity in relation to local audits over the past year as priority was given to the national audits. Furthermore,

many of the groups where these would have been monitored were stood down or met less frequently.

The draft policy that we were provided with during our fieldwork required the outcomes and actions of national and local audits to be reported to a number of forums ranging from a department's or speciality's clinical audit meetings, through to the Quality & Safety Committee. However, we did not see evidence of the outcome and actions of specific audits being reported in line with the draft policy.

Audit proposals are required to be completed prior to undertaking a clinical audit detailing the objectives, rationale and Audit Lead. We reviewed a sample of completed clinical audits and confirmed that the audit proposals were available for all of the audits in the sample.

We made one high priority recommendation in relation to the Clinical Audit and Effectiveness risk register which had previously been used to log all risks in relation to Clinical Audit Department operational and staffing issues. Going forward the register should include outlier related issues such as where the audit results show the Health Board as being an outlier in comparison to other Health Boards, or the clinical audits where there are delays or issues in collecting data and there is a risk in being able to complete the audit. At the time of our review the risk register it was not being consistently used to record these risks.

5. Assurance Summary

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

Assurance Summary					
1	Roles, Responsibilities and Resources			✓	
2	Programme Planning			✓	
3	Programme Delivery & Board Assurance		✓		

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

Design of Systems/Controls

We did not identify any findings that are classified as a weakness in the system control/design for Clinical Audit.

Operation of System/Controls

The findings from the review highlighted six issues that are classified as weaknesses in the operation of the designed system/control for Clinical Audit.

6. Summary of Audit Findings

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

Roles, Responsibilities and Resources

Objective: There is a nominated lead clinician with responsibility for clinical audit across the whole organisation.

We identified the following area of good practice:

- The Clinical Audit & Effectiveness Policy & Strategy confirms that the Executive Medical Director has overall responsibility for clinical audit, with delegated responsibility given to the Deputy Assistant Medical Director for Clinical Audit who oversees the clinical audit and clinical effectiveness functions.

We did not identify any findings under this objective.

Objective: Clinical leads for clinical audit and quality improvement are in place at an ILG level, with dedicated time for this activity.

We note the following:

- The Health Board are in the process of recruiting into posts that will be the clinical audit lead in each of the three ILGs. Each post holder will have dedicated time for clinical audit on their job plans.
- There are named audit leads for the national audits within each ILG. Audit leads either have dedicated sessions to fulfil their audit role or use their agreed Supporting Professional Activity (SPA) time for clinical audit and effectiveness duties. The national audit leads will report to ILG audit leads once appointed.

We did not identify any findings under this objective.

Objective: There are resources in place for the management and administration of the audit programme both at corporate and ILG levels.

We identified the following areas of good practice:

- In recent years, there has been an increase in investment within the clinical audit service that has resulted in resources to cover the TARN national trauma audit, the transition of Bridgend, NICE compliance monitoring with the appointment of a NICE Coordinator and Lead Nurse for Clinical Effectiveness and there are greater development opportunities for all staff.
- A revised Clinical Audit & Quality Informatics team structure has been put in place with dedicated staff assisting and acting as the primary contact for each ILG if required.
- There are a number of Senior Clinical Audit Facilitators within the Clinical Audit Department who along with the Interim Clinical Audit Manager and Effectiveness Mangers undertake quality assurance checks of the clinical audits and assist the Clinicians in carrying out clinical audits.

We did not identify any findings under this objective.

Objective: Relevant staff have been appropriately trained in both undertaking audits and the information governance requirements and in the use of the clinical audit system and using it to monitor data in real time.

We identified the following areas of good practice:

- From April 2021, all staff that are undertaking clinical audits and newly registered on the AMaT system are required to have user training. Following the training, we understand that a trainer will check that staff are using the system appropriately.

- The AMaT system prompts the user to do tasks at certain times to progress the clinical audit. In addition, each of the clinical audits are allocated a Clinical Audit Facilitator who undertake quality assurance checks of the work being undertaken.
- The Clinical Audit Department have a structured training programme for departments delivered over a number of sessions as and when required.

We identified the following finding:

- Since the introduction of the AMaT system in April 2020, while many staff are registered to use the system, due to the pandemic and clinical pressures, not all have received training. (Finding 2 - Medium)

Programme planning

Objective: There is a Health Board agreed approach to clinical audit that links to its strategic aims.

We identified the following:

- Since our previous audit review a draft Clinical Audit & Effectiveness Policy & Strategy has been produced. This confirms that the Executive Medical Director is responsible for ensuring the Clinical Audit Strategy is allied to the Board's strategic interests. This document has been circulated for comment to ensure that it is appropriate and has been updated in line with the observations made.

We identified the following finding:

- At the time of our review, the draft Clinical Audit & Effectiveness Policy & Strategy has been in use for over a year but has not been approved by the Audit & Risk Committee. (Finding 3 - Medium)

Objective: There is a planned programme of clinical audit, which has been appropriately approved and in line with the Health Board's clinical audit approach.

We identified the following areas of good practice:

- There is a Clinical Audit Forward Plan 2020/21 that lists the tier 1 national and tier 2 priority audits. The plan identifies all of the clinical audit projects from the National Clinical Audit and Outcome Review Plan for 2020/21.
- All tier 3 and tier 4 clinician speciality audits form part of the local ILG Clinical Audit Programmes and these are held electronically on the AMaT system for all specialities to ensure consistency in the format and recording of the clinical audit data. There is one *pro forma* on the AMaT system so that the ILGs can share learning across the three areas.

- We understand that during the pandemic the national audits were given priority and have continued, but a number of the local audits have stopped as there has not been the staff resource to continue with them. Management will review plans to see what was initially agreed and ascertain which audits can start again and archive the ones that are no longer applicable.
- Speciality and clinical audit forward plans were available for all the departments that we sampled.

We identified the following finding:

- The approval of the Clinical Audit Forward Plan for 2020/21 was delayed due to the pandemic. The ILG Clinical Audit Programme was not approved by the ILG governance groups mainly due to the ILG governance arrangements not being fully established at the time. In addition, a number of the specialities' forward plans were not approved, as the relevant meetings had ceased during the first wave of the pandemic. (Finding 4 - Medium)

Objective: Arrangements are in place to engage clinicians, managers and service users/patients during the development of the programme, and to ensure Health Board priorities and risks are considered alongside national requirements.

We identified the following areas of good practice:

- There are named clinicians for national audits as they are responsible for undertaking these audits.
- Staff that have specific interests may request to undertake local clinical audits in these areas, must obtain prior approval to ensure that they are appropriate.

We did not identify any findings under this objective.

Objective: Audit proposals are registered, reviewed and approved in accordance with the Health Board's approach to ensure that each has clear improvement aims and objectives and a named lead responsible for delivery.

We identified the following area of good practice:

- There are assurance *pro formas* for national audits that are completed by the Clinicians. A clinical audit registration form is completed for all local audits on the AMaT system detailing the rationale and objectives of the clinical audit. Our sample of forms confirmed they had been completed appropriately and included the audit rationale and objectives as well as the audit lead for the review.

We did not identify any findings under this objective.

Objective: Documented procedures are in place to ensure a consistent approach to clinical audit activity and achievement of the audit criteria

We identified the following areas of good practice:

- Tailored standard operating procedures for each of the clinical audits that are undertaken are in place for the Clinical Audit Facilitators to support and guide staff through the process for the specific audits being undertaken.
- There are documented procedures for using the AMaT system.

We did not identify any findings under this objective.

Programme delivery and Board assurance

Objective: Progress against the planned programme is reported and monitored effectively at both a corporate and ILG level, with use made of real time data from the system.

We identified the following area of good practice:

- The national audit plan is reviewed and monitored on a weekly basis by Clinical Audit Management.

We identified the following finding:

- Due to the pandemic, reports on progress of the Health Board's 2020/21 Clinical Audit Programme were not taken to the Quality & Safety Committee as set out in the draft Clinical Audit & Effectiveness Policy & Strategy that we reviewed during our fieldwork. We understand that an earlier version of the policy had a different reporting requirement, but we have not seen the document to confirm this.

  Furthermore, progress reports on the ILG Clinical Audit Programme were not taken to the Clinical Audit & Effectiveness Group and could not be taken to the ILG Governance Groups as they have only recently become fully established. In addition, as many meetings were suspended during the pandemic progress against the department, speciality or ward clinical audits were not being discussed within these forums, though we acknowledge that these local audits were not deemed a priority. (Finding 5 - Medium)

Objective: Arrangements are in place to ensure that the outcomes of all planned audits are appropriately reported, providing assurance or identifying action where improvement is required

We identified the following areas of good practice:

- We selected a sample of local clinical audits that had been completed and confirmed that the outcome of these had been presented to the speciality groups.

We identified the following finding:

- The national clinical audits outcomes and actions were not being reported to the Quality & Safety Committee as detailed within the draft policy document, although management have indicated that this was not a requirement of the previous version of the policy. There was limited reporting to the Clinical Audit and Effectiveness Group.

  In addition, local audits and recommendations should be reported to the Quality & Safety Committee and the Clinical Audit & Effectiveness Group, but at the time of our review this was not happening. We have recommended that management consider the need for the Quality & Safety Committee's to receive reports on local audits. (Finding 6 - Medium)

Objective: Arrangements are in place to ensure action is agreed and implemented, and improved outcomes achieved.

We identified the following area of good practice:

- From the sample of completed clinical audits that we reviewed, presentations were undertaken at the speciality groups and these included recommendations to address any issues identified.

We have reported the finding within the above objective (Finding 6 - Medium).

Objective: Identified clinical risks are given consideration as to where they are recorded and monitored

We identified the following area of good practice:

- The Clinical Audit and Effectiveness risk log has been expanded beyond clinical audit operational and staffing issues and will now include outlier related risks such as where the audit results show the Health Board as being an outlier in comparison to other Health Boards, or clinical audits that have delays and there is a risk in being able to complete them.

We identified the following finding:

- There were some inconsistencies with the outliers related issues being recorded on the Clinical Audit and Effectiveness risk log. In addition, the log has not been reported to the Clinical Audit & Effectiveness Group. (Finding 1 - High)

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**5**	**0**	**6**

Finding 1 – Capturing, monitoring and reporting risks (Operating effectiveness)	Risk
We understand that the clinical audit and effectiveness risk register has been used for recording risks relating to the Clinical Audit Department. Following the roll out of the Health Board's updated risk management strategy, the department has been advised by management to also capture risks associated with clinical audit reviews. For example, where the outcomes of the Health Board's clinical audits are not in line with other health organisations, or where there is a risk in being able to complete the audit. While the department have agreed to record these 'outlier' risks, responsibility for monitoring and mitigation actions rests with the relevant clinician and department that have the responsibility for delivery of the service to which the clinical audit relates. At the time of our fieldwork the risk register showed two open risks and seven closed risks. As such, it did not appear to capture all of the risks that could relate to clinical audit. In addition, there did not appear to be consistency as to what was being recorded on the register in relation to audits that are at risk of not being completed. For example, when we compared the register to the clinical audit report taken to the March 2021 Quality & Safety Committee, not all of the 'amber' audits in the report were on the risk register. Furthermore, while the risk register is a standing agenda item at the Clinical Audit & Effectiveness Group meeting, we did not see evidence of its review in the meeting minutes that we reviewed.	Clinical issues materialise if risks are not identified due to monitoring and governance arrangements not being in place. Quality issues with service delivery not identified.

Recommendation	Priority level
1. Management should discuss with the Health Board's Governance Team the process to follow to ensure that risks logged in Datix, relating to clinical audits, can be allocated to clinicians to manage. 2. Management need to ensure that all clinical audit related risks are recorded consistently on the risk register, including audits that are delayed or where there has been issues with collecting the data. A wider review of risks should be undertaken to ensure that other risks, such as the reliance on the AMaT system and the current level of training uptake on the system, have been considered for inclusion on the register. 3. The Clinical Audit and Effectiveness risk register should be a standing agenda item on the Clinical Audit & Effectiveness Group and reviewed at each meeting.	**High**
Management Response	**Responsible Officer/ Deadline**
1. Meetings schedule to review the risk log arrangements and agree ILG governance arrangements for logging risks linked to clinical audit outcomes.	Head of Clinical Audit & Quality Informatics & Deputy Head CA&QI and Lead Nurse for Clinical Effectiveness - 31/08/2021
2. Management review of Clinical Audit Risk Log management and development of standard operating procedure for this process.	Head of Clinical Audit & Quality Informatics - 31/08/2021

3. The revised Clinical Audit and Effectiveness risk register has been added as a standard agenda item for the inaugural Clinical Audit & Effectiveness Group meeting in June 2021 and then as a standing agenda item.	Deputy Head CA&QI and Lead Nurse for Clinical Effectiveness - 30/06/2021

Finding 2 - Training (Operating effectiveness)	Risk
Clinical audit training within the Health Board comprises of two elements: • The clinical audit process, which includes data collection, analysing and presenting findings, benchmarking and re-auditing. • Training on the Audit Management and Tracking (AMaT) system that was implemented in April 2020. At the time of our fieldwork 1,142 users were registered on the AMaT system. While approximately 250 clinicians have had training, this has been inhibited by the pandemic. More recently 35 midwives and outreach staff have received training as part of the rollout of the ward audit module. Over the last year, some clinicians chose to continue using paper records for their audits, even though they had been registered on AMaT. Their work was subsequently input onto AMaT by the Clinical Audit Facilitators who had capacity at that time. However, from 1 April 2021 it has been agreed that all clinical audits should be undertaken directly on the AMaT system and therefore staff will need to be trained on the use of the system as will any new users. In terms of wider clinical audit training, a training programme was previously in place but there was poor uptake. As such a decision was made to not have a training programme with fixed training dates for people to enrol onto. Instead structured training is provided by a dedicated lead trainer to specific departments as and when required, with some sessions booked for June 2021.	Clinical issues materialise if risks are not identified due to monitoring and governance arrangements not being in place. Quality issues with service delivery not identified

Recommendation	Priority level
Management should ensure that departments undertaking clinical audits are provided with training on the AMaT system. In addition, the clinical audit department could target staff / departments to be trained on the AMaT system and general clinical audit principles whereby the quality reviews highlight potential problems with how their audits are being undertaken.	**Medium**
Management Response	**Responsible Officer/ Deadline**
A plan has been formalised to address the training backlog for 2021-22, caused by the pandemic, with the Deputy Assistant Medical Director for Clinical Audit that will include: • A regular training session following each monthly / bi-monthly specialty clinical audit meeting. • Formal classroom based departmental training courses booked on a monthly basis. • 1:1 Adhoc training for individual provided by their clinical audit facilitator in person or over Teams	Head of Clinical Audit & Quality Informatics - Training plan in place by 31/07/2021

Finding 3 - Clinical audit policy (Operating effectiveness)	Risk
The Health Board has a draft Clinical Audit & Effectiveness Policy & Strategy that has been used since April 2020. While the Audit & Risk Committee are responsible for approving the policy, it appears that this has not happened. We understand that the policy will be discussed at the Clinical Policy Group in May 2021, and the Quality & Safety Committee in July, before seeking approval at the August 2021 Audit & Risk Committee.	Clinical issues materialise if risks are not identified due to monitoring and governance arrangements not being in place.
Recommendation	**Priority level**
Management should ensure that the Clinical Audit & Effectiveness Policy & Strategy is approved by the correct committee as detailed within the document. Going forward, it should be reviewed on a regular basis to ensure it remains current.	**Medium**
Management Response	**Responsible Officer/ Deadline**
After consideration it was deemed inappropriate for review by the Clinical Policy Group and instead the Policy & Strategy document was approved at the Audit and Risk Committee on the 18/05/2021, Equality Impact Assessment approved on the 20/05/2021 and has been submitted for final approval at the July 2021 Quality and Safety Committee.	Executive Medical Director & Head of Clinical Audit & Quality Informatics - 31/07/2021

Finding 4 - Planned programme of clinical audits (Operating effectiveness)	Risk
The Clinical Audit & Effectiveness Policy & Strategy states that the Audit & Risk Committee has responsibility for approving the Health Board's Clinical Audit Programme and Annual Clinical Audit Forward Plan. At the start of 2020/21 Welsh Government advised that clinical audit work should be stood down due to the pandemic. Following an update to that decision, the Forward Plan was 'noted' at the October 2020 Audit & Risk committee, with approval obtained at the April 2021 committee. Whilst there was a delay in approving the 2020/21 plan, the clinical audits listed were still undertaken. We understand that the Forward Plan for 2021/22 will be presented for approval at the June 2021 committee. ILG governance groups should approve ILG clinical local audit programmes. However, the 2020/21 programmes were not approved due to the pandemic and the ILG governance groups had not been fully established at the time when the programmes should have been approved. We understand that the local programmes for 2021/22 will be approved in accordance with the requirements of the policy. We tested a sample of specialities to ensure that there were clinical audit forward plans in place. Our sample included Therapies, Obstetrics & Gynaecology, Anaesthetics, Medicine including Cardiology and Paediatrics. In all cases the forward plans were available. Therapies and Obstetrics & Gynaecology forward plans had been appropriately approved within their speciality meetings, but the	Clinical audit activity is not undertaken within the Health Board if an approved clinical audit plan is not in place.

other areas did not have their plans approved due to the relevant meetings being stood down during the height of the first wave of the pandemic.	
Recommendation	**Priority level**
Due to the Covid-19 pandemic and the pausing of committees and groups, clinical audit plans were not able to be approved as outlined in the Clinical Audit & Effectiveness Policy & Strategy. Going forward: 1. The Health Board's Clinical Audit Programme and Annual Clinical Audit Forward Plan should be appropriately approved. 2. The ILG Governance Groups, in compliance with the Clinical Audit & Effectiveness Policy & Strategy should approve their ILG clinical audit programmes. 3. The speciality groups should approve the forward work plans for each of their specialities.	**Medium**
Management Response	**Responsible Officer/ Deadline**
1. The Clinical Audit Programme and Annual Clinical Audit Forward Plan has been scheduled for approval in the July 2021 Quality & Safety Committee and dates set for quarterly updates through to March 2022. Due to purdah and the transfer of responsibilities for the NHS Wales National Clinical Audit & Outcome Review Plan (NCA&ORP) from Welsh Government to Digital Health and Care Wales (formerly known as NWIS) there is currently no date set for release of the NCA&ORP for 2021-22.	Head of Clinical Audit & Quality Informatics – 31/07/21

Therefore, the CTMUHB Clinical Audit Plan will be rolled over from the 2020-21 programme of national audits and reviewed once the NCA&ORP is released later this year.	
2. After the Clinical Audit & Effectiveness Policy & Strategy has been approved by the Quality and Safety Committee, in July 2021. The 2021-22 ILG plans will be signed off for their tier 1-4 clinical audits in accordance with the approach defined in the policy and strategy.	Head of Clinical Audit & Quality Informatics - 30/09/2021
3. The specialty group 2021-22 forward plans are on the agendas for the June – August clinical audit meetings for discussion and sign off across all specialities. In accordance with the pre-pandemic process, that was suspended during the pandemic due to restrictions placed by the Health Board on the organisation of clinical meetings.	Deputy Head CA&QI and Lead Nurse for Clinical Effectiveness - 31/08/2021

Finding 5 - Progress against the planned programme (Operating effectiveness)	Risk
The current version of the Clinical Audit & Effectiveness Policy & Strategy states that the Audit & Risk Committee should receive a bi-monthly performance report in relation to the national audits. Clinical audit reports were presented at the October 2020, February and April 2021 meetings. While the October and April reports related to approval of the 2020/21 plan, the February report provided performance and compliance information. The Quality & Safety Committee should receive a more detailed bi-monthly performance and monitoring report, including the progress against the clinical audit programme. Our review of committee papers identified an update report in May 2020, but no further reports presented until March 2021, despite the committee continuing during the pandemic. Following the audit debrief meeting we have been informed by management that the requirement to report bi-monthly was introduced in January 2021 and was not a requirement of the previous version of the policy, although we have not seen the iteration to confirm this. We understand that during the height of the pandemic the national audit plan (tier 1 & 2) was reviewed and monitored on a weekly basis by the Clinical Audit Manager to ensure progress and allow identification of potential issues. Weekly updates were also provided to key staff within the ILGs. The Clinical Audit & Effectiveness Group is responsible for reviewing progress of the local ILG clinical audit programme (tier 3 & 4). However, within the group's minutes, there was no evidence of progress against the ILG clinical audit	Clinical issues materialise if risks are not identified due to monitoring and governance arrangements not being in place.

programmes being discussed, though we did see summaries of national audits discussed at the group. We acknowledge that local audit activity was not a priority at this time. The policy further states that the ILG Governance Groups are responsible for reviewing progress of the local clinical audit programme for their areas. However, as detailed earlier, the ILG Governance groups were only set up recently and therefore the programmes were not being reviewed as anticipated. At a department and ward level, the policy states that the department, speciality or ward clinical audit meetings are responsible for monitoring progress of their own clinical audits. As earlier confirmed, meetings were suspended for a number of the specialities during the pandemic and therefore the progress against the plans were not always being discussed.	
Recommendation	**Priority level**
As the Health Board moves out of the pandemic, clarity should be sought around the role and remit of the Audit & Risk Committee and the Quality & Safety Committee to ensure there is no overlap or duplication of reporting. The Clinical Audit Department should seek advice from the governance team and consider the frequency of providing performance reports on the progress against the Health Board Clinical Audit Programme to the relevant committee. In line the Clinical Audit & Effectiveness Policy & Strategy, the Clinical Audit & Effectiveness Group, ILG Governance Groups and the department / speciality /	**Medium**

ward clinical audit meetings should review the progress of the clinical audit programmes within their areas.	
Management Response	**Responsible Officer/ Deadline**
The CTMUHB Clinical Audit Forward Plan 2021-22 will go to the July Quality & Safety Committee, subsequent update reports will then go to the QSC on a quarterly basis. Submission timetable agree with corporate team. A review of the Terms of Reference for all groups will be undertaken to ensure incorporation of the requirement to regularly review progress against the Health Board, ILG and Specialty audit plans.	Head of Clinical Audit & Quality Informatics – 31/07/2021 Deputy Assistant Medical Director for Clinical Audit & Deputy Head CA&QI and Lead Nurse for Clinical Effectiveness - 30/09/2021

Finding 6 - Outcomes and actions of all planned audits (Operating effectiveness)	Risk
The current version of the Clinical Audit & Effectiveness Policy & Strategy states that the Quality & Safety Committee is responsible for receiving a bi-monthly performance and monitoring reports which consider findings, outcomes and recommendations of national and local clinical audits. The committee is also responsible for ensuring that actions to address the risks identified through clinical audit are implemented. Our review of the two most recent clinical audit papers taken to the committee in May 2020 and March 2021, did not identify any evidence of the committee receiving the details of findings, recommendations and actions of national and local clinical audits. The clinical audit management team have since questioned if taking local audit reports to the Quality & Safety Committee is appropriate and plan to change the policy. The policy states that the Clinical Audit & Effectiveness Group is responsible for receiving summaries of national clinical audit reports and completed baseline assessments to agree recommendations and actions and completed local clinical audit reports and recommendations. Our review of the minutes of this group identified that there were updates provided on some of the national audits, but nothing relating to completed local clinical audit reports. In addition, there was no evidence of the group monitoring clinical audit action plans. We did see evidence of the outcomes of local audits (tier 3 & tier 4) being presented in relevant speciality groups.	Quality issues with service delivery not identified.

Recommendation	Priority level
Management should ensure that the Quality & Safety Committee receive, in line with agreed timescales, a performance and monitoring report which considers the findings of national and local clinical audits, including outcomes and actions to address risks identified. A decision should be made as to whether the findings of local audits should be presented at the Quality & Safety Committee or if there is a more appropriate committee or group to receive these reports. The policy should be updated to reflect any changes. In addition, the Clinical Audit & Effectiveness Group should receive summaries of national clinical audit reports and completed local clinical audit reports with recommendations and action plans.	**Medium**
Management Response	**Responsible Officer/ Deadline**
As part of the review of the Risk Log arrangements in consultation with the Deputy Assistant Medical Director for Clinical Audit and ILGs and agree the approach to considers the findings of national clinical audits, including outcomes and actions to address risks identified. We have already reviewed the policy and saw the mistake in reporting requirements and have notified for changes to made to the policy.	Head of Clinical Audit & Quality Informatics & Deputy Head CA&QI and Lead Nurse for Clinical Effectiveness - 31/08/2021 Executive Medical Director & Head of Clinical Audit & Quality Informatics – 31/07/2021

A review of the Terms of Reference for Clinical Audit & Effectiveness Group will be undertaken to ensure incorporation of the requirement to receive summaries of national clinical audit reports and completed local clinical audit reports with recommendations and action plans.	Deputy Assistant Medical Director for Clinical Audit & Deputy Head CA&QI and Lead Nurse for Clinical Effectiveness - 30/09/2021

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

Facilities Directorate Review (Workforce Arrangements) - Follow Up

Internal Audit Report
2020/21

Cwm Taf Morgannwg University Health Board

July 2021

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Gareth Robinson – Interim Chief Operating Officer
Distribution:	Russel Hoare - Assistant Director Facilities <u>Merthyr Cynon ILG:</u> Catherine Roberts – Interim Director of Operations Neil Cooper – Acute Services General Manager Melanie Smith – Facilities Regional Manager

Rhondda Taf Ely ILG:

Rachel Burton –Director of Operations

Tarek Allouni – Acute Services General Manager

Lisa Rogers – Facilities Regional Manager

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.

Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit & Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cwm Taf Morgannwg University Health Board and no responsibility is taken by the Audit & Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction

A follow-up review of our 2018/19 limited assurance report relating to the Facilities Directorate's workforce arrangements was completed in line with the 2020/21 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

The original Facilities Directorate review was undertaken in the summer of 2018. We issued two reports: one report related to management arrangements, which included opinions on risk and governance, strategic planning, and workforce; and one report related to compliance that had one opinion. Whilst three of the four audit opinions issued were 'Reasonable Assurance', one area, relating to workforce, was reported as 'Limited Assurance'.

Our workforce testing focussed on the portering service that was in operation across the Royal Glamorgan and Prince Charles Hospitals. We made ten recommendations: six high priority; and four medium priority. Due to the changes that were required to be made to the portering service and its roster process we acknowledged that some management actions could take a period of time to implement.

The Audit and Risk Committee has been kept up to date on management's progress against the agreed actions. The complexity of the changes to the service and roster process has meant that the implementation of the agreed management actions has taken longer than originally anticipated.

Since our original review there has been a restructuring of the Health Board's operating model with services, including Facilities now aligned to the three Integrated Locality Groups (ILGs). Our follow up testing has focussed on the portering service within Prince Charles Hospital (Merthyr and Cynon ILG) and Royal Glamorgan Hospital (Rhondda Taf Ely ILG), as these are the sites that we visited while doing our original fieldwork. However, the findings from this review could also be shared with Bridgend ILG for learning.

While this review provides an independent review of the progress made to date against agreed actions, due to the restructuring, any outstanding actions have been directed to the relevant ILG.

The relevant lead for the review is the Interim Chief Operating Officer.

2. Scope and objectives

The overall objective of this review was to provide the Health Board with assurance regarding the implementation of the agreed management responses from the Facilities Workforce Arrangements Directorate review that was undertaken as part of our 2018/19 work programme.

The scope of this follow up review **did not** aim to provide assurance against the full review scope and objective of the original audit. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only.

The areas that this review sought to provide assurance on were:

- Appropriate progress has been made with the implementation of the agreed management responses within the agreed timescales.
- Adequate evidence is available to support the level of progress that has been made.
- The actions implemented have effectively addressed the issues highlighted during the original audit.

3. Associated risks

The potential risks considered in this review were as follows:

- The Directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.
- Services are not effectively planned.
- Reduced service provision / additional costs due to inappropriate or unauthorised absence.
- Staff performance is not effectively assessed and addressed.

4. Opinion

This review considers the high and medium priority recommendations made. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only. We have been able to conclude that the Health Board has made progress towards implementing the agreed management actions from the original review. The overall assurance opinion has remained as 'Reasonable Assurance'.

Reasonable assurance		**Follow up** – All high-level recommendations implemented and progress on the medium and low-level recommendations

In a small number of cases, while the action taken by management to date has meant that the recommendation has been fully implemented, where appropriate, we have made revised recommendations. We based our current assurance rating, and revised recommendation priority ratings, on the progress made in implementing the agreed actions and any residual actions.

From April 2020 the Health Board introduced a new operating model and as such, responsibility for implementing the agreed actions was devolved to the relevant ILGs. Whilst the ILGs have the autonomy to make decisions and take actions that impact their area of responsibility, in the main the two ILGs covered in this follow up review have continued with the implementation of the recommendations we originally made.

We recognise the impact that the Covid-19 pandemic has had, not only on being able to implement agreed actions, but also on the ILGs' ability to carry out 'business as usual' during the last year.

Overall, we found the systems and process in place within the two ILGs are more robust than when we first visited those sites in 2018 but improvements are still needed in some areas.

5. Summary of audit findings

Progress against the ten agreed high and medium priority recommendations to be implemented is as follows:

Original Priority rating	Recommendations to be implemented	Fully implemented	Partially implemented	Not implemented
High	6	2	3	1
Medium	4	1	2	1
Total	**10**	**3**	**5**	**2**

The action plan within Appendix A provides a summarised version of the findings, priority ratings and full management responses from the original review, along with details of the current position, as verified by our follow-up work. Revised recommendations and priority ratings are included where necessary.

As can be seen in the table above, there has been a general trend towards implementing the recommendations. Within the five partially implemented recommendations, we have moved three from their original priority level to a lower priority to reflect the progress made by the ILGs. Two of the partially implemented recommendations have remained the same level of priority as have the two recommendations that have not been implemented.

In two cases, even though we have categorised as fully implemented, new related recommendations have been made. As such there remains seven open or partially implemented recommendations and two new ones.

The revised priority ratings for the remaining recommendations are outlined in the table below.

Priority	H	M	L	Total
Number of recommendations	**1**	**5**	**3**	**9**

1. Summarised version of original finding – Annual Leave Process (Control Design)	Original Risk
Our review of the procedure documents at PCH and RGH identified different documentation in place. The procedure documents in place did not incorporate all relevant information.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.
Original Recommendation	**Original Priority level**
For the management of annual leave across porter services for all sites, clear and consistent guidance on all aspects of annual leave, particularly short notice annual leave requests, and the authorisation of leave, a common policy or set of principles should be developed.	**High**
Original Management Response	**Original Responsible Officer/ Deadline**
At the time of the audit Facilities were fully engaged in a Porter services redesign programme of work and along with business partners they have been developing department principles for managing annual leave, a new rota has also been developed and is being taken forward for all porter services. Currently with this porter redesign work there are a number of 'status quo' situations that have been invoked by Trade unions and staff resulting in disagreement and refusal from porter services staff and supervisors/dispatchers at to accept the new rota and service change. This is currently being taken forward in accordance with the Grievance policy. The new rota and the service redesign will ensure a more efficient process and	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18

that the Porter Services Supervisor will follow the operating guidelines laid down, which will be clear with last minute requests and an agreement that leave should be requested in advance with a minimum period of 2 weeks, so rotas moving forward can be done in a full week prior, staff will already be fully aware of the shift pattern. For the management of annual leave across porter services for all sites a clear and consistent guidance on all aspects of annual leave, particularly short notice annual leave requests, and the authorisation of leave, a common policy or set of principles will be developed.	

Current Position

RGH / RTE

The annual leave policy that was in place at the time of our original audit is still in place. There remain some gaps in the policy on areas such as booking leave at short notice and the process for managing emergency leave. The policy still has the old Cwm Taf name on it and does not specify that it now relates to the RTE ILG.

PCH / M&C

The RGH annual leave policy has been adopted in principle by PCH, though there are some minor differences around how much notification needs to be given when requesting leave. Use of the policy only commenced during the course of our follow-up review, as its roll out had been put on hold until the revised roster templates had been implemented. As noted above, the policy provides no details about the process for administering short notice or emergency leave and does not specify that it now relates to the M&C ILG.

We acknowledge that there has been a change in structure and responsibilities since our original audit. We can see that progress was made in implementing our original recommendation, though there remain some outstanding points that if included, would strengthen the annual leave policies further. As such we consider this action as **partially implemented**.

Updated Recommendation	Updated Priority Level
<u>Both sites</u> 1. The annual leave policy at both ILGs should be reviewed to ensure they capture all relevant aspects of administering annual leave, such as the process for managing emergency leave requests. 2. The policies should reflect the correct organisation name and the name of the ILG that they relate to.	**Medium**
Updated Management Response	**Updated Responsible Officer / Deadline**
<u>RGH / RTE and PCH / M&C</u> The annual leave Policy and operating principles at both ILGs will be reviewed and updated to reflect the new ILG structure.	Lisa Rogers, Facilities Regional Manager RGH Melanie Smith, Facilities Regional Manager PCH 01/09/21

2. Summarised version of original finding – Annual Leave (Operating Effectiveness)	Original Risk
Our testing identified incorrect and incomplete paperwork in relation to annual leave requests, resulting in some staff taking too much leave in the year. A number of staff purchased and carried forward annual leave, but these requests had not been authorised in line with the scheme of delegation.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.
Original Recommendation	**Original Priority level**
1. Segregation of duties should be in place when authorising leave and no annual leave request forms should be authorised unless they are fully completed and submitted before the annual leave date. 2. For those staff still using paper based annual leave records, consideration should be given to using ESR to manage annual leave. 3. A reconciliation between ESR and the system used by the department (paper records or databases) should be carried out periodically to confirm that records remain accurate and the correct amount of bank holidays have been accounted for. This should prevent staff from taking too much leave at the end of the financial year. 4. The directorate should ensure that they are following the Health Board's scheme of delegation when authorising carried forward leave and the purchase of leave. All forms should be authorised by the Directorate Manager or above.	**Medium**

Original Management Response	Original Responsible Officer/ Deadline
All recommendations are accepted and will be actioned. 1. Immediate action will be taken to ensure regular monthly and daily audits take place to ensure compliance and accuracy. This will be undertaken by Porter Supervisor/dispatcher. Management approved principles to be put in place and clarified through training and meetings with all staff for awareness, understanding and compliance. 2. Staff are all trained to understand and use ESR System. This supports their awareness of annual leave entitlement, pay status etc. 3. Facilities admin support team to ensure a regular monthly check against manual entry and ESR entry records are undertaken. To support audit a monthly checklist form has been developed to ensure accuracy and performance to assist monthly review.	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18

Current Position
RGH / RTE 1. Our testing of a sample of annual leave requests confirmed that the correct paperwork had been completed, appropriately authorised and input on ESR, although for 2/5 of the sample two weeks' notice was not given as required by the annual leave policy. 2. The process for requesting and approving annual leave is still paper-based, with supervisors or administration staff inputting approved leave into ESR. We understand that the lack of on-site IT resources has prevented staff booking leave directly on ESR.

3. We saw evidence of reconciliations between ESR and manual leave records being carried out at the start of the leave year. We also saw evidence of annual leave balances being checked a number of times from October onwards in the year to ensure balances were correct and to notify managers of any staff with high remaining balances. Separate audit checks have also been introduced by management, to help identify any errors and non-compliance with the annual leave policy.
4. We looked at five cases of purchased annual leave. In all cases a staff change form was used to record the purchase. Whilst the form does not have an official section for authorisation, all had been signed by the Facilities Manager. The scheme of delegation in place at that time, required Directorate Managers to approve annual leave purchases.

PCH / M&C

1. Our testing of a sample of annual leave requests identified a number of issues including missing leave request forms, meaning our testing was limited, forms were not fully completed, and one instance where leave had not been recorded on ESR.
2. There has been no change in approach for requesting or approval of annual leave. It remains a paper-based system, with supervisors or administration staff inputting approved leave into ESR. Our discussions with management established that the lack of on-site IT resources has prevented the ability for leave to be booked directly on ESR.
3. Reconciliations between annual leave allocations on ESR and manual records do not take place at the start of the leave year. Similarly, there was no evidence of management checking annual leave balances during the year to ensure balances remain accurate and leave is being taken evenly over the year.
4. One case of purchased annual leave was identified and recorded on a staff change form, but as the form does not have an official place for authorisation, it had not been signed. Eight cases of carried forward leave were also identified. Whilst all paperwork could be traced, we identified that the forms had been signed by a Supervisor and not the Directorate Manager.

The Health Board's Annual Leave policy contains forms to be completed for purchasing and carrying forward annual leave. The purchase form requires approval from a line manager, but the current version of the scheme of delegation requires additional annual leave to be approved by the Operations / Group Director for ILG (or equivalent).

Some progress has been made against the various elements of our recommendation and as such we consider this action **partially implemented.**

Updated Recommendation	Updated Priority Level
<u>Both sites</u> 1. At both ILGs, consideration should be given to providing training to the porter service staff on the use of the ESR mobile application in order for annual leave requests to be made and approved directly in ESR. 2. Where annual leave is purchased or carried forward, correct forms should be completed in line with the Health Board Annual Leave policy and authorisation in line with the scheme of delegation should be obtained. <u>PCH / M&C</u> 1. Whilst paper records continue to be used: • All records in relation to annual leave requests should be fully completed, authorised and retained, with approved leave recorded on ESR. • A reconciliation between the ESR system and the paper record should be carried out at the start of each leave year to ensure the correct allocations. Periodic checks should take place throughout the year to confirm accuracy of records and ensure staff are taking leave evenly throughout the year.	**Medium**

2. Consideration should be given to adopting the audit checks in place in RGH to assist in identifying non-compliance with the annual leave policy. Corporate The Health Board's Annual Leave Policy should be reviewed to ensure the authorisation information on the forms contained within it, align to the current version of the scheme of delegation.	
Updated Management Response	**Updated Responsible Officer / Deadline**
RGH / RTE and PCH M&C 1. We will work with Porter Services staff to support access to ESR Accounts. The Health Board are aware of the issues for Facility staff accessing ESR for learning and development and this is being supported with training and learning, development. The paper system for requesting annual leave and approving and recording will be better supported now that staff are in place at Supervisory level to continue and manage – also will be supported by weekly regular audits for compliance monitoring. 2. The purchase of, or the carryover of leave will be supported using the Health Board Policy and relevant changes will be made to the scheme of delegation to reflect the management structures. 3. Regular Audit checks in place in RGH to assist in identifying non-compliance with the annual leave policy. Corporate We will discuss and arrange with Workforce and OD for the Health Board's Annual Leave Policy to be reviewed to ensure the authorisation information on	Lisa Rogers, Facilities Regional Manager RGH Melanie Smith, Facilities Regional Manager PCH 01/09/21

the forms contained within it, align to the current version of the scheme of delegation.	

3. Summarised version of original finding – Flexi / TOIL (Control Design)	Original Risk
Our testing identified there was no consistent policy or processes in place for the management of flexi leave or TOIL.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.
Original Recommendation	**Original Priority level**
While we acknowledge that there is limited use of TOIL within the Porter Service, the Health Board should ensure that consistent and up to date polices are in place across the service area.	**Medium**
Original Management Response	**Original Responsible Officer/ Deadline**
Principles for TOIL that are in place for RGH Site will be adopted and managed across all HB Sites. Principles will be management approved and will be re-iterated to all porter services staff for information and compliance.	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18
Current Position	
Whilst the use of TOIL at either site is extremely infrequent, the 'Time in Lieu' procedure and form previously used by RGH, is now available at both sites. However, the procedure dates from 2015, and as needs to be updated to reflect the new structure.	

Whilst our original recommendation has been **implemented**, we have made a subsequent recommendation in this area.

Updated Recommendation	Updated Priority Level
The TOIL procedure and forms should be reviewed to ensure they meet the ILGs' needs, align to any wider Health Board policy or procedure and are updated to reflect the correct organisation name and the name of the ILG that they relate to.	**Low**
Updated Management Response	**Updated Responsible Officer / Deadline**
<u>RGH / RTE and PCH M&C</u> The TOIL procedure will be amended to reflect correct ILG structure.	Lisa Rogers, Facilities Regional Manager RGH Melanie Smith, Facilities Regional Manager PCH 01/09/21

4. Summarised version of original finding – Absence Management (Operating Effectiveness)	Original Risk
Our testing at both sites identified a number of issues including the absence periods recorded on key documents and ESR not reconciling, missing paperwork such as Return to Work (RTW) forms, missing information such as the reason for absence and absence triggers not acted upon. Through our testing, we also identified errors and inconsistencies with the signing in book at both sites.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.
Original Recommendation	**Original Priority level**
1. In line with the All Wales Sickness Absence Policy a record should be maintained when staff inform their line manager of sickness absence. 2. Comprehensive and timely records of sickness, including the reason for absence should be maintained to allow the proper management of sickness within the directorate and accurate reporting. It should be ensured that self-certification and return to work forms are completed in a timely manner. All information contained on self-certification forms, RTW forms and ESR should correspond. 3. Absence management triggers should be monitored and where periods of absence result in a trigger being breached, the appropriate action should be taken. Audit work undertaken in other areas of the Health Board has seen the use of sickness and absence summary sheets as a good practice tool for monitoring absence and identifying when triggers have been hit.	**High**

4. Management should reiterate to staff the importance of signing in correctly. Staff must not sign out before the shift ends and only they should sign themselves in / out.	
Original Management Response	**Original Responsible Officer/ Deadline**
Principles will be developed clearly indicating pathway for managing sickness absence. Principles approved by management and WF & OD business partners for all Porter Services across UHB Sites. Porter Supervisor/dispatcher will support monthly audit to ensure compliance and accuracy, inclusive of proforma/check list to support and evidence audit. Advisories for failing to meet All Wales S&A Policy Guidelines will be actioned within Porter Services Management Team and ensure compliance through continual close monthly audit as detailed previously. All Porter services supervisors/dispatchers will receive/refresh sickness absence training. Sickness absence performance KPI's are being monitored monthly by the Facilities Operations Board and CBM monthly meetings. A deep dive report has also been provided for scrutiny at CBM by WF & OD business partners. All staff must sign in on arrival and sign out on leaving, end of shift. This will be audited daily by the Porter Supervisors, dispatchers. Porter services staff will be formally reminded through meetings of their obligation for compliance and disciplinary action will follow for any incidences of non-compliance.	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18

Current Position
RGH / RTE 1&2 For the sample tested, point of contact forms were in place for all. In the majority of cases self-certification forms had been completed, as had RTW forms, all of which were completed in a timely manner following the absence. There were some minor differences between the consistency of the absence dates recorded on the paperwork and what was input on ESR. 3 Sickness and absence summary sheets are in place to allow monitoring of prompts (previously called triggers). However, our testing identified that absence review meetings were not routinely taking place when prompts were hit. 4. See finding 9 in relation to signing in and out book. PCH / M&C 1&2 For the sample tested, point of contact forms were in place where necessary. All RTW forms were in place and had been completed in a timely manner and in all but one a case self-assessments form had been completed. All information reconciled to the information held on ESR. 3 During the course of our follow up review, sickness and absence summary sheets were introduced to allow monitoring of prompts. Our testing identified that absence review meetings were not routinely taking place when prompts were hit. 4. See finding 9 in relation to signing in and out book. We were unable to confirm if the Porter services supervisors and dispatchers have received any formal training on managing attendance, and we note that PCH the supervisors now have greater responsibility for the day to day management of attendance. Furthermore, we were unable to identify any localised principles indicating pathways for managing sickness absence.

However, we were able to confirm that workforce KPI data in relation to absence is prepared by the Workforce Business Partner and issued to each ILG for monitoring purposes.

Overall, there has been progress towards implementing the agreed actions at both sites. However, the management of absence prompts does require further attention, as such we consider this action as **partially implemented**

Updated Recommendation	Updated Priority Level
Whilst both sites are now using sickness absence summary sheets that will aid the identification of staff who hit a prompt, the process for subsequent management of staff should be reviewed to ensure compliance with the All Wales Managing Attendance Policy. Where prompts are hit, records of the informal or formal meetings should be held on file. Where management discretion is applied to not undertake an informal or formal meeting, a record should be maintained on file explaining the reason for the decision.	**Medium**
Updated Management Response	**Updated Responsible Officer / Deadline**
<u>RGH / RTE and PCH M&C</u> 1. The process for the management of staff will be reviewed to ensure compliance with the All Wales Managing Attendance Policy. 2. Where prompts are hit, records of the informal or formal meetings will be held on file. Where management discretion is applied to not undertake an informal or formal meeting, a record will be maintained on file explaining the reason for the decision. 3. Supervisory training will further support sickness absence application. To	Lisa Rogers, Facilities Regional Manager RGH Melanie Smith, Facilities Regional Manager PCH 01/09/21

further support compliance Team Leaders will support monthly audits for sickness.	

5. Summarised version of original finding – PDRs (Operating Effectiveness)	Original Risk
Our original findings identified that the PDR compliance rate within porter services was 43% at RGH and 60% at PCH, so below the Welsh Government target.	Staff performance is not effectively assessed and addressed.
Original Recommendation	**Original Priority level**
In line with Health Board targets, all staff should be subject to a PDR on an annual basis. An action plan should be developed to target those areas where compliance is low and to assist in overcoming any problems that may be preventing the completion of PDRs. Correct PDR documentation should be fully completed and forms signed by both the manager and employee. The ESR record should be updated with date the PDR took place. Copies of previous PDRs should be retained and used by management throughout the year to ensure staff are working towards agreed objectives and used in the following years PDR to reflect on achievements during the year.	**Medium**
Original Management Response	**Original Responsible Officer/ Deadline**
Since the audit both acute HB Sites have achieved an improvement in completion of PDR's and action to improve the position will be continued. RGH porters has improved compliance from 43% to 80%. PCH from 60% to 61%. Progress has been made across all Facilities services with overall compliance	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18

reported at CBM 25/9/18 of 85% out of a total number of 940 staff. PDR training template to be used across all HB Sites to support Porter Supervisors, dispatchers, charge hands when completing. Key Skills Framework Outline will support this to ensure full awareness, understanding. Compliance will be tracked, monitored and performance managed monthly at the Facilities Operations Board and in the Facilities directorate report for CBM.	

Current Position

We analysed PDR compliance rates as at March 2021 for both sites. We acknowledge the impact the pandemic will have had on the ability for PDRs to be completed. As such, we obtained data from January 2020 to establish compliance rates prior to the onset of the pandemic.

	RGH / RTE	PCH / M&C
March 2021	5% (3/55)	50% (26/50)
January 2020	93% (52/56)	55% (28/51)

We were unable to determine from either site, what specific actions plans are in place to address the current levels of compliance.

Whilst we acknowledge the impact that pandemic will have had on compliance rates, it would appear that even before the pandemic, the rates at PCH remained low. As such, we consider this action **not implemente**

Updated Recommendation	Updated Priority Level
An action plan should be developed by both sites that outlines the steps they are going to take to ensure all staff have received a PDR.	**Medium**

Updated Management Response	Updated Responsible Officer / Deadline
<u>RGH / RTE and PCH / M&C</u> An action plan and process will be developed that outlines the steps required and action to be taken to ensure all staff have received a PDR. Where required the management and supervisory team will be supported with PDR training.	Lisa Rogers, Facilities Regional Manager RGH Melanie Smith, Facilities Regional Manager PCH 01/09/21

6. Summarised version of original finding – Mandatory Training (Operating Effectiveness)	Original Risk
Our original testing against the 11 mandatory training modules identified that the compliance rate for the porter services was below the Welsh Government target rate. Individual rates for some staff were poor.	Staff performance is not effectively assessed and addressed.
Original Recommendation	**Original Priority level**
The directorate should ensure that all staff are provided with the opportunity to undertake their mandatory training and ESR should be updated accordingly to reflect the training undertaken. Those areas and individuals with low compliance rates should be targeted to encourage completion.	**Medium**
Original Management Response	**Original Responsible Officer/ Deadline**
Since the audit RGH has achieved an improvement in completion of training modules from 27% - 67%. Action to improve the position will be continued. At both RGH and PCH. Training remains on-going across all HB Sites, with significant improvement realised across the past 12-month period. Progress has been made across all Facilities services with overall compliance reported at CBM 25/9/18 of 73% out of a total number of 940 staff who each require 11 modules of core skills training.	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18

We will continue to support, through Porter Supervisor/dispatcher continual monthly review, operationally, we are challenged with releasing porter services staff however, are facing these challenges with support from the Facilities Business Support Manager and supervisory staff from other services who are trained in delivering core skills training. Once we get through the service redesign changes the plan is that Porter Services Supervisors will each be trained to deliver the core skills module within their service. Compliance will be tracked, monitored and performance managed monthly at the Facilities Operations Board and in the Facilities directorate report for CBM.	

Current Position

We analysed training compliance rates at January 2020 and March 2021 for both sites. This shows that there has been a slight decline in compliance over the period, however we acknowledge that the pandemic will have had an impact on the ability for training to be completed, especially as staff have limited access to IT equipment, so rely on a face to face training provision.

	RGH / RTE	PCH / M&C
March 2021	76%	63%
January 2020	84%	76%

Our analysis of the March 2021 data has highlighted some specific areas that need attention:

- Fire Safety training compliance at RGH is 38% and at PCH is 23%.
- Information Governance compliance at RGH is 36% and at PCH it is 48%.

We were unable to determine from RGH / RTE, what specific actions plans are being developed or are in place in order to address the current low level of compliance.

Through our discussions with facilities managers in PCH we established that plans are in place for the 'make up shift' to be dedicated to delivering mandatory training to ensure compliance rates are achieved.

Despite the constraints caused by the pandemic, compliance rates have remained relatively high, though attention is now needed in relation to specific training modules. We consider this action as **partially implemented.**

Updated Recommendation	**Updated Priority Level**
RGH / RTE An action plan should be developed that outlines the steps that need to be taken to ensure all staff complete their mandatory training, with particular reference to those modules where overall compliance rates are low. PCH / M&C The action plan being put in place to address outstanding training should focus in the first instance on those modules where the overall compliance rate is low.	**Medium**
Updated Management Response	**Updated Responsible Officer / Deadline**
RGH / RTE and PCH / M&C 1. An action plan and process will be developed that outlines the steps required and action to be taken to ensure all staff undertake mandatory training learning sessions. 2. A rolling programme of mandatory training will be put in place to	Lisa Rogers, Facilities Regional Manager RGH Melanie Smith, Facilities Regional Manager PCH

address the decline in compliance due to the availability of training which had been reduced due to the pandemic operational impact. Particular focus will be given to those modules where overall compliance rates are low.	01/09/21

7. Summarised version of original finding – Guidance for Porter Service (Control Design)	Original Risk
No consistent or up to date guidance or policies existed for the management of the porter service rosters.	The Porters service is delivered in an inefficient way resulting in savings targets not being achieved
Original Recommendation	**Original Priority level**
A set of policies and procedures should be developed for use across all sites that allows for the consistent and efficient running of porter services.	**High**
Original Management Response	**Original Responsible Officer/ Deadline**
As per the porter redesign and current staff/supervisor/dispatchers Organisational Change process mentioned at previous Finding 6. Facilities supported by WF & OD business partners is currently in a period of status quo and grievance with staff and trade unions on a number of rota compliance and terms and condition issues. Grievance policy negotiations are ongoing with staff and staff side trade union colleagues. The new rota and the principles for rota management are key to ensuring compliance and to be agreed with staff and trade union colleagues and directed across the Porter Services teams at all sites. These Principles will support Porter Services re-design, reflecting appropriate manning levels, rota, service requirements and Supervisor/Dispatcher Organisational Change process.	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 31/1/19

Current Position
The Facilities Directorate Manager has developed a set of common principles for use across all sites. These covered the management of rotas, the allocation of overtime, annual leave and sickness absence. The introduction of the new operating model in April 2020 including the move to an ILG structure has allowed greater autonomy to be applied at the ILG level. We understand that the Facilities Manager in the M&C ILG has refined some sections of the common principles to ensure they fully align to the new roster templates that were introduced in March 2021. We consider this action **Implemented**

8. Summarised version of original finding – Rostering Documentation (Operating Effectiveness)	Original Risk
The times that porter service staff were signing in and out for the shifts did not correlate to shift times on the rotas. Furthermore, some staff were signing in and out of their shifts at the same time or not singing in at all. We also identified at RGH numerous swapping of shifts in a week, not always with the appropriate authorisation.	The Porters service is delivered in an inefficient way resulting in savings targets not being achieved.
Original Recommendation	**Original Priority level**
It should be ensured that all staff sign in and out for their shift in line with what they have actually worked and should not sign out until the end of their shift. Staff should only sign themselves in and should not sign in or out on behalf of others. Staff should ensure that they are aware of their shift start times and where they arrive early for work, they should be informed that cannot assume they can start work early and be paid for the additional time, unless there is deemed to be a specific service need.	**High**
Original Management Response	**Original Responsible Officer/ Deadline**
With support from WF & OD Facilities is working to migrate porter services staff onto e-rostering which will support compliance and with controls in place that are auditable.	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18

The swapping of shifts will be stopped with immediate effect. This will be highlighted in the management principles of rota and overtime management. All staff must sign in on arrival and sign out on leaving, end of shift. This will be audited daily by the Porter Supervisors, dispatchers. Porter services staff will be formally reminded through meetings of their obligation for compliance and disciplinary action will follow for any incidences of non-compliance.	

Current Position

The introduction of E-rostering as a means of resolving a number of the issues encountered with the porter service roster was not progressed as the shift set up within the system did not meet the needs of the service. However, advice was provided by the E-rostering team on how to set up more effective rosters (see finding 9).

We did not see any evidence of shift swapping at PCH. While it still happens at RGH, the number of swaps is much lower than at the time of our previous review and appears to be for valid reasons that are recorded.

Signing in and out books exist on both sites and spot checks are now taking place. At PCH / M&C we saw evidence of spot checks being carried out by the Facilities Manager and emails sent to all staff informing them of the need to record information correctly.

We note that the lay out and use of the signing in and out book at RGH did not facilitate easy monitoring and spot checks. At PCH a signing in / out sheet is used that also separates core hours and overtime.

Whilst our original recommendation has been **implemented**, we have made a subsequent recommendation in this area.

Updated Recommendation	Updated Priority Level
RGH / RTE Consideration should be given to introducing the signing in / out sheets that are used in PCH as these are deemed more fit for purpose than the current signing in / out book and will assist in more accurate completion of pay returns.	**Low**
Updated Management Response	**Updated Responsible Officer / Deadline**
RGH / RTE The signing in sheets have been received from PCH Site and will be introduced to RGH Site to support better protocol for signing in and out.	Lisa Rogers, Facilities Regional Manager RGH 01/09/21

9. Summarised version of original finding – Rostering effectiveness (Operating Effectiveness)	Original Risk
Our review raised concerns around the historic roster templates that were in place and the impact that rigidly adhering to them had on the need for overtime having to be utilised to ensue all rostered shifts were worked. This was made worse by the late preparation of the rosters and late annual leave approvals, which meant that staff were not always being able to work the allocated overtime thus causing the swapping of shifts. The porting job management system used did not provide meaningful information to allow management to analyse service demands.	The Porters service is delivered in an inefficient way resulting in savings targets not being achieved.
Original Recommendation	**Original Priority level**
The review of the historical roster templates that are being used should be progressed with revised rosters realigned to meet the current demands of the services at both hospital sites. It should be ensured that suitable systems are in place to accurately capture the work undertaken by the porters, to better inform future roster amendments and to allow monitoring of staff productivity. Rosters should be prepared further in advance in order for staff to know their core shifts and overtime shifts, if any, thus reducing the need for staff to swap shifts if they are unavailable for the overtime they have been allocated. Where there is a need to make use of overtime, efficient use should be made of all available staff.	**High**

Original Management Response	Original Responsible Officer/ Deadline
As per the porter redesign and current staff/supervisor/dispatchers organisational change process mentioned at Facilities Finding 6 response. Facilities supported by WF & OD business partners are currently in a period of status quo with staff and trade unions on a number of rota compliance and terms and condition issues. Grievance policy negotiations are ongoing with staff and staff side trade union colleagues. The portertrac system is used to monitor daily porter task activity. However the system is nearly 20 years old is challenging to navigate, is not an end user self-serve system, has to be manually interrogated to extract meaningful reports for effective reporting and does not provide accurate data as it is heavily reliant on accurate input from the porter services duty dispatcher. Facilities is currently developing a Facilities Management (FM) service investment in technology plan which would improve on 24/7 service delivery and address staff transactional management, replacing paper based systems of recording and auditing with software systems. This provides electronic log on duty and tracking of each member of the porter services duty teams shift, carrying out service tasks that can be tasked by end user departments using self-serve direct to each member of the porter team through to log off duty. This system will provide an auditable trace and provides service delivery performance information. We need to invest in FM management software solutions which will bring benefits to the Facilities services environment. The Porter Services re-design currently being taken forward will support the correct management of an efficient rota system across porter services at all sites which includes migration to e-rostering. The re-design scheme will also successfully support integration of the porter	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 31/01/19

security requirement to the working rota. At RGH for example no additional staff have been recruited onto the porter establishment to enable the redesign scheme. The 11 porter security staff now in the pool have simply replaced vacancies over time in the porter pool using a new job description and following completion of the required SIA training. The problem has been that the existing old rotas across both acute HB Sites are supporting the new service redesign model which is designed and FY 2018/19 was budgeted for the new rota. The delays in implementing the redesign and new rota have resulting in additional cost and the continued use of the old rota that has already been identified as not cost effective and non-compliant. There have been instances early on in the scheme implementation whereby pool porter security staff have been side lined from tasks because of resistance to change from some members of the pool porter team. The management have intervened in such cases and there is more acceptance as the scheme progresses and pool porter security staff are now being tasked appropriate to their role. This will continue to be monitored. Rosters will be prepared further in advance in order for staff to know their core shifts and overtime shifts. Where there is a need to make use of overtime, efficient use will be made of all available staff. It is acknowledged that there is an immediate requirement for moving forward through negotiations with staff and staff side and support from WF & OD to implement the new rota to reduce cost and realise the final element of the savings associated with this Facilities CRES and service redesign scheme. Despite the push back and challenges with this scheme, the Facilities management team with support from WF & OD business partners are committed and doing everything they can within OCP process to progress the scheme to completion.	

Current Position	
Revised roster templates are now in place at both sites. Whilst the templates are relatively new in PCH (March 2021) and there some issues to resolve in RGH around the Porter / Security Supervisor roles, in the main they have allowed the service to be delivered in a more effective way, enabling rosters to be produced further in advance. The previous porter management system (Portertrac) remains in place at the current time. There has been some work looking into procuring an updated system, but we have been informed that a move to a new system is still a number of years away. **Partially Implemented**	
Updated Recommendation	**Updated Priority Level**
<u>Both sites</u> Work should continue in relation to the procurement of a more up to date portering management system that would allow the service to be delivered in a more efficient and effective manner.	**Low**
Updated Management Response	**Updated Responsible Officer / Deadline**
<u>RGH / RTE and PCH / M&C</u> 1. Work will continue to progress forward in view of managing rota alignment that will support service demands and pressures. This will be always flexible and open to change in view of changing service needs within the Hospitals.	Lisa Rogers, Facilities Regional Manager RGH

2. A bid for funding for a new Porter Services IT management system solution (Symbiotic) has been submitted in the Facilities IMTP 2021-2022.	Melanie Smith, Facilities Regional Manager PCH 01/09/21

10. Summarised version of original finding - Porter Rostering Review (Operating Effectiveness)	Original Risk
Where overtime was used, no prior approval was sought. We identified errors between the information contained on the roster and pay return which led to both over and underpayments.	The Porters service is delivered in an inefficient way resulting in savings targets not being achieved.
Original Recommendation 10	**Original Priority level**
Where overtime is allocated on rosters, the Facilities Managers should approve these in advance of the rosters being published. Accuracy checks should be undertaken on pay returns prior to being submitted to payroll for processing.	**High**
Original Management Response 10	**Original Responsible Officer/ Deadline**
The Facilities managers monitor and check the rotas weekly however it is accepted that whilst they are checking they are not signing to confirm the checks. Action will be taken and instructions will be issued with regards to the management and control of the rota and overtime and allocation. This will also include accuracy checks on pay returns. E-rostering when implemented will also support Porter re-design to ensure compliance and improved rota management control.	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18

Current Position
The updated guidance identifies who can authorise overtime, but our testing of a sample of rosters from both sites did not identify evidence of this authorisation. We tested the pay returns relating to a sample of 15 porters from each site to confirm their accuracy to the worked rosters, and at both sites we found discrepancies that resulted in staff being paid incorrectly. Furthermore, at PCH, as a result of our testing, management identified that the 'make up shifts' periodically worked by the porters were being recorded on the pay return as overtime, when in fact they are part of their contractual hours. We understand that management has taken action to rectify these errors. We did not see evidence of accuracy checks being carried out on the pay returns prior to being submitted to payroll for processing. Whilst the number of errors identified during our testing appears to have reduced, errors in pay are still happening. As such we consider this recommendation as **not implemented**.

Updated Recommendation	Updated Priority Level
<u>At both sites</u> Where overtime is allocated on rosters, the Facilities Managers should approve these in advance of the rosters being published. Accuracy checks should be undertaken on pay returns prior to being submitted to payroll for processing.	**High**

Updated Management Response	Updated Responsible Officer / Deadline
<u>RGH / RTE and PCH / M&C</u> 1. Where overtime is allocated on rosters, the Facilities Managers will ensure that any overtime is approved in advance of the rosters being published. 2. Accuracy checks will be undertaken on pay returns prior to being submitted to payroll for processing. 3. Supervisors and staff will also be briefed on this requirement.	Lisa Rogers, Facilities Regional Manager RGH Melanie Smith, Facilities Regional Manager PCH 01/09/21

Audit Assurance Ratings

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

Follow up - All recommendations implemented and operating as expected.

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

Follow up - All high level recommendations implemented and progress on the medium and low level recommendations.

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

Follow up - No high level recommendations implemented but progress on a majority of the medium and low recommendations.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Follow up - No action taken to implement recommendations.

Prioritisation of Recommendations

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

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

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

Mass Vaccination Programme

Final Internal Audit Report

July 2021

Cwm Taf Morgannwg University Health Board

NWSSP Audit and Assurance Services

Contents

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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 Institute of Internal Auditors.

Acknowledgement

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

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1. Introduction and Background

The review of the mass vaccination programme was completed in line with the 2021/22 Internal Audit Plan. The review assessed the effectiveness of Cwm Taf Morgannwg University Health Board's (the 'Health Board') plan to manage the key risks associated with the roll out and implementation of the mass vaccination programme (the 'Programme').

Since the summer of 2020, the Health Board has been preparing the delivery of vaccination services for health and social care frontline staff and its local population based on a priority rating. The aim being to implement swift activation of the plan when vaccines became available. A Covid-19 Vaccination Programme Board and a wider Stakeholder Group were established, and the Health Board's draft plan was sent to Welsh Government (WG) in September 2020.

On 2 December 2020, the Medicines and Healthcare products Regulatory Agency (MHRA) granted the Pfizer / BioNTech vaccine temporary authorisation for use based on evidence of safety and effectiveness. The Oxford/AstraZeneca vaccine was approved for use later in December, followed by the Moderna vaccine in January 2021. The Health Board started rolling out its mass vaccination programme using the Pfizer / BioNTech vaccine on 7 December 2020.

The Joint Committee for Vaccination and Immunisations (JCVI) has provided an order of priority to vaccinate the population, which is detailed below:

1. residents in a care home for older adults and their carers;
2. all those 80 years of age and over and frontline health and social care workers;
3. all those 75 years of age and over;
4. all those 70 years of age and over and clinically extremely vulnerable individuals;
5. all those 65 years of age and over;
6. all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality;
7. all those 60 years of age and over;
8. all those 55 years of age and over; and
9. all those 50 years of age and over.

The Welsh Government Vaccination Strategy sets out three key milestones in which they planned to have offered a vaccine to each of the above priority groups. The guidelines stated that each health board should start with priority group 1 and work their way through each group in order of sequence. Health boards were able to move onto the next priority group once they had offered vaccines to 50% of the current group.

The initial milestone target for the Health Board was to offer first doses of vaccines to those in priority groups 1 to 4 by 14 February 2021. For the Health Board, this amounted to 110,000 people. To ensure this was achievable, an operational model

using a mobile vaccine team for those based in care homes, hospital vaccination sites for frontline health care staff, and GP practices and community vaccination centres for all others was developed. By the end of January 2021 51 GP Practices were vaccinating their patients and four Community Vaccination Centres (CVCs) had been set up, though this later grew to seven CVCs. The target associated with priority groups 1 to 4 was achieved.

The second milestone related to priority groups 5 to 9 was initially less prescriptive as it required health boards to have made vaccination offers by spring 2021. However, this was later defined as the end of April 2021. The Health Board identified approximately 148,000 residents that fell into these priority groups. Alongside offering a first vaccination these residents the Health Board aimed to offer all those in priority groups 1 to 4 with their second dose of the vaccine. Again, this target was achieved.

The final milestone related to offering the rest of the adult population a first dose of the vaccine by autumn 2021, however this was brought forward by WG to the end of July 2021.

As at 5 July 2021, 569,675 people had been vaccinated by the Health Board, of which 324,810 people had received their first jab and 244,865 had received both jabs.

2. Scope and Objectives

We assessed the adequacy and effectiveness of the internal controls in operation. Any weaknesses will then be brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

The specific objectives that we reviewed were:

- To ensure that an effective plan is in place detailing the delivery of vaccinations for each priority group and in particular:
    - sufficient trained resource to support delivery;
    - all potential patients are identified within each priority group, including individuals not registered with the Health Board;
    - arrangements to ensure patients are offered a vaccination and follow-ups where appointments are missed;
    - the selection of an appropriate vaccine, taking into consideration storage facilities, patient factors (e.g. allergies) and availability;
    - the management and scheduling of second doses, where required;
    - ongoing communication with the population of the Cwm Taf Morgannwg area, to provide assurance over the vaccinations and to answer frequently asked questions;
    - communication with relevant staff to keep them updated of changes that occur (external and internal to the Health Board);
    - key milestones are documented.

- To confirm that appropriate governance / oversight over the delivery of the plan is in place, including:
    - the progress of delivery in line with the JCVI priority list, through regular reporting;
    - lessons learnt and continual improvement; and
    - appropriate approval and monitoring of the plan, including action taken to address shortfalls in delivery or where milestones are not met.

Whilst undertaking the review and testing the controls that are in place, we were mindful that the mass vaccination programme has been set up as an emergency response to the situation NHS Wales finds itself in, and our reported finding and recommendation reflects this.

3. Associated Risks

The risks considered in the review were as follows:

- The plan in place for mass vaccination is not efficient leading to wastage of the vaccine and delays to the delivery of the vaccination programme.
- Insufficient training for staff, resulting in delays to vaccinations being delivered and / or an increased risk of patient harm.
- Reputational damage as a result of a delayed delivery of vaccinations or insufficient information provided.
- Risk of the public not being vaccinated in a timely manner.
- Members of the population are omitted from the vaccination programme.
- Insufficient monitoring of the vaccination programme, resulting in an inefficient delivery.
- A lack of accountability for the implementation of the mass vaccination programme.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

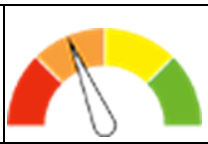
The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Mass Vaccination Programme review is *substantial* assurance.

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

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

5. Assurance Summary

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

Assurance Summary					
1	Effective delivery plan				✓
2	Appropriate governance and oversight				✓

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

Design of Systems/Controls

The findings from the review have not highlighted any issue that are classified as a weakness in the system control/design for the vaccinations programme.

Operation of System/Controls

The findings from the review have highlighted one issue that is classified as weaknesses in the operation of the designed system/control for the vaccinations programme.

6. Summary of Audit Findings

By early July 2021, 569,675 first and second doses have been delivered across Cwm Taf Morgannwg area. This means that 88% of adults have had at least one dose of the vaccine and 67% of adults are now fully vaccinated.

In June, to encourage further uptake, the Health Board trialled a walk-in clinic at their Mountain Ash CVC. This allowed anyone over the age of 18 to 'walk-in' with no appointment for their first dose. After an evaluation of how well the trial worked, walk-in appointments are now available most days at five of the CVC.

The governance arrangements and internal controls in place help to ensure that planning, monitoring and delivery of a successful mass vaccination programme which is aligned to JCVI requirements. Detailed below are our observations for each of the areas that we reviewed. What has been clear through the meetings that we held and the documentation we sighted, is the dedication and commitment of staff in delivering a programme of work that was almost constantly changing. At times this will inevitably have placed members of staff under immense pressure and potentially has been an ongoing risk to the Health Board where there has been reliance on a few key individuals. We have made a recommendation in relation to this.

As the current phases of the vaccination programme roll out draw to a close, a report to capture the lessons learnt is being produced. The Health Board undertook a similar exercise in February 2021 between phases one and two of the roll out and implemented a number of changes, though the current 'lessons learnt' report is more likely to influence future projects.

Objective 1: An effective plan was in place for the delivery of vaccinations for each priority group.

Training to support delivery

The Specialist Immunisation Team were responsible for developing the clinical delivery of the Community Vaccination Centres (CVCs). This included recruitment of staff, identifying equipment needs, administering training and managing rotas. Staff are trained using the recognised standards, which includes CPR and anaphylaxis training and the infection control e-learning module.

The core staff that were recruited and trained to work in the first two CVCs, have since split, so that every CVC team now has an element of the original cohort of staff. Workshop training sessions for the senior team within the CVCs also took place to ensure that the standards continue to be maintained. The Specialist Immunisation Team are still present in the CVCs and can address training needs or identify any failings.

The Health Board has to date recruited approximately 40 WTEs with a wide skill mix. Innovative approaches were adopted when creating the job descriptions that has allowed Allied Healthcare Professionals to also apply, therefore widening the scope of applicants.

Staff absence and annual leave has been covered using Bank staff or with staff from other CVCs where necessary. Furthermore, the Specialist Immunisation Team and some of the community teams are trained to vaccinate should there be a significant staffing shortage. To date, the Health Board has not had to utilise any agency staff within the CVCs

Potential patients are identified

The Welsh Immunisation System (WIS) has been developed by NHS Wales Informatics Service (now Digital Health and Care Wales, 'DHCW') for the roll-out of the mass vaccination programme. Patient data is refreshed daily, which ensures that changes to priority codes are quickly actioned in line with JVCI requirements.

DHCW produced an automated appointment run in WIS. The priority groups were loaded onto WIS based on data extracted from primary care records and appointments were allocated to patients in line with planning and progress through the cohorts. Each automated appointment run included individuals from previous priority groups that had not had an appointment. Daily internal reports were produced to identify anyone who has not had their vaccine within a 12-week period.

Vaccine appointments were generated from information held on primary care records. Local authorities provided information for patients who may not be registered with a GP, such as homeless people or gypsy and traveller communities. Booking appointments, especially for the homeless, proved difficult and the team

have relied heavily on third parties, such as charities and Local Authority homeless groups to co-ordinate their vaccine appointments. The Health Board 'ring-fenced' 10 appointments per day at each CVC to accommodate these groups of people.

Individuals who temporarily work in the area or are home from university were asked to temporarily register with a local GP otherwise their appointment letters would be generated by the Health Board where they are registered.

In care homes where positive cases prevented vaccinations taking place, a RAG monitoring status was introduced to help manage the situation and ensure later visits were planned. This was monitored by the Lead Nurse responsible for the care home campaign. Once 28-days had passed, and there are no more positive cases, the Vaccination Team could visit the care home and carry out the vaccinations.

Missed appointments

Patients can 'suspend' their appointment and should complete an online 'Mop up Clinic' form when they were ready to reschedule. Individuals that do not attend an appointment without an explanation are recorded as 'DNA' (Did Not Attend).

Daily DNA reports are reviewed by the Project Team's admin support and the Contact Trace Team. Patients are contacted by phone or text offering an appointment. If there is no response after three attempts, or if they do not wish to have the vaccine, their status within WIS is changed to 'opt out'. This does not mean that they cannot 'opt back in' at a later date. The Health Board's policy is 'no one is left behind', and this information is made clear to the individual at the time.

To tackle any potential vaccine wastage caused by the DNAs, a reserve list was created for people who could attend a clinic at short notice. The use of reserve lists and the extended life span of the Pfizer vaccine has helped the Health Board to minimise wastage.

Selection of appropriate vaccine

The process for storing and distributing the vaccine to care homes, GPs, ILGs and CVCs is tightly controlled. A vaccine schedule is produced and shared with Pharmacy, that identifies the type of vaccine that will be used in each area on separate days. The Admin Support Team and the Booking Office also receive a copy, so they know when booking appointments, what vaccines will be available to allow appropriate appointments for specific groups to be made.

The Health Board does not mix vaccines between doses and uses one vaccine type in a single location on any day. Application of the Pfizer and AstraZeneca vaccines are different, so controls have been put in place and procedures developed to ensure that the change over from one vaccine to another at the CVCs is completed correctly and safely. These form part of the CVCs Standard Operating Procedures.

Pharmacy is responsible for ordering and monitoring the temperature of the vaccine during circulation. Throughout its journey and whilst in storage the vaccines are temperature controlled using monitors, that records the temperature every minute. Visual temperature checks are also made at the beginning and end of each day, which is documented by the Lead Nurses at the CVCs. This information is hyperlinked and recorded on the Pharmacy vaccine database. The more detailed

temperature analysis from the monitors is also uploaded to this system, should further scrutiny of the temperatures be required. The Pharmacy database also records the supply and delivery of each vaccine by date and venue.

Changes to the clinical requirements of the vaccines, such as the use of the AstraZeneca vaccine on younger people has had an impact on the allocation of appointments. Ensuring that the right priority groups was aligned to the appropriate vaccines was an initial challenge for the Health Board, plus the demand for the Pfizer vaccine also increased as a result. Despite these obstacles the Health Board was able to manage the changes effectively.

A specific pathway is in place for patients with allergies. The administration of their vaccine takes place at one of the ILG hospital sites. A vaccination referral form is sent to the relevant ILG, who will arrange the appointment and carry out the relevant pre-assessment checks. There is a Doctor / Resus team on standby during these appointments. Any complex cases are sent directly to the Cardiff and Vale University Health Board allergy specialist.

Management and scheduling of second dose

The time between the first and second dose is set within WIS. A 'second dose' report details the individuals who have reached that target date and the type of vaccine for the first dose.

Communication with the local population and staff

The communication team have used community Facebook groups and Twitter to share information on the vaccination programme. However, key information, such as the process of rearranging an appointment, may not be reaching members of the public who do not have access to the internet or belong to social media groups. The online information encouraged people to share it with others who may not use social media.

The communication team have worked with the three local authorities: Bridgend, Merthyr and Rhondda Cynon Taff. This relationship has helped with the development of the priority lists and for contacting people at short notice to fill vacant appointment slots, especially for the reserve list.

At the start of the programme the Health Board arranged a 'Q&A' session with the Director of Public Health. A sample of questions raised by the public were addressed and short videos were uploaded onto social media to help answer concerns.

The Health Board's website and intranet have a direct link to a dedicated Covid-19 page, providing information regarding the vaccination programme. The website provides useful links to Public Health Wales (PHW) latest updates, social media posts, and information how to access the reserve list. The intranet site provides the key information for staff on the Covid-19 vaccine, links to policies and procedures, and a range of advice for Healthcare Professionals.

A 'Weekly Vaccination Update' newsletter is produced and shared with staff, external stakeholders and the public via the Health Board's website.

An advice line has been set up by the Health Board to help address concerns raised. The advice line provides guidance on how to complete the online forms for those

members of the community that may need assistance, and to answer the most frequently asked questions regarding the vaccination programme. The advice line telephone number is advertised on the Health Board's website and is the number provided by the Switchboard.

The Health Board has its own staff Facebook page, which allows staff to receive quick information from the communications team. The use of Facebook allows staff to access information using their mobile phones, which is particularly useful for staff who work in communities.

At the start of the programme there were a number of Q&A sessions via Teams which involved Health Board staff. The Chief Executive took part, as did the Senior Responsible Officer for the Vaccine Programme.

The Communications and Engagement Manager attends the Strategic and Operational Board and is a member of the Risk Communication and Community Engagement Workstream. This meeting is chaired by the Senior Public Health Practitioner and includes members from local authority communications team and PHW.

Objective 2: Appropriate governance/oversight of the plan

Approval and monitoring of the plan

The Health Board's Covid-19 vaccination plan was submitted to WG in September 2020. The plan incorporated the composition and governance arrangements for the Strategic Programme Board. Phase 1 of the plan, which was for priority groups 1 to 4, was approved by the Board in January 2021, and an update paper was taken to the Board in March 2021, which explained the position of Phase 1 and the plan for the roll out of Phase 2.

A Strategic Board and Operational Board continue to monitor the progress against the plan. Action plans to address any issues raised at theses boards are in place and monitored on a fortnightly basis.

Progress of delivery in line with JCVI priority list and milestones is reported

The delivery of the priority list is captured and discussed at the fortnightly Strategic Board and Operational Board. Daily monitoring is undertaken by the Assistant Director of Planning and the Project Team using the databases, schedules and WIS reports.

The performance data looks at each priority group to identify how many have received each dose, what number have 'opt out', or have not received a vaccine. DNA rates are analysed to identify trends. Forward planning of the distribution of the vaccine to the CVCs is also shared at the meeting.

At the Operational Board, workforce, finance, pharmacy and communications are discussed.

Lessons learnt

In February 2021, the Health Board prepared a 'lessons learnt' paper on the vaccination programme, which focused on the mobilisation phase of the project and its aims and key objectives in areas such as governance, communication, ICT and

workforce. The report also discussed the planning and operational phase, booking, data entry and logistics and recommendations were identified under each category. A second 'lessons learnt' paper is currently being prepared that will be used to capture good practice and lessons for future projects.

The Lead Nurse for the CVCs met with other colleagues from other health boards who were also setting up CVCs to benchmark and establish best methods.

The Head of Pharmacy, Community and Integrated Services attends an All Wales Pharmacy group, which is chaired by the Lead Pharmacist for All Wales vaccine. This forum allowed health boards to each Health Board to feedback what they are doing, how they are doing it, and to share information and ideas.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	High	Medium	Low	Total
Number of recommendations	0	0	1	1

Appendix A: Management Action Plan

Finding -1 Capturing actions for implementation (Control design)	Risk
What has been clear through the meetings that we held and the documentation we sighted, is the dedication and commitment of staff in delivering a programme of work that was almost constantly changing. At times this will inevitably have placed members of staff under immense pressure and potentially this has been an ongoing risk to the Health Board where there has been reliance on a few key individuals to be making strategic decisions on behalf of the Health Board.	Vaccination programme not delivered efficiently where there is over reliance on key individuals. Wellbeing of individuals impacted.
Recommendation	**Priority level**
Consideration should be given in any future projects to ensuring that there is not over-reliance on a small number of individuals to be managing the programme on a day-to-day basis.	**Low**
Management Response	**Responsible Officer/ Deadline**
The COVID vaccination programme has been established as part of the emergency response to COVID and learning from this will feed into the wider COVID learning. The continued requirements for COVID vaccination, mean that the project needs to be converted to 'business as usual'. A business case is being developed to create a core team for 2022/23.	Clare Williams December 2021

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

Substantial assurance

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

Reasonable assurance

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

Limited assurance

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

No assurance

The Board can take **no assurance** that arrangements in place to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **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** but which are relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

Sunnyside Health & Wellbeing Centre Final Internal Audit Report

August 2021

Cwm Taf Morgannwg University Health Board

NWSSP Audit and Assurance

Contents

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Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Steve Webster, Director of Finance
Distribution:	Julie Denley, Director of Primary Community and Mental Health Services, Senior Responsible Owner (SRO) Tim Burns, Assistant Director of Strategic & Operational Planning Sarah Bradley, Head of Primary Care, Project Director Rosie Cavill, Head of Capital, Project Leader James Chambers, Primary Care Estates Development Manager, Project Manager Darrell Clarke, Community Service Group Manager for Bridgend Integrated Locality Group Georgina Galletly, Director of Governance/ Board Secretary
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

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Executive Summary

Purpose

The review was undertaken to evaluate the progression and delivery of the project against the key business case objectives (i.e. time, cost and quality), and to assess the adequacy of, and operational compliance with, the Health Boards systems and procedures in place to support its successful delivery.

Overview

Key matters arising concerned:

- The project was reported as delayed by up to 8 weeks at the time of audit. This has yet to be formally assessed (or associated costs determined).
- Key contracts/ agreements require completion as a matter of priority.
- There was a need to enhance monitoring & reporting of the Health Board costs.
- The project would benefit from enhanced risk management.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance Summary

Assurance objectives		Assurance
1	Governance	Reasonable
2	Project Management	Limited
3	Tendering & appointments	Reasonable
4	Approvals	Reasonable

Note: The objectives and associated assurance ratings are not necessarily given equal weighting when formulation the overall audit opinion

Key Matters Arising

		Control Design or Operation	Recommendation Priority
1	Effective project governance	Design	Medium
3 - 6	Enhanced cost reporting	Operation	Medium
7 – 8	Enhanced contract monitoring	Operation	Medium
9	Delay control	Operation	Medium
10	Risk management	Operation	Medium
12	Central filing of historic documentation / decisions	Operation	Medium
14	Conclude Pharmacy & G.P. leases	Operation	Medium

1. Introduction

1.1 An Outline Business Case (OBC) for the Sunnyside Health & Wellbeing Centre was submitted to Welsh Government in October 2018 by the former Abertawe Bro Morgannwg University Health Board (ABMUHB). On 1st April 2019 the project was passed to the Cwm Taf Morgannwg University Health Board (CTMUHB) as part of the transfer of services in the Bridgend area.

In September 2020, the Health Board was awarded £10.771m of Welsh Government funding to progress the build.

The health centre is a partnership project with a developer (the current landowner) to build a health and wellbeing centre on part of a wider site proposed for sheltered housing by the developer. The contractual relationships are detailed at **Appendix D**.

The centre will house General Practitioners (G.P.s), dental, sexual health, and community clinics, and provide space for a multi-disciplinary team. It will enable GPs to move from outdated and cramped premises, and for the Health Board to dispose of three community premises that are in poor condition. Payment by the Health Board to the developer will include the value of the building, plus a land swap to include transfer and disposal of the former GP premises. At this point the Health Centre and its land will be transferred to Health Board ownership. Payments made to finance the on-going build, will be protected by a Deed of Cross Rights.

Work on the wider project commenced on site in October 2020, with the Health Centre commencing on 12th March 2021. Contract completion was originally anticipated for the 20th July 2022.

The project remains at an early stage (foundations have yet to be laid). The Health Board have incurred circa £1m to date. A significant portion of costs related to planning pre-contract (design) fees, (**Appendix D**). Only £54k related to construction, and the project remains at an early stage (foundations have yet to be laid, as per project reports to the end of June 2021).

The audit was originally deferred at the request of management, to allow the conclusion of matters such as the development agreement, tender, and planning permission.

Noting the impact of Covid 19, the delivery of this audit has included an increased element of remote working.

1.2 The key potential risk considered in the review was whether project costs/ progress had not been adequately controlled leading to failure to achieve programme/ project objectives.

2. Detailed Audit Findings

Governance: To affirm that there were appropriate accountability structures and allocation of key roles (e.g., SRO, Project Director) – including the identification and engagement of key stakeholders.

2.1 Good governance is the process of decision-making and the process by which decisions are implemented.

2.2 As noted, the project remains at an early stage (foundations have yet to be laid). It is recognised therefore that it is appropriate for governance arrangements to evolve to

reflect the project stage e.g. from greater user requirement input, to more technical oversight of construction costs and issues. Accordingly, observations relating to enhanced scrutiny are in this context.

2.2 The project benefited from a dedicated Project Board, service led Steering Group, site meetings, and routine reporting to an Executive Capital Management Group. These included terms of reference, and provided detailed contractor scrutiny, user engagement, and executive linkage. They also detailed assigned roles, including a Senior Responsible Officer chairing the Project Board, and a lead officer. The project benefitted from key finance, user and estates representation, in accordance with good practice.

2.3 However, arrangements had evolved from those specified at the January 2020 Full Business Case. At the time of the audit, revised terms of reference had been agreed for the various project groups, and the role of the Senior Responsible Officer had recently been re-allocated. There was a need to ensure that the key project roles, accountabilities, and project groups were appropriately aligned as the project transitioned from the design to the construction stage. In particular, noting the lack of detailed cost reports (**MA 3** & **5**), there was a need to ensure appropriate scrutiny of costs at Project Board level (**MA 2**).

2.4 The current project governance arrangements would therefore benefit from a Project Execution Plan (PEP) to define project scrutiny roles and responsibilities and range of contractual arrangements (see **Appendix D**). This included the need to re-focus stakeholder engagement to ensure that delivery effectively meets the specified stakeholder requirements (**MA 1**).

2.5 Noting the general alignment of governance arrangements with good practice and active review, a **reasonable** assurance is presently provided in relation to governance.

Project Management: To affirm that appropriate project management controls are in place, including risk management, cost control, project planning and performance monitoring etc.

2.6 Observations in this section are made in context of project management being managed by the developer, with the Health Board in a monitoring role i.e. to check / sample controls being applied.

Effective cost reporting

2.7 While noting the early stage of site works, the audit sought to ensure clarity in the reported cost position, with the submission and scrutiny of cost reports to relevant bodies, notably the Project Board.

2.8 The project benefitted from contractual rights to separate reporting for the Health Centre together with supporting information, as required (e.g. of project time and cost variations). Valuation reports were provided by the contractor supporting payment requests, including detailed commentary on design issues, progress on site, and provision of contractual documentation. A monthly progress report was also provided by the contractor, including accepted and proposed variations to contract. These were scrutinised by the Project Team (which included the Estates project manager, external project managers and contactor), and summaries were provided to the Project Board.

2.9 Under the Collaboration Agreement, the Health Board are entitled to separate Health Centre reporting. However, while much detail was separated, no overall Health Centre cost

summary was provided by either the contactor, or the developer's project manager. This would ensure that Health Centre costs were understood and not confused with housing costs. Proposed variations of costs were separately allocated but not totalled. There was therefore a requirement for enhanced cost presentation to provide separate Health Centre cost reporting.

2.10 The project groups were also unsighted on the various rates, provisions and allowances within the contract, and therefore, the full liabilities and cost implications of project / design changes e.g., in approving an additional charge of £63,375 for the revised heating system, it was unclear whether a £12,500 provisional sum for heating had been deducted from costs (**MA 4**).

2.11 At the time of the audit, the project was reported by the contractor as being some 8 weeks behind programme. However, Dashboard reporting to the Welsh Government showed the project as remaining on its original payment profile. Financial forecasts and cash flow profiling against budget to the Project Board were not identified. Accordingly, it was difficult to determine the Health Board cost position from existing project reporting. (**MA 3**).

2.12 While project summaries were provided at Welsh Government Dashboards, there was a need to ensure that these were consistent with the evolving project information (e.g., see ***Appendix C - Figure 1****).* Supporting project manager and cost adviser reports were not identified in support of the Welsh Government Dashboard as required (which would additionally detail non-works expenditure). Excepting the Dashboard, the only reporting identified at the project was provided by the contractor (**MA 5**).

2.13 There was also a need for costed and agreed equipment schedules to support reporting of equipment costs (a future action, noting the early phase of the project). (**MA 6**).

Contract management

2.14 The audit sought to understand the effective operation of the defined contractual arrangements to ensure delivery via third parties, and third-party management.

2.15 In accordance with the agreed contract conditions (between the Health Board and the developer), the Health Board is liable for any changes in project costs which they initiate e.g., as a result of changes in design requirements (or as otherwise reasonably arising from the contract). The Health Board should therefore have an active interest in cost control (as the informed client), though it is recognised that such scrutiny and assurance may be selective (noting active third-party management).

2.16 As a contract managed by a third party, various rights and safeguards are included to protect the interests of the client (CTMUHB). However, the Health Board has not yet fully exercised its rights to obtain copies of key documentation defined within the contract e.g. a performance bond (and terms), site inspections, and collateral warranties (which give direct contractual rights against sub-contractors in the event of contractor insolvency). (**MA 7.1**).

2.17 For both the Health Board and third-party appointed advisers, the provision of documents such as adviser activity schedules (within adviser contracts) would facilitate project monitoring e.g. to enabling activity related payments, and enhance performance monitoring based on the same. Monitoring and reporting of adviser costs against contracted sums was not evidenced. (**MAs 7.2** & **7.3**).

2.18 Similarly, noting their liabilities for cost increases, the Health Board were not in receipt of proposed cost variations to the contract in accordance with entitlements to information

detailed at the contract. It is recognised that changes to date have been minimal (**Appendix D**) (excepting the change to the heating network, which was well documented). However, it has been recommended that pending variations are notified, monitored and approved by the Health Board at future project changes (**MA 8**).

Time management

2.19 The audit also sought to examine the mechanisms by which time delivery was managed.

2.20 The project was reported as being 8 weeks behind program at the time of audit. The contactor had reported "claimable delays" (associated with 5.76 weeks of this), which had been increasing across the duration of the project. Accordingly, to avoid later dispute, it has been recommended that 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). (**MA 9**).

Risk management

2.21 The active management of project risks via a risk register is a key project control. As a scheme progresses, risks should generally reduce e.g., once groundworks are complete, risk of unforeseen ground conditions is removed etc. Similarly, project contingency may progressively be utilised. A key consideration therefore is the relation between the value of residual risk and residual contingency.

2.22 While a risk register was reported to the Project Board, its risks were not costed, and risks required updating to more accurately reflect current project issues. Risks reported at the Welsh Government Dashboard were also out-dated. Additional to the potential delay in the project's delivery, several key risks were not reflected within the risk register or at risk reporting e.g., confirmation of the contract (and rental) with Ashford surgery, and confirmation of pharmacy income.

There was therefore a need to actively manage and report project risks (profiling top risks to appropriate groups). There was an associated need to actively monitor and report the residual risks versus remaining contingency, informed by the quantified assessment of risks and project costs (**MAs 10.1 – 10.3**). While it was noted that this latter task now included within revised terms of reference for the Finance and Commercial project group, effective review based on current costed risks remained to be evidenced.

2.23 While noting the quantum of project control issues, including present limitations to risk and cost reporting to the Project Board for scrutiny and assurance, a **limited** assurance has presently been determined in relation to project management.

Tendering and appointments: To affirm that processes to appoint the developer and any advisers accord with local and national requirements.

2.24 The developer was the incumbent landowner (a specialist in the development of sheltered housing). As previously noted, the Outline Business Case (OBC) was submitted by the former Abertawe Bro Morgannwg University Health Board and approved by Welsh Government. This proposed an agreement with the owner to develop the land as part of a joint sheltered housing and health care development. Cwm Taf University Health Board inherited this position in April 2019 upon its formation and sought to build on the approved Outline Business Case. Much information relating to early project decisions rested with the former Health Board (ABMUHB) (e.g., in email records). It has been recommended therefore that such information, relating particularly to the choice of location and developer, are retained in a central project file for reference (**MA 12**).

2.25 The Full Business Case was based on budgets reflecting the market tendered construction price. The contracted works costs were in accordance with these tender prices as evaluated by the developer's project manager and detailed at the December 2019 tender report. The full price payable to the developer includes a land swap of existing G.P. premises (values of which have been assessed by the District Valuer, and to be confirmed on sale – as detailed at the FBC). Executive approvals therefore consisted of approval of the FBC, and Executive approval of the resultant contracts.

2.26 A Collaboration Agreement and a Deed of Cross Rights were both complete and protected the interests of the Health Board – the latter of which safeguards the Health Board's rights in the build in the event of developer failure (including the right to Open Book inspection of costs incurred). The Collaboration Agreement with the developer primarily consisted of the "*design and build*" contract with the appointed contractor - including a range of advisers (**Appendix D**).

2.27 Circa a third of adviser costs incurred by the developer were payable by the Health Board in respect of the Health Centre. Health Board rights to documentation under the contract included the right to inspect developer adviser contracts. Accordingly, to appropriately manage the contract, there was a need to obtain all relevant contractual documentation. As of June 2021, the developer's project manager advised that documentation relating to the appointment of the design team remained to be formally completed (**MA 11**).

2.28 The Health Board project manager was selected from a pre-approved framework (SCAPE), and an appropriate contract was in place. The remaining adviser appointments were below £5k (as supported by detailed ledger monitoring) with approvals according with Standing Orders and Standing Financial Instructions.

2.29 Noting the above, a **reasonable** assurance is therefore provided in respect of tendering and appointments.

Approvals: To affirm that appropriate approvals have been obtained at key junctures and that the project has progressed within these approvals.

2.29 As noted previously, the Health Board was awarded £10.771m of Welsh Government funding in September 2020, to progress the development.

2.30 The Full Business Case was signed off by the Board ahead of Welsh Government approval. This included the tendered costs (which were subsequently those contracted). The Health Board's Chief Executive Officer signed the subsequent Collaboration Agreement on this basis (i.e. the contractual agreement for construction).

2.31 UHB Management reviewed the (inherited) design with users prior to entering into formal contractual arrangements with the developer, and ongoing user engagement was evident via the project Steering Group. Subsequent changes have related to completing technical specifications, which were advised as substantially complete, but awaiting formal sign off. (**MA 13**).

2.33 The March 2021 Commissioning Group meeting noted the need to "*clarify GP's expectations*", and to reduce key project risks (notably in relation to the independently owned G.P. surgery). It has been recommended therefore that signed lease agreements are concluded with relevant parties at the earliest opportunity (**MA 14**).

2.34 As noted at **MA 10.1**, this includes the need to confirm pharmacy income (to ensure the ongoing viability of the Health Centre).

2.35 The general aspirations to improve primary care services were documented at the business case, and a time-tabled schedule for each service has since been devised for occupancy. However, specific agreements have yet to be put in place to provide target outcomes for each service (**MA 15.1**).

2.36 Deliverable outcomes at the Dashboard no longer included positive impacts on Hospitals (Accordingly, management should review and confirm the current project objectives based on only measurable outcomes (**MA 15.3**) and ensure that future business cases only included measurable aspirations (**MA 15.2**).

2.37 There was therefore robust engagement with relevant parties, and contractual approvals were in compliance with Standing Orders and Standing Financial Instructions. While noting the need for full design sign-off, and conclusion of leases, a **reasonable** assurance is presently determined in respect of approvals.

Overall Assurance Opinion

An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review. Key to this is an assessment as to whether the project remains within the parameters of time, cost and quality as ascribed at the business case.

The assurance in respect of key objectives areas are covered in detail above, and the performance against time, cost and quality are summarised as:

- Time – the project was stated as 8 weeks delayed at the time of audit. However, while the contractor has reported claimable delays, no formal claims have been made to date (within time frames required at the JCT between the construction company and the developer),. Accordingly, this has not yet been formally assessed by the developer's advisers.
- Cost – four months into the build, a change from a combined heating system with the housing development remained the only significant cost variation (**Appendix C**). Overall, noting that there may be a cost implication of the delay, there remains circa £1.2m contingency on a scheme of circa £11m (see **Appendix C**).
- Quality – The project remains set to deliver the objectives of the business case, notably to upgrade provision from cramped and dilapidated premises, enhancing the estate, and enhancing and concentrating service provision within a community hub set within social housing (this latter to enable re-focus on wellness support and early diagnostics within a local setting, rather than reactive treatments).

Accordingly, noting the positive financial position of the project (i.e. the significant contingency sums remaining), the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the review is **reasonable** assurance.

Note: Subsequent to the conclusion of the audit fieldwork, the developer's appointed contactor entered administration. It should be noted that the Health Board's contractual arrangement is solely with the developer (and therefore the requirement to re-appoint a contractor and associated advisers (if applicable) rests with the developer). Given the timing of these events (i.e., post audit fieldwork) they have not been considered within this review or the opinion. Nonetheless, there is likely to be a delay and associated cost with the appointment of a replacement contractor.

The Health Board should obtain confirmation of the various contracts/ bonds and explore the coverage of the performance bond in respect of the contractor's administration.

Whilst recognising the failure of the main contractor, the issues identified at the current review should be addressed and the associated recommendations applied, on the appointment of a new contractor and through to the project's completion.

Appendix A: Management Action Plan

Matter Arising 1: Project Execution Plan (Operation)	**Impact**
The NHS Wales Capital Investment Manual states: *"A mandatory requirement is the preparation of a Project Execution Plan (PEP) for all projects requiring NHS Executive approval" (A.6.1.1)* Management confirmed that the project does not currently benefit from a Project Execution Plan detailing terms of reference and reporting arrangements. <u>Internal governance</u> The Full Business Case outlined arrangements for effective governance of the project (**Appendix B**). However, arrangements at the project have been revised for the construction phase. General project governance was overseen by a Project Board. Its new terms of reference defined this as, reporting to both: • the Management Board; and • the Executive Capital Management Group. In turn, in accordance with best practice, the above was supported by sub-groups i.e. a: • Primary Care Contracting Group; • Construction Group; • Commissioning Group (including communications); and • Finance / Commercial Group. Each of these groups benefitted from appropriate attendance and leadership at the new terms of reference, and the revised arrangements permitted greater delineation and focus between construction v service / design issues. However, titles at the Welsh Government Dashboard differed from those at the FBC, with the Project Lead being designated Project Director, and the service lead having no assigned role.	Potential risk that: • Effective governance is not operated.

Contractual relationships There were also a range of contractual relationships e.g., a number of advisers, some contracted to the Health Board, some to the developer (e.g., the "employer's agent"), and some to the construction company (see **Appendix D**). A substantial sum adviser costs were paid as part of "pre-contract costs" (**Appendix D**), and others were to be incurred via the various parties as the contract progresses. Noting these matters, contractual relationships could usefully be summarised at a Project Execution Plan.	

Recommendations	**Priority**
1.1 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**

Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 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.	30th September 2021	Head of Capital

Matter Arising 2: Project Board Scrutiny (Design)	**Impact**
The NHS Wales Capital Investment Manual identified best practice principles to be applied at capital investment projects. It identified the Project Board as the accountable body for project delivery. Minutes of the Finance & Commercial Group of May 2021 recorded the critical task to "*Complete the expenditure monitoring and reporting template.*" This group was chaired by the Head of Capital, who also acted as the project lead. However, the Project Board terms of reference did not contain specific oversight of project costs, and the Board was not in receipt of detailed cost reports (**MAs 3** & **5**). For the Project Board therefore to be the accountable body for delivery of the project, there was need for the consistent presentation of time/cost information to enable independent scrutiny. At the time of audit, a revised cost reporting template was in process of approval.	Potential risk that: • Effective governance is not operated.

Recommendations	**Priority**
2.1 Management should ensure that: • sufficient information is provided to the Project Board to enable appropriate scrutiny/ challenge; and • there is appropriate membership / representation at the Project Board to ensure effective scrutiny of project costs at the Project Board. **(D)**	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 The updated financial reporting spreadsheet will be amended to the standard project Highlight Report which enables the Board to have more detail on the financial position. This will be supported in completion by regular meetings of the finance and commercial group. It will be proposed to the Senior Responsible Officer that the Capital Finance Manager will be invited to attend Project Board.	30th September 2021	Head of Capital

Matter Arising 3: Cost certainty & reporting (Operation)	**Impact**
Welsh Health Circular 2018 (043) - NHS Wales Infrastructure Investment Guidance in its requirements for scheme reporting to the Welsh Government, states that: *"It is essential that organisations ensure that the information from Supply Chain Partners is up to date and contains realistic forecasts in terms of completed works and valuations."* The Collaboration Agreement gives the Health Board the right to separate reporting for the Health Centre (i.e., dis-aggregated from the combined project cost reporting of the associated Health Centre and Housing). The following was concluded from inspection of monthly contractor valuation and weekly contractor reports: • Not all items were separated for the Health Centre e.g., there was no account summary or split of provisional sum adjustments; • Cash flow – no variance commentary was provided; and • No financial forecasts were provided. At the time of audit, the project was reported by the contractor as being some 8 weeks behind programme. However, Dashboard reporting to the Welsh Government showed the project as remaining on its original payment (cashflow) profile. Project forecasts and cash flow profiling to the Project Board were not identified. Whilst the internal monitoring profiled expenditure by month, this did not monitor against the budgeted cash flow. This detailed payment and cash flow monitoring was undertaken by the project lead, but not published to project groups. Project reporting therefore lack significant elements, including: • the approved budget from the Full Business Case; • contacted sums; • expenditure to date; • forecast out-turn; and • associated variance commentary. Reporting of the time and cost position was therefore unclear.	Potential risk that: • Management are not appropriately informed. • Management are not provided with appropriate control assurances.

Recommendations		Priority
3.1 Management should ensure appropriate reporting, forecasting and management of project costs and delivery in accordance with its contractual rights and obligations, including overall project reporting of: • Full Business Case approved budget; • contacted sums; • expenditure to date; • forecast out-turn; and • associated variance commentary.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 The updated financial reporting spreadsheet will be amended to the standard project Highlight report which enables the Board to have more detail on the financial position. This will be supported in completion by regular meetings of the finance and commercial group. It will be proposed to the Senior Responsible Officer that the Capital Finance Manager will be invited to attend Project Board.	30th September 2021	Head of Capital

Matter Arising 4 : Provisional sums (Operation)	**Impact**

The contract includes the following clauses:

Clause 2.1.4:

"The Health Board will pay a fair and reasonable proportion of the proper costs of the Consultants to be agreed between the Health Board and the Developer (acting reasonably)."

Clause 2.1.6:

"The Health Board will pay other reasonable and proper general costs arising from the Health Centre works to be agreed by the Parties acting reasonably."

Given the above, provisional sums should be separately assessed as part of existing contractual obligations.

Excepting the revised heating solution, it is recognised that there have been no adjustments to provisional sums to date. However, with regard the need for future monitoring it was noted that the contract includes significant provisional sums e.g.

Item	Cost	Commentary
Dental fit out	£220,000	Provisional sum
Acoustic soundproof booths / rooms	£82,500	Provisional sum
Car charge points	£17,047	Not yet instructed
Sub-total (example provisional sums)	**£319,547**	of £386,100 total provisional sums
Distributed heating system	£12,500	A stand-alone system is now to be utilised for the Health Centre. Welsh Government review of the business case (by NWSSP: Specialist Estates Services) commented that there was need to confirm the net increase in heating costs). Management confirmed that points raised at this review remain to be fully addressed. No such responses were available to this audit.

Potential risk that:

- Management are not appropriately informed.

Preliminary costs	£649,120	No breakdown provided, to understand elements which may increase with extended time, or time (cash flow) phased charging.
Mechanical (other costs)	£150,754	Not itemised
Electrical (other costs)	£118,213	Not itemised
Total (of example inclusions)	**£1,250,134**	of £6,651,489 total construction contract price

There was need to ensure that the client was not charged for design changes where provisional sums have been made e.g., whether the additional charge of £63,375 for the revised heating system includes a reduction of £12,500 for the provisional sum for heating (as above). The Health Board should also understand the contractual relation between requests / clarifications and resultant adjustments in provisional sums.

While Health Board monitoring of provisional sums was identified, this did not include the car charge points, or break-down of other sums identified in the table above.

Recommendations	**Priority**
4.1 Management should ensure that individual cost provisions within the works information are reported to understand charges and adjustments to provisional sums.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
4.1 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	31st March 2022	Senior Project Manager

Matter Arising 5 : Welsh Government Dashboard (Operation)	**Impact**
NHS Wales Infrastructure Investment Guidance 2018 (043) details: *"To inform the Welsh Government of progress on NHS infrastructure investment projects, all schemes receiving funding are required to report on a monthly basis. Project reports are required to be submitted … each month to the respective Capital Development Manager and the Deputy Head of Capital, Estates and Facilities. It is important for organisations to ensure that these reconcile to the schedules included within the monthly Financial Monitoring Returns".* Project manager and cost adviser reports were not provided in support of the Welsh Government Dashboard as required.	Potential risk that: • Welsh Government are not appropriately informed.

Recommendations	**Priority**
5.1 Management should ensure provision of project manager and cost adviser reports, in support of the Welsh Government Dashboard return.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
5.1 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.	31st January 2022	Senior Project Manager

Matter Arising 6 : Equipment costs (Operation)		**Impact**
Welsh Health Circular 2018 (043) - NHS Wales Infrastructure Investment Guidance requirements for scheme reporting to the Welsh Government, states that: *"It is essential that organisations ensure that the information from Supply Chain Partners is up to date and contains realistic forecasts in terms of completed works and valuations."* Regarding Health Board supplied equipment, as of April 2021 the Commissioning Group stated: "*leads to agree equipment schedule*". Equipment transfer lists were also required. However, this is recognised as a future action, noting the early phase of the project.		Potential risk that: • Costs are not appropriately controlled.
Recommendations		**Priority**
Future 6.1 Management should confirm agreed and costed equipping schedules (net of transfers) for inclusion within cost reporting.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
6.1 Room data sheets and equipment schedules have been drawn up and are in the process of being analysed for transfer and new purchase.	30th November 2021	Senior Project Manager

Matter Arising 7 : Contract Monitoring (Operation)	**Impact**
NHS Wales Infrastructure Investment Guidance WHC 2018 (043) states: *"After selection of the appropriate Advisors, Designers and Contractor (if applicable), the LHB or Trust should submit a schedule of their funding requirement …. It should include the priced activity schedules submitted by each successful organisation."* Each party should therefore submit a payment schedule against which payments and activities should be monitored. Both the developer and Health Board Project Manager submitted activity schedules. In support of its contract for £98,000, the Health Board Project Manager schedule included the following:	Potential risk that: • Parties are not appropriately monitored. • Payments are made in excess of duties performed

Item	**Hours**	**Cost**
Attend RIBA Stage 4 Design meetings	48	£4,179
Prepare Project Execution Plan (not provided)	24	£2,089
Attend RIBA Stage 5 Design meetings	110	£9,576
Attend RIBA Stage 5 Progress Meetings & Attend Site to Review Progress	120	£10,447
Attend RIBA Stage 5 Project Delivery Group Meetings	160	£13,929

It was noted that a Project Execution Plan had not been produced, and payment monitoring against activity schedules was not evidenced.

<u>Performance monitoring of the developer and developer advisers</u>

It is recognised that any monitoring undertaken by the Health Board in relation to developer advisers is in the context of project management being managed by the developer, with the Health Board in a monitoring role.

The application of key performance indicators provides an effective tool to manage internal and external resources. Key Performance Indicators to monitor performance were not being applied at the contract.

In the case of the developer, examination of the tender sum breakdown showed a £36,000 charge for a Performance Bond. There were also specific required actions, such as satisfying planning conditions and providing collateral warranties (due within 20 days of award of a sub-contract – Clause 220 – none supplied to date). These give direct rights to the Health Board against sub-contractors.

For advisers contracted to the developer, the Health Board is liable to pay circa 30% of their fees (via developer charges). Extensions of time for the Health Centre, or additional works may therefore give rise to additional fee and should similarly be monitored. While the Full Business Case provides for a directly contracted site Supervisor / Clerk of Works, such role had been vested solely in the developer. However, the Collaboration Agreement provides for client site inspection as required. No such site inspections had been reported to the Health Board. Accordingly, the Health Board have been unsighted as to the performance or thoroughness of on-site records which should record the quality of the completed work and on-site activities (for which they were being charged). These can also be key records in the event of dispute e.g., contractor delay claims v activities on site. There was therefore scope to enhance project management and assurances by additional monitoring of third parties.	

Recommendations	Priority
7.1 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**
7.2 Payments for both the Health Board's and the developer's adviser activities should be monitored against contracted activity schedules.	**Low**
7.3 Performance of relevant parties should be monitored appropriately.	**Low**

Agreed Management Action	Target Date	Responsible Officer
7.1 These are available and will be supplied by the developer.	30th September 2021	Senior Project Manager
7.2 Schedules are in place and will continue to be monitored at every payment application date.	30th September 2021	Senior Project Manager
7.3 As above although there will be a delay with the appointment of a new contractor.	30th September 2021	Senior Project Manager

Matter Arising 8 : Change control (Operation)	**Impact**
The Collaboration Agreement states that: • a Proposal Cost must be provided within 2 days (3.9.5), outlining the costs to raise a costed Change Request (to be compiled over a maximum of 9 business days); • within 4 days of the Proposal Cost the employer then either instructs to undertake the works, or decides not to progress; • the contractor then within 9 business days, or 19 working days if less than £50,000, upon receipt of the employer's instruction should prepare a change quotation; • the Employer has 20 days to accept the Change Request as costed; • within 10 days into the 20, the Employer may withdraw the request at no cost, or instruct extension of the 20-day time frame, or instruct to proceed; and There were therefore specified time frames within which costs should be appraised and approved. Certain works can also be instructed using "*daywork*" rates (typically for small or urgent works). These may be less economic than assessing an overall sum for a project change. Accordingly, under clause 450 of the Collaboration Agreement, their use should be pre-authorised by the Employers Agent. As previously noted, the contract also includes Clause 2.1.6: *"The Health Board will pay other reasonable and proper general costs arising from the Health Centre works to be agreed by the Parties acting reasonably."* The Health Board are therefore liable for any changes in project costs which they initiate e.g., as a result of changes in design requirements. They should therefore have an active interest (as an informed client), in being informed of, and approving such changes. There have been £171,073 of agreed and pending changes to date (**Appendix C**). However, while these were listed at reports by the contractor, supporting detail was not provided to the Health Board.	Potential risk that: • Contract changes are not appropriately controlled. • Undue time and cost increases are incurred.
Recommendations	**Priority**

Future assurance 8.1 Management should be provided with proposed contact variations and monitoring to facilitate timely Health Board scrutiny, in accordance with entitlements under the contract.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
8.1 This will be provided when the project restarts and all design works are completed.	At future project changes.	Senior Project Manager

Matter Arising 9 : Delay (Operation)	**Impact**
NHS Wales Infrastructure Investment Guidance WHC 2018 (043) outlines the need to monitor "*time, cost and quality*". Delay is separately ascribed to the health centre and housing development via a narrative at the monthly project reports. However, this was not separated at the project summaries provided. The following observations relate only to the health centre. Minutes of the March 2021 site progress meeting stated that the contractor "*are not currently reporting a delay to programme in their report*" but "*it was noted that they are circa 4 weeks behind in their programme*". It also referenced *"claimable"*, weather delays of up to 6 weeks (supported by a separate delay entitlement tracker listing 5.76 weeks *"claimable delay")*. The April 2021 contractor report identified "*potentially*" a 6 week delay due to steel supply. The June 2021 Project Manager report noted that "*the contractor is 8 weeks behind programme* (including steel delay) *but it still looking to maintain the critical path. The contractor stated there are future opportunities to draw this delay back and at this time are not advising on a delay to the Practical Completion date*". It also advised that "*the disruption caused to the overall design programme by involving the contractor in the process of developing an alternative proposal to the Health Centre design could give rise to a claim"*. Health Board management commented that no claims for "Extension of Time" have been received, and no such delay awarded. While there may be aspirations to recover time, there appears to be progressive slippage, and associated increase in the potential liability to incur and fund delays (also noting the early stage of construction works). The contract requires that *"if and whenever it becomes reasonably apparent that the progress of the Works or any Section is being or is likely to be delayed"* the Contractor *"shall as soon as possible, and in any event within 28 days"* give notice of a delay (*Clause 2.24.1*). The contractor has variously referenced "claimable delay" and "potentially claimable delay" within project reporting. However, no formal notice of delays as defined within the JCT contract provisions (e.g., detailing the impact on time and cost and associated contributing events etc.), have been submitted by the main contractor.	Potential risk of: • Late cost increases and delay

Accordingly, to avoid later potential disputes, it has been recommended that the Health Board require the developer to remind the contractor of its contractual obligations in respect of the timely notification and impact of delays.		
Recommendations		**Priority**
9.1 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**
Agreed Management Action	**Target Date**	**Responsible Officer**
9.1 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.	31st March 2022 (subject to timeline for appointment of new contractor)	Senior Project Manager

Matter Arising 10 : Risk Management (Operation)	**Impact**
Welsh Government guidance on completing project Dashboards, WHC 2021 (011), requires a: "*summary of all potential risks & opportunities that may affect the forecast outturn*." NHS Wales Infrastructure Investment Guidance WHC 2018 (043) more generally states: "*Risk registers for each individual project/programme must be completed, shared and monitored, with reference ..to time, cost and quality*". The risk register is intended to act as a key project management tool. Risks should progressively be managed down as the project progresses, and contingency is utilised to address issues i.e., enabling comparison of residual risk with residual contingency. The responsibility for the same rests with the Finance and Commercial project group, as defined within its agreed terms of reference. A risk register was included within the Full Business Case, compiled in January 2020. An updated risk register (dated April 2021) was presented to the May 2021 Project Board but did not include costs. While valuation of residual risk and contingency were not reported, this requirement was recorded as an action at that meeting. The following current project risks were not reflected within the risk register or in risk reporting: • confirmation of the contract (and rental) with Ashford (privately owned) surgery; • confirmation of pharmacy income; • technical design changes / NHS regulatory compliance (RIBA Stages 4 & 5); • Update of room data sheets / equipment; • Covid-19; and • land swap / sales shortfall. While the top five risks to the project were reported at the Welsh Government Dashboard, these were out-dated, and still included delay to Welsh Government funding (received in September 2020).	Potential risk that: • risks are not appropriately assessed and managed.

Recommendations		Priority
10.1 A costed risk register should be regularly maintained and reported to facilitate monitoring of the build.		**Medium**
10.2 Management should actively monitor and report the value of residual construction cost risks v remaining contingency.		**Medium**
10.3 Risks reported at the Welsh Government Dashboard should be reflective of current project reporting.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
10.1 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.	31st November 2021	Head of Capital
10.2 This is picked up in the appendix to the standard Highlight Report discussed in action 2.	30th September 2021	Head of Capital
10.3 The project Dashboard will be updated in line with the Project Board reporting – target date in line with reporting dates for the Welsh Government Project Progress (Dashboard) Returns.	17 October 2021	Senior Project Manager

Matter Arising 11 : Contracts (Operation)	**Impact**
The Collaboration Agreement states that: *"The Health Board accepts full responsibility for all design and specification of the Health Centre Works as contained in or referred to in the Health Board requirements (as if it were its own)"* including *"extension of time or additional loss and expense in accordance with the terms and conditions of the building contract". (3.1)* It also includes clause 2.1.4: *"The Health Board will pay a fair and reasonable proportion of the proper costs of the Consultants to be agreed between the Health Board and the Developer (acting reasonably)."* It also gives the Health Board the right to obtain a certified copy of all contracts. Copies of both the signed Deed of Cross Rights (including Welsh Government rights) and Collaboration Agreement (development agreement) were available. The contract for Project Management advice direct to the Health Board was also completed (in December 2020). However, adviser contracts were unavailable for advisers contracted to the developer, to facilitate understanding of the ongoing rights and obligations of the parties. As of June 2021, the developer's project manager also stated that the design team contract remained to be completed (though it is noted that this is a third party agreement and the developer's risk).	Potential risk that: • Contractual liabilities are not appropriately minimised.
Recommendations	**Priority**
11.1 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**

Agreed Management Action	**Target Date**	**Responsible Officer**

11.1 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.	30th September 2021	Project Leader

Matter Arising 12 : Central filing (Operation)		**Impact**
Welsh Government Infrastructure Investment guidance WHC 2021 (011) states that: *"It is considered good practice to publish key project documentation at each stage of approval to ensure a full and final record of the decisions taken by Local Health Boards and NHS Trusts."* Documentation relation to decisions taken in respect of land and developer options rest with the former (ABMUHB) Health Board and informed the Strategic Outline Business Case. While not forming part of the scrutiny of this audit, it is important that such documentation is obtained to retain a full historic record.		Potential risk that: • The Health Board cannot justify decisions taken.
Recommendations		**Priority**
12.1 The Health Board should obtain and retain all historic documentation within a central repository in the event of any future challenge or contractual disputes.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
12.1 All electronic documentation is filed in a central shared file. All papers will be moved to a single central location accessible by all Health Board project officers.	30th September 2021	Senior Project Manager

Matter Arising 13 : Design sign-off (Operation)	**Impact**
The NHS Capital Investment Manual (best practice) identifies the best practice of "*users to finalise and sign off their requirements*" including "room data sheets" in order to reduce the potential for project changes. The design was inherited from Abertawe Bro Morgannwg University Health Board and reviewed with users for suitability. The Steering Group (operated by CTMUHB to date) had additionally engaged heads of service (e.g., Audiology, Dental etc). While the design was therefore reviewed / refreshed, as fit for purpose by the Health Board, it was at an outline level of design (Royal Institute of British Architects – RIBA – Stage 3). Full Business Cases (FBC) are generally required to be at RIBA Stage 4 (technical design) (RIBA Stage 5 detailing the particular requirements at the construction stage), and both the design and room data sheets would be signed off by users to freeze the design. It is usual at the construction stage for a firm cost to be provided including a risk provision for the precise procurement cost of technical items, or other uncertainties. Welsh Government feedback on the business case (FBC) noted that many such aspects, should be included within an Estates Annex, which was not provided in this case. The developer bid on the basis of the outline design, making appropriate cost provisions to cover uncertainties. There is therefore risk of cost increase if a finalised design cannot be assured. A design at such a level did not include "*fit*" of contents, and specific mechanical and electrical items. The Welsh Government Dashboard to March 2021 confirmed that technical design compliance with NHS Wales technical and service standards has been concluded. Since the original review, no significant user changes have been made. Management confirmed therefore that since that date, that the design was progressed only in respect of mechanical and electrical detail, which has also been concluded in respect of all major items. However, documentation and reporting in relation to this was not provided to audit. While the design has been reviewed for functional requirement, there remained a level of detail to be agreed regarding the technical solution e.g. number and location of electrical outlets; IT provision etc. While not the originators of such changes, the users have an interest in such technical provisions being made. The design was therefore substantially complete, but formal sign off awaited full specification of technical provisions.	Potential risk that: • Design changes increase out-turn cost. • The design does not meet the needs of users. • Delivery is delayed
Recommendations	**Priority**

13.1 Management should instigate a process for formal review and sign-off of any further design changes with relevant parties.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
13.1 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).	30th November 2021	Senior Project Manager

Matter Arising 14 : Lease agreements (Operation)	**Impact**
As noted at Welsh Government scrutiny of the business case, the various lease agreements with service users, notably the General Practitioners (GPs) remain outstanding. Change in circumstances, especially for the independently owned G.P., sales value, the type and volume of services to be provided can all play a part in desire to commit to a forward lease. It is important therefore that leases with the various parties are signed as soon as possible. The Commissioning Group held in March 2021 stated that there remained a need to "*clarify GP's expectations*". The May 2021 issue log further noted the need to: "*Clarify how the building is to be managed, who will manage the building and what the anticipated costs will be for the GP practice tenant*".	Potential risk that: • The project is un-viable. • The objectives of the business case are not delivered.

Recommendations	**Priority**
14.1 Management should obtain signed lease agreements with relevant parties at the earliest opportunity.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
14.1 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.	31st January 2022	Primary Care Estates and Development Manager

Matter Arising 15 : Service Model (Operation)	**Impact**
NHS Wales Infrastructure Investment Guidance WHC 2018 (043) outlines the "*requirement*" for the service delivery model to be supported. The need for "*measurable*" benefits was stated at both the Full Business Case, and the Welsh Government Dashboard. While the business case outlined the social housing aspect within the wider scheme, the Health Board will not allocate tenants, and commits only to benefits isolated to primary care (rather than any hospital impacts). While a sessional timetable had been devised, the audit did not evidence room occupancy information including the level of administrative space / peripatetic use. While general efficiencies were anticipated from combining four G.P. practices, specific efficiencies such as joint reception staff / back-office functions have not been outlined. The six top benefits were outlined at the Welsh Government Dashboard return together with means of measurement. However, these contain no reference to the potential positive impact on hospital admissions. Targets at the Full Business (Appendix H) included: *"Reduced unnecessary attendance, referrals or admissions to hospital".* However, project goals did not include an increase in hospital bed turnover. Similarly, it did not include increased hospital discharges into a supported community setting. In discussion with management, the audit was informed that these objectives were not deemed measurable (i.e., would not be capable of attribution to such a single cause). The Dashboard also indicates only overall improvements in overall delivery of Primary Care services, rather than service specific targets (e.g., for Mental Health access or provision).	Potential risk that: • The service model is not agreed. • Service efficiencies are not optimised. • Post occupancy changes result in sub-optimal outcomes and post project costs.
Recommendations	**Priority**
15.1 Management should confirm an agreed service model with measurable outcomes for front line and support services.	**Medium**

Future 15.2 Objectives at the business case should be measurable.	**Medium**
15.3 Management should review and confirm project objectives based on only measurable outcomes within a Benefits Realisation Plan.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
15.1 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.	31st March 2022	Bridgend ILG Community Lead
15.2 The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	31st January 2022	Head of Capital as lead for the ILG and Primary care teams
15.3 Please see response above .	31st January 2022	Head of Capital as lead for the ILG and Primary care teams

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.

Appendix C: Project Cost development & summary

Cost development

The project was co-ordinated with a developer, via Welsh Government funding. The design was at an outline level of detail rather than full design (the implications of which were assessed in the audit). Construction was tendered by the developer, rather than being delivered via the NHS national construction framework (Designed for Life: Building for Wales) as is generally mandated for NHS construction. Tendering for a construction contractor was undertaken in December 2019 and contracted as below ***Figure 1***.

Non-construction costs were developed from budgets as estimated in the Outline Business Case (OBC). These were increased to recognise changes in heat provision (£142k), land valuations, a client Project Manager, extended program, design finalisation, and leased parking costs at the leisure centre. Equipment and planning contingency were also revised to be based on more robust estimates. Costs were further adjusted to include £1.254m of Optimism Bias (a sum not permitted under framework rules, but included to cater for the level of development risk within the outline design).

Cost Summary

Figure 1 *(Audit analysis – agreed with the Health Board)*

The Health Board is to pay the developer:	**Per Contract**	**Per Contract**	**WG Dashboard**	**WG Dashboard**
Health Centre construction	£6,651,489		£6,651,489	
Additional heating works allowance			£142,157*	
Compliance provision requested by WG			£137,500*	
Pre-contract (consultant) costs	£235,499			
Design changes (as of 15/12/20)	£53,420			
Planning	£169,373			
Consultants (contracted to developer)	£0	£7,109,781		£6,931,146
Plus: VAT at 20%		£1,330,298		£1,386,229
		£8,440,079		£8,317,375

Plus non-developer contracted costs:

(from FBC – *above – net of VAT*)	**Per Contracts**		**WG Dashboard**	**WG Dashboard**
Internally contracted fees (£582,245 - £235,499)	£346,746		£582,244	
Non works (less planning *above £367,035 net - £169,373*)	£197,662		£367,035	
Equipping	£353,270		£353,270	
Planning contingency	£882,166		£882,166	
	£1,779,844		£2,184,715	
Plus VAT	£286,619		£269,233	
Total		£2,066,463		£2,453,948
Total costs		£10,506,452		£10,771,323
Funding				
Welsh Government funding		£10,771,000		£10,771,000
Difference		£264,548		-£323

* Allowances made by the Health Board

As of June 2021, there were £169,189 of agreed variations and £1,884 pending variations (relating to temporary hoarding signage).

Variations to date included:

Revised heating solution	£65,375
Mechanical & Electrical NHS compliance changes	£76,744
Associated derogations required from standard guidance	£25,750
Amended fees	£1,320
Total agreed variations to June 2021	£169,189

Audit Cost Conclusions

Funding surplus			£264,548
Planning contingency			£882,000
Currently available contingency			£1,146,548
Internal fee budget		£346,746	
Less:			
Project Manager	-£98,000		
M&E Adviser (circa)	-£5,000		
Supervisor provision	-£25,000		
		-£128,000	
Forecast surplus internal fees			£218,746
			£1,365,294
Less: agreed and pending variations (£169,189 + £1,884)			-£171,073
Total available contingency (based on above)			£1,194,221

Less any additional sums to be spent on equipment etc.

Less additional fees due to the employer's agent / other parties

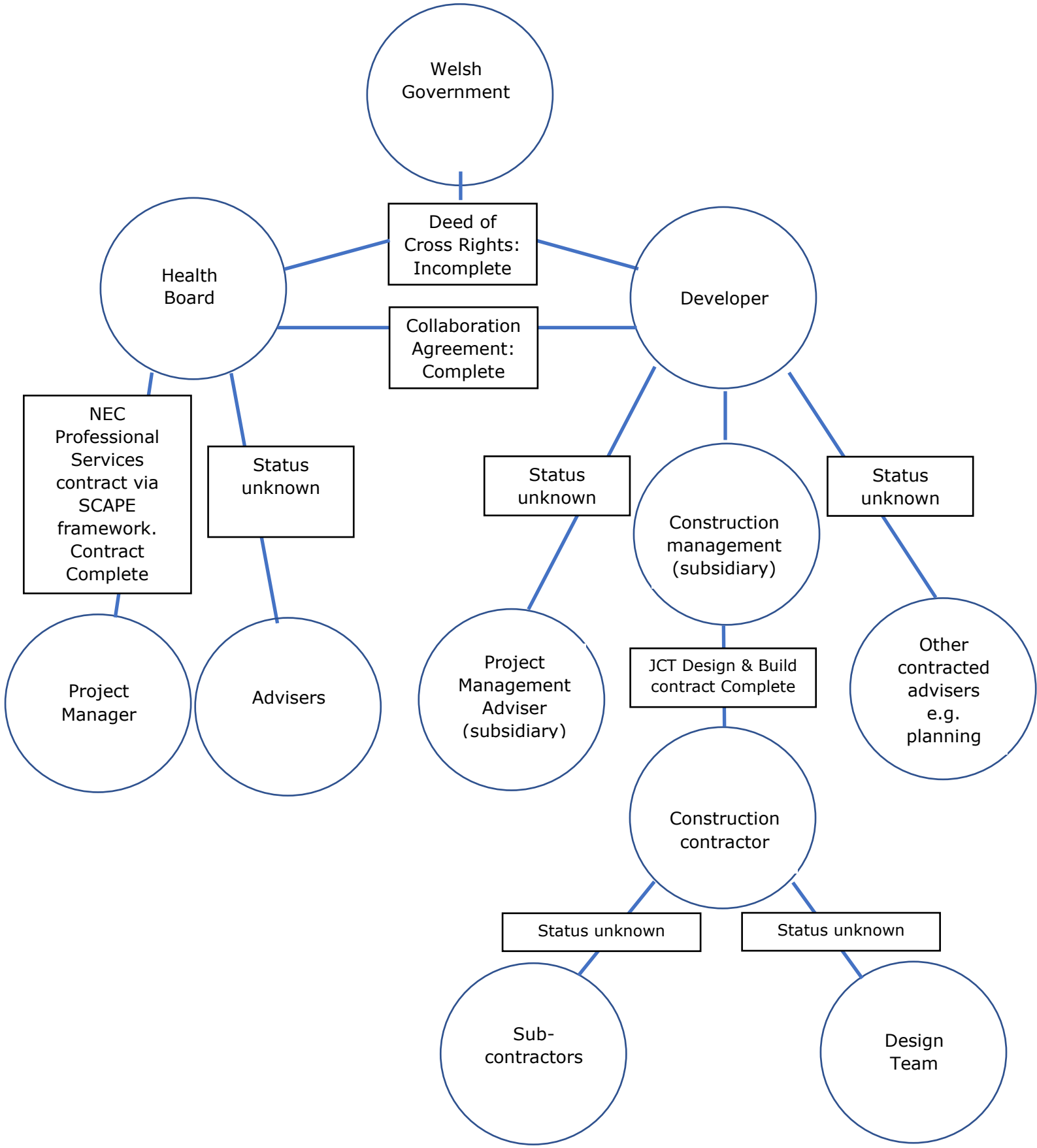
The Health Board have similarly estimated that over £1m of the contingency will remain unspent.

Conclusion – the project presently has adequate contingency & is expected to remain within agreed cost parameters based on current arrangements.

At the time of audit, the development was under construction (contracted duration 12/3/21 – 15/7/22).

Noting the inclusion of Optimism Bias of £1.254m within funding, and the margin between contractually committed costs and funding, there would therefore appear considerable margin for confidence in delivery within budget.

Appendix D: Contractual relationships



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Single Cancer Pathway: Data Quality and Integrity

Draft Internal Audit Report

August 2021

Cwm Taf Morgannwg University Health Board

NWSSP Audit and Assurance Services

Contents

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Approval and final report issued:	TBC
Auditors:	Paul Dalton – Head of Internal Audit Emma Samways – Deputy Head of Internal Audit Murray Gard – Principal Auditor

Executive sign off:	Gareth Robinson – Interim Chief Operating Officer Linda Prosser – Director of Strategy and Transformation
Distribution:	Paula Goode – Cancer Director Keryn Jones – Senior Cancer Manager Rowland Agidee – Head of Performance and Clinical Information Rob Jones – Head of Information
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.

Disclaimer notice - please note

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1. Introduction and Background

Our review of Data Quality & Integrity was part of our 2020/21 programme of work but was delayed due to the pandemic. As such, this review will form part of our 2021/22 work for Cwm Taf Morgannwg University Health Board (the 'Health Board'). The review seeks to provide the Health Board with assurance that there are effective processes in place to manage the risks associated with the quality and integrity of the reported single cancer pathway data.

High quality data is important to any organisation. Within the NHS it can lead to improvements in patient care and patient safety. Quality data plays a role in improving services and decision making, as well as being able to identify trends and patterns, draw comparisons, predict future events and outcomes, and evaluate services. The Health Board must be assured that the data they are using to make decisions is accurate, complete and reliable.

The data collected is subsequently used in decision making and the reporting of key quality and performance indicators at varying levels within the Health Board and beyond, including within the Integrated Locality Groups (ILGs), at Board and committee meetings, and to Welsh Government (WG).

Over the past year, due to the Covid-19 pandemic, while there have been some revised reporting requirements, reporting in relation to cancer targets has remained. Although, changes are being implemented by WG to the way in which cancer targets will be measured.

In November 2018 the Minister for Health and Social Services announced that *"NHS Wales would introduce a Single Cancer Pathway, starting from the moment a cancer is first suspected. This new 62-day waiting time measure includes patients referred from primary care or found to have cancer in hospital care. But most importantly of all, this new Single Cancer Pathway starts when cancer is first suspected."*

In November 2020 the Minister made a further announcement surrounding the Single Cancer Pathway (SCP), which included the following key points:[1]

… "from February 2021, we will report only against the Single Cancer Pathway and will no longer report the previous measures.

… the Single Cancer Pathway will not include any adjustments – we will report the real wait.

… our starting performance measure until March 2022 will be 75%. I expect the performance measure to be revised upwards in subsequent years."

As such, the focus of our data quality and integrity review of will be on the cancer target data that is reported to Board and to WG. This work will help to inform a wider cancer services review that we plan to do in 2021/22.

Under current arrangements, the Performance and Informatics team are 'systems owners' on which data is captured. They have responsibility for extracting data reports from systems within the data warehouse, such as the Welsh Patient Administration System (WPAS). Once extracted, reports are passed to 'data owners'

[1] Written Statement: Progress on the Single Cancer Pathway (18 November 2020) | GOV.WALES

for validation. In the case of SCP data, the Cancer Business Unit perform this validation role and rectify errors ahead of the Performance and Informatics team submitting the data for inclusion in performance reports and WG returns.

In 2020 the NHS Wales Delivery Unit undertook a review within Cancer Services, specifically in Urology and Radiology. As a consequence, management developed an action plan which, at the time of our fieldwork is being implemented. The implementation of those recommendations alongside the implementation of recommendations from our review should help improve data quality in this area.

The relevant Executive lead for the review is the Interim Chief Operating Officer and the Director of Strategy and Transformation.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the integrity and quality of the reported SCP data. The review sought to provide assurance to the Health Board's Audit and Risk Committee that risks material to the system's objectives are managed appropriately.

The review will seek to provide assurance over the following areas:

- Appropriate arrangements and procedures are in place in relation to the collection of SCP data.
- SCP data is accurately recorded for all patients in accordance with WG guidance.
- There are adequate quality assurance checks within the process to ensure the data reported is complete, valid, timely, accurate, relevant and reliable.
- Effective processes are in place to ensure timely monitoring and reporting of the SCP data, both to the WG and within the Health Board.

Our review is concentrating on the accuracy of the reported figures and not the compliance rates.

3. Associated Risks

The potential risks considered in the review were as follows:

- The service does not meet performance measures due to ineffective monitoring and governance arrangements.
- There is a lack of trust in the data due to weaknesses in the accuracy and completeness of the patient management system.
- Exposure to reputational issues for the Health Board, should reported data be found to be inaccurate or incomplete.
- Patients suffer avoidable harm through inefficiency and delays caused by data issues not being managed correctly and expediently.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the single cancer pathway data quality and integrity is *limited assurance*.

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

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

As noted in the scope section, our review did not scrutinise the compliance rates against the WG 62-day SCP target, rather we reviewed if the data that informed the reported results was accurate and reliable. For our sample period of January 2021 (reported against the Single Cancer Pathway), the reported percentage of treated pathways achieving this target was 49%, against the WG initial target of 75%.

The governance structure for Cancer Services includes a recently formed Cancer Steering Group, that allows for the monitoring and reporting of SCP performance. However, we identified that some key members of the group did not regularly attend the meeting due to clinical commitments. The terms of reference for the group also remain in draft.

At the time of our audit fieldwork management were drafting a Standard Operating Procedures (SOP) in relation to data validation. In addition, a number of SOPs for capturing and recording SCP data were in draft and awaiting approval. We also note that, unlike other health boards, the Health Board does not have a corporate policy or strategy surrounding data quality, although a performance and clinical information strategy is in draft.

Our testing of SCP data reported to the Board and WG in March 2021 identified issues in terms of both the accuracy and completeness of the data captured for inclusion, and the validity of the data that was reported. For example, we identified an issue in the scripts that draw the data from the data warehouse for inclusion in the reports, meaning that there has been an under-reporting of the number of patients treated. Furthermore, we understand that there is an all-Wales issue where patients whose records are updated after the monthly data has been extracted for reporting, are not captured in the reported information, either in month or in the subsequent month.

Our testing to validate a sample of the cases included within the data reported in March 2021 identified instances where the source documents had not been uploaded to the clinical portal. This meant we were unable to confirm if the correct dates had been used to calculate performance against the 62-day target. While we understand that some validation work is carried out by staff in the Cancer Business Unit who undertake cancer tracker work, this was limited to those cases that breached the 62-day target and was not subject to any quality reviews. There was no validation work on cases that had met the 62-day target. Issue logs were not kept that would allow the identification of trends and help future learning. Although, we acknowledge that management are taking actions to improve the control environment, which includes the validation processes.

5. Assurance Summary

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

Assurance Summary					
1	Arrangements and procedures in for the collection of SCP data			✓	
2	SCP data is accurately recorded		✓		
3	Quality assurance checks		✓		
4	Timely monitoring and reporting.				✓

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

Design of Systems/Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the system control for single cancer pathway data quality and integrity.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system for single cancer pathway data quality and integrity.

6. Summary of Audit Findings

In this section we set out the good practice and summarise the findings that we identified during our fieldwork. The detailed findings from our review are set out in the Management Action Plan (Appendix A).

Objective 1 - Appropriate arrangements and procedures are in place in relation to the collection of SCP data.

We note the following areas of good practice:

- Cancer Services have a documented governance structure in place that details accountability lines.
- Management has established two key forums where cancer services performance including SCP data is discussed: The Cancer Steering Group (CSG), which reports into the Cancer Programme Board (CPB). The groups share some common members that helps two-way communication.

  The CSG meetings have been held each month since its inception in January 2021. Cancer services performance is a standard agenda item.
- The CPB has a defined ToR that includes key governance information such as membership and purpose.

We identified the following findings:

- The Health Board does not have a corporate policy in relation to data quality, or operational procedures for collecting and validating SCP data. (Finding 4 - Medium)
- The terms of reference for the CSG have not been formally approved by the CPB. We also note that between January and March there were low levels of attendance by key personnel. (Finding 5 - Medium)

Objective 2 - SCP data is accurately recorded for all patients in accordance with WG guidance.

We identified the following finding:

- We identified data accuracy and validation issues in our sample of patient pathways. For example, where non-cancer pathways had been included in the data. (Finding 2 - High)

Objective 3 - There are adequate quality assurance checks within the process to ensure the data reported is complete, valid, timely, accurate, relevant, and reliable.

We note the following area of good practice:

- Monthly validation reports are sent to cancer services for validation prior to internal and external reporting.

We identified the following finding:

- We were unable to fully reconcile the data produced for reporting purposes to the systems containing the raw data as the program that had been set up for pulling the raw data did not capture patients from certain categories, meaning that the Health Board were under reporting on the number of patients treated in a month.

  We also identified a number cases that were not reported where patient records had been updated after data had been extracted for reporting purposes. Although we note that this is an all-Wales matter. (Finding 1 - High)

- Whilst some validation work was being undertaken, there were no quality assurance checks within cancer services on this validation process. Also, an issues log is not being maintained to capture any errors identified through the validation processes and allow for trends to be established. (Finding 3 - High)

Objective 4 - Effective processes are in place to ensure timely monitoring and reporting of the SCP data, both to the WG and within the Health Board.

We note the following areas of good practice:

- The SCP performance against the WG targets is reported to the Planning, Performance and Finance Committee as part of the integrated performance dashboard.
- The Board also receives regular updates on the SCP performance position as part of its assessment dashboard.
- Monthly performance information is also submitted to the WG.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	High	Medium	Low	Total
Number of recommendations	3	2	0	5

Appendix A: Management Action Plan

Finding 1- Accuracy of reported SCP data (Control design)	Risk
The WG SCP target is for 75% of cases to be treated within 62 days. The January 2021 data was reported to WG and the Health Board in March 2021 and showed only 49% of cases achieved the target. Our review is concentrating on the accuracy of the reported figures and not the compliance rates. This 49% is further broken down in the March 2021 Board report and the WG submission to show the number of breaches and treated pathways by tumour site such as lung or urology. There were 194 people recorded as treated on both the WG and Board submissions. However, when we attempted to reconcile this data to the 'number of patients treated' information on the Health Board's 'Klik sense tracker module', that holds the patient pathway data from the WPAS and other data warehouse sources, there was a difference of 15 patients. The tracker showed 209 patients treated in January 2021. The variation was because: • Six patients treated in January had not been included in the 194 cases, as two criteria within the data scripts that are used to produce the SCP report for WG and the Board were incorrect. Data from certain categories of patients was not 'pulled through' for reporting. For example, if a patient had subsequently died and the date of death field had been populated, the data in relation to these patients was excluded, even though they had been patients that were treated in that month. We understand that this error has now been corrected. • The remaining difference of nine patients was the result of a timing issue. We tested the information on the 'Klik sense tracker module' in May 2021. The tracker module is a 'live' system and so had been updated since the January data was extracted in late February, for the March WG submission and Board report. Data is not extracted until the end of the following month to allow for the records of patients awaiting test results, or treated in month, to be updated. The records for these nine patients had not been updated until after the data had been extracted in February. So, whilst they were treated in January and subsequently had a confirmed cancer diagnosis, as their records were not updated until after	The service does not meet performance measures due to ineffective monitoring and governance arrangements.

the February data cut off point, they had not been included in the reported January figures. We note that WG submissions and Board papers only report in-month figures so the nine cases identified above will not be captured in later reporting. It appears that this timing matter could occur each month, which could mean that the reported figures are not a true reflection of the total numbers of people treated in a month. We did not investigate if the nine cases met the WG 62-day target.	
Recommendation 1	Priority level
1. It should be confirmed that the criteria within the scripts used for reporting purposes has been updated, so that all appropriate patients have been captured. 2. Consideration should be given to supplementary reporting of SCP data to ensure that all treated cases have been reported and that cases not included when data is initially extracted are recorded and reported.	**High**
Management Response	**Responsible Officer & Deadline**

Finding 2 – Integrity of the SCP data (Operating effectiveness)	Risk

We tested the accuracy of the data reported to the Board and WG. To do this we used the January 2021 SCP data reported to the Board and tested all the cases relating to a sample of three tumour sites that were treated across the three ILGs. Our sample included cases that both achieved and breached the 62-day SCP target.

	Bridgend		Rhondda & Taf Ely		Merthyr & Cynon	
62-day target:	**Met**	**Breach**	**Met**	**Breach**	**Met**	**Breach**
Urology	5	5	-	-	-	-
Lower Gastro-intestinal	-	-	3	2	-	-
Lung	-	-	-	-	3	3

We reviewed the cases to ensure accurate recording of the initial 'point of suspicion' (when the clock starts), and the accurate recording of when treatment or care commences (when the clock is stopped). We identified data quality issues in 10/21 cases. Our review identified:

- Within the Bridgend sample, 1/5 breach cases, and 2/5 met cases, had been wrongly included in the data. Two of these cases were not cancers and should have been excluded from the data. The other was a progression of a previously diagnosed cancer and should not have been included.

  In one further breached case, the 'point of suspicion' had not been recorded correctly, but this did not change the classification of the case.

- Within the Rhondda and Taf Ely sample, for 3/5 cases we were unable to verify the timing back to the source documentation, as the referral letters had not been uploaded onto the clinical portal to confirm dates.

- Merthyr and Cynon sample – 1/6 cases could not be reconciled back to source documentation. Whilst we were able to confirm the date a scan took place; we could not trace the referral letter that led to the scan.

Patients suffer avoidable harm through inefficiency and delays caused by data issues not being managed correctly and expediently.

For a further 2/6 cases there were similar data quality issues where we could see the source documentation as the scanned referral forms were not on the clinical portal. We note that in recent months, management have undertaken their own review of data quality. We understand that the related findings report will be taken to the Cancer Management Board in June 2021.	
Recommendation 2	Priority level
1. Management should ensure robust processes are put in place that safeguards the integrity of the SCP data prior to it being published and reported on, including accurate input of dates and outcome data onto the clinical portal. 2. Referral letters and other key documents that support the 'start the clock' and 'stop the clock' dates should be added to the clinical portal.	**High**
Management Response	**Responsible Officer/ Deadline**

Finding 3 - Quality assurance monitoring (Control design)	Risk
At the time of our fieldwork there was limited data validation work. Only data relating to the patients who breached the 62-day target were being checked, there was no validation work on cases where the 62-day target was met. Therefore, in relation to the January data that we tested, the target was met for 95/194 (49%) cases, and as such, it appears that no validation work would have been undertaken on these cases. As reported in finding 3, above, we acknowledge that there is a draft SOP relating to the validation of SCP data (weekly or monthly checks) that includes the requirement to undertake validation work on all cases and not just those that breached the 62-day target. In addition, there were no documented quality assurance checks carried out by senior managers on the validation work, although we understand that going forward this will happen. Furthermore, no log is maintained to record issues identified through the validation process such as missing source documentation, such as referral letters, on the clinical portal. Such a log could assist in identifying trends in errors.	Patients suffer avoidable harm through inefficiency and delays caused by data issues not being managed correctly and expediently.
Recommendation 3	**Priority level**
1. While error rates remain high, senior management quality assurance checks should be undertaking to ensure reliability of the SCP data. Consideration should be given to including these check as part of the data validation SOP that is being drafted. 2. Validation checks of both breached and achieved cases should commence in line with the draft SOP. 3. An issues log should be maintained to record discrepancies in the data identified during the validation and quality checking process to help identify any trends in errors.	**High**
Management Response	**Responsible Officer/ Deadline**

Finding 4 - Policy and procedures (Control design)	Risk
At the time of our audit fieldwork there was no documented process in place for the verification of data. However, management have subsequently drafted a Standard Operating Procedure (SOP) for the required weekly and month end validation processes. In addition, following a 2020 NHS Wales Delivery Unit review within Cancer Services (specifically around Urology and Radiology) an action plan was agreed and management are implementing the recommendations which includes the development of SOPs relating to operational cancer management. As such, the draft policies, procedures and other guidance awaiting approval, are: • Escalation Policy; • Breach reporting SOP; and • Downgrade of suspected cancer SOP. Once approved and operational these procedures will help ensure consistent working practices and accurate capturing of data. Furthermore, the Health Board does not have a corporate policy surrounding data quality that sets the strategic direction and the commitment from the Health Board to have robust data quality processes in place. Although, we acknowledge that aspects of data quality are enshrined in existing Health Board policies such as the information governance and medical records policies. We note that the Health Board has a draft performance and clinical information strategy which, once approved and implemented, should aid enhanced operational effectiveness, through access to accurate, timely and secure data. We have sighted similar corporate policies at other health boards.	The service does not meet performance measures due to ineffective monitoring and governance arrangements.
Recommendation 4	**Priority level**
1. A corporate policy in relation to data quality should be developed that sets out the Health Board's strategic direction and its commitment to have robust data quality processes in place. 2. All draft Standard Operating Procedures in relation to the recording and validation of SCP data should be	**Medium**

appropriately approved and implemented as soon as practically possible.	
Management Response	**Responsible Officer/ Deadline**

Finding 5 - Cancer Steering Group (Operating effectiveness)	Risk
The main operational group that has responsibility for ensuring the delivery of cancer performance indicators, including the SCP, is the Cancer Steering Group. This is a newly established group which held its first meeting in January 2021. At the time of our fieldwork the terms of reference for this group were still in draft. Whilst the terms of reference require quarterly meetings, initially monthly meetings took place to allow the group to establish. Our review of the attendance of key personnel between January to March 2021 identified a low level of attendance from certain key personnel such as the cancer lead for one of the ILGs. While there is no formal escalation process for raising concerns about recurring non-attendance, we understand verbal feedback is given.	The service does not meet performance measures due to ineffective monitoring and governance arrangements.
Recommendation 5	**Priority level**
1. The terms of reference for the Cancer Steering Group should be reviewed and approved. 2. Management should either include an escalation process for dealing with frequent non-attendance by individuals or provide clarity in relation to key officers and quoracy within the terms of reference.	**Medium**
Management Response	**Responsible Officer/ Deadline**

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

	**Substantial assurance**	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
	**Reasonable assurance**	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.
	**Limited assurance**	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
	**No assurance**	The Board can take **no assurance** that arrangements in place to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **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** but which are relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

Archwilio Cymru
Audit Wales

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

Date issued: August 2021

Document reference: 123A2017

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.

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Contents

Audit and Risk Committee Update

About this document

1 This document provides the Audit and Risk Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2020-21.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2020-21 Performance Report, Accountability Report and Financial Statements	The Auditor General certified the Performance Report, Accountability Report and Financial Statements on 15 June. The next day they were laid by the Senedd, with a published statement by the Welsh Government. The Audit and Risk Committee is due to consider our Audit of Accounts Addendum Report. This Report sets out a number of audit findings, recommendations, and management's responses.
Audit of the 2020-21 Charitable Funds' Financial Statements	We are due to present our 2021 Audit Plan to trustee members on 11 August 2021.

Performance audit update

3 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- completed work since the last Audit and Risk Committee update (**Exhibit 2**);
- work that is currently underway (**Exhibit 3**); and
- planned work not yet started or revised (**Exhibit 4**).

Exhibit 2 – Work completed

Area of work	Considered by Audit and Risk Committee
Rollout of the COVID-19 vaccination programme in Wales	August 2021
Welsh Health Specialised Services Committee Governance Arrangements	August 2021

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Risk Committee consideration
Orthopaedic services – follow up Executive Lead – Director of Operations	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges.	Report being drafted September 2021
Review of the commissioning and contracting arrangements post Bridgend boundary change Executive Lead – Director of Strategy/Director of Finance	This work will examine the robustness of the arrangements for overseeing and managing the contractual agreements established following the Bridgend service transition in 2019. The work will also consider the programme for service disaggregation (for relevant services), and whether the arrangements support future regional service models currently being explored by the organisations.	Report due to go out for clearance September 2021
Structured Assessment 2021	Structured assessment continues to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. The work is in two phases. Phase 1 - examines the effectiveness of operational planning arrangements when NHS bodies continue to respond to the pandemic and to recover and restart services.	Phase 1 – Complete Phase 2 – Fieldwork Planned date for consideration – September 2021

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Risk Committee consideration
	Phase 2- examines how well NHS bodies are embedding sound arrangements for corporate governance and financial management, as well as drawing on lessons learnt from the initial response to the pandemic.	

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Risk Committee consideration
Review of Unscheduled Care Executive Lead – Director Of Operations	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. Once completed, we will use this data analysis to determine which aspects of the unscheduled care system to review in more detail.	Whole system commentary and data analysis currently being completed Further work not yet started TBC

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Risk Committee consideration
Local work 2021 (TBC)	The precise focus of this work is still to be determined.	Date for consideration to be confirmed

Good Practice events and products

4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.

5 In response to the COVID-19 pandemic, we have established a COVID-19 Learning Project to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to help prompt some thinking, and hopefully support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available here. This includes the material from our recent COVID-19 Learning Week held in March 2021.

6 Details of future events are available on the GPX website.

NHS-related national studies and related products

7 The Audit and Risk Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure.

8 **Exhibit 5** provides information on the NHS-related or relevant national studies published since our last Committee Update. It also includes all-Wales summaries of work undertaken locally in the NHS.

9 The Auditor General has also published his Annual Report and Accounts for 2020-21.

Audit and Risk Committee Update

Exhibit 5 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
Rollout of the COVID-19 vaccination programme in Wales	June 2021
NHS Wales Finances Data Tool – up to March 2021	June 2021
Procuring and Supplying PPE for the COVID-19 Pandemic	April 2021
An overview of Quality Governance Arrangements at Cwm Taf Morgannwg University Health Board: A summer of progress made against recommendations	May 2021

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Archwilio Cymru
Audit Wales

Rollout of the COVID-19 vaccination programme in Wales

Report of the Auditor General for Wales

June 2021

This report has been prepared for presentation to the Senedd under the Government of Wales Act 1998.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

4 Key messages

Context

1 The COVID-19 pandemic has affected everyone. The vaccination programme is a key strategic tool to fight the virus and help reopen the economy and wider society.

2 The purchase and supply of the vaccines is the responsibility of the UK Government. The vaccination programme in Wales is the responsibility of the Welsh Government and NHS Wales.

3 This report considers the rollout of the vaccination programme in Wales. In it, we discuss the shape of the programme, how it is performing, the factors that have affected rollout to date, and future challenges and opportunities. **Appendix 1** describes our audit approach and methods.

4 There are many vaccines in development globally, and the UK government has signed contracts for vaccine supply with eight major pharmaceutical providers (**Appendix 2**). At the time of our fieldwork, three vaccines were approved by the Medicines and Healthcare products Regulatory Agency (MHRA): Pfizer-BioNTech, Oxford-AstraZeneca and Moderna. All three vaccines require two doses to maximise effectiveness.

Key findings

5 Overall, the programme has delivered at significant pace, with local, national and UK partners working together to vaccinate a considerable proportion of the population who are at greatest risk. At the time of reporting, vaccination rates in Wales were the highest of the four UK nations, and some of the highest in the world. The milestones in the Welsh Government's vaccination strategy have provided a strong impetus to drive the programme. To date, the Welsh Government's milestones have been met.

6 The Welsh Government has adopted UK prioritisation guidance from the Joint Committee on Vaccination and Immunisation (JCVI). A national group in Wales provides additional guidance where further clarity on prioritisation is required. The guidance has generally been followed, but the process of identifying people within some of the nine priority groups (**Appendix 3**) has been complex.

7 The organisations involved in the rollout have worked well to set up a range of vaccination models which make best use of the vaccines available, while also providing opportunities to deliver vaccines close to the communities they serve.

8 Overall vaccine uptake to date is high, but there is lower uptake for some ethnic groups and in the most deprived communities. There are also increasing concerns about non-attendance at booked appointments, although health boards to date have been able to minimise vaccine waste.

9 The dependency on the international supply chain is the most significant factor affecting the rollout. Limited stock is held in Wales, primarily to allow for second doses and short-term supply to sites. This means that shortfalls in supply can seriously impact the pace of rollout. However, increasing awareness of future supply levels is allowing health boards to manage the calling of individuals effectively.

10 In the short-term, the workforce supporting the vaccination programme has been meeting the demands placed on it and many staff have been working 'above and beyond'. The current programme is unlikely to complete all second doses until September 2021, and an autumn booster programme is being discussed. This will offer little respite for key vaccination staff in an environment where workforce resilience is vital.

11 Early observations from military partners identified some sites were more efficient than others. Some vaccination sites may become unavailable in coming months as partner organisations look to reopen venues over the summer.

12 As Wales maintains its focus on delivering against existing milestones, there is a need now for the Welsh Government and NHS Wales to develop a longer-term plan for vaccine rollout. This needs to include sustainable workforce models which can respond to supply, whilst also responding to demands as other services are restarted.

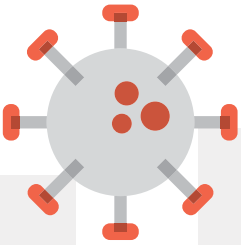
13 Consideration also needs to be given to the longer-term estate requirements to support autumn boosters, with a focus on ensuring that vaccination models are cost effective. Strategies to minimise waste need to be maintained and increased action taken to encourage uptake as the programme moves to the remaining population.

14 More broadly, there is much to be learnt from the positive way in which the vaccine programme has been rolled out to date. The Welsh Government and NHS Wales should be looking to apply that learning to wider immunisation strategies and the delivery of other programmes.

> Wales has made great strides with its COVID-19 vaccination programme. Key milestones for priority groups have been met and the programme is continuing at pace with a significant proportion of the Welsh population now vaccinated. This is a phenomenal achievement and testament to the hard work and commitment of all the individuals and organisations that have been involved in the vaccine rollout to date.
>
> However, the job is far from over. A longer-term plan is needed that moves beyond the existing milestones and considers key issues such as resilience of the vaccine workforce, evolving knowledge of vaccine safety, the need for booster doses, and maintaining good uptake rates - especially in those groups that have shown some hesitancy in coming forward for their vaccinations.

Adrian Crompton
Auditor General for Wales

Key facts



3.3 million

Vaccinations given in Wales

0.4%

Percentage of all vaccines considered unsuitable for use

91.5%

Percentage of the 1.68 million in the 'at risk' priority groups who have received a first dose

£29.4 million

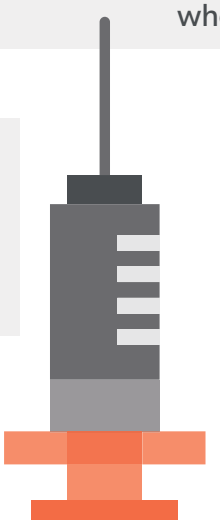
Costs for 2020-21 (excludes redeployed staff and the cost of vaccines)

84.4%

Percentage of the 2.52 million eligible adults who have received a first dose

66.1%

Percentage of the 1.68 million in the 'at risk' priority groups who have received a second dose



Vaccinations being delivered in:

54 mass vaccination centres

346 general practice locations

30 hospital locations

11 pharmacies

18 mobile team units

As of the end of May 2021

Source: Public Health Wales and the Welsh Government

Main report

How the programme is set up

15 Public sector partners across the UK have worked together since the beginning of the pandemic to explore the potential for a COVID-19 vaccination. The programme in Wales was first established in June 2020 to enable an appropriate infrastructure to be put in place before any vaccinations came online.

16 The programme is based around the principle of local autonomy for vaccine deployment through health boards. Supply policy and guidance is nationally coordinated:

a the UK government's Department for Business, Energy & Industrial Strategy (BEIS) led on UK-wide arrangements for research, purchase, and coordination of the national vaccine supply[1] working with the UK Vaccine Taskforce. Responsibility for the Vaccine Taskforce is now shared between BEIS and the UK Department of Health and Social Care. Welsh Government officials engage with the Vaccine Taskforce to streamline vaccine supply and anticipate upcoming issues.

b the Welsh Government is leading on vaccine deployment in Wales. It developed the national Vaccination Strategy for Wales[2] and formed a national programme structure (including Stakeholder and Deployment Boards, and an operational delivery group). The Vaccine Clinical Advisory and Prioritising Group (VCAP) considers clinical developments in vaccination against COVID-19 infection. The group advises the programme and partners on the implementation of the national vaccination programme, interpreting the priorities as outlined by the JCVI for the Welsh context. Collectively, these national groups provide policy and guidance, support financial resourcing, and have facilitated the Primary Care COVID-19 Immunisation Scheme[3] for commissioning primary care.

1 The UK Government Vaccine Taskforce (VTF): 2020 achievements and future strategy report provides an overview of UK level progress

2 The Vaccination Strategy for Wales was first published in January 2021 and formally updated in February, March and June 2021.

3 The Primary Care COVID-19 Immunisation Scheme sets out requirements and reimbursement for Primary Care providers that have signed up to the scheme.

c health boards are responsible for local vaccination plans, set up of mass-vaccination sites through collaborative working with local partners, and aspects of training and staffing. They are also responsible for securing vaccination centres in primary care and outreach/mobile services, with the Welsh Immunisation System (WIS) working to identify those in the priority groups using information on GP and hospital-based IT systems.

d Public Health Wales provides expert advice, surveillance data, vaccine effectiveness and safety monitoring, and public and patient information and reporting. It also assists in the development of training policy, patient group directions (PGDs) and tools.

e other partners are responsible for logistics:

- NHS Wales Shared Services Partnership and the Welsh Blood Service are responsible for supporting the pharmaceutical co-ordination team for consumable and storage logistics.
- Digital Health and Care Wales has led the design, test and rollout of the WIS that enables identification and coordination of priority groups and related appointment booking, vaccination recording and clinical quality assurance such as vaccine batch control. The system also provides performance data.

17 The Vaccination Strategy for Wales provides a high-level framework setting out the expectations for prioritisation and delivery of the COVID-19 vaccine. The Welsh Government has adopted the Joint Committee on Vaccination and Immunisation: advice on priority groups (**Appendix 3**). The national strategy focusses on developing the infrastructure for vaccine deployment, and communication about progress.

18 The first version of the strategy provided a clear milestone for the first four priority groups. In February 2021, the updated strategy provided target dates for the remaining milestones (**Exhibit 1**), with the aim of achieving 75% uptake for priority groups 5-9. This approach has continued to focus all partners on the time-critical aims of the vaccination programme as it continues to roll out.

Exhibit 1: Current key milestones for the vaccination programme

Milestone 1	**By mid-February 2021**: Priority groups 1 – 4 Subject to supply, the aim is to offer first dose vaccination to all care home residents and staff; frontline health and social care staff; those 70 years of age and over; and clinically extremely vulnerable individuals.
Milestone 2	**By mid-April 2021:** Priority groups 5 – 9 Subject to supply, the Welsh Government's aim is to offer first dose vaccination to all remaining priority groups.
Milestone 3	**By July 2021:** Offer first dose vaccination to the rest of the eligible adult population according to the JCVI guidance.

Source: Welsh Government

19 Programme oversight and monitoring take place at national and local levels receiving significant and regular officer level scrutiny as well as ministerial oversight. Public Health Wales and the Welsh Government publish regular updates[4]. Public Health Wales also undertakes enhanced surveillance, including analysis on vaccination uptake by deprivation, age, ethnic background and gender.

20 Vaccination delivery models vary by health board, predominantly based on geography and population density. Mass vaccination sites are being used in areas of higher population density, but in rural and hard to reach areas some health boards have adopted smaller local site models which enable vaccines to be delivered closer to the communities that they serve. Some health boards also depend more on primary care than others. Irrespective of geography, health boards are using outreach models to vaccinate in care homes and have set up temporary and mobile hubs (such as the Swansea Bay UHB Immbulance service).

21 Workforce planning is largely a delegated responsibility for health boards. A national workforce group has created policy and guidance providing high-level productivity modelling and has developed role descriptors for recruitment.

4 Public Health Wales vaccination updates are available on their interactive dashboard. Welsh Government updates are published each week.

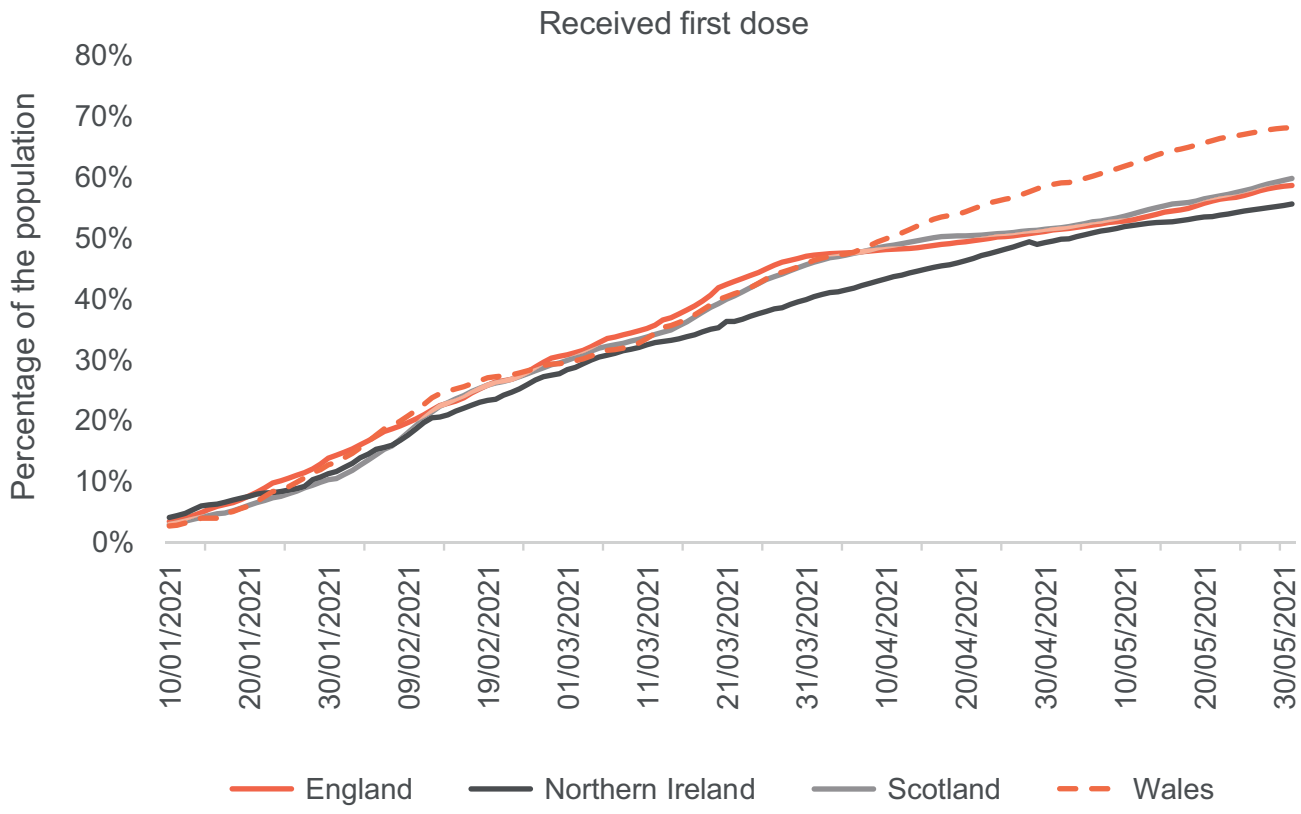
22 To date, vaccine procurement costs have been met by the UK Government in full. The Welsh Government funds the transport, storage, and additional local deployment costs in Wales. It provisionally estimated these costs at £34.9 million for 2020-21, including an estimated cost of £7.8 million for personal protective equipment (PPE). At the end of March, the actual costs for 2020-21 were reported as £29.4 million, as a result of costs associated with PPE largely being funded through existing PPE budget allocation. . Of the £29.4 million, £10.8 million has been spent on additional staffing, £9.54 million on the Primary Care COVID-19 Immunisation Scheme and £0.2 million on capital costs. Some staff are redeployed from within their organisations at no additional cost, although this has potential workforce implications for the part of the business where they originally worked.

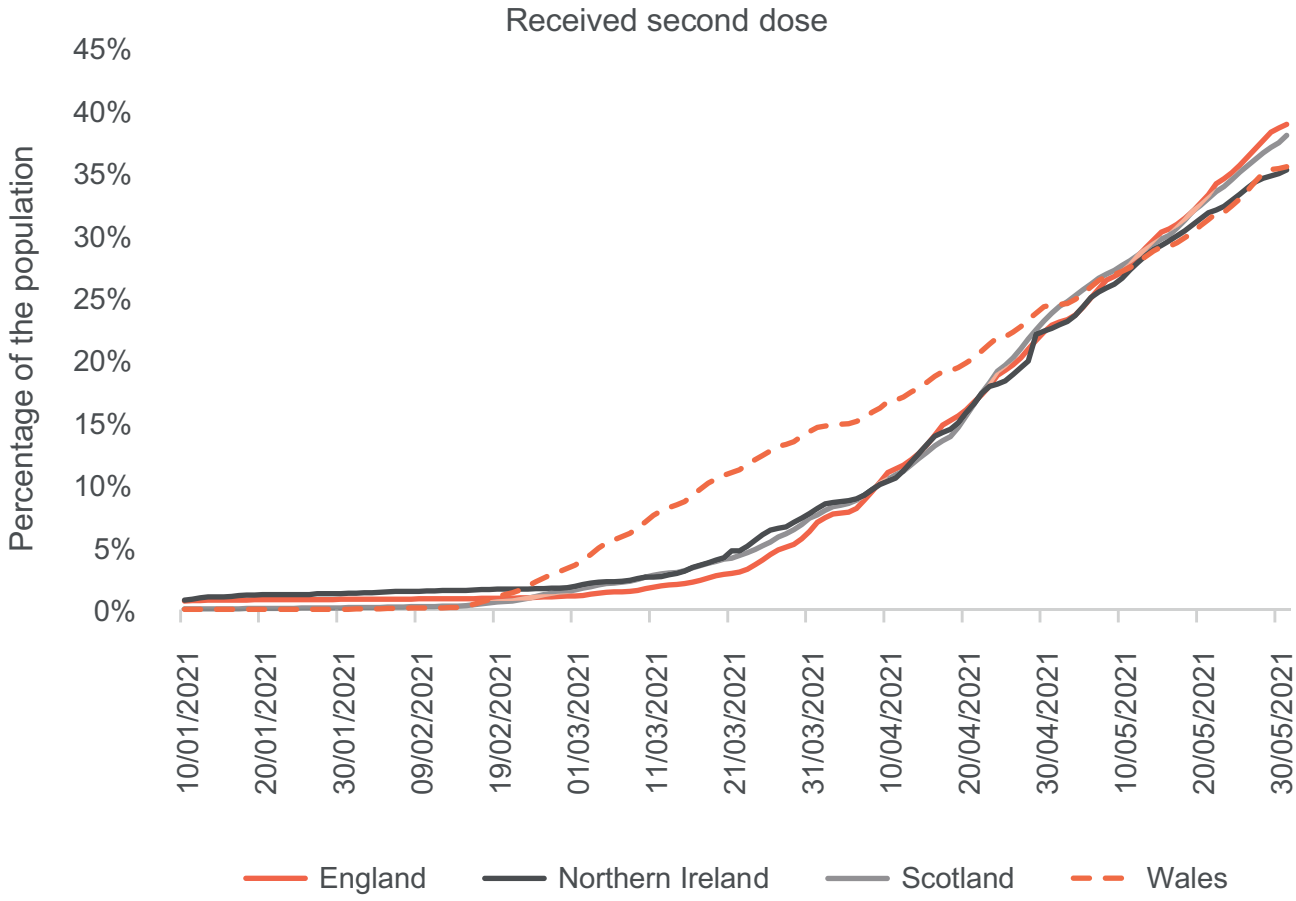
23 Other non-pay costs include transportation, site venue hire, personal protective equipment and syringe packs, security, and communications material. We understand that some vaccination sites are provided to the programme at no additional revenue cost. This is likely to change if local authority or other partners require the return of their facilities and health boards need to relocate to alternative accommodation which may come at a cost. The forecast costs of the programme for the first three months of 2021-22 (April to June 2021) are £31.5 million.

How is the programme performing?

24 Overall, as of 31 May 2021, the percentage of the adult population to have received the vaccine in Wales is higher than in the other UK nations (**Exhibit 2**). Wales made particularly good progress delivering second doses in March, although England and Scotland have now accelerated the delivery of second doses.

Exhibit 2: Percentage of the adult population to have received first and second doses of COVID-19 vaccination by country, as at 31 May 2021

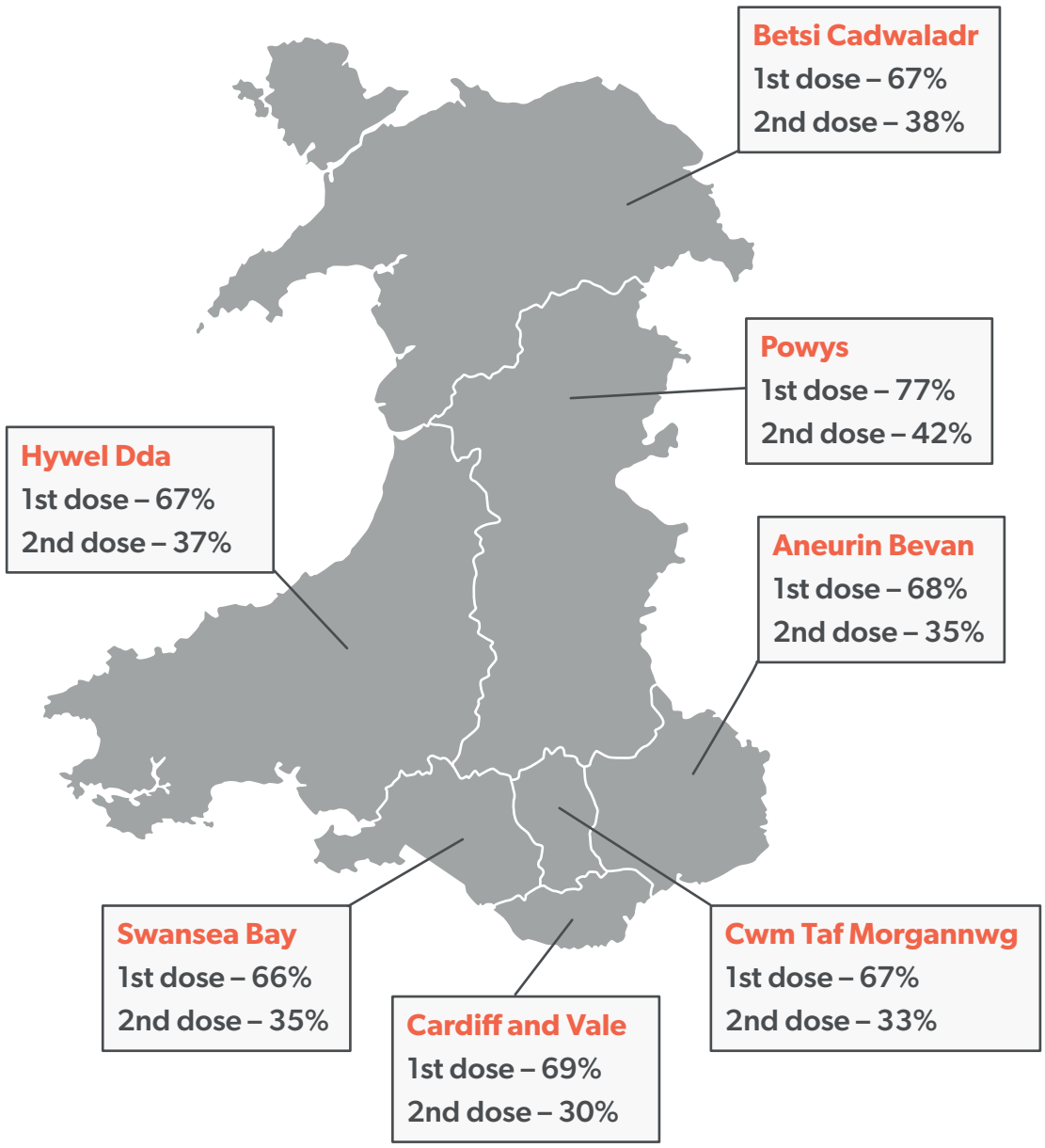




Source: UK Coronavirus Dashboard

25 There is some variation in the progress across health boards, most notably for Powys Teaching Health Board which is making the greatest progress (**Exhibit 3**). This is due to a combination of factors in Powys including a greater proportion of an older population and a higher level of supply per population as a result of batch sizes.

Exhibit 3: Vaccine doses given by health board as a percentage of the adult population as at 31 May 2021



Source: COVID-19 Vaccination Enhanced Surveillance Report, Public Health Wales

26 On 12 February 2021, the Minister for Health and Social Services announced that Milestone 1 of the vaccination strategy had been met. The Minister also announced on 4 April, that Milestone 2 had been met. Both milestones focus on the offering of an appointment for a vaccine. It is not possible to know if everyone eligible within the priority groups 1-9 were identified in the booking process. However, Welsh Government and health board officials took steps to help verify the position, such as contacting care homes to ensure all staff and residents had been offered a vaccination. At 31 May, around 95.5% of those in Milestone 1, and 87.9% of those in Milestone 2 had received their first dose.

27 While the programme has moved ahead to focus on Milestone 3, the Welsh Government and health boards are operating a 'no one left behind' policy. This means that anyone eligible in previous groups who has not yet had a vaccine for any reason can inform the relevant health board and make an appointment.

28 Public Health Wales surveillance reports show that influenza vaccine uptake is typically around 70% for those aged 65 and older. So far, the overall COVID-19 vaccine uptake for priority groups 1-9 is 91.5% which reflects positively in comparison. Reasons for not achieving 100% uptake include for example, people that are too unwell to receive the vaccine and the minority, to date, that have chosen not to have the vaccine. At the time of reporting, 66.1% of the priority groups 1-9 had received their second dose, and good progress was being made with vaccine rollout to younger age groups.

29 **Exhibit 4** shows some variation on uptake of first doses against the prioritisation groups by health board, particularly for priority group 6. We have observed extensive national-level discussion to respond to the challenges of identifying relevant population datasets. This included identifying all those aged 16-64 years clinically at risk where definitions of clinical conditions have needed to be clarified, and information about individuals is contained on different systems. There have also been challenges identifying unpaid carers who have previously not been recorded on any system. This indicates some of the difficulty in using a complex vaccination prioritisation model in the environment where no single centrally maintained population dataset exists for this purpose.

Exhibit 4: Percentage of first doses given by priority (P) group, at 30 May 2021

Priority Group		Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf Morgannwg	Hywel Dda	Powys	Swansea Bay
P1.	Residents of care homes	97.5	98.6	98.0	96.4	98.2	96.8	98.8
P2.	80 years +	96.3	96.0	94.3	95.9	96.1	97.2	96.2
P3.	75-79 years	97.0	96.5	95.9	97.1	96.6	97.2	97.3
P4.	16-69 years clinically extremely vulnerable	94.2	93.8	93.2	94.7	93.9	95.7	94.4
P4.	70 – 74 years	96.6	95.6	95.4	96.5	95.7	96.2	96.6
P5.	65-69 years	94.9	94.5	93.5	95.4	94.3	95.0	95.5
P6.	16-64 years clinically at risk	88.6	86.5	88.1	88.2	86.7	90.4	87.8
P7.	60-64 years	93.6	91.6	91.5	93.7	92.2	91.6	93.3
P8.	55-59 years	91.6	89.4	89.3	91.9	90.0	89.4	91.1
P9.	50-54 years	89.7	87.7	86.5	90.1	87.5	88.1	89.0

Note: P2, P3 and P4 also includes data for those in the respective age groups who are also residents of care homes. Frontline health and care staff, as well as unpaid carers are not explicitly identified at health board level but instead included within the relevant age groups.

Source: Weekly COVID-19 coverage report, Public Health Wales

30 Equality considerations are a growing concern. Public Health Wales data shows clear variation in uptake among different ethnic groups with uptake lower particularly within the Black community (**Exhibit 5**).

Exhibit 5: Percentage uptake of first dose of COVID-19 vaccine by age and ethnic group as at 5 May 2021

Ethnic group	White	Black	Asian	Mixed	Other
80+ years	97.2	80.7	87.3	93.1	82.5
70-79 years	96.6	79.9	87.3	88.0	83.4
60-69 years	94.4	76.8	86.6	84.5	78.9
50-59 years	91.3	71.9	84.3	79.4	71.7

Source: Monthly enhanced surveillance report, including analysis on equality of coverage, Public Health Wales

31 As part of their analysis, Public Health Wales also found lower uptake in deprived communities. Although the differences are not as great as for ethnic groups, uptake between the least and most deprived areas for some age groups varies by up to 5.3%. Analysis of COVID-19 positive cases over the last 12 months has indicated that case prevalence and severity have been higher in Black, Asian and Minority Ethnic groups as well as in some of Wales' most deprived areas, with Merthyr Tydfil experiencing the highest number of cases per head of population. In March 2021, the Welsh Government published its Vaccination Equity Strategy for Wales. The Vaccine Equity Committee met for the first time in April 2021 and is preparing a vaccine equity plan.

32 Vaccine wastage (known as vaccines unsuitable for use) to date is around 0.4% of all vaccines supplied. As of 31 May, this equated to around 14,400 doses. Wastage is more prevalent for Pfizer-BioNTech with 0.8% of doses unsuitable for use. Only 0.2% of Oxford-AstraZeneca doses have been deemed unsuitable, with 0.04% reported for Moderna. In comparison, NHS Scotland has estimated that around 1.8% of COVID-19 vaccines are wasted[5]. The other UK nations do not publicly report vaccine wastage.

5 Scotland's COVID-19 Vaccine Deployment Plan – Update March 2021

33 Reasons for vaccines being unsuitable for use include doses that fail quality assurance on initial inspection, doses that fail quality assurance following preparation and vials/doses which expire during the vaccination session. Specific requirements for storage, transportation, and shelf-life of Pfizer-BioNTech once thawed have presented challenges.

34 Arrangements to minimise wastage include:

a systematic recording of temperatures during the different stages of transportation to ensure storage requirements are met from source to site storage, and then on to vaccine centres.

b using reserve lists so that people can attend at short notice at the end of the day to use any vaccine left because of people not attending booked appointments. Approaches to reserve lists vary across health boards with some making reserve lists open to all priority groups while others are targeted to specific priority groups.

c allocation of the Pfizer-BioNTech vaccine mainly to mass vaccination sites. Pfizer-BioNTech shelf-life once defrosted is shorter than the Oxford-AstraZeneca, so the allocation to mass vaccination sites helps to ensure that it is used rather than reaching the end of its shelf-life.

What have been the factors affecting rollout to date?

35 Vaccine supply is the most significant factor affecting the pace of the rollout. UK-wide supply, while agreed through formal contractual obligations, is constrained by commercial pharmaceutical supply and international demand. In general, the Welsh Government and NHS Wales are informed of the expected notional supply around one month ahead. But this can change at short notice both upward and downwards, so reliable projections are difficult beyond two weeks and are in a range, with best, realistic, and worse case scenarios from BEIS.

36 Supply challenges to date include:

a the temporary withholding of a batch of Pfizer-BioNTech vaccines, equating to 25,000 vials, because of quality control issues in January. The MHRA quality control process ensures that vaccines are safe to administer.

b a reduction in February resulting from the refurbishment of both Oxford-AstraZeneca and Pfizer-BioNTech facilities in Europe to accommodate increased production levels.

c a reduction in April owing to the reprioritisation of Indian-produced Oxford-AstraZeneca vaccine resulting in an expected four-week delay.

37 Workforce models have evolved since the beginning of the vaccination programme, with a need to remain flexible to expand or reduce services at relatively short notice in response to supply. All health boards initially used registered health staff immunisers. This was then supplemented through GP practices, which has enabled vaccination activity to be scaled up and offered close to home. Changes to UK legislation has also enabled non-registered staff to be trained to vaccinate under supervision, and over time other partners, such as the military and more recently fire and rescue service personnel, have assisted in the rollout. Plans are also in place to use community pharmacies, with the first pharmacy offering of the COVID-19 vaccine launched in April 2021 in Cardiff.

38 Support staff, clinical staff who have either previously left or retired, and volunteers are also helping at vaccination sites in a variety of roles. The Welsh Government and health boards recognise the goodwill of retired staff who have agreed to come back and assist, as well as volunteers, but we heard mixed views on how easy and beneficial making use of these groups has been in practice. We heard of cumbersome processes to bring back retired or returning staff, some volunteers were only offering to help for short periods, and there were differing views about the need to undertake mandatory training.

39 Prioritisation in line with the Welsh Government policy and guidance has been an essential element of the programme to date. Almost all (99%) of the population at most risk from COVID-19 are in priority groups 1-9. All health boards have adopted prioritisation principles set out within the national vaccination strategy. However, there have been concerns about how the prioritisation approach has varied across Wales and the risk that some (including NHS staff) may have received their vaccine ahead of their allotted priority group. This has arisen because of the desire not to waste unused vaccine and the differing approaches to manage reserve lists. Welsh Government officials have written to health boards in an attempt to standardise the approach for reserve lists. There have also been challenges defining ‘frontline’ for health and social care staff, which may have also resulted in some staff receiving the vaccine earlier than intended.

40 We found that communications relating to prioritisation for the COVID-19 vaccination at a UK, Welsh Government and health board level have been generally consistent, reducing the risk of mixed messaging. In addition, work undertaken by Community Health Councils has found that the public have generally been happy with the communication that they have received from health boards. However, there appeared to be greater concern at earlier stages of the programme from people:

a wanting to know where and when they will be vaccinated;

b not understanding why, for example, a couple could not go to the same vaccination centre on the same day; and

c feeling that some with lower priority had been vaccinated before them.

41 As the programme has gathered pace, many of those initial concerns have eased. A longer lasting issue related to the format of invite letters. These letters are produced automatically by the Welsh Immunisation System for individuals invited to attend a mass vaccination centre, and for the first three months of the programme there was little that could be done to tailor them. We heard of concerns around:

a identical letters being used for first dose and second doses. An example was given to us where an individual was called back for a second dose at the initial recommended four-week period[6], but they thought they had received a first dose letter again in error and ignored it.

b the format of the letters, with interchangeable use of English and Welsh language over several pages, affecting the clarity of the letter and how to raise a concern or rearrange the booking.

42 The format of invite letters has since been addressed in relation to the use of English and Welsh language although the need to make clearer that the invitation is for second doses remains.

6 Initial guidance from the JCVI recommended that the second dose of the COVID-19 vaccine should be administered at four weeks after the first dose. This was subsequently changed to up to 12 weeks in January 2021.

What are the future challenges and opportunities?

43 The vaccine programme in Wales has progressed extremely well but there is still some way to go. Around 4.5 million doses are needed to protect 90% of the adult population in Wales with two doses. At the current rate, and with 3.3 million doses completed as at 31 May, this could mean that second doses for the remaining adult population are not completed until September. Alongside this, there is increasing discussion of an autumn booster programme. It is likely that there will be little respite between finishing vaccinating the remaining adult population and planning a possible next phase of the programme. This all points to a need to develop a longer-term plan for vaccine rollout that looks further ahead and moves beyond the here and now.

44 Vaccine supply is likely to remain a significant challenge. While new vaccines are also becoming available, the more that are in use, the greater the challenge to coordinate their deployment. Storage, transportation, preparation, shelf-life, and training requirements differ depending on the vaccine. Changes to JCVI guidance may also present challenges. For example, the recent guidance to offer under 40s an alternative to the Oxford-AstraZeneca vaccine[7] could result in slower rollout if alternative vaccines are not available. As more vaccines come on stream in Wales, complexity will increase further as may waste and operational efficiency. The Welsh Government are aware of this risk and are working to mitigate it.

45 The current workforce model is meeting the needs of the vaccination programme. However, as other services are restarted and as the wider economy reopens, a sustainable and still flexible workforce solution will be needed for the medium to longer term. Key issues include:

a some health board staff supporting the vaccination programme have been redeployed from their normal role. As other services are restarted, there will be competing workforce pressures as staff are called back to their core roles.

b we have heard that the workforce is fatigued, with many having worked above and beyond at many stages of the pandemic. This will not be sustainable in the longer term. We also heard that as the economy reopens and COVID restrictions are eased, the supply of volunteers is reducing.

c consideration is being given to the potential to combine a COVID-19 booster programme with the routine flu immunisation programme, or whether there is a clinical need to keep them separate. Either way, there are implications for the development of the workforce to meet demand.

7 JCVI statement on Use of the AstraZeneca COVID-19 vaccine: 7 May 2021

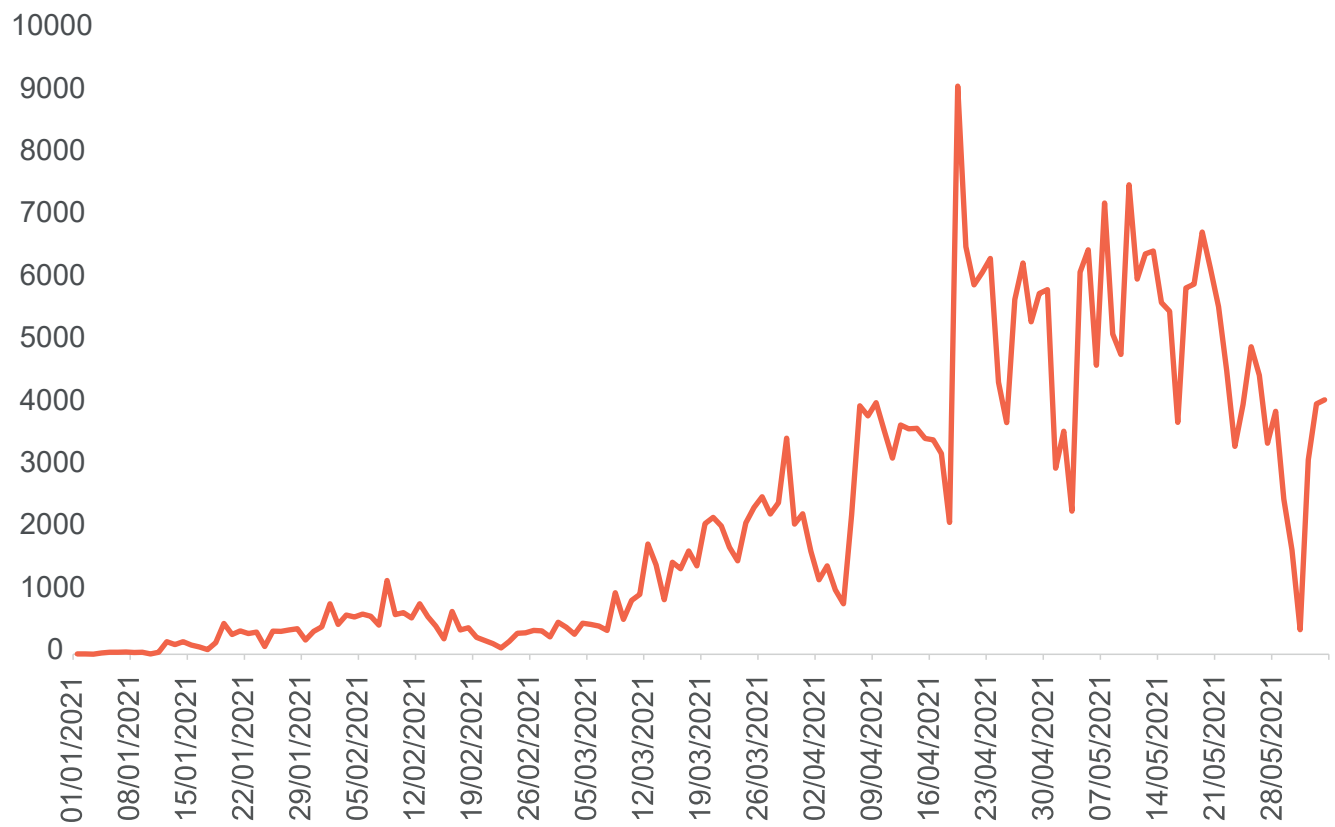
46 Sites used as mass vaccination centres have largely been made available to health boards through the goodwill of partners. Many of these venues were closed due to COVID-19 restrictions. With restrictions easing, organisations will now be looking at the potential to reopen these venues before the anticipated end of the current programme as a way of remaining commercially viable, for example, Venue Cymru in Llandudno. Health boards are likely to need to consider alternative cost-effective options for vaccination centres at relatively short notice to deliver the remainder of the current programme. They will also need to look at how to accommodate the longer-term COVID-19 vaccination programme alongside the wider immunisation programme.

47 There will always be differences in vaccination models to respond to local population needs and geography. Nevertheless, some models will be delivering greater efficiency than others. Early observations from the military partners involved in the vaccination programme identified vaccination sites were not always making the most efficient use of qualified staff and that rates of vaccination per hour per staff varied between 2.6 and 10.2. This variation in vaccination rates merits further investigation by operational officials, but the local variations will be, in part, due to supply and vaccine type. Health boards and the Welsh Government need to maintain a focus on ensuring that service models provide value for money. This will also help inform the shape of future models and programme design.

48 As the programme moves forward, there is a growing concern that the younger population are less likely to accept the offer of a vaccination. Health boards are continually assessing and adapting vaccination models to ensure they are accessible to all and working in partnership with other agencies to understand the reasons for vaccine hesitancy and to put actions in place. This has included some positive actions being taken to engage community leaders in particular ethnic communities, and members of the travelling community. Health boards and partners need to maintain this focus to build trusted relationships and improve the confidence in the vaccine programme. This is likely to be resource intensive if the Welsh Government and NHS wants to maintain its overall positive uptake rate for the remainder of the population and to ensure uptake of second doses is as high as is being achieved for first doses.

49 Having dropped at the end of March and early April, the number of individuals who do not attend for their appointment has since increased again (**Exhibit 6**). It is understood that non-attendance is greater for first dose vaccines, than second dose vaccines. Non-attendance impacts the pace of the programme and represents a cost-inefficiency as staff can end up underutilised. Arrangements to call those on reserve lists in at short notice are helping to fill empty slots, but as the percentage of the population yet to have a vaccine reduces, filling these slots will become more challenging. Non-attendance rates do vary by health board with Aneurin Bevan, Cardiff and Vale, and Swansea Bay University Health Boards experiencing some of the highest levels.

Exhibit 6: Numbers of people invited for vaccination but did not attend by day up to the end of May 2021



Source: Welsh Government

Note: the data used is intended for internal management information purposes and has therefore not been validated

50 Some of the reasons for non-attendance have included delays in invite letters being received, and problems getting through to contact numbers to rearrange appointments, as well as people not turning up because of vaccine safety concerns. Difficulties in getting time off work to attend appointment slots and clashes with holidays as society opens are increasingly likely to result in further non-attendance over the coming months. There is opportunity to reflect on the current approach for booking, with consideration to web-based systems to support self-booking of appointments. This will help provide flexibility and minimise the resource intensive process when people have to re-book or staff must find people to fit in the slots. The programme is actively working on establishing this with Digital Health and Care Wales.

51 Following a recent 'Programme Assessment Review' in March, the Welsh Government has considered future challenges and how it strengthens national programme management arrangements. To date, there has been limited additional central capacity to drive the programme at a national level, and reliance has been placed on a relatively small number of officials both within the Welsh Government and across the NHS to lead the rollout programme. Programme management arrangements during the early part of the vaccine rollout were rather unwieldy, with early oversubscribed Stakeholder Boards due to intense interest. In excess of 60 people from different professional backgrounds attended. Changes have been made to tighten up these arrangements and we understand that more changes are planned to further streamline programme management and governance.

52 Whilst the challenges outlined here need to be carefully considered as the vaccine rollout moves to its next stage, it should be recognised that the programme has moved at a scale and pace not previously seen in Wales. There is much to celebrate in that and there are many positive lessons to learn for the delivery of other programmes and the wider immunisation agenda.

Appendices

1 Audit approach and methods

Our primary focus was on the national vaccination programme and the deployment of vaccines in Wales. We drew on the vaccination deployment of three health boards to obtain an understanding of rural and urban settings. We considered the set-up of the national programme, performance of the programme, and the factors or issues that have affected rollout.

Our work excluded vaccination arrangements administered by the UK government. The National Audit Office has examined the UK government's preparations for potential COVID-19 vaccines[8]. We reviewed that report to help inform our wider understanding of procurement, contracting and vaccine costs, which are administered UK-wide.

Audit methods

We used a range of methods:

- **document review**: we reviewed national strategy, guidance, Welsh Government announcements and update reports, health board vaccination plans, local and national performance reporting. We also reviewed national vaccination stakeholder and deployment board papers and minutes.
- **observations**: we attended several national vaccination stakeholder board and deployment board meetings as observers.
- **semi-structured interviews**: we interviewed Welsh Government officials involved in the vaccination programme, selected members of the national vaccination deployment board, and senior managers from three health boards involved in the set-up of vaccination sites and the deployment of vaccines.
- **data analysis**: we reviewed available data on first and second dose vaccination progress in Wales and the other UK nations. We considered vaccine wastage and deployment costs, in relation to pay costs, non-pay costs and the extent of costs associated with vaccination in primary care settings.

It is not possible for us to present data for the same period throughout this report. Data in this report are taken from differing sources and are published at differing intervals. Detailed information on vaccine availability, stock, and utilisation by manufacturer is not publicly available for reasons of commercial confidentiality.

We completed our fieldwork between February and April 2021.

8 Investigation into preparations for potential COVID-19 vaccines, National Audit Office, December 2020

2 UK COVID-19 vaccines purchased and status as at 1 June 2021

Vaccine	No of doses	Status
Oxford-AstraZeneca	100 million	Approved 30 December 2020 and in deployment across Wales from January 2021
Janssen	20 million	Approved 28 May 2021
Pfizer-BioNTech	100 million	Approved 2 December 2020 and in deployment across Wales from January 2021
Moderna	17 million	Approved 8 January 2021 and in deployment from April 2021 in Aneurin Bevan and Hywel Dda University Health Boards
GlaxoSmithKline/ Sanofi Pasteur	60 million	Phase 3 trials
Novavax	60 million	Encouraging phase 3 safety and efficacy data
Valneva	100 million	Phase 3 trials
CureVac	50 million (initial order)	Phase 3 trials
Total	**507 million**	

Source: Recent GOV.UK announcement, updated based on information from the London School of Hygiene and Tropical Medicine and recent GOV.UK announcement

3 Welsh Government's vaccine prioritisation (based on the JCVI recommendation)

Vaccine prioritisation groups	
1	People living in a care home for older adults and their staff carers
2	All those 80 years of age and older and frontline health and social care workers
3	All those 75 years of age and over
4	All those 70 years of age and over and people who are extremely clinically vulnerable (also known as the "shielding" group) – people in this group will previously have received a letter from the Chief Medical Officer advising them to shield
5	All those 65 years of age and over
6	All individuals aged 16 years to 64 years with underlying health conditions*, which put them at higher risk of serious disease and mortality
7	All those 60 years of age and over
8	All those 55 years of age and over
9	All those 50 years of age and over

Source: Welsh Government

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Audit of Accounts Report Addendum – Cwm Taf Morgannwg University Health Board

Audit year: 2020-21

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Contents

Audit of accounts report addendum

Introduction

1 This report is an addendum to our Audit of Accounts Report that we presented to you on 9 June 2021. The report sets out the recommendations arising from our audit of the 2020-21 financial statements.

2 We would like to take this opportunity to once again thank all staff who helped us throughout the audit.

Recommendations from this year's audit

3 **Exhibits 1 to 9** set out three audit findings and recommendations, together with the management responses to each.

Exhibit 1: Matter arising 1

The Health Board has made good progress in the past year with its review and correction of the high level of old current liabilities	
Findings	We reported to you in June that during 2020-21 officers undertook considerable remedial work in respect of its old current-liabilities, and that we undertook significant additional audit testing. We did the additional testing at 31 August 2020 (Month 5) and 28 February 2021 (Month 11); and we tested the year-end position as usual. Our audit results and the validity of the liabilities improved as we progressed through our testing of the three month-ends. As reported to you by officers, the Health Board removed old current liabilities of some £19 million in respect of 2020-21. Officers' remedial work is ongoing in 2021-22, which includes their review of the Health Board's key processes and core principles for the accounting for accrued expenditure. This work remains critical to getting the Health Board onto a better footing for its 2021-22 financial reporting and beyond. Looking forward, it is essential that over time the Health Board does not get itself into a similar position again.
Recommendation	The recommendations that we made last year remain valid and relevant. The Health Board has made good progress against them, as mentioned at paragraph 4.

The Health Board has made good progress in the past year with its review and correction of the high level of old current liabilities	
	Looking forward, the Health Board should conclude its current review of the core processes and principles in place, and identify and agree the key changes that are needed. The Health Board should look to conclude this work by no later than December 2021, in order to have sufficient lead time into the preparation of the 2021-22 financial statements. As your auditors we could be part of that process by providing timely audit commentary and audit advice.
Accepted in full by management	Yes
Management response	It is pleasing to note that there was good progress on its review of old current liabilities. There is now improved guidance in place and there have been a number of changes to the accrual process, which will further improve the robustness of reviewing current liabilities. The Health Board is happy to have continued discussion with Audit Wales to provide an overview of the enhanced processes prior to the preparation of the 2021/22 financial statements.
Implementation date	December 2021

Exhibit 2: Matter arising 2

Several important audit issues arose regarding our audit of the remuneration report	
Findings	We reported to you in June that our audit of the remuneration report had been far more time consuming and difficult this year, because a number of significant process and documentation issues arose. We stated that we would provide further commentary on the issues in this addendum report, which we set out below. <u>The appointment of the Interim Chief Operating Officer (COO)</u> The Health Board appointed an Interim COO with effect from 11 January 2021 at a salary of £150,000. The salary exceeded the Welsh Government's (WG) salary band for a health board COO, which for 2020-21 permitted a salary no higher than £143,625. Any salary exceeding the WG's salary limit requires the Health Board to seek and obtain the WG's approval. Failure to do so results in a salary being irregular, which could adversely affect our regularity opinion on the financial statements. We established that officers had not sought the WG's approval, and on 2 June 2021 the Health Board's Executive Director for People emailed the NHS Wales Chief Executive to request retrospective approval of the higher salary. The NHS Wales Chief Executive approved the request on the same day, stating that he would do so on this occasion. Without the prompt reply and approval by the NHS Wales Chief Executive, our regularity opinion could have been qualified, or your consideration and approval of the audited financial statements could have been postponed beyond the Welsh Government's deadline. <u>The appointment of the Interim Director of Therapies and Health Sciences (DoTHS)</u> The Health Board appointed an Interim DoTHS with effect from 2 November 2020, at a salary of £131,470, with the appointee working on a 50/50 split across the Health Board and Cardiff and Vale University Health Board. As part of our review, we established that the salary for the role, and key engagement with WG, took place in March and April 2021, some five months after the

Several important audit issues arose regarding our audit of the remuneration report	
	appointment. On 23 April 2021, WG determined the role's salary band to be £123,259 to £132,906. Despite our requests for information, we did not receive the key March and April communications until 2 June. As stated above, this item could also have affected the achievement of WG's deadline, and potentially the regularity opinion. <u>The retirement and return of the Director of Finance (DoF)</u> Under the provisions of the 1995 NHS Pension Scheme, the Health Board's DoF retired on 17 February 2021 and returned to the same role on 19 February. We found the Health Board's documentation of the consideration of request for the retire-and-return to be limited. Late in the audit process, senior officers provided us with a retrospective note of the process that they had applied. We also found that the Health Board had not paid the DoF for the period 19 February to 31 March 2021, because his salary had been entered as £nil in the payroll system. The Health Board had subsequently paid the outstanding amounts in April. The lack of documentation regarding the nature of the return may have contributed to the failure to pay the DoF.
Recommendation	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

Several important audit issues arose regarding our audit of the remuneration report	
	contemporaneously and provide accurate information to the payroll department.
Accepted in full by management	Yes
Management response	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.
Implementation date	Immediate

Exhibit 3: Matter arising 3

The Health Board's related party disclosures were materially incomplete	
Findings	We identified five material audit amendments that were required to add related party disclosures that had been omitted. Four related to the Health Board and one to the Welsh Health Specialised Services Committee. We established that signed declarations had been either: • overlooked and omitted by the finance team; or • disclosed in the financial statements, but with the relevant transactions and balances omitted.
Recommendation	The Health Board should ensure that all relevant declarations are fully disclosed in the financial statements; and that in doing so officers make robust enquiries of the financial ledger to ensure that all transactions and balances are captured.
Accepted in full by management	Yes
Management response	Discussions will take place with the relevant offices to ensure that all declarations are fully disclosed and robust enquiries of the financial ledger take place.
Implementation date	April 2022

Exhibit 4: Matter arising 4

Some of the information submitted for audit was incomplete or inaccurate	
Findings	Each year we agree an 'Audit Deliverables' document with officers, which sets out our respective commitments and the associated delivery dates. Meeting all the commitments in the document is important to the efficiency and timeliness of the audit. We found that some of the documentation submitted for audit was incomplete or inaccurate and did not support the figures in the draft financial statements. These shortcomings led to the need for extended audit time, and more time of management and finance staff. The main problem areas were the: • primary care accruals; and • the analysis of continuing healthcare accruals.
Recommendation	The Health Board should ensure that working papers provided at the start of the audit are as described in the deliverables document and have clear cross-referencing to the relevant figures in the financial statements. Also, where spreadsheets are the underlying form of evidence, the Health Board should ensure that all cell values have an appropriate audit trail and that they are never manually input.
Accepted in full by management	Yes
Management response	The required working papers will be communicated with the relevant finance officers and a request that these are prepared and available in readiness for Audit review.
Implementation date	April 2022

Exhibit 5: Matter arising 5

Management undertook a late review of their draft financial statements and made a number of amendments after the statements had been submitted for audit and to the Welsh Government	
Findings	The Health Board provided us with its draft financial statements by the Welsh Government's deadline of 30 April. However, on 14 May management emailed us with four significant amendments to the draft financial statements. We understand that the post-submission amendments had arisen due to management's review of the financial statements being late.
Recommendation	The Health Board should ensure that management reviews the draft financial statements, and makes all corrections necessary to the statements, before submitting them to us and the Welsh Government on the stipulated date.
Accepted in full by management	Yes
Management response	Timescales for preparation of the accounts are very challenging, the consolidation of the WHSSC accounts provides a further challenge that is not the case for other HBs. There were also a number of late adjustments to the draft accounts from WG and shared services which impacted on the timescales for 2020/21. During 2020/21 there was also unforeseen sickness in the financial accounts team and there was a new appointment at a senior level within the team. Given this processes and timetables will be reviewed and updated to build in time for sufficient review by Senior Management before the draft accounts are submitted.
Implementation date	April 2022

Exhibit 6: Matter arising 6

The Health Board holds numerous fixed assets with a nil carrying value	
Findings	We established that there were 1,878 assets on the fixed asset register as at 31 March 2021, which had a £nil carrying value (or net book value). The assets may no longer be in existence/operational use, or they may still be operational and have a longer asset-life than originally estimated by management. There was no evidence that management had undertaken a review of the status of such assets to ensure that they are appropriately accounted for in the fixed asset register and financial statements.
Recommendation	The Health Board should review all its fixed assets with a £nil carrying value, and take action where necessary, to ensure that the fixed asset register is accurate. Where relevant and appropriate, this could include revisiting the estimated useful lives of certain assets.
Accepted in full by management	Yes – see response
Management response	This is noted and the capital team do undertake regular reviews of assets with a 0 life to confirm they remain in use. It is usual for organisations to utilise assets after the manufacturer recommended life. However, a review of equipment assets will be carried out in the 21/22 financial year to ensure that the most up to date classifications and standard lives are being selected at acquisition.
Implementation date	Immediate

Exhibit 7: Matter arising 7

One of the Health Board's financial returns contained a large error	
Findings	We identified that one of the year-end financial returns to the Welsh Government included an incorrect figure of £114.7 million, in respect of the balance held with the Welsh Risk Pool for expenses recognised by the Health Board but not yet claimed from the Pool. The figure should only include the amounts defrayed (ie, paid) by the Health Board but not yet received, which was £29.9 million. We found the same error last year, which we had reported to officers informally. Given that the error has been repeated, we are reporting it formally this year.
Recommendation	The Health Board should ensure that where required by Welsh Government, its financial returns are based on defrayed expenditure.
Accepted in full by management	Yes – however balances are agreed
Management response	While the error looks significant, the initial figure included does relate to a balance held within the Welsh Risk Pool. It is recognised that the value should be the amounts defrayed therefore working papers and process will be updated to ensure this is included in 2021/22.
Implementation date	April 2022

Exhibit 8: Matter arising 8

The Real Asset Management (RAM) IT system is not part of regular disaster recovery testing, or test restores from backups	
Findings	The Health Board does not specifically and regularly test its RAM system backups, and recovery from them. The Health Board therefore has an increased risk that, should there be a RAM system loss, it would be unable to recover the system and its information. Such a loss could arise through system failure or cyber-attack.
Recommendation	The Health Board should perform a restore of the RAM system from backups to confirm that the process works as expected and thereby provide assurance that the system could be recovered in the event of system loss or failure. The Health Board should carry out such testing regularly.
Accepted in full by management	Yes
Management response	The Capital team will link with the relevant lead in the ICT team to confirm the programme of backups for the RAM system and agree a process and timeframe for checking and testing the backups have recorded properly. This will be actioned early in 21/22 and an agreed programme and process developed moving forward.
Implementation date	Immediate

Exhibit 9: Matter arising 9

The Health Board should strengthen the IT controls in relation to the Health Roster system	
Findings	With regard to the Health Board's Health Roster system we identified that: • Many users have super user access rights that allows them to create/amend user access to the system. This increases the risk of system misuse. • The minimum password length for system-user access is only six characters. This requirement is below the length recommended by good practice. Having strong password requirements would reduce the risk of inappropriate system access.
Recommendation	The Health Board should only allocate superuser access to Health Roster system for users who require it; and remove such access from those who do not require it. The Health Board should also review the minimum user-password length and complexity for the Health Roster system, in line with good practice.
Accepted in full by management	Yes
Management response	The Health Roster team will link with the relevant lead in the ICT team to take forward the recommendations.
Implementation date	December 2021

Recommendations from last year's audit

4 We raised two recommendations last year, one of which the Health Board's management accepted, and one that they partially accepted. We can confirm that the Health Board has made good progress on both recommendations.

5 The accepted recommendation relates to the Health Board's old current-liabilities, which we cover at **Exhibit 1**.

6 Our second recommendation related to entries in the fixed asset register were inadequate because they were far too generic and therefore not meaningful. the Health Board has improved its records, and its improvements are ongoing into 2021-22. We will continue to review this area as part of our annual audit.

Audit Wales

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We welcome correspondence and telephone calls in Welsh and English. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

AGENDA ITEM
6.1

AUDIT & RISK COMMITTEE

POST PAYMENT VERIFICATION INTERIM PROGRESS REPORT - 1ST OCTOBER 2020 TO 31ST MARCH 2021

Date of meeting	17/08/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Amanda Legge -All Wales Post Payment Verification Manager
Presented by	Amanda Legge – All Wales Post Payment Verification Manager
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**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
PPV	Post Payment Verification

1. SITUATION/BACKGROUND

1.1 This paper highlights the narrative on how practices have been performing over the current PPV cycle, and two previous. It also demonstrates the overall performance of the Health Board against the national averages. Post Payment Verification of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General

Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

This year 2020-2021, we have faced major challenges associated with the COVID-19 pandemic. In order to effectively respond to challenges identified within Primary Care, Welsh Government primary care chief officers, in collaboration with associated clinical directors within the service, agreed that Post Payment Verification (PPV) processes would be stood down. This decision was taken to protect our front-line services, to maintain colleagues' safety and to remove any pressure on primary care contractors and their teams during unprecedented times. A review of opportunities and a recovery plan was considered during this time, to return with an acceptable level of PPV, which would continue to provide Health Boards with reasonable assurance that public monies are being appropriately claimed. PPV reinstatement was 1st October 2020, which was agreed by General Practitioners Committee (GPC) Wales and Welsh Government.

The paper is being produced for the Committee to review for information purposes and discussion.

PPV provides assurance in all contractor disciplines, with the exception of General Dental Services. At certain times throughout COVID-19, cash flow to medical and ophthalmic contractors has been maintained based on historical claiming patterns, due to submission of claims for various enhanced services being suspended.

NWSSP reviewed how it was able to reinstate an agreed level of PPV within both the Ophthalmic, Pharmaceutical and Medical disciplines along with the Clinical Waste Audit.

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

2.1 General Medical Services (GMS)

Pre COVID, the visit plan previously run on a 3-year cycle for GMS 2020-2021 and was agreed by Health Board Audit Committees. Following review of the All Wales visit plan, NWSSP reinstated remote access PPV arrangements within the GMS discipline. It was agreed that resources be focused to clear all planned GMS routine and revisits due for 2020-2021 by 1st April 2021. These visits would be completed remotely and would not be intrusive or place additional requirements on local front-line service provision. Remote access verification would take place based on a sample of claims submitted from April 2019 - March 2020, due to the sudden decrease of claims from the point of lockdown in March 2020. NWSSP is, however, allowing a postponement of visits until April 2021, due to the COVID-19 vaccination programme and the additional pressure that contractors are under.

It has been agreed by General Practitioner Committee Wales and Heads of Primary Care that PPV can proceed with the GMS visits during the 2021-2022 financial year as part of the PPV three-yearly cycle, utilising 2019-2020 claim data from April 2021.

2.2 General Ophthalmic Services (GOS)

Pre COVID-19, the visit plan for GOS 2020-2021 was agreed by Health Board Audit Committees. However, ophthalmic practices have been unable to remain open to the public for certain periods and it is a service where PPV teams did not have the ability to undertake reviews via remote access at this time. We are looking at remote access now via TEAMS and hoping to begin this if agreed with all relevant parties in October 2021.

NWSSP provided data to Welsh Government regarding the opening hours and claims for GOS. We are also undertaking the GOS quarterly patient letter programme across Wales to provide elements of assurance to our Health Boards.

2.3 Pharmacy Services (GPS)

Due to COVID-19, the Medicines Use Review (MUR) service was stopped in March 2020.

In April 2021, NWSSP is hoping to introduce a pilot for two new service checks by PPV, which are the Quality and Safety Scheme and the Collaborative Working Scheme.

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

3.1 The report details specific risks as outliers in a traffic light system, but provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.

Due to Covid-19 we are unsure as yet to when 'normal' PPV visits will begin again for General Ophthalmic and Pharmacy Services but we are exploring remote alternatives and hoping to roll these out in the upcoming months.

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	Governance, Leadership and Accountability

standard(s)	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.	Choose an item. 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.
Legal implications / impact	Choose an item.
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	Co-create with staff and partners a learning and growing culture

5. RECOMMENDATION

5.1 The Audit & Risk Committee is asked to **NOTE** the report.

We have
We are in
We have
To use technolo
All PPV
We are
We have
In General Opthalmic Services, previously from
PPV will

GMS						
	Health Board			All Wales		
	2018/2019	2019/2020	2020/2021	2018/2019	2019/2020	2020/2021
Number of practices visited	19	33	**20**	**216**	145	**188**
Amount of claims sampled	6,805	4,871	**12,311**	**93,772**	107335	**83,248**
Claim errors identified	489	378	**664**	**7,585**	9699	**10,401**
Average claim error rate	**7.19%**	**7.76%**	**14.18%**	**8.09%**	9.04%	**12.49%**
Recovery amount	£18,855.66	£13,582.44	**£22,135.19**	**£223,105.62**	£161,817.08	**£215,460.57**
N.B There are 6 visits that were undertaken and we are awaiting Practice or HB responses many of these due to Covid-19 and the Average claim error rate is relating only to the 14 visits that have been closed.						

Cwm Taf

GMS PPV Progres

	0-4%	Low risk
	5-9%	Medium risk
	10%+	High risk

UHB Claim
Oct 2020 to
Recovery A

	Visit 1					
Practice code	**Visit date**	**Visit type**	**Claim error %**	**Recovery**	**Visit date**	**Visit type**
Practice 1	Apr-15	Routine	**0.00%**	£0.00	Jun-17	Routine
Practice 2	Jan-15	Routine	**2.47%**	£350.07	Oct-17	Routine
Practice 3	Jul-17	Routine	**5.38%**	£392.28	Jan-19	Revisit
Practice 4	Aug-15	Routine	**1.55%**	£5.44	May-19	Routine
Practice 5	Jan-18	Routine	**2.83%**	£360.81	Mar-19	Revisit
Practice 6	Oct-17	Routine	**3.83%**	£358.22	Jan-19	Revisit
Practice 7	Apr-18	Routine	**6.94%**	£822.75	Dec-19	Revisit
Practice 8	Nov-17	Routine	**11.44%**	£866.58	Jan-19	Revisit
Practice 9	Mar-15	Routine	**2.51%**	£353.76	Apr-17	Extended
Practice 10	Jun-17	REVISIT	**8.10%**	£986.39	May-19	Routine
Practice 11	Apr-16	REVISIT	**17.65%**	£914.40	Jul-19	Routine
Practice 12	Nov-13	Routine	**3.81%**	£511.66	Aug-15	Extended
Practice 13	Jan-14	Routine	**2.65%**	£368.43	Sep-15	Extended
Practice 14	Jan-19	Revisit	**13.81%**	£2,843.50	Jan-19	Routine
Practice 15	Apr-14	Routine	**1.82%**	£43.15	Apr-17	Routine
Practice 16	May-17	Routine	**1.26%**	£111.75	May-19	Revisit
Practice 17	Aug-14	Routine	**0.80%**	£36.95	Jul-17	Routine
Practice 18	Apr-17	REVISIT	**4.77%**	£1,398.47	Oct-18	Routine
Practice 19	Jun-16	Routine	**1.23%**	£98.60	Sep-19	Routine
Practice 20	May-19	REVISIT	**12.34%**	£654.43	May-19	Routine

There are 6 visits files that have been undertaken that we are awaiting Practice

It is important for the average claim error % to note that a REVISIT checks 100%

f Morgannwg University Health Board

s Report: 1st October 2020 to 31st March 2021

n error % Ave	14.18%
o Mar 2021	
Amount	£22,135.19

Visit 2		Visit 3			
Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors
0.86%	£88.09	Nov-20	Routine	198	14
0.00%	£0.00	Nov-20	Routine	135	1
0.00%	£0.00	Nov-20	Routine	157	2
6.72%	£265.06	Feb-21	REVISIT	116	Vis
29.73%	£968.99	Nov-20	Routine	222	6
8.22%	£2,355.35	Nov-20	Routine	263	22
21.74%	£440.45	Nov-20	Routine	171	3
20.03%	£4,326.44	Nov-20	Routine	210	24
11.79%	£2,002.84	Nov-20	Routine	198	Vis
5.42%	£1,070.59	Mar-21	REVISIT	89	39
7.00%	£637.99	Mar-21	REVISIT	740	371
13.73%	£4,340.33	Feb-21	Routine	166	22
23.49%	£6,218.32	Feb-21	Routine	195	43
6.00%	£1,109.76	Feb-21	Revisit	3271	Vis
3.38%	£134.86	Oct-20	Routine	213	4
20.51%	£242.80	Oct-20	Routine	234	Vis
0.20%	£9.80	Oct-20	Routine	278	2
13.33%	£1,691.29	Mar-21	REVISIT	3499	Vis
3.22%	£470.75	Feb-21	REVISIT	1623	Vis
4.00%	£121.10	Mar-21	REVISIT	333	111

or HB responses many of these due to Covid-19

% of claims triggered from a Routine whereby a particular

Claim error %	Recovery
7.07%	£892.87
0.74%	£25.84
1.27%	£40.32
sit file in progress	
2.70%	£186.96
8.37%	£1,033.17
1.75%	£449.03
11.43%	£1,131.86
sit file in progress	
43.82%	£3,510.00
50.14%	£11,130.00
13.25%	£927.89
22.05%	£2,000.83
sit file in progress	
1.88%	£34.64
sit file in progress	
0.72%	£22.53
sit file in progress	
sit file in progress	
33.33%	£749.25

AGENDA ITEM
6.2

AUDIT & RISK COMMITTEE

LOCAL COUNTER FRAUD UPDATE REPORT

Date of meeting	17 August 2021
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	

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 completed	Choose an 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 Well-being Objectives	Ensure sustainability in all that we do, economically, environmentally and socially

5. RECOMMENDATION

5.1 The Committee is requested to **REVIEW** the report for discussion.

Agenda Item 6.2

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee – 17 August 2021

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	66	16
Ensuring that anti-crime measures are embedded at all levels across the organisation		
Inform and Involve	135	28
Identifying the risks and consequences of crime against the NHS, and raising awareness of these risks amongst NHS staff, stakeholders, and the public.		
Prevent and Deter	135	36
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.		
Hold to Account	255	116
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.		
TOTAL	591	196

4. STRATEGIC GOVERNANCE

The Health Board's Director of Corporate Governance has been formally nominated as Fraud Champion. A meeting was held to discuss the role and support agreed in areas of risk management, proactive fraud detection work and communication messaging.

5. INFORM AND INVOLVE

The Counter Fraud Team have issued a Summer edition of the Counter Fraud Newsletter, The Fraud Reporter. A copy is appended to this report for the Committee's perusal.

Direct access to make changes to the Health Board's Sharepoint Counter Fraud pages has been arranged for the Team. The pages have subsequently been refreshed with up-to-date information and resources. A series of communications articles and awareness materials based around common fraud issues and risk areas have also been produced; the materials will be released throughout the coming weeks. Issue of these messages is intended to be multi-modal utilising internal and external communications streams including targeted delivery, Sharepoint and social media.

The Counter Fraud Team have disseminated 7 awareness messages, alerts and bulletins to staff in this year. They cover targeted communications to local Departments and Teams around specific fraud risks to their area to all staff communications via SharePoint.

6. PREVENT AND DETER

The NHS Counter Fraud Authority (NHS CFA) are undertaking a post event assurance exercise based around Covid-19 procurement activity. The exercise is split into 2 parts and covers spend as well as performance relating to revised procurement policy notices.
Specifically, Part 1 is submission of questionnaire around PO vs Non-PO spend form 2019/20 and 2020/21 split by quarter and in line with NHS eClass categories. Part 2 is submission of questionnaire around testing PPNs issued during pandemic; PPN 01/20, PPN 02/20 and PPN 04/20 referenced. Questions are based around contract cancellations, direct award and supplier relief payments linked to the PPNs.
The deadline for submission of data to NHS CFA is 23rd August 2021, data analysis will be conducted and a report issued to participants. This will be presented to Committee once available.

The Counter Fraud Team have concluded work relating to pre-employment checks compliance amongst NHS recruitment and Nursing Agencies. A concluding report is at Appendix 2 for information.
The exercise found good compliance within the substantive and bank recruitment processes, there was some adjustment during period of Covid restriction particularly around face to face document checks which does heighten risk in this area; this will return to normal face to face document checks from 1st September however.
Nursing agency compliance with All Wales Agreement requirements was mixed and recommendations have been made to address issues encountered.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised in Appendix 3. A summary of basic investigation KPI data is presented at outset of 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.

SUMMER 2021

THE FRAUD REPORTER

Welcome to the Summer Edition of The Fraud Reporter

Welcome to the Summer edition of the Fraud Reporter, the Cwm Taf Morgannwg UHB newsletter to keep you up-to- date with fraud issues affecting the Health Board and wider NHS.

Covid-19 continues to have a massive impact on the NHS. We have all had to adjust ways of working and respond to the new disease. Fraud and scams exploded in the wake of the emerging pandemic with unscrupulous fraudsters recognising the crisis as an opportunity to target people and organisations to line their own pockets. In August 2020 we reported that Coronavirus related frauds had increased by 400%; this is still the case today.

We are regularly updated of specific threats to the NHS arising from Covid-19 and have been working in the background to make colleagues aware of this and assess the risk to the Health Board. We've also been updating everyone on emerging scams doing the rounds via the intranet page.

Inside this issue:

Introductions to the newest members of the Counter Fraud team

Beverley Jones

Local Counter Fraud Specialist.

Bev arrived at Cwm Taf Morgannwg as the Local Counter Fraud Specialist with 34 years of criminal investigative experience.

Bev worked as a Police Officer for South Wales Police, stationed in the Aberdare Valley before joining Rhondda Cynon Taf Council in 2003 and taking up a post as a Counter Fraud Investigator in 2005.

Bev has a wealth of experience in criminal investigative work and benefit fraud.

Alison Williams

Local Counter Fraud Specialist.

Alison is the recently appointed Local Counter Fraud Specialist for Cwm Taf Morgannwg University Health Board.

In 2005 Alison left the Department for Work and Pensions having secured a role with a Local Authority as a Compliance Officer before joining the Counter Fraud Team in 2007.

Alison joins us after gaining significant previous experience as a Corporate Fraud Investigator in a Local Authority.

As always get in touch if you have any fraud concerns.
Our contact details on the back page.

Fraud Awareness Training

Remote Training Available

One of the key aims of an LCFS is to develop an anti-fraud culture within the Health Board and ensure that staff can spot fraud when it occurs so something can be done about it.

Training can be tailored to the fraud risks for your specific work area and can be delivered at a time and place that suits you and your team.

Contact the LCFS to arrange your fraud training:

Tel: 01443 443824

Email:

Beverley.Jones262f07@wales.nhs.uk

Alison.Williams97c4c@wales.nhs.uk

Aneurin Bevan worker conned GP Surgery out of £4,000

Aberbeeg GP surgery manager conned NHS out of nearly £4k.

The member of staff was employed as an office manager at Aberbeeg Medical Centre, Abertillery. One of her roles was to bank cash payments made by patients for medical reports, letters etc..

The office manager was caught out when she went on holiday and the Practice Manager became aware of banking irregularities in relation to cash income at the Medical Centre.

The Practice Manager contacted the member of staff via "WhatsApp" to query the banking of cash income and she responded that the income had been banked prior to her holiday. Bank statements indicated that this response was untruthful and it was at this stage that the matter was referred to the Local Counter Fraud Specialists in Aneurin Bevan University Health Board.

The office manager appeared before Newport Magistrates Court in July 2020, where she pleaded guilty to Fraud by Abuse of Position between April 2018 and August 2019.

She stated that she needed to pay off debts because of an addiction to shopping and spending money.

During the hearing, Judge Martin Brown said "This was a gross breach of trust and she will have to pay the money back".

The office manager was jailed for six months, suspended for two years and ordered to complete a 20 day rehabilitation activity requirement.

She was also ordered to repay £3,882.70 plus costs £85.00 plus a Victim Surcharge of £115.00.

Women guilty of fake cancer GoFundMe fundraising fraud

A woman who faked a cancer diagnosis to claim more than £45k in donations has been convicted of fraud.

Nicole Elkabbas 42, of Broadstairs, Kent, set up an online fundraising campaign claiming she needed money to pay for private treatment for ovarian cancer.

Police began their investigation after a doctor, who had recently given her the all clear, raised suspicions.

Elkabbas appeared before Canterbury Crown Court in November 2020, where she pleaded not guilty, but was convicted of fraud and possessing criminal property.

The court hear that in February 2017 Elkabbas set up a GoFundMe campaign, which said she had just weeks to raise money for a major surgery in Spain. She claimed a costly "break through drug" could improve her chances and included an image of her lying in a hospital bed.

The court heard that the image had actually been taken during routine surgery several months prior.

After she "tricked" people into donating, she "fritted" the money on foreign travel, football tickets and online gambling.

GoFundMe refunded all donations when the misuse allegations were raised.

Elkabbas appeared before Canterbury Crown Court on 10th February 2021, where she received a 2 years and 9 months prison sentence.

COVID-19 Vaccination Scam

Challenge - Could it be fake? Check to ensure it is genuine at **GOV.UK**

Do not respond to text messages that try to get you to send money or personal information

Use official government websites

Challenge unannounced callers to your home

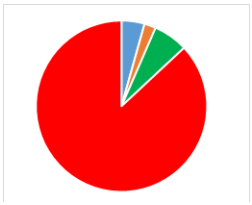
Counter Fraud Survey 2020 — Results

A big 'thank you' to everyone who took part in the survey

100% stated that they would contact Payroll or inform their line manager if they noticed they have been paid too much.

What action can be taken against an employee if they fail to report incorrect payment of wages ?

- All of the above
- Disciplinary Action
- Criminal Action
- Civil Action



You have a close relative whose company supplies goods to the NHS. The Health Board is looking to contract a supplier to supply similar goods. You are asked to be involved in the process of deciding which supplier to use. What should you do?

98% would declare relationship as a potential conflict of interest.

You notice that you have made an incorrect claim on your travel expenses, what should you do?

- Inform Payroll Staff expenses.
- Inform your Manager.

Your receive an unexpected email from your I.T provider advising you that your account has been suspended due to a security breach. The email asks you to click on a link to enable you to confirm your security details. The email states that, once you have been successful in doing this, the suspension of your account will then be lifted. What should you do?

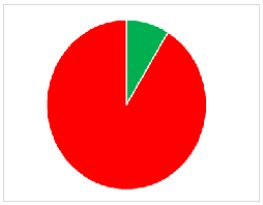
The majority of staff would not click on the link and they would report the email to the I.T Security department.

You are rostered to work a 10 hour shift. It is quiet, so you finish two hours early. What would you record on your timesheet?

100% stated that they would record the actual hours they worked.

You are offered two tickets from the Marketing Director of a company that the Health Board contracts with. The tickets are for a large sporting event and have a value of £100 each. In line with the Health Board's policy and procedures, what action should you take?

- Accept tickets, inform line manager, record on Gifts Hospitality Form
- Thank Marketing Director, decline tickets and record on Gifts Hospitality Form



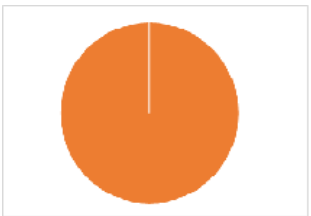
You have been signed off from work for two weeks by your GP, with no exemptions and are receiving sick pay. What other work are you allowed to do during this period?

96% stated no other work was allowed whilst on sickness absence.

4% stated that they had concerns around fraud, bribery and/or corruption within their team/department.

Concerns were reported to:

- Anonymously



GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Further Information

With fraud and cyber crime on the rise across the UK its a good idea that we all know how to deal with scams if we find ourselves unlucky enough to be in that situation. Action Fraud lead the fight against fraud and cyber scams in the UK and they have issued some simple rules to follow to stay safe.

Following this link for Action Fraud https://www.actionfraud.police.uk/

YOU CAN SEARCH COUNTER FRAUD ON THE CWM TAF MORGANNWG INTRANET FOR FURTHER INFORMATION

The Health Board's Counter Fraud Team are responsible for raising awareness of fraud, preventing fraud through 'fraud proofing' exercises and investigating fraud where uncovered.

The Counter Fraud Team are always happy to offer advice about NHS fraud, bribery and corruption.

The LCFS is available to support, guide and assist on all fraud, bribery and corruption matters. If you need any advice on fraud or if you want to request counter fraud training for your team please contact your LCFS.

The Counter Fraud Team

Matthew Evans—Head of Local Counter Fraud Services

☎ 01792 618833 ✉ matthew.evans20@wales.nhs.uk

Beverley Jones—Local Counter Fraud Specialist

☎ 01443 443824 ✉ Beverley.Jones262f07@wales.nhs.uk

Alison Williams —Local Counter Fraud Specialist

☎ 01443 443824 ✉ Alison.Williams97c4c@wales.nhs.uk

You can also make a **report anonymously** you can call the **Fraud & Corruption Reporting Line** on

0800 028 40 60

or search 'NHS Fraud' online for more information.

STOP NHS FRAUD
www.reportnhsfraud.nhs.uk
0800 028 4060

POWERED BY **CRIMESTOPPERS**

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

COUNTER FRAUD, BRIBERY & CORRUPTION

Fraud Detection Exercise – Pre-Employment Checks

June 2021

Executive Summary

In response to identified risks Local Counter Fraud Services have undertaken an exercise to ascertain the validity of required Pre-Employment Checks completed within the Health Board and by Agency Suppliers contracted to supply staff to all work streams within Cwm Taf Morgannwg University Health Board. Pre-employment checks are set out in the NHS Wales Shared Services Partnership Agreement (NWSSP) as detailed within the content of this report.

The risks of not deploying and employing legitimate and appropriately trained staff within the Health Board can have a significant impact on…

1. Patient Safety
2. Staff Safety
3. Health and safety within the workplace
4. Financial Management
5. And the representational image of the organisation

It can be shown that within the Health Board, all pre-employment checks are being completed in full compliance of the Shared Service Partnership Agreement. It should be noted that due to the impact of COVID-19, restrictions have changed in the way in which pre-employment checks are being completed by the NWSSP's recruitment team, specifically, in relation to the viewing of original documents. The Home Office have agreed to extend the virtual checking process until September 2021 with guidance issued for virtual checks to discharge liability relating to right to work legislation.

Sharon Page, Workforce Efficiency Manager, has confirmed that the necessary arrangements are being made for NWSSP's recruitment team to return to face to face checks as of 1st of September 2021.

It should also be noted that no changes were made in the way the pre-employment checks were completed by the recruitment team for bank staff at CTM UHB as all checks were done so via face to face meetings throughout 2019/2020.

In relation to Agency Suppliers for registered nurses, midwives and healthcare assistants, there is clear non-compliance of the Shared Services Partnership Agreement occurring. This can be seen by the lack of pre-employment data that has been provided by the agencies at the request of LCFS.

Recommendations to mitigate the risk of the organisation have been made as detailed at the end of this report.

Introduction and Background

This exercise, led by Local Counter Fraud Services, has centred on pre-employment checks completed by Suppliers when providing Agency Workers to work within Cwm Taf Morgannwg Health Board.

As part of an on-going risk assessment, identified risks to the organisation involved patient safety, staff safety, health and safety in the work place and potential risks to the Financial Management of the organisation.

A proactive approach to reviewing and reducing these identified risks to the Health Board in relation to the provision of Agency Staff has been developed, with a specific remit looking at the pre-employment checks completed by Suppliers and whether these checks are compliant or non-compliant to shared policies already in place at the time of this exercise.

Under the All Wales NHS Shared Services Partnership Agreement there is a Contract Service Specification in place for the supply of registered agency nurses, midwives and health visitors, healthcare assistants and operating department practitioners to the health boards and trusts in Wales.

As part of this contract the following requirements are detailed within the Service Specification…

- Section 3. Point 2:3 - The supplier of such staff must ensure that all of its staff are skilled, trained and experienced in the duties required of them and that they are properly and sufficiently trained and instructed with the awareness of organisation configuration for the areas the agency assigns workers to.

- Section 4, Placement Procedures, Point 4:8 - The contract stipulates that the supplier must ensure that all their registered nurses are fit to practice and this will include assurance that all nurses have gone through appropriate revalidation when required to do so.

- Annex 1 Point A1.8 - The contract relates to recruitment. Sets out the requirements that need to be met by the Supplier when recruiting each Agency Worker. There is specific direction that the Supplier is to obtain and verify information provided by the Agency Worker.

- Point A1.8 (c) - Relates to Photograph ID. In order to verity the personal identification of the Agency Worker, a recent photograph or original birth certificate is required to be seen by the Supplier and a photocopy maintained and kept on the Agency Worker's file for future reference.

- Supplier requirements to validate and confirm professional registrations that may be relevant to the Agency Worker's skill set. For example, written confirmation (including electronic form) of an Agency Worker's eligibility to work as nurse and evidence of this ongoing registration with the Nurses Medical Council should be maintained by the Supplier.

- Point A1.8 (n) - The same onus is also placed on the Supplier in relation to obtaining and retaining evidence of additional certificates and qualifications provided by the Agency Worker. Viewing of the original certificates or qualifications should be carried out by the Supplier and retained on the Agency Worker's file.

- There is also a requirement by the Supplier that they must ensure that the Agency Workers, who are not British Citizens or EC Nationals have the correct Home Office permission to work documents in place. The Supplier must also view and maintain a copy of the Agency Worker's work permit, immigration status and eligibility to work from the Home Office on the Agency Worker's Personnel record.

- Point A1.8 (p) - A further stipulation of the contract relates to the results of the Disclosure and Barring Service (DBS). This is the only reference to DBS within the agreement. A photocopy of the top section of the "Enhanced Disclosure" results relating to the Agency Worker must be maintained by the Supplier on the personnel record of the agency worker.

- Section 8 (Point 8.1) details the Provision of the information. Once requested, the supplier will, within 5 working days of receipt of the request from Health Boards (NWSSP) or it's Agent supply the Health Board with the information requested. In this case, to supply pre-employment check data relating to Registered Agency Nurses and Health Care Support Workers.

Agency 7 is the Managed Service Provider who provide agency Doctors who can be called upon to support the organisation on an ad hoc basis. The onsite role of the managed service is as follows:-

- Liaise with hiring managers
- Liaise with supply chain
- Negotiate with agencies on pay and commission
- Provide progress updates to clients and agencies
- Liaise with client and agencies on start dates, rotas, accommodation etc.
- Resolution of issues and queries received from client and supply chain.
- Review performance, address challenges and forward plan for next period.

The CV's are supplied to the departments for review as stated above. Once the department agree to book the candidate and the rate has been authorised Agency 7 will undertake full compliance checking of the Doctor.

Compliance documents required before the Doctor can start are as follows:-

- GMC
- DBC
- Two references
- Right to work
- Fitness to work
- Mandatory Training
- Verified ID
- Proof of Address

Scope of Exercise

The exercise looked at relevant pre-employment data for the financial year 2019/20 relating pre-employment checks carried out by relevant suppliers. For the purposes of this exercise, pre-employment check data was requested direct from Suppliers (namely Agencies) in relation to registered agency Nurses, unregistered agency Nurses, Doctors and from work streams within the Cwm Taf Morgannwg University Health Board.

Within Cwm Taf Morgannwg University Health Board a cross section of data relating to staff from all work streams and skill sets was collated.

This included pre-employment checks relating to –

- Substantive Staff
- Bank Staff
- Doctors

External pre-employment data was collated from Agency Staff Suppliers in relation to Agency Workers, namely -

- Registered Nurses
- Health Care Support Workers (Unregistered Nurses)
- Doctors

Method

A random selection approach was chosen by Local Counter Fraud Services in requesting the required data in order to run the exercise.

Agency Supplier Data

Staff Bank Manager, Sarah Quirk, provided Counter Fraud Services with a list of all agency suppliers currently contracted by Cwm Taf Morgannwg University Health Board. There are 94 agencies is total.

From this list, seven (7) agencies were chosen at random from the list. These have been anonymised for the purposes of this report –

1. Agency 1
2. Agency 2
3. Agency 3
4. Agency 4
5. Agency 5
6. Agency 6
7. Agency 7

Local Counter Fraud Specialist, Beverley Jones, requested a random selection of agency workers from each of the selected Agencies.

Local Counter Fraud Services then contacted the compliance officers from each of the selected Agencies and requested all pre-employment data in relation to each of randomly selected agency workers listed by CTM UHB as having worked for them. A total of 74 agency workers were listed as part of this selection processes.

Cwm Taf Morgannwg Health Board

Local Counter Fraud Services contacted and requested in house pre-employment data relating to the following work streams selected as part of the exercise.

Substantive Staff:

- Sample requirements looked at the year 2019/2020 staff intake.
- 45 staff randomly selected across the year.
- All work streams and all skill sets
- To include 15 Doctors, 5 Nurses, 5 HCSW and 15 other staff (For example: Estates, Administration Staff)

Bank Staff (Zero hour contracts)

- Year 2019/2020
- 10 staff randomly selected across the year.
- Any mix of work stream and skill set.

The electronic online TRAC system used by Recruitment was used to run the search parameters for all substantive and bank staff pre-employment checks.

Findings

From the data collated by Local Counter Fraud Services the following findings have been documented as follows:-

Cwm Taf Morgannwg University Health Board:

- All pre-employment checks were completed in compliance with the NHS Wales Shared Services Partnership agreement.
- The TRAC recruitment system has a colour coded system in place and highlights areas of concerns (if applicable) through the application process.
- All original pre-employment check documents are produced by the applicant and as a rule are presented to Recruitment to validate in a face-to-face meeting with applicant. Due to COVID restrictions currently in place at the time of this report these meeting have not been able to happen face-to-face and an online process via Zoom or Microsoft Teams has replaced this process.
- Once all checks are complete (relevant to the position applied for) and validated, the TRAC system highlights that the applicant's file is ready for the final supervisory stage. This stage of the pre-employment checking process

allows for any concerns to be raised and addressed before any offer of employment is offered. Thus reducing any identified risk.

Agency Suppliers:

Recording of the data

Counter Fraud Services presented the data collated using an Excel Schedule format, with a tri traffic light system to highlight findings.

- Green – The Agency was fully compliant in providing the data and carrying out the required pre-employment checks under the NHS Wales Shared Services Partnership (NWSSP).
- Amber – Data provided need to be queried or was not fully compliant with the NHS Wales Shared Services Partnership (NWSSP).
- Red – The Agency was non-compliant in providing the requested pre-employment data.

The findings for this sector are detailed below under individual agency findings:-

Agency 1

- Counter Fraud Services requested data relating to ten (10) randomly selected Agency Workers.
- Agency 1 were compliant in responding to the initial request for data within the specified 5-day time frame.
- Agency 1 were compliant with supplying data relating for 2 out of 10 agency workers, however, there was a delay in providing the balance of the data.
- Of the 5 agency workers supplied 2 had queries surrounding references.
- No qualifications were provided for 2 out of the 5 agency workers.
- Agency 1 were non-compliant in relation to 5 agency workers, providing no data at all.

Agency 2

- Counter Fraud Services requested a report for all Agency Workers whose recruitment to CTM UHB commenced during the financial year 19/20.
- Agency 2 were non-compliant in supplying the data requested despite numerous request having been issued.
- From the information supplied by Sarah Quirk, Staff Bank Manager, Agency 2 were not part of the All Wales Contract and were used off Framework at the time the data was requested. There was therefore no contractual obligation to provide this information for review. However, they have since been awarded the All Wales Contract and would be required to adhere to the terms and conditions of the contract going forward.

Agency 3

- Counter Fraud Services requested data relating to nine (9) randomly selected Agency Workers.
- Agency 3 were compliant in returning the data within the specified 5-day time frame.
- Of these 9 agency workers, 2 had reference queries.
- Of these 9 agency workers, 1 had a DBS query.
- No qualifications were provided for 1 out of the 9 agency workers.

Agency 4

- Counter Fraud Services requested data relating to ten (10) randomly selected Agency Workers.
- Agency 4 were non-compliant in returning the data within the specified 5-day time frame.

Agency 6

- Counter Fraud Services requested data relating to ten (10) randomly selected ten Agency Workers.
- Agency 6 were compliant in returning requested data within the specified 5-day time frame.
- 1 out of the 10 agency workers was no longer working via the Agency.
- 2 out of the 10 agency workers had queries on their registration renewal.
- No qualifications were provided for 3 out of the 10 agency workers.

Agency 5

- Counter Fraud Services requested data relating to ten (10) randomly selected Agency Workers.
- Agency 5 were compliant in returning the requested data within the specified 5-day time frame.
- 6 out of the 10 agency workers Photo / Passport/ ID was either out of date or had an address query.
- No qualifications were provided for any of the agency workers.
- 2 out of the 10 agency workers had DBS queries raised for missing information.
- 1 out of the 10 agency workers had a reference query.

Agency 7

- Counter Fraud Services requested data relating to twenty five (25) randomly selected Agency Workers.
- Agency 7 was compliant in returning all requested data within the specified 5-day time frame.
- Out of the 25 agency workers, 1 had a DBS query for missing information.
- CTM UHB had signed Waivers for 13 out of the 25 agency workers for missing pre-employment check information. Six of the agency workers had waivers for more than one area. The waivers related to the following issues:

11 - Missing/gaps in references
1 - Updated CV required
5 - Practical Manual Handling
2 - Fraud Prevention Module
2 - Life Support Certificate
1 - Infection Prevention & Control

- To ensure the departments are securing the agency staff they require and to make the booking process quicker, the compliance checks are carried out once the agency worker has been submitted to a job vacancy. Should there be an issue with missing information, excluding GMC registration or DBS check, the head of department can sign a waiver to allow the agency worker to start placement without a particular document. Each waiver has an expiry date and the compliance team continue to chase the missing documents whilst waiver is in place.

  Should a waiver have been authorised a copy is retained and uploaded to the agency worker's file. The Agency 7 system flags any documents for agency workers that are close to expiration.

  Waivers can only be issued for a CV Gap, References and mandatory training. These waivers require approval from the Clinical Service Director of the relevant speciality.

  If there are any requests for waivers for any other documents then approval will be required from the Integrated Locality Group Director.

Recommendations

Following completion of field work relating to this report the Head of Counter Fraud Services met with NWSSP contacts to discuss fraud risks identified.

The All Wales agreement relating to Nursing Agencies had been recently renegotiated and was at an advanced stage with final specification presented. Options to vary or amendment without creating issues and delay with that advanced process were therefore limited.

The agreement was analysed against issues identified relating to DBS checks, qualifications, record keeping.

DBS Checks
The renegotiated agreement includes references to undertaking DBS checks at Clause 12 and Annex 1. The agreement outlines that suppliers prior to deployment of agency workers will question agency workers concerning convictions; that a satisfactory enhanced disclosure is obtained from the Disclosure and Barring Service and that this is renewed on an annual basis; in instances of an overseas agency worker who has entered the UK and/or become resident in the UK within the six

month period immediately prior to their recruitment by the supplier, the supplier obtains a police check from the country of origin and validates this.

Qualifications
The agreement covers qualifications extensively setting out at Clause 4 that the supplier agency must ensure requisite level of qualification in line with the person specification outlined at Clause 25 of the agreement. There is a requirement for supplier agencies to supply qualification information upon request to the Health Board included within Clause 4 also and a need to maintain records of training and qualifications within Clause 9. The requirement to demonstrate qualifications and skills is included in Annex 1 Recruitment Criteria.

Additionally at Clause 21 and Annex 5 the agreement sets out the specification of training that the supplier agencies must ensure each new Agency Worker receives post recruitment prior to being sent on any assignment. The training is aligned to mandatory and statutory learning requirements and records of training can be requested by the Health Board for review.

Record Keeping
The agreement outlines at Clause 9 that supplier agencies must keep and maintain documents relating to the supply of workers. The records must be kept for a minimum period of 7 years following termination date of the supply contract and all records must be kept secure and reasonably accountable and accessible at all times.

The Local Counter Fraud Services recommends the following:-

1. Revert to viewing and retaining copies of original pre-employment documents. Home Office guidance to adjust face to face document checks to virtual checks negating right to work legislation liability expires on 1st September 2021. This recommendation is applicable to both the Health Board and Agency Suppliers. Sharon Page, Workforce Efficiency Manger, has confirmed that they are making the necessary arrangements for NWSSP's recruitment team to return to face to face checks as of 01.09.2021. The Department will review any updated guidance from the Home Office with this regard should anything be received.

2. Health Boards should continue to operate a reactive and proactive approach to the pre-employment check processes currently in place. As a proactive measure, considerations should be made to conduct quarterly or bi-annual checks against any agency worker changes provided by the Suppliers.

Conclusion

It is clear from the data provided, pre-employment checks are being completed in full compliance by Cwm Taf Morgannwg University Health Board. There are however,

identified risks relating to the pre-employment checks that Agency Suppliers are completing. Disclosure and Barring Service checks, qualifications and training pose a significant risk to the Health Board in relation to patient safety, staff safety and the financial management within our health board.

Key Contacts

Name	Job Title	Contact
Matthew Evans	Lead Local Counter Fraud Specialist	Matthew.evans20@wales.nhs.uk 01792 618833
Beverley Jones	Local Counter Fraud Specialist	Beverley.Jones262f07@wales.nhs.uk 01443 443824
Alison Williams	Local Counter Fraud Specialist	Alison.Williams97c4c@wales.nhs.uk 01443 443824
Sarah Quirk	Staff Bank Manager	Sarah.Quirk@wales.nhs.uk
Nicholas Price	Senior HR Manager, Medical Workforce	Nicholas.Price@wales.nhs.uk
Sharon Page	Workforce Efficiency Manger	Sharon.Page@wales.nhs.uk

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 2021/22
6	5	4

Case Rates

Referrals Received 2021/22	Cases Under Investigation for Over 12 Months
1	3

Sanctions/Outcomes

Criminal Sanctions	Civil Sanctions (Inc. Financial Recovery)	Disciplinary Sanctions
0	1	0

Open Cases			
Reference Number	Date Opened	Allegation	Status
WARO/19/00050	25/04/2019	Alleged false representations made in respect of the completion and presentation of prescriptions	File of evidence is being prepared for submission to CPS for consideration for prosecution.
WARO/20/00032	24/01/2020	Alleged theft of petty cash/False representation of employment history and qualifications	Initial allegation of theft of petty cash was investigated by South Wales Police who deemed insufficient evidence to proceed with any criminal action. An internal investigation was ongoing relating to disciplinary matters. Further information came to light relating to false representations relating to employment application including potential falsification of employment history and qualifications. This investigation has grown considerably during the last reporting period. The subject was arrested by Dyfed Powys Police and home address searched as part of joint operation with LCFS. A large amount of property was seized by Police which has been reviewed by the LCFS with exhibits taken for evidence. Enquiries are ongoing across the NHS including previous employment areas involving cross border NHS organisations and external organisations.

Open Cases			
Reference Number	Date Opened	Allegation	Status
WARO/20/00084	11/09/2020	Alleged overpayment of salary	Overpayment of £8879.31. Financial Investigative support has resulted in money being unable to be located in bank accounts. Interview under caution to be arranged.
WARO/21/00045	30/03/2021	Overpayment of Salary	Subject resigned from employment and continued to be paid for a period of 5 months resulting in total Net overpayment of £6611.08. Enquiries ongoing to assess requirements for progression of case.
INV/21/00041	12/04/2021	Overpayment of Salary	After termination date was entered incorrectly by inputting 2020 instead of 2019 resulting in error in inputting termination information on the system. The subject continued to be paid for 12 months as a result with overpayment totalling Net £8336.70. Enquiries ongoing to assess requirements for progression of case.

Open Cases			
Reference Number	Date Opened	Allegation	Status
TBC – Likely to be logged as Local Proactive Exercise (LPE) rather than criminal case	20/01/2021	Prescription Fraud	Subject registered at multiple GP practices with intent to seek prescription drugs. The subject attended GP practices across South Wales and sought controlled drugs known to have recreational uses successfully obtaining multiple scripts which were dispensed. Criminal case is being dealt with by South Wales Police who have issued a caution and subsequently rearrested the subject following continuation of offending following the caution. The Counter Fraud Team are assessing the situation based around risk to GP registrations and the exposure to fraud. Once this work is complete a full update will be given to Committee on position.

Pending Closure			
Reference Number	Date Opened	Allegation	Status
WARO/17/00114	08/06/2017	Alleged submission of false or misleading overtime claims	Criminal investigations into this matter concluded in August 2019. The CPS concluded that there was insufficient evidence of the required standard to progress to prosecution. The subject was dismissed from employment with the Health Board following internal process. NMC investigations remain ongoing. The LCFS continue to support this process as required. This case will remain open until the NMC investigation has been concluded.
WARO/17/00162	19/10/2017	Alleged to be undertaking alternative employment whilst on sick leave without appropriate authority	Criminal investigations into this matter concluded in November 2019. There was insufficient evidence of the required standard to progress to prosecution. Following a Nursing & Midwifery Council Fitness to Practice Committee meeting, the subject's Interim Suspension Order remains in place. A full hearing is to be undertaken by the NMC in relation to this matter. The LCFS continue to support this process as required.

Pending Closure			
Reference Number	Date Opened	Allegation	Status
WARO/18/00055	06/12/2017	Alleged false representations made in respect of the completion and presentation of prescriptions	Criminal investigations into this matter concluded in February 2020, whereupon the subject entered a guilty plea to a charge of fraud by abuse of position and received a suspended sentence and unpaid work order. All financial losses to the Health Board have been recovered. GMC investigations remain ongoing. Interim conditions have been put in place. The LCFS continue to support this process as required.
WARO/19/00091	16/05/2019	Alleged submission of false or misleading information in respect of hospital travel cost claims	Enquiries have established that the provable loss is £105. Police National Computer checks showed warning markers for subject of suffering mental health issues including suicidal. Assessed as not in public interest to proceed with criminal case and loss to be pursued as civil recovery only. Process of recovery underway.

Pending Closure			
Reference Number	Date Opened	Allegation	Status
WARO/19/00138	23/10/2019	Alleged false representations made in respect of the completion and presentation of prescriptions	Facts of case relate to 2 subjects alleged to have stolen blank prescriptions and patient details during a consultation and subsequently presenting false scripts to access drugs. 1 subject has pleaded guilty presenting scripts and received sanction of 150 hours community service, £310 court costs and £90 victim surcharge. Information from Police was that theft was to be charged and dealt with at Court in February 2021 – it transpired that this had actually been dealt with at the earlier hearing and a subjects convicted of theft and fraud offences at that time. Counter Fraud records will be updated and closure report prepared for this case.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
WARO/19/00090	24/07/2019	Alleged submission of false or misleading information on a job application form	Due to the subject's mental health issues and the lack of available evidence for continuity purposes CPS deemed the case not fit for prosecution and advised civil recovery only. The loss to the NHS was identified as being to another NHS Wales Health Board and invoice was raised and actioned by that Health Board.
WARO/19/00093	12/08/2019	Alleged theft of a salary overpayment	Criminal investigations into this matter concluded in November 2019. There was insufficient evidence of the required standard to progress to prosecution, or to be considered for disciplinary action. Invoice has been raised and Finance colleagues pursuing repayment on civil basis.
WARO/20/00033	02/10/2019	Alleged to be undertaking alternative employment whilst on sick leave without appropriate authority	The subject commenced employment with secondary employer a week after submitting resignation during a sick period, under employment terms therefore no longer employed by Health Board at the time of commencement in new role. Failure by Line Manager to update ESR with the relevant information resulted in subject continuing to receive pay where it should have been the case that this employee would have been on nil pay at the time of new employment commencing.

			Due to the errors in managing the sickness updates a decision was made not to pursue this case criminally and instead to recover the financial loss by way of civil sanction. The total loss being £809.40 Net. Agreement to repay this amount was reached and a repayment plan is in place and being maintained.

AGENDA ITEM

CTM MANAGEMENT BOARD

ORGANISATIONAL RISK REGISTER

Date of meeting	17/08/2021
FOI Status	Open
If closed please indicate reason	Not Applicable – Public Meeting
Prepared by	Cally Hamblyn, Assistant Director of Governance & Risk
Presented by	Georgina Galletly, Director of Corporate Governance
Approving Executive Sponsor	Director of Corporate Governance
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	July 2021	RISKS REVIEWED
Management Board	21st July 2021	MANAGEMENT SIGN OFF OF RISKS RECEIVED
Quality & Safety Committee	9th August 2021	ASSIGNED RISKS REVIEWED

ACRONYMS	
CSGs	Clinical Service Groups
ILG's	Integrated Locality Groups

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to present the high level organisational risks included on the Organisational Risk Register which have been assigned to the Committee, and highlight the management actions being taken to manage or mitigate these high level risks.

1.2 The report should be considered in the context that risks within the organisation are still undergoing a robust review and therefore the organisational risk register remains a work in progress and activity continues to ensure a consistency of approach to the quantification of risk across the Health Board.

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

2.2 The following progress has been made since the last report:

- The ILGs are continuing to work to both rationalise and standardise the Clinical Service Group risk registers, the pace of this activity has been impacted by the operational pressures in response to Covid-19, however, activity has resumed with the target of October 2021 for all risks held on the Datix system to have been reviewed.
- The monthly risk management awareness sessions held virtually via Teams are being well received. 207 members of staff have received the Risk Training Awareness Session - January to July 2021.
- Risks on the organisational risk register have been updated as indicated in red.
- Risk Management Milestones updated to align with the Targeted Intervention programme – see Appendix 2.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 **NEW RISKS**

Rhondda Taf Ely Locality

1. Datix ID 4203 – Unable to provide Surgical Services. Risk Rated as a 20.
2. Datix ID 1133 – Long Term Sustainability and Staffing of the Emergency Department at the Royal Glamorgan Hospital. Risk rated as a 16.
3. Datix ID 4620 – Access to Neath Port Talbot Hospital to deliver breast surgery (mainly cancer patients). Risk rated as a 15.

Bridgend Locality

4. Datix ID 4743 – Failure of appropriate security measures / safety fencing. Risk rated as a 20.

Corporate Governance

5. Datix ID 4699 - Failure to deliver a robust and sustainable Information Governance Function. Risk rated as a 16.

Facilities

6. Datix ID 4282 - Risks associated with the transfer to the new Planet FM System. Risk rated as a 16.
7. Datix ID 4693 – Electrocardiogram (ECG) Carts not connecting to Hospital Network. Risk rated as a 15.

Mental Health Services

8. Datix ID 3337 - Use of Welsh Community Care Information System (WCCIS) in Mental Health Services. Risk Rated as a 15.

   There is an emerging risk being developed in relation to the emerging risk in relation to "A Safe and Fit for Purpose Inpatient Mental Health Estate" that is anticipated for escalated to the Organisational Risk Register.

Public Health

9. Datix ID 4741 – Failure to respond to Population Health Inequalities. Risk Rated as a 16.

Medicines Management & Pharmacy

10. Datix ID 3161– Lack of Wholesaler Dealers Authorisation. Risk Rated as a 15.

11. Datix ID 4590 – Critical Care Pharmacist Resource. Risk Rated as a 15.

3.2 **CHANGES TO RISK RATING**

a) Risks where the risk rating INCREASED during the period

Rhondda Taf Ely Locality

1. Datix ID 4292 – Long waiting times and large backlog for Cardiac Echo. Risk increased from a 16 to a 20 as a result of increased waiting lists due to the Covid-19 pandemic.

Bridgend Locality

2. Datix ID 4149 – Failure to sustain Child and Adlolescent Mental Health Services. Risk increased from a 16 to a 20 as a result of the increased escalation status of Ty Llidiard.

b) Risks where the risk rating DECREASED during the period

No risks on the Organisational Risk Register were de-escalated this period.

3.3 **CLOSED RISKS**

Public Health

1. Datix ID 4105 - Potential Harm and poor experience for Patients as a result of the Health Board's focus and response to the Covid-19 Pandemic. Risk Closed as target score reached.

Merthyr & Cynon Locality

2. Datix ID 4235 – Cancer Performance – Gastroenterology Outcome of Covid-19. It is considered that this risk is captured within the overarching risk 4071 -"Failure to sustain services as currently configured to meet cancer targets". Therefore this risk has been closed this period to remove duplication.

Bridgend Locality

3. Datix ID 3584 –Neonatal Capacity / Stabilisation Cot at Princess of Wales Hospital. Risk Closed as Staffing is 3+1 so stabilisation cot is being funded and covered. CHANTs now operating 24/7 care.

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

Consequence						
	5			4253 3337 4620	4149 4080 3826 1793 4664	
	4				3742 4106 4157 4156 4458 4567 4148 4337 2987 4294 3958 3682 3008 4356 4500 816 4706 4282 4741 4743 4103 4152 4478 2018 4217 4476 4482 4116 3585 4684 4686 4685 3011 3654 3133 4360 3656 4281 4699 1133	4491 4060 4629 4477 4632 3562 4071 4688 4203 4292
	3					3899 3638 3072 4110 3698 3685 3161 4606 4218 4672 4671 4512 4693 4590
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Aim to mitigate risks to patients and staff
Related Health and Care standard(s)	Governance, Leadership and Accountability
	All Health and Care Standards are included
Equality impact assessment completed	No (Include further detail below)
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	Provide high quality, evidence based, and accessible 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.
- **Note** the Risk Management Milestones update aligned with the Targeted Intervention programme – see Appendix 2.

Datix ID	Strategic Risk owner	Strategic Objective	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
4491	Chief Operating Officer	Provide high quality, evidence based, and accessible 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 undertaken when needed. • 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 has established a Planned Care Board, with a full programme of work to address FUNB, demand and capacity and a recovery programme which will include cancer patients; The plans have timescales – which are being monitored, however it is likely that it will take time to reduce waiting times to acceptable levels in the post-covid-19 environment.	Quality & Safety Committee	20	C4xL5	12 C4 x L3	↔	11.01.2021	07.06.2021	31.07.2021
4060	Executive Director of Finance & Procurement	Ensure sustainability in all that we do, economically, environmentally and socially.	Financial Stability Risk	Failure to remain in financial balance in 2021/22.	**IF:** The Health Board is not able to plan changes which enable current run rates of expenditure to align with the available funding for 2021/22 (including Covid funding and Planned Care recovery funding) **Then:** The Health Board will not be able to develop a break-even financial plan for 2021/22 and deliver it . The context is that the draft plan for 21/22 currently shows a deficit of £19.8m which entirely relates to Q3 and Q4, since the Health Board has only received Covid funding for non programme costs for Q1 and Q2 only. **Resulting in:** Potential deficit in 2021/22 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. The context is that the break even financial plan for 21/22 includes significant non-recurring funding for Covid-19 which has yet to be confirmed by Welsh Government (WG). Delivery of the 21/22 Plan is also predicated on a return to levels of efficiency savings close to pre-Covid levels (21/22 Savings target = £14.5m).	2021/22 IMTP and financial plan submitted to WG at the end of June, including the Covid response, TTP, planned care and diagnostics, including prioritisation of planned changes within the available resources. 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. Routine monitoring arrangements in place. Regular reporting to Management Board and Planning, Performance & Finance Committee and Board.	Bottom up savings plans at the end of June are showing a gap of £0.9m against the In year target of £14.5m for 21/22. Further develop the savings planning process identified by the COO and DoF for implementation in July onwards. Financial accountability letters and budget schedules for 21/22 to be issued and signed off by end of July. Further discussions needed with Welsh Government to understand likely funding position for 21/22.	Planning, Performance & Finance Committee	20	C4 x L5	12 C4 x L3	↔	27.01.2021	05.07.2021	31.8.2021
4629	Executive Director of Finance & Procurement	Ensure sustainability in all that we do, economically, environmentally and socially.	Financial Stability Risk	Failure to achieve or reduce the planned recurrent deficit of £33.9m at the end of 2021/22.	**IF**: The Health Board is not able to plan changes which enable current run rates of expenditure to align with the expected available funding for 2022/23. **Then**: The Health Board will not be able to develop a break-even financial plan for 2022/23 and deliver it . The context is that a key issue beyond 21/22 is the recurrent impact of the plan in 22/23 when it is likely that the non recurring funding for Covid in 21/22 will end or significantly reduce as well as non recurring Transformation funding ending. **Resulting in:** Potential deficit in 2022/23 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action.	2021/22 IMTP and financial plan submitted to WG at the end of June , including the Covid response, TTP, planned care and diagnostics, including prioritisation of planned changes within the available resources. 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. Routine monitoring arrangements in place. Regular reporting of the forecast recurring position to Management Board and Planning, Performance & Finance Committee and Board.	Bottom up savings plans at the end of June are showing a gap of £8.2m against the £16.1m Recurring savings target for 21/11. Further develop the savings planning process identified by the COO and DoF for implementation in July onwards. Further discussions needed with Welsh Government to understand likely funding position for 22/23.	Planning, Performance & Finance Committee	20	C4 x L5	12 C4 x L3	↔	10.5.2021	05.07.2021	31.8.2021
4080	Executive Medical Director	Provide high quality, evidence based, and accessible 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 • Explore substantive appointments of staff undertaking locum work in CTMUHB • Feedback poor performance and concerns to agencies • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs	The response to Covid-19 has impacted the original timeframes for these actions due to the requirement to focus on clinical operational service delivery during the pandemic. Revised dates have been included below: 1. AMD and workforce to develop recruitment strategy - 31.3.2021 –Revised Date September 2021. 2. AMD and DMD to develop retention and engagement strategy - 31.3.2021 – Revised Date September 2021. 3. Reduce agency spend throughout CTMUHB – ongoing - The agency spend reduction is dependent on recruitment aligned with the bank launch and switch to ADHs. The bank launch has been delayed due to problems with the rate card and recruitment through the pandemic has been challenging impacting our ability to appoint to positions. 4. Launch of 'medical bank' to Bridgend ILG locality Autumn/ Winter 2020 –Revised Date September 2021. Update June 2021: At present no immediate change to control measures and mitigating actions. The Workforce Strategy Group will be meeting soon and these issues will be raised and addressed following which the risk will be updated as appropriate.	Quality & Safety Committee People & Culture Committee	20	C5 x L4	15 (C5xL3)	↔	01.08.2013	5.5.2021	31.07.2021
3826	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible 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:** 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.	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. Update June 2021 - Unscheduled Care Improvement Programme has now launched - Bridgend ILG is being provided with a Programme Manager to drive forward key projects, the key projects are yet to be launched. These projects will initially focus on the Emergency Department (ED) and Site Flow and measures will be identified that will allow us to track improvements in ED overcrowding. **Timescale: Projects due to commence July 2021.** Target Score Rationale - the rationale for the consequence score reducing at the target level is that increased resources and staffing will support improved patient experience and care reducing the consequence rating.	Quality & Safety Committee	20	C5 x L4	9 (C3xL3)	↔	24.09.2019	4.6.2021	31.7.2021

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1793	Chief Operating Officer / Executive Director of Nursing & Quality (Executive Lead IPC)	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of negative pressure rooms in CTMUHB in line with WHC (2018) 033	**If:** there are no negative pressure rooms available in CTMUHB. **Then:** the service will be unable to isolate patients in an appropriate environment. **Resulting In:** Non compliance with national guidance/ WG expectation	Patients isolated in single rooms. Apply IPC precautions. Isolation policy in place. Alert organisms are dealt with by the IPCT. IPCN's liaise with wards/ departments giving IPC advice/ instruction. All alerts are discussed at weekly meetings. Patients with highly transmissible respiratory infections will be transferred to a regional centre with appropriate isolation facilities	Work with Executive Team, Capital, Estates and Shared Services colleagues to consider recommendations outlined in the WHC(2018)033 Risk currently being reviewed by the Chair of the Infection Prevention and Control Group. Lead Infection Control Nurse is engaging with the Estates / Capital Team on progress to date in relation to the provision of negative air pressure rooms. The risk therefore remains currently unchanged.	Quality & Safety Committee	20	C5 x L4	10 (C5xL2)	↔	16/12/2014	04.05.2021	30.06.2021
4477	Executive Director of Nursing & Midwifery IPC - Decontamination	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is no dedicated operational lead for decontamination in CTMUHB	**If** there is no dedicated operational lead for decontamination in the Health Board. **Then:** compliance with best practice guidance/legislation will not be monitored. **Resulting in:**near misses/increased risk of infection/litigation risks.	The operational lead for decontamination role is undertaken by the Deputy Lead IPCN. The role is part time decontamination lead(0.5 WTE) and 0.5 WTE Deputy Lead IPC Nurse. The Health Board Decontamination Committee group meet quarterly. ILG decontamination meetings take place monthly. Annual audits are undertaken by Shared Services. AP(D) meetings have been set up by the assistant head of operational estates. Liaise with AE(D) and service group leads as required. The operational lead for decontamination/deputy lead IPCN participates in the all Wales decontamination meetings. Centralised decontamination facilities in RGH and PCH. A business case has been submitted to progress this forward in POW. External review of the decontamination infrastructure, governance systems and processes requested by Executive Nurse Director March 2021.	Working group to be set up to perform review. AE(D) Shared Services to form part of team. First meeting being set up to agree terms of reference/plan. Due Date: 30.06.2021 No change as at 5th July 2021 - Review of risk scheduled for w/c 12th July - update will be received in the next submission of the Organisational Risk Register.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	30/12/2020	05.07.2021	31.07.2021
4632	Chief Operating Officer All Integrated Locality Groups Initially raised by Rhondda Taf Ely Integrated Locality	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Demand and capacity across the stroke pathway	**IF** there is continued high demand for stroke beds (currently located in PCH) **THEN** patients will have to be admitted to RGH or non stroke specialist beds **RESULTING in** a delay or inability in specialist stroke management, treatment and rehabilitation	Stroke patients in RGH are managed by the medicine teams and referral to MDT as required but not specific to stroke rehabilitation. Stroke admission pathways have been reconfirmed with WAST to ensure patients are admitted to PCH to access specific stroke care.	Review of the CTM Stroke Pathway. Centrally led task and finish group, leadership from Executive Lead for Stroke. Update July 2021 – a short term draft paper has been developed and will be discussed at the Stroke Planning Group Meeting on Friday 09 July 2021, with the aim of making decisions about the way ahead. Work is underway on the long term plan – this will also be discussed at the meeting on 09 July.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	05.07.2021	31.07.2021	20.08.2021
4253	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ligature Points - Inpatient Services	**IF:** the Health Board fails to minimise ligature points as far as possible across identified sites. **Then:** the risk of patients using their surroundings as ligature points is increased. **Resulting In:** Potential harm to patients which could result in severe disability or death.	Increased Staff observations in areas where risks have been identified. Any areas of the unit not being occupied by patients are to be kept locked to minimise risks. Use of therapeutic activities to keep patients occupied Patients not left alone / unattended in high risk areas Patients placed on observation levels according to their risk In Bridgend Locality there is a Ligature Action Plan in place and remedial work is underway, in addition to the above additional control measures include closing bathrooms and adding additional staff by night irrespective of patient observation levels, placing patients with a functional illness in bedrooms nearer to the nursing office. Remaining area for anti-ligature work is at Cefn Yr Afon site at Bridgend. Funding is approved and there is a programme of work which is due to commence June 21st 2021 after completion of higher risk areas at POW Similarly within the RTE Locality, the ligature risk within the MH inpatient setting is minimised through environmental measures. Environmental security Broadly the anti-ligature work that effects the estate i.e. taking away high and low level structures that might be used as ligatures. Relational security Use of supportive observations on a sliding scale from. Informal and planned 1:1 where the person can use time to work through urges, address low mood anxiety up to a more intensive 1:1 observation when someone is considered high risk. Processes to manage security These will be mitigating processes, such as search polices or maintenance of a safe bedroom space by restricting the type of personal items allowed, or managing a necessary high risk area through maintaining locked doors. Capital work currently underway, estimated completion date July 2021.	**RTE Locality:** RTE Locality Update: Some environmental work has already been Undertaken Anti-ligature doors to be installed to further reduce risk. Current score: 10. This risk therefore now only relates to Bridgend ILG. **Bridgend Locality:** Ligature Action Plan in place. Ligature remedial works underway - Completion of works anticipated July 21 . Update July 2021 - No Change.	Quality & Safety Committee Health, Safety & Fire Committee	20	C5xL4	10 C5xL2	↔	17/08/2020	07.06.2021	31.07.2021
4688	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED), inability to appropriately triage patients in the Minors area of ED, compounded by two current access points that are not co-located with neither incorporating triage.	**IF:** The minors department is over capacity **Then:** there is no ability to appropriately triage and treat patients in a timely manner, neither is there visibility to observe patient acuity from a triage room as this is not co-located within the waiting area. **Resulting in:** Poor patient experience and unknown risk along with high levels of stress for staff.	Production of a flow chart for the management of patients to minors. Escalation cards. Re-direct the workforce to support the triage function. Additional doctor rostered to support the service	Emergency Department Improvement Programme established which includes the key enablers to improve the environment, template and patient flow through the Emergency Department. The programme is anticipated to take 12 months to complete. Emergency Department Improvement Plan being established to address risks in the short term as far as is reasonably practicable.	Quality & Safety Committee	20	C4xL5	12 C4 x L3	↔	11.06.2021	11.06.2021	31.07.2021
3562	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department Overcrowding - within Majors, Minors, Clinical Assessment Unit and the GP Assessment Area at Prince Charles Hospital	**IF:** There is overcrowding as a result of capacity constraints within the emergency Department and Patients are waiting within corridors. **Then:** there is restricted ability to be responsive in emergency situations. There is an increased risk of an unsafe evacuation due to corridor space, personal accidents, breach in confidentiality and poor patient experience. **Resulting In:** Potential harm to patients, staff and visitors, poor patient experience, increase in incidents and complaints. Failure to comply with legislation if confidentiality is breached due to overcrowding in corridors. Impact on evacuation time and potential personal accidents. At times of high escalation it is challenging to clear the corridor of patients on trolleys	Escalation Plans / Cards established. Flow Manager in place Patient Safety Checklists undertaken. SOP for the Management of Patients in Corridors in place. Fire safety checks are to be carried out daily by the NIC to ensure all fire exits are accessible. When patients are nursed in the corridor due to lack of capacity, the emergency pressures escalation procedure is to be followed to de-escalate as quickly as possible.	Action to develop an escalation policy - Completed. Update October 2020: HB policy SoP approved by Management Board with regards to the care of patients in corridors. Completed. Emergency Department Improvement Programme established which includes the key enablers to improve the environment, template and patient flow through the Emergency Department. The programme is anticipated to take 12 months to complete. Emergency Department Improvement Plan being established to address risks in the short term as far as is reasonably practicable.	Quality & Safety Committee and the Health, Safety & Fire Sub Committee	20	C4xL5	12 C4 x L3	↔	22.05.2019	10/06/2021	31.07.2021
4292	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long waiting times and large backlog for Cardiac Echo	**If:** the CSG is unable to increase the capacity within the CPU; **Then:** patients will continue to wait in excess of the acceptable timescale for a test; **Resulting In:** Long waiting time (in excess of 42 weeks), potential risk to patients from delays in identifying and treating disease and progression of disease, delays in receiving appropriate treatment, pharmacological and surgical intervention.	Referrals verified and triaged by the Cardiology team. Patients prioritised in relation to clinical need. Additional room capacity identified to increase outpatient capacity.	Staff sustainability remains and issue and will be addressed as part of the IMTP planning process.	Quality & Safety Committee	20	C4xL5	16 (C4xL4)	↑ 16 Increased from 16 to 20 in July 2021 due to increased waiting lists as a result of Covid-19	14.09.2020	17.05.2021	19.08.2021

Datix ID	Strategic Risk owner	Strategic Objective	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
4071	Chief Operating Officer All Integrated Locality Groups	Provide high quality, evidence based, and accessible 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 ILGs 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 ILG now reports actions against an agreed improvement trajectory.	Continue close monitoring of each patient on the pathway to ensure rapid flow of patients through the pathway. Active management of the diagnostic backlog (including endoscopy) and exploration of all options to reduce this. Comprehensive planning for repatriation of theatre and haematology services for when private provision is lost. This also needs to consider options for continuation during a potential second surge. These actions are ongoing and assigned to the EDO, DPC&MH and Medical Director. The Cancer Business Unit remain fully involved in the processes to improve care and that at present they are awaiting feedback from ILGs on their plans for restarting elective and other activity and their demand and capacity assumptions. Update April 2021 Each ILG are preparing a Cancer Recovery Plan for submission to Management Board in April 2021 that sets out clear performance targets by June 2021 and/or longer term plans for specific specialities that cannot be delivered to the June timescale. Update June 2021 - New Cancer Operating Framework being launched with tightening of Performance Management infrastructure by COO to review weekly performance status - **Review August 2021.**	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	4.6.2021	31.7.2021
4664	Executive Director of Public Health - Interim Executive Lead responsible for ICT. Chief Information Officer	Provide high quality, evidence based, and accessible care.	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 impacting on population health management, patient care, business continuity, organisational relationships & substantial financial risk - culminating in a culture of mistrust of the Health Board and all things digital	**Key Controls**: 1. Email filters from both Microsoft and the National email relay which scan for malicious and suspicious email types and their attachments. 2. National Checkpoint firewalls that monitor for and block suspicious network traffic, including those from known malicious geographical areas. 3. National SIEM that monitors and logs suspicious external incoming traffic. As well as monitoring local network traffic for each NHS Wales organisations. 4. Local Firewalls at each of the Health Board's geographical areas that only allows inbound trusted network traffic. 5. Anti-malware software installed on all Health Board computing devices which includes ransomware behavioural intelligence. 6. Blocking and monitoring of Internet traffic. 7. Locally systems that monitor the local network for suspicious traffic. 8. A monthly patching regime to ensure that all operating systems are up to date. 9. Regular backups of critical information and device configuration which is stored off site as part of DR/BC planning. **Gaps in Controls**: 1. Current National SIEM has presented many issues in terms of access to the Health Board for identifying issues and addressing false positives. 2. The Health Board is currently not addressing the need for the national Cyber Security training to become part of mandatory training to all staff. 3. A regular co-ordinated approach to providing Phishing campaigns as part of staff awareness to indicators of compromise. 4. A process where the Health Board can monitor where staff have read important information/cyber security policies. 5. The current network Intrusion Detection/Intrusion Protection system (IDS/IPS) is no longer licensed under the new generation firewall infrastructure.	The Health Board has purchased a Phishing tool which the ICT Department in co-operation with Information Governance and Counter Fraud are using to simulate Phishing attacks. This is to help educate staff and will be used to push the organisation to add the NHS Wales national cyber security awareness training as a mandatory core competency to all staff via ESR. The ICT Department are investigating ways to improve the security of backups to ensure that these are protected from potential ransomware attacks. The ICT Department are investigating ways to segregate the current configuration of the network infrastructure to ensure that critical clinical systems are better protected from cross infection. The ICT Department will be re-introduce Cisco FirePower which is an IDS/IPS networking software. The ICT Department will be reviewing the current local Cyber Incident Response Plan which will be escalated up to senior and board level management. The SIRO/cyber leads will be undertaking a programme of introducing the NCSC Board Level toolkit to provide knowledge of cyber to Board members. The organisation is recruiting a Director of Digital Services who will be a member of the Board. This position will enhance the complexities and needs of both service delivery and information/cyber risks.	Digital & Data Committee	20	C5 x L4	15 (C5xL3)	↔	26/05/2021	05/06/2021	25/06/2021
4743	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible 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	Funding Bid for approx. £385K has been submitted by Estates	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	New risk escalated to Org RR July 2021	05.07.2021	05.07.2021	31.08.2021
4203	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Unable to provide Surgical Services	**If:** Surgical services cannot meet demand and patients are not treated in targeted timeframes (RTT) **Then:** Patients will not receive surgery and subsequent treatments **Resulting In:** Harm to patients, poor prognosis, reduced treatment options, poor quality of life, risk of claims, increased demand on wider health and social care services including emergency care, staff burnout. Since March 2020 COVID 19 Pandemic has resulted in Surgery being ceased for Urgent and Routine listed patients.	Restart plans including Waiting List Initiative to increase capacity. Limited ring-fenced funding for recovery plans. Outsourcing Some pathway innovations Ongoing validation of waiting lists.	Restarting elective surgery and further outsourcing to private sector. Discuss reconfiguration of acute site to enable more surgical capacity.	Quality & Safety Committee	20	C4 x L5	16 (C4xL4)	New risk escalated to Org RR July 2021	01.07.2020	15.06.2021	01.09.2021
4149	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain Child and Adolescent Mental Health Services	**If:** The Health Board continues to face challenges in the CAMHS Service **Then:** there could be an impact in maintaining a quality service **Resulting in:** recruitment challenges, long waiting times and impact to the implementation of the new model of care. Loss of trust and confidence in the services provided by the Health Board. Difficulties remain in recruiting key staff and new model of care being implemented; waiting times for specialist CAMHS and the new neurodevelopmental service remains challenging. Rationale for target score: Increasing demands being placed on the Core CAHMS Services resulted in long waiting times and the service was experiencing difficulties in recruiting staff	• Reported local and Network pressures across the CAHMS Network with variable problems dependant on the area of the network. • Updates provided to Management Board on developing service model to address reported issues and additional investment secured to increase capacity within the service and to address service pressures. Waiting list initiatives in place whilst staff recruitment is being progressed. • Service Model developed around Core CAHMS in Cwm Taf Morgannwg which includes agreement with General Paediatrics to take the lead on Neurodevelopmental Services and shared care protocols with Primary Care. • New investment impact being routinely monitored A number of service reviews in relation to Ty Llidiard undertaken and monitored via Q,S&R Committee - Regular WHSSC monitoring meetings to be held. Update July 2021 – Ty Llidiard WHSSC escalation level raised from 3 to 4. Risk description and control measures updated. Risk rating reveiwed and consequence rating increased from a 4 to a 5.	Commissioning discussions taking place across the Network in relation to service pressures and funding. Implementation of the Choice and Partnership Approach (CAPA) and being closely monitored. Internal Enhanced Monitoring Action Plan being progressed and monitored on a fortnightly basis by Bridgend ILG. Single Point of Access being developed. Full demand and capacity plans being developed with some assumptions about additional CAMHS demand as a consequence of the pandemic. Update June 2021 - CSG and ILG continue to develop and progress business case proposals to improve service provision and access and recruitment / retention initiatives. Regular WHSSC monitoring meetings to be held.	Planning, Performance & Finance Committee & Quality & Safety Committee	20	C5 x L4	9 (C3xL3)	↗ Increased from a 16 21.7.2021	01/01/2015	21.07.2021	31.8.2021
3742	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based and accessible Care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of 16-18 Year Olds	**If**: Children aged 16-18 years are cared for in an adult acute setting. **Then:** there is a concern that the care provided will not meet the required paediatric standards. **Resulting in**: Inappropriate care and an inappropriate setting.	Cases are managed on an individual basis dependent upon the needs of the child. Ongoing discussion with the medicine specialties and the paediatric teams about the most appropriate setting for each individual. Discussion underway with the CSGs across CTM to understand the support required and the action plan will be updated accordingly, identifying any corporate level support as required.	Discussion with CSG's to understand the support required is underway and the action will be updated accordingly, identifying any corporate level support as required.	Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	19.07.2019	07.06.2021	07.09.2021

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4106	Executive Director of Nursing and Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Increasing dependency on agency staff cover which impacts on continuity of care, patient safety	**IF:** The Health Board increasingly depends on agency staff cover **Then:** the Health Board's ability to provide stability and consistency in relation to high quality care could be impacted. **Resulting in**: disruption to the continuity, stability of care and team communication. Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover.	Recurring advertisements of posts in and nursing continue with targeted proactive recruitment employed in areas of high agency/locum use. Provision of induction packs for agency staff Agency nursing staff are paid via an All wales contract agreement, any off framework agency requests must be authorised by an Executive Director prior to booking (system of audit trail in place). Fixed Term Contracts being offered to all existing HCSW and RN currently on the Nurse Bank. Redesign services wherever possible to embrace a healthier Wales and therefore impact upon the workforce required to deliver services. Overtime incentives offered to workforce in response to Covid-19 pandemic. The Health Board is continuing with the overseas recruitment campaign.	Deputy Exec DON is currently reviewing the nurse rostering policy in conjunction with the workforce team in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's . Established a new nursing workforce taskforce. Consultation with Local Partnership Forum undertaken and amendments to the policy have been made as appropriate, the policy will be seeking approval at the Quality & Safety Committee in May 2021- Timescale 31.5.2021. Bi-Annual Nursing Staffing Levels Wales Act - Acuity Audit to be undertaken in June 2021 to report to Board in October 2021. All Wales "Safer Care Module" on e-roster system due to be received in due course. WG led so await WG timescales. No Change as at 4.5.2021. Nursing & Midwifery Strategic Workforce Group, Chaired by the Deputy Director of Nursing to recommence in April 2021. The Nursing and Midwifery Strategic Workforce Group did not meet in April 2021 as planned due to the need to revise membership in line with ILG structure, however, bi-monthly nursing workforce operational task force meetings have been held chaired by the Deputy Director of Nursing since February 2021. the Strategic workforce group is scheduled to meet on the 11th May 2021.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	12 (C4xL3)	↔	01/06/2015	04.05.2021	30.06.2021
4157	Executive Director of Nursing and Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of high quality patient care due to the difficulty in recruiting and retaining sufficient numbers of registered nurses and midwives	**IF:** the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage **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**: Disruption to the continuity and stability of care and team communication Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover.	• Proactive engagement with HEIW continues. • Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues. • Targeted approach to areas of specific concern reported via finance, workforce and performance committee • Close work with university partners to maximise routes into nursing • Block booking of bank and agency staff to pre-empt and address shortfalls • dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act. • Deputy Exec DON is currently reviewing the nurse rostering policy in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's • Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board • Regular review by Birth Rate Plus compliant, overseen by maternity Improvement Board • Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends. successful overseas RN recruitment. - There is an operational Nursing Act Group that reconvened from April 2021.	Established recruitment campaign - which is monitored at the Nursing Workforce Strategic Group - group due to meet/recommence in April 2021.The Nursing and Midwifery Strategic Workforce Group did not meet in April 2021 as planned due to the need to revise membership in line with ILG structure, however, bi-monthly nursing workforce operational task force meetings have been held chaired by the Deputy Director of Nursing since February 2021. the Strategic workforce group is scheduled to meet on the 11th May 2021. Revised nurse rostering policy currently being taken through the relevant approval process - Timescale 31.3.2021.Consultation with Local Partnership Forum undertaken and amendments to the policy have been made as appropriate, the policy will be seeking approval at the Quality & Safety Committee in May 2021- Timescale 31.5.2021. The operational Nursing Act Group to reconvene. Completed as reconvened in April 2021 - included as a control measure. Await review of Birth Rate Plus Compliant Tool by WG - Timescale - WG led so await WG timescales - No further update at this time.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	~~9~~ 12 (C4xL3)	↔	01/01/2016	04.05.2021	30.06.2021
4156	Executive Director of Nursing and Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Patients and/or relatives/carers do not receive timely responses to matters raised under Putting Things Right resulting in learning and improvement being delayed	**IF:** The Health Board fails to provide timely responses to matters raised by patients, relatives and/or carers under Putting Things Right. **Then:** there will be a delay in identifying potential learning opportunities. **Resulting in:** variable quality in responses, not learning lessons, not meeting regulatory response times therefore increasing the number of concerns being escalated to the Ombudsman and not providing complainants with a resolution in a prompt and timely manner.	-Implementation of the Quality & Patient Safety Governance Framework - Values and behaviours work will support outcome focused care - supportive intervention from the Delivery Unit supporting redesign of complaints management - relocation of the concerns team into Integrated Locality Groups (ILGs) - Governance teams embedded within each ILG - Governance processes in place in relation to PTR guidelines and this provides assurance via their ILG Q&S committees and these report into the CTMUHB Q&S committee and Patient Experience Committee. - Corporate/Executive assurance and review undertaken weekly via Executive Director led Patient Safety review meetings and quarterly Concerns scrutiny panel meetings. - Ensure access to education, training and learning. - Review of systems in place to aid assurance and compliance with PTR guidelines in progress by Corporate Governance Team. Level 1 PTR training added to ESR training module and training ongoing for staff in the DLG's. Member of corporate team continues to provide training surrounding PTR guidelines and governance. - Shared Listening and Learning forum established with its inaugural meeting in February 2021. - ILG Concerns Management Performance is monitored via the regular Executive Led Performance Management Meetings. - Once for Wales Concerns Management System - Claims, Complaints, Incidents and others that were due to go live from 1st April delayed due to All Wales Technical issues, planned to implement 7th May 2021, which will provide greater integration across complaints, claims and incidents, it will also support All Wales learning and benchmarking.	Corporate Governance team reviewing current Datix system to reflect new DLG structures and working with WRP to ensure alignment with new Once for Wales System which is in progress. COMPLETED. Review of the Concerns Process within ILG's underway - Completed. Improvement trajectories to be established with ILG's - Completed. The Health Board has requested an external review of claims, redress and inquest processes and procedures. This review will be undertaken by the Welsh Risk Pool. Timescale: End of September 2021. The Health Board has requested an Internal Audit on the Concerns Process. Timescales: End of August 2021.	Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	01/04/2014	04.05.2021	31.08.2021
4458	Chief Operating Officer All Integrated Locality Groups	Provide high quality, evidence based, and accessible 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.	Live Flow Information Dashboard being scoped - Target Date: 31.3.2021 Unscheduled Care Board focus on SDEC/AEC, D2RA - Contact ahead 111 - Target Date: Contact Ahead: March 2021, 111: January 2021. March 2021 - the 111 system commenced in RTE and M&C Locality in November 2020 - will commence in Bridgend Locality shortly. The Unscheduled Care Improvement Programme will be launched in April 2021. A focus of this forum will be on the improvement of the urgent care pathway through the Health Board with the primary benefits being the reduction/eradication of Ambulance Handover Delays. 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 in August 2021	Quality & Safety Committee Planning, Performance & Finance Committee	16	C4 x L4	12 (C4 x L3)	↔	04/12/2020	4.6.2021	31.7.2021
4706	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based and accessible Care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure of appropriate security measures in mental health services.	**If:** there is a failure in security measures. **Then:** there is an increased likelihood of patients leaving the ward without the knowledge of staff **Resulting In:** absconding events and possible harm to the patient or members of the public	The following control measures are in place: - Signs are placed on doors to ensure staff check the doors lock behind them. - Patients are on appropriate levels of observations - Problems are escalated to estates as they arise	There has been a proposal that Estates undertake environmental checks accompanied by leads within the respective Mental Health Clinical Service Groups to work together to review onsite security systems in mental health services.	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	↔	22.06.2021	22.06.2021	22.07.2021
4567	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of endocrine surgical service in RTE	**If:** there is no provision of a dedicated endocrine surgical consultant for the surgical management of endocrine patients. **Then:** patients with primary hyperparathyroidism, thyroid and adrenal disorders will need to be referred to the UHW for their surgery **Resulting In:** a risk of patients coming to preventable harm due to the lack of surgical management options within CTM and delays waiting to be seen.	Surgical colleagues are considering the options in relation to capacity and resource. Discussion with surgical colleagues at UHW for complex cases. Patients managed on a case by case basis.	Surgical colleagues are considering the options for the future provision of the service within CTM. Discussion with surgical colleagues at UHW for complex cases. Patients managed on a case by case basis.	Quality & Safety Committee	16	C4 x L4	12 C4 x L3	↔	03.03.2021	28.06.2021	31.07.2021

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4103	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible 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.	Action plan developed and on going monitoring - consolidated plan coming forward covering Eye Care. The service has transitioned to Bridgend ILG and Bridgend ILG has engaged in potential national solutions to address FUNB. Update June 2021 - Position paper submitted to Management Board and Quality & Safety Committee .The ILG is in the final stages of Quality Assuring the submission of data to the Royal College of Ophthalmologists in readiness for the external review that has been commissioned. Update July 2021 Evidence submitted for Royal College review.	Quality & Safety Committee	16	C4 x L4	12 C4 x L3	↔	01/04/2014	08.06.2021	31.7.2021
4152	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible 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.	Currently looking at plans for capacity for the whole service - unlikely to see much change in the near future. Locums to support CT service CT vans on site RGH/PCH MRI running at higher capacity Ultrasound concerning 3.2.21 Whilst mobile scanner presence allowed us to reduce the backlog (CT/MRI) routine imaging has since been stopped and has not been reinstated, which will result in a build up of back log. 19.3.21 No change.	Increased capacity required for current referrals to address backlog, particularly in CT/MRI /Ultrasound. Require funding and procurement of mobile scanners in the longer term. Actions: Staffing Resource, Capacity and Demand Planning and business case.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	07/06/2021	14/06/2021
4478	Executive Director of Nursing & Midwifery IPC - Decontamination	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Inappropriate decontamination process in place for laryngoscope handles in RTE & MC	**If:** the current decontamination process for laryngoscope handles continue **Then** staff are not following manufacturer instructions/Welsh Government guidance. **Resulting in:** possible infection transmission/poor patient care/litigation risks. A Welsh Health Circular was distributed in September 2020 outlining that laryngoscope handles must either be single use or decontaminated/sterilised in between use following manufacturer instructions via an accredited Sterile Service Department.	A wipe system is being used to decontaminate handles following use. Risk assessment completed to continue using the current process due to the additional funding required to comply with the WHC. Sheaths used to minimise contamination to the handle which is changed following use.	Assistant Medical Director for QSCE has been tasked to progress the requirements of WHC 2020 15 - Laryngscope Handles - Due Date: 30.06.2021 No change as at 5th July 2021 - Review of risk scheduled for w/c 12th July - update will be received in the next submission of the Organisational Risk Register.	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	↔	30/12/2020	05.07.2021	31.07.2021
2018	Executive Director of Nursing & Midwifery Infection Control	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Poor compliance with IPC training	**If:**there is poor compliance with IPC training **Then:** IPC practice will be compromised **Resulting in:** transmission of infection/ poor patient care	Level 2 training is mandatory and delivered via e.learning Managers to monitor compliance with IPC training and report compliance to Directorate and at IPCC meetings	IPC training is available via e.learning and is a mandatory requirement for staff to complete. Reinstate face to face IPC training sessions once COVID situation improves. IPC team to arrange and discuss with Heads of Nursing/ ILG Nurse Directors. Update: 12.5.2021 -- face to face training being reinstated as COVID numbers fall. Review in June 2021. No change as at 5th July 2021 - Review of risk scheduled for w/c 12th July - update will be received in the next submission of the Organisational Risk Register.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	04/09/2015	05.07.2021	31.07.2021
4217	Executive Director of Nursing & Midwifery Infection Control	Provide high quality, evidence based, and accessible 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 C.Difficile cases - back log of cases and unsustainable 03/03/2021 - there is a back log of IPC investigation relating to community cases due to the additional demands on the IPC service due to the COVID pandemic.	A business case for additional resources for an IPC team for primary care to be developed. Due Date: 31.08.2021 No change as at 5th July 2021 - Review of risk scheduled for w/c 12th July - update will be received in the next submission of the Organisational Risk Register.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	44028	05.07.2021	31.07.2021
4476	Executive Director of Nursing & Midwifery IPC - Decontamination	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Manual decontamination of nasoendoscopes in RTE & MC	**If** the current decontamination process (Tristel 3 Step)continues to be used in RTE & MC. **Then:**inadequate decontamination of the scopes is possible resulting in transmission of infection/poor patient care. It is impossible to guarantee effective decontamination of the scopes every time due to the human factor. **Resulting In:** in variable techniques. The current manual process is not in line with WHTM guidance which recommends an automated system	A risk assessment to be completed for the use of Tristel 3 step by the ENT service group in RGH, YCR and PCH. SOPs in place for users Decontamination lead to complete assurance audits in the departments. Staff in the ENT department to undertake annual training by the representatives for Tristel 3 Step.	Naso-endoscopes should be processed using a validated and automated process in line with WHTM 01-06. Working group to be established to discuss options available to decontaminate naso-endoscopes. SBAR (options appraisal) to be developed and shared with Exec team Evidence of SOPS for manual process to be shared at local decontamination meetings Risk assessments to be shared/agreed at local decontamination meetings - Due Date: 30.06.2021 No change as at 5th July 2021 - Review of risk scheduled for w/c 12th July - update will be received in the next submission of the Organisational Risk Register.	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	↔	30/12/2020	05.07.2021	31.07.2021
4482	Executive Director of Nursing & Midwifery IPC - Decontamination	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Decontamination of dental equipment in the community	**If** dental equipment continues to be decontaminated in community dental facilities. **Then:** the equipment may not be decontaminated effectively as a consequence of the equipment/facilities available to staff. **Resulting In:** transmission of infection/near misses/poor patient care. Some of the hand pieces cannot to processed in an automated washer/disinfector and are manually cleaned before being processed/sterilised in an autoclave. There are also difficulties maintaining clean to dirty workflows in the decontamination areas due to space restrictions. One of the main recommendations from the Welsh Government audit undertaken in November 2019 was to transport community dental equipment into an accredited Sterile Service Department in the Health Board for processing/sterilisation.	Agreed SOPs in use Maintenance programmes in place for decontamination equipment Hand pieces are serviced annually Water dip tests performed quarterly Quarterly water testing performed by estates in line with WHTM Cleaning schedules in place Nominated dental nurse lead for IPC/decontamination Dental Nurse attends Decontamination committee Plans to centralise decontamination of dental equipment in CSSD/HSDU	Dental Nurse Manager to provide SOPs and Equipment Maintenance - Due Date: 25th June 2021. Action Plan to be developed - Due Date: 30.06.2021 Centralise dental equipment decontamination from Pontypridd Health Park to RGH HSDU - Due Date 30.06.2021 The Infection Prevention and Control Committee met w/c 27th June 2021 and agreed to review the wording of this risk. IPC to link in with Assistant Director of Primary Care and update will be submitted in time for the next review of the Organisational Risk Register..	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	↔	30/12/2020	05.07.2021	31.08.2021

Datix ID	Strategic Risk owner	Strategic Objective	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
4148	Executive Director of Nursing & Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non-compliance with DoLS legislation and resulting authorisation breaches	**IF:** due to current capacity the Health Board fails to fully comply with the DoLS legislation. **Then:** the Health Board may have to operate outside the current legislative process. (a change in legislation is coming which will hopefully improve lawfulness) **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.	• Training and DOLs Process impacted by Covid-19 pandemic due to not being able to undertake face to face capacity assessments. Staff recruited to manage demand e.g. independent best interest assessors, a full time secondment transition post and nurse bank hours. As a matter of routine the HB remain in the position that it is encouraging urgent authorisations by the managing authorities and undertaking virtual capacity assessments with standard authorisations and reviews. • Virtual DoLS processes established and in place within the HB during Covid19, this is subject to regular review and monitoring. Urgent authorisations are prioritised over standard authorisation Although this process is effective in terms of identifying patients deprived of their liberty, it is not a lawful process and does not comply with legislation. The HB is therefore at greater risk of breaching the legislation and the rights of those who lack capacity are potentially compromised. • Monthly Safeguarding People training for Covid 19 - there has been a pause in training as a result of the second wave of the pandemic as patient facing activity takes precedence. Training restrictions have also impacted upon the numbers of authorisations requested and alternative ways of delivering Level 3 DoLS & MCA awareness has been developed via TEAMS and will commence in April 2021. • DoLS legislation will subject to change following enactment of the new legislation and statutory guidance. Whilst requirements have increased, mitigation has also been revised to manage increased risk, the HB will need to be prepared for new legislation. Further conversations with our 3 local authorities have been undertaken to recommence a CTM regional understanding and preparation for the changes in legislation, supported by the Safeguarding Board. • Audits are undertaken on time to respond to requests. Virtual capacity and best interest assessments involve family, patient representatives and those who care for the patient. Streamlining and target setting implemented which has led to more authorisations taking place in a more timely manner. • Authorisation breaches are required to be reported on Datix. • The DoLS team maintain an accessible level of virtual support and advice to wards, have supported the development of a consent form for Covid testing for those who lack capacity and the nursing workforce are strong advocates for the rights of individuals who lack capacity. A member of the DoLS teams has been allocated as a link for each ILG. • Audit of the service continues and a business scorecard will be produced on for each ILG Q&S bi-monthly and on an organisational wide perspective on a quarterly basis for review by the CTMUHB Safeguarding Executive Group and the CTM Safeguarding Adult Quality Assurance Group. Quality Assurance Group.	The Health Board has transitioned back to face to face capacity assessments, following a return of staff from re-deployment. Funding has been received from Welsh Government to support the improvement of the Health Boards compliance with DoLS legislation. This funding will support the Health Board to improve capacity for authorisation and prepare for the new Liberty Protection Safeguards. A review will be undertaken in June 2021. June 2021 - Review with DoLS team with a plan to develop Court of Protection Training, Communications in preparation for LPS, Increasing Health Board Signatories, performance management to reduce breach, use of WG grant to develop eLearning for greater HB MCA/Best Interests awareness. There is a further risk in relation to the observance of the new Liberty Protection Safeguards Legislation (LPS). There will be no Supervisory Body to undertake the assessments themselves. The assessments will be undertaken at ward level as part of the ordinary care planning. Therefore if the ward level assessments are deficient the DOL will not be authorised and there is a risk of allowing the patient to leave and risk them coming to harm for which the Health Board could be liable in damages; or unlawfully depriving patients of their liberty until such time as they get the correct evidence in place – this could also attract damages and potentially awards of costs if appealed to court. Therefore the Health Board needs to ensure it is acting lawfully is to ensure that there is sufficient time, resources and training for those making ward level decisions for people who lack capacity to ensure they are working in compliance with the MCA from the outset. Legal & Risk colleagues are reporting a more aggressive trend from those representing patients and a growing appetite for costs and damages related to poorly managed deprivation of liberty. A LPS co-ordinator role has been submitted for transformation monies to support implementation. No further update as at 5th July 2021.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01/10/2014	05.07.2021	31.07.2021
4116	Director of Corporate Governance Chief Executive	Provide high quality, evidence based, and accessible care.	Adverse publicity/ reputation	Organisational Reputation - Lack of confidence in the services and care provided by the organisation.	**IF:** the Health Board does not effectively engage with its stakeholders, communities and staff to demonstrate listening and learning from external reviews and more recently the Health Boards response to Covid-19 **Then:** Trust and confidence in the services of the Health Board will be negatively impacted. **Resulting in:** negative media coverage, lack or credibility with our communities and staff, ineffective communication, loss of commitment, deteriorating morale, increase in staff turnover and recruitment.	Rebuild trust and confidence programme under Targeted Intervention Improvement Programme underway. Maintaining public confidence in the Health Boards response to the Covid-19 Pandemic through regular and robust communication and messaging through the Health Board's communication channels. Improved staff engagement and involvement, new approaches to partnership engagement and involvement. Additional capacity bid included in TI investment bid under the TI programme to WG. Additional capacity bid included in TI investment bid under the SW Programme. Ensure balanced news stories are regularly reported and communicated. Relationships with the media have been strengthened. Partnership working with Channel 4 and proactive engagement with other media outlets - resulting in positive working relationships and fair media coverage. 'In Committee' meetings have been significantly reduced. TTP Communications work stream focussed on provision of accurate and timely information to the Public. Live streaming of the Board meetings now in place to improve transparency and involvement. New Health Board Values and Behaviours were officially launched in October 2020, World Values Day, following the Let's Talk staff engagement programme. The launch was further complemented by a peer recognition 'wall of thanks' campaign throughout Oct/Nov/Dec and a Staff Gratitude Event in December which recognised all CTM staff for their contributions throughout 2020 pandemic year. High visibility, communications and engagement from CEO office internally with staff and externally with key stakeholders since Sept 2020. Media have been given increased access to interviews and filming, most recently in ED at all three acute sites for BBC Wales, ITV and C4. Stakeholder database reviewed in May 2021 to ensure it is as up to date as possible.	Stakeholder engagement survey planned for August 2020 -Stakeholder engagement survey delayed due to Covid-19 outbreaks in autumn but re-scheduled for spring 2021. Update June 2021 - Stakeholder database has undergone a significant review to ensure that it is as up to date as possible in readiness for the survey. Currently exploring the procurement of a company to undertake the survey independently from the Health Board. Anticipated that the survey will be live by the end of summer 2021 - Review Date: 31.8.2021.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01.07.2019	5.5.2021	31.8.2021
3585	Chief Operating Officer. Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible 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. 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. June 21 Update - Capital works for NIV room still ongoing and therefore no progress yet with the rest of the capital build. NIV room to be handed back mid June and patient toilet will be the next priority for completion Update July 2021 - No Change.	Quality & Safety Committee	16	C4 x L4	1	↔	31.05.2019	08.06.2021	30.09.2021
4337	Executive Director of Public Health - Interim Executive Lead for ICT Bridgend Integrated Locality Group	Ensure sustainability in all that we do, economically, environmentally and socially.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	IT Systems	**If:** The Health board is unable to deliver vital clinical information services to the Bridgend locality affecting many clinical systems that are not compatible with Cwm Taf University Morgannwg Systems. **Then:** The Health board will be unable to deliver safe, high quality care to patients without vital clinical information available. **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.	**Key Controls** SBUHB Service Level Agreement Bridgend disaggregation and the one-CTM aggregation plan Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. **Gaps in Control** The business case for 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.	Progress in line with the existing plans which were agreed on the primary basis of their need to be affordable, has been made over 2020/21 with a number of new systems, such as pharmacy management introduced as pan-CTM products. However there is still considerable work required to create a unified digital infrastructure for CTM = around the clinical systems and the remainder of the ICT SLA. The business case details a funding requirement of £8 million. This was discussed at the Digital cell with WG in February 2021 and a further funding request has been submitted to WG at their request, along with complimentary proposals from Digital Healthcare Wales (DHCW) for which CTM has worked with them on. Timeframe - Mid June 2021 when DPIF Funding is announced.	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	26.5.2021	30.06.2021
4684	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department Environment at Prince Charles Hospital	**If:** there is no change to the template for the environment of the Emergency Department at Prince Charles Hospital to improve the areas for Major, Minors, Fractures and GP Assessment. **Then:** there will continue to be challenges to the safety of patients and the management of patient flow through the appropriate departments/areas. **Resulting in:** Potential delays for patients in accessing the right treatment in a timely and efficient manner. Poor Patient experience. The environment does not allow for the EPIC model of consultant oversight which will impact clinical oversight across all areas and silo working.	Caring for patients in corridors SOP established and followed. Flow Manager in place. Additional staff are rostered into the functions above core establishment to support staffing levels. Escalation Plans and Cards established. Surge Capacity Plan in place.	Phase 2 of the PCH Development Plans include the Emergency Department template. Emergency Department Improvement plans being formalised / developed.	Quality & Safety Committee & Health, Safety & Fire Sub Committee	16	C4 x L4	8 (C4xL2)	↔	10.06.2021	10.06.2021	31.07.2021

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4686	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Management of Controlled Drugs within the Theatres Department at Prince Charles Hospital	**If:** dedicated Pharmacy support to manage controlled drugs within the Theatres department at Prince Charles hospital is not improved. **Then:** there is a risk to medicines management and compliance with the requirements to manage controlled drugs **Resulting in:** Medicines not being stored and controlled appropriately within required standards.	Controlled Drugs are locked when not in use. Review of the Medi Well System undertaken. New equipment ordered to improve storage solutions within Theatres.	Task and Finish Group to be established to look at the flow and realign the environment - further update in July 2021. Theatres improvement plan developed. Swipe card system to be extended for 24hrs a day. Request for dedicated pharmacy support made.	Quality & Safety Committee & Health, Safety & Fire Sub Committee	16	C4 x L4	8 (C4xL2)	↔	10.06.2021	10.06.2021	31.07.2021
4685	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Patient Flow within the Theatres Department at Prince Charles Hospital	**If:** we fail to alter the patient flow (in and out) of the Theatres department. **Then:** there is an increased waiting time for patients waiting to enter theatres and potential harm to staff and patients exiting theatres. **Resulting in:** failure to comply with the appropriate theatre standards, inefficiencies, delays for staff and patients, possible cross-contamination.	Maintaining the safety of patients is paramount at all times to ensure the inefficiencies and problems with flow do not impact upon patient safety, however, this control measure does in itself then present a delay for patients waiting as the current flow is not efficient.	Task and Finish Group to be established to look at the flow and realign the environment - further update in July 2021. Theatres improvement plan developed.	Quality & Safety Committee & Health, Safety & Fire Sub Committee	16	C4 x L4	8 (C4xL2)	↔	10.06.2021	10.06.2021	31.07.2021
2987	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible 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 progressed to the point that 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. 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.	Please see detailed update in control measures. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	6	↔	29.11.2017	02.02.2021	30.04.2021
4294	Chief Operating Officer Merthyr & Cynon Integrated Locality Group Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long waiting times and large backlog of patients awaiting Cardiac Echo	**IF:** The health Board is unable to meet the demands for patients awaiting Echo scans for both follow up surveillance **Then:** The RTT WG target will not be met and waits may be 26weeks **Resulting in:** Potential risk to patients from delays in identifying and treating disease and progression of disease	Forms were verified and triaged by Cardiology team. Patients prioritised in relation to clinical need and rated between urgent and routine. I/P room identified away from main department to increase outpatient capacity and to prevent cross infection risks to outpatient services for both staff (inc returning shielders)and patients Clinically urgent completed and move to routine. New forms triaged as received. Overall loss of capacity post Covid circa 56 / month due to test time changes. (+ currently 1.0 wte lts further 120/month. Will submit SBAR to highlight capacity deficit and cost solutions.	See Control Measures Risk also raised via Rhondda Locality which will be reviewed alongside this risk - Datix ID 4292. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Quality & Safety Committee	16	C4 x L4	6	↔	14.09.2020	07.07.2021	19.08.2021
3958	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Elective patients surgery cancelled when high level bed pressures are experienced	**IF:** Elective patients surgery is cancelled when high bed pressures are experienced **Then:** There will continue to be a backlog of patients awaiting treatment/procedures to improve their health and wellbeing **Resulting in:** Potential harm to patients due to delay in treatment/procedures	Consultants are asked clinical opinion when each patient case is cancelled. 12/10/20 insufficient capacity to meet current trauma demand and no short term plan to re-introducing elective orthopaedics during C19 pandemic. Seal area identified but delayed due to RGH IPC issues. As per UHB SoP, clinical prioritization undertaken weekly to list patients with high clinical need. Risk to patients who cannot access. Feasibility study undertaken for elective list in YCC.	See Control Measures As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	14.01.2020	14.01.2020	31.03.2021
3682	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk to Obstetric Theatres National Standards	**If:** There is an aim for 'Gold standard' compliance with theatre staffing standards. Workforce is used from midwifery establishment, and the establishment is impacted by this. **Then:** Midwifery workforce reduced to undertake theatre roles and undertake an agreed robust there is a competency training Programme in the UHB for midwifery staff who scrub **Resulting In:** inefficient staff utilization, where there is a national shortage in the workforce.	Scrub training in place and a rolling programme organised with main theatres There is a business case that has been previously been partially approved for revised staffing levels to achieve compliance with the national standards Acuity impact with no additional resource when midwives are used as scrub midwives impacting on ability to provide a full compliment of midwives for labour ward. Staffing and birth-rate acuity compliance.	Action: Service to update and re submit business case for the Surgical CSG to take ownership of maternity theatres. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	People & Culture Committee	16	C4 x L4	6	↔	26.06.2019	4.12.2020	31.3.2021
3011	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non compliance with appropriate fetal growth detection and management guidance	This is an All Wales risk for all HB`s **If:** there is a lack of USS slots to address the demand we will not be in compliance with the guidance for fetal surveillance and wellbeing. **Then:** 1. Compliance against the Growth Assessment Protocol (GAP) cannot be met. CTMUHB does not have a 7 day USS service which would support compliance and the management of the small for gestation age (SGA) fetus. **Resulting In:**: Women at the greatest risk of SGA receive less surveillance of growth than women with uncomplicated pregnancies resulting in potential harm.	1. Capacity to comply with GAP/GROW 3 weekly - current regime 3-4 weekly 2. Woman are risk assessed, they are allocated one of two pathways. One pathway SFH can be delivered, Serial scanning (37% of population) unable to receive full recommended scanning regime or protocol due to scanning capacity issues. Current regime 4 weekly as apposed to three weekly. 4. The Directorate is working closely with the Radiology department to review low value scans requested. 5. The Directorate is reviewing the option of midwife sonographers being employed. 7. Scanning group for the UHB established. 8. Continued to be reviewed with changes to patient flow due to 'The Grange'	See Control Measures. Radiology to develop sustainable service plan to increase capacity and workforce. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Quality & Safety Committee	16	C4 x L4	6	↔	01.06.2017	4.12.2020	31.3.2021
3008	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible 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 7. Ask other HB`s their MH requirements SBUHB online training package to be shared. 8. Directorate will Seek out any opportunities for online updating to support current practice 9. E-learning module has been sourced for all staff to complete on line update for manual handling.	Organisational plan for compliance training. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	01.05.2017	01.12.2020	31.3.2021

Datix ID	Strategic Risk owner	Strategic Objective	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
3654	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Gynaecology Cancer Service	**If:** Demand continues to exceed the agreed manageable caseload in Gynaecology services across the Health Board. **Then**: there will be a delay in the pathway requiring multiple consultations on site and reliance on an individual Practioner. **Resulting in**: Delay in patient pathways, poor experience, unsustainable demand on the workforce and Gynae Rapid access service development is slow progression. Risk description reframed into the if, then, resulting in format.	Hysteroscopy service business case is being updated - Increased cancer tracking - Review of pathways and service - tracking of results G17Scrub training in place and a rolling programme organised with main theatres	Action: Agreed COVID pathways. Service to re-submit gynaecology 'one stop' Service. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Quality & Safety Committee	16	C4 x L4	9 (C3xL3)	↔	18.06.2019	12.05.2021	11.06.2021
3133	Chief Operating Officer Facilities	Provide high quality, evidence based, and accessible 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.	**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.	Issue of limited attendance raised at Medical Devices Governance Board on 08/04/2021 and Assistant Director Facilities agreed to take forward with Chief Operating Officer (COO). Training dates and flyer have been provided by Medical Device Trainer to Assistant Director Facilities so that he can take to ILG Directors next meeting to be held 13/04/2021. Action: ILG Director leads to improve take up of Medical Gas Training. Timescale: 31/07/2021. Based on this update the risk rating remains unchanged until the required attendance for Medical Gas Training is being consistently achieved. (DW 12/04/2021). Reviewed 5.7.2021 - no change.	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	05.07.2021	31.07.2021
4356	Executive Director for People Health, Safety & Fire Function	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Overdue/Out of date fire risk assessments due to resource issues and the amount required to be undertaken	**If:** Fire Risk Assessments are not completed and reviewed in a timely manner. **Then:** Significant findings on the FRA may have changed which could compromise the safety of patients, staff, visitors/contractors and building fabric. **Resulting in**: Increased risk of fire/harm, enforcement action by Enforcing Authority i.e. Notification of Deficiencies (IN01) which will further escalate to Enforcement Notices (EN01) if no remedial action is taken.	There are FRA's in place however a substantial number have not been reviewed by the review date. Fire safety advisors are reviewing FRA's in areas where it is safe to do so (Covid restrictions are in place in many areas). A concentrated effort will be necessary to reduce the number of overdue FRA's. An initial 12 months funding has been secured to appoint a Fire Officer - post currently out to advert.	It is recommended that additional fire safety resources are provided to support the work of the fire officers to undertake FRA reviews. As referred to in Risk ID:4315, 2 x Band 5 additional fire safety trainers to be appointed. Agreement on additional fire safety training resource (Risk ID 4315) will create additional time for the Fire Officers to undertake this activity - Due by date 31.03.2021. Update June 2021: Recruitment has focussed on an appointment of a Fire Officer who will be able to undertake the Fire Risk Assessment reviews as well as undertake training as required. No specific Fire Safety Trainers are considered to be required at this time. Fire Officer post currently being advertised. Review - July 2021. Update July 2021 - Recruitment to Fire Officer post underway and pending a successful shortlisting exercise interviews are planned for circa mid July.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	26.10.2020	5.7.2021	31.7.2021
4360	Executive Director for People Health , Safety & Fire Function	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Changing the use of rooms/departments without input/advice from the relevant fire advisor.	**If** The Health Board does not follow the procedures in relation to input and advice from the relevant fire advisor. **Then:** Risks within the workplace are increased which in turn increases the risk to patients staff and visitors. Required information for emergencies situations could be inaccurate. **Resulting In** Increased risk of enforcement, increased risks to life. Confusion to those responding to incidents delaying response and assistance leading to increased risk to life again. Reframed into the new "If, then, resulting in" format as at June 2021.	CTMUHB have access to Fire Build Forms, these are in place to document the required action necessary to change either the use of a single room (FB1) or more than one room (FB2). These forms provide documented evidence that the user has the necessary information to perform the change effectively and that the correct advise has been given. http://ctuhb-intranet/dir/fire/Change%20of%20Use%20%20Room/Forms/AllItems.aspx Non compliance with this requirement is identified via Fire Risk Assessment reviews. Communication plan has been developed and is on the SharePoint page to provide guidance for management on the appropriate Fire Build Forms for room/Departmental changes. Reframed risk description as at June 2021	A communications plan to be developed to ensure all relevant managers are aware of the need to complete the appropriate Fire Build Forms for room/departmental changes. **Completed and on Website.** ILG Leads to ensure that any planned changes of use or alterations a fire build form (FB1 for single room / FB2 for multiple rooms is completed by the relevant manager / lead and forwarded to their locality Fire Officer for comments. This issue has been raised through the ILG Health Safety & Fire Risk Assessment Groups where it will be monitored going forward. Face to Face Fire Training and the Senior Management specific training session will support this activity. Face to Face training has currently stood down as a result of the response to Covid-19, however discussions are underway as to when they could be re-introduced.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	28.10.2020	19.05.2021	24.09.2021
4500	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of high patient care due to the difficult in recruiting sufficient numbers of registered therapists and health scientists.	**If:** the Health Board fails to recruit and retain a sufficient number of therapists and health scientists due to increasing numbers of vacancies and shortages of professional staff. **Then:** the Health Board's ability to provide certain services may be compromised. **Resulting in:** increased waiting times for diagnosis and treatment, missed opportunities to diagnose at an earlier stage, potential for poorer outcomes for patients.	Links via the Director Therapies to HEIW for planning. Proactive recruitment for difficult to fill posts. Use of Agency/Locum staff where available. Update as at April 2021 Director of Therapies & Health Sciences have supported participation in streamlining to appoint AHP summer 2021 graduates to band 5 vacancies. This is the first time AHPs have recruited in this way and it is too soon to ascertain whether this will impact positively on staff retention.	Continue with active recruitment wherever possible. Ensure workforce plans included and supported in the Integrated Medium Term Plan (IMTP). Utilise 'novel' staffing approaches where indicated. The review of the graduate approach to the Band 5 Vacancies will be on a 6-9 month timeline as the graduates are not due to commence until late summer. At June 2021 - no change to the above update.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	8 (C4xL2)	↔	21.12.2020	07.06.2021	31.07.2021
816	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Follow up capacity and clinic cancellations (FUNB)	**If:** The Health Board is unable to control and meet the capacity and demand to accommodate all hospital follow up outpatient appointments. **Then:** the Health Board's ability to provide high quality care may be reduced. **Resulting in**: Potential avoidable harm to patients	Clinical Service Group (CSG) plan in place to address the FUNB position across all specialties as part of the restart programme. Additional funding requirements identified. Regular meetings in place to monitor the position.	Harm review processes being implemented. Further discussions underway with Assistant Director of Nursing. No change in risk rating as at June 2021.	Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	18/11/2013	10.05.2021	10/08/2021
3656	Executive Director For People. Health & Safety	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Health Surveillance	**If:** There is an absence of a robust Health Surveillance (HS) Scoping Report. **Then:** The Organisation will not be able to identify the areas and department within the organisation that require Health Surveillance Intervention. **Resulting In:** The Health Board not being able to develop a HS Programme for the organisation as required by the Health & Safety Executive (HSE). Employees working in specific areas/conditions without the relevant health surveillance.	Directors and line managers responsible for own areas and should have own Health & Safety measures such as risk assessments, safe systems of work in place however this does not address any Health Surveillance needs of CTM employees.	Require scoping report to inform the development of a robust Health Surveillance programme. Collaborative working will be required between OHWB, H&S, Workforce, staff side and line managers to implement the programme.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	18.06.2019	19.05.2021	31.08.2021

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4281	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Delivery of the rehabilitation for repatriated major trauma patients.	**If:** The business case for enhanced rehabilitation services linked to Major Trauma is not supported. **Then:** Patients will not receive the appropriate level of clinical intervention. **Resulting In:** Poorer clinical outcomes, increased lengths of stay (with associated clinical risks) and poor patient experience.	Ensuring current nursing and therapies have access to a training programme - however there are concerns about deliverability during Covid pandemic. The new rehabilitation coordinator post will support the delivery of the immediate care planning once a patient is repatriated. Advance notice means we can ensure staff are aware of immediate needs. The network has systems in place to support early care planning and preparation where possible i.e. The health board is aware of the number of patients likely to be transferred 'Rehabilitation prescription' describes nursing and therapy needs prior to repatriation. Rehabilitation coordinators link with counterparts in UHW to ensure our rehabilitation offer is clear to the patient and their family prior to transfer.	Develop a business case to identify and address the specific rehabilitation needs of patients repatriated to CTM from the Major Trauma Centre. This would need to encompass inpatient and community needs across the whole of the Health Board. The Business case will require Management Board / IMTP approval and release of funding. Recruitment and training of required staff then needs to take place. Timescale: 30.9.2021 changed from 31.3.2021 due to the impact of the Covid-19 impact.	Quality & Safety Committee	16	C4xL4	9	↔	10/09/2020	7.06.2021	10/07/2021
1133	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible 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.	ED sustainable workforce plan developed and being implemented (May 2021).	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4 x L4	12 (C4xL3)	New risk escalated to Org RR July 2021	20.02.2014	17.06.2021	31.07.2021
4699	Director of Corporate Governance Information Governance Function	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to deliver a robust and sustainable Information Governance Function	**If:** the Health Board fails to adequately resource the Information Governance Function following an increase in activity and demand since the boundary change and new operating model. **Then:** the health and wellbeing of staff along with the ability to comply with legislation and service delivery will be impacted. **Resulting in:** an impact on the workforce (poor morale, health and wellbeing, retention), Impact on Service Delivery and Compliance with Legislation	Work programme prioritised to focus on the "must do's": - Urgent Data Sharing Agreements - Responding to FOI's from the Public - Responding to Subject Access Requests - Responding to IG activity that relates to the safety of the public, responding to queries from external agencies such as Police investigations etc. - Significant incident investigations and concerns. -ICO activity and audit	Benchmarking with other organisations in Wales undertaken. Business case for additional IG resource developed to seek funding.	Digital & Data Committee	16	C4xL4	8 C4xL2	New Risk escalated to Org RR July 2021	20.02.2014	29.06.2021	31.07.2021
4741	Executive Director of Public Health	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to respond to Population Health Inequalities	**If:** the Health Board is not in a position to provide appropriate resource to respond to the risk stratification and population health segmentation data that will be available in the next couple of months. **Then:** it will not be able to act upon the new information and support primary care with the anticipatory care measures identified in response to the population health needs **Resulting in:** the Health Board being unable to narrow the gap in population health inequalities, poor reputation, loss of trust and confidence from stakeholders e.g. GPs, population partners. It will also impact how the Health Board uses opportunities arising from the transformation fund.	The Health Board is currently exploring multiple funding streams for population health management, and sustainability planning for Transformation Fund.	As indicated in the control measures the Health Board is exploring options for seeking additional resources which will include working in partnership e.g. with the Regional Partnership Board to reconfigure existing resources to ensure there is capacity to follow up the intelligence with action.	Population Health & Partnerships Committee	16	C4xL4	8 C4xL2	New Risk escalated to Org RR July 2021	05.07.2021	05.07.2021	31.08.2021
4282	Chief Operating Officer Facilities	Provide high quality, evidence based, and accessible care.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Risks associated with the transfer to the new Planet FM System	**If:** the Health Board transfers over to the new Planet FM system **Then:** the TAB system will no longer be supported for Support Services, Laundry Services etc **Resulting In**: Business Continuity / Service Delivery not being available leading to service and financial loss. Potential for system to crash with no support available to rectify. No reporting system being available.	The Health Board is still using the TAB system until suitable alternative is found. Additional control measure in place of reverting to spreadsheets being used with manual entry, with additional staff put in post. Option to transfer services over to Planet FM through a phased approach has been looked at but unfortunately this is no longer feasible. Depending on if feasible there may be costs associated with licences, training etc. with new system. This has been included within the 'Support Services Forward Work Plan' to identify a solution in place of TAB system. Following review of this risk, the Technical Services Team have agreed that the risk now needs to be increased following confirmation that Tabs will no longer be supported on an IT server from July 2021, so there will be no system in place. Five demonstrations of alternative systems have been undertaken, however they have not been suitable for the Facilities Services. Other systems continue to be looked at by the Technical Services Team. Based on this update the likelihood of the risk remains at 4, giving a high rating (from 12 to 16). The risk will be reviewed in 3 months or following any mitigating actions being undertaken.	Action: Alternative system for Technical Services and the Laundry Service to be sourced. Timescale: 31/07/2021.	Digital & Data Committee	16	C4xL4	4 C4xL1	New Risk escalated to Org RR July 2021	19/02/2020	15/06/2021	15/09/2021
3899	Executive Director of Nursing & Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Clinical staff resuscitation training compliance	**IF:** there continues to be poor compliance with resuscitation training in relation to clinical staff. **Then:** the Health Board's ability to provide high quality and safe care would be reduced. **Resulting in:** a risk that clinical staff are not up-to-date with their resuscitation training and therefore potentially not able to offer the most up-to-date evidence based care to patients requiring resus. There is a secondary risk that if ESR records are not accurate there is no clear organisational picture which of our staff are resus trained and who are not, presenting a particular risk for rota planning.	ESR record is being reviewed and data checked for accuracy - doctors records need updating as currently ESR not routinely used by Medical staff. New models of training with robust demand and capacity training planning in place need to be identified. This will need to have appropriate resus officer training capacity. An internal restructure has now taken place to ensure a more robust management line. Resus dept. is now managed by the Senior Nurse Clinical Education. 2 x band 7 resuscitation practitioner posts successfully recruited to and both in post end of May 2020. Covid re-emergence in September / October will have a further impact on training availability & compliance levels. Staff availability for training also impacted. All training taking place is compliant with social distancing / PPE requirements for COVID. High turnover/ retirement / long term sickness/ redeployment due to Covid of qualified Resuscitation staff recently have all impacted on capacity to deliver training. Key appointments have now been made, redeployed staff are returning and recruitment to current vacancies in is place.	At the December 2020 meeting the RADAR Committee received an update on the Resuscitation Training Compliance Risk and were advised that the compliance position has deteriorated further during 2020 due to Covid pressures. Training was cancelled in the first wave and release of staff for training has also impacted through the second wave. The Committee has agreed a number of actions to be presented at the March 2021 meeting: • Review of agreed training standards against which compliance is measured. • Review of training formats to include e-learning options. • Review resus departments demand and capacity for training. Timescale - 31.3.2021 Situation reviewed at March 2021 Radar. E-Learning options have now been incorporated into our training standards and key appointments in the Resus department have now started in their posts. Training compliance however has deteriorated further due to a second wave of Covid impacting on release of staff and continuing difficulties in securing adequate training accommodation particularly in RTE and Bridgend localities. Work continues to assess training demand and capacity. Risk however cannot be reduced until improvement is seen. Next review at RADAR June 2021 Update June 2021 - no change to risk scoring. The next review is scheduled for the RADAR meeting on the 28th June 2021.	People & Culture Committee	15	C3 x L5	9 (C3xL3)	↔	20.11.2019	08.06.2021	31.07.2021

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3638	Chief Operating Officer Pharmacy & Medicines Management	Provide high quality, evidence based, and accessible care.	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.	SBAR submitted to CBM in March 18 to increase training capacity in order to meet the demand. Included in IMTP and prioritised as number one priority. A bid was included 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. The secondary care elements were not supported in the IMTP prioritisation process and so this still leaves significant risks. SBAR needed to describe the impact of the new technicians training qualification. Funding approved for primary care lead pharmacist - commenced in post April 2019. Included a new case in 2019/20 IMTP as high priority. 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.	Update June 2021: HEIW have agreed training support grants for trainers to support pre-registration foundation posts which mitigates the risk for this group of staff. However this funding is only temporary and not guaranteed beyond 2022-23, which presents a potential risk around recruitment of suitable staff. The post-registration foundation programme has been deferred until 2022 which buys some time for health boards to explore solution to the significant financial shortfall that will arise form the lack of on going funding for these posts. Update July 2021 - No further update to that recorded in June 2021. Review 30.09.2021.	People & Culture Committee	15	C3 x L5	6 (C3xL2)	↔	02.01.2018	10.06.2021	30/09/2021
3072	Chief Operating Officer Pharmacy & Medicines Management	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Temperatures in medicines storage room on the wards in Prince Charles Hospital not fit for purpose.	**If** there is no control of the temperatures in all the medicines storage rooms on the wards in Prince Charles Hospital. The medicines storage room have pipes in ducts which give off significant heat year round and increased issues in the summer months. **Then:** medicines are being kept above the required temperatures as stated in their specifications of storage as part of their license from MHRA. **Resulting in:** medicines stored at a higher temperature than their specifications which could result in them being less active or denatured and affect patient outcomes.	Some wards are placing small fans in rooms but this does not reduce the temperature. alternative rooms for storage have been discussed but unable to progress due to other ward priorities A SON for air conditioning for each ward will be progressed by medicines management on behalf of ILG	A SON for air conditioning for each ward will be progressed by medicines management on behalf of ILG, however, due to COVID-19 this will be considered in 21-22.	Quality & Safety Committee	15	C3 x L5	6 (C3xL2)	↔	05.02.2018	29.06.2021	04.08.2021
4110	Executive Director for People	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the CTMUHB)	**IF:** the Health Board fails to comply with all the Welsh Language requirements **Then:** the Health Board's will not be compliant with the duties outlined in the Welsh Language Standards. **Resulting in:** damage to the reputation of the Health Board, negative publicity and contact with the Welsh Language Commissioner. As a consequence of an internal assessment of the Standards and their impact on the CTMUHB, it is recognised that the Health Board will not be fully compliant with all applicable Standards. This risk is particularly high in: translation services due to demand exceeding capacity.	The Welsh Language team has undertaken a self-assessment of the requirements of the Standards and how they apply to Cwm Taf Morgannwg. Close constructive working relationships are in place with the Welsh Language Commissioner's Office. Strong networks are in place amongst Welsh Language Officers across NHS Wales to inform learning and development of responses to the Standards. Regular reports to the Board to raise awareness. Working Group set up to support managers. Developing a new bilingual skills strategy. Welsh courses provided to staff. Ward Audits to monitor progress with compliance - ongoing and options to revisit are currently being discussed.. Continue to review and act on the UHBs Self-Assessment findings and related improvement actions; ensure Board is fully sighted. Implement the first year of a 5 year plan outlining the extent to which the health board can carry out consultations in Welsh. All nursing JDs are translated and advertise bilingually. Compliance with Statutory requirements outlined in Welsh Language Standards. Welsh Language in Primary Care Policy developed and approved.	Begin a programme of translation focusing on the job descriptions advertised most frequently - e.g. nursing vacancies. Action plans have been given to the heads of ILGs, Corporate Services and Workforce and OD to ensure senior management are aware of their WL responsibilities. Completed. Continue to develop the Welsh Language skills of the workforce through online learning. No change to risk as at 5th July 2021 – risk undergoing review to consider further mitigating action and further update will be received at the Management Board in August 2021.	People & Culture Committee	15	C3 x L5	9 (C3xL3)	↔	02/07/2018	5.7.2021	31.07.2021
3698	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting List for Autism Diagnostic Observation Schedule (ADOS) assessments and Attention Deficit Hyperactivity Disorder (ADHD) medicals over 1 year.	**If:** there are delays in diagnosing children with ADHD and Autism. **Then:** this results in a delay in management including appropriate school placements **Resulting in:** potential harm to patients, poor patient experience, dignity, staff morale. Complaints.	* The team have reviewed their clinical practice in line with the rest of CTM e.g. no longer undertaking ADOS for all children * Discussions underway re: repatriating service from Swansea Bay and investing funding into enhanced local service in Bridgend * New Consultant starting June 2020 with 3 sessions to support community paeds	Vacant sessions to be recruited to - Additional staff appointed who could undertake assessments would ensure this activity was managed in a timely manner. Update as at June 2021 - risk remains unchanged.	Quality & Safety Committee	15	C3 x L5	4	↔	02.07.2019	08.06.2021	27.07.2021
3685	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No Midwifery Specialist for pregnant women with vulnerabilities	**IF:** there is no dedicated services for substance misuse women, prescription medication, or women with vulnerabilities (social) - national best practice is for there to be a lead in vulnerabilities to see women in a dedicated clinic with the multidisciplinary teams which without leads to disjointed care for our most at risk patient group. **Then:** unidentified opportunities to co-ordinate risk management and support in 'A Healthier Wales' in pregnancy will be missed. **Resulting In:** potential harm to mothers and babies care provision and outcomes.	Women in PCH/RGH are seen in a general Ante Natal clinics Women in POW currently seen in a dedicated clinic, with an SLA agreement with Swansea Bay UHB .2 resource. The directorate need to develop a Statement of need to secure resources to support services across the HB and ensure standardised service delivery.	Action: Service to develop business case for implementing specialist service for women with vulnerabilities. As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Quality & Safety Committee People & Culture Committee	15	C3 x L5	6 (C3xL2)	↔	26.06.2019	01.12.2020	31.3.2021

Datix ID	Strategic Risk owner	Strategic Objective	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
4606	Chief Operating Officer Primary Care Services	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Resumption of Orthodontic Services	**If:** In compliance with WG guidance, if the Health Board is unable to resume orthodontic services over the next 2 years where patients (under 18) do not meet the IOTN of over 4. **If:** the Health Board does not secure funding for establishing a new Orthodontic contract to meet demand following boundary changes. **Then:** patients will experience significant delays in accessing treatment. **Resulting in:** • Those patients with milder cases incurring further delays in addition to having already experienced long waits for treatment. • It is likely this will increase the number of appeals/challenges/complaints from families, currently CTM does not have an appeals process in place. • Pressure on GDPs to communicate this to families and manage patient/family expectation • Risk that patients/families will be offered/coerced into private treatment as an alternative	The Health Board will continue negotiations with the relevant Health Board regarding treatment/payment of historic patient on waiting lists/ and new referrals. The service continues to be provided as it did pre-covid-19 pandemic, the commissioning arrangements with other Health Boards for Bridgend patients are still in place as nothing has changed. What has changed is longer waiting list as a result of Covid-19 and change to the national guidance on the prioritisation of referrals based on need and some patients referred may now not meet new criteria for orthodontic treatment. There is a national review of orthodontics taking place to inform this.	1. Health Board to address concerns regarding guidance directly with WG and through local ortho MCN Chair. 2. Appeals process to be developed to manage complaints/challenges 3. Raise issue regarding additional ortho funding in June during annual WG Dental Team visit to Health Board. Update June 2021 - No change to the risk at present. A detailed report is being received at the Primary Care Board on the 9th June 2021 for consideration following which the detail and recommendations will be submitted to either the Management Board or the Primary Care Performance meeting as appropriate. **Review: 31.07.2021**	Quality & Safety Committee	15	C3 x L5	12 (3x4)	↔	23/04/2021	07/06/2021	31.07.2021
4218	Executive Director of Nursing & Midwifery Infection Control	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Reduced on site Consultant Microbiologist cover for the Bridgend ILG	The Microbiology cover for the Bridgend locality is provided by Public Health Wales Microbiologists via a SLA with Swansea Bay UHB. There are differences in policies/procedures and therefore a lack of standardisation across CTM. There is also a lack of standardisation for multi resistant organism definitions and sampling methods for C.Difficile infection. **If:** there is no dedicated on site Microbiology cover **Then:** there will be no antimicrobial/ ITU ward rounds, no root cause analysis to learn from incidents. **Resulting in:** mismanagement of patients/ inappropriate treatment and no learning to influence practice.	Senior Infection Prevention and Control Nurse on site to support Bridgend ILG with IPC related issues. Lead/ Deputy IPC Nurse to support. IPC Nurses to discuss any concerns with Microbiologist on call for Bridgend ILG The Medical Director for the Bridgend ILG has arranged a meeting to discuss	SLA for Microbiology cover for Bridgend ILG - To revisit SLA with Public Health Wales laboratory. Medical Director for Bridgend ILG to email Medical Director to discuss concerns regarding the SLA. Due date: 1.09.2021 No change as at 5th July 2021 - Review of risk scheduled for w/c 12th July - update will be received in the next submission of the Organisational Risk Register.	Quality & Safety Committee	15	C3 x L5	3 (C3xL1)	↔	16/07/2020	05.07.2021	1.09.2021
4672	Executive Director of Public Health - Interim Executive Lead for ICT / Digital Chief Information Officer	Provide high quality, evidence based, and accessible care.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Absence of coded structured data & inability to improve our delivery of the national clinical coding targets and standards (target is 95% completeness within month coded, and 98% on a rolling 3 month period)	**IF:** The Health Board is not able to record information accurately and reliably & does not address the 25000 backlog of uncoded FCEs **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 DHCW annual coding quality audit. 2020/21 funding addressed backlog and proposals made to extend this into 2021/22. **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 Information and Technical Standards Clinical audit **Gaps in controls** Workforce skills & development programme Insufficient resource available to address backlog Digital solutions not yet using snomed-CT/ structurally coded data	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. Programme to address the backlog using additional sessions and agency codings ran in March and extension for 2021/22 proposed - awaiting consideration via IMTP prioritisation process **Tactical** - EPR programme with deployment of snomed-CT onotology server, WCP & E-forms etc	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	05.06.2021	31.07.2021
4671	Executive Director of Public Health - Interim Executive Lead for ICT / Digital Chief Information Officer	Provide high quality, evidence based, and accessible care.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	NHS Computer Network Infrastructure unable to meet demand	**IF**: The Health Board suffers regular local and/or national network issues and/or outages to clinical and critical business 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.	There are various Service Management boards from ADIs, service delivery and infrastructure management which have representatives from each NHS Wales organisation and departments. These meet regularly with a governance structure to escalate any service delivery and security incidents and risks. SLAs are in place between DHCW and NHS Wales organisations and incidents are escalated up via the national Service Point Service Management system. The Health Board has the Risk Audit Governance & Cyber Security Board which meets monthly to discuss and take action on service delivery incidents. Local and National Infrastructure reviews are presently underway.	Infrastructure and comms actions plans were agreed 24 months ago and are being delivered as funding and staffing are available (recognising priorities changed during Covid). The Health Board to develop a robust incident management process. This is to ensure that regular outages of national systems and infrastructure are escalated to the appropriate governance structures to address such issues locally and nationally.	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	26/05/2021	26/05/2021	25/06/2021
4512	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of patients with mental health needs on the acute wards.	**If:** there is a consistent number of patients with mental health needs who are being cared for on the acute wards without RMN support or there are delays in discharge an appropriate EMI setting; **Then:** patients who have been sectioned and / or are under medication review may remain on wards where specialist mental health therapy and input is not possible; **Resulting in:** incidents of staff and patients assaults may occur; poor patient experience; increased supervision needed.	MHL team contacted for each patient who required support; 1:1 patient supervision where required; Ward manager and senior nurse undertake regular patient reviews; Regular meetings with the mental health CSG in place.	Actions being reviewed	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	30/12/2020	07/06/2021	13/07/2021
3993	Chief Operating Officer Bridgend Integrated Locality Group	Provide high quality, evidence based, and accessible 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	Need building work to be undertaken to ensure safety. Operating theatres will need to close for this to occur.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31/01/2020	07/06/2021	30/09/2021

Datix ID	Strategic Risk owner	Strategic Objective	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
3337	Chief Operating Officer Director of Primary Care and Mental Health Services	Provide high quality, evidence based, and accessible care.	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. Merthyr and Cynon and Bridgend CGS leads have confirmed that WCCIS is on their CSG risk register and their updates have been provided within this this section, therefore aligned. 4. 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 to be established and aligned to this Programme board Programme will be established by the 31st July 2021. 5. Local Authority have recently developed reports for Mental Health which identifies practitioner caseloads, admissions and discharges and care plan for compliance. 6. Community Drug and Alcohol Team in Bridgend have now moved over to WCCIS, early implementation learning continues to take place.	1. Deployment order to be in place for all existing WCCIS mental health staff users. 2. WCCIS Regional Working Group to have a representative from the UHB to maintain pace of delivery for WCCIS mental health rollout. 3.CTM to set up a Project Board in partnership to start preparing for implementation of WCCIS 4. Project manager has been recruited too, preemployment checks in place, develop and lead on the implementation plan. 5. CTM team to network and learn from ABUHB to inform rollout. A CTM programme Board has now being established and will oversea the delivery and governance of this work. Deadline - 30.06.2022	Quality & Safety Committee	15	C5xL3	6	New Risk escalated July 2021	07/11/2018	17/06/2021	31/07/2021
4620	Chief Operating Officer Rhondda Taf Ely Integrated Locality Group	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Access to Neath Port Talbot Hospital to deliver breast surgery (mainly cancer patients)	**If:** There continues to be a lack of clarity about the Breast services Service Level Agreement (SLA) with SBUHB to provide services in NPTH **Then:** There is very limited ward space available for overnight stays and it is only on an ad-hoc arrangement **Resulting In:** Inappropriate and unsafe discharges	Patients are individually risk assessed. High risk operations have been facilitated in Royal Glamorgan Hospital however this impacts on other surgical lists. The RTE CSGM has asked the Bridgend CSGM for overnight capacity in Princess of Wales Hospital. In addition the RTE CSGM has asked for high risk cancer patients to be operated on in Royal Glamorgan Hospital (RGH). This is a challenge because it diverts current RGH theatre and green ward capacity and as new demand this has never been factored in to our theatre and ward plans.	Chief Operating Officer to discuss SLA monitoring arrangements with SBUHB. Commissioning arrangements being discussed with SBUHB to establish clear responsibilities under the SLA. RTE ILG reviewing options for delivering this care at RGH.	Quality & Safety Committee	15	C5xL3	10 (C5xL2)	New risk escalated to Org RR July 2021	06.05.2021	15.06.2021	03.09.2021
3161	Chief Operating Officer Pharmacy & Medicines Management	Provide high quality, evidence based, and accessible care.	Legal / Regulatory	Lack of Wholesaler Dealers Authorisation	**If:** tthe Health Board fails to provide the significant time and resource to secure a Wholesaler Dealer's Authorisation and a Home Office Licence **Then:** it would be unable to sell or supply medicines outside the organisation **Resulting In:** Non-compliance with criminal law and Medicines HealthCare Regulatory Agency Regulations. The ability to respond to the Covid-19 Vaccine requirements and protecting population health.	WDA working group established to progress training, governance and infrastructure requirements to submit to MHRA in August 21, a case will be submitted to Vaccine Board.	Business case being progressed. July 21 case submitted to COVID Vaccine Board	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	New risk escalated to Org RR July 2021	24.06.2016	07.07.2021	16.08.2021
4590	Chief Operating Officer Pharmacy & Medicines Management	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Critical Care Pharmacist Resource	**If:** additional resource is not identified to increase the critical care clinical pharmacy service **Then:** there is a risk that insufficient support can be provided to meet national standards and there would be lack of capacity to support future surges in demand, such as Covid. **Resulting In:** an increasing risk to patient safety, increased workload for critical care nursing and medical staff and lack of appropriate support for digital developments such as e-prescribing	SBAR included in Medicines management and advised to include in ACT directorate IMTPs. Meetings to discuss potential funding arranged with ACT leads. Baseline level of service (0.2wte) pharmacist time per site. A small pool of CC trained pharmacists are providing clinical services to acute wards which would be impacted if they are redeployed to support ITU, resulting in risk to patient safety and flow on acute wards.	June 21: Current situation included in planning review of CTMUHB ICU services Aim is to secure funding for 1WTE 8a specialist pharmacist for each critical care in RGH, POW and PCH and also supporting technician resources	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	New risk escalated to Org RR July 2021	05.04.2021	07.07.2021	30.09.2021
4693	Chief Operating Officer Facilities	Provide high quality, evidence based, and accessible care.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Electrocardiogram (ECG) carts not connecting to hospital network	**If:** The GE ECG carts use DHCP to obtain an IP address from the network so that they can connect to the SBUHB MUSE system and download ECGs. If they are not able to connect to the hospital network then they cannot identify patient demographics from the wrist band using the online ADT functionality. **Then:** This is causing a backlog of tests not being stored centrally and only held locally on the machines. The machines are only capable of storing 200 tests before overwriting historic tests on a first in first out principle. **Resulting In:** the Health Board having no method of recording what tests have been deleted and failed to store on the MUSE server. In addition to this ICT {SBUHB} have looked at the situation and informed us that the wireless connectivity for these machines are running out of IP addresses depending on the number of wireless devices also live on the network at the time. This makes the connection of machines to the network random and unsustainable for the service. This could result in service / business interruption and delays.	There are no control measures that can be put into action currently. Situation is being escalated to SBUHB ICT. The Health Board can only rely on paper copies of the ECGs being kept in the patient notes. There is no mitigation options for digital review and storage of ECGs with GE MUSE System. Based on this update the risk has been scored as a high risk (Consequence 3 x Likelihood 5 = 15) and will be reviewed in 3 months time or when mitigating actions have been implemented.	Action: ICT (SBUHB) to review potential solutions with Clinical Engineering to address the wireless connectivity for these machines and the running out of IP addresses. Timescale: 16/09/2021.	Digital & Data Committee	15	15 (C3xL5)	3 (C3xL1)	New risk escalated to Org RR July 2021	16.06.2021	16.06.2021	16.09.2021

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Rationale for de-escalation	Datix ID
No risks were de-escalated this period													

Datix ID	Executive Portfolio	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Last reviewed	Comments
4105	Executive Director of Public Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential Harm and poor experience for Patients as a result of the Health Board's focus and response to the Covid-19 Pandemic	IF: the Health Boards resources and focus is directing into managing the response to the Covid-19 pandemic. Then: the Health Board's ability to provide high quality care may be reduced. Resulting in: potential harm to patients as a result of reduced service provision and capacity to respond to other areas of the Health Board's population Health need.	Planning preparedness, contingency structures through the Resetting CTM structures. Critical services are operating. Governance process in place for financial and non-financial decision making to support, all predicated on Quality Impact Assessments. Quality & Safety Committee has continued to meet to ensure scrutiny and assurance on behalf of the Board. Indicators of quality and patient safety for all services continue to be closely monitored throughout Covid-19. Processes and guidance in place to ensure clarity on areas such as safeguarding and child protection. Implementation of the Test Track and Trace Programme in June 2020. Regular Population Health Surveys conducted in relation to Covid-19 to gauge attitudes and risk perception within communities. Compliance with National Guidance. Deaths are monitored via the mortality review process. Monitoring incidents, complaints and feedback through social media. Monitoring Core quality and safety metrics. The Health Board's vaccination programme continues to move at a fast pace which will ease pressure on the hospitals as case numbers and severity reduce in time. The QIA process for services changes relating to COVID-19 Management developed and includes an assessment of related impact on any existing service delivery.	Continue to embed the QIA Process. Continuing to roll out the Health Boards Vaccination Programme.	Quality & Safety Committee	10 (C5xL2)	10 (C5xL2)	Risk Closed	23.03.2020	05.07.2021	Risk Closed as target score achieved. Vaccination Programme successful and will continue to be rolled out across the population as appropriate. The QIA process will continue to be embedded for service changes relating to Covid-19 and the risk will be monitored and should the risk likelihood change it will be escalated to the Organisational Risk register as and when required.
4235	Chief Operating Officer Merthyr & Cynon Integrated Locality Group	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Cancer Performance - Gastroenterology Outcome of Covid-19	**IF:** Routine diagnostic activity is not recommenced in full during the C19 pandemic **Then:** there will continue to be a backlog of patients awaiting diagnostic investigations **Resulting in:** Potential harm to patients due to delay in diagnosis and treatment	Endoscopy services have restarted as part of new normal timetables. Backlog is being booked and should be cleared by end of July. 22.9.20 Discussions health board wide to reduce overdue and to work to safe capacity.	See Control Measures As at June 2021 - Led by the Acute Services General Manager a small task and finish group is being established to review this risk with the CSG trimverates.	Quality & Safety Committee	16	C4 x L4	Risk Closed	27.07.2020	05.07.2021	This risk is captured within the overarching risk 4071 - "Failure to sustain services as currently configured to meet cancer targets". Therefore this risk will be closed to avoid duplication.
3584	Chief Operating Officer. Bridgend Integrated Locality Group	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Neonatal Capacity/Stabilisation cot at Princess of Wales	**If**: The neonatal unit at POW is required to deliver ITU level care in the stabilisation cot **Then:** This cot is not staffed, therefore the overall staffing position on the unit is depleted while this is managed, noting that in the absence of a 24/7 retrieval service this can be for extended periods. The stabilisation cot requires 1:1 nursing which is the equivalent of staffing for 2 HDU costs or 4 SCU cots. **Resulting In:** A risk of being unable to provide appropriate levels of care to the babies on the unit as staffing will be below the required levels as per BAPM	* Utilise available staff as effectively as possible depending on the capacity position at the time * Escalation policy in place to limit maternity services to reduce the risks of further admissions to neonates * Seek additional staffing e.g. through bank, agency, overtime when required	Funding required - included on IMTP. Review date extended until end of March 2021. SBAR and Business cases for funding of the stabilisation cot have also been submitted to various meetings . Core Workforce requirements are being reviewed with a view to enhancing the Nursing workforce model and increasing medical consultant workforce capacity. NN services are aligning with Maternity Improvement programme of work whilst developing elements that are defined for neonatal provision including a Quality improvement programme of work	Quality & Safety Committee	8	3	Risk Closed	31.05.2019	05.07.2021	This risk has been closed. Staffing is 3+1 so stabilisation cot is being funded and covered. CHANTs now operating 24/7 care.

TARGETED INTERVENTION RISK & ASSURANCE MILESTONES

The Risk Journey…

Where we were:

- No corporate level lead for risk within the organisation.
- The Corporate Risk Register was not routinely received by the Board or the Board Committees
- The Corporate Risk Register was not always clearly aligned to demonstrate Service to Board escalation where appropriate.
- Detailed risk training was captured in a "Managing Risk Safely Course" this was paused during the Health Board's response to Covid-19, however, will be offered again once restrictions have lifted.
- The Risk Management Policy and Risk Assessment Procedure required review and alignment to the new Operating Model.
- Datix was not used as the system to capture the risks on the Corporate Risk Register. Datix was however used by Directorates and other functions within the Health Board.
- Engagement and communication between Corporate and Service Leads in respect of risk was limited.

Where we are now:

- An Assistant Director of Governance & Risk was appointed on the 27th April 2020.
- The Corporate Risk Register was reframed in format and name – now known as the Organisational Risk Register to reflect the Service to Board Escalation process.
- A Board Development Session was held in September 2020 where Board Members received a refresher on risk training as well as defining its Principal Risks and Risk Appetite.
- The Organisational Risk Register is now received at every Board and Audit & Risk Committee meeting. Board Committees where risks are assigned also regularly receive the Organisational Risk Register.
- The Risk Management Policy, Risk Management Strategy and Risk Assessment Procedure were reviewed and approved by the Health Board in January 2021.
- All risks on the Organisational Risk Register are now entered on the Datix Risk Management Module.
- An Internal Audit was undertaken reporting a Reasonable Assurance to the Audit & Risk Committee in February 2021.
- The follow up review between "HIW and Audit Wales" recognised the improvements made in the risk management journey to date.
- The Assistant Director of Governance & Risk meets monthly with the Chief Operating Officer as well as monthly meetings with the Heads of Quality & Patient Safety in the ILGs.
- The Assistant Director of Governance & Risk has undertaken a peer review of risks with the following functions to ensure processes align with the Risk Management Strategy:
    - Estates, Facilities, ICT, Learning & Disability, Clinical Audit, Primary Care and Mental Health, Workforce and Patient, Care and Safety, Hosted Organisations (EASC and WHSSC).
- With colleagues from other Health Boards across Wales the Assistant Director of Governance & Risk is developing a Risk Management Training Needs Analysis (TNA) and designing training programmes to support the requirements within the TNA which will include an awareness session, more in-depth training for those responsible for risk in their areas and a Board level session.
- The risk page on SharePoint has been revised and updated to reflect the latest policy, procedure and supporting documentation and contacts to aide staff in undertaking risk activity.
- Benchmarking with other organisations in terms of revising the Board Assurance Framework and linking in with activity on an All Wales basis.
- Planning the next Board Development Session in terms of revisiting the Board's Risk Appetite – scheduled for the autumn 2021.
- Represented on the Once for Wales development of the Datix Risk Module.
- Monthly Risk Management Awareness Sessions (Virtually via Teams) were implemented from January 2021 with increasing engagement and attendance growing month on month. The monthly sessions are set in the calendar until the end of 2021 and will continue beyond that date if required.

  207 trained from January to July 2021.

  Extracts of feedback from colleagues who have attended the session are captured below:

  - *"As a doctor who has clinics and lists that can't be moved or left unstaffed, please can I ask that when planning future sessions you move them to different days of the week and vary between morning and afternoon? This will increase the chances of more doctors being able to access this session, which I found very helpful and which I have recommended to the other consultants in my directorate."* In responding to this email an offer was made to tailor a session for the doctors at a time and date of their choice."
  - *"That was a really good and informative presentation".*
  - *"This is really really helpful thank you and I found this morning's session informative and helped clarify some questions I had"*
  - *"I have to say that was one of the best training sessions I have been on for a very long time. Clear, concise and informative. A perfect update for me as I've no doubt slipped into bad habits over the years. I shall review my risks with confidence now."*
  - *"I found the session to be helpful and practicable. Would definitely recommend"*
  - *"I attended the risk training on teams and found it excellent. From my perspective it was an update but I definitely learned new things. The presenting was professional and you all made it understandable and enjoyable thank you"*

- *"Thanks again for the training, it was really informative and user friendly. It gave a good overview of what a risk is and how we categorise them and how we can help to minimise them. Both yourself and Claire spoke confidently and were engaging and interesting to listen to. (This can be difficult when delivering training via teams). You clearly explained the content and I now feel confident to discuss with my CSG managers."*
- *"I have learnt so much from this training – one take way was understanding the importance of being specific to what the risk is - clarity in shaping this is important to managing it."*
- *"For someone new into a managerial post it was helpful to understand risk for a service rather than an individual and the impact of a risk for the organisation. Using the format If/Then/Resulting in has helped me detail the hazard and work out a plan."*
- *"A helpful & accessible session to de-mystify the health board approach to assessing, managing and recording risk – really practical & helpful".*
- *"I found the training very helpful and accessible. The "incident/issues/risk" continuum and "if/then/resulting in" framework provide very clear direction. You and Claire have a very engaging style and work well together".*

	1. BASIC LEVEL Principle accepted and commitment to action	**2. EARLY PROGRESS** Early progress in development	**3. RESULTS** Initial achievements achieved	**4. MATURITY** Results consistently achieved	**5. EXEMPLAR** Others learning from our consistent achievements
RISK, AND ASSURANCE	Risk management is in place, but not systematically used across the health board. Board Assurance Framework (BAF) is recognised as required but may not be up to date. Board committees exist to support the Board in a scrutiny function.	Risk management arrangements are in place for identifying, recording, managing risks across the organisation. A Board Assurance Framework (BAF) is in place and drives Board discussions on risk and confidence in assurance mechanisms and assurance in place. The Board committees are proportionate in their scrutiny of quality, resources, performance	Robust risk management arrangements are in place for identifying, recording, managing and escalating risks across the organisation. A Board Assurance Framework (BAF) is in place and drives Board discussions with a good understanding of assurance gaps and work progressing to address these. The Board committees are proportionate in their scrutiny of quality, resources, performance. With a committee responsible for scrutinising Quality and Safety reflecting the health boards Quality strategy and Quality and Safety framework.	Robust risk management arrangements are in place for identifying, recording, managing and escalating risks across the organisation, with risks managed from ward to board through clear escalation arrangements. The board have developed and articulated their risk appetite. A Board Assurance Framework (BAF) is in place and drives Board discussions with a good understanding of assurance, with limited gaps to address. The Board committees are proportionate in their scrutiny of quality, resources, performance. With a committee responsible for scrutinising Quality and Safety reflecting the health boards Quality strategy and Quality and Safety framework, using sub-groups to improve oversight of Q&S across the whole organisation.	Robust risk management arrangements are in place for identifying, recording, managing and escalating risks across the organisation, with risks managed from ward to board through clear escalation arrangements. The board have developed and articulated their risk appetite. The Board proactively learn from their risk management approach and risk appetite through regular reviews of their decisions around risk. A Board Assurance Framework (BAF) is in place and drives Board discussions with a complete understanding of assurance in place, with few/no gaps in assurance to address. The Board committees are proportionate in their scrutiny of quality, resources, performance. With a committee responsible for scrutinising Quality and Safety reflecting the health boards Quality strategy and Quality and Safety framework, using sub-groups to improve oversight of Q&S across the whole organisation. These committees and sub-groups are regularly reviewed for their effectiveness and changes made to reflect best practice.
Outcome Measures		• Risk Strategy in place • Risk Management Policy in place • Risk Register exists and is received by Board	1. Organisational Risk Register updated regularly with each update approved by Management Board. **Status: Achieved May 2020.** 2. Organisational Risk Register received at every Board	Board Development Session undertaken which reviews and identifies the Risk Appetite, Risk Tolerance levels and grading of principal risks aligned to the new Integrated Healthcare Strategy and the direction of travel for the Health Board – i.e. not necessarily cautious across all risk	Board Assurance Report to Board and Committees triangulating risk, performance and assurance – ambition to link to live system risks. Risk appetite embedded within the organisation – Service to Board.

			meeting. **Status: Achieved September 2020** 3. Board and Committees regular oversight and review of assigned risks. **Status: Achieved September 2020** 6. Strategy and Policy Documents up to date and approved within last 12 months: • Risk Management Strategy • Risk Management Procedure • Risk Assessment Procedure **Status: Achieved January 2021** 7. Clear process map for Service to Board Escalation of risk. **Status: Achieved January 2021** 8. Risk Training Awareness Session –rolling programme to be established – 1 hour open session a month. **Status: Achieved January 2021** 9. Risk Training: including development of a Training Needs Analysis (TNA), dissemination of the TNA across the Health Board, new risk training programmes which are aligned to the TNA. **Status: Anticipated to be finalised by the 31st October 2021** *(some of the activity described above may be completed sooner e.g. the TNA is currently at draft stage as at May 2021)* 10. All ILG risks reviewed and updated following change in Operating Model. **Status: Anticipated to be finalised by the 31st October 2021** 11. Clear and consistent grading of risks that are calibrated and moderated across the	domains. **Anticipated to be undertaken by the 30th September** An efficient risk management process which is seen as efficient and not cumbersome – linked to the new Once For Wales Risk Management System. **Anticipated to be implemented by the 30th April 2022 - external dependency as an All Wales System.** All risks reviewed and aligned to the Risk Management Strategy and upon audit/testing would demonstrate alignment to the Service to Board escalation. Organisational Risk Register shifts to a more Strategic Board Assurance report articulating the links between Strategic Objectives, Principal Risks, Gaps in Control and Assurance. Board Assurance Framework revisited in light of a shift to Strategic risk report. Attendance records for training demonstrate a consistent programme of learning within the Health Board. Clear ownership and responsibility of risks from Risk Owners, Risk Manager and Strategic Risk Owners. Detailed discussions at Committees on scrutiny of risks assigned to them with focus on adequacy of mitigations in place. Risk culture evident with a focus on quality and safety and the following factors evident through discussion at Board and Committees: • Strong and open communication - in accordance with the Risk Management Strategy risks are escalated as soon as identified • Positive attitude to risk management – seen as a dynamic tool. • Visibility and commitment at Board and Committees recognising it is a core element of business. • Risk and decision making going hand in hand. **Evidenced via:**	Decisions are informed by relevant assessment of risks. Board and Committee scrutiny is effective and discussion is driven by the Board Assurance Report and the appetite and tolerance levels within the Health Board. Robust training and education programme where a good risk culture and behaviours lead to: • Encouraging and educating others in risk and risk management. • A desire to be more risk aware and gain more risk management knowledge • Positive attitude to risk management A good "risk radar" that is constantly monitoring the internal and external environment. **Evidenced via:** • Board and Committee agendas, reports and minutes. • Audits – internal and external • IM "Ward to Board" touch points. • Risks dynamic and therefore stagnant trends limited. • Training Attendance Records • "Deep Dives". • Board Assurance Framework (BAF)

			Health Board. . **Anticipated to be finalised by the 31st October 2021** 12. Introduce a revised approach to the Board Assurance Framework and separate Board Assurance Report. **Anticipated to be finalised by the 31st December 2021** **Evidenced via:** • Up to date Risk Management Strategy & Policy • Board and Committee agendas, reports and minutes. • Audits – internal and external • Review of risks on Datix. • TNA and training programmes, Training Attendance Records • Risk Documents. • Board Assurance Report	• Board and Committee agendas, reports and minutes. • Audits – internal and external • IM "Ward to Board" touch points. • Risks dynamic and therefore stagnant trends limited. • Training Attendance Records • "Deep Dives" • Board Assurance Framework (BAF)	

AGENDA ITEM
6.4

AUDIT & RISK COMMITTEE

HIW/AW JOINT FOLLOW UP REVIEW OF QUALITY GOVERNANCE (MAY 2021) MANAGEMENT ACTION PLAN

Date of meeting	17 August 2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	G Galletly, Director of Corporate Governance
Presented by	G Galletly, Director of Corporate Governance
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Management Board	July 2021	SUPPORTED
Board	July 2021	APPROVED

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board

1. SITUATION/BACKGROUND

1.1 At the November 2019 CTMUHB Board meeting, Members received a report following a joint review undertaken by Wales Audit Office (now Audit Wales) and Healthcare Inspectorate Wales of quality governance arrangements at Cwm Taf Morgannwg University Health Board (CTMUHB).

1.2 The publication of the report highlighted a number of significant findings for CTMUHB to which the Health Board provided a comprehensive response to the recommendations which was received and approved at the subsequent Board meeting in January 2020.

1.3 Progress against these recommendations and the management actions in response, has been included in the wider monitoring by the Board and Welsh Government in the context of enhanced performance arrangements associated with CTMUHB being in Special Measures for maternity services and Targeted Intervention for quality & governance, leadership & culture and trust & confidence.

1.4 A year on from the original Joint Review Report, Audit Wales and Healthcare Inspectorate Wales undertook a follow-up review of the Health Board to assess progress against the original 14 recommendations made.

1.5 The findings of the follow-up review were received by the Board at the meeting on 27th May 2021. The Health Board has since developed a management action plan to support the further achievement of the original recommendations made in the November 2019 report, noting the observations on progress and gaps identified in the May 2021 follow-up report.

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

2.1 The Health Board welcomes the report which recognises the commitment to and progress made in improving quality governance across our organisation despite the challenges posed by responding to the pandemic.

2.2 It is acknowledged that whilst many positive changes have been put in place, there is still further work to do and the Health Board has taken the opportunity to reflect on the findings of the follow-up report (May 2021) to inform a management action plan to further progress improvement in response to the original recommendations to ensure they remain focused and addressed.

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

3.1 The Committee is asked to note the continued commitment to improving quality governance of the organisation to support our staff

and ensure the high quality and safety of the services provided to our communities.

3.2 The Audit and Risk Committee will monitor progress against the management action plan via the Health Board's Audit Tracker.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Safe Care
	Continued implementation of the recommendations will improve the quality & safety of our services.
Equality impact assessment completed	No (Include further detail below)
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	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 The Committee is asked to:

- **NOTE** the attached management action plan in response to the Joint Follow-Up Report (May 2021) from Healthcare Inspectorate Wales & Audit Wales which was approved by the Board at its July meeting.

AW/HIW QUALITY GOVERNANCE FOLLOW UP REVIEW (MAY 2021) – ACTION PLAN

Ref		Recommendation made in November 2019	A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)
	R1	**The Health Board must agree organisational quality priorities and outcomes to support quality and patient safety. This should be reflected within an updated version of the Health Board's Quality Strategy.**	**The Health Board has defined what high quality care means but its ambition to agree quality priorities, set out in a quality strategy, has been significantly delayed due to the pressures of the pandemic. In 2019, we found that the Health Board had not articulated organisational quality priorities. The Health Board's Quality and Patient Safety Governance Framework (Quality Governance Framework) implemented in June 2020 defines high quality care as care that is safe, timely, effective, efficient, equitable and patient-centred. These domains provide the framework against which organisational quality priorities can be identified, and their success measured.** **During 2020, the Health Board planned to develop a Three-year Quality Priority Strategy in partnership with the local community, staff, and other key stakeholders. The Health Board appointed an Associate Medical Director with responsibility for quality improvement to take forward development of the strategy with engagement and coproduction with the three ILGs. However, progress has been delayed significantly given the availability of locality teams and re-deployment of staff to respond to the pandemic. Nonetheless, it is important that progress is now made on developing the Quality Priority Strategy. Since completing our fieldwork the Health Board has indicated its intention to integrate the Quality Strategy into the Health Boards Integrated Health and Care Strategy which is due to be published by Autumn 2021.**
	CTM Lead	**Further Actions**	**Completion Date**
1.1	**DoN**	Organisational quality priorities are expressed within the CTMUHB Annual Plan and IMTP for 2020-23 (see R2) It is anticipated that the Quality Priority Strategy will align to the organisational strategy work. The AMD for Quality is leading on this supported by Assistant Director of Quality, Safety and Patient Experience.	**End Nov 2021**

		The quality strategy is being progressed and the quality priorities have been published in the QGF. The QGF will be updated to reflect and align with the overall HB strategy once published. Success will be measured by the connection of the strategy to the everyday function of the HB – through our agreed quality governance architecture, quality metrics and performance, and in the experience of our staff and patients – connecting us to the overall vision and demonstrating how the thread provides connectivity to understanding the reason for our work.	
1.2	**DoTH**	One Deputy DoTh and two Assistant Director of Therapies and Health Science posts will be advertised in July 21 these roles will strengthen quality and patient safety functions for therapists and healthcare scientists and work as part of the Executive function and strengthen succession planning.	**X-Ref R3**
		Recommendation made in November 2019	**A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)**
	R2	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 Health Board has made good progress in this area through the introduction of the new risk management strategy which reflects the new operating model and has good alignment with the Quality Governance Framework.** **The Board Assurance Framework used by the Health Board is continuing to evolve to reflect the new operating model and strategic objectives.** In January 2020 the Board approved the new Board Assurance Framework (BAF). This was seen as an interim step prior to undertaking the significant work needed on the Health Board's processes for managing and identifying risk, agreeing the Health Boards risk appetite, and agreeing the principal risks. During 2020, the Health Board took the first step towards updating the current BAF by undertaking a comprehensive review of its risk management approach. In September 2020, the Health Board agreed the key threats and principal risks that would affect the achievement of their strategic objectives and gained formal agreement from the Board of its current risk

		the Quality Strategy and align to the values and behaviours framework d- Terms of reference for the relevant committees, including the Audit Committee, QSRC[1] and CBM[2], reflect the latest governance arrangements cited within the relevant strategies and frameworks.	appetite. In November 2020 the Board received the new organisational risk register following a large-scale review of risks by the ILGs and the corporate departments. Work to define the mitigating actions and to identify the controls and sources of assurance is ongoing. Once complete, the Health Board intends to produce a more detailed Board Assurance Framework. The Health Board has also articulated its intention, by the end of 2021, to develop a Board Assurance Report (BAR), which will detail the principal risks rather than the operational risks as currently defined in the risk register. **There has been a comprehensive review of the Health Board's risk management approach since our 2019 review.** The revised risk management strategy and Risk Management policy were agreed by the Board in January 2021, after significant work by the Health Board to fundamentally review its approach and reflect the new locality based operational model. The new strategy clearly sets out the risk management process from service to board as described in the Quality, Patient Safety and Governance Framework, as well as articulating the intended plans for the Board Assurance Report process. The risk assessment Procedure was also reviewed and approved by the Management Board in January 2021 which further supports the risk approach and process within the Health Board. **Significant progress has been made on developing and implementing the Quality Governance Framework, however, more work remains to fully embed it within the organisation**. Since our review there have been many iterations of the framework with the latest version setting out the structures and processes that need to be in place operationally and strategically within the Health Board. The framework clearly defines high quality care (see progress against recommendation 1) and aligns to the organisation's Values and Behaviours. During the pandemic it has been easier to operationalise the Quality Governance Framework at an organisation and ILG level, but work to embed the governance structures within the Clinical Service Groups (CSGs) which sit beneath the ILGs is ongoing. **Terms of references for relevant committees have all been updated to reflect the new scheme of delegation and operating framework**. In January 2021 the terms of reference and Health Board scheme of delegation were revised to reflect the updated risk management arrangements. The Health Board took the opportunity to update and revise the terms of reference for each committee following changes to the governance framework after our 2019

[1] In December 2019 the Quality, Safety and Risk Committee became the Quality and Safety Committee, and the Audit Committee became the Audit and Risk Committee
[2] Clinical Business Meetings were stood down following the introduction of the new operating mode introduced in April 2020

			review. These will now be subject to an annual review as part of the ongoing governance processes and is captured in the cycles of business for Board Committees.
	CTM Lead	**Further Actions**	**Completion Date**
2.1	**DoG**	We will introduce a revised approach to the Board Assurance Framework and separate Board Assurance Report.	**End Dec 2021**
2.2	**DoG**	Board Development Sessions will be undertaken to review and identify the Risk Appetite, Risk Tolerance levels and grading of principal risks aligned to the new Integrated Healthcare Strategy and the direction of travel for the Health Board – i.e. not necessarily cautious across all risk domains. The Health Board's Risk Appetite Statement will consequently be reviewed.	**End Sept 2021**
2.3	**DoN**	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	**Quality Governance Framework reviewed and approved by Q&S Committee by December 2021**

		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.	
		Recommendation made in November 2019	**A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)**
	R3	Ensure there is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads: a- Strengthening of the role of the Medical Director and Clinical Directors in relation to quality and patient safety b- Clarify the roles, responsibilities, accountability, and governance in relation to quality and patient safety within the directorates c- Ensure there is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety	**The Health Board has taken steps to strengthen responsibilities in relation to quality and patient safety both across the executive team and within its ILGs.** **Collective responsibility for Quality and Safety is now shared by the four clinical executive directors.** The Medical Director, the Executive Nurse Director, the Executive Director of Therapies and Health Sciences and the Director of Public Health have specific responsibilities for quality and safety, as well as professional leadership across their respective disciplines, with the Executive Director of Nursing acting as executive lead. This is clearly set out in the Health Board's Quality Governance Framework. The capacity of the clinical executive directors has been reduced for a number of years because of the challenge of recruiting a substantive Director of Therapies and Health Sciences. Since our last review, the Health Board did recruit substantively, however, this post became vacant once more. This post is now filled on an Interim basis by the Executive Director of Therapies and Heath Sciences from Cardiff and Vale University Health Board who works across both Health Boards, the Health Board is also recruiting a full time Clinical Director for Allied Health Professionals (AHPs) to ensure professional leadership and capacity. **The Health Board has clarified the roles and responsibilities for quality and patient safety within the new ILGs and CSGs**. The Quality Governance Framework aligns to the operating model that was introduced in April 2020. Responsibilities at an operational level for quality and patient safety are defined by the Quality governance Framework, which sets out the process and structure for the ILGs and their respective CSGs. The new operating model is helping to improve the focus on quality. For instance, ILGs are held to account by the Director of Operations, Nurse Director, Medical Director and Chief Executive for the delivery of high-quality patient centred care in line with the Quality Governance Framework. **The Health Board has invested in additional capacity to support quality and patient safety at a corporate and ILG level.** The Health Board has invested in new roles to support quality and patient safety. Within the nursing management team, new posts include an Assistant Director

			for Nursing and peoples experience, Deputy Executive Director of Nursing, a Head of Corporate Nursing, and a Senior Nurse for Professional Standards and Quality Assurance. The Medical Director has also established several new roles for Associate Medical Directors to lead on development of the quality strategy and clinical audit. The Health Board has also recently established a Quality Improvement team and appointed an Associate Medical Director for Quality Improvement and the Director of Improvement started in post in April 2021. The Health Board is also in the process of establishing the systems and infrastructure to support the Health Board's improvement work. Newly appointed Nurse Directors are in place for each of the three ILGs, and they are responsible for supporting quality governance, which is a shared responsibility across the three ILG senior leaders. In addition, each ILG also has a Head of Quality and Safety in place to support the quality governance agenda. Their role is to support the work of quality and patient safety within the ILGs, linking with the central Patient Care and Safety Team and the Assistant Director for Quality, Safety and Safeguarding. Over the past few months ILGs locally have also started to recruit additional governance staff to address their capacity issues as there are differences in the team sizes across the ILGs. The Bridgend and Merthyr Cynon ILG also have a new appointed Head of Midwifery for their respective obstetric units under the leadership of our Director of Midwifery who commenced in post in Jan 2020
	CTM Lead	**Further Actions**	**Completion Date**
3.1	**MD**	Robust interim arrangements to be agreed to cover role and accountabilities of Medical Director until substantive appointment is made.	**July 2021**
3.2	**CoS**	Review Operating Model and ILG/System Group Structure to evaluate effectiveness.	Formal review to follow appointment of key roles, anticipated by end March 2022.
3.3	**DoTH**	Appoint the AHP CD.	**August 2021**
3.4	**DoTH**	One Deputy DoTh and two Assistant Director of Therapies and Health Science posts will be advertised in July 21 these roles will strengthen quality and patient safety functions for therapists and healthcare scientists and work as part of the Executive function and strengthen succession planning.	**Interviews scheduled by August 2021**

3.5	**DoN**	Quality metrics capturing a greater breadth of HB services and functions, including population health measures, have been agreed and reviewed at the ILG performance meetings, Quality & Safety Committee and Board. The new measures will utilise, where possible, control limits, targets and trajectories. Once for Wales will support the HB to benchmark against other HBs.	**Scorecard data available by end Oct 2021**
3.6	**DoN**	As indicated above development of the Quality Strategy will commence at pace and align with the organisational strategy as it becomes available.	**Quality Strategy in place by November 2021.**
		Recommendation made in November 2019	**A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)**
	R4	The roles and function of the QSRC need to be reviewed to ensure that it is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety governance framework and key corporate [organisational] risks for quality and patient safety. This should include the following; a- Implement the sub-groups to support QSRC must be completed ensuring there is sufficient support (administratively and corporately) to enable these groups to function effectively b- Improvements to the content, analysis, clarity, and transparency of information presented to QSRC c- Focus should be given to ensure the Quality and Patient Safety Governance Framework is used to improve oversight of quality and patient safety across the whole organisation, including Bridgend services. This should be accompanied by the necessary resource for its timely	**Although some aspects of this recommendation have been superseded, there has been good progress with establishing the new governance framework and reporting.** **Plans for implementing subgroups to support the Quality, Safety and Risk Committee[3] were stood down following a revision to the Patient and Safety Governance Framework, therefore this element of the recommendation is superseded.** The Quality and Patient Safety Governance Framework has evolved in response to the new operating model introduced in April 2020. Quality governance arrangements have been established within each ILG and each ILG reports on quality and patient safety matters directly to the Quality and Safety Committee. **The quality of information presented to the Quality and Safety Committee for assurance and scrutiny is improving.** The Committee routinely receives quality and patient safety reports from each ILG and an organisation wide Patient Safety Quality report. These reports cover all service settings including acute, primary and community and mental health services. They also include a set of overarching Health Board wide quality metrics. The reports contain information across a wide range of quality indicators and enable scrutiny of patient experience across all three ILGs in a standard template which enables comparisons. The content covers all service areas, and ILGs are encouraged to flag areas of incidents, claims and complaints (concerns), and risks, and there is appropriate narrative to provide assurance. Reports are delivered by the ILG teams themselves, which enables oversight and scrutiny from

[3] This committee was replaced in December 2019 with the Quality and Safety Committee.

		implementation, internal communications, and training.	Independent members. Our observations of Board and Quality and Safety committee meetings found appropriate levels of scrutiny and challenge with candid responses from officers. The improvements to the quality reports are positive and include the use of trend information but fall short of setting targets or thresholds where further work or escalation may occur, for instance if pressure ulcer occurrence in one ILG area goes higher than expected. There is an ambition to move to live dashboards to improve analysis and data interrogation and discussions have started to move this forward by the end of 2021. Plans have also been developed by the Nursing Directorate to introduce a 'focus on' section in the Health Board Quality and Safety report to address issues requiring greater interrogation and triangulation, and this will be presented to the next Q&S Committee in July 2021.
	CTM Lead	**Further Actions**	**Completion Date**
4.1	**CoS**	Meeting structure to sit under Management Board being developed to support the operational oversight and Health Board wide co-ordination and learning.	**Revised HB management meeting structure in place by end 2021**
4.2	**DoG**	Report writing training is being delivered, focussing on improving the quality of reports presented to Committees and Board.	**50 Report Authors to be trained by end Oct 2021**
4.3	**DoG**	Scrutiny toolkit being developed for Independent Members to support focussed scrutiny at Committees and includes expectations around quality of papers and information.	**Scrutiny toolkit to go live – August 2021**
4.4	**DoN**	An initial 'focus on' report has been submitted at the May Q&SC as part of the CTM Quality Dashboard and the second one due at the July Q&S. The subject for the focus of this supplementary support is decided by the Chair of Q&S and provides responsive 'deep dive' analysis, scrutiny and interrogation of data.	**Next Q&S 'Focus on' Q&S report July 21 – Medication errors.**
4.5	**DoN**	Quality & patient safety reports received at Q&S Committee from each ILG. Agreed metrics outlined in March 2021 Management Board that are being operationalised by performance management colleagues,	**By end Dec 2021**

		after which time, targets will be set with trajectories in SPCs.	
		Recommendation made in November 2019	**A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)**
	R5	Independent members must be appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them.	**Independent Members receive appropriate support through the provision of an induction programme and ongoing development to support them in their scrutiny role.** Our 2019 review identified opportunities to improve induction and development programmes for Independent Members (IMs) to support their work and effectiveness. Since then, the Health Board has introduced a more structured induction programme for IMs, which compliments the Welsh Government's all Wales induction process. Local support for IMs is provided by the corporate governance team. During 2020, all IMs received an appraisal with the Chair of the Health Board and the Director of Governance. Training needs were identified and Personal Development Plans (PDPs) recorded. A programme of external evaluation and observations of Independent Members (IMs) has taken place with feedback given on their performance. There has also been work on engagement and relationships, team building, coaching, direction-setting, scrutiny and the relationship between the Board and its committees. The initial external evaluation of this work has shown positive improvements in areas such as scrutiny of information, and improved relationships between board members.
	CTM Lead	**Further Actions**	**Completion Date**
5.1	**DoG**	Feedback from the Deloitte Board Development Programme (commissioned by WG) and the feedback from David Jenkins (Independent Advisor to the Board) will influence the basis for the Board Development Programme for 2021/2022 and beyond.	**March 2022**
5.2	**DoG**	A significant turnover of Board Members (Executive and IM) will take place in the first half of the financial year so individual and collective development needs will be accounted for by; Induction Programme (in place) Board Development Programme to be supported by relevant professional bodies.	**Commence Oct 2021**

5.3	**CEO/DoG**	Personal Development Plans for all Board Members in place in line with Board Development.	**July 2021**
		Recommendation made in November 2019	**A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)**
	R6	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.	**The Health Board has instigated a number of improvements related to this recommendation, to improve how it learns from patient experience. However, the pandemic response has impeded its ability to further progress and embed these improvements**. In response to our review in 2019, the Health Board began the development of a comprehensive three-year Patient Experience Strategy, however, its completion and implementation has been impeded by the pandemic response, and we have not received an update on its progress and a completion date from the Health Board in this regard. Attention will be needed to complete this strategy which underpins the Health Board's approach to patient experience. The Health Board has implemented a Shared Listening and Learning Forum, and its inaugural meeting was held on 17 February 2021. The forum has been established as part of the Health Board's framework for listening to and learning from incidents and patient or staff concerns and experiences, and to promote and support a learning culture. We reviewed the forum's draft Terms of Reference, which appear appropriate. It is chaired by the Executive Director of Nursing and will meet quarterly, reporting directly to the Management Board. It is, however, too early for us to judge the forum's effectiveness, and the impact it has made on patient experience and learning. Patient stories now form a regular part of the Board and sub-committee meetings, which was not always the case previously. The patient stories provide an opportunity for Board members to gain an insight into the experiences of individuals using the Health Board's services. A consequence of the pandemic has been the curtailment of executive and independent board member's patient safety walkabouts, which includes visiting ward and patient areas. However, there are plans to resume the programme of visits in due course when safe to do so. The ILGs have introduced dedicated leads to manage patient feedback, concerns, and incidents. This has improved reporting to the Quality and Safety committee, as well as the local ILG Quality, Safety and Patient Experience meetings. We saw evidence that themes and trends are identified, but there is recognition more could be done to share and embed learning across the ILGs.

			The Health Board implemented a Friends and Family Test (FFT) tool across the organisation to collect and report real-time patient feedback. It was piloted in early 2020 and subsequently rolled out across the Health Board. However, this was halted due to the pandemic and in April 2021 the Health Board are implementing the new national 'Civica' patient experience feedback monitoring system. There is a commitment to ensuring patient feedback is captured, and the impact of this should be seen in the near future.
	CTM Lead	**Further Actions**	**Completion Date**
6.1	**DoN**	Health Board purchased CIVICA (captures population feedback using a patient insight software platform)	**Purchased May 2021, Pilot site Maternity to go live July 21 with full implementation dependent on company.**
6.2	**DoN**	The shell of the CTM version of the Civica system has been built, and the population of surveys into the system has commenced. The Patient Reportable Experience Measures (PREM) surveys have been uploaded to the system. Links to the survey have been generated and are being tested with members of the Maternity Service Forum, while the automation function is finalised. Project Manager starts in post 12th August and once in post they will be asked to provide a detailed project plan and roll out programme for the project.	**Project Plan for roll out due by end September 2021**
6.3	**DoN**	Webpage on SharePoint set up to support learning & excellence across Health Board. Development of a social media site for the L&LF to use analytics on the social media and SharePoint site to explore the extent of colleague engagement and posting. Feedback from participants will be analysed in relation to what they have learned and how this has impacted upon their practice. For the medium and longer term would expect to see learning and improvement being applied in the workplace through our established quality metrics and patient experience feedback.	**Web-page 'go live' - July 2021**

6.4	**DoG**	Reintroduce Exec/IM Patient Safety walkabouts when safe to do so/COVID restrictions allow.	**Programme of visits to re-commence August 2021**
		Recommendation made in November 2019	**A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)**
	R7	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.	**Good progress has been made by the Health Board in addressing visibility and oversight of clinical audit, but it could be better targeted to areas of organisational risk.** In December 2019, the Health Board approved additional funding to strengthen the Clinical Audit and Quality Informatics Department's ability to monitor compliance with participation, and to improve the quality of data used for all national audits. The additional funding has increased staffing with the appointment of a Deputy Assistant Medical Director for Clinical Audit, a dedicated clinical audit manager to lead on compliance with the national audit programme, a Quality Informatics Manager with responsibility for improving clinical data in Health Board systems and a Deputy Head and Lead Nurse for Clinical Effectiveness. The additional resources are helping the Health Board to utilise the audit findings to inform quality improvement initiatives and service redesign, such as establishing major trauma centres at the Princess of Wales and Prince Charles Hospitals in partnership with the ILGs. Oversight of the clinical audit programme is improving at a strategic level. The Audit and Risk Committee has received the clinical audit forward plan, and in February 2021 it also received, for the first time, a quarterly update report outlining progress of the plan. As part of its forward work plan the Quality and Safety committee plans to receive quarterly updates on the clinical audit plan. We would expect these updates to identify outcomes from the audit, actions being taken to share learning and to provide the committee with a source of assurance on the quality and safety of care being delivered. There is also the opportunity for clinical audit to be targeted to areas of organisational risk such as the impact on patients of Emergency Department overcrowding.
	CTM Lead	**Further Actions**	**Completion Date**
7.1	**MD**	Training Programme for clinicians on the Clinical Audit and NICE Compliance Monitoring IT software (AMaT) being developed for clinical audit.	Module to be rolled out **from August 2021**.
7.2	**MD**	Training module for ward & area audits being rolled out.	**March 2022**

7.3	**MD**	Appointment of Deputy Head and Lead Nurse for Clinical Effectiveness and Deputy AMD for Clinical Effectiveness, a programme of work was established in **January 2021** to create a NICE Reference Group (NRG) to review and manage all priority NICE guidelines and standards.	**To be launched by end October 2021**
7.4	**MD**	A review of clinical audit risk log management process to enhance early detection of risks and outcomes of national audits to support learning & best practice to be completed. The review will ensure alignment with the new ILG assurance and governance framework to support early review of outcomes of national audits to support monitoring of identified risks, learning from audit findings and to promote the sharing of best practice.	**End August 2021**.
7.5	**MD**	ILG specialty clinical audit forward plans.	Sign off **by end Sept 2021.**
7.6	**MD**	Resource review for HB Clinical Audit Service is being developed to ensure correct and sufficient skill mix in the team**.**	**Management Board consideration by end August 2021.**
7.7	**MD**	Undertake audit of compliance against Royal College of Emergency Medicine (RCEM) Standards for ED to identify baseline and inform continuous improvement programmes and improve compliance against the standards.	**June 2021.**
		Recommendation made in November 2019	**A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)**
	R8	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.	**The Health Board has made progress in clarifying the accountabilities and responsibilities for quality and patient safety across ILGs and within the CSGs, but more work is needed to ensure these improvements are embedded.** Accountability and responsibility for quality and patient safety has been strengthened across the ILGs with the introduction of appropriate directives within accountability letters issued by the Chief Executive to the Director of Operations. The letters emphasise the need for quality and patient centred care, and

			appropriately highlight that ILGs and CSGs are accountable for delivering high quality services in line with the quality framework, and that high-quality clinical leadership, supported by strong service management is critical. The Health Board has taken steps to strengthen clinical leadership across the organisation with a greater emphasis on quality and safety. This includes reviewing the accountability and responsibility of the Heads of Nursing roles within each ILG in relation to site management and quality and safety. In 2019 we found that the Head of Nursing was assuming responsibility for a number of non-clinical and estates related issues. In addition, as a consequence of taking over responsibility for the Bridgend County Borough Council, only two of three acute sites had a substantive Head of Nursing in post (Merthyr and Cynon and Rhondda and Taff Ely) and there were disparities in their responsibilities. However, since the implementation of three ILGs, a Head of Nursing role is now in place for the Bridgend locality. Accountabilities and responsibilities for this role are now clearly defined and are consistent across each ILG. In addition, there has been further recruitment to support quality and safety with the appointment of a Head of Nursing, a deputy Head of Nursing and a dedicated Head of Quality and Safety for each ILG. Each ILG holds Patient Safety and Experience meetings, chaired by the ILG Nurse Director to provide assurance. This is a positive development albeit one that is continuing to develop and our observations found that more coverage is needed in certain areas such as Infection, Prevention and Control. However, the Quality Governance Framework does not clearly articulate the quality governance arrangements for the CSGs that sit below each ILG. It has not been possible for some governance meetings to take place at CSG level due to the demand on clinical resources during the pandemic. Internal Audit's recent audit of Community and Adult Mental Health Services also found that the governance arrangements within the CSG were not clear with a lack of clarity about how they operate and function. This is an area that requires strengthening. In addition, whilst accountability and responsibility of the Heads of Nursing is clearly articulated, there appears to be an over-reliance on the Heads of Nursing to represent an overall clinical perspective during key quality and safety meetings, with limited input from medical teams. Due to the pandemic, the Health Board has had to delay its work on the clinical leadership and management development programme. This has impeded progress in terms of further embedding the quality and safety agenda within CSGs. This issue requires attention to ensure that responsibilities in relation to quality and safety are jointly demonstrated by both nursing and medical staff. Some of the formal quality and governance mechanisms established by the Quality Governance Framework were temporarily stood down during recent pandemic outbreaks and have recently been re-established, it therefore has been difficult to fully review

			the processes. Whilst the Health Board has taken steps to address this recommendation, it is clear that these improvements remain at an early stage and still need attention to ensure they are being embedded across the organisation.
	CTM Lead	**Further Actions**	**Completion Date**
8.1	**DoTh**	The commencement of the newly appointed AHP CD will give greater assurance of quality and patient safety for therapy services spanning across the 3 ILGs. This post also strengthens the leadership function in AHP services and sharing of good practice and patient centred care across the UHB. This will be further strengthened with new appointments in the Executive DoThs team.	**August 2021**
8.2	**DoN**	There is still work ongoing however with the progress at the pace it is, the quality & safety system is becoming more robust daily. Within 3 months the processes will be embedded fully across CTM.	**March 2022**
8.3	**DoN**	Quality & Patient Safety Meetings within CSG's are developing within ILG's – these are at differing levels of maturity and it is anticipated that these meetings will be consistent across all CSG's with specific speciality data dashboards by March 2022. CSG's are held to account within the ILG Q&SPE meetings and this is subsequently reflected in ILG performance management meetings and reports to Q&S.	**March 2022**
8.4	**DoN**	Corporate/Central services such as Safeguarding & IPC report regionally in to each ILG Q&PSE meetings.	**COMPLETE**
8.5	**DoN**	Establish Listening & Learning Forum – Quarterly	**COMPLETE**
8.6	**DoN**	Quality Governance Framework to reflect enhanced governance processes	**Review to be reported to Dec 2021 Q&S Committee**

8.7	**DoN**	Centralisation of PSA/PSN process status mapping in progress with a plan/process mapping	**Paper to Q&S September 21**
8.8	**DoN**	Centralisation and Audit of Locssips & Natssips to improve patient safety standards.	**Plan and process paper to Management Board July 2021**
8.9	**DoN**	Central Patient Safety Network – a safety II paradigm approach creating an environment where things are most likely to go right; to measurably reduce near misses, incidents and enhance organisational improvements.	**Planned paper for Q&SC September 2021**
8.10	**DoN**	Ensure the ILG Q&S Meetings receive a formal report from their ILG IPC and Decontamination meetings.	**End September 2021**
8.11	**MD/DoN**	Establish Joint Maternity & Neonatal Improvement Board.	**COMPLETE**
		Recommendation made in November 2019	**A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)**
	R9	The form and function of the directorate governance committees and CBMs must be reviewed to ensure there is a- Clear remit, appropriate membership, and frequency of these meetings b- Sufficient focus, analysis, and scrutiny of information in relation to quality and patient safety issues and actions c- Clarity of the role and decision-making powers of the CBMs.	**Governance arrangements at an operational level have been strengthened. Since our 2019 review CBMs have been removed following the introduction of the new operating model. This recommendation is therefore superseded.** As stated previously, in April 2020 the Health Board made significant changes to the way it organises and manages its business, most notably establishing the three clinically led ILGs. The CBM process has been replaced. Routine executive oversight of the ILGs is now maintained through the Integrated Locality Group performance reviews between the ILG triumvirate and the Executive Director of Operations. The Medical Director, Director of Planning & Performance, Director of Finance and Executive Director of Nursing also attend depending on their availability. These meetings are supported by the ILG business partners for quality and safety, workforce, planning and finance. Consistency of these meetings is ensured with a template slide pack covering information on quality, complaints and incidents, risks, finance, sickness absence and performance. These meetings are an improvement on the CBMs with a clear remit and sufficient focus on information across quality and safety issues. The Group ILG Directors are also formal members of the Management Board[4] (MB) enabling them to escalate issues and concerns.

[4] The Management Board is the executive team responsible for service delivery, which meets bimonthly to discuss operational delivery across the Health board

			At the time of our follow-up work, minutes and actions from Integrated Locality Group Performance reviews were not formally shared within the Management Board meetings, and there is a need to strengthen arrangements for MB oversight of issues raised at ILG level, and action taken in response as this would improve the clarity of decision making. However due to the pandemic a number of the planned the Integrated Locality Group Performance review meetings were stood down and were restarted in March 2021 following the Health Board moving out of the emergency pandemic response phase. Therefore, more time is needed to fully realise the benefits of this process.
	CTM Lead	**Further Actions**	**Completion Date**
9.1	**CoS**	Review being undertaken to review Executive Meetings and Management Board to ensure effective use of time and robust reporting.	Review / analysis complete by – July 2021 Changes enacted to revised meeting structure – August 2021
9.2	**CoS**	It has been over a year since the ILG structure was implemented by the Health Board. It is accepted that the new operational structure was implemented during COVID and therefore there is a requirement to allow the ILG teams to 'test and adjust' in a post-COVID environment. It is accepted by the organisation that some level of operational review should be carried out to look at what is working well and what elements of the structure may require tweaking to support effective decision-making.	Formal review to follow appointment of key roles, anticipated by end March 2022
		Recommendation made in November 2019	**A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)**
	R10	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.	**The Health Board has made good progress in addressing the serious concerns we identified in relation to risk management arrangements and has invested in dedicated support for governance and risk.** Since our 2019 review, the Health Board has reviewed its risk management systems and aligned them to the new operating model. This has been a root and branch review looking at arrangements from service to board. To ensure clarity, the Health Board has implemented a new Risk Management Strategy approved at Board in January 2021.

			Corporate support for Risk Management has been improved through the appointment of an Assistant Director of Governance and Risk. This post supports the executive directors, ILGs and the Heads of Quality and Patient Safety to ensure a consistent approach to describing and scoring risks, compiling risk registers and identifying mitigation actions. This has facilitated an increased focus on risk and driven the improvements that have been delivered. There has been a Health Board wide review of risks at a corporate, ILG and CSG level. This was a large piece of work undertaken at a time of considerable service pressures and is to be commended. The product of this work was the revised organisational risk register, which was presented to the Board in November 2020. This is a significant improvement since the previous risk register, however there is recognition within the Health Board that more work is needed to improve the mitigations and actions as described. Also some aspects of the CSG risk registers are still being updated to ensure they are accurately reflected within the Integrated Locality Group registers. The Risk Management Strategy sets out a clear route from service to board, showing the process for escalating risks through the ILG management tiers within the new operating model based upon risk score. Whilst there is evidence that risks are de-escalated where appropriate to do so, there is still more work to do in relation to where risks scoring less than eight are captured. At the time of our follow-up work, the Health Board had prioritised the capture of risks scoring nine and above on the Datix system given the ongoing response to the pandemic. However, where ILGs, CSGs or corporate teams identify risks that score 1-8, these are captured on local risk registers and not the Datix system. The Health Board acknowledges the risks of maintaining parallel systems and of the need to ensure clarity regarding the process for de-escalation. Internal Audit's recent [5] assessment of one CSG found evidence that not all risks are escalated appropriately, again demonstrating the need to ensure that the improvements made at ILG level are still to be embedded across the CSGs.
	CTM Lead	**Further Actions**	**Completion Date**
10.1	**DoG**	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	**31st October 2021**

[5] Link to IA report when available

		risk training programmes which are aligned to the new TNA.	
10.2	**DoG**	All ILG risks reviewed and updated following change in Operating Model.	**31st October 2021**
10.3	**DoG**	Clear and consistent grading of risks that are calibrated and moderated across the Health Board.	**31st October 2021**
10.4	**DoG**	An efficient risk management process which is seen as efficient and not cumbersome – linked to the new Once For Wales Risk Management System.	**30th April 2022 - external dependency as an All Wales System**
10.5	**DoG**	Implement recommendations from Internal Audit on Risk Management to strengthen risk identification, management and assurance.	**March 2022**
		Recommendation made in November 2019	**A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)**
	R11	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.	**Oversight and governance of DATIX is improving with more use made of information at corporate and ILG levels within the organisation. Further work is needed on strengthening organisational learning from incidents, claims and complaints (concerns).** There is now clarity as to where the ILG Datix teams sits within the Health Board's structure, reporting through the Health and Safety team to the executive Director for People. The Health Board has indicated that these new accountability arrangements will be reviewed over the next three to six months. There is now a renewed focus on ensuring that quality and patient safety is a priority. Mechanisms to improve oversight and scrutiny at an executive team level are in place. The Executive Director of Nursing and the Assistant Director of Quality, Safety and Safeguarding chair a short weekly meeting to review the previous week's complaints and incidents in conjunction with the quality metrics for nurse staffing levels. At the beginning of December 2020 a report to the weekly executive Director-led Patient Safety weekly meeting identified that more than 600 incidents had occurred within the prior six months that were yet to be allocated for investigation. The Health Board is working to address this backlog of investigations and completion of the appropriate fields within the Datix system, prioritising

			these based on the severity of harm. Whilst the Health Board has informed us that since our work it has developed investigation and serious incident trackers to enhance monitoring in relation to incident management, more work is required to ensure that opportunities are taken for identifying early learning following incidents. Use of Datix has improved, although there are some issues with the access to information at the Integrated Locality Level which is affecting their ability to produce localised reports. This is being addressed by the Datix team but does required a considerable amount of work. The Health Board will be implementing the Once for Wales system In July 2021. Information provided by the Health Board indicated that it was not able to accurately identify staff who could investigate incidents and undertake root cause analysis. Additionally, the Welsh Risk Pool (WRP) recently expressed concerns over the time being taken by the Health Board to complete timely Learning from Events Reports (LFER) in line with WRP reimbursement procedures. This has been a challenging area for the Health Board due to the high numbers of legacy and maternity cases and the WRP has expressed concerns around the quality and timeliness of information submitted by the Health Board. In response, further work and progress has been made, and a task force established with weekly progress meetings with a commitment made by the Health Board to submit all LFER by the 31 March 2021. We have also been informed that since February 2021 the Health Board has developed and launched its own root cause analysis module, which has enabled accurate tracking and monitoring of attendance. The Assistant Director of Quality, Safety and Safeguarding holds biweekly meetings with the ILG Heads of Quality and Patient Safety with the aim of ensuring that appropriate actions are taken in response to complaints and incidents. Within the ILGs the monthly Quality and Patient Experience Meetings also scrutinises information from Datix to look at trends and analysis. All three ILGS have identified that analytical capacity is a barrier to using this data effectively and are recruiting to analytical support posts as a consequence. The ILGs have also identified that there is further work to do in addressing training needs for staff in relation to DATIX and ensuring that the right people have access to the system. The January 2021 report to the Quality and Safety committee provided reassurance that feedback from incident reporting through DATIX was improving, however there is further work required to improve the quality of feedback provided to the reporter.

			As noted earlier in the report, the Health Board has also established a Shared Listening and Learning forum which reports to the management board. Part of the forum's remit is to oversee the Health Board's framework for listening and learning from quality and patient/staff related concerns and experiences. In addition, it champions a patient and staff safety culture and facilitates learning and sharing good practice. The forum's inaugural meeting was held in February 2021 with all ILGs presenting themes, issues and learning from incidents, claims and complaints (concerns). Whilst this is a positive development, it is too early to assess the effectiveness of this forum.
	CTM Lead	**Further Actions**	**Completion Date**
11.1	**DoN**	Datix Management being moved from H&S function (DoPpl) into Patient Experience function (DoN) to align with the development of Once for Wales. The tool will be a key mechanism to feed the Listening & Learning Forum of the Health Board.	**transfer by July 2021, incident module due October 21**
11.2	**DoN**	Training is provided to staff ahead of introduction of the new RLDatix Once for Wales, on each relevant module. Training will include feedback to reporter (ie claims & redress 07/06/2021).	**Incident Module will go live in October 2021**
11.3	**DoG**	An independent review has been commissioned by WRP to assess the Health Boards management of claims, including the systems, processes and resources in place to complete timely LFERs. The report will make recommendations that the Health Board will consider implementing to strengthen the current arrangements.	**Independent Report due Sept 2021**
11.4	**DoG**	Ensure all LFERs deadlines agreed with WRP are adhered to.	**July 2021**
11.5	**DoG**	Ensure LFERs have local ownership and are shared across the HB localities, identifying themes and trends.	**December 2021**

11.6	**DoN**	Review all backlog incidents to eliminate duplicates and ensure correctly identified/categorised.	**October 2021**
11.7	**DoN**	Clear the backlog of all legacy incidents.	**January 2022**
		Recommendation made in November 2019	**A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)**
	R12	The Health Board must ensure staff receive appropriate training in the investigation and management of concerns. In addition, directorate staff need to be empowered to take ownership of concerns and take forward improvement actions and learning	**Whilst the Health Board has made progress with addressing this recommendation, oversight of training corporately, and within each ILG, requires further attention.** Our 2019 review identified the need to improve the oversight and management of concerns. This included the operational processes for investigating and learning from concerns. Training on concerns management has been prioritised and has been provided across the Health Board for relevant individuals delegated with the responsibility for managing the concerns process. In addition, the Health Board's concerns policy was also reviewed and approved by the Board in August 2020. Training requirements for managing concerns are identified within the policy. Whilst at the time of our work ILGs were not able to accurately report on the proportion of their staff who have received training to investigate concerns, incidents or undertake root cause analysis, we have been informed that since February 2021 the Health Board has developed and launched its own root cause analysis module enabling it to track who has received this training. There now appears to be consistency of approach and clearer accountability in relation to concerns management across each ILG, with concerns managed within the relevant CSG before gaining ILG approval, and subsequent submission to the corporate concerns team for final response approval. We saw examples of this within quality and safety and experience groups across the ILGs, where there was evidence that staff at local level are taking greater ownership and responsibility for a concern, and for implementation of improvements where required. To further strengthen concerns management processes, recent recruitment has increased the size of locality and corporate concerns teams.
	CTM Lead	**Further Actions**	**Completion Date**
12.1	**DoG**	Restructuring of Exec lead for Concerns, Claims and PTR from Director of Nursing to Director of Governance.	**July 2021**
12.2	**DoG**	Appointment of a Head of PTR (Interim 8b).	**June 2021**

12.3	**DoG**	Appointment of Head of Legal, Concerns and Redress (8c).	**Oct 2021**
12.4	**DoG**	An audit of Concerns has been included in the Health Boards Annual Audit Plan for 2021/22. The Health Board will use the audit recommendations to strengthen the systems, processes and resources in place to investigate and manage concerns.	**Report Due August 2021**
12.5	**DoG**	CTM Improvement Team supporting Concerns Mapping identifying a consistent approach that can be applied across the Health Board. Outcome and implementation to be informed by the internal audit.	**End March 2021**
12.6	**DoN**	Continue to roll out the RCA training module and monitor attendance of ILGs on the training.	**Dec 2021 and on-going**
		Recommendation made in November 2019	**A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)**
	R13	The Health Board must ensure the timely development of a Values and Behaviours Framework with a clear engagement programme for its implementation	**The Health Board has made good progress in developing and rolling out its Values and Behaviours Framework, although it has needed to adjust the implementation timescales as a result of the pandemic.** At the time of our 2019 report, the Health Board was launching a programme of work to develop a Values and Behaviours framework for the organisation. Listening events were held with staff, patients, and service users between November 2019 and February 2020 to help identify the issues that such a framework would need to address. The outbreak of the pandemic meant further work on the Values and Behaviours Framework was delayed until June 2020. However, when the work resumed the Health Board was able to take account of staff experiences of responding to the pandemic and gather baseline information about staff well-being. In total the Health Board collected around 6,445 pieces of feedback from staff, stakeholders and the local community which informed the framework. To inform the development of its Values and Behaviours Framework, the Health Board undertook a series of listening events, engaging with approximately 8,000 people, including patients and staff. External consultants were appointed to support this work and to develop the engagement methodology. The work appears to have had a positive impact on the development of the framework and in planning for the Patient Experience Strategy. The Health

			Board formally launched the Framework on World Values Day, 15 October 2020. There was a live interactive session with a keynote presentation from Professor Michael West on compassionate leadership in the NHS. More than 2,000 staff participated in the event. The framework was also publicised on the Health Board's intranet and social media channels. A detailed implementation plan is in place to embed the Values and Behaviours and this is monitored by the People and Culture Committee. Staff whom we interviewed were generally positive about the Values and Behaviours Framework. The Health Board recognises that it will take time to fully embed the Values and Behaviours across the organisation and to enhance employee experience. In order to help embed them, the Health Board is revising its leadership programmes to incorporate the values and behaviours. The Values and Behaviours are reflected in key Health Board documents and they are visible on its website. They are also reflected in the Terms of Reference for the ILGs.
	CTM Lead	**Further Actions**	**Completion Date**
13.1	**DoPpl**	Launch Phase	**COMPLETE**
13.2	**DoPpl**	Embed Phase	**6 to 12 Months (June 2022)**
13.3	**DoPpl**	Values-Based Team Workshops, delivered	**From April 2021 onwards**
13.4	**DoPpl**	Values Cafés	**Delivered from March 2021 onwards**
13.5	**DoPpl**	Values-Based Leadership Workshops, currently under development.	**Delivered in 2021-22**
13.6	**DoPpl**	Values-Based Recruitment process and training.	**Developed by June 2021**
13.7	**DoPpl**	Values-Based Appraisal (PADR) process and training.	**Developed by September 2021**
13.8	**DoPpl**	Reinforcement Phase To include:-	**12 months beyond**

		Culture Workshops; Repeat Culture Survey.	
		Recommendation made in November 2019	**A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)**
	R14	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.	**The Health Board has started to develop a stronger approach to organisational learning, although the pandemic has impeded progress against this recommendation.** In 2019, we found a lack of formal processes to identify and share learning for improvement across the organisation to support the delivery of safe and effective care. Additionally, in 2019, the NHS Wales Delivery Unit also raised concerns about the management and learning from serious incidents and never events. We have highlighted the Health Board's current position regarding learning and improvement in response to concerns and patient and staff feedback (recommendation 12). Progress has been made in strengthening the overall responsibility and management of clinical and serious incidents across the Health Board. A clinically-led Serious Incident team has been established, alongside a more robust process for the management of incidents, and learning resulting from them. Supporting this, the Health Board has implemented a Serious Incident Tool kit. This tool has reportedly assisted with consistency in managing incidents, and supported sharing learning. The Serious Incident team undertakes a monthly clinical audit and super audit (quarterly) in collaboration with the Patient Care and Safety Team. The findings and actions for learning from these audits are reported through the locality Quality, Safety and Executive groups, and into the Quality and Safety Committee. The Health Board is also establishing an improvement function called 'Improvement CTM', which will bring together learning from audit activity and concerns. Improvement CTM is expected to empower the Health Board's workforce to take responsibility for implementing continuous improvement through organisational learning. This is still early in its implementation and therefore too early to assess its effectiveness. It was widely reflected to us that tackling the issue of improving organisational learning has been a challenge for the Health Board as a consequence of the pandemic response. Whilst there is some evidence of a stronger approach being taken to organisational learning, we have limited evidence at this time to be assured that learning is being effectively disseminated to all areas of the organisation and frontline staff. Minutes and observations found evidence of learning being shared within CSG and ILG quality and safety meetings. However, there is a need to strengthen overall arrangements for sharing learning across the ILGs. The Health

			Board is aware of this and hopes this will improve, particularly with the Heads of Quality and safety now in post across all ILGs Our observations of CSG and ILG quality and safety meetings found that external activity such as HIW inspections are being regularly discussed to ensure that action is taken to address recommendations, and learning is disseminated across CSGs and the Health Board. The previously mentioned Shared Listening and Learning forum will also focus on the learning and dissemination of findings and recommendations from external reviews, audits, and inspections. However, there is limited evidence to demonstrate that wider learning beyond the clinical area being inspected is shared effectively across all other clinical areas and with staff, particularly with those on the front line who are responsible for day-to-day care of patients. Assurances are given to the Quality and Safety Committee about learning from incidents, but the reports do not provide examples of the learning and how it is being applied or shared more widely across the organisation. This is an aspect that needs to be strengthened. Our previous review found that opportunities for learning following the Bridgend transfer in relation to undertaking FFTs had not been taken. In 2019, staff within Princess of Wales Hospital felt there had been little consideration of the benefits for patients and staff through the use of FFT, and its use for real-time patient feedback. However, since our review, the Health Board has embraced this learning and implemented the FFT throughout each site.
	CTM Lead	**Further Actions**	**Completion Date**
14.1	**DoN**	A clinically-led Serious Incident team has been established and the Health Board has implemented a Serious Incident Tool kit.	**COMPLETE**
14.2	**DoN**	Utilise the '7 minute briefings' to capture learning and produce a digestible document across ILGs to support a repository of learning.	**By end Sept 2021**
14.3	**DoN**	Ensure a 'spotlight on' section within the Q&SC report to highlight an area of concern (determined by the committee) to provide an opportunity to give further detail and assurance/mitigating actions from across the organisation to Q&SC.	**COMPLETE**

14.4	**DoN**	Executive Director led Patient Safety meeting in place and meets weekly with Exec Director Nursing and Midwifery, Deputy Nurse Director, Assistant Director Therapies, Director of Corporate Governance, Assistant Director of Nursing & People's experience, Medical Director, Assistant Director Quality & Safety, Director of Improvement to review, mitigate and learn from; • Complaints • SIs • Falls / Pressure Damage • Inquests • Compliments	**COMPLETE**
14.5	**DoN**	Implementation of PREMS and CITRIX system to gather data on patient experience to inform learning and service enhancement and improvement. Project has been initiated and Project Manager appointed.	**Phased implementation from September 21 onwards**
14.6	**DoN**	New Improvement Directorate created bringing together Quality Improvement, Innovation, Value Based Healthcare and PMO in order to coordinate a range of important areas with a constant focus on improving quality for the benefit of staff and patients. QI Mission - Working together with our people, patients and partners to understand areas for quality improvement and develop the capability, capacity and delivery mechanisms across the whole health system to deliver improved outcomes for our patients and improved working practices for our people aligned to the principles of Prudent and Value Based Health Care.	**COMPLETE**
14.7	**DoN**	New Innovation and Improvement board created (sub board of Management Board) and launched focusing on Capability, skills, culture and delivery of QI and innovation and bringing together cross organisational learning.	**COMPLETE**

14.8	**DoN**	Revision of QI training and deployment plan across CTM.	**August 2021**
14.9	**DoN**	First Improvement into Practice cohort scheduled.	**Sept 2021 onwards**
14.10	**DoN**	Implementation of ILG QI Faculty. Resource recruitment completed (clinical, nursing, pharmacy and therapies) with 1 session per week to focus on ILG specific QI and learning.	**COMPLETE. Launch scheduled with roadshows in July 21.**
14.11	**DoN**	QI 12 month rolling programme of activity being developed.	**Deploy Sept 2021 onwards**
14.12	**DoN**	Staff ideas scheme for targeted challenges and QI programs being developed and online portal being build. Comms plan being developed to officially launch.	**Launch Sept/Oct 2021**
14.13	**DoN**	Work being undertaken with IC to scope work to develop and deploy a model ward and operational best practice guide to improve flow, quality and patient safety.	**July 2021**

AGENDA ITEM
6.5

AUDIT & RISK COMMITTEE

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Date of meeting	17/08/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Officer
Presented by	Georgina Galletly, Director of Corporate Governance/Board Secretary
Approving Executive Sponsor	Director of Corporate Governance
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

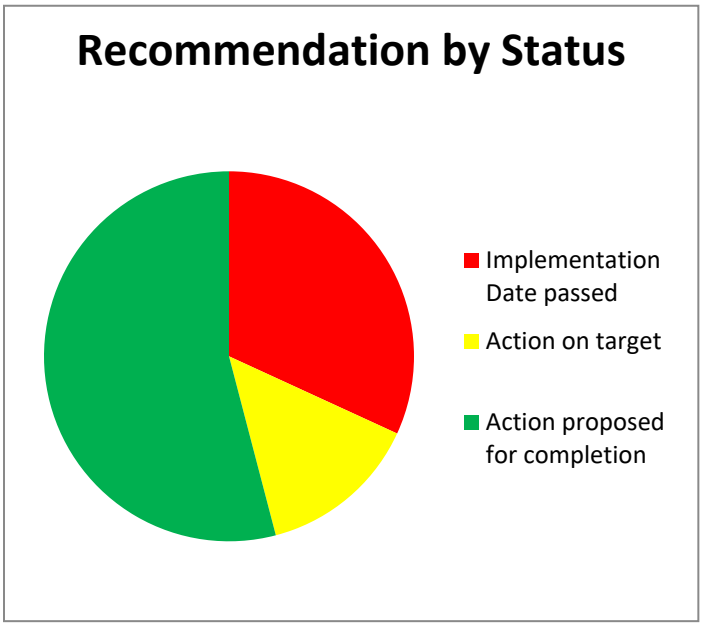
1.1 The main purpose of this report is to present an update to the Audit & Risk Committee on reported progress of Audit report recommendations in the revised format.

1.2 This report relates to both internal and external audit review recommendations.

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

2.1 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. Despite the pressures being experienced by teams in relation to Covid-19, Members will note a further 73 internal audit recommendations have been completed and are proposed for removal from the tracker, together with 6 external audit recommendations.

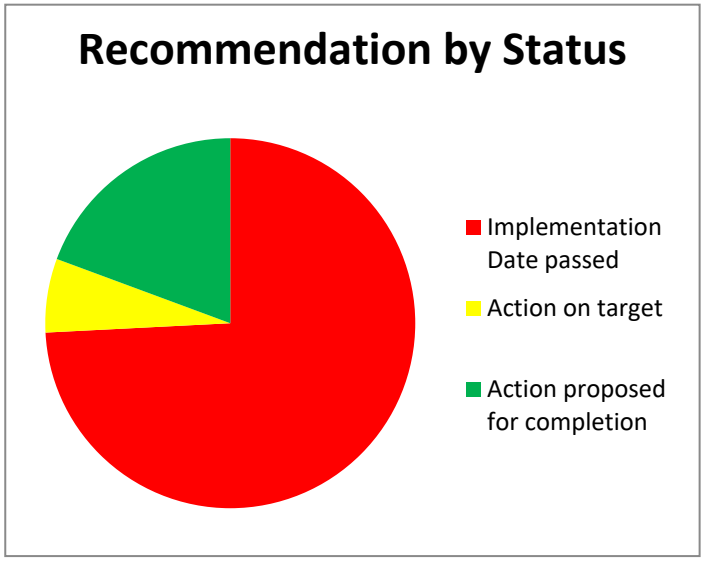
2.2 The tables below provide a summary of the current position in relation to Internal Audit Recommendations, noting that there remains a large number in the proportion of red status indicating actions that won't be achieved in line with timescales, largely due to the impact of COVID-19:



Recommendations by Priority & Status				
Priority	**TOTAL**	Implementation Date passed	Action on target	Actions Completed
High	**44**	16	8	20
Medium	**70**	24	10	36
Low	**21**	3	1	17

Recommendations by Executive Lead & Status				
Executive Lead	**Total**	Implementation Date passed	Action on target	Actions Completed
Director of Corporate Governance	**13**	1	1	11
Director of Finance	**24**	1	2	21
Director of Operations	**52**	17	3	32
Director of Nursing	**3**	1	1	1
Director for People	**17**	9	6	2
Director of Public Health	**20**	11	4	5
Medical Director	**6**	3	2	1

2.3 The tables below provide a summary of the current position in relation to External Audit Recommendations:

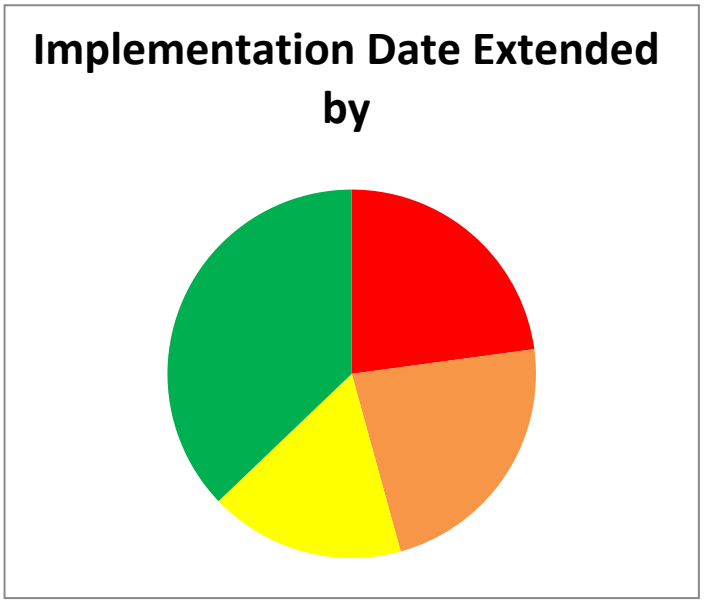


Recommendations by Priority & Status				
Priority	**TOTAL**	Implementation Date passed	Action on target	Actions Completed
High	**5**	5	0	0
Medium/Low	**26**	18	2	6

Recommendations by Executive Lead & Status				
Executive Lead	**Total**	Implementation Date passed	Action on target	Actions Completed
Director of Finance	**3**	1	0	2
Director of Nursing	**2**	1	0	1
Director of Operations	**21**	20	1	0
Director of Primary, Community & MH	**1**	0	1	0
Director of Public Health	**2**	1	0	1
Director of Strategy & Transformation	**2**	0	0	2

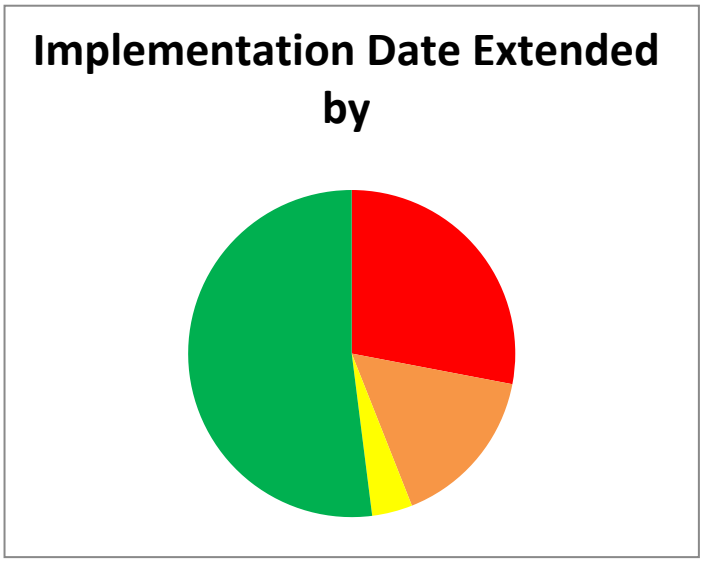
2.4 As requested by Committee Members at the June meeting, we have also included charts which identifies the recommendations which have exceeded their target dates by 24 months, 12-24 months, 12 months and by 6 months.

Internal Audit Recommendations



Implementation Date Extended by					
Priority	TOTAL	More Than 24 Months	12-24 Months	12 Months	6 Months
High	23	1	17	2	3
Medium	32	8	8	4	12
Low	3	0	0	2	1

External Audit Recommendations



Implementation Date Extended by					
Priority	TOTAL	More Than 24 Months	12-24 Months	12 Months	6 Months
High	5	3	1	1	0
Medium/Low	20	4	3	0	13

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

3.1 As outlined in section 2, the audit tracker will continue to be updated.

3.2 The revised format will continue to be further refined over time, but aims to provide a more thorough tracker and audit tool for the Audit Committee.

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 completed	No (Include further detail below)
	Not required
Legal implications / impact	Yes (Include further detail below)
	There may be an adverse effect on the organisation if the UHB 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 Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 The Audit & Risk Committee are being asked to **NOTE** the report.

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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	Previous Updates
Continuing Healthcare (January 2019)													
CHC 02	Jan-19	Reasonable	Following the publication by Welsh Government of a revised CHC national framework, management should review Health Board procedure documents and forms used in the CHC process to ensure all aspects remain relevant and aligned to the national framework. Consideration should be given to having a single document within the Health Board that signposts users to the relevant guidance such as the framework, the FCP, and to the relevant forms that need completing. Management should also provide refresher training to relevant staff within directorates and extending training to local authority counterparts, to ensure that staff are fully aware of any revisions to the framework and fully understand their responsibilities for the aspects of the process that they are responsible for.	Medium	Welsh Government are in the process of finalising the revised CHC Framework for early 2019. Cwm Taf UHB plan to review all documentation in the line with the new CHC Framework to ensure consistence of application and prevent duplication. A joint training programme between health and social care will be an essential element of embedding the new framework.	Director of Nursing	Lead Nurse for CHC and NHS Funded Nursing Care	01/07/2019	01/10/2019 This should be within three months of implementation of the new framework (due to be published on July 2019). April 2021 July 2021		Completed	July 2021 Update - CHC is now in the process of being reaudited therefore this recommendation will now be superceded	March 2019 update - Awaiting publication of new Framework in order to draft policy and organise training programme. March 2020 Update - Welsh Government has confirmed this week that the launch of the new Continuing Healthcare Framework will be delayed from 1 April 2020 until later in the year. November 2020 Update - We are unable to update our paperwork in line with the new CHC Framework until it is launched. We have not been provided with a date from WG as to when this will happen. January 2021-Update: The change required to update procedure documents and training plan used for our internals CHC process is integral to/ dependent on the new Welsh Government (WG) Framework which at the time of audit was planned for launch but this been delayed on at least 2 occasions. Recent, WG feedback before Christmas was the launch of the framework was further delayed and that they wish to revisit aspect of the policy and there would be further delay until Spring of 2021. We are therefore unable to action this one remaining action from the IA outcomes as WG are key to releasing the Framework; as soon as the Framework is released the revised assessment process will be implemented across CTM UHB however, we will continue to follow the current CTM UHB assessment process which is in line with the current WG Framework until the new framework from WG has been released for implementation.. We recognise that this is not a sustainable response to an action which is well over due for completion however, we have been awaiting WG release of the Framework for over 18 months; we will be expecting an update at the next CHC Leads Meeting on 09.02.21 which includes Welsh Government Membership. This would be an All Wales position. March 2021 Update: Further update - Due to Covid 19 the Welsh Government has delayed the publication of this
IT Systems (March 2019)													
IT 01	Feb-19	Reasonable	The organisation should develop an overarching BCP / DR process. This should consider all the systems and use a business impact analysis to prioritise the systems for recovery. The business (Directorates / Departments) should be involved in the process and should be consulted in order to define appropriate RTO / RPOs.	Medium	The organisation will look to develop an overall BCP/DR plan for ICT services. This would require senior management within ICT and the Civil Contingencies Manager to drive this with the co-operation of the various stakeholders within the Health Board. This should be overseen by the Digital Strategy Group. July 2019 Update: Quotes for two suppliers were soliicited and the lower cost supplier has recently been retained to assist with this activity. A detialed plan will be forthcoming once the supplier is on site. We currently estimate to complete this action in October.	Director of Public Health	Assistant Director of ICT	Apr-19	March 2020 December 2020 July 2021 Now December 2021		In progress	July 2021 Update - Work has recommenced since return. Solarwinds document ready for review, Pathology at PCH has also been started. In addition a service catalogue template has been developed using SharePoint online which will provide the Health Board one place where ICT systems and software details can be found. This will also assist in providing information required by NHS Wales Cyber Security Unit (CRU) as part of the NIS Regulations.	October 2019 Update - Senior management are in discussions around BCP/DR plans relating to infrastructure and ICT service affecting systems. Incident process flow diagrams are being drafted to provide visibility on the work flow when an incident occurs. This will be reviewed and completed in readiness for DHSSG. June 2020 Update - No Further Progress - Revised completion date of December 2020. August 2020 Update: Distaster Recovery plans have been created for infrastructure services such as DHCP services, on site mail exchnage services and file storage. Initial work has commenced between ICT governance and the Head of Systems to address clinical systems planning. A template has been produced and is to be agreed for all DR plans. The new Cito system has produced a comprehensive DR and BC plans. November 2020 Update - No further progress made since the August update. January 2021 - Progress made in terms of getting individual system recovery plans produced, DHCP, Hyper-V, CITO, all underway or complete. No Overarchign plan as yet,and BIA to be defined in readiness for NISD giving us which order the applications would need to be recovered in March 2021 - Ongoing. Documents for File services, Kaspersky and Solarwinds now also complete with overarching document started. Regular meetings booked for various technology applications. May 2021 - the member of the Cyber Security team responsible for this work has not been available for over a month which has lead to no progress being made. The member of staff is set to return in the second week of May 2021.

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IT 02	Feb-19	Reasonable	As part of the review process for DR plans, the identified weaknesses should be addressed, with up to date configurations included, along with all relevant contact names and numbers. The plans should also consider the RTO / RPO needed by the user departments and instructions should be complete. Hard copies of the plans should be stored so they are accessible in the event of network loss.	Medium	Management Respponse: ICT will address the identified weaknesses including contact details and the availability of hardcopy. In addition, ICT will consult with the department regarding their RTO / RPO requirements which will be factored into the updated DR plans.	Director of Public Health	Assistant Director of ICT	Apr-19	January 2020 December 2020 December 2021		In progress	July 2021 Update - Work has recommenced since return. Solarwinds document ready for review, Pathology at PCH has also been started. In addition a service catalogue template has been developed using SharePoint online which will provide the Health Board one place where ICT systems and software details can be found. This will also assist in providing information required by NHS Wales Cyber Security Unit (CRU) as part of the NIS Regulations.	July 2019 Update: This will be part of the review process in Finding 1. October 2019 update - Senior management are reviewing contact names and numbers so they are located on hard copy and digital copy in the event of a major incident. Departments are being communicated with Civil Contingency in terms of user based advise and training in the event of their own DR plans in accordance to ICT service delivery. June 2020 Update - No further progress - revised completion date of December 2020. August 2020 Update - work is progressing as per response for IT01. November 2020 Update - No further progress made since the August update. January 2021 - Weaknesses are being noted and also addressed as we find them during this process. As an example, we've recently found DHCP service didnt have certain IP Ranges available in High Availability, so changes have been been raised to rectify. Instead of Hard Copies, our plan is to host on Secure Data Vault which we would use in event of DR. March 2021 - Further issues found during production of solarwinds DR document. A number of devices missing from Solarwinds, now added and monitoring enabled for them. SPOF also identified. May 2021 - Although the member of the Cyber Security team has not been available (as stated in IT01), progress has been made on infrastructure systems. A meeting has taken place with Systems Managers responsible for the Pathology system and progress is being made in this area.
IT 03	Feb-19	Reasonable	As part of the process for reviewing IT DR plans, contact should be made with departments to ask them to establish their required RTO (the time for which they could acceptably work without the IT service being considered). This process should then push departments into developing their own plans for service provision without IT. The plans should consider varying scenarios covering lengths of outage. e.g. 1hr, 4hr, 1day etc. and also the different aspects of IT e.g. network loss, system loss etc.	Medium	Management Response: The Civil Contingencies Manager to review the BC plans within each Department and put mitigations in place as required, addressing the varying scenarios as recommended.	Director of Public Health	Assistant Director of ICT	Apr-19	April 2020 December 2021		In progress	July 2021 Update - no update. RTO will be established with the departments and can then be tested against once documents are complete	July 2019 Update: ICT, NWIS and the Civil Contingencies Manager ran a half day major incident scenario on 24 June. NWIS are going to provide feedback on the our response which we will use to update the DR plans. Engagement with departments will start in September. Note that the recent loss of a national datacentre has also tested our resilience and the learning from this event will be included in the revised DR plans. October 2019 update - Civil Contingencies Manager has advised that he has asked all Directorates to produce their ICT recovery plans with some Directorates asking for further advice. No completed plans have been received to date. ICT are working with Civil Contingency on meeting with departments to undertake an exercise around their DR plans and to raise awareness on what services ICT deliver in the event of a disaster. June 2020 Update - Due to the current COVID-19 outbreak focus has been placed elsewhere. Within the Datacentres ICT have now had implemented a resilient third room based at PCH to provide resilience for major systems. THis is at the PCH Switchroom which although is on the ground floor at PCH it is in a different fire zone to the main datacentre at PCH. Revised completion date of December 2020. August 2020 Update - Work is progressing as described in IT01. November 2020 Update - No further progress made since the August 2020 update. January 2021 - This is being included in each systems DR plan, and will be collated once we have a list list. March 2021 - no further update. May 2021 - no progress has been carried out on this recommendation.
Mandatory Training (March 2019)													

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MT 02	Feb-19	Reasonable	Assurances should be sought that individuals working on behalf of the Health Board, but that are not direct employees, are participating in mandatory training relevant to the role that they are providing. A means of monitoring the training compliance of such staff groups should be put in place. An action plan should be developed in relation to bank staff that includes cleansing the data in ESR and establishing a process to ensure this group of staff participate in training. Monitoring of compliance rates should be undertaken.	High	For agency workers, the UHB's providers manage compliance as part of their contractual obligations. To ensure the UHB is sighted on compliance, at the point of candidate submission the agency is required to submit a number of personnel documents, including a mandatory training certificate. Candidates' documents are reviewed upon presentation. Any gaps in compliance are identified, discussed with the booking department and a risk assessment and a waiver form completed if the level of risk is deemed to be acceptable. For Bank Staff, an action plan is being developed to resolve identified issues, which includes:- • Arrange ESR accounts for all bank workers to access e-learning modules. • Validate and cleansing the staff bank register (commenced). • Validate ESR training records for existing bank staff. Issue of remuneration to be considered as part of this work. • Consider an agreed penalty for non-compliance (e.g. restriction from duties, possible de-registration in line with All Wales Terms of Engagement. • L&D CSTF Strategy to include Bank workers March 2019 progress to date- the ability to receive paper payslips ceased in January 2019. All new starters are immediately set up with NADEX accounts. Validation of the e-system has been completed 360 accounts closed. A Validation of the paper files to be undertaken – due to start mid-March. Bank staff have been contacted to provide evidence of training undertaken outside of CTUHB – this is being received and will be uploaded onto a data load for ESR SBAR is being developed in readiness for Exec catch up for consideration/discussion and approval	Director for People	Learning & Development Manager	Jan-20	January 2020 March 2021 July 2021 Now December 2021		In progress	July 2021 - A steering group has now formed and meeting monthly to address the strateegic issues and challenges of compliance. Hierachies were cited as a key issue and a meeting wwith Dir for People and Heads of Workforce ILG is due to take place to begin to address this issue and improve the controls. Alied to this is training requirements for roles, L&D are drafting an action plan to carry out a grass roots review of roles working with HR and LM's to determine staff correct treaining requirements. L&D are currentyl going through a significant change activity where roles and staff are displaced and we are activly recruiting to meet our compliance outputs. A Festival of Compliance has been trialled in WFOD to look are how we can engage more staff in compliance across CTM more broadly. The aim is to roll out the festival to each ILG. L&D are working with all Wales ESR Training forums to examine more effective ways to engage staff in compliance training, the forum is due to report later in the year. There is work onoing to reduce Inter Authority Training and already this has reduced by 50% with the aim to reduce this further to 30% by the end of July. L&D are short;y to begin work with the ESR team to broaden the HR dashboard and use BI to provide more insightful and usable L&D trainign data. L&D are also drafting a process to backdate training annotations for new starters that were missed due to redpeloyments during Covid, we aim to start this in october once the resources are in place to do this. Staff Bank are activly engaged in compliance but have thier own issues in ensuring staff have the time to complete trianing notwithstanding they are currently not paid for the rime they ahve to take to complete thier training which means compltion rate remain low until a resourcing solution is found.	October 2019 update - see above June 2020 Update - See above July 2020 Update - see above. December 2020 UPDATE: This work has not progressed due to change of senior leadership in the L&D team and other pressures within the team. JANUARY 2021 UPDATE: no update available. APRIL 2021: New senior leadership now in place within the L&D team - this specific action to be reviewed to ensure a practical solution, taking into account training already received by bank staff as part of induction and standard training. Actions to be completed by July 2021. May 2021 - A paper was submitted to the People & Culture Committee citing a series of recommendations of how compliance might be improved. Recommendations were approved this month and I am in the process of setting up a Compliance Steering group and examining how recommendations can be implemented.
Patient Experience (April 2019) Reasonable Assurance													
PE 03	Apr-19	Reasonable	A more detailed action plan should be developed to support the achievement of the actions outlined under each of the six ambitions. This should include responsible officers and timescales for completion. This will allow easier monitoring of the actions over the life of the Patient Experience Plan.	Medium	The patient experience plan is being revised and will include a detailed implementation plan displaying timescales and leads.	Director of Nursing	Assistant Director of Nursing & Peoples Experience	Jun-19	September 2020 March 2021 September 2021		In progress	July 2021 Update - The Patient Experience Plan will be updated in accordance with the Health Board Strategy/Ambition once produced. This will include a joint People's Experience and engagemment Strategy. This will be joint piece of work with the Head of People's Experience, Director of Corporate Governance, and Assistant Director of Communications and Engagement. A project manager has been appointed for the implementation of CIVICA and they commence in post end July 2021.	July 2020 Update - see above. November 2020 Update - Due to the changes in structure and the governance teams now being embedded here, a new Patient Experience Plan will need to be pulled together in the new year. January 2021 Update - The Patient Experience Plan will be reviewed in March 21 and if required, updated March 2021 Update - The HB is scoping a joint People's Experience and communication Strategy. This will be joint piece of work with the Head of People's Experience, Director of Corporate Governance, and Assistant Director of Communications and Engagement. May 2021 Update Due to the changes in ILG structures and the governance teams together with the transisition of PTR over to Corporate Governance during the summer of 2021. The Patient Experience Plan will be reviewed once this transisition has occured and in conjunction with Engagement and communication leads to create a People's Engagement Strategy.
Mobile Phones (May 2019) Reasonable Assurance													
MP 01	May-19	Reasonable	The Health Board should introduce a formal policy and procedure that outlines the organisational approach to, and management of, Health Board provided mobile phones.	Medium	Management Response: The Health Board accepts that a policy is needed. ICT will produce the policy, with reference to, and superceding, existing controls and procedures that are in place. July 2019 Update: The draft policy has been produced and will be reviewed and approved at the July DSSG meeting. From there it will be sent to executive catch up for approval.	Director of Public Health	Assistant Director of ICT	Jun-19	July 2019 April 2021 August 2021		In progress	July 2021 Update - Tender document still out to potential bidders	August 2019: Policy was approved at DSSG From there it will be sent to executive catch up for approval. - still pending - Sept 2019 June 2020 Update - No updates received, however, will be reviewed again in line with the new mobile phone contract that is being prepared for tender. July 2020 Mobile signal survey undertaken in collaboration wth looking at the suppliers and how we improve the mobile contract to provide a better service. August 2020 Update - Coverage review underway, and first draft of mobile phone contract released. November 2020 - ICT ITT Specification completed and passed to procurement. Review of survey completed with Vodafone who have agreed to implement changes to try and improve levels of service. Aiming for completion and migration to tender winner before April 2021. January 2021 - Tender document final changes being made from comments recieved on last draft. Due to be released within the next two weeks. March 2021 - Tender document completed and with Procurement. May 2021 - The tender document has been released and is aiming for a go live date of 1st Aug 2021

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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	Previous Updates
MP 02	May-19	Reasonable	Documentation should be stored electronically to allow for easy referral to forms if necessary. This would allow for more historical forms to be accessed easily.	Medium	Management Response: The Health Board has recently procured an electronic document management system for the scanning and storage of medical records. This system can be used for administrative documents as well. However, this is currently outside the scope of the project as funded in the business case (December 2018). ICT will write a proposal for expanding the scope of the project to include corporate documents. July 2019 Update: A project manager has been allocated to this task. Scoping of the activity is now underway and a project brief will be tabled at the September Digital Strategy Steering Group.	Director of Public Health	Assistant Director of ICT	Jul-19	September 2019 February 2021 April 2021		Completed	July 2021 Update - DPN now live	August 2019 - Project Brief drawn up and circulated to the SRO for agreement. Once finalised it will be discussed at the Project Portfolio Management Board. June 2020 Update - Delays to the DPN project mean that there has been no progress in scannig the documentation. This and other scanning projects are currently on hold. July 2020 Project is progressing looking at the 2 issues of preformance and scanning before UAT commences. August 2020 Update: Position remains the same as June 2020. November 2020 Update - System currently in testing and providing positive responses. Desktop equipment for end users also currently being deployed approximatley 80% complete. January 2021 - Project aims to go live in Feb 2021. All equipment purchased for the project currently at 97% deployed. March 2021 - Project now aims to go live Mid March 2021. All equipment purchased - deployment now at 99% completed. May 2021 - DPN system has gone live further discussions are required to define the process.
Directorate Review Surgery Management Arrangements (July 19) - Reasonable Assurance													
SMA 06	Jul-19	Reasonable	Management should work with consultants to understand what the barriers are to ensuring that job plans are agreed in good time. Actions from this exercise should be implemented to improve job plan sign-off. Management should work with consultants to ensure that job plans are discussed and agreed by all relevant parties ahead of the job planning period. Advice should be sought from other directorates where job plans are completed in a timely manner and a forward work plan should be developed to ensure planning takes place in a timely manner and the CBM should continue to monitor the ongoing status of job plans within the directorate.	High	A plan to undertake consultant job plans that are out of compliance has been developed and this will be monitored through CBM. The major barrier to undertake consultant job plans is Directorate Manager and Clinical Director capacity. The COO has recently agreed an interim Deputy Directorate Manager to increase management capacity in the Directorate.	Director of Operations	Directorate Manager	Ongoing	February 2021 June 2021 July 2021		Completed	July 2021 Update - There is a process in place to increase the number of job plans. This is monitored via the ILG Performance Review Meeting on a monthly basis. This recommendation is completed.	October 2019 update - Consultant job plans ongoing. Interim deputy directorate manager not in post and directorate capacity remains problematic. June 2020 Update - The job plans are ongoing, further progress was made prior to COVID and work will also be undertaken to reflect the changes in responsibility as the result of the ILG implementation. Progress is dependant on implementing a directorate management structure in the RE ILG Surgical and Anaesthetic Directorate. July 2020 Update - Improvements being made and plans being updated to reflect the ILG structure. November 2020 Update The Clinical Service Group is challenging in terms of size and the number of senior staff to manage the process, however the Manager is working on a timetable to manage the Job Plans. An update will be provided in February 2021. January 2021 Update - The focus required by managing covid 19 has meant that there has not been as much management focus as the Directorate would have chosen. However, job plans are being undertaken as a routine matter in the work of the Directorate and as planned an update will be provided in February 2021. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. Any urgent job planning matters that cannot wait are managed through the Service Group by the General Manager and the Clinical Director on an ad hoc basis as needed. March 2021 Update - As a result of the lack of a Deputy SGM (since at least October 2019) this work has not progressed as fast as would have been liked. The SGM has instigated a process to speed up the process of carrying out job planning, any urgent matters are managed by the SGM and the Clinical Director. The following will be available by the end of April 2021: • A plan to progress
Directorate Review Radiology Management Arrangements (July 19) - Reasonable Assurance													

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RMA 02	Jul-19	Reasonable	All Radiology specific policies and procedures should be documented in a central record and assigned an 'owner' responsible for ensuring their assigned policies and procedures are maintained up to date. All directorate specific policies and procedures should be made available to all directorate staff via SharePoint.	Medium	Currently moving forward with a new SharePoint site for Radiology – linking with Karl Carpenter (Digital Services Manager) and maintenance of this will be part of the remit of a Superintendent Radiographer post currently being advertised within the Health Board.	Director of Operations	Directorate Manager	Dec-19	October 2020 March 2021 June 2021 August 2021 Now December 2021		In progress	July 2021 Update - Process underway to update and amalgamate all policies from two distinctive ones to a whole HB approach, with the potential for some local discretion. Regarding updated polices, yes all updated policies will be available on Sharepoint. In addition POW have developed an app for use by SpRs with all policies and help available on their mobile phones. Pilot in POW due to start with August new intake and expect to roll out for next rotation.	March 2020 Update - Test site created by E-Business team. Awaiting further direction from Directorate. July 2020 Update - Work continues led by Dr Ally Yates, Consultant Radiologist to review all policies and procedures. Radiology has its own 'policy for making policies' based on the Health Board version. As policies are being renewed they are being put in to the new format and agreed although formal governance meetings in Radiology have drifted during Covid. With regard to the Sharepoint site a quick dummy site with some new features was developed but no further progress has been made. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - A test site was set up in March 2020 and the process of reviewing all policies started in June 2020 led by Dr Ally Yates. The appointment of the Head of Radiography post will take place imminently and this will aid implementation. A plan outlining expected completion dates will be worked on by the meeting in June 2021. Covid-19 has meant that this process has lost momentum. May 2021 Update - A test site was set up in March 2020 and the process of reviewing all policies started in June 2020 led by Dr Ally Yates. The appointment of the Head of Radiography post will take place imminently and this will aid implementation - this post is going out for advertisement in July 21. A plan outlining expected completion dates will be worked on by the meeting in June 2021. Covid-19 has meant that this process has lost momentum.
RMA 05	Jul-19	Reasonable	1. Suitable arrangements to cover the Head of Radiology role should be put in place as a matter of urgency. 2. Senior management posts should be included in future succession / workforce plans.	High	1. Agree the previous Head of Radiography has gone on a 2 year secondment. A new Head of Radiography needs to be appointed, this will done via a HR process as part of restructuring required for the new Cwm Taf Morgannwg UHB. 2. Agreed the Quality Lead Role for Radiology is included in our IMTP investment as our number one priority.	Director of Operations	Directorate Manager	Sep-19	October 2020 March 2021 August 2021		Completed	July 2021 Update - Head of Radiology arrangements for cover in place – at RGH, PCH and POW. The posts are included in workforce plans going forward. Previous post holder is unlikely to return to CTM and has agreed for advertisement of permanent replacement for Head of role.	Quality Manager Role approved substantively. Still no progress with the Head of Radiography role due to organisational changes to ILG model. July 2020 update - The 'Head of Radiology' is the Professional Head (a Radiographer) rather than the Directorate/General Manager. We still do not have a formally appointed professional head for Radiology although Paul Johnston has continued to undertake the role. The Quality lead role was approved and advertised with no suitable applicants. It remains a priority but is on hold for discussion regarding management structures with the newly appointed General Manager. November 2020 Update - Point 2 - Reviews around the structure of the senior management and clinical leaders within the CSS CSG took place with the ILG directors in the last two weeks and the proposal is being costing and worked up for agreement. One off funding for an external management consultant to come and look at the workforce structure within pathology has been agreed for 2020/21 and this will be sourced in the next month. The intention of this piece of work is to identify what the structure of pathology needs to look like to be realistic and effective. This piece of work may require some careful mediation and support from WOD is being sourced. November 2020 Update Point 1 After a recent round of recruitment into the ILG, a Clinical Director for Radiology has now been confirmed across CTWUHB. A Clinical Service Group Manager for Clinical Support Services has also recently been recruited and supports the group from a managerial perspective. Agreement has just been reached within the ILG to recruit to a HCP Head of Radiology in the next couple of months and is just going through the process of JD, Finance agreement and selection processes. It is anticipated that this post will be an internal only appointment and is in relation to the Senior Superintendent positions January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus

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RMA 09	Jul-19	Reasonable	The Directorate should ensure that all staff are provided with the opportunity to undertake their mandatory training. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for noncompliance with a view to providing support where necessary.	Medium	Agree with the findings however would point out that training allocated to staff on ESR has been done poorly and with no consultation with the Directorate. Directorate is in close consultation with Learning & Development but progress is very slow from L&D.	Director of Operations	Directorate Manager	Dec-19	October 2020 March 2021 August 2021		Completed	July 2021 Update - Mandatory training is positively encouraged in the Directorate. There is a plan to improve performance if necessary and this is monitored monthly at the ILG Performance Meeting. This recommendation is now complete.	L&D are still working on this as they are aware of the issue not just in Radiology. July 2020 Update - Mandatory training continues to be reported however learning subjects on ESR are still allocated poorly. This has been raised on a number of occasions as it leads to incorrect statistics regarding the percentages for competency. Most recently raised at our clinical meeting and Workforce taking forward with learning and development. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. March 2021 Update - Mandatory training continues to be reported however learning subjects on ESR are still allocated poorly. This has been raised on a number of occasions as it leads to incorrect statistics regarding the percentages for competency. Most recently raised at our clinical meeting and Workforce taking forward with learning and development. The issue is being discussed with Business Partners and a plan is being developed – it will be available at the next Audit Meeting Current workforce gaps due to covid and shielding have made it difficult to release staff to carry out training. Where it is possible, staff are being supported to do so. May 2021 Update - Mandatory training continues to be reported however learning subjects on ESR are still allocated poorly. Site leads have now been asked to put together plans for ensuring that staff are able to access stat man training wihtin a reasonable timeframe. Plans are expected to be in place by 1 June Current workforce gaps due to covid and shielding have made it difficult to release staff to carry out training. Where it is possible, staff are being supported to do so and this will
Data Quality Patient Pathway Appointment Process (October 19) - Limited Assurance FOLLOW UP AUDIT UNDERTAKEN IN JANUARY 2021													
DQ 01	Oct-19	Limited	1. Directorate Managers need to: - Remind consultant, medical and nursing staff of the need to complete outcome forms for all patients seen. - Remind outpatient receptionists of the importance of inputting outcome forms on WPAS in a timely manner. - Remind Medical Secretaries to check that outcomes that have been input on WPAS align to outcomes as per dictated letters. Where necessary additional training should be requested to ensure that all staff are aware of their responsibilities in completing the above steps correctly. 2. Management should engage with the two directorates where the electronic outcome form was trialled to understand why it has been adopted in one area and not in the other. Following the conclusion of this engagement the Health Board should consider trialling the electronic outcome forms within all Directorates. 3. Consideration should be given as to how data can be captured to allow the calculation and monitoring of the proportion of patients whose outcome is not recorded on WPAS. **Updated Recommendation - 1. Clinical Service Group Managers need to:** **- Remind consultant, medical and nursing staff of the need to complete outcome forms for all patients seen.** **- Remind outpatient receptionists of the importance of inputting outcome forms on WPAS in a timely manner.** **- Remind Medical Secretaries to check that outcomes that have been input on**	High	We fully agree with all the recommendations and will incorporate this into our action plan. We intend to secure additional resource to assist in the monitoring and implementation of this action plan. A forum will be set up to oversee this work stream and detailed action plan. A process of 'cashing up' at the end of every clinic is required to ensure clinic and administration staff have processed the patients using the outcome form and WPAS. This process needs to include the initiation of diagnostic tests and request forms being processed to cut down on 'dead time' waits for diagnostics. This process needs to be mandated and managed by the clinic manager. Temporary administration and nursing staff need to undertake mandatory training in cashing up clinics. The Assistant Director of Scheduled Care together with the Assistant Director of Performance and Information will engage with the two directorates where the electronic outcome form was trialled to understand why it has been adopted in one area and not in the other. Following the conclusion of this engagement the Health Board will consider trialling the electronic outcome forms within all Directorates. An appointment with no outcome registered report needs to be circulated in order that administration managers can act on patients who have no outcome, validating the patient's position on the pathway. All staff need to understand the implications of failure to comply. Weekly reports need to be circulated to services including consultants with non-compliance addressed by relevant professional leads. **Updated Management Response - These recommendations are accepted, though the ownership at ILG level will be through the Hospital Service Managers.**	Director of Operations	ILG Acute Service Managers/Assistant Director of Performance & Information	Mar-20	01/02/2021 Now November 2021		In progress	July 2021 Update. Additional information received from Information colleagues to be escalated the ILGs immediately.	December 2020 Update - There has been limited progress in taking action to address the previous recommendations. The onset of Covid-19 clearly impacted on the UHB's ability to deliver elective activity, as it concentrated all its efforts in responding to the pandemic. As a consequence, the UHB lost the momentum it had built up through the establishment of a Planned Patient Flow Project to take forward both the recommendations of the Internal Audit report, as well as the those of the Delivery Unit report arising from their supportive intervention on waiting list management. As has been rightly pointed out by our Internal Audit colleagues, the PID did not make reference explicitly to two of the actions from their report (Findings 4 & 5) and whilst the PPF Project may not have been the right forum for aspects of Finding 4 (temporary secretaries), it should have made explicit reference to the action, especially given the focus on training. Finding 5 (watch list functionality) is not something that the UHB can amend and whilst we were seeking a response from NWIS regarding what might be feasible and over what timescale (current thinking is that this may well not be technically feasible), it is not documented within the PID as it should. IA colleagues have noted that a number of changes have occurred within the Health Board, as a result of turnover and ownership of the agreed actions within the report has not been clearly transferred to individuals now responsible for this area, which is accepted. My WPAS Team are still sending out regular reports to relevant departments requesting errors to be rectified and whilst the volume of errors reduced, this was linked to reduced activity during Covid-19, as opposed to any improvement, as noted by IA colleagues. We have not been able to focus on this over the last ten

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DQ 02	October 2019	Limited	1. Directorate Managers and their teams should review the report of patients recorded as being on a closed pathway to ensure that they are on the correct pathway. Day-case and inpatients should be moved back to an open pathway so that they receive the required treatment on a timely basis. 2. Analysis should be undertaken of the cases where the pathway has been incorrectly closed to identify if they are common to one directorate, department or person. Where necessary, further investigation should be undertaken to why these errors are routinely occurring and further training provided. 3. Consideration should be given to escalating the incorrectly closed pathway reports to ensure Service Group Managers and more senior staff within the Health Board are made aware of the ongoing issue. **UPDATED RECOMMENDATION - We have re-raised our original recommendations:** **1. Within each of the Directorates/ Clinical Service Groups, analysis should be undertaken of the cases where the pathway has been incorrectly closed to identify if they are common to one department or person. Further training should be provided within the respective areas.** **2. The incorrectly closed pathway reports should be escalated to ensure that Service Group Managers and more senior staff within the Health Board are made aware of the ongoing issue.**	High	We are fully in agreement with the recommendations and will incorporate this into the action plan response (see above). Recommend clinic outcome letters are an opportunity to validate patient outcomes, a SOP will detail the actions to be taken to achieve this. Where staff are unable to achieve the required standards, a performance monitoring process will be instigated. Agree there is a need for a regular monitoring report to be tabled at Directorate meetings for improvement purposes. **UPDATED MANAGEMENT RESPONSE - We agree with the recommendations, noting that the draft Data Quality** **Assurance Framework and the additional training material developed offer an opportunity to ensure staff are accountable for their actions and this will need to be reinforced through the new operating model. The Performance & Information Directorate will regularly carry out analyses to target additional training towards specific Directorates and/or individuals and escalate concerns to the ILG Hospital Service Managers. This will commence in the new year, with a regular process in place by the end of January 2021.** **The same risk regarding two instances of core operational systems having to be used by all ILGs applies.**	Director of Operations	ILG Acute Service Managers/Assistant Director of Performance & Information	Mar-20	01/01/2021 Now November 2021		In progress	July 2021 Update. Additional information received from Information colleagues to be escalated the ILGs immediately.	December 2020 Update - See above response. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. May 2021 - nothing further to report this month.
DQ 03	Oct-19	Limited	Directorate Managers need to ensure that Medical Secretary training is consistently applied including completion of the Referral to Treatment test. Refresher training should be provided on a regular basis in line with PDR requirements and targeted to those employees who are identified as having a higher numbers of input errors than expected. Where problems remain, consideration should be given to applying the appropriate Workforce and OD policy to manage the situation. **UPDATED RECOMMENDATION - The performance monitoring tool suggested by management at the time of our original audit should be developed as a means to identifying areas that need focused intervention.** **Clinical Service Group managers should request WPAS team training for those areas or individuals identified as having a higher numbers of input errors than expected.**	Medium	A performance monitoring tool will be developed to identify areas of focusedintervention with direct performance monitoring for the Directorate teams. **UPDATED MANAGEMENT RESPONSE - The updated recommendations are accepted and as per the previous** **recommendation, will be addressed through a performance management process initiated through the Performance & Information Directorate.** **The same risk regarding two instances of core operational systems having to be used by all ILGs applies.**	Director of Operations	ILG Acute Service Managers/Assistant Director of Performance & Information	Mar-20	Feb-21		Completed	July 2021 Update - The Information Department is always willing to undertake training - and has just completed work with Medicine and Pathology.	December 2020 Update - See above response. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. May 2021 Update - Nothing further to report this month,
DQ 04	Oct-19	Limited	Service General Managers together with Directorate Managers should consider reviewing the process for using temporary Secretaries within the Health Board to ensure that all receive WPAS training ahead of commencing in a role. **UPDATED RECOMMENDATION - Management should produce a risk assessment to determine the feasibility of Temporary Secretaries assisting in managing Waiting List (WL) data.**	Medium	Temporary secretaries should not be used to manage Waiting List (WL) data input unless fully trained and long term temps. We will carry out a risk assessment to determine the feasibility of this followed by agreed implementation when feasible. These personnel should be used for letter backlogs and typing. Administration managers must ensure staff are fully trained. **UPDATED MANAGEMENT RESPONSE - ILGs have a responsibility to make temporary secretaries known to the WPAS** **team once employed and are not to be given access to WPAS for pathway** **management until such time as they have been trained.** **The same risk regarding two instances of core operational systems having to be used by all ILGs applies, arguably though a greater challenge for temporary staff supporting clinical Directorates.**	Director of Operations	ILG Acute Service Managers/ Clinical Service General Managers	Mar-20	February 2021 March 2021		Completed	July 2021 Update - There are few temporary secretaries appointed - and when they are they are monitored by a Medical Secretary who is a substantive appointee. If they are deemed suitable for training then they will be trained - otherwise they will be deployed typing letters and normal tasks of that nature.	December 2020 Update - See above response. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. May 2021 - nothing further to report this month.

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DQ 05	October 2019	Limited	The process for monitoring patients who are awaiting diagnostic investigation results should be reviewed to ensure all Medical Secretaries are utilising a standard approach that is user friendly and does not restrict access, thus allowing visibility to other staff members. **UPDATED RECOMMENDATION - 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	A review of this process and guidance will be carried out, potentially with external support to assist and add pace to the review. Consistent guidance and emphasis on use will then be provided. Management teams will ensure that locally held spreadsheets are not replacing the mandatory addition to the formally report QL. Request internal audit re-assessment of this in next year's audit plan. **UPDATED MANAGEMENT RESPONSE - A technical assessment on the potential upgrading of watch list functionality to facilitate performance management of Medical Secretaries will be commissioned.**	Director of Operations	Assistant Director of Performance & Information/ Assistant Director ICT	March/April/May 2020	February 2021 March 2021 August 2021 Now October 2021		In progress	July 2021 Update. No change reported.	December 2020 Update - See above response January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. May 2021 Update - Nothing further to report this month.
Consultant Job Planning (October 19) - Limited Assurance													
CJP 01	October 2019	Limited	1. The Health Board should develop an approach to ensure that all consultants and SAS doctors have an up to date job plan that is reviewed on an annual basis. In developing their approach, the Health Board should consult with consultants, SAS doctors and their line managers to identify the barriers that are currently preventing the timely completion and sign-off of job plans. 2. The Health Board should ensure that there are sufficient resources available so that job plans follow the 'lock down' process where the job plans are not formally signed-off in good time. The Approach should be consistently applied across all sites.	High	1. Job planning does not necessarily require a face to face review if the plan agreed the previous year remains satisfactory. That said personal and organisational objectives need to be agreed for the year and can be signed off if non-contentious. 2. Job plan compliance is a standard agenda item at the Clinical Business Meeting (CBM) held with each directorate. The HR business partners are present at the CBMs to understand what if any barriers there are to job planning. The data is also reported through Finance Performance and Workforce Committee via the Board. 3. We acknowledge that there are many job plans which are out of date and /or not signed-off and this will be addressed by either through refreshed directorate training or Medical Director intervention. 4. Likewise, refreshed training is to be rolled out to Princess of Wales to ensure a consistent approach.	Medical Director	Acting Workforce Operational Lead	Mar-20	March 2021 December 2021		Part Completed	July 2021 update - A job planning SOP is now in place and available for staff to use. Job planning rates have doubled since the lowest point in Jan 2021. There is still significant work required in this area as the rates are still very low, which is being hampered by the ongoing problems associated to the pandemic and now the switch to planned recovery work. Job planning is not being prioritised, as the clinical delivery is.	January 2020 Update - Currently there is a gap in training and knowledge of the system in the new areas of CTM. This has started being addressed with training in POW for clinical directors (CD), directorate managers (DM) and assistant directorate managers (ADM) on the 19 December 2019. It has been identified by users of the system, that they feel there is no access to guidance on how to use the system after the training. A standard operating procedure (SOP) will be developed in conjunction with Allocate for users to be able to access when there are questions about how to use the system post training. Allocate have provided a user guide that will be adapted into a CTM specific SOP. There is a need for a spread of responsibility for job planning outside the current CD/DMs tasked with its completion. It is particularly relevant in the areas such as medicine where there is a high amount of medics to job plan for. This is to be supported in the training provided and needs to be factored into each directorates plan on deciding the amount of trained staff needed to have sufficient capacity to meet the demand. July 2020 update - Job planning has been placed on hold for the duration of the Pandemic. We are currently in a situation where very limited job planning activity is being undertaken. This means that compliance is deteriorating. Training was and has been completed in all of the ILGs, though there was very limited engagement even though there was a wide set of staff and medics contacted to let them know the training was being run. An SOP has been developed in conjunction with the guides inside eJP and will be shared with users for comment. The wider spread of responsibility is still desirable, however due to the lack of engagement with the training and the changing structures within the UHB due to the development of the ILGs, it is hard to determine currently who the additional persons involved should be. November 2020 Update - a) The produced job planning compliance report is now distributed via the WOD packs to the ILG management teams monthly. In addition to this,

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CJP 02	Oct-19	Limited	1. The notes section in the Allocate system should be used to record reasons for deviations from the standard Welsh Government consultant's contract and guidance. For example, where there are more or less than 10 weekly sessions in total, or there are more than 3 weekly SPA sessions. 2. A plan should be developed to ensure all PoW consultants and SAS doctors' job plans are reviewed and updated as soon as is practicably possible to align with the new Health Board's objectives. 3. Staff carrying out job plan reviews should ensure that all SPA activity is sufficiently detailed, that Health Board outcomes are linked to IMTP objectives, and that meaningful Service or Directorate outcomes are recorded in all job plans. This may be achieved by providing tailored training to staff responsible for conducting job plan meetings and reviews. 4. Health Board guidance should be provided detailing how breaks should be factored into timetables.	High	1. Clinical sessions which exceed the contractual norm are relevant as determined by the business area, based on clinical requirements. This will also have implications for continuity and safety of clinical care. The additional sessions are also more cost effective for the Health Board as opposed to agency locums. The reasoning behind additional clinical sessions needs to be clear in the job plan. This will be emphasised as part of the updated training package. 2. As soon as the Health Board's operating model and subsequent objectives agreed, all Health Board objectives will need to be revisited through the annual job planning cycle. In the interim, existing job plans for Doctors in PoW will rollover into the next cycle. 3. The appropriate recording of SPA activity and linking to subsequent Health Board outcomes will be highlighted in the reviewed Health Board training material. 4. The Health Board is very clear about the rest break requirements under EWTD. The reason why breaks are not necessarily included is due to the flexibility required for the individual, as all job plans are variable and negotiated in accordance to service need. The requirement to take rest breaks will be further emphasised in the updated job planning training.	Medical Director	Acting Workforce Operational Lead	Nov-19	March 2020 April 2021 May 2021 August 2021 Now October 2021		In progress	July 2021 update – No further update. Awaiting ratification and agreement of guidance.	January 2020 Update - Recording of reasons for differences to guideline amounts of direct clinical care and supporting professional activity splits is variable. Differences to guidelines are acceptable and allowed, but training will need to be provided and referenced in the SOP to ensure the reasons for differences are captured in future. There is some historical differences between sites on the split, this will have an agreed approach for all sites from January onwards for new job plans. June 2020 Update - SPA/DCC split guidance – This was developed between medical workforce, Vijay Singh and Sarah Spencer. It is currently awaiting review at the LNC before wider distribution. Due to Covid19 this has stalled due to no LNCs taking place. July 2020 Update - No chnage to the position. September 2020 Update - The Deputy Medical Director and Assistant medical Director revisited the guidance developed by Dr V.Singh. This was matched and referenced against other organisations policies as well as taking royal college guidance into consideration. This has now been brought to final draft in preparation to be taken to the LNC. This will be shared at the next LNC in November before roll out to the UHB. November 2020 Update - a) There has been a delay in full roll out of incorporating all of the Bridgend ILGs job plans into eJP with updated CTM objectives, thus is due to the onset of the pandemic and pausing of job plan reviews with most staff. This will be picked up and moved forwards when business as usual returns to the ILG. b) The operating model for the UHB is now in place and this has been incorporated into the eJP software to match the new structure. c) SPA and DCC guidance has been developed by the AMD for Medical Workforce. This underpins the application of SPA within the job planning process and will be reflected in the notes in eJP. The implementation date should be extended due to complication from the pandemic. It is likely to take an
CJP 03	Oct-19	Limited	Staff conducting job planning meetings and annual review meetings should ensure that all job plans include personal outcomes that are sufficiently detailed and measurable, and in line with personal outcomes and targets agreed as part of the annual review process. Progress against personal outcomes should be monitored and recorded in line with the Health Board's guidance.	High		Medical Director	Acting Workforce Operational Lead	Nov-19	March 2021 December 2021		In progress	July 2021 update – Job planning SOP now in place. Awaiting agreement of DCC/SPA guidance.	January 2020 Update - The report links the need for personal outcomes to be in the Job plans. This is contrary to what the organisation had seen what Job plans are for. There should be a record of clinical outcomes recorded and referenced, but personal outcomes are for the appraisal and validation process rather than job planning. July 2020 - No change, work has stalled around this due to Covid19. November 2020 Update - Guidance is currently being developed by the AMD for Medical Workforce. No extension needed. January 2021 Update - Personal outcomes are part of appraisal and validation process rather than job planning currently. As part of the job planning training, clear personal outcomes will be factored into the process and now recorded in new job plans. The training that has been rolled out across the UHB covered this. The updated SPA/DCC guidance on this is awaiting comment from the LNC. As previously mentioned, the LNC has not met recently due to the pandemic and dates for the next meetings have not been arranged as of yet. The completion date has been revised to December 2021. March 2021 Update - Personal outcomes are part of appraisal and validation process rather than job planning currently. As part of the job planning training, clear personal outcomes will be factored into the process and now recorded in new job plans. The training that has been rolled out across the UHB covered this. The updated guidance on this was shared with the LNC in February 2021 and a number of amendments were suggested. These have been taken on board, worked into the document where appropriate and will be shared with the LNC at the next meeting in April. May 2021 Update - No further update to provide

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CJP 04	October 2019	Limited	1. An exercise should be undertaken to match the number of sessions from job plans to the payroll for all current consultants and SAS doctors to identify any discrepancies and any potential over or under payments to staff. All discrepancies should be investigated. 2. The current process for updating the payroll with changes to salaries arising from job plan changes should be reviewed to ensure it happens in a timely manner when a plan is signed-off or proxy signed-off. 3. A process should be established for notifying the payroll section of all new job plans and job plan changes for PoW based consultants and SAS doctors. 4. The job planning guidance refers to recording all information in relation to the plan in the e-job plan (Allocate), therefore where plans are created outside of the system, the Allocate system should be updated to reflect this.	High		Medical Director	Acting Workforce Operational Lead	November 2019/April 2019	February 2020 March 2021 May 2021 July 2021		Completed	July 2021 update – The new SAS contract for Wales has changed the remuneration calculations for SAS doctors. This means that this particular problem is no longer relevant, as the eJP software is being changed to use the new calculations. This will then be compared to a paper exercise to see if there is a significant difference present.	January 2020 Update - There is a difference between Allocate and manual Anaesthetics, critical care and theatres (ACT) SAS doctor calculations in regards to session amounts. This is due to ACT using a manual calculation for their sessional data, because there is a belief that Allocates software is not producing the correct data in this area. There are discrepancies between some of the data in the organisation in regards to payments. So a whole organisation review will be undertaken to see how wide spread this is by medical workforce to identify the extent of it. June 2020 Update - Discrepancies in payments/job plans – An organisational review was undertaken. Outside of ACT, only 2 Medics had 'incorrect' salary amounts according to their job plans. ACT has discrepancies due to the Allocate software not calculating the sessional allowance for their work rotas correctly. Allocate have been unable to correct this thus far. July 2020 - No change. Allocate still unable to correct. November 2020 - a) The exercise for matching the sessions against payroll is complete and any discrepancies have been rectified. b) Payroll will only now be informed to change pay for staff with completed and up to date job plans on eJP. The salary is then matched to the session data in eJP. No extension needed. January 2021 Update - Allocate have had an initial meeting with Workforce and Anaesthetics, Critical Care & Theatres (ACT) to investigate why there is a difference in the sessional calculations being produced by eJP to the internal systems used by ACT. They are returning with their findings at the end of January and will give a way forwards to solve the problem. The completion date has been revised to March 2021. March 2021 Update - Workforce have met with Allocate and Anaesthetics, Critical Care & Theatres (ACT) to investigate why there is a difference in the sessional calculations being produced by eJP to the internal systems used by ACT.
CJP 05	Oct-19	Limited	1. Directorates should ensure that all 'Additional Duty' hours are authorised in advance of being worked. Authorisation should incorporate confirmation that a check has been carried out to ensure consultants are not already scheduled (according to the job plan) to work during proposed Additional Duty hours. Furthermore, the check should encompass ensuring that working the additional shift does not mean the consultant is then working 'back to back' shifts or cancelling DCC sessions to undertake the shift. 2. A single standard claim form should be used for ADH claims. Any system utilising electronic claim forms should contain the same data and claimant declarations as manual paper claim forms. Claimants should be required to confirm that they have not cancelled planned DCC sessions to undertake ADH.	High	The Health Board are currently reviewing the ADH process with a view to driving all ADH arrangements through an e-system, as part of the development on an internal locum bank model. This model will address each of the recommendations noted.	Medical Director	Acting Workforce Operational Lead	Apr-20	May 2020 September 2021 Now March 2022		Part Completed	July 2021 update – The medical bank software/app solution has now been launched successfully in the Bridgend ILG. This addresses the concerns in this point for Bridgend ILG. It will be launched in the remaining ILGs over the remainder of the financial year, which will address the problem across the whole of the UHB.	January 2020 Update - There has been a check completed this month on ADH payments and amount of ADH being worked in the organisation. This data is being used to harmonise rates across the HB and to develop a bank system. The standardised ADH rate and bank solution will be in place by the new financial year. June 2020 - An ADH rate card has been produced for all specialties and sites. A sign off process has also been produced. This is still manual in nature though. A project team has been setup to introduce the 'electronic' Medic bank, but due to C19 this has stalled. July 2020 Update - A paper has been submitted to the Management board for approval of the Bank project. A result is being awaited from this to move forwards with. Once agreed and in place, the bank adress all outstanding issues. November 2020 Update - a) An electronic solution to ADH shifts being made available is being implemented within the UHB. This begins its initial roll out in the Bridgend ILG the end of November 2020. This will allow for accurate recording, auditing and allocation of ADHs. This will eventually be the only method that ADHs can be worked, so therefore ensuring there is clear visibility of all future ADHs being undertaken within the UHB. No extension needed. January 2021 Update - A revised standardised rate card has been produced in collaboration between medical workforce, finance, the AMD for Medical Workforce and the Medical Director. This is now under review to ensure it fits in with comments received about the last version from the ILGs. A financial control procedure has been produced and approved. Within this is confirmation of a standard rate card development for payment of ADHs. Following publication of the ADH rate card, it was determined that further work was required on it, to review the proposed rates, following extensive feedback from Medical colleagues and the LNC.
Pathology Compliance (January 2020) - Reasonable Assurance													

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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	Previous Updates
PC 01	Jan-20	Reasonable	An inventory of non-capital assets should be developed by Clinical Haematology detailing their assets, which fit under the definition of the inventory as detailed within the FCP. Inventories should be reviewed to ensure that they hold all of the relevant information as laid out in the Health Board's FCP.	Medium	An inventory of non-capital assets will be developed for Clinical Haematology in line with the FCP.	Director of Operations	Directorate Manager	Apr-20	September 2020 March 2021 May 2021 July 2021		Completed	July 2021 Update - There is very little equipment in Clinical Haematology and what is held in IT kit. All IT kit is held on a Fixed Asset Register. This action is now complete.	June 2020 Update - Not Started: on hold due to COVID-19 pressures, target date has been amended to September 2020. September 2020 Update - The Clinical Haematology services will be repatriated from the WWIC to Ward 15 (PCH) and Tirion Centre (RGH) at the end of September 2020. After a period of settlement we aim to complete this work by the end of October 2020. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. March 2021 Update - This will be picked up as a priority and reported on at the end of April 2021. Service Manager to lead on this. May 2021 Update - This will be picked up as a priority and reported on at the end of June 2021. Service Manager to lead on this, but delayed due to UKAS and nurse manager absence. Will be completed by end Jun 21
PC 03	Jan-20	Reasonable	Whilst it is appreciated that determining the number of tests that will be required to be provided in a year may not be possible, where services are being provided by the Health Board to other health boards in Wales and income is generated as a consequence, SLA's should be in place and approved in line with the Scheme of Delegation.	Medium	SLA's to be developed for work received in line with scheme of delegation.	Director of Operations	Directorate Manager	Apr-20	September 2020 March 2021 May 2021 August 2021		Completed	July 2021 Update - SLAs are in place with all partners. The SLAs are being reviewed at present with the Planning Department, and the intention to do so is included in the IMTP. This action is complete.	SLA's currently in development with assistance of Quality Team. June 2020 Update - In Progress: Departments that generate income are currently developing SLA's, however this is likely not to be compelted bt April due to other comittments relating to COVID -19. Target date has now been amended to September 2020. September 2020 Update - SLA's with C&V and with Harp funeral directors have recently been scrutinised and reviewed. C & V now signed and Harp Funerals ceased. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. March 2021 Update - This will be picked up as a priority and reported on at the end of April 2021. Service Manager to lead on this. May 2021 Update -SLAs are being reviewed and approved via CSGM with clinical input from individual services. UKAS inspection approved work already done on these.
Digitisation (January 2020) - Reasonable Assurance													
DIG 01	Jan-20	Reasonable	The organisation should seek to increase the level of resource into key areas of the project.	High	Work is now under way to fill the vacant training, testing and system supportroles, via a combination of agency and substantive staff. The individual responsible for the 4 work-streams (Project Manager) has a dual role but this is in two consecutive stages; as project manager prior to go-live, becoming Cito Systems Manager on go-live. The substantive roles being recruited now are the Cito system support staff, working to the Cito Systems Manager. Each of the 4 work-streams has a manager, all of whom report to (or work with) the Project Manager. The majority of the project management work will have been completed by go live, therefore the overlap of project management and system management work is not anticipated to continue beyond the short term	Director of Operations	Programme Manager	Dec-19	September 2020 March 2021 May 2021		Completed	July 2021 Update - CITO has now gone live and is progressing. Action completed	July 2020 Update - Shortlisting under way for substantive staff. Go-live decision pending Project Baord August. ECMG approval of revised costs required at August meeting. September 2020 Update Recruitment ongoing for substantive posts; interviews to date have been unsuccessful. Posts revised and interviews are scheduled shortly. External contractors are now funded and will be engaged appropriately before go-live. Project resourced as required. December 2020 Update - 2/12/20. Update:1 Band 4 now in post. Band 6 re-adveertised again; being shortlisted this week. External contractors to be engaged Jan 21 - resourced as required. ILG Clinical and Operational Leads now being engaged, Clinical Assurance Group to be revived. July 2020 Update - Contractors recruited (since terminated). Recruitment commenced - ongoing. Plan for re-engagement of contractors developed, for implementation when we have a confirmed go-live date. July 2020 Update - Covid disruption to project progression. January 2021 Update There has been some progress - though covid has caused significant disruption. March 2021 Update - The band 6 post did not attracted staff of sufficient experience. The decision was made to employ a band 5 for one year to build the e forms and to fund a rebanding of a technical post in infrastructure to cover DPN. The go live is now 18th March due to a delay in NWIS time when they were pulled into a COVID issue that required resolving. An update will be available at the next meeting of the Committee.
DIG 01	Jan-20	Reasonable	The organisation should seek to increase the level of resource into key areas of the project.	High	Work is now under way to fill the vacant training, testing and system supportroles, via a combination of agency and substantive staff. The individual responsible for the 4 work-streams (Project Manager) has a dual role but this is in two consecutive stages; as project manager prior to go-live, becoming Cito Systems Manager on go-live. The substantive roles being recruited now are the Cito system support staff, working to the Cito Systems Manager. Each of the 4 work-streams has a manager, all of whom report to (or work with) the Project Manager. The majority of the project management work will have been completed by go live, therefore the overlap of project management and system management work is not anticipated to continue beyond the short term	Director of Operations	Programme Manager	Dec-19	01/01/2021 May 2021		Completed	July 2021 Update - CITO has now gone live and is progressing. Action completed	There has been some progress - though covid has caused significant disruption. March 2021 Update - The band 6 post did not attracted staff of sufficient experience. The decision was made to employ a band 5 for one year to build the e forms and to fund a rebanding of a technical post in infrastructure to cover DPN. The go live is now 18th March due to a delay in NWIS time when they were pulled into a COVID issue that required resolving. An update will be available at the next meeting of the Committee.
IG Arrangements Community & Mental Health (January 2020) - Reasonable Assurance													

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IGCMH 01 (a)	Jan-20	Reasonable	The records management strategy and policy should be reviewed and updated accordingly to incorporate changes in legislation, the impact of the boundary change and the future vision for records management within the Health Board. Once reviewed and approved staff should be made aware of the revised policy and strategy.	High	The Health Board needs to review and implement a current records management strategy with a regular review date. There is an Information Governance policy in place which sets out legal obligations. A revised Records Management Strategy and Policy needs to be developed and approved by the ICT & Information Governance Committee being established in January 2020.	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk Head of Information Governance	Sep-20	March 2021 July 2021		Completed	July 2021 Update - The Digital and Data Committee approved the Records Management Policy at its meeting on the 12th July 2021. The policy has now been published on Sharepoint. A Records Management Procedure has also been developed and was approved by the Management Board on the 19th May 2021.	October 2020 Update - The September deadline needs to be pushed back to March 2021 as we have not reviewed / updated the records policy during the last few months due to the COVID position. November 2020 Update - In Progress – policy being drafted benchmarking with other Health Boards in Wales to ensure a consistent approach. Review will be led by the Information Governance Team in conjunction with the Health Records team in relation to patient records. The policy will be received at the Information Governance Group in December and will seek approval by the Digital & Data Committee thereafter. March 2021 Update: Records Management Policy currently at consultation stage and comments being sought from Medical Records and Clinical Audit colleagues. Draft will be received at the Information Governance Group in April 2021 to endorse for approval at the following Digital & Data Committee in July 2021. Update May 2021: The Records Management Procedure - COMPLETE - Approved at the Management Board on the 19th May 2021. The Records Management Policy is scheduled for approval at the Digital & Data Committee on the 8th July 2021.
Medical Equipmant and Devices Follow Up (February 2020) - Reasonable Assurance													
MED FUP 03	Feb-20	Reasonable	While we understand that currently, the department does not have the resources to undertake a reconciliation of equipment that has been loaned to wards, consideration should be given to undertaking periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system.	Medium	1. Band 2 Equipment library Job Description is now matched – to be uploaded and advertised on TRAC to appoint staff. This will then enable periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system to be undertaken. 2. Continued use of partial RF-ID system to be utilised with confirmation that data connection to RAM 5000 can be completed. 3. SON to be submitted to Capital for increased RF-ID system coverage for RGH (£244.8K), early indication from Capital is that a more detailed business case will be required as roll out to other sites is also required.	Director of Operations	Assistant Director of Facilities	Apr-20	September 2020 April 2021 July 2021 Now March 2022		Part Completed	3. July 2021 Update - Wi-fi connectivity issues at POW are now resolved. ICT issues with scanning via handhelds has been resolved. Mapping locations is no longer viable under current circumstances with ward moves etc. Department lists will be used instead on Version 2 of software. Fixed reader points have been installed at RGH for extended coverage for oxygen cylinder tracking and bed store equipment. Supplier awaiting approval for remote access (to update and set system up to Version 2 of software and database) from ICT. Access issues for the tracking system on Citrix at POW need to be resolved with ICT. Quote received to apply fixed reader points to fully cover RGH site as next phase and will now be submitted to Capital for funding. Lead member from Clinical Engineering has now left the organisation, which has made planning and implementing the above works difficult. Based on the above updates, the target date has been moved to 31/03/2022. (WG DW 20/07/2021).	1. April 2020 Update - B2 equipment library post - advertised – undergoing shortlisting. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 2. April 2020 Update - RF-ID –limited area in use – no further work done - however attempting to obtain further funding through technology funds from Welsh government in meanwhile. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 3. April 2020 Update - RF-ID –limited area in use – no further work done - however attempting to obtain further funding through technology funds from Welsh government in meanwhile. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 1. July 2020 Update - Interviews held. Recruitment checks in progress for successful candidiate (WG 02/06/2020). Start date confirmed as 20/07/2020 (WG 16/07/2020). 3. July 2020 Update - Business case to be developed for submitting to Capital/Finance to support phased approach to implementation on each site, with request from Finance to be revenue neutral. (WG 09/06/2020). 3rd draft of business case paper to be finallised with various options and costs for funding (WG 16/07/2020). 3. September 2020 Update - SON submitted to Capital and DOF on 30/07/2020, awaiting prioritisation and decision on funding. WG advised that target date has been amended to reflect this update, date amended to 31/03/2021 (DW 28/08/2020). 2. July 2020 Update - Identified costs in IMTP, some work performed by supplier for COVID equipment tracking for mapping sites. Equipment that is tagged will now update 'Last known location' field on RAM each night in background process if within areas with antennae or by using hand held device. Complete (WG 09/06/2020). 1. Role now in place. Complete (WG 28/08/2020) January 2021 Update - Additional hand-held devices have now been ordered and delivered. Further work is in progress by the supplier to implement the site mapping for the devices to be functional on PCH and POW sites. Further purchase orders are to be submitted for additional works and installation, presentation to be provided at next
Nurse Agency Usage (April 2020) - Reasonable Assurance													
NAU 01	Apr-20	Reasonable	1. Clarity should be provided as to whether the Staff Bank Policy Induction Checklist (Appendix C) should be completed or the more recently revised 'Ward induction checklist for bank and agency workers'. 2. Ward Managers / the Nurse in Charge should be reminded of the importance to complete the induction checklist to ensure that new agency nurses are appropriately orientated and provided with relevant health and safety overview of the ward they are due to work on.	High	Induction check list to be reviewed and agreed by Heads of Nursing. Ward Managers & Senior Nurses to receive updated check list that must be completed for all new Bank and agency nurses. Updated Bank/Agency Nurse Induction Checklist to be included into the revised Staff Bank policy.	Director for People	Head of Corporate Nursing	March 2020/April 2020/August 2020	February 2021 June 2021 Now September 2021		In progress	July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September.	November 2020 Update - The Bank Policy is being updated during December 2020/Januay 2021. The updated policy will consist of a review and update of all the bank and agency forms. January 2021 update - Policy has been completed and is awaiting review by policy sub groups. APRIL 2021: Amendments came back via policy infrastructure, which will be incorporated into the policy draft for approval. This will be taken through the Health Board's policy group by Jun-21. Revised implementation date provided.

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NAU 02	Apr-20	Reasonable	1. The Bank / Agency Nurse Quality Monitoring Form should be reviewed to ensure it is fit for purpose and provides a suitable means for the routine monitoring of the quality of work provided by agency staff. 2. Ward Managers should be reminded of the need to complete the quality monitoring form and returning it to the Bank office as a means of formally evaluating the performance of agency nurses and aiding and informing any future acceptance or rejection of potential agency nurses in the event of query or concern. 3. The Clinical Incident Reporting for Agency Staff flowchart and the Staff Bank Policy should be reviewed to ensure consistent guidance for managing and monitoring issues relating to the quality of	High	Revised Clinical Incident Reporting flowchart to be placed into the Staff Bank Policy. Bank / Agency Nurse Quality Monitoring Form will be reviewed to ensure it is fit for purpose and amendments made for updated policy in August 2020. The cross-referencing of patient experience and agency use data is something that we will look into. In the first instance we will need to see if data in relation to patient experience can be obtained from colleagues in the Health Board and we will look to see if meaningful reports can be produced. In the mean-time we will continue to review specific concerns that have been raised via our routine processes.	Director for People	Head of Corporate Nursing	Aug-20	October 2020 February 2021 June 2021 Now September 2021		In progress	July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September.	July 2020 Update - The policy will be written in September 2020, which will coincide with the change in recruitment processes for staff bank workers. Roll out and publication of the policy will be completed by end of October 2020. November 2020 Update - The Bank Policy is being updated during December 2020/Januay 2021. The updated policy will consist of a review and update of all the bank and agency forms. July 2020 Update - Due to outbreak of covid-19 and consequent pressure on staff bank to recruit additional bank workers to support exsisting and new HB services has meant a delay in starting this policy. January 2021 Update - No further chnage/update. APRIL 2021: See above for policy amendments. Remaining recommendations delayed due to the pandemic but will be taken forward in the same timeframe as the policy approval. Revised implementation date provided.
NAU 03	Apr-20	Reasonable	1. The Staff Bank Policy should be reviewed and updated as necessary to reflect current practice, process and systems in place within the Health Board. The policy should more explicitly reference the engagement and management of agency nurses as opposed to just focussing on Bank staff. 2. Where other relevant policies exist, such as the Rostering Policy, these should be cross-referenced within the Staff Bank Policy. 3. Where procedures are developed to supplement existing policies, reference should be made to the overarching policy and if	Medium	The Staff Bank Policy will require updating to include the Collaborative Bank project which is due to commence in April 2020. The updated version will include appropriate references to the UH Rostering Policy. The updated policy will include: - The updated 'Booking Bank & Agency Nurses - Procedures for Ward Managers' - The new Request for Thornbury Nurses proforma. - The updated e-datix reporting algorithm The following documents will be recirculated to	Director for People		March 2020/April 2020/August 2020	October 2020 February 2021 June 2021 Now September 2021		In progress	July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September.	July 2020 Update - The policy will be written in September 2020, which will coincide with the change in recruitment processes for staff bank workers. Roll out and publication of the policy will be completed by end of October 2020. November 2020 Update - The Bank Policy is being updated during December 2020/Januay 2021. The updated policy will consist of a review and update of all the bank and agency forms. July 2020 Update - Due to outbreak of covid-19 and consequent pressure on staff bank to recruit additional bank workers to support exsisting and new HB services has meant a delay in starting this policy. Jan 21 update - Policy has been completed and is awaiting review by policy sub groups. APRIL 2021: See above for policy amendments. Remaining recommendations delayed due to the pandemic but will be taken forward in the same
NAU 04	Apr-20	Reasonable	1. A review of the Temporary Nursing & Midwifery Staffing Decision Checklist (Appendix 5) contained within the Roster Policy should take place to ensure all aspects remain relevant. Consideration should be given if the checklist needs to be completed for every shift filled by an agency employee or if one checklist could be completed covering all agency shifts needed on a week's	Medium	Appendix 5 in the Roster Policy will be replaced with the updated 'Booking Bank & Agency Nurses -Procedures for Ward. Heads of Nursing to ensure the checklist is re-circulated to Ward Managers and Senior Nurses emphasising the importance of the completion of the check list for all new bank and agency nurses to the ward areas/department.	Director for People	Head of Corporate Nursing	April 2020/May 2020	August 2020 February 2021 June 2021 Now September 2021		In progress	July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September.	Appendix 5 has been sent through to the workforce polict review group for the change to be made to the roster polocu it is in the agenda for the aug meeting. November 2020 Update - The Bank Policy is being updated during December 2020/Januay 2021. The updated policy will consist of a review and update of all the bank and agency forms. Jan 21 update - Policy has been completed and is awaiting review by policy sub groups. APRIL 2021: The Rostering Policy has been updated and is currently in the system for approval. A new Rostering Group has been
Cyber Security Follow Up (June 2020)													
CSFU 03	Jun-20	Reasonable	**Original Recommendation** - A formal patch management procedure should be developed that sets out the mechanisms for patching / updating all items within the Health Board. **Updated Recommendation** - A formal patching strategy and SOP should be developed for the patching process that sets out the mechanism and processes for this.	Medium	**Original Management Response** - Formal patching strategy is being put in place and will be submitted to Digital Strategy Steering Group (DSSG) in June. **Updated Management Response** - A formal patching strategy and SOP are currently being worked on and should be ready to publish by July 2020.	Director of Public Health	Assistant Director of ICT	Jun-19	July 2020 December 2020 May 2021 July 2021 Now September 2021		In progress	July 2021 Update - A policy and procedure will be presented to the RAGCSB August meeting.	**Current Position** - We note that the process for patching has been amended, with a rota in place for patching of servers. We also note that the Health Board has purchased the Ivanti patch management solution to help improve the patching process. However, at present there is no strategy as stated in the initial management response, and no standard operating procedure (SOP) in place for the patching process. Based on the progress made and the evidence that we reviewed we consider the original recommendation to be partially implemented and have reclassified the remaining elements as Medium priority. July 2020 update - DT & AE drafting patching policy, summary of patching completed but yet to be finalised and produced as SOP. Expected to be finalised by end of August 2020. August 2020 Update - Due to the pressures of Covid 19 and the resources required for the roll out and ongoing maintenance of Microsoft 365, the timescale has been reset to December 2020. January 2021 - work is continuing on the patch management procedure. March 2021 - a draft procedure is in progress and will be presented to the RAGCSB to review at the April 2021 meeting. May 2021 - there has been a delay in completing the procedure due to work pressures, date has been extended to July 2021.

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CSFU 04	Jun-20	Reasonable	**Original Recommendation** - A formal, resourced plan for the removal of old software and devices should be established. **Updated Recommendation** - The remaining areas of old software should be identified and formally reported to the DSSG / committee, noting where software cannot be easily removed and the associated risk. Linked to this a formal plan for removing /updating old software within the resource constraints should be defined.	Medium	**Original Management Response** - The existing plan will be updated and brought to DSSG for formal approval in June. **Updated Management Response** - A formal risk analysis and remediation strategy is currently being developed which will be presented to the DHSSG by September 2020.	Director of Public Health	Assistant Director of ICT	Jun-19	September 2020 November 2020 May 2021 August 2021		In progress	July 2021 Update - Work is continuing on eradication out of date operating system software. There is approximately around 500 devices left to either update or replace.	**Current Position** - Work to remove old software is part of the general procedures. As new systems are brought on line the older servers are removed so the process is largely led from the bottom up rather than top down and there is no formalised plan to remove old versions of software. We note that old versions of key software such as Java / Windows Server / Windows are still used as they are supporting a vital component of the service and as such the Health Board has removed and updated as much as possible without updating these core applications themselves. We note that there is ongoing work to reduce the risks associated with old software, with older versions of Firefox being removed from desktops. We further note that initial discussions are ongoing over the use of Kapersky to block unofficial and old software within the Health Board. Based on the progress made and the evidence that we reviewed we consider the original recommendation to be partially implemented and the remaining elements remain as Medium priority. August 2020 Update - Work has commenced within the infrastructure team, to address the server operating systems to ensure that all servers are on at least Server 2016 operating systems. An end user device sub group has been formed and will have its first meeting this month to discuss a astrategy of ensuring that Windows operating systems are on the most up to date version. The timescale has been set back to November 2020. January 2021- work is continuing within the working groups to ensure that outdated software is addressed. March 2021 - a formal report and remidiation strategy and will be presented to the RAGCSB to review at the April 2021 meeting. May 2021 - the RAGCSB did not meet in April due to members being unavailable. A Head of End User Computing (EUC) has been appointed and is discussions with Dell on procuring their services to update end of life software (specifically Windows 7). The Head of Server Management recently had a meeting with various Clinical Systems Managers and a plan is in progress of removing/replacing end of life operating systems.
CSFU 05	Jun-20	Reasonable	**Original Recommendation** - The organisation should provide additional resource for a minimum defined period to allow for the data communications team to improve network security. **Updated Recommendation** - Work should continue to improve the network security of the Health Board. Following the firewall audit, the firewall rules should be amended to increase the security position.	Medium	**Original Management Response** - Data communications security will be addressed by the new posts discussed in finding 2. **Updated Management Response** - The firewall audit has been received and confirmed as accurate. Work has commenced in addressing the recommendations highlighted in the audit. The Cyber team have received the Cisco Implementing Advanced Cisco ASA Security and will be addressing the firewall rules starting in June 2020.	Director of Public Health	Assistant Director of ICT	Jul-19	June 2020 December 2020 March 2021 July 2021 Now August 2021		In progress	July 2021 Update - The Skybox server has had to be rebuilt as the configuration ISO was out of date. There has been a few issues with the configuration, however the contract will not commence until the software is up and running.	**Current Position** - As noted above, resources have been provided for cyber security and one of the posts is within the server team. The current position with the firewall is that the rules have not been changed to restrict access from NHS Wales, however in order to improve the security of the Health Board, a company has been engaged to undertake a firewall audit. The purpose of this is to look at the firewall configuration and rules, which will form the basis of the control moving forward. We note that control over changes to the firewall rules is moving to the cyber security team with training for the cyber security team booked with Cisco in order to do this. The process for changing the firewall rules has been improved with a standard form in place for requests, which are channelled through the cyber team for approval before being discussed and agreed at the Change Advisory Board (CAB). January 2021 - work is continuing on addressing the rules on the Firewalls where the bulk of the work should be completed by the end of February 2021. Additional hardware and software licenses have been procured for the upgrade of the Solarwinds network and performance management environment. A date has been set for the updrade to be completed by Friday 12 February. Based on the progress made and the evidence that we reviewed we consider the original recommendation to be partially implemented and the remaining elements remain as Medium priority. July 2020 update: Firewall project to restart in August with gradual handover of firewall rules from Data Comms to Cyber Security Team. Training scheduled between Data Comms Team and Cyber Team to begin handover. We have an additional temporary resource within Cyber Security Team also looking at networking areas and Solarwinds. August 2020 Update - work on the updating of software versions on each firewall is now complete along with configuring each firewall as per recommendations. There has been an isue in auditing the rules on each firewall due to a licensing issues with Solwarwinds. The ICT Department have requested a quote

Head & Neck Compliance (August 2020)

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HNC 01	Aug-20	Reasonable	1. Staff identified as requiring scheme of delegation training as part of their role should complete the on-line training module in ESR as soon as practically possible. 2. Consideration should be given as to whether any other staff within the directorate would benefit from scheme of delegation training, to ensure there is a consistency in training requests across the directorate.	High	Agreed this will be resolved in the NEW ILG structures The action will be as follows: • The staff requiring scheme of delegation training will be contacted individually and required by the Service Group Manager to complete the training by the end of August 2020. • Advice will be taken from Finance Partners regarding which staff would benefit from scheme of delegation meeting – with a particular focus on band 7 staff. • Issue will be raised in the CSG governance meeting and an email sent to all senior staff in the Directorate (from band 7 up) outlining the paramount importance of this issue.	Director of Operations	Service Group Manager	Aug-20	March 2021 May 2021		Completed	July 2021 Update - For RTE ILG (ENT) all staff are aware of mandatory training, prompts from Finance for scheme of delegation training are sent out and the whole process is monitored via ILG Performance Meetings. So for RTE this is complete. No response from MC ILG. For Bridgend ILG (Ophthalmology), all staff are aware of mandatory training commitments and also the widening of training has been considered. For MC, the appropriate member of staff is aware and will undertake on-line training module by the end of August 2021. She only authorises travel claims for staff working between sites. In addition, additional staff have committed to undertake the on-line training module by the end of September 2021.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. Following the changes to the structure connected with the RTE ILG, discussion is ongoing with the new Associate Service Group Director to decide an agreed way to take this matter forward. March 2021 Update - Management actions have been stalled by the demands of covid 19 but remain valid. The Ophthalmology aspect of Head & Neck Service has moved to the Bridgend ILG and will join the ILG's arrangements. Update at the next Committee meeting. May 2021. The Head and Neck Directorate no longer exists, and so consideration will be given by the next meeting to how to explain this to auditors and propose a change in the management actions. For reassurance in the meantime, CSGs now managing these specialties have been contacted and though actions are sometimes slow as a result of covid 19 implications, the services are being subsumed into new arrangements in each ILG. The actions recommended are usually monitored locally by the CSG meeting with the ILG and then at ILG Performance Review Meetings with the COO.
HNC 02	Aug-20	Reasonable	Heads of Department within the Head & Neck Directorate should be reminded of the requirement to complete and maintain an inventory of non-capital assets in line with Financial Control Procedure 11, where applicable.	High	Action will be: • The Heads of Service who did not complete the inventories will be contacted individually and required by the Service Group Manager to ensure that they understand the importance of this issue and asked to produce a compliant inventory by the end of September 2020. • Issue will be raised in the CSG Governance meeting and an email sent to all senior staff in the Directorate (from band 7 up) outlining the paramount importance of this issue.	Director of Operations	Service Group Manager	Oct-20	March 2021 May 2021 Now December 2021		Part Completed	July 2021 Update - For RTE ILG (ENT) more work needed here - though likley to be small numbers. Remains red. For Bridgend ILG (Ophthalmology), all staff aware that this should be completed. No response from MC ILG. For MC (OMFS), colleagues are aware that this should happen and are in the process of undertaking an inventory of each surgery that they work in	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. Following the changes to the structure connected with the RTE ILG, discussion is ongoing with the new Associate Service Group Director to decide an agreed way to take this matter forward. March 2021 - Management actions have been stalled by stalled by the demands of covid 19 but remain valid. The Ophthalmology aspect of Head & Neck Service has moved to the Bridgend ILG and will join the ILG's arrangements. May 2021. The Head and Neck Directorate no longer exists, and so consideration will be given by the next meeting to how to explain this to auditors and propose a change in the management actions. For reassurance in the meantime, CSGs now managing these specialties have been contacted and though actions are sometimes slow as a result of covid 19 implications, the services are being subsumed into new arrangements in each ILG. The actions recommended are usually monitored locally by the CSG meeting with the ILG and then at ILG Performance Review Meetings with the COO. Within RTE, staff have been communicated with recently with a requirement to address this recommendation and in Bridgend the matter is being subsumed into existing management arrangements.
HNC 03	Aug-20	Reasonable	Given the value of items that pass through the audiology department, management should review the current arrangements for managing stock in all departments and then consider drawing up a desktop procedure for the management of stock, which is applied to all departments. The procedure should cover as a minimum: • Ordering and receipting. • Minimum and maximum stock levels (if practical). • Security and access to stock. • Ongoing spot checks. • Annual stock take.	Medium	Actions will be: • The Service Group Manager will see the Head of Audiology personally to emphasise the importance of this issue – including its financial implications for the Directorate as a whole. • The Head of Audiology will be required to improve this situation as part of his PADR and also asked to identify a plan with milestones.	Director of Operations	Head of Audiology	Sep-20	March 2021 May 2021		In progress	July 2021 - No further update provided	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Head of Audiology has set up a meeting to discuss stock control across the sites and draft a procedure. Anticipated this will be completed by end of April 2021. May 2021. The Head and Neck Directorate no longer exists, and so consideration will be given by the next meeting to how to explain this to auditors and propose a change in the management actions. For reassurance in the meantime, CSGs now managing these specialties have been contacted and though actions are sometimes slow as a result of covid 19 implications, the services are being subsumed into new arrangements in each ILG. The actions recommended are usually monitored locally by the CSG meeting with the ILG and then at ILG Performance Review Meetings with the COO. Further, Audiology colleagues across the UHB have met to focus on stock control. Stock is kept securely in Audiology and there are plans to carry out more regular stock takes and the minimum and maximum stock levels, including preparation of standing orders for hearing aid orders. Battery provision will be picked up centrally, with colleagues at shared services are working on this on an all wales level.

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HNC 04	Aug-20	Reasonable	Budget holders should review all budgets with the Finance Business Partner to identify any 'historical' budgets that are no longer applicable and make the necessary adjustments as part of the budget setting process for 2020/2021 financial year.	Medium	Action will be: • Working with Finance Partners, all budget holders will be required to complete reviews of budgets.	Director of Operations	Budget Holders	Oct-20	March 2021 May 2021		Completed	July 2021 Update - For RTE ILG – this action is complete, all SGMs meet their Finance Partners regularly and the financial position is reviewed monthly with the ILG at a Performance Meeting. For BILG – this action is complete, all SGMs meet their Finance Partners regularly and the financial position is reviewed monthly with the ILG at a Performance Meeting. No response from MC ILG For MC – this action is complete, meetings happening on a monthly basis with nominated Finance representative within all parts of the Clinical Service Group.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Management actions have been stalled by stalled by the demands of covid 19 but remain valid. The Ophthalmology aspect of Head & Neck Service has moved to the Bridgend ILG and will join the ILG's arrangements. May 2021. The Head and Neck Directorate no longer exists, and so consideration will be given by the next meeting to how to explain this to auditors and propose a change in the management actions. For reassurance in the meantime, CSGs now managing these specialties have been contacted and though actions are sometimes slow as a result of covid 19 implications, the services are being subsumed into new arrangements in each ILG. The actions recommended are usually monitored locally by the CSG meeting with the ILG and then at ILG Performance Review Meetings with the COO. Financial matters are picked up across the Board by CSG meetings with Business Partners and then with the ILG Team. This is further reviewed in the monthly Performance Review meetings with the COO.
HNC 05	Aug-20	Reasonable	Management should ensure that any additional payments due to staff are correctly recorded and authorised on the monthly pay returns and that all payments are in compliance with Agenda for Change.	Medium	Action will be: • Directorate Support Manager will be required to put in place a system that ensures appropriate payments. This will be audited every three months.	Director of Operations	Service Group Manager	Aug-20	March 2021 May 2021		Completed	July 2021 Update - For RTE ILG (ENT) a system for medical staff is in place and the whole process is monitored via ILG Performance Meetings. So for RTE this is complete. For BILG (Ophthalmology) a system is in place to monitor medical payments happens – as in all Service Groups in BILG. This is complete. No response from MC ILG For MC (OMFS), controls in place within all parts of the Clinical Service Group.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Management actions have been stalled by stalled by the demands of covid 19 but remain valid. The Ophthalmology aspect of Head & Neck Service has moved to the Bridgend ILG and will join the ILG's arrangements. May 2021. The Head and Neck Directorate no longer exists, and so consideration will be given by the next meeting to how to explain this to auditors and propose a change in the management actions. For reassurance in the meantime, CSGs now managing these specialties have been contacted and though actions are sometimes slow as a result of covid 19 implications, the services are being subsumed into new arrangements in each ILG. The actions recommended are usually monitored locally by the CSG meeting with the ILG and then at ILG Performance Review Meetings with the COO. There are checks in place across CSGs to ensure that a full
HNC 06	Aug-20	Reasonable	All budget holders should be reminded of their responsibility to review all monthly financial information sent to them and contact Finance to rectify any errors.	Low	Actions will be: • Working with Business Partners, meetings will be arranged monthly to review financial reports. They will need to be attended by Heads of Service.	Director of Operations	Service Group Manager	Sep-20	March 2021 May 2021		Completed	July 2021 Update - For RTE ILG (ENT), MC (OMFS) and BILG (Ophthalmology) regular review of budgets is in place and the whole process is monitored via ILG Performance Meetings.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Management actions have been stalled by stalled by the demands of covid 19 but remain valid. The Ophthalmology aspect of Head & Neck Service has moved to the Bridgend ILG and will join the ILG's arrangements. May 2021. The Head and Neck Directorate no longer exists, and so consideration will be given by the next meeting to how to explain this to auditors and propose a change in the management actions. For reassurance in the meantime, CSGs now managing these specialties have been contacted and though actions are sometimes slow as a result of covid 19 implications, the services are being subsumed into new arrangements in each ILG. The actions recommended are usually monitored locally by the CSG meeting with the ILG and then at ILG Performance Review Meetings with the COO. There are checks in place across CSGs to ensure that a full check is made of all payments, and in RTE as an example, the CSG Manager meets Finance colleagues twice a month.
Health & Safety Management (Agust 2020)													

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HSM 01	Aug-20	Reasonable	1) It should be ensured that training data in relation to PoW and another Bridgend based staff is input into ESR and included in any performance data reported. 2) Where compliance rates are low in particular areas, management should work to understand what the barriers are that stop staff completing the training. In addition, advice should be sought from those areas that are performing well in order for best practice and ideas to be shared. 3) All Executive Directors should undertake training to the level required as part of their role and ESR records should be updated accordingly. 4) Consideration should be given to the Violence and Aggression training report submitted to the Security and Violence Operational Group and the need for additional resources to meet the current training gap.	High	Actions to address each item are listed below. 1. It should be ensured that training data in relation to PoW and another Bridgend based staff is input into ESR and included in any performance data reported. At the time of audit Cwm Taf Morgannwg University Health Board (CTMUHB) was in the process of aligning ESR Competency data between the old Cwm Taf University Health Board and the Bridgend region of Abertawe Bro Morgannwg University Health Board. The work is now completed and all Competencies at Level 1 have now migrated on to the ESR system for staff in the Bridgend region and performance data is reported. 2. Where compliance rates are low in particular areas, management should work to understand what the barriers are that stop staff completing the training. In addition, advice should be sought from those areas that are performing well in order for best practice and ideas to be shared. Statutory and Mandatory Training has previously been monitored via Directorate Clinical/Corporate Business Meetings within the Health Board. This monitoring will continue and form part of the improvement work of the newly established Integrated Locality Groups (ILGs). A group has recently been established under the Director of Nursing to review the current training requirements for all Statutory and Mandatory Training for all Nurses employed within the UHB. This will help identify the main issues that are	Director for People	Head of Health, Safety & Fire	Mar-21			Part Completed	July 2021 -This work is currently on hold due to the current Covid-19 epidemic and a completion time is not currently predictable.	This work is currently on hold due to the current Covid-19 epidemic and a completion time is not currently predictable.
HSM 02	Aug-20	Reasonable	The Health and Safety policy should be reviewed and where necessary updated to reflect any changes required due to the merger between Cwm Taf and Princess of Wales Hospital, and to reflect the current Health and Safety reporting arrangements within the Health Board.	Medium	In April 2019 the Bridgend region of the former Abertawe Bro Morgannwg University Health Board merged with Cwm Taf University Health Board. Each organisation had in place their own individual Health and Safety Polices and under TUPE arrangements it was decided to allow the organisation 12 months to align these policies. A newly drafted Health and Safety Policy for Cwm Taf Morgannwg University Health Board has been developed. The Policy once approved will be signed by the Chief Executive communicated to all staff through the Health Board's Intranet Training and via regular update training	Director for People	Head of Health, Safety & Fire	Sep-20	May-21		Completed	July 2021 - Health and Safety Policy ratified by Quality and Safety Committee 09/08/2021.	APRIL 2021: This policy is coming to the next Health, Safety & Fire Committee for approval. Revised implementation date provided.
HSM 03	Aug-20	Reasonable	Management should review the Health and Safety Co-ordinator resource and the alignment of work in order to ensure sufficient coverage of the service areas.	Medium	In light of the recent structural changes implemented within Cwm Taf Morgannwg UHB, a review of Health and Safety Coordinator support to each new Integrated Locality Group has been undertaken. It is planned to have 2 Health and Safety Coordinators in each new ILG. There is a current deficiency for 1 Health and Safety Coordinator post in the Bridgend ILG and this is currently being considered through a business case	Director for People	Head of Health, Safety & Fire	Aug-20	Jun-21		Completed	July 2021 - Additional Health and Safety Coordinator appointed on 06/08/2021 to cover the Bridgend ILG.	APRIL 2021: SBAR in draft articulating revised resource requirements, to be taken through Health Board management structures in May and June 2021. Revised implementation date provided.
HSM 05	Aug-20	Low	The pathway on the intranet to the Health and Safety Policy should be made easier in order to ensure easy access for all staff.	Low	The New CTMUHB Health and Safety Policy (once ratified) will be placed under the Risk Management Policies section of the Health Board's intranet pages. A link to this will also be provided clearly on the Health Board's Health and Safety Webpages	Director for People	Head of Health, Safety & Fire	Sep-20	01/06/2021 Now 31/08/21		In progress	July 2021 - The newly formed intranet pages will be live by 31/08/2021	APRIL 2021: Once the policy is approved in May, a new interactive area on the intranet will be developed. The interactive intranet page is currently 2/3rds complete, and will be available to launch by the end of June 2021. A revised implementation date has been provided.
HSM 06	Aug-20	Low	The templates currently being used to undertake annual Health and Safety reviews should be reviewed to ensure they are accurately reflecting the Health and Safety issues within each department.	Low	The Health and Safety Team are developing an audit package for use across the CTMUHB. The package will provide assurance to ILGs and the Board that policies and procedures are being followed in all Service Group Wards and Departments. Once completed, the audit package will be presented to the Health, Safety and Fire Committee for approval	Director for People	Head of Health, Safety & Fire	Jan-21	Jul-21		In progress	July 2021 - Audit Package currently undergoing further testing due so some reporting issues on the AMaT system.	APRIL 2021: An audit tool is being developed, taking learning from the social distancing audit tool developed. The package itself is developed, and by July we will have determined the key areas to be examined via the audit tool. This will be complete and ready to use by the end of July. A revised implementation date has been provided.

Directorate Review Acute Medicine & A&E (July 2020)

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DRAM 04	Aug-20	Reasonable	1. A review of the policies and procedures saved to the intranet should be undertaken to ensure there is a central repository of all documents and all documents that are listed are still relevant, with all out of date policies reviewed and updated where necessary. 2. Where there are common policies across a number of departments, to avoid duplication and possible inconsistencies, consideration should be given to having a set of directorate wide policies with one copy saved and clear information on the lead area for the policy including who is responsible for reviewing and updating the policy.	Medium	The review of policies and procedures needs to be undertaken on each acute site and it is acknowledged that this is an area of concern with focussed attention needed over the next 6 months. There also needs to be clear guidance from the ILG on the process for the approval of policies and procedures in the new operating model.	Director of Operations	ILG Directors/ General Manager	September 2020/December 2020	Apr-21		In progress	July 2021 update. For RTE and MC ILG, no change – remains a key risk area. Will be addressed when capacity allows.	November 2020 Update - The planned review has been delayed due to the COVID pandemic and the timely appointment to the CSG supporting structure. RTE ILG January 2021 Update - The planned review has been delayed due to the COVID pandemic and the timely appointment to the CSG supporting structure. March 2021 Update - Final timing for the completion of this work will be reported by the end of April 2021. May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a key risk for old policies –and this will be a challenging piece of work to undertake with all the other priorities. Both Directorates do, however, confirm that the new policies that were developed as a result of changes involving covid 19 have been stored in one place and are accessible.
DRAM 07	Aug-20	Reasonable	In line with Health Board targets, all staff should be subject to a PDR on an annual basis with copies of PDRs accessible should managers be absent.	Medium	It is acknowledged that every member of staff should have an up to date PDR in place and this will need to be addressed by the CSG general managers and other members of the leadership team such as the Senior Nurses on each of the acute sites.	Director of Operations	General Manager & Senior Nurses	Dec-20	01/12/2020 September 2021		In progress	July 2021. For RTE this area continues to be monitored closely and progress reported to the ILG Directors. In MC ILG, ongoing improvement in PDR compliance with challenge to achieve 5% improvement month on month.	November 2020 Update - The position is monitored via the monthly ILG performance review meetings although it must be acknowledged that this has been difficult during the COVID pandemic. RTE ILG January 21 Update - The position is monitored via the monthly ILG performance review meetings although it must be acknowledged that improvement has been difficult during the COVID pandemic. System issues also remain with the e-rostering system and the ESR system not sharing information. March 2021 Update - This will be an area for focus in the future – further action will be completed asap. May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a key risk –and this will be a challenging piece of work to undertake with all the other priorities. Both Directorates do, however, confirm that this remains on the agenda and in MC there has been work done on the priorities for the CSG which will all be reflected in the PDRs. Given the backlog and the challenge, the likely date has been changed to September 2021. Where urgent cases arise they will be managed proactively – and the issue is monitored at ILG and COO level.
DRAM 08	Aug-20	Reasonable	1. All information contained on self-certification forms, RTW forms and ESR should correspond. Comprehensive and accurate documentation in relation to each episode of sickness should be maintained to allow the proper management of sickness within the directorate and accurate reporting. 2. It should be ensured that self-certification and return to work forms are fully completed in a timely manner following the employee's return.	Medium	It is acknowledged that this position is not acceptable and this will need to be addressed by the CSG general managers and other members of the leadership team such as the Senior Nurses on each of the acute sites.	Director of Operations	General Manager & Senior Nurses	Dec-20	01/04/2021 September 2021		In progress	July 2021 Update. For RTE, there are still issues with the ESR and Allocate systems as they do not talk to each other so the information is never correct. We are regularly reviewing the position and reporting progress to the ILG. In MC ILG, ongoing improvement in PDR compliance with challenge to achieve 5% improvement month on month.	November 2020 Update - The position is monitored via the monthly ILG performance review meetings although it must be acknowledged that this has been difficult during the COVID pandemic. RTE ILG January 2021 Update - The position is monitored via the monthly ILG performance review meetings although it must be acknowledged that progress has been difficult during the COVID pandemic. Review of the consultant requirements for mandatory training has highlighted the need for some changes that will improve the position. March 2021 Update - System issues also remain with the e-rostering system and the ESR system not sharing information. This will be an area for focus in the future – further action will be completed asap. May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a key risk –and this will be a challenging piece of work to undertake with all the other priorities. Both Directorates do, however, confirm that this remains on the agenda and in MC there has been work done on staff training to undertake this process, and both MC and RTE are dealing with issues with the Allocate IT system. Given the backlog and the challenge, the likely date has been changed to September 2021. Where urgent cases arise they will be managed proactively – and the issue is

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DRAM 09	Aug-20	Reasonable	The directorate should ensure that all staff record their mandatory training in ESR and all staff are provided with the opportunity to undertake their mandatory training. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for non-compliance with a view to providing support where necessary.	Medium	It is acknowledged that every member of staff should be provided with the opportunity to undertake their mandatory training and this will need to be addressed by the CSG general managers and other members of the leadership team such as the Senior Nurses on each of the acute sites.	Director of Operations	General Manager & Senior Nurses	Dec-20	Aug-21		Completed	July 2021 Update. For RTE and MC ILG, Mandatory training is recorded on ESR and position is regularly monitored with progress reported to the ILG.	November 2020 Update - The position is monitored via the monthly ILG performance review meetings although it must be acknowledged that this has been difficult during the COVID pandemic. RTE ILG January 2021 Update - demand and capacity plans will be reviewed as part of the development of the IMTP for 2021-23 although it must be acknowledged that the COVID pandemic has had a significant impact of both elements and the long terms plans will need to be planned carefully following the COVID pandemic period. March 2021 Update - The position is monitored via the monthly ILG performance review meetings although it must be acknowledged that progress has been difficult during the COVID pandemic. Review of the consultant requirements for mandatory training has highlighted the need for some changes that will improve the position. This will be an area for focus in the future. May 2021 Update - In both RTE and MC this remains a key area of risk - there will be a further update in August 2021.
DRAM 12	Aug-20	Reasonable	Management should ensure that the directorate's demand and capacity plan is updated on a periodic basis to reflect any issues that arise for any of the specialties. The updated plan should then be formally reviewed at the CBMs.	Medium	Demand and capacity planning remains a challenge for each of the service groups and further action is needed to ensure that robust plans are in place and subject to regular review. It should however be noted that the establishment of the ILG operating model and the COVID-19 pandemic response has delayed progress in this area during 2020. It will now need to be a priority to ensure that we fully understand the position and the actions needed to return to normal working and monitoring arrangements.	Director of Operations	ILG Directors/ General Manager	Sep-20	Dec-20		Completed	July 2021 Update. For RTE and MC ILGs, now complete.	RTE ILG January 2021 Update - demand and capacity plans will be reviewed as part of the development of the IMTP for 2021-23 although it must be acknowledged that the COVID pandemic has had a significant impact of both elements and the long terms plans will need to be planned carefully following the COVID pandemic period. March 2021 Update - This will be an area for focus in the future – further action will be completed by the time of the next meeting. May 2021. All CSGs have been involved in extensive and detailed D&C planning as part of resetting and the IMTP and the plans are complete. They will be monitored monthly at CSG / ILG level and again at the ILG / COO Performance Review meetings on a monthly basis.
DRAM 13	Aug-20	Reasonable	An inventory of non-capital assets should be developed for each department within the directorate, detailing their assets, which fit under the definition of inventory as detailed within the Financial Control Procedure.	High	It is accepted that this area needs attention and this will need to be prioritised by the CSG general managers during 2020-21 once supporting staffing structures are in place.	Director of Operations	General Manager	Apr-21	01/05/2021 August 2021/April 2022		In progress	July 2021 Update - no change for RTE and MC ILGs at present however this remains on the agenda.	RTE ILG January 2021 Update - action has been delayed due to the COVID pandemic and this area will need to be addressed in 2021-22. March 2021 Update - This will be an area for focus in the future – further action will be completed asap. May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a key risk – and both MC and RTE recognise that it will take time to be complete. The CSG Manager in MC has recently sent out information to staff and anticipates an earlier resolution than RTE but it is recognised in both areas.
DRAM 14	Aug-20	Reasonable	1. Management should ensure that all staff are aware of the contents of Patients Property and Money Financial Control Procedure and their responsibilities to comply with it. Consideration should be given to some form of monitoring to ensure compliance. 2. In the meantime, a separate property book should be obtained for use in the major injury unit and disclaimers should be present within wards and departments to make it clear to patients about their responsibility for personal possessions.	High	This is accepted as poor practice and communication will be sent to all wards and departments to outline the required actions to ensure compliance with the Financial Control Procedure.	Director of Operations	Senior Nurses Medicine	Jul-20	01/04/2021 August 2021		Part Completed	July 2021 Update. For RTE this remains an issue. For MC ILG it is complete.	November 2020 Update - Communication has been sent to all wards and departments (July 2020) to outline the required actions to ensure compliance with the Financial Control Procedure. This area remains a challenge and the position has been exacerbated during the COVID pandemic with increased patient movement between wards in line with the IPC guidelines. RTE ILG January 2021 Update - Repeated communication has been sent to all wards and departments to outline the required actions to ensure compliance with the Financial Control Procedure. This area remains a challenge and the position has been xacerbated during the COVID pandemic with increased patient movement between wards in line with the IPC guidelines. May 2021 Update - For RTE this remains a challenging area and there have been a number of claims - mostly for patients bringing large amounts of cash into hospital following admission for covid 19. The area is one of focus for Senior Nurses who have been tasked with improving understanding and awareness and a review is ongoing. In MC this is not regarded as so much of a risk and normal property book procedures are ongoing.
MDR 01													

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MDR 01	Aug-20	Limited	The Health Board should continue to move to using a single medical and dental rostering system that would allow efficiencies in usage, especially where links can be made to other Health Board systems such as consultant job planning. This will also enable the Workforce Development team to provide consistent support across the Health Board.	High	Allocate Health Roster has now been rolled out for the whole of the UHB with the exception of ACT and PoW ED. In particular, the rollout was extended to Princess of Wales (PoW) medics during April and May. ACT currently use a separate rostering product called CLW and have for many years. This is also the case in a number of Health Boards and Trusts as the rostering features have been specifically designed for Anaesthetic rosters. Historically, and prior to the transfer on 1 April 2020 POW Emergency Department have used a separate rostering product. For ED POW and ACT to move over to Health Roster, the additional functionality needed would require the purchase of 2 additional modules from Allocate. The 2 modules are Medic on Duty (MOD) and Activity Manager (AM). In addition, this would require further discussions with Consultants and directorate colleagues as their current processes are considered to be perfectly suitable and adequate for their rostering arrangements and would not be a priority. The link of eJob Planning to health roster is the ultimate gold standard and is fully supported. For this to be possible it requires the purchase of the additional e-rostering products, to allow for the interface and indeed for all business areas to be using the Activity manager. In order to roll out Activity Manager effectively, the rostering team would be required to revisit all ILGs to ensure Health Roster is being used effectively for annual leave, study leave and sickness. This will be	Director for People	Head of Workforce Productivity & E-Systems	June 2020/December 2020	Apr-22		Part Completed	July 2021 Update - After meeting with ED representation and showing them a demo for the system with full functionality, the ED leads have taken the decision that Health Roster does not work for them and they do not want to use it. This puts us in a situation that is difficult to bypass. The areas do not want to use the system and say it doesnt work for them, but the audit report says that they absolutley should be using the systsem. A decision needs to be made as to whether we make the area use a system that they feel doesnt deliver what they want, purely because the audit report recommends it.	January 2021 Update - Allocate Health Roster has now been rolled out for the whole of the UHB with the exception of ACT and the POW Emergency Department (ED). This work has stalled due to the impact of the Pandemic.
MDR 04	Aug-20	Limited	1) The Health Board should develop a rostering policy specific to medical and dental staff. To ensure consistency and no conflict or duplication, consideration should be given to any other related policies and future financial control procedures such as medical variable pay. The policy should also give clear guidance on the alignment between the roster development process, consultant job plans and service demands. 2) The current set of HealthRoster 'how to' guides should be reviewed to ensure they are comprehensive and can be used in all areas of the Health Board as HealthRoster is rolled out. It should be ensured that any procedures or guides created align to the roster policy and cover both the use of the system to create rosters and the use of the system by medical and dental staff to manage their time. For example, booking annual leave and making amendment requests. 3) For areas where the roll out of HealthRoster is not imminent, separate 'how to' guides on that system should be developed. The guides should include the step by step process for creating the rosters and also guides for users of the system, allowing consistency during unexpected	High	A rostering policy will be developed in a collaboration with the ILGs to ensure they are bought into the guidance. Sitting alongside this a separate 'medical establishment' project which will identify the funded posts in each of the ILGs. This is critical to inform the true and accurate development and recording of rosters. There are user guides on how use Health Roster within the Allocate Health Roster system so further guidance would not be relevant. If there is a requirement to refine this guidance, following feedback from Super Users, only then will the Allocate guidance be further developed.	Director for People	Head of Workforce Productivity & E-Systems	Sep-20	Dec-21		Part Completed	July 2021 update - the policy is in active devlopment and a policy group has been set up with stakeholders involved.	January 2021 Update - Intital scoping and collection of documnetation has been completed. This work will commence again after the pandemic.
MDR 05	Aug-20	Limited	Annual leave and sick leave should be recorded on Health Roster which interfaces with ESR for Consultants and Middle Grade staff, thus allowing sickness to be managed appropriately.	High	The addition of PoW (excluding ED and ACT) to Health Roster has already moved a significant way towards achieving consistent recording of absences. The next phase however is to meet with each business area to ensure absences are being recorded on the system, which in turn feeds into ESR. There is a reliance on directorate colleagues in the ILGS to administer the system however regular checks and reporting may also expose where the data is not being inputted. This would be an ongoing exercise and could not be a one-off meeting with the directorate rota administrators and would be reliant on additional rostering	Director for People	Head of Workforce Productivity & E-Systems	Sep-20	Dec-21		In progress	July 2021 update - a training initiative was undertaken with all Medic areas using health roster in the Health Board and everyone was given update training on the system and sickness was included in this. All the training was recorded and certificates of completion issued to all areas.	January 2021 Update - PoW being added to Health Roster has greatly improved the capability to record leave and sickness pan UHB. It has become apparent however, that during the pandemic limited recording of leave & sickness has happened on Health Roster in medic areas. This needs to be visited and understood why this has gone on, as the same has not happened for Nursing areas. This is an area that will now require additional support to the roster managers and training to the Medics using the systems to enable the system to be used to a fuller extent. APRIL 2021: Work delayed during the pandemic, revised implementation dates provided.

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MDR 06	Aug-20	Limited	Management should ensure that there are processes in place for monitoring the rosters including reviewing aspects such as ensuring medical and dental staff are undertaking the correct hours and working in line with the job plans.	High	The monitoring of hours worked against the planned rota is the responsibility of the Directorate and Roster managers. Workforce will provide KPI data to the Directorates through the ILG Medical Workforce Efficiency meetings setting out time frames for requesting leave, sickness data and study leave. The comparison of agreed job plans against rota is again a matter for the ILG Directorates as noted above.	Director for People	Head of Workforce Productivity & E-Systems	Nov-20	Dec-21		In progress	July 2021 update - a training initiative was undertaken with all Medic areas using health roster in the Health Board and everyone was given update training on the system and rota management was included in this. All the training was recorded and certificates of completion issued to all areas.	January 2021 Update - This project work will has stalled due to Covid 19 and will commence after the pandemic. KPIs will be buiolt into the Rostering policy for medics addtionally. APRIL 2021: Work delayed during the pandemic, revised implementation dates provided.
MDR 08	Aug-20	Limited	1) Management should ensure that on granting annual and study leave to staff, that consideration is taken to ensure there is enough Consultants in place to cover all shifts and they are not all granted leave at the same time. 2) The process for requesting and approving annual and study leave should be clearly set out in departmental procedure notes so that all are clear on the expectation of the department.	Medium	A policy has recently been finalised covering study leave entitlements across CTM. This clarifies how much is available and how to record it via the Health Roster system. This policy is awaiting ratification by the LNC. Once all areas are using Health Roster fully, rules can be set on the roster to ensure the correct amount of staff are permitted to be off per day/Week.	Director for People	Head of Workforce Productivity & E-Systems	Nov-20	Dec-21		In progress	July 2021 update - The policy has been to LNC. Additional queries where raised that are being worked on by Nerys Conway. This will be taken to the next LNC for view by the committee with a view for sign off.	January 2021 Update - Policy is awaiting sight and approval at the LNC. Dates for the LNC have not been released for this year yet had the last meeting was cancelled due to the pandemic pressures. APRIL 2021: Work delayed during the pandemic, revised implementation dates provided.
MDR 09	Aug-20	Limited	Management should ensure when they are producing the rosters that the SPAs and DCC session align to the agreed job plans.	Medium	If the Medic on Duty and Activity Manager modules are purchased and integrated into the process, this can automate the upload of the Job Plan into HealthRoster. This will demonstrate whether or not there is a reflection of the agreed job plan. However, this does need to be enforced and managed by each of ILG management teams, not by Workforce. ILG management will need to ensure that actual job plans reflect what is shown on the Roster.	Director for People	Head of Workforce Productivity & E-Systems	Dec-20	Dec-21		In progress	July 2021 update - Medic on Duty and Activity manager have not been purchased as yet. Talks are still underway with IT who finance the prducts to allow for the purchase.	January 2021 Update - This work will not take place until the pandemic is over, due to the current main focus within both the Departments and eRostering being maintenance of current service. APRIL 2021: Work delayed during the pandemic, revised implementation dates provided.
Head & Neck Management Arrangements (August 2020)													
HNMA 02	Aug-20	Limited	1. The Directorate should ensure that a central database is created that records all applicable policies and procedures for all departments that constitute the Head & Neck Directorate. The database should include as a minimum the name of policy/procedure, applicable department, lead person, approval date, review date and committee/meeting responsible for formally approving policy if applicable. 2. Management should also ensure that the information is accessible to all applicable staff including agency workers.	High	The Service Group Manager will work with the Heads of Department to ensure that a dedicated page is established on the intranet site. Thought will be given to nominating a number of more junior staff to come up with proposals and lead the process and develop a communication plan.	Director of Operations	Management Team Ophthalmology	No Date Indentified	March 2021 June 2021 August 2021		Completed	July 2021 Update - For RTE ILG and BILG, policies are held centrally and also any Agency staff are made aware of the policies that they need to know about on a shift by shift basis. For MC ILG (OMFS), policies are held centrally Standard Operating Policies are held locally. They are accessible to all inc agency locums, New starters & trainees via local induction.	January 2021 Update Progress has been made across the UHB with the development and review of Risk Registers. January 2021 Update - Following a follow up review undertaken by Internal Audut the following update was provided: Our recommendation in relation to policies and procedures remains open at the current time. Progress against this recommendation is monitored via the internal audit tracker. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Governance arrangements were followed up by Audit due to its limited assurance rating and a report went to the December Audit Committee. Covid 19 has hampered progress in this area. An update on progress will be available by the end of March 2021 –this recommendation open and progress will be monitored. In the Bridgend ILG, the requirements are being explored and a report will be available by the end of June 2021. May 2021. The Head & Neck Directorate no longer exists and a proposal arround how this is handled will be made to Auditors. In the meantime, a check has been made across the areas where the policies sit and thus far, the new policies that were developed as a result of changes involving covid 19 have been stored in one place and are accessible.
HNMA 06	Aug-20	Limited	1. All episodes of sickness should be recorded on ESR. Comprehensive and accurate documentation in relation to each episode of sickness should be maintained to allow the proper management of sickness within the directorate and accurate reporting. 2. It should be ensured that self-certification and return to work forms are fully completed. 3. All information contained on self-certification forms, RTW forms and ESR should correspond. 4. Absence management prompts should be monitored and where periods of absence result in a prompt being breached, the appropriate action should be taken.	High	Working with colleagues in WOD the Directorate will start an education programme for all staff management issues – with joint workshops as has happened in other areas (for example, Mental Health). This will start a journey for the Directorate towards compliance. Since receipt of the report the detail has been shared with the Heads of Service and improvements have been made which will be qualified if a re-review takes place. Further, this issue will be highlighted to the Bridgend ILG when it takes over management responsibility for this service.	Director of Operations	Service Group Manager	Oct-20	March 2021 April 2021 September 2021 Now December 2021		Part Completed	July 2021 Update - In RTE and MC ILGs, this action is complete. In BILG, training is underway for action 1, for action 2 it is in place for clerical and medical staff and for the other two work is complete.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Covid 19 has hampered progress in this area. Limited action can be proved to have taken place. An update on progress will be available by the end of April 2021 –this recommendation open and progress will be monitored. May 2021. The Head & Neck Directorate no longer exists and a proposal arround how this is handled will be made to Auditors. In the meantime, a check has been made on the arrangements where these services are now held. Colleagues from WOD work closely within all CSGs and provide important support where it is needed. These issues are monitored via internal ILG processes and then via the Performance Review with the COO. At present issues with ESR and Health Roster are the focus of work and as a result the date will be September 2021.

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HNMA 07	Aug-20	Limited	1. In line with Health Board targets, all staff should be subject to a PDR on an annual basis. 2. PDR documentation should be fully completed, with meaningful objectives agreed by the manager and employee. The document should be signed by both parties and ESR with the date the PDR took place. 3. Copies of PDRs can be accessed to be undertaken in Manager's absence.	High	The report has been shared with all Heads of Services and improvements have been made in the specialty area of Dental Services. The new management arrangements for the RTE ILG are in the process of being resolved and in line with the new workforce performance management ILG structure, the detailed improvements will be made. Further, this issue will be highlighted to the Bridgend and RTE ILG when it takes over management responsibility for this service.	Director of Operations	Service Group Manager	Oct-20	March 2021 April 2021 August 2021 Now December 2021		Part Completed	July 2021 Update - For RTE ILG and BILG, this is an aim but not achieved across both areas given the implications of covid. There is a plan with WOD colleagues and intent for this to be improved. This is monitored in ILG Performance Review meetings monthly. In both areas the information is readily available if needed. No response from MC. For MC ILG (OMFS) this is complete.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Covid 19 has hampered progress in this area. Limited action can be proved to have taken place. An update on progress will be available by the end of April 2021 –this recommendation open and progress will be monitored. May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a risk given the size of the challenge and is monitored through internal ILG Meetings and the ILG Performance Review with the COO.
HNMA 09	Aug-20	Limited	The Directorate should ensure that all staff record their mandatory training in ESR and all staff are provided with the opportunity to undertake their mandatory training. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for non-compliance with a view to providing support where necessary.	Medium	This has been raised with the Heads of Service. The new management arrangements for RTE ILG are in the process of being resolved and in line with the new workforce performance management ILG structure, the detailed improvements will be made Further, this issue will be highlighted to the Bridgend ILG when it takes over management responsibility for this service.	Director of Operations	Service Group Manager	Oct-20	March 2021 April 2021 August 2021 Now December 2021		Part Completed	July 2021 Update - In RTE ILG (for ENT), all staff are aware that this is mandatory and so the action is complete. In BILG (for Ophthalmology), ESR is not used and so training is underway, so not yet complete. For MC ILG, this is complete and happening across all areas of the Clinical Service Group.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Covid 19 has hampered progress in this area. Limited action can be proved to have taken place. An update on progress will be available by the end of April 2021 –this recommendation open and progress will be monitored. May 2021. The Head & Neck Directorate no longer exists and a proposal around how this is handled will be made to Auditors. In the meantime, a check has been made on the arrangements where these services are now held. These issues are monitored via internal ILG processes and then via the Performance Review with the COO.
HNMA 10	Aug-20	Limited	1 Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period. 2 Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Directorate Manager and Clinical Director to resolve any problems in a timely manner and ensure plans get signed off.	Medium	The management team agree with this recommendation, and the lack of compliance has been as a result of COVID restrictions. The Clinical Director and the Service General Manager will work to complete this work by the end of September 2020.	Director of Operations	Clinical Director/ Service General Manager	Sep-20	01/03/2021 August 2021 Now October 2021		Part Completed	July 2021 Update - In RTE ILG, the aim is to complete plans annually and there has been an improvement with a plan in place. For action 2 this does take place. In BILG, job planning is underway and should be completed by September 2021, so this is almost complete. In MC ILG, this was complete pre-COVID-19. Unfortunately as a consequence of the response, job plans are still fluid and in a state of flux. However, Job plans for all specialties of the Clinical Service Group are being planned for September 2021.	January 2021 Update The CSG Manager and Director are undertaking job planning across their areas. Issues are discussed and agreed as part of CSG normal business - the status has been changed to yellow to reflectthis. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - As a result of the lack of a Deputy SGM (since at least October 2019) this work has not progressed as fast as would have been liked. The SGM has instigated a process to speed up the process of carrying out job planning, any urgent matters are managed by the SGM and the Clinical Director. May 2021. The Head & Neck Directorate no longer exists and a proposal around how this is handled will be made to Auditors. In the meantime, a check has been made on the arrangements where these services are now held. These issues are monitored via internal ILG processes and then via
HNMA 11	Aug-20	Limited	1. All relevant records (paper and electronic) in relation to annual leave should be accurately completed and retained to ensure managers are aware of leave that has been granted and prevent staff taking more leave than they are entitled to. 2. The annual leave entitlement recorded on paper records or other systems should be reconciled to ESR at the start of each year to ensure opening balances are correct. Where necessary any differences should be investigated, including the variations identified during our testing.	Low	Working with colleagues in WOD the Directorate will start an education programme for all staff management issues – with joint workshops as has happened in other areas (for example, Mental Health). This will start a journey for the Directorate towards compliance. Further, this issue will be highlighted to the Bridgend ILG when it takes over management responsibility for this service.	Director of Operations	Service Group Manager	Oct-20	March 2021 April 2021 August 2021		Completed	July 2021 Update - For RTE ILG (ENT) this is complete, as for BILG and MC ILG.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Covid 19 has hampered progress in this area. Limited action can be proved to have taken place. An update on progress will be available by the end of April 2021. May 2021. The Head & Neck Directorate no longer exists and a proposal around how this is handled will be made to Auditors. In the meantime, a check has been made on the arrangements where these services are now held. These issues are monitored via internal ILG processes and then via the Performance Review with the COO.
HNMA 13	Aug-20	Limited	Workforce Reporting within the Directorate Integrated Governance Business Meetings should be expanded to provide information on a departmental level. This would allow any areas of concern to be highlighted and the Directorate could then determine what action needs to be undertaken and responsible officer.	Medium	The Heads of Service have the reports for their areas and understand the HR issues in their departments. The Heads of Department will work with Business Partners to improve the situation.	Director of Operations	Heads of Service & Business Partners	Nov-20	March 2021 April 2021 August 2021		Completed	July 2021 Update - This is undertaken in RTE ILG (ENT), MC ILG (OMFS) and BILG (Ophthalmology) and is monitored routinely at Performance Review Meetings.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Covid 19 has hampered progress in this area. Limited action can be proved to have taken place. An update on progress will be available by the end of April 2021. May 2021. The Head & Neck Directorate no longer exists and a proposal around how this is handled will be made to Auditors. In the meantime, a check has been made on the arrangements where these services are now held. These issues are monitored via internal ILG processes and then via the Performance Review with the COO.

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HNMA 14	Aug-20	Limited	Management should ensure that all relevant correspondence/documentation relating to the IMTP process is retained if future access is required.	Low	The Service Group Manager will ensure that this is in place in the next round of IMTP planning and submission.	Director of Operations	Service Group Manager	Dec-20	March 2021 April 2021 August 2021		Completed	July 2021 Update - This information is retained in RTE ILG (ENT), MC ILG (OMFS) and BILG (Ophthalmology).	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Covid 19 has hampered progress in this area. Limited action can be proved to have taken place. An update on progress will be available by the end of April 2021. May 2021. The Head & Neck Directorate no longer exists and a proposal around how this is handled will be made to Auditors. In the meantime, a check has been made on the arrangements where these services are now held. These issues are monitored via internal ILG processes and then via the Performance Review with the COO.
Pathology Directorate Follow Up Review (Managerial Arrangements) (October 2020)													
PDFU 04	Oct-20	Reasonable	**Updated Recommendation** - All policies and procedures should be reviewed on a regular basis to ensure that they are current and up to date.	Low	**Updated Management Response** - There are a significant number of policies and procedures within Pathology, document review is monitored monthly through the Pathology scorecard and significant improvements have been made. Pathology will be implementing an electronic quality management solution within the next few months, this will automatically alert staff when documents are due for review, which should result in further improvements. There will also be a visual metrics dashboard which will show the status of document review for each department	Director of Operations	Service Leads	Jan-21	Aug-21		Completed	July 2021 Update - All policies have been updated as part of the UKAS Inspection preparatory work. This recommendation is complete.	Jan 2021 - work is ongoing with service leads and quality manager. March 2021 Update - Covid 19 implications have slowed the process and this area will be a focus for the rest of the year. Work is ongoing with service leads and quality manager. May 2021 Update - Operational pressures have meant that an update has not been possible this month – a full update will be available at the next meeting.
PDFU 05	Oct-20	Reasonable	**Updated Recommendation** - Managers should ensure all staff receive a PDR on an annual basis. Where necessary an action plan should be developed, and consideration given to obtaining assistance from other departments within the directorate to ensure compliance rates can be improved.	High	**Updated Management Response** - 1. Service managers to provide an action plan with target dates for completion of outstanding PDRs. 2. Compliance at 9/9/20 is 56.3%.	Director of Operations	Service Managers	Oct-20	01/06/2021 August 2021		Completed	July 2021 Update - This recommendation is included in the preparatory work for the recent UKAS Inspection. There is a plan to improve performance if necessary and this is monitored monthly at the ILG Performance Meeting. This recommendation is now complete.	Jan 2021 - limitations with increased covid activity and workforce gaps has slowed progress - but is being continued where it will fit within parameters without affecting patient care. March 2021 Update - This area will be a focus for the coming year. May 2021 Update - Operational pressures have meant that an update has not been possible this month – a full update will be available at the next meeting.
PDFU 06	Oct-20	Reasonable	**Updated Recommendation** - The Directorate should ensure all staff are reminded (and provided with support when needed) to complete core module training in line with Welsh Government's expectations. When reasonably practicable (following the Covid-19 crisis) staff should be afforded the opportunity and time to complete mandatory training.	Low	**Updated Management Response** - Managers to provide time to complete mandatory training for staff wherever possible to improve compliance.	Director of Operations	Service Managers	Ongoing	01/03/2021 August 2021		Completed	July 2021 Update - This recommendation is included in the preparatory work for the recent UKAS Inspection. There is a plan to improve performance if necessary and this is monitored monthly at the ILG Performance Meeting. This recommendation is now complete.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - A number of staff were able to access all elearning during covid pandemic and original social distancing strategies - ongoing, but unable to access F2F courses as yet through the Training Department. Work on elearning supporting during covid, but access to F2F courses is limited due to covid response. May 2021 Update - Operational pressures have meant that an update has not been possible this month – a full update will be available at the next meeting.
PDFU 07	Oct-20	Reasonable	**Updated Recommendation** - When consultant job plans are re-established following the Covid-19 crisis, the Directorate should ensure these are completed in a timely manner. A control system should be established to ensure Consultant Job Plans are reviewed prior to expiration and monitoring should take place at an appropriate group within the directorate	Medium	**Updated Management Response** - Review of overdue consultant job plans to take place. A system will be developed to alert consultants when job plans are due for review.	Director of Operations	Clinical Service Group Manager	Nov-20	May-21		Completed	July 2021 Update - The Directorate has a trajectory to achieve this recommendation with the CSGM undertaking two plans a week. There is a plan to improve performance if necessary and this is monitored monthly at the ILG Performance Meeting. This recommendation is now complete.	January 2021 Update - A number of staff were able to access all elearning during covid pandemic and original social distancing strategies - ongoing, but unable to access F2F courses as yet through training dept. Jan 2021 - work on elearning supporting during covid, but access to F2F courses is limited due to covid response. March 2021. Covid 19 has slowed action here. It is anticipated that an update will be available in May 2021. May 2021 - No further update provided
PDFU 09	Oct-20	Reasonable	**Updated Recommendation** - It should be ensured that RTW forms are fully completed, including details of previous sickness episodes, to determine if the current absence has resulted in a prompt being hit. Where a prompt has been hit a record should be made of the action taken, including if no action is taken, with an explanation as to why discretion was applied in this instance.	Medium	**Updated Management Response** - Managers to ensure that sickness continues to be appropriately monitored and managed within their service areas.	Director of Operations	Service Managers	Ongoing	01/05/2021 August 2021		Completed	July 2021 Update - This recommendation is undertaken within the Directorate supported by colleagues from WOD. There is a plan to improve performance if necessary and this is monitored monthly at the ILG Performance Meeting. This recommendation is now complete.	Jan 2021 - CSGM and Deputy CSGM are working with WOD and training to pilot new leadership and management course modules across all band 7 and above workforce. Rigorous support package being developed to aid all supervisors and managers to facilitate better sickness monitoring and absence reviews. March 2021 Update - CSGM and Deputy CSGM are working with WOD and training to pilot new leadership and management course modules across all band 7 and above workforce. Rigorous support package being developed to aid all supervisors and managers to facilitate better sickness monitoring and absence reviews. May 2021 Update - Operational pressures have meant that an update has not been possible this month – a full update will be available at the next meeting.
Medical Agency Usage (October 2020)													

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MAU 06	Oct-20	Reasonable	Following the review of required attendees for the Scrutiny Group, it should be ensured that the remit of the group is clear, there are regular meetings taking place and all relevant staff are in attendance.	Low	The Scrutiny group structure and cohort is currently being revised to ensure it falls in line with the new locality based structures. Representation will be sought from each ILG from a director (or nominated deputy), finance, procurement, workforce and speciality perspective. Current talks are ongoing as to whether to hold three separate meetings per locality or one CTM meeting. A new terms of reference will be developed for this meeting, it has been agreed that this will be chaired by the Medical Director or Deputy Medical Director in their absence.	Medical Director	Assistant Director of Workforce Productivity & Efficiency	Feb-21	01/06/2021 Now 31/10/2021		In progress	July 2021 Update - The Medical Workforce Scrutiny Group (MWSG) has not been implemented yet, this is due to the changes at a Senior level (MD). A meeting between the MD, AMD and Workforce colleagues is scheduled in early September and the first (MWSG) will be set up following the meeting.	November 2020 Update - Discussions around the structure of the Scrutiny group going forward are yet to be finalised. Revised terms of reference will be finalised in January 2021. May 2021 Update: The scrutiny group has been incorporated into the new Workforce Strategy Group (WSG). The draft ToR have been developed for this group and it is predicated that it will be launched in June, once the ToR are ageed by all interested parties.
Risk Management (February 2021)													
RM21 01	Feb-21	Reasonable	Management should ensure that all risks that are scored 15 or more are escalated up to the Organisational Risk Register to enable the Executives to view all risks within their areas. Management should also ensure that all risks recorded on the Rhondda Taf Ely (RTE) ILG Risk Register and the RTE Surgery CSG Risk Register are aligned and all risks scoring over 15 are escalated to the ILG Risk Register	High	ILGs are committed to undertaking a review of all risks within the three locality groups. This work has been significantly impacted by the impact and response to the Covid-19 pandemic with operational focus quite rightly directed to clinical service provision. This work is still planned, however the timeline for this is dependent on the Covid19 pandemic response and the impact of post Covid recovery of planned care. The work will be approached as follows: 1.1 Review of risks and Clinical Service Group (CSG) risk registers ensuring it continues to be embedded in the ILG via a standing agenda item for the CSG and ILG Quality, Safety & Experience meetings. 1.2 ILG Heads of Quality & Safety will continue to work with CSG's to both rationalise and standardise the CSG risk register. 1.3 Through the delivery of dedicated monthly training slots ensure that CSG's have awareness/training in the Service to Board Escalation process and align their risk management approach to the recently	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk	Oct-21			In progress	Update July 2021 - On track for October 2021 implementation date. The Assistant Director of Governance & Risk meets monthly with the Heads of Quality & Safety within ILG's and will be advised if there is any impact to this timeframe.	Update March 2021 - On track for October 2021 implementation date. The Assistant Director of Governance & Risk meets monthly with the Heads of Quality & Safety within ILG's and will be advised if there is any impact to this timeframe. Update May 2021 - On track for October 2021 implementation date. The Assistant Director of Governance & Risk meets monthly with the Heads of Quality & Safety within ILG's and will be advised if there is any impact to this timeframe.
RM21 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		In progress	Update July 2021 - Training Needs Analysis completed and will be shared across the Health Board one the training packages that align to the TNA have been developed. Level 1 Training Package- draft being shared with Elearning colleagues w/c 26th July 2021 to start development of esr module. Level 2 - Training package development to commence August 2021.	Update March 2021 A revised date is requested as the Assistant Director of Governance & Risk is now part of a small Task and Finish Group with other NHS Organisations in Wales to develop a risk training needs analysis that ensures a consistent approach across NHS Wales and avoids duplication. A first draft of a TNA has been developed and will be shared with the Health Board in due course. The trainining packages to support the TNA are being worked through by the group. Update May 2021 Training Needs Analysis currenrly being finalised within the Task and Finish Group. Will be shared with the Health Board once the training packages that align have been developed.
CAMHS Management Arrangements (February 2021)													
CAMMAN 05	Feb-21	Limited	1. We agree with the planned approach to identify CAMHS related policies in existence and to review them to ensure consistency across the localities. This work should also ensure relevance and alignment to current legislation and expected working practices. 2. Once updated, the policies should be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews.	High	CAMHS Policy Group newly established, with ToR being developed. All CAMHS policies to be identified, reviewed and standardised to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan will be devised. Policies will be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews.	Director of Operations	Head of Nursing	Mar-21	01/05/2021 August 2021 Now December 2021		In progress	July 2021 Update. CAMHS Policy Group newly established, with ToR developed. All CAMHS policies identified, to be reviewed and standardised to new format to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan devised to ensure rolling programme. Policies will be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews. Work delayed due to key staff redeployment due to Covid & HB restructure. Confirmation on the action taken will be confirmed in August 2021.	March 2021 Update - Update will be abailable in May 2021. May 2021 Update - CAMHS Policy Group newly established, with ToR developed. All CAMHS policies to be identified, reviewed and standardised to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan will be devised. Policies will be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews. Work delayed due to key staff redeployment due to Covid & HB restructure. Confirmation on teh action taken will be confirmed in August 2021.

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CAMMAN 06	Feb-21	Limited	1. The review of CAMHS risk register should take place to ensure all risks are scored consistently and any risks scoring below eight are, in line with the Risk Management Strategy, removed from the CSG risk register and logged separately by departments. A process should be put in place to review and monitor those risks and where necessary escalate back up to the CSG risk register. 2. The CSG should have appropriate mechanisms in place to review and monitor risks including those scoring below between 6 and 12. This should include clearly defined responsibilities within the terms of reference of the various groups. 3. The CSG should ensure risks are not only individually monitored by risk owners, but that the risk register is collectively monitored at the appropriate level, with escalation and de-escalation between groups and committees if risk scores change.	Medium	CAMHS risk register will be reviewed to ensure risks are scored consistently and any risks scoring below eight are, in line with the Risk Management Strategy, removed from the CSG risk register and logged separately by departments. A process will be put in place to review and monitor those risks and where necessary escalate back up to the CSG risk register. The CSG will have appropriate mechanisms in place to review and monitor risks including those scoring below between 6 and 12. This will include clearly defined responsibilities within the terms of reference of the various groups. The CSG will ensure risks are not only individually monitored by risk owners, but that the risk register is collectively monitored at the appropriate level, with escalation and de-escalation between groups and committees if risk scores change. Putting Things Right – themes & trends will be collated and added to bimonthly	Director of Operations	Senior Nurse Quality & Risk/Head of Nursing	Mar-21	01/05/2021 August 2021		Completed	July 2021. CAMHS risk register has been reviewed to ensure risks are scored consistently and recorded in the required format and any risks scoring below eight are, in line with the Risk Management Strategy, removed from the CSG risk register and logged separately by departments. A process is in place with the Governance team to review and monitor those risks and where necessary escalate back up to the CSG risk register with fortnightly governance meetings to review the register. The CSG has appropriate mechanisms in place to review and monitor risks including those scoring below between 6 and 12. This will include clearly defined responsibilities within the terms of reference of the various groups. The CSG will ensure risks are not only individually monitored by risk owners, but that the risk register is collectively monitored at the appropriate level, with escalation and de-escalation between groups and committees if risk scores change. Putting Things Right – themes & trends will be collated and added to bimonthly report for CAMHS (senior nurses). Julie meeting with Governance team to progress.	March 2021 Update - Update will be abailable in May 2021. May 2021 Update - CAMHS risk register has been reviewed to ensure risks are scored consistently and any risks scoring below eight are, in line with the Risk Management Strategy, removed from the CSG risk register and logged separately by departments. A process will be put in place to review and monitor those risks and where necessary escalate back up to the CSG risk register. The CSG will have appropriate mechanisms in place to review and monitor risks including those scoring below between 6 and 12. This will include clearly defined responsibilities within the terms of reference of the various groups. The CSG will ensure risks are not only individually monitored by risk owners, but that the risk register is collectively monitored at the appropriate level, with escalation and de-escalation between groups and committees if risk scores change. Putting Things Right – themes & trends will be collated and added to bimonthly report for CAMHS (senior nurses). Julie meeting with Governance team to progress.
CAMMAN 08	Feb-21	Limited	1. Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period. 2. Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Clinical Service Group Manager and Clinical Director in order to resolve any problems in a timely manner and ensure plans get signed off. 3. Once all job plans have been brought up to date, the Clinical Service Group should be able to assure itself that the sessions agreed on the job plan are what are actually worked by the consultants.	High	Clinical Director will ensure that all Consultant job plans are reviewed and agreed on an annual basis. A clear dispute process to be followed: Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Clinical Service Group Manager and Clinical Director in order to resolve any problems in a timely manner and ensure plans get signed off. System to provide assurance that the sessions agreed on the job plan are what are being delivered by the Consultants.	Director of Operations	Clinical Director	Mar-21	01/05/2021 August 2021		Completed	July 2021 Update. Clinical Director will ensure that all Consultant job plans are reviewed and agreed on an annual basis. A clear dispute process to be followed: Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Clinical Service Group Manager and Clinical Director in order to resolve any problems in a timely manner and ensure plans get signed off. System to provide assurance that the sessions agreed on the job plan are what are being delivered by the Consultants.	March 2021 Update - Update will be abailable in May 2021. May 2021 Update - Clinical Director will ensure that all Consultant job plans are reviewed and agreed on an annual basis. A clear dispute process to be followed: Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Clinical Service Group Manager and Clinical Director in order to resolve any problems in a timely manner and ensure plans get signed off. System to provide assurance that the sessions agreed on the job plan are what are being delivered by the Consultants.
CAMMAN 09	Feb-21	Limited	1. Staff personal records should be stored in such a way that allows other managers to have access to them should an employee's direct line manager be absent from work for a period of time. 2. In order for absence to be properly managed, comprehensive and accurate documentation in relation to each episode of sickness should be maintained. It should be ensured 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. 3. 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 undertaken an informal or formal warning, this decision should be documented on the individuals file. 4. It should be ensured that all employees are correctly allocated on ESR to the right team within the Clinical Service Group. Incorrect allocations will have an impact on sickness, training and PDR compliance rates for teams and may result in manager not receiving	High	This action will be addressed via the Line Management responsibilities training as per finding 3 in the Compliance Audit report. Staff personal records will be stored to allow access should a line manager be absent from work for a period of time. Incorporated into line management training package. ESR log in details to be shared as required. Comprehensive and accurate documentation in relation to each episode of sickness will be maintained. 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. The Managing Attendance Policy will be followed where periods of absence result in a prompt being breached. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individuals file. All employees will be reviewed to ensure they are correctly allocated on ESR to the right team within the Clinical Service Group.	Director of Operations	Senior Nurse	Mar-21	01/05/2021 August 2021		Completed	July 2021 Update - This action will be addressed via the Line Management responsibilities training as per finding 3 (Termination Forms). Staff personal records will be stored to allow access should a line manager be absent from work for a period of time. Incorporated into line management training package. ESR log in details to be shared as required. Comprehensive and accurate documentation in relation to each episode of sickness will be maintained. 1. Self-certification and return to work forms are fully completed in a timely manner following the employee's return. 2. 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. The Managing Attendance Policy will be followed where periods of absence result in a prompt being breached. Where a manager exercises their discretion and chooses not to undertaken an informal or formal warning, this decision should be documented on the individuals file. All employees will be reviewed to ensure they are correctly allocated on ESR to the right team within the Clinical Service Group.	March 2021 Update - Update will be abailable in May 2021. May 2021 Update - This action will be addressed via the Line Management responsibilities training as per finding 3 (Termination Forms). Staff personal records will be stored to allow access should a line manager be absent from work for a period of time. Incorporated into line management training package. ESR log in details to be shared as required. Comprehensive and accurate documentation in relation to each episode of sickness will be maintained. 1. Self-certification and return to work forms are fully completed in a timely manner following the employee's return. 2. 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. The Managing Attendance Policy will be followed where periods of absence result in a prompt being breached. Where a manager exercises their discretion and chooses not to undertaken an informal or formal warning, this decision should be documented on the individuals file. All employees will be reviewed to ensure they are correctly allocated on ESR to the right team within the Clinical Service Group. ESR Champion roles for each Locality.
CAMMAN 10	Feb-21	Limited	In line with Health Board targets, all staff should participate in a PDR on an annual basis. Where departments are failing to carry out PDRs due to resource constraints, support should be provided.	High	This action will be addressed via the Line Management responsibilities training as per finding 3 in the Compliance Audit report In line with Health Board targets, all staff will participate in a PDR on an annual basis. Support will be provided if a drop in compliance is due to resource constraints.	Director of Operations	Senior Nurse	Mar-21	01/05/2021 August 2021 Now September 2021		In progress	July 2021 Update - This action will be addressed via the Line Management responsibilities training as per finding 3 (Termination Forms). In line with Health Board targets, all staff will participate in a PDR on an annual basis. PDR compliance has increased in CAMHS and is currently at 72.6% Support will provided if a drop in compliance is due to resource constraints	March 2021 Update - Update will be abailable in May 2021. May 2021 Update - This action will be addressed via the Line Management responsibilities training as per finding 3 (Termination Forms). In line with Health Board targets, all staff will participate in a PDR on an annual basis. Support will provided if a drop in compliance is due to resource constraints

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CAMMAN 11	Feb-21	Limited	1. 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 all staff are provided with the opportunity to undertake their mandatory training. 2. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for non-compliance with a view to providing support where necessary.	Medium	This action will be addressed via the Line Management responsibilities training as per finding 3 in the Compliance Audit report. All Line Managers to ensure staff have the opportunity to undertake their mandatory training. LMT will monitor on a monthly basis to identify any problem areas, establish reasons for non-compliance and provide support or escalate to SMT where necessary.	Director of Operations	Senior Nurse	Mar-21	01/05/2021 August 2021		Completed	July 2021 Update - All Line Managers to ensure staff have the opportunity to undertake their mandatory training. This action will be addressed via the Line Management responsibilities training as per finding 3. LMT will monitor on a monthly basis to identify and problem areas, establish reasons for non-compliance and provide support or escalate where needed. Module of the month approach to target training with poor compliance which has led to improvements. Individuals targeted as required.	March 2021 Update - Update will be abailable in May 2021. May 2021 Update - All Line Managers to ensure staff have the opportunity to undertake their mandatory training. This action will be addressed via the Line Management responsibilities training as per finding 3. LMT will monitor on a monthly basis to identify any problem areas, establish reasons for non-compliance and provide support or escalate where necessary
CAMMAN 12	Feb-21	Limited	1. Management should ensure that TOIL documentation is fully completed and the hours are recorded correctly. 2. The Clinical Service Group should have a policy in place that provides guidance on the use of TOIL.	Low	This action will be addressed via the Line Management responsibilities training as per finding 3 in the Compliance Audit report. Line Managers will ensure that flexi / TOIL documentation is fully completed and the hours are recorded correctly. TOIL will be used in line with HB policy.	Director of Operations	Senior Nurse	Mar-21	01/05/2021 August 2021		Completed	July 2021 Update - This is now in place. This action will be addressed via the Line Management responsibilities training as per finding 3 (Termination Forms). Line Managers will ensure that flexi / TOIL documentation is fully completed and the hours are recorded correctly. TOIL will be used in line with HB policy.	March 2021 Update - Update will be abailable in May 2021. May 2021 Update - This action will be addressed via the Line Management responsibilities training as per finding 3 (Termination Forms). Line Managers will ensure that flexi / TOIL documentation is fully completed and the hours are recorded correctly. TOIL will be used in line with HB policy.
CAMMAN 13	Feb-21	Limited	1. In line with the Scheme of Delegation, all requests to carry forward unused annual leave should be authorised in line with the scheme of delegation. 2. Consideration should be given to reviewing annual leave balances at intervals throughout the year to try and ensure leave is taken as the year progresses, to prevent the build of outstanding leave and the need to carry forward so much.	Low	This action will be addressed via the Line Management responsibilities training as per finding 3 in the Compliance Audit report. All requests to carry forward unused annual leave will be authorised in line with the scheme of delegation. Line Managers will review annual leave balances quarterly during supervision to ensure leave is taken as the year progresses, to prevent the accumulation of outstanding leave.	Director of Operations	Senior Nurse	Mar-21	01/05/2021 August 2021		Completed	July 2021 Update - This is now complete - annual leave carry forward requests managed centrally and annual leave balances reviewed regularly to prevent accumulation.	March 2021 Update - Update will be abailable in May 2021. May 2021 Update - An update will be available in August 2021.
CAMMAN 14	Feb-21	Limited	1. Prior to submitting the IMTP for approval, it should be ensured that all key aspects, such as workforce planning information and finance plans are contained and that the Clinical Service Group Manager is fully sighted on them to ensure all information aligns. 2. Plans should be thoroughly reviewed and scrutinised ahead of submission to ensure no omissions.	High	Prior to submitting the IMTP for approval, all key aspects, such as workforce planning information and finance plans are contained and that the Clinical Service Group Manager is fully sighted on them to ensure all information aligns. Plans will be thoroughly reviewed and scrutinised ahead of submission to ensure no omissions and brought to the Business Meeting for discussion.	Director of Operations	Clinical Service Group Manager	Mar-21	01/05/2021 August 2021		Completed	July 2021 Update - This is complete. Prior to submitting the IMTP for approval, all key aspects, such as workforce planning information and finance plans are contained and that the Clinical Service Group Manager is fully sighted on them to ensure all information aligns. Plans will be thoroughly reviewed and scrutinised ahead of submission to ensure no omissions and brought to the Business Meeting for discussion.	March 2021 Update - Update will be abailable in May 2021. May 2021 Update - Prior to submitting the IMTP for approval, all key aspects, such as workforce planning information and finance plans are contained and that the Clinical Service Group Manager is fully sighted on them to ensure all information aligns. Plans will be thoroughly reviewed and scrutinised ahead of submission to ensure no omissions and brought to the Business Meeting for discussion.
CAMMAN 16	Feb-21	Limited	It should be ensured that the reporting and monitoring against non-financial performance indicators is undertaken at a suitable level within the CSG, with appropriate information presented to allow management to take action where necessary.	Medium	Key performance measures and indicators are standing agenda items for all LMT & SMT Business Meetings (COMPLETE) Service Clinical Performance scrutinised in monthly performance meetings A full performance dashboard will be created and updated monthly.	Director of Operations	Clinical Service Group Manager	Apr-21	May-21		Completed	July 2021 Update - This is now complete - key performance measures and indicators are standing agenda items for all LMT & SMT Business Meetings. Service Clinical Performance scrutinised in monthly performance meetings A full performance dashboard is updated monthly and there are monthly performance meetings with the ILG with a comprehensive slide deck completed.	March 2021 Update - Update will be abailable in May 2021. May 2021 Update - Key performance measures and indicators are standing agenda items for all LMT & SMT Business Meetings. Service Clinical Performance scrutinised in monthly performance meetings A full performance dashboard will be created and updated monthly.
CAMHS Compliance (February 2021)													
CAMCO 02	Feb-21	Reasonable	A review of all income budgets should take place to ensure: • Up to date SLAs are in place with all organisations that services are provided to. The SLAs should be approved in line with annual value limits outlined in the Health Boards Scheme of Delegation. Obsolete income targets are removed.	High	A review of all income budgets will take place to ensure: Up to date SLAs are in place with all organisations that services are provided to. The SLAs should be approved in line with annual value limits outlined in the Health Boards Scheme of Delegation. Obsolete income targets will be removed. This work will be addressed in the monthly finance meetings.	Director of Operations	Clinical Service Group Manager	Apr-21	01/05/2021 August 2021 Now September 2021		In progress	July 2021 Update -This should be complete - a final check will be undertaken. A review of all income budgets will take place to ensure: Up to date SLAs are in place with all organisations that services are provided to. The SLAs should be approved in line with annual value limits outlined in the Health Boards Scheme of Delegation. Obsolete income targets will be removed. This work will be addressed in the monthly finance meetings.	March 2021 Update - Update will be abailable in May 2021. May 2021 Update - A review of all income budgets will take place to ensure: Up to date SLAs are in place with all organisations that services are provided to. The SLAs should be approved in line with annual value limits outlined in the Health Boards Scheme of Delegation. Obsolete income targets will be removed. This work will be addressed in the monthly finance meetings.
CAMCO 03	Feb-21	Reasonable	Management must ensure that termination forms are completed and submitted in a timely manner prior the employee's termination dates to prevent over payments occurring.	Medium	Line Management flow chart/SOP & training information pack to be developed, including internal audit process. Training session to be delivered to all line managers to ensure everyone is aware of their responsibilities. Including reminding of the requirement to complete & submit termination forms in a timely manner prior the employee's termination dates to prevent over payments occurring. Responsibility with each professional lead to identify clear line management arrangements – ESR & Health Roster to reflect this.	Director of Operations	Senior Nurse/ Clinical Leads	Mar-21	01/05/2021 August 2021 Now September 2021		In progress	July 2021 Update - This action should now be complete - final check to be undedrtaken this month. Training pack completed & training to be rolled out to all managers. ESR being updated to reflect line management arrangements.	March 2021 Update - Update will be abailable in May 2021. May 2021 Update - An update will be available in August 2021.
IT Service Management (April 2021)													

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ITSM 02	Apr-21	Limited	Procedures and guidance should be finalised and issued with training provided as appropriate. Staff should be instructed to ensure that calls and incidents are classified and prioritised correctly	High	Addressed by the response to finding 1. Guidance has been created that will mitigate the risk moving forward in ensuring ICT staff understand the difference between the both call types when raising service point calls. Documentation has been forwarded to the auditor to address the recommendations and findings made for this objective. This will be incorporated into the starter pack for distribution (COMPLETED). 1) Helpdesk Call Types - Training will be provided in house by one of the Desktop Team leaders on a MS TEAMS conference session to run through the management of calls Dates will need to be defined around the training before end of March 2021.	Director of Public Health	Head of Service Management	Mar-21	Sep-21		Part Completed	July 2021 Update - The staff training element of this recommendation has not yet been completed. Training has not yet taken place	May 2021 Update - Documents under review by the Senior management team in ICT before sign off and approval
ITSM 04	Apr-21	Limited	The process for alerts should be maintained and re-established for each team.	Medium	Alerts and Notifications have now been set and configured as per Service (Local and National). All SLA are in place and ITSM email alerts will be sent for service calls that breach SLA timescales and service calls that are due to breach SLA timescales. Service alerts and notifications on new services will be set as per business go live dates. e.g. (Digital Patient Notes) These will be produced in report format, Service Management will be notified about breached calls and report areas of concern to Service Management Board	Director of Public Health	Head of Service Management	Feb-21	Jul-21		Completed	July 2021 Update - All alerts have been configured for services.	May 2021 Update - The new service Digital Patient notes is being used to pilot the alerts process
ITSM 05	Apr-21	Limited	The formal closure process should be defined that sets out that: - All calls should be closed when finished; and - the extent to which user approval should be sought to close different types of calls.	Medium	Please refer to Finding 3 together with the document created for 'Managing Service Point calls' which guides and supports staff on the basis on managing calls and stipulates the actions for closing calls which will provide consistency within the department moving forward (COMPLETED). ICT staff training will be provided in house by one of the Desktop Team leaders on a MS TEAMS conference session to run through the management of calls Dates will need to be defined around the training before end of March 2021.This finding will be reinforced in ICT staff training. The auditor has been sent documentation which has been recently created to meet the recommendations and findings made for this objective. This will be incorporated into the starter pack for distribution.	Director of Public Health	Head of Service Management	Mar-21	Oct-21		Part Completed	July 2021 Update - Documentation has been distributed to the service desk. Desktop team leaders have taken responsibility of training new members of ICT on the use of the ITSM system.	May 2021 - No further update provided
ITSM 06	Apr-20	Limited	The process should be fully defined with an associated SOP and guidance.	Medium	Cwm Taf Morgannwg have set a deadline for April 30th, 2021 to formulate and sign off a Standard Operating Procedure for problem management. The documentation will cover this functionality within the ITSM system including: Problem logging - Required data capture - Problem management - Problem transference - Accessing the problem record Guidance will be created on how to identify - identification and classification - investigation, diagnosis and resolution - creation of known errors	Director of Public Health	Head of Service Management	April 2021/July 2021			Completed	July 2021 Update - Procedure for Problem Management. Update after speaking to DHCW – The review of the problem management policy and procedure will suffice for Cwm Taf Morgannwg. The auditor is satisfied that this is covered. Staff training will be conducted from DHCW	May 2021 Update - No further update provided

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ITSM 07	Apr-21	Limited	Service management should consider defining a standard mechanism and process for operational knowledge management.	Medium	An initial piece of work is required to collate the various pertinent documents and standardise the format. CTM have already identified the requirement to begin the migration from isolated on-premises data repositories into a centralised, governed environment that will allow the HB to move away from traditionally costly on-premises storage solutions organisation. This programme covers three principles requirements for CTM: • Creation of a new Corporate File Plan for SharePoint Storage • • Design and deployment of CTM branded Intranet site templates • • Migration of shared folder data into SharePoint The creation of the ICT knowledge repository will be based upon the principles above and the creation of the cloud based SharePoint	Director of Public Health	Head of Service Management	Jul-21	Sep-21		In progress	July 2021 Update - EUC have been designing training content and material and the idea was to bolt knowledge management to the new ICT site.	May 2021 Update - The move to O365 file share is underway with ICT and the Exec teams as the pilot areas
ITSM 08	Apr-21	Limited	The basis for the compliance figures should be established, and if necessary, amended to fully reflect the situation within the Health Board. As part of the reporting process, areas for improvement should be identified and improvement plans developed.	Medium	The current ITSM solution is managed and developed by NWIS. The HB will need to work with NWIS to be able to understand the discrepancies identified in the audit. Improvements will need to be identified and escalated to the National Service Management board for discussion.	Director of Public Health	Head of Service Management	Sep-21			In progress	July 2021 Update - No further update	May 2021 - No further update provided
ITSM 09	Apr-21	Limited	The Health Board should define their own impact and service levels for use within their Service Management framework.	Medium	The Health Board follow the NWIS Support Standards and all local Systems and services are governed by these service arrangements. The auditor has received the service catalogue for the ICT department which provides all Systems that are covered and documented. The service catalogue will be reviewed with regards to amending to any local system service delivery.	Director of Public Health	Head of Service Management	Apr-21	01/07/2021 Now November 2021		In progress	July 2021 Update - Service Catalogue is being looked at by Paul Thomas who has only recently starting this process, an import from the existing excel spreadsheet has been conducted. This is work in progress.	May 2021 Update - Needs reviewing in line with ITSM10
ITSM 10	Apr-21	Limited	The service levels provided should be issued and agreed with each user department. As part of this process an agreement setting out the responsibilities and expectations should be defined.	Medium	As part of the IMTP ICT will need to undertake discussions with the ILG and department leads to ensure the service level definitions in the ICT service catalogue are acceptable with regards to supporting the departments.	Director of Public Health	Head of Service Management	May-21	01/07/2021 Now October 2021		In progress	July 2021 Update - This remains ongoing	May 2021 Update - This will be undertaken as part of the IMTP enagement
Estates Directorate Management Arrangements (April 2021)													
EDMA 01	Apr-21	Reasonable	1. Management should ensure that the ToR for the Health Safety and Risk Group are reviewed for relevance and brought up to date to reflect all changes especially those relating to the merger with the Bridgend area. 2. The ToR should give greater clarity on the quoracy arrangements. If a percentage quoracy continues to be used, the ToR should more clearly state expected membership. 3. Management should ensure that where possible, in order to maintain continuity, groups such as the SMT continue to meet frequently as they previously did. They should take advantage of the various IT platforms and tools available such as Microsoft teams. This system has been adopted	Medium	1. It is agreed that the TOR should be amended but please note that Bridgend officers have attended the Health Safety and Risk Group. 2. Agreed, will be reflected in the amended TOR. 3. Agreed, meetings will be held at frequencies determined by the TOR, but please note the Senior team met more often during 20/21 (albeit not minuted) to enable the department to respond to the dynamic challenges of Covid 19.	Director of Finance	Head of Estates	April 2021/May 2021			Completed	July 2021 Update - The TOR was distributed between the members of the Health Safety and Risk Group. Changes made to reflect the ongoing presence of Bridgend locality Management team, but membership now noted in the TOR's. Tor also changed from a percentage of quorum, to a specific number of attendees. The quorum shall consist of at least, The Chair or Vice Chair, one Senior Operational Manager and at least 5 additional representatives. Meeting agreement that the group shall meet quarterly. TORs submitted for scrutiny of the group, and formally adopted by the membership of the Health Safety and Risk committee, and passed by the chair at the 12th May 2021 meeting.	
EDMA 02	Apr-21	Reasonable	A strong relationship with the Workforce & OD Business Partner team should be maintained. In the absence of CBMs, the Business Partner should have a proactive participation with the Directorate through the most relevant group or meeting. Whilst the Directorate is able to produce its own workforce data, the previously provided data packs should be used for discussion at meetings and for reconciling to Estates held data, as it is this corporately produced data that will be used in wider Health Board reporting.	Medium	PDR and training data has been provided by the training department on a monthly basis since January 2021 and has subsequently been reported at the Senior operational management team meetings, and will continue to do so. The directorate is not receiving sickness or other work force data consequently the Workforce and OD Business partner will be invited to the monthly meetings that are currently held with the Finance Business partner. If they are not available to attend the meetings the Head of Assets, Technical services and Governance will request the Workforce data pack on a monthly basis and if received will reconcile it to the directorate records.	Director for People	Head of Operational Estates/Head of Assets, Technical Services and Governance	Apr-21			In progress	July 2021 - No further update provided	

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EDMA 03	Apr-21	Reasonable	Management should ensure that the Asbestos Policy and Service Testing of Electrical Equipment Procedure (STEEP) are updated as soon as possible and all P&Ps which are soon due for review are updated in a timely manner.	Medium	The asbestos policy and STEEP will be updated and endorsed at the next meeting of the relevant group.	Director of Finance	Head of Assets, Technical Services and Governance	May 2021/September 2021	September 2021 for STEEP element		Part Completed	July 2021 Update - The Asbestos Policy has been reviewed, updated approved and published to SharePoint, so this item is complete. The Asbestos Management Plan is reviewed annually with the next review due on the 31st January 2022. STEEP is referring to the In Service Testing of Electrical Equipment procedure, which is being actioned by the Electrical Safety Group, led by Jason Williams. This is currently being reviewed and in the process of being completed, and will require approval through the Electrical safety group, for noting at the HS&R committee, and final approval at the Capital and Estates Governance committee.	
EDMA 05	Apr-21	Reasonable	1. The Directorate should review their approach to risk management in line with any advice they have been provided by the Assistant Director of Governance and Risk. This should include the use of Datix as the organisational platform for capturing risk thus allowing the flow of risks up to the Organisational Risk Register as necessary. 2. Work should be carried out to review the content of the register to ensure it captures risks specifically relating to the Estates Directorate (not limited to, but including) operational and staff concerns. The items on the current register that are deemed as an issue and not a risk could continue to be maintained in their current format. 3. Where deemed necessary, the Directorate should request further support and training on the application of the Risk Management Strategy and use of Datix	Medium	1. This recommendation has been actioned through meetings with Assistant Director of Governance & Risk, regular communication is ongoing by emails between the Assistant Director and the Estates team to transfer high scoring risks into the Organisational Risk Register (Datix). 2. This recommendation will be picked up by the Directorate's Health, Safety and Risk group at the next meeting scheduled for May 13th. Following discussions, group members will be requested to manage general departmental risks through the same Estates Risk Register spreadsheet. 3. Meetings have been held with the Health and Safety team and Datix support meetings with officers from CTM UHB - Information Systems. Training and support has been requested from the Health and Safety team for the updates to Datix, and for the new layout and standard reports.	Director of Finance	Head of Assets, Technical Services and Governance	Sep-21			Completed	July 2021 Update - The Directorate has been working in conjunction with the Assistant director of Governance & Risk, to review and update the content of the Datix Risk Register, and to ensure correct escalating of risk through the corpotarate governance process. Also collaborating with the Head of H&S, and the Health and Safety team, supporting the rollout of the One for Wales new version of Datix. Estates have adopted the requirements of the governance process. Where required training and assistance has been sought and carried out. The process of this project will continue to be an onging process to carryout continual review, monitoring, applying improvements and updating the system. The review of the Datix content will always be ongoing.	
EDMA 06	Apr-21	Reasonable	1. Management should ensure that reconciliations and checks are done periodically, especially at the start of the financial year, between their departmental records and ESR. Contact should be made with workforce colleagues to ensure the correct NHS start date is recorded for staff that have transferred into the Health Board, in order for ESR to properly calculate staff's annual leave entitlement. 2. Requests to carry forward annual leave into future years should be kept to a minimum. Where there is an operational demand and leave cannot be taken, requests and authorisation to carry forward leave should be made in a timely manner and where possible in line with the Directorate's annual leave policy. Authorisation to carry forward leave should be granted in line with the Scheme of Delegation. 3. Annual leave requests should be submitted, approved and dated in a timely manner, as stated in Estate's annual leave procedure and approved leave	Medium	1. Agreed. Checks are currently made and this will be reinforced to the management/ admin team. 2. Agreed 3. Agreed	Director of Finance	Head of Operational Estates/Head of Assets, Technical Services and Governance	Apr-21			Completed	July 2021 - All A/L allocations are checked against ESR allocation to ensure continuous service leave is added to the staff records, with regards to carry over of leave the admin staff do not have access to add the carry over on ESR and have to email ESR to amend the leave allocation. Quarterly reconciliation is carried out on staff leave records and reconciled against ESR	
EDMA 07	Apr-21	Reasonable	1. Management should ensure there is an adequate structure in place regarding the prompt monitoring of sickness prompts, the follow up of sickness interviews and maintenance of required documentation as stated in the NHS Wales Managing Attendance at Work policy. 2. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individuals file.	Medium	1)+2) An adequate supervisory structure and process is in place to ensure the recommendations are adhered to, supervisory/ management staff will instructed accordingly, a review will be carried out in September 2021.	Director of Finance	Head of Operational Estates	Apr-21			Completed	July 2021 - An internal procedure has been introduced to ensure managers are undertaking the necessary action required in line with the All Wales Managing Attendance at Work Policy.	
EDMA 10	Apr-21	Reasonable	Acknowledging that this has been an unprecedented year in the Health Board and IMTPs were superseded, going forward, management should ensure they follow the timeframes and content set out in the Health Board's Local Planning Framework when developing future IMTPs. Evidence should be retained of the work carried out on draft versions of the document	High	Agreed- Timescales will be followed, and draft versions retained.	Director of Finance	Assistant Director of Capital & Estates	Apr-21	Aug-21		Completed	July 2021 Uodate - The IMTP for 2021/24 has been agreed with the Director of Finance and is to be submitted to planning. Throughout the process all draft versions have been filed in a central shared filing system.	

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EDMA 11	Apr-21	Reasonable	While the IMTP programme has been paused, the need to continue to plan for future workforce needs continues. Management should ensure that future planning continues to give consideration to anticipated workforce pressures.	High	Workforce planning is a continual process and discussed regularly at senior team meetings, the outcome of this will be included in the IMTP submission.	Director of Finance	Assistant Director of Capital & Estates	Apr-21	Aug-21		Completed	July 2021 Update - The workforce plan has been included in the IMTP and agreed with the Director of Finance.	
Estates Directorate Compliance (April 2021)													
EDCO 01	Apr-21	Substantial	Staff to be reminded that all paperwork relating to purchases made via the 'Screwfix' emergency purchasing cards should be retained.	Low	It will be reinforced via the supervisors and followed up with an email to operational staff that they retain paperwork and return it to the relevant stores manager.	Director of Finance	Head of Estates	Apr-21			Completed	July 2021 Update - Communication carried out via email, staff meetings and with all management and staff to highlight the audit findings. All management and supervisors notified of the requirement to ensure all documentation with associated Screwfix cards is provided with each transaction. Notification posted also on staff notice boards, and spot checks carried out by senior management to ensure the process is being adhered to.	
Welsh Risk Pool Claim Process (April 2021)													
WRP 01	Apr-21	Reasonable	1) The Claims Team should be reminded of the requirement to submit reimbursement requests and associated paperwork to the WRP in line with the timeframes set out by the WRP. 2) For each claim, all applicable fields within Datix should be completed to allowing monitoring of compliance with timeframes.	Medium	1) Since this audit the claims team have been working closely with colleagues from WRP to ensure on-time submission of all the relevant reports including CMRs and LFERs. For March 21 all requested forms and reports as requested by the WRP have been submitted on time and spreadsheets updated accordingly. All the CMRs for the historic cases have now been submitted and the legacy LFERs continue to reduce with an aim of the LFER Task Force finishing these by end of March 2021. 2) Since the audit, the claims team have been working closely with colleagues from WRP to ensure the accuracy of the updating and reporting of claims and timescales on Datix. Each case has been reviewed individually in order to produce specific spreadsheets as requested by the WRP in preparation for their committee in March 21. CTM UHB will go live on the 1st April 21 with the new Once for Wales claims and redress module on Datix. This will enable more accurate reports to be obtained to ensure weekly review of cases between the Claims handler and	Director of Nursing	Claims Team Manager	Apr-21	01/08/2021 Now September 2021		In progress	July 2021 Update - The claims team continue to work closely with WRP in order to submit for reimbursments on time. The new Once for Wales RL Datix system has been implemented in CTM for Claims, Redress and Complaints. Considerable work has been undertaken to submit LFERs for the 31st July deadline, however, engagement from the operational teams has not been consistent across the Health Board. The taskforce which was in place to follow up on learning and evidence of learning will be stepping down after 31st July. A new process is being proposed going forward linking the claims team directly with the CSGs. In addition a Health Board Committee will be established in order to monitor these more effectively.	May 2021 Update 1) Next deobtor spreadsheet for completion by July 2021. In relation to LFER's, the Task Force are aiming to complete these by end of July 2021. 2) All cases in March 21 were agreed by the WRP committee. Implementation of Once for Wales PTR datix modules has been delayed across Wales. New proposed date is 1st July 21. Once implemented this will enable more accurate reports to be obtained to ensure weekly review of cases between the Claims handler and the Claims and Redress manager.
Financial Systems (April 2021)													
FS 01	Apr-21	Reasonable	1. The current fund holder role should be reviewed and if necessary, an additional fund holder added to take responsibility for expenditure on patients. 2. Fund holders should be made aware of the expectations being placed upon them and their responsibilities in line with the Charitable Funds FCP. 3. Plans should be put in place for the prompt expenditure of donations on patients and staff, in line with the likely spirit in which they were originally donated.	High	The Covid-19 fund that was set up when the initial amount was received was set up for the purposes of patient benefit, staff & equipment. This was included on the signed form for the purpose of the fund by the fund holder. We will ensure that it is known that this fund is available for the agreed purposes. It is the responsibility of the fund holder to manage the expenditure of the fund. The monthly reports provide an analysis of committed expenditure of the fund. There are further aspects of Covid-19 charitable fund donations that are being worked through with the relevant officers, these will be confirmed with identified fund holders and committed expenditure in the new financial year in line with expected use of the funds. Additional Covid allocations have been received from WG during the year to fund Covid related expenditure. This has meant that WG funding has been used in the first instance rather than utilising the Charitable Fund. This would allow for its use in coming months when WG funding may not be available. We will identify future commitments for the fund in the coming	Director of Finance	Fund holder / DDoF / Head of Corporate – Finance	May-21			Completed	July 2021 Update - Appropriate officers have been identified and updates provided. A number of commitments have been made from the various covid 19 funds and applications made to secure further funding. An update will be provided to the Charitable Funds Committee in August.	
FS 02	Apr-21	Reasonable	Specific instructions relating to donations should be clearly communicated to the fund holder to ensure donations are spent in accordance with the donors wishes and expectations.	High	Updated Management Action - When forms are provided to fund holder it will clearly identify types of expenditure allowable. There will be regular communication with fund holders to ensure expenditure is in line with expectations.	Director of Finance	Senior Finance Oficer - Charitable Funds	Immediate			Completed	July 2021 Update - Following last committee discussion took place between Head of Corporate Finance and Internal Audit to agree way forward for this action to be completed. The management action has subsequently been updated.	

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FS 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	Aug-21		In progress	July 2021 Update - Charitable Funds have recently been moved onto the Oracle system which allows for greater consistency of governance and controls, these are currently being bedded in and reviewed. The FCP needs to be updated to reflect these changes.	
FS 04	Apr-21	Reasonable	The work of the project team to identify and implement alternative process for the timely removal from the financial system of terminated users or users that have changed their role should recommence as soon as possible and changes made to the FCP if necessary. In the meantime, consideration should be given to restarting the periodic issuing of Oracle hierarchy reports to managers asking them to confirm that the details are still correct.	Medium	Agreed with recommendation and in line with the FCP, we have actioned the end date of inactive users and a new monthly monitoring process has been put in place which is due to go live this month.	Director of Finance	Systems Accountant	Mar-21			Completed	July 2021 Update - Action now in place	
FS 05	Apr-21	Medium	If there is a move towards less frequent physical verification work by the capital finance team, consideration should be given to other controls: • Reviewing the frequency of requesting directorates (now Clinical Service Groups) to review their asset reports. At the current time reports are issued quarterly with a response required once a year. A move to detailed reports issued every six months and ensuring a greater response rate should be considered. • Liaising with the Clinical Engineering department to cross match assets they have verified as part of their planned preventative maintenance (PPM) cycles of work, allowing the capital finance team to focus their verification efforts on those assets that may not form part of a PPM cycle.	Medium	As mentioned in the finding changes are being made to the current FCP regarding the information sent to directorates and the 18-month physical verification cycle. • Asset reports will be sent to directorates biannually rather than quarterly. It will remain that once a year Clinical Service Group Managers are required to return a signed and dated copy of the report to the Capital Accountant. A greater response rate to this will be targeted through regular follow up. • The change to physical verification is moving to a sample physical verification exercise of each directorate on a 3-year rolling period. The FCP will state that this exercise will include an element of physical verification by the Senior Finance Officer but also using data available from Clinical Engineering records of equipment service and maintenance. In addition to this the FCP will state that this exercise will be formally recorded in the asset register which was not the case previously. Note the action and deadline set for this is considered to be through updating the FCP for the above. Evidence of the changes in action would not be seen in full until March 2022	Director of Finance	Capital Finance Manager	Apr-21			Completed	July 2021 Update - The actions in the management action agreed are now in place.	
FS 06	Apr-21	Reasonable	Management may want to consider creating a procedure, as it will help strengthen efficiencies, deliver best practice and more importantly it will provide added support should the department have new staff working in that area.	Low	Agreed. A manual for the fixed asset register will be created.	Director of Finance	Finance Manager	Sep-21			In progress	July 2021 Update - Action on target to be completed by September 2021	
PCH Redevelopment Governance Audit (April 2021)													
PCH GOV 02	Apr-21	Reasonable	Key roles and responsibilities should be defined at the Project Execution Plan as the main point of reference (D).	Low	Agreed. Whilst individuals are performing the expected roles, the corresponding documentation will be updated.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		Completed	July 2021 Update - Revision of PEP received	May 2021 Update - Review of PEP required to define amendments of roles and responsibilities. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.
PCH GOV 03	Apr-21	Reasonable	Appropriate arrangements will be made to ensure that vacancies identified within the resource schedule are filled as a matter of priority (O).	High	Agreed. All of the appointments for additional resources are progressing and the Senior Responsible Officer has confirmed that all are permanent positions (Noting that the appointments are for a 5.5 year construction programme and employment rights become permanent due to this duration). Responsibility for the appointments rests with departmental heads to progress these positions with assistance from the Major Projects Unit.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		Completed	July 2021 Update - Arrangements in place to resource the project requirements.	May 2021 Update - One Commissioning Officer in post. 2 Estates posts addressed; Offer made and being processed for Informatics Officer and additional hours granted to part time Officer. 2 Estates post being addressed; applications received with no suitable candidates, being re-advertised. Discussion held with IT about committing resource to project of Contracted member of staff. Discussion held with IPC regarding need to advertise for post. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.

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PCH GOV 05	Apr-21	Reasonable	The Deputy Senior Responsible Officer will continue to monitor Project Board attendance (O)	Medium	Agreed. The attendance at Project Board will continue to be monitored. Attendance at the last Project Board (January 2021) was quorate with senior representation from the ILG and planning department. The Health Board recognise the pressures that the Covid pandemic has placed on all individuals to date and emerging structural re-organisation on a locality basis. At the last meeting it was identified that certain strategic decisions were not within the gift of the Project Board and required escalation to Chief Executive and other key individuals. This has been promptly recognised and actioned with an initial meeting being arranged to discuss over-arching Health Board considerations that may have an impact on the project. To this extent attendance has improved (noting that Phase 2 is now 'real' and not something that has had a number of false dawns) and equally recognises its limitations on over-arching matters and escalates	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		Completed	July 2021 Update - Monitoring of attendance reported on at each Project Board	May 2021 Update - Need for attendance stressed to attendees and confirmation of attendance sought. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.
PCH GOV 06	Apr-21	Reasonable	Timing of Project Board meetings will be reviewed in order to ensure there is adequate time for financial papers to be disseminated (O).	Low	Agreed. Depending on when the Project Board falls, it can result in a shortened period for the issue of papers following the Financial Review Group and WG dashboard return. The schedule of Project Board meetings for 2021/22 will be reviewed so that impacted meetings are re-arranged.	Director of Finance	Programme Director				Completed	July 2021 Update - Project Board dates for the rest of the year have been reviewed and are positioned appropriatly towards the end of the month with one expection in December which is unavoidable due to the holiday season. Action complete	
PCH Redevelopment Financial Management (April 2021)													
PCH FM 02	Apr-21	Reasonable	The presentation of funding throughout the cost report should be consistent to allow simple interpretation by lay members of the Project Board (O).	Low	Agreed. The cost adviser will be instructed to review the report ahead of the next iteration.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		Completed	July 2021 Update - Format of cost reports reviewed / amended.	May 2021 Update - Audit recommendations shared with Cost Advisor to address in next round of reporting. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.
PCH FM 03	Apr-21	Reasonable	The narrative at the cost report supporting the VAT reclaim will be reviewed to provide greater clarity for the reader (O).	Medium	Agreed. It should be noted that other cost reporting reflected the VAT position correctly, including reporting to Welsh Government. The cost adviser will be instructed to review the report ahead of the next iteration.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		Completed	July 2021 Update - Cost report narrative considered	May 2021 Update - Audit recommendations shared with Cost Advisor to address in next round of reporting. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.
PCH FM 04	Apr-21	Reasonable	The cost adviser report should outline whether both the approvals and/or costs have been uplifted for anticipated changes, in the derivation of the gain share (O).	Medium	Agreed. The cost adviser will be instructed to review the report ahead of the next iteration.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		Completed	July 2021 Update - Cost report updated to reflect gain share changes	May 2021 Update - Audit recommendations shared with Cost Advisor to address in next round of reporting. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.
PCH FM 05	Apr-21	Reasonable	Terminology used at cost adviser reports will be consistent, to ensure reports are easy to follow (D).	Low	Agreed. The cost adviser will be instructed to review the report ahead of the next iteration.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		Completed	July 2021 Update - Cost report terminology reviewed	May 2021 Update - Audit recommendations shared with Cost Advisor to address in next round of reporting. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.
PCH FM 06	Apr-21	Reasonable	Supporting charts and tables to the Cost Adviser report will be reviewed for accuracy and updated (O).	Medium	Agreed. This information is not routinely referenced and is considered superfluous. It will therefore be removed from future reports.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		Completed	July 2021 Update - Cost report format amended to remove charts	March 2021 Update - Audit recommendations shared with Cost Advisor to address in next round of reporting. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.
PCH Redevelopment Technical Compliance (April 2021)													
PCH TC 02	Apr-21	Reasonable	The full tender exercise for Asbestos Consultancy will be progressed as a matter of priority.	Medium	Recommendation 2 agreed.	Director of Finance	Deputy Senior Responsible Officer	Jul-21	Aug-21		Completed	July 2021 Update - Tender process completed	May 2021 Update - Tender documents being prepared for appointment by end of July 21.
Targeted Intervention (June 2021)													
TI 01	Jun-21	Reasonable	Where appropriate, documentary evidence should be embedded within the self assessment and evidence trackers to support progress claimed. Alternatively, if the information to be included in the tracker is too large, a centralised file of evidence should be maintained. A file naming convention should be developed so that where supporting documentation is uploaded directly to the Objective Connect system, this can be cross referenced to the relevant self-assessment and evidence tracker. Self-assessment and evidence trackers should be fully completed including outcomes and measures, and should have the ILG name, date of assessment and	High	A centralised file of evidence has been established on Admin Control to allow scrutiny by SROs across each of the 3 areas (to allow cross referencing and consistency) and enable IM partners for each area to access and scrutinise the evidence to support the revised self-assessment process. A review of the file system will be undertaken to support file sharing on Objective Connect system and scrutiny from WG colleagues. Self-Assessment Trackers will be reviewed and strengthened to include outcome measures with clear signposting of evidence source, date and self-assessment score.	Director of Corporate Governance/ Board Secretary	Chief of Staff	May-21			Completed	July 2021 Update - Complete: • TI folder set up in admin control giving the full board/SRO access to evidence • The Corporate File structure has been reviewed and is better aligned to new approach • Collecting of evidence is done in a systematic way and via 1:1 meetings to ensure consistency across the ILGs and also more meaningful data for the Board/SROs to review Work underway: • Review of the Objective Connect folders to be aligned to the corporate folder structure • Continue to refine the evidence collecting system to ensure consistency and extracting of more detailed information with timescales	

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TI 02	Jun-21	Reasonable	We would recommend that a facilitated cross ILG 'brain storming' session be held to identify and assess TI risks, and if appropriate that these are recorded within the relevant ILG risk registers.	High	As part of the organisational self-assessment process (next session due in April 2021) which includes ILGs, risks to achieving continued progress will be discussed and captured on the organisational risk register. These will then be formally assessed and escalated in line with the Organisational Risk Strategy and Process.	Director of Corporate Governance/ Board Secretary	Chief of Staff	May-21			Completed	July 2021 Update - Complete: • Collecting of evidence is done in a systematic way and via 1:1 meetings to ensure consistency across the ILGs and also more meaningful data for the Board/SROs to review prior to full Board Self-Assessment Meetings. • Board Self–Assessment Meetings have been set-up bi-monthly for the year with a planned pathway of scrutiny and governance from the: TI/SM Steering Group –> Management board –> Self-Assessment -> to Public Board.	
TI 03	Jun-21	Reasonable	The Management Board should ensure the TI update reports receive an appropriate level of scrutiny and challenge in accordance with the documented TI self-assessment process. Management Board should ensure they have the necessary information in a suitable level of detail and the capacity to perform this 'gatekeeper' role ahead of the TI updates being presented to Board for approval. The meeting notes from the Management Board meetings should demonstrate the challenge and scrutiny process that the scoring has been subjected	Medium	In March 2021, The HB approved a revised approach that strengthen the self assessment process and scrutiny of proposed maturity levels. Independent Member partners have been assigned to each area to support the scrutiny of evidence to inform the proposed maturity level that is presented and discussed in a Board/ILG self-assessment session. This session then informs the proposed maturity ratings for the Board to accept.	Director of Corporate Governance/ Board Secretary	Chief Of Staff	Completed			Completed	July 2021 Update - Complete: • Board Self–Assessment Meetings have been set-up bi-monthly for the year with a planned pathway of scrutiny and governance from the TI/SM Steering Group > Management board > Self-Assessment > to Public Board	
TI 04	Jun-21	Reasonable	As a key tool mapping out the Health Board's progress of continuous improvement, the TI roadmap and project plan will need to be updated as soon as possible. The document should then be updated and reviewed on a regular basis. Management should ensure that there is appropriate resource available so that time can be given to investing in the population and ongoing maintenance of the roadmap.	Medium	The HB's response to the second wave of the COVID pandemic has further been hampered with the vacancy in the key role of Chief of Staff who is responsible for overseeing the TI improvement & self-assessment process. The HB acknowledges that as a result, focus has slipped on updating the Roadmap and project plan. The new Chief of Staff commences in post on 19 April 2021 and will review the HBs approach, prioritising the support to SROs to ensure the Roadmap, including measurable outcomes, is populated and regularly updated	Director of Corporate Governance/ Board Secretary	Chief of Staff	May-21			Completed	July 2021 Update - Complete: • The POAP is in development and will continue to evolve as milestones are agreed and further work defined. Ongoing piece of work that demonstrates the journey (roadmap) with regular updates received at the various TI/SM meetings.	
TI 05	Jun-21	Reasonable	1. There should be a clear alignment of activities undertaken as part of the three TI work streams with the milestones in the TI Roadmap and the objectives in the maturity matrices. 2. There should be a clear link between the evidence / outcomes and measures recorded in the self-assessment and evidence trackers to the TI work streams. 3. For each work-stream, the objectives set, both in terms of number and name, should be consistent between the maturity matrix, self-assessment documentation and project plan	Medium	The HB's response to the second wave of the COVID pandemic has further been hampered with the vacancy in the key role of Chief of Staff who is responsible for overseeing the TI improvement & self-assessment process. The HB acknowledges that as a result, focus has slipped on updating the Roadmap and project plan. The new Chief of Staff commences in post on 19 April 2021 and will review the HBs approach, prioritising the support to SROs to ensure the Roadmap, including measurable outcomes, is populated and regularly updated	Director of Corporate Governance/ Board Secretary	Chief of Staff	May-21			Completed	July 2021 Update - Complete: • Chief of Staff in post • Collecting of evidence is done in a systematic way and via 1:1 meetings to ensure consistency across the ILGs and also more meaningful data for the Board/SROs to review prior to full Board Self-Assessment Meetings. • Roadmap and project plan is in development and will continue to evolve as milestones are agreed and further work defined. Ongoing piece of work that demonstrates the journey (roadmap) with regular updates received at the various TI/SM meetings.	
TI 06	Jun-21	Reasonable	The Health Board should establish a process on how the ILG self- assessments are used to inform the Health Board self-assessment. There should be a clear link between progress through the maturity matrix at ILG level and progress at Health Board level, and document the criteria for the Health Board progressing through the maturity matrix. Where decisions are made by the SROs to score a work-stream differently to the cumulative ILG work-stream scores, this should be documented, and an explanation recorded justifying the decision	Medium	Further improvements will be made to the self-assessment process as each round is completed, noting the need to strengthen the link between ILG self-assessment and progress and the overall HB with any discrepancies between the two been explicitly addressed in the self-assessment process. The criteria for progressing through the maturity matrix will be determined by the TI Roadmap.	Director of Corporate Governance/ Board Secretary	Chief of Staff	Jul-21			Completed	July 2021 Update - Complete • A full schedule of meetings have been planned for the remainder of the year which includes monthly Project Steering Group meetings / routinely reporting into Management Board / Self-Assessment Board meetings and Public Board.	
TI 07	Jun-21	Reasonable	Facilitated learning sessions between the ILGs and SROs should be undertaken on a regular basis.	Low	Facilitated learning sessions between the ILGs and SROs will be scheduled on a regular basis as part of the steering / project group which will take place monthly. This will be factored into the overall process for organisational self-assessment prior to Board ratification of progress.	Director of Corporate Governance/ Board Secretary	Chief of Staff	Jul-21			Completed	July 2021 Update - Complete • A full schedule of meetings have been planned for the remainder of the year which includes monthly Project Steering Group meetings / routinely reporting into Management Board / Self-Assessment Board meetings and Public Board	
TI 08	Jun-21	Reasonable	1. If not already approved, the CTM Management Board should agree and approve the Project Steering Group Terms of Reference. 2. The Terms of Reference for both the Project Steering Group and the Project Group should be updated to include the date of approval and future review date, and the 'Draft' watermark removed. 3. The title of both ToR documents should be amended to clarify which group they belong to	Low	A review will be conducted of the project arrangements required to support the on-going progress of continuous improvement in response to TI, amending and updating documentation as required.	Director of Corporate Governance/ Board Secretary	Chief of Staff	Jun-21			Completed	July 2021 Update - Complete: • Project Steering Group ToR have been agreed. Project Group and Steering group has been consolidated into one cohesive meeting to ensure consistency in approach. • The project has taken a planned approach in terms of activity but with agility to support continuous improvement in response to TI.	

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TI 09	Jun-21	Reasonable	Maintaining accurate meeting notes is important as they may be required as evidence by Welsh Government to support claims of progress as the TI project picks up pace. Meeting notes should therefore include the names of all attendees and should be an accurate record of discussions held. They should clearly document decisions made, any actions arising, the name of the officer responsible for undertaking the action and a deadline for completion. We would also recommend that an Action Log be completed after every meeting to monitor the progress of actions between meetings	Low	As R8. Informal and formal scrutiny meetings with WG are always recorded. Organisational self-assessment sessions to inform maturity ratings prior to submission to Board will be recorded.	Director of Corporate Governance/ Board Secretary	Chief of Staff	Apr-21			Completed	July 2021 Update - Complete: • Meetings and actions are now captured in a systematic way and in stored in the revised folder structure.	
TI 10	Jun-21	Reasonable	The Health Board should consider whether it is feasible to set SMART objectives for relevant aspects of the TI work programme.	Low	Outcome measures will be included in the TI Roadmap, to inform the achievement of progress and self-assessment scores.	Director of Corporate Governance/ Board Secretary	Chief of Staff	Jul-21			Completed	July 2021 Update - Complete: • Collecting of evidence is done in a systematic way and via 1:1 meetings to ensure consistency across the ILGs and also more meaningful data for the Board/SROs to review prior to full Board Self-Assessment Meetings. • Roadmap and project plan is in development and will continue to evolve as milestones are agreed and further work defined. Ongoing piece of work that demonstrates the journey (roadmap) and levels with regular updates received at the various TI/SM meetings	
Digital Response to Covid (June 2021)													
DRC 01	Jun-21	Reasonable	The skills and equipment / infrastructure requirements of staff and patient groups should be formally assessed as the part of any roll out of digital solutions, with any skills gap addressed by training.	High	We agree with the requirement to undertake a formal assessment of the skills & infrastructure that would be needed by both staff and patients when procuring and rolling out future digital solutions, whenever this is practically possible (this caveat is only stated as the covid-19 pandemic circumstances did require an almost immediate response to maintaining access to services for many patients & precluded a detailed assessment) To put this into action we will seek to include usability and training material as a key selection criterion and requirement in all procurements local and national – managing the objectives of this recommendation at the design stage. In respect of skilling up the population, the UHB recognises that we have a supporting role to play in this area, and will work with Welsh Government, our Regional partners and third sector co-operatives such as Digital Community Wales in this area. To ensure we learn from the covid experience, we will audit the uptake of the virtual consultations to determine whether and where there were constraints which resulted in the digital solutions provided not being used, or the uptake potentially increasing inequalities. In respect of assessing and being aware of the skills of our staff we have commenced this assessment initially via a HEIW all Wales initiative for Allied Health Professionals and will endeavour to do a similar exercise for other staff groups, with tailoring of the assessment tool applied to needs where necessary. Our preference is to do this as part of the national programme, however if this is not a timely exercise we will proceed locally. Tactically we are also considering strongly recommending that the digital skills required to undertake the responsibilities of a role are	Director of Public Health	Chief Information Officer	Various May 2021/June 2021/July 2021			Completed/ Ongoing	July 2021 Update - Skilling up our staff and the population in the use of digital and informatics is a continuing process without an end. The national approach is progressing with the date for the workshop and literature having been confirmed and received. It has also been clarified that nationaly HEIW will be leadin on the skills development of the non digital workforce, whilst professional training will become the formal responsibility of DHCW. New digital procurements now do identify skills and users requirements alongside training materials . A local analysis of virtual appointments by age group has been undertaken and this will be extended to consider other factors as analytical resource permits.	
DRC 02	Jun-21	Reasonable	A proactive process of contacting users to identify their digital needs should be established within the Health Board that feeds into the assessment structure such as the PPB.	Medum	The second phase of the infrastructure review will appraise the gaps that exist between needs and capability in the digital area and the options for bridging this gap in the short and medium term, recognising the myriad of other factors that will need to be considered (e.g. cyber resilience, people's willingness to use their own device, fit within the infrastructure architecture)	Director of Public Health	Chief Information Officer	Jul-21	Autumn 2021		In progress	July 2021 Update - Second phase is underway - 5 deep dives have been agreed which incoproate the recommendation. Anticipate these will report in Autumn now. DDC are being kept informed of developments. In addition the UHB has agreed to fund the roll out and implementation of the Nursing Care Record. This is a huge development which will provide learning around what is required in different ward environments. The roll out across YCR will commence in August 2021	

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DRC 03	Jun-21	Reasonable	Work to ensure benefits are achieved should be completed. This should identify what has worked well, what has not worked and should be reconsidered and what needs additional input in to sustain the move towards digital health provision. Factors which have impacted on benefit delivery should be identified to ensure that lessons are learned for the future. As part of this work the impact on clinical outcomes and health inequality should be assessed, both in terms of disease type and population / demographic group. An assessment of the infrastructure required to support the ongoing provision of digital services should be undertaken to ensure that services are sustainable for the future.	Medium	The UHB is approaching this in two phases. The first is to review the wider impacts of covid on the health and wellbeing of our population, to understand: - who got covid - who died during the covid period - who died of covid during the covid period (COMPLETED) The second will then be to ascertain whether there were differentials in access to services over the covid period, and whether or not the organisation's digital response inadvertently had an impact by exacerbating or closing these differentials. The second stage of the infrastructure review has been established to make recommendations of the sustainable infrastructure requirements.	Director of Public Health	Chief Information Officer	Jul-21	Autumn 2021		Part Completed	July 2021 Update - As above this has progressed, and will be completed as analytical resources and competing priorities permit	
DRC 04	Jun-21	Reasonable	The basis by which requests for IT equipment and services are prioritised should be formally stated and included on the webpage and service point request svstem.	Low	The UHB has recently launched a new Statement of Need procedure which addresses the points raised.	Director of Public Health	Chief Information Officer	Completed			Completed		

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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	September 2016 February 2021 August 2021		In Progress	July 2021 - work continues via the Planned Care and Unscheduled Care Programmes in line with Resetting. More information will be available at the next meeting. No revised implementation date provided	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. 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. March 2021. Work in this area is steady. The ILGs have completed their D&C Plans which have been
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	February 2021 April 2021 August 2021		In Progress	July 2021 - work continues via the Planned Care and Unscheduled Care Programmes in line with Resetting. More information will be available at the next meeting. No revised implementation date provided	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 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. March 2021. See above CPOS 01 - consideration of this element of work on orthopaedics will be included in this work. In addition, the COO has recently met Orthopaedic Leads to discuss these matters and a

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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	February 2021 May 2021 August 2021		In Progress	July 2021 - work continues via the Planned Care and Unscheduled Care Programmes in line with Resetting. More information will be available at the next meeting. No revised implementation date provided	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. 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 2021.The ILGs have completed their D&C Plans which have been incorporated into the UHB's IMTP and submitted to WG. This has been significant and detailed work.
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 taking steps to minimise the risk to patients. Where harm has been identified it is capturing this	Director of Operations			01/02/2021 August 2021		In Progress	July 2021 - work continues via the Planned Care and Unscheduled Care Programmes in line with Resetting. More information will be available at the next meeting. This information is now discussed at ILG level and then monthly at the Performance Review Meetings with teh COO - where progress is demonstrated. Harm Reviews are also ongoing. Revised implementation date not provided	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. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next month. March 2021. Implication of covid have meant that this issue has not received the appropriate management focus, however in the last month significant work has been undertaken on Demand and Capacity planning. This process has identified in detail the requirements and also the gaps and ILGs have been required to be clear about where they need additional support to deliver improved waiting times for current and future patients. This will be reported on in coming months via Performance

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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			February 2021 Ongoing August 2021		In Progress	July 2021 - work continues via the Planned Care and Unscheduled Care Programmes in line with Resetting. More information will be available at the next meeting. This information is now discussed at ILG level and then monthly at the Performance Review Meetings with teh COO - where progress is demonstrated. Harm Reviews are also ongoing. Revised implementation date not provided	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next month. March 2021. Implication of covid have meant that this issue has not received the appropriate management focus, however in the last month significant work has been undertaken on Demand and Capacity planning. This process has identified in detail the requirements and also the gaps and ILGs have been required to be clear about where they need additional support to deliver improved waiting times for current and future patients. Special importance is being attached to "other ways" of reducing lists and validation will be a focus of this process. This will be reported on in coming months via Performance Review and other meetings. Additional validation resource has been put into place as a short term response to dealing with the impact of Covid which has resulted in many patient pathways being impacted. While this is contrary to the recommendation, it has been a necessary response to the changed circumstances. May 2021 Update - Given the passage of time since this original review, thought will be given to discussing the recommendations of this audit with Audit colleagues. In the meantime, the UHB can offer assurance by confirming that the activity outlind in previous months is continuing and the Elective Recovery Plan is gathering pace and that it is monitored via weekly
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	February 2021 Ongoing August 2021		In Progress	July 2021 - no futher information this month. Revised implementation date not provided	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. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next month. March 2021 Update - The backlog has grown significantly as a result of Covid Current capacity and demand modelling does not set out a trajectory for resolving the backlog dueing 2021/22.
Discharge Planning (March 2018)												

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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	February 2021 May 2021 August 2021		In Progress	July 2021 - there is no further information this month. Revised implementation date not provided	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next month. March 2021 Update - An Unscheduled Care Improvement Programme has been designed and constructed to focus on all aspects of urgent care. This specifically includes a workstream on discharge planning and managing stranded patients The programme structure and governance has been reviewed and signed off by Exec and Management Board and is scheduled for review by the Q&S Committee in May 2021. Mobilisation of Unscheduled Care Improvement Board in April 2021 with the detailed project development of the identified workstreams to be completed in May 2021 and beyond Review of programme by Q&S Committee in May 2021. May 2021 Update - The Q&S Committee approved the plans of the Urgent Care Improvement Programme (UCIP) in May 2021. The workstreams include consideration of Flows in Hospitals and this issue will be picked up via that route. It is like;y that there will need to be discussions with ILGs as the plans will be slightly different for each ILG.
Primary Care Services (February 2019)												
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	01/03/2021 September 2021		In Progress	July 2021 Update - Workforce review completed and due to be received by Primary Care Board August and will inform service planning thereafter. On Track to complete full action by Sept 21.	Update July 2020 - Delayed as a result of Covid-19 pandemic. May 2021 Update Implementation date has been revised to coincide with the on boarding of the new Assistant Dental Director
Structured Assessment 2018												
SA18 06	Apr-19	The Audit committee tracker should be expanded to include the recommendations of other external agencies e.g. Healthcare Inspectorate Wales and the Delivery Unit.	Medium/ Low	R6 A new tracker (based on the Audit Tracker) will be developed for recommendations of external agencies and regulators. The audit tracker is already of a considerable size and concerns were raised that adding recommendations could be lost. This new Tracker will report to the Quality Safety and Risk Committee.	Director of Nursing		Jun-19	October 2020 February 2021		Completed	July 2021 Update - It was recommended and therefore approved by the Quality & Safety Committee Chair and the Executive Director of Nursing that there is a robust process in place to track all HIW and DU recommendations and therefore including these in the overall audit tracker would be a duplication of work and effort by our teams. It was agreed that the Quality & Safety Committee would continue to receive regular update reports.	July 2020 Update - New tracker currently being populated with recommendations from Healthcare Inspectorate Wales and Delivery Unit reports. Complete database will be complete by September for reporting in October 2020. November 2020 Update - In progress - Tracker has now started to be populated with HIW and DU recommendations
Clinical Coding Follow Up Review												

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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 Operations		Not specified by the Health Board	October 2020 April 2021		In progress	July 2021. Information on this recommendation has been received and will be escalated to the ILGs for comment nect quarter. Revised implementation date not provided.	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. 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
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 Operations		Not specified by the Health Board	October 2020 November 2021		In progress	July 2021. Information on this recommendation has been received and will be escalated to the ILGs for comment nect quarter.	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. January 2021 Update The UHB Clinical Audit Team (CAT) currently undertake an annual audit of the quality of case notes which looks at the documentation in case notes and is aligned to the Health Records Committee (HRC) which no longer exists. The Performance and Clinical Information function will shortly begin conversations around areas of overlap between the HRC and PCISG. The outcome of which will inform which group will provide oversight and assurance responsibilities in relation to the results of CAT medical records quality audit. The newly appointed clinical coding trainer has previous experience with auditing and will be undertaking internal coding audits as a part of her responsibilities. The results of these internal coding audits will be made available to the leadership of the Performance and Information (P&I) Directorate and the relevant oversight and assurance groups. May 2021 - No further update to report

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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 Public Health		Not specified by the Health Board	October 2020 September 2021 Now October 2021		In progress	July 2021 Update - As of May /June 2021 efforts to drive quality efficiency and performance improvement within Clinical Coding continue apace with the trialling 3M Medicode 360 product. The Data Quality Analytics (DQA) and Integrity Plus (IP) auditing solution tool will facilitate clinician engagement by providing the evidence needed for consistent and sustainable engagement built around quality information. Prior to the recently completed 3M Data Quality Assurance Audit, the Clinical Coding Department undertook a quality audit of the information held in the Maternity system MITS against the hand written documentation in the medical record. Aspects of the report provided feedback on the quality of information recorded by clinical staff and plans are being put in place to address the findings. Similarly, the Clinical Coding Department is currently undertaking a ventilation audit on patients admitted with a diagnosis of Corona Virus. It was felt that there had been a lack of recording of ventilation in patient notes and as a result, it was not being reflected in the clinical coding. The Clinical Coding Department continues to work with Clinical Colleagues to ensure Local Coding Policies are kept up to date. The Maternity "Mode of Delivery using Forceps" policy has been updated to integrate Neville Barnes Wigleys and Kellands. In collaboration with Dr Yapp, a new policy has been created to include the link between patients who are diagnosed with Oesophageal Varices in Alcoholic Liver disease. The longer term strategy is to approach greater clinical ownership through data democratisation and coding at source. A key vehicle for this is the roll out of e-forms within CTM will be underpinned SNOMED CT Standard Ontology. This will provide a single shared language, which makes exchanging information between e-forms and any future coding application easier, safer and more accurate.	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. January 2021 Update Training and engagement with Clinicians will be a bigger part of the coding education and engagement programme for 2021/2022. With the provision of quality information we will be working towards reinstating feedback sessions where clinicians have the opportunity to sign off their clinically coded information. We also plan to reinstate presentations at the Junior Doctor induction, engaging with and informing the doctors at the beginning of their career.
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 Public Health		Not specified by the Health Board	October 2020 April 2021		Completed	July 2021 Update - A briefing material, which sets out the implications of poor clinical coding was developed and shared in April/May 2021. Clinical Coding performance continues to be reported via internal reporting mechanisms. Timeliness, Completeness and Accuracy (sourced from CHKS iCompare) are key indicators reported each month within the organisation (benchmarked against the Welsh peer group). CTM is collaborating with 3M as a development partner for the ARC product. The product will facilitate near real time rules based auto coding of clinical activity. A high-level plan is being established to develop natural language processing based auto coding capabilities.	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. January 2021 Update Development of briefing material which clearly sets out the implications of poor clinical coding is one of the objectives set for Q1 2021/22. Unfortunately due to the second wave of Covid -19 and the R-rate continuing to be one of the highest in Wales, we were unable to arrange for the two board members to visit the department. This invitation remains open at a more suitable and appropriate time and we further welcome any senior manager/clinician that may want to learn more about clinical coding to engage with us at any time.

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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 Nursing		Full Est. by April 2023/ December 2020	Sep-21		Part Completed	July 2021 Update - New Improvement Directorate formed under the DOI (April 2021) bringing together PMO, Improvement, Innovation and VBHC. - Review of Improvement capability and recuritment of additional QI and Business Change leads x 2 underway to support business change agenda and ensure sufficient capacity and capability in place. - PMO team structure review being undertaken to ensure correct mix of resources and capability to deliver the change agenda, additional resources being recurited both permenant and fixed term to ensure sufficient capacity to deliver work programme. Additionally reviewing skill mix and team development to ensure sufficienct business change skills. - 3 x ILG QI Facilty created (MDT) to champion and help deliver change and improvements for each ILG (June 2021) and Improvement training commenced. - Work commenced for cross organisational prioritisation assessment matrix to ensure correct alignement of resources to deliver organisational priorities. - Full implementation of revised structures, capability and processes now due September 21.	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. March 2021-Action transferred from Director of Public Health to Executive Nurse Director March 2021-Update Director of Improvement (DOI) appointed and commences post 06 April 2021 March 2021-PMO and Innovation team have moved into the Executive Nurse Director directorate, under the leadership of the DOI and will provide more integrated capacity. March 2021 Update-further progress to be made when DOI commences in post (06.04.21)
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 focuses onTechnical Efficiency • Population Health Efficiency	Director of Finance		Mar-21	01/06/2021 Now 31 December 2021		In Progress	July 2021 Update - Recruitment into the Financila Planning Team is necessary to deliver the agreed action. This is being progressed but the vacancies are not yet filled. It is planned that this work will utilise the Financial Delivery Unit "Vault" of information on benchmarking, the initial stages of which have just become available. After allowing for a 3 month recruitment period to appoint into the Head of Finance post for Value and Business Intelligence, a realistic date for completing this work is now 31 December. Opportunities for temporary staff to progress this work are also being explored.	March 2021 Update - A summary of cost benchmarking information was taken to the Management Board in March 2020, before the Covid lockdown. It was planned to develop this further during 2020/21 but this was not possible because of the focus on the Covid respose. Work is now need needed to use this and other information to create an opportunity analysis aligned to ILGs, and not just for the former Cwm Taf or for CTM. This work has started but will not be complete by 31 March. A revised deadline of 30 June is proposed for an initial high level opportunity analysis , but in reality it is needed before this and as early as possible in 2021/22. Work will then continue to further develop the opportunity analysis during 2021/22. Next Steps: Complete initial high level opportunity analysis as early as possible in 2021/22 and no later than end June 2021.
Audit of Accounts Report Addendum												
AA 01	Dec-20	Given that we will be reviewing the Health Board's old accruals as at 30 September, we will consider the need to raise any recommendations after that audit work. In the meantime, the Health Board should: • stop the practice of accounting on a net basis for a movement in an accrual from one year to the next year. In such circumstances, where the Health Board has judged that an accrual's assessed value has changed, it should always reverse out the previous year's accrual in	Medium/ Low	The above recommendations have already been shared with the relevant members of the Senior Finance team for implementation within their teams.	Director of Finance		Mar-21			Completed	July 2021 Update - Implemented, there were also no issues raised during the 2020/21 audit of the accounts in relation to this recommendation.	March 2021 Update - Guidance given to finance teams on these issues as previously noted. New analysis codes have been agreed to ensure that ongoing identification and reconciliation of balance sheet codes are more robust. We will ensure that the 2020/21 year end accruals are completed in line with the recommendations. Next Steps: The final implementation will be actioned during the year end process.

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AA 02	Dec-20	The Health Board should identify all generic references within its fixed asset register and strengthen the meaningfulness of the descriptive entries, which should include references to actual fixed assets. Where this cannot be done, the Health Board should consider reversing the fixed-asset amounts to revenue expenditure. Looking forward, on acquisition, the Health Board should ensure that all capital expenditure is recorded in detail within the fixed asset register, with	Medium/Low	In the vast majority of cases, where multiple assets are grouped as a single item in the fixed asset register, it is because individually they do not meet the capital threshold, however, they meet the criteria to form a grouped asset and as such are recorded in this way. This often relates to IT equipment, however, is also the case when capitalising items which are part of the 'initial equipping' rule set out in the manual for accounts. The capital team will review the asset register to identify any assets that have been grouped into a single line that should have instead been recorded as separate assets and split these accordingly. In relation to the grouped assets, the names will be reviewed, however, it is considered IM&T Q4 2018-19 is an appropriate name for this type of grouped asset. In relation to tracing these items back to an asset, the capital team will, moving forward, ensure that all PO numbers relating to new grouped assets are recorded in the fixed asset	Director of Finance		Mar-21			Completed	July 2021 Update - PO details are now included to enhance ICT asset tracking.	March 2021 Update - A number of assets have been split out for more accurate recording in the asset register. This will be reviewed again prior to closure of the asset register for 20/21 after all new assets have been added. All PO numbers relating to new grouped assets added Qtr 1 - 3 20/21 have been recorded on the fixed asset register. Next Steps: The final implementation will be actioned during the year end process.
Follow Up Review of Operating Theatres												
OPT FUP 06a	Dec-20	Deliver a project to improve performance management of pre-operative assessment. The Health Board needs to know more about its effectiveness and its impact on cancellations.	Medium/Low		Director of Operations			Aug-21		In progress	July 2021 - No further update provided	Staff were positive about the pre-operative assessment service and its impact on reducing cancellations at both RGH and PCH. There have been some site-specific projects to improve pre-operative assessment. For example, completing pre-operative assessment in day surgery at PCH. However, we found the service is not available to all specialities. For example, it has only recently been introduced for Urology. Our discussions with staff suggested there are inconsistent pre-operative assessment models at RGH and PCH and there was limited evidence to suggest there are performance management arrangements in place for this service. Further progress on this has been affected by COVID-19, and the Health Board is aware that work going forward will need to focus on improving pre-operative assessment as part of the planned care recovery programme following COVID-19. March 2021 Update - Nothing further to report this month. May 2021. The Theatre Department in MC has agreement to a proposal to implement a Theatre Improvement
OPT FUP 06b	Dec-20	Analyse by speciality/surgeon, where day of surgery admission (DOSA) rates are low. Work with these specialties/surgeons to understand/overcome the barriers to increasing DOSA rates.	Medium/Low		Director of Operations			Aug-21		In progress	July 2021 - No further update provided	DOSA rates are monitored at PCH at RGH. There was limited evidence to indicate whether the Health Board is working with surgeons and/or specialties to secure improvements. As part of the COVID-19 recovery plans further work is planned in this area to maximise capacity as part of the planned care recovery. Scrutiny of information will be undertaken within Integrated Locality Groups March 2021 Update - Nothing further to report this month. May 2021 Update - Work continues across the ILGs in this area. See above regarding plans in MC.
OPT FUP 07a	Dec-20	Formally nominate surgeons on each hospital site to act as champions for short stay surgery.	Medium/Low		Director of Operations			Aug-21		In progress	July 2021 - No further update provided	The Health Board has a nominated consultant champion at PCH for short stay surgery, however the Health Board was unable to confirm if there are similar arrangements at RGH. As the Health Board moves forward with its planned care recovery there is an opportunity to ensure there are champions at all sites to improve short stay surgery rates. However, it is noted that the Health Board are working proactively to identify where improvements could be made. March 2021 Update - Nothing further to report this month. May 2021 Update - This is likely to form a significant part of the Theatre Improvement Programme in MC. Monitoring of theatre usage and activity continues to identify where improvements can be made across the UHB.

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OPT FUP 07b	Dec-20	The champions should lead a project with the aim of increasing short-stay surgery rates within the next 12 months.	Medium/Low		Director of Operations			Aug-21		In progress	July 2021 - No further update provided	The champion for short stay surgery at PCH has completed some site -specific audit/improvement work focussing on unplanned admissions following planned day surgery, improving day case laparoscopic cholecystectomies and adequacy of day surgery post-operative analgesia. However, no evidence was provided to indicate whether short stay surgery rates are formally monitored across hospital sites and there is limited evidence to suggest that any projects have been completed across the hospital sites to increase short-stay surgery rates. Due to COVID-19 planned elective work has been affected significantly, opportunities for maximising short-stay surgery will be explored as part of COVID-19 recovery planning. March 2021 Update - Nothing further to report this month. May 2021 Update - This area will form a part of the Theatre Improvement Programme in MC. Nothing further to report this month.
OPT FUP 08a	Dec-20	Reintroduce optimisation charts to reinvigorate the focus on efficiency (without sacrificing quality and safety).	Medium/Low		Director of Operations			Aug-21		In progress	July 2021 - No further update provided	The Health Board uses the Qlik sense system to collate and monitor operating theatre performance with data available for on the day cancellations, in session utilisation, missed opportunities, non-fallow empty sessions, unused planned time and cost of unused planned time. However, there doesn't appear to be any focus on surgical productivity. Our analysis of the performance trends from July 2018 to December 2019, indicates that operating theatre performance is improving, but more work can be done to secure further improvements around on the day cancellations, in session utilisation, non-fallow empty sessions and unused planned time. Our discussions with staff suggest there is a lack of focus on operating theatre efficiency, despite having the performance information available. This view was reflected during our walkthrough of the operating theatre departments at RGH and PCH which revealed that information on late starts, overruns, cancellations and reasons for these are not recorded on theatre quality improvement boards / optimisation charts. We were told that efficiency information is not always recorded if it's not considered an issue. The impact of COVID-19 has significantly affected theatre throughput and activity. As part of recovery planning the Health Board recognise the need to ensure effective monitoring of efficiency and capacity. There are tools in place, and the new Integrated Locality Structures as well as the new general managers
OPT FUP 08b	Dec-20	One of the clinical directors should lead a project to increase awareness and use of the theatre performance dashboard. The project should seek to understand and address any barriers relating to clinicians not owning the clinician-level efficiency data.	Medium/Low		Director of Operations			Aug-21		In progress	July 2021 - No further update provided	Our discussions with staff indicate that clinicians may be kept informed of theatre efficiency performance verbally, but they do not access the theatre performance dashboard themselves. Following the introduction of the new operating model across the Health Board there has been an increase in senior clinical leadership within the Integrated Locality groups and also within the surgical areas through the new clinical service group managers. Further strengthening has been achieved though the appointment of the clinical directors for two of the three surgical clinical service groups. Work on this area has been affected by COVID-19 however the structures should support the achievement of this recommendation. March 2021 Update - Nothing further to report this month. May 2021 Update - Nothing further to report this month

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OPT FUP 08c	Dec-20	Share learning by clinical directors annually peer reviewing theatre data and observing performance in different specialties. Feed this into job planning, revalidation and appraisals.	Medium/Low		Director of Operations			Aug-21		In Progress	July 2021 - No further update provided	Our discussions with staff found that the monthly Clinical Leaders forum provides opportunities to share learning, analyse theatre data and performance of different specialties, but at the time of our fieldwork, the Clinical Director for ACT had just been appointed and as such had not attended a meeting. We were also not provided with any minutes or papers for this meeting during the audit fieldwork, therefore we were unable to verify this statement. Further progress against this recommendation has been affected by COVID-19, it is hoped that the new arrangements and operating model will support this process. March 2021 Update - Nothing further to report this month. May 2021 Update - No further progress to report this month.
OPT FUP ABMU 01	Dec-20	Reintroduce a structured programme for theatre improvement, possibly as a workstream within the Surgical Pathway Board.	Medium/Low		Director of Operations					In Progress	July 2021 - No further update provided	Since the transfer of Princess of Wales Hospital from Abertawe Bro Morgannwg University Health Board to Cwm Taf Morgannwg University Health Board, there has been no work to reintroduce a structured programme for theatre improvement. The Health Board has recently introduced a new operating model which is expected to help support this work. COVID-19 has affected further improvements at this time. The Health Board agrees that Theatre Improvement will need to feature strongly in recovery plans post COVID-19 as Health Board seeks to improve planned care throughput following the COVID-19 impact. March 2021 Update - Nothing further to report this month. May 2021 Update - Nothing further to report this month
OPT FUP ABMU 02	Dec-20	Develop an approach to performance management in theatres that ensures good quality data is widely used to drive improvement.	Medium/Low		Director of Operations					In Progress	July 2021 - No further update provided	There are differing arrangements to monitor operating theatre efficiency at Princess of Wales hospital with operating theatre departments at the Health Board's other hospital sites. Currently, Swansea Bay University Health Board provide Princess of Wales hospital with a monthly theatre utilisation report produced to share among operating theatre staff. Our review of the report found it to contain information on session utilisation and late starts / early finishes. This contrasts with the information available to operating theatre departments at RGH and PCH which is more frequent and has a focus on different performance metrics. Although there have been recent improvements in access to the Qliksense system. Princess of Wales Hospital can generate other theatre data internally to answer specific queries, but there was no evidence to suggest monitoring of other aspects of theatre performance and no plans yet to merge systems. March 2021 Update - Nothing further this month to report. The UHB is in the continual process of refining its data quality and availability. May 2021 Update - Nothing further this month to report. The UHB is in the continual process of refining its data quality and availability.

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OPT FUP ABMU 03	Dec-20	Introduce a mechanism to ensure more regular executive oversight of theatre efficiency, productivity and safety.	Medium/Low		Director of Operations			Aug-21		In progress	July 2021 - No further update provided	Our interviews with staff found there are no meetings to discuss operating theatre performance. Our review of Quality and Patient Safety meetings, as well as operating theatre departmental meetings found limited evidence of discussion or any action taken to address areas of performance. Previously, the theatre user group monitored theatre performance, but this was disbanded because of poor attendance from surgeons. The Health Board's Integrated Performance Dashboard presented at committee and board level includes information on theatre efficiency, but this primarily focusses on cancellations at all three of its hospital sites and doesn't provide a complete picture of operating theatre performance. The introduction of the new Integrated Locality groups and the new quality governance framework agreed formally by the Health Board in September 2020 should lay the structure in place to improve the opportunity for theatre efficiency and productivity to become more focused. This combined with how the Health Board are moving to recovery following COVID -19 for their planned care workload will also drive conversations in this area. March 2021 Update - It is anticipated that one of the benefits of the new opertating model is that the creation of the ILGs will allow appropriate management focus on different Clinical Service Groups. A starting point is the establishment of the Performance Review Meetings held monthly with each ILG. Though quality remains at teh top
OPT FUP ABMU 05	Dec-20	Draw on the expertise of the Health Board's Communications team to promote to staff the benefits of using the WHO checklist and briefings.	Medium/Low		Director of Operations			Aug-21		In progress	July 2021 - No further update provided	There was no evidence to suggest the operating theatre department have drawn on the expertise of the communications team to promote to staff the benefits of using the WHO checklist and briefings. However, discussions with staff at Princess of Wales Hospital as part of our 2020 work found that compliance with the WHO checklist has improved and prelist briefings are regularly completed. Compliance with post list briefings could be further improved, however the team is confident that where an adverse incident has occurred a post list briefing is completed and are committed to continue to improve coverage in this area and improve learning. March 2021 Update - Nothing for report further at this point. May 2021 Update - Nothing for report further at this point formally. In terms of assurance, the issue has been discussed at at leasst one of the Performance Meeting with the COO and the ILG and assurance was received.
OPT FUP ABMU 06	Dec-20	Carry out further work to understand and manage down the high sickness absence rate in theatres.	Medium/Low		Director of Operations			Aug-21		In Progress	July 2021 - No further update provided	Sickness levels remain of a concern. However, the local teams are aware and are monitoring this position routinely. COVID-19 is currently having an impact on these levels due to staff self-isolating and shielding, as well as vacancies. With the support of the local workforce business partners there is ongoing work to reduce sickness levels. We were informed that this is a mixture of short and long-term sickness which was being managed in accordance with the Health Boards Sickness Absence Policy. Ongoing focus will be needed in this area. March 2021 Update - ILGs work closely with their business partners in WOD to look at just this sort of issue. Further information around the numbers and the solutions (if it remains an issue) will be available in June 2021. Sickness levels across the UHB are improving post covid 19. May 2021 Update - No further progress to report this month.

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SA21P101	Jun-21	Targets and Milestones R1 During our 2021 Structured Assessment work we found that the Quarter 3-4 Plan did not set specific measurable targets and milestones. The Health Board should ensure annual plans identify clear targets and milestones and ensure effective reporting on progress, impact, and outcomes.	Medium/Low	The draft Plan set out the overarching targets for the year and work in quarter 1 will refine and set clear milestones by quarter. Scrutiny of the progress, impact and outcomes of the Plan will continue to be through the Planning, Performance and Finance committee	Director of Strategy & Transformation	Director of Strategy & Transformation	Jul-21			Completed	July 2021 Update - A presentation on the revised Annual Plan for 2021/22 was made to the Planning, Performance and Finance (PPF) Committee on the 22nd June that prior to its submission to Welsh Government at the end of June. The Plan is due to be formally approved by the Board on the 29th July. The Plan included key deliverables at the end of each of the nine chapters including Quality and Improvement and Healthcare Reset and Recovery. Performance against these deliverables will be monitored in forthcoming PPF meetings. Also being presented at the October and December meetings will be progress on the development of the 2022-25 Integrated Medium Term Plan which is expected to be submitted to Welsh Government in January 2022 although we await guidance confirming this.	
SA21P102	Jun-21	Independent Member scrutiny of delivery of operational plans R2 During our 2021 Structured Assessment work we found no scrutiny of the delivery of the quarterly plans by the Board or its committees. The Health Board should clarify responsibility for oversight at a strategic level for monitoring delivery of the 2021-22 Annual Plan.	Medium/Low	The Planning, Performance and Finance committee, remains the key committee for overseeing the development and monitoring delivery at a strategic level of the Annual Plan 2021/22. Formal quarterly scrutiny of delivery against the milestones (R1) will be built in to the forward work programme of the committee, commencing following approval of the Plan	Director of Strategy & Transformation	Director of Strategy & Transformation	Completed			Completed		